Pierce County Medical Society
BULLETIN

January, 2004

The 2003 Annual Meeting

Michael Kelly, MD assumes the PCMS Presidency from Dr. Jim Rooks at the 2003 Annual Meeting

Federico Cruz, MD recipient of the 2003 Community Service Award presented by Dr. Peter Marsh

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INSIDE:

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

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

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President's Page

by Michael J. Kelly, MD

Get off the Track or Get Run Over

Michael J. Kelly, MD

"Even if you're on the right track, you'll get run over if you just sit there."
Mark Twain

I realize I used this quote at my coronation as I assumed the presidency of PCMS from **Dr. James Rooks** but I felt its message should be repeated. Time has come to get off the tracks. For too long most of us have watched from the protected sidelines of our practices comforted in the belief someone else would do the work. To be successful today, medical liability reform requires the concerted, combined effort of our entire medical society.

Be buoyed by the knowledge we are not alone. Note the findings of A Kaiser Family Foundation Poll, January 2003: 74% of Americans said that the issue of medical malpractice insurance was either a "crisis" or a "major problem;" and 72% say they favor putting *limits* on the amount patients can be awarded for emotional pain and suffering.

A telephone survey of 600 voters in Washington State conducted from October 24 through October 26, 2003 by two separate organizations revealed: 66% would support a candidate who supports limits on non-economic damages; 72% support limits on the amount of money juries can award for non-economic damages.

Thus, it is the Democrats, entrenched in their false and misguided rhetoric, who are out of step with their constituents. We have captured the interest of the public. We must not squander it. However, with this kind of public awareness, there may be confusion as to why physicians are not mobilizing resources more actively than is apparent. Perception is reality. I suggest we leave no doubt about our commitment to the reform movement.

We must all begin by financially supporting the WSMA liability fund and WAMPAC. The trial attorneys have nine PACs in this state and fund them generously. We have one and fund it poorly, until now. Contact the WSMA for further details.

We have the evidence-based information which supports our contention about the liability-insurance-lessening effects of a $250,000 cap on non-economic damages among other aspects of reform (please see resources available at www.wsma.org, click on "Tort Reform Crisis Coverage"). Each of us must familiarize ourselves with the details of medical liability reform. In this way, we will be able to effectively counter the obfuscation and blatant misrepresentation by the opposition.

A few months ago, Texas showed the nation how properly performed medical liability reform successfully lowers liability premiums. Their reform bill, which included a $250,000 cap on non-economic damages, passed by 90% in the senate and 76% in the house. A referendum regarding a constitutional amendment subsequently passed. This assured that the reform bill would not face legal challenge. With this stability established, the state's largest med-mal insurer, the Texas Medical Liability Trust, announced it would lower rates by 12% beginning January 1.

Washington's reform movement must attain the same two objectives as did Texas; a meaningful liability reform bill with a $250,000 cap on non-economic damages followed by a referendum putting in place a constitutional amendment which will allow the cap to withstand judicial challenge.

As the debate unfolds, we need to remain on message: **medical care starts and ends with medical access.** Access is the mantra of reform.

Just as you would write your orders for a patient, you must also write about this important issue. Write to whomever you believe needs the message. Write your representatives, your senator, the entire house and senate of this state, even the governor himself. Do not be intimidated. *Just as you would never tolerate interference with your medical prescription, do not tolerate this interference with our mandate to care.*

When you write, write with clarity and brevity (one page only). Tell your story from the heart. If there is a caring, feeling, human reading your words with an open mind, your message will find fertile ground. You must believe we can

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New Board of Trustees will lead PCMS in 2004

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

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

J. James Rooks, Jr., MD practices otolaryngology in Lakewood. He attended medical school at the University of Miami School of Medicine. He is a Fellow in the American College of Surgeons and American Academy of Otolaryngology/Head/Neck Surgery.

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

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

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

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

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

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

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

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

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

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

Annual Meeting Recap

2003 Annual Meeting - fun, festive, and social

The Sheraton Tacoma was alive with music and conversation on December 9 as PCMS members visited with old friends and new at the Annual Meeting, traditionally held the second Tuesday in December. The evening did not disappoint, providing social time, dinner, musical entertainment, education, and introduction of the new leadership for 2003.

President J. James Rooks, MD, introduced members of the Tacoma Youth Symphony and thanked them for providing the evening's musical accompaniment.

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

Dr. Rooks asked for a moment of silence in honor of colleagues that died during the past year. **Drs. Douglas A. Tait, Thomas R. West, Bartholomew Kubat, William C. Knittel, Robert G. Scherz, Alan S. Porter**, and **James T. Gillespie** were remembered.

The highlight of the evening was the presentation of the Community Service Award for 2003 to **Federico Cruz, MD**, (see story page 6). Dr. Cruz joined the ranks of previous recipients, **Drs. George Tanbara, Charles Weatherby, Terry Torgenrud, Gordon Klatt, Patrick Hogan, John VanBuskirk, David Sparling, Donald Mott, William Roes** and **Lawrence A. Larson.**

With introduction of past presidents, and a keynote, entertaining speaker Mr. Rick Steves (see story page 7), Dr. Rooks went on to thank the board of trustees for their support and service for the year. He presented **Susan Salo, MD** with a gift and thanked her for six years of service on the board, including terms as a trustee, vice president, president-elect, president and past president.

He then turned the gavel over to **Dr. Michael Kelly**, Lakewood family practitioner and president for 2004.

Dr. Kelly thanked Dr. Rooks profusely for his leadership and commitment to PCMS. He presented him with a plaque and a gift in addition to many thanks.

Dr. Kelly introduced and welcomed new trustees for 2004, **Drs. Jeffrey Nacht, Navdeep Rai** and **Carl Wulfestieg**, noting that he is excited and optimistic about working with the 2004 Board of Directors (page 4). ■

Trustee Joe Jasper, MD (second from left) with, from left, Tom Egnew, husband of Joan Halley, DO. Ruth Roes, wife of Bill Roes, MD, Joan Halley, DO and his wife Donna Jasper

Susan Marsh, wife of Peter Marsh, MD lucky raffle winner - once again!

Dr. Ed Williams, Lakewood Ob/Gyn also a winner of the Foundation's raffle event

Left to right, Past Presidents Drs. Larry Larson (his wife Mary), George Tanbara and Charles Weatherby with new trustee Navdeep Rai, MD

2003 Community Service Award

Federico Cruz, M.D., recipient of 2003 Community Service Award

Eleven years ago, the Board of Trustees thought it would be appropriate to annually recognize a member of our society whose contributions to the community are above and beyond the norm. The first recipient, in 1992, was pediatrician **George Tanbara**. PCMS has continued to honor a physician each year - all very dedicated and committed to their community and profession. Subsequent recipients were **Drs. Charles Weatherby, Terry Torgenrud, Gordon Klatt, Patrick Hogan, John Van Buskirk, David Sparling, Donald Mott, William Roes** and **Larry A. Larson**.

Dr. Peter Marsh, past president of both PCMS and WSMA, presented the award to **Dr. Federico Cruz**:

This year we honor a one-of-a-kind physician. A unique individual. A proven leader. A man more dedicated, more determined than imaginable.

While public health is his job, running for governor is not. Dr. Federico Cruz has been spreading the word of our profession across the state for the past year. With his Healing Washington Foundation, he started a public dialogue about how to make government and medicine work smarter. He wants to make a difference in our state, in our lives and in the lives of our children and grandchildren.

Dr. Cruz's public health roots were planted early with visits to migrant labor camps with his father, who interpreted for Hispanic farm workers. After dropping out of college, he worked at a Berkeley clinic doing health screenings and decided to apply to medical school. Rather than a residency, he went to Guatemala in 1979 where he learned the importance of prevention.

After an Ob/Gyn residency, he worked in both Savannah, Georgia and Boulder, Colorado as the health officer. In usual style, he turned the departments upside down implementing prevention strategies and streamlining the departments. After four years, he moved to the top job in Orlando, Florida where his drive toward prevention was not so readily accepted. After three years, he was en route to Tacoma.

From here, most of you know the rest of the story. Prevention is his mantra. Thinking outside the box is his strategy. Doing the right thing is paramount. He has taken on the tobacco industry and very controversial issues such as AIDS names reporting and fluoride.

His is courageous and not afraid to take chances. He is an agent of change and a proven leader. His is soft spoken and quick to smile. He wants to be our governor. He is our Community Service Award winner for 2003

PCMS congratulates Dr. Cruz.

Federico Cruz, MD, award recipient, with wife Alden Willard and retired pediatrician Joe Wearn and his wife, Pat

Federico Cruz, MD (left) receives his plaque and congratulations from Dr. Peter Marsh (right) while President Jim Rooks, MD looks on

Dr. Marsh also acknowledged and thanked Dr. Cruz's wife, Alden Willard, noting that behind every good man is a good woman. Ms. Willard is a nurse practitioner with MultiCare's Allenmore Internal Medicine Group.

Dr. Cruz thanked everyone for their support and encouragement noting that his public health work is his job and his colleagues should expect no less from him. However, he was honored and grateful for the recognition. ■

Special Feature

by Jean Borst

Rick Steves on Europe: The Beauty of Value Travel

Over 1,500 years ago, Mohammed said, "Don't tell me how educated you are...tell me how much you've traveled."

Following his travels in Europe over 100 years ago, Mark Twain wrote, "Travel is fatal to prejudice, bigotry and narrow mindedness."

In short, "The value of travel is nothing new," according to Rick Steves.

Host of the wildly popular television show, "Rick Steves' Europe," author of 27 travel books, and founder of Edmond-based "Europe Through the Back Door," Steves has been an advocate of smart and independent travel since the 1970s. Speaking to a capacity crowd at the PCMS annual meeting on Decmeber 9, Steves presented a humorous, insightful and thought-provoking view of European travel. Whether you're a seasoned traveler or a nervous novice, Steves truly offered something for everyone.

A Lifelong European Experience

The son of a piano importer, Steves took his first trip to Europe in 1969 with his parents to visit piano factories. "I remember vividly thinking how much I didn't want to go," he recalled. But as a 14-year-old, "I saw it as my wonderland. They had different candy, women with hairy armpits, and one-armed bandits in the hotel lobbies. I was there with my parents, but surrounded by kids a few years older than me with their backpacks and rail passes. I remember looking over at my parents and thinking, 'I don't need you guys for this.' Give me a backpack and a rail pass, and Europe is my playground."

Today, Europe is still his playground, but also his life work. Steves has spent 100 days a year in Europe since the early '70s. "When I traveled, I saw other people making the exact same mistakes I had made before. I had learned to really value travel, and I saw people screwing up needlessly. I thought if I could just package what I had learned from my mistakes in a guidebook, then I could help other people have good trips and I would have a good excuse to go back to Europe every summer to update my material."

Subsequently, Steves established Europe Through the Back Door in 1976. It has grown from a one-person operation to a staff over 60 full-time employees, and emerged from a couple of minivan tours each year to 200 annual bus tours that take over 5,000 Americans through Europe. He has been writing travel books since the company was established, and has produced 80 programs for public television over the last 12 years. "It is such a thrill for me," he said. "I fancy myself as a tour guide, and my tour now is the camera man and director and taking them to all the places I used to take my groups of 20 people." While Steves no longer conducts tours himself, he continues to work very closely with all his guides.

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Left to right, Dr. George Brown, Barbara Young, Radiologist Bill Jackson and wife Donna Jackson, with PCMS Vice President Ken Feucht, far right and his friend, Erik Illi

PCMS Trustee, Dr. Jeff Nacht, and his wife Gail, with retired members Drs. Dick Hoffmeister and past president Stan Harris

The Annual Meeting provided a great opportunity for physicians to see old colleagues and meet new ones

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Looking at Travel in a Different Light

When he was younger, Steves' image of travel was one shared by many - a 1950s vision of "rich people on big ships on the Caribbean," he described. "It was really a way to flaunt your affluence. For two weeks out of the year, you could be really hedonistic. To me, that does not connect us with the world at all. It exacerbates the difference between us and the rest of the world."

Even today, he notes, that notion of travel persists. "For a lot of people, when they think of travel they wonder, 'Can I eat five meals a day and still snorkel when I get into port?' I've been on cruise ships, and they are really impressive. Excellent hedonism. If you've worked hard, you've got money and you want to do that, there's nothing wrong with that. But don't call it travel," Steves warns.

Overcoming the Dumb-Down Tourist Phenomenon

Steves said he so often observes the phenomenon of "dumbed-down tourists," American travelers who essentially have no clue about what they are seeing or experiencing. "They are not tuned in" and are unaware of the historical significance of what they are experiencing. He related a story about visiting Germany's Reichstag in Berlin a couple of years ago. After the building was nearly destroyed by fire in 1933, the Nazis placed the blame on the communists. President Hindenburg and Adolph Hitler subsequently invoked Article 48 of the Weimar Constitution, which permitted the suspension of civil liberties during national emergencies, and the Nazis came in to power. "Today, Germany is united," Steves explained. "The government is back in Berlin, and they've put this amazing glass dome on top of the Reichstag. It is a really incredible piece of architecture and makes a powerful statement. Germans go to the top of it and literally look over the shoulders of their legislators. I was standing on top of that building, surrounded by teary-eyed Germans. Anytime teary-eyed Germans surround you, something exceptional is happening. I tuned in, and I realized that this was a powerful moment in the story of the great nation. People were there symbolically closing a chapter on an ugly period in their history. It was so cool being up there celebrating with these people. Then it occurred to me that probably not one out of 10 Americans who were visiting that place had a clue about what was going on. They were dumbed-down tourists."

Rick Steves, mesmerized the crowd sharing his knowledge and philosophies of travel abroad

Steves explained there is always the temptation to dumb down his TV scripts and provide "just fun in the sun." That isn't a problem, he explained, "but it's a responsibility when I have a voice on public television to expect a lot of my viewers and expect a lot of the experience of travel and help us broaden our perspectives through travel. I try to encourage Americans to connect and be tuned in to the experience. But so many Americans just don't get it," he said. "When we travel, we need to do our best to understand the cultural lay of the land and enjoy it. You want to connect to people in a vivid way. That is one of the beautiful things about travel, and that is why a lot of people are very committed to travel from a world-understanding point of view."

Fulfillment and Europe

Steves explained that fulfillment is a very large part of the European experience. "Europe charms me, because I think people are fulfilled. They do things with gusto. I met a man in Paris who makes crepes like he invented them. When I was in Italy last year, I was poured a glass of wine by someone whose family name had been on that label for 150 years. I was in Paris and there was an organist playing what must have been the most magnificent pipe organ in Europe. I saw a list of names of people who had been organists for the last 300 years warming that same bench - his name was on the bottom of that list. I knew he was fulfilled.

I was in the border area of Turkey and met a man who carved niches for mosques. He held his chisel high in the sky and declared, 'A man and his chisel, the greatest factory on earth.' What a moment that was. I asked if I could buy some of his work, and he gave it to me free. He said, 'For a man my age to know that my work will go to America is reward enough.' It was a beautiful moment."

Similarly, Steves said, "I think doctors must be very fulfilled, and I think that's a beautiful thing in your occupation that you have the joy of doing something that really matters. In my travels, I see people all the time who do things that really don't matter. Take airport and museum guards. These poor people! How can you have any fulfillment just standing there?"

An Exciting Time to be in Europe

The unification of Europe has made this an exciting time to travel, Steves said. With unification, he explained, people might think that the diversity of Europe is being threatened. "One of the charms of Europe for me is the amazing diversity. You go 100 miles, you experience a whole different culture, a whole different cuisine. In actuality, I think unification is making the diversity more vivid. Three different loy-

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Making an Impact

Federico Cruz, MD

As you know, I am a candidate for Governor. The decision to campaign for this position comes from many factors, starting with a commitment to improve the life of people across the state of Washington. That commitment has its roots in public health, particularly successes in this community. I'm proud of what has been accomplished here, often through the partnership of public health and others, including medical providers. I'm also convinced that the approach we have taken here can be applied across the state, to heal Washington.

Let's look at one example that I think will show the value of expanding the public health approach statewide. Many issues, from needle exchange to fluoridation, could be reviewed, but today I want to use the issue of Environmental Tobacco Smoke (ETS). The Tacoma-Pierce County Board of Health looked at the data on tobacco-related illness and death and said, in 1995, tobacco is a threat to the public's health. Let's deal with it. Staff at TPCHD undertook the challenge, creating campaigns to keep people from smoking or to stop smoking if they had started. Over a period of two years, the smoking rate in Pierce County decreased from about 25% to 21%. A success, but not enough. Those who smoked could do so in public areas, threatening not only their own health, but others too.

So the Board held a series of community meetings to discuss the appropriateness of a county-wide smoking ban in public places. Not everyone met the idea with favor, but at the December Board meeting, several formal presentations provided Board members with details on the extensive health impacts of exposure to second hand smoke. During a marathon meeting that lasted nearly four hours, over 100 people testified both for and against a county-wide ban. The Board of Health then voted unanimously to implement a Smoke-free Pierce County policy.

We took on an issue that most affects the health of our community. We didn't look for something that was easy to implement or non-controversial. We knew there were deep-seated problems related to tobacco smoke and a high level of disagreement among community members. Motivated by the desire to confront real public health issues, we took action to move the community forward toward a solution.

This example embodies the core functions of public health: Assessment, Policy Development and Assurance. Assessment means knowing our community and its health issues. Policy development asks us to partner with our community to put a plan together to address the problem and then taking action. The Assurance function requires that we follow through to make sure the policies established are carried out. In the case of the smoking ban, we know this follow-through will mean a court battle.

All three parts of the process have to be implemented to be successful. The secret to the successes at the Tacoma-Pierce County Health Department is that we fire on all cylinders. We have leadership that is shared, not sole-sourced in the Director of Health but dynamically woven between the Board of Health, TPCHD staff, and community members. As a result, we can take on some of the most vexing community problems and make an impact.

Before the Smoke-free Pierce County resolution vote, each Board of Health member told the audience why s/he would vote. In some of the clearest language I've ever heard in my career, they described what public health is all about. They said public health addresses the overall health of our community, prevents disease rather than waiting to react to illness, and acts on the knowledge of one's community. They described the active search for information to describe and characterize the health conditions of our neighbors. They acknowledged the essential nature of partnering with communities to seek better ways to improve health.

The result is, of course, the possibility of cleaner air for Pierce County and therefore less illness and death. The result is also a tremendous message of hope for the public. So much mistrust of government exists, so much deep-seated cynicism toward government's ability to take on tough issues. But here we see a unit of government that is standing up and fighting the good fight, making a difference. I am very proud to be part of this effort and I want to recognize both the Board of Health and staff of the Tacoma-Pierce County Health Department. We are building a healthier Pierce County. From the core of public health, we can impact a community, from as small as a neighborhood to an entire state. ■

Travel from page 8

alties exist - the region, the nation, and Europe. In the last 10 years, Europe has been making it, and that means the nations are becoming relatively less important politically, and that means the regions don't threaten anyone so much anymore."

A unified Europe brings a multitude of changes that will be implemented in the next few years. Much to the pleasure of the audience of physicians, Steves explained that next year every restaurant in Europe is required to have a smoke-free zone, "which is radical," he said. "I never thought it would happen in Europe." An advocate of smoke-free establishments for years, Steves realized he was discriminating against smokers when his England book didn't list one single bed and breakfast that allowed smokers. "My friends who run little hotels in France, Italy and Spain will lose most of their business if they go smoke free, because Mediterranean people smoke like chimneys," he explained. "My friend kept telling me, 'Just wait a couple of years and these Americans will get off this no-smoking kick.' I think Europe is going very quickly into smoke free. Next year is a big year, because even pubs will be required to enforce the new regulation. That will be quite a struggle."

Unification has also brought great advancements, Steves said. As Europe unites, he explained, it is recognizing its weak links and investing in those links. "Transportation in Europe is breathtaking," he said. "All over Europe, they are investing in their transportation infrastructure like we cannot imagine." The English Channel Tunnel now allows travelers to go from Big Ben to the Eiffel Tower in just two and a half hours. "More business travelers now go to London and Paris via train than by all airlines put together, Steves said. "It's the way to go. And it makes more sense not to deal with the airports if you don't have to."

Steves also touted the bullet trains of Spain. "If you had told me 20 years ago there would be bullet trains in Spain, I would think you were talking about Basque terrorism. Today, you're talking 150 miles an hour across La Mancha."

Drivers are enjoying the same kind of improvements. Fifteen years ago, there was not a single freeway in Portugal. "The last time I was there," Steves related "day after day, the roads were screwing up my itinerary. I was arriving at my destinations hours before I thought I would thanks to the freeways."

In Norway, "four million people are filling the longest tunnels in the world blazing together the fjords for highways connecting their towns along the west coast," Steves said. Just a few years ago, Denmark and Sweden opened a massive bridge connecting those two countries, and Malmo, Sweden and Copenhagen, Denmark are now the same metropolitan area. "The advancements are literally changing the face of travel in Europe," he said. "Every time I do my three-week loop around Europe, there are about two hours less driving time due to new roads and bridges."

While transportation is vastly improved, crowds and lines at tourist sites continue to be a major concern and problem. "If you're a smart traveler," Steves said, "you'll think about the lines. There are two IQs of European travelers - those who wait in lines, and those who don't. When I come to an attraction and see long lines, it's my responsibility to my readers to find a way around those lines. And it's virtually always possible to do it," he explained, "You really need to be aggressive. Every time I go to the Uffizi Gallery in Florence, I walk by a 300-yard-long line of hot, sweaty, bored tourists waiting to get in. I call the 800 number two days before I plan to go and make a reservation for the day and time I want to come. That day, I show up with my confirmation number and walk by all those people in line. I go in, enjoy the museum, and leave before the last person in that line has reached the turnstile. The sad irony is that I get to go every year, but for those people in line, they have one day in their life in Florence and they are spending two hours of it waiting to get into the museum. That's just bad traveling."

It's a fun challenge to travel smartly, Steves said, and it's not rocket science. All over Europe there are great ways to get around the lines. And once you're in the museums, there is wonderful new technology available to enhance your experience. At the Tate Gallery in London, visitors can rent an audio wand for $1.50, take it through the gallery and hear pre-recorded comments from the museum curator on the majority of pieces on display. "It's wonderful," Steves said, "and that kind of thing is happening all over Europe."

ATM machines have made traveling in Europe easy and accessible. "I do all my travels on one ATM card," Steves said. The Internet is a great tool for checking weather, booking flights, making hotel reservations and keeping in touch with friends and family back home once you're on the road. You can keep connected to home via a cell

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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.*

Marx and Medicare

Andrew Statson, MD

"One man during an hour is worth just as much as another man during an hour. Time is everything, man is nothing: he is at the most time's carcass."
Karl Marx (1847)

Wearing his proletarian blinders, Marx concluded that everything of value is the product of someone's labor. Since he believed in equality, he postulated that what one worker can produce in an hour is as valuable as what any other worker can produce during the same time. With his labor theory of value, he proclaimed that the value of goods is determined by the time required to produce them.

He had to admit that no amount of work can give value to a useless object. He sidetracked the issue of art valuation. In his view, art was an indulgence of the higher classes, not relevant to the working world.

Applied in practice, the labor theory of value produced the economic disasters of Eastern Europe. While the Berlin Wall crumbled and the Evil Empire disintegrated, the Marxian ideas blossomed in our own back yard. Medicare embraced them as it unveiled its RBRVS.

At the core of the Resource Based Relative Value Schedule lurks the labor theory of value. It takes so many hours to do a procedure. Add the cost of training, amortized over the lifetime of practice, add the overhead and other expenses, and you come up with the value of the service.

Like socialism, this concept has the attraction of simplicity. Like socialism, it has the flaw of delusion. That is not reality. That is not how people determine value.

To avoid delving into axiology, I'll skip the discussion of why the labor theory of value is wrong. I'll only submit a very simple example: When you go to the grocery store, there is a difference in what you tend to buy depending on whether you are hungry or you just had a big meal. Somehow the value of the money in your pocket, relative to the price of goods in the store, is influenced by the condition of your stomach.

Every time someone uses force to impose artificial valuations on the market, the result is a distortion of pricing. Yet prices are a regulatory signal, reflecting the relative abundance or scarcity of goods and services. Altering them is like injecting epinephrine in a subject. The economy receives the wrong signals and responds by increasing production and making investments in the wrong sectors.

After Medicare became enacted, during the late sixties and early seventies, the subsidies to the patients raised prices and induced a boom in hospital construction and medical and nursing school enrollment. When the squeeze came on in the eighties, that boom turned into a bust, with hospitals downsizing or closing. The fate of The Doctors Hospital of Tacoma is an example of what happened across the nation.

When the market is impaired, someone has to make economic decisions in its place. The price signals don't work, so someone has to decide what to produce, how much, and how to price it when it gets to the stores. In Russia, that was done by a central planning commission. They had five year plans for investments and production. They set the retail prices of goods.

The result was a dysfunctional market. The stores had goods on their shelves that few wanted to buy because their price was too high for their usefulness. Then, from time to time, the stores got goods people could use and that were priced too low. Within an hour of receiving the shipment, a line of buyers would stretch outside the store. A day or two later, the whole shipment would be sold.

The store clerks, however, kept part of the goods in the back room and sold them later to friends at a higher price, thus creating a black market. Legal? No. Common? Yes. The market always reigns supreme, even in a dictatorship, even under the threat of concentration camps and firing squads. The black market is the inevitable result of economic interventionism.

So how is that going to play out here? Whether admitted or not, the role of the RBRVS is to control costs. After promising The Great Society, Congress could not go back to the people and say, "Sorry, you can't have it. We can't pay for it." Instead, they decided to reduce availability.

To achieve that, they had to cut

See "Marx" page 16

Applicants for Membership

Pamela L. Alvarez, MD
Neurology
Tacoma South Medical Clinic (FMG)
2111 S 90th St, Tacoma
253-539-9700
Med School: Finch University
Internship: St. Joseph Mercy Hospital
Residency: University of Michigan Hosp

Eugene Cho, MD
General Surgery
Center for M.I.S.
1802 S Yakima #202, Tacoma
253-572-7120
Med School: Northwestern University
Internship: William Beaumont Hospital
Residency: William Beaumont Hospital
Fellowship: University of Maryland

Marta Dzurilla, MD
Internal Medicine
St. Joseph Medical Clinic (FMG)
1708 S Yakima #110, Tacoma
253-627-9151
Med School: University of Oklahoma
Internship: University of Oklahoma
Residency: University of Oklahoma

Brendon B. Hutchinson, MD
Family Practice
St. Joseph Medical Clinic (FMG)
1708 S Yakima #110, Tacoma
253-627-9151
Med School: St. Louis University
Internship: University of Connecticut
Residency: University of Connecticut

Saifuddin M. Kasubhai, MD
Medical Oncology
Northwest Medical Specialties
1624 S I St #405, Tacoma
253-428-8700
Med School: Grant Medical College
Internship: Lincoln Hospital
Residency: Lincoln Hospital
Fellowship: Albert Einstein University

Tachee Kim, MD
Internal Medicine
Gig Harbor Medical Clinic (FMG)
6401 Kimball Dr, Gig Harbor
253-858-9192
Med School: University of New Mexico
Internship: Good Sam & Emmanuel Hosp
Residency: Good Sam & Emmanuel Hosp

Kenneth H. Shibata, MD
Internal Medicine
St. Joseph Medical Clinic (FMG)
1708 S Yakima #110, Tacoma
253-627-9151
Med School: University of Washington
Internship: Med College of Virginia Hosp
Residency: Med College of Virginia Hosp

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

Most intriguing medical facts of 2003

American Medical News encounters a number of fascinating pieces of information every week. Each year they look back at the year just past, and select the most interesting or noteworthy facts from each issue. If you want a copy of any of these articles, go to ama-assn.org or simply call PCMS at 572-3667.

- 46,000 U.S. adults die each year from diseases that vaccines can prevent. (Dec. 22/29)
- Only 5% of smokers successfully quit each year. (Dec. 15)
- One-third of patients follow doctors' treatment recommendations regularly. (Dec. 8)
- Worldwide, there are 745,000 measles deaths each year. (Dec. 1)
- About 8% of the adult population and 5% to 9% of children are affected by serious mental illness. (Nov. 24)
- Asthma is the No. 1 reason for school absenteeism. (Nov. 17)
- SARS has been added to the list of communicable diseases for which quarantine is authorized. (Nov. 10)
- 1.2 million office surgeries are done each year. (Nov. 3)
- 60% of Mississippians are overweight. (Oct. 20)
- 38% of health professionals get annual flu shots. (Oct. 13)
- One Singapore hospital spent $13,000 a day on masks and gloves during the SARS outbreak. (Oct. 6)
- A third of diabetics may be undiagnosed. (Sept. 22/29)
- Medication errors cost the health care system more than $1 billion a year. (Sept. 15)
- More than 70% of practices are small enough to be exempt from HIPAA. (Sept. 8)
- Medicare pays up to 88% more than the VA for some durable medical equipment. (Sept. 1)
- It cost $700 to vaccinate a 2-year-old in 2003. (Aug. 25)
- One in 133 Americans is at risk for celiac disease. (Aug. 18)
- 80% of strokes can be prevented. (Aug. 11)
- Only 2 states have laws requiring doctors to write legible prescriptions. (Aug. 4)
- SCHIP covers children with family incomes of up to 200% of poverty level. (July 28)
- Recent studies on hormone therapy have discredited benefits. (July 21)
- 1 in 5 adults cannot afford to buy some or all of his prescribed medicines. (July 14)
- The biggest U.S. health problems are related to eating, drinking and smoking. (July 7)
- 16 states impose cigarette taxes of $1 or more; the average is 69 cents. (June 30)
- States with the most diabetics: Alabama and Mississippi. (June 23)
- Each day, 17 people in the United States die waiting for an organ. (June 16)
- Only 5% of those who are eligible to donate blood do so. (June 2/9)
- Medicare Part B drug spending increased 35% in 2002, to $8.5 billion. (May 26)
- 25% of the 40,000 Americans infected with HIV each year don't know it. (May 19)
- Only 10% of Americans die suddenly; 90% experience a steady decline in health. (May 12)
- Recertification can cost internists $945 or more. (May 5)
- 18,000 doctors are also pilots. (April 28)
- It would take 7.4 hours a day for primary care doctors to provide recommended preventive care. (April 21)
- California EDs lost $390 million in uncompensated care last fiscal year. (April 14)
- 90% of adverse drug reactions go unreported. (April 7)
- Commuting to work is riskier than receiving a smallpox vaccination. (March 24)
- The federal government loses $28 billion a year from costs of liability insurance and defensive medicine. (March 17)
- Only 20% of insurance claims are paid properly the first time. (March 10)
- The number of Americans 65 or older will double by 2030. (Feb. 24)
- Childhood vaccines were 38 times more expensive in 2001 than in 1975. (Feb. 17)
- 12 million doses of flu vaccine for the 2002-03 season were still unsold in February 2003. (Feb. 10)
- Two quarts of mucous flow each day from the sinuses into the nose. (Feb. 3)
- $1.4 trillion was spent on health care in 2001, about $5,000 per person. (Jan. 27)
- 70% of older teens have used the Internet to look up health information. (Jan. 20)
- Administrative costs account for 40% of the price of an individually purchased health plan. (Jan. 13)
- 58% of the public fears a smallpox attack. (Jan. 6)

Travel from page 10

phone, but don't take yours from home or rent one at the hotel. Find a corner store and buy a phone for $100 that provides you with your own phone number in Europe so you are accessible 24/7. Just purchase more time if you need it.

The conveniences have made travel so much easier, but what good are they with the language barriers? "For 25 years, I've been telling people they can travel to Europe without speaking the languages. English is the only language I speak. And since I started traveling to Europe, we've had an entire generation grow up speaking better English than ever." His advice to travelers? "Rather than frantically trying to learn a few more French verbs between now and your next trip, I would recommend thinking about how to communicate in what the voice of America calls 'simple English.' Enunciate every letter," he advises. "Assume your European friends are reading your lips. Use easy, internationally understood words — no contractions, no slang. If my car is broken down in Portugal, I point to the vehicle and say, 'Auto caput.' That would be understood." He does recommend you always ask in someone's language if they speak English. Don't just assume they will understand you.

Weighing the Risks of Terrorism

"People ask me if terrorism has affected travel in Europe," Steves said. "All I can do is relate my experiences. I've spent 120 days in Europe this year, and there are as many crowds as ever. I suppose a few less Americans are traveling, but my books and tour programs are selling better than ever," he said.

"My advice to you is that if you are planning an international trip, you should plan it with the assumption that there will be terrorist events sometime between now and when you depart — most likely in the city you are flying to. Just get comfortable with that fact. Then you have to decide, am I going to relate to the risk in a logical, statistical way or am I going to flip out and address it in an emotional way? Then you have to do your travels accordingly. I know a lot of people just can't handle the risk and they are going to be staying home. I'm making TV shows for them. I also think a lot of people are going to travel. "

Keep the risk in perspective, Steves suggested. "Last year, 12 million Americans went to Europe. None were targeted or hurt by terrorists. Is it dangerous or not? It's your call. How many school groups, church choirs, French groups went to Europe last year? They were all scuttled virtually because parents were just too nervous.

Steves said Europeans are quite surprised by our fears. "Europeans laugh out loud when they hear the Americans are staying home for safety reasons," he said. "Last year, 8,000 people were killed on our streets by hand guns - innocent victims just minding their own business. How many were killed by hand guns in Europe? In Germany, 180; in England, 112; in Norway, 18. Now, that's a danger. If you care about your loved ones, you'll take them to Europe tomorrow!"

The practical impact of traveling today due to terrorism, Steves said, is just the delay getting out of the country and the delay getting back in. "And there's really nothing else." How has the uneasy climate affected Steves? "Well, I leave my Swiss army knife at home now." Keep in mind, he said, that Europeans have been on orange alert for 20 years. "They wrote the book on terrorism, so life goes on. It's very comfortable and relaxed in Europe right now. Security is high, as it should be, and I'm thankful for that," he said.

"I guess I just believe there is going to be terrorism for the rest of our lives, and Americans are going to be targeted," Steves said. "That's just the way it is.

Steves said that the real risk for travelers in Europe is petty purse snatching and pick pocketing. "Thieves target Americans because they are carrying purses and wallets. I knew a woman who had her purse snatched a few years ago, and in her purse was her money belt. This is why they target us! The thievery in Europe is quite predictable," he added. "If there is any kind of

See "Travel" page 18

Medicine faces a very important 2004 Legislative Session...

Here is the legislative situation as the session approaches:

Tort reform supporters in the Senate will introduce a meaningful omnibus tort reform bill that includes MICRA elements. We need to ensure that it passes the Senate on a bipartisan vote as it did in 2003.

Tort reform opponents in the House will introduce what they claim is reform. They will try to pass it out of the House without the key elements that are part of the MICRA portion of the Senate's omnibus bill.

A variety of other related bills likely will be introduced by friends and foes alike. Bills and bill numbers will be flying. It will be confusing. WSMA and PCMS will keep you informed about bill numbers and on-going status reports as they become available.

The House majority leaders have put forth draft legislation that focuses on changes in three elements, civil justice, insurance and patient safety. Their proposal does nothing to fix the underlying problem of raising liability insurance rates. Their proposals include:

Patient Safety: Sharing of continuous Quality Improvement products, funding proven patient safety/medical error reduction efforts, stricter standards on health professions discipline and requirement of health care providers to participate in and complete patient safety education programs.

Medical malpractice insurance: Medical malpractice insurer reporting, underwriting standards, development of a patient compensation fund (funded how??? by physicians paying premiums to the state!!!) and the establishment of a joint underwriting association particularly for long-term care and children's service providers, Medicaid reimbursement rate increases for ob and emergency physicians, and funding for a program that pays premiums for retired physicians who want to volunteer.

Improving the civil justice system: Early offer settlements, mediation and arbitration, expert witnesses, statute of limitation and statue of repose, and modification of the collateral source rule.

While some of the improvements to the civil justice system make sense and are supported by physicians, this draft of suggested changes is a far cry from where we need to be to have meaningful reform that will impact rates.

The message from medicine is key. Communicate to your legislators and patients the following:

- Tort reform is about access to health care - I want to be there for you when you need my services.
- Tort reform must include the policies that matter and will be effective - a cap on non-economic damages, periodic payments, and a cap on personal injury attorney fees, to begin with.
- Legislators must be allowed to vote on a cap on non-economic damages and the other reforms that matter
- Don't go home in November not having dealt with this crisis. It cannot wait. And, let the people of this state vote on a constitutional amendment to cap non-economic damages.

Please contact the three house majority leaders (even if not in your district):

1. Frank Chopp (D-43) House Speaker - Seattle. 360-786.7920, chopp_fr@leg.wa.gov
2. Pat Lantz (D-26) Chair, House Judiciary - Gig Harbor 360/786.7964, lantz_pa@leg.wa.gov
3. Lynn Kessler (D-24) House Majority Leader - Aberdeen, 360.786.7904, Kessler_ly@leg.wa.gov

Others in Pierce County that need to hear from physicians include:

1. Dennis Flannigan (D-27), 360.786.7930, flanniga_de@leg.wa.gov
2. Steve Kirby (D-29), 360.786.7996, kirby_st@leg.wa.gov
3. Dawn Morrell (D-25), 360-786-7968, morrell_da@leg.wa.gov
4. Jim Kastama (D-25), 360.786.7648, kastama_ji@leg.wa.gov
5. Shirley Winsley (R-28), 360.786.7654, winsley_sh@leg.wa.gov

Points to make:

- I may not be a voter in your district, but I am a resident of our state and our health care is in jeopardy.
- We need meaningful tort reform, including a cap on non-economic damages.
- Please let your party vote on real tort reform in the 2004 legislative session.

For help in contacting your legislators please call PCMS, 572-3667. We will be happy to assist.

Marx from page 11

down on the number of hospital beds, MRI scanners, practicing physicians, you name it. "You want another mammogram? You better schedule it on your way out of the department. We are booked solid for the next sixteen months."

Then, when it takes two years to schedule an elective procedure, as it does in Britain and Canada, they'll appoint a commission to study the problem and propose measures to reduce the waiting times for services. The recommendation probably would be to establish a Promptness Control Board to oversee the scheduling and investigate all complaints about delays.

As it is happening in Britain and Canada, those who can pay out of pocket go to private hospitals or abroad to get their treatments. Those who can't pay, wait. As one of my dermatology friends once said, "When the poor have an itch, they scratch. The rich go to a dermatologist." No matter what we may want to believe, multi-tiered health care has never ceased to exist. There always have been and there always will be some who are more equal than the others.

Right now, the shortage is evident mostly in the staffing of hospitals and laboratories. There have been temporary shortages of injectables and vaccines. As the prices of drugs come under control, those shortages will increase.

At the same time, the squeeze on physicians will continue. Even if the projected cuts in the Medicare fees are repealed, we cannot expect that payments will increase anywhere near the rate at which our overhead is rising, if at all. At some point in the not too distant future, our costs will outstrip our income and we will have to quit.

We are not there yet, but soon the time will come when we'll have to plan for a parallel fee-for-service system, independent from the government and free from government intervention. It would be nice if we could establish such a system openly. However, you can be sure that if the government should try to forbid it, a black market will arise, no matter what the penalties, just as there was a black market for abortions when they were illegal. ■

CORRECTION

An error was made in **Dr. Statson's** article "Relative Value" which appeared in the December 2003 PCMS *Bulletin*. On page 14, fourth paragraph, the second sentence should read: "The **ICD** codes will increase from the 10,000 we now have to **140,000**."

We apologize for the error.

YOU'RE INVITED!

Community Health Care, The Pierce County Medical Society and Pediatrics Northwest invite you to join a celebration of the contribution to our community by Dr. George Tanbara and Community Health Care's 35th Anniversary.

SAVE THIS DATE

WEDNESDAY, MARCH 24, 2004
Tacoma Sheraton Convention Center
Social Hour at 5:30 with Dinner at 6:30

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http://commhealthdinner.kintera.org/
or call (253) 597-4550

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Travel from page 14

big commotion, it is likely designed to distract people — the pickpockets are probably at work. If you have a wallet or purse, expect to lose it. If you are carrying a purse, make sure you only have a little spending money, odds and ends, and a funny little note to the thief. Everything that matters should be tied to your body, tucked in like your shirttail, or left in the hotel. Routinely when I am in Europe, I feel the hand of a stranger slipping into my pocket. And I'm wearing a money belt, so it's just one more interesting cultural experience. It's not a big deal. Don't be vulnerable."

A Different Perspective

His viewpoint may seem quite different than your average American traveler, but that might be because Steves has spent a third of his life in Europe. "I have a different way of looking at things. They tell me — and I believe it — that half the world is trying to live on $2 a day. That's three billion people. They explain to me — and I believe it — that 4 percent of this planet is the United States and we control half of the wealth. And we've elected a government that's doing everything it can to make us wealthier. That's who we voted for and why," he explained.

"The gap is growing between rich and poor," Steves pointed out. "Money is coming from desperately poor countries into our country much faster than it's going the other way. That's a fact that many Americans just can't believe, but the rest of the world accepts it. Only America can be outvoted in the UN 180 to 2 and not find it curious. Or be indignant and say everyone else is ganging up on us.

"When we travel, we have to assume there will be terrorism. We have to keep the risk in perspective. And, if you want to keep those insignificant risks smaller, you can travel the way I've been preaching for 25 years - through the back door. You're melting into Europe."

How Travel Can Open Your Mind

"The driving force for me in my work is how travel can broaden your perspectives," Steves said. "I was raised knowing the world is a pyramid with us on top and everyone else trying to get there. I really believed that, and it was up to us to enlighten people who didn't understand that. I've met people who have less freedom than me, less opportunities, less money and they wouldn't trade passports. It's very inspirational."

Experiences like that are what makes Steves so committed to what he calls value travel. "Travel to me - good travel, thoughtful travel - brings us together. It's a beautiful thing. I think we need it more than ever. If everyone traveled before they could vote, I think our country would fit better into this ever-smaller planet."

There's a magic of travel, Steves notes, and as a travel writer, he is always looking for those magical moments. "They are not a dime a dozen," he explained. "You have to look long and hard for them. And when I find them, I'm a very happy traveler."

And so are his readers, viewers and clients.■

Note: Many thanks to Rick Steves for donating 10% of the proceeds from the evening's book and DVD sales to YWCA Shelter residents.

PCMS Foundation thanks Holiday Sharing Card contributors

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

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

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

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

Tosh Akamatsu

[illegible]

Patrick Hogan

Margaret Larson

David McEniry

Drs. Paul Nutter & Maria R. Reyes

Charles and Shauna Weatherby

President's Page

from page 3

win this battle. We need your positive energy flowing into Olympia by e-mail, letter and with personal appearances. Write letters to the editor. Communicate now! Time is of the essence. The 2004 session, only 60 days long, begins January 12. The PCMS office can assist you with your response.

I do not intend to be the caretaker in a system of slow decline. As your president, I will not retire into the shadow of submission. I will be proud to help lead this mission for the physicians of Pierce County to the inevitable triumph I know we can obtain, helping to rejuvenate the practice of medicine in Washington.■

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.

Mistakes You Can't Afford to Make When You Have Kids

Teresa Clabots, MD

Little did I know that my five bundles of joy would turn into rambunctious teenagers, and together with their fun-loving friends would cause me reasons to have gray hair.

These very active teenagers started to worry us when they entered the driving age. We were faced with tremendous liability risks on a daily basis, with the impending catastrophic accident leaving us one step away from bankruptcy.

Many a sleepless night I waited up for our teenagers. For what would happen, God forbid, if one of our children were involved in an injury accident, and they were at fault? We, as parents, would be liable since the cars and insurance are in our names.

It seems that we are liable for everything. All the toys we had acquired so we could have fun with our kids and their friends (the board, the jetski, the trampoline) are all accidents waiting to happen.

After one of our kids accidentally broke another child's forearm on the trampoline, State Farm threatened us with termination, saying we were high risk. I told them, first of all, we had been with them for 20 years, and second of all, we didn't buy the trampoline, our child had gone out with his own paycheck and brought it home. It didn't matter, we had to get rid of it. They even trespassed on our property to inspect that it had been removed.

I tried to donate it to the school. They didn't want it. Too much liability. So we gave it away.

After surviving teaching them to drive, getting them beater cars, paying for speeding tickets and small dings and dents out of pocket, we got a notice from State Farm. One more accident or ticket and they would drop us. So our son and his lead foot were in the nannymobile (an old white Taurus station wagon) and oops, accidentally ran into another car which was a beatermobile. Our son instantly gets out of the car, and in front of four witnesses (his four cousins visiting) tells the other teenage driver, "Please don't report it to the insurance, my parents are both doctors and they will buy your car so you can get a new one."

We paid some absurd amount for the beatermobile, which then sat on our driveway and refused to start (I was going to make my son drive it for awhile). That hunk of junk we renamed the trashmobile, and donated it to charity, who came and hauled it away.

Every time our son was in an accident, we would demote him. That meant he would drive a smaller, and slower car.

After several demotions, I went to the used car lot and for $1,500 bought him a beat-up bile green Volkswagon Beetle. Then I had to pay $400 to make it drivable, and drove it home. I had a hard time driving it since it did not have power steering and you had to put your foot to the metal and stand up to make it go faster than a go-kart.

There were the glimmerings of tears in his eyes when he realized we were serious and he would have to drive that to school. He took it all in stride, waxed it three times, bought dice to hang from the rear view mirrors, bought zebra covers for the seats and set off for school in a car that wouldn't go over 30 MPH. He won the award for beater of the month.

Then we started getting smart. After hearing about all the water accidents, a skier in our lake hit a concrete dock and ended up in Harborview and I kept hearing of drownings, we talked to our insurance agent. He was more than happy to sell us a liability umbrella and suggested that we talk to an attorney about getting a liability waiver.

Our attorney recommended the following liability waiver be signed by anyone that came to our house (see page 20).

Our hearts were a little at ease. At one graduation party, we were rounding up the kids since it was time to go home. One very stout girl decided to take the jetski on a journey. She revved it up, it flew out of the water (honestly, I don't know how she did that trick), jumped over the dock, knocked three people flat into the water like bowling pins and crash landed on the other side of the dock, then flipped over in the water, bucking her off.

With my heart in my throat, I ran all the way down to the dock, yelling, "How many kids are we missing?"

See "Mistakes" page 20

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Convenient Tuesday Evening Cardiology CME set for January 13 & 20, 2004

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

This year's Cardiology for Primary Care CME program will again be offered on two evenings in two consecutive weeks in January, instead of the traditional 6-hour program on a Friday. This year's program is scheduled for Tuesday, January 13 and Tuesday, January 20 from 6:00 pm to 9:00 pm on both nights.

The program will begin with three hours of CME on the 13th and end with three *additional* hours of CME on the 20th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include:

- Current Testing Strategies for Assessing Your Patients' Cardiac Issues
- Understanding Cardiac Disease in Women
- Statins, Cholesterol, and More
- Heart Attack Prevention
- Co-Morbidity of Depression, Anxiety and Cardiovascular Disease
- PFO and ASD Closure: A Clinical Point/Counterpoint Discussion ■

Don't Postpone Hawaii CME Arrangements

Those interested in attending CME at Hawaii are urged to make plans now for both air transportation and lodging. The College's block of seats on Northwest to Hawaii are going fast.

All Wanderlands Travel, specifically Jeanette, 572-6271, is prepared to assist you in securing your seats.

To take advantage of the reduced rates at our conference hotel - The Hyatt Regency Kauai - you can call directly to 1-808-742-1234.

We hope to see you there! ■

Alternative Whistler Condos Available

At press time, close-by condos to the Aspens were still available for the College's CME program at Whistler/Blackcomb set for January 28-31, 2004 - at the College's discounted rate.

If you're interested in the program, and a great ski vacation and location, To make reservations, you may call the management company at 1-866-788-5588. You must identify yourself as a part of the C.O.M.E. group.

For more information call the College at 253-627-7137. ■

Dates	Program	Director(s)
Tuesday Evenings January 13; 20	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

Mistakes from page 13

Luckily, no one was hurt. Our dock and our jetski took a beating, but the kids were all okay.

I was beyond furious. With the signed liability waiver, I felt like mailing the repair bill to the mom.

I called our insurance agent, who advised me not to turn the claim in.

What gave me a chill was his next comment, "I didn't know you had a boat and a jetski." Yes, I assured him, we have had them for years. "I don't see it in your file," he responded.

It seems that when the branch transferred from the old agent to the new agent, somehow that had never been renewed.

I call my agent once a year now to be sure that everything is up-to-date.

And, I make EVERYONE sign a liability waiver. ■

Liability Waiver and Agreement

I recognize that there are certain inherent risks to both my/my child and his/her friends while engaging in recreational activities on the property, home, and premises of Joe and Teresa Clabots. I fully understand that they live on a lake, have a boat, and jetski which will be used during my/my child's stay there. I understand that I will be personally responsible for any and all actions of myself/my child. I agree to assume full responsibility for any claim, loss or personal injury, or damages of any kind caused by the actions of me/my child, both to others and to myself/themselves. I further agree to indemnify, defend, and hold the Clabots family, and its agents harmless from and against any and all claims, suits, actions, losses, costs of damages of any kind, including attorneys fees rising out of or resulting from the actions of the participants at the party.

Child's Name _____ Guardian Signature _____

Guardian Name _____ Number (home, cell) to reach parent _____

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POSITIONS AVAILABLE

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

Family Practice office in search of a motivated team member: DO, MD, ARNP. Please send curriculum vitae and references to 253-566-4620 or e-mail to sharonlmgr@aol.com.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 851-7550, 468-3539.

The WA Academy of Family Physicians invites you to attend their 55th Annual Meeting & Scientific Assembly at The Coast Wenatchee Center Hotel in beautiful Wenatchee, Washington on May 21-22, 2004. This event has been approved by the American Academy of Family Physicians for 12.75 credits. Topics will include: "What's New in GI," "Pediatric Asthma," "Dermatological Unkowns," "EMR," "Empowering Relationships," and "Menstual Suppression." See www.wafp.net for more information. Call Marie at (800) 621-8424 or email admin@wafp.net to register.

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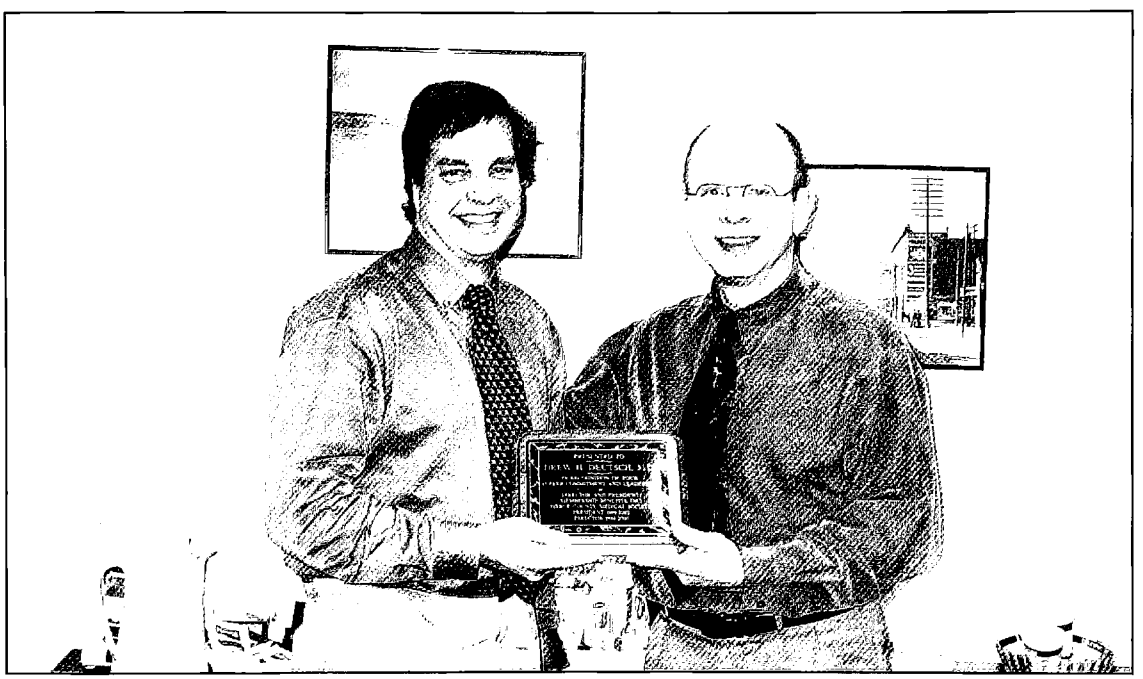
Pierce County Medical Society

BULLETIN

February, 2004



Dr. Tim Schubert, right, presents a plaque of appreciation to Dr. Drew Deutsch for his service as president of the PCMS subsidiary Membership Benefits, Inc., 1999-2003. The plaque was presented at the December MBI Board of Directors' meeting

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INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

February, 2004

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President's Page

by Michael J. Kelly, MD

Damn the Odds Full Speed Ahead

"Overwhelming odds,
Little chance of success...
When do we start?"
- Grimley the dwarf, from "The Return of the King"
Third installment of Lord of the Ring

Michael J. Kelly, MD

As we travel together through this land of legislative acts there are many who disdain of purpose. They make unfounded and misleading pronouncements and try to keep us off balance. When they state that tort reform has no effect on liability rates, please refer them to Colorado, Minnesota, Montana, California and now Texas.

Your board of trustees, eager to learn the lessons from Texas liability reform of 2003, successfully invited Charles W. Bailey, Jr., MD, JD, the president of the Texas Medical Association to address us on January 10. This special address was held in the middle of the annual retreat of the board of trustees. Invitations were sent to the entire membership of the PCMS, the presidents of all the medical societies of the state, the entire legislature and the press. We were honored to have Representative Mike Carrell (R-28) and Senator Rosa Franklin (R-29) present along with a large number of PCMS members.

Dr. Bailey's address was comprehensive and sobering. He had also spent two hours prior to his address sitting in on our discussions and offering his brand of Texas advice.

Texas was able to do what we must achieve - the passage of a meaningful liability reform package. This included a $250,000 cap on non-economic damages, and a constitutional amendment that allowed the reform to survive legislative challenge. As a result, the Texas Medical Liability Trust, the largest med-mal insurer in Texas, announced it would be lowering premiums at least 12% beginning January 1, 2004.

Dr. Bailey stressed that the important ingredients included a well-developed strategic plan with grassroots involvement, sound policy development, message development and timely communications. Physicians in Texas testified extensively about the crisis and its effects on access to care. Numerous meetings were held between physicians and legislators.

Dr. Bailey strongly feels that all politics are local. Talk one-on-one with your patients, he advised; write letters to the paper; address service and civic clubs and meet with legislators. Raise funds but do not try to match the trial lawyers dollar for dollar (in Texas, the Trial bar raised over $11 million while the physicians were less than 10% of that).

Texas succeeded because they remained focused on and true to one constant resonating mantra: access to medical care.

I hope all the membership has had the opportunity to read Patrick O'Callahan's two part Insight editorials in the *TNT* (1/11/04 and 1/18/04). I felt the first installment was an excellent example of the result of a badly damaged medical liability system. Part two represented our proposals for reform but seemed to lend some credibility to the Democrats solutions. Mr. O'Callahan did finally state, "The preponderance of evidence suggests that a $250,000 cap in Washington State would indeed act, over time, to curb malpractice premiums." At long last, recognition - and in print! For those of us close to the situation this is not a revelation but more a vindication.

Please continue to talk to your patients about this issue. I have personalized an information sheet on tort reform, the back of which has an example of a letter to a legislator. I copied a page from the *TNT* showing how to reach legislators by mail or phone or e-mail. Patients receive these sheets, stapled together, as they check in. In the exam room, I mention the need for them to read, respond, and send me a copy of their response. This takes less than a minute and has already produced a great many letters. ■

PCMS Subsidiary, Membership Benefits, Inc., provides service and revenues for members

The Membership Benefits, Inc. (MBI) Board of Directors presented a plaque to **Dr. Drew Deutsch** at their December meeting in recognition of his service as President, 1999-2003. **Dr. Tim Schubert** thanked him for his years of service, acknowledging the financial success of MBI, the PCMS wholly-owned, for-profit subsidiary. Dr. Schubert currently serves as President.

MBI oversees the publication department that generates the monthly *Bulletin* and the annual Physician Directory and operates the PCMS placement service for both temporary and permanent personnel. MBI owns the PCMS building at 223 Tacoma Avenue South, and leases space to other medically related organizations such as the Piece County Dental Society, Pierce County Nurses Association and the American Lung Association of Washington.

The placement service began it's temporary division in 1993 and it has proven to be a timely and successful venture. Providing temporary personnel from one day to several months, it allows the employer to obtain staffing without having to hire, fire, do payroll or provide benefits. Temporary workers are placed in the office and then the employer pays a fee to the placement service for the use of that temporary worker. No record keeping or taxes required. The worker is an employee of the agency and is reimbursed as such. The service has grown from gross revenues of $23,000 in 1993 to over $300,000 in 2003.

MBI was incorporated in 1978 as an avenue for PCMS to generate non-dues income without jeopardizing the nonprofit status of PCMS. Revenues from advertising, placements, rents, programs, etc. are used to forestall dues increases. PCMS has only seen one small dues increase in many years.

MBI has not always operated in a for-profit mode. In 1985-1986 MBI borrowed heavily from PCMS to subsidize their business, as they did initially in 1978-79. All loans have been repaid and MBI currently enjoys financial freedom. In the late 90's, they worked to build reserves should difficult financial times return. In 2003, the building required a new roof, new heating duct work, new garage doors and carpeting. After these expenditures, they will now once again focus on rebuilding reserves.

Other members that have served as MBI Presidents since its inception include: **Drs. Tim Schubert**, 2003; **Drew Deutsch**, 1999-2003; **Keith Demirjian**, 1996-1998; **Joe Wearn**, 1992-1995; **Mark Gildenhar**, 1989-1992; **Robert Whitney**, 1988-1989; **Don Shrewsbury**, 1985-1987; **Gregory Popich**, 1984; **Dale Hirz**, 1981-1983; **Richard Bowe**, 1979-1980; and **Ken Graham**, 1978.

