

BULLETIN

Pierce County Medical Society



January, 2001

The 2000 Annual Meeting



Charles Weatherby, MD
passes the gavel and
PCMS Presidency to
Patrice Stevenson, MD

Patrice Stevenson, MD
introduces Don Mott, MD
recipient of the 2000
Community Service Award



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

The Bulletin is dedicated to the art, science and
 delivery of medicine and the betterment of the
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Managing Editor: Sue Asher

Editorial Committee: MBI Board of Directors

Advertising Representative: Kristi Brittain
 Subscriptions: \$50 per year, \$5 per issue

Make all checks payable to: **MBI**
 223 Tacoma Avenue South, Tacoma WA 98402
 Phone: 253-572-3666; Physicians call 572-3667
 FAX 253-572-2470

E-mail address: pcmswa@pcmswa.org
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2000 Annual Meeting – a rockin’ good time

The 2000 Annual Meeting brought the Sheraton Ballroom to life when the Allen A.M.E. Church Gospel Choir sang under the direction of Victoria Woodards and Willard Loggins. Performing during the social hour and dinner was the Tacoma Youth Symphony Quintet.

President **Charles Weatherby, MD**, conducted the meeting, introducing the musical performers and asking for a moment of silence in honor of colleagues that died last year. They included **Drs. Ali Sarrafan, Dumont Staatz, Charles McGill, R.A. Norton, Marlene Lazarus and Keltie Burt, Robert Truckey and Charles Denzler.**

This year’s raffle winners were Doug Jackman, Executive Director and **Dr. John Rowlands. Bill Ritchie, MD** won the raffle for the fruit to be delivered each month to his home.

Highlighting the evening was the presentation of the Community Service Award to **Donald H. Mott, MD**, Puyallup orthopedist. Colleague and President-Elect Patrice Stevenson, MD introduced Dr. Mott after reviewing his endless resume of community accomplishments. (See story page 5) A brief video was shown highlighting his dedication and commitment to the new Children’s Therapy Center, “The Ark,” in Puyallup.

Dr. Weatherby turned over the gavel and introduced the new PCMS President, Dr. Patrice Stevenson, physical medicine and rehab physician at Good Samaritan Hospital. Dr. Stevenson thanked Dr. Weatherby and outgoing board members **Drs. Lawrence A. Larson, Doris Page and Ted Walkley**, prior to welcoming new Trustees **Drs. Ken Feucht, Steve Duncan and Sumner Schoenike.** (see page 10)

Prior to adjourning the meeting Dr. Stevenson announced that Sue Asher had been named as Executive Director to replace Doug Jackman who was retiring January 1, 2001. ■



PCMS Vice-President Jim Rooks, MD (left) visits with Reverend Joseph Nixon, Pastor of Allen A.M.E. Church. Rev. Nixon gave the invocation



Vern Larson, MD, retired radiologist and his wife Kit, visit with friends during the social hour



Left, Don Mott, MD, winner of the Community Service award visits with Pat Duffy, MD Sumner family physician and his wife, Susie. Dr. Duffy was president in 1984



From left, Dr. Rose-Marie Colombini and husband Rob; David Law, MD and wife, Bev; Marge Ritchie and husband Bill Ritchie, MD. Drs. Ritchie & Law are both past-presidents

More photos page 4



Bill Ritchie, MD, receives congratulations from Dr. Weatherby for winning the raffle for fruit to be delivered to his home monthly. Dr. Ritchie is an ENT physician in Tacoma and served as PCMS President in 1989. He currently chairs the L&I Committee



Doug Jackman, recently retired Executive Director won one of the gourmet raffle baskets. This was his last annual meeting, after attending every one since 1983. He surrenders his ticket to Laura Yu-Blumenthal, daughter of Amy Yu, MD



From left, Drs. Ken Feucht and David Judish, general surgeon and physical medicine & rehab respectively. Both practice in Puyallup. Dr. Feucht was just elected to the 2001 Board of Trustees and Dr. Judish serves on the L&I Committee



The Allen A.M.E. gospel choir were excellent performers and really woke up the crowd at the Sheraton Ballroom. The 45 member choir is well known and performs continuously throughout the year.



From left, outgoing President Charles Weatherby and his wife Shauna with Past-President Larry Larson, DO. Dr. Larson will be stepping down after seven years on the Board of Trustees



From left, Dr. Larry Larson visits with Dr. Rose-Marie Colombini and her husband Rob. Dr. Comombini is a family practitioner in Puyallup

2000 Community Service Award

Donald H. Mott, MD recognized for community service

Editor's note: The following is the introduction of Donald Mott, MD, given by his colleague, Patrice Stevenson, MD, PCMS President, when awarding him the 2000 PCMS Community Service Award at the December Annual Meeting

Dr. Mott began his private practice in Puyallup in 1973 after completion of his residency in orthopedic surgery at the University of Utah. He graduated from the University of Washington Medical School in 1966 and interned at Maine Medical Center and Highland Alameda County Hospital followed by a two-year stint in the U.S. Air Force.

For the past 27 years he has served his patients, his profession, his church and his community with great distinction and humility. Good Samaritan Hospital and its medical staff, the Rotary Club of Puyallup, the Puyallup Valley YMCA and the World Association of Children and Parents are some of the organizations that have benefited from his work. His selfless and untiring efforts on behalf of these constituencies have resulted in his accumulation of numerous awards and much well deserved recognition.

He is a distinguished member of the Academy of Orthopedic Surgeons and is a nominee for the Academy's 2001 Humanitarian Award. He is widely regarded as a consultant and presenter by his colleagues in the Pacific Northwest and across the nation for his competency in orthopedic surgery.

He has served in every governing capacity at the professional and institutional level while on the medical staff at Good Samaritan Hospital. He is widely regarded as a leader and a devoted advocate for providing the best health-care possible during his service to Good Samaritan.

His commitment to the World Association of Children and Parents now spans several years and includes many trips at his own expense to Louyang City in Henan Province in the People's

Republic of China to provide care and treatment to children at the new Children's Rehabilitation Center that he was instrumental in opening. As part of his mission in China he has recruited therapists, physicians, and other healthcare providers to become members of treatment teams who accompanied him to Louyang City. He has been referred to by one of the children he was treating as, "the big American Grandpa."

At Good Samaritan he has treated children in the Children's Therapy Unit for more than 25 years in clinics twice a month donating his time to those children whose families were unable to pay for his services. His dedication to children with disabilities has most recently been demonstrated by his leadership role in the construction of a new Children's Therapy Unit facility "the Ark." He led a team of 25 volunteers in raising more than \$8 million in a capital campaign for this project. This 44,000 square foot facility will provide space for treating more than 800 children per week. He was the driving force from start to finish, arranging the acquisition of the 10-acre site, giving and getting more than \$4.5 million for the campaign, arranging a \$500,000 grant from the Kresge Foundation and overall spearheading a project that has literally changed the face and culture at Good Sam. Finally, he was the primary founder and currently is the Chairman of the newly organized Good Samaritan Foundation.

These acts have been recognized by the hospital board's decision to name the new Children's Therapy Center for Dr. Mott and his wife

Barrie.

I have been doing a Team Clinic with Dr. Mott monthly for over seven years and have learned a lot from him both on technical aspects of orthopedics and even more from his seasoned



Donald H. Mott, MD gave his thanks for the recognition and honor

observations on the politics of healthcare. We used to do our clinic in cramped quarters and examine kids on the coffee table in the director's office. In the new facility we have a nice clinic with a real mat and x-ray box. I was noticing that the x-ray box seemed a bit high on the wall as I could barely reach the 'on' switch. Since Dr. Mott is 6'6" this is just right for him. I was describing this situation to my colleague, Dr. Judish, whose appropriate reply was "well, they didn't name the building after YOU did they?!?!?" Enough said.

It is with great pleasure that I present the 2000 PCMS Community Service award to Dr. Donald H. Mott. ■

Legislative priorities of WSMA

With the 2001 Legislative Session coming soon, the WSMA is busy preparing their annual agenda. The agenda is based on organizational priorities and action taken at the annual meeting in September. Priority items include:

- Adequate funding for public health programs and physician practices
- Opposition to other health care groups' perennial attempts to intrude into the scope of practice of physicians
- Supporting the Liability Reform Coalition (LRC) agenda and introducing, if necessary, separate tort legislation germane to the medical profession.
- Opposing legislatively mandated sharps protections as unnecessary due to WISHA workplace regulations
- Aggressively fighting efforts to further fraud and abuse legislation in our state
- Preserve funds from Tobacco Settlement for tobacco prevention/control

The agenda will be adjusted as the legislative session nears. The WSMA expects to review over 2,000 pieces of legislation and will be actively engaged in several hundred bills as part of their work to represent physician interests.

Mark your calendar for the WSMA Legislative Summit on Tuesday, January 23. (see adjacent article) ■

WSMA Legislative Summit Tuesday, January 23 in Olympia

The annual WSMA Legislative Summit will be held on Tuesday, January 23 at the West Coast Olympia Hotel in Olympia.

Activities will include discussions with Governor Gary Locke, DSHS Secretary Dennis Braddock, Insurance Commissioner Mike Kreidler and L&I Director Gary Moore.

During the lunch session, WSMA will present their legislative priorities for the session, as well as offer talking points and tips on how best to influence your own senators and representatives.

Afternoon activities will include physicians meeting with their own legislators as well as the following sessions:

- ◆ House Health Care Committee Hearing (as well as other hearings)
- ◆ "New to the Process," A learning experience about the Legislature
- ◆ Guided Tour of the Legislative Campus
- ◆ Meetings with Executive Branch leaders



There is no charge for WSMA members to attend the Legislative Summit. Please call PCMS, 572-3667 for a registration form or you may call Patti Smith at the WSMA 1-800-552-0612 for more information. ■



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Tuesday, February 13, 2001

Social Hour: 6:00 pm
Dinner: 6:45 pm
Program: 7:45 pm

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David Roskoph, MBA, CFP

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FOR HER SUPPORT OF MEDICAL ISSUES
DURING HER TENURE IN THE WASHINGTON STATE LEGISLATURE

(Register by February 8. Return form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667)

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

Enclosed is my check for \$ _____ or my credit card # is _____

Visa Master Card Expiration Date _____ Signature _____

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

Signed: _____

Holiday Sharing Card raises over \$15,000 for PCMS Foundation with over 200 contributors

A hearty thank you to members for generously supporting the Holiday Sharing Card 2000. The PCMS Foundation, formed earlier this year to continue the philanthropic work of the disbanded Alliance, raised over \$15,000 in contributions from the Holiday Sharing Card. The holiday greeting 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. Over 200 contributions were made by physicians and/or their families.

And, a very big thank you must go to the volunteers who helped with all the work that accompanies such a project, particularly the preparation for mailing: **Nikki Crowley, Mona Baghdadi, Patty Kesling, Helen Whitney, Mary Lou Jones, Cindy Anderson, Sharon Ann Lawson, Mary Cordova, Yolanda Bruce, Alice Wilhyde and Jim Crowley.**

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

**Gerald W. Bissonette, MD
Dr. John E. Bruce & Mrs. Yolanda Sullivan-Bruce
Mick & Lavonne Campbell
Stephen Elder
Stephanie F. Hoefle, MD
David Judish, MD
David & Bev Law
James L. Patterson, MD**

**Charles Prewitt, MD
Bill & Marge Ritchie
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William Shields, MD
Dr. & Mrs. Thomas H. Skrinar
Janice Strom, MD
George & Kimi Tanbara
Dan A. Wiklund, MD**

Physicians needed for Guatemala trip

February trip being planned to care for abandoned, reformatory boys

On February 17th, 2001 for the eighth time in the last five years, I will be returning to Guatemala for one week. The purpose of this trip is to take a team of medical and health care practitioners to provide practical and immediate care to a group of 150 adolescents in a reformatory located near Guatemala City, as well as a primitive secluded village located in the mountains in the area of Zacapa.

The group in the reformatory does not receive any dental or medical care while serving their sentence. Further-

more, most of these young men are street boys who were abandoned or rejected by their own parents and relatives. Some of these boys are in detention not because of crimes but because they do not have a home to go to. Some of these children have been lured to the streets by vices such as inhaling paint thinner, glue, marijuana, and commercial solvents that are extremely damaging to the human body. Every time I have asked any of them the reason they use such harmful chemicals, their answer is the same, "so I don't feel pain." The pain they refer to is both emotional and physical. I believe that an act of love by anybody that is willing to touch these more than unfortunate kids can make a change in their life and destiny.

Would anyone reading this be interested in traveling to Guatemala to help these children who have been robbed of their humanity? Expenses and contributions are tax deductible. Not only will you make a difference in the lives of souls that are hurting, you will also be changed by what you see and experience.

If you wish to be called to this extraordinary adventure, please contact: Pastor Carlos Arroyo at, pager: (253) 383-0365, home: (253) 857-5150, or email praisecres@integrityol.com ■

MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Health Department offers new 'Child Care Consultant' program



Regular readers of this column know that the Tacoma-Pierce County Health Department looks for ways to prevent those things which create illness, injury or death. We take seriously the community's trust in us to



Federico
Cruz-Uribe, MD

thwart communicable diseases, foil pathogens carried on improperly-handled foods, and discern new approaches for improv-

ing drinking water. In addition, TPCHD staff examine and seal children's teeth, inspect homes and educate families about asthma prevention, educate children and adults on avoiding tobacco use, and recommend safer play equipment.

A relatively new program at the Health Department integrates all of these things. A Public Health Nurse anchors The Child Care Consultant Program. The nurse coordinates skilled professionals from Communicable Disease Control, Food and Community Safety and Source Protection (environmental health) to "improve and sustain the health and safety of the people in Pierce County with emphasis on children in child care centers, their families and communities through health promotion and injury prevention."

In Pierce County there are approximately 900 child care centers and family home providers, serving 50,000 children. Many operators of these facilities recognize that information or technical assistance from the Health Department can help to prevent injuries and illness among the children at the centers. The Nurse Consultant Program assists those centers by providing, at the request of the center:

- ◆ Child care infant nurse consultation
- ◆ Health and safety conferencing, resources, and referrals
- ◆ Educational opportunities
- ◆ Advocates for consistent interpretation of regulations at all levels of government
- ◆ Private sector child care nurse consultant consultation
- ◆ Assistance for children with special health care needs

Education offerings for child care providers, offered by TPCHD staff, include the following:

- ◆ Preventing Shaken Baby Syndrome and other abuse/neglect issues
- ◆ Stress Management and Health Issues for Child Care Employees

- ◆ Caring for your Septic System, Safe Well Water, and other environmental health issues
- ◆ Child Growth and Development Issues, including positive discipline, brain development, infant stimulation, parenting, age appropriate milestones, age appropriate activities
- ◆ Children's Health, including assessing ill children, medication management, communicable diseases, childhood diseases, dental care, immunizations and nutrition
- ◆ Infection Control, including bloodborne pathogens, HIV/AIDS, TB, handwashing, lice prevention and control, sanitation and safe food handling
- ◆ Injury Prevention and Safety Issues, including playground safety, indoor safety, bike helmets and car seats

Your patients may indicate concerns about their child's day care center, or as an operator ask about ways to advance the health of those in their care. Please feel free to contact TPCHD's Child Care Nurse Consultant, Sue Biles, RN, at (253) 798-6487, with those concerns or to ask for more information on this unique program. ■

New Board of Trustees will lead PCMS in 2001



From top left, counter-clockwise, Drs. Patrice Stevenson, Susan Salo, Charles Weatherby, James Rooks and Michael Kelly; Sumner Schoenike, Kevin Gandhi, Kenneth Feucht, Stephen Duncan, Drew Deutsch and Sabrina Benjamin

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

Susan Salo, MD (President-Elect) is a family practitioner with Group Health in Tacoma. She earned her medical degree from the University of Washington School of Medicine and has practiced in Tacoma for 25 years. She lives with her husband, Robert, in Puyallup.

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

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

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

The Board determines policies and transacts business on behalf of the Society as well as manages and conducts all their property, affairs, work and activities. They meet on the first Tuesday of each month except July and August.

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

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

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

Kenneth Feucht, MD, Ph.D. is a Puyallup general surgeon. He graduated from the Oregon Health Sciences University of Medicine and completed a fellowship at the University of Illinois in surgical oncology. He lives in Puyallup with his wife, Betsy.

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

Sumner Schoenike, MD, MPH is a Lakewood pediatrician. He graduated from Baylor College of Medicine in Houston. He completed a fellowship in psychiatry at Oregon State Hospital and received his MPH from the University of Texas School of Public Health. He lives with his wife, Jan, in Gig Harbor.

The Board of Trustees is comprised of the President, Vice President, Past-President, Secretary/Treasurer, President-Elect and six trustees.

In My Opinion....

David Roskoph, MBA, CFP

Did the Federal Reserve Actually Create That Bubble?

In the rearview mirror, trillions of dollars have just evaporated. Gone. I spend the better part of each day in the often-frustrating pursuit of understanding financial markets and have been beside myself trying to explain the



David Roskoph, MBA, CFP

unusual behavior of US equity markets since late summer of 1998. After exhausting every academic rationale, all that remains is a curious irreverent conclusion.

It involves the most respected quasi-public, quasi-private institution on earth, the Federal Reserve Bank (FRB or Fed).

In the fall of 1998 a funny thing happened on the way to the Federal Reserve meetings. Arguably, things were fine in this great union of ours but Asia, the Soviet Union and Brazil were experiencing financial difficulty. As US markets roiled from the *potential* impact of external factors, the FRB dramatically cut interest rates three times; two separate cuts occurred on the same day! All things being equal, when interest rates get cut, equities go on sale and US equity markets took off (chart 1), or did they? At that crucial intersection, a divergence emerged as the highflying tech companies powered on to ridiculous valuations (both those with/without earnings) while the average equity began a steady decent. In addition to dramatically cutting interest rates, the Fed pumped up the money supply. Although almost everyone considered Y2K a non-

event, the Fed was so unsettled that they kept the printing press on 24/7 to guard against money being stockpiled into mattresses. Equity prices follow the money supply (chart 2) and by early 2000 we were awash in a sea of paper money. It made the Fed seem hopelessly out of touch, but was it? While the bubble inflated, Al Greenspan assured his critics that the "asset bubbles could only be recognized in the rearview mirror." Remember that in addition to affecting interest rates and the money supply, speculative excesses could have easily been tempered by raising margin requirements. Margin borrowing had skyrocketed and was a sure sign of speculation. This was never even seriously considered.

Also in the fall of 1998, a tidal wave of innovation was building worldwide with the potential to dilute the US concentration. No one was sure of how the new technology would alter the economy or who the eventual market leaders would be. Therefore, precise financing was impossible and the global financials were high. In my opinion, the Fed indirectly financed the technological renaissance by finding any excuse to

pour money into the economy. The deluge averted a small recession by flooding all companies with financing, tankers and dinghies alike. Alan Greenspan went from repeatedly



Chart 1



Chart 2

calling the markets "irrational" to now standing in awe of their "immeasurable" new efficiencies. In the fall of 1998 the Fed went from its historical role as lender-of-last-resort to the opposite end of the spectrum now functioning as

See "Bubble" page 12

Bubble from page 11

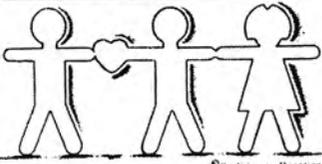
investment banker for the United States. Its role reversal exacerbated, if not created this asset bubble.

The bubble is now deflating in time to compound the recession postponed since the fall of 1998. Except now the circumstances point to a much more protracted slowdown of over one year.

Exposing the fragility of financial markets for the last year has not been the most popular position because no one really wants his or her hopes diminished. Most *vested interests* on Wall Street promote going with the crowd, buying every dip and the certainty of higher valuations. As an independent financial advisor, who has questioned such hype for decades, I feel responsible to expose the efficiency with which such *vested interests* have separated investors from their hard-earned capital for centuries. Whether a fad involves weight control or an investment scheme, the results are usually unsustainable. Appreciating risk when establishing a plan and sticking to it will always beat chasing the crowd. ■

David Roskoph is an independent, fee-based investment advisor and Certified Financial Planner in Gig Harbor.

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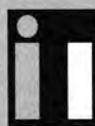
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The Sacred Cow is the Secret of the Hindoo The Dolly Llama

Traveling recently through India, my wife and I were baptized by a rickshaw ride in Delhi. We had our own personal teenage beggar girl with baby, who followed us for about three



Nichol Iverson, MD

miles through the muck, cows, people, cars, smoke, Holy Hawkers and vendors, cows,

lepers, bicycles, smoking motorcycles, and cows. I still don't understand the dairy industry in India; farmers chase those stupid cows all over the place! These sacred animals frequent the freeways, side streets, front doors, and temples, but I know the meaning of sacred cow is no bull. It is the secret of Hindoo. The smell! Stick your head into a septic tank, add diesel smoke, sprinkle traces of every known excrement on the planet, and then add a pinch of curry. Instant enlightenment. Indians sit around meditating so that they don't have to breathe. Incense was invented to mask this odor.

India has given me a gnu perspective on life and medicine. While visiting a hospital in southern India, I was able to see medicine practiced in a manner much better than my preconceived idea. Puttaparthi, a small town north of Bangalore, has a fully equipped hospital capable of complicated cardiovascular surgery, emergency cardiac angioplasty with stent placement, and pediatric urological

surgery. The physicians there also have maintained the true values of treating patients with kindness and respect. This hospital has the support of Sai Baba, considered the man of miracles by many Indians, and more than a handful of Californians. As my wife and I traveled into some villages well off the beaten path, we were privileged to meet with some enlightened teachers. We did also see a couple of teachers who transcended enlightenment.

Where shoes are a luxury, and adequate amounts of food and water are predicated upon the whims of monsoons, droughts, bugs and disease, there were an unusually high percentage of villagers who were smiling. One wonders who are the rich people?

For the truly daft or adventurous types, I suggest on YOUR next visit to India, a Yagya. We sat through this four-hour ceremony, dedicated to Lakshme, goddess of prosperity, and Ganesha, the god who removes obstacles. The priests tossed in about 57,411 flowers and 17 barrels of holy oil into several fires to amuse and appease these deities. I had to wear a Dhوتي. Take a translucent piece of muslin 57 feet long and 3 feet wide. Wrap it around your waist, and tie a knot. Tight. Leave a three-foot length on one end that you stick between your legs, and tuck into your waistband in the rear.

The remaining length is folded in many 3-inch pleats, then tucked in the front to cover certain parts. Voila! A wedgy! Since I was eating Vegan, the strict

vegetarian diet remanded me to the men's room, where I stared bleakly at the Indian squat toilet, flush with the floor. Doing duty in a dhوتي is an enlightening experience. Try removing one of those things, standing barefoot in wet goo, and

“The common folk in India have a spiritual appreciation for life that puts us to shame”

attempting to get the stupid thing back on without letting any of it touch the slimy floor. Or losing your balance.

“Why go to India?” you query. India is home of Hindus, Jains, Buddhists, Moslems, Sikhs, the Dolly Llama, and Mr. Mosquito. America is a spiritual infant. The common folk in India have a spiritual appreciation for life that puts us to shame. Do I hear a SHAME and an AMEN? Poor Americans are independently wealthy by Indian standards. In “impoverished” villages, children and other people I met were smiling. Is it the dhotis? Nope. They have families who care for them as part of their culture. Returning from India one cannot escape the knowledge that the Materialism God runs our lives. At this time of the year, we need to reassess our priorities, and count our blessings. ■

Web Users Search for Medical Advice Most Often

More Americans surfing the Internet look for medical information than for sports scores, stock quotes or online-shopping bargains, said a group studying how the Internet affects people's lives.

An estimated 52 million Americans have used the Internet to gain knowledge about diseases and treatment, investigate how to participate in clinical trials and find low-fat recipes, the group said in a recently released report.

The report "illustrates perhaps the most profound and dramatic impact the Internet is having on Americans," Lee Rainie, director of The Pew Internet and American Life Project, said.

"In an era when the face time a patient gets with a doctor during an average appointment has dipped below 15 minutes, many are turning to the

Web to get the information they crave," he added.

Most people seeking health material online do so at least once a month. Most are looking for guidance about battling a specific disease that afflicts them or someone they know, said the report, based on surveys of more than 12,000 people.

About 55% of all Internet users said they had sought health information. That outranks activities such as online shopping, done by 47% of Internet users, the report said. About 41% of people polled said material found during their most recent online search affected decisions about whether they should go to the doctor, how to treat an illness or how to question a physician, the report said.

Nearly half of Internet users who have gone online for medical informa-

tion said advice found there improved how they care for themselves. The survey found that most people sought medical material through broad Internet searches and gleaned data from sites with which they weren't familiar, leading the authors to suggest that doctors help point patients to reliable information.

Only 9% of people using the Web for health information said they had exchanged e-mails with their doctors, and 10% said they had filled prescriptions or bought dietary supplements online.

Many were concerned about privacy on the Internet, with 63% opposed to keeping medical records online, even at a pass-word-protected site, because of fear that others might see the information. ■

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COLLEGE OF MEDICAL EDUCATION

Women's Medicine CME date to change

The College's CME program, *Advances in Women's Medicine*, will likely be postponed from its previously scheduled February 9th date. Dates in May, possibly May 18th are being considered.

The one-day program addresses a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this CME program features issues related to diagnosis and treatment advances in treating illnesses in women. The program will be directed by **John Lenihan, MD.**

Whistler CME set for 1/24-28

The College's very popular CME in Whistler/Blackcomb still has room for participants. However, the College's reserved block of condos at Blackcomb's Aspen Lodge have all been reserved. The usual block and additional Aspen condos were booked prior to the December 1 deadline. Those still interested in other possible lodging should call individual facilities or a central toll free number, 1-800-WHISTLER. The course will be directed by **Drs. John Jiganti and Richard Tobin.**

Continuing Medical Education

Primary Care Cardiology CME set for evenings of January 9 & 16

The College's sixth annual program featuring subjects on cardiology for the primary care physician will be held at St. Joseph Hospital, Lagerquist Conference Center Rooms 1A & B. The course will be directed by **Gregg Ostergren, DO.**

This year's Cardiology for Primary Care CME program will be offered on two consecutive Tuesday evenings in January, instead of the traditional 6-hour program on a Friday. This year's program is scheduled for Tuesday, January 9th and Tuesday, January 16th from 6:00 pm to 9:00 pm on both nights.

The program will begin with

speakers on the 9th, three hours of CME and end with three additional hours of CME on the 16th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include Genetics & Hyperlipidemia; ACE/ARB Combination; Are Beta Blockers Underutilized?; New Strategy in Treating Hypertension; Optimizing Inpatient Outcomes; Women's Cardiology; Evaluation, Diagnosis and Management, and Lipid Intervention for Primary and Secondary Prevention of CAC. ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Tuesdays, January 9 and 16 (evenings)	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 24-28	CME at Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 9	Advances in Women's Medicine	John Lenihan, Jr., MD
TBA	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesdays, May 16 and 23 (evenings)	Medical Technology	TBA

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Medical School: Spartan Health Sciences University
Residency: Niagara Falls Family Practice

Gill, Alan R., MD Family Practice

Practices at Tacoma Family Medicine, 521 Martin Luther King Jr Wy, Tacoma 98405; 403-2900
Medical School: Univ of Michigan
Residency: University of Missouri

Sun, Howard, MD Diagnostic Radiology

Practices at Tacoma Radiology, 3402 South 18th, Tacoma 98405; 383-1099
Medical School: University of Illinois College of Medicine
Internship: Swedish Hospital
Residency: University of Washington
Fellowship: University of Washington

Directory changes

Please make note of the following changes to your 2000 PCMS Directory.

Kenneth Feucht, MD

Change address to:
1408 Third Street SE #150
Puyallup, 98372-3703
Phone: 841-9640 Fax: 841-7645

Douglas King, MD

Change address to:
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Puyallup, 98372-3703
Phone: 841-9640 Fax: 841-7645

Douglas Hassan, MD

Tacoma address:
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Tacoma, 98405
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State budget cuts to further impact medical practices

Budget writers for the Office of Financial Management (OFM) are proposing a six percent cut in health related programs. The proposed cuts include significantly reducing or eliminating a number of health care programs for low-income Washington residents such as:

- \$30.5 million in reduced services to seniors due to eligibility changes
- \$7 million in reduced services to seniors from eliminating the chore services program
- \$13.4 million in reduced payments for prescription drugs
- \$2.9 million from eliminating dental care for adults on Medicaid
- \$20.4 million from eliminating coverage for the medically indigent
- \$50.7 million from reducing payments to Medicaid providers
- \$29.4 million from reducing payments to Medicaid providers under Healthy Options

NOW is the time to contact the Governor to remind him of the promises he made during his campaign to fight to keep the delivery system viable.

Please contact him by calling the Capitol Hotline at **1-800-562-6000** and leave a message for him or email him at www.governor.wa.gov/contact/govemail.htm expressing:

- Funding should be increased, not decreased for Medicaid and the Basic Health Plan
- Current programs are inadequately funded with Medicaid rates at one-half the commercial health plan average making it a real possibility that physician practices will not be able to continue providing care for these patients
- The state's programs will continue to deteriorate if left under-funded, and more people will seek care in emergency rooms

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BULLETIN

Pierce County Medical Society



February, 2001



John Rowlands, MD, left, thanked Doug Jackman, for 17 years of exemplary leadership as PCMS Executive Director.

Dr. Rowlands was PCMS President in 1996

See story and photos, page 7-9

The physicians of PDR -

Back row, from left, Drs. Cordell Bahn, Jim Komorous, Alan Tice, Belinda Rone, Mark Craddock, Pat Hogan, David Law; Front row, from left, Craig Rone and Ken Graham



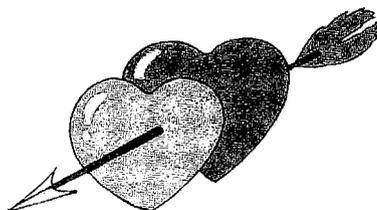
See their story, page 11

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-

Pierce County Medical Society BULLETIN

February, 2001



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

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

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President's Page

Patrice Stevenson, M.D.

The Year of Transition

Well, it's 8:25 p.m. and my first President's Page is due in less than twelve hours. I am a champion procrastinator who believes if it can't be done at the last minute it's not worth doing. When I commuted to PLU during finals week I'd hope to hit as many red lights as possible so I could cram in another paragraph while waiting for the light to change. I will get going before the next light change.

One of the most daunting tasks of the PCMS president is writing the monthly President's Page for the *Bulletin*. I will try to remember what I learned in junior high and high school journalism and hope for good editing from the executive director.

The incoming president is also asked to think about a theme for their presidential year. Some years this may be obvious as the pressing issues cry out for our attention and focus such as health care reform did in 1993 and as the trauma system had in recent years. Other years, absent a clear crisis, one can focus on a particular area of medical interest or social problems such as domestic violence or tobacco

cessation. Some years a path is chosen then mid-year an unexpected crisis diverts our attention such as the current Healthy Options situation. So what did I pick? I decided my theme would be "The Year of Transition." What does that mean? The year 2001 is an odyssey year, a year clearly in the New Millennium. It has the ring of infinite potential. The transitions for 2001 promise the excitement of a good challenge. Personal transitions include moving my office of fifteen years to a new space in Good Samaritan and figuring out what to do with the computer that will be waiting for me there.

The most important transition for PCMS will be the transition to the new leadership of our new executive director. It was with great regret that I accepted the task of chairing the Search Committee for the Society's new executive director knowing that Doug Jackman would leave before I started my term as president. Ignoring my husband's advice to abdicate, I enlisted the help of other Board of Trustees members **Sabrina Benjamin, Mike Kelly, David Law, Larry Larson**



Patrice Stevenson, MD
President

and Doris Page to help select Doug's successor. We had many qualified applicants but by far and away the best-qualified and most enthusiastic one was our own assistant executive director, Sue Asher. Sue and the Board recently met for the annual retreat and have a good work plan for the year. We intend to look at all aspects of PCMS to see if we need to change or improve what we do. We may retire some inactive committees and form new ones. We will strive to keep PCMS a valuable, cost-effective, membership-driven, professional association.

I welcome your thoughts, ideas and suggestions for ways to improve PCMS. You may contact me via the Society or by e-mail currently using athomepop@juno.com and after mid-March on the new computer on my new desk at stevopa@goodsamhealth.org. ■

Hello from New York

by Alan White, MD

Many of you, my colleagues in Tacoma, are not aware where I have ventured to. A little over two years ago I was recruited to take over the Directorship of the newly established Montefiore Institute for Minimally Invasive Surgery (MIMIS) of Albert Einstein College of Medicine. At that time it was a concept and several interviews and visits to New York, I declined the position. I was selected for this position based on my success with Jackie Doyle (Day Surgery of Tacoma) in establishing the MultiCare EndoSurgical Institute which apparently was noticed elsewhere in the US. Clearly MultiCare Medical Center was on the leading edge of bringing advance laparoscopic surgery to Tacoma and still is today through this institute.

A year ago the opportunity at Montefiore Medical Center once again was offered to me and I could not turn it down again. So, I left my surgical group and with a great deal of angst ventured to the Big Apple, starting here on April 1, 2000. In addition to becoming Director of MIMIS, I assumed Chief of Surgery position at Jack D. Weiler Hospital, the teaching hospital on the Albert Einstein College of Medicine campus.

What drew me here was the opportunity to teach advanced laparoscopic skills to newly training residents and fellows as well as to aid the other surgical subspecialties in their adoption of scope technology. There has truly been a revolution in surgery and "minimal access surgery" is becoming the norm and is bringing about marked improvements in care for patients.

Today, the Institute for Minimally Invasive Surgery at Montefiore is a reality. It consists of a skills training center with seven individual trainers to

teach basic laparoscopic skills and three computer-based virtual reality training devices that teach these same skills but allow us to change the degree of difficulty and allow us to measure the skills progression. In addition these devices allow us to measure ambidextrous skills as well as errors in the trainee. Also in the institute there are six animal operatories, totally state-of-the-art equipped with the newest camera equipment, etc. One of these facilities is teleconferenced to the 35 seat conference room. The conference room is teleconferenced to/from two patient operating rooms on each of our two hospital campuses. This allows for broadcast and interchange of ongoing procedures to the teaching facility. Finally, the facility is teleconferenced to the hospitals' auditoriums and to anywhere in the world that has a polycomm link. Currently, we are trying to establish a tele-medicine link to a university hospital and four rural hospitals in India to demonstrate the ability to have an internationally linked teaching modality. These are interesting times, professionally.



Alan White, MD

From a lifestyle standpoint, New York is just like Tacoma, only bigger!! Not true!! It is difficult to summarize the differences in a few words, so I won't try today. Suffice it to say, New York is exciting and entertaining at a minimum. Maybe I'll follow this note to the *PCMS Bulletin* with a follow-up in this regard.

If you find yourself in New York or come to visit, please call. I would love to show each and every one of you our training facility and show you what drew me here.

I can be reached at: Montefiore Institute of Minimally Invasive Surgery, Hofheimer - 2nd Floor, 111 East 210th Street, Bronx, NY 10467, 718-920-5182, e-mail: awhite@montefiore.org, fax: 718-994-3367. ■

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2001...The Odyssey Continues

A Report on the 2001 PCMS Board Retreat

by Jean Borst

The peaceful Commencement Bay setting of C. I. Shenanigan's was a bit in contrast with the issues facing physicians in the coming year and beyond. As the Pierce County Medical Society Board of Trustees came together January 6 for their annual retreat, it was obvious that the road ahead will continue to be a complex and challenging odyssey.

Hearing from a variety of sources – insurance companies, academia, WSMA, and physician groups – the Board received a broad overview of what is going on now and what is to come.

Relationship Issues: Health Plans/Physicians/Hospitals/Groups

"We don't want Band-Aid your problems, we want to find out what the problem is and fix it." As Physician Ombudsman for Regence BlueShield, Dr. Larry Donohue's role is to investigate reported complaints, report findings and help achieve equitable settlements. In addition to sharing some of the examples of the work he is currently doing, Dr. Donohue expressed his desire for a continued positive working relationship with PCMS membership. "I believe we have a good appeals process," he said, "and I encourage you to continue using it. Every complaint is an opportunity for improvement."

Board members voiced a particular concern to Dr. Donohue over what the group termed, "referral rage." While referrals from primary care physicians to specialists are rarely denied, physicians are still required to take the time and effort to make them. Doctors feel they are always in the position of "asking permission," and believe the process is pitting specialists against primary care physicians, slowing down

medical care, and wasting person power. In some cases, it could actually make a difference in providing timely care to a patient.

Referring to himself as a physician first and an administrator second, Dr. Donohue assured the Board that he will act as an advocate for physicians. "As a doctor," he said, "I understand your position and offer this pledge: I will never intentionally mislead you; I pledge that you will be paid to contract terms; I cannot negotiate reimbursement rates; and I will accurately interpret your issues to our leadership."

WSMA Issues and Legislative Priorities for 2001

"For years, our legislative agenda has been focused primarily on one thing" according to WSMA President Nancy Auer, MD, "access to health care services for the citizens of Washington State, and we have promoted that vigorously." However, escalating malpractice claims and a large exodus of physicians no longer able to afford to stay in practice in Washington State has prompted WSMA to shift its approach. "Citizens are mad about health care," Dr. Auer stated, and are expressing their disdain through malpractice claims. In response, WSMA and Physicians Insurance have funded CURE (Citizens United for Reform); a coalition of more than 1,000 patients and several thousand Washington State doctors that last year helped pass the Patients' Bill of Rights. The group is now fighting to get the state Legislature to adequately fund the state's health programs, so that practices and clinics stay open for all patients in every community. This year, the Washington State Medical Education and Research Foundation (WSM-ERF) retained the University of Washington and Wash-

ington State University to conduct an in-depth study of Washington's health care system. The results were not encouraging:

- Funding for state health programs is inadequate to match the programs' eligibility or demand
- Medicare payments in this state ranked 5th from the bottom nationally. Between 1998 and 1999, Medicare payments in Washington experienced the 6th fastest decline of all states
- Premiums for commercial health insurance continue to climb while payment to physicians continues to fall

"If funding problems are not solved," Auer noted, "the ramifications will be serious." Most notably, the following trends can be expected:

- More people will be forced to change physicians or health plans on a regular basis
- More people will seek care in hospital emergency rooms
- There will be longer waits for certain types of care and to see certain types of physicians
- Jobs and the tax base of communities will be threatened
- Chronic underfunding of state health care programs will result in increased costs for businesses and employees.

As a result, WSMA's greatest focus during the upcoming legislative session will be on the budget. "We will be challenging the governor to walk the talk based on what was discussed during the campaign," noted WSMA Executive Director Tom Curry. "It's going to be a tough, tough battle. We know the delivery system is in jeopardy, and we know there are huge economic prob-

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lems with the budget.”

University of Washington Medical School/UWPN Clinics Update

Two years after attending his last PCMS Board retreat, **John Coombs, MD**, UW School of Medicine Associate Dean, returned this year with an update on the UW School of Medicine and the Physicians Network Clinics.

The UWSOM, now considered an “academic medical center” offering education, research and clinical care, currently has 759 medical students, 155 physician assistant students, and 444 Ph.D. students. The school has been a leader and innovator in technology and research, and is now the largest combined cancer research program in the nation. A recent, major curriculum review (the first conducted at the school in 30 years) indicated that the school “does not require a major overhaul,” and that the school’s overall focus will be to “prepare physicians for lifelong learning.” There are plans to divide the school into five colleges, Dr. Coombs noted, and additional expansion and enhancement are being discussed.

Dr. Coombs said 55 percent of UWSOM graduates are practicing medicine in the five-state-area known as WWAMI – Wyoming, Washington, Alaska, Montana and Idaho. This combined area makes up 27 percent of the total US landmass and 3.3 percent of the US population – 55 percent of who live in rural communities. The predominant providers in rural communities are primary care physicians.

A current shortage of specialists (and foreseeable increased shortages) in the WWAMI region, is a concern. Dr. Coombs anticipates a large number of positions available in anesthesiology, diagnostic radiology, nephrology and neurology. “There are areas experiencing significant shortages of these specialists,” he said. “In some communities, the shortages are severe.”

There are various issues affecting graduate medical education at present, Dr. Coombs explained. “In addition to the affects of the Balanced Budget Act of 1997,” he noted, “other factors are significantly restraining our ability to train people.” He explained that rules have changed regarding what a resident can and cannot do with direct supervision; clinical service demands have increased; there have been strategic realignments in community clinics; and accreditation changes have been made. “In terms of organization, quality and finances,” Dr. Coombs said, “we are in real significant period of change.”

In its fourth year of operation, the University of Washington Physicians Clinics system now consists of nine sites staffed by 64 physicians, six physician assistants and two nurse practitioners. Last year, 167,000 patient visits were reported, and 75,000 patients are currently under care. Dr. Coombs listed various issues directly affecting the clinic system, including specialty referrals; finances (“With current reimbursement rates, it’s hard for clinics to break even.”), payer mix; staffing (“The tight labor market makes it difficult to keep clinics fully staffed.”) and integration of students and residents. For more information on the clinics, Dr. Coombs invited members to visit the website: uwphysicians.org/where.html

Contracting, Employment and Relationship Trends:

A panel discussion featuring Rebecca Sullivan, MD, Puyallup Valley Healthcare (PVH); Cliff Robertson, MD, Franciscan Medical Group (FMG); Pat Briggs, Northwest Physicians Network (NPN); and Smokey Stover, MD, MultiCare Medical Group (MMG)

Noting recent developments, current activity and foreseeable trends, representatives from four major physician groups in Pierce County offered

their thoughts and opinions to the PCMS Board. While they all brought a unique perspective to the table, all were in agreement that not only is managed care here to stay, but Washington state will experience a significant resurgence in the next few years.

Rebecca Sullivan, MD: “No Big Surprises Here...”

Admitting that the information she was presenting was likely nothing new to PCMS physicians, PVH’s **Dr. Rebecca Sullivan** offered various national trends in regard to the state of physicians’ practices. The consensus?

Productivity is increasing while salaries are not keeping up with inflation; overhead is on the rise; national managed care is experiencing significant growth and more physicians are taking disability or early retirement than ever before.

Playing the role of soothsayer, Dr. Sullivan offered “Becky’s Crystal Ball,” her “predictions” for the future:

1. Premiums will increase
2. Reimbursements will remain flat or increase only slightly
3. There will be a shift away from tight referral management. “The public doesn’t like it, and it’s not clear that it saves money”
4. There will be a blurring of lines between HMO and PPO (for the same reasons expressed in item 3)
5. There will be a declining number of primary care residents. Reimbursements have had a greater percent change on the income of primary care physicians than on specialists, and referral management has hit primary care hardest
6. Physicians will increasingly refuse to take the lower paying plans (government-sponsored programs).
7. Employers are beginning to look at defined contribution instead of defined benefit, which could cause enormous changes in how health care is

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Special Feature

by Doug Jackman

Thank You for a Very Enjoyable Seventeen Years

The environment of medicine and Pierce County Medical Society have changed considerably since I attended my first PCMS Executive Committee meeting in December, 1983. The medical director was about the only physician employed by hospitals at the time. The major insurer in the county was the Pierce County Medical Bureau with nearly half of its board consisting of physicians. That is not the case today. In an effort to control double-digit health care costs, Medicare adopted DRG's in mid-1984. Today, Medicare is asking its beneficiaries to report any suspected fraud and abuse by the physician or health care provider.

It was at that Executive Committee meeting that a conference call was made to the Society's legal counsel to determine how the organization should respond to an application for membership by an individual that had twice been denied membership. It started a three-year process concluding in federal court with a summary dismissal of the case. The judge ruled that the applicant had misrepresented himself and the facts in his application. Not once did the members of the Credentials Committee or the Board of Trustees consider amending their decision despite the threat of treble damages if we lost the antitrust suit. Needless to say, such a loss would have bankrupted the Society.

Shortly after that meeting I thought I might as well start reading the "help wanted" ads when I realized I was going to be more than 30 minutes late for my first meeting with the new PCMS President. **Dr. Pat Duffy**, Sumner Family Physician, was to meet with Tom Curry, my predecessor, and me in the Good Samaritan Hospital Cafeteria. This was my first week on the job and I

did not really know a thing about the Society or the issues of interest to the members. Tom and I finally walked into the cafeteria about 7:45 a.m. and there was Pat with a big smile on his

face to greet us. With his abundance of patience and ready

wit, Pat managed to tolerate my lack of knowledge and the slow learning curve that first year. I have always appreciated his patience, kindness and sense of humor during that year. I also missed a lot of sleep in 1984, 85, 86, et al.

PCMS has always had a tremendous core of volunteers. It never took more than a few phone calls to recruit members for the numerous positions on committees, task forces and boards. During my tenure the Society never had a president or board member come to the office with a personal agenda or attempt to enhance their particular specialty, office or cause. They all had the best interests of the organization, medicine and the community at heart. All gave freely and graciously of their time devoted to the Society. The Presidents' and Secretary-Treasurers' were the individuals that required much time and interruptions from staff.

During 1984, PCMS spearheaded an effort to secure a county ordinance to control tobacco smoking in public places and in the workplace. PCMS had twelve members, led by Dr.

Duffy, testify before the county council on the harmful effects of second-hand smoke. The ordinance passed and was one of the first anti-smoking ordinances in the state.

"I can't recall many days when I did not look forward to going to the office or another meeting..... I owe a debt of thanks to so many in the Society that I can't mention all of them....."

In 1988, the Public Health/School Health (PH/SH) Committee, with President, **Bill**

Jackson, committee chair, **Terry Torgenrud**, and Alliance volunteers leading the way, secured 5,000 signatures to get the fluoridation of Tacoma's water supply on the ballot. The issue passed quite easily, but the opponents gathered signatures and had the issue placed on the 1989 ballot. The voters again passed the measure and Tacoma children have much better dental health as a result of PCMS efforts. Bill Jackson and I had occasion to meet with then Tacoma Mayor Doug Sutherland and he related to us a phone call he had taken from a lady complaining that the fluoride in the water had killed her goldfish. He had to tell her that the fluoride had not yet been added to the water.

Today, the PH/SH Committee, under pediatrician **Sumner Schoenike**, will be attempting to educate the 16 school boards in the county on the importance of the school nurse, whose role has diminished so much this last decade.

One of the true assets of PCMS has been its Grievance Committee. The Society office used to take a lot of calls

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from patients who were unhappy with some facet of their care. The calls continue today, but are far fewer in number than in the past. The Committee is made up of seven physicians and two lay members. The lay members were added in 1986 and have been a positive feature of the committee. One lay member is a prominent banker and the other is a university provost who has written two books on medical ethics. Probably 80% or more of the grievances are a result of poor communication between the patient and the front desk or physician. The committee reviews the written grievance of the patient and the response from the physician(s) involved and responds accordingly. The Committee always conducted itself with the highest sense of ethics and had no reservations chastising a member for poor communications, unnecessary tests or politely telling the patient that the charges were within the community standard. Attendance of the committee was always very good, particularly when we thought we might get one of **John Rowland's** book reviews.

Alan Tice, Infectious Diseases Specialist, put together the AIDS Committee with patients, agencies and members and led the way to educate the physicians of Pierce County on this new disease long before other communities recognized the seriousness of AIDS. Alan and his Infectious Diseases Group have worked with PCMS subsidiary the College of Medical Education to host the Annual Infectious Diseases seminar.

As we continue to see health care driven by the insurers, Congress and state legislatures, I have found it disappointing that more members did not become more politically involved. I am not a supporter of special interest groups, such as PACS. I believe as they are currently employed it is not healthy for this nation or its future. However, until we have a courageous Congress (is that an oxymoron?) pass some valid campaign finance reform, it

behooves physicians to get to know their legislators and congressman. Experience tells me that they enjoy talking to physicians about medicine. They like to talk to doctors about their experiences. Don't be intimidated if you don't know a bill number or the intricacies of pieces of legislation. Explain to them what is happening in your practice. They need to know what the insurers are doing with their referral systems, delayed reimbursement, harassment, etc. You will be surprised at how accessible they are. Their phone numbers and addresses are in the front of your *PCMS Physician Directory*.

I can't recall many days when I did not look forward to going to the office or another meeting. Not many people are that fortunate. I owe a debt of thanks to so many in the Society that I can't mention all of them, but I do need to recognize the 17 presidents that I served under who were dedicated individuals, willing to give their time and talent to lead the Society for a year of their life. As I noted above

they are a gracious and considerate group of individuals. They made the job easy. They are: **Pat Duffy, Guss Bischoff, Richard Hawkins, Dick Bowe, Bill Jackson, Bill Ritchie, Gordie Klatt, Bill Marsh, Eileen Toth, Jim Fulcher, Peter Marsh, Stan Harris, Dave Law, John Rowlands, Jim M. Wilson** (Internist), **Larry A. Larson** (Ped) and **Charles Weatherby**.

During the 17 years I always had a strong, dedicated, hard-working staff. And, a person could not ask for a finer associate than Sue Asher, my assistant for sixteen of those years. The Search Committee seeking my successor selected Sue after reviewing many applicants and interviews. It was a wise choice. Her knowledge of the membership, the Society, the community and the issues confronting the profession is exceeded only by her professionalism and loyalty to the Society.

Thank you for a very enjoyable 17 years and "May the wind be always at your back." ■

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Special Feature

by John Rowlands, MD

PCMS honors Doug Jackman on his retirement

Editor's Note: PCMS thanks John Rowlands, MD for presiding at Doug Jackman's retirement party. If you missed the party, below is the text of Dr. Rowland's presentation to Doug.

"We welcome you to Doug Jackman's retirement party. As painful as this must be for Doug, we thank him for allowing us to share this evening with him, his wife Connie, and his children, Scott and Susan. As a man who would forever deflect praise and recognition, he needs to know how much we have appreciated his quiet leadership, his unquestioned professionalism, and unending friendship to all who count themselves as members of our Medical Society. He leaves us having been unscathed by the rigors of the job or by the multitude of changes brought on medicine over the past 17 years. The Pierce County Medical Society is the model throughout the state. An advocate for its community's health, a leader in policy-making at both the state and local level, a friend and conscience for its practicing physicians. This is the legacy that Doug has helped forge and that will now be nurtured by our new Executive Director, Sue Asher. She knows that he will kindly offer counsel when he is not busy elsewhere.

So, what do you give a man who is about to retire? The gold watch is just not Doug's style. The Medical Society wishes Doug and Connie to usher in retirement aboard a new tandem bike. What better way to finally realize who the true Executive Director is? **Dan Niebrugge** tells me that a definite tandem-bike culture exists. With Connie riding in the back, she will be in charge of the tire pump to beat Doug senseless whenever he starts spinning out of cadence or takes new directions not to her liking. They may be wearing these matching jackets, donning matching helmets, and drinking from matching water bottles, but there will be no mistake as to who is the boss. That is why I suggest golf as a great retirement activity: there is no boss!

Finally, a small token of gratitude from the 17 past presidents who were so fortunate to have been guided by Doug. What better way to know that you are retired than to realize that the travel voucher given has two potential lives. On one hand, it may purchase a next-day, mid-week, one-night stay over in St. Louis for you to enjoy another AMA Leadership Conference by yourself. On the other hand, when time and deadlines do not exist, CHEEPTICKETS.com will mystically send Doug and Connie to the other side of the world and back. Mai tais are included. You just have to make the right choices, and Doug has always done that. We are forever grateful for your years of service. May your retirement be full of good health, new challenges, and discovery." ■



Over 150 people attended the party, held to honor and thank Doug for his years of service



Doug received his last assignment from Dr. Rowlands - cut the cake! - which he hands out above



Active and retired members and spouses, friends, family, neighbors and colleagues - all were in attendance

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delivered and the responsiveness of the health care system to the consumer

8. Medicare HMO's will not be viable in Washington State. PacificCare in some counties has frozen enrollment already; nationwide, hundreds of thousands of people have had to shift out of Medicare HMOs

9. Fraud and abuse hunts are going to continue, although there will be some decrease in aggressiveness

10. There will be a continued upswing in early retirements and disability "Doctors are saying, 'I've had it!' and are looking for other options.

As a side note, PVH is closing its doors March 1. "We've looked hard at the managed care business and believe it's going to be two to three years before there is a significant shift to being able to contract with groups," Dr. Sullivan explained. "We felt the cost of retaining our organization with limited patients was just not worth it."

Pat Briggs: Building a Strong Infrastructure

NPN is the largest physician-owned organization in the state, consisting of 230 physician owners, another 100 physicians, ARNPs, physician assistants, as well as other specialists who contract with the network. Pat Briggs is NPN's Chief Executive Officer. Briggs noted that, "We are an Independent Physicians Association, but are becoming more of an integrated delivery system in partnership with other entities in the county. But we remain, and will remain, entirely physician owned."

The organization has experienced some difficulties - due to the underfunding of premiums and bad data - but the group is now back on track. "Accurate data and good communication are means by which physicians can become involved with each other in making substantive change in the delivery of care," Briggs said. "Most physician groups have not had the infrastructure to support managed care or risk con-

tracting. One of the things NPN has done over the past six years is put money back into building a very strong infrastructure. It's important for independent physicians to have some sort of organization to support them," Ms. Briggs said. "By having a multispecialty model, where specialists and primary care physicians can work together to deliver care, physicians are able to deliver very high quality care and efficiently use resources." Despite the pitfalls along the way, NPN anticipates a break-even year for 2000 and expects a surplus in 2001.

Looking at the year ahead, Briggs said NPN is focusing on the following:

- ◆ Emphasis on improvement to care-delivery (physician directed)
- ◆ More substantive partnership with other provider partners and with health plans
- ◆ Continued push in getting physicians' voice heard in the health care policy arena

"Physicians have lost their voice and stature in the whole health care policy decision-making process," Briggs noted. Physicians are the main patient advocates. And, you should be helping to set policy about how health care resources are spent."

Briggs also anticipates better funding for Medicare and HMOs, and noted a recent report from PacificCare that indicated a huge infusion back into premiums. Additionally, she noted, payers will be more willing to take more of the risk in order to keep managed care going. "State agencies are more willing to involve physicians, realizing it is the only way to make things work."

Cliff Robertson, MD: Employed Physicians....That's the Ticket

"Physicians being employed and being part of an integrated delivery system is the place I want to be, at least for the immediate future," according to Cliff Robertson, MD, Chief Medical Officer of FMG. While he's never been in private practice, Dr.

Robertson attributes his bias to being owner of a non-medical service business. "There are many parallels," he noted.

Dr. Robertson explained the structure of FMG, in that it is a separate entity from the Franciscan Health System. "Leadership within Franciscan Health System has changed, and they clearly understand the hospitals cannot run the physician practices," he said. "That is why a partnership has been developed with Franciscan Health System - physicians are employed by FMG, not FHS. And so far, we are doing well financially."

Dr. Robertson noted three trends occurring within the organization:

- ◆ FMG is moving to an individual practice model with "system thinking," he explained. "We cannot forget that we are in partnership with a health system"
- ◆ FMG is moving to a revenue/expense compensation model
- ◆ The group's focus is on patient access

Additionally, Dr. Robertson said, "The group is staying in managed care." FMG is now a part of Physicians Health System Network (PHN), and its 65 providers have joined the PHN. We are a single-contracting entity that now has 165 PCPs and 400 specialists in the Franciscan Health System that act in concert. "We are one of a few PHOs left in the state," Dr. Robertson noted. FMG will continue with capitated contracts; work on improving data collection and information delivery; and focus on the high cost of utilization and "get the heck out of the way of delivering care to patients."

Dr. Robertson explained that FMG is not modeled on Group Health. "We are a model that is going to be as close to a professional corporation as it possibly can. FMG is driven by reality - and that reality is bottom-line revenue.

Smokey Stover, MD: Many Issues Driving the Profession

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The Physicians of PDR

For the past 20 years or so, every Saturday and Sunday and most holiday mornings at 8:30 a.m. an informal group of folks gather at Pt. Defiance Park to run. The Point Defiance Runners (PDR) as they have come to be known, run the trails, five-mile drive once or twice, sometimes bike or even swim at the famous park.

A favorite tradition was walking through the rose garden to the water fountain - a necessity after such athletic challenges - until the fountain became rusted and dismantled without plans for an imminent replacement.

About a year ago, **Drs. David Law** and **Alan Tice**, along with a couple other PDR members, decided to gather contributions to fund a new, first-class water fountain for all users of the park to enjoy - the highest faucet for adults, the middle one for children and the close-to-the-ground one for dogs.



Alan Tice, MD, with the yet unveiled fountain, was instrumental in organizing the project

The Saturday before Christmas, they all gathered to celebrate the unveiling of the much needed drinking fountain.

Next time you are at the park, stop by and see the new fountain and plaque at the end of the curve by the rose garden.

And, have a drink while you are there! ■

PCMS physicians and family members, at right, are listed on the plaque by the new drinking fountain adjacent to the rose garden at Pt. Defiance Park. They are regular users of the park; running, walking, biking, or swimming, and contributed to the water fountain that is now available for all park users - adults, children and dogs.

- Cordell & Robbi Bahn
- Mark & Nancy Craddock
- Ken & Kay Graham
- John Houston
- Erin Hogan
- Laura Houtala
- Andrew Inge
- Patrick Logan
- Ann Knott
- David Law
- David Law & Lucy
- Andy Loomis & Miriam
- Ben & Lori Nunn
- Michael Piche
- Emily & William Reed
- Allison Tice
- Eric Tice
- Pat Taylor
- Alan Tice
- Sam Whaley



David Law, MD, volunteered many fund-raising hours



Dr. Mark Craddock, Gig Harbor family practitioner



Dr. Pat Hogan, Tacoma neurologist



From left, Dr. Ken Graham, Dr. Cordell Bahn and his wife, Robbi, and Dr. Jim Komorous

Final HIPAA Privacy Regulation takes effect

The final regulations imposed on physicians, medical providers and health plans will take effect February 26, 2001, with **compliance required by February 26, 2003.**

The rules are intended to protect personal health information from misuse and/or access by unauthorized parties. The rule applies to any unidentifiable health information held or disclosed via any method - orally, on paper or electronically.

Providers must give patients a clear written explanation of how they can use, keep and disclose their health information, keep a record of disclosures and make them accessible to patients. They must permit patients to review and/or receive copies of their records and accept requests for changes. Consent must be obtained before sharing of health care information may be made, with specific consent for non-healthcare purposes.

Policies and procedures will be required including information access and use, staff training, a designated privacy officer and a grievance process.

Enforcement will be by the HHS' Office for Civil Rights which will provide assistance in meeting the requirements, including a toll free line to answer questions, 1-866-627-7748.

For more information you may also contact PCMS, 572-3667, or visit the website www.hhs.gov/ocr or www.hhs.gov/search/press.html. ■

Dr. Zoltani thanks supporters of Leukemia & Lymphoma Society ride



Greg Zoltani, MD (left) and his son, Daniel, biked El Tour de Tuscon, an 111 mile event, for the Leukemia & Lymphoma Society of Washington/Alaska. The chapter raised \$28,000 while the Society raised over \$2 million nationwide for research.

Dr. Zoltani and his son thank everyone that supported them with their donations. ■

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Public Health Accomplishments in 2000

The year 2000, which even now feels like a long-past time, was a filled and fulfilling year in public health. In talking about accomplishments for 2000, it is also an opportunity to provide examples to you of ways the Tacoma-Pierce County Health Department works to improve the health of the community. Much of our success relies on collaborating with a variety of community resources, including private providers. So this list also includes names and phone numbers of individuals you could call for additional information.

The Delta Project

In April, we learned three intravenous drug users (IDUs) had died of and twelve additional IDU's were suffering from acute liver failure due to hepatitis B and Delta. Within days a screening and vaccination clinic was operating. From May through December, more than 2,000 IDUs were screened for Hepatitis A, B, C and D, and were started on Hepatitis vaccine. In addition, all were offered HIV tests and 1,842 agreed. Results show the HIV seropositivity rate in Pierce County among intravenous drug users is a very low 1.1%. Outreach, education and the department's needle exchange program should help to keep that level from rising.

For more information on the Delta project, contact Karen Mottram at 798-5231.

Network Nurses

Network Nurses visit primary care providers, mental health clinics, substance abuse clinics, long term care facilities and day care centers - approximately 1,400 sites - every 90 days. They bring updates and reminders of

disease reporting, review patient records and treatment protocols in contract clinics, and market public health ideas, models and programs. In early 2000, Network Nurses emphasized reporting positive tuberculosis tests. The result was 111 providers reported a total of 520 positive PPD's since March; 174 patients were started on therapy.

For more information on Network Nurses, contact Sandy O'Donnell at 798-7687.

In addition, Network Nurses have focused visits on implementing the "4A Model" for tobacco-use cessation. Asking a patient four simple questions can help her/him to reduce tobacco use or quit altogether. These efforts, and other marketing campaigns resulted in more than 1,200 individuals calling a special tobacco quit line for help during 2000.

For more information on the 4A Model or other tobacco cessation activities, call John Britt at 798-2881.

HIV Counseling, Testing and Case Management

TPCHD staff tested and counseled a total of 3,278 individuals for HIV in 2000; 28 people tested positive (compared to 16 positive results in 1999). Staff then located the sexual or needle-sharing partners of those who were positive and in testing them, found eight to be positive. Each person was educated about how to prevent additional infections.

The Early Intervention Case Management Program (EICM) for HIV positive people combines help for clients in locating resources for medical and community services with education on preventing the spread of the disease. The caseload increased in 2000 - to 71 clients (compared to 24 in 1999).

For more information on HIV counseling, testing or case management, contact Ardythe Fleener at 798-2866.

Substance Abuse Programs

Methadone treatment programs provide methadone, a synthetic opiate, and counseling and resource identification, to assist heroin and other opiate addicted individuals to regain a more healthy life. In 2000, staff increased enrollment by 24% (from 400 clients in 1999, to 500 in 2000), and eliminated the waiting list. TPCHD now provides services for up to ten new clients per week.

For more information on the methadone treatment program, contact Marc Marquis at 798-4764.

The MOMS and Women's Recovery Programs assisted 221 women to cease methamphetamine use, 99 women to cease cocaine, 94 women to cease alcohol, 92 women to cease marijuana, and 9 women to cease opiate abuse/addiction in 2000. In addition, education programs on domestic violence, childhealth, communicable diseases, tobacco cessation, safe gun storage and testing for HIV and tuberculosis, reached another 515 women and their families impacted by substance abuse.

For more information on substance abuse programs, contact David Bischof at 798-6655.

Food and Community Safety

Handwashing and food preparation campaigns resulted in only two reported Hepatitis A cases in Pierce County in 2000 - the lowest number of cases ever (the county's average until 1999 was 80/year, with the highest re-

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ported in one year to be 800). The handwashing campaign - "Got Soap?" - through the mobile handwash trailer reached more than 55,000 individuals. And, staff taught a total of 23,938 individuals in the safe preparation and storage of food, certifying them as "Food Workers."

