Pierce County Medical Society
BULLETIN

January, 2006

The 2005 Annual Meeting

Dr. Patrick Hogan (right) turns the 2006 gavel and presidency over to Dr. Joseph Jasper at the PCMS Annual Meeting

Dr. Mike Kelly (left) was the recipient of the 2005 Community Service Award presented to him by Dr. Jim Rooks

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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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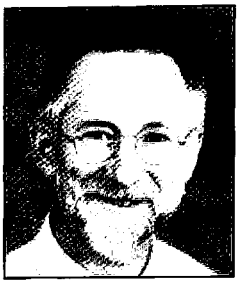
President's Page

by Joseph F. Jasper, MD

Private Practice Survival Issues for 2006



Joseph F. Jasper, MD

The viability of medical practice in America, particularly private practice, is increasingly under assault, challenged by numerous attackers.

Our nation's forefathers wisely established a Bill of Rights for Americans. However, we physicians have allowed our own individual rights to be sacrificed. We face assaults through faulty review systems, economic credentialing, inappropriate hospital influence over referral patterns, and economic pressures. Private practice has been changing and no doubt will continue to do so. What role do we doctors want to assume?

Due Process & Physician Review Systems

I am concerned about faulty review systems. Consider our Medical Quality Assurance Commission and how it conducts its review. Why do ordinary citizens have the right to face their accuser, the right to live and work as innocent until proven guilty, the right to have a record expunged when not guilty, the right to exclude non-convicted accusations from applications – yet doctors do not enjoy these rights? Aren't we physicians entitled to DUE PROCESS under constitutional law by the Bill of Rights?

A physician lodging complaint against or viewed as competing with a hospital may be subjected to undue peer review also known as SHAM PEER REVIEW which may result in actions or loss of privileges, leading to consequences that can render the doctor unemployable. Primarily at issue is the emerging trend of hospitals to change the language of immunity granted peer review. Historically, this immunity is allowed only if the peer review is conducted in good faith. In other words, vindictive peer review is not immune. The language now imposed in contracts and bylaws is now frequently changed to *absolute immunity*. If a hospital drops a physician's privileges vindictively, under absolute immunity rules, the doctor would have no recourse.

Hospital physician staffs in most hospitals were formerly led by, and the bylaws written by, physicians. In Tacoma, this is no longer the case. I believe, as does the AMA and AAPS, physicians must regain control of medical staff bylaws and peer review. We must make certain that contracts with hospitals and insurers are written fairly with our rights secured.

Economic Credentialing

Physicians who appear too expensive to a payer or hospital may lose credentials with the payer or hospital. This ECONOMIC CREDENTIALING has far reaching consequences. An e-mail from one of our colleagues in Texas recounted his experience:

"I just got economically credentialed off of BCBS's special BlueChoice Solutions, having previously been anointed for it. When I asked to see the data they used to determine that I'm not as cost-effective as some of my colleagues, I was stonewalled (hardly surprising). I told them I couldn't improve if I didn't know what I was doing wrong."

Referral Patterns

Hospitals have entered the business of promoting practices that use the hospital's facilities or other hospital employed physicians. Further, hospitals employ both primary care and specialist physicians and now wield unprecedented power of influence over referral patterns. The economic interest of the hospital is prioritized over the quality of care in the referral recommendation. We physicians need to avoid falling for the hospital's financial interests over our patients' best care.

I know of a situation that highlights the hospital influenced referral. A family friend's child has a recent onset of unusual health problems. The family agreed to pursue labs, scans, and other consultations. The hospital employed primary care doctor told the family to use the hospital's labs, radiologic services and doctors. Having no insurance restrictions, the mother wanted alternatives but none were offered. Rather, the family doctor emphasized using only his hospital's facilities. Given the family's desire for alternatives, this referral practice is wrong, economically motivated and significantly impairs the private community physicians of their ability to compete in business. Hospitals should be forbidden from dictating referral patterns. Remember, **DOCTORS PRACTICE MEDICINE, NOT HOSPITALS.**

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Economic Pressures

I read an article this summer that addressed the issue of the **business of medical practice** in America. The author's message was that we cannot practice medicine if we don't get paid for it. More and more often, physicians agree we need to "make money to continue helping patients." Our ability to make money is under attack, whether through declining reimbursements or increasingly unmanageable expenses, including medical malpractice premiums. Some specialties have been fortunate thus far and spared the dramatic increases in malpractice premiums that targeted specialties such as neurosurgery and obstetrics. How much longer before the remainder falls victim to crushing economic imbalance of reimbursement versus the cost of operating a medical practice?

If a child misbehaves repeatedly without facing any stinging consequences, what happens? Typically, the adverse behavior continues and likely worsens. Psychologists and society recommend that there be consequences to bad behavior. During the past three years, the WSMA and our county medical society's main political focus has been reform of the medical liability system. Yet, two legislative sessions and one initiative later, we still have no reform. Trial attorneys are celebrating. I cannot ask physicians to strike or forsake Washington for physician friendly states. However, I can pose the following question. Without *consequences*, what are the legislators and public to think? I would guess they would argue, "There really was not a serious problem." Hence, Washington will continue to fail attempts to reform the medical liability system.

One thing I can ask all of us to do is **budget one day January 23, the WSMA legislative day**. Schedule that day to demonstrate physician solidarity. In the past, of 10,000 WA doctors only 250 would show up in Olympia. I believe it is now time for the majority of us to demonstrate our seriousness, our resolve, our solidarity. Additionally each of us should meet and come to know our three legislators and tell them of physicians' issues.

Role of Physicians

Change will not occur because medical society leadership recommends it. Change will occur when the mass of community doctors take action with one committed voice.

Leading hundreds of physicians toward solidarity and one committed voice is a challenge. I have already enlisted the help of several board members to research in detail the aforementioned topics. Your PCMS leadership shall provide you with more details in upcoming meetings and bulletins. I look forward to hearing from you, and I'll see you in Olympia. ■

Annual Meeting Recap

2005 Annual Meeting - What a Crowd!

The Tacoma Sheraton was alive and well on Tuesday, December 13 when the PCMS Annual Meeting was held, featuring the legendary Warren Miller as guest speaker. With close to record attendance of 245 people, the evening was full, fun and festive. The evening included the ever popular raffle drawings, music by the Tacoma Youth Symphony, special awards and recognitions and of course the changing of the officers and leadership.

The evening's highlights included presentation of the Community Service Award to **Dr. Michael Kelly,** (see page 7) recognition of the many physicians that participated over the years in making Washington State smoke free by **Dr. John Rowlands**, (see page 15) and a wonderful keynote speaker who was thought provoking, funny and included hilarious movie clips from ski lift mishaps that really entertained.

Dr. Pat Hogan, President, opened the meeting by thanking the members of the Tacoma Youth Symphony and introducing Nikki Crowley (**James Crowley, MD**), PCMS Foundation Treasurer who along with Mona Baghdadi (**Tarek Baghdadi, MD**), Foundation Board member organized the holiday sharing card project this year. Nikki introduced Jihara Teague, the artist for the 2006 holiday card. Jihara drew three tickets that were the winning numbers for the raffle. Lucky winners included Patricia Palms (wife of **Kiyoaky Hori, MD**) and Winn Archambeau-Munoz (wife of **David Munoz, MD**) and **Dr. John Blair**, Tacoma orthopedic surgeon.

Dr. Hogan asked for a moment of silence to honor colleagues that died during the past year. They included **Drs. William Burrows, John Merrick, Max Thomas** and **Marshall Whitacre.** He then asked past-presidents to stand and introduce themselves, suggesting that they include the year they served, if they could remember. Past presidents in attendance included **Drs. Ted Baer (1977), Dick Bowe (1987), Pat Duffy (1984), Ken Graham (1979), Stan Harris (1997), Dave Hopkins (1976), Bill Jackson (1988), Mike Kelly (2004), Gordy Klatt (1990), Larry Larson (1999), David Law (1995), Jim Rooks (2003), John Rowlands (1996), Susan Salo (2002), Patrice Stevenson (2001),** and **George Tanbara (1981).**

Dr. Hogan thanked the board members that served during his tenure the past year including **Drs. Joe Jasper, Mike Kelly, Joe Regimbal, Sumner Schoenike, Laurel Harris, David Bales, Ken Feucht, Loren Finley, Jeff Nacht, Navdeep Rai and Carl Wulfestieg.**

With one last, very important, recognition before turning over the gavel to Dr. Jasper, Dr. Hogan asked Dr. Mike Kelly to the podium. Noting that Dr. Kelly's term as past-president was ending, it would bring to an end seven years of service to PCMS from Dr. Kelly. An accomplishment worth noting as Dr. Kelly has served in every officer and trustee position available. Dr. Hogan presented a gift to Dr. Kelly and thanked him for his

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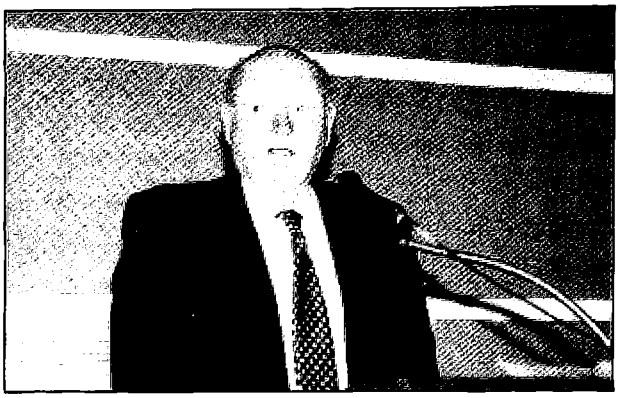

The legendary Warren Miller, speaking to the crowded ballroom of physicians and guests, did not disappoint

Dr. Pat Hogan, at the podium, saying farewell to presidential duties

Dr. Joe Jasper, at the podium, reviewing plans for 2006

Dr. Mike Kelly, at the podium, after receiving the community service award

Dr. John Rowlands, at the podium, chronicling PCMS' tobacco work

Dr. Joe Wearn, semi-retired pediatrician and his wife Pat, seated with Dr. John Blair, Tacoma orthopedic surgeon, left

Nikki Crowley, PCMS Foundation Treasurer, with holiday sharing card artist Jihara Teague and her parents, Lynette and Dion

Patricia Palms, wife of Ki Hori, retired anesthesiologist, was the first winner of three whose numbers were drawn in the raffle that supports the PCMS Foundation

From left, wives Bev Law and Janet Fry visit adjacent to their husband physicians Drs. David Law and Jim Fry, who both practice in Tacoma

Winn Archambeau-Munoz, wife of Dr. David Munoz, selects her basket that she won in the PCMS Foundation raffle

Dr. John Blair, another lucky winner of the raffle drawing, received a "gourmet" basket of chocolate and coffee items

2005 Community Service Award

Michael J. Kelly, MD honored as Community Service Award winner for 2005

The 2005 Community Service Award was presented to Lakewood family physician **Michael J. Kelly, MD.** Presenting the award on behalf of the PCMS Board of Trustees at the Annual Meeting was **Dr. Jim Rooks.** Dr. Kelly was honored for his exceptional work on tort reform the last several years. The introduction is printed below:

I am very pleased to have the honor of presenting the PCMS Community Service award for 2005. As you will realize by looking at this evening's program, this is an honor bestowed upon a select few of our colleagues – some obvious, up-front leaders and some quiet and in the background, as they go about their lives, always contributing in some fashion or another.

Let me assure you, there is nothing quiet about tonight's honoree. A self-described "loquacious Irishman," he fits well among the previous 13 recipients of this award, a blending of drive, determination and fortitude; compassion, caring and humility. One of a kind, really, as he embodies both styles; sometimes up-front and leading, other times hard at work behind the scenes.

He served as our president in 2004 and literally "led the charge" for tort reform. He did so again this year by chairing the tort reform committee while serving as past president. He has even agreed to continue his work for us in 2006 after leaving the Board of Trustees. If you want to know ANYTHING about our current tort system or reform of such, he is the go-to guy. He can quote studies and statistics, or if by chance you are able to stump him, he will refer to his hefty reference manual, a compilation of data that he has organized as backup.

I am sure that there is no one, other than his wife maybe, who really knows the amount of study, research, time, dedication and concern that he has expended preparing to do battle with legislators, patients, trial attorneys, and yes, even us, his own colleagues, over tort reform. He has answers, he is prepared, and he does his homework. He has faced the opposition head on...live debates with personal injury attorneys the likes of Jack Connelly and the past president of the Washington State Trial Lawyer's Association Mr. Rod Ray. He has spoken to more community groups, civic organizations and political bodies in the last three years than the rest of us probably will in our lifetimes. He never says no. He has done our society very proud in representing us credibly and with much aplomb.

His member file at the PCMS office is a good three inches thick. Filled with copies of letters he has meticulously written to newspaper editors, insurance companies, elected officials and the like. Providing helpful and consistent counsel about medicine in efforts to improve the profession is his forte. Layered in are copies of newspaper articles quoting him or about him including one from The News Tribune on physicians accepting Medicare and Medicaid patients. Big picture, front page, stethoscope in place, taking a blood pressure – the embodiment of a true family physician.

Dr. Mike Kelly with his plaque, flanked by his son Spencer and his wife Sam

Of course, there is much more to this incredible man than his profession and his commitment to tort reform and the Pierce County Medical Society. A dedicated family man, he serves as a team physician for his son's high school. He is active in his church and the YMCA. He supports the PCMS CHAMP initiative, keeping himself physically fit and challenged by his self-disciplined exercise. He personifies the term role-model.

I have been close colleagues and good friends with Dr. Michael Kelly for 16 years and I cannot think of anyone more deserving of this award.

Please join me in honoring and saying thank you to Dr. Michael Kelly.

We owe him a debt of gratitude.

PCMS thanks and offers heartfelt congratulations to Dr. Mike Kelly. ■

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exceptional tenure.

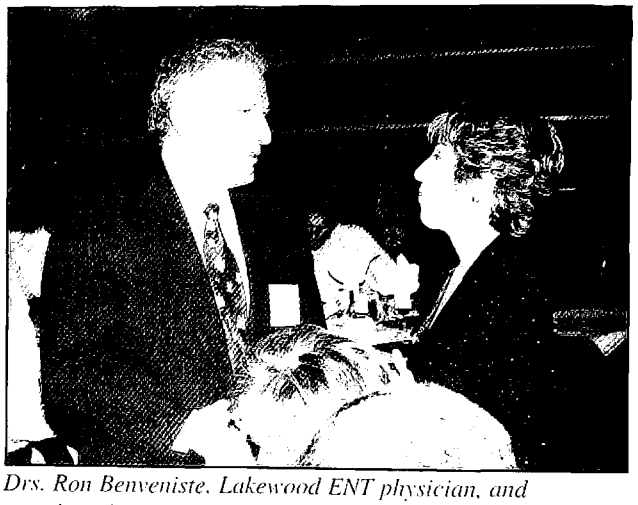
Dr. Hogan then introduced the President for 2006, Dr. Joseph Jasper, and presented him with his gavel. Dr. Jasper thanked Dr. Hogan and presented him with a gift and a plaque for his service to PCMS. Dr. Jasper noted that Dr. Hogan led during an extremely busy year and worked tirelessly on the CHAMP (Coalition for Healthy, Active Medical Professionals) initiative while initiatives for both tort reform and tobacco control were conducted.

Dr. Jasper then introduced the new board of trustees for 2006 that will serve beside him including: **Drs. Sumner Schoenike, Jeff Nacht, Laurel Harris, Nick Rajacich, Pat Hogan, David Bales, Ken Feucht, Harold Boyd, Paul Schneider, Leaza Dierwechter** and **Harald Schoeppner.** Dr. Jasper reviewed what he would like the PCMS priorities to be for 2006 which he called private practice survival issues for 2006 and they include due process and physician review systems, economic credentialing, referral patterns, and economic pressures.

Adding that he hoped to continue the CHAMP and tort reform initiatives into 2006, he promised another very busy year for PCMS. And then, with the strike of his presidential gavel, he adjourned the meeting. ■

Warren Miller's autographed tape and poster sales were brisk before and after the meeting

Dr. Andy Loomis and his wife Toni visit with table mates. Dr. Loomis practices primary care in Tacoma's north end



Drs. Ron Benveniste, Lakewood ENT physician, and anesthesiologist Vita Pliskow visit just before dinner

New PCMS member Dr. Belinda Rone, Fircrest pediatrician, visits with Dr. Julie Gustafson, Puyallup ENT physician and her husband David Keers

Drs. Henry Retailliau, Tacoma internist (left) and Michael Priebe, gastroenterologist, pose for the camera just before dinner starts

New Board of Trustees will lead PCMS in 2006

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.

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.

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.

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.

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

Nicholas Rajacich, MD practices orthopedic surgery in Tacoma. He graduated from Johns Hopkins School of Medicine and completed a residency in orthopedics at San Francisco Orthopedic Training Program at St. Mary's Hospital and a fellowship at Hospital for Sick Children in Toronto.

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

Harold Boyd, MD practices emergency medicine in Tacoma. He graduated from the University of Washington School of Medicine. He completed his internship at Sacramento Medical Center and residency at Shasta General Hospital in Redding, California.

Leaza Dierwechter, MD is a general surgeon in Tacoma. She received her medical education from Yale University and completed her internship at Virginia Mason Medical Center and residency at Maricopa Medical Center in Phoenix, Arizona.

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.

Paul Schneider, MD practices internal medicine in Gig Harbor. He received his medical degree from the University of Washington School of Medicine. He completed his internship and residency in internal medicine at Fitzsimons Army Medical Center and a fellowship in nephrology at Walter Reed Army Medical Center.

Harald Schoeppner, MD practices gastroenterology in Tacoma. He graduated from the University of Wuerzburg in Wuerzburg, Germany and completed his internship, residency and fellowship at Henry Ford Hospital in Detroit, Michigan.

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.

Editor's Note

The State Medical Board's new sexual misconduct policy does include key third parties including, but not limited to, spouses, partners, parents, siblings, children, guardians and proxies. For a copy of the new policy, call PCMS 572-3667 or visit https://fortress.wa.gov/doh/hpqa/HPS5/Medical/default.htm. ■

Correction

The quote, "Never doubt that a small group of people dedicated to a cause can change the world. Indeed it is the only thing that ever has," which appeared in the President's page of the December 2005 PCMS *Bulletin* was not attributed to it's author, Margaret Mead. We apologize for the error. ■

Applicants for Membership

Ahmad Abadullah, MD
Internal Medicine
Peninsula Internal Medicine Associates
4423 Pt. Fosdick Dr NW #200, Gig Harbor
253-853-2702
Med School: Dow Medical College
Internship: Civil Hospital
Residency: Grace Hospital/Wayne State

Edward S. Hutner, MD
General Surgery
South Hill Surgical Practice
11212 Sunrise Blvd E #201, Puyallup
253-770-9111
Med School: Tufts University
Internship: Mt. Sinai Medical Center
Residency: Mt. Sinai Medical Center
Residency: Shands Jacksonville

Meldy Taswin, MD
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253-697-4650
Med School: Universitas Gadjah Mada
Internship: St. Barnabas Hospital
Residency: St. Barnabas Hospital

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Pandemic Flu Preparation

Federico Cruz, MD

Intense community-wide planning has occurred recently to prepare Pierce County for an influenza pandemic. The major areas our plans address are no surprise:

1) Surveillance...making sure that there is a 24/7 system in place to systematically collect data from multiple clinical sites across the county. The who's how's where's and when's of the disease.

2) Disease control...use of isolation and quarantine measures to slow the spread of the virus; distribution of anti-virals and vaccines as they become available.

3) Communication...assuring that timely, accurate and relevant information gets out to the public and to our partners, especially the availability of resources and approaches that people can use to safeguard themselves and their families.

4) Coordination of care...for those with the pandemic strain of the flu.

All of these issues are daunting when you consider the scale of the event. We are a county of over 750,000 people, of whom we know a significant percent will get sick and need care. A flu pandemic will get everyone's attention. We will get the cooperation of our elected officials to focus public and private health care resources. Other government agencies will help to coordinate resource distribution. In a flu pandemic, we will rely on the assistance and cooperation of a variety of public and private enterprises. Because of the compelling nature of this event, policy makers, funders, and, I believe, even the public, will step past much of the pressure of different special interest groups. Under the threat of mass illness and death everyone will see more clearly what we need to do to provide for the community's needs.

This of course does not happen in normal circumstances.

On a day-to-day basis, we know that we have a health care system that just doesn't meet our needs as a community. It is not a matter of money and being under-funded. We spend huge amounts on health care but our health still lags behind many countries. The clarity of response and coordination of resources that will be evident during a pandemic needs to be activated daily to strengthen our medical system.

Each year during December I look back at the year and take stock on what has happened to the health of my community. Have things gotten better or worse? Have any of our local initiatives made any difference? Are we better positioned to take on the big health issues facing us?

2005 has been an eventful year. The highs and lows have been dramatic. From the failure of I-330 to the passage of I-901, we have slipped into the depths and we have ascended the heights. Can we build on our successes and learn from our losses? What are the issues that we need to step forward on in 2006?

My list is short in 2006. I am tasked to prepare our community for the possibility of a pandemic flu outbreak so those complex issues of surveillance, disease control, communication and coordination of care go to the top of my list. We will take them on and make progress as we have huge drivers behind us. But I have to ask myself: can't the discussions and planning activities that will ready our community for a pandemic also be used to address some of the other deep-seated health issues that afflict our community? We talk about accessing the care system during the crisis of a pandemic. Can't we have a similar discussion of accessing the care system during more normal times? How do we structure a system for those in need to get basic services during a time of crisis? becomes "how do we structure our system for those in need to access basic services on an everyday basis?"

There is much energy and anxiety driving our pandemic discussions. It feels very tangible and workable. I would like to have similar discussions on the long-term access to care issues that so plague our county, with comparable energy and urgency. The threat of pandemic flu is real but so is the threat of an increasing number of community members who will not easily be able to access the basic health care that they need to be healthy.

May we live in interesting times. I look forward to 2006 and the discussions we will have. Certainly around pandemic flu preparation but I also hope around access to care. □

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.*

Physician Burnout

Andrew Statson, MD

"In order that people may be happy in their work, these three things are needed: they must be fit for it; they must not do too much of it; and they must have a sense of success in it—not a doubtful sense, such as needs some testimony of others for its confirmation, but a sure sense, or rather knowledge, that so much work has been done well, and fruitfully done, whatever the world may say or think about it."
W. H. Auden (1970)

According to a survey published in the October 2005 issue of *ACOG Today*, the earliest symptoms of burnout are subtle. They consist mostly of tiredness not relieved by rest, irritability, anxiety, poor concentration and forgetfulness.

I had them all. I didn't realize it at the time, but during the last few years in practice, I was burning out. I felt grumpy, tense, pressured, and didn't know why. If during that time I offended any of my coworkers, I apologize and I hope that you'll forgive me. When I quit medicine, I felt an immense sense of relief.

ACOG Today published the results of a poll, carried out during the 2004 annual meeting of District III (Pennsylvania, New Jersey and Delaware). Of the 863 responders, 64% reported symptoms of burnout. Workload was a major factor. Their work week averaged 59 hours, not counting nights on call.

The respondents repeatedly said that they were overwhelmed by the amount of work. They were spinning their wheels and could never get done. Most fellows had increased their volume of work by 20-30% to maintain their income, or even just to keep it from dropping more than 20%. So, among those who increased their workload, the burnout rate was 76%. Among the few who reported a decrease in work, the burnout rate still was 46%.

Pascal Cathebras et al. (*La Presse Médicale*, 18 Dec 2004), in their survey of general practitioners in Saint Etienne, France, listed the manifestations of burnout as emotional exhaustion, depersonalization and dissatisfaction with personal accomplishments. They found that the causes of burnout were high work load, administrative demands, conflicts with social welfare organizations, and excessive demands from patients and family.

They concluded, "Burnout among general practitioners in France is a reality. Their quality of life is significantly impaired, and that may lead to deleterious consequences for the care of their patients."

Martinez de la Casa did a survey in Toledo, Spain, published in October 2003. He polled 106 primary care physicians and 129 specialists. He got replies from 61.27%. Of these, 76.4% reported moderate or high level of burnout (85.7% of primary care physicians, 69.1% of specialists). Even if we assumed that those who did not reply to the questionnaire had no burnout at all, fully 47% of the physicians had moderate or severe symptoms.

An Israeli study, published in the *Israel Medical Association Journal* in August 2004, reported that rates of burnout in samples of physicians from 2001 were significantly higher than in samples from the mid 1990s.

P. Biaggi et al, in the *Swiss Medical Weekly* (June 2003), noted that resident physicians in Zurich suffered from burnout, which resulted in a resentment of patients and even an aversion toward them.

A Medline search of articles on physician burnout listed 499 entries. There were a number of studies from Germany, Spain, Italy, France, Israel, the Netherlands, Denmark, Britain, Canada, and Australia. They came from all over the world, and almost all of them were published within the past five years. A number of them were about nursing and other personnel.

Relatively few were from the U.S., and overall the problems they reported seemed to be relatively mild, compared with those from other countries. One reported a high rate of burnout among orthopedic residents, even after the newly imposed legal restrictions on their work hours.

The recurrent themes in the articles were the loss of professional autonomy, decreased income, decreased personal satisfaction, increased workload, and increased demands from patients and family. An editorial in *Australian Family Physician* (Nov. 2003) expressed the problem succinctly with its title, "Red Tape, Burnout and Fatigue."

In the *Medical Journal of Australia* of October 2004, G. J. Riley et al. wrote, "Stress in doctors is a product of the interaction between the demanding nature

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of their work and their often obsessive, conscientious and committed personalities. In the face of extremely demanding work, a subjective lack of control and insufficient rewards are powerful sources of stress in doctors. If demands continue to rise and adjustments are not made, then inevitably a "correction" will occur, which may take the form of "burnout," or physical or mental impairment. Doctors need to reclaim control of their work environment, and employers need to recognize the need for doctors to participate in decisions affecting their work lives."

So what can we do? We could tighten our belts a few notches, sell our houses and move into condos, make our children work for their education, and reduce our expectations for retirement.

Even so, reducing our work load will not bring back the joy to the practice of medicine. I am afraid that the loss of autonomy, the dictates to practice according to standards developed by lawyers and insurance executives, the growing paperwork burden destined to prove that we are doing what we were told and the way we were told to do it, the routine questioning of our decisions, all these hassles connected with the practice of medicine today have led to our depersonalization as competent, thinking human beings.

We have turned into robots, and probably would readily be replaced with ones, were it not for the manual dexterity needed for the performance of our work.

If anyone had hoped that switching to a National Health Plan would make things better, the reports of massive physician burnout in the countries that already have it should persuade you that such is not the answer.

Our problem is that we care. If we didn't, we wouldn't be in this profession. We care about our patients, we care about doing a good job. We know that we are mistreated. We know that our worth is not appreciated. We know that our services are not compensated at their true value. We know all that, but as long as we continue to practice, we cannot abandon our patients.

We are under attack from all sides, individually and as a profession. Knowing that, we must support one another, or we will not survive. Medicine is a lonely endeavor. Even in a group, we face the patients alone. Most of the time, we have to make decisions on the spot. We strive to do the best we can under the circumstances. We must be confident that our colleagues are on our side. ■

Physicians vital to smoke-free Washington

With Washington State implementing one of the strongest no smoking policies in the nation just five days before the PCMS annual meeting, it seemed timely to recognize and honor the physicians that over the last 40 years played significant roles in achieving this goal.

Who better to review the PCMS "tobacco history" than pulmonologist and PCMS Past-President, **Dr. John Rowlands**. Noting that PCMS did not publicly wave the banner against smoking until the mid 1960s, it was in April of 1964, just three months after the first Surgeon Generals Report on smoking was released, that **Dr. Stan Tuell** reported on his editorial page that quitting smoking had become acceptable - for status seekers.

As Dr. Rowland's pointed out, there have been many people over many years that have played a part in this incredible movement, and now is the time for public thanks to these folks who stepped up to help.

Dr. Rowlands began by asking, how could any public health initiative that has transpired in Pierce County in the last 50 years, not begin with **Dr. George Tanbara**. As chair of the PCMS public health committee in the 1960s, this public health icon watched this entire scenario unfold. As Dr. Tanbara told a discouraged colleague in the 1980s, "these things just take time, be patient and it will happen." Dr. Tanbara remained committed and determined to chip away at helping people not to smoke while at the same time encouraging our policy leaders

See "Smoking" page 16

From left, Drs. Gordon Klatt, Patrick Hogan and Federico Cruz-Uribe - all significant contributors to a smoke-free Pierce County/Washington

David Vance, public health manager with the Tacoma-Pierce County Health Department was honored for his tireless work for a smoke-free Washington

Smoking from page 15

to restrict the unhealthful habit in public.

In 1983, when the health consequences of smoking were well documented, the PCMS Public Health School Health Committee, chaired by **Dr. Terry Torgenrud** made plans to publicly address the issue. **Dr. George Weis**, a PCMS radiologist suggested that they work to have Washington State enact a Clean Indoor Air Act as had been accomplished in Minnesota. **Drs. Larry Larson** and **David Sparling** also served on the committee, which split to an ad-hoc tobacco group in 1984. PCMS members testifying at a Pierce County Council Meeting to restrict smoking in public places and the workplace included **Drs. Pat Duffy, Terry Torgenrud, Alan Tice, George Weis, David Sparling, Joe Wearn** and **Dr. John Rowlands**.

This group of physicians carried the banner through most of the 1980s to city councils, county councils, state legislators and boards of health. The efforts continued as they moved two steps forward and one step back against big tobacco and a public that was not yet ready to fully embrace the changes.

In 1988, the tobacco committee joined forces with other agencies working toward the same goal. The Tobacco Free Coalition, under the leadership of **Dr. Gordy Klatt** set their goal to have Pierce County smoke free by the year 2000. The Tobacco Free Coalition included several PCMS members including **Drs. John Lenihan, Richard Hawkins, Amy Yu,** and **Clyde Koontz.** They worked on banning tobacco advertising, restricting vending machine access to kids, tobacco sales to minors and other important regulatory actions.