Current MBI Board members include **Drs. Steve Settle, Steve Duncan, Tim Schubert** and Secretary-Treasurer **Joe Regimbal**, in addition to **Drs. Demirjian, Deutsch, Gildenhar** and **Wearn**.

MBI strives to provide benefits to PCMS members as well as remain financially viable. MBI also produces the annual Pharmacy Directory, a complete listing of Pierce County pharmacies, and has previously produced laminated coding matrixes. Both the Pharmacy Directory and coding matrixes were distributed at no cost and were developed at the suggestion of members. The MBI Board welcomes ideas about benefits that would be of help to the membership. Please call Sue Asher, 572-3667 at the Society office with your suggestions. ■

The Tacoma Philharmonic presents The Empire Brass, sponsored by physicians

The Empire Brass, presented by the Tacoma Philharmonic is being sponsored by physicians in Pierce County. The performance will be on Saturday, March 27 at 8 pm at the Pantages Theatre in Tacoma.

The Empire Brass enjoys an international reputation as North America's finest brass quintet, renowned for its brilliant virtuosity and the unparalleled diversity of its repertoire. There are five musicians – all have held leading positions with major American orchestras – that perform over 100 concerts a year in cities such as New York, Boston, Chicago, Washington, London, Zurich and Tokyo.

The Tacoma Philharmonic provides world-class classical music for the South Sound. They exist to enrich the cultural life of our community by presenting classical music performances of world-renowned orchestras and artists otherwise unavailable in the Tacoma area and by offering unique music education opportunities.

Following the Empire Brass, the Philharmonic presents the Australian Chamber Orchestra, with Richard Tognetti, conductor and Piotr Anderszweski on piano, Sunday April 18th at 7:00 pm.

The Tacoma Philharmonic is one of the oldest performing arts organizations in the Northwest, having been founded in 1936.

For more information you may call the Philharmonic office at 253-272-0809. ■

Board of Trustee Retreat highlights Texas Medical Association President

The PCMS Board of Trustees retreated on Saturday, January 10th to the Landmark in Tacoma to get acquainted with new board members and set their goals and direction for the year. Their first order of business was review of the membership priority survey conducted last fall. "It is a clear edict," noted **President Mike Kelly**, citing an 87% response for tort reform being the number one priority. Reimbursement followed with 69% and practice viability 52%. It was the consensus of the board that liability rates are the biggest factor affecting the health care system and unless a solution is found quickly, many physicians will not be practicing in the future. While many issues were discussed, it was clear the focus will remain on the tort issue through the legislative session and the remainder of the year, with the focus being patient access.

There was concern regarding physician unity and the lack of solidarity in the profession statewide. There are many ploys to split the profession, by specialty, by employer, by issue, by politics, etc. and everyone agreed this is of detriment to the profession remaining strong and vital and being successful in their attempts to make changes to the health care system.

Len Eddinger, Director of Public Policy and Planning with the WSMA, gave a legislative update on liability reform. He noted the session is a short one, running from January 12 to March 11. He gave a briefing of the Liability Reform Coalition, comprised of 66 members, including Boeing, Weyerhaeuser, Pharmacy Manufacturers, etc. and the poles show that the public stands behind the coalition on the issue.

He also reported on the WSMA and WAMPAC's efforts to make candidates that do not support tort reform and who are up for re-election in 2004 very uncomfortable, something the association has not really used as a direct strategy in the past.

The meeting adjourned to another room where Dr. Charles Bailey, President of the Texas Medical Association gave insight into how Texas was successful at passing their tort reform legislation. His bottom line was that we have to get patients involved and we need to get out of our professions and out of politics and put pictures of our children and grandchildren on the table with the message that preserving our health care system for us and our loved ones is paramount.

In the last session of the day, the board met with hospital medical directors, **Drs. George Brown, Don Mott** and **Mike Newcomb** representing MultiCare, Good Samaritan and Franciscan Health Systems respectively. In agree-

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Past President Dr. Jim Rooks (left) chats with Dr. Charles Bailey, President of the Texas Medical Association

From left, Drs. Mike Newcomb, John Lenihan and George Brown compare notes after Dr. Bailey's talk

Dr. Don Mott (left) and Dr. Ron Morris visit after the retreat. Dr. Morris serves as a trustee of PCMS

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ment, they all reported similar challenges to what physicians are facing. Regulatory issues, payer battles and reimbursement concerns, medical malpractice issues, etc. "We have more in common than not," noted Dr. Newcomb and "We have more in common than divides us," added Dr. Brown. All three hospital representatives said that their health care system does not want to be in the business of employing specialists, but, as Dr. Brown explained, "the malpractice crisis has caused the earth to shift a bit." Employing specialists is not one of their strategic initiatives, but they will employ them to continue to meet the need. The stated preference from all three physicians is that they prefer that specialists remain independent and run successful practices in the community. However, the economic reality is in certain instances, they would look to employment type models.

Closed medical staffs are not being considered by the hospitals. "Closed models are nowhere in Multicare's plans," said Dr. Brown, and "we have absolutely no plans and have had no discussions to close medical staffs, said Franciscan's Dr. Newcomb.

Good Samaritan has an entire new management team and they are aggressively recruiting doctors according to Don Mott, MD. They are building four new operating rooms and looking toward a CON approval for cardiovascular surgery. He added that they will be dropping the Good Samaritan Residency program as the financial losses of the program are not offset by any benefits such as hospital service or physician recruitment.

While all of the hospital spokesman agreed there are many issues in common with physicians, they all agreed that the "line in the sand" is specialty hospitals. Hospital margins are so thin they are forced to fight the threat of specialty hospitals. With inpatient care as their fundamental core service, they cannot afford to lose any business to specialty hospitals.

PCMS members attending the Board of Trustees Retreat **included Drs. Mike Kelly, Jim Rooks, Ken Feucht, Sumner Schoenike, Joe Regimbal, Laurel Harris, Joe Jasper, Ron Morris, Jeff Nacht, Navdeep Rai, Carl Wulfestieg,** and WSMA representatives **Nick Rajacich, Len Alenick** and **Don Russell**. Many members, physicians from around the state, and Pierce County legislators, Rosa Franklin (D-29) and Mike Carrell (R-28), joined them for Dr. Bailey's talk on the Texas experience of enacting medical liability reform. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Endurance

Federico Cruz, MD

Recently I watched the movie *Endurance*, the story of the Shackleton expedition to Antarctica in 1914. It is an amazing story of tenacity and adventure. He and his crew survived two years in the pack ice or on a remote wind-swept island just off the coast of Antarctica. This was before microfibers and freeze-dried foods. I found it very moving to read the book on the expedition and to see the movie. What an amazing experience.

I bring this all up not as a movie critic or as a book reviewer. But about two years ago I started on an adventure to run for governor of this fine but struggling state. Like Shackleton, I knew where I wanted to go (the Office of the Governor), and also like Shackleton, I did not know where I was going to end up. I was jumping into something new for me, as I had never run for public office. I was prepared to change jobs, change lifestyles and go a different way with my life. So I stepped forward and I jumped and I landed in a new and different place. The notion that "you're not in Kansas anymore" pops into my mind on a regular basis.

As I realized how poorly our state was doing, I stepped out of the cocoon of my job as a physician. Things seemed to be sliding, not just one or two high profile areas but across the board we were falling into mediocrity... or worse. So I stepped to the plate and announced that I will give it a try. I am Independent, not afraid to take on tough issues as shown by my consistently trying to address the toughest public health issues facing our community. I am not wedded to the system; if anything I am committed to fundamentally changing it. Since I work in public health, which is a part of government that has been consistently ignored over the years, I have had to learn how to get things done when I lack resources, political standing, or public support. Being creative and resourceful isn't just a nice idea but essential to surviving and thriving in public health.

I spoke to more than 100 groups across the state. I brought a message of change in government: how we do business; the role of state government in addressing local issues; how services are provided. In general, people supported my message and invited me back to each community to speak again. But when it came time to garner the political and financial support for my candidacy, I started seeing Shackleton's icy mush. Almost everyone hesitated, getting trapped in non-issue questions: Who is this guy? Can he win? Is he a good Republican? Does the party support him?

Even as our state desperately needs leaders who could chart an independent course to best guide our state through complex issues, we find ourselves with an election process that screens out independence. All too often candidates have to link themselves with special interest groups in order to get elected. The price that is paid is the flexibility and independence so needed to successfully take on the tough issues.

A conflict arose very early in my campaign between my pledges of change and the need for respecting traditions and speaking to the positives. Candidates make an art form out of telling people what they want to hear. The problem is that our current situation cries out for frank discussions of critical problems and barriers, with commitment to the innovative actions needed to address them.

To make change at a statewide level requires tremendous public support. This can't come just from good ideas and a credible game plan. You have to build it. I discovered how much needed building in my travels this past year (70,000 miles on my car): Creating a movement. Building a statewide organization, community by community. Getting your name in front of people. This is very time intensive and costs resources. I made a good start meeting folks and getting my ideas out there,

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Recommended increase in level of suspicion of SARS

As this article is being written, a third case of SARS (Severe Acute Respiratory Syndrome) has been identified in Guangdong Province, China. No links have been established between the three cases, nor has person-to-person transmission been confirmed.

However, in light of these reports and the ease of worldwide travel, the CDC is recommending that U.S. providers increase their level of suspicion for SARS in patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome (ARDS) AND who have a history of travel to Guangdong Province (or close contact with an ill person with a history of recent travel to Guangdong Province) in the 10 days before onset of symptoms.

The CDC continues to ask providers to consider SARS in similarly ill patients with one of the following:

• A history of recent travel to mainland China, Hong Kong, or Taiwan, or who have had close contact with an ill person with recent travel to these areas.

• Employment in an occupation at particular risk of exposure to SARS (e.g., health care worker with direct patient care, workers in labs with live SARS-CoV).

• Part of a cluster of cases of atypical pneumonia without an alternative diagnosis.

SARS, a febrile severe lower respiratory illness, is caused by a novel coronavirus (SARS-CoV). The disease was first recognized in Asia in February 2003, and over the next several months spread to more than two dozen countries in North and South America, Europe, and Asia. Transmission of SARS-CoV appears to occur primarily through close interactions with infected persons, predominantly via respiratory droplets. Fecal/oral transmission may have occurred in some settings, and the possibility of airborne transmission has not yet been ruled out.

During the 2003 outbreak, the vast majority of individuals who contracted SARS-CoV had these two characteristics: 1) a clear history of exposure to a SARS patient or to a setting in which SARS-CoV transmission was occurring, and 2) developed pneumonia.

If you have a patient who meets the above criteria, or if you have any questions, call the Tacoma-Pierce County Health Department at 253-798-6410. Press "0" and ask to speak with a nurse.

If SARS activity continues to increase globally, recommendations regarding the index of suspicion may change. Details and updates about the disease can be found on the CDC website (http://www.cdc.gov/ncidod/sars/clinicians.htm) or the WHO website (http://www.who.int/csr/sars/en/). The CDC has also updated their reporting form. It is available online at: http://www.cdc.gov/ncidod/sars/guidance/b/pdfapp2.pdf. ■

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but I have not been able to build a credible statewide organization nor raise necessary dollars to pay for the effort. In the short run it means that I do not have a campaign that is ready for the 2004 elections.

For a few days that reality struck me as sharply as Shackleton's realization that his ship and crew were caught in the ice, miles from help. But Shackleton's own words reflect my personal commitment: "A man must set himself to a new mark directly the old one goes."

Powerful reasons directed my course as I began campaigning for Governor. I expected to get further on that journey than I was able to. But the need for new ideas and approaches and strong leadership in Washington continues to press just as intensively today as when I started. My commitment hasn't changed. I will continue to demand that changes be made at the state level. I will get to the many communities across our state, to speak out on key issues and develop relationships so there will be broader support for a movement to change state government.

The Healing Washington Foundation will persist and I will continue to pilot that ship (I kicked off the public process by founding Healing Washington to speak out on changes necessary in our state for healthcare and on the importance of government change). I am a very optimistic person. I believe that we can address the huge problems facing our state. We will start with honesty about what's wrong and then make the painful decisions necessary to heal Washington.

When faced with an impossible task, Shackleton turned his attention to the essentials, and managed to achieve important, though altered goals - in his case, saving his crew and getting them back home. Despite all odds against that happening, he was successful. And he sailed again. My course will shift some, but I know what is important for the health of our state. Come with me as this journey continues. ■

In My Opinion....

by Thomas Bageant, MD

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

Contemplating Retirement

Thomas Bageant, MD

IF you need an income,
IF you enjoy your work,
IF you psychologically depend on your job,
IF your job performance is not impaired by physical disabilities, or mental disabilities, or drug induced disabilities,
DON'T RETIRE.

For those contemplating retirement, remember: Just as a wedding ceremony does not insure an enjoyable marriage, neither does an elaborate retirement party insure an enjoyable retirement. Both marriages and retirement require time, work, planning, and a transition process if they are to be enjoyed.

Financial Planning: Assets minus Liabilities equals Net Worth

A. Assets:
- a. Income from other sources (rental income, investment income, etc.)
- b. Savings
- c. Real-estate
- d. Works of art
- e. Collections
- f. Antiques
- g. Inheritance
- h. Retirement accounts
  - i. IRAs
  - ii. Roth IRAs
  - iii. 401(k) plans
  - iv. Profit Sharing Plans
  - v. Pension Plans
  - vi. Social Security Benefits

B. Liabilities:
- a. Loans - margin accounts - credit card accounts
- b. Dependents
- c. Shared Business Liabilities
- d. Alimony
- e. Contract expenses, written or verbal

A - B = Net Worth

Assessment of net worth should be re-evaluated on a regular basis, as should your budget. Both of these will change with time.

Budget

Make a "retirement" budget and include, at least, the following:

A. Loan Payments
B. Housing
C. Food (at home and for dining out)
D. Utilities: electricity, water, gas, trash disposal, telephone, cell phone, cable, satellite services, internet access, newspapers, magazines, etc.
E. Insurance:
- a. Home owners or renters insurance
- b. Auto insurance
- c. Major Medical Insurance
- d. Long Term care Insurance
- e. Liability Insurance
- f. Disability insurance may not be available if you are not working.
- g. Life Insurance may not be necessary.

F. Travel and Vacations
G. Hobbies
H. Entertainment
I. Charity and Church donations
J. Transportation
K. Home and land maintenance
L. Cars (new and auto repairs)

If your net worth does not generate adequate funds to cover your retirement budget, PLUS INFLATION, you should not retire, increase your income or modify your budget.

Must all retirement funds come from money earned by your retirement investments, without touching your invested principal? Not necessarily. It depends on your health, your age, and what you wish to leave for your heirs.

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Bite them and they'll believe your bark

The 2004 elections are pivotal for the future of medicine with the president, U.S. senate, congress governor, other statewide officials including the insurance commissioner, all of the state house of representatives and half of the state senate up for election.

There is a one-vote majority in the state senate that supports tort reform and a six-vote majority in the state house that opposes it. So the future of tort reform may well hang in the balance of this year's election.

Increasing the majority in the senate and, if they fail to act, changing the majority in the house will require involvement and political action by the medical community on an unprecedented scale. Changing the majority in the house will be viewed by all as backing up our bark with a bite.

How do you go about this? First, use the information sent to you by WSMA to contact legislators during the session. And second, join WAMPAC.

Consider this, in the 2002 election trial lawyer PACs raised over $700,000 - more than triple what physicians raised. In 2003 you made great strives to grow WAMPAC, but more is necessary.

Increasing numbers of your peers are choosing to join WAMPAC at higher levels of $300 or $500, and even $1000. WAMPAC provides the means for the bite so that the legislature will hear the bark. ■

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

Applicants for Membership

Mark T. Murphy, MD
Family Practice
UW Medicine Federal Way Clinic
32018 23rd Ave S, Federal Way
206-520-3169
Med School: Creighton University
Internship: University of Kansas
Residency: University of Kansas

Julius Sziget, II, MD
Ob/Gyn
St. Joseph Medical Clinic
1708 S Yakima, Tacoma
253-627-9151
Med School: Case Western Reserve
Internship: Walter Reed AMC
Residency: Walter Reed AMC

How to contact your state and national lawmakers

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

U.S. Senators and Representatives:

Sen. Maria Cantwell (D), 717 Hart Senate Building, Washington, D.C. 20510; 202-224-3441 (DC) or 206-220-6400 (Seattle) FAX: 202-228-0514 or email: maria_cantwell@cantwell.senate.gov

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

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

Rep. Adam Smith (D-9th), 227 Cannon House Office Building, Washington D.C., 20515; 202-225-8901 (DC) or 253-593-6600 (Tacoma) or toll free 1-888-764-8409; FAX: 202-225-5893, email: adam.smith@mail.house.gov

State Offices:

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

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

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

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

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

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

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

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

27th District, (North Tacoma, East Side)
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Rep Jeannie Darneille (D) 786-7974; darneill_je@leg.wa.gov

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

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

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

For more specific information about the legislative process or for a copy of the 2004 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS, 572-3667. ■

Retirement from page 9

A retiree, in good health, prior to eligibility for either Medicare or Social Security, should make every effort to live without touching his or her invested principal. A retiree of advanced age, or with a terminal illness, may be comfortable spending portions of his or her invested principal. As a retiree ages he or she may choose to spend increasing portions of their invested principal.

Unknowns

A. How much will my investments earn?
B. How much will my medical and pharmaceutical expenses increase with time?
C. How much will inflation increase with time?
D. Will I need "long term care"? If so, how long?
E. When will I die?

Legal Considerations

I suggest that every retiree have a will, a durable power of attorney, and instructions for physicians and lawyers.

I believe anyone contemplating retirement should have legal assistance, help with tax planning, talk with an accountant, and confer with a trusted investment advisor; as well as thorough discussions with their spouse.

Social Security Benefits

Each year the Social Security Administration sends tax payers data based on an employee's last 35 years of FICA payments. This information lists benefits received if taken at earliest eligibility, age 62, and at maturity, age 65 or later depending on your year of birth. One can easily calculate how long they must live to reap maximum benefits, however there are other factors that should be considered with respect to when you might apply for Social Security benefits. Your age at retirement, your need for income prior to your age of maturity, your health status and/or life expectancy, the Social Security benefits available to your spouse at age 62 and at her age of maturity, and the ever-changing Social Security regulations should be considered.

Medical Care and Insurance for the Retiree

If retirement leaves you without medical insurance and you are not yet eligible for Medicare benefits the costs are staggering. Coverage may or may not be available through a working spouse. You must budget for this expense. Because drug manufacturers, major medical insurance carriers, medical liability insurance carriers, lawyers, and alternative care givers, not to mention people who actually provide medical care, have an insatiable appetite for "the medical care dollar," the cost of your care will definitely increase.

Our legislators and government funded programs add to this problem by mandating set remuneration for services, more and more documentation of services, specific coding for services, and a spectrum of unnecessary services. These mandates are expensive and take time away from patient care.

Retirees, depending on their health status and their chronic medication expenses, may consider "catastrophic care coverage." This type of coverage will have a high deductible amount and may not cover the cost of any out-of-hospital medications. You might also check into the feasibility of a "Health Savings Account" which is a portion of the 2004 Medicare Revision Act. Medications are available from Canada. They are less expensive, they work, a three-month supply is available, and they are delivered to your home.

When eligible for Medicare, many insurance companies will only offer supplemental policies. These policies will also increase in price in the foreseeable future.

Retirement is a change of lifestyle that requires an adjustment and transition time. Some retirees enter their retirement with little or no transition time while others may take years. At a recent meeting, a psychiatrist noted that white males, at or around retirement age, who are either single or not getting along with their wives, have a high rate of suicide. I think planning and realistic expectations, with respect to retirement, might lessen this problem.

Most retirees have spent years earning the respect of others, perfecting their skills, making themselves available to others, becoming a resource for anyone interested in their craft, and in return, they receive a great deal of self esteem. Much of one's social life is generated at the work site. These sources of positive feed back change with retirement. Realizing the positive and negative changes that occur with retirement make the transition quite easy.

There is a wide spectrum of activities waiting for retirees to enjoy; from taking time each morning to read the paper and enjoy a cup of coffee to taking a trip around the world. Hobbies, like woodworking, photography, grandparenting, painting, writing, sewing, RV-ing, are available. Sports, like hunting, fishing, boating, sailing, skiing, golf, etc. await the retiree.

Use the internet for news, sports, product reviews, pricing, shopping, and e-mail services. E-mail allows rapid communications with friends and relatives wherever they are and wherever you are located.

Retirement is one of the few times when you really can make your own schedule. Enjoy your retirement.

Remember, most hobbies cost money rather than make money, so put that expense in your budget. ■

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.*

Central Planning

Andrew Statson, MD

"You can never plan the future by the past."
Edmund Burke (1791)

The great projects of antiquity, the irrigation canals of Sumer, the pyramids of Egypt, the Great Wall of China, were the result of central planning. In those primitive economies, humans were used for their muscle power, like oxen, and the projects required the combined effort of thousands. The rulers achieved monumental results. Their workers performed simple functions and were interchangeable with everyone else. The rulers only had to gather the people and crack the whip.

With the development of the crafts, however, the situation changed. The economic activity became more complex, the workers, more specialized. People were interchangeable to a degree within their own field and still obeyed the crack of the whip, but with a subtle difference. The product of their work was measured not only in quantity, but also in quality.

The workers knew about their job and about quality more than those who held the whips. The more intricate the craft and the more specialized the work, the more important the quality relative to the quantity of production. The whip lost some of its effectiveness as a motivating agent. The workers delivered quality more readily when rewarded, not when punished. Capitalism was born.

Prices function as signals of the relative abundance or scarcity of goods and services. The pricing mechanism coordinates supply and demand, so they match. In so doing, the pricing mechanism tends to avoid imbalances, such as gluts and shortages.

Something else has to take over that coordinating function when the pricing system is subverted by government intervention. The duty and the responsibility for that falls on the shoulders of those who subverted the market in the first place. A central planning commission steps in.

In the medical field, the commission has to project the demand, guess what new diseases will appear, what new epidemics will threaten, what new treatments will be developed, then allocate resources to meet those needs. If they guess wrong, there will be a large supply of treatments nobody needs and a shortage of others that people want to use.

This does not mean that businesses cannot make mistakes when assessing the market. Remember the Edsel and New Coke. No, but the private enterprises quickly cut their losses and move on. The public institutions don't know when to stop. Look at Amtrak. In the thirty years of its existence, it probably has never been in the black.

The other advantage of private organizations is that there are many of them. If some make a mistake, others can jump in and fill the void. When there is a profit to be made, they can develop new production techniques and speed the delivery of goods to market, so long as they are not hampered by regulations.

How does central planning work? Somewhere in the Department of Health, a group of planners make a list of health goals. They decide what will be desirable for all of us. They are the experts. They are going to take care of us. We don't have to worry about anything.

The current situation with the flu vaccine is an example of how central planning functions. The committee making the decisions looked at last year's use of the vaccine and decided that we'll need the same amount this year. It also looked at the active strains of virus at that time and decided that we'll need protection for the same strains this year.

Determining the future on the basis of past experience is a little like driving by looking in the rearview mirror. In this situation, that approach resulted in a shortage of vaccine because the outbreak turned out to be worse than the one last year. Also, the effectiveness of the available vaccine was poor, because the predominant strain turned out to be different. Reportedly, only 15% of the time, the flu virus has the antigens included in the current vaccine.

The strange thing about our legal system is that when one of us does not

See "Planning" page 16

Nurses, medical doctors viewed as most honest, ethical

In a 2003 CNN/*USA Today*/Gallup survey on the honesty and ethics of 23 professions, physicians garnered its highest percentage ever.

Doctors' honesty ratings moved higher than 60% for the first time in 2000 and have remained high in every poll since. Nurses topped the list for the fourth time in the past five years. In 2001, firefighters took the top spot.

Nurses 83%
Medical doctors 68%
Veterinarians 68%
Pharmacists 67%
Dentists 61%
College teachers 59%
Engineers 59%
Police officers 59%
Clergy 56%
Psychiatrists 38%
Bankers 35%
Chiropractors 31%
State governors 26%
Journalists 25%
Senators 20%
Business executives 18%
Congressmen 17%
Lawyers 16%
Stockbrokers 15%
Advertising practitioners 12%
Insurance salespeople 12%
HMO managers 11%
Car salespeople 7%

From *AMNews* 2/2/04

Pierce County physicians meet with legislators in Olympia

Four Pierce County legislators turned out for an evening reception in January at the WSMA Olympia office with physicians representing PCMS, hosted by WSMA. The purpose was to help build relationships between physicians and elected representatives and discuss tort and other legislative issues being considered during this short legislative session.

Physicians in attendance included:

Mike Kelly, MD
Carl Wulfestieg, MD
Ron Morris, MD
Nick Rajacich, MD
Vita Pliskow, MD
David Bales, MD
Jim Rooks, MD
Navdeep Rai, MD
Joe Jasper, MD
Don Russell, DO
Pat Hogan, DO
Len Alenick, MD

Also attending the meeting were Sam Kelly and Donna Jasper, wives of Mike Kelly and Joe Jasper who both work in the medical practice setting.

All twenty-one Pierce County legislators were invited to attend the reception. Those attending were: Representatives Mike Carrell (R-28) and Lois McMahan (R-26) and Senators Debbie Regala (D-27) and Marilyn Rasmussen (D-2).

The legislator/physician reception was held in lieu of the former WSMA Legislative Summit held each February, bringing physicians from across the state together for legislative briefings before they went to the hill to meet in groups with legislators from their districts. ■

Ways to reduce your personal liability

When reviewing a contract or a loan document, make sure you check to see what your personal liability is if the deal goes south. Most loans and leases are structured as joint and several among all partners, which can be costly. Here are some key points.

Joint and several liability holds each party to the contract, loan or lease responsible for the entire debt. If the practice defaults, the bank or landlord may collect all amounts due from one partner, even if that person is no longer with the practice.

Negotiate for several liability, under which each physician agrees to be liable for a pro rata share of the loan.

Settlement agreements among the partners often state that former partners shall be indemnified against financial exposure in connection with a lease or bank note. However, that promise is only as good as the practice's continued creditworthiness. The third party can seek payment from a partner, who in turn has the right to seek reimbursement from the other contract signers.

As part of any termination, it is important all departing partners review every obligation of the practice that may result in joint and several personal liability.

Indemnification clauses can result in you or your practice being responsible for acts outside your control. The following is an example of a broad indemnification clause:

"Physician agrees to indemnify and hold payer, its employees, agents and contracting parties (the "Indemnified Parties") harmless from any and all liability, loss, damage, claims, fines or expenses, including costs and attorneys' fees (or upon the option of the Indemnified Party, Physician shall provide a defense to the Indemnified Party), which result from the alleged or actual negligence, or intentional acts (including but not limited to criminal conduct, fraud, defamation and violation of any individual's right to privacy) of payer or any Indemnified Parties in performance of this agreement including losses due solely to the acts or omissions of any Indemnified Parties."

While many states may not enforce this provision to protect the payer against its own criminal or intentional conduct, a limited indemnification provision is safer.

An example: "Physician shall hold harmless and indemnify payer for any and all third-party costs, losses, expenses, awards or fees that payer incurs due solely to the acts or omissions of the Physician for the medical care of an enrolled patient."

Each party to a contract also should seek indemnification from the other's acts. This can be handled by including a mutual or reciprocal indemnification provision, such as: "Each party agrees to indemnify and hold harmless the other party and its officers, employees and agents from and against all fines, claims, demands, suits, actions, or costs, including reasonable attorneys' fees, of any kind and nature to the extent they arise by reason of the indemnitor's acts or omissions."

To reduce personal liability, weed out all joint and several liability provisions and negotiate for several liability before signing any contact, loan or lease. Also, make sure executed settlement agreements include releases from prior obligations and eliminate broad indemnification provisions. ■

From *AMNews* 2/2/04

Planning from page 13

follow the guidelines and a patient suffers, the lawyers and the courts are all over us. Yet not much happens when those who write the guidelines make a mistake and millions suffer.

Now imagine for a moment, difficult though it might be, that we had a free market in flu vaccines. Many companies will make vaccines and bring them to market. They will speed up the production process, so when market demand is higher than they had expected, they can produce more vaccine on short notice.

The companies will be more attentive to the changes in the virulent strains and include a new strain in their vaccine blend more readily and more promptly. They will work harder to project the needs, because their profit depends on that. Chances are that some companies will include a different blend of strains in their vaccine, so that when the flu season develops, they might have a more effective product and obtain advantage over their competitors. The companies that guess right are more likely to profit.

Finally, if the vaccines are not used in the current year, the companies are more likely to find a way to recycle the product and reduce their losses. Reportedly, in the last flu season over twelve millions doses of vaccine remained unused.

For its part, the market reacts to any perceived oversupply or shortage by adjusting the price. If there is too much vaccine, the price drops and the indications expand. People marginally at risk are more likely to get the vaccine. If, on the opposite, there is a shortage, the price goes up, the indications shrink, and only those most at risk are likely to pay the price to protect themselves from the flu.

What about those who are at high risk and cannot pay? I can turn the question around by asking, what about those at high risk when we run out of vaccine? I still want to answer the first question. They should receive it as a Christmas present from their relatives or friends, or from the many charitable organizations, such as the Red Cross and Goodwill. The physicians in the community and the local churches are another resource.

When we receive full price from those who can pay, we can afford to spend a few hours in a neighborhood clinic and give injections at no charge. We cannot readily do that when our fees are already discounted 50%.

The flu vaccine situation shows how the rigidity of a government system can fail in the ever changing complexity of life, while the flexibility of the market allows it to do the job at a profit.

Granted, in the past, medical expenses were a significant contributor to personal bankruptcies. Today, the insurance companies seem to be going bankrupt more often, even though personal bankruptcies have also increased. In spite of the market boom, personal bankruptcies increased more than fourfold from 1980 to 2000.

The concern that patients would not get needed care until they are very sick is at the basis of the main objection to the patients paying for medical services. That concern arises from the situation we frequently see in the ER and in our offices of patients who delay coming in until they have developed a complication, which results in a more involved and more expensive care.

That is partially true. Yes, we do see patients who come late for care with resulting higher costs. They do that now, even though they have insurance. Yet we don't see the many others who start with similar complaints, but whose problem resolves on its own, so that they never come in.

We also see the worried well, who abuse the system because they don't have to pay for the service, and those who look on their visits to the office or the ER as a social event. It is a way for them to meet people and talk about their problems.

There is good and bad on both sides of the issue. Overall, people are more likely to be careful how they use scarce resources when they have to pay out of their pocket. The market functions better and at a lower cost as a moderator of demand, a stimulator of supply and a coordinator of both, than a system of controls by edicts. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Internal Medicine Review CME set for March 13-14

The Tacoma Academy of Internal Medicine's annual two-day CME program set for March 11 and 12 is open for registration

This two-day CME deals with recent advances in Internal Medicine. Faculty includes internists and internal medicine subspecialists from the area and other parts of the country. This program is offered to members of the Tacoma Academy of Internal Medicine and all local physicians.

This year's program is directed by **Gurjit Kaeley, MD** and will be held at St. Joseph Hospital. ■

Endocrinology for Primary Care II scheduled for February 27, 2004

Registration is open for the Endocrinology for Primary Care CME program set for February 27, 2004

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

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

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

- Using New Insulin Analogs in the Management of Type I and Type II Diabetes
- Update on the Management of Chronic Complications of Diabetes
- Diagnosis and Treatment of Osteoporosis in 2004: Case Studies
- Evaluation and Management of the Thyroid Nodule
- Obesity, Fad Diets, and the Carbohydrate Controversy
- Endocrine Hypertension ■

Reminder: Primary Care CME Cancelled

The Primary Care 2004 CME, previously scheduled for February 7, 2004, has been cancelled.

An Update in Imaging CME will likely be available in May. A program brochure will be mailed in April. ■

Dates	Program	Director(s)
Wednesday-Sunday Jan 28 - Feb 1	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 27	Endocrinology for Primary Care	Ronald Graf, MD
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

In My Opinion....

by Daisy Puracal, MD

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

Strawberry Patch

Daisy Puracal, MD

It was May 1980 when we moved into our very first home. It was a modest beige colored house with rust colored trim.

The front yard was open green lawn with a raised flowerbed adjoining the front of the house. The flowerbed was a blaze of color with pansies - bright smiley variegated faces that made my heart smile in turn. It was the pansies that drew me to the house. I would pick these dainties and posy them in the bath and dining rooms - a little touch of cheer in a hectic world.

The house faced west, overlooking the glistening waters of the Puget Sound. The reflected flaming sunsets warmed my senses. The myriad twinkling city lights of Tacoma served as a gorgeous backdrop to the darkening nights. Many an evening would find us out on the deck or at the bedroom window feasting on this jeweled vista.

The children grew up in this house. Jason was three and Janis, one when we moved in. The youngest, Jaime was born here and knows no other home. When they were older they felt cut off from the city life known to their friends, but I have always enjoyed the serenity of the area.

The back yard was terraced into a hill slope. From the very top of the slope, we could look out onto the water and see the ships gliding past. At nights we would hear the mournful blast of the foghorn like the "ohm" of a Tibetan monk and the bark of a seal at play.

There were a few fruit trees in the back yard and a strawberry patch. We came to know the seasons from the changes on the trees. The buds bursting on the cherry trees in the spring giving way to clouds of white blooms. As the petals fell exposing the delicate start of the green fruit it laid a lacy white trail on the grass below. Jason would climb up the tree and bend the boughs with his weight so we could pick the dark plump cherries right off the tree without bruising them. Invariably two cherries for every one that we collected would find its way to salivating mouths. Then came the time for the strawberry patch to bloom. We eagerly waited for it to fruit. I remember my children impatiently turning the leaves to look for the ripe strawberries. And then the sweet reward- juicy unadulterated fresh from the soil, strawberries to thrill the palate.

Late in the summer we would pick the crisp apples from the tree, crunching and savoring each bite. Whatever did not get eaten would find its way to a baking dish to be transformed into mouthwatering apple crisps.

It was a wonderful learning experience for the children - a deep connection to the earth and its abundance. I loved every moment of those days; even the raking of the nostalgic carpet of yellow brown leaves in the fall chasing around in the wind, and the cold, stark branches in winter dusted in light snow, waiting for the cycle to start all over again.

The children are grown now and have left the home.

The strawberry patch is no more. In its place are overgrown weeds. The back yard is neglected, the apples and cherries fall to the ground, an abundant feast laid out for the birds. The ships sound their sad goodbyes as they sail past. The pansies have been replaced by hard concrete walkway. The lights across the water have lost its appeal.

The house feels lonely and empty. The letting go process has begun. What will it be like in the final days when it is time for me to let go of life itself? ■

Classified Advertising

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

Family Practice House Calls! Seeking BC/BE physicians near Tacoma, WA and in San Francisco Bay Area for innovative new house call practice. In our physician-owned, work-from-home model, you can spend more time with your patients and have more personal time. You will be fully supported, have a competitive full-time salary with additional earning potential, and receive full benefits. Onsite healthcare will involve seeing injured workers at their job for acute injuries while at the same time developing a continuity panel of house call patients of all ages. Forward CV or contact: Anthony Barnett, MD, anthony@OnSiteDocs .com or FAX 206-623-7674.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 851-7550, 468-3539.

Office space available in Lakewood/ University Place - 1,500-3,000 sq. ft. m/l available immediately. $14 sq. ft. Call 253-582-6368.

Space For Lease: Valley Medical Center - Auburn Clinic. 3702 West Valley Hwy N #114, Auburn WA 98001. Valley Medical spent $591,000 on a class "A" build-out. We are only asking $12 NNN per sq. ft. 6,150 sq. ft., divisible or expandable. 425-451-1511.

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Outpatient General Medical Care. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for GP, FP, IM.

Contact Andy Tsoi, MD (253) 752-9669 or Paul Doty (Allen, Nelson, Turner & Assoc.), Clinic Manager (253) 383-4351

Retired Doctors' Wives Luncheon

There will be a no-host luncheon Wednesday, February 25, 2004 at 11:30 a.m. at Affairs restaurant located at 27th and Bridgeport in University Place. Wives of retired and semi-retired doctors are welcome. To make a reservation, call Judy Brachvogel (564-4303) or Maryln Baer (564-6374) by February 20. Come and renew friendships!

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

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Pierce County Medical Society
BULLETIN

March, 2004

Ever popular "resort" CME programs offered through the PCMS College of Medical Education continue to offer stimulating education and affordable vacations for physicians. Above: The Krumin family (l-r), Dr. Peter, Stuart, Emma, Christine and Benjamin pose for the camera before the "boys" hit the slopes in Whistler, BC

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INSIDE:

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

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

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Pierce County Medical Society

BULLETIN

March, 2004

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President's Page

by Michael J. Kelly, MD

What's Next?

Michael J. Kelly, MD

"Victory belongs to the most persevering."
Napoleon

As my predecessors can attest, the most difficult part about writing this column is prognostication. Final drafts are due weeks ahead of publication during which time many of the salient issues may have changed. The fate of bill ESSB 5728 will not be known until midnight February 27, although the legislative session ends March 11. If the judiciary committee of the House has not acted upon ESSB 5728 by then, it will be officially dead. It appears we must prepare ourselves for the worst. By the time you read this column, the authoritarian chair of the judiciary committee will most likely have killed ESSB 5728 for the second year in a row. Power corrupts.

With this in mind, we should prepare ourselves for the next battle in this war to reclaim our profession and maintain patient access. When you cannot change the legislation, you work to change the legislators. So, what's next?

Drs. Ron Taylor and **Jim Rooks** brought an article to my attention from the December 2003 bulletin of the American College of Surgeons as a way to answer the above query. Entitled, "A Revolutionary Approach to Achieving Tort Reform," it dealt with a campaign initiated by the medical society of New Jersey and the New Jersey Chapter of the ACS in response to that state's legislature's failure to pass meaningful tort reform during the summer of 2003.

The state of New Jersey faced the same organized opposition to caps on pain and suffering as we have. They mobilized over 8,000 physicians to march on Trenton February 4, 2003. Through their activism, they were able to hammer out a compromise bill with the senate for a $300,000 cap on non-economic damages and other reform measures.

Their chances looked good until the eight democratic members of the assembly, who indicated they would vote for the senate compromise bill, were reigned in by party leadership. The Democrats called for a party block vote against the bill and got it. The democrats defeated tort reform 41-38 - a victory of politics over patients.

New Jersey physicians then asked themselves, "What's next?" They decided against another rally and concentrated their efforts instead into a grassroots advocacy strategy designed to defeat democratic assembly tort opponents in the upcoming election on November 4, 2003. As author Arthur Ellenberger stated in the bulletin article, "Our focus went from changing legislation to changing assembly faces." Their battlefield tactic was local grassroots action assigned to winnable swing districts.

New Jersey physicians chose to use a "...structured, politically savvy approach, speaking directly with the public about the problems they believed democratic assembly members were perpetuating." Physicians were asked to see patients until 2:00 p.m. on Tuesday, October 7 and then leave their offices wearing white coats and meet in groups at 3:00 p.m. in the selected districts. "By the time we knocked on three doors and talked with the residents, we were on a roll. The key is telling your story briefly and asking for support in a friendly way."

They began in groups of four but split into groups of two to cover more homes and hand out more flyers. This first effort was followed by a second on November 1 and went as well as the first.

Unfortunately, New Jersey, like Washington State, suffers from landslide apathy. Very few voters turned out on November 4 and the democrats maintained control of the state legislature. Despite this, the New Jersey physicians felt they had achieved some minor victories. Until their activism, tort reform and caps were not even on the legislative agenda. The state's physicians became more aware of how important the political process was to success in their practices. The state medical society's political action committee raised more funds than ever. New Jersey physicians

See "Next" page 14

Special Feature

by Jean Borst

Community Health Care... Thirty Five Years and Counting

From its humble beginnings in 1969 in the community room at Lister Elementary School and the basement of St. Joseph's Hospital Nursing School, Community Health Care (CHC) has grown to a $22 million organization with 25 medical providers and 13 dental providers. But most important, the agency has continually served the medical and dental needs of low- and no-income residents of Pierce County whom otherwise would have no other access to health care.

"Many of the Medical Society physicians have a good sense of our history," said David Flentge, CHC President and Chief Executive Officer. "They were instrumental in the establishment of CHC and have followed us for a long, long time. However, many are probably unfamiliar with our current status, and I suspect that it will be a surprise to some who consider us a relatively small part of the system."

David Flentge

On the contrary, CHC is a relatively large part of the system as the patient numbers alone indicate. The eight medical clinics in Pierce County saw 34,801 patients in 2003. This year, CHC anticipates it will deliver approximately 350 babies. "We have had major growth in recent years, and now have the ability to serve many more people than we have historically," Flentge said. And they would like to serve even more, considering that out of 700,000-plus Pierce County residents, 100,000 are medically uninsured and 300,000 lack dental coverage.

In the Beginning...

In the late 1960s, well before the doors of the first Community Health Care clinic ever opened, a group of concerned citizens, physicians and community leaders joined together to address how to serve the health care needs of the county's low- and no-income residents. **Dr. George Tanbara** was among the first physicians to take an active role in developing solutions to the pressing challenge of helping those unable to afford health care. He recalls the first meeting held to explore the issue, which was attended by 50 PCMS physicians. They gathered to offer support, ideas and feedback — but also concern. Initially, there was some reluctance to support the clinics as there were a few concerned about competition in the medical marketplace. Due to the tenacity of individuals like Dr. Tanbara, the physicians were convinced of the need for the facilities. With PCMS support, a group came together in a series of meetings (and more meetings) that eventually lead to the opening of two volunteer clinics — the Eastside Clinic and the Family Medical Clinic in downtown Tacoma.

The expansion was slow, but steady, and physician participation and hospital support was phenomenal, Dr. Tanbara recalls. "There were so many people and organizations involved in the success of the clinics," he explained. St. Joseph Hospital was instrumental in starting the Downtown Clinic. Puget Sound Hospital provided sandwiches for clinic volunteers. Good Samaritan Hospital offered lab services. Dick Driscoll, pharmacist at Tacoma General Hospital, made arrangements to receive samples from pharmaceutical reps that could be distributed at the clinics.

In addition, Sixth District Congressman Norm Dicks (with prodding from Dr. Tanbara) was instrumental in changing policy to enable National Health Services Corps physicians to participate in urban programs. NHSC was created in 1970 to place primary care physicians and dentists in areas of greatest need of access to health care — traditionally economically disadvantaged rural areas.

Dr. Tanbara worked once a week at the Eastside Clinic, and then expanded his service time once the Downtown Clinic was operational. And his involvement and dedication continues today. "There were many people involved and responsible for the success of the clinics," Dr. Tanbara said. "My involvement should not be valued any more than anyone else who has been involved. I just happened to be the one who has been around the longest. And I happened to have the interest and the time to do what I did. Others might not have had as much time. But it's important to acknowledge, recognize and appreciate what everyone has done. And I welcome anyone who can help and participate. It's important for each of us to do as much as possible to continue the success of CHC as long as there are underserved and unserved patients."

Up and Running

The clinics slowly expanded, and in 1980 became a part of the Health Department under the Urban Health Initiative Funding. The same year, the Sumner and Lakewood facilities opened their doors.

CHC received its first direct federal grant in 1987 under Section 30 of the Public Health Service Funding Act,

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broke from the Health Department, and established itself as a nonprofit agency. The change required CHC to have a board of directors comprised of at least 51 percent of patients from its system. At present, there are 21 board slots, 11 of which are held by patients reflecting the wide range of residents served by CHC — the majority of whom are low income.

From then on, expansion accelerated:

1989 - Homeless and Adult Dental Clinics open
1992 - Foot Care for Seniors program begins
1993 - Tillicum Clinic opens
1997 - Children's Dental Clinic opens
- Family Medical Clinic becomes Downtown Clinic and moves to its current location
- Agency changes name to Community Health Care
2000 - Parkland and McKinley Clinics begin operation
2001 - McKinley Clinic becomes Soundview Clinic and moves to current location
- JCAHO accreditation achieved
- Parkland and Downtown pharmacies open
2003 - Spanaway Clinic opens doors
- Lakewood Clinic moves to new facility, which includes a pharmacy and 4000-sq. ft. dental clinic
- Eastside and Spanaway pharmacies open
- Internal medicine office opens at Lakewood Clinic

"Our base is a family practice model," according to **Dr. Jeffrey Smith**, CHC Medical Director. At present, 15 physicians are family practice doctors who do obstetrics and one who does not. There are seven mid-level practitioners and two internal medicine doctors. CHC also offers special programs. The internal medicine doctor in the Downtown Clinic specializes in HIV, and Lakewood's internal medicine clinic focuses on Medicare patients.

Currently, the CHC clinics offer a variety of services in addition to family practice medicine. A team of nurses, behavioral health specialists and a nutritionist comprise the Integrated Maternity Support Team. Senior Foot Care, including pedicure level foot care services to maintain mobility and independence, is offered at 13 sites and is available to persons over 60. Health care for the homeless is provided at three homeless shelters two days a week, and psychiatric services are offered once a week. Dental care for all ages is provided at Lakewood and in downtown Tacoma. The agency also supports a part-time psychiatrist outstationed at the Pierce County AIDS Foundation.

Jeffrey Smith, MD

The OB presence in the clinics is significant, as fewer and fewer Pierce County physicians are offering obstetric care. "I am concerned as anyone that our OB provider numbers in Pierce County are shrinking," Dr. Smith said. "He added that they have already seen an increase in the number of OB/Gyn patients seen at the clinics and expects, as more physicians eliminate OB services from their practices, to see an even greater influx.

But CHC needs to see more than just an increase in OB/Gyn patients. "Currently, 40% of our patients are uninsured. While we would love to serve all the uninsured population in Pierce County, we can't stay in business without seeing insured patients as well," Flentge said. "Those numbers are increasing slowly, but we need to see more. We have the capability to expand our services and would love to get back to the point financially where we can add more physicians and see more patients." Long-term plans are to add two or three more physicians in the Lakewood clinic, two more in Spanaway, and renovate the Eastside Clinic. "But we can't survive financially by filling up with uninsured patients exclusively," he said. "We realize that we are competing with everyone else. Obviously, if you are a private practice physician, you are inclined to take the insured patients and let us see the uninsured population. We want physicians to understand that we would like to see both. And we need those insured patients to survive in order to serve the uninsured."

There is also a misconception among the general public that CHC facilities are "free clinics" or exist exclusively to serve the uninsured. "People are quite surprised to find out that we see all patients," according to **Dr. David Cameron**, a physician at the Lakewood Clinic. "It's our job to educate people so they are aware of that. We are here to serve all — uninsured, underinsured, insured."

Flentge concurred. "We are a part of the medical community in Pierce County and desire to be a part of that community. We think we play a very important role in serving as a safety net, and we're very proud to serve the uninsured population. We hope to continue to grow in the way we have grown over the past eight years and serve more and more of the uninsured population here.

David Cameron, MD

"But we are also a medical business like other physicians, and as a medical business, part of our challenge is bringing in total revenues to support total operations. We hope people understand that we want to work with

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them."

Government grants comprise 17 percent of CHC income and are used to provide services to uninsured patients. Fee for service, including Medicaid, constitutes 39 percent of CHC's income, and 39 percent of funding comes from capitated revenues.

CHC's largest single funding source is Medicaid. Forty-two percent of the agency's patients are on Medicaid. The second-largest funding source is a federal grant of $2 million annually. Basic Health Plan, Medicare, Pierce County, United Way of Pierce County and the cities of Tacoma and Lakewood also provide funds.

"The problem now," he said, "is money. There are not enough funds from government sources. We need to raise funds in order to keep the clinics growing as long as there is a need in the community."

While federal funding is secure, at least for the time being, the challenge, Flentge said, has been at the state level. "The state budget crisis caused the legislature to balance the budget on the backs of low-income people. Making changes to the Basic Health Plan, cutting the number of slots, creating need for premium payments for Medicaid kids, deductibles and co-pays — these are the kinds of things that create barriers for low-income people. To individuals with private insurance, they think it's normal to have a $15 co-pay at the time of a visit. But if you're a family with a $10,000 or $15,000 income, you are faced with a choice of paying a $15 co-pay or buying food. We are just very much afraid that it's going to cause parents to not sign their kids up for Medicaid, and that's a real tragedy."

CHC's main priority this year is getting the legislature to use some new federal dollars they received to "back off on those premium payments and co-pays for Medicaid kids." "We would love to see them reverse their decision on that," he said. We are also asking them for a very specific legislative appropriation of $15-$20 million that would go to the 22 community health centers across the state in recognition of the rapidly increasing number of uninsured patients we are serving."

If the legislative actions don't happen, CHC will simply have to live within its means, Flentge said. "We're a business," he explained. "We can't spend more than we take in. We will have to make some difficult choices, and people should understand what the consequences are if things don't change."

In addition to staff cuts, CHC has already reduced one program and eliminated another. Hours have also been reduced. Clinics were previously open Monday through Friday, 8 a.m. - 8 p.m., and three clinics were open Saturdays and Sundays. Clinics are now open 8-4:30 four days a week and one evening, and only the Lakewood Clinic is open on the weekends. Flentge hopes CHC will be able to offer extended hours again in the future.

"I always felt better about our accessibility when we had extended hours," Flentge said. Statistics show that the majority of uninsured people are the working poor. "Those are also the folks whose employers are the least sensitive about letting them take time off during the day," Flentge explained. The extended hours were also very beneficial for managed care patients because it kept them out of the emergency rooms and enabled them to receive services through CHC. Flentge added that part of CHC's legislative agenda has to do with restoring some of the funding that has been lost by the hospitals. "It's critical to their survival and their ability to be a partner to us," he said.

Despite the challenges, the obstacles, and the seemingly unending cutbacks, the mood at CHC remains positive. "We feel very good about what we are doing here," Dr. Smith offered.

The Benefit of Pharmacies

Dr. Cameron believes CHC provides a particularly valuable service through its pharmacies, which are available to its own patients only. This is especially true for Medicare patients who are able to get affordable medications. "Many Medicare patients might not know that," he said. As a federally funded community health center, CHC is able to purchase drugs at a significant discount and pass along those savings to their patients – a very important issue for uninsured and low-income people who are limited on what they can spend on prescriptions. For example, Dr. Cameron explained, in the past, patients with high blood pressure have relied on samples of medication and were unable to afford to get a prescription. "When they would run out of samples, their blood pressure would go untreated for months at a time. But if we can get them a medication they can afford and make sure they get it every month at one of our pharmacies, then their blood pressure is under much better control than if they were relying on samples."

CHC has three main pharmacies and three satellite pharmacies, which are dispensing machines with video uplink with the main Lakewood pharmacy. This allows services to patients in clinics where space is at a premium and volumes are low.

The decision to move into the pharmacy business was a natural leap. "We watched our partners across the country and state over the past few years develop their own pharmacy services," Flentge said. "It took a lot of investment up front. We had to hire a pharmacy manager and staff, a whole new area we had no previous experience with. It's worked out very well, and it's been great for our patients, but we still haven't broken even on our pharmacies. We're still in the investment stage.

"Part of our problem as a system is that we have built our clinics where low-income people of Pierce County are. It would be a lot more efficient for us financially if all of our physicians and other providers operated out of one clinic. But we don't do that. Pharmacy magnifies the problem because a pharmacist can support so many pa-

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Reason to Hope

Federico Cruz, MD

Every year our legislature gathers in Olympia. Every year we have high hopes for progressive action. As physicians, tort reform is at the top of our list every year. And every year we are disappointed. This year, we are committed to different outcomes. This is possible because we have engaged at a level that we normally don't reach. We are united and consistent in our message, we are committing resources - both money and time - that we normally don't do. There is a resoluteness that just may get us to the next level.

We have reason to hope.

But, before we relax into that hope, I want to remind folks that there is another issue that comes up every year that we as physicians have long supported, argued for and gotten nowhere with our legislature. This is a smoking ban to apply across the state in all public places. Hot rhetoric each year but no movement. Is this year more of the same? Unfortunately yes in many ways. The leadership in Olympia has not made it a priority and has not advanced any bills with a concerted effort. But this year could be different because of the momentum developed by the smoking ban that went into place here in Pierce County. Following the decision of the Board of Health, Pierce County went smoke free on January 2. The decision was widely supported before implementation and has garnered additional public support after the restaurants and bars went smoke free. Though the ban is now on hold through a court challenge, the effort to challenge the status quo on smoking has not stopped. Anti-tobacco coalitions across the state are poised to go the next step: a citizens' initiative.

Initiatives have a clear place in Washington politics. When the legislature repeatedly fails to act on an issue of clear importance to the broad mass of the public, then an initiative is an option. The public wants a smoke-free environment when they go out. The temporary ban here in Pierce County sparked a massive amount of support to continue with a smoke-free environment. Our own Smoke Free Coalition of Piece County is committed to achieving a smoking ban in public places. It is time to take the next step. Get an initiative on the ballot for next November.

This in not an easy endeavor. About 280,000 signatures have to be collected. There is a deadline of July 2, 2004 to get on the ballot for this November. Many initiatives are begun and fail because they cannot gather enough signatures. Many resort to hiring professional companies to gather the signatures. We are in a stronger position. A smoke-free environment in public places has very strong public support. There has been considerable public discussion on the issue. Especially after the Pierce County ban there was a saturated stretch of news coverage on television and on the radio. All the major papers in the state ran numerous articles discussing secondhand smoke and its potential harmful effects. The public is aware. And is supportive.

"Physicians can provide leadership and be part of the team that rolls up its sleeves and gets involved with the nitty gritty activities needed to gather enough signatures."

Organized medicine needs to weigh in. Physicians can provide leadership and be part of the team that rolls up its sleeves and gets involved with the nitty gritty activities needed to gather enough signatures. We are saying loudly and passionately that tobacco use is dangerous to the individual and to the community around them. It is our responsibility as physicians to reinforce this message. Again and again.

This can be done simply. Posters in your offices about the dangers of smoking are a good start. And as part of the next step, make petitions available in your offices so that your patients can contribute their signatures to the effort.

If doctors' offices across the state do this, we will not have any problems collecting the needed signatures. Getting active on this one is a clear and sure step for us to take. Physicians are key members of their communities. We need to use our positions to better the overall health of our communities. This must be more than just patient care but extend to the political arena. This is an area in which we have been reluctant to go. As a group, physicians have lost much of their influence because of our unfamiliarity with the

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tients and so many scripts per day. Finding that balance has been a challenge. The satellites are a very intriguing possibility, because we don't have to hire a full-time pharmacist for another site. The Lakewood pharmacists are not only filling scripts from the Lakewood and Tillicum clinics, but they are also on the tele-video with three other sites. The investment in equipment and meds has been significant, and we are still sorting out the right balance between the number of pharmacists and techs and the volume of scripts. It's just another example of the challenges we have."

CHC will not expand another clinic or open another facility without also putting in a full-time pharmacy. In addition, any future expansion will also involve the opening of additional dental clinics. "Each of the patients that we serve also need dental care," Flentge explained.

"People are turned away every day in the dental clinics," Dr. Smith said. "We could probably double our dental clinics and fill them within two weeks. The demand is overwhelming."

The discouraging news on the dental side is that compared to 100,000 medically uninsured residents in Pierce County, there are over 300,000 uninsured for dental services. There are more private dentists reluctant to take Medicaid due to the low rate structure than there are private doctors unwilling to take Medicaid. And, of course, Medicare provides no dental coverage. Senior citizens pay their own way for dental services, unless they have private insurance. "Add to that the fact that they are not graduating enough dentists from dental schools to replace those who are retiring, and you have numerous factors that make providing dental services really challenging," Flentge said.

Continuing our Commitment

While some difficult choices and actions may be on the horizon for CHC, the agency remains committed to its mission: "To provide the highest quality health care with compassionate and accessible service for all."

"First, we maintain our commitment to the people we are already seeing," he explained. "But we are also out there marketing to the insured patient, which in our case are Medicaid and Medicare patients. Approximately nine percent of our folks have private insurance, and those are often the patients who initially came to us when they were uninsured, but are pleased with the quality of their provider and so keep coming after they get insurance."

Dr. Smith concurs. "We have a really good core of doctors here. I'm proud to be part of this group. CHC draws its providers from across the country, as well as Washington State. They arrive here via different paths, but always for the same reason, they feel a calling to community health care."

Dr. Cameron has been with CHC for just over a year. A Washington native, he did his undergraduate training at Duke and attended the University of Washington Medical School. He completed his residency at Tacoma Family Medicine, and went through a month of medical training in the Eastside Clinic.

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political process. We cannot afford to continue this disconnect. Our profession is at stake. We as professionals must step out and mold and shape health policy in our communities. Now we don't. Instead we complain and whine when others outside medicine make flawed policy and we are left with the task of having to try to make it work. We need to change this mindset. We do have to step out of our comfort zone, but what the heck, we can pick issues that are a straightforward connection to better health. A smoking ban in public places is an easy issue and physicians' role in spreading the word on the health risks of tobacco use are a natural platform to get involved politically.

Let's do it! We as a profession are committed to collecting the signatures and educating the public on the importance of voting yes on a ban on smoking in public places. ■

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"I really felt called to do this kind of work, and my training made me realize that this is what I wanted to be a part of," he said. "This is really taking care of a need in Pierce County where we have 100,000 people who don't have health care. I'm thrilled to be a part of something that is a viable structure that has resources available so we can prevent people from going to the emergency room and costing the state even more money by having large fees. We can take very good care of them here. If CHC wasn't here, along with other community health care organizations, our nation would be in not only a health care crisis, but also a financial crisis. Most patients would end up in urgent care and emergency rooms."

Dr. Smith found his way to CHC via a different route. He grew up in a small town in eastern Washington and had every intention of returning there to practice medicine. When he was recruited by CHC, he decided to join the agency because of the medical school loan-repayment options. "I came here thinking, 'I'll put in my time. It's a good deal. I'll do my good work and move along," he said. That was over eight years ago. "The longer I'm here, the more I like it," he said. "I'm not going anywhere. I hope to work here until I retire. I just can't see doing anything else." Dr. Smith calls the work addicting. "All doctors are providing a service," he explained. "It's especially nice to be providing a service to people who otherwise wouldn't be seen. So, while the physicians at CHC have taken different paths to get here, we all feel exactly the same way about the work we do."