For more information about Food safety or handwashing training/campaigns, contact Diane Westbrook at 798-6045

Family-based Services

More than 1,400 families in Pierce County were visited by a Public Health Nurse in 2000. Their visits helped to strengthen parenting skills, identify health needs of the children and parents, and connected the families to additional resources in the community. In addition, prevention education was provided to each family on ceasing tobacco use, alcohol abuse, and violence.

For more information about Family-based Services, contact Allison Kemmer at 798-4700.

Source Protection Programs

Environmental Health Specialists at TPCHD successfully joined the newly formed Pierce County Methamphetamine Lab Team and responded to over 120 meth lab interventions throughout Pierce County in 2000. The Code Enforcement Program responded to over 1,700 service requests in 2000, dealing with issues related to garbage, rodent sightings, and other problems. Those with public health implications received the highest attention.

For more information about Source Protection Programs, contact Steve Marek at 798-2955.

Adolescent Health

Public Health Nurses and other professionals provide to the families of young moderate offenders Functional Family Therapy, to help those youth

avoid continuing criminal behavior and keep them in schools. Staff handled a caseload of 228 families in 2000 (compared to 158 in 1999).

The Tacoma Middle School Project was successfully transitioned into the BECCA Truancy Project in 2000, doubling capacity from 150 clients to 3,000. This project received referrals from Juvenile Court of youth who have been truant from school. A public health nurse visits the family, assesses their needs and connects them to community resources and reconnects them with the school district, with the intention of getting the student back into classes.

For more information about Adolescent Health Programs, contact David Vance at 798-6542.

Prevention Programs

Throughout the Tacoma-Pierce County Health Department, staff have found ways to educate the public about our three prevention priorities: tobacco use, alcohol and other drug misuse, and violence. In addition to various activities in those programs, seven teams of staff are working with organizations to build the community-level campaigns and programs that will make our prevention efforts effective. Activi-

ties include:

9,000 students in grades 1-6 participated in a curriculum designed to prevent tobacco use. Preliminary results show this curriculum plays a significant role in reducing tobacco use among youth.

More than 1,200 individuals called the health department's tobacco quit line after seeing anti-smoking posters distributed by staff.

A county-wide partnership has been established to reduce the incidence of college binge drinking. This included training 30 college counselors in the use of brief interventions with students to lower the risk of alcohol misuse.

More than 150,000 cards were distributed throughout the county with information about the Domestic Violence helpline. This resulted in more than a 20% increase in calls to that line in 2000.

For more information on prevention programs, contact Rick Porso at 798-6417.

2001 will bring new challenges and opportunities for us all. We're looking forward to ways to continue working with all physicians in Pierce County. Please let us know how we can work with you. ■

MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell

Attorney at Law & Arbitrator

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IN MEMORIAM

ROBERT B. TRUCKEY, M.D.
1921 - 2000

I was greatly saddened by the death of my friend and mentor, **Bob Truckey**. I have always and will forever be grateful to Bob for inviting me to Tacoma to practice. I always wanted to return to Washington but this city was not high on my list. As I told him then, over 30 years ago, Tacoma was just a Big Stink south of Seattle.

I visited only a few months after Bob had opened his office in Allenmore. After he took me to Gig Harbor, Lake Steilacoom, Gravelly Lake and American Lake, my view of Tacoma was changed. I remember Bob telling me, "See, you don't even notice the odor." I discovered he wasn't completely correct but he always chose to look on the good side of things. A year later, I returned and began a wonderful association with Bob and **Ron Spangler**.

My fond memories of Bob are too numerous to relate but one was profound and has lasted through the years. He gave me some advice not long after I arrived. Something that all young doctors, especially surgeons, need to learn. As I was rushing through the hospital hallway, literally running, big Bob stepped in front of me bringing me to a sudden halt. He said, "Whoa! What's the hurry?" I said, "Bob, get out of my way, I'm late!" He said, "Let me give you some good advice Del, when you're late, just be later." Afterward I reflected on what he said and thought, what important advice for a young surgeon. As I have gotten older and wiser, I see it as a wonderful philosophy for life. Bob is now where people don't need to rush around and I know he is relaxed and taking his time.

Del Prewitt, MD

In the summer of 1961, I arrived in Tacoma to begin practice in the Medical Arts Building. It was my good fortune, while unpacking my equipment, to be visited by a tall soft-spoken otolaryngologist from down the hall. Thus began my friendship with **Bob Truckey**.

Over the years Bob cared for the medical and surgical ENT problems of our family and was always available when we needed him. For these services I am forever grateful. Bob also was on hand if I needed advice about a patient or had someone who required evaluation or surgery, both of which were top notch. On occasion I would wander into his operating room at Allenmore to watch his work, which he performed with ease and precision.

On the home front our kids played together and our wives have been great friends since 1961.

Bob's passing on December 2, 2000, is a loss beyond words. It was wonderful to have known him.

Max Brachvogel, MD

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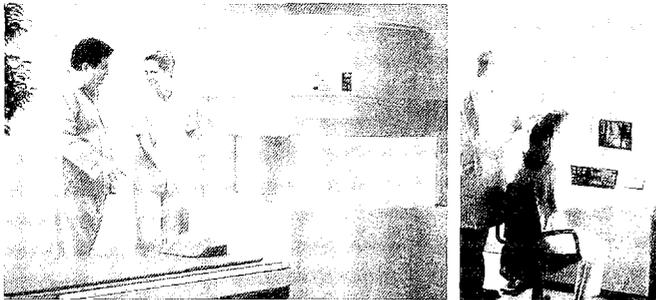
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In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

The Genesis of Managed Care

"More! is as effective a revolutionary slogan as was ever invented by doctrinaires of discontent. The American, who cannot learn to want what he has, is a permanent revolutionary."

Eric Hoffer (1995)



Andrew Statson, MD

Some restaurants have buffet service for Sunday brunch. A few serve buffet lunch and dinner all the time. The rule about buffet service is that you may eat as much as you can, but you may not take any food home. No restaurant could survive if it allowed that. In this situation, consumption is limited by the capacity of one's stomach. Some buffet restaurants try to keep their prices lower and their expenses in line by making the foods a little too greasy, or a little too salty, or a little too spicy, so that people cannot eat as much.

Recently AOL started sending disks of their software to get on line, offering 700 free hours during the first month after signing up. Since there are only 720 hours in thirty days, how could anyone be able to spend that much time on line? In general, Internet access in this country is available for a flat fee per month, regardless of use. The limitation is in the time a person can spend on line. Of course, there also are the problems of getting connected, which may be tedious, and getting disconnected, which may be frustrating.

No matter how plentiful an item may be, consumption always has to be limited by some factor, or it would overwhelm the supply. The most common and most practical system is the market mechanism, where purchases are limited by the resources of the buyers. Even oxygen has a price when in limited supply. People, such as sea divers and mountain climbers, pay to get it. Unavailability, rationing, spe-

cial allocations and restrictions have also been part of the picture in times of scarcity.

When patients do not pay for their medical care, their consumption of health care resources is limited by the amount of time they can spend and by their reluctance to undergo painful or unpleasant treatments or tests. Frequently, going to a free clinic, or even to the clinics in our military hospitals and some HMO's, involves waiting for hours before seeing a provider, who may not even be a physician. This is a form of rationing. The patients do not pay in cash, they pay in wasted time.

To some patients, however, going to the doctor's office, the clinic or the Emergency Room is a social event. It is an occasion to get out of the house, to meet people and to share the stories of their aches and pains. A few patients have even asked to have a sonogram at the time of their annual examination, so they could look at the screen and see for themselves if there is anything wrong. Many pregnant patients ask for a scan, just to make sure the baby is doing well. If they could, they would gladly get a sonogram at every visit.

We can always consume more. We can live in bigger houses, have more furniture, more gadgets, more toys. We can take more time off work, go on exotic trips, etc. In our consumption, we are limited to our resources. A bumper sticker put it very well. In the game we play, "he who dies with the most toys wins." Wins what? That remains unmentioned. Translated to the field of medical care, that becomes "he who dies af-

ter the most treatments wins." Wins what?

When Generalissimo Francisco Franco died in 1975, he was in the intensive care unit of a Madrid hospital for a full month, subjected to heroic measures to keep him alive. Franco was quoted as having said, "Why is it so difficult to die?" He was 83 at the time, severely ill, had several cardiac arrests, but was resuscitated again and again. He was kept alive because no one dared pull the plug.

Samuel Butler said, "All progress is based upon an universal innate desire on the part of every organism to live beyond its income." Another bumper sticker expresses the same truism, "I owe, I owe, so off to work I go." Concerning medical care, however, this rule does not apply. People have been told they have a right to medical care. They don't have to pay for it, they don't have to earn it. There are no limits. They don't owe anything to anyone by getting it. Someone else owes it to them.

If I remember correctly, when the Medicare and Medicaid laws were enacted, the initial outlay was less than two billion dollars per year and the official projections were that the costs might reach at most five billion dollars. The reality surpassed even the wildest expectations. Now the annual expenditures on healthcare are one trillion dol-

See "Genesis" page 18

Genesis from page 17

lars and the governmental share is about half of that. Granted, the value of the dollar is about one fifth of what it was then, but even so, the increase in costs is staggering.

Some time ago, as the expenditures kept going up, the authorities got alarmed. They had promised too much and found they could not deliver. They established the system called "managed care" in the hope that it would introduce the needed limits, something they did not dare do, and would save them. Many large companies also complained at the time that the health care benefits for their workers cost too much and affected their ability to compete in the international market. The car manufacturers specifically reported that health care benefits cost them about 700 dollars per car, while the costs of the Japanese producers were much lower.

Much of the blame was placed on the physicians and managed care was purportedly established to control physician practices and thus reduce health care expenses. The net intent, however, was to reduce the access to care and the choice of treatment the patients had. By blaming the physicians, the authorities thought they would be able to silence the patients. Little did they know.

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

Recently, I reviewed a number of

the Case Records of the Massachusetts General Hospital reported during the last ten years in the New England Medical Journal and compared them to what I remember from the decade of the sixties. At that time, most of the pathology specimens were obtained at autopsy. The majority of the patients were over the age of 70 and had spent several weeks in the hospital before they died. Perhaps an extreme case was that of an 84 year old woman who underwent a number of treatments, including a few trips to the operating room, and had an autopsy done after she expired on the 182nd hospital day. Many of the patients had been in the hospital for two, three or four months, subjected to a variety of treatments, until they died.

The difference in the patient cases

during the last ten years is striking. The patients over 70 were fewer than 10%. Only an occasional autopsy was done. Most of the patients had diagnostic procedures and definitive treatment after a short hospital stay, seldom exceeding two weeks. I suspect this change in case selection reflects a change in the general practice of medicine. We have become aware that health care consumes resources which cost money, and these resources must be used wisely.

From the patients' point of view, managed care has been a failure. However, it brought to our attention the economic reality of health care. This is a fact all of us, physicians, patients and payors, will have to face and deal with, preferably before the barbarians come to our gates. ■

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Internal Medicine Review 2001 scheduled for March 8 & 9

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

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

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

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

- Coagulation Disorders

- Sleep Disorders and Drug Addiction
- Syndrome X
- The Role of ARBs
- Management of Unstable Coronary Plaque: New Strategies Towards CHD Prevention
- Insulin and Diabetes
- Reluctance to Prescribe Opiates: The Issues and Answers
- New I. D. Agents
- New Therapies for Osteoporosis
- Management and Treatment of Respiratory Infections
- Advances in Parkinson's Disease Management
- GERD and Pulmonary Issues
- And More ■

Surgical Update- dissections, CME set April 27 & 28

Dr. Glenn Deyo, Tacoma general surgeon, is directing the 70th Annual Surgical Club meeting which will be held Friday and Saturday, April 27 and 28, 2001. The very popular dissections, demonstrations and lectures presented annually by the Tacoma Surgical Club will be held at Tacoma Community College in the Lecture Hall, Building 16. ■



The very popular dissections, demonstrations and lectures presented annually

Allergy, Asthma & Pulmonology CME - May 4

The College's CME program featuring subjects on allergy, asthma & pulmonology is set for Friday, May 4 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD.**

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

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
TBA	Advances in Women's Medicine	John Lenihan, Jr., MD
Friday, April 6	Pain Management	David Paly, MD
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Saturday, April 28	Surgery Update 2001	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesdays, May 16 and 23 (evenings)	Medical Technology	TBA

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Retreat

from page 10

I'd rather discuss my experiences over the last four years in the Washington market instead of focusing so much on MultiCare," said Smokey Stover, MD, Medical Director of MMG. In speaking to the Board, he echoed the sentiments of his counterparts, reiterating the fact that "docs in Washington State are working harder and making less money than physicians nationally." In his experiences, he finds the following issues will offer continued challenge to MultiCare and other systems:

Specialists. "There are other ways to have cooperative relationships with specialists," Dr. Stover said, "and employment is probably not the optimal methodology in most cases. The exception is when you require a very tight working relationship with a specialist."

Small Group Practices and Regulation. "It will be very difficult for a lot of practitioners to comply with all the regulations that are coming down," Dr. Stover noted. "Small group practices are going to face enormous challenges. The overhead for smaller offices will probably go up dramatically in order to comply with some of the regulatory issues."

Provider supply issue. "It is becoming evident that there are a number of specialties that are and will continue to be in very short supply," Dr. Stover predicted. One example: MultiCare has been trying to recruit a dermatologist for over two years. Urology is becoming increasingly difficult to recruit, and a significant shortage in specialists is expected over the next ten to 15 years.

Significant change in expectations among physicians coming into the workplace. "In a nutshell," Dr. Stover said, "many physicians are simply not willing to work as many hours."

Gender issues. Dr. Stover noted that female physicians tend to want to work part time, or shorter hours. "MultiCare has a number of female physicians who are part time," he said. "And, while they bring something very valuable to the group, accommodations have to be made as a result."

Dr. Stover expressed his belief that the medical profession has reached the point

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Medical School: University of
Massachusetts Medical School
Internship: University Hospitals of
Cleveland
Residency: University Hospitals of
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Gleyzer, Elena A, MD
Family Practice

Practices at Western State Hospital
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98498; 582-8900
Medical School: First Leningrad
Medical Institute
Internship: Sepulveda Valucra
Residency: University of Texas

Gray, Gina L, MD
Family Practice

Practices at CHC (Lakewood)
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Lakewood 98499; 589-7030
Medical School: Loma Linda
University Medical School
Internship: Idaho State University
Residency: Idaho State University

Karanam, Sambasivarao V, MD
General Practice

Practices at General Medical Clinics,
15005 Pacific Ave, Tacoma 98444;
537-3724
Medical School: Patliputra Medical
College
Internship: Patliputra Hospital

Kelley, James L, MD
Pathology

Practices at Digestive Health
Specialists, 1901 South Union #B2005,
Tacoma 98405; 272-8177
Medical School: Oregon Health
Science University
Internship: Tripler Army Medical
Center

Metcalf, Sharon L, MD
OB/Gyn

Practices at The Lakewood Clinic,
11311 Bridgeport Way SW Suite 309,
Lakewood 98499; 581-6688
Medical School: Virginia
Commonwealth University Medical
College
Internship: Eastern Carolina University
Residency: St. John Hospital

Mooney, Maureen A, MD
Dermatology

Practices at Cascade Eye and Skin
Centers, 1703 South Meridian #101,
Puyallup 98371; 858-3000
Medical School: University of
Minnesota
Internship: Hennepin County Medical
Center
Residency: New Jersey Medical
School
Fellowship: New Jersey Medical
School

Newcomb III, Everett W, DO
Internal Medicine

Medical School: Kirksville College of
Osteopathic Medicine
Internship: Walter Reed Army
Medical Center
Residency: Walter Reed Army
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Fellowship: Walter Reed Army
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Nutter, Paul B, MD
Physical Med Rehab

Practices at Good Samaritan Hospital,
407 14th Ave SE, Puyallup 98371
841-5849
Medical School: University of
Washington
Internship: University of Washington
Residency: University of Washington

Reid, Dennis G, MD
Pediatrics

Practices at Tacoma South Medical
Clinic, 2111 South 90th Street
Tacoma 98444; 539-9700
Medical School: Case Western
Reserve University School of
Medicine
Internship: 60th Medical Group David
Grant Medical Center
Residency: 60th Medical Group David
Grant Medical Center

Reilly, Philip A, MD
Family Practice

Practices at Seamar Community Health
Centers, 1112 Cushman Ave
Tacoma 98405; 593-2144
Medical School: University of
California San Francisco
Internship: Providence Family Practice
Residency: Providence Family Practice

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where "we can no longer afford to always do something of net value to the patient. We are going to have to start looking at "is it worth the cost?" For example, is one day less of symptoms worth \$50 or \$60 of treatment? "My fear, in terms of a single-payer system, is trying to get all parties at the table to agree on ways to reform the system so it is more rational and also accommodates the person who needs the extra reassurance of running to the doctor every time they cough as well as the person willing to sit on it awhile. I don't think people have the energy to set up a system with that kind of flexibility, and I fear we're going to end up with a rigid system like that as a default and everyone will have less choice as a result." ■

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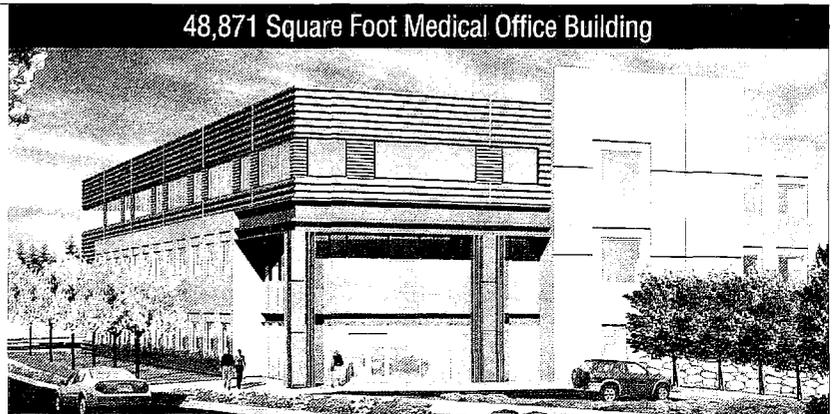
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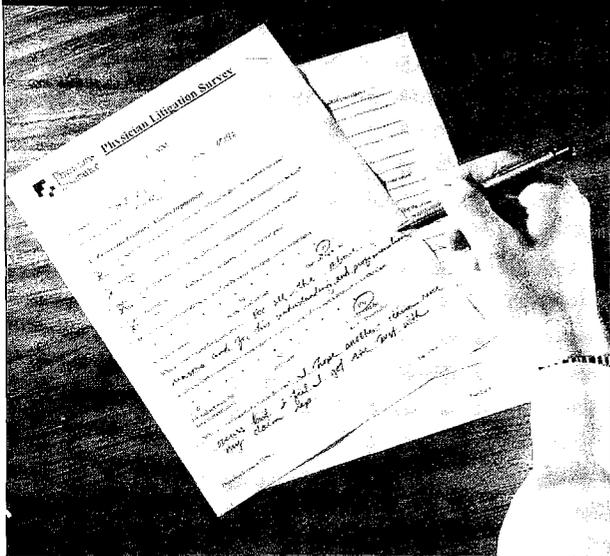
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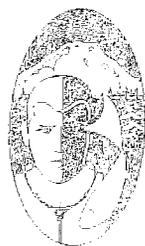
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March, 2001



John Gray, MD, sees a newborn at the Lakewood CHC Clinic. He serves as chair of the Pierce County Immunization Coalition - a group working to immunize Pierce County children by the age of two

See story page 5

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Pierce County Medical Society

BULLETIN



March, 2001

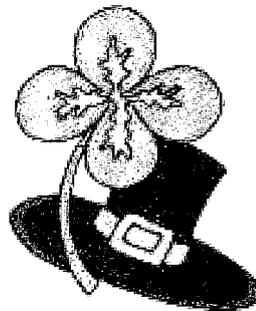


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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in **The Bulletin** are the 15th of the month preceding publication.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

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President's Page

by Patrice Stevenson, MD

I Am an Allopath

I was fortunate to sit next to Senator Lorraine Wojahn at the last General Membership Meeting and hear some of her comments about the current legislative session and the inevitable attempts of assorted practitioners to expand their scope of practice. There is proposed legislation to allow naturopaths to call themselves physicians and gain prescriptive authority. Perhaps I am confused, but I thought they were generally against the chemical "poisons" requiring prescriptions! Senator Wojahn has consistently supported the rigors of professional training and sought to ensure that the public was protected from inadequately trained persons attempting to practice medicine. We wish her well in retirement but will miss her reasoned voice in Olympia.

As I was thinking about this more I thought about the different "schools" of practice and their evolution over time. There are naturopaths, homeopaths, osteopaths and allopaths. There are also chiropractors but I suppose they could have been called "chiropaths" as well. As I type this the auto-spell checker underlined my creation, "chiropath," but also the correctly spelled allopath. This confirms my belief that most people have never heard that term and certainly do not recognize the Doctor of Medicine degree to be synonymous with allopathic medicine.

Webster's Dictionary defines these terms as follows:

Allopathy: The method of treating disease by the use of agents producing effects different from those of

the disease.

Osteopathy: A therapeutic system based on the premise that restoring or preserving health can best be accomplished by manipulations of the skeleton and the muscles.

Homeopathy: Therapy by means of an agent that is similar but not identical with the causative agent of the disease.

Naturopathy: A method of treating disease using food, exercise, heat, etc. to assist the natural health process.

Chiropractic: A therapeutic system based on the premise that disease is caused by interference with nerve function, the method being to restore the normal condition by adjusting the segments of the spinal column.

Now the practitioners of the above therapeutic systems may take exception with those definitions but that is what the layperson would find looking the term up in a dictionary. I find myself spending a lot of time trying to educate patients who bring in a stack of information downloaded from the internet about the scientific method and how to interpret data and articles. I see them glaze over as I extol the virtues of a prospective, randomized, cross-over, placebo controlled study published in a respected peer reviewed medical journal over articles published solely on the author's own web page. One such author's web page had greatly impressed my patient because it said he was a nominee for the Nobel Prize in medicine. Looking further there was a copy of a nomination letter written by a senator and this physician



Patrice Stevenson, MD
President

had the audacity to put "Nobel Laureate Nominee" on his letterhead! This particular patient was unimpressed by my arguments and thought I didn't want him to recover from the hemiplegia caused by his stroke some five years earlier.

I find the current trend of holding allopathic and osteopathic medicine to even higher standards of proof of efficacy of treatments by the cry for "evidence based medicine" to be in curious contrast to the general belief that the other therapeutic systems are at least safe and effective until we prove them otherwise. In essence the burden of proof falls on us from both sides.

I have recently tried the tactic of countering these patient queries by telling them that I practice allopathic medicine and then explain my point of view. For some reason when they hear the word "allopathic" they sit up straighter, lean forward and look at me intently as I explain things the same as I did before. When I previously started my discussion with "medical doctors believe..." I saw them assume defensive body postures with crossed arms, slouched posture and tune out. Somehow the term allopathy give us back the sense of mystery and knowledge of a sage. Today's patients seem to be seeking that. Give it a try with your next discussion. ■

Personal Problems of Physicians Committee

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Use of physician extenders posing coding problems for practices

Physicians hiring physician assistants and nurse practitioners should keep in mind that billing requirements of their services may vary.

With many physicians using increasing numbers of practitioners and assistants to help them increase productivity, confusion about billing Medicare and commercial insurers also increases.

The best way to find out exactly how to code and bill is to contact commercial insurers and HCFA directly, although general billing guidelines do exist.

If a physician is unable to find out what an insurer's policy is regarding physician extender billing, the best policy is to follow Medicare regulations, which allows billing to physician services or the billing to be done independently.

How Stark II rules might affect your pay

HCFA recently released the first two phases of the Stark II final regulations. Stark II is the law that prohibits physicians from referring Medicare and Medicaid patients for certain designated health services, such as clinical laboratory, physical and occupational therapy, radiology, inpatient and outpatient hospital services to any facility or entity with whom the referring physician (or immediate family member) has any financial relationship, unless an exception set forth in the statute or regulations is satisfied. It also prohibits the entity furnishing the service from billing for it if the referral is prohibited. Penalties for a violation of Stark II are harsh and include denial of payment, imposition of severe civil monetary penalties and exclusion from participation in the Medicare and Medicaid programs.

Physician compensation, particularly distributions of productivity bonuses and profit shares by physician practice groups to their individual practice physicians are impacted by the final rules, with primary relevance to employment and shareholder agreements. In general, profit and bonuses interpretations are less restrictive.

Consult advisers to ensure that your groups makes compliant use of HCFA's Stark II regulations.

Both from AMNews 2/26/01.

For complete copies of either article, call PCMS, 572-3667



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Special Feature

by Jean Borst

Childhood Immunizations..... Prevention is the Only Cure

Few will argue that the development of vaccines to prevent childhood diseases is one of the most far-reaching medical advances of our century. For years, cases of diphtheria, pertussis, measles and rubella have been rare; and an epidemic of any of these illnesses is something most of us have never experienced. But since the late 1980s, health-care providers have faced the re-emergence of vaccine-preventable diseases. In 1989-90, more than 55,000 cases of measles were reported; there were more than 150 reported deaths. And in 1993, this country experienced its largest outbreak of pertussis since 1967.

While vaccines are available and accessible, national immunization rates are lower than most physicians believe. And with parents typically depending on physicians to alert them about their children's health care needs, it's vital for providers to take the lead.

Like the rest of the nation, concerns over childhood immunizations came to light in Pierce County following a measles outbreak in 1989. **In 1992, the Tacoma/Pierce County Health Department conducted a door-to-door cluster survey to determine the immunization rates of 24-month-old children in Pierce County. Results showed that Pierce County lagged behind the rest of the state in immunization rates. More disturbing, a follow-up survey conducted four years later indicated rates were even lower.**

The measles outbreak, survey results, and a growing anti-immunization force in the East County prompted the Tacoma/Pierce County Health Department to orchestrate a meeting with

members of the health community to address immunization concerns. Out of that initial meeting, and subsequent discussions, came the formation of the Pierce County Immunization Coalition under the leadership of Tacoma family physician, **Dr. John Gray**. While the group has diminished in size since that initial meeting — it now has a core group of about 10 members — the goals and commitment of the Coalition remain intact.

"We realized that we needed to reaffirm for the community how important and safe immunizations are," Dr. Gray explained. "Anyone over the age of 50 knew someone with polio, had friends or family members in braces, using canes or crutches, or who had completely lost the use of their legs.

"People have forgotten the statistics," he continued. "Thousands of people were crippled annually from a disease that today we never see. We have eliminated paralytic polio caused by wild type virus here in the U.S. Young people have literally never experienced anything like it."

The measles outbreak in the late 80s brought to light a serious issue. "Measles kills if people are not immunized. If we are 70 percent or below on immunizations, the entire community is at risk."

The Immunization Coalition: A three-fold effort

The Immunization Coalition has focused on three fronts: outreach/community education, provider education, and promotion of an immunization registry system.

Community efforts have been ongoing. Billboard advertising, community awareness programs, and partnerships with local organizations have focused

on having children properly immunized by the age of two. Community assessments have been conducted; areas with low rates have been identified, and methods for improvement have been determined.

Provider education has been more intensive. Coalition member **Cindy Miron**, Community Health Care Nurse for the Tacoma/Pierce County Health Dept., has been instrumental in that area. "Cindy has done a great job of developing a teaching module for practices," Dr. Gray said.

Miron has worked closely with providers to implement a reminder/re-call system that automatically generates letters to be sent to parents; encourage physicians to be aware of all opportunities to immunize; and provide training for the entire office staff.

"It's important for providers to realize that this is an office-wide issue," Miron noted. "Everyone has to be on board and committed to immunize every child who comes through the office door."

Physicians also must be continually aware of all opportunities to have kids immunized. For example, if a child comes in for treatment, the physician must take the opportunity to find out if they are due for a vaccination. "Don't pass up opportunities," Miron said. "That parent might not return for a well-child visit."

Miron noted that a follow-up assessment would be conducted in the near future to determine how effective the provider education efforts have been in raising immunization rates.

CHILD Profile: An Integral Part of the Equation

The third focus of the Coalition —

See "Immunizations" page 10

PCMS honors Lorraine Wojahn on her retirement

More than 80 people were in attendance when PCMS honored Senator Lorraine Wojahn at the February General Membership meeting on her retirement from the Washington State Legislature after thirty years.

President Patrice Stevenson, MD, introduced Len Eddinger, WSMA's Director of Public Policy and Planning as presenter of the honor and gift to Senator Wojahn.

"They don't come greater or grander," according to Eddinger. Lorraine Wojahn, he lauded, was one of medicine's best friends. Her support of physicians and the health care community was steadfast and unrelenting. "In Olympia she was known as the Norse Goddess of Terror - and, that is a compliment and a testimony to her as a person," he explained.

Senator Wojahn served on the Health Care Committee for years and paved the way for many meaningful programs and decisions for our community and the state. Too many to men-

tion here, a sampling includes, First Steps, Second Steps, Mental Health System Reform, Physician/Patient Relationship, Trauma, Scope of Practice, and the last piece of legislation she influenced was the Patient Bill of Rights. She fought for five years or more to require that the director of the Department of Health be a physician, and finally won, only to have the legislation vetoed by the governor. "Nobody has ever stood up for physicians more than Senator Wojahn," said Eddinger as he introduced her to the audience.

Admitting that she is having withdrawal symptoms, Senator Wojahn said her fight for medicine was an easy one. "When you take marching orders from the likes of **Dr. Tanbara** and other such physicians, it's easy," she noted. Her philosophy during her tenure was 'stick to your guns.'

As the legislature currently discusses prescription rights for naturopaths, it is unfortunate for medicine that Senator Wojahn is not there to



Senator Wojahn talks politics with Randy Lindblad, MD, Puyallup ophthalmologist before the meeting

stand in the way. "I wanted to tear my television out," she noted, "It was so upsetting just hearing about it."

PCMS extends congratulations to Senator Lorraine Wojahn on her retirement and wishes her well. ■

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FRAUD HOTLINE	1-800-562-6906
HEALTHY OPTIONS DISENROLL/EXEMPTIONS/COMPLAINTS (CLIENTS ONLY)	1-800-794-4360
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February General Membership Meeting Recap

by Jean Borst

Planning for Retirement.....

You Can't Repack Your Parachute After You Jump!

David Roskoph is the first to admit that 30 minutes does not a retirement plan make. As keynote speaker at the PCMS February General Membership Meeting, Roskoph conceded that a half-hour presentation certainly doesn't allow for exploring the contingencies and intricacies of the retirement-planning process. Roskoph, MBA, CFP, is a Registered Investment Advisor and owner of Total Asset Management, Inc., in Gig Harbor. While his time with the group was brief, he provided some valuable information and basic dos and don'ts of retirement planning.

"This group is a little bit atypical of the normal retiree," he said, "in that normal retirees are going to spend a certain percentage of their pre-retirement income – say 70 percent. That's because they don't have all the costs associated with their former career. However, as income levels go up, the probability that there's going to be a great decrease in spending goes down. So chances are, what you should plan for is that your spending is not going to be dramatically different once you pass through the veil of retirement. If most of your assets are kept in a qualified plan, and you're going to be releasing them, of course you're going to pay ordinary income tax. Therefore, your tax rate may not go down precipitously either."

The Concept of Retirement

"Right now, we are living in a golden age of retirement", Roskoph said, defining retirement as between the ages of 65 and 95. "People are amassing enough wealth and carrying forward enough health to actually en-

joy some time away from their profession. Just 60 years ago, it just wasn't so." Each decade of retirees is more or less redefining the golden age of retirement, he noted. "Each batch of retirees is enjoying more time. Some people are spending virtually half their lives in retirement."

In looking at this new age of retirement, Roskoph noted the importance of "**Critical Mass**", a term he defined as "**the accumulation of enough wealth to live in the style to which you are accustomed for the remainder of your life.**" In essence, **Critical Mass is the absence of monetary anxiety. According to Roskoph, this accumulation is going to be contingent upon two very big variables:** (1) The growth of the principal that remains as you deduct from it every year of your retirement, and (2) How many years that principal has to roll forward to keep this Critical Mass alive. Roskoph noted that "everyone has access to a world of information out there." There is a plethora of financial web sites that offer relatively simple processes to determining retirement calculations, and he encouraged everyone to take advantage of the resource.

Principal Growth

This country's economic climate over the last few years has been ... well, quite astonishing. Traditionally, the market (the S&P 500) returned roughly 10-11 percent a year. Between 1995 and 1999, however, there was a period of tremendous growth, and "we didn't have to do very much to make money in the market during

that time", Roskoph said. The S&P Index made about 26.5 percent a year on an annualized basis – about 250 times its historical average.

As a result, Roskoph believes the market is "long overdue for a rest." When you prepare for retirement, he said, you gather your assets and think about bailing out into a more leisurely lifestyle. "But you never know what economic climate you're bailing into." Roskoph explained, "I'm here to say if you really want to prepare for a secure retirement, you have to take into account that you might be going into a protracted recession. What's going to happen to your anticipated accumulation? When you put money away, and you're projecting it for a long period of time, the first few years are critical. It's my belief that we're in a recession right now, and it will last until the end of the year."

Determining the Ideal Asset Allocation Mix

"When the time comes", Roskoph said, "I want to enjoy my retirement. I really do not want to feel like I need to watch every bead of sweat on Alan Greenspan's forehead. I don't want to be tied that intimately to the market." He presented to the group a simplified approach to asset allocation that would provide a good return and relative peace of mind. The formula: Subtract your age from 115. The difference is going to be what you allocate to large-cap equities; the remainder is allocated to fixed-income instruments. For example, a 60-year-old investor would allocate 55 percent to stocks and 45 percent to bonds.

"In analyzing what markets, capitalizations, and bonds have done over the past several decades – in recessions, de-

See "Retirement" page 8

Retirement from page 7

pressions, booms, busts, peace, war – you find that an allocation of 63 percent into large-cap stocks and 37 percent into intermediate-term government bonds (10-year), will give you safe, critical mass. You will have a collection of monies built to withstand the best of times and the worst of times, regardless of when you take retirement.” Roskoph noted that this allocation would give you a safe 4.15 percent distribution to last from age 65 to 95. “This gets us to the basic rule of 24”, he explained. “If you take what you want in retirement for an annual distribution at age 65 and multiply it by 24, you have a safe Critical Mass.” The emphasis of that statement is on the word “safe”. If you want to take out

more than 4.15 percent, it gets more challenging and presents greater risk, he noted.

Just How Long Will I Live?

But what if you live beyond age 95? At present, life expectancy is considered to be 98.5 years. Human Genome research is just underway and has the potential to not only decrease morbidity, but also substantially extend life. So, what happens to your retirement blueprint if you live longer than planned? And how does that affect that 4.15 percent you were going to draw out? “You just need to be a little more careful about the deductions from that pool of assets”, Roskoph said.

The question, however, still remains. Can you afford to live too long? ■

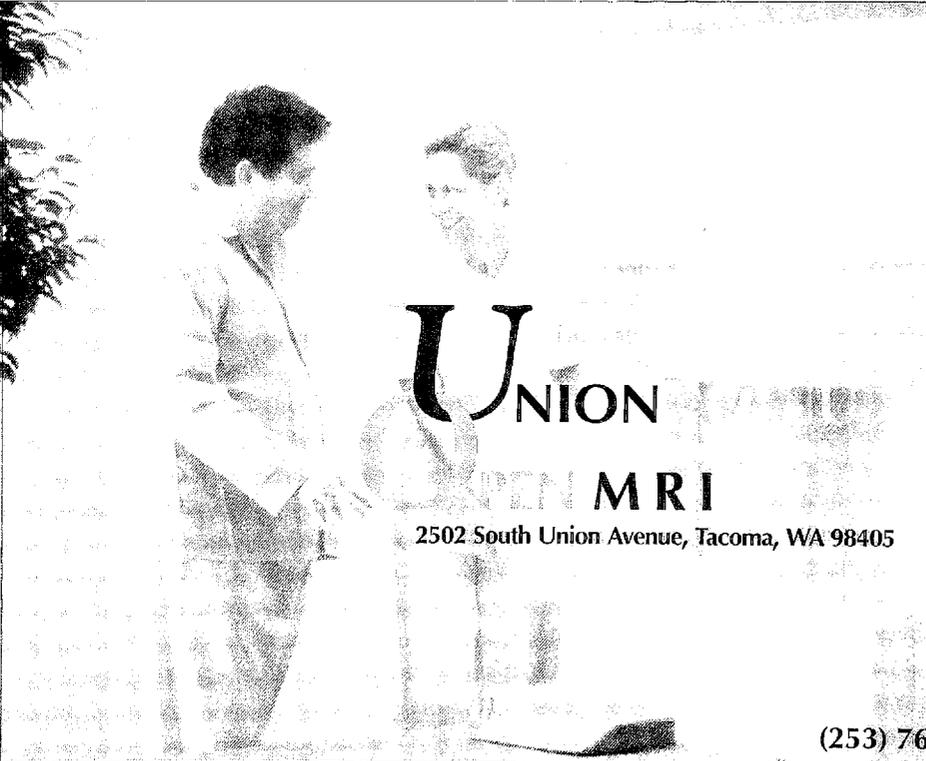
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Mike Kreidler

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- ▶ University Place native
- ▶ Doctor of Optometry (Pacific University)
- ▶ Master's in Public Health (UCLA)
- ▶ Group Health Optometrist (20 years)
- ▶ 16 years in Washington State Legislature

Discussions will include:

Priorities and plans for the office

Specific changes and how they will impact health insurance in Washington state

Restoring the individual insurance market

Oversight of plans: contract review, network adequacy, compliance, etc.

Kreidler's Crystal Ball: How will our health care system operate in 2010???

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Immunizations *from page 5*

and perhaps the most important and most challenging component of all — the immunization registry system.

CHILD Profile is Washington State's health promotion and immunization registry system designed to help ensure that Washington's children receive needed preventive health services. It is jointly managed and operated by the Snohomish Health District and Public Health Seattle and King County, in collaboration with Washington State Department of Health. It has been funded primarily by public and private grants since its inception in 1993.

"The registry is one centralized repository for the state", according to Sherry Riddick, Customer Service Manager for CHILD Profile. "When a child's record is pulled up, providers can see at a glance exactly what immunizations a child has had and needs. It's an incredibly valuable tool for the provider and staff.

"Ours is an increasingly mobile society," Riddick continued. "If a child changes health care providers, the new provider may access the registry to review records and input new information ensuring the child's immunization information is updated in one central location. And with an increasingly complex immunization schedule and the frequent addition of new vaccines, the challenge of maintaining up-to-date information is compounded."

There is no charge for the services CHILD Profile offers, Riddick explained. "With the support of federal, state, and private foundation funds, CHILD Profile is committed to providing registry services into the future at no cost to participants."

Nationally, the development of immunization registries is promoted by the CDC and other organizations as a way to monitor and increase immunization levels of children. It has proven to be a benefit to providers and parents alike. Demographic information is en-

tered into the system from the public portion of the birth certificate and by participating health care providers. This information forms the foundation of two components of the CHILD Profile system — reminders and health information mailings for parents, and the immunization registry for health care providers. This two-pronged approach is based on the belief that children's health is most effectively improved when parents and health care providers work together.

For health care providers, the immunization registry component is a tool that allows access to patients' immunization information in a shared, secure database. It includes:

- Immunization histories
- Recommendations of immunizations needed
- Recall lists and mailing labels of patients needing immunizations
- Vaccine usage reports
- Data for practice-specific immunization reports, such as CASA
- Tracking of children eligible for state-supplied vaccine

Office staff and providers can look up immunization histories; update immunization information; enter new children and immunizations into the system; update addresses of patients; print an individual's immunization record; view and print recommendations of needed immunizations; and enter and view exemptions.

"This is an excellent way to better track immunization coverage/levels and raise rates," according to Cindy Miron.

In addition to the obvious time saving benefits of reducing paperwork, offering a centralized resource of information, and eliminating multiple documentation, CHILD Profile can:

- be accessed with any computer that can run a terminal emulation pro-

gram or has access to the Internet. There are four access methods available so providers can choose the one that best suits their individual practice needs. The service does not require any special software.

- ♦ generate several types of reports including documentation required by the county, state and the CDC

- ♦ ensure vaccine safety by providing notification of vaccine recalls

- ♦ provide parents with a consolidated list of all vaccines — a great benefit for providing information to schools, day care and for sports activities

- ♦ identify areas of need, enabling public health departments to reach out to those communities and work to increase immunization rates

One very important and valid concern among providers is confidentiality and security. Access to CHILD Profile is available to providers who sign an information-sharing agreement that emphasizes confidentiality, privacy and security of the registry. "This is a very secure system," Riddick noted, "featuring several different levels of security requiring log-in, passwords, fire walls, and other state-of-the-art security features."

"It will be very important in the future to have a system to track and create a reminder recall system that makes it effortless for providers and parents," Dr. Gray said. "Currently, the system can be manually intensive, and we realize that is a barrier. But technology will be continually enhanced and the barriers will fall."

"For nearly 70 percent of all children in the state of Washington, some immunization data already exists. The more physicians participating in the registry, the greater the amount of data available for all," Riddick noted. "We understand that staffing is an issue, and that is why we help with alternative ways to get historical data into the reg-

See "Immunizations" page 21

How to contact your state and national lawmakers

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

U.S. Senators and Representatives:

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

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

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

Rep. Adam Smith (D-9th), 116 Cannon House Office Building, Washington D.C., 20515; 202-225-8901 (DC) or 253-926-6683 (Tacoma) or toll free 1-888-764-8409; FAX: 253-926-1321, email: adam.smith@mail.house.gov

State Offices:

Governor Gary Locke, Legislative Building, PO Box 40002, Olympia 98504-0001, 360-753-6780, FAX: 360-902-4110, home page: www.governor.wa.gov

State Representatives: Washington House of Representatives, PO Box 40600, Olympia, WA 98504-0600

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

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

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

2nd District, (South Pierce County)

Sen Marilyn Rasmussen (D) 786-7602; rasmusse_ma@leg.wa.gov
Rep Roger Bush (R) 786-7824; bush_ro@leg.wa.gov
Rep Tom Campbell (R) 786-7912; campbell_to@leg.wa.gov

28th District, (West Tacoma, U.P., Fircrest, Lakewood)

Sen Shirley Winsley (R) 786-7654; winsley_sh@leg.wa.gov
Rep Mike Carrell (R) 786-7958; carrell_mi@leg.wa.gov
Rep Gigi Talcott (R) 786-7890; talcott_gi@leg.wa.gov

25th District, (Puyallup, Sumern, Milton)

Sen Jim Kastama (D) 786-7648; kastama_ji@leg.wa.gov
Rep Dave Morell (R) 786-7968; morell_da@leg.wa.gov
Rep Sarah Casada (R) 786-7948; casada_sa@leg.wa.gov

29th District, (South Tacoma, South End, Parkland)

Sen Rose Franklin (D) 786-7656; franklin_ro@leg.wa.gov
Rep Steve Kirby (D) 786-7996; kirby_st@leg.wa.gov
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Sen Bob Oke (R) 786-7650; oke_bo@leg.wa.gov
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Rep Brock Jackley (D) 786-7802; jackle_br@leg.wa.gov

30th District, (NE Tacoma, Federal Way)

Sen Tracey Eide (D) 786-7658; eide_tr@leg.wa.gov
Rep Maryann Mitchell (R) 786-7830; mitchell_ma@leg.wa.gov
Rep Mark Miloscia (D) 786-7898; miloscia_ma@leg.wa.gov

27th District, (North Tacoma, East Side)

Sen Debbie Regala (D) 786-7652; regala_de@leg.wa.gov
Rep Ruth Fisher (D) 786-7930; fisher_ru@leg.wa.gov
Rep Jeannie Darneille (D) 786-7974; darneill_je@leg.wa.gov

31st District, (East Pierce County)

Sen Pam Roach (R) 786-7660; roach_pa@leg.wa.gov
Rep Chris Hurst (D) 786-7866; hurst_ch@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 2001 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS, 572-3667. ■

Directory Changes

Please make note of the following changes to your 2000 PCMS Directory.

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Change address to:
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Phone: 572-8777
Fax: 572-8835

Glen Deyo, MD

Change address to:
7206 Meadow Park Rd W
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Lael Duncan, MD

Change address to:
222 15th Ave SW Suite B
Puyallup, WA 98372
Phone: 845-8991
Physician Only: 845-0609
Fax: 845-9148

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Defining Public Health

"The challenges of public health have never been greater, either in ... Los Angeles, ... Minnesota, or ... the Russian Federation. The community has expanded ... (to) ... six billion human beings, more than five billion of whom live in the global equivalent of New York City's 1890's tenements.

Public health needs to be – must be – global prevention."

(Garrett, Laurie. Betrayal of Trust: The Collapse of Global Public Health. Hyperion. New York: 2000.)

Pulitzer-prize winning author and Newsday Science Editor, Laurie Garrett, sounds a clarion call in her new book, *Betrayal of Trust*. The book is a good read, whether you like a good medical detective story or an engaged, researched essay on the collapse of public health. Her well-documented contentions:

- 1) globalization means that no one is safe from epidemics, environmental toxins or biowar;
- 2) the public health system, historically key to protecting our collective well-being, is too fragile to safeguard anyone, currently;
- 3) radical new approaches are needed, including working together – across disciplines and national boundaries – to prevent health problems and to respond in unity to any new disease that arises.

Garrett's intimidatingly thick book is filled with engaging anecdotes that show the impacts of changes in public health and hold one's interest through the avalanche of historical and present-day health statistics. She starts with a plague outbreak in 1994 in India, caused when residents abandon their communities after an earthquake. When they return and open the stores of grain, rats that have taken refuge in the warehouses pour out, sharing fleas

and yersinia pestis. Trying to avoid panic, the Indian government shared confusing data, and the World Health Organization found their labs unable to respond. By luck, rather than the concerted effort needed, the plague faded. And, most frightening, no specimens survived, so no one will know the true disease, etiology, and vector.

In the next chapter, health workers in Zaire (now Congo) were forced to re-use syringes and do without the simplest of medical equipment (gloves, microscopes, sheets for hospital beds). As a result, ebola spread throughout the community, on the hands of caregivers and medical personnel. An international effort brought that disease under control, for now. It is obvious from Garrett's report that without changes, which are not on the horizon, a new epidemic is waiting to erupt.

Garrett then traveled to Russia in 1997 to observe the onetime superpower's current state of health. Economic disaster has destroyed their health systems, compounded by alcohol abuse, environmental degradation, an abundance of violent gangs, overuse of antibiotics, and other changes among the citizens that draw a picture of Russia as a very unhealthy place.

Throughout, the reader can hope to hide behind the seemingly-excellent health system in the United States, but Garrett then takes that on, indicating huge gaps and political processes that leave us all vulnerable. Comparing public health of 100 years ago, Garrett outlines the decades of budget cuts, public disinterest, and political stress on private healthcare for the wealthy versus public healthcare for everyone. The result is a US public health infrastructure unable to handle a serious infectious disease outbreak. The US chapter is called, appropriately, "Pre-

ferring Anarchy and Class Disparity," indicating the impact of anti-governmentalism and class-based biases.

She then gives a vision of the future, with bioterrorism a real threat, leaving the reader shaken about the potential to fix any of this.

Garrett makes a number of important points, which boil down to the core competencies of public health. Public health, she says, is not "an ideology, religion, or political perspective" and then shows that when any of these powers meddle in public health, morality and morbidity rates rise. Instead, she argues that public health is the prevention of those factors which interfere with health, realized in such a way that all people – not just the wealthy, powerful, or those armed with insurance – benefit. She says that:

Public health is a negative. When it is at it's best, nothing happens: there are no epidemics, food and water are safe to consume, the citizens are well-informed regarding personal habits that affect their health, children are immunized, the air is breathable, factories obey worker safety standards, there is little class-based disparity in disease or life expectancy, and few members of the citizenry go untreated when they develop addictions to alcoholic or narcotic substances.

The Tacoma-Pierce County Health Department has been chal-



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lenged regularly by people who want to know why we privatized our clinics rather than serving indigent people ourselves, and what in the world we are doing asking people to stop smoking and abusing alcohol. The answer is very clear in Garrett's book: **we're trying to safeguard and protect the health of Pierce County citizens in the most effective ways, by preventing problems in the first place, and then monitoring diseases to be able to mount a response quickly.** As you know, we do that most effectively by using resources and partnerships with private providers. Together, we are responding in Pierce County to the challenges posed by Garrett's book. Put this important volume on your reading list. It may help you to understand even more clearly why our united effort is key to a healthy future. ■

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In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

The Quest for Certainty

"Oh! Let us never, never doubt

What nobody is sure about!"

Hilaire Belloc (1897)

If nothing else, the recent election should have proven to most people that when you count thousands of items several times, you get several different answers. Mathematicians have known for a long time that when you deal with reality, numbers are only approximations. I wonder whether the general public will understand that, too. Another point is that the more carefully we count, the more expensive it becomes. When our money consisted in coins of silver and gold, we frequently could dispense with the counting, weighing the bags of coins instead.

For whatever reason, people crave certainty. They want to know what will happen next. When something happens, they want to know why. The lack of explanation is even more distressing than the lack of foreknowledge. It creates more uncertainty in the minds of people, perhaps because it creates the feeling that things are out of control. Generally, we have control over our lives, but only within certain limits, not fully. Many people have some difficulty accepting that.

This quest for certainty, or is it for reassurance, must be a basic human need. It has existed since the beginning of history. Answering it has been, and still is, a big business. The temple of Apollo at Delphi was one of the richest in the ancient world. The oracles were consulted by kings and states from all over the Eastern Mediterranean and the Middle East. The interpretation of dreams and omens; the

reading of entrails of sacrificial animals; the meaning of planetary positions; the vision of prophets, seers and psychics were widely sought, and still are. Many people are eager to believe that someone can tell them what the future holds for them. Many people base their decisions on such advice.

In obstetrics, we frequently are confronted with the question of the baby's sex. In the past, that was a question for psychics and seers, but now it is mainstream medicine. Even though the ultrasound scan is not always correct, it is much more reliable than a psychic. Some people are willing to pay for this, but most aren't. At least, not if they don't have to. Why is it so important? How much is such knowledge worth and who should pay for it? At present, we don't have a good answer to these questions. Medicine does not function in a free market, where such questions can be answered.

For patients, a certain symptom may provoke anxiety about the possibility of a serious illness. They may even know someone who started with vague aches, tightness in the chest, heaviness in the abdomen, and ended up with a heart attack or cancer of some sort. In other situations, patients may not want to know. Beyond the consideration of cost, the child of a patient with Huntington's chorea may have to make perhaps one of the most difficult personal decisions. The chance of carrying the gene is 50% and a test is available. Some have chosen to find



Andrew Statson, MD

out, frequently out of concern for their own children. Others have found it easier to live without knowing.

One patient presented with a 3-4 year history of recurrent right lower quadrant pain. She described it as a sharp pain, sometimes bad enough to double her over, which came almost every day, not related to her cycle nor to any activity, lasting less than a minute. She wanted to know what caused it and whether she would have to live with it for the rest of her life. In the presence of a negative physical examination, how far do we go in testing?

Another patient said, "I'm worried about my baby, doctor. Is my baby going to be okay?" Probably, but how can one be sure? The ultrasound scan did not show anything obvious. Overall, the chance of malformation if a baby is born at term is less than 4%. The chance of major malformation is about 1%. This is based on the clinical observation of millions of births. We could say with a 95% confidence that the baby would be normal.

Such a confidence level would meet the criteria for evidence based medicine. However, our legal friends strongly discourage us from making such a statement. If we were to tell the patient "We will take care of you and the baby will be normal", we would be making a promise and entering into a

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contractual obligation. If by any chance the baby were not normal, we would have breached our contract with the patient and could be liable for damages. Gone are the days when we could look at the odds for the outcome and reassure the patient.

There are many situations like that, where patients insist on test after test. They may even accuse us of a lack of compassion or caring for their baby, if we were to refuse them a scan. Sometimes they are right and a scan may reveal a problem. Frequently, however, the scans are normal. Even then, we cannot reassure them. Yet, often enough, whether we find some kind of a problem or not, the management of the pregnancy will remain the same. We will not act on the information.

Scans are popular with patients because the technique itself does not have known side-effects. The problems with ultrasound scans are related to misinterpretation, either by seeing something that is not there, or by not seeing something that is there. The patients are much more reluctant to undergo tests, such as amniocentesis or umbilical vein sampling, because of the risks to the fetus.

The patients' requests for reassurance can lead to expensive testing. Insurance plans and government programs create a different problem. They ask for certification of disability, return to work or life expectancy for their beneficiaries. Some time ago, nursing homes in New York had a problem with Medicare. As far as I remember, the report said that Medicare would cover nursing home care for eligible patients during the last six months of their life. Physicians were asked to certify that the patients were expected to die within that period of time, so they could be admitted to a nursing home. As you would guess, some patients did not cooperate, but continued to live for a while longer than their allotted time.

As a result, Medicare requested that the nursing homes refund all payments for care in excess of six months.

The nursing homes then turned to the certifying physicians and refused to admit any of their patients unless it was absolutely certain that they would die within the prescribed time. Thus, many patients were held back and admitted only when they were practically dying. The average nursing home stay for these patients dropped from about 18 days to about 11 days. The families complained to their congressmen and eventually Medicare had to relax its rule.

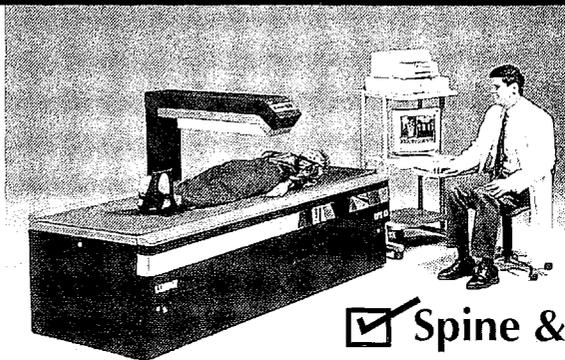
The problem with such rules is that it is impossible to know how long a patient may live. In his *Ethics*, Aristotle wrote, "It is the mark of an educated man to expect in each subject the sort

of precision of which it is capable."

When a physician certifies a patient, who then lives longer, the physician and the nursing home get in trouble with Medicare. When the patient dies sooner, he is deprived of a benefit to which he is entitled. How can we know for sure what will happen to such a degree of accuracy? This is a situation in which we cannot win.

Medicine has made great progress within the last century. We have learned a lot about many diseases, their course and the effect of their treatment. Frequently, we can guess the outcome. We can never be absolutely certain. However, there is one thing in medicine we can be sure about. It is that all of us will die some day. Probably. Rejuvenation treatments might be right around the corner. If so, sign me up. ■

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COLLEGE OF MEDICAL EDUCATION

Women's Medicine CME Rescheduled for May 18

The third annual CME program on Advances in Women's Medicine has been rescheduled for May 18, 2001. The conference will be held at St. Joseph Hospital and was previously scheduled for February 9, 2001. The course is a one-day program addressing a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this CME program will feature issues related to diagnosis and treatment advances in treating illness in women. **John Lenihan, MD**, the course director, promises presentations on timely subjects with "outstanding" national speakers. ■

Allergy, Asthma & Pulmonology CME - May 4

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

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

At present, initial planning includes presentations on: COPD, Pneumonia, Asthma & Allergy. ■

Continuing Medical Education

Internal Medicine Review 2001 scheduled for March 8 & 9

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

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

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

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

- DVT Prevention and Treatment: The High Risk Groups
- Sleep Disorders and Drug Addiction: Behavioral and Medicinal Strategies
- New Treatment Options for Diabetes Patients with Syndrome X The Role of ARB's in Diabetic Nephropathy

- Geriatric Depression
- Diagnosis and Treatment of Infection in Lower-Airway Disease
- New Innovative Treatments of Rheumatoid Arthritis
- Manipulation of the Unstable Coronary Plaque: New Strategies Towards CHD Prevention
- What's New in Antimicrobial Therapy
- Insulin Secretory Defects in Type 2 Diabetes: The Issues and Answers
- Laryngeal Pharyngeal Reflux: Extra Esophageal Therapies
- Reluctance to Prescribe Opiates: The Issues and Answers
- Osteoporosis Update: A Practical and Pharmacological Approach
- Latest Developments in the Diagnosis and Management of Alzheimers ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Thursday-Friday March 8-9	Internal Medicine Review 2001	Ulrich Birlenbach, MD
Friday, April 6	Pain Management	David Paly, MD
Saturday, April 28	Surgery Update	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Tuesdays, May 16 and 23 (evenings)	Medical Technology	TBA
Friday, May 18	Advances in Women's Medicine	John Lenihan, Jr., MD

CME at Whistler program maintains popularity

CME at Whistler, the College's winter resort program brought together a number of Pierce County physicians in British Columbia for family vacationing and continuing medical education. A number of physicians outside Pierce County also joined the group.

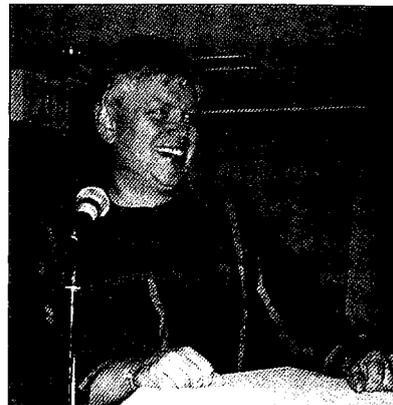
The program featured a potpourri of educational subjects of interest to all medical specialties.

Conference attendees particularly

enjoyed the rare opportunity to have in-depth discussions about clinical situations.

Out of the classroom, conference participants and their families enjoyed snow, skiing and other social activities. The program was directed by **John Jiganti, MD**, Tacoma orthopedist.

The College will plan a ski CME program next year and will likely return to the Whistler resort area due to its popularity.



James M. Wilson, MD answers questions about geriatric assessment



Drs. and spouses, Mark Ludvigson and Carol Kovanda enjoy the sun on top of Blackcomb Mountain



Carlos Moravek, MD and Kevin Schoenfelder, MD take a break on one of the Blackcomb Mountain runs



Dr. Steve Settle and wife Sheila in front of the Aspen's Lodge with their nephew David and niece Anna



The Jiganti family, including sons (l-r) Max, Zach and Kyle, finish a big day on the slopes



Peter Krumins, MD with son Benjamin (left) and Kyle Jiganti



Maureen Mooney, MD, new dermatologist in Pierce County



CME at Whistler regulars, Dr. John Samms and his wife, Kathy



Douglas Hassan, MD discussed common hand problems



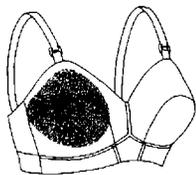
Gregg Schlepp, MD (left) with friend Bob Starkey



Gig Harbor physicians John Jiganti, Tom Herron and Mark Craddock (l to r) with their wives



Ralph Katsman, MD, Tacoma gastroenterologist and Maureen Mooney, MD, Puyallup dermatologist



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Immunizations from page 10

istry – such as through electronic downloads of billing data.”

CHILD Profile in Action: Community Health Care Tacoma

Community Health Care Tacoma is currently piloting CHILD Profile in two of its clinics and plans to bring other clinics on board. Sandy Bauer, Immunization Coordinator for Community Health Care in Tacoma, explained that the clinics are utilizing the Web-based access method (CHILD Web) for data entry in the clinics. Clinics with Internet access, or those that operate on an Intranet, can easily establish access to the registry. Typical users are large clinic organizations or any provider with Internet access.

Bauer hopes other users of the system will spread the word about its value and benefits. “The population our clinics serve is very mobile, but the patients’ records are not. It’s very common for parents to have outdated or nonexistent information about their child’s immunizations.

“It’s a fast and efficient system, and very easy to use,” Bauer continued. “While there are barriers to overcome, offices have to realize what tremendous benefits come with this. From my personal experience, the data entry is really not a big hindrance,” Bauer explained. “True, historical data needs to be entered, but the time spent initially saves so much time later. The perception is that it’s a lot of work, but the return is wonderful. I believe physicians and the community will realize the benefits.”

“It’s important for the entire office staff to recognize the importance of a registry tracking system,” Cindy Miron said. “Anyone working in a providers’ office knows that it’s entirely possible to call several different places to get information on a patient. CHILD Profile offers a one-stop resource.”

“We strongly encourage providers to participate,” Riddick added. “The

more data we have in the system, the greater the effectiveness of the registry. The better the system, the greater the benefits.”

“It is my goal for CHILD Profile to get every child in Washington State on the registry,” Dr. Gray stated.

In the meantime, Gray encourages anyone who is doing pediatric medicine to do whatever necessary to see that kids get the required immunizations by the age of two. “Immunizations are a mundane subject,” Gray

admits, “and that’s great! But we can’t become complacent. It’s like breathing — if you forget to do it, you die.”

“There is no single, magical way to raise immunization rates,” Miron noted. “Many elements are involved, and that’s what makes it so challenging. But it can be done. We are all accepting of the fact that change comes slowly.”

“Developing vaccines is a luxury that was hard earned,” Dr. Gray said. “We’ve done amazing work in the last 50 years. We can’t let that slip away.”

Editor’s Note: For more information about the Pierce County Immunization Coalition call Sue Asher at the Medical Society, 572-3667, or Cindy Miron at the Health Department, 798-6556.

For more information about CHILD Profile, call (425) 339-5242 or (800) 325-5599, or check their web site at www.childprofile.org. The web site is an excellent place for providers interested in participating in the registry.

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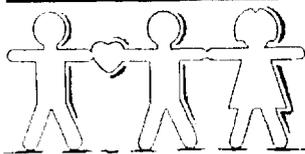
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Equipment needed for community clinic: The Neighborhood Clinic of Tacoma (staffed by volunteers and providing care to the local indigent population) is seeking an inexpensive or donated spot-check oximeter and a laboratory microscope. Other needs include stethoscopes, sphygmomanometers, otoscopes, exam lamps and office surgery instruments. Contributions are tax deductible. Please contact Phillip Schulze, MD, 253-858-5263 or watx@foxiinternet.net.