In 1989, Dr. Klatt led the effort to convince the six non-governmental hospitals in the county to adopt no smoking policies - a forerunner to the total hospital campus ban that will take effect January 1, 2006.

And, let's not forget one of the most applauded accomplishments prompted by **Dr. Richard Waltman,** with great kudos to Drs. Gordy Klatt and Clyde Koontz, the removal of the Marlboro Man from Cheney Stadium at the end of the 1991 baseball season.

In 1992 Dr. Pat Hogan assumed the Presidency of the Coalition as they began a new decade of battle. County advocates became united and organized under Dr. Hogan's leadership. Quickly becoming a well known crusader for better health, he dedicated every spare minute he had to eliminating tobacco from people's lives. It can't be overlooked that his contributions have not only been regulatory reform, but equally as significant for smokers trying to quit smoking. He formed the non-smoking sup-

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Snow is great and everyone is anticipating a busy, fun ski season so plan now for the College's January 25-28 CME program at Whistler.

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The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, Sunday - Friday, April 2-7, 2006.

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DON'T DELAY, MAKE YOUR RESERVATIONS NOW!■

Continuing Medical Education

Cardiology for Primary Care Course Postponed

The Cardiology for Primary Care CME course scheduled for Tuesday evenings, January 10 and 17 in early 2006 has been postponed and will be rescheduled on the course calendar for 2006-2007. We apologize for any inconvenience. If you have questions, call the College of 253-627-7137.

Dates	Program	Director(s)
Wednesday-Saturday January 25-28	CME at Whistler	John Jiganti, MD
Friday, March 10	Mental Health Review	David Law, MD
Sunday-Friday April 2-7	CME at Hawaii	Mark Craddock, MD
Friday-Saturday May 5-6	Internal Medicine Review 2006	John Hurst, MD
Friday, June 2	Primary Care 2006	Steve Duncan, MD

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port group that to this day meets every Thursday evening at St. Joseph's hospital. Dr. Hogan has attended these meetings for the past 12 years! Trying to outline the contributions Pat Hogan has made in the last 13 years to our state now being smoke free would take all night.

The success of eliminating tobacco smoke in public has taken the work of many people. Add one dedicated and determined public health officer and we are almost home. Convincing his board of health that eliminating public tobacco smoke in our county was the right thing to do, **Dr. Federico Cruz** set off a firecracker that forced people to engage, at least one way or another.

The Pierce County smoking ban was on and then it was off, after unsuccessful legal challenges. More determined than ever, Dr. Cruz came back with a vengeance. Facing the reality that county health boards could not implement the restrictions, and given that the state legislature would more than likely never do so, it became obvious the only way to be successful was to let the voters decide via the initiative process. And, fortunately, Dr. Cruz stepped up to his only option and the challenge he faced.

Well, the rest is very recent history, but it did take two attempts to be successful. The first in 2004, was successful in many ways, but ultimately failed due to lack of funding. However, it becomes a very important piece of the process as it paved the way for the "big three" non-profits, the Heart, Lung and Cancer organizations to finally step forward and put their clout, but more importantly their money behind the second, organized attempt.

There is no doubt, as was recently editorialized by *The News Tribune*, "the new law's roots lie in Pierce County."

After recognition of physicians, Dr. Rowlands turned the podium over the Dr. Pat Hogan who gave thanks and recognition to the one non-physician who contributed most significantly to the success of Initiative 901. David Vance, public health manager with the Tacoma Pierce County Health Department worked tirelessly on his own time to ensure that the initiative undertaking would be successful. As Dr. Hogan read from his plaque, "with heartfelt gratitude the physicians of Pierce County honor and give thanks to David Vance for your leadership and dedication in making Washington State smoke free."■

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service, Madigan Army Medical Center will be hosting the 21st Annual Physical Medicine and Rehabilitation Conference on March 14th-17th 2006 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will lecture on Technological and Therapeutic Advances in the Management of Chronic Spine and Musculoskeletal Pain, Electrodiagnosis, Stroke, Peripheral Neuropathy, Pediatrics, Osteoporosis, Prosthetics & Orthotics, War Time Injuries and Rehabilitation, and Evidence Based Medicine.

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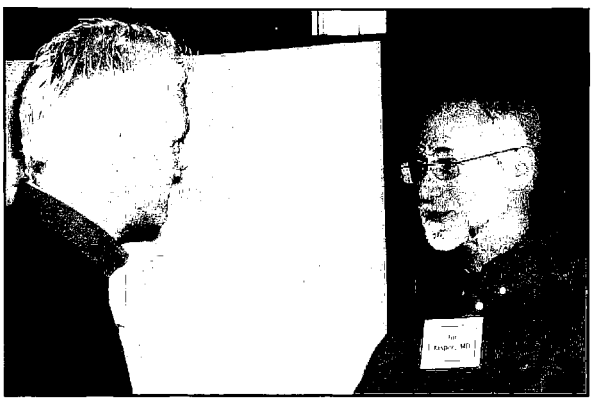
Pierce County Medical Society
BULLETIN

February, 2006

PCMS Leadership Participates in Annual Retreat



L to R: Sumner Schoenike, MD, PCMS President-Elect and Joe Jasper, MD, PCMS President

L to R: Patrick Hogan, DO, PCMS Past President and Harald Schoeppner, MD, PCMS Trustee

L to R: Paul Schneider, MD, PCMS Trustee and Ken Feucht, MD, PCMS Trustee

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of 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, 2006

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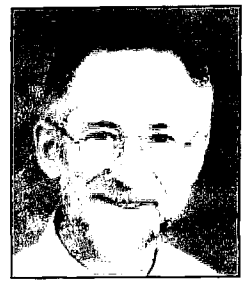
President's Page

by Joseph F. Jasper, MD



Joseph F. Jasper, MD

Reimbursement

"Now that you are President, what are you going to do to increase Medicare reimbursement?"

Minutes after I was sworn in as PCMS President, the spouse of a respected Tacoma physician posed the question to me. Her question reflects that physicians are feeling the pinch of decreasing gross income while overhead expenses continue to climb. Obviously, the perception exists that medical leadership has the power to change reimbursement.

Supply and demand drives pricing. Physicians are the suppliers, patients the consumers. Over the years, both the state Medicaid and federal Medicare folks have met with me. They told me that reimbursements will remain low or drop further so long as there are sufficient numbers of doctors willing to provide care for the enrolled patients. Leaders in the AMA, WSMA, and specialty societies have confronted government with claims of doctors leaving practice, restricting practice or leaving the state. Medicare counters with statistics demonstrating that 96% of doctors are "enrolled" to provide care to Medicare patients. Medicaid simply states there is no lack to access yet. If the payers find that "doctors A through W" are continuing to provide service for low reimbursement, why should they listen to the demands of "doctors X, Y, Z?" Have the complaints of "doctors A-W" been diminished because these doctors continue to provide services?

If a doctor finds that he is working hard yet losing money, he will go out of business. Physicians will have to stop practicing medicine if reimbursement is inadequate. When enough physicians are forced to close their doors, then an access problem will become real. When enough patients complain they cannot find physicians, change will occur then, not before. The low reimbursement issue should not compel doctors to withdraw from Medicare enrollment, but it might. Doctors fear withdrawing from Medicare because withdrawal requires two years before one can re-enroll. But why stay enrolled if we are losing?

As to the effectiveness of withdrawing from participation we can look to the efforts of both obstetricians and hospitals in the 1980s when Medicaid reimbursements for obstetrical care became intolerable. Doctors and hospitals closed their doors to Medicaid obstetric care. Within a short time, rate of reimbursement jumped dramatically to become more in line with the private market.

Factors Affecting Medicare Reimbursement

The *pie* is only so big for Medicare Part B which pays for physician office visits, lab tests, minor procedures, physician-administered drugs, and hospital outpatient services. We hear that reasons for low Medicare reimbursement are due to a balanced budget, sustained growth rate (SGR) formula, and over utilization. Until these factors change, reimbursements are not likely to increase.

Balanced Budget [1]

Under the current physician reimbursement system, the SGR formula determines annual updates to Medicare's Physician Fee Schedule. The SGR formula dictates that if Medicare spending

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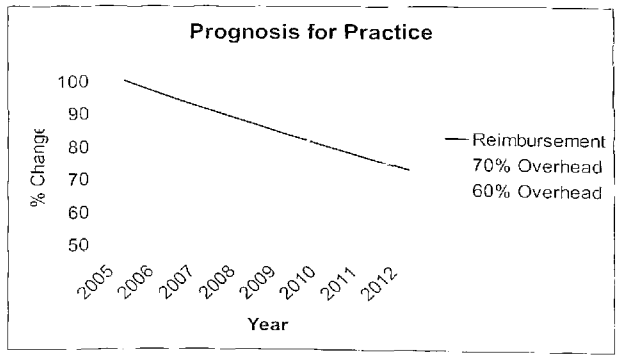

Figure 1. The proposed cuts for Medicare physician reimbursement were 4.4% per year for seven years. During the same seven years, practice overhead expense is estimated to increase a total of 19%. The breaking point at which business is no longer profitable is where the lines cross. Examples are provided for practices with 70% vs. 60% overhead.

Reimbursement from page 3

on physician services in a given year exceeds the target set by this formula, reimbursement in the following year is reduced. The problem is that this formula is tied to the gross domestic product (GDP), bearing no relationship to patients' health care needs or physicians' costs to furnish services. Under the SGR formula, Medicare physician payments were slated to be cut approximately 30 percent between 2006 and 2012 despite the fact practice expenses are estimated to increase 19 percent during the same period. A 4.3% cut in physician payments was set to take effect as of January 1, 2006. The physician payment cut has been granted a temporary freeze. Because of the flawed SGR formula, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

Value Based Purchasing [1]

We need a rational fix. The Medicare Value-Based Purchasing for Physicians' Services Act of 2005 provides a rational fix to the current badly flawed system of physician reimbursement. Congresswoman Nancy L. Johnson (R-CT) is the sponsor of the bill. Congresswoman Johnson's bill would replace the SGR formula with one based upon the Medicare Economic Index (MEI), which more reasonably reflects inflationary pressures on medical practice costs.

However, Congresswoman Johnson's bill also contains provisions embracing pay-for-performance (PFP) principles, which reward physicians for quality care. Such provisions include:

· The phased establishment of a value-based purchasing program

· The development of evidence-based quality and efficiency measures in collaboration with the physician community

· The permitting of certain gain-sharing arrangements between physicians and hospitals.

In addition to Congresswoman Johnson's legislation, the medical community has also developed a consensus framework for the phased establishment of a PFP methodology. The SGR and PFP are inconsistent methodologies. Consequently, implementation of PFP must be made contingent upon the repeal of the SGR formula.

Over Utilization

Over utilization is predominantly a product of legitimate use of medical services that are more expensive as time passes. As an example, imaging studies are increasingly expensive progressing from x-rays to CTs to MRIs and PET scans. Complex imaging has been a terrific valid method of diagnosing many pathologies and injuries. However, indications for complex imaging are sometimes bypassed due to medico-legal fears, known as *defensive medicine*. Hence, part of the solution to over utilization lies with medical liability reform.

Solutions to the problem of low reimbursement:

1. Refuse to perform work for inadequate reimbursement. This does not mean to stop providing charity care when appropriate.

2. Restructure our practices to reduce overhead and to legitimately bill for provided services. However, do not engage in creative billing.

3. Analyze the services we provide against the reimbursement received. Is there a way to restructure the services we provide?

4. Support legislation and legislators who promote a fix for physician reimbursement. This requires all physicians to participate, not just leadership.

5. Reduce over-utilization to increase availability of money available to physician reimbursement.

6. Promise to become part of the solution rather than enable perpetuating the current status of reimbursement.

So, to rephrase the opening question, ***"What are we, the collective mass of doctors, going to do to increase Medicare reimbursement?"*** Doctors *en masse* must unite to effect desired change. Leadership, whether county, state or national, will not bring about change without the mass action of all doctors. ■

Physical Medicine and Rehabilitation Conference

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PCMS Board of Trustees Attend Saturday Retreat

The PCMS Board of Trustees, including the WSMA Representatives, met on a Saturday in January at Shenanigan's Restaurant on Tacoma's waterfront to learn about issues and discuss agenda items for the 2006 year.

President **Joseph Jasper, MD** had a full contingent including officers, **Sumner Schoenike MD**, President Elect; **Laurel Harris, MD**, Treasurer; **Jeff Nacht, MD**, Vice President; and **Patrick Hogan, DO**, Past-President. Trustees included **Drs. David Bales, Harold Boyd, Leaza Dierwechter, Ken Feucht, Paul Schneider** and **Harald Schoeppner**. WSMA Representatives included **Drs. Len Alenick, Ron Morris** and **Don Russell**. **Dr. Nick Rajacich** was excused.

The board was joined by **Federico Cruz, MD**, Tacoma Pierce County Health Department Director, and Hugh Maloney, MD President-Elect of the Washington State Medical Association as well as WSMA staffers Tom Curry, CEO and Bob Perna, Director of Economic Affairs. Andy Dolan, health care attorney, joined the group for discussions in relation to health care economics.

The day began with a debriefing from WSMA regarding last fall's initiative attempt for tort reform. Mr. Curry highlighted the positives from the failed campaign including the fact that physicians mobilized as they have never before, the WSMA and the WSHA (Washington State Hospital Association) worked together favorably, and the campaign reinforced the public's understanding of the issues as 783,000 patients voted in favor of I330, all of these potential jurors! He added that going forward the legislature will most likely focus on HB2292 (Plan B) that was considered last year. The concern is not what HB2292 does, but what it does not include, such as Joint and Several Liability, Collateral Source rules, and provisions for Periodic Payments, all vital for meaningful reform.

Dr. Hugh Maloney discussed the 2006 WSMA Business plan reviewing one of the major priorities for 2006, to "Make Washington a Better Place to Practice Medicine and Receive Care." He noted they will work on patient safety and error reduction efforts, economic viability measures including decreasing complexity and increasing efficiencies, and promotion of best practices and evidence-based medicine. While they will continue to work on tort measures, they will use a different style and approach than has previously been used.

Dr. Jasper then asked board members to report on topics that will be prioritized for the 2006 year, including Economic Credentialing, Sham Peer Review, Pay for Performance, Concierge Practices, Evidence Based Medicine, Exclusive Provider Panels, Due Process for Doctors, Collective Bargaining with Big Insurers, and Hospital Influence. Each topic was presented and discussed in efforts to learn more about the issue and better understand its importance and significance in our community.

Andy Dolan gave a very thorough and thought provoking insight into the process of analyzing and understanding the issues. He particularly pointed out that a very clear definition of each topic is paramount along with a careful analysis of the issue from the other side's perspective. For example, as a seller of health care and analyzing from that perspective, also analyze from the buyer's perspective. It will help give a full understanding and total perspective of the issue.

Bob Perna, Director of Health Care Economics for the WSMA gave a review of the economic work plan for 2006. The priorities include reimbursement from health insurers, including increase practice revenues, improve coding quality, reduce claim denials and compliance monitoring to identify lost revenues and billing errors. Protecting practices against disadvantageous activities by health insurers, including inadequate and daunting due process and appeals mechanisms, evidence based medicine, restrictions of "provider networks" and burdensome and expensive administrative requirements and improving the financial viability and operational efficiency of practices are also in the work plan.

While there were no resolves at the Retreat, there was certainly an understanding of the issues and their complexities faced by the profession. With the focus on the many economic practice issues facing physicians, attendees agreed by consensus that the work of CHAMP (Coalition for Healthy, Active, Medical Professionals), led by Dr. Pat Hogan and Tort Reform, led by Dr. Mike Kelly, in addition to an emphasis on emergency preparedness should continue.■

L to R: Dr. Federico Cruz, Health Director, chats with WSMA Representative Dr. Don Russell

L to R: PCMS VP Jeff Nacht, MD shares a laugh with WSMA President-Elect Hugh Maloney, MD

Few States Get High Marks in Report on Liability Environment

By Amy Lynn Sorrel, reprinted from *AMNews*, Feb. 6, 2006

States that received failing grades for their medical liability environment have one thing in common: No effective cap on noneconomic damages in medical liability cases.

Eleven states and the District of Columbia received F grades in the "National Report Card on the State of Emergency Medicine" released by the American College of Emergency Physicians in January. ACEP gave D's to 30 other states in the "medical liability environment" category, assessing the level of caps, reform initiatives and the increase in insurance premiums.

"We believe the most important reform is caps," said ACEP Immediate Past President Robert Suter, DO.

Medical liability has a significant effect on whether emergency physicians can afford to practice and whether the specialists they depend on for follow-up care can afford to stay in business, said Dr. Suter, a Houston emergency physician. That's why the medical liability category counted for a hefty 25% of a state's overall grade and why caps on noneconomic damages weighed so heavily, he said. Only one state on the failing list, Maryland, has a cap on noneconomic damages. But at $650,000, it is still "largely ineffective," said Michael Preston, the Maryland State Medical Society's executive director.

The grade also took into account pretrial screening, expert-witness rules, joint liability reform and the increase in medical liability insurance rates for physicians and specialists from 2001 to 2004. Only a few of the failing states succeeded in some of these areas.

While each "F" state admits to struggling with caps, some medical societies criticized the report for not giving enough credit to alternative medical liability reforms.

The ACEP report handed out 30 D's and 12 F's.

"Their data is outdated and doesn't consider other tort reforms that were passed," since the study began, said David Wroten, executive vice president of the Arkansas Medical Society.

Although the study measured the increase in medical liability premiums, "it did not compare actual malpractice premiums," which can be a better gauge of whether doctors will relocate, Wroten said.

Other states' officials noted legislation to curb frivolous lawsuits and limit high damage awards not mentioned in the ACEP study. For example, Arkansas, Pennsylvania and New Jersey require certificates of merit, and Arkansas and Pennsylvania prohibit venue shopping.

"We're also looking at specialty courts and an apology rule," said Mark Piasio, MD, executive director of the Pennsylvania Medical Society.

Nevertheless, caps remain the goal for each of the failing

See "Liability" page 12

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:

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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

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

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

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

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

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

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

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

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

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

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

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

For more specific information about the legislative process or for a copy of the 2006 Guide to the Washington State Legislature which includes listings for elected state and federal officials, please call PCMS 572-3667.

IN MEMORIAM

RICHARD C. OSTENSON, MD

1949 - 2005

Richard Ostenson, MD

Dr. Richard Ostenson died December 24, 2005 from metastatic melanoma.

Dr. Ostenson received his medical degree from the University of Washington School of Medicine in 1974. He completed his internal medicine internship and residency at the University of Arkansas in 1978 and completed his hematology/oncology fellowship at the University of Washington in 1981. He served as the staff oncologist and then Chief of Medicine at the American Lake VA Medical Center until he entered private practice in oncology in Puyallup in 1990.

Dr. Ostenson worked for ten years toward the building of the Cancer Center at Good Samaritan Hospital in Puyallup and was instrumental in its development and completion. While he was never able to practice medicine at the new center, he contributed many months of administrative work there and experienced this facility as a patient.

PCMS extends condolences to Dr. Ostenson's family.

IN MEMORIAM

JOHN P. (JACK) LIEWER, MD

1926 - 2005

Dr. Jack Liewer died December 4, 2005 in Sun City, Arizona.

Dr. Liewer received his medical degree from the University of Iowa School of Medicine in 1956 and completed his internship at St. Joseph Hospital in Tacoma in 1957. Dr. Liewer practiced general medicine in Lakewood until his retirement in 1990, when Dr. Michael Kelly acquired his practice.

Through the years he enjoyed travel, golf, salmon fishing, flying, ham radio and skiing. After retiring, he and his wife moved to Sun City, Arizona. He was preceded in death by his wife of 51 years.

PCMS extends condolences to Dr. Liewer's family.

In My Opinion

by Kenneth Feucht, 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.*

Music and Medicine

Kenneth Feucht, MD

"God is dead, and we have killed Him." Nietzsche

"Medicine is dead, and we have killed it." Feucht

Gustav Mahler, in his 9th symphony, detailed in musical terms the arrhythmia which would eventually lead to his demise. According to Leonard Bernstein, who stands as one of the great Mahler interpreters of the twentieth century, the 9th symphony remains the greatest musical testimony to death ever written. Bernstein claims that it is within the 9th symphony that Mahler prophesied and depicted not only his own death, but also the death of tonality in music, as well as the death of society. Mahler's musical prediction about the death of tonality in music proved to be correct. The remainder of the twentieth century bore witness to the correctness of Mahler's prediction about the death of society, when the world twice attempted wholesale suicide in the space of two world wars, leaving a culture which more resembles a zombie than a living person.

Mahler's 9th symphony needs to be the official theme song of Medicine. We are currently observing medicine in its peri-mortem state, experiencing the pain and irregular heartbeat that portends the demise of the entire system. We look in horror as we see arising from the ashes the twentieth century reinvention of medicine, and find it to be not a beautiful and majestic Phoenix that takes lofty flight, but rather a horrid behemoth that neither man nor creator can control.

Who killed medicine? We did. We have only ourselves to blame. I attribute the death of medicine to three factors. First, we abandoned our oaths. The time honored Oath of Hippocrates, though written by a "pagan" Pythagorean mystic in ancient Greece, was immediately adopted by Christian caretakers of the ill, revised by the Jewish physician Moses Maimonides, and adopted in similar form by Muslim practitioners of the healing arts. While having a superficial resemblance to these ancient oaths, modern oaths, such as the Oath of Geneva and AMA Oath, possess an entirely different flavor and intention. Modern oaths fail to adequately protect the rights of the physician or the rights of the patient, including the unborn or infirm elderly patient. The ancient oaths realize that a covenant exists between the physician, the patient, and God or gods. In modern oaths, God is replaced with government, society or third party payors. The new oaths hold us equally responsible to society as to our patient, causing unease when the good of the patient and the good of society seem to conflict. The Hippocratic Oath defines moral standards; the AMA Oath only suggests what may be inappropriate behavior. Na und? Hospitals now tell us to call our patients "customers." When I complained to the Customer Relations person at my hospital about the inappropriateness of her title, I was soundly rebuked for thinking poorly of my patients by not considering them customers. We arbitrarily and frequently change the standards of behavior that define the good and moral physician. This week, if I fail to date AND TIME my notes and orders, I will be considered an immoral physician worthy of sanction. Last week, I could have been sanctioned for writing q.d. as an abbreviation (I actually wrote instead the latin equivalent "quaque dium" on an order in order to avoid writing the dangerous and forbidden abbreviation, and almost had my privileges revoked for that sin). Who knows what moral standards I will be held to tomorrow?

Secondly, we rolled over dead when ordered to allow physician advertising. The AMA held strong statements forbidding physician advertising (AMA Code of Ethics, 1847) until ordered in 1975 by the federal trade commission to allow this. Poof! Ethic by government edict. There are few physicians or hospitals nowadays that do not advertise. As a result, medicine has become a business and not a profession. Pharmaceutical firms have found that they can outdo physicians, and have inundated not only medical journals, but popular press and television with promises of cures, health, happiness, and vitality that resemble the traveling miracle man in his stage coach pawning off his snake oil to a desperate but wantonly gullible audience.

Thirdly, we have failed by allowing administrators into our relationship between the patient and ourselves. These

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are the government and third party payors. The Great Society notion of Medicare was hailed as the cure for the elderly lack of access to care, yet has done the opposite, making it more likely that a Medicare-aged person will not be able to find a physician. With third party payors, I am given no reason to contain costs. I want what's best for my patient. My patients want what's best for them-self, and will go elsewhere if I don't provide what's best. Spare no cost, the insurance company will provide. As a result, the costs of health-care have gone from reasonable to ridiculous. The current economic system of healthcare is unsustainable, and will soon collapse. The replacement health-care system will not likely be better.

We all abound with thoughts about the cure to the wounds that will not heal in medicine. We no longer possess the elixir vitae, nor the salve of Isolde that healed Tristan. So, let's sue somebody. Let's sue the hospital. Let's sue the insurance companies. Let's petition our legislators. Let's march on Olympia. Let's beg and plead and polish some legislator's shoes. Let's get more laws. Let's get counter-laws. Let's remove laws. We need safer hospitals, so let's regulate them more. Let's regulate the regulators of the regulators. Let's devise programs that measure and influence public (customer) sentiment. Let's pump even more money into the problem. Let's eliminate (terminate) the inconvenient or the expensive patient from the system. We need a single-payor system. We need to eliminate third parties. We need medical savings accounts. We need rationing of care. Medical courts. Tort reform! Nuke the lawyers! Let's force patients not to smoke or drink or get sick, and force them to exercise and eat only organic grains. Then, let's force patients to love us!

So, this week, I will listen to Mahler's 9th symphony. Solti and Karajan offer superlative recordings of that symphony. So does Bruno Walter, who was Mahler's student. Bernstein's recording is transcendental and a must-hear. Mahler's music, while focusing on death, seems to be more cheerful than thoughts about the future prospects of medicine. Next week, I'll listen to Korngold's Die Tote Stadt (The Dead City), the official opera of medicine. If you haven't heard or seen it, Eric Korngold achieves as a twentieth century composer a mastery of atonal music and stage so sublime as to bring tears to the eyes of even the most amateur musical dilettante. Rummy stuff, that music about death: how can it cheer ole' doc Feucht?

"The harvest is past, the summer is ended...the wound of my people is my own heart wounded; I mourn and dismay has taken hold on me.Is there no balm in Gilead? Is there no physician there? Why then has the health of my people not been restored?" — taken from Jeremiah 8:20-2 ■

PCMS Members Visit Olympia - Meet with Legislators

WSMA held their annual Legislative Summit in late January, bringing together doctors from all counties in the state to hear from elected officials and meet with their own legislators. Governor Christine Gregoire was the featured speaker, highlighting her goal of "improving the quality of health in Washington while helping to contain costs, improve quality and open up more access to the system."

Pierce County physicians that participated in the day's activities included **Len Alenick, Federico Cruz-Uribe, Pat Hogan, Joe Jasper, Mike Kelly, Vinay Malhotra, Jane Moore, Ron Morris, Nick Rajacich, Matt Rice, Don Russell, Sumner Schoenike, George Tanbara,** and **Guthrie Turner**. After hearing speakers in the morning, participants were taken by bus to the hill to meet with their own district legislators. Also on the agenda for the afternoon were meetings with the Governor's Health Policy Advisors, Christina Hulet and Mark Rupp as well as the Honorable Mike Kreidler, Washington State Insurance Commissioner.

Participants had a "briefing" on priority issues to discuss with their legislators and they included:

- Patient Safety/Error Reduction
- Medical Liability Reform
- Office Based Imaging
- Medical Discipline
- Cosmetic Surgery Tax
- Specialty Hospitals
- Outpatient Oncology and Anticancer Drugs and the B&O Tax

While many of these issues will be debated and voted on in the next few weeks prior to the legislature's adjournment in early March, the Governor claims that her commitment to her issues, aimed at "fixing" the perceived problems with the state's health care system, will focus on the "doable" as opposed to sweeping reform from the top down. She told the crowd of 150 that her proposal would take charge of the state's health care system for a long-term remedy to the rising costs of health care and decreasing access. The Governor's plan includes five areas:

1) Information Technology *"We must bring our health care systems into the 21st Century. Let's use our new technology to eliminate waste, trim down administrative costs and get more efficient, timely delivery of care."*

2) Purchasing for Quality *"People who purchase health care should be empowered with a more transparent system that lets them be informed customers who shop for health care by price and quality."*

3) Evidence Based Purchasing *"We should significantly increase our use of evidence-based medicine. We're going to look at results, not watch television commercials, to determine the best care options."*

4) Health Care for Vulnerable Populations *"I want us to better manage chronic care by working to keep more people out of it, because right now 5 percent of people consume 50 percent of health care costs."*

5) Prevention and Wellness *"We need to take responsibility for both our personal health and everyone's health by promoting healthy lifestyles and choices in our schools, workplaces and communities."*

The WSMA is working closely with the Governor's office to participate in the areas she outlined at the Summit. WSMA is encouraged that the Governor is taking a strong and collaborative position on health care issues, but is cautious regarding "cost containment" being a driver, as they have seen other such efforts lead only to further reductions in reimbursement and increases in administrative hassles.

For more information on any of the priority legislative issues, please call PCMS, 572-3667 and we will fax you a fact sheet. ■

Save the Date - WSMA Leadership Development Conference

The WSMA Leadership Development Conference is scheduled for May 19 and 20 at Campbell's Resort at Lake Chelan. This is a conference you don't want to miss. Hailed as one of the best leadership conferences in the Pacific Northwest, physicians, physician assistants and practice managers will gain tools they can use in developing their leadership skills. The theme for this year's meeting is *The Art of Leadership*. More information about the conference will be coming soon. In the meantime, mark your calendar to attend this meeting!

Liability from page 6

states and are "probably the most important thing and are proven to work across the country in states like California and Texas," said Peter Lavine, MD, board chair for the Medical Society of the District of Columbia.

California and Texas have a $250,000 cap on noneconomic damages in medical liability cases, and those states received an A-plus in the report card's liability section.

Among those that received an F, Arkansas, Connecticut, New Jersey, North Carolina, Pennsylvania, Rhode Island, and Wyoming also are on the American Medical Association's 2005 list of states in medical liability crisis because insurance premiums are driving doctors to retire early, eliminate high-risk procedures or move out of state.

Overall, the United States earned a C-minus on its emergency care system. The report said the system is plagued with overcrowding, declining access to care, poor disaster preparedness and soaring liability costs.

Not Making the Grade

A-plus: California, Texas
A-minus: Montana, Nevada
B-plus: South Carolina
B-minus: Colorado, Georgia
C-plus: Alaska
C-minus: Missouri
D-plus: Nebraska
D: Florida, Idaho, Kansas, Louisiana, Maine, North Dakota, Ohio, South Dakota, Utah, West Virginia, Wisconsin
D-minus: Alabama, Arizona, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, New Hampshire, New Mexico, New York, Oklahoma, Oregon, Washington
F: Arkansas, Connecticut, District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Wyoming ■

Retired Doctors' Wives Luncheon

The Retired Doctors' Wives will meet at Affairs Cafe, 2811 Bridgeport Way, University Place, February 22, 2006 at 11:30 am. Please RSVP to Marlyn Baer (564-4308) or Judy Brachvogel (564-6374) by February 17.