CHC providers face multiple challenges. Language barriers can cause problems and be very time consuming. In addition, many of the patients have significant medical problems and require additional tests or the care of a specialist. Dr. Cameron credits an excellent staff of outreach workers who try very hard to get patients in to see specialists. "If someone doesn't have insurance, they may be sent to the UW or to Harborview," he explained. "We are also trying to do some of the social work, too, and try to get them the resources they need. It can be very time consuming. Also, we have to do quite a bit of paper work with contracts." In addition, "we have some very needy patients. They are very ill and don't have health care insurance. Sometimes, they can't qualify to get state assistance because they don't have a Social Security number. So there are times we try to be advocates for them to get them the applications to apply for DSHS. That involves many forms and a lot of time." And now, with staff cutbacks at CHC, physicians have taken on more responsibilities previously handled by support staff.

"It goes in cycles, somewhat," Dr. Smith said. "A few years ago, the reimbursement for Medicaid was adjusted and made things a little better. But we're seeing changes again. Managed care also puts a squeeze on things. In some cases, we have to send people to Harborview because there is no one in the county we can send them to." While Harborview is very good about seeing patients that CHC sends their way, the greatest challenge is finding a way to get the patients to the facility. "Most of these people have transportation difficulties, so getting all the way to Seattle is a problem," Dr. Smith said. In many cases, patients and Harborview physicians are in contact with CHC, but "many times we never hear anything from the patient again. We try our best to follow up." Additional challenges pose themselves. A patient might visit a clinic on a Monday, provide a phone number, and by Wednesday the number is disconnected.

Dr. Cameron gives credit to support staff, including Outreach Workers and nurses for their tenacity in following up with patients who, in many cases, can be nearly impossible to track. "They are especially good with patients who need to be getting meds or have an abnormal pap or mammogram," he said. "Those are things that absolutely need to be tracked. Basically, they just keep after them until they come in. To them, it's just a part of the job." Drs. Cameron and Smith agree that the majority of CHC employees — providers as well as support staff — seek out employment at CHC because it's the kind of work they want to do. "Some of them, like me, just say, 'Oh, I'll give that a try,' and find they love it," Dr. Smith said, adding, "We couldn't do what we do here without our staff."

Moving Forward

Certainly, there is no shortage of patients to be seen at CHC clinics. And the agency would like nothing more than to expand to serve as many patients as possible. Everyone at CHC recognizes that the medical profession is facing difficulties right now. "Doctors in the private realm are being squeezed on all sides," Dr. Smith said. "Rates are going down. Medicaid and Medicare are squeezing their rates. Tort reform is a priority issue as insurance premium payments are skyrocketing. We've heard concerns expressed as we talk about balancing our budget and need to make sure that a certain number of our patients are insured — Medicare and Medicaid patients. And we've heard some feedback from private doctors — 'Wait a minute. You're here to serve the uninsured.'" Dr. Smith notes that he thinks there is some lack of understanding about what our budget limitations are. "We don't have enough money to serve the number of uninsured that we are currently serving, let alone all the uninsured in the county. So, our message is, to those physicians who are not accepting new private insurance patients, or are not accepting Medicare and Medicaid patients, we would love for you to refer them to our clinics," he said.

On March 24, Community Health Care will celebrate their 35 year anniversary and will honor Dr. George Tanbara. The event will be held at the Tacoma Sheraton Convention Center beginning at 5:30 p.m. Tickets are available by calling 253-597-4550. ■

Applicants for Membership

Allen H. Graeve, MD
Cardiothoracic Surgery
314 ML King Jr Way #202, Tacoma
253-403-7257
Med School: Creighton University
Internship: University of New Mexico
Residency: University of New Mexico
Fellowship: University of Tennessee
Fellowship: Medical College of Virginia

Anna D. Hohler, MD
Neurology
Madigan Army Medical Center, Tacoma
253-968-1445
Med School: Boston University
Internship: Madigan AMC
Residency: Madigan AMC

Londe A. Richardson, MD
Diagnostic Radiology
Medical Imaging Northwest
222 15th Avenue SE, Puyallup
253-841-4353
Med School: Yale University
Internship: University of Washington
Residency: University of Texas
Fellowship: University of Texas

David E. Shook, MD
Diagnostic Radiology
Medical Imaging Northwest
222 15th Avenue SE, Puyallup
253-841-4353
Med School: Creighton University
Internship: University of Missouri
Residency: University of Colorado
Fellowship: Mayo Clinic

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

IN MEMORIAM

MICHAEL T. HAYNES, MD

1949 - 2004

Dr. Michael Haynes was born in Tacoma on February 17, 1949 and died on February 13, 2004. He had suffered a massive heart attack three days earlier.

After receiving his medical degree from the University of Washington School of Medicine in 1975, he completed a family practice residency at Jackson Memorial Hospital in Miami, Florida. In 1977 he joined the family medicine practice of Dr. Charles Vaught in Puyallup and continued practicing in Puyallup until his retirement in 2002.

Dr. Haynes joined PCMS in 1978.

Those wishing to remember Dr. Haynes can make gifts to the Michael T. Haynes, MD Scholarship Fund, in care of Hill Funeral Home, 217 E Pioneer Ave, Puyallup WA 98372; or Puyallup Valley Bank, 209 S Meridian, Puyallup WA 98371.

PCMS offers condolences to Dr. Haynes' wife, Kristine, and their family.

Has HIPAA Changed How We Treat Minors?

Since the enactment of the HIPAA Privacy Rule, many insureds have asked how the Privacy Rule has impacted the way health care providers deal with minors. While the Privacy Rule has changed many of the things you do in your medical practice, there has been **no change** in the Washington laws relating to treatment of minors. HIPAA does not change or limit the Washington Sate law that grants minors the authority to consent to certain types of health care. Further, HIPAA has no effect on Washington law that allows minors to control access to their "protected health information" (PHI) in those instances where they are granted authority to consent to their own health care. In short, the federal law know as HIPAA **does not** preempt Washington law when it comes to the treatment of minors.

The age of majority in Washington State is 18. At age 18, an individual is an adult and can provide consent to all proposed health care and authorize access to PHI. An individual under age 18 is considered a minor and, for most medical care, must have a parent or guardian's consent. However, state law allows minors the right to consent to certain health care without a parent or guardian's consent. As a quick reminder, a minor may consent to medical care:

- If the minor is emancipated (legally independent) or married to someone at or above age 18.
- In the event emergency care is necessary.
- For birth control and pregnancy-related care at any age.
- For outpatient drug- and alcohol-abuse treatment beginning at age 13.
- For outpatient mental health treatment beginning at age 13.
- For sexually transmitted diseases, including HIV, beginning at age 14.

As many know, there are several tricky issues relating to treatment of minors. One involves maintaining confidentiality of information specific to treatment authorized solely by the minor. Remember, if a minor consents to care as allowed by law, he or she can request confidentiality for that aspect of care - which would prohibit you from releasing this information without the minor's signed authorization. Obviously, this can be a challenge when dealing with a parent's request for records. Parents must be reminded that their minor child has state-granted rights regarding treatment and confidentiality and that you are prohibited from releasing records or discussing certain aspects of care without **the child's express written permission**.

The billing issues created by a minor's request for confidentiality are also significant. Keep in mind that when a minor requests confidentiality, you are prohibited from billing the parents or the parent's insurance carrier for the cost of treatment. **Because the parents did not consent to the treatment, they are not financially obligated for care.** You must advise minor patients that they alone are responsible for payment if they request confidentiality.

Finally, to avoid miscommunication, it is highly recommended that you always remind minor patients of their confidentiality rights, and resultant financial responsibility, when treating them for care to which they can consent. ■

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.*

Punitive Damages

Andrew Statson, MD

"Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."
Amendment VIII, US Constitution

The idea of punishment, that is of discouraging future offenses by the same or other parties, is a recent development in tort law. Punitive damages give the plaintiff additional compensation, above the amount for the injury sustained, with the purpose to punish the defendant and to deter others from following his example.

In his Law of Torts (fourth edition, 1971), Prosser relates another purpose, reimbursement for legal expenses and "wounded feelings." (Do wounded feelings mean pain and suffering?) He also adds that in order to award punitive damages there must be aggravating circumstances, such as outrageous behavior, evil motivation, or deliberate disregard of others. Mere negligence is not enough to justify punitive damages.

In defense of punitive damages, jurists claim that they provide compensation to the plaintiff for the expenses of litigation, such as attorneys' fees. In Britain, the law requires the losing party to pay the legal expenses of the winner, but in America those expenses are not compensable and are not included in the verdict.

Another argument presented in favor of punitive damages is the opportunity for redress they give to those who have suffered multiple small injuries, which by themselves are not worth the expense of pursuing in court, such as class action suits.

From another point of view, the award of punitive damages brings up a question of justice. By definition, justice requires that everyone receive his due, no more and no less. Yet punitive damages are an undue compensation to the plaintiff in excess of the compensation for the sustained injuries and contrary to the notion of justice. They are a windfall, not a right. As such, they are awarded at the discretion of the jury.

Another point in this debate is that punitive damages can be awarded only when compensatory damages have been given. If there had been no compensation, a cause for action must not have existed. Even more discussion addresses the proportion of punitive damages to the amount of the awarded compensation. This has been all over the map, from damages close to the amount given for compensation to others, totally out of proportion. You may remember a recent case where the Supreme Court gave a guideline for punitive damages not to exceed ten times the compensatory damages.

Punishment implies the commission of a crime and the payment is like a fine. However, it is levied during a civil procedure, without the usual safeguards of a criminal trial, such as proof of guilt beyond a reasonable doubt. Furthermore, the amount of the fine is determined by the whim of the jury and is not from an established schedule of penalties, like the fines for traffic violations. The latter are determined by statute and are set according to the type of violation. You don't wear your seatbelt, you pay eighty-five dollars, period.

Some legal experts have suggested that since punitive damages have the characteristic of a fine, which is a payment for a criminal offense, they should be paid to the state. One problem with that solution is that the state then becomes an interested party to the action. That could lead to a conflict of interest to the detriment of the defendant. Another problem is that it can create double jeopardy if the defendant has broken a law and may be subjected to a criminal trial and additional punishment.

The award of punitive damages has stirred even more debate on the question of who should pay them. In tort cases, the employer is charged with paying the compensatory damages. Punishing him, when the misconduct of the employee was neither directed, nor authorized, nor ratified, is not just. However, the majority of the courts have made the master responsible for punitive damages even in the absence of approval or ratification.

That has been especially true in the case of corporations, where the innocent shareholders pay the price. The basis of the argument is that corporations can only act through their agents. The main goal has been the expected

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Doctors for Medical Liability Reform

Doctors for Medical Liability Reform (DMLR) is a coalition of 230,000 practicing medical specialists dedicated to protecting patients' access to healthcare by promoting the passage of federal legislation to put a cap on non-economic damages awarded in medical liability cases. DMLR's membership includes:

Neurosurgeons to Preserve Health Care Access
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Surgeons Professional Association
Society of Thoracic Surgeons
American College of Cardiology
American Academy of Dermatology Association
National Association of Spine Specialists
American Urological Association

Escalating jury awards and the high cost of defending against lawsuits – even frivolous ones – are driving medical liability insurance premium increases nationwide, with devastating results for millions of Americans. The American Medical Association has identified 19 states currently experiencing an access-to-care crisis. Of the remaining states, 25 have the potential to be deemed "in crisis." Only six states – California, Colorado, Indiana, Louisiana, New Mexico and Wisconsin – are considered stable; the common denominator is that all six have instituted some type of reform.

The DMLR's Protect Patients Now initiative seeks to educate and inform patients, physicians, business leaders and legislators about the destructive effects to our nation's healthcare and our national economy. States that are facing serious healthcare and economic crises will be highlighted throughout the initiative. Washington State has been highlighted by the DMLR in their media campaign and has been featured in full page advertisements in the *Wall Street Journal* and *USA Today*. A 30-minute video, including Dr. Art Maslow, has been produced. To view the ad and download the 30-minute video - go to protectpatientsnow.org.

For More Information: Contact Jason Kemp or Bill Powers (703) 299-0557; dmlr@protectpatientsnow.org ■

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are now "recognized players" in the political arena.

So what does this have to do with us, you ask? I believe the same grassroots approach applied on targeted districts can succeed in Washington. Don't forget, Pat Lantz (D-26) won her last election by a slim 2% of the vote. Her opponent, Ed Mitchell, this November is a bright, articulate, well-seasoned candidate. Dawn Morrell (D-25) won by the slimmest of margins, 50.5% in the last election. The point is, many legislative seats can be changed by active appropriate activism.

The "Advantages of 'Battlefield Deployment'" from the ACS bulletin are detailed below. While there is time to consider other options in this fight to win back the legislature, I find the New Jersey "deployment" a very reasonable approach. We are looking for other ideas as well. Your board of directors encourages your thoughtful input in this important battle.

Advantages of "Battlefield Deployment"

1. Physicians did not miss a day of practice.
2. Physicians, and the hospitals supporting them, did not lose income.
3. Physicians maintained public good will.
4. It was not likely to draw adverse editorials. What could the media or the FTC say was anti-patient?
5. Surgeons exercised their constitutional right to influence legislators through a day of structured, appropriate grassroots activism.
6. By making grassroots noise, we did something physicians have never done before: create a block of squeaking wheels. This outcome alone is likely to cause some legislators indigestion and situation reassessment.
7. We built future good will for scope-of-practice, other important patient and physician legislative issues. ■

Whistler's 18 inches of snow, great skiing, quality CME highlight this year's CME at Whistler program

Dr. Pat Hogan and Joan Brookhyser enjoy the sun after a great day of skiing

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

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

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

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

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

The Nordestgaard family (l-r) Ida, Dr. Aksel, Rie and Lisbet, prepare for a day of skiing following the morning CME meeting

The Wright family (l-r) Rick, Sally, Julia, Dr. Robert and Robert Jr. pose for the camera after a great day on the slopes

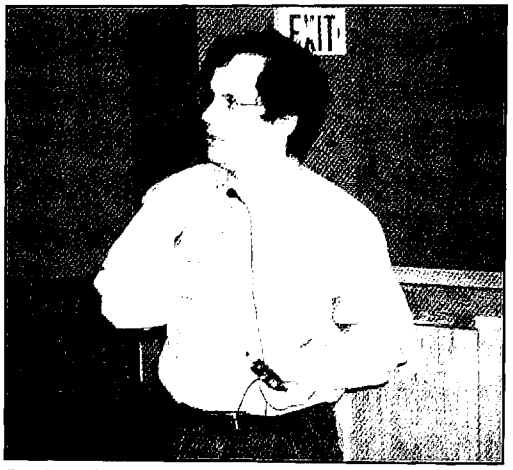
Left to right, Dr. Mark Craddock, Dr. Jennifer Smith, Jack Ecklund and Jinny Craddock enjoy pizza at the pre-conference reception in the Aspens Condo meeting room

An apres ski dinner is enjoyed by CME attendees (l-r) Drs. Donald Boutry, Donald Shrewsbury and Rick Tobin. Dr. Tobin co-directed the course with Dr. John Jiganti

Dr. Gary Taubman and Tracy Gage are set for some Whistler sight-seeing and shopping following the morning's CME session

Dr. Carl Wulfestieg and wife Susan are all smiles after a terrific (and sunny) day of skiing. Dr. Wulfestieg went up for one more run

The Schoeppner family (back, l-r) Sabain, Kelly, Dr. Harald, and (front) Hanna, bundle up for a walk to the Whistler Village



Dr. Daniel Heller answers questions after his presentation on "Imaging Screening." Dr. Heller practices diagnostic radiology in the Tacoma area

Bruce Snell, with Gig Harbor's NW Sports Physical Therapy, covered "Proactive Approach to Musculoskeletal Injury and Degeneration"

(L-R) Drs. Mark Hassig, Robert Wright and Tejinderpal Singh are looking forward to a great day of skiing

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Allergy, Asthma & Pulmonology CME set for April 30

Plan to attend this year's CME program focusing on subjects on allergy, asthma & pulmonology for the primary care physician. The annual course is set for Friday, May 21 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

A program brochure with registration details will be mailed in early April. ■

Internal Medicine Review CME set for March 11 and 12

The Tacoma Academy of Internal Medicine's annual two-day CME program is set for Thursday and Friday, March 11 and 12. A program brochure was mailed in February.

The two-day CME deals with recent advances in Internal Medicine. Faculty includes both local internists and internal medicine subspecialists as well as national speakers. This program is offered to members of the Tacoma Academy of Internal Medicine and all local physicians.

This year's program is directed by **Gurjit Kaeley, MD** and will be held at St. Joseph Hospital in the Lagerquist Conference Center, Rooms 1A & B. The program offers twelve Category I CME credits.

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

- The Role of Angiotension 2 in Hypertension in Cardiovascular Disease
- Infectious Diseases Update
- Current Pharmadynamic Approaches in Alzheimers Disease
- Common Dermatologic Problems
- Dermatologic Manifestations of Systemic Diseases
- Current Diabetes Prevention Problems
- Evidence-Based Approach to the Treatment of Pain
- Advances in the Management and Treatment of Anxiety and Depression
- What's New in GI Medicine: A Potpourri
- Cholesterol Management: New Targets, New Options
- The Art of Rheumatology for the Primary Care Internist
- Oncology Advances: Diagnosis and Treatment ■

Women's Health CME Scheduled for May 21

Plans are nearly complete for the College's Advances in Women's Medicine CME scheduled for May 21, 2004. The conference will be held at St. Joseph Hospital.

Recognized women's health experts will lead this one-day program directed by **John Lenihan, MD** that will address a variety of timely subjects relative to contemporary medicine for women.

A course brochure with program topics and details for registration will be mailed in late April. ■

Dates	Program	Director(s)
Thursday-Friday March 11-12	Internal Medicine Review 2004	Gurjit Kaeley, MD
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

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deterrent effect and the hope that such damages will encourage the companies to better control their employees and to prevent outrageous torts.

Concerning liability insurance, it would appear that punitive damages should not be covered, but most of the decided cases on the subject have held that the insurance contract covers them. A few courts have held the contrary position. Another position on this issue, which may be considered a compromise, is that insurance should cover vicarious liability, but not cases where the defendant is charged with any wrong of his own doing.

Through all that, punitive damages must not be excessive. A verdict must have some sense of proportion in it, some connection with reality. I am not speaking in defense of the tobacco companies, but I must mention the verdict of twenty-two billion dollars against a company, the total worth of which was about sixty billion. If one person is going to receive one third the value of the company, does that serve justice in regard to all the other people who may have been injured by the negligence of that same company. Even liquidating all its assets would barely pay for the compensation of two other persons.

The interesting twist in the story of tobacco litigation is that the states have a strong interest in the viability of the companies because of the settlements they have reached. The ability of the companies to continue paying on their settlement agreements with the states is predicated on their customers continuing to buy their product. That also means that the states have a strong financial interest in having people continue to smoke.

One final point of this issue is the trend toward excessive compensation. I have previously related cases where compensation ran in excess of ten million dollars, up to one case of eighty million against a New York obstetrician. Most of us carry insurance of about two million. Very few among us have assets exceeding five million (I am generous). What benefit can accrue to the plaintiffs, and to our society in general, by verdicts that bankrupt the physicians?

When people are sentenced to paying an amount of punitive, or even of compensatory damages that throws them into bankruptcy, I think that represents an excessive fine, and is banned by the US constitution. It also produces severe distress to the defendants, and as such, it constitutes cruel and unusual punishment. I think that in such cases the defendants should have the protection of the Eighth Amendment to our constitution. ■

Classified Advertising

POSITIONS AVAILABLE

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

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 851-7550, 468-3539.

Office space available in Lakewood/ University Place - 1,500-3,000 sq. ft. m/l available immediately. $14 sq. ft. Call 253-582-6368.

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Pierce County Medical Society
BULLETIN

April, 2004

George Tanbara, MD

Thank you, Dr. Tanbara for fifty years of medicine in Pierce County

See story, page 7

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

April, 2004

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President's Page

by Michael J. Kelly, MD

A Mandate for Change

Michael J. Kelly, MD

"You'll never plow a field by turning it over in your mind."
- Old Irish saying

The time to take renewed action is soon approaching. Most of you have already been very active writing letters to legislators, discussing tort reform with your patients and even traveling to Olympia to testify. As it played out, that was just the warm up. The real game is about to begin - changing the faces of the legislature.

The need for this activism is apparent for anyone who has been paying attention. Our actions to pass tort reform these past two years have been met with merciless, unyielding, unflinching opposition. Only a fool would give this dysfunctional democrat house leadership a third chance to defeat reform in 2005. Their consistent obstruction is our mandate for change.

Plowing the legislative field, to continue the Irish analogy above, uproots the obstructions and removes undesirable noxious weeds. The seeds of tort reform will find fertile ground only in a garden which has been properly prepared. Growth of those reform seeds will occur as we continue to nurture them by supporting our candidates and reaching out to the electorate. This clears the way for a successful crop in the 2005 legislative session.

The PCMS Board of Directors has chosen a special Ad Hoc committee to develop concepts on how to change the faces of the legislature to obtain meaningful tort reform and other medical-friendly legislation. This committee will then report to the Board and eventually the membership of the Society. Members of the committee include co-chairs **Drs. Ron Morris** and **Mike Kelly** along with **Drs. Laurel Harris, Len Alenick** and **Navdeep Rai**.

The committee will look into creative ways to educate the press, public, physicians and legislators. By the time you read this, we will be well along with our planning but still open to ideas from you on such effective political action. We will also be discussing these issues and coordinating efforts with the WSMA.

Before I continue, permit me a brief digression. I am assuming one thing - that your waiting room and exam rooms leave no doubt as to the depths of the present crisis and the need for meaningful liability reform. I am also assuming you have briefly, and appropriately brought up the subject with many of your patients. Do I assume too much?

I am concerned because I have heard from patients that they completed their visit to their doctor without having received any information in the form of posters, handouts or comments about the reform movement. Do not miss such an opportunity to educate your patients. Those patients who have some knowledge of the crisis *expect* you to at least mention the subject. To do otherwise, plays into the hands of the personal injury attorneys who steadfastly claim there is no crisis at all.

In last month's *Bulletin* article, I discussed one example of political action, the "New Jersey" approach, which involved door-to-door, grass-roots activism. If this is used, we will communicate with you on the participants, exact timing, date and districts.

Other ideas may include bumper stickers targeting specific candidates. One bumper sticker can be worth more than $1,000 in advertising dollars. We will look into the cost and dissemination of these mobile advertisements, if cost effective.

Placing the faces of physicians who have left the state or retired early due to liability issues on the back of milk cartons ("Missing Physicians") is another possibility. This will occur only with the acquiescence of the physicians, not to mention the financial feasibility.

PCMS has developed a user-friendly tort talk, complete with readable text, available to any Society member who would like to use it as a platform to educate patients or service groups in the area. It can be downloaded from the new PCMS web site into your computer. We encourage anyone with a voice to consider using this tort reform promotional tool. If Rob McKenna, Republican candidate for Attorney General, can use it, physicians with a more intimate understanding of the issues should have no problem.

The November elections are now our new focus. Other states, including Texas, teach us that legislative change is imperative if we are to succeed. To do this, your county leadership will be depending upon your direct, intimate involvement. Please follow our lead. We will not ask any more of you than we ask of ourselves.

Your Society leaders will thoughtfully turn the options over in our minds, and then communicate them to you. Then we will ask you to make noise; be enthusiastic; be assertive; and plow that field. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

National Health and Nutrition Exam In Pierce County

Starting on March 10, 2004 the Centers for Disease Control (CDC) and the National Center for Health Statistics (NCHS) began exams and surveys of select Pierce County residents as part of the comprehensive study of the health and nutritional status of U.S. residents. Annually for more than 40 years, the CDC has randomly selected approximately 5,000 residents in 15 counties to participate. Data gathered provides estimates on heart and respiratory diseases and conditions such as diabetes and osteoporosis.

The National Health and Nutrition Examination Survey (NHANES) will ask about 400 Pierce County residents to receive a comprehensive physical exam and answer questions during a health interview. Participants selected for the survey represent the U.S. population in age and ethnicity. A mobile unit has been established at the Puyallup Fairgrounds, including a team of health personnel and state-of-the-art equipment.

No medical care is provided directly in the examination center, but medical and dental reports of findings are given to each participant if they wish. Individual information will be kept confidential, although the collated data will be useful for health professionals and policy-makers in determining policies and practices that match the health picture of the U.S.

One or more of your patients may receive a call to take part in this exam and survey. You may want to share this information with them and encourage them to contribute to this unique resource for health information in the U.S. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Breathe Easy, Washington! A Citizen's Initiative for Clean Indoor Air

Federico Cruz, MD

Our legislature unfortunately was true to form. They passed on dealing with Tort Reform and they looked the other way when public health tried to confront Big Tobacco. So the session is over and now it is time to move on. Wrong! It is not time to change the subject or to accept their shoddy behavior as acceptable. When legislators repeatedly fail to act then we as the electorate have several alternatives. The most obvious is to vote in a new set of legislators. There is a general election coming up in November. It is prime time to make change. There is an opportunity to get a new legislature and a new Governor and to get our ideas to the ballot box via a citizen's initiative.

For both tobacco-related issues and tort reform we have labored since the 80s to get legislative action. But special interests have stopped any meaningful movement by our elected delegations. So it's time to take a more direct step.

For tort reform to happen in the state of Washington we need a new Governor and a new Speaker of the House. The democratic incumbents will not permit real reform to take place. This means GETTING INVOLVED WITH THE CAMPAIGNS. Supporting individual candidates. Working in the election. Raising money. Talking to voters. The challenge is in front of us. If we want tort reform to happen, we have to make it happen.

Likewise, to have a smoke-free environment we will need a new law creating a statewide smoking ban in public places. An initiative process has already begun. A petition was filed with the Secretary of State's office on Monday, March 15. At a press conference, Washington State Medical Association and the Washington State Dental Society joined with a number of bartenders and waitresses and other hospitality workers to support passage of the Breathe Easy, Washington! initiative. The initiative calls for the establishment of a statewide ban on smoking in public places. This mirrors the ban already in place in Pierce County.

"So the session is over and now it is time to move on. Wrong!"

So how can we as physicians help?

1) **Financial Support**: The initiative process costs significant dollars. We need donations for the start-up costs ASAP. It is one of the wisest and most prudent investments we can make in the health of our communities.

2) **Petitions**: We need to position them in each of our offices so that each of our patients at sign-in can read the petition and decide whether to sign them.

3) **Advertise**: We need to get the initiative into the public's eye. Posters and brochures will be available and we need to get them posted in our offices so as many people as possible see them.

After the miserable experience of this last legislative session, we have an issue in front of us that we can embrace wholeheartedly. It is positive and uplifting and can mean real positive change for our communities. So let's get behind:

Breathe Easy, Washington!
A Citizen's Initiative for Clean Indoor Air
PO Box 11324
Tacoma, WA 98411-0324
www.BreatheEasyWa.org
253-383-7744
253-276-0086 fax ■

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Residency: University of Texas

Personal Problems of Physicians Committee

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Your colleagues want to help

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Bill Dean, MD	272-4013
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Confidentiality Assured

Fifty years of medicine in Pierce County

Editor's note: The News Tribune recognized Dr. Tanbara for his work in the community with an article and picture the day following the recognition dinner. They followed with an editorial that is reprinted below.

Over 750 people attended Community Health Care's 35th anniversary/annual meeting on March 24th to recognize **George Tanbara, MD** for 35 years of service to CHC and 50 years of medicine in Pierce County. It was a magical evening, bringing together a vast spectrum of friends and supporters: from patients and colleagues to politicians, business and community leaders, tennis buddies and family.

The event, presented in partnership with Pierce County Medical Society and Pediatrics Northwest, focused on the history and growth of CHC, beginning in 1969 with volunteer operations of two medical clinics, one on the eastside and one downtown Tacoma. Dr. Tanbara and his wife Kimi, both worked at the clinic. Today, the nine medical and three dental clinics serve over 30,000 patients each year. While the Pierce County Medical Society and physicians in the community contributed, Dr. Tanbara was the driving force and guiding light of continual operations and success of the clinics for many, many years. Today, he still serves as consultant and avid supporter of CHC.

A highlight of the evening was the announcement of George Tanbara day, by proclamations from the City of Tacoma, Pierce County, the State of Washington, by the governor and legislators from both the Senate and the House. As representatives from each of these bodies stood in the audience, speaker Lyle Quasim noted, "Dr. Tanbara, all of these folks never agree on anything. However, they all readily agree about you."

Rounding out the highlights was the announcement that CHC will name their new eastside clinic, after Dr. Tanbara and his wife Kimi.

Dr. Tanbara joined PCMS in 1954 at the same time he opened his solo practice, now known as Pediatrics Northwest. After completing his internship at King County Hospital in Seattle in 1952 and his residency at Children's Orthopedic Hospital in 1954, Dr. Tanbara settled in Tacoma where we now know, he would dedicate the next 50 to helping the poor and disadvantaged.

Dr. Tanbara served as President of PCMS in 1981. He has chaired many committees and has served on just about every one during his 50 year tenure. Dr. Tanbara was the impetus for the formation of the PCMS Community Service Award, being the first recipient in 1992. He has received numerous awards including but not limited to, The Children's Home Society of Washington, the Boys and Girls Clubs of Pierce County, the Sisters of St. Francis of Philadelphia, the Rotary Club of Tacoma, The Municipal League, as well as many others.

PCMS thanks Dr. Tanbara for 50 years of compassionate medicine and community leadership in Pierce County. ■

Dr. Tanbara's lasting gifts to his community

*For half a century, **Dr. George Tanbara** has embodied the highest ideals of the medical profession.*

The good news is that the 81-year-old Tacoma pediatrician is showing no sign he'll be hanging up his stethoscope anytime soon. He continues to practice medicine and serve as a consultant to Community Health Care, an important Pierce County health care organization he helped found 35 years ago.

Evidence of Dr. Tanbara's impact on the community's well-being was on display Wednesday at the Sheraton Tacoma Hotel Convention Center. More than 700 people showed up to pay tribute to Tanbara and the CHC, which has since grown into a vital health care syndicate serving the medical and dental needs of 34,000 low-income and working class patients throughout the county.

Several speakers praised Tanbara's decades-long dedication to the poor. CHC President and Chief Executive David Flentge said he was "the conscience of the agency."

Tanbara deserved the accolades. He also deserved the decision to name a new medical building to be built in Tacoma's Salishan neighborhood after Tanbara and his wife, Kimi.

Salishan is where it all started. In 1969 Tanbara volunteered to staff a medical clinic for low-income patients in a quonset hut in the East Tacoma neighborhood. While his wife did the paperwork, he treated patients once a week.

His dedication to the poor was shaped at least partly by his own experience with hardship and injustice. Like all persons of Japanese ancestry living on the West Coast during World War II, Tanbara was rounded up and taken to internment camps in the nation's interior. Over the years, he has treated thousands of patients who otherwise wouldn't have been able to afford medical care. His decades-long advocacy on behalf of the poor has indirectly helped many more.

What Tanbara's managed to accomplish is impressive by any standard. And he isn't done yet. ■

Reprinted from the TNT, 3-26-04

Class-action lawsuits against insurers: Settling for fair treatment

The power of organized medicine and the attention of individual physicians will ensure that settlements with managed care companies result in better conduct toward doctors.

One of the lead private attorneys handling physician class-action lawsuits against managed care companies calls settlements with Aetna and CIGNA "one of the greatest victories the medical societies have achieved for their patients and their physicians," and it's easy to see why.

The settlements put the companies' feet to the fire, setting medical necessity standards, forcing them to follow CPT guidelines and otherwise creating more open communication between the companies and physicians. The AMA, state, county and specialty societies worked on physicians' behalf, providing considerable leverage to get, so far, Aetna Inc. and CIGNA Corp. to promise to act fairly.

As any physician knows, leverage is key in negotiating a managed care contract, and until these settlements, the leverage seemingly always belonged to the health plan. As co-lead counsel Archie Lamb Jr. said, "The voice of those medical associations corroborated what individual physicians said for years, and it was a bullet hole between the eyes to those plans mocking and humiliating individual physicians who chose to step forward."

Organized medicine is involved in similar lawsuits and settlement discussions against companies such as Anthem Inc. and WellPoint Health Networks Inc., which recently finalized their merger to become the nation's largest plan. This provides the possibility that even more plans will see the light and decide to treat physicians with some measure of respect, ending the unfair business practices by managed care companies that have tainted their relationships with doctors.

The Aetna and CIGNA settlements are being wrapped up as the U.S. District Court in Miami, which is overseeing them, hears the last appeals on those cases. But organized medicine is urging physicians not to wait in making sure that they get the maximum out of these settlements.

To that end, they recommend physicians look at a Web site (www.hmosettlements.com) created by the plaintiff's attorneys in the Aetna and CIGNA cases. The site gives physicians the details on every settlement. It includes what individual physicians must do to get a share of money for past offenses such as downcoding — for example, in the CIGNA settlement, physicians can resubmit claims for which they believe to be underpaid. Physicians could be leaving tens of thousands of dollars on the table if they don't resubmit.

Also, the Web site spells out how any future disputes will be handled against the companies that have settled. Each settlement has its own process in how a physician would dispute a claim, or would complain about company conduct.

The Web site should be a handy reference to physicians to ensure that they get what's coming to them, although it won't be the only resource available. The AMA and other societies also stand ready to answer questions from physicians about the settlements and how they will affect individual doctors.

This is not to say that physicians would notice an immediate turnaround in their fortunes once the settlements are fully implemented. What is true is that organized medicine has given physicians leverage they didn't have. With the pressure from organized medicine, and the vigilance of individual physicians, the medical community can see to it that health plans no longer run roughshod over physicians with impunity again.■

Reprinted from AMNews, 4/5/04

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.

Social Engineering

Andrew Statson, MD

"Cursed be the social lies that warp us from the living truth."
Lord Tennyson (1842)

A good, all-encompassing definition of torts does not exist. Torts are described as civil wrongs. Each tort addresses a specific issue, not connected to any of the other torts. The only point they have in common is that someone has been injured and may deserve compensation.

In his "Law of Torts" (fourth edition, 1971), Prosser mentions that the purpose of the law is to discourage anti-social behavior. He adds that liability must be based on socially unreasonable conduct and the injurious act must be measured by an objective, disinterested and social standard.

Prosser admits, however, that starting in the 1930's, the courts have moved toward discarding the absolute requirement of fault in order to determine liability. Instead, they consider the question of which party's interest should prevail, even though nobody may be at fault.

In spite of all its efforts, the judicial system cannot remedy all wrongs. Most instances of ingratitude, broken promises, cruel disregard of the feelings of others remain uncompensated. Prosser justifies that by stating that to admit such claims as valid will flood the courts with trivial cases.

Of course, courts have better things to do than to spend their time trying trivial cases. Even so, I suspect the real reason is more likely to be that most of those who commit the above transgressions do not have the means to compensate their victims, and especially, their victims' lawyers. The fact that a defendant is sued is an indication that he has some means of payment. I think that if there were money to pay it, even the most trivial case would be brought to court. The main thing trivial about any case is the defendant with no money.

A dramatic change in the law of torts occurred with the widespread use of the automobile and the growth of liability insurance. The law began to look on liability insurance as a way to compensate the injured party even in the absence of negligence. A statute requires drivers to carry insurance and when someone is hurt, the insurance pays the compensation.

The social effect of insurance has been to mitigate the personal responsibility of individuals for their actions. Getting into an accident is not as ruinous, since we have insurance to compensate us, therefore we don't have to be as careful.

In the past, insurance did not cover injuries by drunk drivers, for instance, but currently an injured party may have cause for action against the insurance company, even when the insured has broken a law or declared bankruptcy.

We can debate whether the higher court awards are due to the increased popularity of liability insurance coverage, or whether the prevalence of insurance is the result of the increased liability risk. I suspect that the two have fed on each other and have become the monsters of today, threatening to devour our society.

The current legal policy, which penalizes carelessness by compensating for every casualty without regard to predictability or fault, claims to be justified by stating that more dangers are now predictable and should be prevented. Therefore the liability has to be more pervasive. Since we can now predict that children may fall off swings, we have to remove such dangerous equipment from our playgrounds. I wonder what our grandparents were thinking when they put them there. Didn't they know we could fall and injure ourselves?

While the courts may consider such compensation without fault as socially desirable, it destroys the sense of individual responsibility of both the defendant and the plaintiff. It has increased the cost of all commercial transactions between the members of our society. The yearly costs of litigation are estimated at between $50 and $100 billion. It has influenced both public and private relationships between people by reducing mutual trust and cooperation and by restraining the natural tendency of all to come to the assistance of a person in distress.

A lot has been written about the

See "Social" page 12

WSMA Conference: "The Alchemy of Leadership"

The Washington State Medical Association's annual Leadership Development Conference is scheduled for May 7 and 8 at Campbell's Resort on Lake Chelan. The conference, entitled "The Alchemy of Leadership" will feature an outstanding faculty and will include plenary sessions as well as hands-on and interactive breakout sessions focused on sharpening specific skills.

The conference is designed for current and future leaders of county medical societies, state specialty societies, hospital medical staffs, medical group practices and other organizations that depend on physician leadership. Leadership/management teams are encouraged to attend.

The conference is being held in conjunction with the WSMA Board of Trustees retreat, and attendees are invited to attend the Board dinner on Saturday night as well as the Board meeting on Sunday morning.

The keynote speaker, Jeffrey Bauer, is a nationally known health care futurist and economist who will speak on "Mastering Chaos: Creativity 101 for Health Care Leaders." Other topics include:

- Relationships, Interests, and Power: Practical Negotiating Strategies
- From Ricky & Lucy to Beavis & Butthead: Managing the New Workforce
- Building a Culture of Safety and Quality
- Living Right Side Up in an Upside Down World: The Importance of Integrity in Leadership and Your Life
- Be Proactive: Be Your Own Grassroots Advocate

This activity meets the criteria for up to 14 hours of Category 1 CME.

To register or for more information, contact Sue at PCMS, 572-3667 or the Washington State Medical Association directly at 800-552-0612 or www.wsma.org. ■

IN MEMORIAM

CHARLES R. VAUGHT, MD

1924 - 2004

Charles Vaught, MD

Dr. Charles Vaught was born in Boise, Idaho in 1924 and died peacefully at his home on March 14, 2004.

After receiving his medical degree from Creighton University in 1948, he completed his internship at the U.S. Naval Hospital in Bremerton and family practice residency at Pierce County Hospital. He began his practice in 1952 in Puyallup, where he continued practicing until his retirement in 1989.

Dr. Vaught joined Pierce County Medical Society in 1952.

Those wishing to remember Dr. Vaught can make donations to the Children's Therapy Unit, Good Samaritan Foundation, 1401 E Main, Puyallup WA 98372, or to the charity of your choice.

PCMS offers condolences to Dr. Vaught's wife, Deva, and their family.

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proliferation of cautionary labels on just about every product on the market. Most of the comments have been directed at the implication that the people who will use the product are morons. Coffee is hot. Knives are sharp. Soap can produce burning in the eyes. Cleaning agents can be harmful if swallowed. Ovens get hot when turned on. Excessive intake of food causes weight gain. A three-hook fish lure can be harmful if swallowed. Isn't it nice fish can't read?

Almost nobody mentions that all those labels have costs, and even though we shouldn't need them, we have to pay for them. The defendants are spending billions of dollars in a generally futile attempt to protect themselves from the risk of litigation. I say futile, because as soon as they take measures against one threat, another one appears on the horizon. There is no end to the ways people can get themselves into trouble, and as long as the courts allow them to blame someone else for their problems, they will do it.

For their part, the plaintiffs refuse to assume the responsibility for their actions. Perhaps the most clear example is the tobacco litigation story. By 1960, there was enough medical evidence to suspect that cigarette smoking can cause lung cancer. In 1964, The Surgeon General ordered all packs of cigarettes to carry a warning about the health hazards of smoking. Even before that cigarettes were called coffin nails. There is nobody in this country who does not know that smoking can cause disease.

Methods to help people quit have been around for decades. One of the most effective programs, without the use of medications, was run by the Adventist Church. Apart from that, nicotine gum has been available for twenty years and nicotine patches for fifteen. Yet, recent juries awarded billions of dollars to plaintiffs who did not avail themselves of the resources at their disposal to help them quit and developed lung cancer. Didn't they have a responsibility for themselves? What can be said about us when we make others responsible for our actions?

Liability insurance has had several effects. A substantial portion of the claims are settled without regard to the existence of liability. The insurance companies pay many claims to avoid the expenses of litigation for cases in which the defendant clearly was not at fault or the plaintiff clearly was. When the cases go to trial, the availability of insurance as a means of distributing the expense of a loss over a large population has influenced the court decisions.

For their part, juries in general tend to return verdicts, or larger verdicts, against defendants who have insurance. Most jurisdictions do not allow attorneys to tell juries about insurance, but the plaintiffs' lawyers usually are able to convey that information to the jury. That results in larger compensation payments, which in turn has an effect on liability insurance rates.

Some arguments favoring the defense, such as the issues of contributory negligence and the assumption of risk by the plaintiff, have weakened over time. In practice, they have been almost completely disregarded. As a result, the verdicts in tort cases are no longer based on law. They are an effort at social engineering, an attempt to solve social problems through legal decisions.

The compensation of the victims regardless of fault is a subversion of justice. It is an acceptance, tacit though it may be, in the concept proposed by Karl Marx and Friedrich Engels in the Communist Manifesto: "From everyone according to his abilities, to everyone according to his needs." The court determines that the plaintiffs have needs, while the insurance companies have the ability to pay.

As I have stated previously, such socialistic slogans have the attraction of simplicity. They also have the flaw of delusion. Needs have the uncanny trait of stretching without limit, while abilities tend to shrink as more and more is expected of them. Such systems are unworkable. Some people get outsized benefits while the going is good. Then the system collapses, because it is unsustainable in the long run. When that happens, everybody suffers, including those who benefited from it while it lasted. ■

COLLEGE OF MEDICAL EDUCATION

Women's CME Set for May 21

Plans are nearing completion for the College's *Advances in Women's Medicine* CME scheduled for May 21, 2004.

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

A course brochure with program topics and details for registration will be mailed in late April.

Topics under consideration for this very popular program include:

- Women's Depression
- Alzheimer's/Speet Scanning
- Ovarian Cancer
- ICS/Pelvic Pain
- Sleep Disorder
- Contraception
- Osteoporosis
- HRT Update
- Access to Women's Care

As usual, the course will qualify for at least 7 Category I CME credits. The conference will be held at St. Joseph Hospital's Lagerquist Conference Center - Rooms 1A & B. ■

Continuing Medical Education

Allergy, Asthma and Pulmonlogy CME for Primary Care - April 30

Registration for this year's CME program focusing on subjects on allergy, asthma & pulmonology remains open for Friday, April 30 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

A program brochure with registration details was mailed in late March. The one-day update is designed for the primary care provider focusing on advances in the diagnosis and management of common pulmonary problems and will offer 6 Category I CME credits.

This year's course will focus on the following:

- An Update in the Diagnosis and Management of Pneumonia
- Current Concepts on Allergic Rhinitis Management
- Advances in Asthma Management
- Current and Future Strategies in Managing COPD
- The Changing Landscape of Atopic Dermatitis Treatment
- New Emerging Role of Small Airways in the Treatment of Asthma ■

Dates	Program	Director(s)
Monday-Friday April 12-16	CME at Hawaii	Mark Craddock, MD
Friday, April 30	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 21	Advances in Women's Medicine	John Lenihan, Jr., MD

In My Opinion

by Daisy Puracal, MD

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

Rituals and Bowls

Daisy Puracal, MD

I cup my hands into the shape of a bowl and feel the cool clear water from the faucet run over my fingers. Water is life, soothing, cleansing and refreshing. Its softness belies the strength and violence it can wreak, as in tornadoes. I lift my cupped hands and splash the stimulating water over my sleepy face — a chilly brace to start the fresh new day. I bend over and fill my mouth with water from this makeshift container and rinse my mouth. An ordinary daily ritual – these ablutions of the morning. But yet, it sets the tone for my day. I am alone. I have time to think. I don't generally blast the radio in the shower - that would just jar my senses like the squabbling crows in summer. The sound of the running water is calming and inviting. I stretch my naked arms out to the warm, delicious spray from the shower head and cavort in its reverberating stream. I lather up with soft fragrant soapy suds. Mmmmm!! I love the feel of a clean shower in the morning and this little sacred time to myself.

The cupped hands –the very first receptacle that mankind ever used. The shape of the cupped hands inspires all manner of bowls — the soup and salad bowls, the chalice, the goblet and the tea bowl. Ah, the tea bowl – that is indeed sacrosanct with its association to the Japanese tea ceremony. A simple ordinary daily activity like bathing, walking or drinking tea can be brought to the level of ritual and a way of life. I could compare it to breaking of bread and drinking of chalice wine at the communion table except for the religious associations that no longer holds true for me.

The Tea Ceremony as taught by Sen Rikyu is an expression of Harmony, Reverence, Purity and Calm. Someone asked Rikyu what the Mysteries of Tea were. To which he replied, "You place the charcoal so that the water boils properly, and you make the tea to bring out the proper taste. You arrange the flowers, as they appear when they are growing. In summer you suggest coolness and in winter coziness. There is no other secret." In addition according to Soshitsu Sen, "You give those with whom you find yourself every consideration." Such eloquence - give those with whom you find yourself every consideration!!

Many though there be
Who with words or even hands
Know the way of tea
Few there are or none at all
Who can serve it from the heart
Sen Rikyu

We had a tea ceremony in our spiritual circle— just the four of us. Ann made sure that the water boiled just right. Powdered tea was placed in each tea bowl one at a time and dissolved in the steaming water with purposeful whisks of a bamboo brush.

When you hear the splash
Of the water drops that fall
Into the stone bowl
You will feel that all the dust
Of your mind is washed away
Sen Rikyu

The tea bowls were set before each one with "every consideration." We cup our hands around the warm bowl and sip. We are of one purpose and mind - connected by this simple act - our circle made sacred by presence and intent.

Imagine all of life being experienced in this manner - to savor each moment with gratitude and reverence. ■

Classified Advertising

POSITIONS AVAILABLE

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

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

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 565-2444, 468-3539.

OFFICE SPACE

Office space available in Lakewood/ University Place - 1,500-3,000 sq. ft. m/l available immediately. $14 sq. ft. Call 253-582-6368.

GENERAL

Coffee Connoisseurs! Want some exceptionally good tasting Peruvian that is Fair Trade, Organic and Shade-Grown to boot? Will deliver to home or office. Order online at www.cafelas americas.com or 253-272-3969.

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Pierce County Medical Society
BULLETIN

May, 2004

PCMS physicians enjoy CME in Hawaii

Dr. Jack Stewart and family, l-r, daughter Lia, wife Therese and daughter Carly, enjoy the sun and beautiful grounds of the Hyatt Regency Kauai

The Dr. Drew Deutsch family, l-r, daughter Hanna, wife Rebecca Smart, and daughter Molly, anticipate much fun in Hawaii on the island of Kauai. The Poipu beach is in the background

Inside:

Your practice can play a very important role in ensuring clean indoor air in Washington State. Initiative I-890 needs 270,000 signatures.

Details see page 4

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

May, 2004

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President's Page

by Michael J. Kelly, MD

Taking the Initiative

Michael J. Kelly, MD

"Pick battles big enough to matter, small enough to win."
- Jonathan Kozol

There are many things which do not go together. Seems reform of the tort system and legislative action in that regard is one example. For the past two years, the democratic leadership, with the able accompaniment of the chair of the house judiciary committee, has killed meaningful liability reform. Is there an alternative to this legislative madness?

Yes there is. It is an alternative well known to Tim Eyman and others dissatisfied with legislative inertia. It is the initiative process.

In political terminology, the initiative is a process that enables citizens to bypass their state legislature by placing proposed statutes, and in some states constitutional amendments (not Washington) on the ballot. The first state to adopt the initiative was South Dakota in 1898 - the most recent, Mississippi in 1992. There are twenty-four states with an initiative process.

There are two types of initiatives: direct and indirect. In the direct, or initiative to the people, petition signatures must be filed no less than four months before a general election, or by July 2, 2004 this year. The indirect initiative, or initiative to the legislature, petition signatures must be filed no less than ten days before the next regular session of the legislature, or by December 31, 2004.

It is the initiative to the legislature which seems to make sense. The leadership of the PCMS, the WSMA and the presidents of all the state's county medical societies discussed this and other tort reform options at a recent meeting on April 21. The discussion of these options has been going on for many months. The consensus favored the initiative to the legislature not only because of the longer period to acquire signatures, but also because of the strict requirements it places on the legislature. Once submitted, the legislature must take one of the following three actions:

- The legislature can adopt the initiative as proposed, in which case it becomes law without a vote of the people; or
- The legislature can reject or refuse to act on the proposed initiative, in which case the unmodified initiative must be placed on the ballot at the next state general election the following November; or
- The legislature can approve an amended version of the proposed initiative, in which case both the amended and original proposal must be placed on the next general election.

The initiative actively constrains the legislature, dictating few options and guaranteeing the public debate and vote we have been denied these last two years in the legislature.

To certify an initiative, to the people or to the legislature, the sponsor must circulate the complete text of the proposal among voters and obtain approximately 200,000 signatures.

This is a blueprint for success! The physicians of this state, fed up with the persistent failures of the legislature, given a creative alternative, will find the gathering of signatures a therapeutic exercise of self-help. The fact that we have until December 31 further enhances our chances.

Many initiative signatures are acquired through the work of paid signature gatherers. I contend we have such a stake in this battle that paying others to gather signatures for us, to secure our future, will not be necessary. This is our battle, not that of a mercenary.

The exact wording of the initiative is a work in progress. It will contain the same basic elements present in senate bill 5728 that passed the senate earlier this year only to be ignored to death in the house.

You may wonder, once passed, how vulnerable is the new statute? It would take a two-thirds vote of both houses of the Washington legislature to repeal or amend an initiative. After two years, a majority vote is required to repeal or amend.

Does this mean we are abandoning our fight to change the faces in the legislature? Not at all. As I mentioned in the last *Bulletin*, we will be announcing plans in the near future that will target specific districts where we feel we can effectively elect a legislator supportive of meaningful liability reform. Your board of directors is working hard to formulate these plans and will communicate them to you at the proper time.

We are excited about the chances for change this fall. With these new strategies and your supportive action, I know we will succeed. Stay tuned to this station for further bulletins... ■

Breathe Easy, Washington
I-890 Workplace Clean Indoor Air Initiative
Medical and Dental Practices I-890 Signature Gathering Process

Your practice can play an important part in reducing the effects of secondhand smoke by gathering signatures to support the I-890 Workplace Clean Indoor Air Initiative. I-890 will provide smoke-free workplaces for all workers in Washington State by banning smoking in all indoor public places. Workers and patrons of restaurants, bars, taverns, bowling alleys and other public places will no longer be exposed to the toxic effects of secondhand smoke.

In order to be placed on the November 2, 2004 ballot we must submit 197,734 valid signatures to the Secretary of State no later than July 2, 2004. Given historic signature validity rates the campaign goal is to collect 270,000 signatures in order to insure that 197,734 valid signatures are submitted.

The Washington State Medical and Washington State Dental Associations have endorsed I-890. It is possible for medical and dental practices to collect enough signatures to put I-890 on the November 2, 2004 ballot.

Campaign Strategy

Breathe Easy Washington will:

- Provide I-890 petitions
- Provide campaign literature
- Provide ongoing technical expertise and support

Medical and dental practices will:

- Identify a "champion" who will be responsible for the I-890 signature gathering process for their practice
- Place petitions in clearly visible public places (i.e., front counter, waiting room, etc.)
- Train staff to ask people to sign the petition
- Make sure that I-890 petitions are easily accessed (not lost in the shuffle of business, not covered up with other materials)
- Return/mail the I-890 petitions right away or call the Medical Society office to pick up (572-3667). Do not wait to send them all at once (the petitions are self-mailers)

Key points:

- Several factors are critical to the success of the I-890 campaign:
  - Physicians and dentists personally asking their clients to sign the I-890 petition
  - Medical and dental staff trained to consistently ask patients to sign the petition (provide rewards/incentives to staff)
  - Office managers and supervisors are supportive of front office staff in the signature gathering process. Front desk staff play a vital role and need to be supported and motivated to ask clients to sign the petitions.
  - The Secretary of State's office has confirmed that signature gatherers do not have to be registered voters and there is no age restriction for signature gatherers. Anyone who signs the petition must be a registered voter, however.

Goals:

- 1,000 physicians and 1,000 dentists and their staff actively participate in collecting signatures
- Each physician and dentist practice collects a minimum of 300 signatures (15 petitions @ 20 signatures per petition)
- All petitions submitted to the Breathe Easy Washington office no later than June 25, 2004. Do not wait to submit the petitions all at once. Once a petition is full (20 signatures) submit it right away

Timelines:

- June 25, 2004 – last day to mail petitions to Breathe Easy Washington
- June 28, 2004 – last day to hand deliver petitions to the Pierce County Medical Society office or Breathe Easy Washington
- July 2, 2004 – 270,000 signatures delivered to the Secretary of State
  - I-890 petitions may be downloaded and printed from the website www.BreatheEasyWa.org in the toolkit area or by contacting the Breath Easy WA office or the Pierce County Medical Society
  - I-890 information, frequently asked questions, why support I-890, and other information is available from the website toolkit

Physicians, dentists and their staff can put I-890 on the November 2, 2004 Ballot!!!!! Thank you for your help.

Breathe Easy, Washington!
PO Box 11324, Tacoma WA 98411-0324
253-383-7744
Or call Pierce County Medical Society
253-572-3667

www.BreatheEasyWa.org

In My Opinion

by Richard Waltman, 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.*

But At Least I Tried

Richard Waltman, MD

It started out as a typical Friday. Lots of follow-up appointments, a few annual physical exams. Some add-ons, people who had put up with rashes and coughs all week but didn't want to be sick over the weekend. But in the afternoon things began to get interesting.

A new patient at 1 PM, a Mr. George Herman Ruth. Mr. Ruth was a stocky 32 year-old man who described himself as "just an old ballplayer passing through town." His complaint was cough and congestion, and he acknowledged he was a heavy smoker, well over two packs a day. On exam he had a rather severe acute bronchitis, but he also had evidence of early COPD. I gave Mr. Ruth some antibiotics and an expectorant for the bronchitis, but I also talked to him about smoking cessation. I told him what we had learned about the harmful effects of smoking and indicated to him some newer methods for cessation. I discussed the benefits of stopping for an athletic young man like him. He indicated he had a chronic cough and was "huffing and puffing around the bases when I hit one out." He agreed it was time to stop. We outlined a cessation program, and I gave him some gum and patch samples. "I'm going to do it, doc," Mr. Ruth said. "And keep an eye on the newspapers. The Babe has a few more dingers left to hit out." I smiled. "And thanks," he said. "No more smoking for me. Thanks a lot." He poked me in the arm and left.

The Babe, how strange, I thought, but before I could think very long I heard "Another new patient in 2."

The name on the chart was Baker, Norma Jean. In the exam room I found a very attractive, very anxious young woman. She told me that she was an actress. She said that people were expecting too much of her and making too many demands on her. "Pose with this director, go to that party, try this hairdo, wear this outfit. I just don't have any time for myself," she said. She told me that she was using pills to get to sleep at night and other pills to wake up in the morning. She had pills to lose weight, pills to relax, pills to pay attention. "I just wanted to be in the movies," she said. "I never expected all of this." And she started to cry. Ms. Baker was obviously very depressed.

We talked about depression and how life events can initiate changes in brain chemistry. We talked about the dangers of taking so many pills and the need for her to get some counseling and begin anti-depressant medication. She was very excited to hear that there were newer medications and methods that could be done to make her feel better. She really opened up, and we had a great talk about her fears, her worries, and her dreams. I gave her a prescription for one of the SSRI agents and the name of a very good counselor. One of my nurses called and made her first appointment. She thanked me for listening to her – "most people don't," she said. She told me she felt much better and was going to "get better." She kissed me on the cheek and said, "Tell your wife that Marilyn Monroe kissed you today." And then she was gone.

Marilyn Monroe, I thought. How odd. But as I felt where she had kissed me, my nurse said "Another ballplayer, in 3."

The name on his chart was Mantle, Mickey Charles. He too was a baseball player, but a much younger one. He was playing his first season in the Majors. "Some people call me the next Joe DiMaggio," he said "but my favorite player has always been Babe Ruth." "Mine too," I told him. His complaint was an upset stomach, and as I took a history it was easy to see why. Mr. Mantle was eating poorly, taking too much Aspirin, and consuming too much alcohol.

I talked with him about improving his diet and about the damaging effects of alcohol on the liver. He told me that he really didn't enjoy drinking and had started when he got to New York "because all the other players did." We talked about peer pressure, about being strong enough to say no, and about the need to stay healthy if he wanted a successful career. "You're right, doc," he said, "I can do without the booze. From now on it's ice tea for me –long balls, not highballs." I gave him some Zantac samples and said we would do an endoscopy if his symptoms did not resolve. I gave him a phone number for AA and encouraged him to contact them or to

See "Tried" page 6

Tried from page 5

call me if he ever felt he needed a pep talk. "I'm OK now," he said, "Maybe some day they'll be talking about 'the next Mickey Mantle,' who knows." He slapped me on the back and was gone.

Mickey Mantle, I thought, Mickey Mantle, and I went into my office to dictate notes on these three remarkable patients. But before I could start, my nurse poked her head in: "One more new one, room two again, then we go home."