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Pierce County Medical Society



April, 2001



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Pierce County Medical Society

BULLETIN



April, 2001

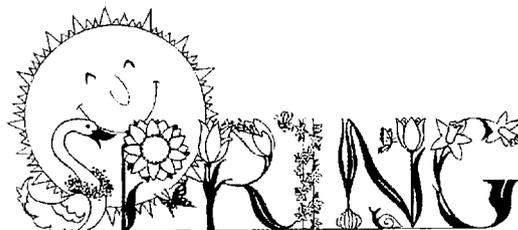


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The Bulletin is published monthly by PCMS Membership Benefits, Inc. for members of the Pierce County Medical Society. Deadlines for submitting articles and placing advertisements in The Bulletin are the 15th of the month preceding publication. (i.e.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

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

Managing Editor: Sue Asher
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Advertising Information: 253-572-3666
 Subscriptions: \$50 per year, \$5 per issue

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President's Page

by Patrice Stevenson, MD

Spring Cleaning

Remind me to clean my office more than once very fifteen years! As I mentioned in my first President's Page this would be a year of transitions, including moving my office into space in the new Good Samaritan Rehabilitation Center. I am half way done...now the unpacking and reorganizing begins. I have been in the same office since I started practice after residency in 1985. Somehow I was more organized back then. It may have something to do with the addition of three children over the years or the fading of youthful enthusiasm or the fact that no one was grilling me to quote the article that just came out. There was always some guy in medical school that seemed to have a copy of the article from The New England Journal of Medicine that just came out the day before in his back pocket and was ready to impress the attending with his ability to quote the hot off the press literature. I wonder what his office looks like today. I have always "ripped and clipped" journal articles then filed them in appropriately labeled file folders that were alphabetically

arranged in the file cabinet. When I was chief resident it seemed I was always preparing to give a talk on something and then had most of the current rehab literature at hand. I think I last really filed something in that system in 1986 before I took my oral boards and would be expected to be very familiar with the current literature. Since old habits die hard I had still been **meaning to file** the articles that I have continued to rip and clip since then. The results of my good intentions were piles and piles of articles yellowing while waiting to be filed. More recently, I was just piling up journals with sticky notes marking the articles waiting to rip and clip. You get the picture...no horizontal surface uncovered...it was not a pretty sight!

I had to fight a strong urge to sort through these piles as I packed. I then came to the realization that if I hadn't needed that article in the last fifteen years then I was unlikely to need it in the next fifteen. It also occurred to me that it just might be getting a little out of date by now and if I someday really needed it I



Patrice Stevenson, MD
President

could probably track it down from an Internet literature search. I felt free! I could toss out tons (or at least many pounds) of piles! I essentially filled a very large recycle dumpster starting with my neatly labeled files from residency. I even came across a certificate of completion from a Career Track Seminar I took in the past entitled "Organizing Your Life and Ending Clutter." Of course it was deep in a pile but now adorns my empty old office door.

I also had saved many political and business type articles relating to medicine, along with prior years of strategic plans for various organizations. I was struck by the fact that for many of these I could have put today's date on them and no one would know the difference. Other predictions never came true (such as a totally capitated health care delivery system). I recycled them too. It felt good! Now on to the piles at home... ■

Senate Bill 5993 will ban smoking in facilities where minors are present

At press time, Senate Bill 5993, which will effectively reduce public smoking, had been approved by the Senate and forwarded to the House. After House passage, and approval by the governor, the new law will prohibit smoking in public except for taverns, lounges and cardrooms.

Historically such legislation would never have made it out of committee. But in today's climate, where voter initiatives are outlawing smoking in public entirely, the normal foes of such legislation, the tobacco industry and restaurant association, view this legislation as a compromise to a total

ban.

The restaurant industry actually helped craft the initiative. Experience has proven that curtailing smoking in restaurants actually increases business. Cleaning costs are reduced, employee health and morale increase and potential liability of not providing a safe work place for employees is drastically decreased. And, of course, education about the effects of second-hand smoke to non-smokers, particularly children, has raised awareness about the need to lessen exposure to tobacco toxins.

This legislation also levels the

playing-field for all restaurants state-wide. Tacoma and Pierce County restaurants continually opposed local legislation that they feared would drive customers to King or Thurston counties. A state regulation makes all restaurants operate with the same rules, a rule that many supported if mandated on a state-wide basis.

Call your representative today (see page 15) to voice your support for Senate Bill 5993. And don't forget to call and thank your senator for passing this "healthful" legislation. ■

Spina bifida education could save thousands of lives

Because most women tend to get their health information from what they read and hear, the Spina Bifida Association of America (SBAA) "Folic Acid Counseling Kit" hopes to encourage increased discussion between women and their health care providers. A recent survey reported in *Reuters Health* found that only 30 percent of women of childbearing age knew why folic acid was important. Approximately one out of every 1,000 newborns suffers from spina bifida, a permanently

disabling birth defect.

Folic acid preventable spina bifida and anencephaly could be reduced by up to 75 percent if women take the recommended doses of folic acid.

The resource kit contains patient education materials and a pocket-counseling card for physicians to quickly provide folic acid recommendations to their patients. The U.S. Public Health Service recommends all women of childbearing age consume 0.4 mg of folic acid prior to becoming

pregnant and during the first trimester of pregnancy. Furthermore, according to the recommendation, women who have had a child with spina bifida or a history of neural tube defect pregnancy need 4.0 mg of folic acid by prescription.

The AMA encourages physicians to help protect children during their fetal development by communicating this message to their patients, family and friends. ■

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Community group considers prevention for dental needs of children

Several members of the medical/dental community convened in March to discuss a program to provide preventative dental services for Pierce County children under five. It has been estimated that 71,000 kids between one and 18 are eligible for dental care funded by Medicaid, but only 22,000 received care. Everyone is in agreement that the need exists and no one will deny the real trauma that untreated dental problems bring to a young child's life. There is no argument that prevention works and with education, fluoride treatments, sealants and regular check-ups, dental catastrophes for children can be avoided.

At the table to hear about what is happening in other counties in the state were medical and dental society leaders, local health department and state representatives, community clinic volunteers and staff and community agency representatives. In other counties, the ABCD program (Access to Baby and Child Dentistry) has been implemented and focuses on preschool children from birth to age five. The program began as a pilot program in Spokane County from efforts of the Medical Assistance Program and the Washington State Legislature to expand Medicaid dental services for children. In Spokane, the program is operated as a partnership of the Medicaid program, Spokane Dental Society, Spokane Regional Health District, Washington State Dental Association and the University of Washington. Dentists in the program are trained and certified and receive enhanced payments to provide improved dental services to the young clients. Case-management services are provided to minimize the number of missed appointments.

Karen Sorenson, DDS, organizer of the Pierce County meeting, practices two days a week at the Lindquist Clinic and recognizes the severe need

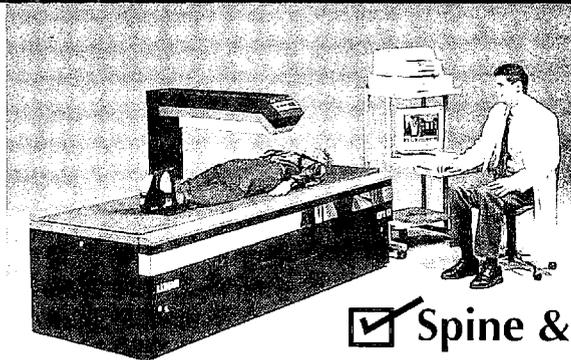
for prevention. "My time will be much better spent trying to implement a prevention program for these children as opposed to continuing to drill and/or remove their teeth," she explained. "The need is huge," she added.

Several issues were discussed that create barriers for treating these very young folks. "Many dentists are not comfortable with their skill level in treating infants and young children," noted Dr. Peter Milgrom, from the University of Washington School of Dentistry. "They say they can't afford to take Medicaid children, but sometimes the real issue is fear of treating young patients." Add to this that most

dental offices are very busy and with the administrative and practice burdens of treating Medicaid patients, many dentists opt out. Only about one-third of people in the state go to the dentist regularly. With dental offices as busy as they are, Washington state does not have the resources to provide care.

Which is all the more reason that the community needs to solve the problem from a comprehensive, prevention approach. Dr. Sorenson is on the right track of bringing community representatives together to brainstorm creative solutions for Pierce County's children. The reward will be their smiles. ■

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

A Crisis in Dental Health

Recently, I published an article in the *Tacoma News Tribune* (March 4, 2001) about the difficulty



Federico
Cruz-Uribe, MD

low income children faced in accessing dental care in Pierce County. There are approximately 70,000 children

eligible for care but only about 22,000 actually make it into a provider, because there are so few providers who accept families with Medicaid.

No one argues that these kids shouldn't have services. The need is glaringly obvious. The Health Department's Dental Hygienist regularly screens students in the elementary schools across the county. She finds gross dental disease in small mouth after small mouth. And following their screening many of these kids do not get the restorative and on-going care that they need, even with information and referrals sent home to parents.

A typical response to this problem is a knee jerk reaction: focusing on the dysfunctional nature of our health care system. In particular, we hear about the horrible problems both users and providers encounter when participating in the Medicaid

program. I've collected a laundry list of system problems, low reimbursement being but one of many. But we cannot allow this to distract us from the basic problem: kids are not able to access the care they need to be healthy. This should be our driver.

Much as I wish that our elected officials in Olympia and in Washington, DC had the answers, I have learned from bitter experience that it is not wise to wait for their answers to local needs. Of course we must work with our elected officials to craft long term solutions to systemic problems. And we do need to build a more rational health care system. But, this does not give us the luxury of stepping away from critical problems that need our attention right now. We must participate with our communities in addressing real-time problems now. So the Medicaid program is seriously flawed. Does that mean we do not treat the needy children in the meantime? In the area of dental health, unfortunately that is what has happened. Dentists over the last ten years have grown increasingly disconnected from the Medicaid program and have abandoned it in droves. We've now reached a point where only about 4% of dentists participate in any meaningful manner. This means that ever increasing numbers of ill children have been turned away. This is unacceptable. We can do

better than that.

Before the federal government stepped in with the Medicaid and Medicare systems, county governments were on the hook for assuring that there was a response to the healthcare needs of the indigent. Our county responded by developing a system of county clinics and a county hospital for providing the basic care needed for the uninsured. Private medical providers were responsible for taking their share of patients through this system. The vast majority of these kinds of systems across the United States closed over the years as the Medicaid and Medicare systems became functional. But those systems could only do what they were intended to do if providers continued to participate. If providers didn't take on their share, patients fell through the cracks. Sometimes in small numbers but as in the case of our local dental providers, the numbers have become alarmingly large.

What are our alternatives? Though re-instituting the county clinic system seems like a radical step, unless we can come up with real-time alternatives to get the needed care to our children, it may be the best option open to us.

What do you think? I'd be interested to know what your ideas are for care for indigent kids in Pierce County. ■



Personal Problems of Physicians Committee

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Legislative Updates

Optometrists' and naturopaths' attempts to expand their scope of practice continue. SHB 2034 and SSB 6000 provide a broad expansion of the definition of the practice of optometry and prescriptive authority. SB 5581 would allow naturopaths to be referred to as physicians, and ironically, would give them prescriptive authority for legend and controlled substances. These remain alive in the legislature and need your voice to be defeated. (See page 15)

SB 5211, Partial Mental Health Parity for Kids has passed the Senate and has moved to the House. This bill addresses the disparity between insurance coverage for mental health services and coverage for medical surgical services and requires a minimum level of mental health coverage for children. Please call your representative, particularly if they are a member of the House Health Care Committee and voice your support. (See page 15) ■

Payment Integrity Program

DSHS has agreed to work with a group appointed by the WSMA to review the program's "black box" algorithms and prejudicial communications with medical practices. However, this is in no way an endorsement of the PIP program. Medical practices statewide continue to limit their acceptance of Medicaid patients or drop out of the program altogether. These difficult decisions must be made on an individual basis factoring in the complexities and offensiveness of the PIP program. ■

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Residency: Highland Hospital, NY

**Baca, Carlos E, MD, PA
General Practice**

Western State Hospital
9601 Steilacoom Blvd,
Steilacoom 98498; 582-8900
Medical School: Universidad Nacional
Mayor De San Marcos, Lima, Peru
Internship: Hospital Del Empleado

**Bernardo, Johann V, MD
Internal Medicine**

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Philippines College of Medicine
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Residency: Metropolitan Hospital, NY

**Berns, Robert M, MD
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Residency: Santa Monica Hospital

**Chang, Emery J, MD
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Practices at Tacoma South Med. Clinic
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Internship: Boston University
Residency: Western Reserve Care

**Cieri, Martin V, MD
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Residency: Strong Memorial Hospital

**Fegley, Janis E, DO
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Medical School: Philadelphia College
of Osteopathic Medicine
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**Field, Dean A, MD
Family Practice**

Practices at Gig Harbor Medical Clinic
6401 Kimball Dr, Gig Harbor 98335;
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Medical School: University of Arizona
Internship: Good Samaritan Medical
Center, Phoenix
Residency: Good Samaritan Medical
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**Ho, Phoebe F, MD
Ob/Gyn**

Practices at Tacoma South Medical
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539-9700
Medical School: USC, Los Angeles
Internship: USC, Los Angeles
Residency: Northeastern Ohio
Universities

**Hong, Hui, MD
Internal Medicine**

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Clinic, 2111 S 90th St, Tacoma 98444;
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Internship: Virginia Mason Med Ctr
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Fellowship: UCLA

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Residency: UW Children's Hospital

**Larson, Todd D, MD
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Res: Santa Barbara Cottage Hospital
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University, Afghanistan
Internship: Kabul University
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Fellowship: All India Institute of
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**Sullivan, Kevin J, MD
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Residency: UCLA

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Practices at Gig Harbor Medical Clinic,
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Medical School: George Washington
University
Residency: Bridgeport Hospital

**Woodman, Troy J, MD
Orbital Facial Surgery**

Practices David Pratt, MD
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627-2900
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Internship: U of Washington
Residency: Baylor College of Med
Fellowship: UCLA, Jules Stein Eye Inst

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In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

Too Good to Be True

*"A promise is binding in the inverse ratio
of the numbers to whom it is made."*

Thomas de Quincey



Andrew Statson, MD

A number of years ago, a reporter from one of the Seattle television stations addressed our medical group. He had investigated the ads that appear on television, selling some products which could only be obtained by mail. Most of them were in the price range of 20-30 dollars and were touted to be very useful and valuable. He ordered a number of these products, and as you probably expected, he received items that were poorly made, from cheap materials, which one could buy in a hardware store for a dollar or two. His conclusion was, as that of many other consumer protection reporters, that if it sounds too good to be true, it probably is.

I have been told that I have a right to health care. I am trying to figure out what that means. I don't know whether that is one of those inalienable rights, with which my Creator has endowed me. I have life, my right to it means to me that nobody may take it away from me. I presume that I would forfeit that right if I were to take someone else's life. I presume it should work the same for the right to liberty and the pursuit of happiness.

I would have these rights even if I were on an uninhabited island. I cannot imagine myself in such a situation, so I will look at the story of Robinson Crusoe. One his island, there were no predators to threaten his life. In any event, he had a rifle and could defend himself. His liberty was constrained by his need to provide for himself, but ba-

sically he was free to do what he wished, if able to do it. He also had the right to self-care. When he got sick, he took care of himself.

So that is one meaning of the right to health care. When I have a headache, I can take aspirin. When I have a cold, I can fix myself chicken soup. My right to such health care means to me that nobody may interfere with it. If I should take some herbal tea, or a food supplement; if I should use acupuncture, or moxibustion: as long as I did it to myself, nobody, not even the FDA, would be allowed to stop me.

I suspect that is not what is meant when I am told I have a right to health care. I suspect the meaning is that I can call on someone else to care for me. I suspect it means someone else is obligated to give me health care. Someone else must give it to me not because I will pay for it, not because I have done anything to deserve it, but because I want it.

How can such a system work? Robinson Crusoe obviously could not exercise his right, if he had it, to that kind of health care. He did not have someone else around, to whom he could submit his claim. In real life, this is a claim we as children frequently make from our parents. We even don't have to verbalize it. We are sick, we cough and snuffle, we hurt and cry, or we have a fever, and our parent are there, doing things for us, taking us to a doctor or to the emergency room, giving us the care we need to restore us to

health.

That is fine while we are children, when we depend on our parents for everything, not only for health care. What happens when we become adults, presumably self-supporting? As children, we were told home is where, when you go there, they have to take you in. When we became adults, this was not longer true. If we did not make a place a home and paid the rent, they would kick us out. We couldn't write checks if we had no money in the bank, either. The bank would not honor them. As we gradually take over the responsibilities for our own lives, and eventually even the responsibility to take care of our parents, do we not assume the responsibility for our own health care?

I suspect my right to health care means that we don't. The responsibility for my health care falls not upon me, but upon someone else, someone who would act in the role of my parents when I was a child. In a monarchy, the people are the subjects of the king, who treats them as his children and they call him "Sire." The king and his men support the hospitals, the hospices and the clinics, usually run by the church, which tend to the sick. In our republic, it is the Governor or the President and their agents who handle

See "Good" page 12

Good *from page 11*

things in a similar fashion.

How then do I make good on my claim to health care? In theory, I should be able to get it when and how I want it. In practice, it does not work that way. In practice, there are malingerers children, who pretend to be sick, just so they don't have to go to school. In practice, there are malingerers adults who pretend to be sick, just so they don't have to go to work. Parents usually know, or easily figure out, when their child is not really sick.

How are the governor's agents going to figure it out? By putting hurdles in our way to get health care. We have to prove that we are sick. We have to prove it is an emergency. We are made to wait in the emergency room, for an appointment, for a test, for an operation. I don't have to give you examples. We already have many of that sort around us. If you want to know more, ask any Canadian, Briton, or Russian. They'll tell you more than you want to hear.

My father lived in Montreal. He had a hernia he wanted to have repaired. He had to wait six months for an appointment with the surgical clinic. When he finally got to consult a surgeon, he was scheduled to have the repair done two years later. In the meantime, he had to wear a truss and put up with the disability and pain. When he presented to have the operation, they found an excuse to cancel it. He was not a complainer, so he put up with it. He died several years later, still wearing his truss. Is that what a right to health care means? The last I heard about health care in Canada, the waiting time for heart surgery was about six months; for a mammogram, about the same, for colposcopy in the presence of an abnormal Pap smear, about three months.

Under such a system, a person has to complain loudly enough, to whine, to cry, to beg. Some people may call this

kind of health care a right. In practice it is alms, given reluctantly, to a snivelling beggar. When I present my claim to health care, together with thousands others, the people who pass judgment on those claims, have no good way of knowing how real, how important, or how pressing my claim may be.

The resources assigned to take care of these claims are rapidly spent. The system, overwhelmed by the requests, has to resort to some kind of triage, to apportion limited resources in the face of unlimited demands. Meanwhile, the people who are expected to make good on these claims are overworked. They reach the point where they don't care anymore. They look on the people who come to them with their claims not as patients, to be treated, but as an annoyance, to be avoided. If they could brush off a claim in some way, or just delay it for as long as possible, they would gladly do so. Frequently enough, they are able to do just that.

When the system then turns to the sources of funds, such as the government or the insurance companies, it is told there is no more money to be had. The taxpayers and the ratepayers have rebelled against further increases in taxes and rates. At the same time, the recipients of health care are clamoring for more benefits. While all that is going on, the people working in the medical field burn out and leave.

Those who are still working are asked to do more and more with less and less, in the expectation that some day they will be able to do everything with nothing. That is what the dream of the perpetual motion machine was about. In the field of physics, that dream died many years ago. It still lives in the field of the social sciences. Medical care as a right, whenever and in any way we want it, without doing anything to earn or deserve it, given to us on the sole basis of our wishes, sounds too good to be true, and so it will turn out to be. ■

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Certificate Program in Medical Management This program provides participants with basic knowledge and practice-oriented skills in health services management, and helps participants determine if they would like to go further in their management training. The application deadline is August 21.

Both programs are offered by the University of Washington Department of Health Services and Educational Outreach with representation from the UW School of Medicine.

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Medical Societies in other states take aim and fire ...

Texas physicians issue nominations for "Clean Claims Hall of Shame"

The Texas Medical Association (TMA) is asking Texas physicians to submit nominations to its "Clean Claims Hall of Shame," to help the association spotlight reimbursement delays and denials it says insurers have turned into an "obscene art form." A recent TMA survey found that about 60 percent of all Texas physicians are reporting cash flow problems - despite two Texas prompt pay laws.

The 1997 law required insurers to

pay clean claims within 45 days, but insurers and health plans ignored the law because it lacked meaningful penalties and allowed health plans to modify the time period.

The 1999 law contained interest and other penalties, but health plans again were allowed to modify the time period required to pay.

"We want the public and lawmakers to know that when insurers refuse to pay what they legally owe to physi-

cians, patient care is put at risk," said TMA President James Rohack, MD. "We want a law with teeth."

The TMA proposal includes not allowing health plans to modify state law through contract provisions and providing strong civil penalties and administrative enforcement. TMA also is pressing the state insurance commissioner and legislature to do what is necessary to ensure that laws are enforced. ■

Illinois fair-contracting bill takes positive first step

After their Fairness in Contracting bill was passed last week by the Illinois House Executive Committee, the Illinois State Medical Society (ISMS) and its "Fairness in Contracting" coalition members are readying themselves for even stronger opposition from Illinois health plans. The bill would:

- Provide reasonable standardization and simplification of terms and conditions of health care service contracts with health plans to facilitate understanding and comparisons; and

- Eliminate provisions contained in health care service contracts which may be unfair, deceptive, misleading or unreasonably confusing in connection with the administrative requirements, services covered or with reimbursement or payment for services.

In addition to ISMS, the coalition includes the Illinois Hospital and Health Systems Association; nurses, physical therapy, podiatry, optometry and psychological associations; state dental and chiropractic societies; the Illinois Free-Standing Surgery Center Association; and the Illinois AFL-CIO. The coalition represents more than one million physicians and other professionals.

"We are committed to restoring the balance between large payors and individual health care

professionals and providers," said Leroy Sprang, MD, ISMS president. "No physician, health care provider or any professional should be forced into 'take it or leave it' and other unfair contract situations." ■

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Tacoma, WA 98405

Anthony Johnson, MD

Change address to:
5920B 100th Street SW #26
Lakewood, WA 98499

Robert McLees, MD

Change address to:
502 South M Street Second Floor
Tacoma, WA 98405

Joseph Robinette, MD

Change address to:
502 South M Street Second Floor
Tacoma, WA 98405

Craig Romney, MD

Change address to:
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Jay Sacks, MD

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How to contact your state and national lawmakers

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U.S. Senators and Representatives:

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

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

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

Rep. Adam Smith (D-9th), 116 Cannon House Office Building, Washington D.C., 20515; 202-225-8901 (DC) or 253-926-6683 (Tacoma) or toll free 1-888-764-8409; FAX: 253-926-1321. email: adam.smith@mail.house.gov

State Offices:

Governor Gary Locke, Legislative Building, PO Box 40002, Olympia 98504-0001, 360-753-6780, FAX: 360-902-4110, home page: www.governor.wa.gov

State Representatives: Washington House of Representatives, PO Box 40600, Olympia, WA 98504-0600

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

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

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

2nd District, (South Pierce County)

Sen Marilyn Rasmussen (D) 786-7602; rasmusse_ma@leg.wa.gov
Rep Roger Bush (R) 786-7824; bush_ro@leg.wa.gov
Rep Tom Campbell (R) 786-7912; campbell_to@leg.wa.gov

25th District, (Puyallup, Sumern, Milton)

Sen Jim Kastama (D) 786-7648; kastama_ji@leg.wa.gov
Rep Dave Morell (R) 786-7968; morell_da@leg.wa.gov
Rep Sarah Casada (R) 786-7948; casada_sa@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 Brock Jackley (D) 786-7802; jackle_br@leg.wa.gov

27th District, (North Tacoma, East Side)

Sen Debbie Regala (D) 786-7652; regala_de@leg.wa.gov
Rep Ruth Fisher (D) 786-7930; fisher_ru@leg.wa.gov
Rep Jeannie Darneille (D) 786-7974; darneill_je@leg.wa.gov

28th District, (West Tacoma, U.P., Fircrest, Lakewood)

Sen Shirley Winsley (R) 786-7654; winsley_sh@leg.wa.gov
Rep Mike Carrell (R) 786-7958; carrell_mi@leg.wa.gov
Rep Gigi Talcott (R) 786-7890; talcott_gi@leg.wa.gov

29th District, (South Tacoma, South End, Parkland)

Sen Rose 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

30th District, (NE Tacoma, Federal Way)

Sen Tracey Eide (D) 786-7658; eide_tr@leg.wa.gov
Rep Maryann Mitchell (R) 786-7830; mitchell_ma@leg.wa.gov
Rep Mark Miloscia (D) 786-7898; miloscia_ma@leg.wa.gov

31st District, (East Pierce County)

Sen Pam Roach (R) 786-7660; roach_pa@leg.wa.gov
Rep Chris Hurst (D) 786-7866; hurst_ch@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 2001 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS, 572-3667.

Physicians Insurance report claim trends by specialty

With the rise in public expectations of the medical system and the legal system's pro-plaintiff bias, it is no surprise that claim frequency and severity are increasing. To help physicians avoid situations and behavior that can lead to malpractice claims, Physicians Insurance continually identifies and analyzes claim trends. National data and their own records tell them that the **highest total payments involve brain-damaged infants, breast cancer, pregnancy, and acute myocardial infarction.** Below is a list by specialty of medical-malpractice allegations that have been the most expensive to resolve:

- **Anesthesiology:** failure to monitor, failure to complete patient assessment, improper intubation/positioning
- **Cardiology:** diagnosis of myocardial infarction, complications from catheterization, medication management of anticoagulants
- **Dermatology:** failure to diagnose skin cancer, improper treatment of psoriasis, improper treatment of acne
- **Emergency medicine:** failure to diagnose myocardial infarction, failure to diagnose spinal fractures, failure to diagnose appendicitis
- **Family practice:** obstetrics, failure to diagnose breast cancer, failure to diagnose myocardial infarction
- **Gastroenterology:** failure to diagnose abdominal cancer, failure to diagnose appendicitis, failure to diagnose esophageal stricture
- **General surgery:** surgical complications of gall bladder surgery, hernia surgery, and breast surgery
- **Internal medicine:** failure to diagnose breast cancer, failure to diagnose bronchus/lung cancer, failure to diagnose myocardial infarction
- **Neurology:** failure to diagnose herniated disc, improper treatment of seizure disorder, failure to treat risk of stroke
- **Obstetrics:** improper reading of fetal monitor strip, failure to do a timely c-section, failure to diagnose breast cancer
- **Ophthalmology:** cataract surgery, treatment of retinal detachments, diagnosis and treatment of glaucoma
- **Orthopedics:** surgical complications of intervertebral disc, surgery/treatment of femur fractures, carpal tunnel syndrome
- **Otolaryngology:** treatment/surgery of sinusitis, treatment of upper respiratory diseases, treatment of deviated nasal septa
- **Pediatrics:** treatment/resuscitation issues of newborns, diagnosis/treatment of infectious disease, medication errors for chronic problems
- **Plastic surgery:** reduction mammoplasty, augmentation mammoplasty, rhytidectomy
- **Psychiatry:** failure to properly treat depression, improper treatment of personality disorder, sexual contact
- **Radiology:** diagnosis of breast cancer, diagnosis of lung cancer, complications from invasive procedures
- **Urology:** treatment of renal calculi, prostate surgery, renal disorders

Good record keeping and patient rapport remain the cornerstones of effective risk management. If record keeping is adequate and patient rapport is good, the likelihood of a claim - regardless of the technical aspects of the care - is greatly minimized.

If you would like to know more about managing risk in your practice, please contact Physicians Insurance - risk@phyins.com or at 1-800-962-1399. ■

"Getting on the Right Track: Life with ADD", a national conference, will be held in Seattle, May 3-6, 2001. Key presenters include: Edward Hallowell, MD; Peter Jensen, MD; John Ratey, MD; Timothy Wilens, MD; Thomas Brown, PhD; Sari Solden, MD; and Thom Hartman. Featured presentations include "A User's Guide to the Brain - Through the Lens of Attention" (Ratey); "Inattention and Executive Functions: New Understandings of ADHD" (Brown); "ADD and the Law in Post Secondary Education and Employment" (Latham and Latham); and "ADHD/NLP: Two Days to Transformation" (Hartman). Up to 15 CEs available. Web site: www.add.org; e-mail: conference@add.org; phone: (847) 432-ADDA.

Attention Deficit Disorder Resources, a non-profit organization based in Tacoma, has a five hour training video for clinicians on ADD that professionals may borrow and view for free (deposit and \$5 P&H required). This excellent training video, produced by Dr. Daniel Amen, normally sells for \$300, but because our organization is committed to educating professionals about this disorder, we loan it out for free. Interested persons should contact us at addadhd@home.com or by writing ADD Resources, PO Box 7804, Tacoma WA 98406. We also maintain a free register of ADD Clinicians. If you wish to be on this register, complete the necessary form at our web site or request the form in writing.

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Pain Management Focus set for April 6 CME

Allergy, Asthma and Pulmonology CME - May 4

The College's CME program featuring subjects on allergy, asthma & pulmonology is set for Friday, May 4 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

A brochure with details regarding the conference was mailed in late March.

Presentations on COPD, Pneumonia, and Asthma & Allergy will be covered in the annual course.

To register call the COME at 627-7137. ■

Pain Management is the focus of the College's continuing medical education program scheduled for Friday, April 6, 2001. The program is complimentary for PCMS members.

The one-day course is designed for all physicians and specialties and will offer lectures covering acute and chronic pain management including interventional and pharmacological therapies. A program brochure detailing the topics and faculty has been mailed to your office.

The program is under the direction of Dr. David Paly, a Tacoma anesthesiologist and will be held at St. Joseph Hospital's Lagerquist Conference Center.

This Category I CME program focus is a first for the College and is in response to strong physician interest and both PCMS and WSMA continue to encourage education for physicians

in pain management relative to public concerns, discussions, and political initiatives during the past decade.

Topics for the course include:

- Current Strategies in Opiate Postoperative Pain Management
- Current Strategies in Opiate Chronic Pain Management Including Legal Issues
- Recent Advances in Interventional Pain Management
- Problems in End-of-Life Pain and Symptom Management
- Rational Use of NSAIDs for Acute and Chronic Pain Management
- Regional Anesthesia Advances for Postoperative Pain Management
- Pains, Past and Future ■

Medical Technology CME Joins PCMS Membership Meeting

The planned Medical Technology CME program meeting originally scheduled for May 16 and 23 will now be combined with the June PCMS General Membership meeting.

Initial plans include review of options for technological advances in electronic medical records. Details regarding the program will follow in future *Bulletins* and membership correspondence. ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, April 6	Pain Management	David Paly, MD
Saturday, April 28	Surgery Update	Glenn Deyo, MD
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 18	Advances in Women's Medicine	John Lenihan, Jr., MD

Technology Today

From Harrison Coever & Associates... "Companies that use the Internet technology to cut cost and improve productivity are reaping big rewards. American Airlines spends less than 10 cents to create an e-ticket compared with \$12 for a paper version.

The Las Vegas Bellagio Hotel screened 84,000 applicants in 12 weeks, interviewed 27,000 finalists in 10 weeks, and processed 9,600 hires in 11 days without a single sheet of paper."

Seen on the Internet...

In Japan, they have replaced the impersonal and unhelpful Microsoft messages with their own Japanese haiku poetry.

**A file that Big?
It might be useful.
But now it is gone.**

**Three things are certain:
Death, taxes, and lost data.
Guess which has occurred.**

**Chaos reigns within,
Reflect, repent and reboot.
Order shall return.**

**Windows NT crashed:
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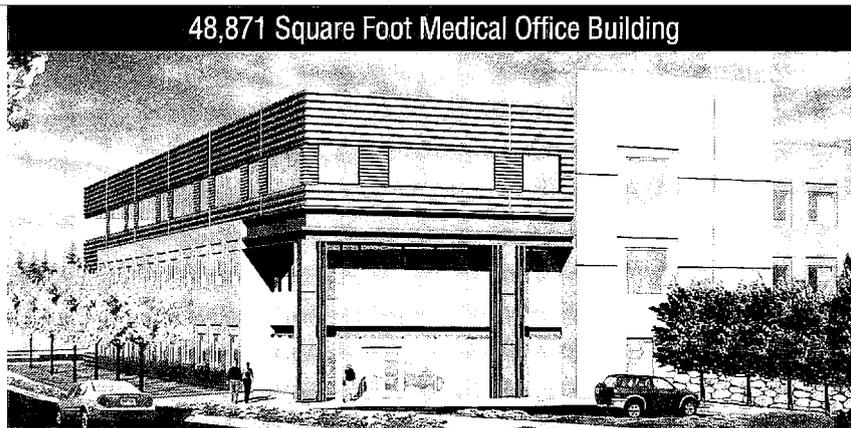
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Equipment needed for community clinic: The Neighborhood Clinic of Tacoma (staffed by volunteers and providing care to the local indigent population) is seeking an inexpensive or donated spot-check oximeter and a laboratory microscope. Other needs include stethoscopes, sphygmomanometers, otoscopes, exam lamps and office surgery instruments. Contributions are tax deductible. Please contact Phillip Schulze, MD, 253-858-5263 or watz@foxiinternet.net.

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Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

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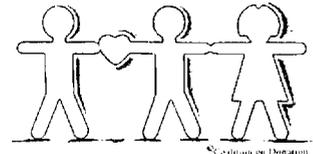
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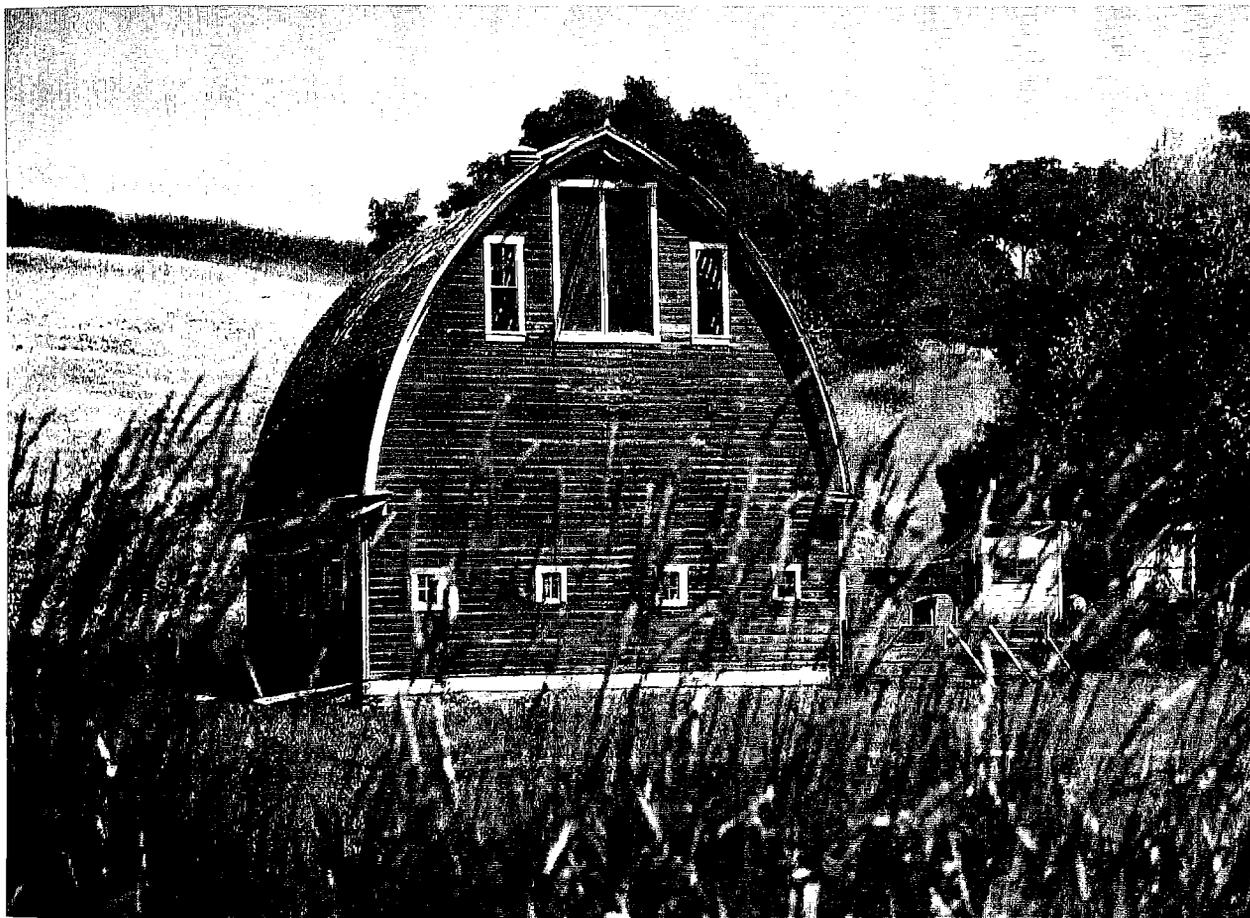
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Pierce County Medical Society



May, 2001



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Pierce County Medical Society
BULLETIN 

May, 2001



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

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

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President's Page

by Patrice Stevenson, MD

Kreidler Comes Calling

It was a dark and stormy night when new Insurance Commissioner Mike Kreidler came to the April 10th general membership meeting. It was darker and still stormy when he left. If we were hoping for a ray of sunshine to replace the gloom of Deborah Senn, we were not blinded by the light.

Commissioner Kreidler is an optometrist with a Master's degree in Public Health. Prior to being a politician his practice settings were the military and Group Health. He last worked as the Regional Director of the

U.S. Department of Health and Human Services, Region X, giving him close exposure to the

bureaucracy of HCFA. While his optometric practice settings are hardly reflective of the real world of health insurance, it would seem better than a background as an attorney for giving him some insight into the concerns of practicing physicians. No doubt he is also a subscriber of health, auto, property and casualty and life insurance policies. His background should prepare him for the Office of the Insurance Commissioner (OIC).

Recognizing that he has only been in office three months and that his first priority has been to restore the national accreditation to the state Office of the Insurance Commissioner, I may have expected too much. His talk was full of campaign platitudes and vague, politically correct generalities. He noted that this was his first opportunity to speak to

a group of "providers" since taking office. Although several PCMS members politely told him that we are physicians and cringe at being called "providers," it kept popping out of his mouth. I graduated from the University of Washington School of Medicine and therefore am a medical physician. If I had graduated from the "School of Provision" I could be called a "provider." I had hoped for a little more specific information as to how he could address the real concerns of physicians in their

dealings with insurance companies.

I think physicians overestimate the regulatory authority of the insurance

commissioner. There is no regulatory oversight of federally funded programs (Medicare, Medicaid, Military, Veteran's Affairs and CHAMPUS). He is left with commercial carriers and is basically limited to their regulating ability to stay financially solvent and to do what they are contracted to do. There is certain required and prohibited contract language but beyond that and looking for coverage for any state mandated benefits the insurance companies can offer any product line they choose and the financial terms of the agreement are not subject to OIC regulation. The companies do need to show an adequate network of "providers," but since they get to define adequate, there is little to regulate there.

Commissioner Senn wrote a



Patrice Stevenson, MD
President

prompt payment rule that does not seem to have really benefited any of the physician practices represented by the attendees. Commissioner Kreidler feels this rule is legally weak and could be easily challenged in court by the insurance companies, according to OIC attorney review. Several members spoke of the problems of cash flow and sustaining practice viability that lack of prompt payment causes. **Dr. Jasper** eloquently described his practice as becoming less like a 7-11 with payment at the time of service delivery and more like a bank where he provides a service that is then financed interest free for months with large write-offs when he does get paid. Commissioner Kreidler appeared sympathetic but notes there is nothing his office can do without the specifics of each case, i.e., details of service provided, claim submission and payment dates. Bob Perna from WSMA was in attendance and offered to be the contact point for these complaints. You may contact him at 1-800-552-0612.

I asked Commissioner Kreidler if he would like a Physician Advisory Panel for the OIC. The answer was a hesitant maybe...if it had broad state geographic representation (not just PCMS physicians) and didn't cost the OIC anything. I would still offer one

See "Kreidler" page 4

Kreidler *from page 3*

through the auspices of the WSMA, so let Bob Perna know of your interest.

Commissioner Kreidler noted that the OIC gets the most consumer complaints about auto insurance. This means that physician complaints are certainly not at the front of the line so the more specific we can be and the better organized the more likely we are to have some satisfactory resolution. I thought I would end with some pithy quotes:

"I'm tired of reading about the problems in health care. I know the problems...I'd like to read about the solutions." - Dr. Donald Mott, PCMS 2000 Community Service Award recipient and Chair of the Board of Good Samaritan Community Healthcare.

"Nobody ever went to medical school because they couldn't get into business school." - Dr. Stuart Seides, President, Medical Society of the District of Columbia, addressing the AMA National Leadership Conference.

"I'd like to meet the guy who first said, 'We can bill your insurance for you.'" - Mike Podrasky, CPO and owner Valley Orthopedics. ■

A short history of medicine

- 500 B.C. "Here, eat this root."
- 300 A.D. "That root is heathen. Say this prayer."
- 1750 A.D. "That prayer is superstition. Drink this potion."
- 1900 A.D. "That potion is snake oil. Swallow this pill."
- 1945 A.D. "That pill is ineffective. Take this antibiotic."
- 2000 A.D. "That antibiotic is artificial. Here, eat this root."

PCMS FaxNews system down, upgrading in process

The popular, biweekly PCMS FaxNews, has not been delivered for the past month due to computer difficulties.

The FaxNews is a compilation of news and current events pertaining to medicine and health locally, statewide and nationally. Giving just a brief summary of newsworthy items from numerous sources, the FaxNews can be briefly read and if further information is preferred, the source document is faxed to the reader upon request.

The FaxNews can be faxed or emailed to your home or office. Watch for your copy soon. If you were not receiving the FaxNews and you would like to be on the list, please call PCMS with your fax number or email address. ■



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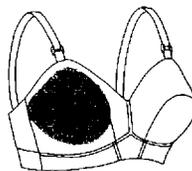


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April General Membership Meeting Recap

Insurance Commissioner Mike Kreidler meets with PCMS physicians

Recently elected Insurance Commissioner Mike Kreidler addressed the 65 attendees of the April General Membership meeting to inform them of plans and direction during his tenure of leading the Office of the Insurance Commissioner (OIC). (see page 3 for details)

Many participants remained after the meeting to discuss particular areas of concern with the Commissioner and/or attempt to resolve dilemmas of long-term unpaid claims or frustrating payment procedures.

"Healthcare is a challenging environment. The system is fragile and consumers are beginning to rebel," noted Kreidler. "We will be visiting these challenges as time goes on," he said.

Physicians in the state hope that the time comes soon. ■



Commissioner Kreidler welcomed questions and discussion after the meeting



Gordon Klatt, MD (right) visits with Tom Bageant, MD. Dr. Klatt is a Tacoma colo-rectal surgeon and Dr. Bageant a retired anesthesiologist



Drs. Charles Weatherby (left) and Mark Gildenhar enjoy visiting. Dr. Weatherby is a family practitioner and Dr. Gildenhar an ophthalmologist



Tom Charbonnel, MD, Tacoma pediatrician, answers an important call



Dr. Joe Jasper and his wife Donna discuss a specific issue with Ann Koontz from Molina Healthcare of Washington

EMTALA: "the law of unintended consequences"

From "AMNews, 4/23-30/01

Fifteen years after the "anti-dumping" law has passed, Emergency Departments (EDs) are struggling to meet an unfunded mandate burgeoning with new regulations and lawsuits.

EMTALA - the Emergency Medical Treatment and Active Labor Act - has become the "law of unintended consequences," harming emergency medicine.

Congress passed the law in 1986 to stop hospitals from turning away patients who couldn't afford care. Over the years, Health Care Financing Administration regulations and court cases have expanded it. Now, some doctors say it is so burdensome that it's a large contributor to the crisis in America's EDs.

Patients know they can't be turned away from EDs, so they use them as primary care facilities. Emergency department waiting rooms sometimes get so crowded that patients wait for hours to see a doctor. Yet hospitals and physicians often don't get paid for their time or the supplies they need to treat patients. It's led some to call the law American's "national health care system."

And, while the number of patients in emergency departments increases, the number of specialists willing to be on call in the ED declines. That leaves some departments without specialists to back up emergency physicians.

Some say EMTALA can be blamed for all the woes. A nursing shortage, some HMO's practice of using the ED as a way to get free care to increase profits and other health care system breakdowns contribute to the problems that EDs face. But, there is no doubt that EMTALA is a big contributor to their daily headaches and changes need to be made soon.

Health care lawyers say that patients are increasingly incorporating EMTALA violations into medical malpractice cases, and it is an inviting area for new litigation.

As a result of the problems, younger physicians are subspecializing and finding ways to avoid taking call in the ED. ■

New members elected to NPN Board of Directors

The Northwest Physicians Network (NPN) annual shareholder meeting was held March 20, 2001 at the La Quinta Inn in Tacoma. **John P. Lenihan, MD**, president, recognized the contributions of board members in 2000. Dr. Lenihan also welcomed incoming board members **Fred Thompson, MD** Tacoma-based Orthopedic Surgeon, **Nancy Karr, MD** Puyallup Rheumatologist, and **Jonathan Jin, MD** Lakewood Internist. Medical Director **Ralph Johnson, MD** honored outgoing members **Drs. Andrew Loomis, David Munoz**, and **Alnasir Adatia** for their leadership in the organization.

The physician-owned network of 330 primary and specialty care providers is the largest independent practice association in the state. Its mission is to assure the provision of high quality managed care for its 20,000 members of all ages through improved care coordination among hospitals and network providers throughout Pierce and South King County.

"The organization's goal is to define the standard of excellence for independently provided managed medical care for the State of Washington," said Patricia Briggs, CEO. She applauded NPN providers who improve the quality of care delivered to members while being successful in reducing avoidable costs in medical care delivery. She warned that the unfavorable tide in national politics regarding HMOs has created a political environment increasingly hostile to all managed care plans. She challenged leaders in Olympia and the leaders of medical plans to learn from managed care organizations like NPN. She concluded by saying that what is already known about effective patient care management is being used to contain costs through systematic refinement and measurement of improvement. ■



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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Antibiotic Resistance

Around the world, increasing attention has focused on the development of drug resistance among many of the most common organisms that cause disease. We have not been unaffected in Pierce County, although, fortunately, right now the resistance in some organisms is lower here than across the county. In 2000, we saw in Pierce County:

- twenty-one percent of *Staphylococcus aureus* isolates were methicillin-resistant, up dramatically from 7% in 1996
- Vancomycin resistance in enterococcus species is also on the rise, having grown from virtually zero in 1995 to almost 4% in 2000
- Many isolates of *Streptococcus pneumoniae* and other bacteria have shown resistance not only to front line antibiotics but to the back-up drugs routinely used in the past when there were treatment failures

There are two areas to concentrate solutions on, and work needed at every level, from local, to state, to federal, even globally.

Physicians in Pierce County have a large role to play in preventing antibiotic resistance. Much of the resistance is driven by local antibiotic use. Our local medical community needs to confront the issue aggressively. The best strategy requires that we do more than just issue or re-issue guidelines on the judicious use of antibiotics and to tighten or re-tighten infection control procedures. We have to look more carefully at other causes that are more awkward to confront.

It's common knowledge that patients push and cajole and outright demand antibiotics, even for routine treatment of viral infections. The media

and, through it, the drug companies have pressed the notion that technology has the answer for most health problems. "Got a pain, a cough, the flu? There is a drug for you and you'll feel better almost instantly. Call our toll-free number for details."

Patients want their problems dealt with quickly, leaving physicians in a bind. Wanting to provide good care and to please patients causes a great deal of stress. Add to that the limited amount of time for each patient and you get a formula for over-prescribing antibiotics. Something has to change.

We know that patient education is a valuable investment of time, both for treating problems appropriately and for preventing health issues. Recent studies show that many physicians give in to patient pressure to maintain high patient satisfaction scores. But, the studies show that patient satisfaction is not associated with receiving an antibiotic prescription, but rather with the patient feeling that the physician explained the illness and the patient understood the treatment choice. We need to add patient education time to physician schedules - this has to be part of the cost of doing business.

The second major issue is the use of antibiotics in agriculture. This is a real problem in this state and across

the county that has to be addressed by lawmakers. Here are some statistics that should make us all cringe:

- 84% of all antibiotics manufactured are used in agriculture
- 70% of all antibiotics made are used as growth promoters in cattle, hogs and chickens
- Numerous studies have shown that antibiotics used in animal feeds are not limited to impacting animals, but create health dangers for humans

With continuous use of antibiotics

on farms, multi-drug resistant organisms eventually appear and are passed to humans, often leading to

untreatable illness. We need to take the time to educate state and federal officials about the menace of continued antibiotic misuse in agriculture. Only then will we have the chance of slowing or even stopping the spread of these dangerous organisms.

The Health Department has organized a Pierce County Task Force to share information and ideas about ways to prevent the increase of antibiotic resistance organisms. Do what you can to help, by looking at your own practice and by educating not only patients, but lawmakers, about the threat. ■



TACOMA-PIERCE COUNTY
HEALTH
DEPARTMENT

"Patients want their problems dealt with quickly, leaving physicians in a bind. Wanting to provide good care and to please patients causes a great deal of stress."

May 14-18 is National Women's Health Week

Women-Related E-Mail Addresses

American Academy of Cosmetic Surgery
www.sinuscarecenter.com/laseraao.html

American Diabetes Association
www.diabetes.org/

American Dietetic Association
www.eatright.com

American Heart Association
www.women.americanheart.org

American Obesity Association
www.obesity.org

American Medical Women's Association
www.ama-assn.org/

Arthritis Foundation
www.arthritis.org

Asian & Pacific Islander Women's Health
www.4woman.gov/faq/Asian_Pacific.htm

Breast Health Access for Women With Disabilities
www.bhawd.org/

Center for Research on Women with Disabilities
www.bcm.tmc.edu/crowd/

Common Uterine Conditions: Options for Treatment
www.ahrq.gov/consumer/uterine1.htm

Eating Disorders Awareness/Prevention
www.edap.org

FDA: Guide to Contraceptive Choices
www.fda.gov/ldac/features/1997/397_baby.html

Frequently Asked Questions: Birth Control Methods
www.4women.gov/faq/birthcont.htm

Get a Mammogram: A Picture that Can Save your Life
www.hcfa.gov/pubforms/mammog.txt

Hormone Replacement Therapy
www.nih.gov/nia/health/agepages/hormone.htm

How to Perform a Breast Self-Exam
www.cancer.org/NBCAM_breast_self_exam.html

Menopause Guidebook
www.menopause.org/mgintro.htm

National Asian Women's Health Org.
www.nawho.org

National Association of Anorexia Nervosa and Associated Disorders
www.anad.org

National Cervical Cancer Coalition
www.nccc-online.org

National Institute of Mental Health
www.nimh.nih.gov

National Ovarian Cancer Coalition
www.ovarian.org/

National Women's Health Information Center
www.4woman.gov

National Women's History Project
www.nwhp.org

Personal Health Guide – Put Prevention Into Practice
www.ahrq.gov/ppip/ppadult.htm

Phlebology: The Treatment of Leg Veins
www.phlebology.org/brochure.htm

Sisters Together: Move More, Eat Better
www.niddk.nih.gov/health/nutrit/sisters/sisters.htm

Staying Healthy at 50+
www.ahrq.gov/ppip/50plus/

Weight-Control Information Network
www.niddk.nih.gov/health/nutrit/win.htm

What You Need to Know About Breast Cancer
http://cancernet.nci.nih.gov/wyntk_pubs/breast.htm

Women and Bleeding Disorders
www.4woman.gov/owh/pub/Bleeding%20Disorders/index.htm

Women and Men: 10 Differences that Make a Difference

STDs - Women are 2 times more likely than men to contract a sexually transmitted disease, and 10 times more likely to contract HIV during unprotected sex with an infected partner.

Depression - Women are 2-3 times more likely than men to suffer from depression in part because women's brains make less of the hormone serotonin.

Osteoporosis - Women comprise 80 percent of the population suffering from osteoporosis, which is attributable to a higher rate of lost bone mass in women.

Lung Cancer - Women smokers are 20 to 70 percent more likely to develop lung cancer than men smokers.

Heart Disease - Women are more likely than men to have a second heart attack within a year of the first one.

Anesthesia - Women tend to wake up from anesthesia more quickly than men - an average of 7 minutes for women and 11 minutes for men.

Drug Reactions - Even common drugs like antihistamines and antibiotic drugs can cause different reactions and side effects in women and men.

Autoimmune Disease - 3 out of 4 people suffering from autoimmune diseases such as multiple sclerosis, rheumatoid arthritis, and lupus are women.

Alcohol - After consuming the same amount of alcohol, women have higher blood alcohol content than men.

Pain - Some pain medication (known as kappa-opiates) are far more effective in relieving pain in women than in men.

Letter from John K. Stutterheim, MD

Editor's Note: Dr. Stutterheim submitted the following letter to the Tacoma News Tribune, the PCMS Bulletin, the Tacoma Pierce County Health Department and KOMO television.

PCMS was saddened to hear of Dr. Stutterheim's illness and offers condolences to him and his family.

Editor,

During the month of March, the *News Tribune* published an article about arsenic and lead findings on the hill below the water tower at University Place, west of Tacoma. Even though the EPA seems to know which properties contain high levels of arsenic, they were not specifically mentioned.

As you probably know, arsenic effects the human body mostly in four ways, namely: skin, nervous system, kidneys, and lungs by inhalation.

My family of seven people used to live in University Place from 1964 through 1996. My youngest daughter was born at that address. She came down with kidney cancer at the age of 28, clear cell carcinoma. My wife died from lung cancer, small cell carcinoma, the worst kind, in 1999. During the year of 2000, my eldest and third daughter both contracted multiple sclerosis, extremely rare to have two cases in one family.

Last week I was diagnosed with kidney cancer. Two cases in one family is unheard of.

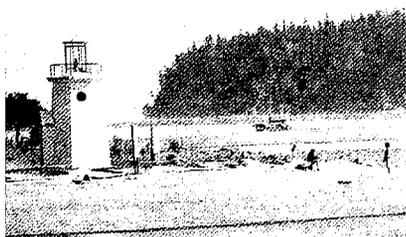
I would like to break a lance to get an epidemiologic study started to research ailments that occurred among children in these families who used to live in University Place during the sixties, seventies and eighties. I am fully aware that many may have moved away and must be tracked down, possibly a costly affair. Imagine the value of such an investigation. I urge you to consider this project.

I am looking forward to a positive response from your department and remain sincerely yours.

John K. Sutterheim, MD

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Personal Problems of Physicians Committee

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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 Practices at Tacoma Radiology
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 253-383-1099
 Medical School: Stanford University
 Internship: Santa Clara Valley Med Ctr
 Residency: UCSF
 Fellowship: UCSF

Opp, Randon L, MD

Diagnostic Radiology
 Practices at Medical Imaging NW
 222 15th Ave SE, Puyallup WA 98372
 253-841-4353
 Medical School: Loma Linda Univ
 Internship: San Bernardino Med Ctr
 Residency: Loma Linda Univ Med Ctr
 Fellowship: Loma Linda Univ Med Ctr

Sadiq, Raheela, MD

Internal Medicine
 Practices at Internal Medicine NW
 316 Martin L. King Jr Way #304
 Tacoma WA 98405
 253-272-5076
 Medical School: The Aga Khan
 University Medical College
 Internship: Central Texas Med Found.
 Residency: Central Texas Med Found.

Yee, Lorrin K, MD

Internal Medicine
 Practices at Northwest Medical
 Specialties
 1624 S I Street, Tacoma WA 98405
 253-428-8700
 Medical School: UCLA
 Internship: University of Wisconsin
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In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

The Multi-tiered Alternative

"All animals are equal, but some animals are more equal than others."

The Animal Farm
George Orwell (1946)



Andrew Statson, MD

Some writers have maintained that it is unethical for some people to get better medical care than others. According to them, all should receive the same quality of medical care. I don't know for sure whether they mean it ought to be equally good, or equally bad. I wonder whether they really expect the President will receive care by medical students or residents on the teaching ward of Johns Hopkins or of Parkland Memorial. The reality is that the President will likely have an entire floor of Walter Reed or Bethesda naval reserved for him and his retinue, should he ever need hospital care. Only the top brass would be involved in his treatment. I wonder whether they think that senators and congressmen will share rooms with indigent patients at Emory or Charity or LA County.

In the army, there was a joke that when an enlisted man had a drip, he was given penicillin and the chart note said he had GC. When an officer had a drip, he was given penicillin and the chart note said he had URI. After all, rank has its privileges.

The idea of equality under the law probably found its first expression in the democracy of Athens. When the Athenians overthrew their tyrants and established a democracy, they were very jealous of their new-found freedom. They established a rule to prevent anyone from obtaining excessive dominance over the affairs of the state. When a citizen became prominent

enough and threatened to control the political life of the city, the citizens voted to ostracize him, which meant that he was forced to leave the city for ten years. After that time, he was allowed to return, but usually by then his influence over the politics of the city had dropped sufficiently, so that he was not a threat any longer.

Of course, the notion of equality applied only to men who had the title of citizen. Women, noncitizen residents and slaves had no such rights. Even so, that rule did not mean equality in property, in ability, in skills, but equal protection by the law from arbitrary power, from injustice.

The Roman republic was established on the same basis, "the rule of laws more powerful than men," as Livy wrote. Roman citizens had certain rights and enjoyed the protection of the law. They could not be subjected to punishment without a trial. Whether patricians or plebeians, they were equal under the law of Rome. They limited the power of their officials by forcing them to share it, pitting them one against another, and by electing them for only one year. That disappeared with the Empire. The emperors were divinely ordained to rule.

The idea of equality came back on the scene during the eighteenth century. Equality was one of the slogans of the French revolution. The French are not blind. They never thought that humans were equal or that they could be

made to be. They did not even think that equality would have been desirable, had it been possible. During the revolution, they rebelled against the caste system of aristocrats and serfs. They called not for equality, but for equality of opportunity. They wanted people to be able to occupy their place in society on the basis of their ability, not on the basis of the accident of their birth. That was an echo of the American revolution and of the principles of the American constitution.

In the middle of the nineteenth century, a number of writers picked up the call for equality. Marx in particular. They did not pretend that humans were equal, or they would not have adopted the slogan "from everyone according to his abilities, to everyone according to his needs." Their dream was that humans ought to be, and it is possible and desirable to make them be equal. The application of this idea during the twentieth century led to the tragic suffering and death of millions of people in Europe and Asia. The dream of forcing all humans to be equal turned into a nightmare. May this dream never come back to haunt us again.

It should be clear by now that equality in health care is part of this impossible dream. Once we realize that and accept it, we can start looking for

See "Alternative" page 12

Alternative *from page 11*

reasonable solutions to the problem of health care. Our problem is that we have painted ourselves into a corner. We have turned to the law to grant people the right to health care. Since we also base our republic on the principle of equality under the law, we are forced to maintain that all people have equal right to health care and, therefore, should receive equal care.

No matter how prosperous our country might be, it is economically impossible to give everybody the best of medical care, such as private rooms, one-on-one nursing, no waiting in the office, or in the Emergency Room, or in the pharmacy, immediate control of pain, immediate availability of treatment facilities and operating rooms, tertiary care facilities in every hospital, etc. It should be obvious that we cannot give equally good medical care to everybody.

Since the law requires us to give equal care, it will have to be equally bad. People will have to wait for service, they will have to wait for their pain medication until someone gets around to giving it to them, they will have to wait for an operation, or for a test, perhaps for months, sometimes for years. Everyone will have to wait equally for his turn.

What is more, if some people are willing to pay out of pocket to get prompt and better medical care, they must be forbidden to do so, if equality of medical care is to mean anything. People are granted health care by law, they are equal under the law, therefore they shall receive equal health care. This is the contradiction we face and we have to resolve before we can make sense of any societal approach to the problem of health care.

To repeat what was stated in the past, a society cannot function, and certainly cannot prosper, without order. People who are destitute or sick could be a source of disorder. A wise society needs to have a mechanism to defuse

the tension these people may create and to take care of them. Traditionally, and even with the current growth of the welfare state, this still to a large extent is done through the work of charitable organization, supported either by churches or by private foundations.

The government programs have high overhead, because they are subject to rules, which decree that things be done in a certain way, that expenditures be supported by proof of need. The regulating agencies add a variety of other requirements, changing them as they go. Congress has to write laws, agencies have to issue regulations, everybody has to file forms, get permits, make reports, etc. For this reason about 50% of the money spent on government programs is for the costs of administration.

Private charitable organizations do not have to meet such requirements. When private institutions run the programs, especially when they are not subject to government mandates, controls or restrictions, the administration costs are of the order of 10%. So they are better placed to meet, at a lower cost, the needs of the indigent. These patients will be able to earn the care

they receive by allowing physicians in training to learn medicine while taking care of them.

An interesting step in the direction of multi-tiered health care is the Tri-care military program. The safety net here is provided by the military hospitals, where the charges to the patients are the lowest. They have to pay more to get the second level, at which they can seek care from a network of physicians and hospitals, who work under a contract and discount their charges. This limits the patients' choice of treatment facilities. The third level is regular indemnity insurance, for which the patients pay even more, but which gives them the ability to go to their physicians of choice and to decide on their treatment options without much interference.

The above example is an official admission that equal health care for all is not possible. People will always look for the best medical care they can get at the best possible price they can afford. That will vary from person to person. Our society must accept as inevitable the variations in the quality of health care people receive. ■

MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell

Attorney at Law & Arbitrator

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In My Opinion....

by Teresa Clabots, MD

Mary's Angels

As a resident in Kansas, during our obligatory ten months of neonatal ICU, we were always short staffed during our first year. My favorite nurse was Mary. Mary was an old-timer. She believed that you lived and died by the rules. And, she had a very thick New York accent that at times was quite difficult to understand.

Body language was her answer. One look from her and you could wither into the wall knowing that you had touched your hair, and would need to start rescrubbing all over again: the mandatory five minute scrub from fingernail to elbow with a harsh antiseptic soap that surgeons used.

She would say, "Doctor."

I would answer, "Yes, Mary."

She would admonish you. "Doctor, you touched your hair."

"Sorry Mary, I'll go rescrub" (as I held my hands in front of me like phantom limbs, already dried and cracked from all the scrubbing).

Returning to my place on rounds, and she would say, "Doctor," to the next person, and they would answer, "Yes, Mary."

"Doctor, you touched your nose."

"Sorry, Mary." And the poor doctor would go and rescrub up to the elbows and come back.

With her ever-vigilant eyes she would say, "Doctor."

"Yes, Mary?"

"I can see nail polish." And, one would have to leave rounds to go remove every hint of nail polish and rescrub.

Once in awhile, the fascination with babies would overwhelm you and Mary would say, "Doctor, don't touch the babies."

"Yes, Mary."

When the infant was on its deathbed (and usually Mary's instincts were uncanny), you knew that you would have a rough shift when she would say, "Doctor, I'm going to go and wash this baby's hair." (I am going to go and baptize this baby.)

"Yes, Mary."

And you knew you were close to the end when she would say, "Poor little angel." She didn't want those little angels stuck in limbo, and would baptize every single one of them.

I remember the occasion of a difficult delivery. The baby was transferred from the regular nursery to the neonatal ICU. Although the delivery had been difficult, there had been no meconium, yet this baby developed a cough that racked its ribs. One that you could hear all the way down the nursery. Mary came up behind me and whispered in my ear. "Do you know why that baby is coughing?" I turned and looked at her eyes and said, "No idea, Mary. But what do you think?"

She answered, "Mark my words, that baby is very sick." With a knowing look I stood there, baffled and said, "Yes, Mary, but what do you think it has?"