In My Opinion

by Nichol Iverson, MD

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

Darwin and Telephones

Nichol Iverson, Em Dee

"Friends, Romans, countrymen, lend me your cell phones."
Shakespeare's fateful look into the future of communications

As Chuck Darwin predicted, systems of communication in medicine continue to evolve under my watchful eyes and my attentive ears. I started 2006 on call. One would think that after over thirty years in medical practice, I would have seen and heard most of the stupid things that can bollix up simple communications. We have digital pagers, voice messaging, text messaging, cell phones, wireless blackberries, Palm pilots and lap tops, and an occasional lap talk. Then we also can use Mp3 players, iPods, answering services, faxes, e-mails, and occasionally f-mails, not to mention plain old sticky notes, special doctor communication pages, and hollering in the hallway. However, I continue to be amazed at new permutations of failures to communicate medical information.

Historically, there were lights that one pushed on entering a hospital letting the operator know that you were there. The lights burnt out, I failed to push the button entering and leaving on occasion, and overhead pages were not heard if one was engrossed in the reading room. Answering services gave me a "beeper" that told me only to call the service (for a fee, of course) at which point I was at the most distant place possible from any phone service. Yelling was of little use. Using a pay telephone without the appropriate change was frequently a challenge. The beeper at the bedside was always necessary as the answering services would call (for a fee) nearly every number on the planet from which I had ever called, failing to assume that at 03:21, I was most likely trying desperately to sleep.

Along came digital pagers, but the numbers were frequently incorrect, and calling a redneck at 03:22 expanded my vocabulary, and added some ingenious colloquialisms to my expanding list of anatomical options. My favorite digital numbers, however, were those with only six digits. Spending approximately 11 years of my life looking for these devices also began during these early years.

Soon after digital pagers came the first generation cell phone. These were 33 pound babies that could cook microwave popcorn on their antennae. If this were not enough of a deterrent, they were able to pick up a signal in only about 31 percent of the county, and were totally useless anywhere near any hospital. Unfortunately, this particular feature of cell phones has never been fixed. "Dropped calls" from callers who are listed on the incoming calls as "private" or "caller unknown" or any assortment of messages continue to plague these devices. In addition, when the batteries run low, the phone will always be misplaced in a location where they will not respond if you try to find them by dialing their number. Another year or two searching for phones is ahead, and we may be facing an epidemic of acoustic neuromas, and unilateral micro waved brains.

On the other end of the communication loop is the caller. There are many "subsets" of hassles in this category. If I am unable to reach my lost phone when I hear it ringing in the corner of the doctor's lounge, under a sofa cushion, then the caller goes to a message center. On a paging system patients can also leave messages. One of my favorite types is "I am having a problem with my husband (patient, medicine, dog, cell phone, etc.) and he has fifty seven medical problems, all of which have gotten worse in the last three minutes.... Blah, blah, yakkity yak....five minutes later, "click." No name, no number. Rarely does the sick person call except to breathe and wheeze then exclaim perhaps to a significant other "what the hell am I supposed to do now?" Click. Another variant is, "I need the doctor on call to return my call. This is an emergency!" Click. Apparently, listening to the message before getting my telephone number, "If this is an emergency, call 911..." never crossed their shriveled, micro waved noggins. Five minutes later, "Please call me back!" Click. Two minutes later, "This is the third call, and (in an irate smoker's voice) you have still not called me!" Click.

Recently a lady by the name of Lorna Doon called and said, "This is Lorna Doon calling, and I need my doctor to call me as soon as possible." Click. One hour later, "This is Lorna Doon calling again, and I am going to put in my telephone number for you ....zzzik, tiky, tiky, tiky... zzik, tiky, tiky, tiky, tiky, tiky, tiky... zzik, tiky,.... At least there were all ten zzik's for me to count if I were able. Since I was wait-

See "Telephones" page 18

Applicants for Membership

Thatcher T.H. Felt, MD
Pediatrics
2206 N 29th St, Tacoma
253-779-0453
Med School: Chicago College Ost Med
Internship: Hope Children's Hospital
Residency: Hope Children's Hospital

Antoine D. Johnson, MD
Family Practice
PO Box 5918, Tacoma
253-272-8865
Med School: Meharry Medical College
Intership: Meharry Medical College
Residency: Meharry Medical College

Ambrish K. Ojha, MD
Internal Med/Infectious Dis
Internal Medicine Northwest
316 ML King Jr Way #304, Tacoma
253-272-5076
Med School: Patna Medical College
Internship: Texas Tech University
Residency: Texas Tech University
Residency: Thomas Jefferson University

Michael J. Wilson, MD
Cardiology
Cardiac Health Specialists
11311 Bridgeport Way SW #202, Lakewood
253-983-5040
Med School: University of Minnesota
Internship: University of Kentucky
Residency: University of Kentucky
Fellowship: Brooke Army Med Ctr

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

The Fitness Challenge

Federico Cruz, MD

There has been much publicity about the epidemic of obesity in our country. Tacoma/ Pierce County has not been exempt from this. Levels of obesity across our community are quite high, with steadily increasing rates of overweight children being most worrisome. Of course we all agree that a good diet and proper levels of exercise are valuable, but so what. What role does the physician play in confronting this critical community health problem? I think we have at least three roles.

As a public health physician I look at the population as a whole and ask what needs to change in order to have a healthier community. You, as a health care provider, view the problem through the lens of the individual patients that you see. I see the need for changing the values of our community around diet and exercise. You look at how you can get a patient to change personal habits and practices that prevent her/ him from being healthy. These are not incompatible viewpoints.

The big challenge for both of us is: How do we get our patients (the public) to take seriously the need to exercise more and to eat more wholesomely? Change has to start somewhere. Our first role is the one-on-one time in the medical office. During a clinical visit a patient needs to hear – consistently and repeatedly – the incredible importance of being physically active and eating a healthy diet.

But as each of us knows, it is not enough. And discouragement both for the patient and the clinician is often right around the corner… as behaviors don't change. There is struggle or ambivalence, and it can seem easier to not bring the issue up when seeing the patient. Avoiding the issue won't help, however. We have to continue to engage our patients on the importance of diet and exercise and their powerful link to health.

And, even more is required from us, both as clinicians treating the individual and as members of the community, influencing the culture. Our second role is in setting a personal standard.

Physicians can help people change their behaviors, first by engaging in discussions and then by serving as role models. A doctor with a pack of Marlboros in a pocket probably has created a barrier to helping patients stop smoking. The same is true for those of us who are not physically active and fit. When we start a dialogue with a patient on the importance of physical activity and diet in preventing disease, we are less credible.

Sure, it seems like a lot to ask that we practice what we preach, however, we have very little wiggle room. Role modeling the desired behaviors is a necessary part of any successful health strategy around obesity and the prevention of the associated chronic diseases.

But it is not just on the physician's shoulders that success or failure rests. The community also has to step forward, and we have a responsibility there, too. To change someone's behavior requires continual reinforcement and support throughout the day and night and at multiple times and places in the community. The average person needs to be getting a consistent message about the importance of diet and exercise in being healthy.

Our third role is to help shape and share those messages.

Even as physicians are being asked to engage patients and show how to become healthier personally, so each of us can do more to assist the community as a whole to deal with the issues that prevent a healthy life. Many coalitions here in Pierce County already work to support efforts to be healthy. Groups and activities campaign and encourage regular exercise, weight loss, stress management and alcohol and drug abuse. A large gap from many of these groups is a physician's perspective. They need to hear the specifics of what individual patients need to be successful with their diet and exercise plans. What are the specific barriers? What discrete support does each person need to become healthy? It is only in partnering – clinicians with community groups – that the individual patient has a real chance of success. Broad systems of support will develop. Consistent messages can be generated across the community. All of this will make a difference.

I see real enthusiasm throughout our community to take on the issue of poor health habits. People are worried about their kids and are much more sensitized to the dangers of obesity and a poor diet. I hope you will join with me in supporting these community efforts. It means that physicians must first engage patients in our offices, then show how to improve health and then, finally, to step out into the community. To me, it can't be done any other way. ☐

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.*

Rationing

Andrew Statson, MD

"It is true that liberty is precious - so precious that it must be rationed."
Vladimir Ilyich Lenin

How do you ration a right? Simple - you deny it.

Our forefathers proclaimed that we are endowed by our Creator with the right to life, liberty and the pursuit of happiness. Yet at any time under communist rule, close to ten percent of the population were confined to a prison, or to a concentration camp, or perhaps to a mental hospital. About half of them were rationed out of their lives. Most of those on the outside, if not all, were denied some freedoms, freedoms that they should have been able to enjoy.

We were brought up with the notion that withholding health care is not acceptable. In fact, the strongest proponents of health care as a right have backed their position with the claim that people should not be denied care just because they cannot pay for it. We have heard a lot of talk about that during the past forty years or so. Now, as the bills are piling up, we are beginning to hear the inevitable corollary, that health care must be rationed, therefore withheld.

It is distressing when the reality of life comes to interfere with high principles, such as "To everyone according to his needs." The problem is a common one. Life imposes limitations on us and we have to make choices. Whenever we do something, it is always instead of something else, something that we must forego. We are limited in the time life has allotted to us and in the resources at our disposal.

For myself, I know that if I lived to be double my current age, I still would not have enough time to do everything I would like to do. I suspect that most of us, even if we lived to be a thousand years old, would still want to have, as Robert Heinlein so aptly put it, "Time Enough for Love."

The limitation in resources doesn't seem as imperative as that in time, because people frequently consume resources produced by others. Yet nobody can consume something that has not been produced. Even the oxygen we breathe was produced by chlorophil containing organisms.

Our problem is that we can always consume more: we can live in bigger houses, have maids do the housework, drive more comfortable cars, have more leisure time, take longer vacations, etc. But in order to consume more, we have to earn it by producing more. If not, someone else has to produce it for us. Then, we can consume it by borrowing against future earnings, by receiving it as gift or alms, or by taking it by force or fraud.

Rationing is a system of resource allocation. No matter how unsavory it might be, at a certain level of consumption, when the resources are sufficiently scarce, rationing might become desirable, and even inevitable.

The market is another system of allocation. It deals with scarce resources in a different manner. Trade is voluntary, while rationing carries the unpleasant connotation of coercion. In the market, all parties to a transaction engage in it because they expect to derive a benefit. Those who sell would rather get the money than keep the product, and those who buy would rather get the product and spend the money. After the transaction, all parties find themselves better off than they were before it occurred. Trade is a win-win situation.

In medicine, that system is fee-for-service. Of course, illnesses frequently are unexpected, unplanned, and expensive to treat. Here comes the role of insurance, which can be purchased to help pay for expenses in excess of a certain amount. I have discussed in the past how insurance policies could cover catastrophic expenses, while remaining affordable for most people.

The inevitable question here is, what about the indigent? In a non-coercive system, they'll have to rely on charity. They will not get the most expensive care, and it is possible that they will have to satisfy themselves primarily with supportive and custodial care, but they are not going to be left dying in the streets, as some people claim.

What about rationing? Well, let me give you a glimpse of how it worked behind the Iron Curtain. Health care was free. People could go to an outpatient clinic and be seen. For non-emergent care, they usually could get an appointment within a month or two.

The rationing came in the time and

See "Rationing" page 20

Telephones from page 13

ing for a lab test at the hospital, I cleverly used the internet to look up Lorna Doon. Unlisted. "Hah!" I said, "I shall look this patient up on the hospital EMR." Never been there.

In the faxing department, there are similar situations with a full page of information, written in a beautiful artistic hand written hieroglyphics, all of which are unintelligible. When I sent the fax back asking to write the note in a legible fashion, the return note said, "THE PATIENT HAS A **U.T.I.**, May we have an antibiotic?" My response is **"Does the patient have allergies???"** The return fax came back three minutes later saying, "You did not respond to this fax"...(the original fax written in Sanskrit.)

The future would be bleak were it not for Nichol's Universal Technical Service (wow.**NUTS**.com) to make all of the communication systems redundant. Every time we place or receive a call, all incoming and outgoing calls will be recorded, and backed up on a separate web site, stored in an off site Public Storage locker in an undisclosed location, and in the operating system of each individual device we use. An e-mail (and occasional f-mail) will be created by voice recognition, and a fax will be sent to every location in which we work. The voice recordings will be downloadable on a website as a digital recording, and we will get a FEDEX copy of the communications, both in paper form and on a CD, and the Postal Service will provide back up delivery. We shall also have an iPOD record the information in rap musak, which will be translated into text format, and the information will be placed on the new hit reality TV show "Doctors Drivilings" in HD, available through cable, satellite, web TV, and Netflix, so that we could see it on our DVR, over and over again. A bureaucrat's dream!! ■

Nichol T. Iverson, Em Dee @wow.NUTS.com

Is Obesity a Disease? Clinicians Disagree

According to J. Michael Gonzalez-Campoy, MD, PhD, an endocrinologist from Eagan, Minn., patients who have a body mass index of more than 30 have the disease of obesity. They need to be advised on lifestyle changes, prescribed medication if appropriate and referred for surgery as necessary. In other words, the condition is serious.

"Obesity is a disease, and it should be treated like any other disease," said Dr. Gonzalez-Campoy, chief executive officer of the Minnesota Center for Obesity, Metabolism and Endocrinology.

Paul Handel, MD, a Houston urologist who works on obesity issues, also believes obesity is a serious problem. It is not a disease in its own right, he believes, but leads to many serious diseases and should be addressed by policies that encourage individual responsibility and lead to societal changes that nurture healthier lifestyles.

"If we consider obesity a disease, what it really implies is that individuals have no control over what's happening, and, therefore, as a nation and as a culture, we need to commit more of our resources to treating the complications of the weight and obesity problem rather than saying it's a preventable event that really demands a societal response," said Dr. Handel, vice president and chief medical officer at BlueCross BlueShield of Texas.

These two physicians take obviously divergent positions in the ongoing debate about solutions to America's weight problem. The discussion turns on a very basic question: Should obesity be defined as a disease?

Please write to the *Bulletin* and let us know what you think, via email to sue@pcmswa.org.

Should obesity be considered a disease?

Yes

- *Obesity is linked to considerable morbidity and mortality.*
- *Patients would take the condition more seriously.*
- *Society would direct more public health resources toward addressing it.*
- *Reimbursement for medical services would become easier.*
- *Obese people would not be stigmatized as lazy or lacking willpower.*
- *It is an accurate classification.*

No

- *The evidence is insufficient to implicate obesity as a risk factor in its own right.*
- *It would negate individual responsibility.*
- *It would place too much emphasis on medical interventions and not enough on societal changes.*
- *How obesity is defined should have no impact on insurance reimbursement.*
- *It would stigmatize obese people who are otherwise healthy.*
- *Obese patients do not view themselves as having a disease.*

Excerpted from AMNews, February 6, 2006

Rationing from page 17

amount of care. In internal medicine, for instance, the physicians had twenty minutes for a new patient appointment, of which four minutes were allocated to record-keeping. Repeat appointments were ten minutes. If the patient needed more time, he had to make another appointment and come back. The physicians had a budget for tests and medications they could order and had to stay within it. Ordering an expensive test or drug meant that other patients will have to go without any.

For hospital care, the patient was referred to a hospital clinic, was examined by the hospital physician and scheduled for admission. For a surgical case, he would be operated on by whoever worked in the OR on that day.

All physicians had to work in the government clinics or hospitals, but the work week was forty-eight hours, and that included time on call. The usual work day was over by one p.m.

To get around that system, some patients visited physicians in their homes. Most had a room to use as an exam room. The living room usually served as a waiting room. The patients paid out of pocket, on a fee-for-service basis. They received as much attention as they needed. If they needed an admission or an operation, those physicians arranged for it and did the procedure.

Thus, by paying a fee, a patient could select the physician who would operate on him. Things did not end there, though. If there should be problems in scheduling, delays in obtaining treatment, or some complicated situations, the patients frequently gave gifts to the physicians hoping to obtain some special attention or care, that otherwise would not have been granted.

So, even in the presence of rationing, the market continues to operate. If banned to do so openly, it goes underground and becomes a black market. When special favors are wanted, they are bought with bribes of various sorts.

How would rationing work here? Let us imagine a panel of experts reviewing patient records and deciding on approval or denial of care. Let us assume that those experts are not in practice, so they would not have conflict of interest in favor of their own patients. Let us also assume that they are as knowledgeable and experienced as the physicians in active practice.

A patient is denied care. One evening he goes to the home of Doctor X, a physician on the panel, carrying a gift. A mutual friend told him that Doctor X liked a certain brand of Scotch, and he just happened to have a bottle. May the Doctor enjoy it. And oh, by the way, he had applied for such and such a treatment. It was denied by mistake, and he is appealing, so when it comes up, perhaps the Doctor would be kind enough to remember him. Thank you very much, Doctor.

The above is a crude example. More subtle ways exist, so much so that the recipient may not even become aware that he is bribed. It may be a gift from a friend, a contribution to his favorite charity, an appointment to a consulting board or some honorary, but paid position, etc.

An Eastern European proverb says, "To really know someone, put power in his hands." Not everybody abuses the power he wields, but many do. Power tends to corrupt. It affects the great and the small. The more power one holds, the bigger the temptation to abuse it.

Rationing gives power to some over others. In so doing, it becomes a source of corruption, to the people holding the power, and to the entire social system. Only the discipline of the market, with voluntary transactions of value for value exchange, can avoid that problem. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Mental Health CME set for March 10

David Law, MD is the course director for the Mental Health Review CME program that will be held on Friday, March 10 at the Fircrest Golf Club in Fircrest. The program is offered at no charge by the College and offers a maximum of 6 hours of Category I credit.

The course begins with registration and continental breakfast at 7:30 a.m. followed by the first speaker at 8:00. Lunch will be provided at 12:30 p.m. and the program will adjourn at 3:30 p.m.

Registration is required by calling 253-627-7137.

Topics of scheduled talks include: Meditation as an Adjunctive Therapy for Mental Health Counsel; Co-Morbidity of Depression, Anxiety and Cardiovascular Disease; The Continuum of Self-Harm and Suicidal Behavior in Children and Adolescents; Depression, Anxiety and a Little More: The Use of Antidepressants; A New Conceptual Model of Insomnia; and It's Not the Question of Remembering, but the inability to Forget.

Featured speakers include psychiatrist Steven Juergens, MD from Bellevue and Steven Mitchell, MD, Ph.D. from Seattle in addition to Kelly Schloredt, Ph.D. from Children's Hospital in Seattle. Rounding out the agenda are Pierce County physicians, **Dr. William Dean**; and Drs. Richard Schneider and Fletcher Taylor, psychiatrists.

This one day review will focus on the diagnosis, treatment and management of mental health complaints faced in the primary care and internal medicine practice. Participants will be able to understand the technique of meditation as a way to reduce fear and anxiety, identify and discuss the co-morbidity of depression, anxiety and cardiovascular disease, discuss current concepts in evaluating and treating children and adolescents with suicidal behaviors, review and discuss the broad spectrum of drug choices for depression and anxiety, discuss the latest developments in treating insomnia without shutting down the entire nervous system and understand and recognize post traumatic stress syndrome.

For a program brochure or to register for the course, call the College at 253-627-7137. ■

Hawaii CME - April 2-7... Make Plans Today

The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, Sunday - Friday, April 2-7, 2006.

Offering 16 Category I credits, the Hawaii program is designed for PCMS and other physicians and features addresses on a variety of topics.

Reservations must be made early for both travel and hotel. Call Jeanette Paul at All Wanderlands Travel, 572-6271 or email her at jeanette@awtvl.com.

DON'T DELAY, MAKE YOUR RESERVATIONS NOW! ■

Upcoming CME Programs

Friday, March 10, 2006
Mental Health Review
Program Director: **David Law, MD**

Sunday-Friday, April 2-7, 2006
CME at Hawaii
Program Director: **Mark Craddock, MD**

Friday-Saturday, May 5-6, 2006
Internal Medicine Review
Program Director: **John Hurst, MD**

Friday, June 2, 2006
Primary Care 2006
Program Director: **Steve Duncan, MD**

Washington State Medical Association Practice Management Seminars

Efficient Patient Service *** Treating Patients Right

The WSMA will offer two practice management programs in Tacoma on **Wednesday, March 8** at King Oscar Convention Center on South Hosmer Street.

The morning session, from 9:00 a.m. to 12:00 noon will focus on Efficient Patient Service: Improving Productivity with Modern Patient Flow Techniques. Clogged exam and consulting rooms, ringing telephones, patients on hold, and crowded waiting rooms create stress. Wasted motion, inefficient patient service and lack of direction can cost your practice money, patients and good personnel. But it doesn't have to be that way. At this idea-filled seminar, learn the productivity secrets of the most efficient and successful practices.

You will learn:

- **Efficiency Basics** - Learn how to think about the work of the office in a new way. Quit doing so much work.
- **Rethinking Who Does What** - Often rearranging the work of the office pays big dividends. Learn how to do your own analysis.
- **Appointment Scheduling** - We will cover these essentials of scheduling: patients' needs versus physicians' needs, how to see more patients in less time, and eliminating long waits.
- **The Telephone System** - We'll cover how to handle more calls efficiently and make a good first impression on the phone.
- **Reception Streamlining** - The patient welcoming procedures in your office can put you at a disadvantage before the doctor ever meets the patients. We will cover how to be fast and gracious.
- **Medical Records** - Come learn how to get this essential part of the work done more easily.
- **Back Office Patient Flow** - Come learn how to use task analysis and new communication techniques to reduce confusion and increase patient satisfaction in the clinical suite

The afternoon session, 1:30 pm to 4:30 pm, participants will learn about Treating Patients Right - Tact, Courtesy and Etiquette in the Medical Office. The best marketing is internal marketing, and studies continually show that the personnel in the medical office are the most widely stated reason for patient dissatisfaction. This half-day seminar covers the essentials of etiquette and customer service for the medical office. Group exercises, role playing and case studies will be used.

You will learn:

- The patent service roles in the practice
- Using "TLC" to keep patients happy
- The telephone: Don't let it ruin your day
- Improving written communication
- Non-verbal communication: "It's not what you said, ..."
- Listening...it's half the process
- Saying what you mean...and making them love it
- Projecting authority to build patient confidence
- And, when you just can't avoid a bad situation
- What not to say when the answer has to be "no"

The presenter at both sessions will be Judy Bee, a well respected leader and expert who has consulted with over 700 physicians in more than 300 medical practices. She has conducted over 600 seminars in thirty-six states, Australia and Canada, gaining a substantial reputation in the industry since 1971. Judy is President of Practice Performance Group and Publisher of UnCommon Sense, a management newsletter.

You can register for either one or both of these programs. Cost for WSMA or WSMGA members for either program is $189 per person, or $229 for both programs. Group discounts are available.

You can register On-Line on the WSMA's web site at http://wsma.org/memresources/seminars.html or by calling Beth Chapman at the WSMA, 1-800-552-0612. ■

Classified Advertising

POSITIONS AVAILABLE

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 + incentive. Fax your CV to 253-847-9630.

Tacoma, WA – Occupational Medicine MultiCare HealthWorks, a division of MultiCare Health System seeks a board certified occupational medicine/IM/ER/FP physician, certified MRO to join an established program. Qualified applicants must be flexible, self-motivated, committed to program development and have **at least 2 years** occupational medicine experience. As a MultiCare physician, you will enjoy excellent compensation, benefits and system-wide support. Three-year residency in accredited U.S. program required. Email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org.* "MultiCare Health System is proud to be a drug free workplace"

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org.* "MultiCare Health System is a drug free workplace"

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 - Well established FP seeks enthusiastic associate in desirable Gig Harbor/Tacoma area. Office based. Minimal call. No OB. Full-time/part-time option. Great opportunity. E-mail resumes to Dr. Finkleman at hazak@msn.com.

Established Spanaway Family Medical Center looking for P/T or F/T Board Certified or Board Eligible physician/ARNP/PA to join practice. Base salary plus inventive, great support staff. Fax CV to 253-536-3070 or e-mail to waynekim@hotmail.com.

OFFICE SPACE

Medical practices needed in Orting. Two spaces available. Call for details, 253-228-9841.

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Pierce County Medical Society

BULLETIN

March, 2006

Whistler and CME... Learning can be fun

Drs. Mark Craddock, Craig Rone, John Hautala and Pat Hogan join family and friends for fun on the slopes

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Hospital Influence on Referrals

Joseph F. Jasper, MD

"I'm sorry, but Dr. X cannot refer his patients to you because he is now a hospital employed physician and is required to use only our hospital's services and doctors."

This is certainly something neither private physicians nor patients want to hear: those referrals are made in the financial best interest of the hospital rather than the medical best interest of the patient.

Several physicians in Pierce County have alerted PCMS to the influence that the hospital staff has on referral patterns in our community. The concern is that there are a considerable number of hospital subsidiary owned physician primary care and specialty practices. It is proposed that these employed physicians are being told that they should refer within a hospital's resources over using the private community resources for consultations, referrals and facilities.

The Executive Committee shall be meeting with the hospital executives to ascertain the facts. We shall then try to seek clarification to the employed physicians and their staffs regarding the ability to use outside services.

In this issue of the *Bulletin*, **Dr. Sumner Schoenike** explores the controversy of hospital influence on referral patterns. (See page 5)

Legislative Meddling

The following are some of the bills floated through our state legislature; the quoted portions are excerpted from WSMA's *Monday Memo* of February 13. I urge you to express your opinion to your own representatives and senators.

· Mandatory CME for Cultural Diversity (SB 6194) – The WSMA opposes on principle any mandatory CME that is subject-specific. It will be hard to stop this bill, given that 2006 is an election year and no candidate, save a few, will want to be appear to be against cultural diversity." CME has traditionally been the responsibility of the house of medicine, typically through various medical societies, specialty societies and hospital educational offerings. The only previously mandated CME was included in the AIDS Omnibus Bill for HIV education. It is unlikely wise to allow the state legislature to determine what is important in our continuing medical education. This bill has political interests at heart, not our patients' best medical interest. This will be another uncompensated requirement for doctors to fulfill. What would happen if we all just did not show up? Can we refuse to recognize the state as the authority to determine CME content? Perhaps we need a house bill that requires legislators to sit through an educational program on medical practice diversity and medical economics so they can perform their duties better.

· Any Willing Providers (really another nail in the "scope" coffin at the payment level) – HB 2342 says a health plan that has 40% of the market must contract with any willing provider. It also applies to networks. . . Another bill, HB 2344, says plans can't discriminate against a class of providers. It also says that plans cannot force providers to participate in all products of the plan. . . These bills will further dilute the premium dollar for payment of physicians' and surgeons' services, and will drive up costs. The WSMA will continue to oppose both bills." Who is to protect the average citizen from quackery? A physician is traditionally understood to be an MD or DO. Typically, physicians also understand their limitations and make referral to other experts. Why pass a bill that permits non-physicians to bypass medical school and provide physician level care to patients?

· HB 2292 – oft referred to as tort reform 'lite,' the bill is out of the House and will be heard in the Senate Health and Long Term Care Committee next week. We believe the bill is on the verge of being considerably improved, but we cannot honestly say it represents meaningful tort reform. We continue to work closely with the hospital association on this issue." This is an example of a legislature that has no real grasp of the problem of medical liability. They are trying to treat an arterial hemorrhage with a Band-Aid so the public will think something is being done. This is another political bill with no significant meaning. Yet it will have negative impact on your practice.

· Specialty Hospital Bill (HB 2669/SB 6278), which essentially prohibits physician-owned specialty hospitals, passed out of the House today on a 65/31 vote (with 2 absent) but is apparently "on hold" in the Senate as the nurses and hospitals duel over one or two other bills the nurses want passed and which the hospitals oppose (one relates to "heavy lifting" in hospitals, the other to nurse staffing ratios). The WSMA will continue to oppose." Politics again rears its ugly head and takes priority over equal rights and the free market capitalism that our country is supposed to enjoy. Opposition to specialty hospi-

See "Influence" page 4

Influence from page 3

tals stunts progress. Competition will help assure that hospitals provide a high excellence of care; if they cannot affordably do so, let the competition prevail. The hospitals complain that specialty hospitals should be required to provide ER and indigent care. Okay, give the specialty hospitals state and federal funding, tax breaks, endowment funds, tax exempt gifting and other benefits that regular hospitals enjoy. Let us not forget that many regular hospitals were founded by physicians. There exists evidence that specialty hospitals can provide more efficient and cost effective care with high patient satisfaction and safety records. Hospitals have faced evolution in care before, adapting to shorter stays, higher intensity, increased specialization and increased technology. Their role in the medical community will continue to evolve. Let us make sure the evolution continues to improve patient care. Let us oppose efforts that would prevent positive steps in evolution.■

Good Sam Rehab 50th Anniversary

Good Samaritan Rehabilitation Center celebrated 50 years of service on February 24th at their rehab center in Puyallup. Those celebrating included current and former staff, physicians, board members, volunteers as well as patients, family and friends.

The 25-bed unit was actually opened in 1954 by then founding MD and Medical Director Dr. Sherburne Heath and is the oldest in Washington. Today it serves as a Level I Trauma Rehab Adult and Pediatric Rehab Center and CARF, accredited in adult and pediatric comprehensive inpatient rehab. After Dr. Heath's retirement in 1998, **Marvin Brooke MD** assumed the position serving until 2003. **Dr. Patrice Stevenson** is the current Medical Director; she also served as Pierce County Medical Society president in 2001. Other physicians on staff, in addition to Drs. Brooke and Stevenson include **Drs. Paul Nutter, Peter Lux** and **David Judish**.

Good Sam rehab has a unique reputation for being one of the premier rehab sites in the Northwest. It is highly unusual for a rehab center of this size and scope to be located in a small community hospital; most are affiliated with a University based program.