I entered room two and found myself face-to-face with John Fitzgerald Kennedy. "Mr. President," I stammered, "what brings you to my office?" "Going on a campaign trip," he said, "and I need something to settle my stomach. Would you believe after so long I still get sick on planes?" We talked about the stress of his job and the difficult times we faced as a nation. I told him I was seeing lots of very angry folks in the office, people who had started fights, people who were rude, people who were talking about violent actions against the government. I told him we were now trying to deal more effectively with road rage, spousal and child abuse, and random acts of violence. I gave President Kennedy something for air sickness, but I just felt I needed to say something to him. "Sir, a lot of us are counting on you to really change things. There are some folks out there that don't like you and what you stand for. Promise me you'll be very careful on this trip. Take good care of yourself." President Kennedy thanked me for my kind words and said he would be careful. "Just for you, doctor. I'll take no chances on this trip." We shook hands, and the 35th President of the United States was gone.

I went back to my office and slumped into my chair. "Someone go over to Starbucks," I yelled to the front office. "After this afternoon I need a double shot latte. And a chocolate chip cookie."

I finished my charts, drank my latte, ate half of the cookie, made hospital rounds, and headed home, trying to make sense of what had happened to me that previously typical Friday afternoon.

I got home and rushed in to tell my wife. "Ruth," I said, "I think I saved the lives of four people this afternoon. Four important people." And I told her about these amazing and unexpected patients, what they wanted, what I had told them, what they were going to do. She smiled. "I'm sure you did a great job for all of your patients today, darling, but..."

"But what?" I interrupted.

"You've told me that sometimes even the best doctor can't save every patient and that sometimes even your best is not enough. Right?"

"So? " I asked.

"Babe Ruth died in 1948 of throat cancer caused by smoking. He was 53. Marilyn Monroe died in 1962 of an overdose of sleeping pills. She was 36. Mickey Mantle died in 1995 of alcoholic liver disease at 63. And John F. Kennedy was assassinated on that trip in 1963. He was 46. You did your best, Rick. You can't save everyone."

She smiled and hugged me. Tears fell out of my eyes and ran over my face. I had failed. I pondered her words: "You can't save everybody..." She was right of course, as usual. Then I hugged her back and nodded my head. And then I said my favorite line from my favorite movie:

"But I tried, didn't I?...At least I did that."

"Yes you did," she said, "Yes you did. At least you did that."

And I knew then that the next Monday I would pull into the hospital parking lot at 6 in the morning and try even harder, just like you. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

MRSA 2004

Federico Cruz, MD

For many years antibiotic resistance has risen in Pierce County, a phenomena which is not just a local phenomenon, but a nationwide trend. The dangers of resistant microorganisms are straightforward: Increases in morbidity and mortality and, of course, dramatic increases in treatment costs for resistant cases. Like other medical challenges, when standard therapeutic approaches fail, extraordinary measures to treat common infections become necessary.

So, has MRSA become a hot topic in the medical community, at the top of everyone's to-do list? Unfortunately, no. We do discuss this fairly regularly but little concerted action has taken place. With all the nightmarish possibilities of resistant organisms running amok in our community, shouldn't there be more of a response or a rising level of concern?

What do we know about MRSA (methicillin resistant staph aureus)? Pierce County providers have been voluntarily reporting MRSA since 2001. Statistics show the number of cases increased from 659 in 2001 to 1144 in 2003. Local hospitals reported the bulk of these cases and those data show the 40% of isolates done in our hospital labs are showing drug resistance. At this point most of the cases are found in the elderly but there is a steady increase in the number of cases in the 30-60 year age range. The vast majority of MRSA infections are in soft tissue sites.

There are concrete steps we can take to address drug resistance. The most important involve behavior change, with both providers and patients re-looking at how they utilize antibiotics. Patients need education about the fact that not every infection needs (or responds to) an antibiotic, such as routine upper respiratory infections, especially ear infections, which are predominantly viral. Patients need to stop pressing providers to write out a prescription. In turn, providers need to assert good science-based decision making, prescribing antibiotics only when really necessary. That's the physician's role, which requires guiding conversations with patients and sometimes even saying "no."

This addresses prevention of drug resistance. Now, what about existing cases? Should we have a registry?

"The problem of drug resistant infections is going to continue and the numbers will grow. Is it time to address this issue in our community aggressively?"

Should providers know when a patient, admitted to a hospital or long-term care facility, harbors a drug resistant organism? If the provider were aware of an existing drug resistant infection would this change how the patient was treated or cared for by staff? My guess is that there are many answers to these questions. And, I think that in many cases the answer would be "yes," advanced knowledge of a patient's status would be helpful for best serving the patient's needs and in protecting other patients.

How difficult would it be to gather and share information? Even with all of the restrictions in place from HIPAA, setting up a registry for identified cases of MRSA and/or other resistant organisms would be allowed, since the cases are potential threats to our community. Other challenges then surface: Collecting the information and then getting it to providers in their practice settings. Both of these activities are doable. Would the different hospitals and long-term care facilities use this information? Would providers change treatment practices once they knew resistant organisms were present in the patient?

All of this paints an uncertain future. We do know one fact: The problem of drug resistant infections is going to continue and the numbers will grow. Is it time to address this issue in our community aggressively? Should we systematically identify the cases in our area and develop standardized approaches for care?

I think the answer is clear. We cannot ignore this problem. We do have to confront it. We have some simple tools - reporting and a registry - but we probably need more. Please join me in developing a new system for addressing antibiotic resistance - both prevention and containment. To do this, we need a new attitude about drug resistance. ■

In My Opinion

by Francesca

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

Dr. Anderson The Hero

Francesca

Editor's Note: The following essay was written by 10-year-old Francesca, the daughter of a surgery patient of Dr. Gerald Anderson. Thank you Francesca for sharing your story.

I think there are a lot of ways to show courage. One way is to do something you know is right even if you aren't sure how other people will feel or what they will think. I know somebody that showed really awesome courage that way. His name is **Dr. (Gerald) Anderson**. He is a surgeon in Tacoma and he operated on my mom. I will tell you how he had to trust his own feelings and not just my mom's tests.

When my mom went into surgery the doctors were looking for one tumor that showed on the tests. They though it was so small that it would even be hard to find, so before surgery they used ultrasound to find it for Dr. Anderson. He didn't just look at the tests though, he paid really close attention when he operated on my mom. He didn't worry if it took a long time or what anyone else thought, he just cared about my mom.

I am so relieved my mom had the surgeon she had, because there were three more tumors besides the one that showed on the tests. Dr. Anderson had courage to go slow and look around and not just do what the tests and the other doctors told him to do. Dr. Anderson said, "My hand guided me and I knew I should look around." He trusted his feelings and did what he thought was the best thing to do.

When all four tumors got sent to the lab there was shocking news. The people in the lab called the operating room and said there were two different kinds of tumors. The ones that did not show on the tests were a different kind than the one that did.

Dr. Anderson was shocked and could not believe it. He was so amazed he went down to the lab himself to glance at the tumors. Dr. Anderson saw for himself that the lab was right, then he changed the kind of surgery he was doing on my mom. When he came to the waiting room to tell our family, I really felt like he cared about my mom and even about us. He was so nice to us. I think that it was hard for him to come and tell us that she needed more surgery, but he did it anyway.

I am so glad Dr. Anderson found those tumors so he could take them all out of my mom. He saved my mom's life and I think he is a hero. Dr. Anderson is a great surgeon and I think he showed a lot of courage through the whole thing. One of my biggest hopes is that he will be a surgeon for a long time so he can save even more lives. ■

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.*

Promises and Results

Andrew Statson, MD

"If you want to hurt someone in America, you may not be able to do it with impunity using a scalpel or a car, but you can do it with a lawsuit and no one will lay a glove on you."
Walter Olson

At the birth of the twentieth century, the practice of medicine inherited the two major developments of the nineteenth, the discovery of germs and the invention of anesthesia. Armed with carbolic acid and ether, we continued in the tradition of our profession.

With full attention to their problems and sympathy for their suffering, we gave encouragement and hope to our patients, encouragement to keep going and hope that their condition might get better. Frequently, hope was all we could give them. It helped, even when both we and the patients knew it was a lie.

The last century brought about drastic changes in the relationship between physicians and patients. Medicine made huge strides during that time, but so did the law. The lawyers put the first blot on our profession by hampering our ability to express compassion.

We could no longer tell patients that they would be fine. That represented a promise and became a contract. Then, when the patients didn't get well, we became liable because we had failed to fulfill our contract with them.

Thus, the admonition to us at mid century was not to promise anything. We still cared about our patients, but we could no longer give them hope. That put the first chill in our relationship with them. We lost our warmth.

As our treatment methods improved, the lawyers placed another burden on our shoulders, the expectation of results.

We can never assure the patient what the result of our treatment will be. Will they get better? We think so. Maybe. Maybe not. The risk of a complication, of an unexpected reaction to medication, or of a lack of effectiveness is ever present.

When problems occur, we try to fix them. Sometimes we are successful, sometimes not. Yet the current legal climate has whipped the public into expecting the impossible. We cannot perform miracles. We cannot deliver perfection.

An even worse threat is looming on the horizon, criminal prosecution. Several jurisdictions here and in Europe have attempted to do that. So far, not much has come out of their efforts, but the threat is there.

For now, we only have to put up with punitive damages. I have heard that Washington State does not provide for punitive damages in tort cases. Perhaps, but a verdict of fifteen million looks very much like punishment to me.

In a case concerning the payment of professional fees, Judge James Robert Pottle, of the Court of Appeals of Georgia, ruled as follows:

"It would never do to hold that a doctor is entitled to recover only where he cures the patient. If we did, the members of this learned profession might hesitate to respond in extreme cases where the chances were against them. So far as we are concerned the doctors may continue to bury their mistakes and recover for their services as they have always done." (Hall v. Mooring, 12 Ga App. 74; 76 S.E. 759; 1912)

Of course, that was in 1912. Many things have changed since then. What has not changed is the truth of Judge Pottle's statement. Physicians do hesitate to treat complex cases when they are expected to produce magical cures.

That was old-fashioned wisdom, but the reality of it is around us. Within the last two years almost half of the OB-GYNs in our community have stopped doing obstetrics or retired altogether. We had four perinatologists. We dropped to one and a half. The residency programs in our state are uninsurable and some of them may fold. I won't discuss the situation in neurosurgery, orthopedics, cardiovascular surgery and others. The old judge knew what he was saying.

Before the Iron Curtain rusted through and through, and the Berlin Wall crumbled, the elections in those countries went 99.9% for the ruling party. Stripped of their voice, the people voted instead with their feet. At that time, a joke made the rounds in

See "Promises" page 18

Doctors Express Liability Worries

An overwhelming number of physicians surveyed in four states say they are concerned about the effect of medical litigation on their practice. This is a breakdown of the survey results of how concerned they are:

	Very	Somewhat	Not too	Not at all
Louisiana	62%	27%	7%	3%
Mississippi	84%	10%	3%	3%
Texas	74%	24%	2%	3%
W. Virginia	76%	20%	1%	0%

From *AMNews*, May 3, 2004

U of W tops medical school list

The best primary programs, according to U.S. News and *World Report*

The University of Washington Medical School was recently rated as having the number one program in primary care, family medicine and rural medicine. Johns Hopkins took top honors for internal medicine while Harvard rated first in women's health and pediatrics.

Total medical school enrollment at UW was 790 students in 2003 with 50% of graduates entering primary care medicine. The average undergraduate GPA of students was 3.69, with out-of-state tuition totalling $29,788.

Applicants for Membership

David P. Langworthy, MD
Anesthesiology
Tacoma Anesthesia Associates
515 South M Street, Tacoma
253-274-1642
Med School: Loma Linda University
Internship: Loma Linda University
Residency: Loma Linda University

Lester P. Wang, MD
Urology
Urologic Consultants
1519 3rd St SE #210, Puyallup
253-840-4994
Med School: University of Missouri
Internship: University of Minnesota
Residency: University of Minnesota
Fellowship: Baylor College of Medicine

Community Health Care

Downtown Medical Clinic
will reopen May 3, 2004

Children's Dental Clinic
will reopen June 1, 2004

Retired members gather

Retired members and guests had a wonderful afternoon on April 8 when they met for lunch at the Fircrest Golf Club. A sunny day helped make the occasion memorable.

Visiting with friends and former colleagues, enjoying the lunch buffet, and a special speaker rounded out the afternoon. Dr. Mian Anwar, retired anesthesiologist, introduced the speaker, Mr. Bob Pittman.

Mr. Pittman is an estate planning attorney who practices in Tacoma. He is also the well-known and respected host of KIRO Radio's Legal Line. He captivated the audience with important information about estate planning, emphasizing that everyone should have a "what about me" segment in their plan. This directive instructs the caregiver about personal preferences of a person should they become unable to communicate their preferences. He cited an example of Mr. Jones, who loved to golf, preferred mushroom soup and enjoyed country music. If Mr. Jones instructs that he would like to be driven around the golf course each week, prefers mushroom soup and likes the radio tuned to country music, this becomes an easy way for the caregiver to make Mr. Jones comfortable and more secure accommodating his preferences.

The retired members and their guests meet three times annually for lunch at Fircrest Golf Club with a featured guest speaker. If you would like to attend and do not receive an invitation, please call PCMS 572-3667. ■

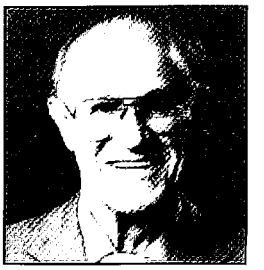
Left, Mr. Bob Pittman answers questions of Dr. Gil Roller after lunch

Left, Dr. Stan Mueller visits with Dr. Mian Anwar and his wife Patty before lunch

IN MEMORIAM

GEORGE G.R. KUNZ, MD

1914 - 2004



George Kunz, MD

Dr. George Kunz was born in Tacoma in 1914 and died peacefully in his sleep on April 14, 2004 after a valiant battle with pancreatic cancer.

Dr. Kunz received his undergraduate degree from the University of Washington, where he also completed one year of law school before deciding to follow his father in the practice of medicine. He received his medical degree from Temple University in Philadelphia in 1943, followed by an internship at Harborview Hospital in Seattle and postgraduate work at Cook County Hospital in Chicago. Dr. Kunz practiced general medicine/surgery in Tacoma from 1944 until 1980, when he retired

Dr. Kunz was a member of the Pierce County Medical Society since 1944.

Memorials may be made to the Tacoma YMCA or the Tacoma Humane Society.

PCMS offers condolences to Dr. Kunz's wife, Lorraine, and their family.

IN MEMORIAM

WILLIAM H. WRIGHT, MD

1924 - 2004

William Wright, MD

Dr. William Wright was born in Michigan in 1924 and died on February 17, 2004.

After receiving his medical degree from the University of Arkansas School of Medicine in 1948, he completed his internship and residency at Brooke Army Hospital and graduate training at Walter Reed Army Medical Center. He began his internal medicine practice in Tacoma in 1966, where he continued practicing until his retirement in 1996.

Dr. Wright joined Pierce County Medical Society in 1966.

PCMS offers condolences to Dr. Wright's family.

Expert Help with Environmental Health Risks

The Northwest Pediatric Environmental Health Specialty Unit (PEHSU) provides free telephone consultation on pediatric environmental health risks to health care providers, public health professionals, communities and families (1-877-KID-CHEM). Catherine Karr, MD, MS, is the lead pediatrician on the grant, and recently responded to calls about pediatric risks associated with mercury in childhood vaccinations, consumption of well water contaminated with formaldehyde, and exposure to silica dust from dad's work clothing.

PEHSU details:

· PEHSU experts also include toxicologists, occupational and environmental medicine physicians and other environmental health specialists on faculty at the University of Washington.

· PEHSU also works with CARE Northwest, a UW telephone consultation service that provides information on the effects of drugs, chemicals and other agents during pregnancy and lactation.

· Expertise on acute exposure calls, such as drug poisonings, is provided by the Washington Poison Center.

· PEHSU professionals are also available to provide educational assistance on pediatric environmental health risks to health care providers, government agencies and other groups. For example, PEHSU experts provide lectures at community hospitals for providers evaluating children/families with health concerns related to a nearby EPA Superfund site. (Call 206-341-4448).

· PEHSU serves Alaska, Idaho, Oregon and Washington.

For professional assistance call 1-877-KID-CHEM (1-877-543-2436). For general assistance, contact PEHSU Coordinator Nancy Beaudet, MS, CIH (206-341-4448). ■

CME at Hawaii includes education, family and sun

CME at Hawaii, a College of Medical Education resort program, was termed a huge success by conference participants. The program brought together Pierce County physicians for family vacationing and continuing medical education on the island of Kauai at the highly praised Hyatt Regency Hotel.

This year's program, organized by longtime director **Mark Craddock, MD** was the College's largest Hawaii program attracting over 60 physicians and other health care providers and their families. The program was COME's 7th Hawaii program and participants returned to Kauai, site of the first such program in 1992.

The program featured a potpourri of educational subjects of interest and value to all specialties. Conference attendees particularly enjoyed the rare opportunity to have in-depth discussions about various case studies.

Out of the classroom, conference participants and their families enjoyed exploring Kauai, water sports, helicopter rides, golf, biplane rides, horseback riding and, of course, great weather.

The College continues to offer resort CME conferences both in ski locations and in sunny resort areas. The next ski program will be held again in Whistler, British Columbia in January of 2005. The next CME at Hawaii program will likely be schedule for spring vacation of 2006. ■

Dr. Michael Lyons addresses CME participants on the latest developments in the diagnosis and treatment of Hepatitis C

Dr. Steven Duncan and his wife Lynda enjoy lunch in Hanalei following a rigorous hike up the Napali coast

From l-r: Dr. Daniel and Lori Nehls, Dr. Mark and Jinny Craddock, Dr. Pat Hogan and Joan Brookhyser, and Dr. Jim and Penny Rooks following a run down the hotel water slide

Drs. Alex Mihali, Chris Jordan and Joe Clabots as the sun drops into the Kauai surf behind them

Dr. John and Kathy Samms with Dr. Laird Findlay and wife Linda Bentson enjoy the conference reception

Dr. Greg Carrougher fields questions from the 60 physicians and other health care providers attending the semi-annual CME in Hawaii program

Dr. Janis Fegley (right) and Deborah Curtis, ARNP in front of the many shops in the beautiful Kauai Hyatt

Dr. Greg Carrougher and his daughter, Lisa, share smiles at the end of a great week in Kauai

Proud grandparents Dr. Ron and Karen Benveniste enjoy time with their granddaughter, Leah, around the hotel's beach and swimming pool

Dr. Dan Nehls and his son, Brady, swim in one of the Hyatt's many pools - this one a large salt water lagoon always heated to 82 degrees

Former Cedar Surgical partners reunite at the opening reception. From left, Dr. Chris Jordan and his wife Dr. Elaine Kubota, Dr. Stan and Debi Harris, and Dr. Ron and Ann Taylor

PCMS physicians, l-r, Drs. Doug Malo, Leslie Malo, Teresa Clabots, Frank Senecal and Joe Clabots, during the traditional Sunday night reception

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Advances in Women's Medicine Draws National Faculty May 21

Plans are complete for the College's *Advances in Women's Medicine* CME scheduled for May 21, 2004.

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

A course program brochure with topics and details for registration was mailed recently.

The course will qualify for 6.5 Category I CME credits. The conference will be held at St. Joseph Hospital's Lagerquist Conference Center - Rooms 1A & B.

Topics for this very popular program include:

- Depression: A Woman's Perspective — Mark Curtis, MD, MED, FACOG
- Hormones and Abnormal Brain Function: The Role of Spect Scanning — Pat Donley, MD
- Age-Related Fertility: New Options — Paul Lin, MD
- Contraception Update: New Options for Today's Woman — Albert Yuzpe, MD
- Ovarian Cancer Update — Howard Muntz, MD
- Hormone Replacement Therapy: What Now? — Sherri Winer, MD
- Update on Management of Abnormal Pap Smears — Kris Ghosh, MD ■

Promises from page 9

Eastern Europe:

"What will you do when they open the borders?"

"I'll climb a tree."

"Why?"

"So I don't get trampled."

So far, only a few physicians in a few fields have voted with their feet. When the rest of us get squeezed tighter, watch out for the stampede.

To cheer up those of you in the low risk specialties (is there such a thing?), the March issue of "ACOG Today" reported the results of a poll of the fellows for the years 1999-2003.

One half of the fellows of the college have been sued during the past four years. The average time in practice after residency was sixteen years. The average number of suits per fellow was 2.6. Over 76% had had at least one claim, 57% had two or more. The malpractice premiums rose 53% from 1999 to 2003.

The above figures are for the whole country. The situation in Washington State is worse. Our premiums doubled during that time. Many other costs of running a practice went up as well. To meet that increase in overhead, we have Medicare raising payments by 1.5%, with the ever present threat of cutting them later. Medicaid promised to increase the payment for obstetrical care by 5%.

Lewis Carroll expressed our feelings well. You probably remember the following passage from "Through the Looking Glass":

"Well, in our country," said Alice, still panting a little, "you'd generally get somewhere else—if you ran very fast for a long time as we've been doing."

"A slow sort of country!" said the Queen. "Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"

Then, to help quench her thirst, the Red Queen gave Alice a very dry biscuit. How appropriate! While we need significant increases in our reimbursement rates to meet our rising overhead, we get cuts, or at most, a promise of a 5% increase.

Fortunately for Alice, she woke up from her dream. Why do I have the feeling that ours is going to last a while longer?

In various discussions in some physician on-line services, one of the fellows repeatedly writes, "We control access. Without us, there can be no medical care. Think about it."

I know the problem. It is very difficult to stop practicing, even for a short time. The flow of income stops, while the overhead costs keep piling up. As long as we make enough to cover the bus fare to go to work and also have something left over, we'll keep going.

For many of us, the time when we shall not be able to cover our expenses is getting close. It is time to consider other options. When enough of us make the switch, things will change. Until then, we'll continue our trek through the land behind the looking glass. ■

Classified Advertising

POSITIONS AVAILABLE

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

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

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

Choice office space in Medical/Dental complex in Gig Harbor available January, 2004. 2,354 sq. ft. on main floor. Two entrances, offices with decks and outside doors. Large reception and front office. Lab space, consultation room, heat, electricity and water included. Beautiful, wooded setting. 5122 Olympic Dr NW, Suite A203. Call Dr. Mary Griffith 565-2444, 468-3539.

Retired Doctor's Wives Luncheon

There will be a no-host luncheon Wednesday, May 26, 2004 at 11:30 am at Affairs restaurant located at 27th and Bridgeport in University Place. Wives of retired and semi-retired doctors are welcome.

To make a reservation, call Judy Brachvogel (564-4308) or Marlyn Baer (564-6374) by Friday May 21. Come and renew friendships!

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

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Pierce County Medical Society
BULLETIN

June, 2004

New members - from left, Amol Shah, MD and wife Sam Song, MD with Tammi Stefanelli, MD at the PCMS new member reception in May. Dr. Shah is an emergency room physician at Tacoma General, Dr. Song an ob/gyn with Good Samaritan and Dr. Stefanelli is a family physician in Tacoma's north end

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

June, 2004

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President's Page

by Michael J. Kelly, MD

Important Political Agendas

Michael J. Kelly, MD

"A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of Public Health."
- Point VII, AMA's "Principles of Medical Ethics"

There was a time I thought being a physician would be all I would ever do. Now I realize to continue to be a physician, I must become a politician.

So you're getting tired of hearing about tort reform and legislative action plans, eh? I understand. Please accept my apologies but I feel compelled to stay with the message.

However, I thought I would begin this *Bulletin* with a plea for your help about another area of state politics. Initiative 890 - the Breathe Easy, Washington campaign (www.Breathe EasyWa.org). In the May *Bulletin*, I mentioned the Tort Reform Initiative to the legislature, a signature gathering campaign that will start in July. Breathe Easy is an initiative to the ballot presently underway. I will return to tort reform later.

I'm certain all of you, well-informed physicians that you are, have heard of Initiative 890 and the campaign, which will ban all Washington State employers from exposing their employees to secondhand smoke. If not, crawl out from under that rock or get the spinach out of your ears. Page four of last month's *Bulletin* has an excellent overview including "key points" and "timelines." Sometimes repetition helps.

This is a true workplace protection measure, which will eliminate employee exposure to known airborne carcinogens. As many of you know, **secondhand smoke is the third leading cause of preventable death** in the U.S. after active smoking and alcohol use. To say that this merits our full support is an understatement. Such support should come in the way of acquisition of initiative signatures and, possibly, financial support.

Success in this initiative will make Washington the sixth state to become smoke-free in all public indoor places. The process requires we obtain approximately 270,000 signatures before July 2 in order to qualify for the November ballot. You can obtain petitions from the PCMS office or download via the internet. Simply go to www.breathe easywa.org/toolkit/.

Spearheading the state campaign is our own President-Elect, **Dr. Pat Hogan**. He and your PCMS Board of Directors strongly encourage you to place petitions in clearly visible places in your offices ("hello" area, waiting room, etc.) and train staff to alert patients to the presence of the petition. According to legal council, there are no HIPAA violations in acquiring signatures in this manner. Once a petition is full (20 signatures) submit it right away, either by mailing (the petitions are self-mailers) or by calling the PCMS office to pick it up (572-3667).

Initiative 890 will fulfill the above referenced ethical directive to "...participate in activities contributing to the improvement of the community and the betterment of public health." Your patients, especially the waitresses and bartenders, will thank you.

Point IX of the same AMA "Principles of Ethics," referenced above, states, "A physician **shall support access to medical care** for all people." This is a directive to support medical liability reform if there ever was one. In this politically charged arena, where one committee chair can seriously affect medical access across the entire state, "..support of access" has come to mean support of politicians who can help us guarantee such access.

Let me introduce you to two people you need to know, Matt Rice, MD, JD, and Colonel Bob Lawrence USAF (ret.). Dr. Rice has just announced as republican candidate to unseat Pat Lantz (D-26) while Bob Lawrence announced his candidacy for the 28th district to fill the seat presently held by Rep. Mike Carrell (R-28), who is campaigning for state senate. Rep. Carrell, long appreciated as a champion for medical causes, seeks the senate seat available due the retirement of Shirley Winsley. His campaign can be reached at 253-581-2859 or www.ccarrell @ix.netcom.com.

Matt Rice, MD, JD is senior vice president and chief medical officer for Northwest Emergency Physicians. Dr. Rice's CV is extensive and impressive. He has served as director of the emergency department of St. Clare Hospital, chairman of emergency medicine and residency program director at Madigan Army Medical Center and received his

See "Agendas" page 16

Premera conversion ruling due in July

The seemingly never-ending Premera conversion process (the Plan announced its intention to convert to a stock company 24 months ago) may have reached a milestone. Last week, Deputy Insurance Commissioner Jim Odiorne, presenting the OIC staff's recommendations, advocated that the Insurance Commissioner deny the conversion.

Odiorne said if the Insurance Commissioner was disposed to approve the conversion, he should do so with many substantial conditions. However, even if all the conditions he recommended were adopted, the Office of the Insurance Commissioner (OIC) staff still recommended the Insurance Commissioner reject the conversion.

Premera had the opportunity to rebut the staff recommendations later in the week. The Commissioner has until July 19 to render his final decision on the conversion.

Some of the specific concerns noted by OIC staff included:

- Potential adverse impacts on subscribers, either directly through increased premiums or indirectly through lower reimbursements for providers.

- Premera's focus on growth in overall revenue and overall membership is a focus reflecting shareholder interests, not the insurance buying public.

- The transaction would not transfer the full market value of the company to the foundations.

- Premera has not provided a complete description of the transaction, and the Commissioner has been denied total access to what Premera's plans are post-conversion.

- Premera has already made negative changes pre-conversion that reflect a for-profit orientation, such as dropping Public Employee Benefits Board (PEBB), Healthy Options, Basic Health, and its Medicare fiscal intermediary role.

It is gratifying that Odiorne included provider issues as a basis for rejection, which was virtually straight from the testimonies of WSMA President Dr. Jeff Collins and Director of Health Care Economics Bob Perna, both having testified at the hearing.

He noted that their testimony showed the link between reimbursement and patient access and quality patient care (one of the legal standards is that the conversion can't be "harmful to subscribers"). Allowing Premera more market power, he concluded, would reduce already inadequate reimbursement.

Commissioner Kreidler could issue his ruling sooner than July 17. With Premera having already spent a reported $31 million plus on the conversion, many observers think the Plan will appeal if the Commissioner rules against it. ■

Industry not ready for HIPAA security mandate

Health care organizations are woefully unprepared to comply with the HIPAA security rule and must act immediately to meet the April 21, 2005 deadline, according to a report by URAC, a health care organization accrediting agency.

URAC warned the industry to start compliance efforts now because it will take six months to a year to implement a program to protect the confidentiality, integrity and availability of patient records stored in an electronic format or transmitted electronically. URAC based its assessment on contacts with 300 health care entities that have inquired about or gone through its web site and HIPAA privacy security accreditation programs.

Although URAC did not consult with small physician offices for its report, it believes - as do other industry observers - that doctors are equally unprepared for HIPAA security compliance.

Compliance will be challenging regardless of size, but "smaller practices obviously have less work to do in the sense that they have smaller (information) systems and smaller number of individuals with whom they need to be concerned," said Claire W. Barrett, a URAC accreditation reviewer who co-wrote the report.

"The other thing to keep in mind is the security rule is desigend...to be scalable so the compliance activity of physicians will be inherently less than a complex hospital's or health plan system's," said Garry Carneal, URAC's president.

URAC's report identified four key barriers toward compliance: incomplete or inadequate risk analysis effort; inconsistent and poorly executed risk management strategies to address security vulnerabilities; limited or faulty information systems activity review; and ineffective security incident reporting and response.

The report lays out a 12-month timetable of activities and recommendations for meeting the security rule compliance deadline. ■

Watch for state access survey

Every physician with a Washington State license - active, retired, in or out of state - will soon receive a brief questionnaire from the WSMA. The goal: determine what type of practice setting each physician is in, and how malpractice premiums are affecting their practice.

We must substantiate access to care problems being experienced on an ongoing basis. The questionnaire should take only about 10 minutes to complete, and respondents can call a toll free number at their convenience and enter their replies.

Amateur Astronomy - May General Membership Meeting Recap

Amateur astronomy proved to be a hot topic for PCMS physicians and their guests at the May 11 General Membership Meeting. Just over 100 attended the event at the Landmark Convention Center in Tacoma to hear **Dr. Charles Jacobson,** Puyallup internist, teach about his revered avocation.

Giving a well-rounded presentation, Dr. Jacobson spoke not only of the Solar System but of the other astronomical objects, galaxies, nebulae, and star clusters. He outlined numerous organizations, events, publications, and other such items that avail themselves to the astronomical enthusiast. He spoke of the public star parties at the Fort Steilacoom campus of Pierce College, Project Astro, an education project for grades 1-9, sponsored by the U of W department of Astronomy. He urged individuals to come to the annual August Astronomy Fair sponsored by the Tacoma Astronomical Society. He mentioned three observatories for the public in the NW. On the PLU campus, the Keck Observatory, the Goldendale observatory in Goldendale, WA and the Battle Point Observatory on Bainbridge Island.

Dr. Jacobson was very informative about what amateurs do. Amateurs observe the heavens, experiment with a variety of photography equipment and computers, and explore telescope making and amateur optics. They also enjoy star parties. The really serious submit serial observations of their favorite subjects to professional groups. Having been involved since the age of 13, and with the knowledge and experience accumulated over the years, there was no doubt by anyone attending that Dr. Jacobson is a "serious guy."

His own collection of equipment includes 17" and 12.5" Newtonian reflectors, a 7" Astro-Physics refractor and a 60 mm Coronado Solar Scope.

His quick rundown on the Solar System:

- The **Sun** - gorgeous and changing
- **Venus** – white only with phase changes
- The **Moon** – great contrasts and moonscape reliefs
- **Jupiter** – enormous, a failed Sun, with great atmospheric details

See "Recap" page 18

Puyallup physicians Drs. Charles Jacobson (speaker) and Julie Gustafson and husband David Keers (right)

Dr. William Holderman (right) with daughter Lauren and Dr. Daniel Ginsberg with daughter Rachel

Drs. Jim Rooks (left) and Pat Hogan carefully review a petition for Initiative 890 - for clean indoor air

ASTRONOMY RESOURCES

Tacoma Astronomical Society
Meetings: First Tuesday of each month
Rm. 130 Thompson Hall, UPS
Star Parties: Monthly Pierce College Ft. Steilacoom Campus
Astronomy Fair: Saturday August 7th
Further information: www.tas-online.org

Battle Point Astronomical Association
206-842-9152

***Jack Newton**: Osoyoos*
www.jacknewton.com

Goldendale Observatory
509-773-3141
http://community.gorge.net/friendsofgosp
email: goldobs@gorge.net

Seattle Astronomical Society
http://www.seattleastro.org

Telescope information
TAS members
Charles Jacobson 848 7095
e-mail: jacobsonc@comcast.net

***Star Ware** by Phillip Harrington*

***Captain's Nautical** in Seattle*
Anacortes Telescope and Wild Bird
Orion Telescope

Applicants for Membership

Stanley G. Cheng, MD
Diagnostic Radiology
Tacoma Radiology Associates
3402 S 18th St, Tacoma
253-383-1099
Med School: New York University
Internship: Swedish Medical Center
Residency: University of Washington
Fellowship: University of Washington

Jill D. Robinson, MD
Diagnostic Radiology
Tacoma Radiology Associates
3402 S 18th St, Tacoma
253-383-1099
Med School: Univ of CA, San Diego
Internship: Univ of CA, Irvine
Residency: Univ of CA, Irvine

John C. Russell, MD
Urology
Urologic Consultants
1519 3rd St SE #210, Puyallup
253-840-4994
Med School: University of Washington
Internship: Dartmouth
Residency: Dartmouth

Berndt P. Schmit, MD
Diagnostic Radiology
Tacoma Radiology Associates
3402 S 18th St, Tacoma
253-383-1099
Med School: Tufts University
Internship: University of Arizona
Residency: University of Arizona
Residency: Mount Auburn Hospital
Fellowship: Brigham and Women's Hosp

Charles E. Wang, MD
Diagnostic Radiology
Medical Imaging Northwest
222 - 15th Ave SE, Puyallup
253-841-4353
Med School: Tufts University
Internship: Cleveland Clinic
Residency: U of Massachusetts Med Ctr
Fellowship: Mayo Clinic Foundation
Fellowship: Tufts New England Med Ctr

Special Feature

by Jean Borst

Matt Rice: Republican Candidate for the 26th District Another Way to Make a Difference

Physician, military officer, law degree, businessman, teacher…Dr. Matt Rice is someone who believes he can make a difference, and he's spent his entire life putting that belief into action.

Currently a practicing emergency room physician and senior vice president of Team Health West, a company that provides physician services to contracted hospitals in the Northwest, Rice is now preparing to make a difference in the political arena as he declares his candidacy for the 26th District seat in the Washington State House of Representatives.

Rice believes it is vital for people to get involved in the process in order to have a say in the issues that impact all of us. "It would be wrong for me not to run," he said. From tort reform to transportation, Rice is looking forward to the prospect of representing the 26th, a district that covers parts of Pierce and Kitsap counties and includes the cities of Gig Harbor, Port Orchard and parts of Bremerton. His decision to run is one that should be of significant interest to all PCMS members, for Rice is seeking to unseat incumbent Pat Lantz (D).

Lantz has served as state representative to the 26th district since 1997 and is currently in her fourth term. She was instrumental in stopping two Senate-approved malpractice relief measures from reaching the floor of the House from the Judiciary Committee, which she chairs. Lantz has publicly denounced tort reform and believes Washington State is in need of insurance reform and other less sweeping measures to relieve doctors from the economic squeeze that includes steadily declining federal Medicaid reimbursement rates.

While tort reform is sure to be a pressing issue in this highly visible campaign, it's just one reason why Rice is hitting the campaign trail.

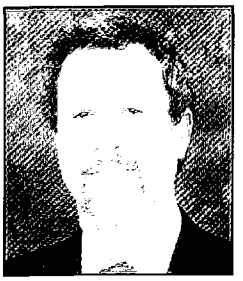
"I think this is the right time to get involved and give back to society," Rice said. "If people like me don't serve at the local, state or national levels, then they can't get involved in the things that impact us in important ways." Becoming involved in this way, he believes, "is just as important as the care we provide as physicians."

Rice has been considering a run for the last year or two, "but it's been in the last six to eight months that I've felt I could really be a part of the process and do a better job than Pat Lantz," he said. "I have nothing against Pat as a person, but I think I am the better candidate, and I think I can make a contribution in this role."

Making a Difference, his Whole Life

Born and raised in rural Pennsylvania, Rice was a biology major at Gettysburg College and received his MS in physiology and medical degree from Penn State. He joined the ROTC along the way, and his strong desire to serve his country lead him to active duty in the army after medical school. He completed an internship at Tripler Army Medical Center in Honolulu and served as a battalion surgeon and as Director the Stuttgart, Germany (5th General Hospital) Army Emergency Department during the Cold War. He received his emergency medicine training at Brook Army Medical Center in San Antonio, Texas.

"Dr. Matt Rice is someone who believes he can make a difference, and he's spent his entire life putting that belief into action."



Matt Rice, MD

For many years, Rice served as emergency medicine residency director for the Madigan Army Medical Center/ University of Washington Program and was also the chief of emergency medicine at Madigan for 10 years. In 1988, Rice received his law degree from Seattle University School of Law. He retired from the army as a colonel in 2000 and is currently senior vice president of Team Health West and chief medical officer of Northwest Emergency Physicians.

Rice has also volunteered countless hours as instructor and advisor for the Tacoma Community College Paramedic Program and Pierce County EMS, as race physician for the Sound-to-Narrows, and as a volunteer physician for the American Red Cross. He is a past member of the Washington State Governor's Council on EMS and Trauma Systems, the Washington State West Region EMS Committee, and lectures to numerous groups on medical, patient safety and legal issues. He is the recipient of numerous awards, including the GSC ACEP Outstanding Service Award and Order of Military Medical Merit. He

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Chlamydia Infections Rising

The number of people infected with Chlamydia continues to rise across the state and in Pierce County. In 2003, 2,644 cases were reported in Pierce County, compared to 1,990 cases in 2000. Since at least 70% of the cases are asymptomatic, regular testing of sexually active men and women, particularly those under the age of 25 years is critical to controlling the spread of the disease.

Healthcare providers are uniquely positioned to intervene with the spread of Chlamydia with patients under 25. Studies have shown that young people accept the advice of medical providers; and, those under the age of 25 state that they prefer to receive sexual health education through their physicians.

TPCHD recommends the regular annual tests for Chlamydia for sexually active men and women 25 years old and younger and women over the age of 25 with a new sex partner or more than one sex partner. In addition, the following should be screened for Chlamydia:

- Pregnant women
- Women with mucopurulent cervicitis (purulent or mucopurulent cervical discharge, or easily induce cervical bleeding), pelvic inflammatory disease (PID), and/or urethral syndrome (acute dysuria and pyuria with bacteriuria)
- All sex partners of persons with chlamydial infections
- Women planning IUD insertion, depending on their risk
- Men with urethritis or epididymitis

The most reliable laboratory test is the new nucleic acid amplification test (NAAT), because these tests have a 98-99% specificity and are also the most sensitive. The cervical swab has a sensitivity of 92-98% and sensitivity of the male urine test is 96-99%. In contrast, the Gen-Probe Pace has a sensitivity of 40-65%.

Chlamydia cases should be reported to the Tacoma-Pierce County Health Department (253-798-6534) to assure follow-up of close contacts and to manage potential outbreaks.

For more information, contact TPCHD Nurse Epidemiologists at 253-798-6410 and/or look at the following websites:

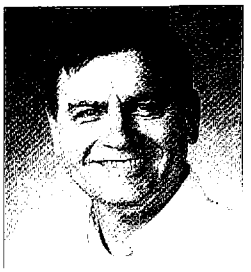
Centers for Disease Control:
www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm

Washington Department of Health:
www.doh.wa.gov/cfh/STD/factsheet.htm ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Clean Indoor Air Initiative



Federico Cruz, MD

Editor's Note: James M. Wilson, MD, PCMS Past-President and Pierce County Board of Health member is featured in this article discussing how difficult it has been to stay the course with the county smoking ban

In the argument about the indoor smoking ban, I've been proud of our Board of Health. They made a decision and continue to uphold the resolution, even as we face court battles and monthly testimony about pain and suffering caused by the ban. At the May meeting, **Jim Wilson, MD** responded to the large group of people who argued against the clean indoor air resolution by recognizing both sides of the situation. Some businesses are losing revenues as people travel to King County restaurants and tribal casinos where they can continue to smoke. On the other hand, directly smoking or breathing in second-hand smoke has health impacts.

Jim Wilson, MD

Jim spoke from the heart. As you talk with patients who are wondering whether to quit smoking, maybe his words will inform and assist you on what to say:

"This is hard. This is really, really hard. My heart goes out to business owners and workers and people whose jobs are threatened. We determine who we are in our self-esteem and our livelihood by how we provide for our families and how we provide for and meet our personal needs. Every time we have a Board meeting, I find myself coming closer and closer to saying, 'Gosh, can't we find a compromise here? Can't we find a way that we can have it both ways?'"

"Then I go back to my other life. And in my other life, I spent an hour, just this morning, sitting with a man who was just sobbing, who was sitting and holding his head in his hands and sobbing because he is dying from lung cancer. And he's not just dying from lung cancer, he can't breathe and uses oxygen. He had a huge tumor that came out on his neck that was just ugly and horrible and terrible and required a horrible surgery. He was just recovering from the surgery and walking down the street and his leg broke. The big bone in his leg just snapped right in two. It snapped in two because there was a big tumor in there from his lung cancer. And, you know, this guy is someone I have known and taken care of for a long time. We have been down a lot of roads together. I tried to talk him into quitting smoking and he actually finally accomplished it a couple years ago, after his lungs got so bad that he was on oxygen all the time."

"There is a new box to check on death certificates that indicates if smoking contributed in any way to what happened. It has just amazed me how frequently I have to check 'yes.'"

- Jim Wilson, MD

"The other thing that sways me is you know they changed the death certificate. I take care of older people a lot. I guess that I wouldn't be doing my practice a great service by saying that I fill out a lot of death certificates. But, tragically, in what I do for a living, I do. And I've seen that they've changed the certificate. There is a new box to check on death certificates that indicates if smoking contributed in any way to what happened. It has just amazed me how frequently I have to check 'yes.' And it is not just the lung cancer."

"You know, you hear somebody today say to the Board of Health, 'Gosh, I have smoked for years and I don't have lung cancer.' Yeah, but if she gets it tomorrow, she is going to be a sad person because that is a pathetic way to go. Heart attacks and strokes and all kinds of lung diseases and things that we do not think about normally being affected by smoking, and smoke that we get when we are exposed in bowling alleys or in that train station or in your casino, really does affect us and really does impact our lives."

"This is tough. This is tough because I want you guys to be successful. I want your businesses to be successful. I want to tell all of my friends to come to your bowling alley now because they can come there and not have to be plagued by the smoke. You are going through a tough time right now, and I am sorry. But I think this resolution, the banning smoking, is the right thing." ■

Matt Rice from page 7

supports and participates in various community events and organizations.

Rice has lived in Gig Harbor since 1988. He and his wife, Kirin, have three dogs. Despite his busy professional schedule, he swears he has spare time and enjoys gardening, kayaking, hiking and anything else that is related to he outdoors. "I love nature," he said.

The Issues

With a unique perspective that comes with his experience in medicine, business, law, the military, and education, Rice comes to the campaign with a broad perspective and ready to tackle a wide variety of issues. His first order of business if elected, he says, is to "listen..a lot."

Among the critical issues that will highlight the campaign are:

• **Tort reform**. "I am obviously very interested in tort reform, but not just for physicians, but for society as a whole. It's an issue we need to address, because it is a cancer eroding the very core of what is important to us as Americans. We must not lose sight of the individuals who in many cases do need protection, but we cannot allow the continuing abuse."

• **Access to care** and the availability of medical care. "This is an issue at the forefront, and very important to businesses and individuals."

• **Transportation**. "Transportation is an issue that impacts our entire social structure – people, jobs, etc.," he said. "While I don't have all the answers to our transportation problems, I do have a logical mind and an openness to learning."

• **Education**. For Rice, education has always been a passion. He has extensive experience in residency training, and has held numerous faculty assignments. "I plan to look at standards, expectations, and alternatives to our current system," he said.

Rice believes his experience as a physician is very relevant to the issues at hand. "All of the issues are socially important and relative to what we see everyday in medicine: homelessness, lack of insurance, issues affecting the elderly, joblessness. I believe my experience gives me a broad perspective."

Preparing to Run

While there was never any question that Rice was committed to becoming actively involved in the political process, the decision to take the leap and run for office did not come lightly. While his colleagues, friends and associates are excited and supportive, an impending campaign and the very real possibility of being elected is perhaps not the best business decision Rice could make. "I have 300 doctors who are depending on me in my job," he said. "I want to make sure my decision doesn't hurt the people who are counting on me." Rice has worked hard to communicate with the physicians and make sure they understand what his limitations could possibly be in the coming months, and is taking measures to ensure they have the support they need. "I have also assured them that they will be a part of the process and I will welcome and encourage their input."

Over the coming months, Rice will file his papers and begin the process. The first step, he said, is to get his name out there. He has been working closely with representatives of the local and state Republican Party and with groups that have an interest in legislative issues. He's been learning the nuances of getting involved in the process, and while he might not be taking the plunge early in the game, he is confident that his timing is not too late, either. One thing is certain, however. This is sure to be a highly visible campaign. "I will need the support of a lot of folks to get my message out there," Rice said. "That's how I will be successful in the campaign and ultimately have the opportunity to represent those who have similar views."

"If elected, I'm looking forward to working with some outstanding people in our society," Rice explained, "people who are core to what we do, but who are not always heard – professional people as well as the average person. All people contribute to our society. I look forward to serving various groups and providing the best representation possible."

Rice reiterates that his decision to run for office isn't based on unseating an unpopular incumbent, but about believing that he can truly make a difference as the 26th District representative. "The incumbent is a good person," Rice said, "but I believe that one-to-one, I'm the better candidate. It's important to get a fresh-eyed view of what we do in this state and not just look at how we've done things in the past. We need to find solutions that will serve us today and in the future." ■

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.*

Running Faster

Andrew Statson, MD

"The most curious part of the thing was, that the trees and the other things round them never changed their places at all: however fast they went, they never seemed to pass anything."
"Through the Looking Glass" Lewis Carroll (1865)

You probably understand very well how Alice felt. For years we have been running faster and faster, just so we could stay in the same place.

During the past ten years, a number of papers appeared in the medical literature discussing a new topic, physician satisfaction (or is it dissatisfaction?). These studies were based on responses to questionnaires. That is at least as subjective as assessing pain on a scale of zero to ten. For whatever they are worth, I'll give you some figures.

In January 2003, *JAMA* published an article on the changes in career satisfaction of physicians in 1997-2001. In 1997, 42.4% of primary care physicians and 43.3% of specialists were very satisfied. That went down to 38.5% and 41.4% in 2001, not much of a drop. However, among locations, only 8.8% of physicians in Lansing, Michigan were very dissatisfied, compared with 34.2% in Miami, Florida. It must be a question of climate. The physicians in Lansing must like the snow—it keeps the lawyers away.

The strongest factors of dissatisfaction were the loss of physician autonomy, including an increase in work hours, and the lack of ability to obtain required services for their patients. The article concluded that the decline in income did not have much to do with a drop in satisfaction, but the increase in work hours did. Why did the physicians increase their work hours? Wasn't it to avoid an even bigger drop in their income?

Another paper, from the Indiana University School of Business, calculated that for every one dollar drop in hourly net income, the population of retired physicians increased by 1.46% within two years. Based on figures from 1999, an earnings decline of ten dollars per hour will motivate eleven thousand physicians to retire early. However, the authors say, don't worry. We have an excess of 50,000-150,000 physicians in this country, so the physician surplus will continue for a while.

The Center for Studying Health System Change reported in May 2003 that between 1997 and 2001 the physicians' ability to provide services according to demand tightened. Patients waited longer for appointments and more physicians reported having inadequate time with patients. In response, more physicians worked with nurse practitioners and other care givers. Currently, the authors concluded, physician capacity constraints might ease if higher out-of-pocket costs prompt patients to seek less care.

Decreased payments prompted us to increase our work week. Thirty years ago a comedian said that if you wanted a doctor on a Wednesday, you had to go to the golf course. Not any more. Today we cannot afford to take a day off during the week, even though we continue to take the same night and weekend calls. We frequently start making hospital rounds before 7 o'clock, then work in our offices or the OR with barely fifteen minutes for lunch, and do not get home until 7 o'clock at night or later.

In September 2003, the *American Journal of Obstetrics and Gynecology* published a poll of the Houston obstetricians. About 62% of them reported working more than eighty hours a week. That is more than the maximum allowed for residents under current rules. A private practitioner can only dream of thirteen hour shifts on call and a day off after working at night.

In 1990, Weeks and Wallace did a study, comparing educational costs and incomes of physicians and other professionals, published in May 1994 in the *New England Journal of Medicine*. The annual yield on the educational investment over a working life (hours-adjusted internal rate of return) was 16% for primary care physicians, 21% for specialists, 21% for dentists, 25% for attorneys and 29% for businessmen.

They repeated the above study in 1997 and published it in April 2002 in

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Connecticut doctors push for tort reform veto

Connecticut Gov. John G. Rowland is expected to veto tort reform the Legislature passed earlier this month, and that's just fine with physicians.

The measure didn't contain a cap on noneconomic damages, something physicians and insurers argue is key to stabilizing the medical liability insurance market. "The bill is totally inadequate without any caps," said Connecticut State Medical Society Executive Director Tim Norbeck.

At press time, Rowland had not announced whether he would sign the bill, but on several occasions he has said he wouldn't sign legislation without an awards limit.

Either way, Norbeck said, physicians will go back to the state capital next year to lobby for a bill that includes a noneconomic damages cap.

Until then, he said, more physicians will retire early, leave Connecticut or reduce services to keep their insurance premiums affordable. Connecticut is one of 19 states the AMA says is experiencing a medical liability crisis.

But lawyers and some consumer advocates argued that an award limit wouldn't reduce physicians' insurance rates and ultimately would hurt injured patients. Connecticut Patients' Rights, an advocacy group of about 200 families, believes the legislation would be good for the state and is fair to all sides. "It's a remarkable start," said Jean Rexford, the group's executive director.

Meanwhile, the New Hampshire Senate approved a bill that would create a committee to review medical malpractice lawsuits before they go to trial. The panel would have the power to determine damages if a defendant admitted to being wrong and if the defendant and plaintiff agreed to let the committee determine the award.

In Ohio, the House on May 5 approved a bill that the Ohio State Medical Association believes would reduce the number of non-meritorious medical malpractice lawsuits. The measure calls for a certificate of expert review, tighter medical expert witness requirements, and an "I'm sorry" law that allows doctors to apologize or sympathize when there is a bad outcome without fear of their comments being used as evidence of liability. ■

Medical Marijuana: Clearing the Air

by Charles Heaney, Ph.D.

Washington is one of nine states that allows for the medicinal use of marijuana; the others are California, Arizona, Hawaii, Alaska, Nevada, Oregon, Colorado, and Maine. All are the result of voter-approved initiatives with the exception of Hawaii where the state legislature passed a bill enacting medical marijuana provisions.

In passing Initiative 692 (November 3, 1998), Washington voters stated their belief that "...some patients with terminal or debilitating illnesses, under their physician's care, may benefit from the medical use of marijuana." They further felt that the decision to authorize marijuana for such patients was a "...personal, individual decision based upon their physician's professional medical judgment and discretion."

The intent of the people was clear, that qualifying patients (those with specified illnesses or conditions) or their primary care givers could not be convicted of a crime for the possession and use of medical marijuana, and further, the "Physicians also be excepted from liability and prosecution for the authorization of marijuana use to qualifying patients for who, in the physician's professional judgment, medical marijuana may prove beneficial." (Wash. Revised Code 69.51A.005)

For physicians who believe that marijuana can be efficacious in certain situations and who would be positively inclined to recommend, or "authorize" it when appropriate, there are two key responsibilities under the current state guidelines.

First, they must establish that a patient has a "terminal or debilitating medical condition" defined as:

- Cancer, HIV, MS, epilepsy, or other seizure or spasticity disorder
- Intractable pain, that which is unrelieved by standard medical treatments and medications
- Glaucoma, acute or chronic, meaning increased intraocular pressure unrelieved by standard treatments of medications
- Any other conditions approved by the state Medical Quality Assurance Commission

(Since the passage of the initiative, the Commission has added Hepatitis C and Crohn's Disease to the list of conditions considered appropriate for medical marijuana.)

Second, the physician must provide the patient with "Valid Documentation" which is defined as:

"A statement signed by a qualifying patient's physician, or a copy of the qualified patient's pertinent medical records, which states that, in the physician's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the

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Medical Marijuana from page 13

health risks for a particular qualifying patient..."

Language is very important here and "would likely" is the key phrase. If the physician writes that the benefits "may outweigh" the risks, etc., a patient could be in jeopardy of prosecution and, in fact, an appeals court in Spokane upheld the conviction of a primary care giver, in part, for that very reason. In its ruling, the court declared that "It is not enough for the treating physicians to simply say that the potential benefits of the medical use of marijuana may outweigh the health risks for a qualified patient: the statute requires the physician to express his opinion about the medical benefits of marijuana to a level of medical certainty." In order to help physicians and patients avoid any deficiencies in the provision of valid documentation, a form was developed that contains the necessary language. The form can be downloaded from the "Membership Resources/Practice Resource" section of the WSMA website (www.wsma.org).

Once a physician gives the patient a statement authorizing the use of marijuana, the patient can either grow his or her own plants or obtain a supply through patient networks such as the Green Cross Foundation (206-720-6171 or www.greencross.org). The principle stipulation here is that a qualifying patient can posses "...no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty-day supply..." What constitutes a 60-day supply is not specified and, of course, can vary based on a patient's unique needs. Patients, therefore, must exercise prudence in how much marijuana they have in there possession at any given time. Clearly, a hundred plants in the basement probably won't cut it with the police.

And so the choice is yours as to whether you believe that marijuana possesses any medical efficacy and that it could be appropriate for any of your patients under the guidelines set out by the state. The courts and Washington State have guaranteed you the right to discuss and/or authorize its use if you choose to do so free of legal challenges. For those of you struggling with these judgments, it might be helpful to see how the Court of Appeals dealt with the questions of the medical benefit of marijuana. Making reference to analyses by the American Public Health Association, the Institute of Medicine, and other groups, and developments in other countries, one of the concurring justices alluded to "...a legitimate and growing division of informed opinion on this issue" and went on to state that "...what matters...is that there is a genuine difference of expert opinion on the subject, with significant and anecdotal evidence supporting both points of view." The justice then went on to express a sentiment that few would disagree with; "For the great majority of us who do not suffer from debilitating pain, or who have not watched a loved one waste away...it doesn't much matter who has the better of this debate. But for patients suffering from MS, cancer, AIDS, or one of the other afflictions...and their loved ones, obtaining candid and reliable information about a possible avenue of relief is of vital importance."

For more information on Washington's medical marijuana regulations:

Washington State Dept. of Health:
http://www.doh.wa.gov/Topics/marijuana%20Fact%20Sheet.DOC

ACLU:
http://www.aclu-wa.org/issues/war_on_drugs/index.html ■

Excerpted from King County Medical Society's *The Bulletin*, April 2004

In My Opinion

by Daisy Puracal, MD, ABHM

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

Rainbows

Daisy Puracal, MD

I am zooming north on route 509 from Tacoma over the arching suspension bridge with its tall twin pillars and white painted cables fanning out on either side. This man-made concrete marvel, silhouettes stark, against the sky. I whiz by the Tacoma Dome with its pyramids of muted, blue gray colors circling, ever paler towards the top, simulating our states treasure - Mount Rainier (or Mount Tahoma as it was originally called). As I crest the concrete snake, suspended high above mortal ground, the horizon stretches 360 degrees around me. To my right is the majestic, mystical mountain itself with its ever-changing face, each more beautiful than the last. And in front of me…joy oh joy…a rare spectacle of wonder - a panoramic view of a double rainbow!! A promise of hope. No, a double promise of hope - like birthdays and Christmases wrapped in one.

In Christian tradition the rainbow is the reconciliation between God and humanity - a promise to Noah that God would not destroy the earth again by flooding. The Mayans tell of the fiery rain that fell wreaking destruction below. Those that escaped saw a rainbow appear as a sign that the destruction was over and a new age had begun.

This colorful arch, this vision of beauty, "its own excuse for being," to use the words of Emerson, took my breath away. "My heart leaps up when I behold a rainbow in the sky," says Wordsworth. Basking in the glow of that ephemeral, iridescent beauty, I come home to my mundane tasks but am buoyant with that brush with God's palette. In a German creation myth the rainbow is the bowl God used to hold his paints while coloring the birds.

The mystical rainbow is viewed by the Navaho, Polynesians and several other cultures as a bridge between heaven and earth. In a Japanese myth, first man Isanagi and first woman Isanami walk down to earth from heaven on the mythical rainbow bridge called Niji. They watched the animals and learned how to make love. They watched the birds and learned to eat with chopsticks.

The rainbow has inspired artists through centuries and is one of the first drawings that you see a child engage in. But no painting can ever truly capture that evanescent luminosity in its three dimensional glory. "To gild refined gold, to paint the lily…or add another hue unto the rainbow is wasteful and ridiculous in excess," declares Shakespeare in King John.

The Irish say that at the end of the rainbow is a pot of gold. As a child I used to wonder where the end of the rainbow was and if the rainbow encircled the earth, to be seen at the same moment by someone on the other side of the world. I wanted to find that pot of gold. But if you run towards the rainbow it moves away from you before you get there. It is as illusory as a mirage. The vision of beauty is real but the rainbow is ethereal and intangible. "The rainbow's lovely form vanishes in the storm," to quote Robert Burns in Tom O'Shanter.

The rainbow is sunlight spread out into its spectrum of colors from red to violet and even beyond the colors that the eye can see and is diverted to the eye of the observer by water droplets. Each eye sees its own rainbow. So too are perceptions entirely our own. Reflected rays cause the light to be brighter inside the bow (i.e., the rainbow encapsulates the light). Also, the rainbow can only be seen when the sun is behind you - the sun being the real source of the spectacular optical light show.