She smiled a little grin and said, "Ever heard of cystic fibrosis?"

I was taken back. I asked her, "How did you know?"

She said, "Seen it. Listen to that poor angel cough."

Now, the problem in those days was how to prove that a newborn had cystic fibrosis. There were no diagnostic tests. This was before the sweat chloride. So, I read up on cystic fibrosis, called the genetics people, and then I had to ask permission of the parents to cut the baby's hair and cut the baby's



Teresa Clabots, MD

nails and send them to a specialized lab in Chicago (remember this was the old days). I never heard back what the final lab results were.

The next month I was in the endocrine service, and lo and behold, that baby's brother was being seen as a failure to thrive. It turned out that the dad was a GI fellow and his wife was a dedicated teacher who was devoted to the children's care. The older brother sure enough had multiple signs of cystic fibrosis with steatorrhea, chronic pneumonias, and failure to thrive.

I followed the children over the course of three years.

As the senior chief resident, I was taking care of the younger brother, the one who had the more severe cystic fibrosis who wound up in respiratory failure, in an oxygen tent, and in CO2 narcosis in the ICU at the age of three.

To monitor his fluids, and narcosis, he ran out of veins, so he had a central line. I refused to authorize painful arterial sticks on him. In and out of consciousness the baby went with cyanotic fits of coughing, rectal prolapse, significant dyspnea, slipping in and out of comas. I found the mother many a time inside the oxygen tent reading to her three year old, an act of pure love and desperation, since she knew of nothing else to comfort him or occupy his time. He'd had a rocky three years in his short-lived life. I was held up before the surgery committee for drawing blood from a central line that they had placed. (They didn't want me to use

See "Angels" page 14

Angels from page 13

the central line to draw blood.) The Chair of the department threatened to terminate my chief residency. I prayed that the baby would go quickly since I couldn't bear to poke him anymore. (I was the only one he would allow near to draw blood.) I wonder now, if it would have been more merciful to have left him in the CO₂ narcosis rather than seeing him drown in his own secretions. I cried every night through those horrible weeks.

He finally died, and I presented this case at M & M conference. Afterward with tears in his eyes, the father who had attended the M & M confer-

ence approached me, hugged me, and told me that his wife had just delivered a little girl. They had named her Teresa.

We have kept in contact through the years, and the father has become a renowned research physician in the field of gastroenterology, specifically in cystic fibrosis. They have three more children, and the large household is happy, busy, athletic and successful even with a chronic debilitating disease. That little boy taught me a lot about accepting when bad things happen to good people. His father has devoted his life to research in that field and to helping other children with cystic fibrosis. ■

New Members

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Hirota, William K, MD **Gastroenterology**

1112 6th Ave #200, Tacoma 98405
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In My Opinion....

David Roskoph, MBA, CFP

Why must a recession follow an expansion?

After more than ten years of rising markets, the cry once again rings out, "Why must recessions follow expansions?" The answer is simple. Long expansions are never linear and have always (so far) created dramatic imbalances in the economy that take a recession to correct. The excesses generally involve some form of credit.

Credit excesses occur in equities markets when investors' bid-up prices are based upon unrealistic earnings forecasts.

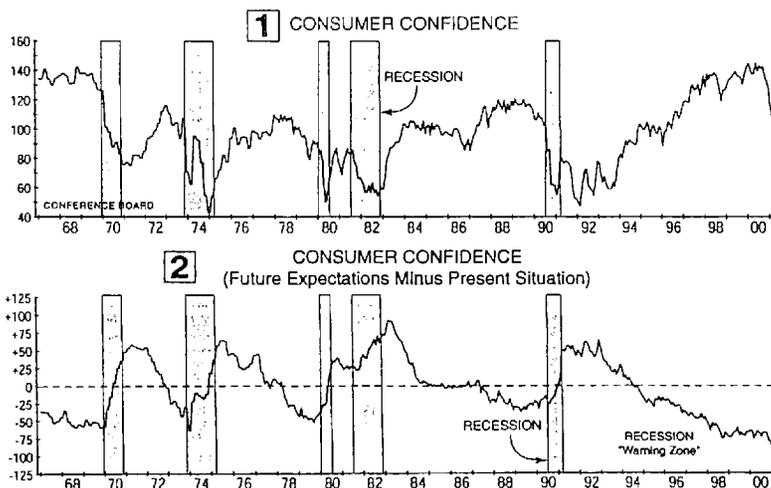
Credit excesses occur in our banking system when loans are made based upon unrealistic growth projections.

Credit excesses occur in our personal consumption when we borrow too much based upon an unrealistic feeling of security.

All three examples revolve around unrealistic feelings of overconfidence. When Alan Greenspan exercised some control over the monetary system he referred to this as "irrational exuberance." Unfortunately, the Federal Reserve got into the punch bowl even though they were supposed to be the designated driver. They lost control of the system back in the fall of 1998 and are still struggling to regain it. Even the earliest economists realized that there is only so much rationality in a system where emotions are so important. The economy is nothing more than the expression of our collective hopes and fears manifested in our spending habits. We are all prone to emotional excesses that are economically described as "animal spirits." They refer to the insidious creep of irrationality into an otherwise rational system until irrationality is the norm. It happens this way:

When economies expand, consumer confidence is high, which in turn boosts business confidence. Businesses then produce to meet the rising demand with larger capacity. In essence, everyone takes a snapshot of today and assumes it will only get better tomorrow. Money is loaned, plants are built and employees hired to meet the ever-voracious consumer. Confidence is King as few, if any, question the projections of non-stop acceleration. The valuation of equities departs from reality as the Wall Street machine gets cranked up. In this case, the internet was central to the

down and stock prices weaken. As investment accounts drop, consumer confidence follows. Now the cycle begins to feed on itself. The feeling of confidence goes a long way in an economy. I'm reminded of the saying, "When Momma ain't happy, ain't nobody happy." Replace Momma with consumers and you understand capitalism. If you watch only one economic indicator, make it consumer confidence. The financial markets don't necessarily react to conditions as they occur but rather when the confidence is sufficiently altered to affect the flow of money. As



market excesses but the real fuel was loose credit. You could see 125% mortgages or the no-money-down offers but few saw the astronomical rate at which people borrowed to buy stock (margin). These were the warning signals for a monetary policy that was too loose. When the flaw became painfully obvious, the projections were finally brought into question. First, consumers took a breather, which means inventory accumulated. When inventory backs up, earnings forecasts are revised

the reality that we are actually in a recession sets in, the headlines will continue to get scarier. Interest rates project the recession to last until at least the end of 2001 but the markets will find a bottom before then as markets usually precede the headlines. Getting positive about the market will feel as counter-intuitive as feeling negative did at its peak last year. ■

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

Directory Changes

Please make note of the following changes to your 2000 PCMS Directory.

Marvin Brooke, MD
Change office # to 864-2703
Add Physician Only # 864-5057

Pamela Cowell, MD
Change address to:
120 14th Avenue SE #c
Puyallup, WA 98373
Phone: 435-5200
Fax: 435-8873

David Judish, MD
Change office # to 864-2703
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Paul Nutter, MD
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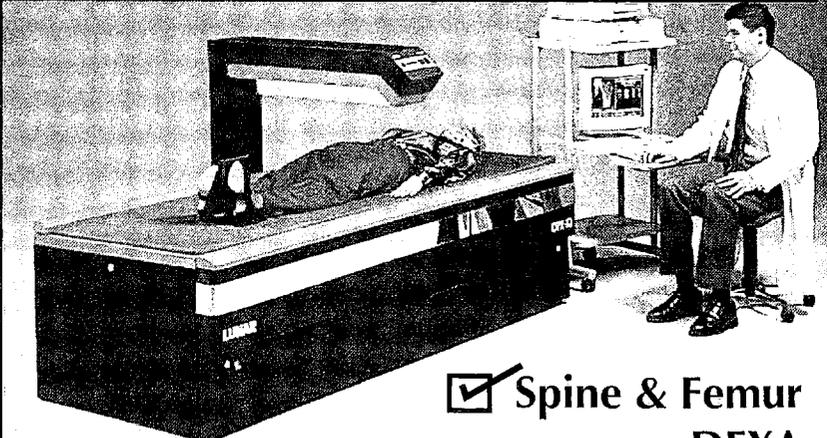


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Allergy, Asthma and Pulmonology CME - May 4

Registration for this year's CME program focusing on subjects on allergy, asthma & pulmonology remains open for Friday, May 4 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

Subjects will cover:

- Pneumonia for the Primary Care Physician
- New Directions in the Treatment of Asthma: Managing Outcomes
- Understanding Allergic Rhinitis: Clinical Update
- Frustrations in Treating Urticaria
- COPD in Clinical Practice: Differential Diagnosis and Management
- Asthma: Current Trends and New Strategies
- Food and Drug Allergies

Call C.O.M.E. at 627-7137 to register. ■

Medical Technology CME featured at Membership Meeting

The planned Medical Technology CME program meeting originally scheduled for May 16 and 23 will now be combined with the June PCMS General Membership meeting. ■

Nationally recognized expert Leon Speroff, MD, Professor from the Oregon Health Sciences University in Portland, will keynote this year's Advances in Women's Medicine CME program set for May 18. Dr. Spiroff will speak twice at the annual CME program - on hormone replacement therapy and cardiovascular disease and HRT and breast cancer.

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

Subjects scheduled to be covered include:

- New concepts in Osteoporosis: Prevention, Diagnosis and Management
- State of the Art: Hormone Replacement Therapy and Cardiovascular Disease

- State of the Art: Hormone Replacement Therapy and Alzheimer's Syndrome
- State of the Art: Hormone Replacement Therapy and Breast Cancer
- Panel on Hormone Replacement Therapy
- New Approaches to the Management of Obesity in Women
- Depression in Women: Best Management
- Clinical Pearls: Herpes and Vaginitis
- Contraception: Newest Options and Alternatives

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

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

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, May 4	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 18	Advances in Women's Medicine	John Lenihan, Jr., MD

Federal Health Observances for May

- National Osteoporosis Prevention Month
- National Arthritis Month
- National Digestive Diseases Awareness Month
- National High Blood Pressure Education Month
- National Stroke Awareness Month
- National Teen Pregnancy Prevention Month
- National Melanoma/Skin Cancer Detection and Prevention Month
- National Mental Health Month
- Asthma and Allergy Awareness Month
- Better Hearing and Speech Month
- Better Sleep Month
- Hepatitis Awareness Month

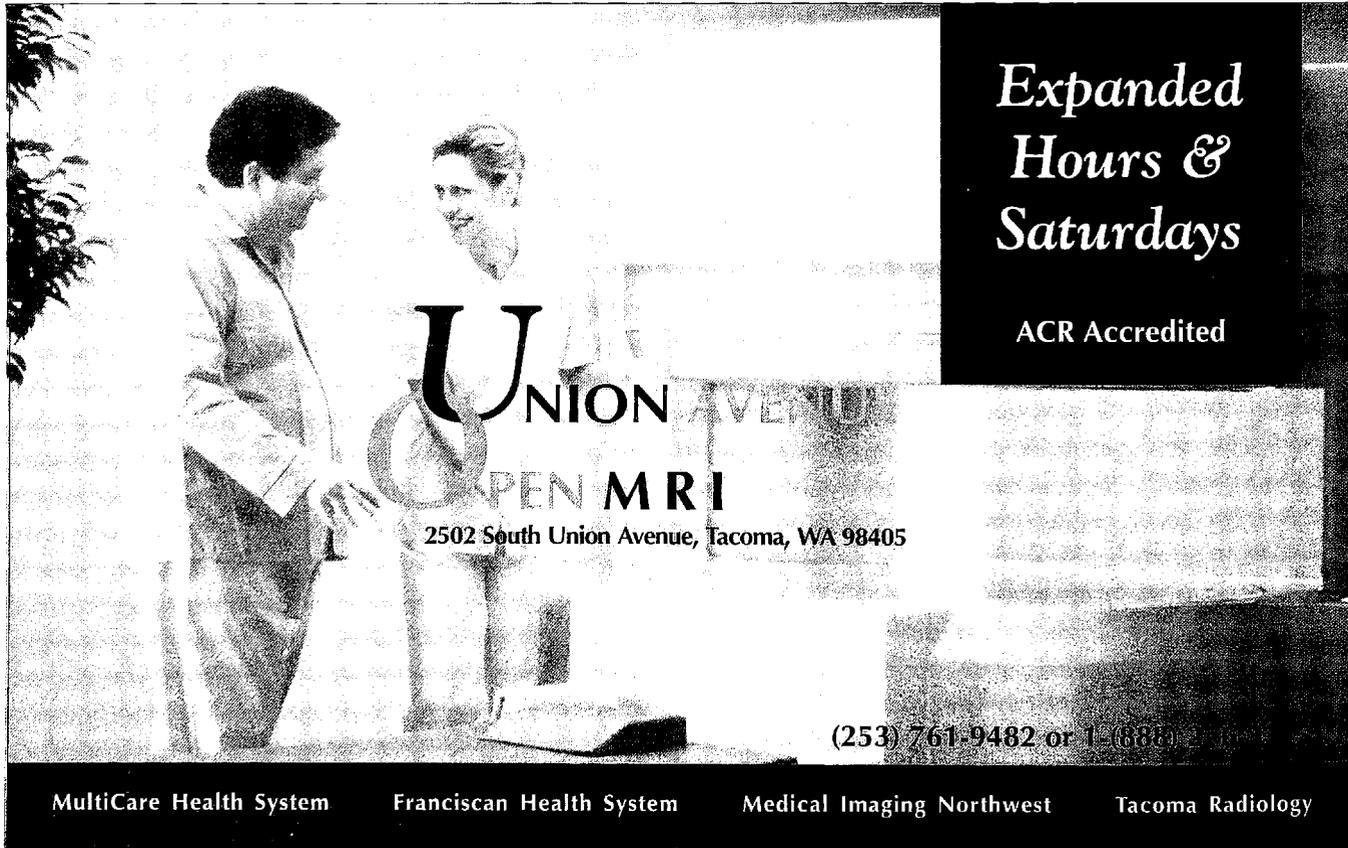
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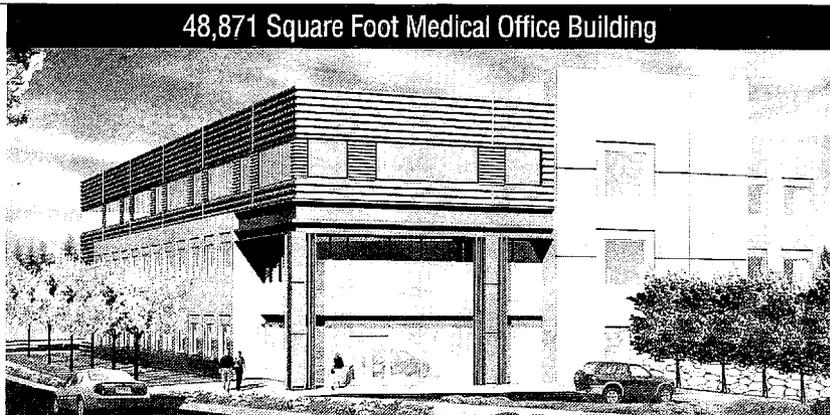
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BULLETIN



June, 2001



L to R: Carol Jones (Peninsula), Janice Doyle (Bethel), Summer Schoenike, MD (Lakewood Pediatrician) and Susan Newell (Clover Park) are all actively involved in the work of the Public Health/School Health Committee. This year the group is focusing on school nurse issues. Dr. Schoenike chairs the committee.

See story page 5

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 - 7 Tacoma-Pierce County Health Department: "The AIDS epidemic"
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Pierce County Medical Society

BULLETIN



June, 2001



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

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

Managing Editor: Sue Asher

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President's Page

by Patrice Stevenson, MD

Leadership

"Perhaps I'm a leader because I'm a poor follower."

Herman Richard Matern, MD, FACS
2001 AMA Pride in the Profession Award Recipient



Patrice Stevenson, MD
President

One of the benefits of being the PCMS President is the opportunity to attend the WSMA and AMA Leadership conferences. These were informative and thought-provoking meetings covering topics from genomic medicine to e-medicine. There are also discussions on the nature of leadership that provide fodder for President's Pages.

The Human Genome Project has identified the base sequence letters of the human genome. With much more work, the words, sentences and stories of this genetic map will be delineated. Ultimately all the genes to explain disease as well as normal traits may be identified. I expect they will also localize a gene for leadership tendencies. This likely will be localized near the gene that makes one join medical societies in the first place. The leadership gene likely has variable penetrance dependent on a multitude of environmental factors. These factors include place (being in the wrong or right one) and time (being there at the wrong or right time) and linkage (to the inability to say "No" gene).

One of the best speakers at the recent WSMA Leadership conference was Joseph Bujak, MD, Vice President of Medical Affairs at Kootenai Medical Center in Idaho. He used a team analogy to help physicians think of better ways of working together to achieve common goals. He said that when you ask most physicians to think of a team they think of a golf course foursome. In

a foursome the success of the "team" is based on the cumulative, individual scores. Physicians think the team will be successful if only everyone would pull their weight. He preferred a volleyball team model with the coordinated teamwork of six players who can all bump, set and spike with precision and play well from all positions on the

"While leadership is important good followership is just as critical to the success of an organization."

court. Individual heroics, such as a killer serve, will certainly help but it's the passing and setting (i.e., the support and enhancement of the play of all teammates) that is the basis of a great team. Well I guess I'm atypical as I've only played putt-putt golf but lettered in volleyball in high school so the golf foursome didn't come to mind. He went on to describe physician cultural traits that get in the way of our working together such as being strongly competitive, valuing personal autonomy above all else and tending toward linear and "reductionistic" thinking that causes poor systems thinking.

Fortunately, I have not witnessed poor teamwork among the physician leadership at PCMS. We have a dedicated and hard working group of officers, board members and committee

members. While **leadership** is important, good **followership** is just as critical to the success of an organization. Physicians are all very busy people and have less time and money today to put into professional society membership than ever before. Our societies need to be responsive to the needs of the members or they will cease to exist. However, a few leaders cannot do all the work of an organization. Good followers may be willing to give input, respond to "calls to action" for letters to legislators or serve on committees. These activities take a limited time commitment from any given member but en masse are what truly makes an organization work effectively.

The professional staff of a medical society is also key to its success. They allow the ideas and directions of the physician leadership and followership to be put into action. We are fortunate to have excellent help in our mission from our executive director, Sue Asher, and her staff. I am fond of using Star Trek Captain Picard's directive line, "make it so." I don't have to tell good workers how to "make it so." as they know what to do without micromanagement.

I invite you to actively lead or actively follow and together we will make our medical society a better one. ■



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Special Feature

by Jean Borst

The Issue of School Nurses...

A Band-Aid Won't Fix a Major Break in the System

In a perfect world, a school nurse is responsible for the medical care and safety of no more than 750 students.

In a perfect world, medical mistakes in the school setting don't happen, and near misses are nonexistent.

In a perfect world, school nurses spend time in classrooms sharing their skills, knowledge, and expertise.

And, in a truly perfect world, school districts have the money to make it all happen.

Then there's the real world. And it's the real world that the Public Health/School Health Committee goes head to head with.

Established in the 1970s with the merger of a Schools Committee and Public Health Committee, the Public Health/School Health Committee "exists to increase communication and bring people to the table to talk about issues and concerns," according to PCMS Executive Director Sue Asher, a long-time committee member. The committee includes school nurses from most of the Pierce County schools districts, physicians, the Pierce County Health Department and various other agency representatives from organizations that champion children. **Dr. Sumner Schoenike** currently chairs the committee.

Most notably, the committee championed such issues as fluoridating Tacoma's water and introducing city and county smoking ordinances. "This group never has an agenda problem," notes Asher. "They always have something to discuss."

Susan Newell, head nurse of the Clover Park School District, has been involved with the committee off and on since 1993. She views the committee as

a valuable resource for disseminating information; providing a forum for the community to present to or communicate with school nurses; offering networking opportunities, as well as a vehicle to present concerns and issues; and to provide nurses a chance to discuss issues with physicians on an informal level.

The committee has tackled numerous issues in the past, and typically adopts one issue "focus" each year. Over the years, they have explored such issues as health promotion, community education, communicable diseases, mental health issues, low-income resources, barriers to assessing health care, immunizations and more. Last year, the group's concentration on school violence resulted in the implementation of violence prevention programs in several school districts.

This year, the committee zeroed in on school nurse issues, in light of dramatic decreases in school nurses and the resulting consequences of those staffing cuts. The committee is looking at three specific areas: (1) delegation of nursing duties to unlicensed staff; (2) administrative structure/accountability of school nurses; and (3) caseload.

At the heart of the matter is the caseload issue. "The national recommendation for school nurse staffing is one nurse to every 750 regular education students," notes Susan Newell. "The state staffing model recommendation is 1 to every 1,500 students. In Pierce County, we have school nurses responsible for well over 3,000 students, and this may include special education and medically fragile students. This poses a health and safety risk to students and staff, and leaves very little time for health promotion."

Janice Doyle, head nurse for the

Bethel School District and a committee member for over ten years, concurs. "One of the nurses is responsible for 6,000 students," she notes. "The pre-existing notion that there is a nurse in every school simply isn't true." With diminishing numbers of school nurses, responsibilities that historically have fallen to nurses are now in the hands of health technicians and paraeducators. "Many services are provided by unlicensed staff with a CPR and first aid card," Doyle said. "While we've had no catastrophic consequences yet," she explained, "there have certainly been numerous 'near misses' in Pierce County." For example, a child might sustain a head or abdominal injury, the severity of which is not recognized by a staff member. In one specific case, a school secretary incorrectly allowed administration of insulin to a student, an error that could have conceivably killed the child.

Consequences can be far reaching, according to Carol Jones, Peninsula School District head nurse and a committee member off and on for the last 10 years. Regardless of who is administering care, the school nurse is ultimately responsible. Training, direction and follow up are provided to school staff by the nurses, but when you are dealing with many students at multiple schools, it is virtually impossible to always closely supervise the treatment.

So while the safety of children in our schools is seemingly at the forefront these days—particularly in light of extraordinary school violence the nation has witnessed in recent years—why isn't the medical care of students a priority?

School districts are the guardians

See "Nurses" page 6

Nurses

from page 5

of public education and public funds, notes Carol Jones. In most Pierce County school districts, nurses are part of the teachers' union, and therefore under the teachers' salary scale. When financial decisions are made regarding teachers and staff, nurses are part of that scenario. Over the years, Pierce County schools have experienced dramatic increases in enrollment, decreases in nurses and the addition of "health technicians." These staffers are required to have a first aid card and CPR training. Period. While the techs and paraeducators are trained annually by nurses to follow specific health care plans, accuracy isn't ensured. Carol Jones shared a recent incident that occurred in one of her schools. A new student came to the office for a prescribed dose of Ritalin. The dosage was written for 5 mg, the bottle indicated that the tablets were 5 mg, but when Jones got ready to administer the medication, she noticed that the tablets were actually 10 mg. She didn't give the meds. Classified staff — the people who would typically give the child his medication — admitted that they would not have noticed the error. "I work with highly professional people, and our health techs have used excellent judgement, but there are times when mistakes are made because they simply are not trained to recognize those mistakes."

Susan Newell adds, "Health paraeducators are increasingly the ones responsible for the health room. These people have very little, if any, training and have suddenly become the health experts on campus."

The perception of school nurses is not what it used to be. They are supplying more than band aids and ice packs. "Nurses are not simply tending to the day-to-day bumps and bruises," according to Janice Doyle. The entire make-up of medical care and medical issues in the schools has changed dramatically over the years. "Kids are coming to school sick more often, children with severe medical issues who in the

past might have been institutionalized, are in the school setting and demand one-on-one care," Doyle added. "We have nurses administering to medically fragile and severely challenged children." Among her own caseload is a high school student with the mental capacity of a six-month-old. There are children with tracheotomies, feeding tubes, and on oxygen. In severe cases, state aid provides 18 hours of daily nursing care. Some families have nurses accompany children to school, while others opt to have nursing care while the child is at home. If a nurse isn't available during the school day, school districts are required to hire LPNs to provide care.

And with their time stretched so thin, nurses are unable to do what they want to do most. Carol Jones said, "School nurses can do so much more than we are able to do now. Our skills are in teaching, but time in the classroom is very limited due to all of our other responsibilities."

Making a problem to fix a problem

"As a pediatrician, I'm much more inclined to fix problems — not create them," noted Dr. Schoenike. "But it was important to start a fire in this case."

Dr. Schoenike and Janice Doyle recently presented the Committee's concerns to superintendents of Pierce County schools. "Our purpose in going directly to the superintendents was to bring about an awareness of what school nurses are actually doing," Dr. Schoenike explained. "There is a misconception about what these people have to deal with day to day. We want to show the districts that the nonclinical aspects of the job — developing education and health plans, communicating with staff, administrative duties — belong to the districts. The clinical part of the job, however, should not be in their jurisdiction. There needs to be clarity on that issue. And along those lines, it's vital that caseload determinations and delegation be made with Board of

Nursing input, not at the level of the school district," says Dr. Schoenike. But, he notes, schools pay school nurse salaries, and they want to be in control of those decisions.

Dr. Schoenike also presented findings to the superintendents that supported the committees concerns about excessive caseloads and delegation issues. "Caseloads are pushing the envelope beyond what is reasonable," he said. "Mistakes are being made, and it's vital that we track those mistakes." For the past few months, nurses in various school districts have been recording near misses that have occurred. Those findings were summarized and presented to the superintendents, along with a proposed "Near-Miss Reporting Form" the committee plans to have in each district.

"Needless to say," Schoenike continued, "the documented cases highlighted the problems in the system, and we got their attention." The form, which included an item for potential litigation against a school, really set the fire, Dr. Schoenike noted. The districts are now reviewing the form — with specific input from attorneys weighing risk management issues — and all the parties plan to come back to the table before the end of the school term in June. Dr. Schoenike is pleased with the reception he received at the superintendents' meeting and is optimistic about continued discussion and action.

"The issues include case loads, delegation, administrative structure and accountability — they are all tied together," Dr. Schoenike explained, "and they are only going to get to be bigger problems before they are fixed."

The Committee: A Positive Experience

Dr. Schoenike, Carol Jones, Janice Doyle and Susan Newell all agree that the Public Health/School Health Committee is a positive and effective vehicle. After all, when members join a committee and stay for over 10 years, it

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

The AIDS epidemic

The AIDS epidemic continues relentlessly. Even though we understand the disease better now than ever before, the virus keeps moving through our communities. We are disadvantaged by there not being a vaccine, but we have successfully controlled other sexually transmitted diseases for which we lacked an effective vaccine. We have been distracted by the new drug combinations that seemed to lower dramatically the viral loads in many patients, losing sight of the fact that the cocktails are not cures. Today, our only hope of stopping the virus relies on an aggressive prevention campaign.

Across the country and certainly across our state, we have struggled with what effectively prevents AIDS. Attempts at fully utilizing our traditional disease control techniques have been met with a myriad of arguments that opposed much of what we've tried. The arguments focus on perceptions about the disease; 1) HIV infection is unique and therefore it requires a different approach to prevention; 2) The privacy needs of infected individuals preclude our using many of the testing and partner notification approaches used in traditional disease control.

HIV infection in our community is not a unique disease. We understand how it is spread, how it gets from one individual to another. We know specifically the kinds of behaviors that lead to a more likely spread of the virus through a population. Those behaviors parallel other sexually transmitted diseases - there is nothing unique about HIV contagion. And when we collect information and begin the traditional follow up with partners to prevent further infection, we take extensive confidentiality precautions.

Denial pervades our community so

well that many individuals resist getting tested despite high levels of known-to-be-risky behavior. Disease control efforts fail in this environment. And because of this we see new infections in our community. Especially troubling is the increasing proportion of new cases linked to heterosexual contacts. More and more women are getting infected, especially women of color.

The bottom line is: we need your help to prevent HIV diffusion. We need to know how the Health Department can help you to get more people tested for HIV, particularly those people whose behaviors put them at highest risk.

There are two primary groups that we have targeted because of their prominence in the continuing spread of HIV in Pierce County: IDUs (injecting drug users) and individuals with multiple sexual partners. Sharing needles/syringes and having more than one sexual partner puts one at considerable risk for being exposed to a bloodborne and sexually transmitted disease, including HIV. In order to check the spread of HIV, we need to identify all the HIV positive individuals in our county and notify the partners of each one. Each partner would be tested and counseled and, as needed, their partners notified. Each HIV positive individual would then be registered and followed routinely to reinforce ways to protect themselves and others. One's personal health is not the only thing that changes when contacting the disease. An HIV positive individual becomes a potential threat to the health of the entire community - for the rest of her/his life. This carries responsibility and requires a change in behavior.

We are ready with skilled and sensitive personnel, a secure system for

confidential information, and a desire to protect the health of all Pierce County residents. How do we reach all of the HIV infected individuals here? We need to find points of contact with each of the key populations. For IDUs and people with multiple sexual partners, two critical places are the county jail and the offices of local physicians. If someone regularly uses IV drugs, eventually s/he will end up in the criminal justice system and that means a stay in jail. We can - and do - test people there. If one has multiple sexual partners, eventually that individual will develop the symptoms of a sexually transmitted disease and seek medical attention. This is where I ask for your assistance. What can we do when these individuals come into your office so that they get an HIV test? Without getting tested, we are in the dark as to who has the virus. We are unable to follow through with our public health disease model.

Let me know what you need to help you convince someone to be tested. You can call me at (253) 798-2899, or e-mail me at feruz@tpchd.org. Or, I'll have one of our network nurses drop by your office with an official request for your assistance.

I'm tired of getting caught in the net of denial and avoidance. It's time to work together to get in front of this disease, and we can only do that by working together. ■



Nurses

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means something is working.

For Dr. Schoenike, the experience has given him insight into what school nurses are doing. "My involvement in the committee has put a face on school nursing issues for me. I know what they are dealing with, and I've come to realize that school nurses are a great group of highly dedicated individuals. They don't choose school nursing to be rich or famous. They do it because they love it. There aren't a lot of jobs out there that can be said for. They are enthusiastic and excited about what they are doing. And they maintain that enthusiasm while working under increasing duress. But they know now that we can do something to fix them."

Carol Jones finds that "the Public Health/School Committee has provided unending support and a forum for open communication. As a school nurse," she added, "I'm comfortable calling the Medical Society, health department or a physician if I have a problem. The support has been tremendous."

Showing Support, Taking Action

Additional action can be taken to

ease the burden of school nurses. Dr. Schoenike asks fellow physicians to consider something that he hadn't realized before joining the Public Health/School Health Committee. "When you write an order for a patient in school, it's just like writing an order on a hospital chart for nursing staff. Whatever the order, it's going to be done, but it needs to be clear and free of ambiguity."

Janice Doyle also wants physicians to realize that when they are writing orders for students, those orders are likely going to be carried out by health technicians or paraeducators. While nursing care is increasingly delegated, nurses still remain ultimately responsible.

"It's been a long road, but we're not giving up," said Carol Jones. She hopes physicians and other members of the medical community understand the problems school nurses are facing and encourages them to speak out to school districts and the legislature. She feels the continued support is even more important now in light of added concerns in the schools — most notably a possible impending energy crisis that could put additional drain on nearly nonexistent district budgets.

"The bottom line we must convey is that we need more nurses to provide safe care," says Janice Doyle. "The current situation is not fair to schools or families. The nurses do the best they can," she said, "but we have great safety concerns. In Connecticut, Doyle noted, it wasn't until a student choked to death on a hot dog that a nurse was placed in every school. But she remains optimistic. "The superintendents' meeting was a very encouraging step in addressing these issues," she notes. "We're educating people, and we're definitely moving in the right direction."

And, while moving in the right direction might not lead to the "perfect world," perhaps there might come a time when the following statement rings true: "School nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning." (Source: National Association of School Nurses, June 1999) ■

Applicants for Membership

Hassig, Walter M, MD

Gastroenterology

Practices at Digestive Health Specialists
1901 S Union #B4006, Tacoma WA 98405
253-272-5127

Medical School: Michigan State

University College of Human Medicine
Residency: Blodgett/St. Mary's/Michigan
State University

Fellowship: Henry Ford Health System

McDonough, Michael J, MD

Radiation Oncology

Practices at Tacoma/Valley Radiation
Oncology Center

314 MLK Jr Way, Tacoma WA 98405
253-627-6172

Medical School: St. Louis University
School of Medicine

Internship: St. Mary's Hospital and
Medical Center

Residency: The Cancer Therapy and
Research Center - The University of
Texas Health Science Center

Residency: Ohio State University

Residency: Wayne State University

Marsh, Robert E, MD

General Surgery

Will have a solo practice in Puyallup
1430 3rd Street SE

Medical School: Oregon Health
Sciences University

Internship: Creighton University

Residency: Creighton University

IN MEMORIAM
WAYNE BERGSTROM, MD
1936-2001



Wayne Bergstrom, MD

Wayne Bergstrom was a friend of mine. I'm proud to say that because he was an admirable man.

Wayne was born and raised in the Midwest in a small town in Iowa just across the border from Omaha. His heritage in the Midwest molded his character-devotion to duty, friendliness, liking people, etc.

Wayne and I both went to medical school in Omaha. He to Creighton, I to the University of Nebraska. We did not know each other then. He graduated in 1963.

His father was a GP in Missouri Valley, Iowa all his life. Those were the days when, if a farmer couldn't pay his bill, you got a couple of chickens, or a pig for delivering a baby. There frequently was chicken on the Bergstrom table.

Wayne went to the University of Iowa for pre-med, then Creighton Medical School and internship in Cedar Rapids, Iowa. He served in the Army at Ft. Lewis and Madigan General Hospital. In 1966, he came to Tacoma. He came and talked to me about an association. It was my loss that this didn't work out. However, we shared weekend call the last few years that we practiced. Wayne was a good doctor, admired by his patients and peers alike. He seldom made mistakes and his hospital workups were exemplary. He was Board Certified in Family Practice in 1977 and he was a member of PCMS, WSMA, and AAFP (local and national). He served on various medical committees and served as President of the Pierce County Medical Bureau.

Wayne had two passions (probably others I didn't know about): golf and story telling. After retirement several years ago, he was able to pursue golf more vigorously, but several surgeries cut into that.

Wayne's stories were always funny, but at times risqué. I never heard Wayne speak criticism about another human being. In fact, if I criticized an individual, he often would change the subject, as he was uncomfortable with the thought.

Wayne married Reta (a childhood sweetheart) close to 40 years ago. They had a good marriage. He must have been an easy man to live with. Certainly, friendship with him was easy and enjoyable.

Jim Blankenship, MD

IN MEMORIAM
DAVID F. DYE, MD
1921-2001

David wandered out of the world of people and time into the world of Spirits and eternity on April 15, 2001, surrounded by his family and friends. His leaving was not totally unexpected but, none the less, a loss. For him it is the beginning of another adventure.

David's journey began on October 5, 1921 in Roundup, Montana, where he was the 3rd child. He left Montana on a freight train headed for the West Coast. His tales of his adventures between then and the end of WWII filled many an hour with joy and mirth. A lifelong Husky, he graduated from the UW School of Medicine in 1952 and set up practice in South Tacoma.

David liked being a person who could help others and saw Medicine as his way to do that. He had to be reminded, at the end of his first year of practice, to bill people. David never got over the idea that medicine should be free to those who could not afford it. However, the joy he received more than made up for any financial damage that he may have suffered. He counted as one of his many blessings the lifelong friendships that he established with many of his patients.

David was never inhibited by a lack of knowledge when he approached any non-medical problem. This resulted in, among other things, his building a swimming pool in the family's home that lasts to this day. The family still recalls the time he filled the pool with goldfish (unaware of the effects of chlorine on goldfish) for his granddaughter's birthday.

David had a strong sense of public service. He served on the City of Tacoma Utility Board and was its chairman in 1981-1982, was on the Pierce County Medical Bureau Board of Directors and was a member of the Board of the Bayview Condominiums.

David is survived by his wife of 45 years, Rosemary, sons David (Rebeca), Michael (Jeri), Craig (Noreen), and Eric; daughter Rosemary (John) and grandchildren, Caroline, Lewis, Greta, Georgia, Robin, and Nathan. Daughter Robin preceded him in death.

In keeping with David's spirit of public service, he asked that contributions be made to the Tacoma Art Museum, 1123 Pacific Avenue, Tacoma WA 98402.

IN MEMORIAM

RONALD C. JOHNSON, MD

1946-2001

Editor's Note: The following eulogy was presented at Dr. Johnson's memorial service by his friend, Dan A. Wiklund, MD.



Ronald C. Johnson, MD

I see so many familiar faces of colleagues as well as patients and friends of Ron. He surely would have been delighted to see such a turnout even though he was a humble man. My name is **Dan Wiklund** and I am one of Ron's medical colleagues. Our friendship dates back 30 years to our PLU days and has survived many mountain hikes, snowcamping and arguments, including one that completely destroyed Ron's hiking tent.

I am here today with my three adorable daughters and my lovely wife, Ulrike. Somewhere it has been written, "He had no time for death, so death kindly waited for him." Ron did not die easily nor did he ever care to take the easy way out of anything. During the last week of Ron's life, his wife along with Ron's sister, Candy, stood vigil over his bedside. Ron's sister particularly cared gently and lovingly for every need from the telling of sweet childhood stories to moisturizing his cracked, parched lips. The scene reminds me of the loving kindness of Mary, sister of Martha and Lazarus of Bethany, who anointed with fragrant oil the feet and hair of Jesus, a few days before his crucifixion. Thank God for women.

I am not here today to tell Ron's life story nor to recount his accolades or foibles. Many of you know that Ron received the rare distinction of being awarded PLU's alumnus of the year a few years back as well as having the Puyallup Helping Hand House named the Ron C. Johnson Home. Ron was humble and would be embarrassed with a litany of praise. Rather, I would like to share with you a personal story that recounts the sweetness and tolerance in our relationship as well as a farewell poem.

First, let me begin with a Ron story. There are many of them. Sitting in the pews I believe is Art Schneider, a dear patient of Ron's who recently celebrated his 180th birthday or something close to that. Art is a packer and has a pasture full of mules and pack horses and wanted to take Ron and me to the Goat Rock wilderness area high above Packwood. Now Art is a real cowboy and I was fortunate enough to grow up with horses as well. Unpacking the horse trailers was a nightmare with a half dozen pack animals and enough equipment to set up base camp at Everest. My wife always teased Ron and me that we spent enough money on camping equipment to be able to spend a month at Seattle's Four Season's Hotel. Anyway, Art, myself and all the pack mules are headed up the trail

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IN MEMORIAM
J. GALE KATTERHAGEN, MD
1935-2001

J. Gale Katterhagen, MD passed away April 10, 2001 after an extended bout with cancer.

Dr. Katterhagen was born in Calgary, Canada and is from a long line of wheat farmers, most of whom still reside in Canada. In 1942 the Katterhagen family moved from Canada to Seattle. The family operated a small truck farm while his father worked as a machinist at Boeing and his mother at Sears.

Dr. Katterhagen graduated from Seattle University and in 1961 graduated from Creighton University Medical School. He made significant contributions to the field of Oncology. He was a practicing oncologist in Tacoma for over 20 years, then left in 1986 to develop and implement cancer treatment centers for hospitals in Springfield, Illinois and also Burbank and San Francisco, California. In April of 2000, he returned to MultiCare Medical Center to develop the Regional Cancer Center and Cancer System.

His greatest gift to those with cancer was his selfless giving and listening to those in need of help and insight. His appetite for life extended to many areas, including running, swimming, taking saunas, and traveling with his wife and many friends. He loved to be with his family and cherished the delights of a yearly family pilgrimage to Lake Chelan.

He will be missed dearly by his family and friends.

IN MEMORIAM
ROBERT A. O'CONNELL, MD
1923-2001



Robert O'Connell, MD

Robert "Bob" O'Connell, MD passed away Monday, April 16, 2001 at St. Joseph Hospital, the place of his birth, after a courageous battle with cancer. Bob was born in Tacoma on March 18, 1923 and was raised on Puyallup Avenue, at the foot of McKinley Hill, atop his father's establishment, Tom's Tavern. He attended Holy Rosary Grade School and Bellarmine High School. Sports were always an important part of his life and he was extremely proud of his athletic accomplishments, having earned all-state honors in football and attending Santa Clara University on a baseball scholarship.

Dr. O'Connell received his M.D. degree from Marquette University in 1947 and continued his residency training in Milwaukee, Wisconsin, where he met and married his wife of fifty years. He practiced internal medicine in Tacoma for over forty years.

Bob received many honors and awards for his professional contributions and leadership in the community. He was Chief of the Medical Staff and a member of the Board of Trustees of St. Joseph Hospital, a founder of Allenmore Medical Center and Hospital, served as President of the Washington State Heart Association, and is a member of Bellarmine's Sports Hall of Fame. He was active in Tacoma athletics, serving for forty years as team physician for Stadium and Bellarmine High Schools and giving free sports physicals to thousands of recreation league children.

Dr. O'Connell retired from the practice of medicine in 1988 and spent the golden years with his wife, close friends and family - laughing, loving, golfing, and cheering his teams to victory.

IN MEMORIAM
 MAURICE L. ORIGENES, JR., MD
 1925-2001



Maurice Origenes, MD

Maurice L. Origenes, Jr., MD passed away on May 15, 2001, at Northwest Hospital in Seattle at age seventy-five due to complications from prostate cancer.

He was a pediatrician with specialties in pediatric oncology and hematology since 1957. Dr. Origenes was a longtime member of the Tacoma and Seattle communities, respected for his professional and civic contributions and religious ministries.

He earned his medical degree at the Catholic University of The Philippines in 1954. In 1958, Dr. Origenes came to Seattle as a Fellow in Pediatrics at the University of Washington School of Medicine. In 1967 he opened a private pediatric practice in Tacoma, until his retirement in 1992.

Dr. Origenes was a pediatrician for the Puyallup Indian Nation, Jesse Dyslin Boys Ranch, Tacoma Runaway Youth Program, Kitsap Youth Homes, Tacoma Community House, Southeast Asian Refugees, the El Salvador Sanctuary Refugees and Peruvian Inca Indians, both in Tacoma, and a sports physician to numerous youth organizations.

He was recipient of a variety of civic and medical honors and awards, including "Distinguished Citizen" which was awarded by the Municipal League of Pierce County "in recognition of outstanding dedication to good government and the betterment of our community."

In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

Insurance Overhead

"The high cost of living isn't so bad if you don't have to pay for it."

Don Marquis (1927)



Andrew Statson, MD

Once upon a time, in the years BC (Before Computers), the insurance forms contained the personal information of the patient, the diagnosis, the procedure and the charge. As long as the treatment was a covered benefit, the insurance paid 80% and that was that. Computers were supposed to make things easier for us and reduce our work load. They did the first, but not the second. Because some things were easier to do, the work expended to fill the available time, then overflowed it.

Computers can't understand human language, so the first thing that happened was to switch from descriptions to codes for the work we do. Codes are slots where we have to fit diagnoses and treatments. A rose is a rose is a rose, until you listen to Ed Hume. Then you realize that it isn't. The same is true for diagnoses and treatments. Diabetes is not diabetes is not diabetes. They are all different from patient to patient. The same is true for colectomies, hysterectomies or for any other surgical or medical procedure or treatment. There is an average, there is a median, but in every patient the treatment is different. As long as the insurance companies kept paying 80% of our charges, there was no problem. We could charge according to the difficulty of the case.

That was not good enough. The insurance companies decided they would pay not according to how much we charged, but according to the treat-

ment code. Fine, but patients don't fit the slots of treatment codes very neatly. There are too many situations where the diagnosis can be placed in this slot rather than that, and the treatment is more likely to be coded here rather than there. The insurance companies called that upcoding. That approach did not work as well as expected, so the next step the insurance companies took was to make the lines between the slots as thin as possible. The slots were described precisely, so that the gray areas could be eliminated.

As a result, coding became more and more complex and developed into a branch of medicine in its own right. The diagnosis codes went from three to four to five digits and there is rumor a new system with six character codes is coming. The treatment codes added modifiers and were matched to specific diagnosis codes. In spite of all this, human beings still don't fit into slots. Coding is so complex now that we have to go to classes, buy books, subscribe to periodicals and buy computer systems to help us with the coding requirements of insurance billing. To make things even more difficult, the codes change every year, so we have to relearn coding, get new books, upgrade computer programs, etc.

Not only do we have to be trained and retrained in coding, but so does our staff. I don't know what the total cost is to us, nor how much we spend for every claim we submit. I suspect it varies from practice to practice. When

we total all the costs related to billing, we probably spend at least ten and possibly as much as twenty dollars per claim. This includes, in addition to the time for training, coding and billing proper, the cost of the required documentation to support our charges, the costs of our time and that of our staff spent on the phone getting approvals, authorizations, following up on claims that have not been paid, etc.

At the same time, the insurance companies have to buy computers, to train and retrain their staff every year. As the rules change, they have to upgrade their programs, issue periodic regulations, print rule books and formularies. They have to submit some claims to medical review, return and reprocess others, send explanation of benefits and other correspondence to offices and to patients. They also have to audit and credential the physicians on their panels and meet a variety of other requirements, imposed on them by those who buy their insurance policies and by the government.

I don't know what the cost is to an insurance company to process and pay a claim. Indemnity insurance overhead is about 10-15% of premiums. The size of the average claim is probably about \$100-200, so the cost to process a claim is probably between \$10-30. For managed care, the overhead is double that,

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about 20-30% of premiums, so the average cost per claim is probably closer to thirty dollars.

The combined cost of preparing, submitting, processing and paying a claim probably comes to forty dollars. When a claim results in a fifty dollar payment, the processing costs are 80% of payment. For one hundred dollars they would be 40%.

Let me look at the patient now. Here comes a patient who gets medical care and pays fifty dollars for the medical care and forty dollars for the paperwork. This exercise consumes ninety dollars in premiums. Isn't that too steep? Even paying one hundred dollars for

the care and forty for the paperwork is too high. Since the great majority of the claims are for less than \$200, the patients pay between 20-40% more in premiums than what it would cost them if they would pay for their medical care directly, out of pocket.

Insurance coverage for high ticket services has a much lower overhead. The patient would have to pay only one percent more in premiums to have a charge of \$4000 paid by the insurance. The insurance overhead is proportionately less as the size of the claim increases. The question here is at what level of medical costs does insurance coverage become worthwhile. This

threshold level will vary from person to person, from family to family, depending on their ability to meet out of pocket expenses.

One option, available under the current insurance system, is the policy with a high front end deductible. The cost of such policies is lower than first dollar coverage. This option, however, does not eliminate the processing of small claims. The claims still have to be submitted and processed. They just don't result in payment until the deductible is satisfied. They eliminate the payment, but not the filing and processing costs. Even capitated contracts ask us to submit claims for services, just for bookkeeping purposes, even though they would not result in a payment.

Another problem with this option is the tax consequence of health care payments. Since most people are insured through their employer, premiums are a tax deductible expense, out of pocket costs usually are not. A half-hearted attempt to correct this problem is the system of medical savings accounts. It has not been widely adopted because the rules governing that option are not simple enough. Our tax code encourages first dollar coverage, thereby raising the administrative costs of health insurance policies.

The most helpful thing the government can do is either to allow full tax deductibility of all health care expenses, insurance premiums and out of pocket alike, or to disallow it. Then the insurance companies will be able to develop and market new products with low overhead expenses. The largest number of insurance claims, and therefore the largest costs in processing them, are the small claims. I don't know the exact number, but I suspect 90% of all claims are for less than \$300. Eliminating them will do away with 90% of processing costs and will probably reduce the cost of insurance premiums by a significant amount.

Would such a solution come to pass? I am afraid it is too simple, so it is unlikely that it will. We would rather create a new agency. ■

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MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell
Attorney at Law & Arbitrator
3055 - 112th Avenue SE, Suite 211
Bellevue, WA 98004

(425) 822-1962 • FAX (425) 822-3043
email: grocket@msn.com • website: ggrockwell.wld.com

New Members

Cosgrove, Anne E, MD

Pediatrics

Practices at Tacoma South Med Clinic
2111 S 90th Street, Tacoma
253-539-9700

Medical School: U of Massachusetts
Internship: U Hospitals of Cleveland
Residency: U Hospitals of Cleveland

Fahmy, Raed N, MD

Cardiology

Practices at Cardiac Health Specialists
1802 S Yakima #307, Tacoma
253-627-1244

Med School: George Washington U
Internship: UCLA-SFVP
Residency: Loma Linda U Med Ctr
Fellowship: UCLA-SFVP

Gill, Alan R, MD

Family Practice

Practices at Tacoma Family Medicine
521 Martin L King Jr Way, Tacoma
253-403-2900

Medical School: U of Michigan
Residency: U of Missouri-Columbia

Kelley, James L, MD

Pathology

Practices at Dig Health Specialists
1901 S Union #B2005, Tacoma
253-272-8177

Medical School: Oregon Health Sci U
Internship: Tripler Army Med Ctr
Residency: Tripler Army Med Ctr

Metcalf, Sharon L, MD

Ob/Gyn

Practices at The Lakewood Clinic
11311 Bridgeport Way SW #309
253-581-6688

Med School: Virginia Commonwealth U
Internship: Eastern Carolina U
Residency: St. John Hospital

Mooney, Maureen A, MD

Dermatology

Practices at Cascade Eye and Skin
1703 S Meridian #101, Puyallup
253-848-3000

Medical School: U of Minnesota
Internship: Hennepin County Med Ctr
Residency: New Jersey Med School
Fellowship: New Jersey Med School

Nutter, Paul B, MD

Physical Medicine and Rehab

Practices at Good Samaritan Hospital
407 14th Avenue SE, Puyallup

Medical School: U of Washington
Internship: U of Washington
Residency: U of Washington

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104A 23rd Avenue SE
Puyallup WA 98372
Phone: 770-5151
Fax: 770-5152
Sponsor: Robert Vandeburg, MD

Andre Joseph, MD
Change address to:
1708 S Yakima Ave #40
Tacoma WA 98405

Todd Kihara, MD
Change Access Line Pager to 444-5193

Jay Klarnet, MD
Delete pager number
Add: Paging Service 1-800-235-4263

Patty Kulpa, MD
Change address to:
7282 Stinson Avenue Ste C
Gig Harbor WA 98335

John McCloskey, MD
Change address and phone to:
314 Martin L. King Jr Way #303
Tacoma WA 98405
Phone: 396-4868
Fax: 396-4870

James Morgan, MD
Change address to:
1708 S Yakima Ave #60
Tacoma WA 98405

Philip Vance, MD
Change address to:
1708 S Yakima Ave #50
Tacoma WA 98405

Matthew White, MD
Change address and phone to:
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Nationally known antibiotic resistance expert Dr. Charles Stratton has agreed to keynote next fall's Infectious Diseases Update CME.

Dr. Stratton is an Associate Professor of Pathology and Medicine and the Director of the Clinical Microbiology Laboratory at Vanderbilt University.

This year's program is set for Friday, November 2, 2001 and is directed by **Dr. James DeMaio**. In addition to a presentation by Dr. Stratton, the program will feature presentations by Infectious Limited physicians.

This program is designed for physicians as an update on common outpatient and inpatient infections. A brief review and clinical update will be made on a variety of important topics. ■

Whistler CME likely January 23

Registration will soon open for the College's CME at Whistler/Blackcomb program. Program brochures will be mailed this summer. The conference is tentatively scheduled for January 23-27, 2002.

The program offers family vacationing, skiing and the usual quality continuing medical education to PCMS members and other physicians. With Category I credits, the CME program features a potpourri of subjects of interest to all specialties.

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Continuing Medical Education

CME at Hawaii returns to "Big Island," Hapuna in 2002

The Hapuna Beach Prince Hotel, on 32 acres edging on Hapuna Beach at the Mauna Kea Resort (hailed as "one of the world's 10 best"), has been selected as the site for the CME at Hawaii program in 2002 - specifically the week of April 7-13.

The CME program returns to the "Big Island" and the Hapuna for a variety of reasons including great reviews resulting from those who attended the 2000 meeting at the same hotel. The College was again able to secure a "world-class" resort at greatly reduced rates. Registrants may benefit from our negotiated group rates for ocean view rooms from \$190. A second adjoining room for children under 18 is available at \$50 below the group rate.

Program brochures will be mailed this summer. In addition to outlining the CME program (16 Category I hours), the brochure discusses transportation and encourages early registration.

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Johnson from page 11

and we shortly discovered that Ron is nowhere to be found. I forgot to ask Ron if he had ever been on a horse before and, of course, he had not, except for the one in front of the Safeway store. His horse was headed back to Puyallup. We collected Ron, gave him driving instructions and nicknamed him the Buckaroo. The name stuck and became a metaphor for many of the comical aspects of Ron's personality. Ron was always accepting and tolerant of my teasing. He taught me how to be a friend, not to be embarrassed of hug-

ging another man and the importance of daily friendship. I could always count on Ron calling me every morning at 9:30 just as I was falling behind in my clinic, telling me it was time to catch my breath. Ron worked six days a week, twelve hours a day and knew how to pace himself. His compassion and kindness to his patients will always be my model.

Ron had many passions and one of the greatest was his books. He was an avid reader of poetry and philosophy. The scary thing is that he read most of

them and understood them. I think it was a part of why he enjoyed ambiguity and why he was often conflicted. His basement looks like an annex to a university library with over 3000 books. We attended many lectures at UW's Kane Hall and the Science and Technology lectures at the Paramount hearing great speakers from the Jungian psychologist, James Hillman, to the agnostic anthropologist, Stephan Jay Gould. His true love was poetry and I would like to share one with you that you probably know by Alfred, Lord Tennyson. Tennyson also had a devoted friend from college, Arthur Halloran, who single-handedly encouraged Tennyson to publish his early poetry. Halloran unfortunately died unexpectedly at an earlier age than even Ron did. At age 81, just three years before his death, Tennyson picked up an envelope and wrote "Crossing The Bar" across the back of it. The metaphor in this poem refers to the pilot boat that brings you safely across the rough waters of the bar into the safe, quiet waters. It reads:

*Sunset and evening star,
And one clear call for Me!
And may there be no moaning of the bar,
When I put out to sea,
But such a tide as moving seems asleep,
Too full for sound and foam.
When that which drew from out the
boundless deep
Turns again home.
Twilight and evening bell,
And after that the dark!
And may there be no sadness of Fare-
well,
When I embark;
For though from out of our borne of
Time and Place
The flood may bear me far,
I hope to see my Pilot face to face*

Ron will see his Pilot face to face, a man of strong faith. ■



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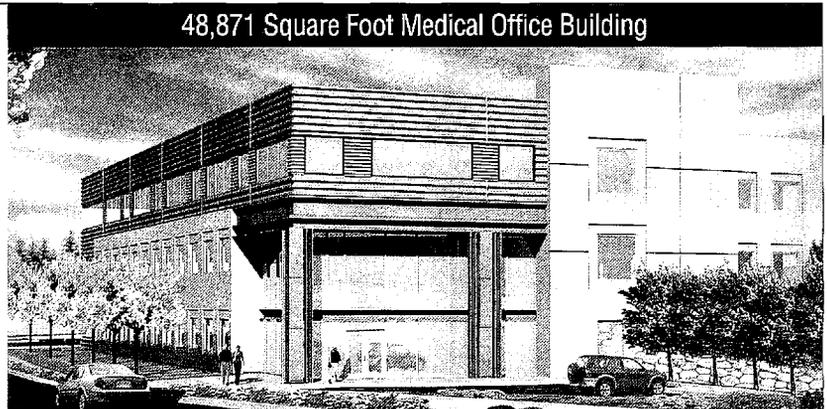
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BULLETIN

Pierce County Medical Society



July, 2001



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Pierce County Medical Society

BULLETIN



July, 2001



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

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

Managing Editor: Sue Asher

Editorial Committee: MBI Board of Directors

Advertising Information: 253-572-3666

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President's Page

by Patrice Stevenson, MD

The Fish Head Guy

I was flying on Southwest Airlines recently and reading their magazine (to procrastinate from reading the book on time management I've been carting around for months). There was a little snippet in a trivia column mentioning that the now world-recognized Nike "Swoosh" logo had been created by a graphic arts college student in 1977 for \$37. This seemed to be a pretty good return on investment. I then started thinking about logos in medicine.

I am a member of the American Academy of Physical Medicine and Rehabilitation and serve on their Historical Preservation Committee. The subject of our logo was the topic of the editor's (Claire Wolfe, MD) column in our March 2001 newsletter, *The Physiatrist*. The outer



circle contains the organization name and the inner contains "founded," some Greek, and the founding date (in Roman numerals). The Greek was the topic of debate. A couple of Greek Orthodox priests were consulted and said it meant nothing. An "elder statesman" physiatrist was certain the logo had been developed and approved by the board of trustees in 1958. A search of the academy records could not find mention of the logo's creation nor official adoption.

Our committee chair, Dr. George Kevorkian (no relation) has a Greek PM&R resident in his program who says the words do mean something that would poorly translate into "Physical Medicine and Rehabilitation." The Greek was old and formal (isn't all Greek?) and the meanings of the words picked for the logo were close, but not quite correct. The word for "medicine" meant drug or medication, not the practice of medicine. My conclusion was that some physiatrists went out for drinks with a Greek dictionary in tow and set out to add some culture to the logo and got only so close. The rest of the committee thought that a likely scenario.

So what is the origin of the PCMS logo? The fish head guy (my personal term of endearment for him) is also dark and mysterious (at least the left half of his head).



He also just started showing up some time in the 1960s. I had our former executive director, Doug Jackman, dig through the PCMS files and he couldn't find specific mention of the logo's creation or adoption. The fish head guy has a certain early sixties look to him with his hairstyle and the Ben Casey white uniform shirt. The stethoscope implies he is a doctor. The

black and white likely does not represent our ethnic diversity, but the India ink medium used to draw him. I like the representation of Mt. Rainier and the water...but what is with the fish? Is it coming out of his head ala *Alien* or leaping out of the water to attack his stethoscope? He seems oblivious to the fish's presence. Does the fish have some Biblical connotation or is it symbolizing one of our area's economic activities? If the fish were not there, what would you put there? Well, there could be a representation of a female physician as we do have many women members, but not a single fish has ever applied for PCMS membership. Perhaps the name or initials of the Society could be there. I am not sure what should replace the current logo, but I, for one, would like to "can" the fish.

Perhaps I am alone in my opinion. Perhaps the fish head guy is a cherished icon of the membership. Perhaps we could sell PCMS T-shirts sporting his image. If not, how about a new logo for the new millennium? I ask that you submit your logo ideas to the PCMS office. ■



The Medicare scare - are physicians really opting out?

*Editor's Note: According to a recent PCMS survey, 36% of primary care physicians in Pierce County are **not** accepting new Medicare patients. See "Physician Numbers" on page 8 for specialty statistics.*

Seattle Neurosurgeon Michael Schlitt, MD could be called a trendsetter when it comes to Medicare. He decided to drop out of the program ten years ago citing government arrogance and a growing distrust of physicians and new payment equations. Dr. Schlitt figured it had to be easier to treat Medicare patients for free.

He once performed brain surgery for \$1. "I have a beautiful three-foot-long and three-foot-tall boat that a patient gave me for payment for surgery," he says.

His decision has not hurt his practice or his patients, something he says doctors worry would happen if they leave Medicare. "To my knowledge, I have never denied care to anyone who needed it," he says. "I was more than compensated by the freedom to make the right decision for my patients and the relief of getting the government out of my operating room."

Now, many of his colleagues are following in his footsteps. Mired in thousands of treatment codes and pages of regulations, physicians are feeling overwhelmed and overburdened. Administrative headaches, along with complicated reimbursement formulas, lowered or denied payments for certain services, and the threat of fraud-and-abuse investigations, are leading some physicians to say, "no more."

The government says its figures don't support the contention that doctors are rejecting Medicare. But studies and anecdotal evidence indicate that in many urban areas, including Denver, Atlanta, Austin, and even in our own state, elderly patients are having difficulty finding physicians and are getting shuttled from doctor to doctor until they come across one willing to accept

Medicare.

Studies in Colorado show that 40% of family physicians will not accept new Medicare patients. In Denver, barely 15% of doctors take new Medicare patients.

When Medicare was passed 36 years ago, there was initial and sometimes vehement opposition by doctors because they feared government intrusion. Most voluntarily agreed to the terms, but with each passing year, the rules have changed, and the government's reins tightened. Two of physicians' biggest complaints are the paperwork burden and complex Medicare rules.

Lawrence Huntoon, MD, a neurologist from Jamestown, N.Y., keeps an eight-foot-tall and 186 pound stack of correspondence with HCFA in the back of his office. "I call him little Frank," says Dr. Huntoon, a reference to Mary Shelley's *Frankenstein*. "I spend as much time on bureaucracy as treating patient."

There are more than 7,000 medical treatment codes, says Dr. Huntoon, who treats Medicare patients, but is nonparticipating. "There's a code for injury that occurs while riding an animal that collides with another animal, a code for injury from being pecked by a bird, and a code for injury due to a fall from a spacecraft, flagpole or commode."

One of Dr. Huntoon's biggest beefs is with advanced beneficiary notices. He routinely performs two different ultrasound procedures on the same patient. When Dr. Huntoon billed for both procedures, ABNs went to 100 of his patients, warning that their doctor may have broken the law by billing for both procedures.

"I went through nine months of ap-

peals and I won every case," he says. "When I proved the services were necessary, and Medicare agreed I did nothing wrong, they refused to notify my patients. Many won't come back.

Physicians also include payment among their Medicare concerns. In Colorado doctors get paid about 20% less than physicians in Los Angeles or New York for the same services. Many say they are losing money.

But one of the reasons nearly half of Colorado's family doctors are limiting the number of Medicare patients they will treat has to do with fear of fraud-and-abuse audits and huge fines or legal costs. They are not alone!

Dr. Schlitt says he worries about the law and hidden rules. Because of changes in the law since he dropped out of Medicare, he is required to bill the program for some patients. He has spent about \$30,000 on lawyers to make sure he's not doing something wrong. "I have always wanted to be in compliance with the law," he says about his Medicare encounters over the past decade. "But I always wanted to care for the patient."

HCFA officials report their data do not support the widespread claims of doctor defections, but they are listening to physicians' concerns.

They contend that physicians participation in Medicare is actually increasing. It reached 86.3% in 2000 - a four percentage point increase over 1999. The Medicare Payment Advisory Commission also doesn't have hard evidence of doctors leaving the program but they have heard anecdotal reports and say that "we have no analytic reason to think there's a problem," according to Murray Ross, executive director of MedPAC, which advises Congress

See "Medicare" page 8

Electronic Medical Records: June Meeting Recap

There is no doubt that everyone attending the June 12 General Membership Meeting had a definite interest in electronic medical records. With 150 people, including ten vendors displaying their wares, the Temple Theater ballroom was a hub of activity.

Kudos are in order for PCMS Secretary/Treasurer **Mike Kelly, MD**, Lakewood family practitioner who is in the middle of transitioning to an electronic medical record system. From a PCMS interest survey conducted a year or so ago, it was obvious that many in the medical community wanted more information. Dr. Kelly studied the survey results in order to put together a program that would meet the needs and interest of the majority of respondents.