The rehab program has moved and remodeled and grown and condensed over the years. However, the speed at which they help patients rehabilitate has accelerated and the love of what they are privileged to do and the commitment to patients has not changed during their 50 years of service.

The Pierce County Medical Society congratulates the physicians, staff and patients of Good Samaritan Rehabilitation Center. ■

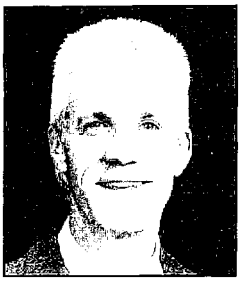
In My Opinion

by Sumner Schoenike, 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.*

Hospital Influence on Referral Patterns

Editor's Note: This article is the first in a series from the Board of Trustees to provide information and insight into issues directly impacting the viability of medical practice.



Sumner Schoenike, MD

Introduction and Context

Medicine is in a period of unprecedented change. It is moving inexorably towards a corporate medicine model in which the private practice as we once knew it will become a relic of the past. This corporate model has some tremendous advantages in economies of scale, but it also has its potential pitfalls. Keeping the professional arm of medicine focused on the greatest good for the patient and the practice of medicine and insulating it from a bottom-line driven traditional corporate influence will be a challenging and evolving process.

Overview

There are several prominent examples of hospital and corporate influence over referral patterns and practices in a community. These influences, partly a function of the size and nature of the community include: 1) hospital gainsharing arrangements with physicians, 2) mandatory use of hospitalists, and 3) hospital contractual and other arrangements with community and hospital-based physicians.

Hospital Gainsharing Arrangements

Hospital gainsharing is an arrangement between hospitals and physicians to cooperate in cost reductions by aligning physician incentives with hospital cost-saving efforts. The arrangement gives physicians a share of any reduction of the hospital's costs attributable to the physician's efforts. Arrangements can vary; some are narrowly targeted by giving the physician a financial incentive to reduce the use of specific medical devices and supplies, to switch to specific products that are less expensive, or to adopt specific clinical practices or protocols that reduce costs. Other arrangements that are not targeted at utilization of specific clinical practices and are more problematic, offer payments to physicians to reduce total average costs per case below target amounts, so-called "*black box*" gainsharing. It is under this type of arrangement that there is little accountability and insufficient safeguard against improper referral payments.

The Office of the Inspector General (OIG) of the Department of Health and Human Services recognizes the potential benefits of gainsharing arrangements and that hospitals have a legitimate interest in enlisting physicians in efforts to reduce and eliminate unnecessary costs, but has historically been very wary of gainsharing arrangements because they implicate Civil Monetary Penalty, Federal Anti-kickback statutes and perhaps even physician self-referral or Stark legislation.

Civil Monetary Penalty addresses Medicare and Medicare beneficiaries. It prohibits hospitals from knowingly making a direct or indirect payment to a physician as an inducement to limit items or services to beneficiaries and is a reflection of concerns by Congress that hospitals might offer physicians incentives to discharge patients too soon (quicker and sicker) or to otherwise truncate patient care.

The Federal anti-kickback statutes speak more specifically to hospitals influencing referrals of Federal health care program business, such as "cherry picking" healthier patients for hospitals offering gainsharing and sending sicker, more costly patients elsewhere. The OIG is concerned that in these cases, gainsharing may lead to unfair competition among hospitals competing for physician-generated business. The OIG additionally prohibits gainsharing to hospital-employed physicians.

Mandatory use of Hospitalists

Hospitals insisting that patients be admitted to hospitalists over their primary care physician constitute a form of hospital influence over referral patterns. This practice has the potential to create a two-tiered system of medical care and threatens to create a two-tiered system of medical training.

The AMA takes the stand that hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs." Further, the AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and/or jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

Attempts to avoid making the use of hospitalists mandatory are constantly under attack by health care plans and hospitals and this may be an effort that proves successful over time. The State Legislature of Texas, however, recently defeated House Bill 2112 which would have amended the Texas Health Maintenance Organization Act

See "Referrals" page 6

Referrals from page 5

to prohibit the mandatory use of hospitalists. Major health plans of Texas mounted a huge lobbying campaign to defeat the bill.

Contracting Issues for Hospital Based Physicians

Hospitals must have certain specialists consistently available to the hospital, such as radiologists, anesthesiologists, pathologists, hospitalists and emergency room physicians. These collectively are called Hospital Base Physicians (HBPs). Contract arrangements between HBPs and hospitals must not, by law, influence or give the impression of influencing referrals.

Regardless of the nature of the arrangement, all arrangements between hospitals and physicians must comply with Federal anti-kickback laws designed to prevent situations where patient referrals were made on the basis of considerations other than the patients' best interests. In the most egregious cases, blatant monetary consideration is paid in exchange for patient referrals or based upon things such as facility or equipment usage.

The flip arrangement may also pertain; an arrangement in which a physician instead of a hospital is asked to "give" something, which could be construed as outside of "fair market value." In this situation, the hospital based physicians stands to receive referrals from the hospital because of the physician's or physician group's location within the hospital. In this situation, the physician-hospital arrangement must reflect fair market value, as well, and physicians cannot take on inordinate administrative or managerial responsibilities without reasonable compensation. In other words, they cannot work for free or at substantially reduced rates without probable sanction.

Overlap of Hospital Referral Influence and Economic Credentialing

Current economic trends in healthcare have caused hospitals to begin basing credentialing decisions on the level of a physician's referrals to that hospital. Some hospitals have established "conflict of interest" policies or "loyalty oaths" to ensure that physicians will refer their patients to that hospital or risk losing their hospital privileges. Through these policies or "loyalty oaths," some hospitals have refused to grant staff privileges to physicians who own, have financial interests in or have leadership positions with healthcare entities or refer patients to competing healthcare entities.

General Considerations and Strategies

There are many arenas where hospitals may influence referral patterns in the medical community. Most of these are reasonably visible and are, consequently, likely to be detected by regulatory agencies and affected parties. They are also likely to be avoided by sophisticated hospital systems.

What is more likely to affect referrals and referral patterns is a more nebulous and difficult to detect and prosecute system of acknowledging and rewarding 'loyalty." It is this and other non-contractual methods of coercion that pose the greatest threat to the preservation of a fair and equitable distribution of referrals. ■

FitTips #13

by Patrick J. Hogan, DO

Benefits of Exercise for the Brain

The greatest **benefit of exercise is to produce fitness of the brain** and enhancement of all the brain circuits. **Exercise strengthens your brain**.

When the brain is challenged it will respond by producing **muscular strength** and improved **endurance**.

EXERCISE IS A POWERFUL TREATMENT FOR ALL BRAIN DISORDERS and WILL HELP THE BRAIN FUNCTION BETTER IN NORMAL LIFE:

Brain injury from stroke or trauma: Exercise promotes growth factors that stimulate the formation of new brain cells and repair of connections that were damaged.

Migraine: Regular exercise will decrease the frequency and intensity of migraine headaches and will decrease the amount of medication needed for control of migraine.

Pain control: Exercise will improve the coping capacity for pain and raise the pain threshold that decreases the amount of pain a person feels from any disorder.

Alzheimer's disease prevention: Regular exercise three or more times per week produces a 30% decrease in the rate of getting Alzheimer's disease.

Normal aging memory loss: Regular exercise enhances the performance in both younger and older people on all cognitive function of memory, thinking clarity and reaction time.

Parkinson's disease prevention and slowing of progression: Exercise will delay the onset and progression of Parkinson's; Exercise will improve mobility and strength of the muscles improving ability to do daily life activities; Exercise is the only way of improving balance and preventing falls; Exercise improves Parkinson's cognitive (memory) function and relieves depression with heightened moods and zest for life.

Maintaining balance with normal aging and prevention of falls: The loss of balance that normally occurs with aging is prevented; Loss of balance that already is present can be reversed with exercise.

Fibromyalgia treatment: Fibromyalgia is a brain disorder. Exercise affects the brain and raises the pain threshold and improves the ability to do daily activities more comfortably. Aerobic and resistance exercise is a crucial part of any fibromyalgia treatment program.

Exercise for Chronic fatigue: Many studies have demonstrated that a slowly progressive exercise program will produce even more improvement in fatigue states than medications can through enhancement of brain dopamine.

Exercise enhances brain dopamine levels, serotonin balance and endorphins to improve control of depression, fatigue, Parkinson's, pain and addiction disorders.

Exercise for tobacco or other drug addictions: Exercise can activate the same areas of the brain as addictive drugs. It is an excellent substitute for the addictive drug in decreasing cravings and improving the stress during tobacco or drug cessation efforts. It is also the best way to prevent the weight gain that can occur with stopping tobacco.

Exercise for mood control: Many studies over decades have demonstrated the benefits for depression and anxiety. A regular exercise program will enhance the balance of neurotransmitters in the brain needed for the sense of well being. This effect will improve the response to medication or replace the need for medication.

Heart function and blood pressure: Even the benefits of exercise for the heart and blood pressure are mostly occurring as a result of changes in the nervous system in response to a regular exercise program.

Conditioning the brain for better sport performance: Much of the improvement in speed or endurance in training occurs through a response of the brain challenged by exercise. The brain becomes reprogrammed to more efficiently activate the muscles with a greater level of endurance and strength.

Strength is improved even without muscle hypertrophy after resistance training related to **brain conditioning** causing the muscles to contract with greater power and efficiency.

Skilled sports are improved predominantly due to the **circuit reorganization effects on the brain** that occurs with repetitive training of a sport such as tennis and golf.

Challenge the brain and it will respond: All of these benefits of exercise will not occur without an adequate level of exertion that stimulates the brain and nervous system. This will not occur with casual occasional exercise. It will require a program most days per week with intermixed exercise of aerobic (elevating the heart rate) and resistance (weight or machine) training. The benefits of making exercise a routine part of daily life are guaranteed to far outweigh the effort and discomfort.

See previous *FitTips* on the various methods of exercise to produce an adequate level of conditioning for greater mental and physical wellness. ■

Washington State Bill Offers Safe Harbor for Retainer Practices

The proposed legislation would not require physicians who charge a monthly or annual fee to follow all of the same regulations that cover insurance companies

By Mike Norbut, reprinted from AMNews, March 6, 2006

A new bill proposed by the Washington State Office of the Insurance Commissioner would create a safe harbor for most physicians who operate retainer practices in the state.

That would allow them to offer patient care for a monthly or annual fee without having to follow many of the regulations that govern insurance companies.

While physicians may look at the bill as a matter of common sense, the legislation was born out of years of discussion between doctors and state regulators.

"We are very pleased we were able to reach a point in hammering out a safe-harbor bill," said Bob Perna, director of health care economics for the Washington State Medical Assn. "Physician practices came up with a different revenue model and in no way thought they would fall under the regulatory arm of the insurance commissioner."

HMOs in Washington are required to keep $3 million in reserves to protect customers in the event of insolvency, said Stephanie Marquis, a spokeswoman for Insurance Commissioner Mike Kreidler. Under the proposed bill, however, retainer physicians would not have to meet this requirement.

Instead, they would be required to keep patient fees in a trust account so a portion of the funds could be returned to the patient should the retainer agreement be terminated early. Retainer physicians also must send an annual letter to the insurance commissioner certifying that they are in compliance with the law, Marquis said.

The bill, which was passed overwhelmingly by the state House of Representatives and was waiting for a vote by a Senate committee at press time, attempts to define retainer practices in the context of health insurance. While physicians likened it to any service for which you would pay a monthly fee, insurance regulators said they needed to have a mechanism to protect patients because the doctors were accepting payment in advance.

"They're still accepting risk, but we see it as minimal risk compared to a commercial insurer," Marquis said.

The bill very well could be a test case for how retainer practices around the country could be protected, said Garrison Bliss, MD, a Seattle internist who operates a retainer practice and serves as president of the Society for Innovative Medical Practice Design, the national retainer physician organization.

"I don't know of any formal legislation anywhere else," Dr. Bliss said. "This is an acknowledgment on the part of the government that things are so broken that they're willing to look at innovations."

The bill has drawn opposition from the Assn. of Washington Healthcare Plans, which says that if the insurance commissioner feels that physicians are providing insurance, there should be no secondary regulations for them.

"We would expect our insurance commissioner would utilize the same requirements for anyone who comes into the state and practices insurance," said Sydney Smith Zvara, executive director of the association.

With annual fees in the $20,000 range last decade, retainer practices started as a niche service for the wealthy. But the movement started to pick up steam a few years ago as physicians started charging fees that were more accessible to the middle class. For about $100 a month in many practices, patients generally receive same-day and extended appointments, 24-hour cell phone and e-mail access, and primary care services.

Retainer practice models are generally divided among those that do not accept insurance and those with fees that cover only additional services not covered by an HMO contract, such as longer appointments and cell phone access.

The Washington bill would apply only to those practices that do not submit insurance claims, so their monthly fees would cover all primary care and extra services. Physicians said more discussion is expected on how to define and regulate practices that still maintain insurance contracts while providing retainer services. ■

In My Opinion

by Edmund Lewis, 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.

Medications/supplies wanted for African Valley

In the Chanjuzi area of the Luangwa River Valley, several hundred kilometers from the nearest town of any size, 50-100 people a day visit the medical clinic where malaria is rampant. The tribe in this area is the Besa and they are ruled by a self-serving tribal chieftain, as is often the case.

The clinic is run by Fred Kamathi, a trained midwife and his wife, and fortunately the company I hunt with, Muchinga Adventures and I can work directly with Fred. They deliver about ten to twelve babies a month on average.

In addition to the 30 new cases of malaria each month, infection is rampant. **When we ask Fred about medications he could use he answers.... "antibiotics, antibiotics, antibiotics, please!"** Child mortality due to infection is high; infants are not given a name until six months of age because so many of them don't survive that long. Eye infections, including trachoma, and skin disorders/infections are commonplace. Diabetes is common, yet alcoholism is rare, despite the native brewed beer.

Trauma is most often due to wild animals with frequent maulings by lions and leopards. Many of the Africans resort to "bush medicine" administered by a local witch doctor – yes, they still do exist! Fred delivers the babies with assistance from his wife, although they do not do C-sections and send the complicated obstetrical cases by truck to the nearest "modern" facility, an 18 hour journey along rutted, dirt roads through the bush. Some women succumb along the way and stillborns are common.

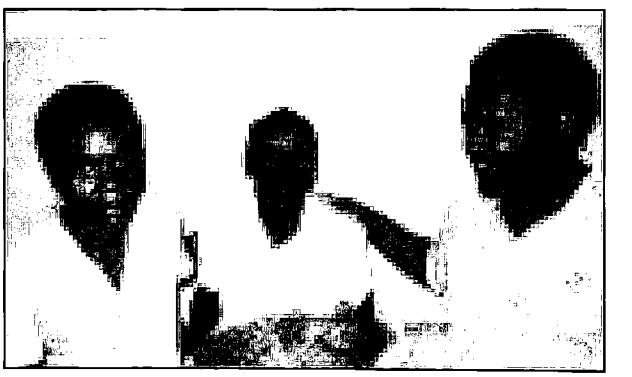
I've intimately learned about this valley due to my annual visit to see Fred and offer assistance to the clinic. I have arranged private funds for building a maternity wing on the clinic ($500 can buy an amazing amount of home-made bricks and other building materials), but the real need is for medicines.

If you or your clinic/practice could provide any drug samples, even outdated ones that could assist primary care in the bush, I know the people would be grateful for your contributions. They would be very well received, particularly antibiotics. I already have several physicians and dentists providing basic equipment and drugs for my next trip.

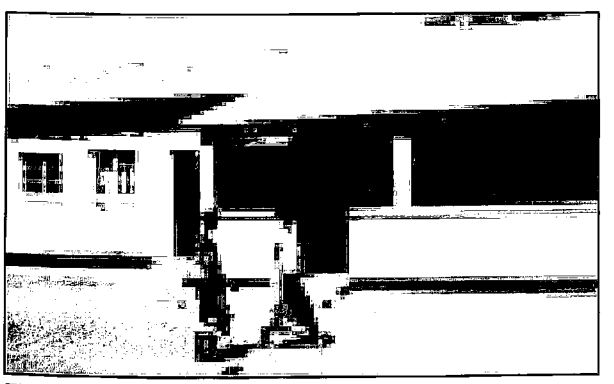
Edmund Lewis, MD

I have made arrangements with British Air for transport of medical supplies to Lusaka, from there we take them into the bush by small plane. Any contribution you can make will certainly be recognized by Fred and the tribal members.

Thank you for your interest and concern. Please drop off any supplies, particularly medications, to the PCMS office, 223 Tacoma Avenue South, M-F 8-5, or call 253-572-3667 for more information. ■



Fred, his wife and patient who delivered 15 minutes before picture was taken



The Medical Clinic, several hundred miles from the nearest town

Children from the Chanjuzi area - they are striking

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Preparation

Federico Cruz, MD

There has been much talk of the preparations our community needs to take in order to respond to a flu pandemic effectively. Many issues and details need to be confronted and worked through. In an all-encompassing event like a pandemic, each time decisions and plans have been made on one level, another, more detailed level rises to the surface, demanding analysis and response.

One area that I have only touched on with you deals with critical ethical issues surrounding decisions that will have to be made during the pandemic. These issues are:

- Health worker's duty to provide care during a communicable disease outbreak;

- Restricting liberty in the interest of public health by measures such as quarantine;

- Priority setting, including the allocation of scarce resources such as vaccines and anti-viral medications;

- Government policies with broader implications, such as travel advisories and trade restrictions.

The Toronto community had to deal with each of these issues when it was confronted by SARS back in 2003. Much was learned that I think will help us as we prepare for a potential pandemic flu. In November 2005, the University of Toronto Joint Centre for Bioethics released a report called *Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza*, which takes the learnings from the SARS outbreak and applies them to preparations for pandemic flu. The following is an excerpt from that report:

The duty to care for the sick is a primary ethical obligation for health care workers for a number of reasons, including:

the ability of physicians and health care workers to provide care is greater than that of the public, thus increasing their obligation to provide care; by freely choosing a profession devoted to care for the ill, they assume risks; the profession has a social contract that calls on members to be available in times of emergency (in addition, they largely work in publicly supported systems in many countries).

When SARS broke out, health care workers in a number of countries were on the firing line, and had to make decisions for which they were not always prepared. They faced an unknown and deadly communicable disease, a coronavirus for which there was no known effective treatment. They were rapidly forced to weigh serious and imminent health risks to themselves and their families against their duty to care for the sick. A significant number of health care workers were infected with SARS because of their work, and some died. Many workers were placed under work quarantine.

Workers generally showed heroism and altruism in the face of danger during the SARS outbreak, but some balked at caring for people infected with SARS, and a few were dismissed for failing to report for duty. Post-SARS, many health care workers raised concerns about the level of protection to themselves and their families. Some even left the profession.

A flu pandemic would put far greater pressures on health care systems around the world. Faced with a very serious disease for which there may be no absolute protection or cure, health care workers will find themselves facing overwhelming demands. They will be forced to weigh their duty to provide care against competing obligations, such as their duty to protect their own health and that of families and friends. Initially the primary care and emergency services workers will take the full brunt of responding to the flu, and therefore bear a disproportionate risk compared to more specialized care providers. There will likely be pressure on other health care providers to come to the front lines.

Some believe that under dire circumstances, professionals should have minimal self-regard and pursue their duties at potential cost to their own lives. By analogy, firefighters do not have the freedom to choose whether or not they have to face a particularly bad fire, and police to not get to select which dark alleys they walk down. Others claim that it is unreasonable to demand extreme heroism from health care workers as the norm, and even more unreasonable to demand that workers put the lives of their families at high risk or make themselves unavailable to care for them should they become ill.

At times like this, health care workers' ethical codes should provide important guidance on such issues as professional rights and responsibilities.

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Preparing for the Worst: Are America's Doctors Ready?

The Department of Homeland Security's first "top doc" urges physicians to get informed about their communities' emergency response plans — before disaster strikes

By Amy Snow Landa, reprinted from AMNews, March 6, 2006

How many physicians know what to do after a biological or chemical attack on their community?

Not many, according to Jeffrey W. Runge, MD, the recently appointed chief medical officer at the U.S. Dept. of Homeland Security.

"When I go out to talk to medical societies and medical groups, I ask them: How many of you have read your county's disaster plan? How many have seen your hospital's disaster plan? Do you know your role if there is a biological attack on your community, or a dirty bomb, or chemical attack?"

The response has surprised him, he told *AMNews*. "I'm afraid not many hands go up."

Dr. Runge has been urging doctors to reach out to their local public health departments and to get connected to their communities' emergency preparedness efforts so they'll know what to do in the event of a terrorist attack, flu pandemic or large-scale natural disaster such as Hurricane Katrina. "Every physician — whether they're office-based or hospital-based — needs to understand what their role is should their services be needed in a disaster."

Dr. Runge warned that local communities likely will be on their own, at least initially, in providing emergency medical response after a catastrophic event. "People can't expect help from the federal government in the first hours after an attack."

Doctors should find out before disaster strikes how their community plans to respond, how they fit into those plans, and who they can contact with questions and concerns, he said.

"We need to weave our private medical practitioner community into the fabric of preparedness."

That has been Dr. Runge's core message to physicians in his first six months in the newly created position of Homeland "top doc."

It is a message that should resonate with many doctors, not just emergency physicians.

Internists realize that many patients who are injured or exposed during a catastrophic event are likely to present to physicians' offices, rather than to hospital emergency departments, said John Mitas, MD, deputy executive vice president and chief operating officer of the American College of Physicians.

"Internists will be key players," Dr. Mitas said. "But if they're not thinking about it, not prepared, and don't think they have resources readily available, they may not be as effective as they could be."

Dr. Runge said all doctors should ask themselves: "If they see a chest x-ray and suspect anthrax, do they know who to call? Do they know the name of their local health director? Do they have him on speed-dial?"

Every medical staff should have someone who knows how to get in touch with local poison centers for advice on suspected chemical attacks and weapons discharges, he said. They should have ready access to infectious disease colleagues well-versed in such concerns as weaponized anthrax and bubonic plague.

"With the threats that we face, we simply cannot wait for a disaster to be exchanging business cards."

Dr. Runge has struggled to manage expectations about what he can accomplish at DHS.

Some observers would like to see him weave the "fabric of preparedness" much tighter at the department itself, where medical preparedness activities have been dispersed among its many different branches — from the Federal Emergency Management Agency to the U.S. Coast Guard — with little coordination.

They also would like to see various federal agencies — including Homeland Security, Health and Human Services, Defense and Veterans' Affairs — pulled together more effectively.

But Dr. Runge is careful to emphasize that his resources and authority as chief medical officer are limited.

"Our office is a young office," he said, when asked what has been accomplished to date. "We are underresourced for the task at hand."

Dr. Runge has a five-member staff and a $2 million budget. Compared that with the 700-member staff and $650 million budget he oversaw in his previous position as head of the National Highway Transportation Safety Administration.

"We're working 14 hours a day, and every problem takes 18 hours a day," he said.

President Bush has proposed raising the chief medical officer's budget to $5 million in fiscal 2007. Dr. Runge said he would use the additional funding, if approved, to hire more staff.

"We need people to do the work," he said.

Looking for leadership

DHS Secretary Michael Chertoff established the office in July 2005 as part of a broad reorganization of the department. Dr. Runge came into the position in early September, barely a week after Hurricane Katrina roared onto the Gulf Coast, exposing major gaps in the nation's emergency response capabilities.

To many observers — including physicians and public health experts — the appointment of a chief medical officer at DHS was a welcome decision and long overdue. Before Dr. Runge's appointment, the department lacked a centralized medical structure.

That contributed to its multiple failures during Hurricane Katrina, said Shelley Hearne, DrPH, executive director of the Trust for America's Health, a non-

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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.*

Action and Reaction

Andrew Statson, MD

"To every action there is always opposed an equal reaction."
Newton's Third Law of Motion

The dark clouds of Pay-For-Performance are gathering on the horizon. It looks like the storm will hit in another two or three years.

Many people are working to design the system, and most of them expect to run it, or somehow to profit from it. A few might give up, and say that it can't be done, but their voices will be drowned by the majority, who will forge ahead.

Medicare is in trouble and Congress is desperate. Businesses and government units look at their troubled health plans, and they feel desperate, too. Something will have to be done, and they pin their hopes on PFP.

Whatever they have tried already did not stem the rising cost of health care. Managed care was a public disaster. Gate keeping, prior authorizations, formularies and other restrictions only increased the paperwork burden on the physicians and angered the patients. PFP will not fare any better, but they don't know it yet.

Today I will ignore the clouds on the horizon and look at the silver lining. While the AMA, the AAFP and the ABIM seem to support and encourage the development of PFP, at least one of our professional organizations, ACOG, has some doubts about it.

In the January 2006 issue of "ACOG Today", Doctor Ralph Hale, executive vice-president of the College, wrote, "Instituting a rigid body of rules is not in the best interest of the patient or the physician."

Indeed, all Practice Bulletins of the College carry the statement: "These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice."

Doctor Hale went on to say that as PFP and related issues have arisen, ACOG has been asked about the qualifying statements in its documents.

"The answer is both simple and complex," he wrote. "First, anyone who has treated patients understands that some patients do not fit into a classic pattern and that [their] management requires the physician, in the best interest of the patient, to go outside the usual guidelines.

"There is a more complex reason as well. When writing the guideline, the authors have to consider the usual patient, with the usual findings, who will respond in the usual way. In any bell-shaped curve of two standard deviations, 95% will be inside the curve, and 5% will be outside the curve. It's the management of these 5% that can be confusing and difficult. After four years of medical school and four years of specialty training, the physician can and should be able to make a decision for the best care of the patient that may not follow a guideline."

Three cheers for Doctor Hale and ACOG!

The effect of the report cards on medical practice is another issue which has a bearing on PFP. It isn't new, but received more attention recently.

We faced profiling twenty years ago. In obstetrics, it stressed Cesarean Section rates. Both physicians and hospitals were graded. We spent many hours compiling the figures and discussing them in committees. I don't remember whether these reports were ever released to the public, but the objective of the insurance companies clearly was to shame us into doing fewer sections and more VBACs. That went on for some ten years, then faded away.

The State of New York decided in 1989 to publish the mortality rates of angioplasties and coronary artery bypass grafts, broken down both by physician and by hospital. The first figures were released on the web in 1991.

Robert Kolker wrote a review of the New York experience with report cards, published in "Medical Economics" in December 2005. He cited several studies, which looked at the results and raised the question that heart surgeons in New York perhaps were refusing to operate in certain cases in order to keep their mortality rates low.

According to some studies, the

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people in New York are more likely to die from a heart attack than those in any other state, and the death rate from heart disease in general is disproportionately high. After the report card program began, the Cleveland Clinic received 31% more referrals from New York hospitals than previously, and the patients were sicker than those coming from other states.

A Michigan group reported in June 2005 that "if you come into the hospital in shock having a heart attack, you're four times as likely to have the cardiologist open up your coronary artery in Michigan than if you were in New York."

Robert Kolker explores the various ways in which physicians and hospitals have tried to game the system and make their statistics look good. Of course, the decision to operate or not is based on clinical judgment. One can argue that the patient might be better off not having an operation. Maybe, but then again, maybe not. It is also possible that some of the patients selected for surgery were mild cases, who may have done better with only a medical treatment.

In some respects that reminds me of the old paradox facing people who apply for a loan. They almost have to prove that they don't need it in order to become eligible for it. Perhaps the patients in New York almost have to prove that they don't need an operation in order to get it.

One internist related to me that some of his patients with severe coronary artery disease asked to go to Saint Francis because of their good report card. He referred them to a surgeon there, who refused to operate. He then sent them to Long Island Jewish, where they had their operation done. Of course, such practice affected the statistics of the surgeons and of the hospitals.

Things like that happen in many local situations and in many subtle ways. Right now, that is the result only of public disclosure of mortality rates. There is no money involved, except that a better rating tends to attract more business. What do you think will happen if in addition to that physicians and hospitals were paid 10% more for better performance? How many physicians will become "dump artists" in a PFP system?

I don't know what conclusion the authorities will reach from the disclosure of the New York experience with report cards. I don't know what effect that conclusion will have on the implementation of PFP. I do know that a reaction to any action is a basic law of Nature.

Since human beings are complex entities, their reaction is not as readily predictable as that of mechanical systems, but it is always there. All actions have consequences, and all too frequently, especially when they are performed on a large scale, many of the consequences are not what the actors had intended.

We saw that with all the previous attempts to control the practice of medicine by forcing patients to fit a mold. It is an impossible undertaking, and at least ACOG has been able to see it as such. ■

Coalition for Healthy Active Medical Professionals

CHAMP

Pierce County Medical Society

METROPARKS TACOMA

CALLING ALL MEDICAL PROFESSIONALS including office staff and families!

-CHAMP SWIM CHALLENGE-

HAVE FUN. JOIN IN. IMPROVE YOUR LIFE. ENJOY THE WATER. CELEBRATE FITNESS!

SUNDAY, MARCH 19TH

1:00PM - 4:00PM

EASTSIDE COMMUNITY POOL

The Tacoma Eastside pool is a 25-meter, six-lane, indoor pool located at 3524 East L Street in Tacoma The pool's minimum depth is 3 feet and maximum depth is12 feet featuring a one-meter diving board and a 12 person capacity spa

Challenge yourself to swim for 15 minutes, 30 minutes, one hour or longer! Fun for all levels of fitness!

This non-scored event is offered at no cost due to the sponsorship of Pierce County Medical Society and MetroParks Tacoma. It is being held to help promote the Coalition for Healthy Active Medical Professionals and to celebrate healthy lifestyles, people, families, workplaces, and communities.