A double rainbow occurs with two internal reflections inside the raindrop with a reversal of the colors of the primary rainbow. It is not a replication of the first - the secondary rainbow is actually a flipside of the first - a gentle reminder that there are two sides to a story.

John O'Donohue, an Irish Catholic priest describes our lives as an arc stretching from the darkness of the unknown before birth to the darkness of time after death. Stretching this image a little further it is as I turn to the sun (or source of life) that my life takes on hues that I never dreamed possible and my world appears lighter and brighter like the inside of the rainbow. I like to think that when I am in tune to and reflect this source of being, a secondary rainbow forms in the lives I brush against - just as so very many have touched my life and inspired me.

So, I'm working on keeping the sun at my back, to paint the canvas of my life in ways that I could not on my own. ■

Agendas from page 3

JD at Seattle University School of Law. Dr. Rice is a prolific writer, including textbooks and periodicals dealing with topics related to emergency medicine. He also authored an article titled, "Medical Malpractice Insurance," posted on the ACEP website March 2004. He can be reached at www.matt_rice@teamhealth.com.

Bob Lawrence, 56, is a college instructor for both graduate and undergraduate students in organizational leadership/behavior and ethics for the local Chapman University campus. He was recently selected instructor of the year. Bob is a member of the Clover Park Rotary, Lakewood Chamber of Commerce and Tacoma Elks. He is a lifetime member of the Disabled American Veterans, Airlift/Tanker Association and other veteran organizations. His campaign can be reached at 253-564-4613, www.electbob@att.net, www.bob lawrence.net or PO Box 39320, Lakewood WA 98439.

Now that we've been introduced, it is up to all of us to become familiar with the political positions of these and other candidates. I have had the opportunity to meet and talk with Dr. Matt Rice and recommend him to you as an excellent candidate for representative of the 26th district. If your board approves, we will be designing ways to acquire name recognition for Dr. Rice along with possible fund raising ideas. Mike Carrell has a proven record of accomplishment of support of medical issues including liability reform. His would be a strong voice in the senate on behalf of patient access and other medical issues. He deserves strong PCMS and WSMA support, financial and otherwise.

Whom to support? How much to give? How deeply involved to become? We answer these questions as individuals. In a democracy, we all have the right to make our own choices. In formulating such conclusions, I ask that you jettison party alignment and follow our ethical directions asking us to "...contribute to the improvement of the community and the betterment of public health" and "...support the access to medical care for all people." By keeping the patient first, and following our ethical guidelines, we will make the right choices. ■

WAMPAC endorsements of statewide candidates explained

The Washington Medical Political Action Committee (WAMPAC) recently voted to endorse Dino Rossi for Governor. WAMPAC is the Washington State Medical Association's political action committee.

"Our number one goal is to endorse candidates who support meaningful tort reform," noted Don Russell, DO, chairman of WAMPAC and a pediatrician from Puyallup. "Mr. Rossi is a strong supporter of tort reform. His voting record in the Senate demonstrates this."

Rossi received high marks from the PAC for working to preserve patients' access to health care in Washington State while a member of the State Senate. In his interview with the WAMPAC board, Rossi committed himself to work to improve patients' access to health care, particularly their doctors, by working to reform the state's liability system if elected governor.

Based on their support of meaningful tort reform, WAMPAC also endorsed Brad Owen for Lieutenant Governor and Rob McKenna for attorney general.

Brad Owen, a Democrat, has been lieutenant governor since 1996. In his role as chair of the Senate Rules Committee, Lt. Gov. Owen voted in support of the Omnibus Tort Reform (SB 5728) bill this past session. Both the WSMA and WAMPAC supported SB 5728.

Rob McKenna, a Republican King County councilman, has made tort reform - and his commitment to meaningful tort reform - a very public part of his campaign for Attorney General.

The above announcements sparked interest and questions by several WSMA members. There was concern regarding selection of candidates based on a single issue.

The WSMA's response is that these discussions demonstrate the vitality of the WSMA leadership, and healthy engagement by physicians in the policy and priorities setting processes of the association - which can be viewed as two hallmarks of a growing, responsive association.

It also is a reminder of other points worth noting:

• The WAMPAC Board is independent of the WSMA Board of Trustees. Its endorsement decisions were based on interviews with the candidates, with their responses applied against the goals and objectives of the WSMA.

• The WSMA organizational priorities, suggested by the Executive Committee and approved by the Board of Trustees and House of Delegates, provide the basis for our business plan and budgeting each year.

• The 2004 Business Plan represents the WSMA's concrete plan to implement policies and programs that support the needs of physicians and the communities you serve.

• Some members are increasingly frustrated with the idea that somehow our agenda will be better pursued by just building "rapport" with politicians, while others believe that perhaps the WSMA will be better respected, and/or less taken for granted, if it is seen as taking a strong stance on issues and fighting for it aggressively.

• Republicans and democrats alike need to know that the support of the WSMA is not unconditional.

• Those who argue that supporting a republican candidate because of his or her position on tort reform makes it more difficult to work with democrats on issues of access, for example, lose sight of the fact that tort reform is an access to care issue, and that too many incumbent democrats are trying to make access to care, scope of practice and tort reform (to name three) issues all mutually exclusive - and they are not.

• Mature politicians will understand and respect why an interest group makes a policy-based decision to endorse an opponent. They may not like it, but they will respect the rationale and will not punish broader constituencies when their interests are also supported by the association (in other words, if Attorney General Gregoire is elected governor, she should not automatically reject our positions on behalf of patients on issues other than tort reform).

• WSMA President Dr. Jeff Collins' April letter to the membership listed 11 specific activities, 10 of which are not tort reform, and many of these other activities put the WSMA in partnership or alignment with liberal constituencies and policy-makers.

• Significant growth in WSMA membership and WAMPAC membership reflect a growing awareness of the WSMA's work to provide strong advocacy, which is clearly articulated, and physician driven. ■

Running from page 11

Academic Medicine. The hours-adjusted internal rate of return was 16% for primary care physicians, 18% for specialists, 22% for dentists, 23% for attorneys and 26% for businessmen. That was before the recent surge in liability costs.

So what is a physician to do? We have responded to the cut in payments with an increase of working hours and a reduction of our office costs. Our staff also suffer, because we cannot afford to pay them well. We cut on the quality of our supplies. We cut on the time we give to patients. Overall, a definite decline has occurred in the quality of attentive, personal medical care both in our offices and in the hospitals.

In April 2004, in front of a joint U.S. House-Senate committee, a Florida physician testified that he had changed his pattern of practice. Previously he had a panel of 2,500 patients and he figured that in order to give them the currently recommended preventive care he needed to spend 7.4 hours daily, which left him very little time for care of illnesses. He affiliated with the firm MDVIP, cut down his patient panel to 600, charging each one $1,500.00 a year. Now he has the time to take care of his patients and is paid adequately.

If I remember correctly, a medical group in Seattle started a similar program, with the guarantee that subscribing patients will have immediate availability of a physician and almost all their care will be provided by their personal doctor. Our insurance commissioner thought that was a form of insurance and wanted to regulate it, but I don't know whether her attempt was successful.

Other physicians across the country, and a few in our area, canceled all their insurance contracts and now run their practices on cash-only basis. They charge less, get paid in full, and have more time to give to their patients.

Such an approach is feasible for physicians who do most of their work in the office. It would not work well for intensive surgical or medical care in the hospital setting.

Representative Pete Stark, D-Calif. (the name should be familiar), ranking member of the above mentioned committee, said, "The danger is that if a large number of doctors choose to open up these types of practices, the health care system will become even more inequitable than it is today. The wealthy will pay for exclusive access to quality care and everyone else will continue to have inferior access to primary care physicians, specialists and basic medical advice."

To correct that situation, Congress needs to repeal a basic law of economics: in the long run, you cannot get more than what you pay for. They may even try it, but that law is derived from a broader physical law, sometimes called the second law of thermodynamics, and more generally, the law of the conservation of mass and energy. Repealing that may be beyond the reach of Congress.

An English proverb says: "Sail!" ordered the king; "Hold," said the wind. ■

Recap from page 5

- **Saturn** – beautiful rings, rather bland atmospheric details
- **Mars** – has it all! Clouds, dust storms, polar caps, surface details include 'those canals' and the home for the current rovers.

He cautioned everyone about buying expensive equipment before becoming knowledgeable.

"If you are interested in astronomy, don't buy a telescope first," he warned. "Come to star parties, Tacoma Astronomical Society meetings, ask questions, and read either *Astronomy Magazine* or *Sky and Telescope Magazine*." His best advice - consider a pair of 8x50 binoculars and a star chart to get started."■

Classified Advertising

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

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OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals. Call 253-272-2224.

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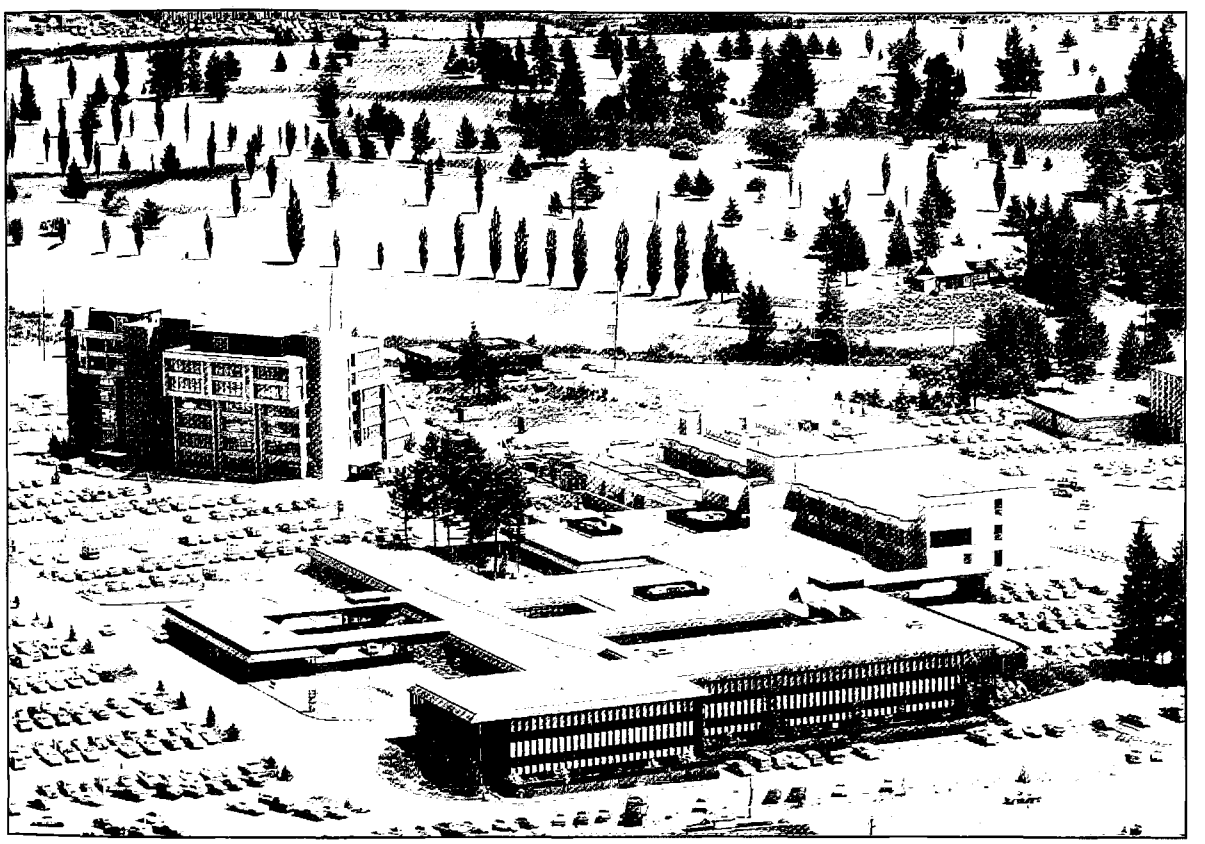
Pierce County Medical Society

BULLETIN

July, 2004



Early days of Allenmore medical complex, South 19th and Union Streets

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

July, 2004

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President's Page

by Michael J. Kelly, MD

The Collective

Michael J. Kelly, MD

"We will add your biological and technological distinctiveness to our own. Your culture will adapt to serve us. Resistance is futile. We are the Borg."
- "The Borg, Star Trek The Next Generation (The Best of Both Worlds, Part I)"

Ever had a brief psychotic moment? It's one where you let your mind freely associate with a few dozen thoughts at the same time and see what happens. I have a love of science fiction and have more than a passing interest in Star Trek. It was during one of these wanderings that I pondered the Borg.

I was in one of my feeling powerless moments when the actions of the state legislature these past few years and the Borg philosophy popped into my subconsciousness. It then made the grueling 5 mm journey through the thalamus to my conscious mind (two hours). Of course, why didn't I see it before? The Borg. The legislature. I began to wonder - who is part of the collective - when did this occur?

As I'm certain you know, Star Trek is easily the most popular science fiction epic of all time. Over the past three decades, the saga has given birth to four television series, eight motion pictures, dozens of novels, and a variety of paraphernalia - including technical manuals of the Enterprise, English/Klingon dictionaries, and even books on themes of leadership lesions in Star Trek.

Star Trek's vision of the future is optimistic. However, it presents a most disturbing example of full-fledged collectivism currently available on film or in print (unless one was to visit certain politicos in Olympia in person). The Borg is a race of cyborgs, the product of a technology that "hardwires" artificial intelligence directly into the brain and central nervous system. There is the removal of most human aspects producing a gigantic robotic "intelligence" that shares a "group mind" - a kind of organic Internet accessed with thoughts instead of computers. Only silly science fiction, you protest!

I contend that the Borg is already in Olympia. Just look at the record. They automatically go where the "group mind" wills; say what the group mind thinks, vote the way the group mind directs. For those of you familiar with the series, this is The Borg Collective. Their power is absolute. Politicians so infected act as one, unable to vote their conscience. One legislator, for example, in the house of representatives (Borg drone), acting at the behest of the collective, killed a bill seen as a threat.

They say, "Resistance is futile, relax. We have your best interests at heart. Look, we passed sixteen tort reform bills and sent them to the senate where an evil force defeated them." They leave out the fact that their bills would not have led to a change in medical liability premiums and would not have improved access to health care.

Ayn Rand once wrote, "...there is no such thing as a collective brain." Intentionally or not, the last legislative session gave us a chilling depiction of what a collective brain would look like. Their vision can be viewed as an extended metaphor for what collectivism offers individuals - a stark choice between submission or abandonment (loss of party support).

Collectivism thrives in our society among those who advocate taxing and redistributing the fruits of other people's labor instead of producing and trading goods in a free market. Collectivism, too, advocates the use of force when necessary. In its politically correct permutations in academe, collectivism is virulently anti-intellectual (unable to grasp the arguments which favor reform, for example) and regards individuality as an enemy concept. In operation, collectivists have an ugly record of accomplishment that rivals that of the Borg in Star Trek.

I suggest Collectivism and the Borg mentality, so noted in the present legislature, have done little to solve Washington State's economic, cultural and technological problems. We inhabit a physical universe that does not take care of us. Our minds are, indeed, our means of survival: We must discover regularities in our surroundings and act based on objective causality (the fact

See "Collective" page 12

Applicants for Membership

Peter P. Chuang, MD
Diagnostic Radiology
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3402 S 18th Street, Tacoma
253-383-1099
Med School: University of Minnesota
Internship: UCSD Medical Center
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Urology
Puyallup Surgical Consultants
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Med School: University of Texas
Internship: Lisbon VA Hospital
Residency: Tripler Army Medical Center

Peter Shin, MD
Neurosurgery
South Sound Neurosurgery
1519 - 3rd St SE #101, Puyallup
253-841-8939
Med School: NE Ohio Universities
Internship: Rush Presbyterian/St. Lukes
Residency: Rush Presbyterian/St. Lukes

Ronald K. Woods, MD
Thoracic Surgery
MultiCare/Mary Bridge
311 South L Street ,Tacoma
253-403-3560
Med School: University of Illinois
Internship: University of Washington
Residency: University of Washington
Fellowship: Children's Mercy
Fellowship: University of Washington

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Federico Cruz, MD

Get Active

An election is looming. Candidates have stepped forward. Campaigns intrude on our lives daily. This is all very real. We have complained and complained every year for as long as I can remember that the legislature is not listening to us. The simple fact of the matter is that they are not. And unfortunately they will not listen to us around tort reform with the current members in place. So is it time to go back to our offices or back to our communities and forget about it until next year? I think not. The answer is right in front of our noses. We must get active in the political process. If there are legislators that have resolutely opposed any real dialogue on tort reform, then we must work to see that they get un-elected.

The easy out on this need to be active is to just give money. That is not enough. In modern politics money is important, but for the kind of changes that we see needing to be done in the health care system, this will require real involvement. Real involvement, as in the personal sweat equity we see in first time homeowners who build through Habitat for Humanity. Put some money on the table but also your own personal effort to drive nails and cut lumber.

Experienced and successful politicians will tell you the secret of their success. They establish a relationship with their constituents and they interact with them on regular basis, not just when there is an issue that they feel strongly about. It means time, personal time, to interact with the voters in your district. Physicians actually have an advantage over many groups when trying to get the attention of voters on an issue. People come to them on a regular basis. The voters are right there, in your office. Talk to them. Spend some time getting the issue out in front of them. There is an issue of extreme importance for the future of medicine right now in front of them. Get them to hear about it. Get them to think about it. Get them to hear that it has not been dealt with. And get them to hear about the barriers that are preventing medicine from better meeting their needs. TORT REFORM = PATIENT ACCESS. It is very straightforward. **Do not hesitate to politicize your practice; it is already at the front of politics whether you see it or not.**

"...we have to venture out of our comfort zones. Get involved, make noise, get in people's faces, step on toes. Things will happen."

Health care is being driven by political agendas. This has been apparent for many years. The patient-focused art of medicine is almost inconsequential in the eye of decision makers. For them, it is all about bottom lines, profit margins, serious lobbying, special interest groups that have little focus on quality of care but rather on bettering their own area of the economy (think insurance companies, think drug companies). The power of the practitioners of medicine is there to protect the practice of medicine. But we have to venture out of our comfort zones. Get involved, make noise, get in people's faces, step on toes. Things will happen. A message will get out; if it is sincere. If it reflects realities in voters' lives, it will get traction and we will see change. I look forward to the next four months. It will be crazy and will be challenging but if we take it seriously and put ourselves into it, we are going to see change. And that, my friends, is what this is all about. ■

Please make the following changes to your 2004 Physician Directory:

Wendall Adams, MD
Add Suite #100 to office address

David Bemiller, MD (retired)
Change address and phone to:
3905 View Ridge Drive, Anacortes 98221
360-293-3158

K. Royce Hansen, MD (retired)
Add wife's name "Genny"

George Jackson, MD
Change office zip to 98467

Gurjit Kaeley, MD
Change fax # to 581-1191

Jacob Kornberg, MD
Moving to King County:
900 S 336th St, Federal Way 98003
253-815-8803

Thu Le, MD
Change office suite to #39

Mary Ann Lee, MD
Remove "John Peltz" from listing

Robert McLees, MD
Change website to www.gyftclinic.com

Sharon Metcalf, MD
Please add listing:
Ob/Gyn
34503 9th Ave S #100,
Federal Way 98003
253-952-8231
253-835-8000 fax

Elizabeth Neuhalfen, MD
Change office address and phone to:
115 Orchard Ave N, Eatonville 98328
PO Box 1060, Eatonville 98328 (mailing)
253-832-6106
253-832-6109 fax

Richard Rynes, MD
Change fax # to 581-1911

Sumner Schoenike, MD
Change E-mail address to:
schoenike@comcast.net

Neal Shonnard, MD
Change office address to:
3801 5th St SE #100, Puyallup 98374

Lynn Smelser, PA-C
Change office address and phone to:
3315 S 23rd #200, Tacoma 98405
459-7008
572-3791 fax

John Steedman, MD
Add Suite #100 to office address

Steven Yamamoto, DO
Change address to:
3801 5th St SE #100, Puyallup 98374

Members complete Sound to Narrows 2004

Nearly 6,000 runners participated in the Sound to Narrows on Saturday, June 12 and the 43rd overall person to cross the finish line was **Dr. Tom Herron**, Gig Harbor pediatrician. He finished second in his division with a time of 46:49.

Dr. Ron Taylor, Tacoma general surgeon, was the 167th person to cross the finish line. He finished first in his division with an excellent time of 52:57.

Dr. Bill Jackson, Tacoma radiologist, finished fifth in his division with a time of 1:05:47 and **Dr. Martin Goldsmith**, Tacoma pediatrician, finished third in his division with a time of 54:52.

Congratulations Drs. Herron, Taylor, Jackson and Goldsmith!

One of the remaining few who has run in every Sound to Narrows for 31 years, was **Cordell Bahn, MD** retired cardiovascular surgeon, who finished with a time of 1:20:20.

Congratulations to all PCMS members and their family members for a great accomplishment:

Irfan Ansari, MD, Tacoma physical medicine & rehab, 1:32:32

Loren Betteridge, MD, Tacoma family practitioner, 57:51

Lauren Colman, MD, Tacoma oncologist, 1:03:15

Stephen Elder, MD, Tacoma anesthesiologist, a competitive 54:41

Robert Ettlinger, MD, Tacoma rheumatologists, 1:34:31

Patrick Hogan, DO, Tacoma neurologist, 1:00:37

Charles Hubbell, MD, Tacoma dermatologist, 1:14:42

George Jackson, MD, Tacoma psychiatrist, 53:10

Gilbert Johnston, MD, Tacoma cardiologist, 1:15:44

David Law, MD, Tacoma internist, 1:07:06

Dan Niebrugge, MD, Tacoma pediatrician, 1:03:10

Aksel Nordestgaard, MD, Tacoma vascular surgeon, 58:05

Henry Retailliau, MD, Tacoma internist, 1:21:17

Jim Rooks, MD, Lakewood otolaryngologist, 1:12:51

William Shields, MD, ophthalmologist, 1:19:14

Darryl Tan, MD, Lakewood pediatrician, 1:01:12

John Van Buskirk, DO, Tacoma family physician, 1:15:26

Congratulations to all Pierce County Medical Society members and their families on completing such a challenging run.

Please forgive us if we failed to list your name and contact the PCMS office (572-3667) so we can include your name in the next issue of the *Bulletin*. ■

Family finishers - 12k

Haris Ansari, 1:21:46

Bryce Betteridge, 57:50

Verna Herron, 57:22

Donna Jackson 1:01:37

Lisbet Nordestgaard 1:00:25

Janet Olejar 2:10:16

Stephen Taylor 46:11
(finishing 37th overall!)

Physicians Insurance Lifts New Business Moratorium

The board of directors of Physicians Insurance, Washington State's largest medical malpractice writer, voted to lift the company's moratorium on new business as of its May 19, 2004 board meeting. This moratorium was put in place in October of 2002.

"We are pleased that the improved financial performance of the company allows us to once again solicit new business from physicians domiciled in Washington State," said Tom Myers, the company's president and CEO. "This decision signals that Physicians Insurance is well on its way to regaining the financial stability it has enjoyed in the past."

During these difficult times, many physicians have had to scramble to find coverage from the few remaining providers in the state. The lifting of the moratorium will help physicians who are new to the state or establishing new private practices find quality coverage.

"This decision is also a testament to our long-term member policyholders who have remained loyal to the company over the years," said Tom Myers. "It is their loyalty that now allows Physicians Insurance to address the needs of their colleagues." ■

IN MEMORIAM

LEWIS E. LITVIN, MD

1916 - 2004

Lewis E. Litvin, MD

Dr. Lewis Litvin died April 28, 2004 at his home in Palm Desert, California.

Dr. Litvin practiced general surgery in Puyallup from 1969 until his retirement in 1980. He received his medical degree from Boston University in 1941 and completed his internship at Providence Hospital in Seattle and his residency at King County Hospital.

Dr. Litvin practiced in Seattle from 1946 until 1969 when he relocated to Puyallup.

PCMS extends condolences to Dr. Litvin's wife Juanita and their family.

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Enhancing Revenue

Andrew Statson, MD

"It isn't important to come out on top; what matters is to be the one who comes out alive."
"Jungle of Cities" Bertold Brecht (1924)

We face an unprecedented squeeze in the practice of medicine. Colleagues across the country reported that this year they had to borrow money so they could pay their overhead, but they would not be able to do that again next year.

Contrary to the situation during the Great Depression when patients appreciated our services and attempted to pay the best they could, if not in cash, then in kind, our patients today think that they have paid us in full when they flash their insurance card. Some of them even grumble about our request for the co-pay.

Back then we waved our fees for hardship cases, but charged more those able to pay. We have no such option today. Back then, the costly and time consuming documentation requirements for patient care and for the business of running an office did not exist.

Now we have to record all positive and negative clinical findings, even though irrelevant to the presenting problem; we have to prove that we gave the service and protected the privacy of the patient. We toil under a cruel hoax: the statement that something was not documented, therefore it was not done. We face the burden of CLIA, ADA, OSHA, HIPAA, control of infectious waste, ergonomic workplace, proof of CME, recredentialling every two years, etc. In a story on 1-18-01, *The Olympian* reported that managed care and recent legislation produced such a paperwork burden that almost 50 cents of every dollar we collect are spent on administration.

Our problems are much broader than the economic issues. We lost our autonomy. We lost control over our practices and our lives. We are traumatized by the legal consequences of patient expectations impossible to fulfill.

We are human. We cannot deliver perfection. We will make mistakes. The claim that a judgment error is an offense and must be punished is a rejection of our humanness. It places us in an impossible situation. How can we continue to function? How can we hope to survive?

So far our best course has been to increase our work hours. Including the time on call, sixty hours per week is now a minimum in private practice. The median is close to eighty hours. Physically, mentally and emotionally, we cannot do more. We are close to our breaking point.

Some physicians have already taken refuge in salaried positions, offered by public clinics or hospitals. In Southeastern Pennsylvania, including the five-county Philadelphia region, 50-75% of practicing obstetricians have become hospital employees. Without hospital intervention, the region would have faced an extraordinary crisis in availability of obstetrical services.

The liability reform in Pennsylvania provided for a tax-supported fund to give rebates to physicians against their premiums. Obstetrics is one of four specialties targeted for a 100% rebate.

That sounds like much, but it does not cover primary liability, the cost of which is still going up.

The region lost 25% of its OB beds. Seven hospitals shut down their OB departments. Three others closed their doors. As never before, during the past year HUP (Hospital of the University of Pennsylvania) has had to close its ER for OB admissions at least every other week because of overflow. It rarely refused transfers from other hospitals in the past. Now it is closed for transfers at least one third of the time.

In Sellersville, PA a group of four general surgeons had to pay 1.3 million for insurance. With the rebate from the state, it is down to 1,052,000. (*Physician's News Digest*, May 2004)

In this environment, the private clinics cannot survive for long as people drop out, because of the unsustainable pace of work required to maintain the same income. Those who are left have to assume a greater load, just to keep their heads above water.

An example is the obstetric clinic in Mansfield, Ohio. Women's Care Inc

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had seven obstetricians last year and did 1,093 deliveries. Their insurance went up from $65,000 to $125,000 per doctor this year. One of them, Dr. Stewart Rickman, age 52, retired at the beginning of the year without tail coverage. He decided not to pay the 200,000 dollars it cost. Another physician moved out of state. The five remaining doctors had to get a loan to pay the insurance and now have to do the work seven of them did last year. They hope they'll be able to continue, but if premiums go up another 20% or more next year, they'll have to close shop. (*Mansfield News Journal*, 5-3-04)

If we are hoping for improved reimbursement, we might as well forget it. Rep. Charlie Norwood (R.-Georgia) stated that Medicare needs to focus on new ways to control the volume and intensity of physician services. Those are the hidden culprits of Medicare physician spending.

According to Bruce Steinwald of the GAO, since 1998 the growth of Medicare physician payments per beneficiary has outstripped both medical inflation and the overall increase in physician payments due to increased volume and intensity of services.

David Walker, U.S. Comptroller General, head of the GAO, stated that deciding which health care expenses are "individual wants" and which are "societal needs" is the key. Societal needs could include vaccines and protection from financial ruin due to catastrophic illness.

So what are we to do? Women's Health Connecticut, a group of 150 obstetricians, comprising one third of the obstetricians in the state, announced that in September they will initiate a surcharge of 500 dollars for obstetrical care, payable at the first pregnancy visit. It is not known whether the insurance companies will cover that charge, but the group intends to drop any insurance contract that would prevent them from collecting it from the patients. In Connecticut the liability contracts are renewed on September 1. Currently obstetricians pay $120,000-$160,000 and the rumored increase in premiums is 83%.

Other physicians have started to assess all patients an administrative charge of ten dollars per year. Some have looked at services not covered by their insurance contracts, and are beginning to charge for them. For example, some physicians charge for prescription refills when not connected with an office visit, for missed appointments by repeat offenders, for filling out health forms for school or work, for e-mail and telephone consultations, etc.

I don't know how successful they have been in their efforts. Even if they were, this is at best a stopgap measure. The outlook for the practice of medicine, even with some form of liability reform, is bleak. Ohio enacted a cap, but the previous one was struck down by the Supreme Court in 1998, and the fear is that the new law will suffer the same fate.

The news about physicians closing their practices and retiring or moving out of state is heart-rending. The problem is widespread across the country. Yet, in spite of the deterioration in the quality and the availability of health care, so obvious to us, the official line is that the physicians are still on their jobs and if anything, there is a surplus, rather than a shortage.

I am sorry to be so pessimistic. We have set our hopes on the November election and we'll do our best, but I am afraid we'll be disappointed. We cannot win this game. We love what we do and we care for our patients, and that is our weakness.

We cannot afford a work action in lieu of a strike, such as providing only urgent care for several months, as we did in California in 1975. Yet we have to make our point. Soon our only recourse will be to fold up and walk away. The options are to retire, if we can afford it, or to find a job in a related field not involving patient care. When enough of us do that, things will change. ■

In My Opinion

by George Tanbara, MD

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

Dear Pierce County Medical Society Members,

George Tanbara, MD

Thank you all for the help in getting Community Health Care clinics (previously known as Eastside, Downtown, Urban Health Initiative, Community Health Care Delivery System) to where it is a true safety net for all patients that find themselves in a position requiring a health care home. You may have patients that are in a position that they cannot continue in your care because of outside or personal decisions.

In the late 1960s, fifty Medical Society members arranged by Tom Curry, executive director of our Society then, assembled in the old gym of Tacoma Community House for a morning session of how to meet the health needs of people without funds, welfare medical, former patients of Mountain View Hospital (previously Pierce County) and the clinics and emergency rooms. The highest need appeared to be the Eastside Salishan Housing Project area. Under the leadership of Dr. Eugene Wiegman (President, Pacific Lutheran University) and James Walton (now interim Tacoma City Manager) with co-administrators Bob Pfotenhauer and the Urban Coalition, met frequently throughout the community with community members, organizations and future patients, and initiated the Eastside Clinic. Many volunteers and one staff person ran the clinic. The weekly clinic was open every Wednesday evening at the Community Room of the old Lister School with a dentist, Dr. Dan Cook; a hygienist; pharmacist Richard Driscall while Puget Sound Hospital provided radiology services and sandwiches for the staff. Laboratory services were provided through Good Samaritan Hospital and Dr. Charles Larson. Good Samaritan and Mary Bridge supplied the hospitalization, emergency services, as well as clinic and other services. Bates Vocational contributed many hours to start parenting classes.

The generosity of the Medical Society membership provided much needed services at little or no cost to patients. Due to the increased number of patients and the success of the clinic, the Tacoma Housing Authority suppled a Quonset. Dr. George Race took care of the adults for a number of years until the clinic hired personnel including physicians and administrators. There was a great need for a downtown clinic so St. Joseph Hospital supplied personnel to nightly clinics in the basement of the old nursing school, which had been replaced for expanded space.

Community physicians, especially staff of St. Joseph Hospital, as well as Doug Jackman and Sue Asher, your subsequent executives, have always been helpful and supportive and generous with their time and energy. I really tried to thank each and every one for services rendered but many never informed me, so we are very grateful to all of you.

Further information can be obtained from Pierce County Medical Society, Community Health Care, or me at gtanbara@mbcha.net, at the office 383-5777, vm 3022 (when I'm in the office, let personnel know that I asked to be called to a phone) or at my home 272-5235.

We continue to need your help.

Kim and George Tanbara

Collective from page 3

that caps on non-economic damages hold medical liability costs down thus improving health care access, for example.)

We physicians are not Borg. We have no wish to be. We resist the Borg mentality by acting individually on our choices. We look for opportunities to find the political meaning in this state, not pre-formatted and digested meaning fed by a Borg queen. We are republican, democrat, libertarian, and independent. We apply our ethics and values against the political platforms of the parties in this state. We speak with the legislators in person and formulate a slate commensurate with our individual belief system. This process has helped to liberate us from the Borg mentality. Thanks to Star Trek, it is no longer impossible to imagine what a society controlled by an actual "collective mind" would be like. It isn't pretty, and neither is Olympia.

We are now called to act by supporting candidates, which support the survival of the practice of medicine. National, state and local elections need your support both monetarily and voluntarily. WAMPAC, our one and only PAC, warmly solicits your contributions. Give now to change the future in this state. Give now because we are up against it, fighting for our profession. Give now to prevent the further assimilation of reason by the Borg in Olympia. ■

Doctors need to take a leading role on electronic medical records

With EMRs becoming an inevitability, it's essential for the physicians' voice to be heard in how the technology gets implemented

Editor's Note - The PCMS Connectivity Committee, chaired by Matt White, MD, continues to make progress on options for electronically connecting the Pierce County medical community.

With so many heavy hitters in government pushing for their use, the question of physicians' adoption of electronic medical records is not if, but when.

But before there's a when, there are a few key hows that need to be answered. Before EMRs are in every office, doctors need to know how to make a standardized technological platform, how to make sure records are secure, and how to make sure the costs don't completely fall on physicians as yet another unfunded mandate.

Physicians must have a voice in creating EMR systems that will allow the gains in patient safety, efficiency and cost savings that advocates say can be achieved.

Currently, various surveys show that some 10% of American physicians use EMRs, and that few of those physicians have systems that allow them to exchange information with a physician using a different system.

Physicians at a recent American Medical Association meeting spoke of looking at systems that appeared to do similar things, yet cost anywhere from $30,000 to $70,000 per physician, not including licensing and support fees that continue to be paid long after the initial purchase. Also, there were worries about how quickly those systems could become obsolete, and the inability to transfer an EMR to a colleague that has an EMR with a different software platform.

There are various proposals to address these problems while accelerating the pace at which physicians adopt EMRs.

President Bush said in April that he had a goal of getting a personal, portable EMR for every patient in 10 years, while some senators also have proposed bills that would require developing EMR standards.

The AMA has long been involved with attempts to create a standardized EMR. A draft standard has been approved and will be tested for the next two years.

The question of whether EMRs would be mandated and if physicians would be expected to foot the bill themselves for a system remains.

The AMA House of Delegates has passed a resolution directing the AMA to continue to assert its role in the conversations over EMRs and encourages setting health care information technology standards that would allow different products to be interoperable, yet also would allow software companies to develop competitive systems.

It also calls for working with Congress and insurance companies to "appropriately align incentives" as part of the development of the National Health Information Infrastructure — a public-private initiative to create an interoperable health network. Finally, it asks for review of security, standardization and cost issues when participating or commenting on initiatives related to NHII. ■

From *AMNews*, 7/5/04

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Pierce County Medical Society
BULLETIN

August, 2004

New Zealand Waterfalls — Photo by Sam Insalaco, MD

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

August, 2004

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President's Page

by Michael J. Kelly, MD

Lessons from the Rogue

"There is a tide in the affairs of men
Which taken at the flood leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current when it serves,
or lose our ventures."
- William Shakespeare, "Julius Ceasar"

Michael J. Kelly, MD

Disclaimer: The comments and suggestions herein represent my opinion only and do not necessarily reflect the opinion of the Pierce County Medical Society or its Board of Trustees.

The upcoming state legislative elections remind me of rafting down a wild river. In a previous life, my wife and I enjoyed many years of rafting the Rogue River near Grants Pass, Oregon. We learned some very important lessons on that stretch of white water which seem apropos to the upcoming legislative elections.

First, the river does not care (neither do many voters or legislators). A mistake could lead to grave consequences. Second, and just as important, preparation is key. The Rogue River guides reminded us that the most important part of rafting was to properly line up your craft before entering the rapids. This was important because once you entered into the powerful river hydraulics there was little you could do to change your course or outcome.

We find ourselves drifting slowly into the vortex of the upcoming election frenzy. Like the placid river before the drop, it is calm now, but not for long. What we do to "line up" our ship will allow us to successfully negotiate the elections. To prepare ourselves, I would suggest the following:

- Familiarize yourself with the candidates in your legislative district and actively support those whose platform includes support for tort reform

- Contribute your time and monetary support of these candidates, including displaying bumper stickers, planting signs, and talking with your patients

- Place a personal letter in your waiting room voicing support of these candidates and why. Consider a shortened form to use as a "bill stuffer" to reach more of your patients

- Obtain voter registration materials to have in your waiting room (PCMS can help supply these). Encourage those not registered to vote to do so while they are visiting your office

While there are many important legislative contests in this state, let me suggest the need to focus our efforts primarily in the 25th, 26th and 28th districts. These are important districts in our legislative fight to enact meaningful tort reform.

I know I should have paid more attention to my high school civics class when they discussed the authority of the committee chair. The majority party has control of the chairs of the committees, a position of absolute power concerning the fate of legislation. We have observed the abuse of that power in the house judiciary committee for the past two legislative sessions. There must be a way to achieve control of these committees in order to help better guarantee access to medical care.

I suggest the following slate of candidates as friends of medicine and urge your support of their campaigns:

In the **25th District** (Puyallup):
Wally Nash, Joyce McDonald, Rose Hill
In the **26th District** (Gig Harbor):
Matt Rice, Lois McMahan
In the **28th District** (Univ Place):
Mike Carrell, Bob Lawrence, Gigi Talcott

While these are all very important races, one stands out as a litmus test for the strength of conviction of the physicians of Pierce County. I'm referring to the race between Matt Rice and Pat Lantz. Matt Rice, local emergency doctor, is eminently qualified to lead the 26th district and represent its constituency. He is a leader who can grasp the intricacies of this important post. He is also a symbol. His election will say volumes about the depth of physician feelings and the cry for appropriate leader-

See "Lessons" page 16

Denial of Premera Conversion Request Big Success for Physicians/Patients

What's the insurance commis-sioner's ruling against Premera's conversion request worth to physicians? Physicians could have lost close to $23 million per year in reimbursement if the Plan's conversion to a stock company had been approved, and the Plan brought its physician payments in line with other for-profit carriers. (This figure is based on careful review of company data by the WSMA's legal counsel.)

Thus, when Commissioner Kreidler announced his rejection of Premera Blue Cross' proposal to convert last Thursday, he delivered a huge win for the WSMA and its members.

In making his announcement, Kreidler made many of the points we stressed over the course of the two-year long process. As noted in a *Seattle Times* article covering the event:

- "Kreidler's announcement...came after consumers, doctors and hospitals vigorously opposed Premera's plan and two months after the insurance commissioner's own staff formally recommended rejecting it."
- "I've reached my decision following a careful consideration of the law and all the evidence," Kreidler said... "I'm confident it is a fair and just decision." He said the move would have negatively affected policyholders and the public.
- "I believe that for-profit status brings with it a high likelihood that Premera would be acquired by a national insurer," he said.

In spite of the plan's advertising promising that its conversion would create a charitable windfall to benefit consumers, and that the conversion was necessary to raise needed capital, independent experts hired by the state twice concluded that a for-profit Premera would more likely raise premiums and cut payments to doctors and hospitals in Eastern Washington by using its market clout. ■

Special Feature

by Jean Borst

Home Grown

Region's Three Hospital Systems Expanding Services and Capabilities

As the demand for health care services increases, the region's three hospital systems are responding with state-of-the-art technology, patient comfort and convenience, and advanced medical capabilities. Franciscan Health System, Good Samaritan and MultiCare Health System are all in the throws of phenomenal growth in order to meet the increasing demands of the populations they serve. And they are creating facilities that not only best serve their patients, but their physicians and staff as well.

Here is an overview of what's happening around the Sound.

Good Samaritan

Puyallup-based Good Samaritan is currently in the midst of a multi-phase plan to expand its medical campus as well as its medical staff. During the next decade, Good Samaritan is poised to invest as much as $222 million on capital projects that will provide a series of new state-of-the-art facilities.

"Eastern Pierce County is one of the most rapidly growing regions in the state of Washington," said George Govier, Good Samaritan President and Chief Executive Officer, "and Good Samaritan is building the capacity to care for our expanding community."

In June, Good Samaritan opened its new advanced Sleep Medicine Center, a six-bed facility featuring state-of-the-art technology. Construction is currently underway on a new 34,000-square-foot clinical unit within the west wing, which marks a $24 million investment in medical facilities and associated remodeling projects. The new unit will include a 14-bed intensive care unit and four operating rooms as well as space for a second cardiac catheterization laboratory. The increase in operating rooms signifies a commitment by Good Samaritan to expand its surgical programs. Further expansion is also planned for cardiovascular services.

With an Emergency Department providing service to more than 56,000 patients annually, Good Samaritan also recognizes the need to expand emergency services. During coming years, the hospital will invest approximately $70 million to construct a new 150,000 square-foot Emergency Department and Patient Care Pavilion.

Good Samaritan is engaged in an aggressive plan to recruit physicians to the region. The hospital's Medical Manpower Plan developed a strategy to recruit 60 new physicians to the Good Samaritan medical staff during the next five years. More than one third of those physicians will be family practice and internal medicine physicians. High demand specialty recruiting areas include obstetrician/gynecologists, general surgeons, orthopedic surgeons and cardiologists.

One of the largest phases of Good Samaritan's expansion is the planned opening of a new state-of-the-art cancer center early next year. "The center will unite some of the world's most advanced cancer-fighting diagnostic technology, comprehensive treatment and support services for cancer patients and families, and an expanded laboratory to support Good Samaritan's cancer research program," says Govier.

The center will offer the revolutionary Positron Emission Tomography/ Computer Tomography (PET/CT) technology. Extraordinarily advanced, the scanner combines two well-known imaging systems to provide physicians with critical new information that can lead to more successful cancer treatment. "This diagnostic technology is very advanced," said **Dr. Richard Ostenson**, medical oncologist at Good Samaritan.

The Cancer Center will also feature expanded research facilities, providing a more conducive environment to discover new cancer treatments, as well as greater support of clinical trials for new cancer-fighting drugs.

"Good Samaritan is setting the new standard for regional cancer care," according to Ostenson. "For years, Good Samaritan has provided among the

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This will be the new Good Samaritan Cancer Center slated to open early next year. The center will feature comprehensive treatment and support services for cancer patients and families and an expanded laboratory to support research

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most highly respected cancer services for patients in the state. We are proud that our community's new Cancer Center will lead the way again by offering diagnostics, treatment, support and research in a single location close to our patients' homes."

Centralized care is at the heart of the center's design. "This model of comprehensive care marks a significant investment in the well-being of our patients, their family members and friends, and ultimately our entire community," according to Margaret Eade, RN, Director of Oncology at Good Samaritan. "When patients and families find cancer services in a single location, they are able to have a more holistic, healing experience."

By offering this centralized model of care, the new Cancer Center will eliminate the need for most cancer patients to travel to multiple locations for treatment.

Also housed in the Cancer Center will be Good Samaritan's Rainier Oncology offices, which include medical oncology chemotherapy, and independently owned Tacoma Valley Radiation Oncology. Within steps, patients will find medical services including diagnostic imaging, chemotherapy, radiation treatment, infusions, symptom management and access to clinical trials.

The Center will also consolidate several support services, including an education and resource center, appearance center, nutritional counseling, pastoral care, psychosocial programs, support groups and a lending resource library.

Boasting an environment conducive to the utmost in patient care, the center will feature stunning valley and mountain views through large spans of glass, as well as the soothing elements of natural light, music, artwork, private spaces and gardens.

Franciscan Health System

The recent openings of new facilities, the expansion of existing services, and plans for future construction – including a new hospital – are on Franciscan Health System's slate.

In response to increased demand for outpatient surgeries and other services, St. Joseph Medical Center recently opened its new Outpatient Center, a state-of-the-art health care facility that features the latest in medical technologies, a serene healing environment, speedy admissions process, convenient access to a broad range of services, and free valet parking.

The 152,000-square-foot facility incorporates Franciscan's philosophy of treating the mind, body and spirit, according to Joe Wilczek, Franciscan's president and chief executive officer. In addition to advanced medical technologies, the center features comfortable patient-care areas, welcoming visitor area; a gentle and soothing atmosphere of natural colors, curved hallways, artwork, and large windows offering sweeping views and natural light.

Features of the new center will include:

• **Gene and Mary Ann Walters Day Surgery Center**, featuring eight 500-square-foot surgery suites equipped with multi-use video and digital equipment that allow surgeons to perform a variety of procedures on an outpatient basis.

• **St. Joseph Center for Advanced Endoscopy** includes four sophisticated procedure rooms for diagnosing and treating gastrointestinal diseases and other conditions.

• **Diagnostic Imaging Center** is equipped with the newest technologies for MRI, computerized tomography (CT), ultrasound and digital X-ray.

• **Rehabilitation Therapies Center** features comprehensive physical, neurological, occupational and speech therapy services, centrally located for convenient access by patients, physicians and clinical staff.

The advanced technology of many procedures has decreased the need for overnight hospital stays, according to Wilczek. "The St. Joseph Outpatient Center provides a unique healing environment that responds to the needs of the increasing number of patients who come to St. Joseph for diagnosis, treatment or rehabilitation without the need for overnight care" he explained.

The new facility "is a model of efficiency for physicians," according to Gale Robinette, Franciscan's marketing and communications manager. "The facility features the newest medical technology throughout. Members of our medical and nursing staffs provided im-

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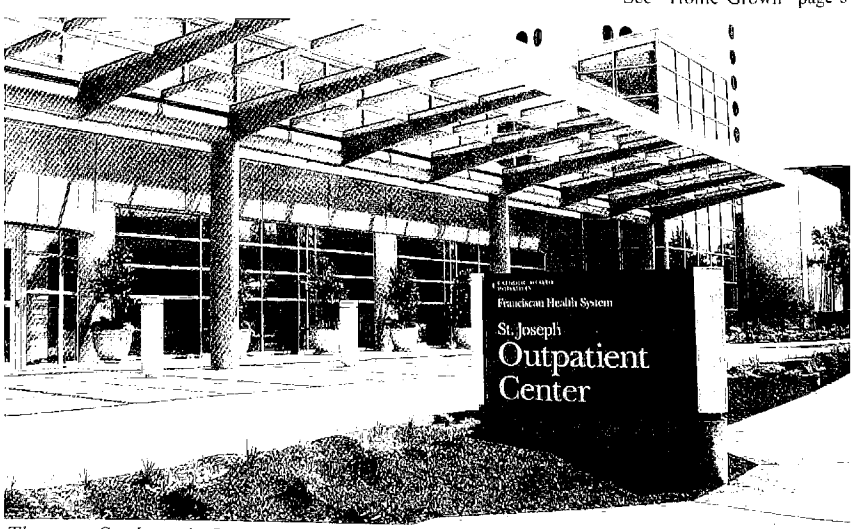
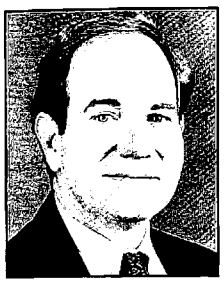


The new St. Joseph Outpatient Center, adjacent to the hospital, houses the new Outpatient Diagnostic Imaging, Outpatient Rehabilitation, the Gene and May Ann Walters Day Surgery and the St. Joseph Advanced Endoscopy Center

Les McCallum "retires" from College of Medical Education position

The College of Medical Education lost a long-time, valuable staff member when Les McCallum left his program administrator position July 30. "It's a huge loss for the College," said President **John Jiganti, MD**. "Les has done a tremendous job for us and will be very difficult to replace," he added.



Les McCallum

As an independent contractor for the College, McCallum worked other jobs and chose to downsize as he works toward retirement. After 16 years of program organization, he made the difficult decision to leave his College position and move on to a less hectic lifestyle.

McCallum was instrumental in helping the College of Medical Education identify programs that would best serve the mission, which is to provide a local resource for quality Category I CME programs. The intent is to give the medical community an option to share and exchange expertise, increase competence, and provide quality patient care. The programs planned are intended to provide some element of specialized education to most medical specialties, but primary care education is given the highest priority. The College is financially self-sustaining and has to consider not only what subject matters are of most importance and need in the community, but must keep an eye on the financial feasibility as well. "It's getting increasingly difficult each year," noted McCallum, "as pharmaceutical companies are being more restrictive with funds and physicians have many more options for obtaining low cost CME."

Les has done an incredible job, particularly in ensuring not only the commercial integrity but the financial integrity of our CME programs, noted Sue Asher, Executive Director of PCMS. He has been consistently committed and worked extremely hard in offering substantive accredited programs at no or very low cost.

The College Board of Directors consist of twelve physicians appointed by the PCMS Board of Trustees, three physicians appointed by the College Board and one representative appointed by each hospital system in the county; Franciscan Health System, Good Samaritan, and MultiCare Health System. The Executive Director of PCMS serves as Secretary. The College Board oversees the finances and the administration of the College.

The College Board of Directors voted to offer fewer courses in the 2004-05 program year to make the transition easier for a new staff person. Eight programs will be offered (see program schedule page14) including the annual Whistler course, as opposed to the normal eleven. Hawaii will continue in 2006 and other courses will either be offered annually or will rotate from year to year.

Scott Peterson has been hired to replace McCallum and began his new position August 1. Peterson hails from Olympia with a public relations and program administration background. He served as campaign manager for Federico Cruz's gubernatorial campaign and assisted on Initiative I90.

Fortunately, McCallum has offered to remain involved to ensure a smooth transition, so you may see him at upcoming College courses. Particularly at the Whistler CME program in January, when he will be assisting Peterson with his new duties. ■

Dermatologist Lloyd Elmer, MD, 89th President of PCMS to retire

After practicing Dermatology in Tacoma for the past 35 years, **Dr. Lloyd Elmer** retired June 30. Dr. Elmer practiced in the Allenmore area during his career, opening his practice in 1969 at Allenmore Medical Center after completing his internship at Madigan General Hospital and his residency in New Orleans at Charity Hospital of New Orleans.

Lloyd Elmer, MD

Dr. Elmer was very active in the medical community and the medical society. He served as the 89th President of PCMS in 1982 after having served as Secretary-Treasurer in 1978 and 1979, and as a PCMS Trustee in 1976-1977 and 1980. He also was a member of the Credentials Committee, chairman of the Budget and Finance Committee and served as a delegate at the WSMA Annual Meetings in 1979 and 1980. He served as a Trustee on the WSMA Board of Trustees in 1980.

Dr. Elmer was instrumental in the formation of the PCMS for-profit subsidiary Membership Benefits, Inc. in 1978. The subsidiary, today known as MBI, continues to work well for PCMS as it generates non-dues revenue from publications, personnel and other services, and has purchased and owns the building which provides rental income for MBI, assisting PCMS in keeping their dues to a minimum.

PCMS thanks Dr. Elmer for his years of membership and service and wishes him the very best in his retirement. ■

Home Grown from page 6

portant suggestions and ideas during the design phase of the Outpatient Center, which helped ensure that the facility would be patient-centric and meet the daily needs of our healthcare providers."

St. Joseph Medical Center is also undergoing a $15 million renovation of its inpatient surgery, which will be complete in September, 2005. The existing operating rooms will be converted to eight large 600-square-foot-plus suites. The remodeling will extend to surgery support areas, including a new waiting room, new physician and staff locker rooms, renovation of the anesthesia office and new surgery administration offices.

Franciscan Health System has also received authorization from the Washington State Department of Health to build an 80-bed, acute-care hospital in north Gig Harbor. Construction on the 197,000-square-foot facility will begin next summer, and the doors will open in 2007 or 2008. St. Anthony Hospital will feature a 24-hour-emergency department; medical, surgical and critical care units; inpatient and outpatient surgery; a heart catheterization lab; diagnostic services; physical, occupational and speech therapies; and a sleep disorders clinic. A medical office building will be adjacent to the hospital.

"As with the St. Joseph Outpatient Center, we will seek input from our medical staff members regarding how our new hospital in Gig Harbor should be designed and equipped to best meet the needs of physicians and their patients," according to Robinette. "The participation of our medical staff in reviewing programming and design concepts will be absolutely vital for us to achieve our vision for the Gig Harbor hospital, just as such participation helped turn the vision for the St. Joseph Outpatient Center into reality."

Other projects at Franciscan include the expansion and renovation of St. Clare Hospital in Lakewood, which will be completed this month and include a new emergency department.

In addition, Franciscan recently opened the new St. Joseph Dialysis Center in Gig Harbor, which features six dialysis stations equipped with the latest technology and provides outpatient hemodialysis.

FHS has also received approval from the Washington State Health Department to develop an inpatient hospice center in the Tacoma area which will begin service sometime in 2005.

MultiCare Health System

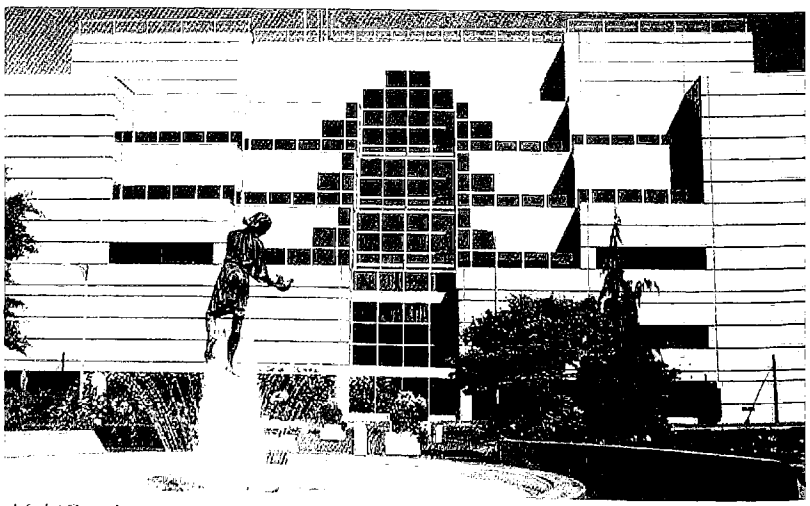
With several projects in the works or on the drawing board, the most high-profile expansion project at MultiCare Health System is the new Surgical Care Center and Regional Heart and Vascular Center, which opened in June. The advanced surgical facilities, complete with the latest technology available, was designed to allow for seamless integration of the next generation of surgical advancements, such as robotics and comprehensive electronic medical records. Physician and staff input was an integral part of the Center's design process.

"Our goal was to create a surgical center complete with high-tech tools and low-tech healing environments, that equipped physicians and healthcare professionals with everything they need to provide our patients with the highest quality care possible," said Shelly Mullin, RN, Administrative Director of MultiCare Surgical Services. "We believe with these enhancements, MultiCare is more poised than ever to meet the needs of our patients and physicians."

Featuring the latest medical technology, the new surgical center offers:

- Touch- and voice-activated controls for lighting, temperature and equipment.
- The Picture Archive and Communication System (PACS) in all operating suites to allow physicians to access three-dimensional diagnostic images.
- Ceiling-mounted surgical booms.
- Four dedicated cardiovascular suites, larger than normal to provide adequate space for the medical teams and equipment vital to the most complex cases.
- Four cardiac catheterization labs, including one dedicated to pediatrics, located just steps away from adjacent cardiovascular suites to further improve surgical access.
- Cameras in the surgical lights so procedures can be viewed to facilitate Continued Medical and Nursing education, while maintaining patient confidentiality.
- A center core that provides easy access to medical supplies at any moment during surgery.

See "Home Grown" page 12



MultiCare's expansion project, including the new Surgical Care Center and Regional Heart and Vascular Center, overlooks the fountain and rose garden, highlights of the MultiCare campus

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Disaster Planning

Federico Cruz, MD

Missing vials of anthrax. A stolen crop duster. A plane crash in Puyallup. Bioterrorism comes to the Puget Sound. This was the scenario played out for us at a recent training in Puyallup that public health staff participated in. As I sat through one of the sessions talking about isolation and quarantine issues my mind wandered and I thought about how probable, how really likely was a bio-terrorist event in our county. It is certainly possible but it's not likely. So, with resources being so scarce, why are we doing this? There are good answers to this question but my mind was on a roll and I evaded them and pressed on. What are we most likely going to confront in the near future? Are there threats, serious public health threats that loom in our near future.

I have to share with you that I had mentally already stacked the deck on this issue. I just finished reading an account of the Great Flu Pandemic of 1918. The book, call *The Great Influenza*, gives a gripping account of how the epidemic started in a little town in central Kansas, spread rapidly to a nearby army base, then to the trenches in France and then back to the U.S. Two years later tens of millions of people worldwide were dead and over a 100 million had fallen desperately ill. Many of us have read accounts of what happened in this country: The massive disruptions; closed schools; businesses with no employees; hospitals so over run that no care was offered to the sick; the dead piled up nightly on the curb to be carted off to mass graves at the edge of town.

When I talk with my colleagues in public health, without exception, they all feel that a flu pandemic is in our future. With the recurrence of avian flu in many parts of the world, it is just a matter of time before we see its crossover into the human population.

So I am sitting there in Puyallup fretting over the time I am spending on a farfetched anthrax scenario. Does this help our community prepare for a possible flu pandemic where ten's of thousands of Pierce County residents suddenly fall ill and flood our local health care systems needing care? Fortunately, the simple answer is yes. The constant meetings, mockups and drills do indeed work. We need to become more familiar with each other - police and emergency responders, the military, hospitals, pharmacies, clinics, individual providers, port officials, jail officials, parks and library leaders. All contribute to how a community would respond to a disaster. These drills help us to develop the relationships now, encourage us to learn how to work together. We actually do the needed planning and then practice executing joint efforts. Now, today, before pandemic flu or the next earthquake, so if a major event happens we are not winging it when lives are threatened.