Bringing together colleagues, **Drs. James Brown**, Lakewood Allergy/Immunology; **Ron Morris**, Puyallup Family Practice; **Ed Pullen**, Puyallup Family Practice and **David Munoz**, Tacoma Internal Medicine. Dr. Kelly planned a program that offered an array of personal experiences, opinions, and system knowledge. Each speaker offered their own "story" and each was quite unique in their approach regarding the complexities and realities of EMR systems.

Prior to the program, PCMS President **Patrice Stevenson, MD** welcomed everyone and introduced new members **Drs. Pauline Anderson, Martin Cieri, Walter Hassig, James Pickett, Reheela Sadiq, Najib Stoman** and **Troy Woodman**.

Those that visited five of the ten vendors were eligible for a drawing for a \$100 gift certificate to a local premiere restaurant. Dr. Stevenson drew new member/ob/gyn **Dr. Pauline Anderson's** name as well as Lakewood general practitioner **Moo K. Lee, MD**.

Congratulations to the winners. ■

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Panel members, left to right, Drs. David Munoz, James Brown, Ron Morris and Ed Pullen answered questions after their presentations.



Participants had many questions and were very interested in vendor displays.

Members complete Sound to Narrows 2001

More than 6,000 runners participated in the Sound to Narrows on Saturday, June 16, with **Dr. Tom Herron**, Gig Harbor pediatrician, finishing in the top 200 men with a time of 50:39. **Dr. Ron Taylor**, Tacoma general surgeon, finished second in his division with an excellent time of 52:54.

One of the remaining few who has run in every Sound to Narrows for 29 years, was **Cordell Bahn, MD** re-

tired cardiovascular surgeon.

In addition to the members pictured below, the following physicians are to be congratulated:

Dr. Majeed Al-Mateen, Tacoma child neurologist, improving his time by over two minutes at 59:16

Dr. David Benson, Tacoma ophthalmologist

Dr. Loren Betteridge, Tacoma family practitioner, finished at an in-

credible 56:37 compared to 1:18:00 last year

Dr. Lauren Colman, Tacoma oncologist, did an even 1:00:00

Dr. Stephen Elder, Tacoma anesthesiologist, a very competitive 53:45

Dr. Jim Furstoss, retired otolaryngologist

Dr. Martin Goldsmith, pediatrician, just over an hour

New member **Dr. William**



John Bargren, MD



Drew Deutsch, MD



Ken Graham, MD



Gil Johnston, MD



Dave Law, MD



Craig Rone, MD (54:57)

Hirota, Tacoma gastroenterologist
Dr. Tom Irish, Tacoma plastic surgeon

New member **Dr. Sharon Metcalf**, Lakewood Ob/Gyn

Dr. William Shields, ophthalmologist

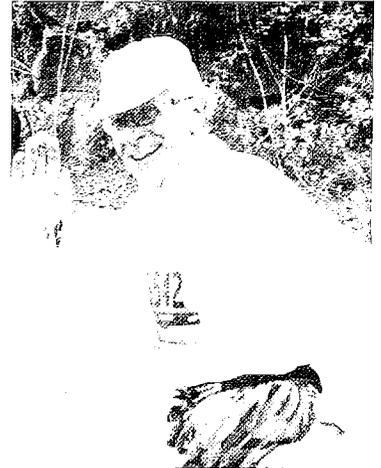
Dr. Darryl Tan, Lakewood pediatrician, improved his time by almost two minutes at 1:03:05

Dr. Carl Wulfestieg, Tacoma ENT

Congratulations to all Pierce County Medical Society members and their families on completing such a challenging run.

Please forgive us if we failed to list your name and contact the PCMS office (572-3667) so we can include your name in the next issue of the *Bulletin*. ■

Editor's Note: Thanks to Doug Jackman for his photographic abilities.



Cordell Bahn, MD



Tom Herron, MD (50:39)



Patrick Hogan, DO (59:29)



William Jackson, MD



Jim Rooks, MD



James Schopp, MD (59:28)



Ron Taylor, MD (52:54)

Medicare

from page 4

on Medicare issues.

Some experts argue that Medicare's procedures aren't any worse than other payers. The program pays faster than most, and the administrative and clinical challenges are like other managed care demands, they say. According to HCFA's medical advisor, some physicians' problems with Medicare stem from misperceptions and the agency's regional offices are working with physicians to clear up some of the confusion, she says.

But Colorado physicians are skeptical. The doctors think they will be prosecuted. Dr. Paul, who will meet with physicians this July, admits the program has some problems, but says recent changes - heightened education efforts for carriers and physicians, and ongoing PRIT initiatives - eventually will pay off. PRIT's targets include: ABNs; certificates of medical necessity, coverage of follow-up visits for cancer patients, often denied as routine screenings, coverage of pre-operative evaluations, also often denied, and laboratory services. Dr. Paul says PRIT's efforts in the past few years are leading to changes. "I'm hopeful that even the work we've done in the past two years will begin to be felt at the bedside," she says. "By the end of the year, physicians should begin to see some very specific results." Another positive development is an increased number of practicing physicians advising HCFA.

Nonetheless, some physicians say it will take more than just internally motivated changes. "Things like fairness, integrity and good business should apply to HCFA and it just isn't happening," said Dr. Corlin. "There is a cumulative building of inappropriate implementation that has been done so badly, they are collapsing of their own weight." ■

Excerpted from *AMNews* 6/25 01

Physician numbers:

Amid rising defections, the total percentage of physicians participating in Medicare has been increasing:

2000: 86.3%
1999: 82.3%
1998: 80.4%
1997: 77.5%
1996: 74.8%

Source: Health Care Financing Administration

Numbers of physicians accepting new Medicare patients in Pierce County

Primary Care 145 out of 227 = 64%
Specialists 389 out of 395 = 98%

* Total 534 out of 622 = 86%

Source: PCMS Fax Survey, 2001

*excludes pediatrics

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Hepatitis as a Sexually Transmitted Disease

I have written several articles for this journal that focused on HIV, looking at the difficulties we face in trying to stop the spread of this virus. I have stressed that in order to get in front of



Federico
Cruz-Uribe, MD

the disease we need to treat it like any other communicable disease. HIV is predominantly a sexually

transmitted disease (STD). So the work-up for an STD needs to include HIV testing.

But a quiet epidemic has affected many more people and caused more morbidity than HIV/AIDS. The disease? Viral hepatitis (both B and C). Though it is a mild disease for many infected individuals, it can have significant morbidity. The acute phase of the illness can result in prolonged numbers of days with fever, fatigue and jaundice. For a significant percent, it can lead to chronic hepatitis, with the long term effects of liver failure and liver cancer.

Nationwide, 80,000 new hepatitis B infections occur annually; fifteen percent will continue with chronic infection. Last year, Pierce County experienced a hepatitis B outbreak with 26 cases and three deaths, compared with seven cases and one death in 1999. A total of 3,600 cases of chronic hepatitis B have been reported in our community, and that is likely a very low number. People with hepatitis B can trans-

mit the virus through blood or sexual contact.

Approximately 3.6 million Americans are infected with the hepatitis C virus. This is also spread through blood, particularly by those sharing needles, or occasionally by sexual contact. Chronic liver disease is the tenth leading cause of death among adults in the U.S. and 40% can be attributed to hepatitis C disease; in addition, it is the leading indication for liver transplantation in the US. Since hepatitis C became reportable in July 2000, in Pierce County 3,700 cases have been reported. This is likely just the tip of the iceberg.

There are many factors causing the high numbers of infections in our community. The virus tends to be very hardy and tolerates broader changes in temperature, humidity and pH than many. Virus in blood or body fluids that are rapidly dried and left exposed to air remain infectious for a long period of time. We in public health failed to address viral hepatitis effectively for many of the same reasons we have floundered in addressing HIV. Because it is found much more prevalently in the injecting drug user (IDU) community and in the group of persons who have multiple sex partners, we assumed these persons would come to the health department for counseling and testing. We assumed they would take advantage of the available vaccine for hepatitis B. Some did come because of outreach but the majority did not. For the IDU community we needed to come up with novel and aggressive ways to get them tested. This was conceptually easy to do, as we have good contacts with our local needle exchange, with our local drug treatment programs, and with the staff at our county jail. Between these three ven-

ues we feel we are potentially reaching a very significant part of the IDU community.

For those at high risk because of multiple sex partners, we have looked to the private medical community for assistance, since most of those at risk for hepatitis access their health care providers. But many cases are missed if individuals have mild symptoms or if they are asymptomatic. Many times they are missed because we often don't think of viral hepatitis as a sexually transmitted disease. Every encounter with a patient who comes in with the symptoms of an STD is an opportunity to assess them for viral hepatitis. If they are positive, report this to the health department.

Here is where the private provider plays a key role in our disease control efforts. Through your screening efforts we get in touch much more rapidly with the individual sources of the infection that can potentially rapidly spread through our community. **If physicians routinely screened for hepatitis B and C in every patient presenting with the symptoms of a sexually transmitted disease, we would reach an ever-widening net of infected and exposed individuals.** We can educate those at risk. Those not infected but at risk for hepatitis B, we can offer a vaccine to protect them. For those positive, we can offer support and counseling on how to take better care of themselves and to protect those around them from contracting the disease. By doing these traditional disease control measures we can get in front of the disease and greatly slow its spread through our community. ■

IN MEMORIAM
 MYRON A. BASS, MD
 1924-2001

Dr. Bass was born in Seoul, Korea, where his father Harold and mother Ethel were missionaries. He lived in Tacoma and Gig Harbor most of his adult life, after years of schooling and serving in the armed forces. He was a beloved husband, father, grandfather, brother and physician. He practiced Obstetrics and Gynecology for more than thirty years in Tacoma. He enjoyed his family and his home on the water.

Dr. Bass was a board certified Ob/Gyn. He received his medical degree from the University of Oregon in 1948 and completed his internship at Pierce County Hospital and residency at Magee Women's Hospital. He practiced in Tacoma from 1956 until his retirement in 1986.

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IN MEMORIAM
ARTHUR P. O'LEARY, MD
1913-2001

Dr. Arthur P. O'Leary was born in Anaconda, Montana on December 12, 1913 and quietly passed away on June 2, 2001. He received his premedical degree from Carroll College in Helena, Montana and his Doctor of Medicine from the University of St. Louis School of Medicine in 1941. He served his internship at St. Joseph's Hospital in Tacoma in 1941 and 1942.

Dr. O'Leary began private practice in General Medicine and Surgery in Tacoma in 1942. He was appointed as Director of the Intern and Residency Services at St. Joseph's Hospital and held this post for several years, orienting, guiding and teaching the interns and residents. He also was a past President of the Pierce County Medical Society. I met Dr. O'Leary when I came to serve my Internship at St. Joseph's Hospital in 1944. He was a great deal of help to me with his guidance, instructions and in the starting of my own practice.

Dr. O'Leary was a very charitable, honest and compassionate man. He was a very competent physician and an excellent diagnostician. He turned no patient away. He treated them, not only medically for their physical needs and diseases, but also for their spiritual needs. He rendered considerable, charitable services without hesitation. His interest was mainly in obstetrics and gynecology in which he excelled. He believed that the life of even the most destitute was as important as his own, which led him to give them full medical and spiritual service very willingly. He was a physician for all seasons.

In 1944, Dr. O'Leary married Nancy Stewart and he is the father of six children, all of whom hold him in high esteem and love. Nancy preceded him on her journey to heaven in 1979. He began to wind down his practice after Nancy's passing. But the sudden passing of Dr. Frederick Schwind, who was in the office adjoining his, resulted in escalation of his practice, which he continued until 1985.

Dr. O'Leary did have a neurological disorder, which he did not allow to handicap him. I had the privilege of his assistance in surgical procedures. He was very interesting to work with. He was professional and fully evaluated the patients he referred. He was dearly loved and respected by his patients and peers.

Dr. O'Leary loved his family and they love him. One of his granddaughters stated that he entertained them at his home for dinner every Sunday and every holiday.

I enjoyed visits with Dr. O'Leary during his years of retirement. He maintained a mental sharpness and kept abreast of new medical developments as well as other events. He also continued to present a great sense of humor to the end. He will be greatly missed by his friends, certainly me and most definitely his family. My personal message to him is "Via Con Dios, Arturo."

Leo Annest, MD

Personal Problems of Physicians Committee

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- Bill Dean, MD 272-4013
- Tom Herron, MD 853-3888
- Bill Roes, MD 884-9221
- F. Dennis Waldron, MD 265-2584

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Congratulations

Congratulations to **Dr. Gerhart Drucker** on his 90th birthday, August 23. A longtime Tacoma-area physician, Dr. Drucker was born in Vienna, Austria in 1911. Upon finishing his medical studies, he immigrated to America in 1936, settling in Tacoma in 1941. His many years of general practice included three years as Director of the Coronary Care Unit at Lakewood General Hospital (now St. Clare Hospital), one year as Chief of Staff there, and innumerable house calls. When not busy with his patients, he could usually be found climbing up a mountain or skiing down one.

Dr. Drucker retired in 1982 and now lives at University Place Care Center. His family will host a birthday reception August 19 at the Temple Theatre in Tacoma. For more information, call the PCMS office.



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In My Opinion...

Dr. Stan Harris says goodbye

Dear Friends and Colleagues,

I have decided to give up full time surgical practice effective July 1, 2001. I have had a wonderful career with Cedar Surgical Associates and have been extremely fortunate to have such incredible partners.

I am not leaving because of illness or because I am unable to perform the duties required of a busy surgical practice. I am sad to say that I am tired - tired of the hassles and the business of a surgical practice. The government regulations, dwindling reimbursements, the no-win situation with the insurers, and the unreasonable expectations from our patients have soured my outlook. I no longer feel the personal satisfaction of helping people who do not wish to help themselves. I no longer wish to be awakened at night to work for free.

My patients will continue to receive the highest quality care from my partners. I hope that the physicians who have been kind enough to refer to me will continue to send patients to Cedar Surgical Associates. I would have any one of my partners care for my family or me without any reservations.

I plan to stay in the area and perhaps assist my partners in the operating room occasionally. I plan to pursue my hobbies of golf and bridge and perhaps get to read things I have not had time for. Perhaps I will find time to write a few articles in the surgical journals. Perhaps I will get bored and need to get back into the stream. Perhaps I will just eat right, workout, and stay healthy.

I thank you all for your kind and generous support and wish all of you the best in the upcoming tumultuous years of "medical reform."

Sincerely, **Stanley C. Harris, MD**

New Members

James C. Cook, Jr., MD

Cardiology

Cardiac Study Center
1901 S Cedar #301, Tacoma
253-572-7320

Medical School: Tulane University
Internship: LA County-USC Med Ctr
Residency: LA County-USC Med Ctr
Fellowship: Hosp of the Good Samaritan
Fellowship: Loma Linda University

Janis E. Fegley, DO

Family Practice

St. Joseph Medical Clinic
1708 S Yakima, Tacoma
253-593-8456
Medical School: Philadelphia College of
Osteopathic Medicine
Internship: Allentown Ost Med Ctr
Residency: Allentown Ost Med Ctr

Elena A. Gleyzer, MD

Family Practice

Western State Hospital
9601 Steilacoom Blvd SW, Lakewood
253-582-8900
Med School: First Leningrad Med Inst
Internship: Sepulveda Valucla
Residency: University of Texas
Residency: St. Joseph Hosp, Houston

Holly N. Johnson-Colt, MD

Pediatrics

Woodcreek Pediatrics
1706 Meridian S #120, Puyallup
Medical School: Dartmouth Med School
Internship: UW Children's Hospital
Residency: UW Children's Hospital

Everett W. Newcomb, III, DO

Executive Medicine

Franciscan Health System
1717 S J Street
253-591-6974
Med Sch: Kirksville College of Ost Med
Internship: Walter Reed Army Med Ctr
Residency: Walter Reed Army Med Ctr
Fellowship: Walter Reed Army Med Ctr

Howard Sun, MD

Diagnostic Radiology

Tacoma Radiology
3402 S 18th Street, Tacoma
253-383-1099
Medical School: University of Illinois
Internship: Swedish Hospital
Residency: University of Washington
Fellowship: University of Washington

Kathy J. Thomas, MD

Family Medicine

Community Health Care
11225 Pacific Avenue S, Tacoma
253-531-6198
Medical School: U of Pennsylvania
Internship: Swedish Family Medicine
Residency: Swedish Family Medicine

Gail C. Venuto, MD

Ob/Gyn

Gig Harbor Medicine Clinic
6401 Kimball Drive, Gig Harbor
253-858-9192
Medical School: George Washington
Residency: Bridgeport Hospital

J. Denise Wells, MD

Orthopedic Surgery

4700 Pl Fosdick Dr #206, Gig Harbor
253-851-6075
Medical School: U of Arkansas
Residency: U of Maryland

Directory Changes

Please make note of the following changes to your 2001 PCMS Directory

Ulrich Birlenbach, MD

Change address to:
5920 100th Street SW #32
Lakewood WA 98499

Teresa Clabots, MD

Change fax number to: 588-2688

Pamela Cowell, MD

Change physician only # to: 435-8786

Nancy Karr, MD

Change address and numbers to:
102 - 23rd Avenue SE #A
Puyallup WA 98372
Phone: 446-0311
Phys Only: 446-0234
Fax: 446-0233

MEDICAL LICENSURE ISSUES

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Applicants for Membership

Mary Anne B. McDonald, MD

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Medical School: Loyola-Stritch
Internship: Internal Medicine-Spokane
Residency: Internal Medicine-Spokane
Fellowship: Baylor College of Medicine

Patricia J. Russell, MD

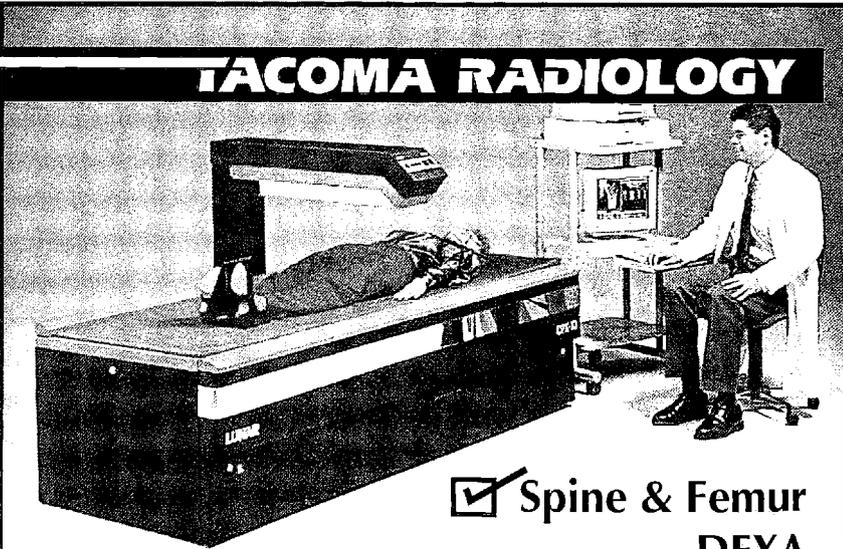
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In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

Whittling the Middleman

"Man can defeat any system that man can devise."

The Economics of Trust
John Whitney



Andrew Statson, MD

I want to start with a disclaimer. Human society is a complex organism and the provision of health care from a societal point of view does not have simple solutions. The creativity of the entire nation would be required to develop and to maintain a workable system. This is only possible to achieve when people are free of restrictions, so they can try different solutions until they find the ones that work best for them. There can be no single resolution that will be best for everybody. People also have to be free to fail and to learn from experience. What I describe here is not offered as a solution, but as an example of what part of the solution may look like.

First dollar coverage is no longer available from private insurance companies. The only one that provides it is "Mutual of Olympia." I think it was about eight years ago when the welfare department introduced a co-pay requirement of one dollar for office visits, but that did not work out. Collecting a co-pay from people who are entitled to their care and have never had to pay their way turned out to cost much more than one dollar.

Today, health insurance for a family with children with a modest front end deductible and various co-pays costs over one thousand dollars a month. The overhead of the best run indemnity plans is about 10% of premiums. For the worst run managed care plans it is more than 30%. The average overhead across the industry is probably of the order of 20% of premiums.

The average payment to providers is probably about \$150.

To pay out that amount and cover their overhead, the insurance companies have to collect \$180 in premiums. The cost to us to submit a claim is about \$10. So, out of a payment of \$150, only \$140 purchases medical care. In sum, \$180 in premiums buys \$140 dollars of care. This is in addition to the co-pays and deductibles the patients have. As a result, they pay 32% more in premiums than what their care would cost, if they had paid for it directly.

The health care industry amounts roughly to \$1 trillion per year in rounded numbers. One half of that is consumed by the government programs. The private sector spends over \$500 billion, of which over \$100 billion are for the cost of administration. In the government programs, because of imposed regulations, mandates and superimposed levels of management on top of the subcontracting insurance companies, the administration costs 50% of the money spent on the programs, or equal to the amount of health care purchased. So, the \$500 billion cost of the government programs buys about \$250 billion of health care. The actual figures for 1999 were \$1,211 billion total, \$662 billion private, \$549 billion government. The private funds include out of pocket payments.

Here I'll address the issue of the private insurance plans. Processing a claim costs about the same, whether it is for \$50 or for \$5,000. About 90% of all claims are probably for less than \$300,

and certainly for less than \$500. Eliminating the processing and the payment of these claims will reduce the administrative costs of private insurance by close to 20%, or about \$100 billion per year. This would translate into a decrease of the monthly premium from \$1000 to \$800.

In addition, eliminating the insurance coverage of small claims, for amounts below a certain limit, will reduce the monthly premiums by at least another \$300, and perhaps as much as \$500, to the level of about \$500, or even \$300 a month. With this kind of savings on premiums, a family should be able to meet medical expenses of up to the limit, of say \$300 or even \$500 by paying out of pocket. For claims bigger than that amount, the insurance would pay 80%.

The above figures are hypothetical. There are no actuarial studies to confirm them. To my knowledge no insurance company offers this type of policy. All front end deductibles that now exist are not per claim, but per year. They require the submission of claims, no matter how small, with the associated cost of their processing. It should be obvious that insurance overhead and insurance premiums can be reduced substantially if claims of less than a certain amount can be dropped from coverage completely. The cost of

See "Whittling" page 16

Whittling *from page 15*

processing them is just too high. Instead of front end deductible per year, we would have no coverage at all for claims of less than a certain amount.

The potential problem of the above described coverage for the insurance companies would be a low claim limit, such that the patients and physicians would tend to build up the charges to above that limit, so they would be payable by the insurance. This probably would be common with a limit of \$100, less so with \$300, and rare with \$500. Policies with various limit amounts can be offered, with cost adjusted according to projections. The patients will decide which limit of insurance coverage is best for them on the basis of their individual circumstances.

A potential problem for the medical equipment companies is that certain tests, let us say a scan, may cost \$300 to perform. If the limit of the policy is set at that amount, the patient would pay 20%, or \$60. If new equipment is developed, which could reduce the cost to \$100, it would not find ready acceptance, since the total amount would then be the responsibility of the patient. It would need to bring the cost down to less than \$60 per test in order to be widely used. However, such equipment would be beneficial for patients who have a \$500 limit. It would reduce their costs significantly.

The potential problem for the patients of such a policy would be the risk of multiple small expenses during the year, which could come up to a large total. This is particularly important for patients with chronic conditions that require repeated treatments at a cost lower than the coverage limit. Now, after they reach their yearly deductible, their expenses are covered at 80%.

The solution to this problem would be similar to what we now do in obstetrics. We have a flat fee for obstetrical care. It actually covers basic care given from about six weeks of pregnancy to six weeks after delivery, care

which includes a large number of office visits throughout the pregnancy and after delivery. Medical or surgical patients, who require multiple treatments, could be allowed to submit one claim for a session of treatments. Their insurance policy would then cover 80% of that cost. An example would be physical therapy once a week for three months. Of course, the more a policy covers, the more expensive it becomes.

As long as people are given a choice from a range of coverage, they can pick the one best suited to their needs. This type of insurance policy will probably have its own problems when put into practice. One situation was the tendency of people to delay needed care when they had to pay for it at the time. There are always other things on which they would rather spend their money.

In the early days of the welfare

programs, there even was a move to pay patients when they kept their appointments for care. Such well intentioned programs don't work. Even when their care is paid for, people still tend to delay treatments and not follow through. They don't want to put out the effort and spend the time. As the proverb says, you can take a horse to water, but you can't make him drink.

The most important problem will remain the tax deductibility of health care expenses. The above proposal is one example of how the cost of insurance overhead can be decreased so much, that it would allow people to pay for their care from the savings on the cost of their insurance and probably have some left over. What is more, it would put the responsibility for most health care expenditures back in the hands of the patients, where it belongs. ■

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Continuing Medical Education

Whistler CME set January 23-26; Condo/Hotel Reservations Open

Reservations are open for both the traditional Aspens Condos AND the nearby and elegant Chateau Whistler Hotel for the annual CME at Whistler program scheduled for January 23-26, 2002.

In addition to the condos, typically a part of the "room block" secured by the College, a block of ten rooms at Chateau Whistler have been reserved this year. The rooms are available to CME participants at a reduced conference rate.

The College of Medical Education has again selected the Aspens Condos for accommodations because of the very competitive rates and quality of the lodging. These negotiated group rates will remain the same as the 2001 rates, and combined with the Canadian/US exchange rate, result in major savings for the conference registrant.

A collection of one and two bedroom luxury condominiums just steps from the Blackcomb chair and gondola are available. Space is available on a first come first served basis in the Aspens.

The conference will be held in the Aspens Condo building. A program

brochure, with conference and registration details, will be mailed this summer.

CME at Whistler participants are urged to make their condo and hotel reservations early.

For reservations for the block of condos, ALL IN THE ASPENS, you must make your reservations soon, as conference dates are during the high ski season. The College's reserved block of rooms **will be released after December 1, 2001.**

Reservations can be made by calling *Aspens on Blackcomb* toll free at 1-877-408-8899. You must identify yourself as a part of the COME group.

For reservations in the **Chateau**, you should also make your reservations soon. This block of rooms must be released by December 10, 2001. Again, you must identify yourself with COME and can reserve your room at the Chateau by calling 1-800-606-8244.

The program is under the direction of **John Jiganti, MD** and **Richard Tobin, MD. ■**



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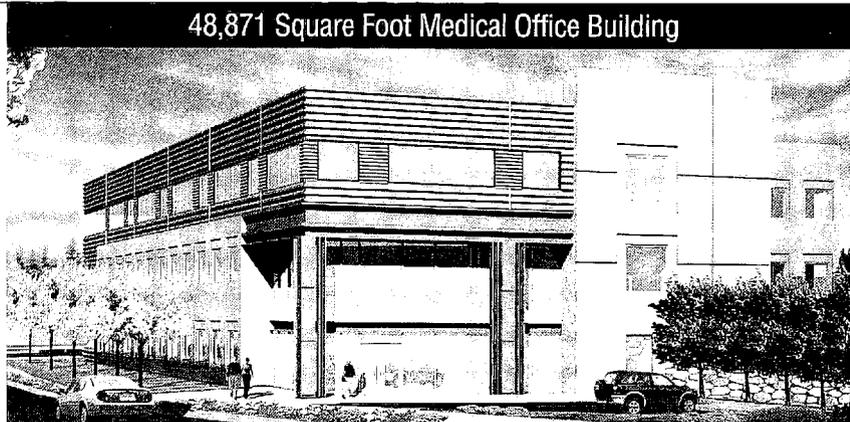
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Pierce County Medical Society



August, 2001

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CME at Hawaii - April, 2002

For reservations see page 17



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Pierce County Medical Society

BULLETIN



August, 2001



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

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

Managing Editor: Sue Asher

Editorial Committee: MBI Board of Directors

Advertising Information: 253-572-3666

Subscriptions: \$60 per year

Make checks payable to: **MBI**

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President's Page

by Patrice Stevenson, MD

Access to Care

We have all read numerous articles and editorials about the problems with access to care over the past few years. Most of these are anecdotal and make it difficult to accurately assess the extent of the problem. Even Washington state statistics may be too general to be truly useful locally. Your Board of Trustees decided to send out a PCMS membership survey to try to define the situation in Pierce County including breaking down the data by areas: Tacoma (includes University Place and Fife), Lakewood, eastern Pierce County (includes Puyallup, Sumner, Eatonville and Milton), and Gig Harbor. We looked at acceptance of patients by payer source for Medicare, Medicaid, Healthy Options, Labor & Industries and car insurances as those seemed to be payers we were hearing about as potential access problems. We did not inquire about commercial insurances or whether the practice was closed to all new patients. We had a better than anticipated response rate of 227 primary care and 352 specialists responding for a total of 579 responses from 650 active members (89% response rate). The survey results were briefly mentioned in the July *Bulletin*, and a summary is provided in the adjacent chart. If you would like the complete data please contact Shana Osmer, membership services coordinator, at the PCMS office, 572-3667 or e-mail shana@pcmswa.org.

There has also been a long held belief, especially by non-medical types, that the access problem was getting into specialists for care and that everyone could have a primary care physician. I once had a patient with Secure Hori-

zons define their primary care physician as "the doctor I have to see to do the paper work to get me into the doctors I want to see." Well, the data strikingly shows the opposite is true. For the purpose of discussion, I will only focus on the acceptance rates of new patients with Medicare or Medicaid funding. Across the county the percentage of specialists accepting new Medicaid patients varies from 74-86% while new Medicare is 95-100%. For primary care the percentage accepting new Medicaid varies from 15-85% while new Medicare is 27-85%. Tacoma is the highest with both being about 85%. In my neck of the woods (eastern Pierce County), it is a dismal primary care acceptance rate of 20% for Medicaid and 27% for Medicare. The specialist acceptance rates are 74% Medicaid and 100% Medicare. As Puyallup pulmonologist **Vernon Nesson, MD** explained, this results in specialists doing more primary care by default and generally less thoroughly and less efficiently than those trained



Patrice Stevenson, MD
President

to provide it. There is also an eastern Pierce County primary care shortage relative to the booming population growth that results in practices closing to all patients. Orting and Eatonville still only have one physician each. New physicians quickly fill once the word gets out that someone is actually taking new patients.

I have no easy answers to these access problems and support each individual's right to make their own decisions regarding practice issues. However, as Dr. Nesson remarked to me, I would encourage us to "share the wealth (of the better payers) and share the burden (of the Medicare and Medicaid patients)." ■

PCMS Care Survey				
	Accepting New Medicare		Accepting New Medicaid	
	Primary Care	Specialty	Primary Care	Specialty
Tacoma (includes UP, Fife)	84%	95%	85%	84%
Lakewood	75%	100%	15%	84%
East Pierce County (includes Puyallup, Sumner, Eatonville, Milton)	27%	100%	20%	74%
Gig Harbor	60%	100%	56%	86%



Dale Overfield, MD with Sister Anne McNamara. Dr. Overfield has served on the College of Medical Education Board of Directors since 1991 while Sister McNamara has served as Treasurer equally as long

Dale Overfield, MD thanked by College Board of Directors for many years of service

Dale Overfield, MD. Puyallup neurologist was honored at the June meeting of the College of Medical Education Board of Directors for his many years of service to medical education in Pierce County.

Dr. Overfield began his board tenure in 1991 and subsequently served three more terms on the College Board. He served as President from 1998-2000.

An advocate for local, low-cost CME programs as well as a supporter for resort location programs. Dr. Overfield was innovative and realistic about course offerings sponsored by the College. He continues to serve as a faculty member for many CME offerings.

The College of Medical Education, administered by PCMS, is a non-profit independent organization that offers continuing medical education programs for physicians. Organized in 1970 under the leadership of Marcel Malden, MD, the College offers courses on a variety of subjects, determined by an interest survey of the PCMS membership. A course is offered each year at Whistler for family fun and skiing, and every other year in Hawaii.

College board members are appointed to three-year terms by the PCMS Board of Trustees and by the College board for one-year at-large appointments. Each Pierce County hospital system has a board representative. Sister McNamara serves as a representative of the Franciscan Health System.

If you have interest in continuing medical education and would like to participate in local activities, please call Sue at the Society office, 572-3667. ■

Sound to Narrows Update



Dennis Reid, MD. Tacoma pediatrician, completed the 2001 Sound to Narrows run in 4 minutes and 48 seconds over one hour (1:04:48). PCMS will be watching next year and proposes a challenge to Dr. Reid to "break" one hour!

Also completing the course was **William Shields, MD,** Tacoma ophthalmologist. Dr. Shields ran the event with his son, Kenneth.

PCMS apologizes to Drs. Reid and Shields for inadvertently omitting them from the list of participants in the July Bulletin. ■

Global Health Care topic of Hogness Symposium

Journalist Laurie Garrett will discuss "The Critical Issues in Global Health Care" at the annual John R. Hogness Symposium which will be held Thursday, October 11, 3:00 pm, in the Hogness Auditorium of the University of Washington Health Sciences Building. A reception will follow at 4:30 pm in the lobby.

Garrett is a Pulitzer-prize-winning science writer for *New York's Newsday*. Her latest book, *Betrayal of Trust: The Collapse of Global Public Health* (2001), details the fall of public health systems worldwide and weaknesses in the U.S. medical system. In *The Coming Plague* (1994), she investigated the re-emergence of infectious diseases. Garrett has received the Peabody Award and the Polk Award for coverage of international health-care issues.

Their symposium is free and open to all. For more information you may contact Julie Collier, 206-685-1933 or jcollier@u.washington.edu. ■



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In My Opinion....

by Robert A. Yancey, MD

Reflections on Vietnam

The United Nations has proclaimed 2001 the International Year of Volunteers and the vast number of opportunities to help is equaled only by the amount of personal rewards to be gained. I was very fortunate to be able to take time out from my practice for the month of March to work as a volunteer orthopedic surgeon in Vietnam under the auspices of Orthopaedics Overseas and Health Volunteers Overseas. The primary purpose of the trip was to teach operative techniques and exchange information about the practice of pediatric orthopedics. I also helped set up some trauma protocols with appropriate technology in four major trauma centers throughout Vietnam.

The trip was a unique opportunity for me, my wife BettiAnn, and our five year old daughter to be hosted by Vietnamese physicians and their families in four major cities in Vietnam. Not only was I able to break away from the daily grind of insurance authorizations, paperwork, and the winter weather, but I was able to explore the geography and culture of a beautiful country in Southeast Asia.

Before I left I realized that almost everyone has their own individual perception of Vietnam and the Vietnamese people. For many Americans, the somber recent history of the Vietnam War is our only tangible link to SE Asia. When the war ended in 1975, the country fell into economic stagnation and international isolation. This isolation continued for another decade until they pulled out of their conflict with Cambodia. In the 1990s, major economic and political reforms led to an overall improvement in their situation. Normalization of diplomatic relations with the USA resumed in 1995, opening the

door to increases in western foreign aid, international investments, and tourism.

While much of Southeast Asia has made considerable advances in the past 20 years, there has been a significant gap in the development of Viet-

nam exist as health care centers. A fair number of Vietnamese orthopedic surgeons were trained between 1965 and 1975 in the principles of acute trauma surgery by the American physicians in Saigon and Danang.

When one wanders through some



Dr. Yancey in Hanoi

nam. No longer the enigmatic crouching tiger we remember from the 1960s, Vietnam is now just another SE Asian underdeveloped country struggling to raise their stagnant economy from a quagmire of dependency and debt. **Per capita income is about \$333 per year. Orthopedic specialists in Vietnam earn approximately \$100 per month.**

Medicine in Vietnam is a melting pot influenced by their history. Many patients are seen in the hospital after having been treated by a traditional healer or "bonesetter" in the provinces. Hospitals and medical schools still have very active departments of Chinese traditional medicine. The French developed a fairly sophisticated western medical system during their colonial period from 1850 to 1954. Some of the old colonial style Pasteur Institutes still

of the hospitals in the south of Vietnam the physical plant, operating room plan, and equipment appear strangely familiar - US Government issue caught in a time warp from 1965. Other large hospitals were built in Hanoi to provide care for the northern forces during the war. These hospitals were either military hospitals (which I could not visit) or expansive structures with a French influence consisting of pleasant open air wards without much equipment. It reminded me of pictures I have seen of old city hospitals in the 1930s.

In general, the Vietnamese hospitals were overflowing with patients and they had very few supplies or equipment. Wards are open air rooms of 10-15 patients. Families generally stay with the patients on the wards and provide the food and some of the nursing care.

See "Reflections" page 6

Reflections

from page 5

Orthopedic equipment was sparse and limited by access to materials for manufacturing them. They had very few orthopedic implants. **There is only one MRI in the country.** Three out of the four major hospitals that I visited did not have x-ray or fluoroscopy in the operating rooms. I learned to never assume that anything was available which made me re-evaluate how I planned operative cases. This necessity to be carefully innovative made operating somewhat more stressful, but extremely satisfying.

I had the opportunity to visit four major cities during my stay. My first stop was at the Center for Traumatology and Orthopedics (CTO) and Cho Ray Hospital in Ho Chi Minh City (formerly Saigon). CTO is a 440 bed orthopedic hospital that serves over 300,000 patients per year. **They put on over 100 casts per day in the ER!** I was greeted at the airport by my physician hosts and taken to the hospital in their old ambulance. Rounds consisted of 60-80 pediatric orthopedic patients followed by 70 patients in the morning clinic. Children and their families are admitted for weeks at a time. The orthopedic pathology was fascinating. It became immediately evident that safety issues, nutrition, and access to care are the key factors in the prevention of childhood orthopedic problems. I saw a number of problems such as TB of the spine and neglected infections that are only of historical interest in orthopedics in the USA because of preventive medicine and access to care. **Despite the large number of patients in the clinic, the pace seemed reasonable, partly due to the paucity of paperwork.** Most of the 25 operative pediatric and adult cases per day were related to trauma from motorbike accidents and congenital pediatric cases. The surgeons were very innovative in their use of the limited equipment. I learned very early how to work without x-ray and power equipment in the operating room. We

carefully re-used everything in the OR, including rubber and plastic tubing, endotracheal tubes, drapes and gowns.

I also visited Cho Ray Hospital in Ho Chi Minh City. It is a 1,000 bed general hospital that cares for the multi-system trauma patients in the region. They had 120 orthopedic inpatients in their 90 bed ward. They were so busy that they routinely do two major orthopedic cases in one room at the same time. Surprisingly, the infection rate was relatively low for the severity of the trauma and the continuous use of the rooms. There really was no choice in the matter because of the overwhelming amount of work that needed to be done and the scarcity of equipment. I will never forget the sight of the ICU at Cho Ray Hospital. It was a large open ward of

about 60 critically ill patients. Everyone wore white. When they ran out of ventilators, 24-hour hand bagging seemed to work just fine. It was an unforgettable site to see human ventilators. All the physicians I worked with in these two hospitals were bright, energetic, and extremely eager to learn new techniques. Despite the fact that the physicians were overworked and underpaid, hardly an evening went by that I was not graciously invited out for dinner or to someone's home.

Hanoi was my second stop. It was my first city in the north of the country and I wondered if I should expect some anti-American sentiment there. On the contrary, I was greeted again at the airport and brought to the Old

See "Reflections" page 8



Dr. Yancey in Danang



Natalie Yancey, age 5, in Hue market

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Preventing Childhood Deaths in Pierce County

The tragedy of a child's unexpected death can affect a family and community. Often, most stunning are those situations in which a young child dies of something that could have been prevented. In 1998, with support from Governor Locke's executive order creating a statewide child death review system, the Tacoma-Pierce County Health Department facilitated a process to establish a Tacoma-Pierce County Child Death Review Team (TPCCDRT). The team analyzes the causes of death of children between 0 and 17 years old and looks particularly for ways to avert that kind of death in the future.

TPCCDRT is a collaborative process, incorporating representatives from Mary Bridge Children's Hospital, Pierce County Sheriff's Department, Tacoma Police Department, Pierce County Medical Examiner's Office, Tacoma Fire Department, Pierce County Prosecuting Attorney's Office, Madigan Army Medical Center, Puyallup Tribal Health Authority, Child Protective Services, and the Tacoma-Pierce County Health Department.

The TPCCDRT's first annual report (December 2000) included the review of 48 unexpected deaths and 91 natural/medical deaths in 1999. Within the unexpected deaths, 81% were determined to have been preventable. The chart on page 10 lists the causes of unexpected deaths in Pierce County children in 1999, and whether they were deemed preventable.

SIDS and motor vehicle accidents constituted the majority of unexpected deaths. Recommendations for preventing motor vehicle-related deaths include:

Increasing child passenger safety education

The use of infant/booster seats and seat belts has been shown to increase dramatically the chances of survival in a car crash.

Graduating driver licensing for teens

Motor vehicle crashes are the leading cause of death for teens. Limiting their driving privileges at first and then expanding them as they gain experience may reduce the numbers of death in this age range.

Using ignition/interlock devices that prevent drunk driving

This device prevents the operation of a vehicle if it detects alcohol on the driver's breath.

SIDS - the sudden, unexplained death of an infant under one year old - continues to lead the causes of preventable deaths in children in Pierce County. In 1999, 14 SIDS deaths were investigated. In 2000, 12 were reviewed by the TPCCDRT. Through June, 2001, five deaths have been examined. TPCCDRT recommends the following to prevent SIDS deaths:

Put infants to sleep on their backs

An Australian study in 1992 demonstrated that infants who slept on their backs achieved a statistically significant decrease in the rate of SIDS deaths.



Avoid use of soft, fluffy items in the sleeping area

Soft mattresses and bedding, pillows, comforters, and other items that are made of soft, fluffy materials seemed to contribute to the numbers of deaths from SIDS, possibly because they obstruct an infant's airway.

Educate everyone providing care to infants about safe sleeping

Parents are not the only ones who care for infants. All involved in caretaking should know the best sleeping environments for preventing SIDS.

Avoid exposure to tobacco smoke

Research continues to associate maternal smoking during pregnancy and smoke exposure after birth with the risk of death from SIDS.

Discourage co-sleeping

An infant who shares a bed with a parent or other family members can increase the risk of death by

See "Preventing" page 10

Reflections

from page 6

Quarter of the city with its French architecture, tree-lined streets, and urban lakes left over from the colonial times. The populace seemed less affluent and there were more tribal minorities in the city. People did stare at me more often in Hanoi, but probably because I was the only person on the back of a motorbike with a helmet!

Although the hospitals in Hanoi were similar to those in the south with their open air wards, the ones in Hanoi seemed less busy and better equipped - including a brand new arthroscopy set-up donated by a German aid agency. Unfortunately, no one had ever reviewed the set-up procedures, sterilization protocols, and techniques of arthroscopic surgery with the surgeons nor the operating staff. My hosts in Hanoi had a definite agenda for me. They had lined up a number of potential arthroscopy patients for me and after we translated the directions of the set-up we proceeded to perform the first arthroscopic surgeries ever done in Hanoi. See one, do one, teach one was our motto. We first made practice models out of small cardboard boxes filled with objects to learn scope techniques. Towards the end of my visit I think that our team was getting proficient with simple set-up and arthroscopic techniques using sustainable technology. It was wonderful to recently receive an e-mail with an attached digital photo of my colleagues captioned "Arthroscopic Surgery Center of Hanoi."

From Hanoi, we traveled to Danang and Hue, located in central Vietnam near the coast. Hue is a beautiful city with an ancient walled citadel that has been a cultural and religious center for centuries. Although its name is derived from the Vietnamese word for peace and harmony, it was unfortunately the center of the infamous Tet Offensive in 1968. They were strategic sites of staging during the Vietnam war, but now serve as a referral base for several million people.

Hue Central Hospital has 1,000 beds and is the base for the major resident teaching programs and medical school. Their orthopedic department library consists of a single set of outdated orthopedic textbooks from twenty years ago. Danang General Hospital is an 800 bed facility built by the French in 1953 and refurbished by the Americans as an evacuation staging center during the war. Although both hospitals were extremely busy, they were severely under-equipped and lacked advanced technology. Anesthesia had no oximetry for monitoring patients. There were no MRI's or CT scanners. Fluoroscopy was not available in the operating rooms. Simple x-rays were our only diagnostic tools. When we needed to fix a fracture, we would wander down to the hospital storeroom with our x-rays in hand and rummage through all the donated boxes of orthopedic implants to see if we had anything that would fit. Sometimes we would modify implants at the machine shop so that they would fit a specific application. It was definitely an opportunity to be orthopedically creative. I have more than a few stories about simple yet elegant innovations, created by necessity but surprisingly effective.

The Vietnamese physicians and their families were incredibly gracious hosts and there is a very positive feeling towards Americans. I was honored to have many personal discussions with my hosts. A generation has passed since the war and it seems we all are retrospectively re-evaluating our involvement in Vietnam. For many of the current young generation of orthopedic surgeons in their 30s and 40s the recollection of the war consists of requests for chewing gum and pens from American GIs and the echoes of distant gunfire. The older generation of surgeons, many of whom are fluent in French, are more somber in their discussion of the war. Some from the south spent time in "re-education"

camps after the war. Others watched their families split up and leave on boats as refugees to avoid persecution for being affiliated with the "defeated" side. Most physicians have lived in an educational vacuum limited by years of bureaucratic and economic limitations. Everyone seemed to be thirsting for some intellectual and cultural exchange without any reference to differences in our political ideology.

In the future, the internet will be a key ingredient in improving communication and education in Vietnam. Tourism will help fuel the expanding economy and generate some needed capital. Volunteer physician programs and donations of medical equipment and textbooks will help these dedicated orthopedic surgeons to keep up with the 21st century. Despite the present economic hardships they look at the present time as a period of relative tranquillity in their lives. We spent many late evenings talking about how we could improve care to the patients and education for the physicians. There was very little conversation about possible emigration strategies and green cards.

This is my fourth trip overseas to work as a physician. As always, I am impressed by the hospitality of my host colleagues in developing countries. I feel that I contributed some insights, techniques, and textbooks to their practices but it always seems like they give me more in return. The physicians with whom I worked truly represent health care in the trenches...incredible caseloads, difficult cases, long hours, and low pay. My trip re-affirmed my belief that as physicians, we have a unique opportunity for cultural and educational exchange. I would encourage any other physicians who might be interested in Vietnam or working travel abroad to contact Health Volunteers Overseas at infor@hvousa.org or their website. Meanwhile, I have since made a number of connections to help

See "Reflections" page 16

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

The Power of Discrimination

"The first sign of corruption in a society that is still alive is that the end justifies the means."

Georges Bernanos (1995)

Rifle versus shotgun. This debate must be at least as old as gun powder, probably much older. When Herod was informed that a king had been born in Palestine, he ordered all male infants killed. He had no way of knowing who could be the eventual king, so he used a shotgun. That approach is frequently used by people in authority. The rifle uses less power, but requires knowledge of the target. Authority has a lot of power, not much knowledge, so the shotgun is easier. Never mind the long range effects of such power.

When a sailor on a ship misbehaves, all hands have their shore leave cancelled. When a student misbehaves, the whole class is detained after hours. When a child brings a gun or a knife to school, all children have to go through metal detectors forever after. What message do we give the good children? We tell them we don't trust them. We tell them they are considered guilty until they can prove to us they are innocent. Meanwhile, those who want to shoot can do it on the playground, in the street, at the school bus, even at the local McDonalds.

With a rifle we can hit a point, when such accuracy is not possible, a shotgun allows us to scatter lead over a broad area and hit whatever is there, whether we want to hit it or not. In medical practice, there are many situations where we use a shotgun, because we lack the knowledge to discriminate.

Only one woman in nine will ever develop cancer of the breast. Our problem is that we don't know who she is. Indiscriminately, we urge every

woman over the age of 40 to get a yearly mammogram. Granted, mammograms cost money, expose the women to radiation and can be painful. Still, at our current level of knowledge, since early detection of breast cancer saves lives, we need the shotgun approach. One day we may be able to test a woman and tell her she will not get breast cancer and she does not need to get mammograms. Today we cannot.

We like to know what we are treating. We believe that the success of our treatment confirms the correctness of our diagnosis. That is not always true. During the 50s and early 60s, the standard antibiotic treatment was penicillin and streptomycin. Those were about the only injectable antibiotics we had. In the presence of serious intra-abdominal and pelvic infections, we couldn't go higher than one gram of streptomycin a day, but we bumped the penicillin up to over 100 million units a day.

We were treating enteric bacterial infections. We thought the bad smell of gangrenous bowel was from coliform bacteria. When injectable chloramphenicol became available, the combination of penicillin and chloramphenicol worked very well. We did not find out until the mid to late 60s that the foul smell was due to anaerobes and the high doses of penicillin and the chloramphenicol were an effective treatment. So much for knowing what we were treating.

At that time, we made the therapeutic decisions and had to justify them



Andrew Statson, MD

only to ourselves and to our patients, with the occasional review by our peers. When Keflex first came out, it was marketed as a urinary antibiotic. One of our maverick general practitioners admitted a patient with pneumonia and prescribed Keflex. The medical committee reviewed the case and sent him a letter, asking him to justify the use of a known urinary antibiotic for the treatment of pneumonia. Peer review is good, but it is not always right.

Enter the third party payors. Now treatments have to be justified to them as well. They want clean rifle shots, no guessing, no hunches, they want proof. The problem is that sometimes definite proof comes a little too late, like that of the suspected hypochondriac, who had it written on his tombstone, "I told you I was sick!"

Is it good for the babies to prove they are in distress before we can do a cesarean section? Granted, some of them may deliver spontaneously and do well, but some of them won't and we can't always tell the difference. We have to act on hunches and guesses. Our power of discrimination is not that good. If we wait until we have definite proof, we may intervene when it is too late to make a difference.

Is it good for women to lose more than 30% of their red cell volume to

See "Discrimination" page 14

Preventing from page 7

SIDS because the individual could roll onto the infant. Alcohol or drug use by the parent poses a greater potential for rolling onto the infant and should also be discouraged.

Private providers can educate parents and caregivers on ways to prevent SIDS and other accidental deaths. For more information on the Tacoma-Pierce County Child Death Review Team and their suggestions for preventing death among children, contact Susan Pfeifer, RN, BSN, at (253) 798-6542. For more information about SIDS, contact Sue Walen, RN, BSN, at (253) 798-6517. ■

1999 Child Death Review Determination of Preventability by Cause of Death				
Cause of Death	Preventable			Total
	Yes	No	Undet	
Sudden Infant Death Syndrome (SIDS)	14	0	4	18
Motor Vehicle	12	0	1	13
Fire	0	1	0	1
Firearm	6	0	0	6
Drowning	0	1	1	2
Other (includes SIDS in 2 children older than 12 months)	7	1	0	8
Total	39	3	6	48

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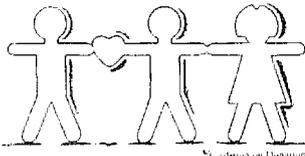
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In My Opinion....

by John K. Sutterheim, MD

Nostalgia of WWII...

Doctors Rounds in Concentration Camp Bangkong, Java, During October 1944

*John Sutterheim, MD*

In the Indies there is a small and generally welcome nocturnal lizard, called a tok'e, or gecko, a harmless, tropical, insectivores, six to ten inches long. Its name, tok'e, describes its odd, croaking mating call, and if you hear this animal say seven times tok'e, luck will drift your way. It attaches itself to the ceiling, hunting for mosquitoes. The beak reminded me of a miniature crocodile. As kids we would feed them tobacco attached to a stick, in order to reach them high on the walls or ten feet ceiling. The tok'e's bite was firm and he would not let go; to end up in a free fall and walk like a drunk. Like so many other people in camp with nicknames, one of the few Dutch adult men became known as the tok'e.

This man, the Tok'e, was one of the three doctors allowed to practice in camp, although there were many more physicians, sixteen in all, who were assigned to field work, and two in the kitchen. Dr. Neuberger was the head of the hospital, and the Tok'e treated kids, while making rounds. Because this doctor suffered from throat cancer, the Tok'e could hardly speak, his voice sounded explosive, and he always looked exhausted. He made daily rounds throughout the camp during the morning hours, but seeing to 1,400 boys was an impossibility. The Tok'e was too weak to enter the individual rooms and bend over the patients who were lying on the floor, so he would sit down behind a small portable table on the patio outside the Hans. The sick boys dragged themselves out of their rooms, not feeling well, to stand in front of a doctor who had great difficulty speaking to them. Some weak kids had

to be held up by others. The trust in such a man was really low: many kids complained, and scoffed about this physician in open defiance, not realizing how unfair their treatment was. If he determined that a boy was sick enough, the child would be sent to the hospital, which was nothing more than a few empty classrooms with mattresses on the floor, and a few steel beds, supervised by several of the nuns. Some of these scenes, with a sick child and a sicker doctor, were unforgettable.

In the shade of the balcony was a simple four-legged table, behind it this skinny man, seated on a rickety chair, his body leaning heavily on the table top. He supported his elongated head with his left arm, the left elbow resting on the table. His eyes were sunken and his stubbly beard was colored like salt and pepper. In front of him stood a feeble boy, held up and supported by two other skinny kids. The patients awaiting their turns were sitting or lying on thin mattresses spread out on the floor. When they were finished the entire scene moved a door or two down, to evaluate the next sickly group. An assigned group of younger boys would carry the table and chair to the various locations where the doctor would hold "office hours." The European and Dutch doctors outclassed the Japanese ones by miles, especially in treating tropical diseases, but the Tok'e could not combat the severe malnutrition and advancing starvation that was at the root of most ailments in camp.

When patients were dragged in front of this doctor to be examined, we all knew it was only to try to obtain a diagnosis, or to listen to the verdict,

"You go to the hospital." As with our roommate, Leon van der Broeke, going to the hospital didn't offer any comfort to most of us.

There were hardly any medicines available, although many requests for medicines were put in to the Japanese. On top of the list was quinine. The typical answer of the commandant was, "The Japanese army has none, so you do not get it either." If we argued about it, we received a beating, or worse, everybody had to skip a meal. We knew that the western part of the island of Java produced 90% of the world production of quinine. We reminded them about that fact but that infuriated the Sons of Heaven. They must have sensed that we indirectly accused them of lying.

I had found those medical texts fascinating not so very long ago when I had been confined in Malang and had worked to clean the doctor's office. Further, Mother's common sense approach to dealing with parasites and tropical diseases had been ingrained in me, and so I always listened to try to understand the doctor's diagnosis, when he frequently saw my brother Anton or another boy of our Han. Some of the diseases were worse than others, especially if they were contagious. We could not hope to contain spreading diseases when our bodies were depleted and there was such poor sanitation in camp.

One of the most persistent and debilitating problems in camp was diar-

See "Nostalgia" page 12

Nostalgia

from page 11

reha, but there were different causes and diagnoses. Two forms of diarrhea were not contagious. One kind, which caused the thin-wall condition of the bowel, was due to total emaciation. The second type was known as Pellagra, from the Italian word for rough skin. The cause of this diarrhea was the deficiency of niacin, which was often combined with a lack of B2 and B6 vitamins. So in essence, pellagra was a complex multi-deficiency ailment, and surely it was no surprise to the doctor to see it as often as he did. The onset was insidious, with a loss of energy, melancholy, and photophobia, followed by diarrhea. Having pellagra and being forced to work in the hot sun created a discoloring dermatitis, which would itch horribly. Later, symptoms were burning feet and an inflammation of the optic nerve. The end stage was dementia and death.

When pellagra struck me in the

later months in Bangkong, I stood in front of the doctor with my dermatitis which would itch incredibly in the sunshine, only to be told that there was no therapy available. My own treatment was to apply mud on the affected spots so the condition became tolerable.

More than once I found myself standing next to my bother in front of the Tok'e and listening as he abstractly described the symptoms one or another of us was suffering. Other vitamin deficiencies clouded the differential diagnosis, and the continued efforts to make clear and accurate distinctions became ironic, however, because the diagnosis didn't matter when there were no remedies. I had the luck of some knowledge of the cause of the dermatitis and found kangkung in the fields that I ate; this created some small degree of control over my diet.

The most common vitamin deficiency, lack of vitamin B1, resulted in

beri-beri, what we called hunger edema. When protein deficiency was added, the heart would go into failure and we saw many of our companions swell with fluid in the ankles and bellies. At tenko time I spotted in the lineup many swollen ankles of my buddies, especially during 1945. This became so common that we tried to ignore the obvious. Both deficiencies were common causes of death, especially among old men in camp, who had none of the resilience of youth to help their bodies fight back. Perhaps as important, often they gave up hope, to crawl on their mattress and drift into a coma. Death by starvation in the final stage seemed to me a way not to experience any more suffering. The deadly and somewhat contagious disease of despair gradually spread through the camp in the advancing months of 1945. ■

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Discrimination from page 9

prove that they are bleeding heavily, before we can do a hysterectomy? At what point does bleeding become too much? At what point does pain interfere too much with the normal life of a patient? How does one prove pain, weakness, inability to lead a normal life?

With every advance of our science we get tools and knowledge to address specific problems and to treat with rifle precision. We are far ahead of the enemas and purges, leaches and bloodletting, which were the tools of the medieval physician. Even so, we have not learned all of nature's secrets. Even more so, there are many instances when we think we know, but in fact we don't. This does not mean that anything goes. We have to be cautious, to respect the integrity of the patients, to treat them as individuals and to allow for the limitations of our knowledge and our abilities.

Medical practice cannot be based on a book of recipes, even though many people think that it could. It cannot be a free-for-all, either. Medical practice has to be based on the reasoning ability of knowledgeable practitioners. The mindless robots, that go through the motions they have been programmed to perform, have no power of discrimination. They are limited to the if-then-else of their programs. They cannot handle the exceptions nature persistently throws at us. Decisions about exceptions can only be made by the human mind. In order to make them, we have to be free to think. Discrimination is a function of the free mind.

The question whether to use a rifle or a shotgun is a spurious one. Both are tools and each has its place. The important question is who should decide what to use. Should it be the patient, the physician, the insurance company, the FDA, the CDC, the legislators, the executive, the judiciary? Each one of these parties has its own agenda and their interests do not necessarily

coincide with the interests of the patient.

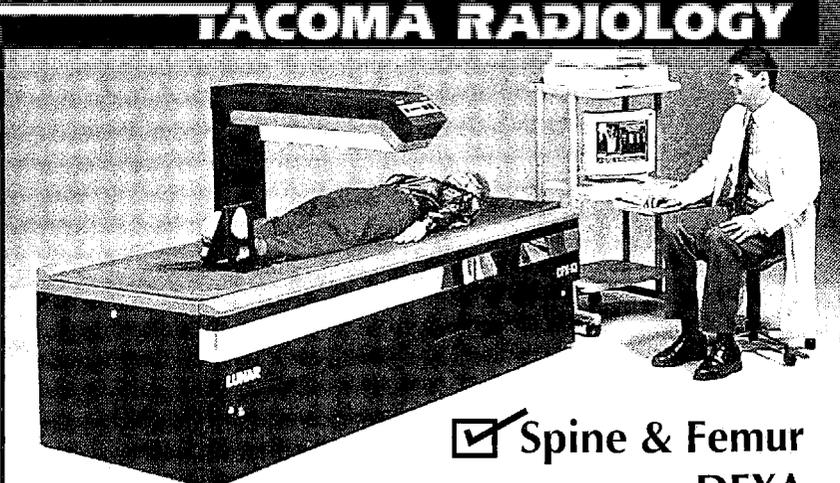
After consultation with the physician, discussion with friends, surfing the Internet, and perhaps after much thought about all the information thus obtained, the ultimate decision should belong to the patient. The ethicists call it patient autonomy.

A negative mammogram, Pap smear or colonoscopy does not mean the patient does not have cancer. A negative culture does not mean the patient does not have an infection. As a current court case made it clear, a positive test doesn't mean the patient has the disease, either. We rely so much on laboratory and imaging to help us discriminate between normal and abnormal, between health and disease, that we forget to use our heads. As a result, our patients suffer. However,

when we try to base our decisions on clinical judgement, the reviewers, who look at the chart, but never at the patient, tell us we cannot do what the patients have decided, because it is not justified by the tests. They tell us we must treat the tests, not the patients.

When the patients are not allowed to make the decisions about their care, when they lose their autonomy, they lash back when they get the opportunity, especially if something goes wrong. They strike at the closest and most convenient targets, those who happen to be around, regardless of whether they had anything to do with the problem or not. This type of outburst is what some have called patient rage. Woe to those who stand in its way. ■

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Effective Aug. 24 change address to:
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Peter Bertozzi, MD

Change phone # to: 872-4746

Donald Boutry, MD

Change address and phone to:
314 ML King Jr Way #302
Tacoma WA 98405
Phone: 272-1037
Fax: 272-3396
Phys. Only: 272-1960

Martin Cieri, MD

Change fax # to: 593-8436

Keith Demerjian, MD

Effective Aug. 24 change address to:
1812 S J Street #102
Tacoma WA 98402

Kevin Kennedy, MD

Office address should read:
1901 S Union #B3010
Tacoma WA 98405

David Kennel, MD

Change address and phys. only # to:
5920 100th Street SW #31
Lakewood WA 98499
Phys. Only: 584-4879

Hay San Meas, MD

Change fax # to: 473-5309

Susan Salo, MD

Change address and fax to:
1708 S Yakima, Tacoma WA 98405

Richard Schoen, MD

Change phone # to: 403-8770
Change fax # to: 403-8771

Thomas Siler, MD

Change fax # to: 403-1783

Charles Weatherby, MD

Effective Aug. 24 change address to:
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Donald Weber, MD

Change fax # to: 826-4792

Bridging the Gap - Medicine and Technology

2001 Annual WSMA House of Delegates Meeting

This year's WSMA Annual Meeting will have a special focus on integrating electronic technology into the medical practice. The keynote speaker will discuss how to use medical informatics to improve practice efficiency and patient outcomes. All WSMA members are invited to attend.

Delegates will gather to set policy for the association - exchanging ideas and deliberating issues affecting the practice of medicine and the profession.

Any member of the House of Delegates may submit a resolution. August 21 is the final deadline for all proposed resolutions to be submitted to WSMA. If you are not a delegate but have a resolution that you would like to submit, please contact PCMS at 572-3667.

This year's meeting will be held September 21-23 at Jantzen Beach, Double Tree Hotel in Portland. ■

From cost cutting to patient satisfaction...

Several plans have begun to pay doctor bonuses on quarterly payments if they score well on patient satisfaction surveys and on how well they provide services. Historically, bonuses have been tied to how successful physicians were at controlling costs.

In theory, a health plan's move toward compensation not based on cost savings would stop giving incentives to doctors to skimp on care. But doctors are not so sure that such a change will truly be beneficial to them. "Everyone knows you cannot trust health plans to come up with an answer for patients and doctors. We are suspicious that this is more public relations than real change," according to Peter Warren, spokesman for the California Medical Association, which has a lawsuit pending against Blue Cross regarding alleged downcoding of claims.