Please join us for a new start or a continuation of a healthier life, with increased exercise and fun

-PLEASE JOIN US-

Registration Form Yes, please register me for the CHAMP Swim Challenge for health and wellness at NO COST:

Name: (please print) _____ Phone Number: _____

SWIM CHALLENGE (circle one): 15 minutes 30 minutes 1 hour Other: ____

ESTIMATED START TIME (circle one): 1:00pm 1:30pm 2:00pm 2:30pm 3:00pm 3:30pm

YES, I would like to order a COOLMAX T-SHIRT with a CHAMP logo at a fantastic price of $10 per shirt. Size: S M L XL

- ☐ I will pick up and pay for my shirt on event day, unless I pick it up at the PCMS office prior
- ☐ I will mail my check and this form to PCMS, 223 Tacoma Avenue South, Tacoma WA 98402 (checks payable to PCMS) and have a shirt mailed to me at the following address: _____

Please FAX your registration form to PCMS 253-572-2470 (Call PCMS for any special arrangements prior to event day: 253-[illegible])

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partisan public health advocacy group in Washington, D.C.

"If you look at what happened with Katrina, there was redundancy among several emergency management systems and also efforts to reinvent the wheel in the midst of the crisis," Dr. Hearne said. "There was not a clear game plan for the health response."

There still is no clear game plan, she said. In December 2005, the trust gave the federal government a grade of D+ on its post-9/11 public health emergency preparedness.

Across the board, medical preparedness activities are not well-coordinated, said James J. James, MD, DrPH, MHA, director of the American Medical Association's Center for Public Health Preparedness and Emergency Response.

"All the different efforts on preparedness really suffer from a lack of integration in planning and operation, especially between the public and private sectors."

Dr. James, who met with Dr. Runge in December, said it would be helpful if someone in the Bush administration — whether it is Dr. Runge, the U.S. surgeon general or someone else — could bring together all of the various elements involved in medical preparedness. "We want to see someone in federal government who is knowledgeable, capable, who carries the mantle of top doc and can actively play a role in overseeing some of this."

Defining the role

But whether that will be Dr. Runge's job remains to be seen.

The exact nature of his role at DHS is still unclear, said Scott Lillibridge, MD, who heads the Center for Biosecurity and Public Health Preparedness at the University of Texas Health Science Center in Houston.

"The question is, will DHS organize this into an effective office that has operational, policy, and budgetary control over the health components throughout DHS, or will he be a health adviser and that's all?"

Dr. Lillibridge hopes it will be the former, but some physicians are concerned that Dr. Runge's office is evolving toward the latter.

"Many people in emergency care circles thought that someone with his credentials, coming into an agency that is so critical to the safety of the country, would have substantially more resources than it looks like he's had," said Arthur Kellermann, MD, MPH, a trustee at the American College of Emergency Physicians.

ACEP representatives met with Dr. Runge in October 2005 and later sent him, at his request, a list of recommendations for improving medical preparedness. Among their top concerns is the limited surge capacity in the nation's hospital emergency departments, said Dr. Kellermann, who chairs the Emergency Medicine Dept. at Emory University School of Medicine in Atlanta.

Metro areas such as Atlanta have six to 10 hospitals diverting ambulances on any given day, he said. "So how in the world are we supposed to handle another Olympic Park — which was a pretty minor-league bombing, as bombings go — compared to a much larger terrorist attack, not to mention a major outbreak of influenza or another biological agent?"

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ACEP hopes that Dr. Runge, who is board-certified in emergency medicine, can bring high-level attention to the issue.

Dr. Runge is noncommittal. "We do talk about it, and surge capacity is a huge issue. But it's HHS' issue." He said the Dept. of Homeland Security would "work toward generating requirements around surge capacity," but that his office first would need to see hard data on the problem.

Dr. Runge has spent the bulk of the past six months working on pandemic flu preparedness.

"My time has been just sucked up with avian flu. But if we do things right on avian flu, we will be much better prepared for a biological attack because the systems that you use to deal with medical needs are the same for both."

When asked to describe his role at DHS, he said his "immediate mission is to make sure the secretary gets the best possible incident management advice to drive his decision-making in the event of a disaster of medical significance."

In the event of a catastrophe, he will be "at the secretary's elbow," Dr. Runge said, "making sure our response elements, namely the National Disaster Medical System and our relationships with first responders, are where they need to be."

Being visible to the public is not part of the job. "HHS has to step up and have the spokesperson, and that spokesperson should be a doctor."■

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It is important for health care professionals, from doctors to nurses to hospital and ambulance staff, to articulate codes or statements of ethical conduct in high-risk situations, so that everyone knows what to expect during times of communicable disease crises. These codes or statements should cover such issues as:

how much risk should health care workers be required to take; their duty to care for the sick, and to care for themselves so they can continue to provide care; and, their duty not to harm others by transmitting diseases. (http://www.utoronto.ca/jcb/home/documents/pandemic.pdf, pages 9-10.)

At this point we don't have a clear code or set of policies to guide us if we were to confront a massive outbreak of a deadly disease. We need to craft a code of ethics now, not when we are in the midst of an outbreak. I hope that the Pierce County Medical Society will take the lead in seeing that the medical community does have a carefully thought through set of positions on the role and duty of health care professionals during the crisis of an outbreak. This will only strengthen our profession and at the same time better prepare our community for these potential catastrophes. ■

Applicants for Membership

Elisa L. Garza, PA-C
Surgery
915 - 6th Ave #200, Tacoma
253-403-7277
Training: University of St. Francis
Residency: Norwalk/Yale University

Don D. Palencia, DO
Family Practice
6401 Kimball Dr, Gig Harbor
253-858-9192
Med School: Kirksville
Intership: Family Medicine of St. Louis
Residency: Forest Park Hospital

The Uninsured in Washington State
A Public Opinion Poll

This excerpt provides the major findings of a representative telephone study conducted in January 2005 among 750 likely voters in Washington State. The "People Without Health Insurance in Washington State" poll was conducted for members of the Working for Health Coalition, Inc. by Widmeyer Research and Polling of Washington, DC. The margin of error for the study is +/- 3.5%.

The major **conclusions** of the study are:

1. Voters say that healthcare is now the single most important issue or problem facing Washington State today. The uninsured problem is believed to have a major impact in increasing overall healthcare costs.

2. Voters are extremely concerned about people without health insurance and say the current healthcare system is not addressing this problem. Concern about the uninsured has grown since last year and large majorities of voters support the goal of providing health insurance to all residents.

3. Voters overwhelmingly support a viable "healthcare safety-net" that provides care to people without health insurance. Support for the healthcare safety-net has increased from last year.

4. Large majorities of voters support actions that the state legislature could take to provide health insurance for working families and poorer residents who have none. Voters express concern that the "will of the people" is being thwarted by the state legislature on the issue of expanding health insurance for the uninsured.

5. Voters believe that employers have a responsibility to provide health insurance to their employees and believe, when companies don't, that it increases costs for everyone. Voters want the state to require large employers to provide health insurance.

6. Voters support mental health parity in health insurance and want the legislature to require it. They believe cutting expenditures for mental healthcare increases healthcare costs.

7. Voters recognize that increased taxes are necessary to offset healthcare cuts that have been four years running. There is strong support for new taxes on cigarettes and alcohol and for closing certain tax loopholes, but minimal support for small increases in monthly health insurance premiums.

8. Although voters say they worry most about children that do not have health insurance, they express nearly as much concern for uninsured seniors, the working poor and low-income families. The bottom line is that voters are concerned about all people without health insurance.

The survey revealed specifically that while 27% of voters identify health care as the most important problem, 12 percent cited the economy and another 12% identified public education as the single most important issue facing Washington State today. And, while 94% of voters agreed with the importance of a safety net that offers affordable health care to all people, 9 out of ten voters (87%) agree that community health clinics that provide healthcare to anyone regardless of their ability to pay should be supported by the state.

The vast majority of voters believe it is important that employers provide at least basic health insurance to their employees and believe that the state should require it of larger employers. And, they put their money where their mouth is by agreeing that repeated cuts in the healthcare budget over the past few years now necessitates raising revenues through new taxes. A majority of voters STRONGLY support taxes on cigarettes, alcohol and soda to raise revenues to provide health insurance for low-income and working families who have none. The polls clearly indicated that Washington voters are concerned about many groups of people who lack health insurance, but are primarily concerned about children.

For a complete copy of the report including all major findings, please call the Pierce County Medical Society office 253-572-3667. ■

Whistler and CME meets with success and great snow... Skiing a great recreational, family sport

A winter paradise coupled with good skiing met with good company and first class continuing medical education programs at the 2006 Whistler and CME course this year. Oh, and throw in some good food and you have a real winning event.

Over 60 PCMS physicians attended the January 25-28 conference that offered ten hours of CME over four days at the renown Whistler resort town. The CME programs provided the latest updates in many topics ranging from sudden cardiac death and COPD to Alzheimer's treatment and weight control. The popular schedule allows for classes from 7:00 a.m. to 9:30 a.m. Thursday, Friday and Saturday, and again from 4:00 to 5:30 on Thursday and Friday. This easily allows for 6 hours of skiing mid-day on Thursday and Friday, and after 9:00 a.m on Saturday and all day Sunday.

The skiing was excellent with perfect snow and lots of it. Skiing affords a valuable family opportunity in today's busy world. A number of PCMS members attest to the best times spent with their kids has been on the ski lifts or cross country trails where they are not distracted or pulled away by electronic technology or patients.

Skiing is especially valuable for the overloaded lives of physicians such as **Mark Craddock, MD** who claims that "physicians are involved in an intense occupation and we need a recreation equally as intense to clear our minds." The all encompassing stimulation of skiing focuses the mind to enjoy the true fun of fun. This can be the ultimate stress release.

And, of course, the best advantage of skiing is participating in the annual College of Medical Education's *CME at Whistler* program held each year. Aside from the great educational opportunities and skiing, hot tubbing, dining in town, shopping and many other activities provide great camaraderie among participants.

This year the opening reception, thanks to new CME coordinator Lori Carr, offered an array of delightful food prepared by two local sisters who do catering for special functions. Offering home made cuisine of all kinds, participants found it a welcome surprise from the tried and true pizza from previous years. Evaluation forms noted "a big improvement" in the food department.

No doubt, the Whistler CME course will be offered again in January of 2007. Think now about making plans early, as lodging does fill during popular ski times. You won't find better snow, better camaraderie with your colleagues and more favorable learning conditions than those provided at Whistler. ■

Dr. Rick Tobin (left) and "boys" are all smiles with the great snow and good times

Past Presidents Drs. Patrick Hogan (left) and David Law (right), buddies on the slopes

Dr. Patrick Hogan and Joan Brookhyser preparing to do the "expert only" Spanky's Ladder

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

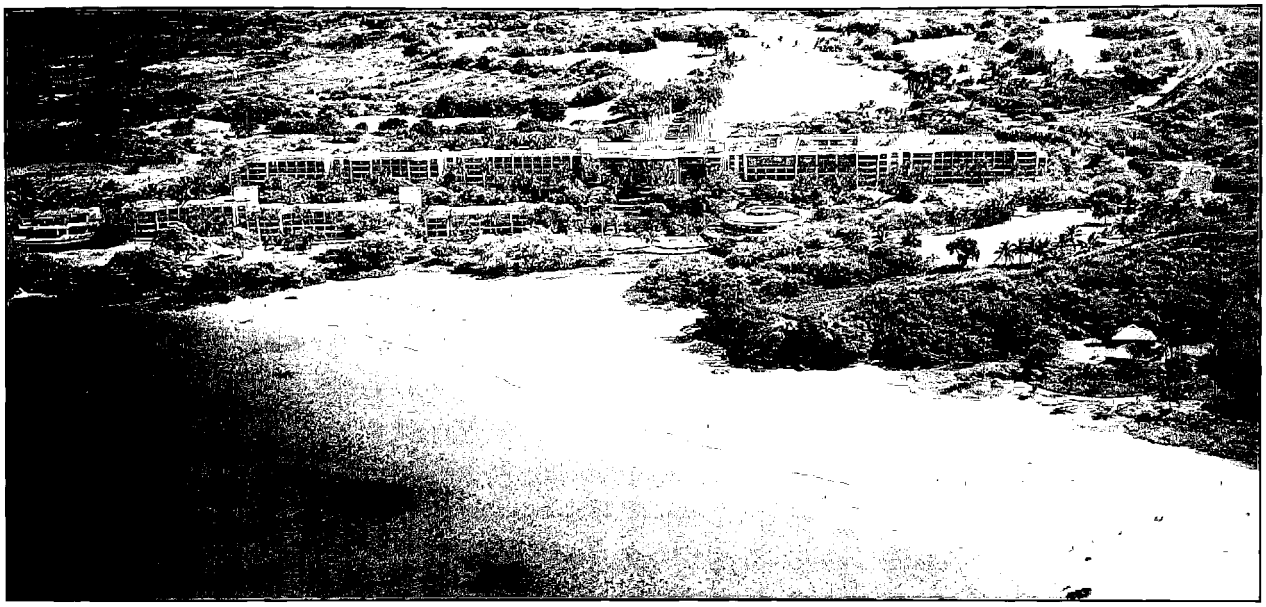
Hawaii CME - April 2-7

The Hawaii CME course will be held at the Hapuna Prince Hotel on Hapuna Beach on the island of Hawaii, Sunday - Friday, April 2-7, 2006.

Offering 16 Category I credits, the Hawaii program is designed for PCMS and other physicians and features addresses on a variety of topics.

Reservations must be made early for both travel and hotel. Call Jeanette Paul at All Wanderlands Travel, 572-6271 or email her at jeanette@awtvl.com.

DON'T DELAY, MAKE YOUR RESERVATIONS NOW! ■



Hapuna Beach Prince Hotel, Island of Hawaii

Upcoming CME Programs

Friday, March 10, 2006
Mental Health Review
Program Director: **David Law, MD**

Sunday-Friday, April 2-7, 2006
CME at Hawaii
Program Director: **Mark Craddock, MD**

Friday-Saturday, May 5-6, 2006
Internal Medicine Review
Program Director: **John Hurst, MD**

Friday, June 2, 2006
Primary Care 2006
Program Director: **Steve Duncan, MD**

Internal Medicine Review set for May 5 and 6

The ever popular *Internal Medicine Review* CME course will be held on Friday and Saturday, May 5-6 at St. Joseph Hospital in the Lagerquist Conference Center. This program, free to members of the Tacoma Academy of Internal Medicine has a $150 registration fee to non-Academy members. Mark your calendars and watch for the conference brochure which will be mailed soon. The conference is under the direction of **Jonathan Hurst, MD**. ■

Primary Care 2006 set for June

The *Primary Care 2006* CME course is set for Friday, June 2nd at Fircrest Golf Course. The course director is **Steve Duncan, MD**. This one day course is [illegible] no charge and is targeted to primary care physicians. Watch your mail for [illegible] brochure. ■

Doctors consider giving up obstetrics, say risk is too great

By Brad Shannon, reprinted from the Olympian, Feb. 27, 2006

One Bellevue-based obstetrician, Dr. Elisabeth Anton-McIntyre, said Friday she is actively considering whether to stop delivering babies, switching instead to a gynecology practice.

Another obstetrician, Dr. Bina Souri of Olympia, also is considering her options after 36 years in practice.

Both said they see little in the Legislature's proposed medical liability bill that would make it more attractive to continue practicing.

"I won't say I'm going off now," Souri said Friday, "but this is going to be the deciding year for me, too."

"These proposals really do nothing to lower the exposure risk for obstetricians," said Anton-McIntyre, who had confronted Gov. Chris Gregoire last month during a state medical association meeting in Olympia.

Anton-McIntyre, who said she has never been sued for her obstetrical care, told Gregoire that she needed to see improvements in the liability environment or she would give notice to her practice June 1.

"When there is a damaged baby, it is limitless" for damages, Anton-McIntyre said in an interview. "Without some kind of program in Washington to protect obstetricians, it's unreasonable to expect us to expose ourselves like this."

Anton-McIntyre said she would favor a system more like Canada's, where the government assumes the costs of caring for children damaged by birth injuries, she said. Similar "no fault" programs funded by doctor fees also care for birth-injured children in Virginia and Florida.

State Rep. Pat Lantz, D-Gig Harbor, said she is considering reviving such a no-fault proposal for Washington, but she was roundly criticized for trying to raise the issue two years ago.

Others have suggested that higher reimbursements to doctors who deliver babies for government-paid Medicaid patients could help compensate for high malpractice premiums, which dropped to $66,419 per year in 2005 for Physicians Insurance policies in Washington.

Souri also criticized the legislative compromise reached by Gregoire and representatives of the state medical and legal communities. She said doctors are put in a terrible financial vise by rising costs and lower reimbursements from insurers and government payers, while malpractice premiums have soared in recent years.

Slight increases of physician-fee payments to $520 per Medicaid delivery, which Lantz had supported a few years ago, would not be enough, Souri said. And Anton-McIntyre complained that a 1 percent fee on all other physician services would have been used to pay for the higher per-birth allotment.

Souri said it was ridiculous for state Insurance Commissioner Mike Kriedler to say the crisis is passing, because malpractice rates are still unaffordable — doubling to $130,000 this year for one colleague whose first insurer canceled his policy.

Souri also questioned why women — who give birth and in many cases are the doctors and midwives who deliver babies — are the ones squeezed by the malpractice premiums and low reimbursement problems.

"In a state where the governor is a woman and the bill is sponsored by a woman, why are the women not being taken care of?" Souri said. "I am not going to keep on being a victim of the system. I cannot tell my patients not to be victims if I am letting myself be a victim of the system." ■

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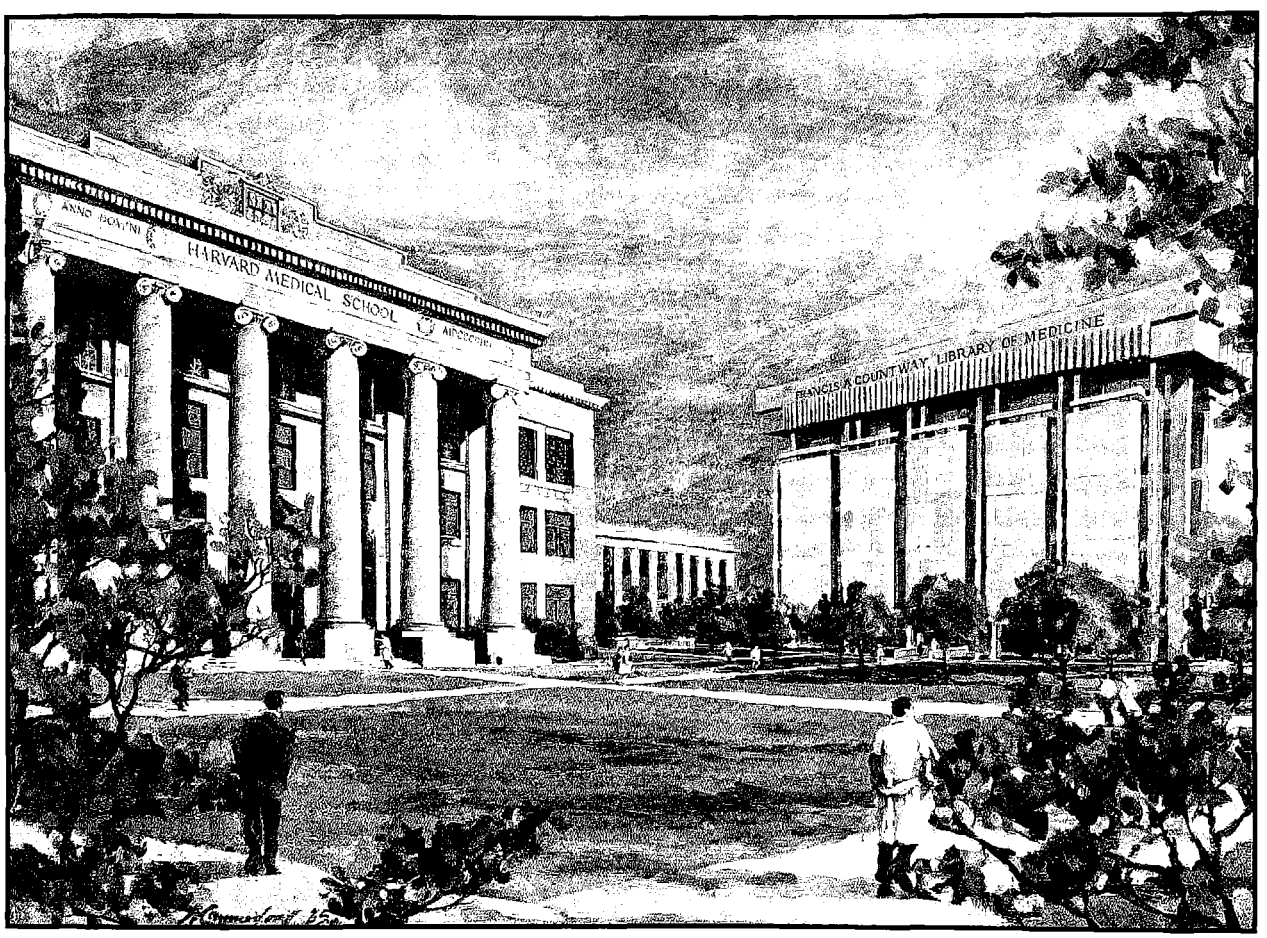
BULLETIN

April, 2006



Harvard Medical School — Francis A. Countway Library of Medicine

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Bringing Us Together, While Forces are Trying to Divide Us

Joseph F. Jasper, MD

Introduction

The doctors' lounge and doctors' dining room and the hospital nurses stations provided doctors with significant opportunities to discuss patients, business and just plain socialize. Annual meetings of every physician with privileges used to take place to discuss and modify bylaws before doctors voted to pass the final version. For many of us these appear to be part of a bygone era in medicine. So how do we preserve the society of medicine? We hope that the PCMS can provide opportunities for social interaction and promote continued collegiality.

Meetings

Our general membership meetings offer a combination of reasons to gather. Meetings begin with a social hour. This is followed by a relevant topic of PCMS business and a guest speaker. Our annual meeting in December is usually the best attended, yet still only brings in about 1/5th of our members. We would like to make these meetings appealing to more of the membership to increase attendance. Please, send in your suggestions to Sue Asher, and attend the meetings.

The College of Medical Education will continue to provide opportunities for both CME and collegial and family fun. Check out the calendar of events.

Professional Relationships

We are promoting an open referral system in the community. On a professional level we want to promote a unified society of doctors, not one fractionated by corporate ties. This applies to all doctors whether private, small group, IPA or employed. Doctors in the private community should feel open to referring to employed physicians and *vice-versa*. Patients should be confident that referrals are made in the best interest of quality and timely care. With an open referral system we get to know and depend on one another rather than develop polarized or isolated practices and social patterns.

Web Site

We are reformatting the PCMS web site. Goals of the project are to make it a useful site to members and keep it up to date. At www.pcmswa.org you will find four general categories on the main page: Medical Society, Employment Agency, College of Medical Education and the PCMS Foundation. Under the Medical Society heading, easily navigate to a variety of pages:

- Calendar of events - our meeting schedule, and other important dates
- PCMS mission statement
- PCMS Board of Directors
- Bulletin – our monthly newsletter
- Healthcare economics page
- Public Health information
- CHAMP
- Information download
- Contact us
- New members announcements
- Helpful links

From the information download section you will be able to retrieve lectures made available to PCMS on a variety of topics.

"We are here to serve all of you, private or employed."

Liaisons

On the PCMS Board of Trustees we have representatives from the private community, Franciscan Medical Group, MultiCare Medical Group and Northwest Physicians' Network. We have already initiated contact with the hospital medical groups and an owner member of NPN to explore ways to keep our medical community integrated.

The hospitals are also making a social effort with Doctors appreciation days. I hope you all will attend. Say "hello" to colleagues old and new. Interpersonal social efforts will likely go far to prevent the development of corporate schism, so stay in touch with your colleagues.

A Medical Reserve Corps is being formed in conjunction with the Health Department. We have two sterling volunteer liaisons – **Drs. David Bales** and **Cordell Bahn** - who are helping ensure that practical considerations for physicians are addressed.

Help Us Make PCMS Better For You

We are entertaining other thoughts on "Bringing us back together." We are here to serve all of you, private or employed. Please, call or write [illegible] your thoughts on socially developing a cohesive medical society.

Physician turnover and retention: A growing concern

Groups are paying closer attention to physician turnover and focusing more on retention efforts.

The main reason, concludes a recent survey conducted by Cejka Search, a St. Louis-based health care search firm, and the American Medical Group Association, is cost. It's more cost-effective to take the time to find the right long-term fit instead of frequently hiring physicians, says Carol Westfall, president of Cejka Search. Results are based on surveys filled out by 95 AMGA member groups out of the 275 groups that received them:

	2004	2005
Annual tracking of turnover		
Track turnover	73%	90%
Do not track turnover	27%	3%
Don't know	0%	7%
Top reasons for voluntary separation		
Practice issues	31%	44%
Compensation	20%	21%
Location	13%	21%
Spousal reasons	10%	14%
Pressure of clinical practice	10%	N/A
Physician retention initiatives		
Have	48%	58%
Do not have	52%	40%*

	2004	2005
Written retention plan		
Have	27%	41%
Do not have	73%	41%*
Physician tenure at time of separation (2005)		
Less than 1 year		9%
1-3 years		38%
4-5 years		13%
More than 5 years		40%

* Note: Some groups in 2005 marked "Don't know" as a response to the questions about retention plans and retention initiatives.

Reprinted from AMNews, April 3, 2006

CHAMP Swim Challenge

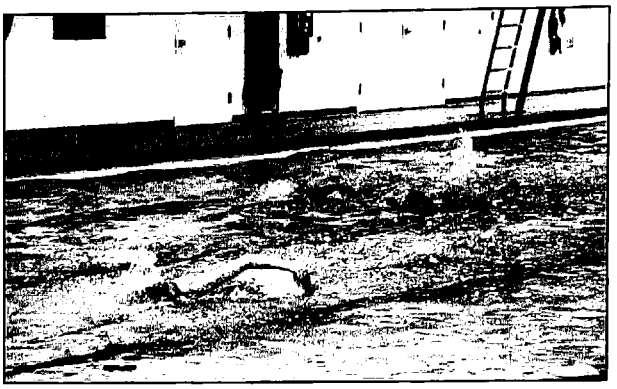
The CHAMP swim challenge, organized by **Jane Moore, MD**, was held on Sunday afternoon, March 19th at the Eastside Community pool. The 25 meter, six lane indoor pool is operated by Metro Parks and opened solely for the CHAMP event.

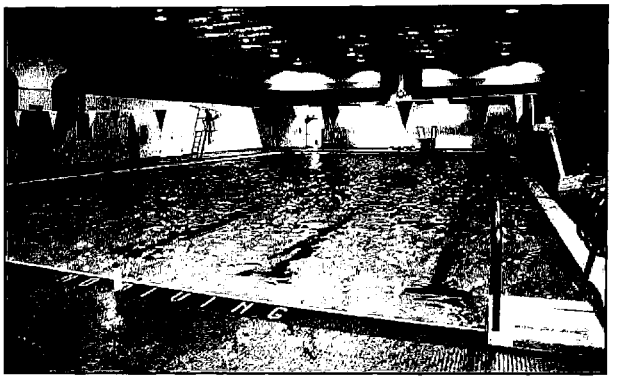
Several PCMS members enjoyed the luxury of the uncrowded facility including the pool and large capacity spa; competing with the event was a gorgeous spring day with long awaited sunshine.

CHAMP will sponsor the event annually in efforts to keep CHAMP's goals of creating a healthy medical community, changing societal attitudes about the importance and necessity of fitness and nutrition on health, all while having fun.

CHAMP will also sponsor the 2nd Annual CHAMP walk/run in Point Defiance Park in October. Start walking now.....

Join CHAMP. Call PCMS for a brochure, 572-3667.





Pictured right: Top, most participants swam laps from 30-60 minutes while time keepers recorded the number of laps and times

Bottom, the open pool was large and inviting for uncrowded lap swimming

Kitzhaber rallies for health reform

Former Gov. John Kitzhaber officially launched his grassroots reform movement April 2nd with a forum that attracted about 200 people determined to change the way the country thinks about health care.

The goal of the kickoff meeting, in Southeast Portland, was to brainstorm ways to get the word out to more people, enough to spark a national debate.

To help with that, Kitzhaber has recruited political adviser Joe Trippi, who successfully used the Internet to rally bottom-up support for former presidential candidate Howard Dean.

The project, Trippi told the crowd, is a chance to start small and build "until we have 100,000, 200,000 and, eventually over the longer haul, millions of Americans committed to each other, not to some top-down thing, but committed to each other that we will, can change the system."

Roughly 50 million Americans lack health coverage, Kitzhaber said. He has called for scrapping Medicare and Medicaid using money in those programs to provide a basic level of coverage for all Oregonians.

In a rousing opening speech, the former emergency room doctor berated the current system as defying "logic and common sense," essentially an outdated model that refuses to pay pennies for preventive services but shells out for more expensive emergency care.

"It's a policy that says, in effect, we won't ensure that all the women in our communities have access to good prenatal care, but we'll be happy to pay the cost of resuscitating a 500-gram infant in a neo-natal intensive care unit," he said.

"That should not be acceptable to any of us."

Kitzhaber served as Oregon's governor from 1995 to 2003. He pushed through the Oregon Health Plan, which reduced the state's uninsured and became a national model by covering more people under a limited package of benefits.

He announced the Archimedes Movement in January, after rejecting the idea of running for a third term as governor. Since then, the group has raised about $180,000 from individuals, unions, hospitals and businesses, and added about 800 to 900 people to its list, he said.

Kitzhaber said the group will focus on drafting a proposal for the 2007 Legislature when it meets in January.

An exuberant Kitzhaber called Sunday's turnout "remarkable" given that he had expected about 60 people for a project that's been called a pipe dream.

Participants, who varied in age and occupation, quickly settled into serious talk, lobbying ideas for how to hone their message and whom to target. They all agreed - ditch the web address - Archimedes is too difficult a word, get politics out of health care, and any changes must bubble up from [illegible] and come from the people. ■

Excerpted from "The Oregonian" [illegible] 2006

Wisconsin governor signs liability cap

Trial lawyers say they will fight the new limit

By Amy Lynn Sorrel, reprinted from *AMNews*, April 10, 2006

Wisconsin physicians succeeded in their effort to reinstate a cap on noneconomic damages when Gov. Jim Doyle on March 22 signed into law a $750,000 limit on jury awards.