"When I talk with my colleagues in public health, without exception, they all feel that a flu pandemic is in our future."

In this exercise, one of the standard critical issues comes up early: how to connect with the public and keep a clear channel of communication going. Hysteria is always a real threat and can ruin any effective response to a crisis if the public is not kept in the loop and reassured.

We have to remember that each of us is also part of the public. Even though as health providers we would play a very active role in confronting a flu pandemic we have our own personal needs just as any member of the public has. We can't pretend that we would act any differently than other non-health professionals. When we look at what happened in the pandemic of 1918, we have to recognize that, though many of our colleagues jumped right in and provided heroic amounts of care (and there were very high morbidity and mortality rates among providers), many of our colleagues absented themselves from any organized response out of fear and concern for their own personal situations. People will be demanding much of us during a disaster and we need to see that we are there and can perform. This is our role as physicians. But we can't accomplish our medical role if we don't resolve now the personal demands on us. We have to prepare for community crises, and recognize that our own needs will have to be met if we are to be effective. Our families will need attention and care while patients will also require our best professional skills.

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Disaster from page 9

In any disaster planning, we have long known that priority needs to be given to those persons and their families that play a central part in the community response to a disaster. They are the ones who are going to keep the community pointed in the right direction during the tough times. Being totally distracted and consumed over personal worries doesn't cut it when we are called on to serve on the front lines of community service.

So how to prepare. We need to schedule county-wide events where the major parts of our local health care systems actually participate in the activities and we as providers get the training and orientation we need to face a community-wide threat such as a flu pandemic.

So grumble now about the inconvenience, complain to your partners that this is not the best use of my time and then get over it and participate. Your community needs you. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

The New Serfdom

Andrew Statson, MD

"I didn't know I was a slave until I found out I couldn't do the things I wanted."
Frederick Douglas (1845)

On January 26, 2004 the *AMA News* reported the story of Julie K. McCammon, MD. She had practiced as a solo OB-GYN in Clarksburg, West Virginia, since 1988. She wanted to relocate to neighboring Virginia at the end of 2003 because of rising insurance costs.

She had to pay $190,000 to get tail coverage and could not afford it. Then she learned that her insurance company will stop writing liability coverage in her state in 2005 and she would have to close her office.

She filed suit against the West Virginia Trial Lawyers Association and its president for engaging in frivolous lawsuits, thus increasing the cost of insurance coverage. She argued that every time a physician was named in a lawsuit, even if dropped later, the insurance company had to open a file, review records, etc. That preliminary work could easily consume more than ten thousand dollars.

Her grievances included economic loss, professional limitations, emotional distress, mental anguish and other non-economic damages.

The first judge assigned to the case recused himself because the doctor had delivered his wife ten years earlier. The second judge accepted the case, even though his wife is a trial attorney. He dismissed the claim. That decision is on appeal. Dr. McCammon hopes that she will be allowed to proceed with discovery of evidence.

While this case received the most publicity, many other physicians have had to decide whether to pay huge amounts of money to escape from a stifling liability environment or to take their chances and forgo the tail.

The examples abound and come from across the country. *The Southern Illinoisan* reported on 5-11-04 that according to a physician recruiting firm in Saint Louis, malpractice issues will keep as many doctors in Illinois as they will keep away. Many Illinois physicians are tied down by their tail coverage. They typically must pay double the yearly rate when changing policies.

The same paper interviewed a native of Carbondale, who will start her residency in internal medicine in Saint Louis. Lana Clark graduated from the Southern Illinois University Medical School in Springfield (story from 6-19-04). She would like to return to Carbondale to practice, but not unless the malpractice situation improves by the time she completes her residency.

The paper reported that Madison and Saint Clair counties in Southern Illinois are considered judicial hell holes. They are havens for attorneys and plaintiffs to reap big jury awards.

As a result, in spite of the cost of tail coverage, more physicians are leaving Illinois than going in. Georgia, Nevada and probably Pennsylvania are in the same situation. In May of this year, the Wyoming Medical Society reported a long list of physicians who are moving out, mostly to Colorado, where the liability climate is better.

The trial lawyers use official figures to dispute those claims, but the statistics of licensed physicians do not reflect the number of those in active practice. Besides, the time lag of the data is at least a year, if not more.

Compared to the total number of physicians, those who abandon their practices and relocate are still a small percentage. In the face of our growing and aging population, however, the trend is in the wrong direction.

So what options do we have?

If you are considering retirement, make sure you'll have a good tail insurance. If you have to pay for the tail, perhaps it would be better to stop practicing before the effective renewal date of your policy with its concomitant increase in premiums.

If you are thinking of relocating, see that you can afford the tail. If next year the cost of insurance for obstetricians goes to $160,000, as projected in Maryland, or higher, as expected in Connecticut, you may need to pay over $300,000 to buy the policy.

If you are a resident, you should look for a place with favorable liability laws and hope they don't change during the thirty or more years you'll be in practice. If you are going to work for a

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The center also features a pre-surgical assessment area, a relaxed environment where family members can stay with patients, reducing preoperative stress for everyone. With a confidential code, family members are also able to track a patient's progress throughout surgery and recovery. With the thoughtful division of space in the visitor waiting area, physicians are able to speak privately with family members in an adjacent consultation area.

"Our team worked closely with our medical and nursing staffs to design the new facility to be the most advanced surgical facilities in the region with the latest medical integration and imaging systems," says Todd Kelley, Media Relations Manager for MultiCare. "That collaboration and integration directly benefits our patients."

As the doors opened to the surgical center in June, the walls were being raised on another major building project. Next spring, in time for the 50th anniversary of Mary Bridge Children's Hospital, the new Mary Bridge Children's Health Center will open the doors to a new state-of-the-art outpatient facility. The 60,000-square-foot addition will include 50 patient rooms, support services including lab, pharmacy and X-ray, and patient-family services.

Natural light, open space and imaginative design aptly describe the specialty clinic, which combines two important principles – modern medical uses and patient comfort. Windows at the end of corridors, two outside courtyards, stunning artwork and a theme for each floor are some of the elements that help provide a soothing and serene atmosphere for patients, families and staff. The first floor will feature a sea motif, the second floor focuses on land, and the third floor will boast a sky theme.

"I'm very proud of the work of our staff and the design team," said Mady Murrey, Mary Bridge administrator. "Mary Bridge has a long-standing reputation for providing excellent clinical care. With this new facility – and the attention our staff and donors have given to creating an ideal healing environment for kids – I believe our reputation as a healing, child- and family-focused facility will continue to grow."

In 2004, MultiCare is also advancing Medical Imaging technology. MultiCare has opened a new outpatient imaging center in Gig Harbor, installed state-of-the-art Magnetic Resonance Imaging MRI at Allenmore Hospital and installed a new 16-row Computed Axial Tomography (CAT) scanner at Tacoma General/Mary Bridge. Renovations to install a second 16-row CAT scanner and 1.5 Tesla MRI with TIM technology at TG/MB are well underway.

MultiCare is also moving toward filmless imaging technology. This technology will allow us to control and move images electronically, will significantly shorten exam times and improve

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PCMS debates WSTLA and educates Pierce County about tort reform

On Friday, July 9, President **Mike Kelly, MD** had the distinct pleasure of debating the issue of tort reform with then President-Elect of the Washington State Trial Lawyer's Association (WSTLA), attorney Rodney Ray. Installed later in July as WSTLA's President; Mr. Ray practices in Tacoma and is a graduate of the UPS Law School.

The debate was hosted by the Eastern Pierce County Chamber of Commerce and was held at the Best Western Park Plaza in Puyallup. The lunchtime debate attracted a favorable crowd of about 80 people.

In traditional debate format, each participant was given ten minutes to present their perspective on tort reform. Dr. Kelly, of course, focused on patient access, citing the facts that patients will continue to see increased difficulties finding physicians if changes aren't instituted. He blamed the legal system noting that runaway jury awards must be stopped. Mr. Ray cited the expected arguments against reform of the current tort system, blaming insurance companies and their investment practices as well as bad doctors that are not disciplined. After their introductory remarks, each was given two minutes to answer the same questions asked by the moderator. After answering questions, both were given two minutes to give closing comments. The debate was then opened to questions from the audience to either or both presenter.

While nothing was resolved, audience members had lots of questions and were very interested in hearing from both leaders of their respective professions.

Dr. Kelly has been very busy speaking to numerous organizations and groups about tort reform this year. He has developed two power point presentations, both data driven, one being more comprehensive than the other. He has had many opportunities to share his wealth of knowledge about tort reform, and is currently serving on a special task force of attorneys, legislators, and physicians trying to think creatively about how the issue could be resolved. This is in spite of the fact that there is no agreement, nor probably ever will be, regarding the primary cause.

From right, PCMS President Mike Kelly, MD and WSTLA President Rodney Ray, JD after their tort reform debate before the Eastern Pierce County Chamber of Commerce in July. Dr. Kelly's excellent data and presentation obviously didn't open Ray's eyes

Dr. Kelly has addressed numerous groups regarding tort reform such as the Government Affairs Committee/ Eastern Pierce County Chamber of Commerce, Health Care Access Team (United Way), Franciscan Inpatient Team, Tacoma Area Medical Managers, Washington State Republican Caucus, KKMO Radio, and both the Pierce County Democratic Party and the Pierce County Republican Party organizations. He has also met with numerous legislators including Congressman Adam Smith.

If you would like give a presentation on tort reform to any organization or civic group, Dr. Kelly will gladly share his power point presentation and script and PCMS will provide the equipment and assistance. Call Sue Asher at the Society office 572-3667 for more information. ■

Please make the following changes to your 2004 Physician Directory:

Patty Kulpa, MD
Change office name to: Women's Premier Health Center

Eugene S. Lapin, MD
Add information to active member section and
delete name from retired section:
Lapin, Eugene S., M.D. (Margaret)
Cardiology - T
Off: 1901 S Cedar #301, Tacoma 98405.....572-7320
FAX (medical records, Tacoma).....627-0712
FAX (bookkeeping).....627-3191
Off: 1322 - 3rd St SE #330, Puyallup 98372.....841-4347
FAX (medical records, Puyallup).....845-4948
Res: 2944 E Bay Dr NW, Gig Harbor 98335.....858-0775
DSHS Billing # 8185100
UPIN # A08772

Theodore Lau, MD
Change office address and phone to:
Cardiac Health Specialists
1802 S Yakima #307, Tacoma 98405.....627-1244
FAX.....627-6576

Sharon Metcalf, MD
Add informationto active member section:
Metcalf, Sharon L., M.D.
Ob/Gyn
34503 9th Ave S #100, Federal Way 98003.....253-952-8231
FAX.....253-835-8000

R. Ivan Zbaraschuk, MD
Change office address and phone to:
2709 E Main, Puyallup 98371.....848-4520
FAX.....848-5249

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access for referring physicians. Our first large scale deployment of this technology is expected at Allenmore Hospital by the end of the year.

Another significant expansion effort for MultiCare is the continued roll out of Electronic Medical Records (EMR) throughout the system. MultiCare recently unveiled the *My MultiCare* patient access system, which allows MultiCare Medical Group patients to communicate electronically with their physicians and access parts of their medical record. *My MultiCare* allows patients to schedule or change appointments, order a prescription refill, view results of medical tests or screenings and receive health reminders.

MultiCare will continue to implement the electronic medical record throughout its hospital in 2005 and beyond, which will allow health care providers to document, at the bedside, all patient information electronically. ■

PCMS endorses WSMA's legislative initiative on tort reform

Editor's Note: The PCMS Board of Trustees has endorsed the "Doctors for Sensible Lawsuit Reform." WSMA's campaign to enact reasonable tort laws in Washington.

The Washington State Medical Association, working through a campaign committee called Doctors for Sensible Lawsuit Reform, recently filed an initiative to the legislature with the Secretary of State.

The objective is to break the gridlock that is preventing sensible liability reform in Washington State.

In the past two legislative sessions, despite a demonstrated need for action, a few obstructionist politicians in the House have refused to take action on bills passed by the Senate - essentially killing them in committee and preventing members from voting. Physicians are left with no choice other than to try to force the legislature to take action on this important issue.

The initiative, I-300, is medical only and includes provisions to:

- maximize patient recovery of damages
- fully compensate patient injury
- guarantee payments over time
- simplify the process
- make juries aware of other payments
- require defendants to be accountable for their share of fault
- require notice prior to a claim
- establish a specific period of time for filing suits

Attorney Phil Talmadge, former chair of the Senate Judiciary Committee, former State Supreme Court Justice, and ardent foe of tort reform - filed objections in Thurston County Superior Court on behalf of WSTLA to the language submitted for the tort reform initiative. As is their right, the other side can object to the ballot title and summary for the initiatives, which are drafted by the Attorney General's office.

The drafts from the AG's office didn't reflect what was suggested, but WSTLA has objected and WSMA will proceed to file necessary briefs to improve the language. After a hearing (not yet scheduled), the court will have five days to make a decision.

The formal ballot title and official summary will occupy just a small portion of the initiative form - and will be more than offset by the public positioning of the initiative and the other language and material distributed as a part of the campaign.

An initiative to the legislature forces action. The legislature will have these options. They can:

- Adopt the initiative as proposed, in which case the initiative becomes law without being sent to the ballot.
- Reject the initiative or take no action, in which case the initiative goes on the November 2005 general election ballot.
- Approve an alternate version, in which case both the original measure and the alternate go on the November 2005 ballot. ■

Lessons from page 3

ship. We must support him with all our resources and enthusiasm. To do otherwise, is to demonstrate to the personal injury attorneys our lack of commitment.

Many of you have already received, or will soon receive, invitation(s) for fund-raising events. I encourages you to put your money where your conviction lies. We may not be able to match the trial bar dollar-for-dollar, but we can make a significant impact.

So let's line our raft up well as we prepare to enter the fray. I believe our preparations will bear fruit. Then we'll know that euphoria of taking on the turbulent unforgiving rapids while successfully navigating through. Then we'll demonstrate physicians are a force in this state, an effective advocacy group with a place at the legislative table. Then we'll experience the victory celebrations which symbolize the opportunity for meaningful tort reform leading to improved access to medical care.

COLLEGE OF MEDICAL EDUCATION

Common Office Problems CME set October 29

Topics are set for the College's *Common Office Problems* CME scheduled for Friday, October 29, 2004. The conference will be held at St. Joseph Medical Center, Rooms 1A & B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

This year's course will offer:

- A Primary Care Dermatology Review and Update
- Osteoporosis: What's New in Primary Care Diagnosis and Management
- *Initial* Insulin Therapy: Choices for Primary Care
- Treatment Options for COPD: An Update
- An Update on Depression
- An Update on Pediatric Cardiology

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137. ■

Continuing Medical Education

C.O.M.E. Board Announces 2004-2005 CME Program Schedule

The College of Medical Education's Board of Directors announced its CME schedule for 2004-2005 at the June meeting. Courses are offered in response to local physician interest an are designed and directed by local physicians. All courses offer AMA Category I credit.

A course calendar identifying the course title, dates, brief description and course directors will be mailed in early September. For additional information on next year's offerings, please call the College at 627-7137. ■

CME at Whistler, Blackcomb Lodging Reservations Available

Plans are set for CME at Whistler scheduled for next January 26-31, 2005. A program brochure was mailed in late July.

Those interested in attending should secure their condos soon. The College has arranged for accommodations primarily at the Aspens Condos at the same rates as 2004. Reservations for the condos can be made by calling *Aspens on Blackcomb*, toll free at 1-866-788-5588. You must identify yourself as part of the COME group. You are encouraged to make your reservations soon to ensure space - at least by December 1, 2004, when any remaining condos in the block will be released. ■

Dates	Program	Director(s)
Friday, October 29	Common Office Problems	Mark Craddock, MD
Friday, November 12	Infectious Diseases Update	Lawrence Schwartz, MD
Tuesday (evenings) January 11 & 18	Cardiology for Primary Care	Gregg Ostergren, DO
January 26-31	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 4 or Saturday, February 5	Gastroenterology for Primary Care	Ralph Katsman, MD
Thursday-Friday March 31- April 1	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

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group, make sure that your contract provides insurance coverage in case you are laid off or decide to leave.

For example, when a hospital closes its OB department or Emergency Room, the physicians it employs are out of a job. Will they also lose their coverage?

The Physicians News Digest for Eastern Pennsylvania reported that perhaps two hundred physicians were laid off in the Philadelphia area with the recent closings of nine obstetric departments and several hospitals. I couldn't find out whether they got tail coverage and who paid for it. Will the company that hires them afterwards also insure them for their previous work?

I apologize again for the bad news. I feel like the man in "Fiddler on the Roof," who read in the paper about pogroms in other villages and tried to tell his neighbors, but they didn't want to listen. Then, one day, their turn came. Perhaps a few of them were wise enough to get out earlier, but after the pogrom they all had to leave.

Our situation here is not much different. Is there a way out? I don't know. I'll stop now and leave the discussion of our options and what our colleagues in other places are doing for next month. ■

Classified Advertising

POSITIONS AVAILABLE

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

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

Established Spanaway Family Practice looking for P/T to F/T Board Certified or Board Eligible physician or ARNP/PA to join a practice. Work 4-5 days a week with a great support staff. Base salary plus incentive. Fax your CV to 253-536-3070.

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

Opportunity to start new medical practice without large outlay for overhead expenses. Waiting room, business office space, physician's office and two exam rooms available. Two separate entrances and partially furnished exam rooms. Rent only, no staffing offered. Please call 206-861-1810 or fax CV 206-709-8452.

Primary Care/Internal Medicine Practice opportunity. MD or ARNP - 100% outpatient primary care practice specializing in HIV care and management. 30 hours/week, no nights, weekend nor inpatient care. Parking, medical/dental/vision, malpractice and salary. Candidate should be gay-friendly, open-minded and work with an attitude of no judgment and no guilt. This position requires membership in KCMS, Medicare, DSHS and all private local billings plans. Please call 206-861-1810 or fax CV 206-709-8452.

Tacoma, WA - Three provider group (1 MD, 2 NPs) seeks a part-time B/C or B/E family practice or internal medicine physician who has a special interest in geriatrics and providing nursing home care. Practice is adult primary care with large Medicare component. Enjoy the uniqueness of the Northwest lifestyle with the back up and support of a full service integrated healthcare delivery system. Competitive benefits and salary make this a choice opportunity that won't last long. The right candidate will enjoy an excellent call schedule, compensation and benefits. Candidates must have completed a three-year accredited US residency program. Please email your CV to MultiCare Health System at providerservices@multicare.org or fax your CV to 866-264-2818. Please mention opportunity #273. Website: www.multicare.org "MultiCare is a drug-free work place"

Join Northwest Kinetics' expert early-phase pharmaceutical research team Northwest Kinetics, a Phase I & II clinical research organization, is seeking a Research Physician to join our team. Company offers outstanding benefits – 401k plan, medical, dental, paid time off and an opportunity to work in an entrepreneurial, high-growth environment. Physicians are integral members of our research team, serving as study investigators, performing procedures and providing medical assessments, judgments and leadership in support of all study activities. Qualified applicants must have current Physician's license in good standing in the State of Washington (or license in good standing in home state, with Washington State license forthcoming) and experience in the conduct of clinical trials, with Phase I experience desirable. For immediate consideration, send resume and cover letter w/wage requirements to: Rikki Johnson, Human Resource Manager, Northwest Kinetics, 1401 N. 5th St, Tacoma, WA 98403, Fax: (253) 682-4351, Email: rjohnson@nwkinetics.com. Visit us at www.nwkinetics.com.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals, ownership options. Call 253-272-2224.

Office space for lease in medical complex, Gig Harbor. 2354 sq ft, main level. 468-3539 or 565-2444.

New office building for sale or lease. 3000 leased, 3600 for lease. Large parking lot. Fircrest. 564-8784

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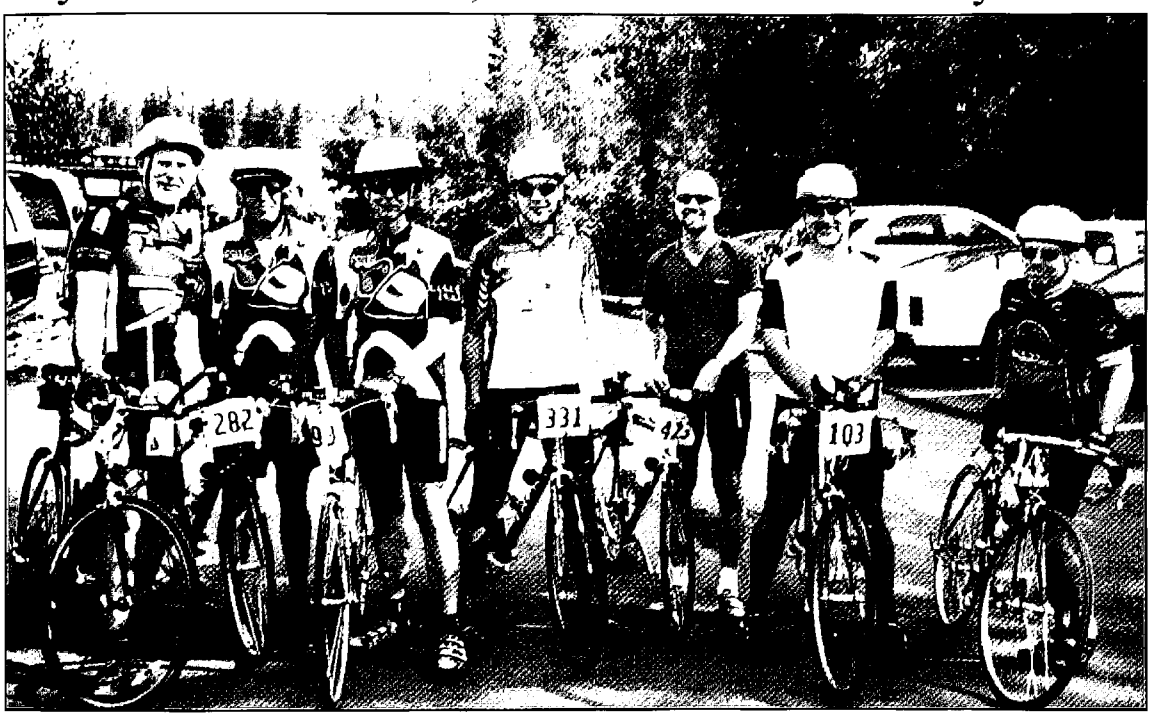
Pierce County Medical Society
BULLETIN

September, 2004

Physicians bike for fun, for health and for worthy causes



From left - Drs. Pat Hogan, John Loesch, Henry Retailliau, Patrick Mosler (physician from Heidelberg, Germany), Harald Schoeppner, Mark Craddock and Don Shrewsbury atop Snoqualmie Pass ready for the start of the Courage Classic

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INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

September, 2004

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President's Page

by Michael J. Kelly, MD

The Proper Use of Power

Michael J. Kelly, MD

"Place your iron hand inside a velvet glove."
- Napoleon

It's already September. Can you hear the strange sucking sound? It's the hiss of the vacuum left by the massive movement of campaign contributions from the personal injury attorney PACs to the coffers of their handpicked candidates. We shouldn't be surprised. After all, money curries favor, obtains influence. It reminds me of the axiom: "He with the gold rules." At least that is the principle to which the trial bar ascribes. While it is true money can buy a degree of power, it is not the final determinant. Since we cannot match the trial bar dollar for dollar, how do we overcome such power? Perhaps we need to understand just what power is.

Power is not something to which physicians overtly and actively aspire. To many of us the notion of consciously playing power games - no matter how indirect - seem evil, asocial. However, like it or not, we are all trapped in a giant scheming court. There is no use in trying to opt out of the game. You may choose to avoid political action, but I suggest at your own peril.

Instead of struggling against the inevitable, instead of arguing and whining and feeling guilty, it is by far better to excel at power. Learning the game of power requires a certain way of looking at the world and at our situation as physicians - a shifting of perspective. It takes effort since basic skills are required which do not come naturally.

Power is essentially amoral and one of the most important skills to acquire is the ability to see circumstances rather than good or evil. Power is a game, and in games you do not judge your opponents by their intentions but by the effect of their actions. Representative Lantz states she is pro tort reform, yet she killed physician-sponsored senate legislation two straight years in her judiciary committee. How often are someone's intentions made the issue only to cloud and deceive? It is only natural for the people of the 26th District to cover up her actions with all kinds of justifications, always assuming that she acted out of goodness. We know differently and need to communicate this to others.

We physicians have the potential power to assure the medically favorable outcome of this election - if we choose. Couldn't be true you say? This is absurd, we are only humble servants of our patients, you add. Perhaps. However, what if every physicians in Washington State communicated with ten people a day concerning their medical candidate(s) of choice? The power invested in such a concerted effort would be enormous!

Most acknowledge that all politics is local. In the same manner, medicine is practiced locally, one patient at a time. People come to physician offices by the hundreds each week. Trial lawyers do not have a fraction of such exposure. Our patients respect our opinions. When we tell them how the present crisis of medical access could adversely affect them and their families, they will be greatly influenced. This is our fundamental edge and the lawyers' greatest weakness. We must utilize this strategy.

The communication I envision need not involve a direct discussion by the physician with the patient. Consider these suggestions for obtaining power in this election:

- Hanging wall posters regarding the issues and candidates, generously placed about the waiting room and exam rooms
- Constantly playing a 30-minute videotape on the medical liability crisis from Doctors for Medical Liability Reform (DMLR) in the waiting room (available at no cost from WSMA)
- Displaying bumper stickers and yard signs announcing your choices
- Doorbelling for your candidate(s) of choice, door to door - a daunting but very effective use of power
- Placing voter registration material (available from PCMS office) in your office and encouraging those not registered to do so during their visit. If you doorbell, take registration material with you on your walk
- Actively contributing money to the candidates who support tort reform

I know the physicians of Pierce County and Washington State can use their extraordinary and unique power to affect the outcome of this election to maintain access to medical care and preserve our practices. In the end, life is short, opportunities are few, and we have only so much energy to draw on. Let us not squander this opportunity!■

Antitrust reform: Physicians need the right to negotiate

With the FTC and the Justice Dept. reiterating their stance against joint negotiation with health plans, it's more important than ever for Congress to pass antitrust relief for physicians

Two key federal agencies cite the need for more competition in the health care market as a reason why they, again, are refusing to allow physicians to negotiate collectively with health plans. And yet these agencies, again, are failing to recognize the long-term impact health insurance company mergers would have on patients and physicians.

The Federal Trade Commission and the Dept. of Justice (DOJ) on July 23 released a 300-page report saying, again, that collective bargaining by independent physicians would have a negative impact on health care competition. This comes after 27 days of testimony in 2002 and 2003.

The AMA was among those testifying about why antitrust relief is necessary. A big reason why: health plans continue to get larger and larger, giving physicians less and less leverage to negotiate contracts. The plans not only dictate reimbursement, but also unilaterally define medical necessity and other coverage issues that would affect patients. Despite the FTC and DOJ report, the AMA remains committed to bringing antitrust relief to all physicians.

The FTC and DOJ report restates their past position that physicians may not negotiate collectively with plans unless they are employed, or they work in a handful of states that have passed physician collective bargaining laws. Instead, the report recommends that insurers and the government find payment methods that encourage physicians to lower costs, improve quality and innovate. Perhaps if groups that integrated clinically found ways to meet those goals, rather than focus on prices, the FTC and DOJ say they may look kindly on collective negotiation.

Certainly, lowering costs while improving quality is a laudable goal. However, even the agencies acknowledge in the report that most plans' payments to physicians generally are based on a simple accounting of services rendered, with no connection to quality.

What's a more likely result of health plans' virtually unchecked power is a profit-driven squeeze on physician pay and patient benefits — hardly an encouraging picture for patient access or choice.

Meanwhile, the consolidation goes on. AMA and other physician advocates have told the government that health plans continue to grow larger and hold more power over the health care marketplace.

The FTC and DOJ found no trouble at all to health care competition when they approved the $16.4 billion merger of Anthem Inc. and WellPoint Health Networks to create the nation's largest health plan, and the $3.7 billion merger of Oxford Health Plans by the nation's No. 2 health plan, United HealthGroup. (As of this writing, Anthem is suing a California regulator who refused to approve the merger, and United is fighting the Medical Society of New Jersey's effort to overturn state regulators' approval of that deal.)

Neither agency made a peep about the impact health care plan consolidation - with the top two plans in any given metropolitan area generally having greater than a 50% market share - is having on health care.

What physicians are looking for is a fair fight. And, the AMA is continuing to look for support for the Health Care Antitrust Improvements Act of 2003. It's a House bill that would allow physicians to negotiate collectively with insurers. It also would limit sanctions against physicians who were found not to be in accordance with antitrust statutes, but whose conduct was deemed to be in "good faith." It also would establish demonstration projects allowing doctors jointly to negotiate contracts with health plans.

This is what is needed to ensure that managed care doesn't get a greater and greater carte blanche to impose its will on physicians and patients. Again. ■

- Reprint AMA/News 8/30/04

Bike riders enjoy both Seattle-to-Portland and Courage Classic events

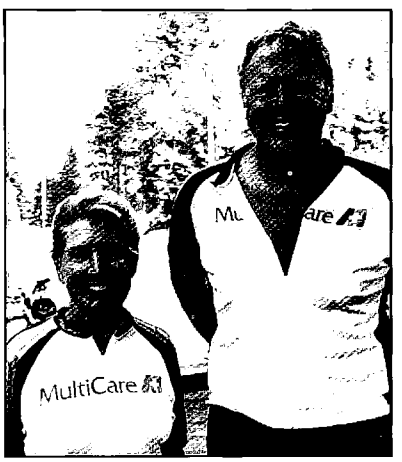
Congratulations are in order to PCMS members who rode this year's Courage Classic and/or Seattle-to-Portland bike riding events. They are Drs. **George Brown**, Administrative Medicine; **Mark Craddock**, Family Practice; **Allen Graeve**, Cardiothoracic Surgery; **Pat Hogan**, Neurology; **Nick Iverson**, Internal Medicine; **William Martin**, General Surgery, and his wife Karyl; **Robert Osborne**, Vascular Surgery; **Henry Retailliau**, Internal Medicine; **Harald Schoeppner**, Gastroenterology; **Steve Settle**, Physical Medicine and Rehab; **Don Shrewsbury**, Otolaryngology; and **Gary Taubman**, Gastroenterology.

The 13th Annual Courage Classic (CC) bicycle tour, which took place on August 14-16, started in Snoqualmie with the first day ending 57 miles later in Cle Elum. The second day leads riders to Leavenworth after a 55 mile ride. The third day riders end up in Skykomish after completing the final 60 miles of the ride, for a total of 172 miles. Total elevation gain for this ride is 10,036 feet! Proceeds from the Courage Classic benefit the Rotary Endowment for the Intervention and Prevention of Child Abuse and Neglect at Mary Bridge Children's Hospital as well as the Children's Trust Foundation.

The 25th Annual 200 mile Seattle-to-Portland (STP) Bicycle Classic Ride took place on July 17-18. Most of the 8,000 riders stay the first night in Centralia or Chehalis, which is 94 miles from the University of Washington starting point. About 1,500 of them do the ride in one day.

Congratulations to all riders! ■

Drs. Bill Martin (left) and Mark Craddock at a rest stop on Stevens Pass on day 3 of the Courage Classic



Diane Cecchettini, CEO/President of MultiCare, and Dr. Allen Graeve feeling great on day three of the CC

Dr. Steve Settle on day three of the Courage Classic takes time for nourishment at the top of Stevens Pass

Dr. George Brown (rt) and his brother Dr. Russell Brown stop in Leavenworth, the second day of the Courage Classic

Dr. Nick Iverson refuels at the halfway point in Centralia on the Seattle-to-Portland ride

Drs. Harald Schoeppner (left) and Gary Taubman start out fresh on day one of the Seattle-to-Portland ride

Applicants for Membership

Keith F. Dahlhauser, MD
Ophthalmology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Med School: University of Iowa
Internship: St. Mary's Health Services
Residency: University of Minnesota

Troy Davis, PA-C
Dermatology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Training: University of Nebraska

Rachael Elrod, MD
Ophthalmology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Med School: University of Washington
Internship: Legacy Emanuel Hospital
Residency: University of Washington
Fellowship: Fletcher Allen Healthcare

Eugenia Guray, MD
Family Practice
Puyallup Clinic
800 S Meridian #A, Puyallup
253-845-6645
Med School: Manila Central University
Internship: Eastern VA Medical School
Residency: Eastern VA Medical School

Jeffrey J. Harrison, MD
Family Practice
Gig Harbor Medical Clinic (FHS)
6401 Kimball Dr NW, Gig Harbor
253-858-9192
Med School: University of New England
Internship: Naval Medical Center
Residency: Bremerton Naval Hospital

Julie Jarvis, PA-C
Dermatology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Training: Wichita State University

Jessica H. Kim, MD
Dermatology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Med School: University of Maryland
Internship: Walter Reed Army Med Ctr
Residency: Walter Reed Army Med Ctr

"Applicants for Membership" cont. page 14

Pierce County Medical Society

explores

Electronic Medical Records

and

Electronic Connectivity for Pierce County

The How's and Why's of EMRs
Improve access to information
Decrease expenses, operate more efficiently
Increase reimbursements; improve documentation
Meet regulatory and liability concerns
"Find your champion"

Connecting Pierce County
An update on the PCMS Connectivity Committee
Developing a 'community' solution
Secure Messaging
Bringing labs, xrays, etc. to your EMR
No more scanning or OCR!

Presented by: Matthew White, MD; Chair, PCMS Connectivity Committee
Featuring: 'Testimonials' by Pierce County physicians

September General Membership Meeting

Vendor displays ❖ complimentary dinner

Other important agenda items:

- **Initiative 330 discussion, WSMA's Initiative to the Legislature for tort reform**
- **Four at-large members will be selected for the 2005 Nominating Committee**

Tuesday, September 14, 2004		**Landmark Convention Center**
Displays, Social Hour:	**5:30 pm**	**Temple Theatre**
Dinner:	**6:30 pm**	**47 St. Helens Avenue**
Program:	**7:30 pm**	**Tacoma**

Registration required by September 10th. Return form to PCMS 223 Tacoma Ave So, Tacoma 98402, fax to 572-2470 or call 572-3667

Please reserve ___ dinner(s) for me at no charge. **(ONE FREE GUEST PER MEMBER)**
Additional guests/staff or non-member registration fee is $25

Member Name (please print) _____ No Charge
Guest/staff name (please print) _____ No Charge
Additional guests (please print) _____ $25 each (attach check or pay at door)

The parking lot across the street charges $3, but there is usually ample street parking at no charge

Thank you. We hope you will join us.

Social Security Disability and the Electronic Future

The Social Security Administration (SSA) and its affiliated State Disability Determination Services (DDSS) each year request about 15 million medical and other records on behalf of claimants for Social Security disability benefits. SSA is probably the largest single third party requester of protected health information. SSA has begun several initiatives to improve the timelines and efficiency of its huge disability programs, including development of a paperless case processing system. Health professionals play a key role in determining the efficiency, effectiveness and, ultimately, the success of SSA's efforts.

SSA is migrating to a fully electronic case processing system. This means that Social Security records will be maintained in an electronic folder that is entirely paperless. For a fully electronic case processing system, SSA must store medical and functional evidence in an electronic format. Therefore, it makes sense to receive evidence in an electronic format whenever possible. Otherwise, we must digitally scan the paper and then arrange for its disposal. Transferring documents electronically will mean savings for providers, SSA and taxpayers.

The Social Security Administration recognizes that providers may have a wide range of electronic capabilities and needs, therefore, is building a flexible set of HIPAA-compliant tools to obtain electronic records. To find out more information about exchanging records electronically please contact the Washington State Division of Disability Determination Services, Medical/Professional Relations Department at 1-800-562-6074.■

In My Opinion.... The Invisible Hand

by Joseph Jasper, 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 Sea Turtle

Joe Jasper, MD

I find studying nature helps me learn about people. A recent visit to an aquarium taught me about sea turtles. As we all know, they have a hard shell, impenetrable to most predators. Thus, the turtle glides about the shallows feeding along the coral reefs relatively unconcerned about threats lurking within the ocean. If threatened, it can tuck its head and limbs within its armor. Unfortunately, sharks are capable of seizing the creature and crushing the shell.

Doctors see themselves as capable of practicing medicine without interruption. Our worlds are perceived as within some sanctum that no one should dare breach; we would never dare to venture outside. Society will revere and care for doctors. There has been no time for politics.

Our security is as false as the sea turtle. Our livelihood is threatened by rapidly rising overhead, and income that fails to keep pace with inflation. The culprits of our demise are known: trial attorneys and the politicians they have contributed so heavily to that dare not support tort reform.

While the sea turtle must evolve a better defense over millennia, we must adapt to our new world more rapidly. We must realize we have no impenetrable shell; it has been shattered; our flesh exposed. We must participate with our time, action and dollars.

Please, do not ignore the pleas for your participation. Fundraisers for politicians will help our side become stronger in the effort to bring about meaningful tort reform.

Do not be a complacent turtle. Let us turn the tables. Become the predator, not the helpless prey. ■

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.*

Exodus

Andrew Statson, MD

"Some people change when they see the light, others, when they feel the heat."
Caroline Schroeder

The city of Carbondale, Illinois, felt the heat. The *Chicago Tribune* reported on 7-13-04 that the Carbondale city council passed an ordinance establishing caps on medical malpractice cases and restricting venue, so that all incidents leading to claims that occurred within the city would be tried in the city. Carbondale is in an area considered a judicial hell hole.

What prompted them to act was the departure of the last two neurosurgeons, who closed their office in May and relocated to South Carolina. Drs. Theo Mellion and Sameel Lal were partners in Neurological Associates of Southern Illinois. They shopped for insurance and the best quote they could get was $300,000 per person. In South Carolina, they'll pay $40,000 each.

The mayor of Carbondale, Brad Cole, said that the cries for help needed to be answered before they became tears of sorrow. Nicely put. Their action will be too late for the leaving neurosurgeons, but it might help recruit someone else.

In the meantime, the liability reform bill is stalled in the Illinois legislature and the governor is opposed to caps. The physicians who can get out of there are moving to Wisconsin, Indiana or other places, while the party (for the trial attorneys) goes on.

The list of hospitals closing their obstetrical departments, emergency rooms, trauma centers, etc. grows. So does the list of physicians relocating or leaving the practice of medicine. The St. Clare Hospital in Lakewood was not the only one. The physicians in our community who retired or stopped doing obstetrics were not alone. The phenomenon is widespread and affects most states of the union.

As an example, four of the six obstetricians in Enid, Oklahoma stopped doing obstetrics this summer. They did 1,200 deliveries last year. Can two obstetricians handle that kind of volume by themselves? How long do you think they will last? Perhaps they might recruit someone. Will they recruit four?

Various citizen and consumer groups, perhaps acting as fronts for trial attorneys, dispute the claim that care is not available or that physicians are leaving in large numbers. On 4-18-04, mcall.com in Harrisburg, Pennsylvania reported that there was no exodus of doctors from that state. The medical society is crying wolf. If anything, there are more physicians practicing in Pennsylvania now than there were a few years ago. The only decrease was in the number of neuro-, ortho- and general surgeons and obstetricians, who went from 4,721 in 2002 to 4,665 in 2004, certainly not a big drop, and the reporter disputed the accuracy of that figure, too.

Even with tort reform, the outlook is bleak. Rates are not going to go down. Ohio, for instance, enacted a cap last year, but that has not been tested in court and the previous law had been overturned. The insurance companies are cautious and they currently project an increase in premiums of fifteen percent for 2005, in spite of the cap.

In a decision handed down on 7-7-04, the Michigan Supreme Court ruled that "damage caps are constitutional in causes of action springing out of the common law because the Legislature has the power under our Constitution to abolish or modify nonvested common law rights and remedies."

The case, Phillips v. Mirac Inc, concerned a 1995 Michigan law limiting the vicarious liability of car rental companies to $20,000 per person and $40,000 per accident in case one of their cars was involved. Prior to that law, the liability of the rental companies was unlimited. The above decision does not mention medical malpractice caps, but it is a nice precedent.

I don't know what will happen in our state, and we don't have a cap yet. Maryland and Connecticut have no cap and the projected increases in premiums are 40-90% or more, depending on the specialty. In Connecticut, the premiums for obstetricians will double. GE Medical Protective already increased its average rates by 89.6% in July. Obstetricians pay 93.7% more.

Our opponents obviously cannot see the light. How bad do things have to become for them to feel the heat? I'll repeat something I have said before. Since I am retired, it is easy for me to say it. If you can figure a way, leave the practice of medicine. It may be hard to believe, but there is life outside of

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Obesity Epidemic

Federico Cruz, MD

I had the opportunity to see the new movie "Super Size It!" As most of you know, this film chronicles the efforts of a young man who goes on a McDonald's diet. Yes, 100% McDonald's fast food breakfast, lunch and dinner for 30 days. I saw the film with my 16-year-old daughter, a sobering experience as we reacted to the film very differently. I would cringe at a scene and she would say "wow!" I gagged and she responded "neat!" to gross encounters on the screen. I would hear music that I liked and she would comment it was boring. But, the basic point of the film got through to both of us. Eating fast food every day was basically harmful to your health.

We all know this intuitively. We as physicians are aware of how important a good diet is to good health. Yet, it has not been a central part of our efforts to combat disease. We see too many children from a very early age become accustomed to high fat/high carbohydrate diets. And not just any fats but saturated fats. Fats that are partially hydrogenated (the trans fats), the very dietary factors that are most prone to causing long term health problems. Add to those fats huge amounts of sucrose and other highly refined carbohydrates and you've got a health problem waiting to happen.

The end result of all this culinary mayhem is that our country has become "fat." The CDC has released maps of the United States that show the progression of obesity state by state, starting in 1970, then by 10-year increments until 2004. It is shocking. The maps show "progression" from a few areas plagued by obesity in both adults and children to the majority of states with obesity levels of at least 25%-30%. We see extraordinary numbers of kids with pre-diabetic conditions.

I wish that I was exaggerating but I am not. Poor diet, lack of sufficient exercise (the all too pervasive couch potato syndrome), poor role modeling by parents and other adult role models, and ineffective health education curricula in our schools has added up to a situation with grave consequences for the current and future health of our country. Despite obesity being at epidemic levels and the cost of health care for the associated chronic diseases, there is not a nationwide or statewide or even countywide effort to confront this problem.

"It won't be easy but we have to take obesity on with a passion."

Why we haven't jumped forward on this in a reasoned, measured and comprehensive way is a complicated issue. The health issue is not due to an infection; just getting an antibiotic to the afflicted won't do. Likewise, there is no vaccine to prevent obesity from happening. Obesity involves behaviors, it entails attitudes, it requires public policy directly affected by large business interests.

It won't be easy but we have to take obesity on with a passion. Physicians need to be directly involved both in the office and, just as importantly, in the community. We can't solve this by health education alone. Powerful coalitions need to be put together with our school districts, with our churches, with local government and with broad citizen groups and private agencies. There is a clear unifying issue: the health of our community.

This is an opportunity for us as physicians to shine in our role as healers. Our communities have become sick and are in dire need of treatment. The crossover to political action is obvious. This isn't about money or malpractice issues. This can't be misconstrued as self-serving. We are venturing out on an issue of over-arching importance to the broad community (pun intended!).

I think that our credibility as leaders is at stake. It is important for the public to see doctors valiantly struggling with others to take on this important issue, stepping out to demand changes. We have to take initiative on this one: No one is going to hold our hands or publicly speak up mandating our involvement. Our engagement is expected and it is necessary. And everyone will notice if we don't step to the plate. Get involved! A countywide coalition is forming up to create a strategy to reverse the direction of the epidemic of obesity. Each of us should consider joining and support its efforts. ■

WSMA Launches Initiative Campaign to Force Action on Liability Reform

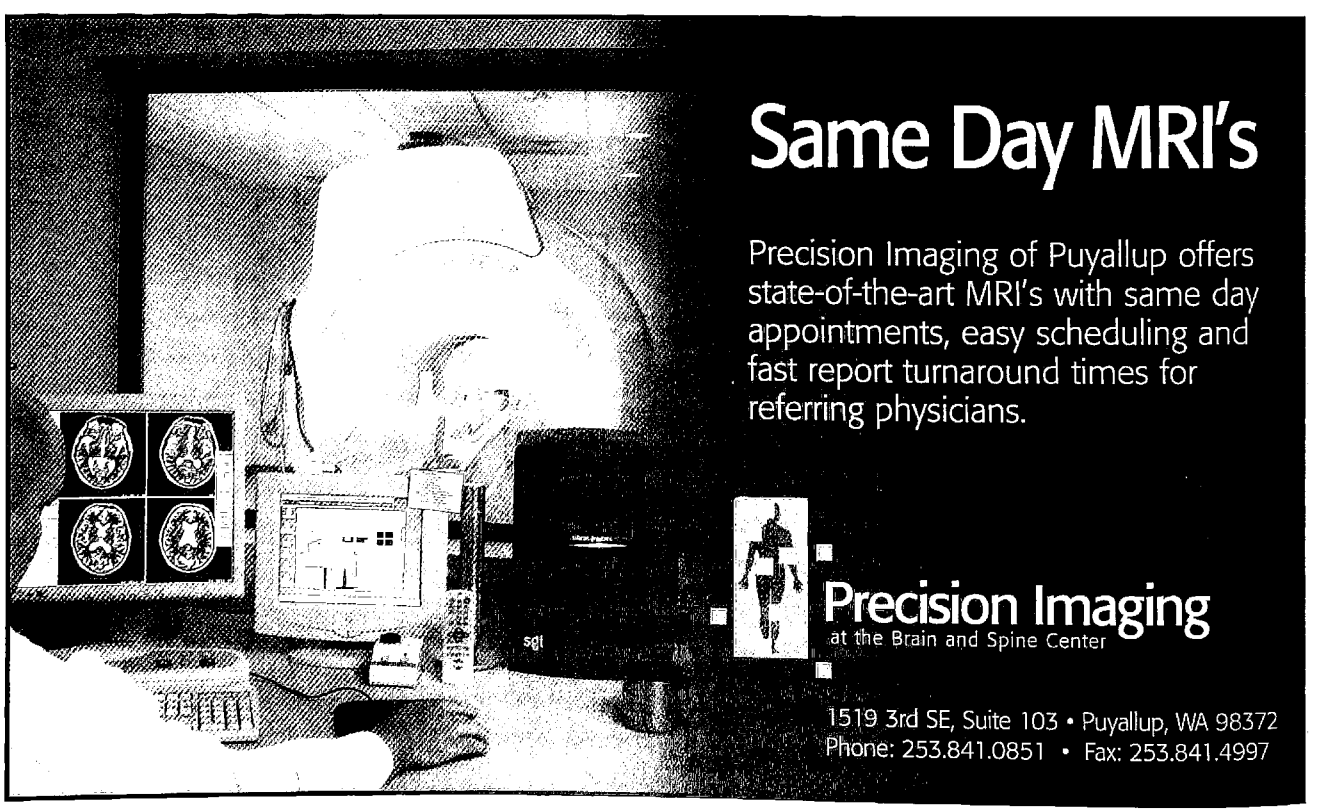
Frustrated by the lack of action on meaningful medical liability reform, the WSMA has launched an initiative campaign designed to break the gridlock in Olympia over sensible reform of medical liability laws. Doctors for Sensible Lawsuit Reform, a group representing more than 9,000 physicians in Washington State, will begin gathering the required 197,734 valid signatures to place Initiative 330 - The Health Care Access Initiative (I-330) before the legislature in 2005.

"For the past two legislative sessions, despite a demonstrated need for action, a few obstructionist politicians in the House have refused to take action on meaningful medical liability reform, preventing House members from even voting on the issue," said Dr. Jeff Collins, president of WSMA and practicing internist in Spokane. "This gridlock must end. We have no other choice than to compel the legislature to do its job so we can get back to doing our job - treating patients without the constant fear of a lawsuit."

I-330 restores fairness and balance to the liability system so doctors can continue to practice medicine and serve their patients and communities. If the legislature fails to act on the initiative during the legislative session beginning in January, I-330 will proceed to the general election ballot in the fall of 2005.

For several years physicians have been warning that excessive costs and an unfair legal system are threatening the ability of physicians to practice medicine - potentially leaving patients without access to needed care.

Doctors are limiting vital services such as obstetrics, mammography, trauma care and brain surgery because of the fear of being sued and the uncontrolled costs of the legal system. ■



In My Opinion

by Loren Finley, 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 last Ob/Gyn in Gig Harbor speaks out

Editor's Note: This op-ed piece, written by Loren Finley, MD was published in July in the Peninsula Gateway.

I am deeply concerned about the future of our medical care system. If changes are not made soon, people will have a difficult time finding a physician, especially in OB, orthopedics, neurosurgery, and general surgery.

The excess cost of business, especially malpractice premiums, are driving physicians out of Washington state. My fear is that it will take the death of a child, pregnant mother, or unborn baby, due to the unavailability of a physician before any prevention measures are implemented. This is not acceptable.

I am the last OB/GYN physician seeing patients in Gig Harbor. Three years ago there were four. Tacoma has seen a reduction from 25 to nine in three years. In the last 4 years 39% of family practitioners, and 19% of OB's have dropped obstetrics. We are experiencing three to six month waits for urology and dermatology referrals for insured patients. And, it is almost impossible to recruit new physicians to our area unless they have family ties or some compelling reason to live here.

We see the impending crisis and want to prevent it. Here are a few concerns/misconceptions I have heard discussed:

1. **"Malpractice premiums are not a significant part of a doctors overhead cost."** This is absolutely untrue. I personally have to make up this increased cost in volume (deliveries). To date, I am willing to do this, but many of my colleagues have been unwilling or unable to do so.

2. **"Insurance companies overcharge for premiums."** Liability insurance companies spend large amounts of money in pretrial as well as jury trial defense. In cases that go to trial, the jury finds for the defendant (physician) 8.5 of 10 times. My insurance company spends between $500,000 and $1 million to win a case; costs that are reflected in all the policy holders' premiums. The number of claims has not increased in years, but the award settlements (payouts) have significantly increased in the last three to four years, causing skyrocketing rate increases. Less than 5% of my insurance company's reserves are held in anything other than secure, principal protected financial entities, as required by the State Insurance Commissioner.

3. **"Caps on non-economic damages don't work," and "Caps are unfair to people."** Bunk! Physicians believe that in all cases of proven negligence, all medical care be provided and all economic damages be compensated, along with a reasonable 'pain and suffering' award. Society needs to determine a maximum level for non-economic damages (often called pain and suffering) that is "fair," as everyone pays for runaway jury awards. I was shocked when Rep. Patricia Lantz used the example of the Strep infection patient (in the January, 2004 *Gateway* editorial) and implied that this person would be limited to the cap amount. That is outright ridiculous and misleading. What Rep. Lantz failed to report is that all this patient's medical care, prosthesis care, car expenses, future earnings, and so on (defined as economic damages) would be compensated without limit. This was not the implication made by Rep. Lantz as she stated that the cap amount would be the total amount of the patient's compensation. This is an example of the outright misrepresentation that personal injury lawyers use to muddy the water. It has been proven in numerous studies that caps on non-economic damages do work to stabilize premiums. My insurance company, Physicians Insurance, has clearly stated they would reduce premiums a minimum of 10% if and when the legislature passes a $250,000 cap on non-economic damages that is enforced by the courts. They agreed to this because the true data clearly shows that caps do stabilize premiums.

We have a legal system that attempts to right the wrongs that occur in life. This is very important and physicians truly want patients to have their day in court. But how many dollars are enough for pain and suffering? How can Society afford to pay these exorbitant awards? How does Society

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Applicants for Membership cont. from page 10

Chad B. Krilich, MD
Family Practice
Spanaway Medical Clinic (CHC)
134 - 188th Street S, Spanaway
253-847-2304
Med School: Tufts University
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Theodore K. Lau, MD
Cardiovascular Medicine
Cardiac Health Specialists
1802 S Yakima #307, Tacoma
253-627-1244
Med School: McGill University
Internship: University of Texas HSC
Residency: University of Texas HSC
Fellowship: Baylor College of Medicine

Kevin F. Murray, MD
Family Practice
Tacoma Family Medicine
521 Martin L King Jr Way, Tacoma
253-403-2900
Med School: University of Washington
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Eric O. Rasmussen, MD
Dermatology
Peninsula Dermatology & Laser Clinic
4700 Pt. Fosdick Dr NW, Gig Harbor
253-851-7733
Med School: UC - Davis
Internship: University of Colorado
Residency: Oregon Health Sciences Univ
Fellowship: Oregon Health Sciences Univ

David M. Shaw, MD
Pulmonary & Critical Care Medicine
Pulmonary Consultants
316 Martin L King Jr Way #401, Tacoma
253-572-5140
Med School: Yale University
Internship: UC - San Diego
Residency: UC - San Diego
Fellowship: UC - San Diego

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In My Opinion

by John Stutterheim, MD

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

Dr. Hekking

Dr. Han Hekking, while working on the infamous Burma-Thai Railroad, saved many American POW's lives of the Lost Batalion and the Cruiser USS Houston during WWII. He was honored by Congress in 1983

The lost battalion was the National Guard 131st Field artillery unit from Texas under Colonel Eubank, sent originally to the Philippines, but diverted to the island of Java, in the former Dutch East Indies. They surrendered with the Dutch troops on March 8, 1942. The Cruiser USS Houston survived the battle of the Java Sea but was torpedoed by the Japanese in the Strait of Sunda, where many sailors swam ashore in Bantam, Java. The Japanese moved American, Dutch, British and Indonesian coolies to work on the planned Burma railroad, to connect Siam with Burma. This railroad was built through the mountains in record time at the cost of so many lives.

Dr. Hekking was a Dutch physician in the colonial army and ended up on this RR track to take care of the Americans of the lost Battalion and USS Houston.

He was born in Surabaja, Java in 1903 and spent many years with his grandmother in the mountains where he was exposed to her herb treatments of the natives. He learned to collect herbs in the forests. He studied in Leiden, Netherlands and in 1929 as an MD in the armed forces was sent to Celebes, Kolonodale, an outpost with few resources. He grew vegetables and herbs in the back yard of the hospital. He loved nature and became acquainted with many tropical plants and came to appreciate their importance for the sick people.

In 1938, he spent time to study medicine in Bergamo, Italy where the population was so poor and he saw pellagra, a deficiency disease, an ailment rampant on the death railway.

Dr. Hekking's actions and heroic spirits saved many American lives, only 13 died out of 90. He conflicted in his treatments with the two British doctors, fresh from Europe, who amputated severely ulcerated legs in a hurry, and used hot poultices, making the bacterium grow faster. None of Hekking's people underwent amputation due to his treatments. He collected herbs and fat and used even arsenic to combat dengue fever. A sharpened teaspoon was used to dig out ulcerated tissues, very painful indeed while somebody was holding down the leg. Maggots were instilled to eat the dead tissue. Caused by a virus, a tropical ulcer never crusts over in contrast with bacterial infections. He filled the scraped out ulcer with a mixture of purple tannic powder and fat, covered by a ranunculoides leaf. Tropical leaf tea was given to bring temperatures down. Ground up charcoal was the remedy for diarrhea, the most common ailment. Dr. Hekking himself became ill, unconscious for seven days. They all walked in G-strings, barefooted through the muck, mixed with excrements of sick patients.

The ex-POW's of Texas, during their 39th reunion, invited the 80-year-old Dr. Hekking to come to Texas. He had an overwhelming welcome at the Dallas/Fort Worth airport. Many parties were given in his honor and attended by U.S. Senator John Tower.

The newspapers wrote his story and the culmination of his visit was his introduction to the U.S. Senate on Friday, November 18, 1983.

It started as follows: "Mr. Towers and Mr. President, I would like to take this opportunity to pay tribute to a hero of World War II." Many former crew members came forward to state that they owed their lives to him. He was described as a physician and psychologist, to somehow treat the mind, spirit and soul of those prisoners of war who had little or no reason to be confident about the future.

Dr. Hekking died at the age of 90 in the same hospital room where his wife Mae was being treated for a stroke.

He was forgotten by the Dutch government, but not by his fellow Americans.■

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decide? Should it be a legislative body and the people, or a jury?

Representative Lantz chaired the House Judiciary Committee where crucial tort reform bills died the last two years. As chair, she had the power to bring the bill forward for discussion, but she never allowed it out of committee. Would it have passed? With current party politics I don't know. Perhaps a robust discussion could have uncovered some creative solutions. If the Chair doesn't agree to look at data, what can you do? Representatives in the House are up for reelection every two years. They need to know how you feel about the issues, and how you will vote at their next election. If we do not like the actions of our legislative representation, our power is in our right to vote.

It is my opinion that we need to develop new systems of medical accountability, censure the rare bad doctor more effectively, and allow for patients that are harmed to be rapidly and fairly compensated. We need a cap on non-economic damages that society determines is fair. We need legislators who will look at the issues, determine the truth, and make changes that will stabilize and improve our medical care system in a complete reform package. We need to replace legislators that won't look at true information. The sad part about our current situation is that we will all be losers. Once our health care system is gone, we will not get it back easily. ■

COLLEGE OF MEDICAL EDUCATION

Whistler CME set January 26-31

Plans are set for CME at Whistler scheduled for next January 26-31, 2005. A program brochure was mailed in early September.

Those interested in attending should secure their condos soon. The College has arranged for accommodations primarily at the Aspens Condos at the same rates as 2004. Reservations for the condos can be made by calling *Aspens on Blackcomb*, toll free at 1-866-788-5588. You must identify yourself as part of the COME group. You are encouraged to make your reservations soon to ensure space - at least by December 1, 2004 when any remaining condos in the block will be released. ■

Plan for ID CME on 11/12

The very popular and annual *Infectious Diseases Update* CME is set for November 12, 2005.