Even some health plans are skeptical of satisfaction-based pay, for different reasons. According to Robert J. Forster, MD, vice president of care and network for Florida Blue Cross and Blue Shield, "There's no relationship between patient satisfaction and the quality of health care. The relationship of the doctor to the patient and their access, all will impact satisfaction scores, but not necessarily the technical delivery of health care."

More plans are increasingly using patient satisfaction or quality measures as a greater baseline for compensation.

Performance pays:

- Blue Cross of California will reward physician groups up to 10% based on quality care measures and patient satisfaction. Parent WellPoint Health Networks Inc. says it may expand the system to other plans.
- Harvard Pilgrim Health Care in Boston will pay Partners HealthCare Systems Inc. doctors based on quality measures, rather than cost cutting.
- Indianapolis-based Anthem is basing 5% to 10% of bonuses to 500 New Hampshire doctors on preventive health standards.
- Blue Shield of California in January initiated a quality incentive program. Medical groups can earn up to 5% more based on quality measures.
- PacificCare Health Systems Inc. has a quality reward system in place since 1998, based on about three dozen clinical measures. High-performing groups are assigned more members, which, the insurer says, results in more revenue. ■

From AMNews 7/30/01

Reflections from page 8

collect appropriate fluoroscopy to the trauma centers. Donations are welcome! If anyone is interested in traveling there for work or pleasure feel free to contact either myself or my wife. It is a beautiful country and tourism helps support their economic growth.

In conclusion, I offer reflections upon two recurrent thoughts. First, we are very fortunate in America to have the technology and economy to support our medical system. I am reminded of this every day. Second, I was treated so well by so many people who have so little that it makes me want to contribute again to their advancement in the future. I have many good memories about my trip to Vietnam and I plan to return soon. Did I mention that their miles of white sandy beaches have not been touched in thirty years? A journey to Vietnam could become quite a habit. ■

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COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

College Board announces CME schedule through June, 2002

The College of Medical Education's Board of Directors announced its CME schedule for 2001-2002 after their June meeting. The courses are offered in response to local physician interest and are designed and directed by local physicians. All courses offer AMA and AAFP Category I CME credit.

A course calendar identifying the course title, dates, brief description and course directors will be mailed in early August. For additional information on next year's offerings, please call the College at 627-7137.

Common Office Problems CME October 5

Topics are set for the College's Common Office Problems CME scheduled for Friday, October 5, 2001. The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD.**

This year's course will cover:

- What You Should Know About New Antibiotics
- Pediatric Asthma
- Insulin Analogues and the Basal-Bolus Approach to Diabetes Management
- Dermatologic Diagnostic Dilemmas
- Geriatric Assessment: Quality Versus Quantity
- Fibromyalgia - Is it All in Their Head?
- Osteoporosis Update
- Early Intervention in Chronic Renal Failure ■

Air reservations encouraged for Hawaii CME

To assure you are able to secure seats and get a reasonable price for CME at Hawaii, we urge you to make your reservations soon.

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

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, October 5	Common Office Problems	Mark Craddock, MD
Friday, November 2	Infectious Diseases Update	James DeMaio, MD
Friday, December 7	Medicine & Mental Health	David Law, MD
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Saturday, April 27	Surgery Update 2002	Preston Carter, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

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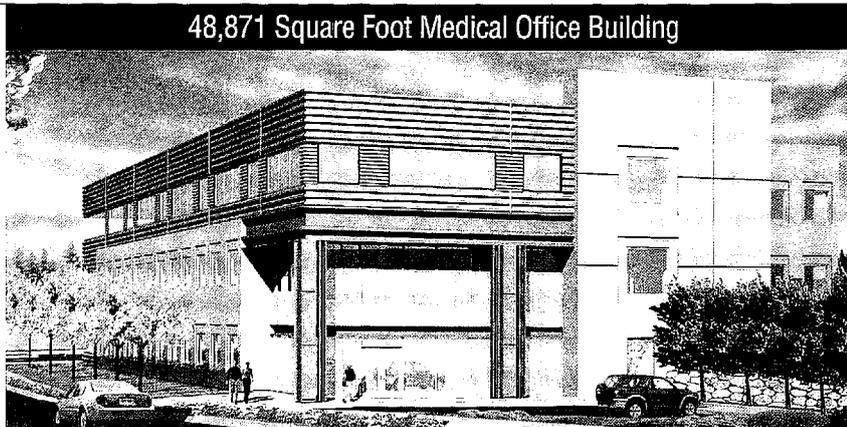
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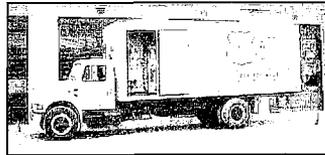
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BULLETIN

Pierce County Medical Society



September, 2001



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BULLETIN

Pierce County Medical Society



September, 2001

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

The Bulletin is dedicated to the art, science and
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Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
 Subscriptions: \$60 per year

Make checks payable to: **MBI**
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President's Page

by Patrice Stevenson, MD

So, What's the Good News?

These are the good old days of medicine for our younger colleagues. As bad as things may be today, they can always get worse. Unfortunately, these were the messages I took away from a recent meeting with Congressman Adam Smith (D-9) and your PCMS Executive Committee (**Dr. Susan Salo, Jim Rooks, and Mike Kelly**). We were joined by: Sue Asher, PCMS Executive Director; Tom Curry, WSMA Executive Director; Len Eddinger, WSMA Public Policy Director; and Sean Eagan, Field Representative for Congressman Smith's office.

Congressman Smith, an attorney, wanted to meet with the PCMS leadership to help his understanding of the current concerns of practicing physicians. Dr. Rooks spoke of the reduction of Medicare and Medicaid surgical fees to the point that he earns less performing ENT surgery than his colleague who has given up the scalpel for an office-based practice. Dr. Kelly described the conflict about taking the extra time needed to meet the concerns of his geriatric patients, during what was to have been a short office visit, when they pull out the grocery list of symptoms from their pocket. The patient is not satisfied if those concerns are not addressed, which requires extra history taking and more physical examination than the allotted appointment time. Now already running behind, he doesn't have the additional time to adequately document the encounter to pass the scrutiny of "the Medicare police," so he ends up "down coding" as a potential source of increased utilization of services, resulting in higher overall health care expenditures. This likely does not happen in the medical office

setting if the patient is not paying anything out of pocket for the visit. This is the Costco mentality of buying way more of something than needed because it is cheaper per unit. You may have saved a lot but you spent more doing it.

Tom Curry and Len Eddinger reviewed the state statistics for Medicare and Medicaid. Washington ranks 45th in Medicare payments and between 1988 and 1999 had the sixth fastest rate of decline in payments among the states. Certainly our cost of living does not parallel these trends. They reviewed MERFA, "The Medical Education and Regulatory Fairness Act of 2001" (HR 868 and S 452) and thanked Congressman Smith for his support. This would give some protections to providers similar to the regulatory reigning in of the IRS provided by the IRS Restructuring and Reform Act of 1998. The unfunded administrative mandates of HIPAA, "The Health Insurance Portability and Accountability Act," were discussed with respect to the great expense and difficulty implementing these regulations for medical practices with the current time lines. Congressman Smith also supports the "HIPAA Administrative Simplification Act" (HR 1975 and S 836) which would extend the HIPAA implementation deadline from two to four years. For additional information on these issues, contact PCMS, 572-3667.

Congressman Smith listened intently and heard our concerns. He reminded us of the political climate at the time of the creation of the Balanced Budget Act of 1997. At that time the Society Security Trust Fund was predicted to be bankrupt this year. It is



Patrice Stevenson, MD
President

currently expected to be there through 2028. He predicts more economic pressures in the next five years and more hard political decisions to be made regarding the federally funded health care programs. This may include a financial means testing for Medicare eligibility with higher out-of-pocket costs for the well-to-do retired. He asked our thoughts on a single-payer system. While this may have some appeal in the face of the current health care financing chaos, we urged caution in looking to that as a solution. Tom Curry reviewed the excellent WSMA report on various models of health care financing presented at last years annual meeting.

The conclusion was that Congressman Smith was "not optimistic" about seeing major Medicare or Medicaid restructuring or administrative relief for physicians. He noted that the government tends to use the teaching tool of punishing the group for the transgressions of the few by piling on administrative rules and regulations. Like most physicians, I don't have the time, energy or cleverness to defraud the Federal Government. We're just trying to meet the needs on our patients' grocery lists without being accused of criminal acts and trying to not go broke in the process. ■

(See related article page 6)

Retired Members' Luncheon Meeting Recap

Sharing, Caring and Successful Aging

Over 40 retired physicians met at the Fircrest Golf Club in August for lunch and to visit with former colleagues. The group had not met for some time, but after responding to a recent survey, overwhelmingly concluded that they did want to meet three or four times each year for lunch at a local restaurant. Speakers remained popular, but topic preference was just about anything EXCEPT medicine.

In keeping with that request, **Josephina Vallarta, MD**, retired pediatric neurologist, addressed the group on "Sharing, Caring and Successful Aging." Dr. Vallarta was introduced by moderator **John Colon, MD**, who made announcements and asked for a brief silence for the physicians that have died this year. They included **Drs. Myron Bass, Wayne Bergstrom, Paul Bondo, Keltie Burt, Charles Denzler, David Dye, Ralph Huff, Ronald Johnson, Gale Katterhagen, Hugh Larkin, Robert O'Connell, Arthur O'Leary, Maurice Origenes, Earnst Randolph, John Shaw and Robert Truckey.**

In introducing Dr. Vallarta, Dr. Colon said that she retired from her child neurology practice in 1994 and was the founder and first medical director of the Neurodevelopmental Program at Mary Bridge Children's Hospital and a clinical associate professor emeritus of neurology and pediatrics at the UW. Dr. Vallarta maintains that "retirement from work is wonderful," but personal work must continue to keep one happy and healthful. She shared many of her personal habits and philosophies that contribute to remaining young and vital. She also shared known factors associated with healthy brain aging and enhanced brain function:

1. **Education** is an enriching and liberating process. Learn more, learn something new, knowledge brings joy and the brain networks of neuronal connections are stimulated to form and grow.

2. **Regular moderate exercise** maintains the health of blood vessels supplying oxygen and blood to the brain and the rest of the body. It increases lung capacity and the oxygen supply to the brain. Make a firm commitment to walking at least 4 hours a week and walk briskly. At age 60 to 69, walk at a speed of 15 to 17 minutes a mile. Brisk walking and aerobic dancing burn an average of 7 calories per minute. To lose one lb. a week, we must burn 3,500 calories per week.

3. **Self efficacy** is defined as belief in the value of one's accomplishments and that one is in control of one's future, health and destiny. It also measures how stressful events are understood and responded to. When stress is not handled appropriately, the adrenal glands produce cortisol or stress hormones which can damage the hippocampus.

4. **Curiosity** is a complex brain function which results in



*John Colon, MD
moderated*



*Josephina Vallarta, MD
presented*



Pictured above: Retired physicians enjoyed themselves and the environs of the Fircrest Golf Club at their recent luncheon

motivation, attention, preference for novelty, learning, interaction and involvement with the world and others. The more we learn, the more we want to learn.

5. **Energy** decreases with aging due to loss of activating and alerting neurotransmitters in the brain. Energy can be increased with proper amounts of exercise, rest and restorative

See "Aging" page 13



Pierce County Medical Society

welcomes.....

KIRO Legal Line's

BOB PITTMAN, JD

Bob Pittman is an attorney in private practice with an emphasis on estate planning and wealth preservation. Bob is a graduate of the University of Washington Law School and has hosted Newsradio 710 KIRO's Legal Line since 1991. He is a member of the National Network of Estate Planning Attorneys, and holds the designation of "Advanced Wealth-Strategist Planner" from the Esperti Peterson Institute for Global Wealth Strategies Planning. He was recently honored by the Washington State Supreme Court in a special Court Resolution commending his work on the radio.

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Tuesday, September 11, 2001

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Program: 7:30 pm

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Executive Committee meets with Congressman Adam Smith (D-9)

Members of the Executive Committee met with Congressman Adam Smith (D-9) in August to discuss issues of concern, particularly federal regulations, declining reimbursement, MERFA, HIPAA, and other complexities of today's health care delivery system. Congressman Smith began by acknowledging many of the problem areas and agreed that reimbursement rates are tight, that there is less money per patient in Washington State even though the state provides the highest in quality care, paperwork requirements are onerous and the Medicaid program is disastrous.

"My overhead is 60-75% now," noted one specialist, and "I see 25-30 patients per day to help cover costs," added a family practitioner. While Congressman Smith heard the complaints and sympathized, he wasn't optimistic about quick fixes. "Health care is expensive, new technology costs are exorbitant, we have an increasing number of seniors needing comprehensive care," he said.

He specifically asked for ideas of how a new system might work, considering Medicare eligibility, defined contributions, or other new ways of doing business. "There are not easy answers and I am not optimistic for any immediate changes," he added.

The meeting with Congressman Smith was significant because health care in Washington State is integral to the state's economy. In 1996, total personal health care expenditures in the state totaled \$17.8 billion, or about 11.1% of all state economic activity for that year. Medicare and Medicaid programs paid for about one-third of this spending. Concerns include:

- The imposition of numerous state and federal regulations that drive up administrative expenses without compensatory reimbursement

- Declining reimbursement for medical services

- Deteriorating health plan networks as physicians and clinics are forced to drop contracts that do not cover the cost of providing services

- A tight labor market that makes it difficult to recruit physicians and administrative staff

- Increased physician frustration and reduced hours available for patient care

Congressman Smith has signed on to support both the Health Insurance Portability and Accountability Act (HIPAA) (H.R. 1975) and the Medical Education and Regulatory Fairness Act of 2001 (MERFA) (H.R. 868).

MERFA will make important changes to Medicare operations in an attempt to create a more inclusive, non-adversarial system for addressing the complexities of Medicare coding and billing requirements and related regulations imposed on physicians, hospitals, health plans, skilled nursing facilities, home health care and other providers. Specifically, it will curtail HCFA's (CMS's) use of "extrapolation," prohibit payment demands until fair determination, provide meaningful

options for appeals, and protect health professionals from Federal, unfounded mandates.

H.R. 1975 will extend the HIPAA implementation deadline from two to four years. An extension would provide: an opportunity to spread the budget over longer cycle increasing affordability, reducing the impact of pass-through costs from clearinghouses and health plans to providers, decreased demand (and prices) for vendors; increased availability, increased likelihood that all standards are implemented simultaneously, adequate time for testing to avoid system glitches that shut down or delay health plan payment mechanisms and opportunity to request vendor certification program from HHS.

PCMS thanks Congressman Smith for his willingness to listen and discuss issues of concern. It was clear that he really wants to understand the difficulties and complexities of today's medical care system from the doctors perspective while contemplating workable solutions.

For more information on Medicare and Washington State Physicians, contact PCMS, 572-3667. ■



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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Treat Rather Than Incarcerate

You may have seen my recent article in The News Tribune about the need to treat rather than incarcerate.



Federico
Cruz-Uribe, MD

To summarize, we've tried the prohibition model - it didn't work. For decades now, we've arrested people who abuse alcohol

and use other - illegal - drugs. That doesn't seem to be working, either. Recidivism rates are high since no treatment is offered to change the behavior that brought the person to jail in the first case. Regardless of additional police officers, jail beds, and other programs to penalize the abuser, drug abuse levels are staying high. Are we accomplishing what we set out to do? I think not. There is little or no data to show that we improve our communities when we arrest more drug abusers. There's a lot of data, however, that shows that treating drug abuse as a disease works.

We know that treatment works - individuals regain their health, stop using cocaine, heroin, alcohol and other drugs, get back to work, obtain homes for themselves and their families, and stop committing crimes to support their habits. Complete rehabilitation, where the physical and emotional addiction is interrupted is best, of course, but even maintenance helps. Our Methadone

Clinics serve approximately 450 people with the synthetic opiate, getting them back on track after years of heroine and cocaine addiction. We've got plenty of testimonials about people who have renewed their lives, even returned to professional-level positions, by using methadone for daily maintenance. Jailing these individuals would not have resulted in positive outcomes. I recently saw statistics that showed that, for drug abuse, law enforcement costs fifteen times as much as treatment to reach the same result. In 1992, the US government spent 93% of its drug-control budget on cops and courts and only 7% on drug treatment. Ten years later, in Pierce County, we will spend 80% of the local tax dollars on the jail and criminal justice programs, and 0% on treatment. We're going the wrong way.

You can help get us back on the right track, in a couple of ways. One is to ask clients, in earnest, about their use of substances: alcohol, other drugs, tobacco. Physicians are still highly respected by most people and a suggestion by you that a client's health is being diminished by using or abusing substances carries a lot of weight. Let them know where they can sign up for cessation classes or get them on the nicotine patch or other tobacco treatment; refer them to rehab for drug detoxification and treatment; recommend programs from controlling alcoholism, from Alcoholics Anonymous to inpatient care.

Prevention is also essential. If you work with kids, make sure they know that using substances is the wrong choice. Imagine the Pee Wee League catcher or quarterback saying, "My

doctor says I shouldn't use tobacco at all. Forget it. Bud, don't even bother offering me a cigarette or a chew."

Prevention and intervention are key and are points where you can make important contacts, one by one. Don't forget the population-based stuff, however. Influencing policy decisions can also make a difference. By taking a few minutes to let decision-makers know that money spent on treatment makes more sense than putting dollars into the jail, or getting onto citizen advisory groups looking at changing community policies, we can create a healthier community. Since the courts turned down the Board of Health's resolution on tobacco advertising, soon we will see billboards and full-color ads featuring cartoon characters, enticing the kids to use alcohol and tobacco. Those ads will be almost as colorful as the people on the street corner, offering a low-cost upper or downer to improve the kids' lives. Community members who say, "This is not acceptable" can force store owners to change their ads and drive drug sellers out of the neighborhood.

None of this is new. It's a reminder for all of us that we can do more. We need to be intentional about prevention, intervention, and policy-setting, doing what we can at every level. The old War on Drugs hasn't worked. Let's start a new approach and get it right this time. ■



- Retirement Congratulations -

Surinderjit Singh, MD

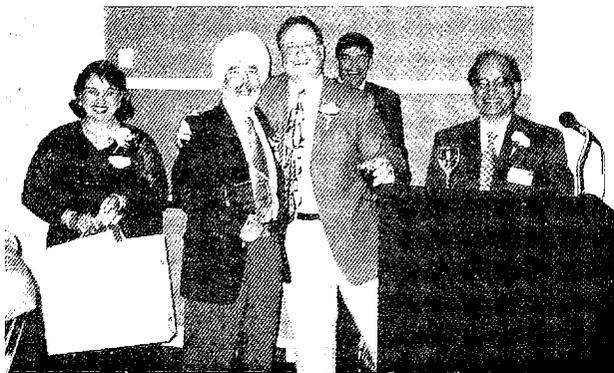
Surinderjit Singh, MD, was honored on Friday, June 29 at a retirement party sponsored by his colleagues at the Tacoma Sheraton Hotel. Dinner, dancing and revelry were included. Over 200 people attended the event.

Dr. Singh graduated from Christian Medical College in India and received his physical medicine and rehabilitation training from the University of Wisconsin Hospital and University of Washington Hospital. He founded Electrodiagnosis and Rehabilitation Associates in 1980 just after joining PCMS in 1979.

He served on the College of Medical Education Board of Directors for many years including as president in 1994-1995 and served as Examiner for the American Association of Electromyography and Electrodiagnosis from 1982-1998.

Dr. Singh is a world class cricket player and represented the U.S. team in 1979.

Congratulation to Dr. Singh! ■



L to R: Drs. Tabassum Saeed, Surinderjit Singh, Edgar Steinitz, Alan Tice and Mohammad Saeed



Dr. and Mrs. Steinitz enjoyed dancing after dinner

Stanley Harris, MD

Staff and colleagues were in abundance at the retirement party for Stan Harris, MD on Friday, June 29 at the Cedar Surgical Associates office building on South 19th Street in Tacoma. Featuring mega decorations, a harpist, and a heartfelt and humorous poem written by practice-partner **Chris Jordan, MD**, attendees vacillated between laughter and tears. He was give a Ping driver as a retirement gift with expectations that his handicap will lower to 2!

Dr. Harris graduated from the University of Washington School of Medicine in 1970 and did his general surgery training at Fitzsimons Army Medical Center. He has been a PCMS member since 1989 and has been extremely active in Society activities, including in his tenure as president in 1997.

PCMS congratulates Dr. Harris on his retirement and wishes him well, particularly on the golf course! ■



Dr. Harris was "adorned" and adored by his office staff



Dr. Harris with office staff; saying goodbye was hard

In My Opinion.... *The Invisible Hand*

by Andrew Statson, MD

Patient Rage

"...a *dying* culture invariably exhibits personal rudeness. Bad manners. Lack of consideration for others in minor matters. A loss of politeness. of gentle manners, is more significant than a riot... This symptom is especially serious in that the individual displaying it never thinks of it as a sign of ill health, but as proof of his/her strength."

Friday

Robert Heinlein (1982)



Andrew Statson, MD

When Robert Heinlein wrote those lines, the word rage was not yet part of the social vocabulary. It came on the scene some ten years ago, first in the expression "road rage." Then we heard about passenger rage from the airlines and about customer rage from the stores. Recently, stunned by several large verdicts during the last year, for mishaps deemed defensible, or at least worth much less than the eventual awards, WSPIE told us about patient rage.

Many jurors have themselves received poor care or know someone who has. In court they see someone who has suffered a mishap related to health care and they sympathize with the patient. They are angry at the health care system and this is their way of expressing it. This is how they can get back at the system and show their rage, perhaps also their outrage.

In nature, when faced with a threat, animals tend to run away. When that is not possible, when they are cornered, they turn back on their aggressor with all the strength and fury they are able to muster. They know they will be hurt and probably die, but they intend to inflict as much harm on their attacker as possible before they die. We have the same characteristic. There are many examples in the history books of men who fought to the death in the defense of their territory, having as their only goal to kill as many

of their enemies as they could, before they themselves got killed. There is a good example of that in the pages of American history.

The defenders of the Alamo, fewer than 200 men, faced an army of 4000. Outnumbered twenty to one, they all perished, but they inflicted several fold their number in casualties on the army of General Santa Anna. They knew they were going to die. They chose to exact as high a price for their death as they could.

That was an example of battle rage. What could it have in common with road rage? Yes, it is different, but the action is still based on being trapped, on the lack of alternatives, on the impossibility of escape. The population of our area has increased by 50% during the past twenty years, yet the roads have changed little during that time. When it takes one hour or longer to go to work, and the same to come back home, day after day, with no hope of improvement, with traffic getting worse instead of better, when you have to hurry back to pick up the children from daycare before it closes, or to cook dinner, or for some other appointment, and someone cuts in front of you, or slows you down, your reaction tends to be not courtesy, but exasperation. People get irritated and they blow up.

The same thing is seen with air passengers. They make reservations,

work out their schedule, make plans. When they get to the airport, they find out that their flight was overbooked or cancelled, they find themselves in a bind and they strike back. Customer rage is similar. People buy a product or a service, yet it is not what they expected. Maybe they misunderstood, maybe it was misrepresented. As long as they can exchange it or get a refund, they are usually satisfied. When they cannot resolve the problem amicably, they feel trapped and become enraged.

Patient rage develops in a similar fashion. Long waits for service, denial of service, lack of consideration for their time or for their suffering, all these lead to unfulfilled expectations, which the patients see as broken promises. They feel they are in a bind, they feel nobody is paying attention to them, nobody cares about them. To a certain degree, such complaints have always existed, but in the past it was easy to walk out and go someplace else. Now they are much more likely to feel trapped. They put up with that kind of treatment as long as they can, then something happens and they snap.

In addition to the expensive jury awards, we can expect other problems. In the past, physician defendants won about 80% of the malpractice actions. I

See "Rage" page 10

Rage

from page 9

have not seen the more recent figures, but I will not be surprised if this year the plaintiffs win at least a third of the suits. It is likely that in the future that ratio will turn more and more against us. We are told that suits are just another cost of doing business. That cost probably will get higher than what it is now. Added to our other overhead, it will make it even more difficult to meet expenses. Our best defense is to treat our patients with the utmost care and consideration we are able to give them. We can only hope that such an approach on our part will be able to defuse patient rage.

I am not sure that we will be successful. After all, we have our problems, too, and feel trapped. At least, we can try. At least until we reach our limit and explode in physician rage. Physician rage? That is not conceivable, but a strange thing is happening to our profession. The annual meetings of the ACOG used to be exciting and fun. They were a good opportunity to meet friends from all over the country, to learn new things, to enjoy a few good evenings in the company of people who were happy. A few years ago, at the last meeting I attended, the exhibits and lectures were there, the friends were there, but the laughter sounded hollow and the happiness was gone. The bodies were there, but the spirit was missing. It was a very sad feeling, like looking at a dear friend who was dying, knowing we couldn't do anything to help him.

Patient rage is the wake-up call for the entire health care system. Road rage did not wake up the transportation department until several initiatives of the people mandated road improvements. Passenger rage induced the airlines to be more careful about booking their flights. Customer rage led the stores to review their policies on handling complaints. Patient rage will have to shake up the health care system and make it more responsive to their needs. The deterioration in patient care we

have witnessed cannot continue indefinitely. We will have to heal the health care system. The alternative is much too gloomy to even consider.

This rage is everywhere, not just in patients, customers, passengers or drivers. In fact, patient rage is expressed as jury rage. When people serve on juries, they find themselves with the power to strike back at someone, anyone. The two billion verdict against Philip Morris is an example of jury rage. In our country, juries are the representatives of the people. Jury rage is people rage. People are hurting and, as jurors, they want to hurt back, to punish those who happen to be in their hands.

A French writer, I think it was Anatole France, wrote, "Hatred is the anger of the weak." Anger is a healthy emotion. It bursts out because of a disagreement and dies down as soon as it is expressed. Hatred is bottled in, because the people are not free to express their discontent and cannot obtain satisfaction. It arises out of broken promises and unfulfilled expectations. It is pent-up because of powerlessness. It simmers on a fire fed by multiple irritations, frustrations and resentments

and fanned by envy. It builds up pressure, until it explodes into rage. It is destructive, to the people who harbor it, and to the entire culture that allows it to exist. Some people hope they can profit from it and fan the flames, but they will be consumed by the heat of its explosion together with the rest of us.

Insurers have a saying, "The large print gives, the small print takes away." People are promised health care, but when the promises are not kept, people stop believing them. "You can fool some of the people some of the time, and some of the people all the time, but you cannot fool all the people all the time," (Lincoln, 1858). No, people are not fools. When they are mistreated and nobody pays attention to them, their anger turns into hatred, and the hatred, into rage. People rage is a dangerous thing. That was what pushed some Bostonians to have a tea party. It ended up costing King George III much more than he could have ever hoped to collect from the tea tax. We need to find the safety valve and relieve the pressure before something like that happens, the sooner the better. ■

MEDICAL LICENSURE ISSUES

Mr. Rockwell is available to represent physicians and other health care providers with issues of concern before the State Medical Quality Assurance Commission. Mr. Rockwell, appointed by Governor Booth Gardner, served for 8 years as the Public Board Member of the Medical Disciplinary Board from 1985-1993. Since then, Mr. Rockwell has successfully represented over 60 physicians on charges before the MQAC. Mr. Rockwell's fees are competitive and the subject of a confidential attorney-client representation agreement.

Gregory G. Rockwell
Attorney at Law & Arbitrator
3055 – 112th Avenue SE, Suite 211
Bellevue, WA 98004

(425) 822-1962 • FAX (425) 822-3043
email: grocket@msn.com • website: "grockwell.wld.com"

In My Opinion....

by Stan Harris, MD

The Phone Call

My father is 89 years old. Despite growing up in a Minnesota depression family who lost their farm, he was able to best his father's first grade education and through hard work graduated from the University of Minnesota School of Medicine as a general practitioner. He became a company doctor for the Northern Pacific Railroad in the small Montana town where I grew up. He was the quintessential country doctor, always on call, making house calls virtually every night, delivering babies and doing whatever was necessary to care for his patients and friends. He practiced until he was 77 years old. He loved medicine, loved his patients and they loved him.

Unfortunately, recent years have not been good to him. He has suffered a series of mini-strokes and now has rather significant dementia. Much to everyone's dismay, this once proud and independent man is no longer able to care for himself. He is sometimes fairly lucid but most of the time he is confused, doesn't remember where he is and cries like a baby when he wants things and can't get them. My wonderful stepmother has been caring for him day and night but she is 87, she recently developed her own medical problems, which hampered her ability to care for Dad. When she was hospitalized, no one was able to calm Dad in the "Rest Home." He became combative and threatened suicide in spite of multiple medications and visitations from his family practice doctor of many years. My older sister went home to see what she could do. That is when the problems began.

My sister, a medical technologist, was obviously extremely distressed to

see the profound change in my father's mental condition since she had just seen him a few months earlier. She talked to the charge nurse and was told that his doctor "only" visited him once a week and the nurse was not sure my father was getting the latest dementia medications. The natural next step was to talk to his doctor to determine his opinions for Dad's long-term care.

She called the doctor's office and reached the receptionist, who took the message and told her "Doctor" would call her back after his "very busy office." He didn't call so she called him again. Her efforts continued for three days until she gave up and called me after deciding to change to a "good" doctor. I defended the family doctor and told her that little could be done to ever make Dad better anyway. The practitioner had obviously just been overwhelmed with work and inadvertently had not been able to return her call. I told her that I knew the man and he had known Dad for many years and certainly was able to deal with the myriad of problems my father suffered better than a new doctor. She said her mind was made up because a doctor who wouldn't return calls must not be any good. I asked her to reconsider, but her mind was made up. Since she had power of attorney, she talked to one of the other ten physicians in town who agreed to take him on.

I felt very badly about the situation and had told her to at least call the original doctor one more time and tell him why she was doing what she was doing. She again said "no" emphatically.

I decided to give the doctor a call myself and apologize to him for a no-



Stan Harris, MD

win situation. I called him six times and was told he was seeing patients and would call me after work. I told the receptionist that I was a "surgeon" and wanted him to be interrupted. She then came back on the phone and told me he was not in the office as he had gone to an urgent meeting. I never received a return call from him even after I told the receptionist I was not calling to criticize him but to praise him for dealing with my father's problems so well for so many years.

Unfortunately, because of the lack of a return call, my own opinion of him changed for the worse. I am and was a "busy" general surgeon who always tried to return all my requested calls. I never minded being interrupted by another physician and would always talk to them immediately if I wasn't in the middle of cutting on someone. It set me to thinking about my own experiences in practice and what many of my colleagues did. I vividly remember, on multiple occasions, calling another doctor's office and having the receptionists tell me the doctor was in with a patient and did I wish to talk to him or her? I would reply that I would not have called if I did not want to talk to him or her. I just assumed that "all" of us were busy seeing patients. As a surgeon I am certainly as arrogant as the next but I guess most of us in the profession can be accused of the same

See "Phone Call" page 12

Phone Call from page 11

malady. I guess the assumption of many of my colleagues is that "my time is more valuable than yours regardless of what you are calling me about," including this Montana family doctor.

As I reflected upon the events that my sister had related, I too felt the anger of being considered too inconsequential for a return call to discuss my father's care and "I am a SURGEON!!!!" How dare he not return my calls! Still I was very much against abandoning a very fine practitioner for such a seemingly small slight. I needed the validation, just as everyone else, that I was doing a good job. How many times do we do things as well-intentioned physicians that are perceived so completely negatively by our patients and their families? A simple phone call is a very big deal. I know that in the future I will be more considerate and hope that you will be too.

PS. My arguments to my sister prevailed and my father is still with the same doctor. I, however, still would have switched to a "good" doctor, since he never has called me back! ■

Directory Changes

Please make note of the following changes to your 2001 PCMS Directory

Diane Combs, MD

Change office listing to:
4700 Pt. Fosdick Dr NW #207
Gig Harbor, WA 98335
Phone: 851-3992
Fax: 851-4310

Larry W. Larson, MD

Change office address to:
2115 S 56th Street #301
Tacoma, WA 98409

Susan Predmore, MD

Change office listing to:
3333 N Whitman
Tacoma, WA 98407
Phone: 759-3065
Fax: 759-3075

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Ageing from page 4

sleep including naps when needed, involvement and enthusiasm about people and events.

6. **Keeping busy, diversity and novelty** with physical and mental exercises, new and creative activities such as traveling, reading, games and classes. Engage in a diverse range of activities that are interesting and enjoyable. Combine active activities with passive ones in groups or individually. If you choose to retire, retire to something, not from something. The mentally creative person never thinks of himself as retired.

7. **Linkage, continuity, friends and social networks:** renew and maintain good friendships and resume activities which one has enjoyed in the past; reading, writing, dancing, traveling to new and old places, visiting relatives and friends. Make new friends. Be a good friend and maintain links with the young. An older person's morale depends on how often she gets together with her friends rather than on how often she sees her children.

8. **Healthy diet** with moderate caloric restriction; decrease intake of saturated fats and easily oxidized amino acids and increase intake of foods with free radical oxygen inhibitors or antioxidants.

9. **Reduce stress and accept undesired changes in physical and mental functioning.** Acceptance demands a balanced approach to life. Change your inner attitude toward frustrations, problems and unwanted experiences. If you cannot change what is happening, think how you can learn from it and reformulate them into challenges which will give you a sense of control. Reduce anxiety about normal age associated memory impairment and slowing of general responsiveness of work performance. Reading and memory training utilizing memory tools such as writing diaries, lists and the use of computers increase brain network connections.

10. **Maintain good physical health with normal levels of blood pressure, blood sugar and cholesterol.** Avoid injuries with safety precautions. Improve your balance, increase your bone and muscle strength, eye hand coordination and finger dexterity with exercises. Avoid exposure to toxins, addicting drugs, harmful activities, infections and factors that can further reduce your immunity and hasten aging of the arteries and the brain.

More than two thousand years ago, Cicero said: But it is our duty to resist old age; to compensate for its defect by watchful care; to fight against it as we would fight against disease; to practice moderate exercise; and to take just enough of food and drink to restore our strength and not to overburden it. Nor, indeed, are we to give our attention solely to the body; much greater care is due to the mind and soul; for they too, like lamps grow dim with time, unless we keep them supplied with oil. Intellectual activity gives buoyancy to the mind. ■

New York Medical Society Sues Six Insurers

The Medical Society of the State of New York sues six insurance companies with managed care plans in the state

Physicians of the Medical Society of the State of New York have joined the growing ranks filing suit against managed care firms that challenge the way the companies do business.

MSSNY, which represents 27,000 physicians, filed separate lawsuits in August against each of the six largest insurers in the state: Aetna, Cigna, Empire Blue Cross/Blue Shield, Excellus, Oxford, and United HealthCare.

The suits claim the companies breached contracts with physicians by arbitrarily denying medically necessary care, capriciously reducing reimbursement claims and subjectively downcoding and bundling claims. The suits also accuse the companies of using computer programs to deny claims based on arbitrary guidelines.

"We need to finally get the insurers to take the charges seriously," said MSSNY President Robert Bonvino, MD. "It really is sad that we have to go to the court system to make HMOs live up to their contract. Unfortunately, there's no other way."

Paul Macielak, New York Health Plan Association president, said the lawsuits weren't about patients and that they instead aimed to enrich doctors' pocketbooks.

"If the medical society and its doctors are truly concerned about patient care, they would use their considerable resources on efforts to improve overall quality of care and reduce medical errors," he said in a prepared statement.

Cigna had not seen a copy of the suit but called it unwarranted. The firm has worked with doctors and other health advocates to boost health care quality and simplify administrative practices, said Cigna spokesman Wendell Potter. "Medical coverage decisions are made by medical professionals. Our physician medical directors share the same commitment to quality care as other physicians in New York and across the nation." ■

From AMNews 8/3/01

“Tending the Fire: Burnout Prevention & Time Management for Physicians

Physicians Insurance workshop

If you're a doctor then you're vulnerable to the occupational hazard known as burnout. Your commitment and conscientiousness, along with stressors unique to the medical profession, put you at risk for overwork, isolation from support, and lapses in judgment that lead to malpractice claims.

This workshop will offer practical strategies to increase efficiency and to bypass burnout. It will guide you towards tending the fire of your passion and priorities, so that you might incorporate what is most important to you into your medical practice and your personal life.

You will leave this workshop able to:

- Cite the stressors that most impact your satisfaction with clinical practice.
- Implement three practices that consolidate your workload and save you time.
- Formulate a personal plan for burnout prevention.

This two-hour workshop is being offered on multiple dates and at various locations. For more information contact Physicians Insurance at 1-800-962-1399. ■

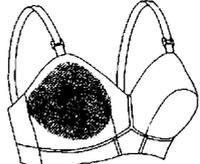
WSMA 2001 Annual Meeting

Bridging the Gap - Medicine and Technology

Plan now to attend this year's annual meeting of the WSMA House of Delegates in beautiful Janzten Beach September 21-23. This year's meeting, titled "Bridging the Gap - Medicine and Technology" will have a special focus on integrating electronic technology into your practice.

At this year's opening session Mr. Frederick Galusha, Chief Information Officer at Inland Northwest Health Services, will discuss using medical informatics to improve practice efficiency and patient outcomes. Also, we will continue our Donald M. Keith, MD. Lecture on Physician Health with a presentation by Stephen McPhee, MD. Dr. McPhee will define the concept of presence, drawing upon several works of philosophy and theology, and explain by example how it applies to the physician-patient encounter.

The opening session will conclude with a discussion on health care financing reform, including a progress report from a special WSMA task force charged with recommending policy on changes to health care financing to promote greater access to affordable health care. ■



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Pierce County Medical Society



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Women In Medicine

Wine & Cheese Reception

Wednesday, September 26, 2001

6:00 to 8:00 PM

Landmark Convention Center

Mt. Adams Room

47 Saint Helens Avenue, Tacoma

Special guest Nancy Auer, MD, WSMA
Immediate Past President and Vice
President of Medical Affairs at
Swedish Medical Center will speak on
being a woman in a leadership role of
organized medicine, and other gender-related issues.

Social Hour: 6:00 PM
Program: 6:45 PM
Discussion: 7:15 PM

This is a complimentary reception for PCMS woman members and non-members.
We hope it is the beginning of a series of supportive and educational forums for the
unique needs and interests of women physicians practicing in Pierce County.

If childcare prevents you from attending, please let us know.

Please register by September 19th, by sending this portion of the form to: PCMS, 223 Tacoma Ave. S, Tacoma, WA 98402
or FAX to 572-2470 or call 572-3667. You may also register by email to pcmswa@pcmswa.org

Name: (please print) _____

I am interested in childcare services for this reception: (phone number or email address)

When Bad Things Happen

Every three weeks, a Medical Quality Assurance Commission (MQAC) Initial Review Panel screens between 60-80 complaints to find the 25% or fewer that require further review by the Commission. From July 2000 to May 2001, 603 cases were categorized looking for patterns or trends that could provide helpful feedback to Washington physicians. For this article, we will examine two of the more popular categories: **Technical Problems** and **Bad Surgical Outcome**:

Technical problems are those unplanned deviations that lead to a bad outcome.

Bad surgical outcomes include bad results with or without identifiable errors of procedure.

There were 41 technical problem cases. Thirteen involved insurance settlements ranging from twenty-five thousand to one million dollars. Three deaths were assigned to this group. There were 43 cases with bad surgical outcomes. Four deaths were in this group.

Similar repetitive problems appear

in both groups:

- Bowel and viscus perforation from surgical penetration procedures.
- Failure to perform timely cesarean section.
- Wrong surgical target.
- Post-surgical ureteral obstruction.

In the remaining cases, one is impressed with the random diversity in the types of procedures which have been vulnerable to mishaps and unexpected bad outcome.

"Bad things can and do happen in the practice of medicine as in all of life."

Applying the wisdom of retrospect, many situations might have turned out better had management systems been different. Commission members must separate flawed management that may continue to injure patients from complications that develop in spite of good care. In the process, we are increasingly aware how some complications produce formal complaints from patients while others do not. In the case material, patients write that calls to report early signs of trouble were ignored by the physician or office staff,

and that no one willingly took the trouble to completely explain what went wrong, *as if the problem was somehow the patient's fault.*

What can Washington physicians do to reduce the impact of technical problems and bad outcomes?

- Understand that anyone performing surgical procedures can and probably will have complications.
- Document your judgment and procedures with the completeness an expert would require to evaluate the standard of care you provided.
- Know and use the skills of your colleagues for help during troublesome situations.
- Be alert and responsive to the early signs of a complicated outcome.
- And finally, no matter how embarrassed and humiliated you may feel, go out of your way to personally keep your patient and family fully informed! ■

Reprinted from the Washington State Medical Quality Assurance Commission's Summer 2001 Update

Applicants for Membership

Katherine A. Choi-Chinn, MD

Diagnostic Radiology

Diagnostic Imaging Northwest

222 15th Avenue SE, Puyallup

253-841-4353

Medical School: New York Med College

Residency: Tripler Army Medical Center

Melawati Yuwono, MD

Pediatrics

NW Pediatrics Gastro & Nutrition Assoc

311 South L Street, Tacoma

253-403-1473

Medical School: Medizinische Hochschule

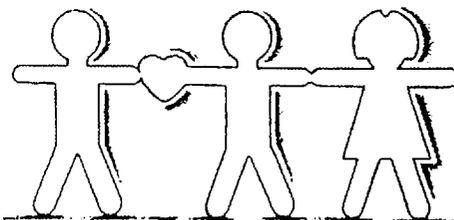
Hannover

Internship: Neustadt Krankenhaus

Residency: Children's Hospital of Buffalo

Fellowship: Children's Hospital of Buffalo

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COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Common Office Problems CME Offers Timely Primary Care Topics

Registration is underway for the very popular Common Office Problems CME program. This year's conference is scheduled for Friday, **October 5, 2001**. The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6.5 Category I CME credits and is again directed by **Mark Craddock, MD**.

This year's course will cover:

- What You Should Know About New Antibiotics
- Pediatric Asthma
- Insulin Analogues and the Basal-Bolus Approach to Diabetes Management
- Dermatologic Diagnostic Dilemmas
- Geriatric Assessment: Quality Versus Quantity
- Fibromyalgia - Is it All in Their Head?
- Osteoporosis Update
- Early Intervention in Chronic Renal Failure ■

ID Update CME set November 2

The annual Infectious Diseases Update is set for Friday, November 2, 2001. The very popular course will be held this year at the La Quinta Hotel. The program is directed by **Jim DeMaio, MD** and will feature nationally known expert Dr. Charles Stratton joining Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections.

The registration brochure will be mailed in September. ■

Whistler CME Registration open

Registration is open for the College's CME at Whistler/Blackcomb program. The conference is scheduled for January 23-27, 2002. The program brochure was mailed in August.

Reservations for the Aspen condos can be made by calling **Aspens on Blackcomb**, toll free, at 1-877-408-8899. You can reserve your room at the **Chateau** by calling 1-800-606-8244. In both cases, you must identify yourself as part of the COME group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by December 1, 2001, when any remaining rooms or condos in the blocks will be released. ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, October 5	Common Office Problems	Mark Craddock, MD
Friday, November 2	Infectious Diseases Update	James DeMaio, MD
Friday, December 7	Medicine & Mental Health	David Law, MD
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Dr. Shields' staff volunteer for "Paint"

Staff members of Willie Shields, MD - Brenda Hanley and Tracy Sanabria - worked with the Pierce College crew to paint South Tacoma resident Dale Brenzel's house on Saturday, August 4 and Saturday, August 11. The crew spent four days preparing and painting the house, fence and shed as part of the "Paint Tacoma Beautiful" project organized by Associated Ministries.

Congratulations on a job well done! ■

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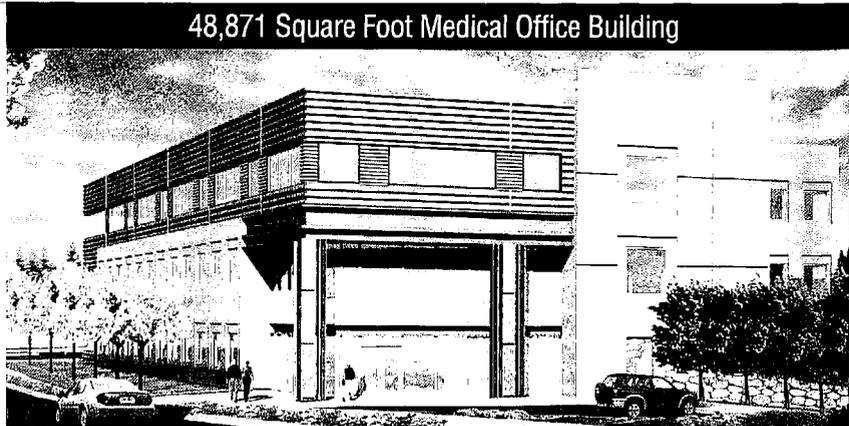


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Office Space For Lease. Sound-view Medical Plaza, located at 3611 South D Street, currently has office space available for lease to medical or general healthcare practices. We offer very competitive lease rates; spacious, updated facilities; shared reception; accessible support staff; excellent security, maintenance and janitorial services; and access to onsite radiology and blood labs. Our location, just off of Pacific Avenue, is adjacent to the Pierce County Health Department and Puget Sound Behavioral Health, and is easy access to and from freeways and on a bus line. For lease rates and more information, call Lindy Vincent at 798-4520.

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Corrine Jedynak-Bell, DO, Tacoma, Washington

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BULLETIN

Pierce County Medical Society



October, 2001



"Harvest Time" Palouse Wheatfields

Cover photo by Sam Insalaco, MD

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BULLETIN

Pierce County Medical Society



October, 2001



Happy Halloween

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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
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Managing Editor: Sue Asher

Editorial Committee: MBI Board of Directors

Advertising Information: 253-572-3666

223 Tacoma Avenue South, Tacoma WA 98402

253-572-3666; FAX: 253-572-2470

E-mail address: pcmswa@pcmswa.org

Home Page: <http://www.pcmswa.org>

President's Page

by Patrice Stevenson, MD

Back to School

It's back to school...for our children and for humanity. It's time to learn the lessons of relative complacency and the value of freedom to our society. It is in part our freedom that allows terrorists to live among us and have us train them how to fly our planes. Unfortunately it always seems that with threats of violence it is the freedoms of the innocent that are more restricted. We curtail our normal activities, lock our doors and endure invasions of our privacy in the name of heightened security while the perpetrators roam free...until they're caught. Then we give them every protection our laws allow and treat them fairly in our criminal justice system.

It was back to school for my three children, Collin 15, Caitlin 13 and Christopher 10, with the attendant excitement mixed with dread. Caitlin spent three weeks in New Zealand and Australia on a People to People Student Ambassador trip. President Eisenhower founded the program in the 1950s to increase understanding and awareness of other cultures and their citizens. Collin had been on a similar trip in 1999. He also went to New

York City for a whirlwind tour during Spring Break that included a trip to the top of the World Trade Center. On 9-11-01 we got ready for school like any other day and ironically he was wearing his "I Love New York" T-shirt. We didn't have the TV or radio on so knew nothing of the terrible events unfolding in New York, Washington, D.C. and Pennsylvania. He changed shirts so as not to appear insensitive.

His New York trip had been lead by his humanities teacher so they spent time reviewing their New York experience and photos. Collin had photos of the World Trade Center from the Empire State Building and a shot looking down from the top. He also had a picture of the lobby rimmed with the flags of the world. I am glad he had that experience. I don't know if I will send Caitlin and Chris. If the terrorist attacks weren't enough, they then had a "lock down" at Sumner Junior High as a man was running around downtown with a gun. This drill has come in the wake of school shootings and the students lock the door, pull the drapes, turn off the lights



Patrice Stevenson, MD
President

and hide under their desks. When the security guard jiggled the doorknob to be sure it was locked they all about lost it. They were especially glad to see us come home that evening.

Collin is also the student body president and is suggesting that they specify if a lock down is from an "external threat" versus an "internal threat" so maybe they won't be as scared next time. If only our "external threats" weren't as scary now. He also believes that we should clean up the mess and re-build the World Trade Center and not retaliate. If only we could put the idealistic fifteen year olds in charge!

We should be proud of the tremendous work and sacrifices of the emergency personnel and health care workers in these situations. It is always the worst behavior of some that brings out the best behavior in these heroes. ■

September General Membership Meeting Recap

KIRO's Legal Line attorney, Bob Pittman, gives estate planning and asset protection advice

Bob Pittman, host of Newsradio 710 KIRO's Legal Line, and Tacoma attorney, addressed over 40 members at the September General Membership Meeting on Tuesday, September 11. With 75 registrants, it was uncertain if the meeting should be cancelled in light of the tragedy that occurred earlier that day on the east coast, but with the Landmark Convention Center and Mr. Pittman in agreement, the meeting was held.

PCMS President **Patrice Stevenson, MD** introduced and welcomed new member **Robert Marsh, MD**, Puyallup general surgeon and son of PCMS past-president **William Marsh, MD** (1991) and called for nominations for four at-large members for the 2002 nominating committee. **Drs. David Law, Patrick Hogan, Mohammed Saeed and Richard Bowe** were nominated and will serve with the five members of the executive committee in nominating trustee and officer positions for 2002.

Pittman, with emphasis on estate planning and asset protection, described the details of Limited Liability Corporations, (LLCs), Family Limited Partnerships and Trusts. He outlined the risks of inside and outside predators, including estate tax and probate, citing several examples of individuals and families who fell victim to such predators due to a lack of proper planning.

"Estate planning is changing all the time," noted Pittman. "President Bush recently signed into law a change in the tax laws. You can now pass \$675,000 to heirs and pay no estate tax. The exemption will increase over the next decade," he explained.

He stressed the importance of appointing an individual or trust as beneficiary to avoid probate and the unnecessary



Mr. Bob Pittman, answering one of many questions asked by the audience after the meeting

To every person in the room, he deemed it essential to have an umbrella insurance policy. "Do it tomorrow," he said.

costs of the probate process. "Life insurance and life insurance trusts continue to be very valuable tools in estate planning when they are bought right," he said.

"Asset protection is complex and often needs interpretation, yet it can be as

simple as setting things up properly and documenting instructions for control of the assets," he said. He described it as a "loving way" to take care of business for the children or grandchildren. And, to every person in the room, he deemed it essential to have an umbrella insurance policy. "It provides a layer of liability insurance over your house and car and is one of the best and easiest asset protection steps you can take," he said. "Do it tomorrow," he added.

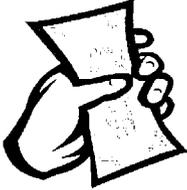
Bob Pittman's radio show "Legal Line" can be heard on KIRO radio 710 am on Saturdays from noon to three p.m. ■



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October General Membership Meeting

Tuesday, October 9, 2001

Social Hour: 6:00 pm
Dinner: 6:30 pm
Program: 7:30 pm

Landmark Convention Center

Temple Theatre, Roof Garden
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Tacoma

spouses/guests welcome

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(Register by October 5. Return form to: PCMS, 223 Tacoma Ave S, Tacoma 98402; FAX to 572-2470 or call 572-3667)

Please reserve _____ dinner(s) for me at no charge

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

Your name (please print or stamp) _____

Is a Handheld Organizer for You?

By: Klaus Gottlieb, MD, MBA

I started typing this little contribution on a Palm VIIx using a fold-away keyboard waiting for my wife to get ready for dinner. I have just submitted my hospital charges via email to the billing office and synced my appointments with my web-based scheduling system. Earlier in the day I checked dosages and interactions of certain medications on the epocrates program on my Palm and received a wireless email regarding a tumor board case I am supposed to present tomorrow. Obviously, the Palm is an integral part of my professional life, but it took me months to get there. I would like to share some of my experiences with you.

Palm Pilots: Toys for soccer moms or productivity tools for mobile professionals?

I bought my first Palm Pilot in late 1998 and tried to use it mostly as an appointment book and organizer. I frequently forgot it either at home or lost it in the hospital. The software I would have liked to have was not available. I planned to write some myself but, not unexpectedly, never got around to doing it. The Palm Pilot ended up in my pile of useless gadgets.

The PDA Revolution

When I started setting up my new practice, I gave the whole field of personal digital assistants (PDA) another look. The software I was interested in had suddenly materialized but the 2 MB of the Palm III from 1998 were no longer sufficient. I briefly had a Visor but then settled for a Palm VIIx (wireless) with 8 MB of storage space, an expensive but powerful and versatile device.

Palm OS or Microsoft CE?

More than 80% of all handheld devices currently operate with the Palm

operating system. Software titles are more abundant for Palm OS than for Microsoft CE based devices. However, obviously, the Microsoft CE products integrate more tightly with Microsoft desktop software. In addition, Microsoft CE can run more complex application software. The Compaq iPAQ 3635 Pocket PC showcases the capabilities of Windows CE nicely, and is definitely worth a look. However, the software I will discuss in the next sections is not currently available for that platform.

Graffiti: Every doctor does his own

One of the things that is a relative turn off in the handheld world is data entry. Graffiti is a type of hieroglyphics that must be learned and increases handwriting recognition to 99%. Alternatively, a small stylus is used to pick letters from the screen. None of that works when you need to scribble a little note in a hurry while you are holding your cell phone in one hand and the PDA in the other. If there would only be some electronic scratch paper... Well there is: The BugMe program (bugme.net). All my scratch notes are in one space and I don't lose little bits and pieces anymore. I just use the stylus to scribble a little note and it stays on my PDA until I delete it. I could even instruct the program to remind me (bug me) that I have to attend to these notes, but I don't use that feature.

ZapBill: Your electronic charge ticket

There is nothing wrong with little paper slips or super bills but a PDA based charge capture system is worth a look if it can help eliminate steps in your billing process. Compliance issues require a more active role of the

physician in CPT and ICD coding. Eventually, charge capture will occur at the point of service, of course, with a PDA. The charges will be transmitted in real time to the billing program for verification of subscriber data and consistency and then be electronically submitted to the insurances. Full implementation of such a system for a large group practice is a daunting task. One way to make this easier and to gain experience could consist of a smaller scale trial with selected providers only. There is certainly enough available to get started now. The ZapBill program (www.zapmed.com) has a lot of functionality and is inexpensive. It integrates with Palm appointment books and thus eliminates duplicate data entry.

CME on the AvantGo

Serious users of handheld PDAs synchronize data on their handheld with a desktop on a regular basis (syncing in PDA lingo). It is possible, of course, to sync the handheld with data on a website, for example, a scheduling website or one with third party content, such as AvantGo (www.avantgo.com). This is where it becomes interesting: What if you could study current journal abstracts on your handheld when you have some unexpected downtime? Check out www.handheldMD.com and see what is available; you will be surprised.

Avoiding medication errors with epocrates

It is estimated that about one third or more of medication errors originate with the prescriber. Epocrates is a truly useful, well-done and comprehensive free drug database for your PDA. You will love it. It is self-updating (works via the hot-sync operation) and allows to check interactions between multiple

See "Handheld" page 18

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Controlling the spread of HIV

We are at a crucial time now as we address the spread of the HIV virus in our community. Many measures and half measures have been taken to try to



Federico Cruz-Uribe, MD

stop the epidemic. The track record for public health, during the epidemic, has been spotty. We have vacillated between taking a more aggressive

traditional disease control approach of identification of the person with the virus and notifying partners, and following the lead of the bigger metro areas that stressed education both of the general public and targeting high-risk groups. Resources are tight. The virus continues to spread. There is no cure. There is no known vaccine.

For many patients, the *cocktails* have slowed the disease's progression. But there is increasing resistance and serious compliance problems for a large percent of patients. There is a hope that AIDS can become a manageable chronic disease. But, we are not there yet.

There are concrete steps we can take now to get in front of the epidemic here in Pierce County. We know the types of behaviors that put people at risk. We know who needs to be tested. We have the disease control structure in place at the Health Department to handle all the HIV positive patients identified.

But they are not getting tested!

Our structure is basic and means for each HIV positive patient:

- 1) The individual is assessed
- 2) S/he is referred into care
- 3) Partner notification is done to see who else was exposed
- 4) Case management is provided to follow the patient over time (as long as they are infected) to assist them to not spread the virus.

Critical to making this approach work is to know who is positive. The two important groups to reach are:

- 1) **persons with multiple sex partners**
- 2) **heavy drug users, especially intravenous drug users (IDU).**

In a nutshell, how do we systematically approach and test these individuals? Many of those most needing testing are mistrustful of the system and feel stigma attached to knowing their status. But, they still need to be tested so that we can implement the process outlined above.

The Health Department recommends three strategies to test as many high risk people as possible. These are:

- 1) Test all inmates of our Pierce County jail, who are arrested on drug- and sex-related charges
- 2) Test all patients who come into a healthcare provider's office with the symptoms of a sexually transmitted disease (STD)
- 3) Require all pregnant women to be tested for HIV as a routine part of their prenatal care.

I ask for your support on all three recommendations, and specifically (since they will impact your work) on the second and third proposals. Testing every person with symptoms of a sexually transmitted disease is essential to our disease control measures. Each and every person at high risk needs to be identified and worked with. Our public

The Tacoma-Pierce County Board of Health will soon consider a resolution on controlling the spread of HIV. Elements of the resolution include requiring the testing for HIV of:

- *All inmates of the Pierce County jail who are arrested on drug- and sex-related charges*
- *All patients in who have symptoms of a sexually transmitted disease and are seen by a Pierce County healthcare provider*
- *All pregnant women, as part of their routine prenatal care*

All providers are encouraged to participate in the public discussion. Call Federico Cruz-Uribe, MD, MPH, for date and time of the meeting. (235) 798-2853.

health system is ready to do this! But, we cannot be successful without your active support.

This fall, we will make these recommendations to the Board of Health for approval. As the issue moves forward for public discussion, I hope that you will participate and help us to confirm these advances in the effort to control the spread of HIV in our community. ■

Medical Practice Survey 2001 - Response is critically important

The Medical Practice Data Project will be instrumental in successfully educating the news media and the general public about the deteriorating medical practice environment in Washington State. The project is important to the economic survival of medical practices statewide. No other survey or project collects this level of detailed data on Washington's medical practices. The results are vital to support work in the public policy arena as well as with the news media.

Last year's project, commissioned by the Washington State Medical-Education and Research Foundation directed a team of analysts from the UW and WSU to examine the evidence regarding financial, administrative and other pressures that negatively affect financial viability of medical practices. Last year's most important findings

were:

- A declining share of health care spending going to medical practices
- Slower growth in expenditures for public health insurance, and increasing budget constraints
- Rising premiums and growing instability in health insurance markets
- Many uninsured in Washington State, impeding access to care

Please complete your survey for this year and return it today!! Far too many of Washington's medical practices have still not completed the survey questionnaire for the 2001 Medical Practice Data Project. Please don't place the entire project in jeopardy by not responding.

PHYSICIANS: Take a moment to ask your practice manager if he or she has received, completed and re-

turned the Medical Practice Economic Survey Questionnaire. If your practice has not received or cannot locate the survey questionnaire, please call the Washington State University Research Center at 1-800-833-0867 to obtain a replacement copy.

PRACTICE MANAGERS:

Please plan on time to complete the Survey Questionnaire. If you have any specific questions on how to complete the questionnaire, please call Bob Perna at the Washington State Medical Association Seattle office, 1-800-552-0612 or email rjp@wsma.org.

THINK ABOUT IT: This project is critically important to the survival of many (maybe your own) medical practices. The results are absolutely necessary for continued work on the economic viability of medical practices in our state. ■

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In My Opinion....

by Cordell Bahn, MD

The Phone Message

As a retired surgeon who is only a few years senior to **Dr. Stan Harris** (PCMS *Bulletin*, September 2001), a reflection of my own origins, career and present attitudes leads me to a similar view on the present state of collegiality in our profession. A phone *message*, rather than a call, is central to this essay.

One of my father's best friends was our family doctor and school physician. I spent hundreds of hours talking with this man about his life, walking the orchards and woods of his farm with him and sitting in his school office, listening to countless stories of wintry house calls, late night vigils and home deliveries, and being "always on call," like Stan's dad. I also counted him as a best friend, and was likewise saddened to watch him deteriorate into near-total blindness and cardiac disability.

Later, as an orderly in our community hospital, I got to know the physicians in our town. I would have lunch with them, make rounds with them and watch them operate. Their relations with one another as well as the nurses' attitudes about them were cardinal issues in my later decision to go into medicine.

Medicare had not yet been enacted in my later pre-medical and medical school days. My parents, both elderly in that time, began to need general medical and specialist help from our local doctors. I don't think they were

ever billed over those years for numerous visits, and with each request to the physician for a bill for services rendered, they were told "our doctors helped me and my family when I was in medical school and I'm just passing it along."

I was never able to identify any of my patients as medical students or parents of medical students but I was fortunate to have several physicians or their family members as patients in Tacoma and Bend, Oregon. I never billed them for my services beyond whatever their insurance covered, even into the period of disgraceful reimbursement of the late '90s.

What am I coming to here? Simply that it is a changed practice culture that Dr. Harris and I have chosen to leave, probably in both of our cases several years before we had to. I began my Tacoma career debt-free, and the tax laws favored a degree of enterprise which allowed me to accomplish retirement at the right time. I had been fairly compensated for my work, largely by a Medical Bureau (PCMB) that I helped manage.

As I move unavoidably into the status of health care recipient from health care provider, I believe the practitioners that I depend upon now or will do so in the future were not as lucky, and I'm willing to spot them the unanswered calls, exasperating as that is, if they are eventually there to



Cordell Bahn, MD

take care of me and those I love. As to the billing - above what paltry Medicare allows - I'll understand. It is harder for you to get here than it was for me.

Back to "The Message." I think I saw it coming shortly after I returned from practicing in Bend in 1992. The general and internal medicine offices where I rented space changed their phone message greeting to the very uptown "Thank you for your call, our doctors are busy with other *customers*. Please stay on the line." The manager for these younger physicians around me had decided upon this greeting as more in line with the day's business environment of medicine and it had been accepted without complaint. At that same time, I realized that my years of deep satisfaction in my work along with personal recognition and reward for the effort, were indeed numbered. ■

Directory Changes

Please make note of the following changes to your 2001 PCMS Directory

Lon Annett, MD

Change office address to:
1812 S J St #210, Tacoma WA 98405

Duncan Baer, MD

Change office address to:
2202 S Cedar #100, Tacoma WA 98405

Richard Bowe, MD

Change office address to:
2202 S Cedar #100, Tacoma WA 98405

Dean Field, MD

Change office phone # to: 858-9192

Martin Goldsmith, MD

Change fax # to: 403-7921

John Goodin, MD

Change office address to:
2202 S Cedar #100, Tacoma WA 98405

Gregg Ostergren, DO

Change office phone # to: 403-8740
Fax: 403-8741
Physician Only: 403-8739

Joseph Pham, MD

Change office address to:
2202 S Cedar #100, Tacoma WA 98405

Henry Retailiau, MD

Change office phone # to: 403-7199
Fax: 403-7196

Maan Salloum, MD

Change fax # to: 952-7987

Wendel Smith, MD

Change office address to:
1812 S J St #210, Tacoma WA 98405

Kevin Sullivan, MD

Change office phone # to: 858-9192

Gail Venuto, MD

Change office phone # to: 858-9192

Christopher Young, MD

Change fax # to: 435-9318

New Fee Schedule for Searching and Duplicating Medical Records

A rules hearing was held on July 10, 2001, for the purpose of amending WAC 246-08-400, fees for searching and duplicating medical records. Every two years the Department of Health is required to adjust the fee that medical providers may charge for searching and duplicating records. The adjustment is based on the change in the consumer price index for all consumers for the Seattle/Tacoma area.