The Legislature overwhelmingly passed the bill two weeks earlier. It had strong support from the medical community, which said the measure was needed to preserve access to care.

The new cap will not be adjusted for inflation and will be reviewed every two years by the board that approves fee changes to the state's Injured Patients and Families Compensation Fund. It took effect April 6.

"While we are extremely pleased to have this new law, we still must recognize that a $750,000 cap is among the highest in the nation," said Wisconsin Medical Society President Mark Belknap, MD. "We'll watch closely to see that it's having the desired effect of stabilizing insurance premiums and discouraging baseless lawsuits that are nonetheless expensive to defend."

Doyle's approval came just three months after he vetoed a $450,000 cap approved by lawmakers. After consulting legal experts, he believes the new limit stands a better chance of being upheld by the state Supreme Court, he said.

"The court will have to make its own decision, but I believe this bill represents a reasonable compromise," Doyle said.

The WMS and the Wisconsin Hospital Association joined with legislators to determine a cap that could address the concerns of the state Supreme Court, which struck down Wisconsin's 10-year-old ceiling last July.

The court ruled the $445,775 limit was arbitrarily set and violated plaintiffs' equal protection rights because it was too low. Doyle said he rejected the $450,000 proposal because he believed it would not pass the high court's constitutional test.

Trial lawyers denounced Doyle's approval of the $750,000 cap and have pledged to fight it in court.

The new law "takes away the rights of the most severely injured to be treated equally," said Wisconsin Academy of Trial Lawyers President Daniel A. Rottier. The WATL disputes arguments that a pain and suffering cap will reduce medical liability insurance rates and keep doctors practicing in the state.

"It appears that it will again be up to the Supreme Court to be the true guardian of our constitutional rights," Rottier said. ■

In My Opinion

by Kenneth Feucht, 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.*

Beethoven's Gastroenterologist

Kenneth Feucht, MD

According to musicologists, Beethoven's second symphony was written at a time when he was suffering from a severe gastrointestinal ailment. You will find in the fourth movement of this symphony a musical description of Beethoven's abdominal symptoms. I am grateful that there were no gastroenterologists existent to treat his abdominal ailment. The severe discomfort of this medical condition provided the stimulus for the progressively radical, revolutionary, and immortal 3rd through 9th symphonies. Space is inadequate to detail the massive volume of string quartets, piano sonatas, and other compositions by Beethoven which redefined that "auditory stimulus" we call music. Beethoven demonstrates one of many instances where mankind has been more blessed by the absence than by the presence of physicians. Perhaps another one of those times could be right now.

It is unwise to ask physicians to go on strike to protest their multitude of grievances. Physicians tend to care for patients even when inadequately reimbursed, threatened by massive personal inconveniences or lawsuits, and when un-thanked. Physicians are not requested, but demanded, to perform at 100%, often working many 24-hour days straight, awakened many times through successive nights. Most of us can usually remain cheerful through this entire ordeal of exhaustion and sleep deprivation, and still act concerned about our patient's welfare. This concerned behavior is usually because we actually do care about our patients.

The rules have slowly changed for physicians. Historically, patients were grateful for physicians, and accepted that things did not always work out. Medical care now has become a constitutional right. Medical care is now regulated and monitored, quality controlled and measured. Quality management has become the buzz-word across every specialty and across all 50 states. The tolerance for human error has reached zero. Safety is the summum bonum of medicine.

Other industries have observed that human performance tends to degenerate with exhaustion. Industrial scientists have identified that degeneration in performance tends to occur unnoticed by a person, especially when performing high stress and complex decision making tasks. There is good reason why the airline industry thought it best to severely restrict work hours for their pilots and flight attendants. Even the American Nursing Association is aware that nurses that work greater than 12 hour days tend to show severe degeneration in their performance and a greater incidence for mistakes, and has asked Congress for laws which severely restrict nursing work hours.

Oddly, physicians do not feel that their work performance degenerates with exhaustion and sleep deprivation. I recall instances in residency when my total sleep time for the week (Monday to Saturday morning) contained less hours than the total fingers on one hand. I took great pride in my ability to perform surgery while totally asleep, not recalling a thing I did minutes after the completion of the procedure, yet noting that the patient got better and did well. Bravissimo! I protested loudly when the feds decided to regulate residency work hours at limits of 80 hour weeks and no more than 24 hours continuous duty at work. No more heroism in residency. No more tales of the "good ole' days" when chief residents in surgery operated through the night, since it was then that they could operate independent of the attending.

Work-hour restrictions regulate the wrong doctor. The young and supple, healthy physician-in-training is most capable of loosing sleep and still performing well. The older doctor does less well at handling a long busy night on call preceded and followed by a full clinic day. Those late night decisions tend to be the most perilous. Specialties that have a low potential for disaster from poor decisions generally do not have to make those decisions at 2:00 am. If you use the wrong ointment to treat a skin rash, if you make an error in the refraction of an eyeball, if you wrongly advise an antidepressant when a good vacation might be more effective, the outcomes and treatment plans may easily be adjusted days or weeks later, sometimes to an unhappy, but rarely ever dead patient. A 2:00 am miscall on a ruptured appendix, myocardial infarction, or a delivery that is not going well, and you end up with the highly possible chance of performing in a theater of law defending your "thoughtless" actions which "caused" a poor outcome or death.

The public desires to have matters two ways. First, they want no possibility of medical error. Secondly, they wish to have medical care immediate and on demand, paid for by somebody else. The public is currently receiving a close

See "Beethoven" page 14

The Art of Leadership, May 19-20, Lake Chelan

The WSMA Leadership Development Conference will be held at Campbell's Resort on Lake Chelan, May 19 - 20. A conference agenda and registration information can be viewed at www.wsma.org.

This conference provides a great opportunity to sharpen your leadership skills and discover new trends in health care organization, while at the same time allowing you an opportunity to relax and network with other physician leaders.

Learn about some of the crucial issues of the day, such as pay for performance, consumer driven health care, patient safety and health care disparities. Breakout sessions offer attendees the opportunity to hone skills such as Leadership and Financial Accountability, Mentoring and Leadership, and Dealing Effectively with Anger to name a few.

Registration materials will be mailed shortly. For more information, call Meigs Naylor at the WSMA Seattle office, 1.800.552.0612 or 206.441.9762 (email meigs@wsma.org). ■

Coverage, in pieces

By Susan Brink, reprinted from *Los Angeles Times*, April 3, 2006

Health insurance coverage is cyclical. It changes with age, jobs, income, marriage, divorce — even with sickness itself. Some stories of what people do to stay covered are whispered in confidence: a marriage of convenience, a divorce put on hold, a person too sick to work kept on the payroll by a compassionate boss.

Others are more obvious: a hated job held onto; retirement ruled out because a worker, or the worker's spouse, is not yet 65 and, therefore, ineligible for Medicare; an economically comfortable couple, thriving on one self-employed income, sending the other spouse to a 9-to-5 job for the health insurance.

The nation's political, business and community leaders are all grappling with the escalating cost of healthcare. But it's not just Medicare and Medicaid budgets that cause concern in the public discourse. Events that once may have been seen as unrelated corporate decisions, such as layoffs at General Motors, are readily linked to the problem of rising healthcare costs. Among the general public, there is a gnawing uneasiness that anyone, at any time, is a pink slip away from joining the ranks of the uninsured.

But it can happen even without the pink slip. A good job used to mean good health insurance. Since 2001, employees' share of health insurance costs has risen 58% for family coverage, 63% for single coverage. Working people who can no longer afford the bite out of their take-home pay become uninsured. And more companies are dropping health benefits altogether. Today, only 61.9% of working people get coverage through their employers, according to the Kaiser Family Foundation, down from 71% in 1987.

In discussion groups around the country, called for by Congress in a little-noticed provision of the Medicare Modernization Act of 2003, individuals are talking about their worries. Town hall-style meetings are scheduled in many cities. In the fall, these opinions will be added to a mix of reports Congress will receive summarizing meetings held in 36 cities, as well as survey results received on the Internet (www.citizenshealthcare.gov).

"I think many people are starting to feel the slipping-through-the-cracks phenomenon, that it could happen to them," says George Grob, executive director of the Citizens' Health Care Working Group, which is organizing the meetings. "In general, people worry about the cost of care, about access to care for themselves, and for everyone else. A common theme is that it's time to do something about it."

Congress is committed, if not to act, at least to listen. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

The Search for a Better System

Federico Cruz, MD

Health care is a mess. The background noise of complaints has turned into groans and in many cases into outright anger and frustration. When a majority of health care providers stop advocating to their own children a career in health care, we know we've sunk to a pretty low state. As a public health person I have had to deal directly and openly with both government-controlled and private sector health care systems for many years. I have grown used to rigid thinking and wildly inefficient use of resources. I see decision-making that lacks any strategic sense or any kind of common sense being made routinely.

So, when I am asked in my role as the director of the local health department what we can do to improve the system, I do have a ready answer. Make the system be under local control. I am not advocating any particular approach. This is not a backhand ploy to plug a Canadian style system. It is an observation from many years in systems that those systems most accountable to the people that they serve are those that are most immediate to them.

If a system is run out of Washington D.C. or out of Olympia, who gets to make the decisions about what services are offered, to whom and how? What's clear to me is that the people actually making the decisions are not those who are in the best position to make sound decisions.

I am not thinking that there is something about local people that makes them superior to those working at the state or federal level. There are many very talented people in state and federal governments. What I am saying is pretty basic. It is harder to hide at a local level. Right now special interest groups have skewed and warped and altered any reasonable attempt to alter the current system so as to hold their particular group harmless. The rubber meets the road at the local level. For a local health care system this means that the critical driver is meeting the actual needs presented to our local health care providers. Yes, there are special interests maneuvering to get their areas enhanced but this is all looked at in a context where the work needs to get done. There are real patients with real problems who need to be seen. And there is only so much resource. Practical questions will get onto to the decision making table more quickly under local control.

Critical to the success of any system is the existence of feedback loops; continuous feedback that alters and guides the functioning of the system. Locally, we have come to expect these loops in most systems we function in. Federal and state health care systems, on the other hand, have different drivers. Their feedback systems are primitive and extremely slow to respond. They are really a variation that is entitlement driven. The only feedback that comes through this system is how many people are seen, who is eligible, and how much we pay. This system doesn't have feedback loops that actually carry information that can improve the effectiveness of the care. It is all about getting as many people covered as possible and paying for it.

Who needs care, what kind of care and how to make available care effective don't get addressed in any systematic way. A locally run system would be under continual scrutiny. There would be a constant dialogue with the community about what care is available and who is eligible. How much would be spent isn't an academic question. For a locally controlled system making wise decisions about how to use scarce resources would be essential to how it would have to be run. We can't print money locally and our taxing authority is limited. As a result we couldn't operate any other way.

There would be many mistakes made in a local system but they would be our mistakes and we would have to own them. Having feedback loops means we would learn from our mistakes. If they prevent essential care from reaching people in need, public pressure would see that something was done about it.

This is not Pollyanna speaking. I don't live at Sunnybrook Farm. What I do see is the power of ownership. We will never own the current system or any system that is run from far away. Decision-making has to be local so that we can see directly the results of our efforts. I don't doubt that we can build a better system this way. ▫

Dr. Tomski practices Physical Medicine and Rehab in Puyallup.....

Mark Tomski, MD was inadvertently not included in the listing of Good Samaritan physical medicine and rehabilitation physicians referenced in the March *Bulletin*. Good Samaritan Rehabilitation Center celebrated 50 years of service in February with a gathering of current and former staff, physicians, board members, volunteers as well as patients, family and friends. PCMS apologizes to Dr. Tomski. ■

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Dartmouth work force study seeks better system, not more doctors

The United States needs to improve its health care delivery system, not add physicians, a study says. Several work force leaders disagree

By Myrle Croasdale, reprinted from *AMNews*, April 10, 2006

A controversial new physician work force study says the United States doesn't need to expand the physician supply, it just needs to be more efficient in how it uses what it has. But critics say patients might not want a more efficient health care system if it means restricting access.

The study, by Dartmouth's Center for the Evaluative Clinical Sciences, examined how much time a physician spent in treating Medicare patients during the patients' last six months of life. It found that some of the 79 academic medical centers studied relied on a much higher number of physician consultations, referrals and evaluation procedures, such as diagnostic imaging, than others.

The study measured physicians' labor in full-time equivalents.

According to the study's data, if hospitals were to emulate the Mayo Clinic in Rochester, Minn., with its equivalent of 8.9 physicians per 1,000 patients, there would be no need to increase the physician supply to meet patient demand. But if hospitals modeled the New York University Medical Center, with 28.3 physicians per 1,000 patients, the country would need 111,558 more physicians by 2020.

The data led report authors to conclude that emulating efficient academic medical centers would be a wiser use of limited health care funds than spending it on expanding medical school enrollment or residency positions.

"Adding more physicians to the work force doesn't necessarily lead to better outcomes any way that it's measured," said the study's lead author, David C. Goodman, MD, a professor of pediatrics and community and family medicine at Dartmouth Medical School in Hanover, N.H. "If you're going to spend more money, where are you going to spend it? We would argue it should not be spent on increasing physician training."

The study challenges rising opinion in organized medicine that a doctor shortage will be felt by 2020 unless more physicians are trained.

Ed Salsberg, director of the Center for Physicians Workforce Studies at the Assn. of American Medical Colleges, agreed there were variations in efficiencies at academic medical centers, but he disagreed with the study's conclusions.

The physician-to-population ratio will peak in 2015, Salsberg said. By 2020, the U.S. population will be increasing 8.3% a year. Meanwhile, if the U.S. allopathic medical school supply is expanded by 5,000 students or 15% as the AAMC has called for, the total physician supply will increase just 6% annually, leaving the physician-to-patient population on the decline even if there is an increase in physician training.

On top of that, Salsberg said a significant portion of the nation's 700,000 practicing physicians are nearing retirement age.

"We have 250,000 physicians over the age of 55 who are active in medicine, 100,000 over the age of 65. These people are going to be retiring, and younger doctors don't want to work the longer hours. When you put it all together, we think we have to increase medical school enrollment just to keep up," he said.

David Blumenthal, MD, director of the Institute for Health Policy at Massachusetts General Hospital and a physician work force expert, agreed greater efficiencies are needed, but practically speaking, he doesn't expect this to gain public support.

"It would behoove us to make academic medical centers more efficient, but voters don't tend to advocate to reduce supply," he said. "No state government is going to say we need fewer doctors to reduce health care costs."

Yet spending more on medical schools and residencies is prohibitively expensive.

"This is a very complicated process," he said. "We have not come up with good solutions that are politically palatable. We could restrict doctor supply or the supply of hospital beds or new technologies, but every solution tends to fall apart politically, as it actually decreases people's access to care. That's the conundrum we've been facing all along. How do we control costs in a system that has no political will to do it?" ■

Beethoven from page 7

approximation of this ideal, but to the progressive bankruptcy of the system. Physicians are serving as the sacrificial lambs to make this short-term myth occur. We work progressively harder each year, yet are reimbursed continually less, while suffering from increasing taxes and overhead costs and oppressive state laws. This system is not **sustainable—something is going to break.**

So, let's deliver medical care with safety as its highest value. The public demands it—we should give it to them. Physicians should not work more than 60 hours a week (40 hours/week if you are greater than 50 years old and retirement mandatory at age 60), and nobody should work more than a 12-hour stretch in 24 hours, including time while being on call or on beeper. Our decisions and performances will be made when we are fresh, rested, and in optimal working conditions. Applying these regulations (which is still far more permissive than the airline industry regulation of pilots) will shut down the practice of medicine, but that is not our problem. Our problem is to deliver safe medicine. Lawyers may fill in for our absence at night.

Time for a little more Beethoven. Beethoven's fifth symphony is a first instance of rhythm rather than melody defining a piece of music. Just say ba-ba-ba-baaaa in a monotone and everybody will know that it is Beethoven's fifth. Those immortal four beats are said to be fate knocking on the door. Soon, we'll all be singing Beethoven's fifth. It is not surprising that the best classical music today (e.g., Goreki, Arvo Pärt) is coming from the old eastern block, where there is a serious shortage of physicians, and most non-life-threatening symptoms fail to receive a sympathetic ear. Washington State just might find the absence of physicians a similar blessing in disguise. Just don't take away our lawyers—you'll need them for night call. Maybe they'll be too tired to "serve" us in court the next day. ■

IN MEMORIAM

GERHART DRUCKER, MD

1911 - 2006

Gerhart Drucker, MD

Dr. Gerhart Drucker, a highly respected family doctor who practiced in Tacoma and Lakewood for over 35 years, died peacefully on March 8 at age 94. He touched the lives of countless patients who remember his unbounded compassion and diagnostic prowess. Born in Vienna, Austria in 1911, Dr. Drucker emigrated to the United States after graduating from the University of Vienna School of Medicine in 1936. He undertook internship and residency programs at hospitals in New York City before moving to Washington State and setting up practice in Olympia in 1940. Dr. Drucker volunteered for military duty during World War II and served as a US Army physician throughout the European Theater. After the war, he established his medical practice in South Tacoma and became prominent at area hospitals. He moved his office to Lakewood in 1961, and in addition to his regular practice he was director of the Coronary Care Unit at Lakewood General Hospital for a number of years. He retired from practice in 1982. Fluent in six languages, Dr. Drucker was truly a renaissance man. He was an expert mountaineer and skier, an acclaimed amateur thespian, a published author of short stories and poetry, a gifted artist, and a lover of classical music and opera. He was a long-time member of the Tacoma Mountaineers, the Alpine Club of Canada, and the Tacoma Writers Club, and was one of the founders of the Crystal Mountain Ski Resort. In his retirement years, Dr. Drucker occasionally undertook volunteer medical work in Central America and enjoyed mountain trekking around the world.

Dedicated to medicine even in death, Dr. Drucker willed his body to the University of Washington School of Medicine for research and education.

Audrey Drucker

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Left to right: Peter C. Shin, MD, MS, Neurosurgeon; Dean G. Mastras, MD, Radiation Oncologist; Kenneth S. Bergman, MD, Radiation Oncologist; Michael J. McDonough, MD, Radiation Oncologist; Richard N.W. Wohns, MD, MBA, Neurosurgeon; Seth Joseffer, MD, Neurosurgeon. Not shown: Daniel G. Nehls, MD, Neurosurgeon, Randy Sorum, MD, Radiation Oncologist and Michael Soronen, MD,. Radiation Oncologist.

Peter C. Shin, MD, MS, and Michael J. McDonough, MD are South Sound Gamma Knife's Medical Directors.

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Internal Medicine Review - May 5 and 6

The ever popular *Internal Medicine Review* CME course will be held on Friday and Saturday, May 5-6 at St. Joseph Hospital in the Lagerquist Conference Center. This program, free to members of the Tacoma Academy of Internal Medicine has a $175 registration fee to non-Academy members. The conference is under the direction of **Jonathan Hurst, MD**. Topics and speaker include:

Friday, May 5	
Differential Diagnosis and Medical Management of IBD	Scott Lee, MD
Dealing with Disruptive Behavior in the Medical Practice	Daniel O'Connell, PhD
An Overview of Different Skin Disorders	Nancy Anderson, MD
The Management of Thyroid Tumors: A Multidisciplinary Approach	Mary Samuels, MD and James Cohen, MD, PhD
Update on ADHD in Adults: A Childhood Disorder Transformed	Robert Sands, MD
Update on Celiac Disease	Michael Saunders, MD
Advances in Cancer Screening	Frank Senecal, MD
Saturday, May 6	
Transplantation Surgery	Michael Mulligan, MD
Fatty Liver Disease	Anne Larson, MD
Metabolic Syndrome	Bradley Bale, MD
Atrial Fibrillation: Demography, Treatments and New Advances	Raed Fahmy, MD
Restless Leg Syndrome	Patrick Hogan, DO

At the conclusion, participants will be able to: Understand how to diagnose IBD and differentiate from other similar symptoms; Recognize and solve disruptive behavior within the medical practice; Cite the most recent developments and treatments for skin disorders; Provide an integrated, detailed, evidence-based approach to the evaluation and treatment of benign and malignant thyroid lesions; Identify the most recent treatments for ADHD; Learn and appreciate the diverse clinical manifestations of Celiac disease and understand the diagnosis, potential complications and management of Celiac disease; Explain the latest techniques for diagnosing and screening for cancer; Explain and discuss latest developments in transplantation surgery; Understand the scope and nature of fatty liver disease; Describe the latest developments in the risk assessment and cardiac therapy for metabolic syndrome; Identify and explain recent advances in atrial fibrillation; Understand the cerebral pathogenesis of restless leg syndrome, the symptomatic manifestations and the treatment strategy.

To register, please call the College of Medical Education at 253-627-7137. ■

Primary Care 2006 set for June

The *Primary Care 2006* CME course is set for Friday, June 2nd at Fircrest Golf Course. The course director is **Steve Duncan, MD**. This one day course is offered at no charge and is targeted to primary care physicians. Watch your mail for a course brochure. □

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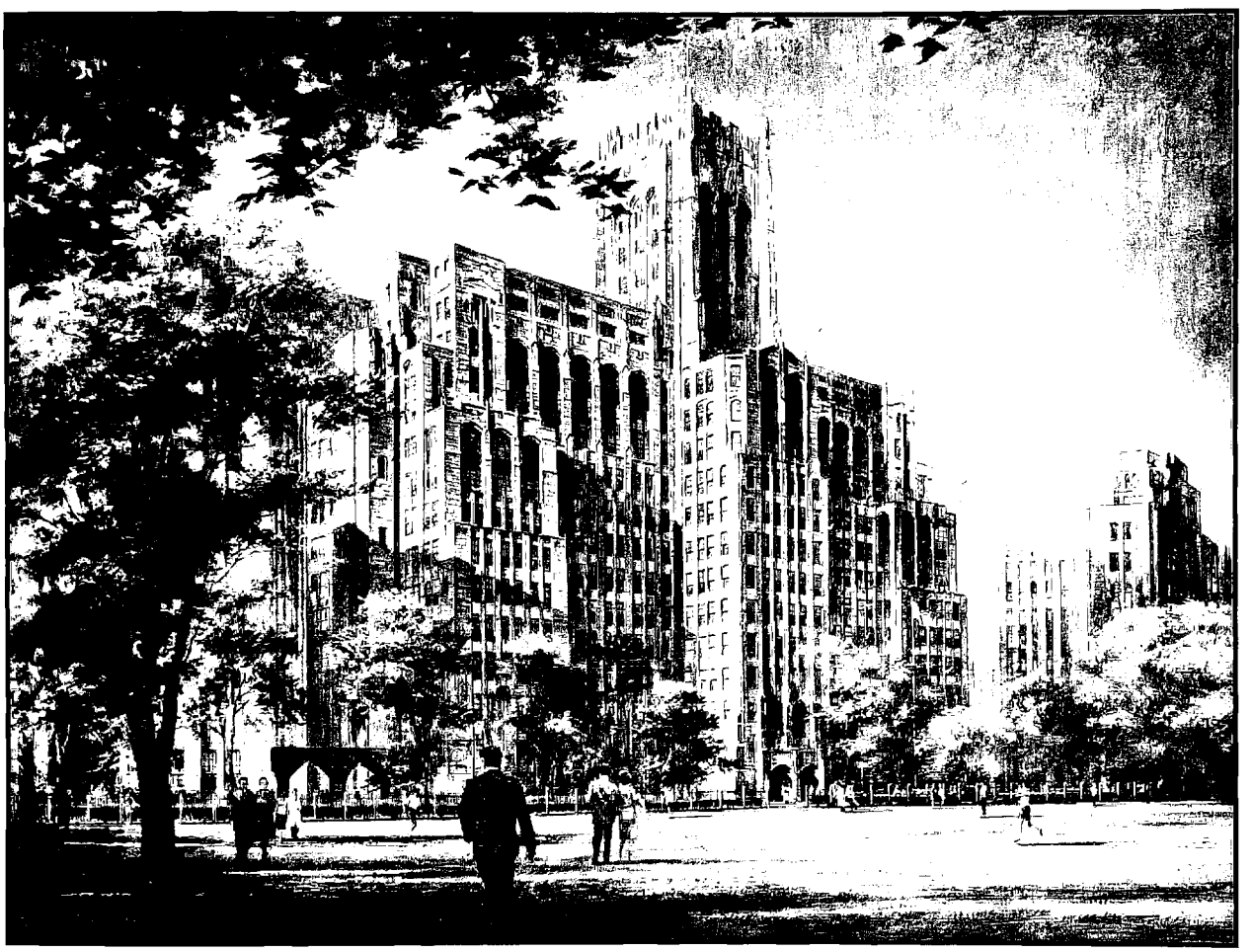
May, 2006



Northwestern University Medical School

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The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of 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, 2006

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President's Page

by Joseph F. Jasper, MD

Facing Challenges Together

Joseph F. Jasper, MD

The economics of practicing Medicine is rapidly evolving. Physicians may quickly recognize the changes and adapt, or may choose to not change yet must guard against illegal infringements as long as possible. The Pierce County Medical Society is supportive of physician practices - that is ALL models of business practice. We shall all find challenges in the changing times ahead. We stand a better chance of facing these challenges as a cohesive medical society. Large third party payers, large medical group employers and large hospital corporations increasingly influence physician practices. A number of cases in which doctors perceived their rights violated have garnered national attention, and a few instances in Washington State. There are some common themes: economic credentialing, sham peer review, exclusive provider panels, and the abuse of "evidence based medicine" in denying coverage.

Economic Credentialing

The use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges.

When an accrediting body uses financial data to base their decisions, a situation of economic credentialing exists. A third party payer may use their claims data to decide whether to accept a physician on their panel for a particular product or all products that they offer; this is most practically applied to managed care products, but is likely to appear in other products. A hospital might review the degree to which a physician contributes to the hospital bottom line – referral for radiology, lab, and other in house services - as well as perceived competition - when deciding on credentialing or contract renewal. The hospital economic credentialing issue has brought forward a number of legal cases based upon anti-kickback statutes. Cases have occurred in at least Arkansas, California, Idaho, Ohio, Pennsylvania, Texas and Wisconsin. Eleven states have enacted legislation restraining the use of economic credentialing. I am not aware of any such cases yet in Pierce County.

Economic credentialing is viewed as a powerful form of controlling the behavior of doctors. The AMA is aware of the economic credentialing problem and has some policy in place. Similar alertness and action may be required at each state level, and possibly each community level. (http://www.ama-assn.org/ama/pub/category/10303.html)

Sham Peer Review

Quality assurance investigations of physicians are a requisite part of patient safety in every place medicine is practiced. QA is protected so long as it is done in good faith. If an investigation is launched due to a physician's behavior (rather than quality of care), whistle blowing, or because the doctor is in competition with a hospital, the peer review body is on shaky ground and may not be protected. This is quite serious, as the review process may result in loss of privileges for an individual doctor. Peer review is intended to be applied evenly throughout the medical community. Courts have stated that peer review is not to be a tool for dismissing irritating doctors or competitors. Sham peer review may be one of the tools of economic credentialing or independent of economics. A wonderful series has recently been written by Steve Twedt of the *Pittsburgh Post-Gazette* called "The Cost of Courage," detailing a number of physicians who have suffered from sham peer review and the consequences they have had to pay (http://www.post-gazette.com/pg/03299/234499.stm).

Again, the AMA has a policy statement against Sham Peer Review. We must make sure that Bylaws and contracts do not grant an organization "absolute immunity." Otherwise we may be sacrificing our ability to take recourse.

Exclusive Provider Panels

In attempts to curb spending or protect other economic interests while providing coverage, an organization may choose to create a panel of doctors that patients may access; the patients would be restricted from accessing doctors outside the panel. This can be another form of economic credentialing. This may occur in any of the settings previously discussed, most commonly an insurance plan or possibly a hospital or large medical group.

Another form of such panels occurs, not to exclude expensive doctors,

See "Challenges" page 4

Challenges from page 3

but merely to form alliances and guarantee coverage for basic services at a hospital or for a third party payer. Ideally a doctor would have open opportunity to provide care at all local hospitals and under all insurance plans. In Tacoma it has long been tolerated that OR radiology, anesthesia and pathology (RAP) have exclusive provider contracts with hospitals. This guarantees that patients accessing the hospital under an admitting surgeon or medical doctor will not lack these coincident services. Such relationships have been challenged in courts. Typically, RAP has been upheld and other specialty arrangements found in favor of the plaintiff doctor seeking privileges. There is an emerging, though likely unjustified, anxiety among private specialists in our community that they might be excluded from privileges at a hospital because the hospital has hired their own staff. To date, I know of no move by any of our local hospitals to close panels in surgical or medical specialties beyond the usual RAP.

Abuse of Evidence Based Medicine in Coverage Decisions

Virtually every payer in the state is looking to some form of Evidence Based Medicine (EBM) coverage revision. This includes Medicare, Medicaid, L&I and private payers. Governor Gregoire has made this a priority for our state. Our legislators have overwhelmingly supported the bill and appropriations necessary to carry out her agenda. Private payers are saying that they will likely follow coverage decisions made by the state. I suspect they mean they will follow denials of coverage.

Physicians from the community who are engaged in dialogue with the governor, Medicare and other payers have plead the following: Lack of evidence to support a therapy is not equivalent to a lack of efficacy. Indeed one would have to produce quality studies that strongly convince us that a therapy does not work or is harmful to reach the conclusion that it should not be covered. In a recent presentation, **Dr. Harald Schoeppner** provided a practical example: parachute use lacks a positive randomized controlled trial (RCT) in humans; does that mean the Army should stop buying parachutes and push the Rangers out at 3000 feet without one? What RCTs exist for appendectomy? We have seen instances in our state where valuable therapies have been denied use in patients simply because high quality RCT with positive results are lacking. The payer wants to save money. We want to provide patient care.