The program this year will be directed by **Larry Schwartz, MD** and the program has moved to the Fircrest Golf Club. A program brochure should be available in early October. ■

Continuing Medical Education

Common Office Problems CME features timely primary care topics

Registration is set for the College's *Common Office Problems* CME scheduled for Friday, October 29, 2004. The conference will be held at St. Joseph Medical Center, Rooms 1A & B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

This year's course will offer:

- A Primary Care Dermatology Review and Update
- Osteoporosis: What's New in Primary Care Diagnosis and Management
- *Initial* Insulin Therapy: Choices for Primary Care
- Treatment Options for COPD: An Update
- An Update on Depression
- An Update on Pediatric Cardiology

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137. ■

Dates	Program	Director(s)
Friday, October 29	Common Office Problems	Mark Craddock, MD
Friday, November 12	Infectious Diseases Update	Larry Schwartz, MD
Tuesday (evenings) January 11 & 18	Cardiology for Primary Care	Gregg Ostergren, DO
January 26-31	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 4 or Saturday, February 5	Gastroenterology for Primary Care	Ralph Katsman, MD
Thursday-Friday March 31- April 1	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

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medicine.

Retire, work for an insurance company or in other administrative position, in a community or public health clinic, as a financial analyst of medical and pharmaceutical companies, anything, but get out of practicing medicine. When the changes occur and you want to go back, do so.

Fine, but there are other options. For gynecologists and family physicians, it is to stop doing obstetrics. Many have already done that. The coming rises in premiums will force many others to follow.

What about the other specialties? What would happen if all internists, family physicians and pediatricians stopped doing hospital work? Restrict your practice to the office, take care of minor problems and send the really sick patients to the hospitalists. Your work may become boring after a while, but the legal risk will be much lower.

What would happen if the surgeons stopped doing the procedures with the highest risk of liability? Refer the patients to the university. Let them handle the complications. If you had a bad outcome, the lawyers will claim you were incompetent. Why not say up front that you are not qualified to handle the problems and send the patients out?

A radiologist told me that GE Medical Protective stopped writing policies for radiologists and pathologists in his state. He wanted to retaliate by not buying GE equipment, but there is a better way.

You probably figured out that the reason for that step must be the risk of delayed diagnosis of cancer and specifically, breast cancer. Mammography is developing as a subspecialty of radiology. I vaguely remember that Congress encouraged such a move.

What would happen if all the general radiologists declared that they are not competent to read mammograms and sent every film to a specialist for interpretation, at the university, the CDC, the National Cancer Institute, in India, or wherever?

What would happen if all the general pathologists sent their tumor slides to the university or to the AFIP for confirmation of the diagnosis before they recommended treatment?

Do you think that such actions might, just might, turn the heat on high enough to get us liability reform? Well, it is something for you to think about and for me to dream about. ■

Classified Advertising

POSITIONS AVAILABLE

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

Tacoma, WA - Three provider group (1 MD, 2 NPs) seeks a part-time B/C or B/E family practice or internal medicine physician who has a special interest in geriatrics and providing nursing home care. Practice is adult primary care with large Medicare component. Enjoy the uniqueness of the Northwest lifestyle with the back up and support of a full service integrated healthcare delivery system. Competitive benefits and salary make this a choice opportunity that won't last long. The right candidate will enjoy an excellent call schedule, compensation and benefits. Candidates must have completed a three-year accredited US residency program. Please email your CV to MultiCare Health System at providerservices@ multicare.org or fax your CV to 866-264-2818. Please mention opportunity #273. Website: www.multicare.org
"MultiCare is a drug-free work place"

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

University Place, Family Practice. We are in search of an MD or DO to join our team. Great support staff. Vacation and health benefits available. Our doctor called to active duty, immediate opening. Please fax us your CV to 253-566-4620.

Established Spanaway Family Practice looking for P/T to F/T Board Certified or Board Eligible family physician, pediatrician or ARNP/PA to join a practice. Work 4-5 days a week with a great support staff. Base salary plus incentive. Fax your CV to 253-536-3070.

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals, ownership options. Call 253-272-2224.

Office space for lease in medical complex, Gig Harbor. 2354 sq ft, main level. 468-3539 or 565-2444.

New office building for sale or lease. 3000 leased, 3600 for lease. Large parking lot. Fircrest. 564-8784

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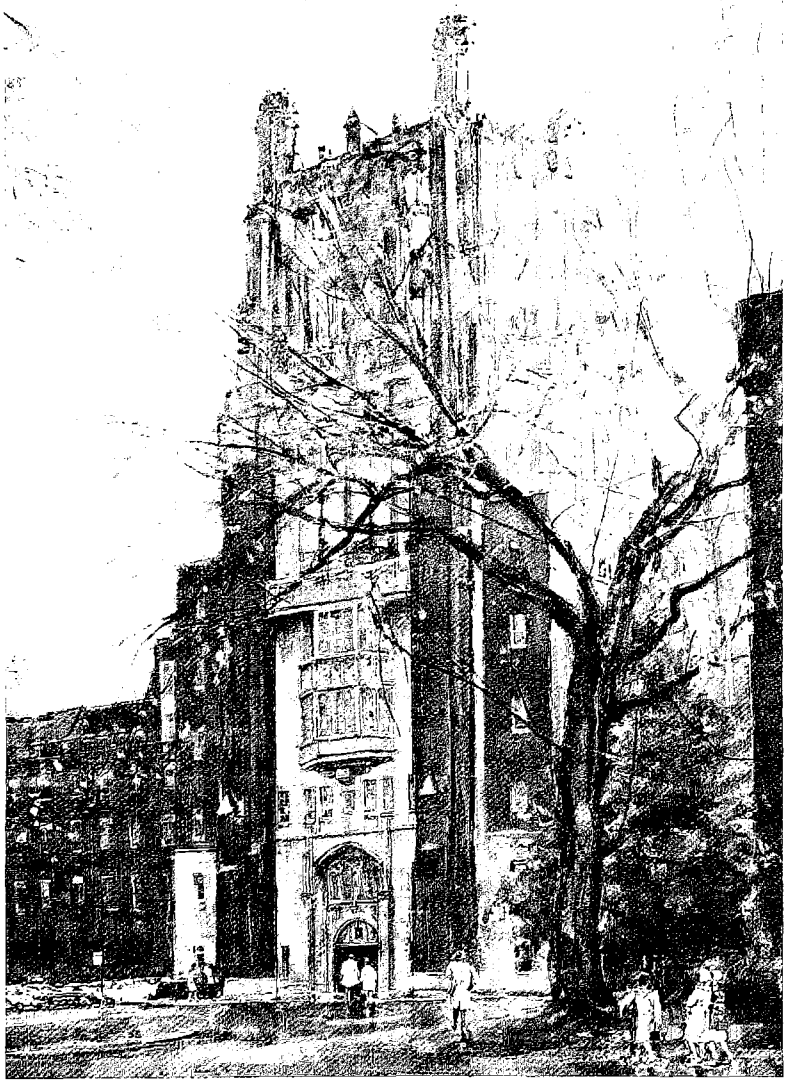
BULLETIN

October, 2004



The University of Iowa College of Medicine

INSIDE:

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Pierce County Medical Society
BULLETIN

October, 2004

Table of Contents

Correction:

In last month's issue of the *Bulletin* an error occurred in Dr. Stutterheim's article "Dr. Hekking." The first sentence of the fifth paragraph should have read "...only 13 died out of 190." PCMS apologizes for this error.

President's Page

by Michael J. Kelly, MD

The True Cause of Escalating Liability Premiums

Michael J. Kelly, MD

President's Note: The article which follows may be redundant for those of you who are avid readers of the The News Tribune. It was submitted on September 20 and should have already appeared on the editorial pages as an Op/Ed. I would hope so. However, I fear not - which is the reason we decided to publish it in our Bulletin.

I would like to address the confusion surrounding medical liability insurance premiums. I am a board certified Family Physician actively practicing in Pierce County. A patient, aware of the crisis of affordability of medical liability insurance, recently asked me why our premiums were so high and wanted to know what we physicians were doing about it. His comments reflected an understanding that such skyrocketing costs were leading to a well-recognized crisis in access to medical care. What is not well-recognized is the cause of our liability premium problem, the subject of my comments.

Such premium increases have affected most every physician in Washington State, including Drs. Robert Pringle and **John Lenihan**. Both are well respected Obstetrician/Gynecologists. Dr. Pringle, Mount Vernon physician, stopped delivering babies this year because his liability insurance rose to $79,000, nearly twice what it was two years ago. Dr. Lenihan, Tacoma physician, also stopped delivering babies last January as his insurance bill ballooned to $74,000. He had wanted to continue delivering babies for another eight years. His insurance premium dropped to $28,000 as he limited his practice to gynecology.

Their insurance woes are now medical access problems for their patients. This is not, however, an isolated situation. Since the year 2000, 14% of Obstetrician/Gynecologists (37 out of 264) and 39% of Family Physicians (150 out of 386) have stopped delivering babies in Washington State.

"...the public's attitude toward the insurance industry is being manipulated by special interests that have a need to transfer this distrust to the companies who insure physicians for medical malpractice. They want you to believe the worst about these companies and direct your anger and frustration toward them."

Drs. Pringle and Lenihan are representative canaries in the medical mine shaft, two examples among hundreds of Washington physicians from all specialties that are restricting, retiring or relocating their practices as a direct result of the extreme cost of medical liability insurance. This is a concern for everyone because such alterations in physician practices directly affect your access and that of your family to medical care.

Most of us have a love-hate relationship with insurance. We resent the cost but recognize the responsibility to purchase coverage, fighting the persistent, uneasy feeling we are being overcharged and underserved. After all, these are big, unresponsive, powerful companies. We all have little love or patience with the insurance industry.

However, the public's attitude toward the insurance industry is being manipulated by special interests that have a need to transfer this distrust to the companies who insure physicians for medical malpractice. They want you to believe the worst about these companies and direct your anger and frustration toward them. This calculated obfuscation clouds the legitimate underlying cause of escalating liability insurance premiums - the cost of insurance company defense, settlement and jury awards.

There are personal injury attorneys who claim that "all" of the non-partisan studies on this issue trace the rising premiums charged by medical liability carriers to their incompetent management, careless stock market investments "compounded by their greed."

See "Liability" page 4

Liability from page 3

This is a serious charge worth further investigation utilizing "non-partisan" sources.

A study published by Americans for Insurance Reform, October 2002, seems to back up the trial bar, stating, "Insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses." The report contends the medical liability companies suffered huge losses in the stock market following the dot-com crash and post 9-11, not losses due to liability claims.

However, on the other hand, Brown Brothers Harriman and Company, the oldest and largest privately owned bank in the US, a well-respected company specializing in insurance asset management, finds the AIR arguments both "...misleading and inaccurate." In January 2003, BBH published a study entitled, "Did Investments Affect Medical Malpractice Premiums?" which analyzed the impact of insurers' asset allocation and investment income on the premiums they charge.

BBH stated that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.

Continuing this assertion, according to AM Best's Aggregates and Averages, Property-Casualty, 2002 edition, the investment yields of medical malpractice insurers have been stable and positive since 1997 because most of their investments are not in the stock market. Those returns have averaged from 5.0 – 5.5%, and include income from interest, dividends, and real estate income.

Physicians Insurance, a medical liability company that covers more than 67% of the doctors in Washington State, invests over 85% of its assets in fixed-income instruments such as treasury, municipal, and corporate bonds and less than 5% in the stock market. Their return on invested assets is almost exclusively influenced by bond market performance, not stock market performance. The personal injury attorneys, on the other hand, want you to believe that medical liability company losses, such as Physicians Insurance, occurred in the stock market, not the courtroom. They consistently and shrewdly misrepresent this subtle, but very important difference.

BBH concluded that, "Investments did not precipitate the current (medical liability) crisis." Instead, this crisis of the affordability of liability insurance is the direct result of the cost of insurance company claims losses.

The trial bar further claim "big" insurance companies are "greedy" profiteers whose purpose is to gouge us unsuspecting physicians. This contention is laughingly incorrect considering Washington doctors own Physicians Insurance, which writes only one type of insurance, medical liability. In fact, over 60% of the medical liability companies in the U.S. are doctor-owned and stick to a limited menu of insurance options.

To place Physicians Insurance in the same category of other "big" insurance companies is quite a stretch, but once again serves the purpose of the trial bar to harness the latent hostility many of us have toward these unfeeling and dictatorial monoliths and direct it toward the medical malpractice companies. Moreover, as for the alleged greed of Physicians Insurance - for us doctor-owners to overcharge ourselves, makes no sense at all.

Another safeguard for medical liability company investments is oversight. There are significant constraints on the investment and business activities of these liability carriers, which preclude the type of stock market investment, claimed to have caused the cash flow problems for the insurance companies. The Office of Insurance Commissioner of Washington strictly regulates and monitors the solvency of medical liability companies such as Physicians Insurance. In addition, there are strict limits on the type and risk of investments insurers can purchase and extensive requirements regarding public accountability.

To maintain solvency, Physicians Insurance and similar companies must set rates based upon their best clairvoyance regarding future liability costs during the upcoming year, factoring in costs of defense, settlement and jury verdicts. Those of us who pay monthly insurance premiums realize the true cause of liability rate increases and continue to support Physicians Insurance, our company.

The trial bar, a select group of professionals with a glaring conflict of interest in the realm of medical malpractice, wants to maintain the present liability system that so richly rewards them. As you have seen, however, the medical liability companies are not the bad guys, as these special interests want you to believe.

Recognizing that claim severity and costs of defense and settlement are the problem leads us to potential solutions. Many expert non-partisan groups, such as the Joint Economic Commission of Congress, the General Accounting Office, the Congressional Budget Office, and the Agency for Healthcare Research and Quality, agree that meaningful reform of the present liability system including a cap on non-economic damages stabilizes the rampant rise in liability premiums leading to improved access to medical care. Such reform, strongly backed by physicians of all political persuasions, creates no limits, whatsoever, on recovery of economic damages. Doctors support this approach to reform because we know it will lead to the predictability that the insurance industry has long sought.

Meaningful liability reform in Washington State will prevent future loss of physician talent the caliber of Drs. Lenihan and Pringle, just as it has in other progressive states. Ask your doctor about this vital issue. Discuss tort reform with the legislative candidates from your district. Their future decisions in Olympia will determine whether medical care in Washington State improves or declines. ■

September General Membership Meeting Recap

Electronics highlighted at September Meeting

The September Membership Meeting focused on electronics – for medical records in the physician's office as well as connectivity for all providers in our health care community.

Over 100 people attended to hear **Dr. Matthew White** give an update on the PCMS Connectivity Committee that has worked on this issue for the past two years. The committee recently recommended to the Board of Trustees that they support the NPN collaboration with Siemens/Reach My Doctor Community Healthcare Network product. Siemens provided a review of how the project can work in a community that has myriad EMR systems in place without causing interruption. The project is now under development and will be revealed in a later issue of the *Bulletin*.

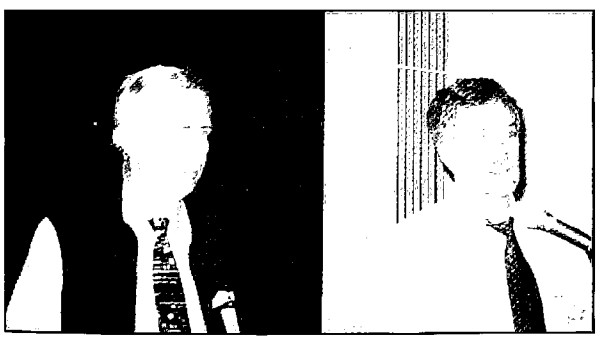
Matt White, MD

Dr. White gave a presentation on the how's and why's of electronic medical records and was supported by colleagues **Drs. Steve Egge** of Summit View Clinic/Puyallup and **Joe Regimbal** of Internal Medicine Northwest/Tacoma giving their personal testimonials. They concurred that operating efficiently, decreasing expenses, improving access to information and enhancing regulatory and liability concerns were all benefits of an electronic system.

Vendor sponsors for the evening included A4 Health Systems, Chart Logic, Physician Mircro System and Siemens Medical Solutions. While Siemens is not a provider of electronic medical records, they participated as a vendor because of their collaboration on the community network association with NPN.

Other agenda items included three members being nominated to the Nominating Committee. They were **Drs. Gary Tart, David Law** and **Nick Rajacich**. New member **Dr. Keith Dahlhauser** was introduced.

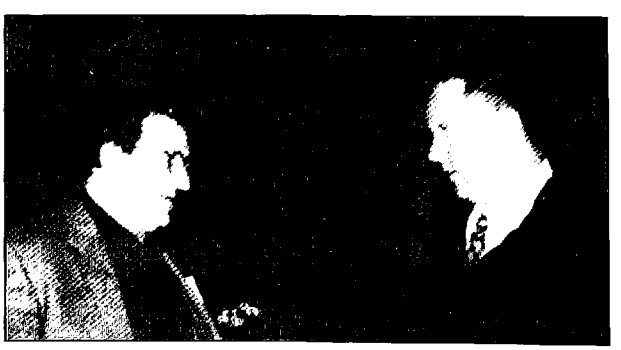
Dr. Mike Kelly also reported on the WSMA Initiative 330 for medical liability reform encouraging everyone to take petitions, posters and patient handouts for their offices. Over 200,000 signatures must be secured to present to the legislature by the end of this year. ■



Drs. Joe Regimbal (left) and Steve Egge reported personal experiences with the use of EMRs

Drs. Nick Rajacich (left) and Andy Loomis visit after the meeting

Family practitioners Haven Silver (left) and Bill Roes compare notes after the meeting



Puyallup physicians Dr. Ken Feucht (left) and Robert Marsh chat during the social hour

Seattle-to-Portland Update

In the September 2004 issue of the *Bulletin*, the Medical Society congratulated members who completed the 25th Annual Seattle-to-Portland (STP) Bicycle Classic Ride, which took place July 17-18 and took riders from Snoqualmie to Skykomish. We inadvertently failed to include **Maureen Mooney, MD**.

Our apologies to Dr. Mooney and congratulations! ■

PCMS Has New Email Address

PCMS has changed their email address to **pcms@pcmswa.org**. Please make a note in your directory. ■

I330 Petitions Available

PCMS has ample supplies of petitions, posters, patient handouts and other I330 campaign materials. Please call the PCMS office, 572-3667, if you need additional materials or if you have completed petitions to pick up. We deliver! ■

Mark Your Calendar for Annual Meeting

Please save the date of Tuesday, December 14 for the PCMS Annual Meeting. The speaker this year will be David Thomas who will present his entertaining and enlightening presentation about "Living Right Side Up in an Upside Down World." This talk about "integrity" is one you won't want to miss. ■

Applicants for Membership

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Residency: University of Illinois

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Internship: In His Image Residency
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15610 89th St Ct KPN, Lakebay
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Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Be A Leader

Federico Cruz, MD

This is a complex time for the medical profession. Our workloads are staggering. The satisfaction of practicing good medicine faces intrusions on all sides. The altered patient-physician relationship, the litigious nature of modern society and the fiscal pressures of "managed care" all make for a shaky and often unpleasant mix.

All of this means more and more pressure is placed on the physicians' shoulders: To be caring, to be efficient, to be precise, to be knowledgeable, to be technically expert, to be communicative. The list is actually longer and an impossible one to meet. I have bad news for you. There is another addition to the list that we cannot ignore, but one that if we master it can take off much of the pressure from the other expectations. It is a straightforward one and a difficult one: To be leaders!

Many issues face our communities that need physician involvement. Unfortunately as our practices get more and more demanding, our actual engagement with community-level activities gets more and more tenuous. This has happened gradually over many years. Previously, any renewal effort, community development campaign, any school board or school policy effort always had prominent physician engagement. The public expected it. Physicians, held in high esteem, often acted as brokers between the different factions or special interest groups that spring up in any community. And, the physician was looked to in her/his role as the keeper of the health agenda. Creating a more healthy community was seen as the physician's purview, and people were both comfortable with that perspective and also actually expected it.

I am saddened by what has been lost. Physicians are no longer engaged the same way. And it's not just that a truly important perspective is not being heard but that we are set up for failure by people who think we can solve community-level issues one-by-one in our offices. Many of the health problems that patients bring into our offices find their roots in culture-based behaviors that require new social norms. A physician can't realistically expect to change much in those behaviors, yet the patient still brings those problems to us.

"This is an open window for docs to show their knowledge, their commitment, their compassion and selflessness."

Where do we go with this? What is to be done?

Let's look at a specific situation as an example needing a solution. In a previous article for the PCMS *Bulletin* I talked about the obesity epidemic that our community struggles with. The glaring truth is that clinical interactions in physicians' offices will not resolve the obesity crisis. Too many obesity foundations lie within society at large and therefore need community-based strategies to make any change. But the expectations are still there for physicians to be involved. The easy response for this public expectation is to continue to talk to our patients about obesity and engage them clinically as we treat the symptoms - one person at a time. That is one approach, but one that squanders a huge opportunity to cement the important role physicians play in the health of their communities.

Let me be blunt: We have to step out of the box, away from the securities of our practices. We've got to engage with community efforts, using our personal time in churches and school systems, school boards and United Way campaigns, wellness programs in private and public agencies and so forth.

The physician brings wonderful skills to these processes and ones that are desperately needed. This is an open window for docs to show their knowledge, their commitment, their compassion and selflessness. These are very public processes. You will be seen for what you put in on the table. If it is energy and enthusiasm, if it is just hard work and the ability to merge different ideas together, you will be amazed at

See "Leader" page 12

New report a "primer" on shaping up health care

The Washington Alliance for a Competitive Economy recently released a health care report on shaping up health care in our state and the nation.

The eleven page report pieces together the various data and perspectives on health care costs and conditions in order to understand their effects on employers and on the business climate in which they must compete. They did find changing national policies and trends in health care that provide some optimism for the future. But, they note that Washington State has significant work to do if it hopes to benefit from the national trends and reforms and to be competitively positioned for continued economic recovery.

The third-party payer system, coupled with the complications of subsidies on which the system depends, causes much of the confusion in paying for health care. While private sector trends depict a problem, the public sector is a system out of control, they report.

• 71% of Washington's major employers require workers to contribute to their health insurance premiums compared to 88% in the West and 83% nationally

• Employers who require an employee contribution average $40 monthly compared to $73 in the West and $78 nationally

• 64% of Washington's large employers offer "alternative medicine coverage" compared with 50% in the West and only 27% nationally

Many analysts believe that the most important factors driving health care costs are government health insurance mandates, litigation costs, hospital costs and prescription drugs and drug importation – all factors in which state public policy has a role to play.

Washington State's mandates drive up our costs significantly. Washington is the only state in the country that requires coverage of neurdevelopment therapy and one of only two states requiring port-wine stain elimination and coverage of denturists. Coverage for prescription drugs and chiropodists are covered by only three states, Washington being one, and coverage for massage therapists and naturopaths are provided by four states, one being Washington. These mandates drive up costs of health care insurance by as much as 45% in some markets and increase the percentage of people who go without insurance coverage due to cost, the report claims.

The report gives the following conclusions and recommendations:

Asked if there is a particular villain responsible for the current state of health care, economist Michael E. Porter says no one "entity has made the fatal decisions that have caused the system to be the way it is. Indeed, there was a set of incentives created partly by government regulation and partly by history. They have led each actor in the system to behave in ways that were rational for them but were not aligned with improving health care value...The system is not designed to reward to most efficient providers...people have tried all the simple things, and they haven't worked. I think most people are now stepping back and saying, "...we've got to rethink this whole system." (Holstein 2004)

In a new book on health care, former Colorado governor Richard Lamm strikes a more alarming note, "American expectations for health care over the last thirty years have been developed during the most massive transfer of wealth into one sector (health care) that history has never seen. Health care is a fiscal black hole into which we can pour all of our children's future." (Lamm 2004)

Health care reform is necessary. There are basically two directions to go from our current situation: Universal care or consumer-driven care. The evidence is compelling that consumer-driven care holds the most promise for success. Informed patients, in consultation with their doctors, have the best potential for deciding how best to spend their health care dollars, sorting through the options available and selecting those most effective

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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.*

No Safe Haven

Andrew Statson, MD

"And I have asked to be
Where no storms come,
Where the green swell is in the heavens dumb,
And out of the swing of the sea."
Gerald Hopkins

While the malpractice whirlwind sweeps most of the country, a few states enjoy a relative calm. Relative is the key word.

Indiana was the first state to enact a medical tort law in 1975. It established a patient compensation fund. All physicians pay to the fund with a surcharge on their liability premiums. I think that the amount of the surcharge varies according to specialty.

The compensation for pain and suffering is limited to $250,000 and the total recovery in medical cases was $750,000 for acts that occurred prior to 7-1-99, raised to $1,250,000 thereafter. Any amount awarded in excess of these limits is paid from the patient fund. Contingency fees for the amount paid by the patient fund are limited to 15%.

The patient fund must have already been in trouble when the legislature passed that increase. Perhaps that was the reason for the change. The reserves of the fund were 118 million dollars in 1999. They dropped to 4.3 million in 2003.

The average premiums increased 72.6% in 2004. Neurosurgeons and obstetricians saw the biggest rises. The premiums for obstetricians went from $26,000 in 2003 to $49,000 in 2004, an 89% increase. Other practice costs also rose, but reimbursements did not keep up and the physicians are feeling the squeeze.

Colorado limits the total award for damages in medical cases to one million, of which $250,000 (increased to $300,000 in 2003) can be for noneconomic damages. I am not clear whether the one million limitation also applies to future costs of medical care. Colorado, like California, allows binding arbitration contracts.

The California law is well known. It has a cap of $250,000 for noneconomic damages. The trial lawyers have repeatedly attacked the cap, hoping to raise it, but so far they have not been successful. Contingency fees are limited to 15% on any amount above $600,000. Thus an award of one million allows a $222,000 fee. That in itself may be a damper on the number of suits. The Texas experience after enacting the cap seems to confirm that.

New Mexico limits total damages in medical liability cases to $600,000, except for the costs of future medical care and related expenses. Louisiana does the same, but has a $500,000 limit.

Wisconsin, like Indiana, has a patient compensation fund. It covers damages above the basic coverage of one million dollars. Physicians pay into the fund. The rates vary according to specialty. The cap on noneconomic damages was set at $350,000, indexed for inflation. It was $422,632 in 2003. Contingency fees on the amount paid by the fund are limited to 20%.

Last year the patient fund had $600,000,000 in assets. In June of 2003, the legislature attempted to tap the fund for $200,000,000 to help balance the state budget. Fortunately that move was defeated. The fund in fact had an actuarial deficit of $200,000,000, because it had to allocate $800,000,000 for future claim payments. Some recent awards have exceeded several million dollars.

Why are these states less affected by the liability crisis? Caps seem to help, but they are not enough. Nevada enacted a $350,000 cap on 10-1-02, but that did not work. Insurance premiums continued to rise. More insurance companies dropped their medical liability line. The number of new physicians is not growing as it did in the 1990's.

Since the law became effective in Nevada, more physicians have been named in suits than previously. The cap created a perverse incentive to sue, because the limit is per plaintiff and per defendant. The more plaintiffs join the suit and the more defendants are named, the higher the award can be.

The limit on the contingency fees is probably more effective. Attorneys tend to avoid handling claims unless they can hope to get more than what trying a case would cost them. That cost now runs at $300,000-500,000 or more. A preliminary report from Texas confirmed the impres-

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sion that the number of potential low return cases has decreased. Lawyers have refused to handle cases where the only claim for damage could be pain and suffering.

Even though the above states are better off than the rest of the country, the effect of their liability laws is steadily eroding. In another five years they may well be where we are now. The average malpractice premiums remained relatively steady through most of the 1990's, but between 2000 and 2002 they increased by close to 40% in states without caps and 50% in states with caps.

As long as payments for medical services remain frozen, the squeeze on physician incomes will continue. I am afraid the solution can only be a completely different approach to physician payments and a completely different system for patient compensation in case of negligence.■

In My Opinion

by David Aoyama, 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.*

Tangled Webs and Truth

David Aoyama, MD, Internal Medicine, Seattle, was insured with Physicians Insurance during the course of the lawsuit described below. He wrote the following article to explain his experience, educate his colleagues, and comply with a court mandate.

It had been a day not unlike any other workday. It was 6:30 p.m. and I was attacking the ever-growing pile of mail on my desk - the usual amalgamation of journals, verbal orders, DME orders, VNS certifications and correspondence from consultants. Working through the pile at a steady pace, I thought that there was a glimmer of hope that I could be home by 7:30 p.m.

Suddenly, dealing with the mail stopped, time stopped, my world stopped. There, buried in the stack of mail was my landmine for the day - a request for a patient's medical record by a malpractice plaintiff attorney.

I recalled the case. I had repeatedly advised the patient to have an endoscopic evaluation for an iron-deficiency anemia. After she had left my practice, one of her friends had told me that her new physician had discovered colon cancer. She had had curative surgery, but had been left with a colostomy. At that time, I remember wondering how her new physician had convinced her to have the endoscopy when I had been so unsuccessful. As I reviewed the chart, I found a copy of my letter of referral to the gastroenterologist but, incredibly, there was not a single notation in the chart documenting the referral or my repeated instructions to see the gastroenterologist. The gnawing sensation in the pit of my stomach grew as my panic escalated.

I am a solo practitioner. A lot has been written about solo practitioners' being a dying breed because declining reimbursement and rising overhead is leading to ever-increasing workloads. This all may be true, but our real Achilles heel is liability insurance. Without liability insurance, we are out of business.

I continued to page through the chart, but I couldn't focus on its contents. Fear rose as I came to the "obvious" conclusion that a malpractice action would most certainly lead to the cancellation of my liability insurance. After all, we all know physicians with spotless malpractice histories who were victims of nonrenewal based solely on their specialty. I would lose my practice. Seventy-hour weeks for 20 years, all for nothing. How would I support my family? The feeling was intense and overwhelming. It quickly mushroomed out of control. I decided to make the chart bulletproof.

A dishonest act, in many ways, is like sliding down a steep ice field without an ice axe. It starts with a small slip. First, you make additions to the chart. After all, you are simply documenting what really happened. You begin sliding down that icy slope. You withhold your dirty little secret from your own attorney. Faster and faster. You lie at the deposition about the additions to the record. You are now careening uncontrollably down that slope. More quickly than you can imagine, you reach a point where the only thing that will stop you is a large crevice or a huge rock. And it will. And it will have consequences.

You will lose an otherwise defensible case. The case will be referred to the National Practitioner Data Bank. You will be reported to the Washington State Medical Quality Assurance Commission. You will have to explain your actions to the credentialing committees of the hospitals at which you practice and to the insurance plans with which you participate. You will be humiliated and suffer the loss of your integrity and credibility before your colleagues, patients, friends, neighbors and family.

Oh, yes. Your malpractice insurance will not be renewed. The nonrenewal letter will mention concerns over alternations of the records as a reason. You may be able to get coverage through surplus liability carriers. Multiply your current premium by three. You may also be subject to a sanctions hearing to establish your punishment for making additions to the records and then lying about it. This hearing is separate from the malpractice action. Your malpractice carrier is under no obligation to pay for your defense at this hearing. I was lucky. My carrier paid for my defense. Any monetary sanction comes out of your pocket. I am applying for a loan.

A sanctions hearing is the modern-day equivalent of a public flogging. Expect television and newspaper coverage of the event. I took the witness stand and endured a well-deserved public humiliation. It seemed to last for an eternity. During the hearing, one of the plaintiff's attorneys quoted Sir Walter Scott: "Oh what a tangled web we weave, When first we practice to deceive."

At the end of the hearing the judge delivered a much deserved, scathing rebuke of my conduct. He next imposed monetary and nonmonetary sanctions, including writing this article to help educate physicians about the perils of my behavior. It was the worst day of my life. It was a painful, embarrassing, and humiliating experience, but I had survived the ordeal, or so I thought.

After the hearing I went to work. As I waded through the self-propagat-

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how responsive your community will be.

Let me tell you a secret. I started this article talking about leadership. That's what you will be displaying when you step up to the plate with these community efforts. Simple and old-fashioned leadership. When the tough issues are being faced, when there are no easy answers but a clear need to join hands across professions and socio-economic lines, there is where we should find ourselves, pushing, urging, designing, and building ways to improve the health of our communities.

I hope that as we move forward with our prevention campaigns to confront obesity here in Pierce County, you will stand shoulder to shoulder with me and other "leaders." There is no better place for you to be to show that part of being healers for your patients also means healing your communities. ■

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for their personal circumstances. Health care markets will respond, in turn, by offering more of what patients discern to have value and less of what they perceive to be unnecessary.

The main question remaining is what specific policies will achieve this outcome. Enactment of federal legislation allowing health savings accounts has taken us a long way in setting the stage for an appropriate consumer-driven response. And markets have already begun to anticipate and respond to the need for better consumer information systems.

The following recommendations address several important health care reforms that remain for state legislative action:

1. In order to encourage the full range of physicians and health practitioners and to discourage unnecessary price spikes for pharmaceuticals:
   - Adopt caps on non-economic damages.
   - Eliminate or restrict joint and several liability.
   - Establish a fair statute of limitations on liability.

2. In order to enhance access to fullest range of personal health insurance products:
   - Eliminate state mandates requiring insurers to cover various health providers, services, and patient populations.
   - If full elimination of mandates is not feasible, allow insurance companies to offer a more affordable plan for smaller employers.

3. Encourage development of HSA options within insurer portfolios. Include these options in plans offered by government employers and programs.

4. Review existing hospital rate setting, payment, and regulatory systems, in light of new and changing competitive environment that includes opportunities for cash-paying patients and boutique hospitals.

To obtain a copy of the full report, call PCMS 572-3667 and provide your fax number or mailing address. ■

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

Solutions for Family Caregivers, Older Adults, and Persons with Disabilities

There's only so much a physician and office staff can know. Meeting the myriad needs of family caregivers, older adults, and adults with disabilities can be a perplexing dilemma. Pierce County Aging and Long Term Care can be the best place to start.

Aging and Long Term Care invites physicians and office staff to attend a special orientation to the scope of services provided to the community through the Family Caregiver Support Program, Senior Information and Assistance, Pharmacy Connections, case management services, and a variety of associated resources. The presentation will include a review of services and programs, methods to access them, resources for staff, materials for physicians' offices, and models for implementation.

The 40-minute workshop will be held six times: Tuesday, October 12 at 7:00 a.m., 9:00 a.m., and 12:15 p.m. and Wednesday, October 13 at 7:00 a.m., 9:00 a.m., and 12:15 p.m. at the Pierce County Human Services building, 3580 Pacific Avenue in Tacoma. A continental breakfast or light lunch will be served. There is no cost for this presentation. Reservations are requested by calling Bob Riler at 253-798-7384.

In Pierce County it's more than likely that about one-quarter of a physicians' patients are family caregivers. Some are long-distance caregivers; some provide care in their own homes. They carry the practical responsibilities of providing housing, fixing meals, arranging transportation, and organizing care during work time. They also carry the emotional weight of seeing their loved one – spouse, parent, child, relative, or friend – struggle through what may be a difficult time.

Providing adequate support to caregivers, older adults, and persons with disabilities is one key to a healthy community. Aging and Long Term Care coordinates appropriate programs and services available in the community that best fit the needs of the individual in their particular situation.

Aging and Long Term Care, a service of Pierce County Human Services, is one of 13 Area Agencies on Aging in Washington State. It is our job to speak for the rights of elders and to plan and manage long term care programs that help older and disabled people to remain secure and independent. We are able to achieve our goals by coordinating long term care services with the Washington Department of Social and Health Services and other local agencies. ■

Save the Date

The Edwin C. Yoder Honor Lectures

Friday, November 19, 2004

This year, our Yoder presenter is James P. AuBuchon, MD, FCAP, FRCP who is the Chair of Pathology and Professor of Medicine at Dartmouth Medical School, Dartmouth-Hitchcock Medical Center. He has worked closely with clinicians to promote improved transfusion practices through the Transfusion Committee and implemented innovative approaches to reduce the two greatest risks of transfusion, bacterial contamination and mistransfusion. He served as a member of the Advisory Committee on Blood Safety and Availability of the US Department of Health and Human Services (1997-2000) and has frequently been called upon to testify before Congressional committees and federal advisory committees. He served the American Association of Blood Banks as chair of the Scientific Section Coordinating Committee (1998-2002) and a district director (2003 - present) on the Board of Directors. He chairs the Transfusion Medicine Resource Committee of the College of American Pathologists. He is the current chair of the Biomedical Excellence for Safer Transfusion Collaborative, an international research group dedicated to improving transfusion safety and efficacy.

This program is designed for physicians and is accredited for 2.0 Category 1 hours.

Location: St. Joseph Medical Center - Rooms AB&C

Schedule:

2:00	3:00 pm	Social Hour with hors d oeuvres and wine
3:00	4:00 pm	Transfusion Safety: Aligning Efforts with Risks James P. AuBuchon, MD
4:00	4:15 pm	Break
4:15	5:15 pm	Managing Change in Transfusion Medicine James P. AuBuchon, MD

Reservations required. Limited seating. Please call in your reservation no later than Thursday, November 11th to the FHS Office of Academic Affairs at (253) 426-6035

This is a Physician Only Event

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 Category 1 credits to satisfy the relicensure requirements of the Washington State Medical Quality Assurance Commission and toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Infections Limited, P.S. is pleased to announce the arrival of two new associates.

Marina Arbuck, MD graduated from Medical school in Yaroslavl, Russia. She completed Internal Medicine training at St. Vincent Hospital in Indianapolis, Indiana followed by an Infectious Diseases fellowship at Indiana University Medical Center. Attracted to the beauty and climate of the Pacific Northwest, Dr. Arbuck relocated here one year ago. She joined the physicians of Infections Limited in July of 2004. Her son Michael is an Indiana University graduate and is pursuing a Masters' degree in Biology at Medical College of Ohio.

Her other interests include classical music, opera, theater, hiking, gourmet cooking, and taking care of two Scottish terriers.

Dr. Arbuck's special interests in Infectious Diseases include bone infection, travel medicine and infections in immunosuppressed patients.

Ann Hyder, ARNP has been a Nurse Practitioner in the Tacoma area for the past 10 years. Prior to joining Infections Limited she supervised the HIV Clinic at Madigan Army Hospital for much of that time. While her husband was in the Air Force she traveled extensively, receiving her Bachelor of Science degree in Los Angeles and her Masters degree from Kings College London. After settling in Tacoma, she received her NP degree from Pacific Lutheran University.

Ms. Hyder has been in practice with Infections Limited since December of 2003 where she manages many of the clinic's HIV and Hepatitis C patients. She also sees other patients in consultation with the infectious diseases physicians.

When not working, Ann enjoys gourmet cooking, bead work and embroidery.

Dr. Arbuck and Ann Hyder are accepting referrals at our Tacoma office at 253-627-4123.

COLLEGE OF MEDICAL EDUCATION

It's Whistler time! January 26-31

Everyone interested in attending the CME at Whistler, British Columbia is encouraged to make plans now for travel and lodging. This popular event is scheduled for Wednesday through Saturday, January 26th to the 30th, 2005.

Reservations for the program's condos can be made by calling *Aspens on Blackcomb*, toll free at 1-866-788-5588. You must identify yourself as part of the COME group. You are encouraged to make your reservations soon to ensure space - at least by December 1, 2004 when any remaining condos in the block will be released.

All Pierce County Medical Society members have been mailed detailed information on the program and lodging, but feel free to call Les McCallum for more information at 253-627-7137.

The Whistler CME is a "resort" program. It combines family vacationing, world-class skiing, a resort atmosphere, and our usual high-quality continuing medical education.

This program features a potpourri of subjects of interest to all specialties. The course directors are **Dr. Richard Tobin** and **Dr. John Jiganti**, and the speaking lineup is better then ever. ■

Continuing Medical Education

Infectious Diseases Update Scheduled for Fircrest Golf Club, November 12

The annual *Infectious Diseases Update* is set for Friday, November 12, 2004. This important course was held for the first time last year at the Fircrest Golf Club, and we return. The food, facilities and setting are perfect for continuing medical education.

The program is directed by **Dr. Larry Schwartz** featuring nationally recognized authorities, as well as our own infectious disease specialists serving Pierce County. The Pierce County Health Department will also report on new approaches for diagnosing and treating community-associated methicillin-resistant S. aureus (CA-MRSA).

This program was developed for physicians and is designed as an update on common outpatient and inpatient infections. A brief review and clinical update will be made on a variety of current and important topics. This year, specialists and sub-specialists will focus on specific practice areas.

This is a popular program, please register early. ■

Common Office Problems Set for October 29

Don't forget to sign up for the Common Office Problems CME focusing on practical approaches to primary care medicine set for October. Call COME at 627-7137 to register. ■

Dates	Program	Director(s)
Friday, October 29	Common Office Problems	Mark Craddock, MD
Friday, November 12	Infectious Diseases Update	Larry Schwartz, MD
Tuesday (evenings) January 11 & 18	Cardiology for Primary Care	Gregg Ostergren, DO
January 26-31	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 4	Gastroenterology for Primary Care	Ralph Katsman, MD
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

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ing stack of mail on my desk, there were no requests for medical records from plaintiffs' attorneys. Thank God for little favors. The thoughtful physician with whom I share call responsibilities graciously insisted on taking call even though he had been on call for the past two weekends while I prepared for the hearing. Feeling a sense of relief, I drove home.

The sense of relief was short-lived. I was met at the door by my daughter, whose first comment was "Gee, Dad, they made you out to be the worst doctor in the world." She had recorded the television news piece for me to enjoy at my leisure. It turned out that this was not necessary, because through the marvel of 24-hour news channels, I could see the clip once an hour. This, I thought, is the price of freedom. I had just been visited by the First Amendment.

I knew I should call my relatives to tell them my side of the story. It would save them needless embarrassment and concern. I had a martini and went to bed instead.

The next morning, I went to work with a sense of dread over what would undoubtedly be my biggest humiliation. I work at a small community hospital. There is no such thing as anonymity. I went to the doctor's lounge and discovered that my case had made the second section of the newspaper. Bracing for the worst, I stayed in the lounge and answered questions and explained my side of the story to my colleagues. Next, with the same sense of dread, I arrived at the office and took the same tack with my patients. Much to my surprise, I received a tremendous outpouring of support and encouragement from my colleagues, the hospital staff and my patients.

One of my attorneys called. I think she was afraid I might fall on my sword. I was truly touched by this act of kindness. Now I feel better about the fact that her children will grow up having never won an argument with their mother.

That night when I got home, I realized that I only thought that I had faced my biggest embarrassment and humiliation. I called my relatives. To be perfectly honest, my wife made me call my relatives. I am glad she did.

This could have turned out differently. Juries understand that busy practitioners do not always do a good job of documentation. A chart with poor documentation is always better than an altered chart. An altered chart is worse than having no chart. Trust your attorneys to handle your problem. Worst-case scenario, you lose the case. That is why you have insurance. We, as physicians, must never lose sight of the larger issue. Sacrificing your integrity and betraying the public's trust, as I did, is wrong. Please do not let it happen to you.

Walter Scott's observation 200 years ago is no less valid today. Mark Twain offered another: "When in doubt, tell the truth."■

Reprinted from Physicians Risk Update, Volume XV, Number 4

Classified Advertising

POSITIONS AVAILABLE

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

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

OFFICE SPACE

For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals, ownership options. Call 253-272-2224.

Office space for lease in medical complex, Gig Harbor. 2354 sq ft, main level. 468-3539 or 565-2444.

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Pierce County Medical Society
BULLETIN

November, 2004

WSMA Delegates - Your Leadership

PCMS members at the WSMA House of Delegates in Spokane. L to R - Front Row: Drs. Ken Feucht, Len Alenick, Joe Jasper, Laurel Harris, Mike Kelly and Patrice Stevenson. Back Row: Drs. Don Russell, Sumner Schoenike, Nick Rajacich, Federico Cruz, Pat Hogan, Ron Morris and Richard Hawkins

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INSIDE:

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

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

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Pierce County Medical Society

BULLETIN

November, 2004

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President's Page

by Michael J. Kelly, MD

Pre-Emptive Election Reflections

Michael J. Kelly, MD

"A citizen of America will cross the ocean to fight for democracy, but won't cross the street to vote in a national election." ~Bill Vaughan

"Politicians are like diapers. They both need changing regularly and for the same reason." ~Author Unknown

With all the election hype and concern over the issues that deeply affect us, it recently occurred to me no one pays much attention to how people decide to vote, or whether to vote in the first place. As far as the incentive to vote, a friend of mine told me, it was easy. Just launch a promotional campaign, take out a couple of ads, and 10 million people will cast ballots for their favorite new M & M color. Alternatively, put an *American Idol* on the air and watch the finale draw 65 million votes.

Yet, if you held a presidential election and spent $343 million, as candidates did in 2000, somehow it only manages to eke out 105 million votes, about 51.3 percent of eligible voters. "Doesn't seem logical," Spock would say.

O.K., so John Kerry is no Fantasia Barrino, and George Bush can't pronounce Reuben Studdard let alone sing like him, but that doesn't mean we can't get more people motivated to vote, absentee or in the flesh. According to a local political think tank, all it would take is a few changes to the process itself. However, more about that later.

I'd say it's a sad day when 25 percent of our eighteen to twenty-four year olds can't name both presidential candidates. This not-so-startling news recently came from MTV, the world's foremost source for music videos, dry ice smoke, and Mentos commercials, so you know it's true.

The same survey found that 70 percent of the respondents had no idea who the vice-presidential candidates were, one-third thought they might get around to voting and the vast majority wanted to know how to write in Daisy Fuentes' name. Trust me, if the Federal Elections Commission would allow write-in votes as hearts with initials inside, she'd be president faster than you can forget the name Monica Lewinsky.

Another survey found that 21 percent of young people eighteen to twenty-nine obtain their political opinions from comedian Jon Stewart of Comedy Central's "The Daily Show." Jon himself labels his program "Fake Journalism." There is obviously a significant disconnect between what is "fake" and what is real journalism. But it gets worse: 40 percent of voters under 30 years of age say they get their political information from late-night TV talk show monologues. It's scary to

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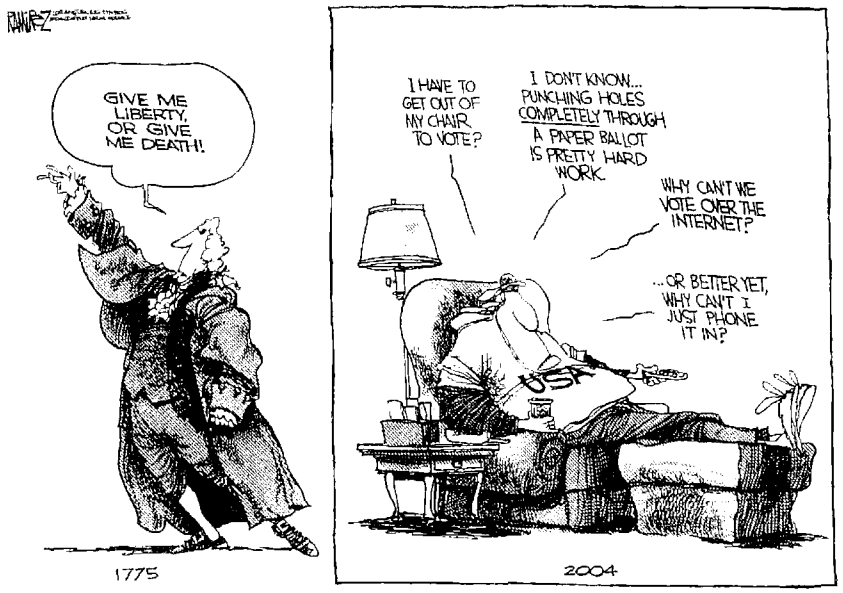

Reprinted from the Los Angeles Times

Campaigning for Matt Rice

In efforts to elect Matt Rice to a House of Representatives position in the 26th Legislative District (Gig Harbor), many Pierce County physicians became politically active for the first time in their lives. From sign waving to doorbelling, attending fund raisers to letter writing, physicians participated like never before.

Numerous physicians participated in overpass sign waving organized by neurologist **Dan Nehls, MD**. Dr. Nehls worked tirelessly organizing physicians to wave Matt Rice campaign signs each and every morning on the overpass in Gig Harbor as commuters inched along on their way to work. Beginning the day after Labor Day, September 7, until Election Day, November 2, Dr. Nehls or one or two of his colleagues were on the overpass early in the morning until rush hour ended. Joining Dr. Nehls were **Drs. Rob Kunkle**, Wes Greydanus, and **Joe Jasper**, Physician Assistant **Lee Bergmann**, **Drs. Karen Nelson**, Paul Mathews, Wes Hart, **Loren Finley**, **Jos Cove**, Phil Bouterse, **Kirk Rue**, **Jim Rooks**, Dave Langwort, **Gerry Anderson**, **Gordy Klatt**, Stacy Sweeney, Brad VanDuker, Todd Donato, Tim Lord, **Randy Otto**, **Carol Kovanda**, **Claire Spain-Remy**, **Kari Vitikainen**, Tony Forte, **Charles Souliere**, **Andre Joseph**, Bill Cammarano, **Bob Finnerty**, **Jim Taylor**, **Craig Rone**, Belinda Rone, **Bob Wright**, **Mike Martin**, **John Blair**, **Theresa Terem**, **Cliff Porter**, **Peter Kesling**, **Mark Ludvigson**, **Cordell Bahn**, **Ian Lawson**, **Nick Rajacich**, **Vicky Silas**, **Neal Shonnard**, Tony Garcia, **Frank**

Doorbellers for Matt Rice from left - Jason Chambers, campaign staff, Drs. Steve Duras, Mike Kelly, candidate Matt Rice and wife Kirin, Drs. Willie Shields and Jim Rifenbery. Not pictured - Dr. Vita Pliskow

See "Rice" page 6

WSMA Annual Meeting Recap

WSMA sets organizational priorities for 2005

The WSMA Annual Meeting, held in Spokane in late September, was well attended by representatives from Pierce County.

Representing Pierce County were PCMS Board members **Drs. Mike Kelly, Pat Hogan, Ken Feucht, Laurel Harris, Sumner Schoenike, Ron Morris** and **Joe Jasper**; WSMA Board members **Drs. Len Aleniek, Nick Rajacich** and **Patrice Stevenson**; WAMPAC Chair **Dr. Don Russell**; and alternate delegates **Drs. Federico Cruz** and **Richard Hawkins**.

The House of Delegates is the policy setting body of the organization and determines the priorities and direction of the Association. For 2005, the House adopted Board of Trustee Report G, which outlines the WSMA priorities as follows:

As an organization, the WSMA is strong. The association has a committed leadership, a growing membership, and remains financially sound.

The WSMA's focus is a means to an end. The purpose of our work is to maintain practice viability, enact tort reform and push for more administrative simplification to create an environment where physicians can practice the art and science of medicine.

The WSMA's policies also reflect 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, by training, experience and ethical code - responsible and accountable for medical decision-making; and
- We promote the health of all Washingtonians.

One of the hallmarks of the WSMA is that it represents strong advocacy, clearly articulated, and physician driven. The association works tirelessly to represent our values and priorities.

We partner with county medical societies and specialty societies through the County Medical Society Council and the Interspecialty Council. We partner with our practice managers, through individual contacts, and the state chapters of the Medical Group Management Association and American Medical Group Association. We will partner with any group or organization that shares our objectives.

The purpose of the WSMA is reflected in the following recommended organizational priorities for 2005: To represent the professional interests of the membership on behalf of patients - including their ability to have access to affordable health insurance and physicians - and to promote effective physician leadership in the evolving health care system.

Recommendations:

THEREFORE BE IT

RESOLVED, that in 2005 the WSMA focus its resources on the following organizational priorities:

Core:

1. Enact meaningful tort reform as a means to promote the capacity of the delivery system to meet the public's need for access to care, and to foster an environment that promotes patient safety and error reduction.
   - Affirmative legislative action on I-330 or an agreeable alternate, and/or voter approval of I-330 or an agreeable alternate in November 2005.
   - Focus public awareness of the impact of the tort system on access to care and medical practices.
   - Have 100% of the active members contribute to the I-330 Campaign Fund if the initiative goes to the November 2005 ballot.
   - Enactment of a constitutional amendment allowing a cap on non-economic damages if necessary.
   - Support passage of a federal tort reform bill.
   - Evaluate and promote, if feasible, other types of long-term tort law reform beyond those represented in I-330, including the establishment of a medical court system.

2. Improve the quality of medicine in Washington State; promote patient safety and error reduction efforts.
   - Promote programs and relationships with other organizations and the purchasing community to support this priority.
   - Use the WSM-ERF as a vehicle to bring physicians and purchasers together to identify common measurements of safety and quality and to promote or conduct programs to support the priority.

3. Promote medical practice economic viability and simplification of administrative requirements.
   - Seek better funding of Medicare physician payments.
   - Seek better funding of Medicaid physician payments.
   - Achieve tangible reductions in administrative complexity and operating expenses for medical practices.
   - Push the public discussion of health care "reform" away from nonproductive reiterations of long-held assumptions and positions. Reiterate the WSMA's position of supporting a marketplace-based approach to reform of the financing system while challenging both ends of the

See "WSMA" page 8

Learn to live Right-Side Up at the PCMS Annual Meeting

Fun, festive and entertaining as always, the PCMS Annual Meeting will be held on Tuesday, December 14 at the Tacoma Sheraton Hotel.

The annual dinner meeting will host a number of activities including music by the Tacoma Youth Symphony during the social hour, a raffle to benefit the PCMS Foundation, a keynote speaker and, of course, installation of new officers and Trustees. **Dr. Mike Kelly**, will thank **Dr. Jim Rooks** for his many years of service on the board and will install **Dr. Pat Hogan** as the new President.

As always, toys for children and gifts for women will be collected for donation to the YWCA Support Shelter for women.

The keynote speaker, David Thomas from Houston, Texas will talk about integrity – and the importance of "living right side up in an upside down world." With a wave of corporate scandals and the realities of a post 9/11 world, integrity must remain a timeless and timely virtue. In an entertaining and enlightening manner, Mr. Thomas will answer questions such as what is integrity and why is it important, why is integrity vital in the workplace, and how can we remain ethical when we are surrounded by those who operate differently. This is a presentation you will not want to miss – entertaining and thought provoking!!

Please mark your calendar for Tuesday, December 14 and join your PCMS colleagues, spouses and guests for the PCMS Annual Meeting. Watch your mail for details. ■

Rice from page 4

Kim, Ron Knight, Steve Hammer, Mark Craddock, John Samms, Christina Cszigeti, **Tom Irish, Pat Hogan** as well as others.

Physicians statewide contributed financially to Matt Rice's campaign. Most all physicians realized the importance of defeating his opponent, Pat Lantz (26-D) in the election. Lantz single-handedly refused to allow tort reform legislation to be passed out of her committee for discussion on the House floor for two consecutive years. Matt's Public Disclosure Commission report had not only Pierce County but many physicians from many counties in the state listed as contributors, recognizing the critical need to replace Lantz.

A few hearty souls were even willing to go door to door in efforts to help Dr. Rice. Drs. **Mike Kelly, Steve Duras, William Shields, Jim Rifenbery and Vita Pliskow** all experienced political campaigning from the grass roots level as they visited Gig Harbor residents door to door asking for support of their candidate. "I feel like I am really contributing and doing something," noted Dr. Shields. "This is action." Others were equally exuberant. Dr. Rifenbery visited the homes of many patients, noting "they were really surprised to see me at their door."

At press time the outcome of this election is unknown, but win or lose, candidate Matt Rice has hopefully felt the support and efforts of his colleagues in his efforts to go to Olympia.

PCMS congratulates Dr. Matt Rice on a well run and valiant campaign effort.■

PCMS has a new e-mail address

PCMS has changed their e-mail address to:

pcms@pcmswa.org

Please make a note in your directory

Applicants for Membership

Deborah J. Conway, MD
Diag Radiology/Pediatric Radiology
TRA Medical Imaging
3402 S 18th St, Tacoma
253-383-1099
Med School: University of Alabama
Internship: Memorial Health University
Residency: Memorial Health University
Fellowship: University of Washington

Mary C. Hoagland-Scher, MD
Family Practice
Group Health
209 Martin L King Jr Way, Tacoma
253-596-3300
Med School: Harvard Medical School
Internship: Framingham Union Hospital
Residency: Group Health Cooperative

Timothy R. Kennedy, MD
Anatomic & Clinical Pathology
Navy, active duty
Med School: Michigan State University
Internship: Portsmouth Naval Hospital
Residency: Portsmouth Naval Hospital
Fellowship: Medical Univ of S Carolina

Andrea R. Manzo, MD
Diagnostic Radiology
TRA Medical Imaging
3402 S 18th St, Tacoma
253-383-1099
Med School: University of Tennessee
Internship: Eisenhower Army Med Ctr
Residency: Madigan Army Med Ctr

J. Marshall Newbern, DO
Family Practice
Lakewood MultiCare Clinic
9332 Bridgeport Way SW, Lakewood
253-459-6060
Med School: West Virginia School of Osteopathic Medicine
Internship: Flint Osteopathic Hospital
Residency: Henry Ford Hospital

Christine Puig, MD
Otolaryngology, Head & Neck Surgery
Ear, Nose, Throat & Plastic Surgery Assoc
101 2nd St NE, Auburn
253-833-6241
Med School: Texas Tech University
Internship: Mayo Clinic
Residency: Mayo Clinic
Fellowship: University of Missouri

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Vaccine Shortage

Federico Cruz, MD

The Chiron Corporation. A name that I had seldom heard before now confronts me daily. Currently, the U.S. population receives flu vaccine from two companies. This vaccine is the main bulwark in protecting our communities from the ravages of an influenza epidemic. We truly depend on these companies for their vaccines. There is no fallback plan. We have no magic reserves, no hidden stockpiles.