Fees for copying were adjusted to:

- **Eighty-three cents per page for the first thirty pages**
- **Sixty-three cents per page for all additional pages**
- **The provider can charge a nineteen-dollar clerical fee for searching and handling records**

This rule is effective August 20, 2001 through June 30, 2003. If you have any questions, please contact Yvette Lenz at (360) 236-4606. ■

Business Examiner offers special subscription rates

The Business Examiner newspaper is offering special discounted subscription rates to members of the Pierce County Medical Society. A one-year subscription which would normally cost \$36 is being offered at \$25. Special two and three-year subscriptions are also available.

If you are interested in subscribing the Business Examiner, please contact the PCMS office (572-3667) and we can mail you the subscription form. ■



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In My Opinion....The Invisible Hand

by Andrew Statson, MD

Professionalism and Commercialism

"There are two fools in every market, the one who asks too little and the one who asks too much."

Russian proverb



Andrew Statson, MD

Several leaders of our profession have spoken against commercialism in the practice of medicine. The essence of their comments was their objection to using financial considerations as the basis for medical decisions. *Obstetrics and Gynecology* carried an article on professionalism in its July issue. I suspect the concern expressed in these statements has to do with the goals of treatment. The question is whether the treatment should aim to palliate symptoms at the lowest possible cost, while resulting in a lower quality of life and a more significant limitation of function than could be achieved by more expensive means. One example would be the treatment of hernia with a surgical repair or with a truss. The former would restore the patient to normal activity, the latter would relieve some of the discomfort, but the physical activity of the patient would remain significantly limited.

First, I'll discuss commercialism. It is defined as an approach which puts the stress on profit, without concern about quality or service. It is frequently called crass and associated with the term unbridled capitalism.

There is no doubt that many people in business and elsewhere have an inflated notion concerning the value of their products or services. In a free market, they are rapidly deflated to size. Before IBM entered the personal computer market, the indisputable leader was Apple Computer Co. Visicalc was a program that made it very attractive. It was developed by two programmers in about six months.

It helped sell Apple computers, and Apple computers helped sell Visicalc. Both were priced quite high relative to the cost of production and gave a high return on investment. In addition, Apple made its computer architecture proprietary, which excluded any competition. Neither company considered what the cost of entry into the business by other companies would be.

When IBM introduced its PC, it inadvertently made the right decision by opening the architecture. Within one year the market took off with the support of the clones and left Apple in the dust. Several other calc programs appeared as well and Visicalc became history. Apple tried to fight back, but lost and is now just limping along. IBM was stunned by the success of its PC, decided that it had a good thing going and thought it would be able to corner the market and get the competition out. To that end, it developed a significant improvement to the PC with the Microchannel bus and the OS/2 system. In order to keep the market to itself, it made both proprietary. As a result, the market pulled the rug out from under it.

It is easy for someone who has created a market to believe that he owns it, just as parents sometimes believe that they own the children they have created. Wrong. Children belong to themselves, and so do markets.

Sony made the same mistake when it developed the Beta format for videotapes. It had come out with the VHS first, made it open and, of course, had many competitors. It thought it was big

enough to corner the market and get rid of the competition. It fell flat on its face. Had it made the platform open, it is possible that manufacturers would have produced video recorders with both tape capabilities until the Beta format proved itself superior and took over the market, just as the 3 1/2 inch floppy eventually displaced the 5 1/4 inch format in computers.

Phillips had a different approach when it developed the tape cassette. It opened the platform to all comers. Some people said that it made a mistake and should have kept it proprietary. Perhaps, but the result was such a huge market, that Phillips probably sold many more recorders and tapes than it would have otherwise. At the same time, the proprietary 8-track cartridge faded away.

Most big companies that thought they were strong enough to control the market have had the same experience. Even though profit is the goal of any business enterprise, no business can survive by shortchanging its customers. If it does not deliver good quality products and services, it will not make it in the marketplace. Only a government monopoly can continue to exist regardless of the sort of service it provides, but even then, not forever. No private park, not even Disneyland or Sea World, could continue to exist if it al-

See "Professionalism" page 12

Professionalism

from page 11

lowed on its premises the level of security, perhaps I should say insecurity, we have in our public parks. Commercialism without concern about the quality of its products and services leads nowhere. It is self-destructive. It is the fool who asks too much. To quote Alan Abelson as he paraphrased Dorothy Parker, "Time wounds all heels."

When Henry Ford came out with his Model T, he charged his customers less and paid his workers more than any other car manufacturer of that time. When he became complacent, General Motors overtook Ford by introducing a variety of styles and colors. When the American industry fell asleep at the wheel, it was rudely awakened by the Japanese and VW.

In their efforts to cut down costs, the large employers were the strongest proponents of managed care. Unfortunately, they did not pay enough attention to the discontent of the workers with their health care coverage. The employees had to turn to the politicians for redress and the current backlash against managed care became a political, rather than an economic battle, resulting in a higher cost for everyone.

Professionalism, on the contrary, is defined as stressing service and is not concerned about profit. It is frequently qualified as altruistic. Professionals are people in some service businesses. They are expected to give their services even to people who are unable to pay for them. In this respect, and particularly in the medical profession, it has the features of the priesthood.

In the current economic environment, this is done less and less. When we are barely able to cover our expenses, we are not in a good position to give away our services at no

charge. Some of our leaders have decried this change. It has been the tradition of the medical profession to take care of the poor without expecting payment. How come we don't want to do it any longer?

Physicians who practiced during the Great Depression related that they frequently treated patients who had no money, but were able to pay them in kind. They would get a chicken, a dozen eggs, a slab of meat, a basket of fruit or vegetables, whatever the patient could afford to give them. However, when they treated patients who could pay, they charged and received their full fee.

In the past, we considered it our obligation to take care of the poor, since overall we were properly paid for our services. At present, we are squeezed dry. We have no more left to give. During the past 15 years, our incomes have dropped by more than 50%. At the rate we are paid now, we are barely able to meet our overhead. To those of our leaders who want us to return to our professionalism by asking that we be paid what our services are worth, I want to express my deep gratitude.

If any among them would want us to return to our professionalism without regard to our reduced income, I would be presumptuous enough to speak in the name of most of my colleagues and say to them, "We have an offer to make you. Hand us over half of your paychecks and we will provide to the poor all the care that your money will buy. It is only fair. Our income has dropped by half, let yours do the same."

In the marketplace, we seldom hear about the fools who ask too little. They quietly fade away. Unfortunately, it looks like that is what is happening to our profession. ■

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

Setting it Straight

A sentence was inadvertently omitted from Dr. Patrice Stevenson's President Page in the September *Bulletin*, explaining Dr. Mike Kelly's report to Congressman Adam Smith about coding complex office visits. The corrected paragraph shows the omitted portion in **bold** text.

"Now already running behind, he doesn't have the additional time to adequately document the encounter to pass the scrutiny of "the Medicare Police" so he ends up "down coding" **the visit to be on the safe side. Repeat this scenario multiple times a day and physicians end up over worked and under compensated. I have also read of the dangers of "down coding"** as a potential source of increased utilization of services resulting in higher overall health care expenditures."

PCMS apologizes to Dr. Stevenson and Dr. Kelly for the error. ■

In My Opinion.....

by Daisy Puracal, MD

My Journey Through Menopause

Menopause has been viewed as the onset of aging. Cartoons and jokes abound making fun of the menopausal woman. Is it any wonder that millions of dollars are being spent to staunch this tide to keep menopause and aging at bay? Part of this movement is potentiated and supported by the medical profession touting hormone replacement therapy as preserving the youthful nature of skin and mucus membranes (in addition to the other benefits).

As I transitioned through menopause, I came to this crossroad with all the fears of growing old. The current thinking was strongly supportive of HRT (hormone replacement therapy). So I tried estrogens, but in spite of reducing the doses to even a tenth of the recommended dose, I found I could not tolerate the medication. I felt "cloudy," not myself, as if I needed to "get out from under." I knew HRT was not for me.

I felt I needed a new paradigm to deal with and understand what was happening to me. In my search I read Nietzsche's writings where he talks of the three metamorphoses of the spirit...the stages of the camel, the lion and the child. The camel is the stage of life where knowledge is "loaded" or piled onto one - the growing up or student stage. The lion that conquers and fights with the dragons is the adult achiever, focused on home, family and work, getting on with life. The last state is back to the child - a new beginning, a first movement, a sacred "yes" to the universe. The spirit now comes into her/his own and goes inward to conquer her/his own world. The meno-

pause for me is the threshold for this new dimension - time for myself after the children are gone and the "sowing and reaping" are done.

Similarly, Jung talks about the lifetime being divided into two: the first half is the time for relationships and the second half for following the "Marga" (path) or finding the sense of life within, without care for achievement or prestige.

"In primitive tribes, we observe that the old people are almost always the guardians of the mysteries and the laws. And it is in these that the cultural heritage of the tribe is expressed." - Jung

In tribal cultures, women achieved increased power and wisdom after the menopause and became high priestesses or attained "elder status."

I looked into the physiology of the hormonal changes in the lifetime of a woman. I came up with some interesting revelations. Looking at FSH/LH levels during the lifespan of a human being we note a peak during the second trimester of fetal life, another peak during the first six months of the neonatal period, and then regular rhythmic elevations corresponding to ovulation during the reproductive years. Each of these elevations is associated with tremendous changes and is of momentous significance. The young adolescent girl goes through body, mood and menstrual changes much like the perimenopausal woman. Yet we do not stop these changes in the adolescent knowing what is in store for her.

During menopause and thereafter FSH/LH levels increase. But this increase, we were taught, is a secondary



Daisy Puracal, MD

response related to the deteriorating ovarian function. No studies have been done to research the function of FSH/LH after the reproductive years. Could it be that these hormones have a role to play in the larger scheme of life? Could it be that these are wisdom hormones? (A concept touched on by Christiane Northrup, MD and others.) Could we be doing humanity an injustice by suppressing these hormones with estrogens and robbing future generations of the wisdom of the ages? (Note that similar FSH/LH elevations are seen in males of the same age.)

With this in mind I designed a questionnaire to compare spiritual growth as an end-point of wisdom amongst users and non-users of HRT.

I interviewed 13 postmenopausal women (ages 52-68), six of them being HRT and the rest not. No meaningful statistical conclusions can be drawn from this small study, but subjectively I felt that the women who were non-users exhibited a deeper level of individuation and social commitment than users. Even if this may be a biased opinion, this issue definitely needs more research.

I have not personally used the "natural" hormones such as soy products and Dong Quai, although anecdotally some women have had good results with these. We do not know if these products would have a similar effect on

See "Menopause" page 14

Menopause from page 13

FSH/LH levels. We do need to be cautious with these however, in view of the stilbestrol experience and because of the higher incidence of uterine cancer in Orientals.

I present this not to discount the use of estrogens, but rather to present an alternate viewpoint to give women choices to navigate this period of their life. As for me, I now view this time of my life as a wonderful rite of passage taking comfort in the fact that this is a natural process and not pathological. This is a time for me to cultivate creativity and spiritual growth. The symptoms of menopause are insignificant as I look toward greater spiritual fulfillment and I welcome PMZ (postmenopausal zest)!! ■

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“Mary Bridge emergency crunch mirrors nationwide crisis”

Editor's Note: This editorial, by PCMS President Patrice Stevenson, MD appeared on the editorial page of The News Tribune, 9/16/01

While aptly reporting on the surgeon scarcity affecting care at Mary Bridge Children's Hospital, Sandi Doughton (TNT, 9-2) failed to mention that this problem is not new nor unique to Tacoma.

U.S. News and *World Report's* Sept. 10 cover story, “Crisis in the ER,” outlines a “national emergency” created by a demand for health care without adequate resources to provide it.

For example, hospitals in Virginia are often on “reroute,” meaning ambulances just drive on by. Massachusetts in investigating a death from an asthma attack that happened because the hospital diverted the ambulance. A California hospital lost three lives from delayed dialysis treatments.

Long waits, major frustration and fear abound, even at nationally renowned hospitals like Johns Hopkins Hospital, University of California at San Francisco Medical Center and Cleveland Clinic - where ambulances were on reroute 50 percent of the time. Insurance doesn't help, status doesn't help, wealth doesn't help. When there is not a bed and not a nurse or doctor, you don't get care.

The problem is complex and is caused by myriad factors. Emergency room visits are rising sharply as the vast number of uninsured seek care in emergency rooms. Supply has been reined in

as hospitals have decreased beds and have been forced to operate, like doctors, on decreased Medicare and Medicaid reimbursements that used to be reasonable enough to provide care for those unable to pay.

Attracting physicians is difficult, in some specialties impossible, with increased paperwork, federal regulations and reimbursements cut so low it's difficult meeting overhead expenses. Commercial insurers have squeezed reimbursements and taken advantage of physicians' inability to say no to contracts that don't adequately reimburse

worrying about “not working too many hours and having enough compensation.” In our state, private medical practices lost an average of \$95,000 last year, they are taking out loans to meet payroll; they are turning away Medicare and Medicaid patients, and in some cases they are even shutting their doors.

In California, 25 percent of medical practices are on the brink of bankruptcy, according to the *Los Angeles Times*. Physicians' workweeks have increased tremendously due to paperwork requirements, and many in this

U.S. News and World Report's Sept. 10 cover story, “Crisis in the ER,” outlines a “national emergency” created by a demand for health care without adequate resources to provide it.

them.

To add insult to injury, the government not only expects doctors to take care of the poorest patients at below cost reimbursement rates, but hassles them about fraud and abuse for doing so.

Carrie Whalen's Sept. 6 letter to the editor chides physicians for only

state are working more than 70 hours per week.

They have had to hire additional staff to comply with paperwork and referral requirements of government and commercial payers, with no additional revenue to offset the expense.

No physician went to medical school because they really wanted to be a small business owner, but unfortunately that is what they have become. It is not surprising that our best and brightest are retiring at earlier ages than ever, seeking new careers and not encouraging anyone they know, particularly their children, to enter their once-beloved profession.

It's hard to fathom that our country, with state-of-the-art technology, the world's best physicians and nurses and the ability to provide the finest medical care, is on the brink of disaster. ■

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Save The Date

The Edwin C. Yoder Honor Lectures

Friday, November 16, 2001

This year, our Yoder presenters are Stephen M. Ostroff, MD who is the Associate Director for Epidemiologic Science at the CDC and Colonel Edward M. Eitzen, MD who is the Commander of the U. S. Army Medical Research Institute of Infectious Diseases. The topic of this program is bioterrorism and emerging infectious diseases. Dr. Ostroff will discuss emerging infectious disease threats in the USA. Dr. Eitzen will discuss the medical effects of biological agents and the management of biological injuries.

This program is designed for physicians and is accredited for 2.0 Category 1 hours.

Location:	St. Joseph Medical Center - Rooms 1ABC
Schedule:	Please note the change in the program schedule this year. Based on your feedback, we are attempting to start the program later in the day to minimize your time away from the office.
2:00 - 3:00 PM	Social Hour with hors d'oeuvres and wine
3:00 - 4:00 PM	<i>"Emerging Infections of the New Millennium"</i> Stephen Ostroff, MD
4:00 - 4:15 PM	Break
4:15 - 5:15 PM	<i>"Bioterrorism: Reality and Response"</i> Colonel Edward M. Eitzen, Jr., MD

Reservations required. Limited seating. Please call in your reservation no later than Thursday, November 8th

Invitations will be mailed in October. For reservations, call
The FHS Office of Academic Affairs at (253) 207-6035.

"CHI-W/FHS Academic Affairs is accredited by the Washington State Medical Association CME Accreditation Committee to sponsor continuing medical education for physicians. CHI-W/FHS Academic Affairs designates this educational activity for a maximum of 2 hours in Category 1 to satisfy the relicensure requirements of the Washington State Medical Quality Assurance Commission and the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity."

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ID Update set for November 2 at the La Quinta Inn This Year

Mental Health CME set for December 7

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The complimentary program, directed by **David Law, MD** offers 6 Category I CME credits.

A program brochure will be mailed in October. ■

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The annual Infectious Diseases Update is set for Friday, November 2, 2001. The very popular course will be held this year at the **La Quinta Hotel**.

The program is directed by **Jim DeMaio, MD** and will feature nationally known expert Dr. Charles Stratton joining Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections.

This year's program includes presentations on:

- Hepatitis C: You and Me
- The Man in the Blue Suit
- HIV for the Primary Care Physician
- Antibiotic Resistance
- Antibiotic Resistance in Pierce County
- Infection Prevention
- Advances and Retreats in Infectious Diseases
- Mad Cow Disease: Is it Here?
- Infections in the IV Drug User ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, October 5	Common Office Problems	Mark Craddock, MD
Friday, November 2	Infectious Diseases Update	James DeMaio, MD
Friday, December 7	Medicine & Mental Health	David Law, MD
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Handheld

from page 6

drugs. Point your browser to www.epocrates.com.

Avoiding trouble with the Organization formerly known as HCFA

The coding of evaluation and management services is a major headache. Of course, the medical Palm community has come up with an answer, the STAT E&M coder. This is a program that can be used concurrently during dictation of the visit note. Elements of the 1997 HCFA documentation guidelines are checked off as one dictates along and the currently reached CPT level is indicated. I bet that after several months of using it the prompts are no longer required and the program has outlived its usefulness. A trial version is available for download at www.statcoder.com.

Anatomy on your PDA

I have a schematic of the liver, gallbladder, bile ducts and pancreas on my handheld, which is useful for patient education or obtaining informed consent for ERCPs. I use a program called FireViewer for image display. I have to admit that images on most handhelds are less than awe-inspiring. The above-mentioned iPAQ is an exception. Recently a stunning anatomy suite was released that really looks good on this Windows CE based device.

Crashes, Hackers and the Future

The PDA culture in 2001 resembles, to a certain extent, that of the Internet in 1995 when large scale adoption in the business community was just around the corner. Popular programs are still written by amateurs and some-

times crash unexpectedly. The Palm OS almost always recovers gracefully, though. Backups (hot syncs) prevent data loss. Palm OS extension programs carry such colorful titles as Hackmaster, which must send chills down the spine of directors of hospital IS departments. Some of the most useful programs (ZapBill) require some tinkering by the end user before they become fully functional (i.e., populate databases with CPT and ICD codes). Eventually, the Palm OS will probably go the way of Netscape and the amateur developers will turn to new ventures. However, PDAs can boost your productivity now and the upfront investment is small. ■

Reprinted from Spokane County Medical Society's monthly newsletter, "The Message"

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If you or anyone you know is interested in providing a home for Norman, please call Tanya at the Medical Society office. 572-3667. ■

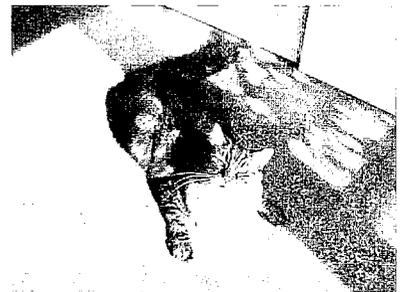
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BULLETIN

Pierce County Medical Society



November, 2001



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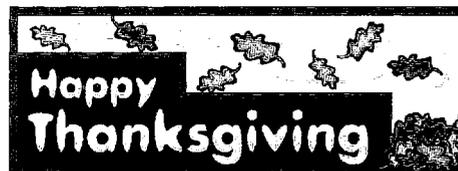
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Pierce County Medical Society

BULLETIN



November, 2001



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The Bulletin is published monthly by PCMS
 Membership Benefits, Inc. Deadline for submitting articles
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Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
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President's Page

by Patrice Stevenson, MD

Focus



Patrice Stevenson, MD
President

In his inaugural address, incoming WSMA President Sam Cullison, MD emphasized the need for focus in the next year. In fact, focus was his top three priorities for the year. He meant this for physicians individually and for the house of medicine collectively.

In tough economic times our focus needs to sharpen from the telephoto lens to the close up. We need to be sure things are in order and running as efficiently as possible in our office as well as in our medical organizations as there is simply no more slack in the system. We can only work so much harder, so to improve practice economics we focus on the essentials and the non-essential niceties go by the way side. This could be from stopping offering free coffee in the office waiting room to dropping professional society memberships. It is an unwritten goal of PCMS and WSMA to be considered an essential professional business expense to our members.

While most physicians abhor the business side of medical practice, the recent economic downturn forces us to pay attention to these details. We have been shocked by the economic failures of long term institutions such as the Memorial Clinic in Olympia. Many hospitals are currently in the red or running on the narrowest of margins. I've re-

cently had several patients who have lost primary care and specialist physicians to out-of-state moves. One woman lamented that she had had the same doctor growing up and in the past five years has had to change primary care physicians four times due to practices dropping her insurance or moving.

I still think it is a long time coming until the public understands the true economic pressures of providing the type of medical care they want, expect and demand. Quality care is a given expectation of providers, payers and patients. Quality costs. All I have read about medical economics is in the most negative of terms...skyrocketing costs, the drain on businesses and individuals to pay for it, cost centers and burgeoning administrative expenses. People expect health as a baseline but do not like to pay for it.

It was mentioned at the WSMA meeting that Regence had paid more out in massage therapy benefits than for chemotherapy! This tells me that patients want "satisfying" care more than "quality" care. Satisfying does not necessarily mean satisfactory. Satisfying care to one patient may be receiving cutting edge diagnostic evaluation and treatment while to another it is low tech but high touch, such as massage

therapy.

Focus is not an easy task with the multitude of things demanding our time and attention. It is easy to get chronically distracted and become disorganized and drained. Ideally we should go from one patient to the next or one task to the next in a chain of focused and productive efforts. We could then go home and be focused there and return to work the next day refreshed and ready to focus again. Unfortunately I have not figured out how to do this in 16 years of practice. For those of you who have achieved this ability, please share your wisdom!

At least for PCMS we are fortunate to have efficient and focused staff to help in our efforts. Our newly created membership committee chaired by **President-Elect Susan Salo, MD** is working toward a better understanding of the wants, needs and desires of the membership. We want you to be satisfied that you got your money's worth for your investment in PCMS. ■

Pierce County physicians participate in WSMA policy making

The Annual Meeting of the Washington State Medical Association, held in Portland, set the work goals and priorities for physicians and staff for 2002. The meeting was held September 21-23, just ten days after terrorists attacked the United States. No doubt, the incident had an impact on those attending the meeting, and perhaps, even contributed to the less contentious, more uniform decisions made by delegates.

The attack also prompted discussion regarding the need for coordination in response to terrorist activities. A resolution was passed directing the WSMA to coordinate with existing national, state and local disaster agencies a response system to mobilize all physicians and medical students to volunteer assistance in the event of a disaster in Washington state. This would include bio-terrorism, chemical exposures, radiation and/or mass casualties.

Delegates also directed the WSMA to continue its work to support a market-based approach to the deteriorating delivery system and to work with the Washington Healthcare Forum Services to seek tangible and meaningful administrative simplifications for medical practices. Specific actions to restore the state's health care delivery system include:

- Seeking increases in the state's Medicaid program so that it reimburses medical practices at today's Medicare rates.
- Advocating for more affordable "bare bones" health insurance, including the repeal of mandates that currently require a variety of non-essential benefits and providers of services.

- Creation of incentives to encourage citizens to obtain insurance coverage and promotion of "needs testing" so that society ensures access to coverage for low-income citizens.
- Support of federal legislation to:
 - Create fully refundable tax credits for individuals who buy health insurance in the individual insurance market.
 - Elimination of the cap under federal law on the amount of Medical Savings Accounts given preferential tax treatment.
 - Creation of more balance in the private marketplace between insurers and physicians and other providers of care.
- Support of legislation to eliminate the Business & Occupation (B&O) Tax on revenues that medical practices receive from public payers such as Medicare, Medicaid and the Basic Health Plan.

The House also accepted Report H, WSMA Organization Priorities, including adoptions of resolves that included reaffirming the overriding organizational value statement that:

"Regardless of specialty or practice setting we remain, at our core, physicians. The WSMA represents and advocates for all physicians who are - and must be - responsible and accountable for medical decision-making, and promotes the health of all Washingtonians."

The report calls for WSMA resources to be focused on the following organizational priorities:

- Preserve and promote the viability of medical practices in Washington State.
- Promote the health of the public.
- Maintaining and building medical practice revenue whenever and by whatever means possible.
- Promoting quality care, patient safety and physician accountability.
- Maintaining the WSMA's viability - economically, as the "place to come" for physician support and assistance, and as an information/understanding resource.

Attending this year's meeting for Pierce County were Board of Trustees members:

Patrice Stevenson, MD
Charles Weatherby, MD
Susan Salo, MD
Sabrina Benjamin, MD
Steve Duncan, MD
Ken Feucht, MD
Sumner Schoenike, MD

Alternate Delegates included:

Federico Cruz-Uribe, MD
George Tanbara, MD
Cecil Snodgrass, MD
Ron Morris, MD

AMA/WSMA/Specialty Society Reps included:

Len Alenick, MD
David Law, MD
Nick Rajacich, MD
Don Russell, DO
Richard Hawkins, MD
David BeMiller, MD

October General Membership Meeting

by Jean Borst

Embezzlement... The Medical Practice's 'Dirty Little Secret'

Dr. Jeff Nacht shares his not-so-pleasant experience to help others

Close your eyes and imagine this...

You think your marriage and family life is great. There might be some bumps and problems, but for the most part, everything seems fine.

One day, you wake up and you find out your wife has left you, your house has been taken by the bank, your kids hate you, and all the money you had in the bank is gone. Then you realize that it isn't a divorce. It's your business. That person wasn't your wife; it was your employee. And he embezzled you.

It's shocking, unconscionable, illegal... and common. Embezzlement in the medical office might be thought of as just a "dirty little secret," but it's a prevalent issue that Pierce County physicians must be aware of.

This silent and financially draining crime is happening at medical offices across the nation and across the street. And, as victims of this white-collar crime can attest, it's difficult to discuss and admit. But, talking about the issue, sharing experiences, and working to prevent others from succumbing to this crime is the key. And that's why **Jeff Nacht, MD** brought his own experience to the forefront at the October 9 General Membership Meeting of the PCMS.

"This is a problem that is very much within our community," Dr. Nacht explained. "One-third of the physicians in this room will be embezzled. This is not a small problem."

What Happened to Our Office?

In an effort to bring a higher level of sports medicine to the community, Drs. Nacht and Greg Popich estab-

lished a practice in 1990, dedicated to the high school and small-college athlete. They originally considered a joint venture with St. Joseph's Hospital, and that's how they began their association with Francis Corey-Boulet. A vice president at St. Joe's, Corey-Boulet had excellent references, extensive management and planning experience, and came highly recommended by the hospital's president. Corey-Boulet came on as the medical office's manager.

The practice flourished, but its finances did not. "We realized very early that our projections weren't on target," Nacht said. "We did a lot of re-adjusting, but the problems kept occurring." As the practice grew, the problems remained. "We were struggling to pay bills, regardless of our growth. We were very busy, and didn't see the forest for the trees," he explained.

Things became increasingly shaky over the years, but their office manager always seemed to have an answer for their financial woes. The difficulties weren't ignored, however; the office was subjected to three separate audits over the years performed by the Department of Revenue, a partner's personal accountant, and St. Joe's accounting department. The audits revealed nothing out of the ordinary.

Significant developments occurred



Dr. Nacht (left) and his wife Gail, answered many questions after his talk at the October General Membership Meeting

in 1998. "Our wives started to talk to each other about the issue," Dr. Nacht recalls. His own wife, Gail, had an extensive business background and agreed to look at the state of the practice. At the same time, the bank called in their loan of several hundred thousand dollars and wanted immediate payment. (Unknown to Drs. Nacht and Popich, the bank had placed the offices' accounts into "special credits" because of numerous late payments.) "We knew we were having problems, and had been thinking about going back to St. Joe's and working on a joint venture. So, we approached the hospital and discussed our problems and the hospital agreed to pay off the loan and purchase a portion of the company. It was a solution for us, but it was a solution that was very hard for us to swallow."

Gail Nacht started discretely looking at the office's system. She examined the accounting system and bank

See "Embezzlement" page 14

Retired members dine with Bart Ripp, *The News Tribune* restaurant critic, at Fircrest Golf Club

Over sixty retired physicians and their guests met for lunch and visited with former colleagues at the October retired member luncheon at Fircrest Golf Club. And what a lunch it was. Attendees were delighted by the gourmet spread provided by Fircrest Golf Club in honor of the day's very special guest speaker.

PCMS Past-President, **Robert Florence, MD (1971)** moderated the program and asked for remembrance of physicians who had died since the August meeting. A moment of silence was held for **Drs. Ralph Huff, Edward McCabe and Bernard Rowen.**

Dr. Florence introduced the man of the hour, *The News Tribune's* restaurant critic, Bart Ripp, who spoke on "The World of Restaurant Criticism."

Mr. Ripp introduced his supervisor, Assistant Features Editor Linda Dahlstrom, who corroborated that Bart Ripp is truly his real name.

A lifelong sports and history buff, Mr. Ripp admitted that he did not seek to be a restaurant critic, nor even to be a journalist at all. "In fact," he confessed, "I don't have a journalism background. I never took journalism or even worked for my high school newspaper." However, in 1972, while attending the University of Iowa, "I became a sports writer," he said. His first article was on fellow student "Downtown" Freddy Brown, later of Seattle Sonics fame.

The following year he became a sports writer and general assignment reporter for a newspaper in Albuquerque. In 1985 his life changed when his editor said "you eat, you write. I want you to cover for the restaurant critic." "I begged for reassignment," he explained, but was denied. Knowing nothing about restaurant criticism and not enjoying it, he had to learn as he went along. "There are no courses in restaurant critiquing and no qualifications to be a critic," he said. Just eating and writing are what's required.

Mr. Ripp quickly became an Albuquerque celebrity with his face and name on billboards and buses. "Covering" for the restaurant critic had become a full-time job, bringing with it fame and fortune. It also brought little privacy.

Seeking a change, Mr. Ripp came to *The News Tribune* in 1989 under the guise of general assignment writer. However, it was a particular sample of his writing that won him the job, a restaurant review. He agreed to take the job under one condition, that he dine anonymously and without pictures or promotions. The Tribune agreed and it was then that he found his niche.

But dining anonymously soon proved to have its problems. Diners would identify themselves as Bart Ripp, something he never does. They would wine and dine without paying the tab, while the restaurants waited for a "review" that



Bart Ripp, center, with Dr. Robert Florence and his wife, Helen. Dr. Florence moderated the luncheon and introduced Bart Ripp as the guest speaker.



From left, Drs. Robert Florence, new retiree Surinderjit Singh and Ken Graham visit before lunch.

was never written. After many calls, the paper hired a private detective to track down the impersonator. He was charged with second-degree felony of "deceiving an innkeeper" and sentenced to perform community service.

In response to questions from the audience, Mr. Ripp did have some words of wisdom to ensure a pleasant dining experience. "Always ask what's fresh," he said, adding that the best day to dine is Thursday. "Chefs all work on Thursday when fresh food is delivered in preparation for a busy weekend," he explained.

He said that it's okay to send food back, but don't eat it and then complain. He suggests that the tip be equivalent to the experience. "It's okay to stiff but you should tell the manager why," he said. He also encouraged people to not lose sleep over a bad meal. His parting words were "it's just dinner!" ■



Pierce County Medical Society

invites you and your spouse or guest to the

2001 ANNUAL MEETING

**Tuesday, December 11, 2001
Sheraton Tacoma Hotel, Ballroom
1320 Broadway Plaza**

**Social Hour: 6:30 pm
Dinner: 7:00 pm
Program: 8:00 pm**

“Boomers to Busters - How Generations Relate”

a humorous and entertaining session

featuring

Marilyn Moats Kennedy

Business owner, author, career consultant and nationally-known speaker. Moats Kennedy is founder and managing partner of Career Strategies, a 24-year old consulting firm in Willmette, Illinois

♦Introduction of the 2002 Officers

♦Please bring an unwrapped toy (for a child) and/or a wrapped gift (for a woman) for YWCA Shelter residents

Please return before Friday, December 7 to: PCMS, 223 Tacoma Ave S, Tacoma, WA 98402. You may fax to 572-2470 or call 572-3667

Please reserve _____ dinner(s) at \$35 per person. Enclosed is my check for \$_____

Or, charge my credit card # _____ Expiration Date _____

Visa Mastercard Signature _____

My name for name tag: (please print or stamp) _____

My spouse/guest name for name tag: _____



**CITY OF PHILADELPHIA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF DISEASE CONTROL**

SUMMARY OF BIOLOGICAL WARFARE AGENTS

Agent	Clinical Syndrome	Incubation Period	Diagnostic Samples	Diagnostic Assay	Patient Isolation Precautions	Treatment	Post-exposure prophylaxis	Comments
Anthrax	Inhalational - febrile prodrome, resp distress, bacteremia, meningitis. CXR - wide mediastinum (Cutaneous ulcer, GI syndrome - less likely)	1-5 days (up to 42 days described)	Sputum, blood, CSF; stool, ulcer swab (BSL-2)	Gram stain, culture	Standard (no person to person transmission)	Cipro 400 mg IV q 8-12; doxycycline 200 mg IV then 100 mg IV q 8-12; penicillin 2 MU IV q 2h plus streptomycin 30 mg/kgIM q day	Cipro 500 BID x 4 wks plus vaccine, or doxycycline 100 mg BID plus vaccine	Vaccine schedule 0.5 ml SC at 0, 2, 4 wk and 6, 12, 18 mo, then annual boosters
Brucellosis	Febrile prodrome, osteoarticular disease, genitourinary infection, hepatitis; endocarditis and CNS involvement rarely	5-60 days, occasionally months	Serum; blood, bone marrow (BSL-2)	Serology; culture	Standard precautions; contact isolation if draining lesions	Doxycycline 200 mg/d po plus rifampin 600-900 mg/d po x 6wks	Doxycycline and rifampin for 3 wks if inadvertently inoculated	Trimethoprim-sulfamethoxazole can be substituted for rifampin, although 30% relapse rate
Plague	Pneumonic - fulminant pneumonia, septicemia; bubonic less likely	2-3 days	Blood, sputum, lymph node aspirate; serum (BSL-2/3)	Gram, Wright, Giemsa or FA stain; culture; Serology	Pneumonic - droplet precautions until patient treated for 3 days	Streptomycin 30 mg/kgIM q d in 2 divided doses x 10 days; gentamicin, doxycycline; chloramphenicol	Doxycycline 100 mg po q 12 h x 7 days; ciprofloxacin 500 mg po BID x 7 days	Vaccine not protective against pneumonic infection
Q fever	Fever, systemic symptoms, pneumonia, hepatosplenomegaly	10-40 days	Serum (BSL-2)	Serology	Standard precautions	Tetracycline 500 mg po QID x 5-7 days; doxycycline 100 mg po BID x 5-7 days	Doxycycline 100 mg po q 12 hrs x 14 days; tetracycline g/d po x 14 days	Vaccine available - investigational
Tularemia	Ulceroglandular, typhoidal (septicemic) - fever, weight loss, pneumonia	2-10 days	Serum; Blood, sputum, ulcer swab, lymph node aspirate (BSL-2/3)	Serology; Gram stain, culture	Standard precautions	Streptomycin 30 mg/kg IM x 10-14 days; gentamicin 3-5 mg/kg/day x 10-14 days	Doxycycline 100 mg po q 12 hrs x 14 days; tetracycline g/d po x 14 days	Transfer culture to BSL-3 after initial isolation of organism
Smallpox	Fever, systemic toxicity, vesicular rash with centrifugal distribution, lesions synchronous in stage of development	7-17 days	Pharyngeal swab, scab material (BSL-4)	ELISA, PCR, viral isolation	Airborne precautions	None (cidofovir effective in vitro)	Vaccine within 4 days of exposure, VIG (0.6 ml/kg IM within 3 days) if vaccine contraindicated	Pre-exposure and post-exposure vaccination recommended if > 3 yrs since last vaccination
Viral encephalides	VEE: fever, headache, malaise, photophobia, vomiting; WEE/EEE: febrile prodrome, somnolence, delirium	VEE 2-6 days; WEE/EEE 7-14 days	Serum; CSF (BSL-2)	Serology; Viral isolation	Standard precautions	Supportive	None	Vaccines available, although poorly immunogenic
Viral hemorrhagic fevers	Fever, myalgia, hypotension, hemorrhagic features	4-21 days	Serum; blood, formalin-fixed tissue biopsy (BSL-4)	Serology; Viral isolation, PCR, immunohistologic at detection of antigen in tissue	Contact precautions (consider additional precautions if massive hemorrhage)	Supportive; ribavirin for CCHF/arenaviruses; antibody passive for AHF, BHF, Lassa, CCHF	None	Aggressive management of hypotension, secondary infections
Botulinum	Ocular symptoms, skeletal muscle paralysis - symmetric, descending; respiratory failure	1-5 days	Nasal swab, serum, stool (BSL-2)	Antigen detection (toxin) - ELISA	Standard precautions	DOD heptavalent antitoxin serotypes A-G; CDC trivalent equine antitoxin serotypes A, B, E	None	Skin testing for hypersensitivity before equine antitoxin administration
Staphylococcal enterotoxin B	Fever, headache, cough, respiratory distress, GI symptoms	1-6 hours	Nasal swab, serum, urine (BSL-2)	Antigen detection (toxin) - ELISA; serology	Standard precautions	Supportive	None	Vomiting and diarrhea may occur if toxin is swallowed

Caution to a possible bioterrorist attack: single cases of disease due to uncommon, non-indigenous agents in patients with no history suggesting an explanation for illness; clusters of patients with similar syndrome with unusual characteristics (e.g., unusual age distribution) or unusually high morbidity and mortality; unexplained increase in the incidence of a common syndrome above seasonally-expected levels (e.g., increase in influenza-like illness during summer), or with negative tests for influenza and other respiratory viruses). Contact DDC at 215-685-6740 (215-685-1776 if after hours) to report suspected cases, access diagnostic testing or obtain more information.

The Tacoma Trauma Center: A Lesson in Cooperation

Lori Morgan, MD, Trauma Director, talks of successes and challenges that remain

Auto accidents, falls, gun shot wounds, burns, stabbings, blunt assaults. To the victims of traumatic injuries, seconds are precious and minutes can mean the difference between living and dying.

Recognizing the importance of providing the best care to the communities they serve, two hospitals have ensured that Pierce County residents have the quickest possible access to trauma care. On June 21 of last year, Tacoma General Hospital and St. Joseph Medical Center were jointly designated as adult Level II trauma centers serving Pierce County. The two locations alternate daily seeing trauma patients. (Madigan Army Medical Center is also a state-designate adult Level II trauma facility and operates concurrently 24 hours a day, seven days a week.) The cooperative effort was a coup for the community. Prior to the center's opening, Pierce County trauma victims were transported to Harborview Medical Center in Seattle. By offering trauma care closer to home, the chance of survival for critical cases improves dramatically.

Headed by **Lori Morgan, MD**, the core of the center is a staff of four surgeons board certified in general surgery and critical care, and six physician assistants, each of whom has completed PA surgical residencies and are extensively trained. But the success of the program goes way beyond the surgical team, as Dr. Morgan notes. "I see the surgeons and PAs as the final piece of the puzzle," she said. "We make it go, but we couldn't do it without the resources we have."

No "Typical" Days

"You just never know what might happen around here," said Dr. Morgan, in a much more understated tone

one might expect - her calm demeanor seems incongruous with her position. Not even the sudden demise of her Palm Pilot appears to shake her. Dr. Morgan recently took a short time out (literally between traumas) to reflect on the trauma unit's first year in operation. While the fledgling center is only 13 months old, there seem to be relatively few growing pains.

Dr. Morgan joined Tacoma General Hospital one month before the center opened. She recalls the kick-off and subsequent year with enthusiasm. "For a new system that required a lot of preparation and participation, things have gone remarkably smooth," she recalled. Dr. Morgan noted that the patient numbers have been higher than anticipated, but the center has been equipped and prepared to handle the load. Over 1,400 trauma care patients were seen in the center the first year.

The Tacoma Trauma Center is a designated Level II facility. Leveling follows very closely the American College of Surgeons levels and is based on the condition of the patient and what resources are necessary to devote to that patient. Level I trauma centers provide the highest level of definitive and comprehensive care for patients with complex injuries. The center sees a variety of trauma cases, from relatively minor trauma to catastrophic injury.

"You never know what's coming in the door," Dr. Morgan said. "You might have a patient go home, or you might end up in the OR with a patient losing 30 units of blood. When a trauma patient comes in, you assess the patient, make a plan, and move on and decide the best way to take care of him or her. Everyday is different. Every minute is different. There is no typical day."

This might, however, be a possible

scenario: There is a car accident. EMS personnel arrive on the scene and contact triage base stations at either Good Samaritan Hospital or Madigan Army Medical Center. Depending on the EMS assessment, the base station will call the hospital on call for trauma, and determine the level of injury. With a Step 3 case, Dr. Morgan explained, EMS personnel may not find abnormalities, but "boy, does that accident look bad!" With a Step 2, they see a fairly significant injury, but the patient - from a blood pressure or hemodynamic standpoint - appears to be ok. With Step 1, the victim appears to be fairly injured and there are some definite abnormalities either in neurological status, or as indicated by blood pressure or heart rate.

Morgan noted that there is sometimes a fine line when the triage system is making the decision about sending a patient to the trauma center. "Particularly in a new trauma system, I would much rather see over-triage than under-triage," she said. "It's better to see a few too many patients than miss someone who really needs to be seen."

At the hospital on call, a trauma surgeon and physician's assistant are available and immediately on the scene when a trauma case arrives along with ER nurses and technicians, IV therapists, respiratory therapists and radiology technicians. Depending on the level of trauma, OR nurses and anesthesiologists may be involved.

"This is a tremendous medical community effort," Dr. Morgan said, and credits the commitment of administration at both hospitals and a vast array of subspecialists. "The trauma center is a significant resource user," Dr. Morgan said. "We try to release personnel as

See "Trauma" page 18

Pierce County women physicians meet in recognition of Women in Medicine Month

In recognition of "National Women In Medicine Month," Pierce County Medical Society held an inaugural Women In Medicine Wine and Cheese Reception on September 26 at the Landmark Convention Center in Tacoma. The reception was open to women physicians practicing in Pierce County.

In keeping with the theme "Leaders Making a Difference," PCMS President **Patrice Stevenson, MD** and WSMA Immediate Past President and Vice President of Medical Affairs at Swedish Hospital, Nancy Auer, MD spoke with their colleagues on a variety of subjects. The history of the Women In Medicine Committee, healthcare policy, legislative aware-

ness, healthcare reimbursement issues, and other such concerns were discussed.

Dr. Auer encouraged physicians to contact their government officials and share their stories of poor reimbursement and the overwhelming bureaucracy of the healthcare system and the impact it has on their ability to practice medicine. She encouraged physicians and patients alike to be advocates in the healthcare community. "An angry patient is a strong advocate with a strong voice," she said.

"There are a myriad of opportunities to share your passion of politics or policy at your local, state and national levels," added Dr. Auer. "We must be active at all levels."



The next Women In Medicine event is to be announced. It is hoped to be the beginning of a series of supportive and education forums for female physicians. ■

Everett Medical Office Closing Doors

The Everett Family Practice Center, founded in 1977, and one of the largest stand-alone family practices in Snohomish County, will close their doors for good on November 16, 2001. The practice serves approximately 6,000 families.

Over the past six months, the number of doctors at the center has fallen from fourteen to seven. More doctors left than they could possibly replace in a short period of time, according to Dr. Julie Komarow, the center's president.

Not surprisingly, the practice is closing due to the loss of physicians, the general economic downturn and tight insurance reimbursements. Changes in the regulatory environment disenchanted some doctors. New Medicare rules, designed to tackle fraud, greatly increased paperwork requiring chart notes to be twice as long,

significantly increased costs. And, squeezed profit margins - with government payers as well as private party insurance were all factors in the decision to close. The clinic reached a point where the challenges became too large to overcome, according to Dr. Komarow.

The clinic cut the equivalent of 17 full-time employees, trying to slash costs but it wasn't enough. They also sought a merger partner, but failed. The doctors who remain on the center's staff are interviewing for new positions elsewhere, Komarow said. Patients were notified of the pending closure in mid-October and will be notified by letter in November as to where their physicians will be. The remaining 62 employees were also notified that their jobs would terminate as of November 16. ■

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Betrayal of Trust

The September 11th events have been truly unsettling. The pain and suffering of victims in New York and at

the Pentagon touched every one of us. Throughout the days that followed the terrorism, many staff at the Health Department came by



Federico
Cruz-Uribe, MD

my office to ask if I was okay. Each time I hurriedly offered back "sure, I'm fine." But then it dawned on me why were they asking. They often found me sitting in my office, in the dark, staring at the wall. I was overwhelmed by the enormity of what happened. And also - I'm afraid to say - by the enormity of what could happen next.

Part of my staring at the wall was my having to think the unthinkable: To prepare for mass suffering and death if WMD - weapons of mass destruction - are used. We have known about WMD, or bio-weapons, for many years. From history we know that plague and small pox were released many times into cities to weaken resistance to an invading army. Our own government developed and stockpiled bio-weapons during the cold war era. But we stopped production, along with most countries, as the weapons became more and more horrific. Designed to be easily dispersed

through air or water, a bio-weapon sickens and kills many people over a fairly short period of time. Human compassion, dignity, respect for life, the rules of law go out the window when one of these weapons gets used.

I have been trained to prepare for bio-terrorism. But I will admit to you that while I was listening to the lecturers, part of my mind was saying, "Don't worry, Federico, this will never happen. People will not cross this line. It is too horrible. Pay attention, but you will never have to use this information." As I was sitting there in the dark last week looking at my wall, I realized that the line had been crossed. There were no moral restraints or customs of civilization that would prevent the terrorists who plunged those airplanes into the World Trade Center and the Pentagon

There is much that can be done to preserve the health of our community, even in the event of bio-terrorism. It's standard public health practice, magnified...

from using bio-weapons against the people in my community.

So what are we to do when faced with the specter of their use? Just as the military has different levels of alertness during times of national disasters, public health also has alerts, particularly to respond to chemical and biological terrorist activity. This past week we were put on a heightened state of alert by the Centers for Disease Control.

There is much that can be done to preserve the health of our community, even in the event of bio-terrorism. It's standard public health practice, magnified: Look for patterns, identify the virus or bacteria or chemical used, and prevent further spread of the agent. In the short history of the United States, we have had to face many a horrific plague - malaria, yellow fever, cholera. These plagues killed thousands and sickened tens of thousands. There were no vaccines or drugs to fight them. But they were stopped because communities came together, instituting

clear and straightforward control measures. They restricted travel, they often placed severe limitations on personal behavior. They instituted strict quarantines on infected individuals. This was the beginning of public health in our country.

The Tacoma-Pierce County Health Department is ready to respond

to a weapon of mass destruction. We've asked emergency rooms, physicians and clinics to contact us if they see patterns of unusual illnesses in the population or a rise in deaths from what looks like a common respiratory disease. Once notified, we'll take the actions necessary to control the spread of the bio-weapon.

Weapons of Mass Destruction not

See "Betrayal" page 10

Betrayal

from page 9

only kill, but disrupt the typical activities of living: the economy drops, jobs are lost, substance abuse and suicides rise. The terrorist attack on the East Coast both destroyed and disrupted. The disruption is felt by many of us in the Pacific Northwest. Here, it is seen in increases in use of alcohol, tobacco and other drugs. Alcohol outlets, for example, have reported an increase in the sale of booze. It is also seen in higher levels of violence, in this case, against Islamic Centers and individuals. If history repeats itself, we'll soon see a rise in the number of cases of domestic violence as people strike out against each other and their children, in the fear and frustration started by the first plane crash.

Just as we respond to bio-terrorism on a local level, we also need to be ready to respond to behavioral issues - as a community, working together to look for patterns, identifying the problem, and preventing its continuation. This level of alertness, however, calls upon us as individuals, members of families, and residents of neighborhoods. We need to be aware of our own conduct and help others in our household or communities to moderate tobacco, alcohol and other drug use, and shun violent acts and language in our homes.

A strong public health system can control the impacts of weapons of mass destruction and modify the results of weapons of mass disruption. But we can't do it alone. We are only as strong as the support given to us by our local communities. In Laurie Garret's book, *Betrayal of Trust*, she looks at the terrible condition that basic public health has fallen to because of lack of attention and conflicting priorities. Her message to public officials is blunt: When public health weakens, communities suffer. Funding to support a strong public health infrastructure is key, but not sufficient alone. We also have to have the cooperation and involvement of everyone in Pierce County. We need to look at ourselves and our neighbors, taking care not to abuse tobacco, alcohol and other drugs, or react in uncontrolled violence against innocent people. We have much work in front of us, but I have great confidence that our community can rise to the challenge. These are the actions we can - and should - take that will allow each of us to turn our lights back on and stop staring at the walls - or the television set - to try to comprehend the magnitude of this disaster. Global disasters are also local. Individual reactions can strengthen the health of whole communities. ■

Anthrax Update for Health Care Providers

Despite multiple "scares," there is currently no evidence that any person, business, or organization in Washington State has been the target of an anthrax threat. Testing for exposure to anthrax (nasal swabs or serologic testing) should only be done in the setting of an epidemiologic investigation following a known exposure to anthrax. Prescribing antibiotics for a presumed exposure to anthrax should only occur after consultation with Communicable Disease Epidemiology at the State Health Department to determine the likelihood that the situation represents an exposure to anthrax. Testing at the Public Health Laboratory thus far has not found any evidence of anthrax in of the many specimens we have received.

Washington State Department of Health, 10/17/2001

Please see blue insert for copy of Summary of Biological Warfare Agents. For a complete packet of information on anthrax, call PCMS at 572-3667.

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Find out how you can help:
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Highlights of Some International Projects:

- Tbilisi, Republic of Georgia - Assisted orphans
- Armenia, Kazastan, Kyrgystan, Georgia, Russian Far East and China - Distributed pharmaceuticals; taught family practice principles to physicians; volunteered in Heart to Heart Medical Missions

Robert Klein, M.D., P.S.
Family Practice • Personal Injury • Immigration
253-474-8777 • 253-474-8700
7513 Custer Road West • Tacoma
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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 Sickness of Terrorism

"Trade is the natural enemy of all violent passions. Trade loves moderation, delights in compromise, and is most careful to avoid anger. It is patient, supple and insinuating, only resorting to extreme measures in cases of absolute necessity. Trade makes men independent of one another and gives them a high idea of their personal importance: it leads them to want to manage their own affairs and teaches them to succeed therein. Hence it makes them inclined to liberty, but disinclined to revolution.

*Democracy in America,
Alexis de Tocqueville (1840)*



Andrew Statson, MD

I hope I'll be forgiven for diverging from my usual topics on economics and medical practice to discuss the economics of a sick mindset. There are two ways to obtain goods and services in this world, by trade and by force. Those who use force are robbers. They are the kleptocrats. They use their position of power to enrich themselves. They have been around since the beginning of history and there is very little chance that they will ever go away. Perhaps the most notorious recent examples were Marcos of the Philippines and Suharto of Indonesia.

More baffling to us, the producers of wealth in this world, are the terrorists who are not interested in wealth. They are satisfied to live in their tents and to travel with their camels. They don't want our skyscrapers or our jets. Yet, they don't want us to have them, either. They don't want to get out of the mud in which they live, they want to drag us into it. They don't want to rise to our level, they want us to sink to theirs. As their recent actions proved, they don't care to live, they want us to die.

The heart-rending story of **Dr. Stutterheim** is an example of terrorism in action. One may try to dismiss it as something from the distant past, not

relevant to us today, as the effort of a man to exorcize from his mind the ghost of the evil he suffered as a child. Yet the horror he describes is related to that we witnessed on September 11. The questions Alexander Solzhenitsyn raised when discussing the Soviet Gulag was not a rhetorical one. "How could humans be so cruel to fellow human beings?" he asked. The answer is in the mindset of the terrorists.

No matter which god they bow to, if any, terrorists share the same religion, the religion of violence. Its basic tenet was expressed best by Mao Tse Tung, "Power flows from the barrel of a gun." No matter whether they bomb embassies or military installations, trade centers or abortion clinics; no matter whether they abuse and torture their spouses and children or defenseless strangers; no matter whether they burn books or humans, churches or synagogues; no matter whether they kill people in gas chambers or herd them in concentration camps, terrorists share the same belief, that they are the masters, destined to rule the world. They share the same goal, power over others.

We fought WWII against the mindset of the master race, not against

the German and the Japanese people. A sizable minority, probably even a majority among them, did not share the goals nor approve of the methods of their rules. They were terrorized into submission and many of them died in the war. We fought the cold war against the mindset of the master social class, not against the Russian people, who suffered more than anyone else under the tyranny of the communists. Now we are faced with the mindset of the master faith.

Terrorism is not an issue of religion, of social class, or of race. It is an issue of the terrorist mindset, based on their determination to acquire and maintain power and control over others. Religion, class and race are excuses. If terrorists did not have them, they would invent others. The fight against terrorism is the fight against the terrorist mindset. We need to understand it, to learn to recognize it, to isolate and destroy it, in order to win.

In the preface to *Leaves of Grass*, Walt Whitman expressed the meaning of America, as the country of the common people, as the place where the President takes off his hat to the people, while they keep theirs on. This

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Terrorism

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is in contradistinction to the East, where people may approach their leaders only while crawling on their hands and knees.

The rulers who maintain themselves in power through terror have a very good reason to fear and hate America. Again, this is not an issue of religion. They readily dealt with the Soviet Union, in spite of its atheism, even though it was a definite military threat to them. The communists were fellow terrorists. They could understand each other.

They fear and hate America because they cannot deal with us on their terms. We are traders, not victims. They fear and hate the rays our Torch of Liberty shines across the ocean to their lands. They fear and hate our system of individual freedom, capitalism and the free market. They fear and hate our prosperity, the result of productive work.

They fear and hate Israel, because it is an outpost of freedom, capitalism and the free market at their doorsteps. Some clerics look across the border and see, oh horror, women walking in the streets without veils over their faces, going to work side by side with men, even serving in the army and shooting with rifles. They look at their men as they watch across the border a productive people lead a free and happy life, wanting the same for themselves. They look at their women and see the yearning for freedom in them as well. Then the clerics understand that they are losing control over their own people and they declare a holy war against the "Satan of the West" and against Israel.

There have been enlightened leaders in the East who tried to modernize their countries and bring them in step with the Western world. Tsar Peter the Great of Russia built Saint Petersburg and moved his capital there to be closer to the West, to stimulate more contact between his own people and Western Europe. He did not achieve much and change in Rus-

sia is painfully slow.

Another one was the Shah Riza Pahlevi of Iran. He recognized that he needed an educated middle class to help him bring his country into the twentieth century. Starting shortly after WWII, at government expense, he sent a large number of high school graduates to the universities of Western Europe, to learn medicine, engineering and the sciences, to help bring technology to his country and to develop its industrial base. Some clerics did not like his efforts and eventually gathered enough strength to depose him. In spite of that, the ferment of freedom is stirring the masses in Iran. It may still take a long time, but freedom is going to shine there as well.

These are the reasons America is a target for destruction. They, who cannot design planes and build skyscrapers, want to destroy ours, so that they can more easily keep their own people enslaved. They don't want us to have the good life, so as not to tempt their

people to revolt. We have to understand the reason for this threat in order to face it better. We have to understand that they target us because of what we are, because we exist.

So what do we do about that? Unfortunately, bullies don't understand nice language. An illustration of that is a statement attributed to Stalin. When told of something the Pope had said, he replied, "And how many divisions does the Pope have?" Perhaps the answer we seek is in the words from a Country-Western song, "You don't have to fight to be a man, but when you are a man, sometimes you have to fight." Why would we want to do that? Because, while realizing that we can never achieve absolute safety, we want to make the world a little safer for our children; because we want to live in a world where there is room for all faiths, for all classes and for all races, where humans treat each other as humans; finally, because we are traders, not victims. ■

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In My Opinion.....

by Teresa Clabots, MD

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

How Do You Do It?

I get tired of people asking me the same question all the time. How did I do what? Raise five kids with a job? Work 'round the clock and take call? Why, millions of women around the world do it all the time, and some barely make enough to eat. I feel privileged and lucky to be in a country where I have extraordinary freedoms, and unequalled luxuries; a car, a toilet, a TV, a phone, a computer, enough food that I am never hungry, and control over my own body. Then that gets me to thinking about my mom.

My mother was the world's worst cook. I say that with a little pride, since I am not a very good cook, but she makes me look like a gourmet cook.

She was raised in the lap of luxury, the youngest heiress to a tobacco plantation owner in Cuba. She then married a prominent physician with the busiest pathology practice in Havana. Those golden days were spent raising her ten children with the help of the cook, the seamstress, the many nannies, the chauffeur, and the maids. She could speak three languages, entertain, and embroider beautifully. She was a lady.

Then came the revolution, and the family lost everything to Castro who confiscated the lands, the houses, the cars, and froze the bank accounts. All was lost.

When I was six, the schools were closed at gunpoint, and I stood in line

for rice, milk, and toilet paper. By bribing our way out with my mother's jewelry, we were able to escape first to Spain and then waited two years for the quota to come to America, the land of opportunity.

However, my mother had to learn how to fend for us kids. She learned to drive, to scrub floors, to wash clothes (many a thing was shrunk in the dryer, or had holes when she threw the gallon of bleach in with the blue pea coats from Salvation Army).

She used her embroidery skills to darn our socks over and over again and to hem our hand-me-downs. Our knee socks were held up by rubber bands, giving me varicose veins at the age of 15. She had to learn survival skills, but we never went on welfare. One winter she traded in her coat in exchange for the school tuition. We did without.

How did we survive? By having good friends. I was always eating someone's left over lunch, and early on figured out that by working in a restaurant at least food was assured. The summer I was on the swim team I ate a lot of left over pie, but quit the team since I just too darned hungry.

I look now at the Sunday soup that I make and all the ingredients my mother could never afford. Our Sunday soup back then was one poor little skinny chicken, extra neck bones and



Teresa Clabots, MD

innards (each) thrown in with chicken bouillon, lots of potatoes and a lump of Crisco. The only good thing about it is that it was warm and salty. Believe me when I say that was the best meal in her cooking repertoire, which was complemented with donated Safeway bread, old enough that we had to pick the mold off the crust. (To this day I have an aversion to bread crust.)

If you ate your chicken soup (or pretended to), you were rewarded with a single cone of delicious neopolitan ice cream for dessert. Yum.

As I throw chicken breasts, fresh vegetables, potatoes, bouillon and olive oil into our Sunday chicken soup, I think of my mom, and how hard she had it.

For in difficult times, it is not what is in the soup that nourishes our soul. It's the ultimate sacrifice our parents made, the courage it took, and the unspoken love that it stood for that counted.

I am proud to be an American, living in the land of hope and opportunity. ■

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Embezzlement

from page 5

statements, posing numerous questions to manager Corey-Boulet. "He had an explanation for everything." In general, his response was that the practice was "hard to manage." Gail was concerned that her continual inquiries were "bothering" the manager, and she decided to go directly to the bank to inquire about missing checks. She discovered all the missing checks were written to cash, signed and endorsed by Corey-Boulet, and deposited into his personal account.

While it was initially thought that \$20,000 had been taken from the business, extensive investigation determined that Corey-Boulet had embezzled over \$800,000 during his eight years managing the practice. "We didn't see a pattern of loss creeping in, because it was happening from the beginning," Dr. Nacht explained. The crowning blow came with the discovery that \$10,000 was stolen July 9, 1990 - the very first day the practice was in operation under his management.

Embezzlement happens all the time...and the perpetrators are not your usual suspects

Embezzlement is the fraudulent appropriation of property by a person to whom it has been *entrusted*. It is a different crime from ordinary theft or larceny. (FYI...the average bank robber nets the crook \$34,000; the average embezzler nets \$102,000) Embezzlement is perpetrated by someone in your company whom you trust.

Physician practices rank number one as the most frequently embezzled business in the United States, followed by attorney's practices, dental offices, and CPA firms.

"We didn't make a strong effort to conceal what had happened to us," Dr. Nacht explained, especially once the story appeared in the newspapers. His office received many supportive calls from PCMS members, and he recalls that about one of five went something like this, "I feel terrible about what hap-

pened to you, is there anything I can do to help? And.....let me tell you about what happened to me!!!" "Unfortunately, most of us don't share this information with each other," Dr. Nacht said, "but we should. It's very valuable. But it's very embarrassing. It's not that we're not smart, it's that we're unprepared. If we share these stories with each other, we're protecting each other as a family. And that's why I'm here."

What's Happening in Your Back Yard?

Dr. Nacht shared a laundry list of what he termed, "Embezzlement Schemes from the Real World of Tacoma," with the hope that physicians will take note of how to avoid the traps. "All these occurrences are preventable if you know the intra workings of your office," he explained. Here are some incidents shared by local offices:

- Office manager writes checks to "cash," deposits them to his personal account, and enters a false entry into the general ledger to account for the check amount.
- Office manager leaves enough space on check to fill in extra amounts.
- Office manager adds fictitious employee name to roster, pockets the funds from salary and withholding.
- A temporary or terminated employee is issued additional paychecks in the general ledger (checks made out to "cash.")
- Vendors or purchasing agents offer supplies manager rebates or kickbacks for use of their price-inflated supplies.
- Employee purchases items for personal use with the company credit card or account.
- Employee undercharges or writes off charges for relatives or friends.
- Overtime is falsified.
- Employee swaps checks received in the mail and credited to patient's account for co-payments re-

ceived at the front desk; pockets the cash.

- Employee over-withholds income tax payment and applies for rebate the following year.
- Employee records a write-off of all or a portion of a check received toward an account, then endorses the check to himself or herself and deposits it to their personal account.
- Office manager slips personal bills into stack of practice checks to be signed.
- Employee pockets cash received as co-payments at the front desk after crediting patient's account.

You know it happens...now how do you prevent it?

Dr. Nacht has learned that there are some important initial steps to take to ensure your practice is protected. **Run background and credit checks on all prospective employees before hiring.** "Our manager was someone who came to us with great credentials," he explained. "He was vice president at St. Joseph's, vice president at Hillhaven, his wife was a Pierce County prosecutor, he had experience in planning, and he was introduced to us by the president of the hospital who said, 'Here is a guy who I think can help you.' What we didn't know was that his personal finances were in chaos, and he was in and out of credit counseling." Dr. Nacht recommended talking to an accountant about getting background checks.