The state legislature once crafted a law governing the way the medical director of L&I should make coverage decisions. About five different factors were to be considered, only one of which was *best medical evidence*. Two of the other required pieces were the *opinion of local experts* and *the standard of care*. In this day, a national standard of care should be useful. We should have a similar system with Evidence Based Guideline development with all agencies. Otherwise, agencies will be slashing coverage in the name of cost savings while denying standard of care to Washington citizens. The better model would utilize an independent review process including the opinion of experts and of specialty societies plus the standard of care in the U.S. should be of equal importance to the evidence.

This will involve physician supervision and vigilance during the development of guidelines. By physician I mean full time practicing doctors, not administrators. While we are involved, we do not want to become these agencies' scapegoats. "Doctors were involved in the process of making the decision to deny you access to this procedure." After all, doctors would prefer to have all reasonably safe therapies and procedures covered. We do not want to become the scapegoat of agencies and payers slashing coverage.

Conclusion

As entities with growing clout present us with policies and agreements, it is important for all of us to scrutinize language in contracts and in Bylaws for possible infringements on our rights. We should look to each other for support in preserving those rights. Our county, state and national societies are familiar with these problems but will require all of us to support their recommendations and policies on these tough issues.

Additional Links

Legal websites:

http://ahlaweb.healthlawyers.org/hlw/issues/040903/040903_a_art_01_Milligan.cfm

http://hollandhart.typepad.com/healthcare/2004/02/economic_creden_2.html#more

http://www.utahasca.com/news/national/Opinion%2002-02-06.pdf

http://physiciansnews.com/law/406jones.html

http://www.medlawblog.com/archives/cat-credentialing.html

http://physiciansnews.com/cover/998.html

http://www.postschell.com/attorney.cfm?attorney_id=122

An ad for a manual on constructing an Economic Credentialing Policy (one of many such sites):

http://www.apollomanagedcare.com/Credentialing%20&%20Privileges%20+%20Peer%20Review%20-%20contents%20lists.htm

A doctor run website on sham peer review:

http://www.peerreview.org/

A general economics lecture by Steve Forbes:

http://www.hillsdale.edu/imprimis/default.asp ■

General Membership Meeting Recap

Federico Cruz-Uribe, MD
Director of Health

Penny LeGate gives motivating presentation to membership

Speaking to doctors "is intimidating," confessed Penny LeGate at the April General Membership meeting, noting that she would keep her talk focused on the human aspects of polio and not the clinical issues. She did give a brief overview of history, reminding everyone that it was April 12, 1955, almost 51 years to the date, that the Salk vaccine became available. Prior to that, it was sugar cubes, iron lungs, and unfortunately, no swimming for those unfortunate ones who contracted the disease. In her words it is a "terrible disease, insidious, and attacks the most vulnerable people."

Her trip to Ethiopia, supported by the Rotary International Foundation, was to participate in Ethiopia National Immunization Day in efforts to eradicate polio. The beginnings were in 1985 when a group of Evanston, Illinois folks got together to tackle polio and see it gone by the centennial. They figured they would need to raise $100 million and vaccinate 500 million kids. The Rotary got involved, CDC, Unicef and the WHO launched the global polio eradication initiative, the largest ever. Almost successful, the project had a huge setback in 2004 when Nigeria suspended their polio immunization program because they heard it was doing harm to people. Ethiopia saw 25 new cases. They soon learned that one new case represents an epidemic, and eleven months later they resumed their vaccination program.

If you want to change your life forever, Ms. LeGate suggests you get involved. Fighting polio, malaria, TB, AIDS or any other scourges in foreign countries is a powerful, personal commitment that will find you making others happy and feeling extremely fulfilled. ■

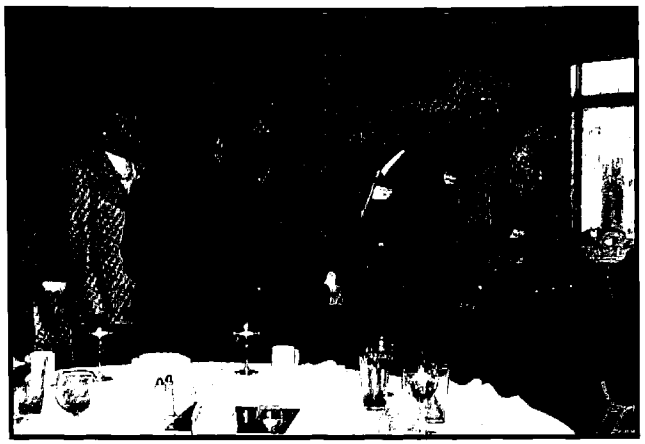
President Joe Jasper, MD and Penny LeGate as she takes questions after her presentation on eradicating polio

From left: PCMS Past Presidents Dr. Charles Weatherby (2000) with Shauna Weatherby and Dr. Pat Hogan (2005) with Joan Brookhyser

From left: PCMS Vice President Dr. Jeff Nacht, Dr. Bill Roes and his wife Ruth, and Dr. Carlos Moravek listen intently

Dr. Jeff Nacht and PCMS Secretary Dr. Nick Rajacich visit with Penny LeGate and her husband after the program

Retired physicians learn to take life by the funny bone...



Mrs. Marge Ritchie (Bill), Mrs. Jo Roller (Gil), Dr. Mian Anwar and Dr. and Mrs. Robert Florence chat with speaker Dorothy Wilhelm after the luncheon

Retired physicians that attended the April luncheon got lots of exercise just laughing with humorist Dorothy Wilhelm, guest speaker. According to Ms. Wilhelm, you need 30 minutes every day of internal laughing to have good health. She had suggestions for building your own humor library and tips on how to cheer yourself up.

Ms. Wilhelm is a familiar northwest media personality. She is host/producer of "My Home Town" on AT&T TV and hosted (50-50) on TCI-TV for ten years. She writes a column for *The News Tribune* and is a professional, inspirational speaker and humorist, presenting keynotes and seminars nationally and internationally.

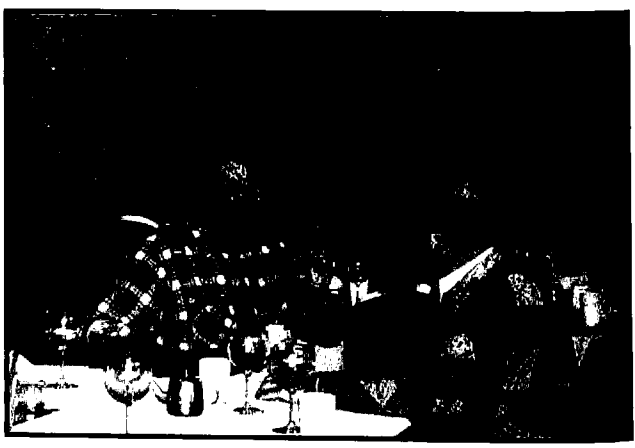
"This was one lunch that was not difficult to stay awake for," noted one attendee.

(Mrs. Wilhelm waived her speaker fee for this program for a donation to World Vision Fund in honor of Phoenix Anderson. Phoenix died at 5 1/2 months from meningitis.)■

Mrs. Marge Ritchie, Dr. Pat Duffy and Mrs. Helen Whitney (Bob) share a laugh

Attendees always enjoy the lunch buffet at Fircrest Golf Club, where they meet every few months

Dr. Anwar has fun with several of the funny "props" that Ms. Wilhelm used to tickle the funny bone!



Drs. John Stutterheim and Jim Blankenship (left to right) enjoy visiting before lunch

IN MEMORIAM

AMY T. YU, MD

1954 - 2006


Amy Yu, MD

Tacoma oncologist Amy Yu, MD succumbed to the very illness that she helped many of her patients battle, breast cancer. She died at home in Gig Harbor on April 30, 2006.

Dr. Yu graduated from Loyola University Stritch School of Medicine in 1979. She completed her internship and residency in Internal Medicine at Northwestern University Medical Center in Chicago. In 1984 she completed a Fellowship in oncology at the Fred Hutchinson Cancer Research Center in Seattle. In July of 1984 she joined Medical Oncology-Hematology Associates, Inc. in Tacoma and joined the Pierce County Medical Society at the same time. She served as a PCMS Trustee and board member for the College of Medical Education. Her contributions to PCMS were many and varied.

Dr. Yu leaves behind her young children, Laura a junior in high school and David, six years old. Laura, an accomplished artist, donated her time to the PCMS Foundation and designed the Holiday Sharing Card for many years. Her artwork helped raise over $100,000 that has been contributed to non-profit organizations in Pierce County.

Dr. Yu closed her practice the end of 2005 to spend more time with her children and be at home. She was an accomplished and caring physician and mother and she will be desperately missed by many. Her untimely and unfortunate death leaves a large void in many lives. PCMS offers heartfelt condolences to her children.

Remembrances may be made to the American Cancer Society, an organization that Dr. Yu believed in and supported. She served on their Board of Directors, chaired many of their committees and volunteered for many of their activities.

Leonard Alenick, MD - honored by WAEPS


Leonard Alenick, MD

Len Alenick, MD, Lakewood ophthalmologist, was honored by the Washington Academy of Eye Physicians and Surgeons at their April 7 Annual Meeting. He was awarded the Lifetime Achievement Award in appreciation for his continuous service and dedication, leadership, insight, promotion and support for the past thirty years. The award is the first ever given in the 101 year history of the organization.

Dr. Alenick says he will proudly display the award in the reception area of his office adjacent to the PCMS Community Service Award he received from PCMS in December, 2004.

Congratulations, Dr. Alenick. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Semper Paratus

Federico Cruz, MD

The motto of the Coast Guard ("always prepared") seems very appropriate for the roles we find for both our health department and for our local medical community. Because of the threat of terrorist attacks and with mounting apprehension over the possibility of a pandemic flu outbreak, we are asked to confront unthinkable situations: community wide events involving mass casualties are at the center of all these scenarios.

How do we prepare for catastrophic events? If you asked someone in the Coast Guard how they maintain their focus on daily duties and still be ready for the potential big events, their answer would be simple: practice, practice, practice.

As a health department we have taken this advice to heart, applying our book learning and existing relationships with emergency responder agencies and medical providers to a test of a realistic event. Through these drills we learn about ourselves: about what works and more importantly what doesn't.

Recently you may have seen in the media or experienced at one of the hospitals the activities around a planned event "Tahoma Resilience," a 3-day exercise held on April 4-6. This was a joint local, state, and federal exercise to test the capacity of our emergency response systems in a mass casualty event. Most exercises since 9/11 have been terrorist oriented, with explosions, nerve gas or other weapons of mass destruction. This event was focused on the release of a biological agent in our community by a terrorist group. The health department was the lead agency, as we would be in a real event, giving direction to other responder agencies.

Planning for the event began in July of 2005 and involved a small group of "trusted agents" who worked out the details of the scenario. Only a few local health department and emergency response staff were part of this so as to impart as much realism to the event as possible. We did not know what was to happen in the event other than it involved a biological agent.

The basic outline of the scenario involved a terrorist cell here in Tacoma. Four foreign nationals attending a local community college decide to release a bacterium that they brought in from Southeast Asia: *Burkholderia pseudomallei*. They grow quantities of the bacteria and develop sprayers, which they use to disperse the agent at four sites across the county.

In this simulated process the four perpetrators infect themselves and become ill. The exercise starts when a 9-1-1 call comes in from their apartment from two of the members who are very ill. This is the start of a rapidly appearing flu-like illness across Pierce County. Soon all 3 emergency departments in each of our hospital systems is overrun with patients with acute respiratory illnesses and with about 10% needing critical care. Local police and the FBI expose the terrorist side of this during the first day of the drill and our local systems have to react to an ever-increasing number of very sick patients showing a up at their institutions. Both environmental samples and clinical samples are run up to the state lab. And in the afternoon of the first day we learn the identity of the agent we are facing. We also know from the epidemiological investigation that there are thousands of potentially exposed individuals from the 4 exposure sites. Our County Executive calls a public health emergency locally. Later in the day the governor declares a state emergency and asks the Department of Homeland Security to activate the SNS (Strategic National Stockpile). These declarations of emergency allow us on a local level to access additional resources from outside our community.

The event played out over the next two days as we set up PODs (Points of

See "Paratus" page 10

"Three critical areas stood out: Communication, disease investigation and coordination of care for those infected. Lessons learned about these areas from the exercise were huge."

Paratus from page 9

Distribution) in 18 locations across Pierce County (three high schools and in 15 responder agencies and hospitals). All those exposed to the agent were directed to a POD in order to receive prophylactic antibiotics. The federally stockpiled drugs (in this case M&Ms and Skittles) were delivered to Pierce County for distribution to volunteer "patients."

On the third day issues of environmental clean up were confronted and continued epidemiological investigations documented the course of the outbreak. Temporary sites were dismantled and supplies routed back to stockpiles both locally and outside Pierce County.

We took this event very seriously. I was very impressed with the engagement of my staff. We had a 1% no show rate due to illness or other personal issues otherwise everyone participated in some way. Hundreds of volunteers from our community and non-essential employees from county agencies were trained to help staff our PODS and to be victims.

Three critical areas stood out: Communication, disease investigation and coordination of care for those infected. Lessons learned about these areas from the exercise were huge. The importance of clear, accurate and timely communications can never be over-stated. Most of the problems we faced in the event stemmed from some kind of flawed communication. This occurred both internally or in our conversations with the state or feds. We were plagued by poorly timed information, inaccurate or incomplete info, and, of course, information that never did get to the persons it needed to go to.

Accurately identifying the agent as early as possible was critical to our efforts. Information needed to be systematically collected. (It was.) Environmental and clinical samples of the agent needed to be gotten up to our state lab as rapidly as possible with the results reported in a timely manner. (This happened.) Information updates on each step of the process needed to be given to our partner agencies on a regular basis (We struggled with this.)

Lastly, the coordination of care became very difficult to do. As emergency departments maxed out, confusion became common. There was little surge capacity and the facilitation of capacity expansion didn't occur in a timely manner. It was a very daunting task to find beds for hundreds of acutely ill patients who came into our systems over a 10-12 hour period. Under stress many of the participating agencies reverted to agency oriented problem solving and system's thinking was put aside.

All in all, no better comment can be made about this training than to say that we learned a great deal about our capacity to handle a mass event.

And yes, I think that "Semper Paratus" does fit right here in Tacoma. ■

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 Touch of Intervention

Andrew Statson, MD

"Whipping and abuse are like laudanum; you have to double the dose as the sensibilities decline."
"Uncle Tom's Cabin" Harriet Beecher Stowe (1852)

"We haven't had a free market in medicine for a long, long time. It has been so long that not only do we not remember what it was like, but most of us cannot even imagine what it could be like.

Let me step away from medicine for a moment and follow in thought the repercussions across the economy of a simple intervention. Imagine that Congress decided to make sure that every family could afford to buy milk for its children. How would it go about it?

One way would be to fix the price of milk below the market level. Congress can establish a Federal Milk Authority (FMA). The FMA will examine the books of the milk producers and will determine a price, at which the lowest cost producers can make a minimal profit. Then it will declare that if companies A, B and C can produce milk profitably at that price, so should everybody else.

What happens next? Naturally, the lower price stimulates demand. The low cost producers may increase their output to a degree and still make a profit, but the high cost producers will have to divert their production to specialty cheeses or other higher margin goods, or go out of business. As a result, the total supply of milk will go down. Meanwhile, the marginal producers, who can just barely break even, can survive only by watering their milk.

Suddenly, the FMA is faced with two serious problems, a developing shortage of milk and a drop in quality. Now, it has to establish a Milk Quality Control Commission, to test the milk on the market. It also needs to stimulate production, and for that it has to subsidize the dairy farms.

The budget requirements of the FMA go up, and Congress has to raise taxes. The higher tax level increases the cost of living for everyone, and the poor families need even more help to buy milk for their children. And the spiral continues upward.

Instead of subsidizing the dairy companies, the FMA has another option. It can reduce their cost of doing business. To accomplish that, it can fix the prices milk producers pay to their suppliers and employees. Therefore, the FMA will have to freeze the wages of the milkers and cowhands, the prices of alfalfa and corn, of milking machines and electricity, etc., etc.

The same problem then will affect the alfalfa producers, and the intervention will spread across the economy until no industry remains free.

Now back to medicine. Do you see that something like that has been going on in our field for a number of years? Do you see the progressive accumulation of price controls, restrictions and regulations, which are strangling our profession?

There can be no such thing as a touch of intervention. As with laudanum, the economic organism adjusts to it, the effect weakens, and the intervention has to be expanded, until it covers the entire economy and brings it to its knees.

The basic fallacy of the interventionists is at the same time the inherent weakness of their system. The fallacy is that Price = Cost + Profit. Therefore, it is enough to know how much it costs to produce a good to determine what its price ought to be.

The reality of the market is such that a predetermined "ought" does not exist. Every purchase is made by individuals, who assess the goods on the market according to their personal needs and preferences, who choose those items which would best satisfy them, and who want to buy them at the best price they can get.

The buyers don't care how much it may have cost to produce the goods they want to buy, or how much profit the sellers might make, if any. Their only concern is to satisfy their needs the best way they can with the resources they have. The value of a product, and therefore its market price, is entirely determined by the subjective assessment of every individual purchaser of how much satisfaction he can get from that product for the amount of money he has to spend.

That should explain the incongruous situation in the socialist countries,

See "Touch" page 12

Touch from page 11

where the prices of goods were determined by a central authority. The stores carried goods which sat on the shelves for a long time because they were priced too high, while a shipment of low priced goods was sold within hours. An interventionist system has no mechanism by which to price goods. Only the market has that, and in so doing, it has the ability to direct production resources toward those goods that can be sold at a profit.

Such is the problem we face in medicine. We know that there is a demand for certain services, but we have no way of knowing, for any individual patient with an individual problem, what is the most economical solution. Because of the lawyers watching over our shoulder, we are tempted to do everything we can, regardless of what resources we might use.

That may indeed be the best for our patients, but neither we, nor they, have enough information to make the right decision. Of course, we have management protocols. They apply to the average patient, if there is such a thing, and they are based on last year's conditions. But medicine does not stand still. New procedures and treatments are introduced; old approaches are made obsolete. Should we wait until the protocols catch up, or go ahead and treat our patients the best we can?

Every action has an immediate effect which is readily seen. Intervention reduces the price of milk. "Good," we say. We don't see the ripple effects that follow weeks, months, or years later. We have to foresee them, to understand the cost and benefit balance sheet of that action.

Frédéric Bastiat discussed that issue in his pamphlet "What is Seen and What is not Seen."

He said that the only difference between a good economist and a bad one is that the bad economist bases his policy on the immediate effect we can see, and ignores the later consequences, while the good economist takes into account both the effects that are seen, and those that must be foreseen.

Yet this difference is very important, because it frequently happens that when the immediate consequence is favorable, the later consequences are disastrous, and vice versa. The bad economist thus trades a small present good for a great evil that will follow, while a good economist pursues a great good in the future at the risk of a small present evil.

The same rule applies to morality and hygiene. You steal, you get caught and go to prison. Immediate gain, long term pain. You work hard and get ahead. Immediate pain, long term gain. Flossing your teeth every day is a pain, but losing your teeth years later will be a much bigger pain.

To give you an example of how far intervention can lead, Ludwig von Mises describes what happened in Germany under the rule of the National Socialist Labor (Nazi) Party:

"[It] seemingly, and nominally, maintains private ownership of the means of production, entrepreneurship, and market exchange. So-called entrepreneurs do the buying and selling, pay the workers, contract debts and pay interest and amortization. But they are no longer entrepreneurs. In Nazi Germany they were called shop managers. . . . The government tells these seeming entrepreneurs what and how to produce, at what prices and from whom to buy, at what prices and to whom to sell. The government decrees at what wages the laborers should work and to whom and under what terms the capitalists should entrust their funds. Market exchanges are but a sham. As all prices, wages, and interest rates are fixed by the authority, they are prices, wages, and interest rates in appearance only; in fact they are merely quantitative terms in the authoritarian orders, determining each citizen's income, consumption and standard of living."

You may look at the controls over your practices and decide for yourselves how far down that road we have traveled already. ■

Gamma Knife Technology Brings New Options to Your Patients

Choose Medicare-approved, safe, effective, non-invasive treatment options for patients with benign and malignant brain tumors, vascular disorders, and functional disorders of the brain such as Parkinson's disease.

Gamma Knife offers hope to patients with tumors formerly considered inoperable or high-risk for open surgical procedures due to illness, advanced age, or other medical conditions. Patients may be eligible for Gamma Knife even if they previously had open brain surgery, radiation or chemotherapy, or embolization for arterio-venous malformations (AVM).

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- Metastatic tumors within the head originating from a primary site elsewhere in the body
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- AVMs and other vascular disorders of the brain
- Trigeminal neuralgia (if conservative therapy fails)
- Movement disorders, such as Parkinson's disease or essential tremor

Insurance Coverage

Gamma Knife procedures are covered by most medical insurance plans. Prior authorization is required and limited to specific diagnostic reasons. South Sound Gamma Knife at St Joseph will pre-authorize the procedure with your patient's insurance carrier.

Referral Process

For more information or referrals, please call South Sound Gamma Knife at 253.284.2438 or toll-free at 866.254.3353.

Left to right: Peter C. Shin, MD, MS, Neurosurgeon; Dean G. Mastras, MD, Radiation Oncologist; Kenneth S. Bergman, MD, Radiation Oncologist; Michael J. McDonough, MD, Radiation Oncologist; Richard N.W. Wohns, MD, MBA, Neurosurgeon; Seth Joseffer, MD, Neurosurgeon. Not shown: Daniel G. Nehls, MD, Neurosurgeon, Randy Sorum, MD, Radiation Oncologist and Michael Soronen, MD,. Radiation Oncologist.

Peter C. Shin, MD, MS, and Michael J. McDonough, MD are South Sound Gamma Knife's Medical Directors.

South Sound Gamma Knife at St. Joseph

1802 S. Yakima, Suite 102,
Tacoma, WA 98405
Phone: 253.284.2438 or
toll-free at 866.254.3353.
Fax: 253.272.7054
www.SouthSoundGammaKnife.com

Brain Surgery Without a Scalpel

Retired Doctors' Wives Luncheon

The Retired Doctors' Wives will meet at Affairs Cafe, 2811 Bridgeport Way, University Place, May 24, 2006 at 11:30 am. Please RSVP to Marlyn Baer (564-4308) or Judy Brachvogel (564-6374) by Friday, May 19.

Directory Changes

Please make the following changes to your 2006 Physician Directory:

Michael Lyons, MD
Change office suite number to "D"

Terrill Utt, MD
Change office address and phone to:
11025 Canyon Road E #C
Puyallup WA 98373
536-1020 Phone
536-1612 FAX

In "Nurse Practitioners" section:

Rupinder Deol, ARNP
Change address and phone to:
3611 South D Street #4
Tacoma WA 98418
474-4667 Phone

Judith Sloan, ARNP
Change office suite number to "D"

Applicants for Membership

Kaditam V. Reddy, MD
Neurology
Neurology & Neurosurgery Associates
915 - 6th Avenue #200, Tacoma
253-403-7299
Med School: Brown Medical School
Internship: Tripler AMC
Residency: University of Texas
Felllowship: Univesrity of North Carolina

David "Champ" Weeks, MD
Urology
1901 S Union #A221/222, Tacoma
253-572-6835
Med School: Medical University of South Carolina
Internship: Georgetown University Medical Centerr
Residency: Georgetown University Medical Center

Linli Xuan, MD
Int Med/Hem/Onc
MultiCare Hematology/Oncology Group
4700 Pt. Fosdick DR NW #203, Gig Harbor
253-851-2328
Med School: Shanghai Medical University
Internship: Case Western Reserve University Hospitals
Resdiency: Case Western Reserve University Hospitals
Fellowship: Case Western Reserve University Hospitals

Law mandates legible prescriptions beginning June 7

On March 6 of this year, Governor Gregoire signed the compromise Tort Reform Bill, House Bill 2292 into law. One focus of the legislation is patient safety and calls for prescription legibility. The legislature found that prescription drug errors occurred because the pharmacist or nurse could not read the prescription from the physician or other provider with prescriptive authority. The legislature further found that legible prescriptions could prevent these errors.

The law defines "legible prescription" as a prescription or medication order issued by a practitioner that is capable of being read and understood by the pharmacist filing the prescription or the nurse or other practitioner implementing the medication order. A prescription must be hand printed, typewritten, or electronically generated.

Practitioner means a physician, dentist, podiatrist, veterinarian, registered nurse, advanced registered nurse practitioner, licensed practical nurse, optometrist, physician assistant, naturopath, pharmacist and dental hygienist when operating under a dentist's license. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Hawaii CME - A favorite for many

Over 60 physicians with family members and friends attended the Hawaii and CME course on the Island of Hawaii in early April. Half day CME programs in the morning allowed participants to enjoy the Hawaiian island in the afternoons and evenings.

Start planning now for the Hawaii CME course in 2008 which will be held, by popular demand, in Maui. Bargain air fares, hotel rates and exceptional vacation and education opportunities are included in the Hawaii package! ■

From left: PCMS Past Presidents Drs. David Law (1995) and Jim Rooks (2003) enjoy reception time with their wives Bev and Penny

Drs. Mark Hassig (left) and Tod Wurst (right), gastroenterologist and radiologist respectively, visit at the opening night reception

Left: Dr. Gordy Klatt and his wife Lou visit with friends while Dr. Gary Park visits with Mrs. Ginny Craddock (Mark)

Dr. Mark Craddock (center) visits with Dr. Dale Overfield in the midst of the reception gathering

Primary Care 2006 - Not Too Late!

The *Primary Care 2006* CME course is set for Friday, June 2nd at Fircrest Golf Course. The course director is **Steve Duncan, MD.** This one day course is offered at no charge and is targeted to primary care physicians. It's not too late to register for the program and you may do so by calling the College of Medical Education at 253-627-7137. ■

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.

Family Practice - Well established FP seeks enthusiastic associate in desirable Gig Harbor/Tacoma area. Office based. Minimal call. No OB. Full-time/part-time/locum option. Great opportunity. E-mail resumes to Dr. Finkleman at hazak@msn.com.

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 + incentive. Fax your CV to 253-847-9630.

Tacoma, WA – Occupational Medicine MultiCare HealthWorks, a division of MultiCare Health System seeks a board certified occupational medicine/IM/ER/FP physician, certified MRO to join an established program. Qualified applicants must be flexible, self-motivated, committed to program development and have **at least 2 years** occupational medicine experience. As a MultiCare physician, you will enjoy excellent compensation, benefits and system-wide support. Three-year residency in accredited U.S. program required. Email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org.* "MultiCare Health System is proud to be a drug free workplace"

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Internal Medicine – part-time. Tacoma, WA. MultiCare Medical Group seeks a p/t IM or IM/Peds physician to job share with an IM/Peds doc. This is an outpatient position and the practice is primarily adult based. Group utilizes electronic medical records. The practice is located within 30 minutes of downtown Seattle. Three year Internal Medicine residency in accredited U.S. program is required. As a MultiCare Medical Group physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please visit our website at www.multicare.org to learn more about MultiCare Medical Group. Submit CV with references to: Provider Services. MultiCare Health System. Email: providerservices@multicare.org Fax: 866-264-2818 Or Mail to: Provider Services, P.O. Box 5299, 737-2-PHYS, Tacoma WA 98415-0299. This position does not qualify for J-1 Visa waiver. "MultiCare is a Drug Free Workplace"

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Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@soundfamilymedicine.com. Equal Opportunity Employer.

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GENERAL

Exceptional Tacoma Classic - $1,050,000. 50's Frank Lloyd Wright-like courtyard home w/Commencement Bay views & lush grounds. ++Adjacent buildable lot! Privacy, comfort, understated elegance & quality updating. Five BR, 4 BA, 2 LR, formal dining, paneled library, 2+ garage, dble carport & guest parking. Easy commuting. Barb Bailey, PSRE (253) 312-4400, MLS #25184430.

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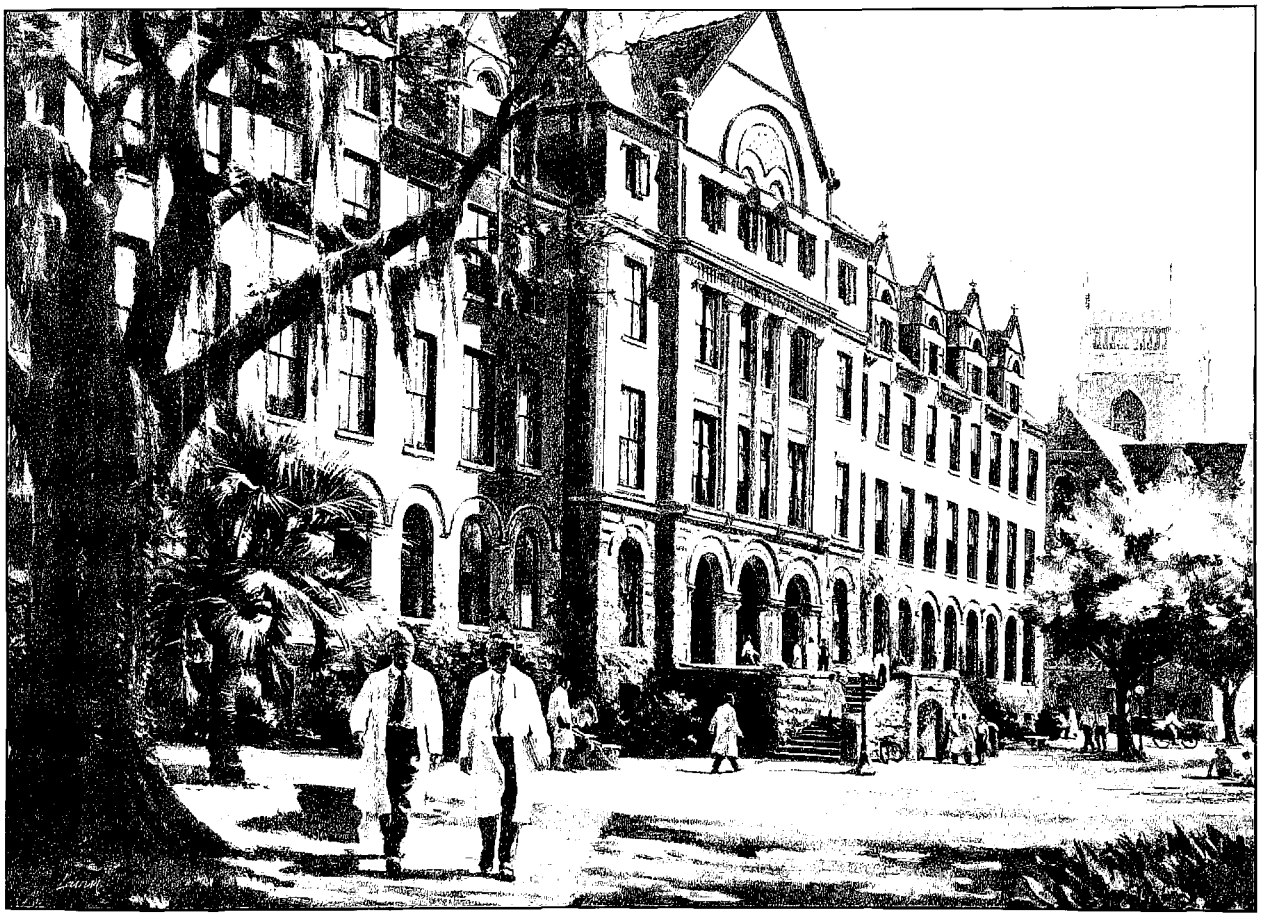
Pierce County Medical Society
BULLETIN

June, 2006



Tulane University School of Medical

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Decreasing Obesity and Promoting Fitness

Joseph F. Jasper, MD

Obesity and lack of sufficient exercise have reached a high incidence in both our adult and pediatric populations. Secondary effects have results on physical and mental health, lifespan and our medical economy. Fortunately, our society is responding appropriately. Awareness of the problem has occurred throughout our communities. Action plans are emerging.