As you know, Chiron recently announced that the British government had seized all of their current stock of flu vaccine because of irregularities in production. No risks to the public have been clearly stated, but there are allegations of widespread contaminants in different lots of the vaccine. Over 50 million doses were seized, half of the approximately 100 million doses needed in the U.S. to cover the high-risk populations and those in the general public who sought to avoid the disease. Without Chiron's production, we are desperately short. The average person will probably not have access to vaccine this year. Washington State's share of the U.S. vaccine supply was to have been about one million doses. The chances of our state getting its full share are slim, since much of the vaccine is already committed to contracted vendors and distributors across the country. And, the one million number was low from the outset: using CDC guidelines, well over one million people in our state are in the high-risk categories.

This does not bode well for us as we move quickly into the flu season. Significant numbers of high-risk persons will be vulnerable to this illness.

How did we get into this situation? It's a long, sad story, filled with much rhetoric and posturing by many sides. What is missing from the equation is a side that solely represented the public, which said during every policy discussion, "We must make certain enough flu vaccine is available for every citizen in need." Instead, discussions were dominated by concerns about liability, profits, market forces, agency authority, and a host of peripheral issues that succeeded in keeping everyone's eye off the primary, essential concern of availability for all.

The process and current outcome make me want to scream obscenities and tear my clothes. I did not go into public health in order to participate in disease control situations designed to fail. We are scurrying around, trying to make the best of a bad situation. This is not the way to run an anti-influenza campaign. In the future in order to respond to the low-vaccine/high-need circumstance, I may have to issue an emergency order that binds all agencies and individuals who administer flu vaccine to their patients and the public to follow CDC guidelines.

In the meantime, my recommendations are straightforward: **All existing stocks of vaccine should only be used to vaccinate high-risk individuals, as defined by the CDC**:

- All children, aged 6-23 months
- Adults over 65 years old
- People between the ages of 2 and 64 who have underlying chronic medical conditions
- All women who will be pregnant during influenza season
- Residents of nursing homes and long-term care facilities
- Children 6 months to 18 years on chronic aspirin therapy
- Healthcare workers with direct patient care

"If we follow the CDC guidelines, we should be able to protect a large part of the most vulnerable in our communities. Sometimes during a bad situation, where there are no solutions, we can only work to make it a little less bad."

See "Shortage" page 8

WSMA from page 5

political spectrum to look at new concepts. Promote greater access to affordable insurance.
- Promote a medical care-financing environment that supports new medical practice options.
- Promote the use of appropriate technology in physicians' practices.

Support:

4. Build the strength and viability of the WSMA as a primary resource to physicians.
- Realize a net membership gain as of December 31, 2005.
- Expand and increase the "brand awareness: of the WSMA programs and services.
- Strengthen the Interspecialty County and County Medical Societies Council to promote effectiveness and foster two-way communications.
- Maintain a demographically representative governance structure.
- Maintain a fiscally sound association.

Other House actions included Resolution A-1 introduced by PCMS Board member **Ken Feucht, MD**, Puyallup surgeon, on generated waste in the health care system. The resolution was adopted with two resolves calling for the WSMA to recognize that medical waste contributes to environmental degradation and risk to health and that they support and promote, when possible, the use of reusable, recyclable and/or biodegradable products.

Dr. Feucht also introduced Resolution B-13 calling for limitation of physician work hours. This resolution was referred, meaning that the WSMA will study it further. The resolution calls for support of 12 hour limitations in each 24 hour period for physicians to be involved in either call or actively working and a 60 hour limitation per week for working. It also asks for a compliance agency to fine and discipline for infractions. Dentists, alternative health care providers, associated health care providers, psychologists, licensend health and human service providers, and law and political professionals also fall under the guidelines.

Drs. Joe Jasper and Ken Feucht sponsored Resolution B-4, an appeal for a Physician Bill of Rights which was also referred by the House of Delegates. This resolution asks the WSMA to approve of a Physician Bill of Rights and recommend that the AMA support the bill, and that they stand supportively by a physician when any of their rights are violated.

Dr. Feucht's Medicare Age Reduction resolution was amended by asking the WSMA Interspecialty Council to address policies of the Medicare program in regard to eligibility, benefits and payments to physicians. This resolution was asking for many changes to the Medicare program including age limitations and treatment coverage options.

Dr. George Tanbara's resolution, Improving Access to Care for Children, was adopted by the House of Delegates and directs the WSMA to work with County Medical Societies, where appropriate, in bringing together governmental, nonprofit, and other interested organizations to improve access to care for the uninsured and the underinsured.

Resolution C-11, Achieving Universal Health Coverage in Washington State, drew the most attention and called for vote counting on the House floor. The Resolution was amended and finally accepted. The final resolution eliminated nine specific principles to the plan and that the WSMA retain a research firm to conduct a poll measuring the public's acceptance of a universal health insurance plan. The Final Resolution, as originally submitted directing that the WSMA urge the Governor and/or state legislature to appoint a blue-ribbon commission to develop recommendations for achieving universal health coverage and access for citizens of Washington, and that the commission include representatives of the legislature, the executive branch, federal health program officials, providers, employers, labor, the health insurance industry, consumers, and the uninsured. ■

Shortage from page 7

- Out-of-home caregivers and household contacts of children under 6 months old

Public flu clinics and private practice offices must screen out every individual who comes forward to be vaccinated who is not on the list. **All agencies who have flu vaccine through their own contracts with a distributor should report the amounts of vaccine to the Health Department. This will assure new shipments of vaccine will get distributed rationally.**

My goal is not to make life harder for providers and distributors, but to protect the youngest, oldest and those chronically ill. With your cooperation, we should be able to protect a large proportion of those high-risk patients in our community. But it does leave a huge number of the rest of the population uncovered. We have to hope that we do not have a severe flu season this year.

But even if it is a milder flu season, we don't have enough vaccine to protect everyone. I therefore want to repeat myself: If we follow the CDC guidelines, we should be able to protect a large part of the most vulnerable in our communities. Sometimes during a bad situation, where there are no solutions, we can only work to make it a little less bad. Please, do your part in making the best of this. ■

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.*

Serving Two Masters

Andrew Statson, MD

"He who serves two masters must lie to one of them."
Italian proverb

You must remember the story about the frog that was trained to jump on command. The trainer cut off one of its legs, then another. Finally, with all four legs cut off, the frog didn't jump and the trainer concluded that it had become deaf.

Think of us in the position of that frog for a moment. Our trainers cut their payments to us and we still jump, even though it is harder, even though it requires more effort. We work longer hours and spend less time with each patient, to compensate for the smaller payments.

Then, our trainers cut another one of our legs, this time by piling regulations on us that rob us of our time and energy. Again, we jump on command. We put in even more effort and time, we grit our teeth, and we keep working.

How long will we continue? How long can we? When are we going to exhaust our physical and emotional strength? When are we going to turn deaf?

The latest plan abroad is the link of payments for services to quality and effectiveness of care. The argument in favor of that is based on the recent study from the Rand Corporation, which found that fully half of the patients with certain conditions did not get the recommended care.

As reported in *The Wall Street Journal* on 9-17-04, insurers and health plans claim that doctors have failed to provide high quality cost-effective care. The stress, as expected, is on cost-effective.

How does one determine quality?

The patients usually can tell. We treat them, they get better and they are satisfied. Or perhaps, we didn't help them. There was a complication, or their expectations were not met, and they are unhappy.

It was so under the fee-for-service system, when the patients were in the driver's seat. They made the decisions. We served them. Now, we serve a different master. The third parties make the decisions on what is good care for the patients and what isn't.

The Peoples State of Minnesota has another plan. The Citizen Council on Health Care in Minnesota reports that the state will issue directives on disease management and the physicians, hospitals and all ancillary services will be held accountable if they do not comply.

In addition, HealthPartners, a major insurance company in that state, has announced that it will not pay for services when a medical error has occurred. They will decide what constitutes a medical error and then, nobody will get paid for services given during the course of that treatment, whether before, during or after the error occurred. That includes all services the patient received, by hospitals, physicians and others. Considering that sometimes errors are not discovered until a year or two later, for how long are they going to withhold payments? Or are they going to ask for a refund of payments they already made?

The most common method the new masters use to determine quality is by review of the records. As long as we treat the patients' charts right, we have done our job. Whether we have spent a minute or an hour on the subject of weight reduction, smoking cessation, seat belt use, caution about alcohol and drug use or safe sex, and all the other politically correct aspects of care, as long as it is in the chart, we have done our job.

At one time, a criterion for good obstetrical practice was a low cesarian section rate and a high rate of vaginal deliveries after sections. Now, the pendulum is swinging toward sections on demand. So what is right and what is wrong? It all depends on the pronouncements of those in power.

The problem about disease management (I apologize for repeating myself) is that diseases don't exist independently of patients and what may be right for one patient may be wrong for another. The role of the clinician is to make that determination and to treat the patient accordingly, without running the risk of getting a black mark for not following the directives.

Behind the Iron Curtain, we had a

See "Masters" page 10

Masters from page 9

joke about the perfect party man. He was the one who firmly adhered to the party line and wavered along with it. We'll have to do that in our practices, waver along with the official line. We have a patient on a previously recommended treatment, and it is working. When the official line on how to treat his disease changes, we either have to change the treatment or be blacklisted.

When the current flu season approached, the officials told us that it was going to be bad and everyone should get the vaccine. When the shortage became obvious, the official line changed. The flu season was not going to be bad, so only those at very high risk of complications should be immunized.

Yes, of course. Right on. Three cheers for the party line. Long live Big Brother. The old truth goes down the memory hole. The new truth is plastered in the headlines. You thought 1984 never happened.

The rising costs of health care, largely due to the regulatory and liability burden, and the declining quality of care, due to shortages of staff, supplies and equipment, have resulted in widespread popular dissatisfaction. The din for a national health service is getting louder.

If it should ever come to be, we should seek to obtain one important provision in the mechanism of payment. In Canada, neither the patients nor anyone else is allowed to pay directly for services. Physicians can only bill Medicare. The only way Canadians are able to opt out of their system is to come to the U.S. for care.

Australia, on the contrary, allows physicians the option either of billing medicare, which they call bulk billing, or of charging the patients directly. When they bulk bill, they get paid the amount medicare allows for their services. When they charge the patients, they set their fees. The patients then send their claims to medicare and get reimbursed according to the official schedule.

As you can understand, the payment schedule of Medicare has not kept up with the rising overhead expenses and liability premiums. More and more Australian physicians have stopped bulk billing and look to the patients for the payment of their fees.

The same type of arrangement existed in France when I was there. The patients paid the physicians directly and the Health Service paid them back according to the official schedule, which at that time was about half of the usual physician fees.

Another important option is available in Britain, where physicians can have a private office and work for the NHS either part time or not at all. Britain also has private hospitals and insurance companies that sell private health insurance.

The reports coming out of Western Europe, Canada, Japan and other countries reveal creaking systems that are chronically underfunded. Faced with progressively worsening staff shortages and increasing waiting lists, these systems are now turning to more and more restrictions on medications and services, and to patient participation in the cost of care with more deductibles, higher copayments and more frequent denials of service.

I hope that the sheer cost of such a system will militate against it. I hope that the experience of the other Western countries will penetrate the skulls of our leaders and help turn us away in our march on the road to disaster. I hope that Americans will have enough sense to understand that our health care system cannot serve two masters. Our master will either have to be the patient in a fee-for-service system, or the payor, single or multiple, in a third party payor system. ■

PCMS Welcomes Scott Peterson, new College of Medical Education Program Administrator

Scott Peterson is feeling some pressure.

"I feel a burden to maintain what Les McCallum has built here," said Peterson, who recently replaced McCallum as the new College of Medical Education's program administrator. "I hope to maintain the standard of excellence and continue to provide first-class, and in some cases world-class, continuing medical education for our doctors."

A public relations and public affairs consultant, Peterson is no stranger to Pierce County or to many of the area's physicians. As campaign manager for **Dr. Federico Cruz** during his recent gubernatorial bid, Peterson had the opportunity to meet several PCMS physicians. Now, wearing a different hat, he is looking forward to meeting and working with the membership as he takes the helm at the College of Medical Education.

"I'm starting to make contacts, and I am currently meeting with course directors," Peterson said. He recently completed his first COME program of the year, *Common Office Problems*, held October 29th.

A native of Portland, Oregon, Peterson lived for several years in the Washington, DC area. Involved in politics from the time he was in high school, he took a different track in college, graduating from the University of Virginia with a degree in religious studies. "Liberal arts degrees are equally useless," he joked, "so I wanted to pick something that would be interesting and challenging — something that would prepare me for getting back into politics. The best liberal arts degree offered at the school was in religious studies which is a combination of history and philosophy, essentially. And, it was a great experience, and definitely worth it."

Scott Peterson

Going to school so close to the nation's capitol also exposed Peterson to a diverse and exciting group of classmates. One friend's father was secretary general at the UN. Another classmate was the son of a diplomat, although Peterson recently found out that he was actually in the CIA. "I loved being so close to DC," he said, adding that he frequently made the two-hour train ride

See "Peterson" page 18

ACCME changes conflict-of-interest rules

Tighter controls would limit continuing medical education speakers

Editor's Note: These changes to CME accreditation rules become effective May, 2005 and will not impact the College of Medical Education programs for the 2004-2005 calendar year. Any impact the new rules will have on College courses and/or the continuing ability to provide no-cost, quality CME programs for physicians is not completely known at this point.

Pressure from the Office of Inspector General has the medical profession making serious changes to continuing medical education, according to CME leaders.

The Accreditation Council for Continuing Medical Education, of which the American Medical Association is a member, laid out revised rules September 28 to further distance CME from commercial influence. CME providers will have until May 2005 to come into compliance, and the impact of these changes is still being weighed. But physicians who make presentations at CME events or help plan these activities can count on tighter controls over what they can speak about.

Van Harrison, PhD, a professor at the University of Michigan Medical School and director of its CME office, said, "As I've talked with other long-term CME directors, this change has more impact than any other change ACCME has made in the last 20 years."

What's new is that the ACCME no longer will accept disclosure of a presenter's ties to a drug company or medical device manufacturer as sufficient to resolve this conflict of interest. Individuals must end their financial relationship with the company or not speak on a topic.

All involved in planning a CME event will be held to these same standards. Conflicts of interest in financial ties of spouses or partners also must be resolved.

Marcia Jackson, PhD, president of the Alliance for Continuing Medical Education, said this means that some qualified people will not be allowed to speak. For example, if a doctor is asked to present information on a new diabetes treatment and the research was funded by the drug company, he or she may report only on the data and results of the research. Someone else must discuss the recommendations for using this treatment, but there might be no one else qualified to speak because the drug is so new. ■

Reprinted from AMNews, 10/18/04

Reflections from page 3

think that Conan O'Brien and Jay Leno are giving the future leaders of America their civic lessons.

I was mulling over these election-related thoughts the night of October 24 as I prepared this President's Page. Consider it a written time capsule which you will open as a November PCMS *Bulletin* article three weeks from now – obviously following the general election of November 2. I wanted to write something now that would be relevant then – a sort of pre-emptive reflection on the now future, but as you read, past election.

So, who won – who lost? I now spend part of my time, as perhaps you, listening to attack adds on radio and TV. I read the various political distortions in the TNT and other publications. Promotional mailings multiply in my mailbox. The reality is, by the time you read this, federal, state and local elections and initiatives will have been settled - barring any challenge from the "...cloud of locust-like lawyers" (George Will Editorial 10/24), poised coast to coast, representing the vanquished presidential aspirant.

Any regrets? Can we honestly say we did enough to educate and stimulate our patients, the electorate, and indeed our own medical colleagues, about the important issues of the now past national and local political campaigns? How effective was our "doctors lobby?" Were you involved? I'd like to think we helped to influence the elections of George, Dino, George, Matt, Mike, Gigi, Marilyn, Bob, Dick and many others - but did we?

Did the political soothsayers get it right? How close were they? These days it seems that there's a new press release every 45.2 minutes (with a margin of error of 4%). The *News Tribune* published its local, state and national choices, including a surprise endorsement of Dino Rossi. The pundits have worked up complicated computer models of prediction. State party chairs publish the Public Disclosure Commission's information regarding trial attorney, union and special interest contributions and discuss whether a dog's thighbone points north if tossed at a baying cat under the full moon.

Despite all the information, it seems when it comes to political depth of thought, most of Washington State and the U.S. are wading in the unnaturally warm, shallow-end of the kiddie's pool. A local political think tank, The KILL, has instead taken a bold head-first leap into the deep end of that same pool – and "Ouch!"

The Kelly Institute of Lame Logic (motto: "Same daily thoughts, different conclusions"), working on developing the science of prognostication, produced an algorithm to predict who will win the presidency. To be clear, an *algorithm* is a mathematical construct, not a jab at the 2000 Democrat candidate's peculiar dancing style. Using our own patented electability factors, the KILL concluded that either Democrat Governor James B. Hunt, Jr. or Republican Governor William J. Janklow would win the 2004 election. However, since Janklow ended up in jail for killing a motorcyclist and no one knows where Hunt is, our research and development seems a bit suspect.

The Institute's most important work, however, has been to focus on ideas to increase voter involvement. A brief overview will give you an idea of the quality of those thoughts:

1. Allow call-in voting. This recognizes the basic laziness of the average American. We're used to being able to sit back in our Lazy-Boy and order a pizza, CDs, an Air Turbo Microwave Pasta Cooker, just by getting someone to hand us the phone, so why can't we vote that way? No, don't get up...

2. Hold the election during prime time. Since we'll be able to vote by phone, the polls don't have to be open as long. Besides, being an anti-delayed gratification, short attention span, ADD nation, we want our election to be quick and painless, not a miniseries. So why not hold it after dinner when we're relaxed? We can try to focus on it, vote and comfortably fall asleep – ZZzzzz - perhaps in that order.

3. Let people vote more than once. Election history shows us only 76 percent of those who are of voting age are registered, and of that group, only 67 percent bother to vote – which means that just over half of those people who can vote, did.

Therefore, the Institute advocates letting people vote more than once. Consider the fact that each *American Idol* viewer voted an average of twice. We say if all those potential presidential voters aren't going to use their ballots, why not let others who are actually concerned about what happens to this country use them. Why let all those votes go to waste? Remember, there are children in China who go to bed voteless. ■

In My Opinion

by Daisy Puracal, MD

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

Teeter/Totter (more or less)

Daisy Puracal, MD

Lately there has been a great deal of talk about obesity and Type II diabetes in our young children. So much so that McDonald's has taken off the market their super-size programs. That program was a marketing ploy which led us to believe that we were paying less for more. You may also have noticed that there is not much to take home in doggy bags from restaurants anymore. But the prices of the foods have not changed. In other words, we are getting less for the price we paid.

It is funny that with the current low cholesterol fad diets, extra fat is removed but the cost of this reduced food is more. Similarly, for caffeine-free drinks and even bottled water we get less for more.

I am dairy intolerant, so in restaurants I have to order pizza without cheese or spaghetti without Parmesan. But the price still stays the same for me. So I pay more for less. Yet, if I had asked for additional mushrooms you can bet the price would be more.

A few years ago there was a push to use generic medications rather than name-brand drugs to help cut the cost of medical care. But what has happened is that new drugs are priced several times higher to ensure that a profit is made before the patent runs out. The generic version is now priced somewhat lower than the name brand but even so, the cost is probably more substantial than the cost to manufacture the drug in the first place. So as a result the consumer pays more for a less reliable product.

Similarly, in order to cut costs, massage therapy was offered as a health benefit. By divorcing massage therapy from physical therapy a patient referred for physical therapy, for whatever reason, is given the therapy without massage. Patients are paying more and getting less of a benefit from the therapy.

Health insurance premiums have steadily climbed over the years and so have co-payments but the benefits provided have not changed. It may have even decreased. Neither has the health of our country improved as a result of this. We are paying more for less.

Malpractice insurance premiums have been steadily increasing over the years. In order to keep abreast with these increases, I have given up delivering babies and assisting in major surgeries. So I am utilizing less and less of my skills and paying more and more in premiums.

In medical offices, in an effort to be efficient and maximize time, an invisible barrier is placed around doctors so they are not distracted from "productivity" by patient calls. Patients are getting less of a service even though they pay more in premiums and co-payments.

Less time has to be spent with patients to allow more time for more documentation for more dollars. In my own practice I have found myself having to take on more and more of the responsibilities which had been delegated to staff in the past (e.g., coding). Cheat sheets are no longer practical as more and more specific codes are required for better reimbursement. So I spend more time with the codebooks and, hence, less time with patients.

To satisfy insurance companies when they come in for their audits and lawyers in case of a lawsuit, I spend more time documenting, therefore less time with patients. Because they have to read my notes, I now scribble on paper at the time of the patient visit, then dictate the encounter into a machine. These notes are sent off to a third world country where they are transcribed and then sent back to me. I then check and edit and sign off. Again, doing more for less of the service I was trained to provide. More and more we are caught up in this elaborate system that serves no purpose in the larger scheme of things.

Years ago, frustrated with the long hours at work with inadequate remuneration and little appreciation for the work I was doing, I made a conscious effort to streamline my practice and reduce my work hours. Doing less at work gave me more time off to pursue other interests in life that have really allowed me to grow as a person. I am no longer the slave to my vocation that I had tended to be before.

Recently, I closed my private clinical practice of 21 years and joined a physician group as an independent contractor. The intent was to let go of my administrative functions and responsibilities so I can do less for more peace of mind. We will have to wait and see if this goal is achieved.

Have I made some wrong choices along the way? More likely than not. Would I have been more financially successful? Very possibly so. Yet, am I happy with the way my life has evolved? Yes - more or less. ■

Lawyers sick over Texas malpractice caps

Damage caps on medical malpractice awards, which took effect in Texas a year ago, are reducing the frequency of lawsuits, providing an incentive for specialized physicians to practice in the state and slowly reducing the cost of malpractice premiums, according to the *Dallas Morning News*.

Lawsuit filings have declined in several Texas counties: In Dallas, lawsuits dropped from about 127 per month between January and August 2003, to 19 per month after September 2003, when the damage caps took effect.

Physicians practicing in high-risk specialties such as neurosurgery and obstetrics have increased: In May 2004, 419 neurosurgeons are licensed in the state, up from 407 in May 2003, while licensed obstetricians, gynecologists and Ob/Gyns number at 3,201, up from 3,054 last year.

Insurance premiums have gone down for many hospitals, particularly those that self-insure for the initial $5 million, $10 million or $25 million of potential losses: The state's hospital association said that on average, its members reported an 8 percent decrease in premiums in 2004 and a 17 percent drop for renewals into 2005.

The Texas Medical Liability Trust, the state's largest medical liability insurer, has reduced its rates by 16.4 percent. Meanwhile, the state's joint underwriting association was denied a 35.6 percent rate increase by the Texas Insurance Commissioner.
Source: Terry Maxon, "No Cure-All: Time Hasn't Healed Controversy Over Caps on Damages," and "Doctors Still Awaiting Lower Rates," Dallas Morning News, September 26, 2004. ■

Site to help residents buy drugs from Canada

Editor's Note: In regard to pharmaceutical sales from country to country, ***Dr. Len Alenick*** *discovered in his research that there is a little known world trade agreement passed in 1994 that dictates that any U.S. company that refuses to comply with another country's pharmaceutical price controls by selling drugs at greatly reduced prices risks losing its patent protection. This agreement – which only applies to pharmaceuticals – has the purchaser saying, "we'll pay you half the cost of your drugs and if you don't agree, we will violate your patent and make knock-off versions."*

Part of this deal is that the purchasing country will not turn around and re-sell the drugs to Americans. But, purchasing countries like Canada are illegally re-selling anyway, as the law is rarely enforced.

Consequently, the pharmaceutical companies don't like this and are limiting supplies they sell to Canada for their use, but not enough to re-sell back to Americans. It is anticipated that as demands from the U.S. increase because of costs, there will be a dwindling supply for Canada to sell back to the U.S.

Washington state recently launched a website to help guide senior citizens and others to Canadian pharmacies for lower-cost prescription drugs.

Outgoing Governor Gary Locke, a Democrat who has clashed with the Bush administration over its ban on reimporting U.S.-made drugs from Canada, announced the state's plan to defy that edict and link with Wisconsin's online access to Canadian pharmacies.

"It's for our citizens that we are taking matters into our own hands and fighting against the skyrocketing cost of prescription drugs," the governor told a news conference.

The website, www.rx.wa.gov, does not directly link to any pharmacies. Instead, it offers a link to the Wisconsin site. The Wisconsin site offers links to three Canadian pharmacies.

The Washington site also includes background on buying Canadian drugs, various warnings about possible downsides and an acknowledgment that reimporting U.S.-made drugs from Canada or those manufactured abroad violates federal law.

Clifford Webster, a lobbyist representing the Pharmaceutical Research and Manufacturers of America, had no immediate objection to Locke's new program.

"He has essentially done a gigantic Google search for consumers, something they can already do," he said. "The devil will be in the details."

Locke said he assumes that the Bush administration will object, but that it's up to Washington state residents whether to avail themselves of the consumer information. The states have a strong legal basis for helping their citizens this way, said Locke, who is not seeking a third term.

Locke said Wisconsin and Minnesota have checked out the companies and attest that they are "safe, reputable and reliable."

Bruce Reeves of the state Senior Citizen Lobby said Rhode Island and Vermont have similar programs.

"If they're safe for Canadians, they're safe for us," he said.

By December 1, the state will launch a retail price comparison service for the 25 most commonly used prescription drugs, including the Canadian prices.

Locke said that more than 700,000 Washington residents, including an estimated 210,000 seniors, don't have prescription drug coverage and have to buy at full price. They will be the most likely to benefit from buying Canadian, he said. ■

Reprinted from the Seattle PI, 10/27/04

Don't Forget to Make Those Whistler Condo Reservations

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

CME at Whistler participants are urged to make their condo reservations early. A collection of one and two bedroom luxury condominiums just steps from the Blackcomb chair and gondola are available. Space is available on a first come first served basis.

Reservations for the block of condos, ALL IN THE *ASPENS ON BLACKCOMB*, are available. To take advantage of these savings, you must make your reservations soon, as conference dates are during the high ski season. The College's reserved block of rooms will be released after December 1, 2005.

Reservations can be made by calling the *Aspens on Blackcomb* toll free at 1-866-788-5588. You must identify yourself as a part of the COME group. For more information call the College at 627-7137. ■

CME at Whistler program lodging location - the Aspens on Blackcomb - has ski-in/ski-out one and two bedroom condos at last year's conference prices

COLLEGE OF MEDICAL EDUCATION

Need Whistler Condo Reservations!

January 26 - 30

Don't forget, the popular CME program at Whistler is Wednesday through Saturday, January 26th to the 30th, 2005. It is important for you to reserve your lodging as soon as possible.

The College has arranged for accommodations primarily at the Aspens Condos. Reservations can be made by calling *Aspens on Blackcomb*, toll free at 1-866-788-5588. You must identify yourself as part of the COME group. Please make your reservations by December 31, 2004, because after that date any remaining condos will be released.

The course directors are **Dr. Richard Tobin** and **Dr. John Jiganti**. Course topics include:

- *New Concepts in Migraines and Headaches*
- *Outpatient Spine Surgery*
- *Fat: The GI Perspective*
- *33 Seconds and Counting*
- *Advances in the Diagnosis and Treatment of Breast Cancer*

The Whistler CME is a "resort" program, combining family vacationing, skiing, a resort atmosphere, with continuing medical education. ■

Continuing Medical Education

Cardiology for Primary Care coming January 11 and 18, 2005

Sign-up begins now!

The College's eighth annual program featuring topics in cardiology for the primary care physician will be held at St. Joseph Hospital in the Lagerquist Conference Center. **Gregg Ostergren, DO** returns as the Course Director.

The *Cardiology for Primary Care* conference will be held on two consecutive Tuesdays, January 11 and January 18, 2005.

This is an evening program for your convenience, giving you CME credit opportunity outside of office hours. The programs run from 6:00 pm to 9:00 pm on both nights, for a total of six credit hours.

This is a popular program, please register early. ■

Continuous Improvement at the College

The College of Medical Education is respected throughout Pierce County, as well as our entire region, for the quality of its continuing medical education. This is not an accident. Every year, each aspect of the College is evaluated. Everything from course content to conference locations to quality of speakers is reviewed, searching for areas of improvement, as well as affirming those areas that were successful.

For fifteen years, Les McCallum set a standard of excellence, and the new Program Administrator Scott Peterson will continue that tradition by constantly improving. Scott encourages the physicians of Pierce County to stay in touch, providing feedback, both positive and critical, so the College can always do better. You can reach Scott at (253) 627-7137 or via e-mail at scott@pcmswa.org. ■

Dates	Program	Director(s)
Friday, November 12	Infectious Diseases Update	Larry Schwartz, MD
Tuesday (evenings) January 11 & 18	Cardiology for Primary Care	Gregg Ostergren, DO
January 26-31	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 4	Gastroenterology for Primary Care	Ralph Katsman, MD
Thursday-Friday May 5-6	Internal Medicine Review 2005	Art Knodel, MD
Friday, April 22	Radiology for the Non-Radiologist	Rick Tobin, MD Andy Levine, MD
Friday, May 20	Primary Care 2005	Steve Duncan, MD

Peterson from page 11

into the city.

Peterson and his wife Janet, a Spokane native, returned to Olympia a few years ago with their three children (now ages 10, 11 and 13). "We needed to get the grandkids close to their grandparents," he said. He still feels a close connection to DC, however, and makes certain to keep close contacts there for visits when the opportunity arises.

Peterson's professional life is varied as he provides public relations and public affairs consulting services to a variety of clients, including Microsoft, Kraft Foods, Southern Company, as well as other Fortune 500 businesses. In addition, he consults with a coalition of utility companies on federal regulations; deals with the local American Heart Association on tobacco-control issues; and provides development assistance to Pierce County nonprofit organizations, including the Tacoma Urban League, Central Latino, and others. He has been extensively involved with the Clean Indoor Smoking Initiative Campaign, and also provides pro bono help to the Olympia Symphony and the Thurston County Habitat for Humanity. In addition, Peterson worked in the Washington State House of Representatives during the 2001-2003 legislative sessions.

With the demands of running his own business, Peterson doesn't have a lot of spare time these days, but he does enjoy golf, reading and touring U.S. historical sites when he has the opportunity. He and Janet are also busy attending their children's band concerts and tennis matches.

He looks forward to continuing the success of the College of Medical Education and welcomes new challenges as they are presented to him.

PCMS and the College of Medical Education welcome Scott Peterson.■

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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
2200 – 112th Ave NE, Suite 140
Bellevue, WA 98004

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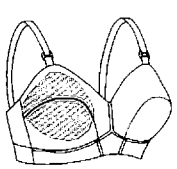

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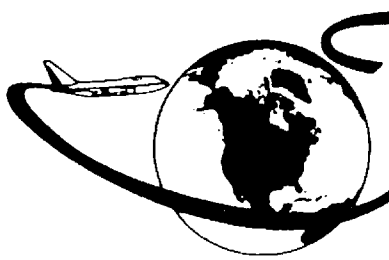

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Pierce County Medical Society

BULLETIN

December, 2004

2004 Holiday Sharing Card
Artist: Laura Yu, daughter of Amy Yu, MD

Annual Meeting: See page 5

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

December, 2004

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President's Page

by Michael J. Kelly, MD

The PCMS Stretch

Michael J. Kelly, MD

Politics, it seems to me, for years, or all too long, has been concerned with right or left instead of right or wrong.
- Richard Armour

When trouble arises and things look bad, there is always one individual who perceives a solution and is willing to take command. Very often, that person is crazy.
-Dave Barry, "Things That Took Me 50 Years to Learn"

I don't think there is a PCMS president who doesn't feel relieved that his/her tenure is nearing its end. And why not? The job is truly daunting, time consuming, challenging, frightening, while at the same time, rewarding, self-revealing, and oddly satisfying. The job truly causes one to stretch, and grow. So - thanks for the stretch.

As 2004 began, I quickly found myself moving outside my tidy comfort zone of medical practice right into the foreign realm of politics. This process of politicization concerned me greatly. I didn't want to become a politician. Call someone a politician and he or she may well challenge you to choose between swords and pistols at sun-up. We cry politics when we think someone has made a statement that leaves a credibility gap – as if you are accusing that person of having a forked tongue.

But it wasn't as bad as I feared. Despite nearly 12 months on this job, my tongue is intact. Not only that, I've learned that it is possible to be political without becoming an obnoxious, self-serving, power-hungry despot (though some state legislators may disagree…). I learned it is possible to work with physicians and politicians of disparate political philosophies toward common goals affecting our profession without inviting political invective or acrimony, whether the issue is fluoride, smoke-free workplaces or tort reform.

For the past year, I have observed the political activities of the WSMA with great admiration and regard. Their support of the Pierce County Medical Society this past year is worthy of note. The WSMA-introduced Initiative 330 is an excellent example of the appropriate use of power on behalf of the patients and physicians of this state. By the time you read this, we should have enough valid signatures to present this important initiative to the legislature in 2005.

It should come as no surprise to all but the politically naïve that if we are to maintain practice viability, continue to speak out for the medical welfare of our patients, and work toward meaningful liability reform, continuing and, indeed, increasing our political activities are of paramount importance. However, with the wide range of political philosophies and sensitivities, is this truly possible? For the answer, one has only to look at the activities of the members of our society this past year - one in which political commitment became a cause celebre.

Our own Health Department Director, **Federico Cruz** led the way by running for governor. Emergency department physician Matt Rice mounted a strong campaign to unseat incumbent Rep. Pat Lantz in the 26th district. **Ron Morris**, board member of PCMS and recently elected member of the WSMA board of trustees, committed himself and his family to the daunting task of running for the state house of representatives from the 25th district. **Pat Hogan**, incoming president of PCMS, led the statewide effort to make the Washington workplace smoke-free. **Dan Nehls** became the lord of the overpass in Gig Harbor as he organized the early-morning sign waving for legislative candidate Matt Rice. **Joe** and Donna **Jasper** gave generously of their time for many medically friendly candidates, including a fundraiser for Sen. Mike Carrell. **Ken Feucht** went door to door with Wally Nash in Puyallup to energize Wally's campaign.

I could continue this litany, but time and space limit the inclusion of many other worthy PCMS physicians

See "Stretch" page 6

Do you tend to undercode? You're not alone

A study confirms what many doctors already believe - they don't give themselves credit for everything they do. That affects fees and, perhaps, quality measurement

Bill Thrift, MD, a family physician in Prescott, AZ says his office frequently undercodes claims after treating patients with multiple, complex problems. He's just anticipating what insurers might reject.

"One of the hardest things for us to do is really charge what we're worth," he said. "We're not aggressive at working the system."

Weary of fighting with insurers, fearful of getting audited by Medicare, or merely unsure about what they can code for — for whatever reason, many physicians habitually undercode.

A recent study has quantified how much family physicians don't put on their bills. The numbers raise questions not only about undercoding's effect on a physician's income, but also about its effect on quality measurement programs that use claims data to determine how well patients fare, and what sort of cash bonus a doctor might receive as a result.

The coding study, by researchers at the University of Wisconsin Medical School, found that family doctors manage an average of 3.05 problems per patient visit. But they record only 2.82 in the chart, and 1.97 on the bill.

"I have been tending to undercode my visits, and I didn't really realize it until this project," said Cynthia Haq, MD, a family doctor in Madison, WI who was one of 29 physicians whose charting and billing methods were scrutinized. "I often undercode ... and write down one or two [problems] when there might be four or five."

Family physicians tend to accept that they advise patients on a variety of issues but will be compensated for only some, knowing insurers will look at some CPT codes but ignore others if they feel additional payment isn't warranted for the same visit. Physicians don't have enough time to record every facet of a visit if the system doesn't reward that kind of thoroughness, Dr. Haq said.

But in some cases additional coding could result in more income, experts say. The Wisconsin study found family physicians, in particular, don't often bill when they counsel for mental illness, substance abuse or tobacco addiction, because they don't think reimbursement is likely.

Though 29 physicians may seem like a small sample, many say their experiences are typical. Dr. Thrift, who wasn't part of the study, said he spends about 30% of his time on matters related to emotional problems but many payers reimburse family doctors reluctantly or not at all for anything that looks psychiatric. "We are very good at [counseling]," he said. "All [family doctors] do it, and all of the time, and we don't get paid for it."

In other cases, physicians want to shield patients from possible adverse actions if insurers learn about emotional problems or addictions, and leave those conditions off the bill or chart or both, according to the study, which appeared in the September-October *Annals of Family Medicine*.

Doctors should record the level of service they provide, despite their doubts about payment, said John C. Nelson, MD, MPH, president of the AMA. It is "no wonder physicians are apprehensive about appropriately reporting complex procedures and services they provide for fear of health plan retribution, given current health plan business practices of downcoding, bundling and reassigning physician CPT codes to reduce or deny physician payment," said Dr. Nelson, a Salt Lake City ob-gyn.

But if primary care physicians are telling insurers about only a portion of what they do, quality measurement programs may not work to their potential, experts said.

"Most of the time looking at claims data, you don't know what took place at the encounter," said Josie Williams, MD, an internist and gastroenterologist and co-chair of the Physician Consortium for Performance Improvement, a large group of quality experts periodically convened by the AMA.

Charles M. Cutler, MD, head of national quality management for Aetna Inc., said claims data can still be useful for tracking adherence to certain best practices ranging from child vaccinations to mammogram rates. He said he'd be " happy to hear about" ideas for better measurements from family physicians.

But Dr. Cutler, an internist, added: "I don't know one could ever measure the universe of what a family physician does."

Dr. Thrift, for his part, is trying to survive in that universe, even if he understands that payers never will know everything he does for patients. After one recent patient visit, he decided to be a bit bolder in his billing.

The patient, who has developmental disabilities, talked about her anxiety and sleep disturbances and the medications she takes for them. Dr. Thrift checked her blood pressure and explained the importance of controlling it. But for the bulk of the visit, he spent time cutting her painful toenails, because he knew the payer did not cover trips to a podiatrist.

In what he calls a "risk" and a "gamble," Dr. Thrift decided to add the toenail trimming to the bill using a CPT modifier — a $20 charge. It was a very tiny but, in his view, a long-overdue step in the direction of opposing self-downcoding.

"This is the first time I've tried to bill for it, and I've done it a zillion times before," he said. "Whether they'll pay for it is something that remains to be seen. Let's see if I can do it."■

Reprinted from AMNews, Nov. 22/29, 2004

Pierce County Medical Society

2004 ANNUAL MEETING

Tuesday, December 14, 2004
Sheraton Tacoma Hotel, Ballroom
1320 Broadway Plaza, Tacoma

Social Hour: 6:30 p.m.
Dinner: 7:00 p.m.
Program: 8:00 p.m.

Integrity:
"LIVING RIGHT SIDE UP IN AN UPSIDE DOWN WORLD!"

A wave of corporate scandals and realities of a post 9-11 world confirm that integrity is a timeless AND timely virtue. In a challenging and upbeat manner, this topic will be addressed by exploring such questions as: What are the crucial aspects of integrity and how can it be defined? Why is integrity important to today's workplace? How can it be maintained when those around us operate differently? A presentation on integrity might be anticipated to be boring, dry or preachy, but this promises to be none of these.

David Thomas

David Thomas launched his speaking career in 1996 with the formation of IntegriTalk.....Making a difference with integrity! A graduate of the University of Texas at Austin (BBA, JD) he became a CPA and has acquired valuable business experience in the public accounting, commercial banking, and retailing arenas. He is a licensed attorney and certified seminar leader and has inspired audiences throughout the U.S. and Canada.

- Raffle and holiday card sales to benefit PCMS Foundation
- Introduction of the 2005 Officers and President, Dr. Patrick Hogan
- Please bring an unwrapped toy (child) and/or a wrapped gift (woman) for YWCA Shelter residents

Please return before Friday, December 10 to: PCMS, 223 Tacoma Avenue South, Tacoma, WA 98402
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We hope you will join us!

Stretch from page 3

who have contributed their time, money and support to medical political agendas this past year.

Our society has bucked the trend toward ideological segregation as we have chosen to set aside partisan politics for the good of our patients and our profession. We bridge this gap by getting to know one another. Whether conservative, liberal or libertarian, physicians on our board and in the medical society hold many common values and similar professional qualities. It is of great importance to the success of PCMS and the physicians of this state, that we maintain this focus and fraternity.

Because of our allegiance and strength of purpose, we have attracted more physicians to join PCMS, during this past year, than in the recent past. We have become a larger, stronger, and more vocal society.

Senator Dale Brandland said at a rally in 2003 that we naïve physicians were being "out politicked." He strongly suggested we needed to learn the political ropes and apply such knowledge if we were to evoke change in Olympia. Since then we have proven to be an effective political force, deserving a seat at that table. Through our concerted efforts, we have achieved a degree of recognition and respect with key members of the legislature.

So what of the future? This is not the time to stand around patting our collective selves on the back, or whining about missed opportunities this past year. There is plenty to do. There is also great opportunity. Lucky for us we have the right physician to lead us, Pat Hogan. Pat is a proven leader who will be backed by an excellent board of directors, including incoming members **David Bales**, and **Loren Finley**. He is just the man Dave Barry had in mind.

The superb anchoring influence of our executive director, Sue Asher, will continue to serve PCMS in 2005. Sue is the hub around which we physician spokes emanate - the glue that holds us together and keeps us true to our mission. With her outstanding leadership and with the help from the PCMS staff, we can continue to be a force for our profession.

At the request of Pat Hogan and with the blessing of the board, I will continue to be active on behalf of medical liability reform. I know that with persistence we will eventually achieve meaningful results rendering any such further tort-related activities unnecessary.

"Everything has an end – except a sausage, which has two," so goes an Old Danish proverb. In my case, though my tenure as your president was not a sausage, it may have seemed hammy on more than a few occasions. Nonetheless, it has ended. I've had a wonderful time representing you. So, thanks again for that stretch, a period of growth, better than anything I could have imagined!■

Liability premium increases slowing, yet rates remain at record highs

15% of insurance companies expect "significant" rate increases over the next year. In 2003, 83% held that outlook

More than 67% of medical liability insurers say premiums seemed to be leveling off in 2004, according to results from the annual *Medical Liability Monitor* rate survey that looks at how much medical liability insurers are charging doctors.

But that's a thin silver lining in what is still a substantial cloud.

Rates are not leveling off everywhere. Triple-digit increases are still being reported by some carriers, the survey showed. And physicians who are experiencing smaller increases are still paying record-high rates.

Also, no one is predicting the end of a "hard market" that has insurers pulling out of certain areas and being more choosy about which physicians they'll insure.

"The crisis we see is not over," said American Medical Association President John C. Nelson, MD, MPH. "It's a tough time for doctors right now in the liability arena."

Tort reform that includes a $250,000 cap for noneconomic damages remains the AMA's No. 1 legislative priority.

Some liability insurers are reporting triple-digit rate hikes.

Those with a hand in the insurance business agree that the problem isn't solved.

"A lot of the big increases are behind us, but insurers have had big losses," said Lawrence Smarr, president of the Physician Insurers Association of America, an association of doctor-owned and/or operated medical liability insurers.

The 2004 rate survey asked companies to report their mature claims-made manual insurance rates with limits of $1 million/$3 million as of July 1 for three specialties: internists, general surgeon and ob-gyns.

Among the 788 rates that were reported, the majority of increases fell within the 6.9% to 24.9% range. That's an improvement over last year, when the majority of increases fell between the 10% and 49% range.

Barbara Dillard, editor of *Medical Liability Monitor*, noted that although the increases might be smaller, they are being added on to historically high insurance bills.

"Even though Dade County, Fla., obstetricians, for example, experienced only an 11.3% increase, their annual premiums were reported at $277,241 by one insurer," she said. "Illinois obstetricians are paying as much as $230,428, and in Michigan, it's as high as $193,819."

Location matters

Where physicians practice medicine did make a difference in how much they paid.

Medical Society of the State of New York associate counsel Moe Anster said rates continue to be trending upward, not stabilizing.

But in Nebraska, the environment is stable. Physicians there pay some of the lowest premiums in the country, and they credit tort reforms first enacted in the 1970s for the friendly environment. "We have doctors moving here from other states," said Sandy Johnson, executive vice president of the Nebraska Medical Assn.

In some states, whether a practice is in an urban or a rural area often makes a difference in rates, too.

Physicians in large urban areas tend to pay higher rates than doctors in other parts of the state, the survey showed. For example, internists in the Detroit area insured by APCapital are quoted $33,514 under the survey's criteria. The rate quoted for internists insured with that same company in other parts of the state (with the exception of the Saginaw and Grand Rapids areas) is $16,757.

"On the east side of the state [where Detroit is], we are hearing anecdotal stories about problems that physicians are experiencing," said John MacKeigan, MD, president of the Michigan State Medical Society. "A number of physicians in Wayne County have been forced to take employment situations with hospitals. It's the only way to continue practice. ... On the west side of the state, we're not hearing the same difficulties."

Dr. MacKeigan said the latest numbers are discouraging. Michigan has some tort reforms, including tough expert witness standards, a rule that holds physicians responsible only for their portion of the damages and a cap that is tied to inflation — more than $350,000 now.

"We are trying to get a handle on why we are paying some of the highest rates in the country," he said. "We are looking at alternative dispute resolution mechanisms."

For the most part, though, doctors in states with tort reforms tended to fare better than those in states without reforms, according to the survey.

For example, in California, where there is a $250,000 cap on noneconomic damages and other tort reforms, the highest reported rate for an ob-gyn in the Los Angeles area was $89,953, according to the survey. In Illinois, where the state Supreme Court has struck down previously passed caps, the highest rate reported was $230,428 in the Chicago area.

"The tort system is broken," said Harold L. Jensen, MD, chair of ISMIE Mutual Insurance Co., a policyholder-owned and -operated company. "The hard market is not over."

NORCAL Mutual Insurance Co. executives said they see a difference in

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Liability from page 7

the need for rate increases based on whether tort reform is in place. The company needed a 2% rate increase in California this year and took a 20% increase in Rhode Island after actuaries said a 51% increase was needed in the state, which lacks reforms.

"So much hinges on the local tort laws," said Phil Hinderberger, senior vice president and general counsel for NORCAL. As long as California's MICRA is in place, "we're looking at rate increases that track the cost of living."

Looking ahead

Compared with past years, fewer insurance firms expect to have to raise rates "significantly" in the coming year, the rate survey showed.

About 15% of firms that responded to the 2004 *Medical Liability Monitor* rate survey said they expect rates to increase significantly next year. In 2003, 83% forecast significant increases in the next year. (The survey did not quantify "significant.")

Physicians in states that have passed tort reforms in recent years are particularly optimistic. Mississippi and parts of Ohio are starting to see some stabilization.

In Texas, where voters enacted a $250,000 cap and then passed an initiative that made the cap constitutional, about half the state's physicians have seen a decrease in rates, with the Texas Medical Liability Trust decreasing rates by 17%.

"We're beginning to turn the corner," said Texas Medical Association President Bohn D. Allen, MD. "We're just keeping our fingers crossed that other states get relief."■

Reprinted from AMNews, 11/15/04

(See related graph page 11)

Local doctors staff medical tent at Ironman Triathalon Championships

From left, Drs. Loren Betteridge, Michael Bateman and Ben Betteridge

Drs. Loren Betteridge, Mike Bateman and Ben Betteridge staffed the medical tent at the Ironman Triathlon Championship in Kona, Hawaii in October to provide medical assistance to participants. Dr. Ben Betteridge is currently the chief resident of Emergency Medicine at Madigan. Dr. Mike Bateman and Dr. Loren Betteridge are family/sports medicine doctors with private practices in Tacoma. Dr. Bateman serves as the team physician at the University of Puget Sound. Dr. Loren Betteridge has provided medical support for Curtis High School athletics and competed in marathons and local triathlons.■

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.*

A Call to Action

Andrew Statson, MD

"We are born to action; and whatever is capable of suggesting and guiding action has power over us from the first."
Charles Colton Cooley (1902)

Even though I strongly mistrust politicians and have minimal faith in the political process, I thought I should pass along the information I just gathered, for the benefit of those of you who still believe that the legislature might want to do the right thing and grant us relief.

So far public rallies and meetings with legislators have been ineffective. Whenever our representatives have condescended to listen to us, they have taken what we had to say "under advisement" and have continued on their merry way.

One colleague from Maryland reported that their representatives, after canceling several scheduled sessions, finally met with the physicians and said that they will work on solving the problem, . . . eventually.

In the meantime, in Cheverly, Prince George county, there were eight practicing obstetrical groups prior to November 1, 2004. Only one has continued to do deliveries. The average increase in premiums for Maryland physicians was 28% this year and will be 35% in January. Of course, neuro-surgeons and obstetricians face much higher increases.

The physicians on the staff of Prince George Hospital in Cheverly voted to request from the administration that they be allowed to practice without insurance. So far the request has not been granted and there is little likelihood that it will be. The physicians are considering work slowdowns.

Virginia already has a cap on total awards in medical malpractice cases. Currently it is $1.75 million and is set to rise to $2 million next year. Obviously, that cap has not worked. Malpractice premiums have continued to rise with no relief in sight.

The Virginia physicians asked for a limit on attorney fees and a cap on pain and suffering of $250,000, in a way, a cap within a cap. They had rallies, meetings with the legislature and work stoppages, but so far they have not been successful.

This time, the Medical Society of Virginia has decided to stage a sit-in during the coming legislative session. They will have one hundred doctors wearing white coats in the chambers of the legislature every day that it is in session. I don't know whether they intend to carry signs or just be there and be seen.

Of course, the trial lawyers have countered that they will parade patients who have been presumably injured by malpractice through the halls of the legislature, wheelchairs and all. The confrontation, if they indeed proceed with it, promises to be interesting.

The Maryland Medical Society has not decided yet, but it may follow the example of the Virginians. The Connecticut Medical Association is currently discussing a similar approach and it seems that there is enough agreement among them to go ahead with it.

Whether anything will come out of these attempts is another story, but we are getting desperate and we are reaching for desperate measures.

As I indicated, I am pessimistic. As long as we remain on the job and continue to take care of patients, the legislators will look on us as just whining and nothing much is going to happen. Our voting block is too small to matter. We may contribute to political campaigns, but we can never hope to outspend the trial lawyers.

Our only hope is to appeal to the decent citizens of our state. When they understand our predicament and that it affects them as well; when they see that the more we suffer, the more they will suffer; when they realize what the powers that be are doing to us and that it is destroying our profession and at the same time destroying their chances for obtaining good medical care; they will come to our rescue and then we will win, but not before that.

I don't know whether actions as the one planned in Virginia will make a difference. I'm sure we'll hear if anything comes out of the Virginia legislature.

A German proverb asks, what is the use of running when we are not on the right road? The question before us is which one is the right road. I am afraid we don't yet have a clear answer. ■

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

Who's Paying What

See related story page 7

By specialty, these are the geographic areas with the highest or lowest reported premiums as of July 1. Companies reported the numbers based on their manual rates for specific mature claims-made policies with limits of $1 million/$3 million. They do not reflect credits, debit, dividends or other factors that could reduce or increase a premium. The ranking is by state, based on the highest and lowest rate reported in each state for each specialty. It is not an average for all of the rates reported for that specialty in that state and rates may vary by geographic area.

Highest Rates	2003	2004
Internists		
Florida (Dade)	$65,697	$69,310
Illinois (Cook)	$34,099	$58,514
Michigan (Wayne)	$39,562	$63,898
Ohio (Northeastern)	$18,883	$41,998
Texas (Cameron, Hidalgo)	$38,568	$36,018
General Surgeons		
Florida (Dade)	$226,542	$277,241
Illinois (Cook)	$99,806	$183,560
Michigan (Wayne)	$120,538	$193,819
Missouri (Kansas City)	$64,875	$132,314
Pennsylvania (Philadelphia)	$131,348	$135,406
Obstetricians-gynecologists		
Florida (Dade)	$249,196	$277,241
Illinois (Cook)	$138,031	$230,428
Michigan (Wayne)	$163,807	$193,819
Pennsylvania (Philadelphia)	$128,114	$172,178
Texas (Cameron, Hidalgo)	$136,020	$165,054

Lowest Rates	2003	2004
Internists		
Idaho	$3,770	$3,770
Minnesota	$3,375	$3,375
Nebraska	$3,212	$3,212
South Dakota	$3,697	$3,697
Wisconsin	$5,147	$5,147
General Surgeons		
Georgia (North Ga.)	$17,003	$17,003
Idaho	$14,514	$14,514
Minnesota	$11,306	$11,306
Nebraska	$9,621	$10,976
South Dakota	$9,597	$11,545
Obstetricians-gynecologists		
Idaho	$19,320	$19,320
Minnesota	$18,307	$19,630
Nebraska	$16,194	$16,194
South Dakota	$14,662	$17,638
Wisconsin	$23,677	$23,677

Source: Medical Liability Monitor 2004 Rate Survey

Physicians in crisis states contemplate moving

In states that the American Medical Association lists as being in a medical liability insurance crisis, 60% of physicians have considered moving to another state to reduce their premiums, according to a survey of 816 physicians.

They study, by physicians search company Jackson & Harris, also found that:

- 41% of physicians in crisis states have considered dropping their insurance and "going bare."
- 92% of physicians in crisis states said they were not happy with the way liability reform is progressing in their state.
- 86% of physicians in crisis and noncrisis states said medical liability reforms should apply uniformly across the United States. ■

Reprinted from AMNews, 11/15/04

Applicants for Membership

Kristin R. Briejer, MD
Family Practice
University Place Medical Clinic (MHS)
4230 Bridgeport Way W, University Place
253-459-7140
Med School: University of Washington
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

George N. Giacoppe, MD
General Medicine/Pulm/Crit Care Med
Madigan AMC, Tacoma
253-968-1290
Med School: Uniformed Services University of the Health Sciences
Internship: Madigan AMC
Residency: Letterman AMC
Fellowship: Fitzsimons AMC

Nancy R. Juhlin, MD
Otolaryngology/Allergy
Ear, Nose, Throat & Facial Plastic Surg Assc
101 2nd St NE, Auburn
253-833-6241
Med School: University of Iowa
Internship: Washington Hospital Center
Residency: Georgetown Univ Med Center

Kirin M. Rice, DO
Emergency Medicine
St. Francis Hospital
253-944-7971
Med School: Chicago College of Osteopathic Medicine
Internship: Brooke AMC
Residency: Brooke AMC

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COLLEGE OF MEDICAL EDUCATION

Register now for the Cardiology for Primary Care Program

The College's eighth annual Cardiology program featuring topics in cardiology for the primary care physician will be held at St. Joseph Hospital in the Lagerquist Conference Center.

This is an evening program that offers a total of six credit hours over two consecutive Tuesdays on January 11 and January 18, 2005. **Gregg Ostergren, DO** continues as the Course Director.

Topics for the upcoming program include:

- *Metabolic Syndrome: Risk Assessment and Cardiac Therapy*
- *Interluminal Health*
- *Women and Cardiovascular Disease*
- *Radiology and Cardiology*

This is an evening program for your convenience, giving you CME credit opportunity outside of office hours. The programs run from 6:00 pm to 9:00 pm on both nights.

This is a popular program. You can register right away by calling 253-627-7137. ■

Continuing Medical Education

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

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

CME at Whistler participants are urged to make their condo reservations early. A collection of one and two bedroom luxury condominiums, just steps from the Blackcomb chair and gondola, are available. Space is available on a first come first served basis.

The College's reserved block of rooms were released on December 1, but rooms may be available.

Reservations can be made by calling the *Aspens on Blackcomb* toll free at 1-866-788-5588.

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

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

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

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

The Power of the Apology

In this day and age, with physicians feeling besieged by malpractice claims and the fear of litigation, many physicians firmly believe that apologizing for a bad outcome in care is equivalent to an admission of guilt or wrongdoing. The obvious concern is that well-intended expressions of empathy will later be used as evidence against the physicians by the very patients they were trying to console! These same physicians naturally assume that their insurance company would not want them apologizing for a poor result or revealing information to a patient about what went wrong and why. Certainly, when actual medical errors do occur, the appropriate response should always be "deny and defend," right?

Actually, nothing could be further from the truth. In our view, it is always appropriate to be straightforward with the patient regarding all aspects of care. This applies in all circumstances, whether you are dealing with a bad outcome or actual patient injury resulting from a medical error. The facts regarding your care are what they are. The facts will not change and they should be shared with the patient. In short, your patients have a right to all of the information you possess relevant to their medical condition.

Our experience at Physicians Insurance clearly demonstrates that an authentic and sincere apology or expression of caring and concern over the patient's outcome has a tremendous influence in strengthening the physician-patient relationship and promoting patient trust. Importantly, this enhanced trust greatly reduces the likelihood that the patient will seek answers through the financially and emotionally taxing legal system.

Most often, it is a *lack of communication* or a physician's *failure to commiserate* that make a patient believe the physician is unconcerned. Then the patient considers ways to take control of the situation to get the physician's attention. Typically, this involves hiring a plaintiff attorney to "get some answers" - and then the misery begins!

Fortunately, the State of Washington also believes that saying you are sorry is a good thing to do. The state encourages these sympathetic gestures by reducing concerns that these expressions may later be used as evidence against you. This was accomplished through enactment of RCW 5.66.010, which states:

RCW 5.66.010
Admissibility of sympathetic gestures.

1) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident, and made to that person or to the family of that person, shall be inadmissible as evidence in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be made inadmissible by this section.

2) For purposes of this section:

a. "Accident" means an occurrence resulting in injury or death to one or more person that is not the result of willful action by a party.

b. "Benevolent gestures" means actions that convey a sense of compassion or commiseration emanating from humane impulses.

c. "Family" means the spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half brother, half sister, adopted child of a parent, or spouse's parents of an injured party.

Of note is the fact that any "statement of fault" is admissible.

In summary, you should always remember the *power of the apology* and the importance of your expressions of concern and caring. These are some of the most important tools you can use in developing patient trust and confidence, allowing you to then enjoy all of the benefits of a stronger physician-patient relationship. ■

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Classified Advertising

POSITIONS AVAILABLE

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

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For Rent: 3300 sq ft Class A medical office in Tacoma Medical Center, 1112 6th Ave, third floor. Elevator, underground parking, close to hospitals, ownership options. Call 253-272-2224.

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