Awareness is the key, Dr. Nacht stressed. "Understand how your internal system works." He also suggested these additional, ongoing actions:

- Be certain you have different employees handling your accounts payable and accounts receivable
- Require that bank statements be delivered to the physician/managing partner unopened.
- Review all cancelled checks, match them with invoices, and be aware of any unusual patterns such as dual en-

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IN MEMORIAM
EDWARD F. MCCABE, MD
1916-2001

Dr. McCabe was born in Idaho Falls and grew up in Spokane. He attended the University of Washington, received his undergraduate degree from Gonzaga University and his medical degree from Marquette University. He served as Lieutenant in the Medical Corps of the U.S. Navy and served aboard the USS Drew in 1944-1945. He was a prominent family physician in Puyallup for 42 years until his retirement in 1989.



Edward McCabe, MD

Dr. McCabe served on the medical staffs of Good Samaritan, St. Joseph's, Tacoma General and Mary Bridge hospitals. He was a member of Pierce County Medical Society for 54 years, joining in 1947 when he opened his Puyallup practice.

PCMS offers condolences to his wife Lue and their children.

IN MEMORIAM
BERNARD R. ROWEN, MD
1919-2001

Dr. Rowen was born in Queens County, New York in December, 1919. He graduated from Yale University School of Medicine in 1943 and completed his internship at Mt. Sinai Hospital in New York. He did residencies in bacteriology and pathology at Mt. Sinai and internal medicine and gastroenterology at the Los Angeles VA Hospital. He served in the Army Medical Corps from 1944-1946.



Bernard Rowen, MD

Dr. Rowen practiced internal medicine in Tacoma beginning in 1987 until his retirement in 1985. He was a Pierce County Medical Society member for 44 years, having joined in 1957.

PCMS extends their sympathies to Dr. Rowen's family.

Embezzlement

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dorsements or unfamiliar vendor names.

- Physicians should sign all checks, and two signatures should be required in larger practices.

- All blank checks should be locked up and secure and accessible only to authorized personnel.

- Lines of credit should only be accessed by two members of executive committee together.

- The employee who opens the mail and strips checks should not be the same employee who collects and deposits co-payments from patients or posts payments to accounts.

Once you've taken these initial steps, you must be vigilant! Keep your eyes open and be aware. "These are very simple fixes," Dr. Nacht said.

"Start to get smart about what happens in your office and look for places where theft occurs. As Dr. Nacht stressed continually, you can prevent or at least stop embezzlement if you take the right steps.

- Take note of employees of modest income who suddenly adopt a lavish lifestyle

- Keep abreast of office gossip. Something might be going on that could make an employee desperate enough to steal.

- Be suspicious of any employee who avoids vacations or letting others assist with their job.

- Watch for employees hiding cancelled checks or replacing one payment for another.

- Examine the accounts payable.

- Sign only vendor checks that have an invoice.

- Segregate duties.

- Create computer security codes so only office managers and/or front desk supervisors have authority to adjust patients' account balances.

- Never allow the person who writes the checks to reconcile the bank statement.

- Use your office computer system security programs.

- Run background checks on all unknown vendors to be certain they exist.

- Track expenses.

- Consider an "employee dishonesty coverage" policy. Weigh how much of a loss you can sustain without insurance coverage against the amount of the premiums.

- Whatever you do, don't be too trusting! Dr. Nacht quoted M. Matthews of Physicians HealthCare Advisors, Inc.: **"You have to assume that every employee has a price. You just don't know how much it is. For some employees, it's pretty low."**

If you notice something is wrong...

If you discover theft, act quickly! Change all locks and computer security codes immediately. Notify the bank and secure all paperwork. **Dr. Nacht also recommends carrying a fidelity bond on all employees.** It's very inexpensive and allows recovery of some money in the event of embezzlement. It also takes the decision to prosecute out of your hands.

If you can prove that someone is stealing, consider prosecuting. "Keep in mind that if you don't prosecute, they will probably do it again to one of your colleagues," Dr. Nacht warned. But consider your options. "It's not cheap," he said. The criminal case against Corey-Boulet would not go forward until the civil action was completed. The civil case cost Nacht's practice \$122,000 in legal fees.

The Fallout...The multiple costs of embezzlement

Dr. Nacht cited a favorite quote by Marvin Wolfgang, professor of criminology at the Wharton School of Business, University of Pennsylvania. "A conservative is a liberal who's just been mugged." Embezzlement changes you, Dr. Nacht explained, and you can expect some radical alterations

in your way of life. Here are a few ...

- Your self-esteem is a wreck because you feel like you've failed.

- Your relationship with your spouse will be strained or threatened.

- Partners might assign blame to you.

- Employees may quit outright or slowly drift away.

- Employees may blame you for the embezzler's actions.

- If your finances are impacted, you may be forced out of your banking relationship.

- You might suffer tax consequences due to losses not written off or taxes left unpaid. (Dr. Nacht said that by going to the IRS and explaining their situation, penalties were waived.)

- If employee pension funds were stolen, you may, as a fiduciary, be personally responsible for their restoration, regardless of corporate protection.

- The legal and accounting costs can be daunting or overwhelming.

- You may feel your reputation in the community has been seriously damaged.

- Long-term plans (retirement) may be postponed or destroyed.

- Personal property/house may be encumbered or even seized to pay off or guarantee obligations.

- You may suffer depression and feels of loss of self-worth. Counseling may be necessary.

- Vendor relationships may become tenuous as you struggle to pay bills.

"We worried that our reputations had been tainted," Dr. Nacht said. "But that feeling went away. Our colleagues were very supportive. And we found out that the same thing had happened to many of them." In addition, he said that being up front with vendors and authorities was very beneficial. Department of Revenue and IRS personnel actually waived penalties associated with late or nonexistent payments.

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However, the interest cannot be waived.

"You're not the only culpable people here. Think about it...physicians, dentists, attorneys, CPAs — you would assume that these people would be able to avoid embezzlement, but they are the ones who get hit the hardest and most frequently. I know that by sharing my experiences, people have gone back to their offices and taken simple steps to make sure it doesn't happen to them. I feel better that they have at least avoided it as a result of my experience," he said.

In August of 1999, Francis Corey-Boulet was given a 4-year, 3-month sentence, which was subsequently reduced to 3 years, 4 months. At present, he is on work release. The court mandated a lien on all his future wages to pay the debt, but as Dr. Nacht points out, he can't work any place he is required to have a license. "I don't know that he will ever make enough money to pay us back," he said, "but we just needed to walk away from it." ■

Some Frightening Embezzlement Statistics

- Estimates by the accounting industry indicate that internal fraud costs U.S. organizations \$400 billion per year.
- The average U.S. company loses \$9 per day to its employees.
- Among health care employees, the median amount stolen from health care offices is \$105,000.
- One-third of all business failures can be attributed to employee theft.

Source: 1996 report by Association of Fraud Examiners, Austin, Texas



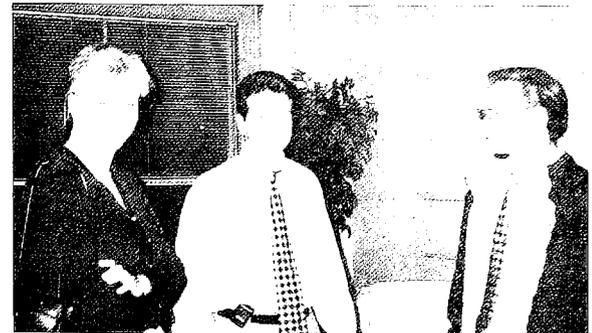
Past Presidents Drs. Charles Weatherby (2000), left, and Eileen Toth (1992), right, discussed past-presidential matters



Left to right - Dr. Matt White, Ruth Roes, and her husband Dr. Bill Roes, visit with Dr. Tom Herron during the social hour



Drs. Sam Insalaco (left), pathologist, and Don Shrewsbury, otolaryngologist enjoy visiting during the social hour



The social hour was a great opportunity for physicians to meet new colleagues and visit with old ones

Trauma

from page 7

soon as we can in order to take pressure off the system. We bring support staff in, assess the situation as quickly as possible, and get people back to their daily jobs."

Trauma Centers: A Relatively New Concept

A formalized trauma care system ironically emerged out of one physician's tragedy. While driving through a rural part of the U.S., the physician and his family were involved in a serious car accident. They were taken to a small emergency room, with no team or skill sets available to deal with trauma. The results were catastrophic: his wife and child died. His experience led him to develop Advanced Trauma Life Support (ATLS), a course taken by most surgeons and other physicians and medical personnel. "You take an extremely systematic approach to patient care, and you do not deviate. Sticking to the system, you're going to find things that are not obvious." As a result, state and regional trauma systems were developed to ensure that patients with severe injuries are identified and transported to medical centers appropriate to the level of care they need. Leveling systems were developed for that purpose.

Formalization of this new approach, however, didn't come to fruition until 1990, when Congress passed Public Law 101-590, the Trauma Systems Planning and Development Act. The value of implementing trauma systems through statewide planning has been recognized and has already demonstrated that these organized regional systems result in dramatic improvements in patient outcomes. These systems ensure that the severely injured patient can be rapidly cared for in the facility that is most appropriately prepared to treat the severity of the injury.

"Trauma care is what I've trained to do my entire career," Dr. Morgan said. "So, I firmly believe that having trauma-trained specialists really makes

a difference. And having a systematic approach and dedicated resources is the only way to do it."

What Lies Ahead?

With a successful year under their belts, the Tacoma Trauma Center contemplates the future. "Fulfilling the needs of the community is still the prime directive," Dr. Morgan said. Dr. Morgan does, however, have definite plans for down the road. "It is imperative that we do a better job of educating the community," she said. "Seat belts make a tremendous difference; bike helmets can mean the difference between a minor injury and a trauma. While it seems redundant, we need to keep saying things like 'Don't drink and drive,' and we need to concentrate on firearm safety. We need to get out in the public arena and share information. It's not a new concept, but it needs to be repeated."

Dr. Morgan also hopes to do clinical research and make contributions to

trauma care in that regard. But that will come with a more mature system, she notes. "We are still very young, and we are still working out resource management. We have some things to work on clinically before we start to turn our attention to other things.

"I think we've done a great job this year," Dr. Morgan said. "But when I say 'we,' I don't mean just the four trauma surgeons and six PAs. There have been tremendous efforts and cooperation on the part of both hospital administrations, and an unbelievable devotion of resources and willingness to do this for the communities they serve." She credits everyone involved in the effort. "We've taxed the system - virtually no service or subspecialty in the hospital has been left untouched."

"This has been a huge medical community effort, and that certainly isn't lost on my team. We work hard, but we couldn't do it in isolation." ■

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Continuing Medical Education

Medicine and Mental Health Conference offered December 7

A continuing medical education focusing on the diagnosis and management of mental health complaints faced in the primary care and internal medicine practice is set for Friday, December 7.

The complimentary program, directed by **Drs. David Law and Mark Craddock** offers 6 Category I CME credits. Topics include:

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- Managing Challenging Patients in Primary Care
- Sexual Dysfunction and Depression

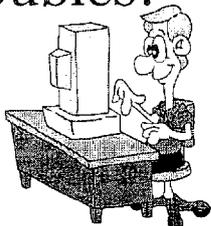
- Depression in Women in Their Lifecycles: PMS, Pregnancy, and Perimenopause
- Treatment of Geriatric Depression Management
- Optimal Management of Psychosis and Agitation in the Elderly
- Mental Health Patients: How to Code Their Visits

The program is scheduled for the Lagerquist Conference Center of St. Joseph Hospital Medical Center. Call 627-7137 for registration information. ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Friday, November 2	Infectious Diseases Update	James DeMaio, MD
Friday, December 7	Medicine & Mental Health	David Law, MD
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

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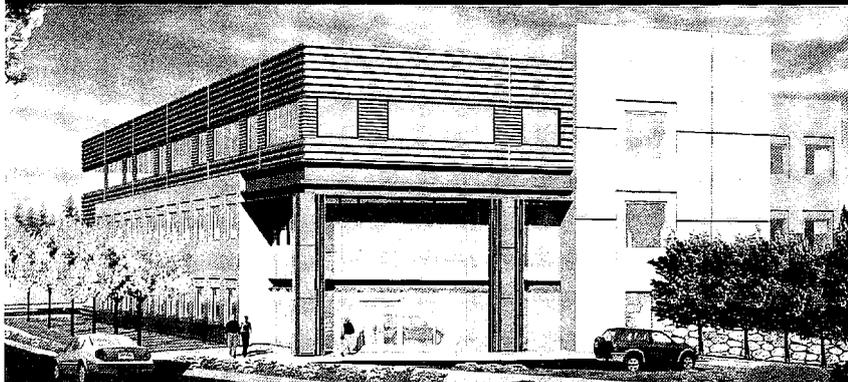
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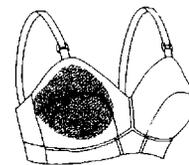
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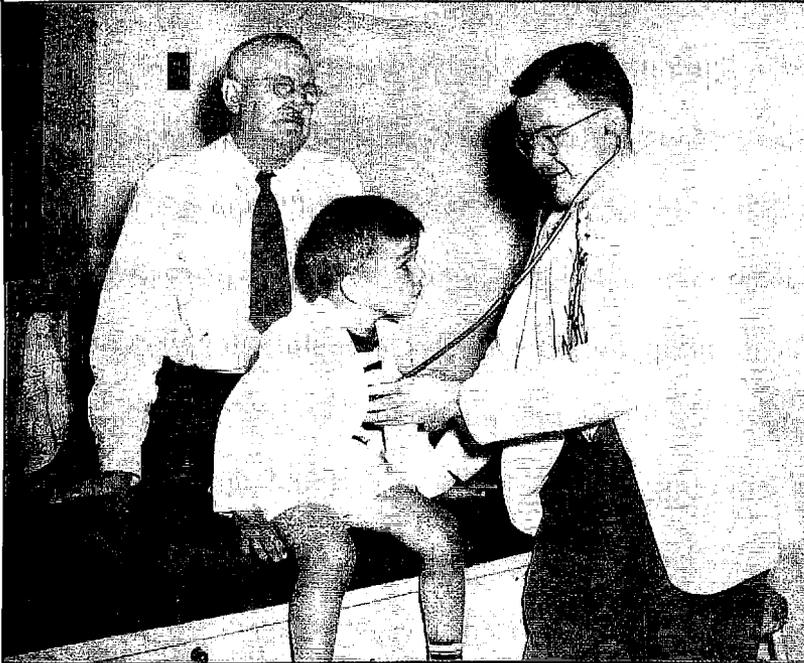
BULLETIN

Pierce County Medical Society



December, 2001

PCMS pays tribute to Alan Tice, MD



A family of physicians:

Dr. Alan Tice, center, is examined by his father,
Dr. George Tice, while his grandfather,
Dr. Claude Tice, observes

PCMS owes a debt of gratitude to Dr. Alan Tice for his significant contributions, particularly his commitment to public health issues, political advocacy and professional education.

He has been an ardent and tireless supporter, providing subtle and innovative leadership for both Pierce County Medical Society and the College of Medical Education.

Thank you, Dr. Tice.

— See story page 5 —

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- 13 In Memoriam: Drs. Robert M. Freeman and Robert C. Johnson

Pierce County Medical Society

BULLETIN



December, 2001



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The Bulletin is published monthly by PCMS
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President's Page

by Patrice Stevenson, MD

Time flies...



Patrice Stevenson, MD
President

Time flies... whether you're having fun or not. I have a watch with that on the face. It is one of the many I wear but ignore (if you ask my husband). Here it is time to write my last President's Page and it truly seems the year has flown by.

This was to be "The Year of Transition" as I wrote in the February Bulletin. PCMS rather seamlessly transitioned to the leadership of our new Executive Director, Sue Asher. She has figured out the few inner workings that she didn't already know and continues to organize and streamline operations. She made a wise choice in hiring Shana Osmer as our Membership Services Coordinator in May. She will continue to increase her duties and is staffing more of the committees. She is also working on construction of the new and improved PCMS web site (www.pcmswa.org) to open 12-10-01. PCMS continues to look at ways to keep the membership informed and hopefully involved. We still have many in-person meetings and

are one of the most active county medical societies in the state. We also communicate with phone, FAX and e-mail. Perhaps some day we will be a totally "virtual" medical society but for now I value the personal connection with physicians from all specialties and practice settings. As we all seem to be working harder these days, it is nice to get together and put a face to the name.

Reflecting on the year sometimes I wonder what we really accomplished. I was sitting next to **Dr. George Tanbara**, PCMS President in 1981, at the November 13 General Membership meeting. He was telling me to save my President's Pages and look at them again in twenty years to see if anything had really changed. We did not slay any dragons but kept up the fight for patient and physician rights with governmental and private payers. We shared in the voice of WSMA and the AMA on many regulatory issues to try to simplify the practice woes we encounter on a daily basis. After September 11th it was hard to place the same

priority on those issues as we had before. We suddenly realized the value of a strong Public Health System as we scrambled to get up to speed on the diagnosis and treatment of Anthrax and other potential diseases of bioterrorism. The spotlight on the emergency medical system may help to increase public awareness of the fragility of that aspect of our health care system and bolster it to avoid widespread collapse. With all of that, will anyone care about MERFA (Medicare Education and Regulatory Fairness Act of 2001)? Or HIPAA (Health Insurance Portability and Accountability Act)? Only time will tell and it flies by... whether we accomplish our goals or not.

I sincerely thank you for the opportunity to have served as your President for 2001 and confidently turn over the gavel to **Susan Salo, MD** for 2002. ■

November General Membership Meeting Recap

November General Meeting, a "high tech" adventure

"Your life will be affected by the Internet." These were the opening words of Dr. Bill Crouse at his presentation to over 50 members at the November 13 General Membership Meeting.

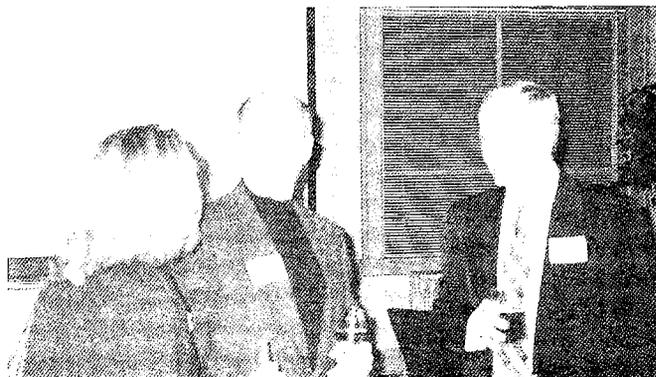
The meeting, "Medicine in Cyberspace" was held at the Landmark Convention Center in Tacoma and dinner was complimentary, thanks to sponsors Horizon Medical Systems and Regence Blue Shield.

Dr. Crouse wowed the audience with a power point presentation of his pioneering partnership with Microsoft to provide health information, secure web messaging and the "virtual office visit."

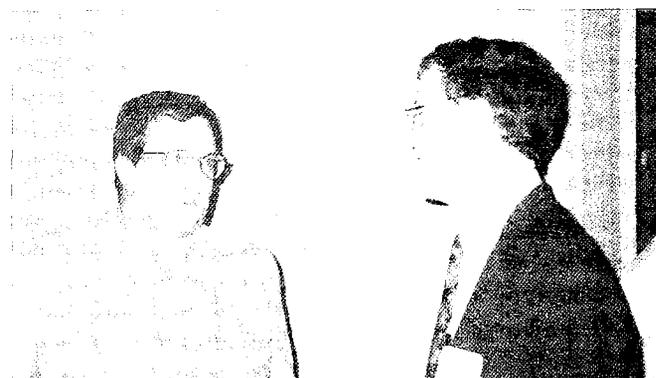
Citing several statistics such as "75% of Internet users want more health services on-line" and "89% of physicians have access to the Internet," Dr. Crouse believes that physicians can deliver care through technology. He added that patient and physician Internet communication must be private, confidential and secure, and should not be used for emergency situations.

He also described the future impact of the Internet on our daily lives. "In the next five years, the Internet will involve every electronic device in your home from your television to your trash compactor."

Dr. Crouse's take-home tip was: "Those who control the information will



Dr. John Lenihan, Tacoma Ob/Gyn, left, and Dr. Bill Crouse, speaker, visited with other attendees before the meeting



PCMS Trustee and Puyallup surgeon Kenneth Feucht, MD, left, visits with Puyallup colleague Dr. Marvin Brooke

control the market. Patients seek information. If we cannot provide it, they will go elsewhere or coordinate their own care. We, physicians, are in the information business. We gather, interpret and share that information with our patients and colleagues."

Dr. Crouse is a board certified family physician and Vice President of Medical Technology for the Overlake Venture Center in Bellevue. He is also Senior Vice President and founder of Dr.Goodwell.com, an internet start-up working in partnership with Microsoft to provide health information and "virtual clinic" medical services to employees in high-tech industries. ■

Neighborhood Clinic

Wanted: Executive Director

The Neighborhood Clinic, which has provided free health care to our community for over 20 years, is looking for a volunteer Executive Director/Board Member to serve part-time.
(Training and guidance provided!)

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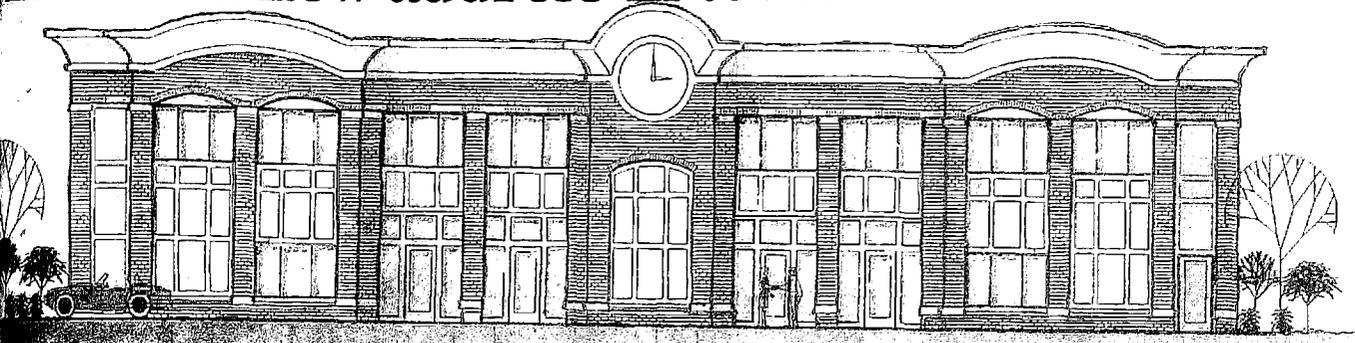
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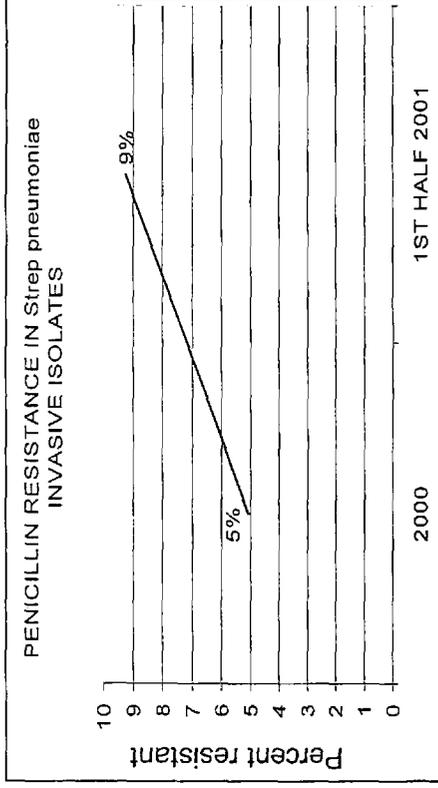
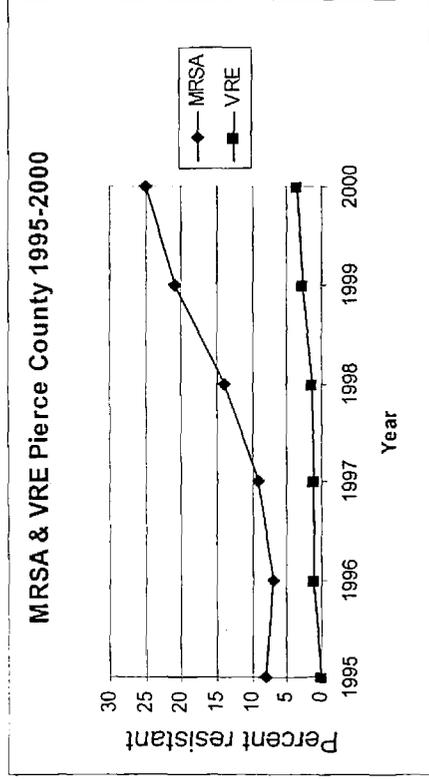


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Fact: approximately 50% of these prescriptions are inappropriate (Source: Gonzales R, et al.

Excessive antibiotic use for acute respiratory infections in the United States. *Clin Inf Dis.* 2001;33:757-762.)

What practitioners can do:

- Do not prescribe antibiotics for common URIs likely of viral origin (see Judicious Use Guidelines at www.washingtonaware.org)
- Before prescribing an antibiotic, obtain cultures, if appropriate
- If an antibiotic is needed, prescribe the narrowest spectrum agent that will cover the pathogen
- Do not succumb to patient pressure for antibiotics. Patient satisfaction has been shown not to depend upon receiving a prescription, but upon receiving an explanation of the illness
- Rigorous infection control practices are essential

**For More information call the Tacoma-Pierce County Health Department,
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Special Feature

by Jean Borst

PCMS Bids 'Aloha' to Alan Tice, MD

"I'm graduating — not retiring," says **Dr. Alan Tice**.

Bidding farewell to patients, colleagues, friends and peers at an open house at the end of September, Dr. Tice closed one long and illustrious chapter in his life and prepared for another. After more than 20 years, he made the decision to leave his medical practice and relocate to Hawaii. Typical retirement scenario? Hardly. Dr. Tice's departure actually marks as much a beginning as it does an end. In this case, it's just a little more than ironic that the Hawaiian word "aloha" means both good-bye and hello.

Destination Hawaii

He's not exactly trading his stethoscope for a surfboard, although Dr. Tice does plan to spend a good deal of time in the Pacific waters in an outrigger canoe.

With connections throughout the world, he explored the possibility of relocating to several locations, including Switzerland, Australia and England. But an international move posed problems, particularly with Internet access, insurance, and an American high school curriculum for his daughter. His personal connections in Hawaii and an opportunity to teach medical residents at the University of Hawaii School of Medicine drew him to the islands. Joining him are his wife, Constance, and high-school senior daughter, Amanda, who were "thrilled by the decision." "They were ready and willing for the change," he said. He added that his wife, a dentist, has been pleased with the change from our unique northwest weather.

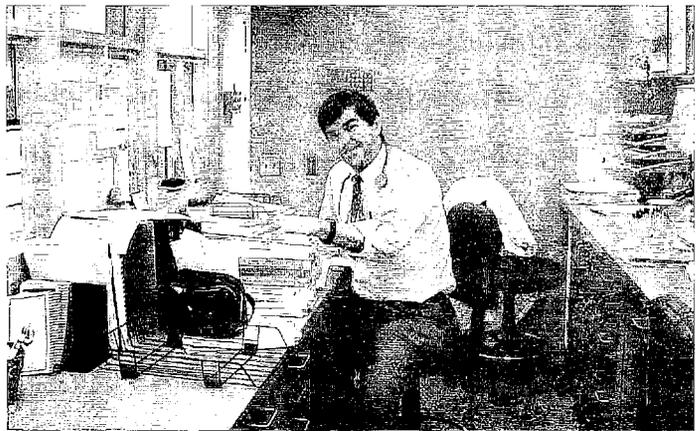
The move was well planned and meticulously laid out. Two years ago, Dr. Tice asked his partners for a year-long sabbatical in Hawaii. The support

and encouragement from his partners and staff was immense and much appreciated. "I am very grateful that they allowed me the opportunity and cared for my patients while I was away," he said.

"I knew I had to take a break. I wanted more time with my family. I needed time to examine my life and figure out what to do with what is left. I felt as if I had been running a marathon and had to slow down. It did not seem

With his decision made and his partner's permission, all that was left was breaking the news to his patients. "That was the hardest part," he recalled. "It was very difficult to say good-bye to my patient family. They mean a lot to me." And, it was imperative to Dr. Tice that his "family" all find quality health care with other physicians in the area.

"Trying to find primary care physicians to take my patients was very dif-



Dr. Tice at work in his Infections Limited office

possible to do it and continue to practice." In so many careers, Tice explained, the focus is on "climbing the mountain. You get as high as you can then what do you do? My career had been worth all the hard work, but I had reached a plateau, and it was time to find my way back down. I realized that the journey wasn't over, it was just time to go in a different direction." While on sabbatical, Dr. Tice made the decision to leave his practice and move to Hawaii permanently. "It was time to graduate," he said. "It was time to go to another level or take on a smaller mountain."

ficult," he said. "I wanted to be sure they would continue to get the quality care they deserved. After all, they depended on me. I needed to be sure they were taken care of."

The process was long, arduous, and emotional for everyone involved. "Many patients were upset, but almost all thanked me for my care and expressed a great deal of warmth and appreciation. They told me they would miss me but understood why I was going and encouraged me. That was very comforting." Dr. Tice mentioned only one patient who was angry with him

See "Dr. Tice" page 6

Dr. Tice from page 5

for leaving. "He thought he deserved me as his physician," he said.

After so many years of serving others, Dr. Tice felt confident in his decision to leave his practice. "Am I being selfish? Am I doing the wrong thing? I don't think so," he said. "When I entered this profession, I felt indebted. I was very fortunate to have been able to go to medical school and be trained in internal medicine and infectious diseases. I felt I owed people for those opportunities, but I have now paid back the debt. My obligation was to take care of my patients, and I did that by being a doctor for 30 years and in practice for more than 20. In the process, I sacrificed a lot of myself and time with my family. It was not easy. I feel good about what I've done, but that I don't have to sacrifice any more. Now I have finished that chapter, and I can go on to the next. I feel very fortunate to have the opportunity."

That next chapter will be partially set in an academic environment. Dr. Tice will be teaching at the University of Hawaii John A. Burns School of Medicine. He will supervise medical residents in the Queen Emma Clinics part time and cover for his friend, Steve Berman, another infectious diseases specialist. "My work with medical students and residents will allow me to pass on what I have learned over the last three decades. It is fun to tell them the lessons I learned from my patients in Tacoma. They get a different perspective than the academics give and they listen well," said Dr. Tice. In addition, he will continue with his work in outcomes research, outpatient parenteral antimicrobial therapy (OPAT) and his web sites (www.IDLinks.com and www.OPAT.com) through his consulting office in Tacoma.

"I will miss my patients, my partners, the other physicians in town, and the weekend runners in Point Defiance Park, but it is time to move on."

A Stellar Career

Alan Tice was born into medicine.

His grandfather was a country doctor, his uncle a psychiatrist, his father a surgeon, his brother an emergency medicine physician, and his sister a dermatologist. After graduating from Harvard College and Columbia College of Physicians and Surgeons, Dr. Tice trained in internal medicine at Roosevelt Hospital in New York and New York University. He completed his fellowship in infectious diseases at Tufts New England Medical Center, and spent several years on the faculty of Brown University's School of Medicine be-

oping the Harvard Resource-Based Relative Value Scale, was the liaison to the American Society of Internal Medicine and testified before Congress and the Health Care Financing Administration on behalf of the IDSA. He also helped organize the first IDSA clinical conference in 1990 and the Managed Care in Infectious Diseases Conference in 1995. In 1996 he was honored with the IDSA Clinician of the Year award.

Dr. Tice founded the Outpatient Intravenous Infusion Therapy Associa-



The Tice Family in their new Hawaii home. From left, daughter Amanda, Alan, and wife Constance

fore relocating to Tacoma in 1978. With extraordinary vision, creativity and determination, Dr. Tice established a group of infectious diseases specialists to provide hospital and clinical care. Infections Limited grew from a one-physician operation to a group of seven partners. The practice offers a travel clinic, reference microbiology laboratory, and a tuberculosis clinic. They have also developed programs in outpatient parenteral antimicrobial therapy (OPAT), clinical research and infection control.

During his years as a member, then chairman, of the Infectious Diseases Society of America (IDSA) Clinical Affairs Committee (1988-1994), Dr. Tice represented the IDSA in devel-

tion (OPIVITA) and was president of the organization until 1995. He is currently director of the OPAT Outcomes Registry, which is based in Tacoma. Dr. Tice was a founder and president of the Infectious Diseases Society of Washington, and is also responsible for creating the Hepatitis Resource Network for infectious diseases specialists to develop programs to improve treatment for patients with viral hepatitis.

Dr. Tice is on the Board of Directors of the National Foundation for Infectious Diseases and Clinical Councilor of the Society of Healthcare Epidemiologists of America. Some of his other activities include serving as the editor of *Current Treatment Options in*

See "Dr. Tice" page 10

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Now is Not the Time to Cut Public Health

There has been much doom and gloom emanating from the events of the last two months. Terrorism in all its many facets has been a terrible burden

and distraction to our daily work. There are some positives flowing from this that are important to reflect on. Public health is working



Federico Cruz-Uribe, MD

with other core parts of government in new and meaningful ways. The central protective parts of government (law enforcement and the emergency responders) work with us on a daily basis and see us more fully as part of the team. It took tragic events and an ongoing threat to remind people that public health has been around a long time and was ALWAYS part of a community's core functions. Police, fire, and epidemic control were what local governments started with when they first came together and functioned to serve their communities. Like police and fire departments, we are in the protection business.

Unfortunately, despite this public refocusing on public health's important role, there has been much benign neglect over the years. We in public health have been pretty invisible, which means our elected officials have not given our budgets much priority. Now with our economy slowing down, we are facing another round of reductions

by our funders at the state and local level. This is not the usual slow death by a thousand cuts but rather dramatic and deep cuts to our core funding. Proposed cuts: City 8%, County 14.4% and State 15%. If these cuts go through, they add up to a significant part of our budget. The state cuts alone would result in the closing of most of our Family Support Centers, decreasing markedly our drug treatment services to pregnant and parenting moms, and slashing our childcare and teen health programs.

To my physician colleagues, my message is simple: NOW IS NOT THE TIME TO CUT PUBLIC HEALTH. Individually and as a group, we need your help. Our elected officials need to know that cutting public health will put our communities at risk.

Please let your local legislator know in no uncertain terms that they need to support public health, not undermine it. We will make available to you and PCMS staff more detailed information on the specific cuts being proposed. The legislative session starts in January

and hearing from you will be more effective if it happens before then. Your support in this issue is critical to us.

As we head into flu and cold season, it is even more important to reassure patients that not every upper respiratory infection needs an antibiotic. We continue to move forward locally to address the increasing prevalence of antibiotic resistant organisms. Our Pierce County Task Force on Antibiotic

Resistance is coming out with regular updates, and these will be sent to you by PCMS. The first is the ivory insert included in this issue of the *Bulletin*. Please look at the data. Close to 70% of upper respiratory infections are due to viral agents. There are simple things you and your staff can do to lessen the level of resistance that develops in our commu-

nity, mostly, in educating your patients in the appropriate use of antibiotics. It does take time to have these discussions with your patients, but studies show that it will have a significant impact. ■

"To my physician colleagues, my message is simple: NOW IS NOT THE TIME TO CUT PUBLIC HEALTH. Individually and as a group, we need your help. Our elected officials need to know that cutting public health will put our communities at risk. Please let your local legislator know in no uncertain terms that they need to support public health, not undermine it."

Referral Coordinators Meeting

Over 80 Pierce County Primary Care and Specialty Referral Coordinators met at Tacoma's King Oscar Convention Center in November for the inaugural Referral Coordinators meeting. After responding to a recent PCMS and TAMM (Tacoma Area Medical Managers) survey, medical office staff overwhelmingly concluded that they were interested in meeting quarterly for information and support.

The goal of the first meeting was to share ideas, network, open up a dialogue and diffuse some of the tension between primary care and specialty office. Topics for discussion ranged from information needed for a referral, to dealing with the lack of uniformity between offices and insurance companies.

TAMM President Paulette Groves welcomed speakers and guests to the first quarterly session.

Speakers Tory Shestopal and Isabelle Berka, insurance specialist and referral coordinator respectively, led the discussion and shared their ideas of how primary care and specialty offices can work together cohesively when initiating or receiving referrals. "Our main objectives are to work as a team between offices and have a better understanding of each other's office policies and personalities," explained Isabelle. Tory Shestopal is an insurance specialist with Cardiac Study Center and Isabelle Berka a referral coordinator at Summit View Clinic. Representatives from Regence and Molina also answered

questions from the audience and explained their policies on handling referrals. They also shared information regarding on-line resources such as Ndex.

Comments and feedback after the meeting were positive, and attendees indicated a desire to meet quarterly to share ideas and seek ways to streamline everyone's work load and standardize the process, where possible.

Future topics will include retroactive referrals, dealing with patients without referral authorizations, and presentations from various insurance representatives.

The next meeting is to be announced. ■

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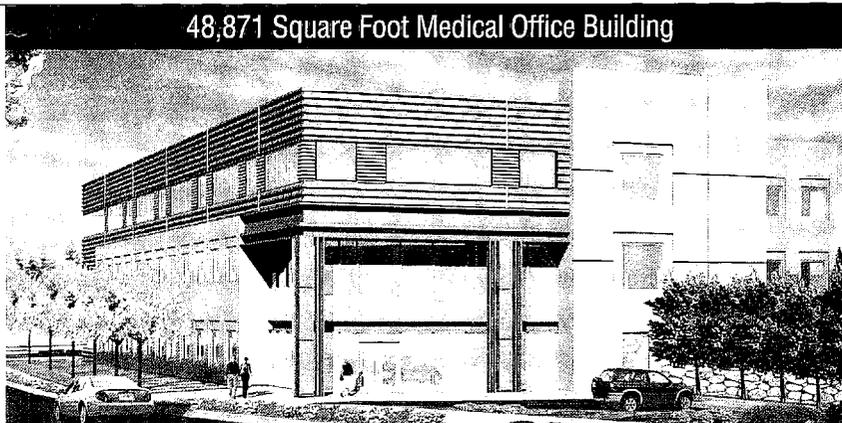
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In My Opinion.... *The Invisible Hand*

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.

Opportunity Costs

"Human felicity is produced not so much by great pieces of good fortune that seldom happen, as by little advantages that occur every day."

Benjamin Franklin (1759)



Andrew Statson, MD

Every human action is a trade-off. Out of several options, we choose one. Whatever we do is done instead of something else. The foregone opportunities are part of the cost of the action we have chosen to perform. In economics, these are called opportunity costs, to differentiate them from the direct costs of the performed action. They vary from person to person and from situation to situation.

The opportunity costs are separate from the costs incurred in the action itself. For instance, imagine taking six months off work to go sailing around the world. The opportunity costs are the lost income during the time off and the value of any other things we might have done had we stayed in town. The costs of the action itself are the cost of the sailboat and all the other expenses incurred while away. If the sailing trip enriched our outlook, recharged our batteries and we were more productive upon our return as a result of the trip, then the costs were outweighed by the benefits and the trip was worth its while.

To give a simple example of opportunity costs, consider this situation: Peter and Paul misbehave in class and the teacher detains them after hours. That is intended to be a punishment. It is so for Peter, because his family is going to the lake for a picnic and some

boating, so he is going to miss out on the fun. Paul, however, is expected home to help clean the basement and help his father take the trash to the dump. To him, being detained after school is more like a reward than like a punishment. If Paul instigated the whole incident to get out of doing the chores at home, Peter would have a very good reason to be angry.

Instead of becoming physicians, we could have chosen to be business executives, airline pilots, computer scientists, Navy officers, truck drivers or assembly line workers. In making our choice, we expected that becoming physicians would be more rewarding than any other option we could have considered.

For a long time, that was true. In the current economic environment, the effort is harder to justify. One complaint from medical residents is that while their schoolmates in other fields have been at work for several years and are already making huge amounts of money, the outlook for the medical residents is rather bleak, considering the length and cost of their training, and what they can expect to earn once they have completed it.

We all have had to scale down our expectations. Even though many of us would rather practice medicine than do anything else in the world, the number

of those who find that it was not worth it is growing and they are looking at other options. The costs of getting into medicine are so high, that is it difficult to let them be lost while looking for more satisfactory alternatives.

The situation is different for other people in the medical field. Many years ago, a hospital administrator talked to me about staffing. "In boom times, staffing is always short," he said. "People go to work in the factories, they get better pay and better hours. When the other jobs are scarce, they come to work in the hospital." The cost to enter the field and to switch to another one are much lower for nurses and technicians. Their work in medicine may be more interesting, but it is hard, emotionally draining and does not pay well enough to attract more people.

Yet the complexity of the work requires a large amount of knowledge, sound judgment and sensible decision making. The authorities will not be able to reduce the incidence of medical errors unless they pay enough to hire people to do the work. Passing laws banning medical errors is not going to do it. Limiting work hours and call

See "Opportunity" page 14

Dr. Tice from page 6

Infectious Diseases and as a section editor for *Infectious Diseases in Clinical Practice*, *American Family Practice*, *ID Alert*, and multiple other journals. He has also constructed the IDLinks web page for infectious diseases specialists, providing information and resources available in infectious diseases and clinical microbiology, as well as services for the infectious diseases community not available otherwise. The site consistently has over 40,000 hits per month and attracts a wide variety of international professionals, including physicians, pharmacists, nurses, academics and government employees.

Dr. Tice's scientific contributions include authoring over 50 articles and abstracts on subjects ranging from outpatient parenteral antibiotic therapy to urinary tract infections, new antibiotics and managed care. His areas of particular interest include OPAT, outcomes measures, networking, managed care, hepatitis, and appropriate antibiotic use. In addition, he has lectured extensively on Outpatient Parenteral Antibiotic Therapy in Argentina, Australia, Canada, China, Columbia, England, Greece, Hong Kong, Israel, Japan, Korea, Mexico, New Zealand, Paraguay, Peru, Poland, Saudi Arabia, Singapore, South Africa, Spain, Uruguay and Venezuela.

While internationally renowned, Dr. Tice's contribution to the local community is immeasurable. Founder of the Pierce County Medical Society's AIDS Committee, Tice has provided care to more people in Pierce County with AIDS than any other single medical provider. He organized an annual conference for physicians on AIDS for more than a decade. He is a continual proponent for provider care about AIDS, and consistently encouraged acceptance for people with AIDS by other members of the medical community.

Consider Your Options...Explore Alternatives

With so many years of experience

under his belt, Dr. Tice has seen many changes in the medical community. And what he is seeing now is disturbing. "There are a lot of unhappy people in this profession – and they started off as the brightest, most dedicated people in the world," he said. "But the paperwork and other problems associated with medicine and patient care are overwhelming. Doctors are losing sight of their value and are questioning the purpose of what they're doing because they are being squeezed by the business end of medicine. The rewards of this profession are in helping people, but there is an uphill battle that isn't being won. The obstacles are stripping away physicians' pride in what they do. Some are just thinking of retirement as soon as possible."

"Physicians are burned out," he continued. "They want to work 60 hours a week, not 90 to 100. But physicians are blamed for the problems in medicine, insurance companies have created more barriers and obstacles, there are increasing controls over the physicians' role, and the industry is top heavy with managers and administrators. Doctors just can't do everything."

However, he cautions doctors to not lose sight of the satisfaction from patient care despite the pressures of business. "We went into this profession to take care of patients and to be appreciated for it. We are dependent on our patients for a feeling of self-worth – the money should not distract us."

While retirement and a move to a tropical island might not be for everyone, Dr. Tice does encourage physicians to consider alternatives and options. "Doctors are very dependent on their patients. They don't think about any alternatives. Sometimes you need to move on. You can do other things and you can carry on," he said.

"Think differently," he advised. "Work to find a balance between helping the patient and your own happiness." He also counsels doctors to think ahead and think hard about the idea of a sabbatical. "Academic professionals get one every seven years. Why shouldn't physicians have the same opportunity? We need refreshment and a change of perspective every few years." Dr. Tice proposes the establishment of some type of program for Pierce County physicians that would

See "Dr. Tice" page 18



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IN MEMORIAM
JAMES L. VADHEIM, MD
1912-2001

Jim Vadheim wrote his own reflections on humility and humor titled, "How I learned to be humble." He described a house call when, as a boy in Tyler, Minnesota, he accompanied his father on visits to farms. On asking how a fee of \$10 could be profitable when \$30 was paid for getting towed out of a mud hole, his Dad had replied, "James, that is not the point. I had to go because the patient was sick and needed help." Later, already with his MD degree, he would be asked to sit with sick family members. He recalled spending a night by a woman having a gall bladder attack because her own doctor had a busy day and the patient's son wanted that doctor to be well rested when "he finally could come to see his mother." And not long after coming to Tacoma, he was flattered by the wife of an officer from Philadelphia coming to him for a cholecystectomy via Fort Lewis. On being asked why he had been the selected surgeon, the woman blushed and her husband said, "Well, to tell the truth, yours was the last name in the phone book."



James Vadheim, MD

My earliest medical experience of him was when my neurosurgical partner, Dr. John Robson, recommended I wait outside Dr. Vadheim's office and see how all his patients left smiling. As his wife Jeanne has said, "he touched everyone." As a fully trained general surgeon, he came here from the Mayo Clinic to quickly develop a huge case load. A familiar face in the corridors, he was also frequently seen in his surgical clothes hurrying across K Street between our office and Tacoma General. He was much enjoyed by nurses and colleagues alike. I have been told by a leading surgical nurse how "he was unique: we all loved him." Not only was he considered locally by the staff to be "the best general surgeon on the West Coast," but he also fought for the maintenance of the nursing school in Jackson Hall and became a member of the Nurses Alumni. "He was never irritable or bad tempered" - certainly an achievement in the surgical world, and there was felt to be a mutual trust between him and those caring for his patients. In the traditional way of general surgery, he did not hesitate to work in any area of the body at any time of the day or night. And also in the tradition of general surgeons, he had opinions. I remember asking him once if a certain old gentleman was still practicing. He replied, "Yes, he needs all the practice he can get." With Art Wickstrom he helped freely with tracheostomies in those head injured patients with severe chest problems. He was a much sought after host at hospital meetings and special events. As host and hostess, Jim and Jeanne provided many good times. The parties at Christmas time are clearly recalled. He is well remembered for his laughter. His early recollections as a country doctor included his attention to "a man brought in with what looked like the cleanest craniotomy flap I had ever seen. He was perfectly alert and surprised me by saying, "By gosh, I must be getting old because for 15 years I have ducked that horse's hoof, but today I was too slow."

In Tacoma and Hawaii we all shared many good times. In the midst of his treasured Oahu vacation, he once suddenly returned to Tacoma to take care of a friend who he had promised surgery during this same Easter so as not to lose time teaching school.

At one time he used his power boat for rounds in the South Sound. He took us together with John and Emma Bonica water skiing on Wollochet Bay. One so well remembers Jeanne's clever elegance as she took off from a sit-

See "Vadheim" page 12

Vadheim from page 11

ting start on the dock - her bathing suit literally never got wet, much to the satisfaction of a proud husband who drove the boat! One favorite escape of his was the Tacoma Lawn Tennis Club where he would often play with Fritz Haines, Jim Fairbourn and Bob Gilroy. Clearly pictured also are Larry Evoy, Bill Fry and Mack Koon. In later years he would be seen at the Pacific Northwest Tournament serving beer and sandwiches in the marquee - always with friends.

Following a road accident and a severe head injury 20 years ago, this successful man had to stop work. Simultaneously a slowly growing malignancy in his lower abdomen contributed to his distress. His wife Jeanne provided every detail of home care during that long period of time. He became increasingly bowed and dependent on both a walker and the help of family and friends. Friends he never lacked and thanks particularly to the efforts of men like **Stan Mueller** and **Gil Roller** he continued to frequently attend Harbor Lights for lunch with retired physicians. At those meetings he would glow, so delighted to be with colleagues again. That goodness which affected us all included the excitement of youngsters joyriding with him in his Corvette. In an early lecture in anatomy it was pointed out by the Professor that "amongst the best people the most remarkable are the least remarkable." Many years later a medical speaker closer to home here described the most successful man as being so often the one who is the most liked. This was the essence of Jim Vadheim. ■

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IN MEMORIAM
ROBERT M. FREEMAN, MD
1914-2001

Dr. Freeman was born in Oakland, California and moved with his family at a very young age to one of the first homes in Fircrest. He received his medical degree from the University of Washington in 1952 and was a general practitioner in University Place until his retirement in 1966. After retiring from medicine, he assumed full responsibility for the manufacturing at Wood Freeman Autopilots in Fircrest. Dr. Freeman, the son of the inventor of the magnetic compass marine autopilot, was an inventor of mechanical, electronic and navigation devices and was the holder of ten patents. Prior to attending medical school, he had a distinguished Naval career, was an accomplished pilot and received a Navy commendation for his work developing radar equipped aircraft.

PCMS extends sympathies to Dr. Freeman's wife Ethel and their children.

IN MEMORIAM
ROBERT C. JOHNSON, MD
1928-2001

Dr. Johnson was born in Tacoma, Washington in July, 1928. He graduated from the University of Washington School of Medicine in 1954, opened his Tacoma practice in 1957, and practiced family medicine until his retirement in 1992.

Dr. Johnson served as Chief of Staff at Tacoma General Hospital and was the school physician at the University of Puget Sound for 22 years. He was a pioneer in the sports medicine field. He was a founding member of Baseball Tacoma and has had the same Cheney Stadium season tickets since 1960.



Robert Johnson, MD

PCMS extends their sympathies to Dr. Johnson's wife Betty, son Cliff and daughter Betsy.

Opportunity

from page 9

schedules cannot help until there are enough people to do the work or to take call.

One approach is to import workers from Eastern Europe and Asia. The computer industry, for instance, relies heavily on immigrants from India and South East Asia for its work force. To many people in the world, working for the wages paid by our hospitals would lead to a dramatic improvement in their lifestyle. This country has always looked to immigration as a source of labor. The poem by Emma Lazarus says it well. "Give me your tired, your poor, your huddled masses yearning to breathe free, the wretched refuse of your teeming shore. Send these, the homeless, tempest-tost to me. I lift my lamp beside the golden door!"

This is as valid today as it was in the nineteenth century. The difference is that now the immigrants need to have much more knowledge, judgment and decision-making ability than ever before. Growing up in America tends to give freedom of thought and independence of judgment, qualities which are usually quashed in the authoritarian systems of the old continent. When recruiting from there we have to add. "Only rebels need apply." That was how this country was built, that is how it can continue to prosper.

Recruiting nurses, technicians and even physicians from abroad may be one solution to the staffing problems we experience. The people we recruit will have to be trained to work in our environment. That will take time and may turn out to be an expensive undertaking.

Most of us who work in medicine do so because there is nothing else we would rather be doing. There are rewards for doing a good job when taking care of people that transcend economic compensation. These rewards consist in the recognition not only by ourselves, but also by our patients and others that we have done a good job.

When that recognition is not present, we are deprived of that type of compensation.

Benjamin Franklin did not say what happens to human felicity when, instead of little advantages every day we meet with little hassles and aggravations. What happens to human felicity when we do our work, take care of our patients, answer the emergency calls, and instead of being rewarded, we have to write letters to justify our prescriptions, to explain our recommendations, to beg for authorization to test or to treat?

The last ten or fifteen years have seen a significant reduction in the benefit of becoming a physician. The inevitable result will be the re-evaluation of the opportunity cost by everyone who considers entering this field. With many

other options open to them, it is possible that the best and the brightest will choose other fields in preference to medicine.

Both the economic situation and the outside interference with the practice of medicine will have to improve substantially to attract the number and the kind of people into medicine who will have the knowledge, judgment and skill needed to do their job well. That is the most important factor which will improve medical care and reduce the incidence of medical errors. Medical care is much too complex to hope that devising a system, modeled after the cooking of hamburgers and fries at McDonalds, can provide quality and eliminate errors, especially in the absence of adequate staffing. ■

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In My Opinion.....

by David Roskoph, MBA, CFP

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 Market Has Left the Launch Pad

For almost two years now the caution flag has been held high because of the irregularities beneath the market's misleading exterior. On September 3rd the yellow flag was lowered and the green flag raised. This market is a rocket that has lifted off the pad and is headed up. Don't hesitate – get on. This particular rocket has three stages to get it into orbit. First, the Federal Reserve has loaded the economy with 40-year-low interest rates (monetary policy) and billions in liquid capital (fiscal policy) that will provide the majority of the thrust. Once the ship is safely on its way, the next stage of increasing pension plan contributions will kick into the market at the beginning of 2000. The last stage will be the trickle-down effects of the income tax reduction written into law last June. That, however, won't kick in until the summer of 2003. These three economic boosters are fundamental drivers for our economy and therefore, for financial markets. Despite the tumult and tragedy of recent weeks, investors must focus on the fundamentals that drive financial markets and not the emotion that all-too-often directs their actions.

Markets neither go up nor down forever and many investors make decisions with emotion while ignoring the all-important fundamentals. Even before the terrorist attack, the economy showed signs of hitting its eventual bottom soon. This year's interest rate reduction is the most aggressive in the Fed's 88-year history! Even before the recent crisis, the Fed's interest-rate cuts were unprecedented. With the lone exception of the Great Depression, the market has never ignored such rate-cuts: neither will it now. The first 8 rate cuts by the Federal Reserve

set the stage for an economic recovery by early 2002. That recovery was only obscured by the events of September 11th, not stopped. Put in perspective, the terrorist attacks created uncertainty in an otherwise sublimely certain America. Was the threat of further Middle Eastern terrorism more severe than the nuclear standoff that occurred in 1962? Mid September saw emotion take the markets down well past their rational values.

The losses to the US economy from terrorism are real but they did not create the recession we entered at least eight months ago. The unemployment rate, manufacturing capacity utilization and consumer confidence figures all corroborate a recession. Since the economy is strapped to the back of the consumer, however, we've been reassured that if we all just hold hands and buy an SUV everything will work out. A quick study of history reveals that markets recover **BEFORE** the economy. Profit is lost waiting for someone to say "sell" because it's *officially* a recession and profit is lost waiting for someone to say "buy" because it's *officially* a recovery. By paying attention to fundamental indicators markets can be better anticipated so that less profit is lost in waiting for *official* pronouncements. When the fog clears, much of the opportunity available now will be gone.

If you're still not convinced monetary and fiscal policy alone will get this ship off the ground, consider the government's stealth campaign to take the burden off Social Security. Quietly, the government is taking the pressure off of the mathematically-troubled Social Security system so it will not be the sole source of retirement for so many. A new tier of qualified retirement plans

was created in 1997 and, in June of this year, all plans were liberally expanded. The contribution limits for all qualified retirement plans were raised and indexed to inflation. There are across-the-board catch-up provisions that allow those 50 and over to actually contribute more than the rest of us toward their retirement plans. For example: Individual Retirement Accounts (IRA's) that have been stagnant at \$2,000 per year since 1974. They will be going up to \$5,000 per year by 2006 and \$5,500 per year if you're 50 or over. It is plain to see that the government is making it easier and more attractive to put your own money away instead of banking on Social Security. Eventually most of those new contributions dollars will find their way into the market carrying it even higher.

Finally, tax cuts stimulate economies - just not immediately. There is always a lag of 18 to 24 months. However, the downward-sloping tax rates will eventually manifest in increased economic activity. Rates are going down in every income tax bracket. For example: the present 39.6% will decrease to 35% by 2006. That's a 13% reduction in the gross margin! This third, and final stage will carry the market even higher when its effects manifest in a few years. The bottom line to reinvesting now lies not in the fact that we're in a recession, or that the market has reeled from the terrorist attacks, or that things *look* cheap, but simply because of the fundamental monetary & fiscal climate. Foremost, the Federal Reserve is prepared to do what it must to get the job done. Liberalization of the private pension system and the income tax cut lead to the same conclusion but will kick in later. The economic headlines will continue to worsen as recession is finally

See "Market" page 16

Washington State Department of Health HIV Early Intervention Program Pays for HIV Care

No person with HIV should go without treatment because they cannot personally pay for it. Early access to clinical care can slow or stop the progression of HIV infection and provide opportunities to reinforce risk-reduction messages, and may reduce patients' infectiousness.

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Call 1-877-376-9316 for the EIP formulary, list of contracted labs, and medical and dental schedules of coverage and maximum allowances. Or access this information at <http://www.doh.wa.gov/cfh/hiv.htm>. EIP staff can also refer callers to local case managers.

- **Medical Care.** EIP medical providers can be reimbursed for services, and office visits, consultations and risk reduction counseling. See the program's Medical Schedule of Coverage and Maximum Allowances for rates

and details.

- **Prescription Medications.** EIP covers at 100% those antiretrovirals and medications used to support adherence and treat the complications of HIV that appear on the current EIP formulary.

- **Lab Tests.** Many chemistry and hematology tests, HIV viral load, HIV genotype, T cell count, related serologies, and additional tests are covered by EIP when work is done at a contracted lab.

- **Dental Care.** EIP covers some dental services. Call us for more information.

- **Medical Insurance.** Since EIP is not an insurance plan (it covers specific HIV care services and medications), clients should acquire comprehensive insurance coverage. EIP can help with that task, and pay insurance premiums and Medicaid spenddown.

- **Referral to local case managers.**

Provider Contracting

Medical and dental providers and labs must contract with the Department of Health to be reimbursed for services to EIP-enrolled clients. Monique McLeod at 360-236-3493 answers questions and mails contracts. Pharmacies

should contact PMDC Systems at 1-888-311-7632 to become an EIP provider.

Eligibility and Enrollment

HIV patients must reside in Washington, but do not have to be U.S. citizens to receive EIP support. Eligibility guidelines include limited assets and a gross monthly income at or below 370 percent of current federal poverty level (for a single person, \$2,649 in 2001). EIP clients cannot be eligible for VA assistance, but the EIP program can provide limited help to clients with private insurance and those who need help with Medicaid spenddown. Call EIP for referral to local case managers who can help clients assess eligibility and apply for EIP enrollment. The EIP website contains information for clients and case managers, including enrollment forms.

HIV/AIDS Consultation

Dr. Chris Behrens offers telephone consultation, on-site case consultation, and on-site training to providers free of charge, through the University of Washington's AIDS Education and Training Center. Dr. Behrens can be reached via pager at 206-994-8773, and voice mail at 206-731-1058. ■

Market from page 15

acknowledged and damage from the attack is quantified. Historically though, it is only when a recession is accepted that a market-bottom goes into place. Your emotions (and an onslaught of economic disinformation) may tell you there is no tomorrow for the market. Now is the time to assess the situation intellectually and act against your emotions. ■

David J. Roskoph, MBA, CFP is a fee-based Investment Advisor.



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COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Primary Care Cardiology CME set for evenings of January 9 & 15

Whistler CME set for 1/23-27

The College's very popular CME in Whistler/Blackcomb still has room for participants. However, the College's reserved block of condos at Blackcomb's Aspen Lodge at press were booked. Those still interested in other possible lodging should call individual facilities, the Whistler Lodging Company at



1-800-777-0185, or a central toll free number, 1-800-WHISTLER. The course will be directed by **Drs. John Jiganti** and **Richard Tobin**. ■

Primary Care Orthopedic CME set for February 8

A new COME program designed for the primary care physicians' attention to their patients' orthopedic problems is set for February 8.

The one-day program will feature speakers on evaluation, treatment and management, and include review of appropriate imaging, joint injections, referral protocols and more.

The course is directed by **Drs. Michael Bateman** and **Charles Weatherby**. ■

The College's sixth annual program featuring subjects on cardiology for the primary care physician will be held at St. Joseph Hospital, Lagerquist Conference Center Rooms 1A & B. The course will be directed by **Gregg Ostergren, DO**.

This year's Cardiology for Primary Care CME program will be offered on two evenings in two consecutive weeks in January, instead of the traditional 6-hour program on a Friday. This year's program is scheduled for Tuesday, January 9 and Wednesday, January 15 from 6:00 pm to 9:00 pm on both nights.

The program will begin with speakers on the 9th, three hours of

CME and end with three additional hours of CME on the 15th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include:

- Congestive Heart Failure Management for Primary Care Physicians
- Appropriate Cardiac Testing
- ARBs and Their Role in Heart Failure and Cardiovascular Disease
- Rationale for the Aggressiveness of the NCEP - ATP III Guidelines
- Women's Cardiac Issues
- Managing Your Diabetic Patients' Cardiac Needs ■

<u>Dates</u>	<u>Program</u>	<u>Director(s)</u>
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Dr. Tice from page 10

offer assistance and guidance to those interested in taking a leave. "It would be of tremendous value for doctors," he said.

Dr. Tice also stressed that part of looking ahead includes financial planning. "Our investments allowed us the freedom to make this move," he said. "Constance and I both worked for many years, saved money, and made good choices."

A Farewell Luau

Prior to his leaving the mainland in September, Infections Limited organized a Hawaiian-theme open house at the office. "I wanted to be able to thank my patients for what they have done for me, and I wanted to have the chance to say good-bye to them and for them to say good-bye to me," he explained. Dr. Tice discussed his father's death and lamented that the elder Dr. Tice never really knew how much he meant to his pa-

tients. "They only really told me and thanked him at his funeral. He would have been very proud," he said. "I didn't think that was right. And I didn't want that to happen to me."

Dr. Tice's "farewell luau" was also attended by a veritable Who's-Who of Pierce County medical professionals – surgeons, oncologists, nephrologists, family practice physicians and more – a further testament to his far-reaching influence in the medical community. They were there to have a good time, enjoy wonderful food, and honor one of their finest. "Alan Tice has provided so much to the community," said **Dr. John Van Buskirk** of Tacoma Family Medicine. "He has been very involved with Tacoma Family Medicine helping for years to train residents to provide care to indigent patients. I will always be grateful for his contributions. He has been a tremendous help to the indigent patient. He will be missed."

Dr. James DeMaio, a partner at Infections Limited, concurred. "We have

a great group of doctors here, but Alan Tice will be sorely missed," he said. "He has the most creative mind I've ever seen. He is always thinking out of the box. It is extraordinary watching him work. No one comes close."

Former PCMS president and Tacoma pulmonologist **Dr. John Rowlands** is a personal friend of the Tice family. "I have always marveled at Alan's energy," he said. "He is not unlike a parent. He's leaving behind a great practice that he's developed and a wonderful group of physicians. They will carry on, but there will always be a void that can't be filled. I believe the Tice family will always consider this their home, however, and they will miss their ties and friendships here."

Dr. Alan Tice's involvement has been far reaching, and his presence in the community will be missed. He is a man who has truly made his mark here – an indelible mark that can't be erased.

Aloha, Dr. Tice. ■

Alan Tice welcomes comments from physicians. He can be reached via email at alantice@idlinks.com.

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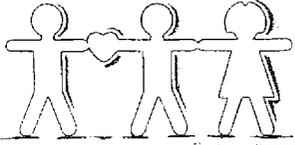
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