At the school level, education of student and modification of foods and beverages available at schools is occurring. Parents, politicians and physicians have advocated for change effectively. The push must continue. **Dr Sumner Schoenike** is our PCMS liaison to the school and public health communities. He assures us that constructive steps are being taken that should help. As physicians we must continue to pressure parents and kids to make healthier choices. Just cutting back on sugar containing soft drinks alone may have a huge impact.

"As physicians we must continue to pressure parents and kids to make healthier choices."

Communities have also risen to the challenge. A community meeting has already been held with participation from PCMS by **Drs. Paul Schneider, Pat Hogan, Sumner Schoenike, Jane Moore and Mark Craddock**. The purpose for the meeting was to discuss how to proceed with creating a community plan for Gig Harbor to improve health and focus on prevention. The focus will be on encouraging more physical activity and developing the city to be more conductive to all kinds of sports and activities. Support is already present from Rick Porso of the county health department. Participation from other organizations and resources will be sought. First, data collection and realistic goals and timelines are being developed. They are applying for grant monies to address obesity and fitness issues. Plans also include establishing a website as a central resource to anyone seeking activities and fitness tips.

Our own medical society is trying to lead by example. Dr. Pat Hogan and the PCMS launched the Coalition for Healthy Active Medical Professionals (CHAMP) program last year. CHAMP has distributed pedometers and exercise prescription pads, is publishing a FitTips manual and will soon be organizing the 2nd annual CHAMP walk/run. Most recently, CHAMP organized a Sound to Narrows team, complete with bright gold CHAMP T-shirts. Call PCMS 572-3667 for a CHAMP membership brochure.

PCMS is proud to be a part of a solution for a healthier community. ■

In My Opinion

by Kenneth Feucht, 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 Rule of Law and Tort Reform

Kenneth Feucht, MD

Paul Johnson, in his seminal history of the twentieth century titled *Modern Times,* observes that successful governments succeed only by exercise of the rule of law. By rule of law, it is meant that the law is transcendent and non-arbitrary, containing the rules that govern society and dictate public morality, applying to the whole of society without prejudice or exception, and is neither affected by the will of the majority nor the coercion or whim of those that govern.The rule of law ensured citizens that misbehavior and its penalties would be clearly identified, that those penalties would be fairly applied, and that individuals would be able to engage in commerce and recreation reasonably free from government interference. Those countries that have exercised the rule of law have been shown throughout history to prosper, with the greatest contentment among its citizens.

History shows that when the rule of law is absent in society, the rule of an elitist few becomes the norm, resulting in the oppression of the majority. One need only look at the serfdom of the middle ages, the slavery of the American South, or the unfortunate masses of the twentieth-century social experiments of the Soviets and the Chinese for evidence. In America, the rule of law is subtly being replaced by an imitation that masquerades as freedom, but is actually another form of oppression, the rule of individual rights.

We were told repeatedly by lawyers during the I-330 campaign that tort law should not be changed, since it would lessen individual rights. Individual rights have become the defining aspect of what it means to be American. Yet, as more individual rights are defined, paradoxically we progressively *lose* more of our rights. Ultimately, the rule of rights, without the standard of an absolute reference point for law, degenerates into either the rule of the mob or the rule of the elite.

The rule of the majority is essentially mob rule rather than the rule of law. Mob rule was appealed to in the I-330 campaign, with physicians hoping that the majority could be persuaded by emotional argument that physicians were being unfairly treated in the courts. At the waning of the Roman Republic, political rivals who garnered the largest mob before the senate controlled the senate. The Roman senate in return catered to public appeal (the mob) through free bread and circuses—food stamps, public entertainment, and free health care. It was no surprise when I-330 went down, as the doctors were neither providing to the public free bread and circuses, nor creating mass hysteria on the steps of the legislative building in Olympia. Our history is Roman history.

The rule of the courts is a form of elitist rule: few rule over the many. Rule by the courts obviates the rule of law by allowing these "enlightened" few, whether it be the Supreme Court or a local court, to adjudicate in an arbitrary fashion dictated by the judge or jury's emotive perception of the case. Outside of actual rule of law, cases that come to court degenerate into the absurd, and the rulings are governed by the rhetorical skills of the plaintiff and defense counsels, the personal gain of the judge or jury, and the whims of the moment. The courts find it to their advantage to promote such elitism, which offers them power that is not possessed by other political entities. An example of how the rule of the courts replacing the rule of law affects medical malpractice is the strong tendency to settle out of court, since it is evident that the emotional persuasion of the judge or jury can easily trump the legal merits of the defense case.

The U.S. Constitution was intended to assure citizens that disputes and wrong-doings would be adequately addressed by the authorities, and that there would be proper redress of injustice. Instead, we have down-graded the role of personal and public morality and focused on rights. The result is a dread of the law, a fear of the courts even when one has not done wrong, and the sense that the law system has become so complex that everybody is guilty regardless. We experience neither domestic tranquility, nor the blessings of liberty, as is promised in the preamble of the constitution. Indeed, the virtues of the rule of law for which Paul Johnson so heavily argues are negated by our

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progressively rights-oriented interpretation of law. There is no business interchange, personal interaction, or public discourse that escapes the risk of a capricious lawsuit since the law no longer protects individuals.

The result of the migration from a rule of law to a focus on rights has led to our frustration in the realm of tort law. Even California, with its strict MICRA provisions, has a serious tort problem. MICRA (and I-330) touch upon economic aspects of the tort crisis, but do nothing to address their root causes. An epidemic of frivolous lawsuits, all based on skewed concepts of law and personal rights will not be fixed by an initiative neither in medical law nor civil law. Examples abound (see for example www.overlawyered.com or www.stellaawards.com).

Looser-pay-all provisions may put some restraint on a lawsuit-bent culture. Medical courts are a solution that has worked well in many other countries. has allowed physicians and not lawyers to judge physicians, and has kept politics and emotional argument from clouding the judgment of a case. Medical courts have the potential for corruption, with judgments made for political or personal expedience rather than by rule of law. Without a return to rule of law in the courts, we have no hope of ever seeing justice for either physician or patient. ■

IN MEMORIAM

JOSEPH D. SUENO, MD

1949 - 2006

Joseph Sueno, MD

Dr. Joseph "Dodoy" Sueno was called by the Lord after a brave battle against melanoma. Dodoy was a physiatrist with clinics in Tacoma and Olympia. He and his wife Nena, took me and my family under their wings when we first moved to Tacoma in 1992. Dodoy became my mentor in medicine as well as in life.

Dr. Sueno's multiple achievements include heading the Filipino-American Physicians of Washington (FAPWA), involvement in the Catholic Church, being a moving force in his medical school fraternity and in multiple professional, civic and charitable organizations. He was a longstanding member of PCMS.

Although Dr. Sueno will never grow old with his loving wife nor see his grandchildren from his four children: Jay, business graduate, Paul, medical student, Carolyn, law student, and Michael, culinary arts major, he lived a full life. A life full of love, kindness, and generosity towards his fellow man.

It is an honor to have him as a mentor and a friend. He will be terribly missed by family, friends and colleagues.

Eduardo Cuevas, MD

The CMS Physician Voluntary Reporting Program

With rising health care expenditures and a payment system that rewards quantity of care over quality, the Centers for Medicare & Medicaid Services (CMS) is beginning work to better align payment with quality. The Physician Voluntary Reporting Program (PVRP) is a first step in this effort.

PVRP uses the existing administrative billing mechanism to capture clinical information about quality of care. Currently there are 16 evidence-based quality measures, agreed upon by national quality organizations, which apply to different specialties (see table). Physicians submit codes related to the quality measures, in addition to their usual ICD-9 or CPT codes, with their billing claims. Depending on the measure, temporary G codes and/or CPT II codes are used.

Table. 16 Starter Quality Measures
- Aspirin for patients with acute myocardial infarction
- Beta-blocker for patients with acute myocardial infarction
- Beta-blocker for patients with prior myocardial infarction
- Hemoglobin A1c control in patients with Type I or Type II diabetes mellitus
- Low density lipoprotein control in patients with Type I or Type II diabetes mellitus
- Blood pressure control in patients with Type I or Type II diabetes mellitus
- ACEI or ARB for patients with left ventricular systolic dysfunction
- Antidepressant medication for patients with major depression
- Assessment of elderly patients for fall risk
- Dialysis dose in patients with end stage renal disease
- Hematocrit level in patients with end stage renal disease
- Arteriovenous fistula use for patients with end stage renal disease requiring dialysis
- Antibiotic prophylaxis for surgical patients
- Thromboembolism prophylaxis for surgical patients
- Use of internal mammary artery in patients undergoing coronary bypass graft surgery
- Pre-operative beta-blocker for patients with coronary artery bypass graft

CMS is currently encouraging practices to register their intent to participate in PVRP at http://www.qualitynet.org/pvrpintent. By registering intent to participate, physicians will be able to receive confidential feedback at the practice level on the reporting rate and performance rate for each measure. Physicians that register intent to participate are not in any way obligated to participate in PVRP, and physicians may submit data on PVRP measures without registering intent to participate.

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The Health Status of Pierce County

David Harrowe, MD, MPH
Medical Epidemiologist

New Pertussis Vaccines

In 2005, the FDA approved two new single-dose vaccines to boost immunity against pertussis (whooping cough) in adolescents and adults. These are Boostrix (GlaxoSmithKline) for individuals 10 to 18 years-old and Adacel (Sanofi Pasteur) for those 11 to 64 years-old. Use of these inactivated vaccines may significantly reduce the incidence of pertussis, a disease with significant morbidity in young and old.

Last year, after Chlamydia, gonorrhea and chronic hepatitis C, pertussis was the most common communicable disease reported to the Tacoma-Pierce County Health Department (TPCHD). In recent years, about one-third of Pierce County infants under 12 months-old with pertussis were hospitalized. Infants often acquire pertussis from older children and adults in the same household. These older household members have waning immunity after childhood vaccination, and become once again susceptible to pertussis.

Boostrix and Adacel are referred to as Tdap vaccines. Tdap stands for tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine, adsorbed. (The vaccines used in infancy and childhood for primary immunization are referred to as DTap vaccines.) Tdap vaccines should be given only to individuals who have had a primary series.

How long immunity to pertussis will last after Tdap is uncertain. Based on DTap experience, the estimate is about five to ten years.

The Tdap vaccines may be given as early as two years following a Td booster. Giving Tdap sooner after Td may increase risk of adverse reactions. The new vaccines will likely replace Td for circumstances in which tetanus boosters are indicated.

Their use is also encouraged for postpartum women as soon as practical after delivery (their use with breast feeding is okay) and for women who anticipate pregnancy. (The CDC is currently reviewing recommendations for use in pregnancy.) Other indications are for older children and adults who share a household with an infant, and for health workers and others who regularly care for infants. The optimal age for adolescent vaccination with Tdap is 11 to 12 years, and it may become a requirement in Washington State for entry to middle school grades.

Precautions and contraindications are similar to the DTap vaccines, but clinicians should follow package insert guidelines.

Tdap vaccines cost about thirty dollars per dose and may be ordered directly from the manufacturers. If administered as part of Washington's Vaccines for Children (VFC) program, Tdap should be obtained through TPCHD. (You may call Cindy Smith at 798-3578 for more information about obtaining VFC vaccines.) Both Tdap vaccines should be stored at between 2° and 8°C (36° and 46°F). ■

"Last year, after Chlamydia, gonorrhea and chronic hepatitis C, pertussis was the most common communicable disease reported to the Tacoma-Pierce County Health Department."

Risk Management tip from Physicians Insurance, A Mutual Company

"Be aware that the current Physicians' Desk Reference has a black box warning that Fentanyl patches are indicated for persistent, moderate to severe chronic pain and ***contraindicated in the management of acute pain.***"

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PVRP provides an opportunity for practices to develop the most efficient way for them to submit information on quality before payment is attached to reporting or performance rate. Additionally, feedback at this stage is extremely valuable and can be sent to pvrp@cms.hhs.gov.

As a benefit to registering and participating, the American Board of Internal Medicine (ABIM) will allow those enrolled in ABIM's Maintenance of Certification program to use performance data provided through PVRP to receive credit towards meeting the requirement for self-assessment of practice performance. Other specialty societies are considering a similar policy.

The future goal is to have widespread adoption of electronic health records (EHRs) from which quality information can be easily uploaded, and practices either with existing or interest in implementing EHRs might consider contacting the state Quality Improvement Organization to learn more about the Doctor's Office Quality- Information Technology program (DOQ-IT). Participation in DOQ-IT counts toward PVRP participation.

For more information on PVRP, including a complete listing of G codes and CPT II codes and tools to assist with participation, please visit http://www.cms.hhs.gov/PVRP. You are also welcome to contact me with any questions or comments at kenneth.fink@cms.hhs.gov or (206) 615-2390. ■

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.*

Rudderless

Andrew Statson, MD

"No man is great enough or wise enough for any of us to surrender our destiny to. The only way in which any one can lead us is to restore to us the belief in our own guidance."
"The Wisdom of the Heart" Henry Miller (1941)

The world health care systems are in disarray. Every country has a department or a ministry of health. They all have institutes and multiple agencies which study, analyze, plan and manage their health care systems. Yet in spite of that, or rather because of that, the system in every country is thrashing about like a chicken with its head cut off.

Health care expenditures are straining government budgets. In many countries the chronic underfunding is reaching a dangerous level, at which it will no longer be possible to gloss over disasters, like those in France with the HIV contaminated bank blood, and their thousands of deaths during a recent heat wave. Several countries have experienced overt or covert physician strikes and other forms of protest against their systems.

The total expenditures on health care are bumping against the ceiling, which is the taxing power of the governments. The systems lack the funds to meet the demand. Why is that?

The health care systems are based on a contradiction. Their premise is that health care is a legal right, implying that people should be able to get every treatment they may require. The economic reality is such that it is impossible to give to all the people all the care that they can use.

No matter what promises were made, health care must be rationed, which means that frequently it must be delayed, and often enough, it must be denied altogether.

The market has its own way of rationing care, according to what people have earned and deserve. They deserve the care precisely because they have earned the money to pay for it. The denial of treatment due to inability to pay may seem heartless to many. Perhaps, but the denial of treatment for any other reason to people who have earned it and deserve it may be even more unfair.

Some have suggested rationing according to age. People over 75 should not have a coronary bypass, or a total hip, or whatever. So those who have worked and paid into the system for forty, fifty years or more should be denied care because they now are too old to work. That is a whif from "Animal Farm," where the old horse was sold to a meat packing company.

No country, no matter how prosperous, no economy, no matter how advanced, can supply all the care its medical system can render to all the patients who may want it. So the rationing can be done according to the contribution the patients or their families have made to the community as reflected in what they have earned and can pay, or it can be done according to some other criteria, but it has to be done. Those other criteria for allocating resources will not be voluntary, as are the market exchanges, and will have to be implemented by force.

The regulating mechanism of the market imposes a discipline on people. They cannot spend more than they have earned. At the same time, pricing allocates the offerings of the market to those who are most likely to benefit, because they are willing to forego other expenses in order to meet the price. In that sense, the market rations medical care according to the patients' readiness to pay. They may pay with funds they have earned, or borrowed, or received as alms. They may tap their insurance for help. The process is open, simple and direct.

Apart for its role as a system of trade, the market also acts as an allocator of goods and services, and as a regulator of production. The pricing mechanism directs the flow of capital and labor toward supplying those goods and services from which they are most likely to profit. When prices are determined arbitrarily, industry loses the guidance of the market in making business decisions. The direction of research and development, of training and practice, is ordained by the authorities. We need seven hours for AIDS training, sixteen hours for cultural competency, fifty hours per year for CME, etc. Does that help us take better care of our patients? Did it alleviate the malpractice crisis?

The problems with such regulation are expense and waste. The system is

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expensive to administer, because it meets with popular resistance. Remember the story about the six boy scouts helping an old lady cross the street? Why six? Because the lady didn't want to cross the street.

The system needs to be enforced by establishing procedures, mandating courses of action, and watching closely over the shoulders of physicians and patients. Thus, every step we take has to be documented, so it can be audited for compliance. The process is time consuming and expensive both for us, who have to abide by it, and for those who have to check on us to make sure we do. At the same time, it introduces delays in treatment by requiring permission to proceed, by limiting the available facilities, and by fostering long waiting periods before care can be given.

It is wasteful also because it directs that resources be used according to the protocols we have to follow, not according to the needs of the individual patients. I know, theoretically, in an ideal world, the protocols should meet the needs of the patients. The reality of patient care is different. Every individual has different needs and no protocol can cover all the possibilities.

Thus we have to begin with a standard treatment, which may have been proclaimed standard because of its lower cost. Then we may proceed step by step through several other treatments, until we get to the one we should have given in the first place.

The situation in medicine today is similar in many respects to the general economic conditions behind the Iron Curtain. A Central Planning Commission determined what goods shall be produced, and where and at what price they shall be sold.

Through all that, however, there was a difference. The Planning Commissions in Eastern Europe could get some idea of relative valuation from the free market prices in the West. Of course, the situation in their countries was not the same, and only a crude comparison could be made, but they could get a glimmer of the relative values of sugar and flour, of shoes and watches, and use that information to price the goods in their country.

Instead of market pricing, in medicine we have the Resource Based Relative Value Scale (RBRVS). As I have stated in the past, that scale is based on the Marxist fallacy that Price = Cost + Profit. The result is a lack of market discipline. The patients don't know how to value what they get, so they want everything, as long as it doesn't hurt too much. We don't know how to value what we give them, so we try to do everything we can think of to avoid getting summons from a lawyer. The insurance companies try to limit expenditures by making rules, but they are subject to legal action as well. The government is the only institution that can put its foot down and not be sued, so that is where we are headed. It means rationing by law.

Well, not exactly. It means rationing by a legally established Rationing Board. Its members will be humans like all of us, with their own strengths and weaknesses, imperfections and prejudices. But they will hold the power of life and death over us. We saw a hint of that when trying to get prior authorization for operations and procedures. One patient comes to mind. I counseled her about genetic screening and she decided on Chorion Villi Sampling. It had been around for a few years but was a relatively new procedure. I called her insurance company and their nurse told me she considered CVS experimental and denied it.

I like the old saying, "When it gets darkest, the stars come out." While the current system crumbles, a free market alternative will rise from the ruins. If it is banned by law, it will go underground, as a black market, or move off shore. Perhaps there is India in our future.

Power, even absolite power, has limits. In one of the most oppressive regimes, Stalin's Russia, there were alternatives. Patients could go to a doctor's home, be seen, and pay out of pocket. A free market, even when prohibited, continues to function as a black market. Services are provided on the sly; payments are made under the table; life goes on. ■

PCMS FOUNDATION announces grant recipients – thanks membership for generous giving

Nine Pierce County non-profit organizations were selected by the PCMS Foundation Board of Directors as grant recipients for 2005. Pierce County Medical Society members contributed $19,142 this year via the Holiday Sharing Card Project, raffle sales at the Annual Meeting, holiday card sales and contributions made with dues payments.

Grantees must be 501(c)(3), non-profit organizations that will use the funds in Pierce County. It is preferred that funds not be spent on agency overhead but must directly impact people in need with health care services given priority consideration. The agencies selected at the May Foundation Board meeting include:

American Lung Association	$2,000 to purchase asthma supplies for the asthma outreach program
Catholic Community Services	$2,000 for supplies to assist people to become self sufficient
Family Renewal Shelter	$2,000 to provide safety to victims of domestic violence
Neighborhood Clinic	$3,000 for medical supplies and prescription medications for patients
Trinity Neighborhood Clinic	$3,000 for prescription medications and liability insurance
New Phoebe House	$2,000 for emergency shelter and transitional housing to women
Pierce County AIDS Foun.	$1,000 for items for their essential needs bank
The Tacoma Rescue Mission	$1,000 for shelter and food for the homeless and hurting
Crystal Brame DV Center	$1,000 for to protect women from dangerous domestic situations

In the past four years contributions to the sharing card have increased about $4,000 while contributions made with dues payments have decreased about $3,000. Contributions by category are illustrated below. Raffle sales are made at the PCMS Annual meeting:

	2005	2004	2003	2002
Raffle sales:	$552	$508	$789	$432
Card sales:	$250	$144	$516	$282
With dues:	$2,160	$3,200	$5,185	$3,863
Card donations:	$16,180	$16,350	$12,130	$12,030
TOTALS:	**$19,142**	**$20,202**	**$18,620**	**$16,607**

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Applicants for Membership

David J. Harrowe, MD
Public Health
Tacoma-PC Health Department
3629 South D Street, Tacoma
253-798-7388
Med School: Creighton University
Internship: Creighton - St. Joseph
Residency: University of Oregon HSC
Residency: USC-LA County Med Ctr
Fellowship: M.D. Anderson Hospital
Fellowship: University of Indiana Med Ctr

Farrukh Javaid, MD
Internal Medicine
11102 Sunrise Blvd E #109, Puyallup
253-845-0545
Med School: Dow Medical College
Internship: Grant Hospital
Residency: Rush Presbyterian/West Lake

Ralph M. Neighbor, MD
Ob/Gyn
Community Health Care
1213 South 11th Street, Tacoma
253-597-4163
Med School: University of Kansas
Residency: St. Lukes Hospital

Regence puts Select Network on hold for one year

After protest from Puget Sound physicians and members of SPEEA (Society of Professional Engineering Employees in Aerospace), Regence acknowledged that they failed to communicate with their members and their physicians regarding their new Regence Select Network plan and agreed to put it on hold until July, 2007.

The WSMA went right to work devising a battle plan which included filing a lawsuit against Regence for libel. The letter that Regence sent to patients stated that "the new Regence Select Network includes health care providers who deliver high-quality, efficient care, as determined by an assessment of the medical practice patterns and treatment costs, as compared to their peers. As a result of this evaluation, (name of physician) will no longer be a network provider under the Traditional Medical Plan."

While SPEEA negotiated with Boeing for a medical plan that was cost efficient and quality based, they did not anticipate losing their physicians. The process that Regence employed was based on old claims data that was terribly inaccurate. And from SPEEA's perspective "doctors should have helped develop the rating criteria and be afforded a chance to improve before being dropped. The process wasn't encouraging anyone to get better, it was just telling them to get out."

Regence stated that they will carefully review what happened, why it happened and take necessary steps to prevent it from happening again. ■

- Excerpted, Carol Ostrom, Seattle Times 6/2/06

WSMA seeks physicians for Legislative Leadership Team

The WSMA is inviting interested physicians to join their Legislative Leadership Team. The team will focus on the WSMA's number one priority – making Washington a better place to practice medicine and receive care. Issues will include tort issues, medical practice economic viability and other such concerns – which include both offense and defense in the legislature.

WSMA will kick off their new program with a get-acquainted, introductory meeting on Friday, **July 14 from 12:00 to 4:00 at the Sea Tac Hilton**. At this meeting, WSMA staff will review the "game plan" for this new program. Items to review will be how best to develop a relationship with your local legislator, how to work with a legislator who is not typically supportive of the WSMA's efforts, and what is expected of you in the role of a "Legislative Leader." The WSMA will reimburse you for mileage costs.

It is well recognized that building a personal relationship with your legislators is one of the best methods of having influence when it comes time for them to make decisions that will affect you, not only in your practice, but also personally. With established relationships, they will depend on your advice and information for learning specifics about an issue. Your time and effort in building this relationship will pay off in many ways.

If you have questions about the program, or are interested but unable to attend the meeting, **please contact Len Eddinger at the WSMA Olympia office at 360-352-4848 or 1800-562-4546 or email len@wsma.org.** ■

COLLEGE OF MEDICAL EDUCATION

Washington State medical education requirements for physicians' licensure

Licensed physicians must complete 200 hours of continuing education over four years as required by Washington Administrative Code 246-12, Part 7.

Categories of creditable continuing medical education activities approved by the commission include:

Category I: CME activities with accredited sponsorship

Category II: CME activities with nonaccredited sponsorship (max. 80 hours)

Category III: Teaching of Physicians or other allied health professionals (max. 80 hours)

Category IV: Books, papers, publications, exhibits (max. 80 hours)

Category V: Self-directed activities

Credits must be earned in the 48-month period preceding application for renewal of licensure.

All 200 credit hours may be earned in Category I, while a maximum of 80 credit hours may be earned in Categories II-V.

For more specific details of education licensing requirements, call the College at 627-7137. ■

Continuing Medical Education

Survey data will be used for course planning

Thank you to those members who responded to the College's annual CME survey. Responses are used to help guide the College Board and staff in determining programs and content for the next program year. Just over 100 responses were received from practicing Pierce County Medical Society physicians. Of those that responded, 71% reported that they had attended a College of Medical Education program while 26% had not.

This is what you told us:

The primary reasons that physicians do not attend College courses is either because of time – they can't take off from work or they are too busy, or because of content – the course topics do not apply to their specialty. When asked what the College could do better, most said nothing, but a few asked for more weekend and evening meetings or asked for certain specialty program offerings.

Fridays continue to be the most favorite day for daytime courses, with Saturdays not too far behind. However, one day offerings were preferred two to one over evening programs.

Seventy percent of survey respondents reported that they primarily get the CME by attending local, low cost programs, but 60% indicated that self study is gaining in popularity. Specialty Society courses followed at 53%.

The College has considered charging a nominal fee to help defray program expenses, particularly given the change in financing from the pharmaceutical companies, and 82% of survey respondents indicated that this would be acceptable to them, if in the $50 to $100 range. Hopefully this will not be the case, but the College will be prepared to institute course fees if necessary.

Preferred course categories order of their interest were obstetrics, ophthalmology and pediatrics tied for second, alternative care issues and addictive disease and gynecology tied in fourth and psychiatry in fifth. These topics along with specific requests for content will be utilized in course planning for the 2006-2007 College program year.

Thanks to all physicians who participated in the CME survey. If you would like a copy of the results, call the 253-627-7137 and a copy will be mailed or faxed to you. ■

Directory Changes

Please make the following changes to your 2006 Physician Directory:

Marvin Brooke, MD
Puyallup phone should be: 841-3168

Change FAX (medical records) to: 845-4948 for the following:
Peter Chen, MD
Chad Christopherson, MD
James Cook, MD
Robert Emerick, MD
Melvin Henry, MD
Uma Krishnan, MD
Eugene Lapin, MD
Vinay Malhotra, MD
Kingson Momah, MD
John Nagle, MD
Jaime Pugeda, MD
Michael Rome, MD
Tariq Salam, MD
Devendra Vora, MD
Needham Ward, MD
Marlene Bridgforth, ARNP
Judith Chelotti, ARNP
Heidi Kresken, ARNP
Kathy Marks, ARNP
Susan Marsh, ARNP

Foundation from page 13

The PCMS Foundation was formed in 2000 when the PCMS Alliance (formerly the Auxiliary) disbanded. The PCMS Board of Trustees wanted to ensure the continuation of the Holiday Sharing Card project, a major fund raiser for Pierce County charities.

The Foundation is led by President **Charles Weatherby MD**; Past President **Larry Larson, DO**; Nikki Crowley (James, MD) and Mona Baghdadi (Tarek, MD).

PCMS members interested in serving on the PCMS Foundation Board or working on projects to raise funds for the Pierce County non-profit community should call Sue at the PCMS office, 572-3667. ■

Classified Advertising

POSITIONS AVAILABLE

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org.* "MultiCare Health System is a drug free workplace"

Sound Family Medicine currently has a career opportunity for an RN / Case Manager for Medication Management. The Case Manager is primarily responsible for patient follow up visits for ongoing use of certain medications. The primary focus will be getting the prescriptions signed in a timely manner for the patient and follow up visits for certain chronic diseases. Qualified candidates must have a minimum BSN and three years experience in an out patient clinic. If you would like to learn more about this position mail/fax/email your cover letter and resume to Attn: HR/RN 3908 10th St SE Puyallup, WA 98374, fax to 253-845-7073, or email to: recruitment@soundfamilymedicine.com. EOE

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 + incentive. Fax your CV to 253-847-9630.

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@soundfamilymedicine.com. Equal Opportunity Employer.

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

Medical Office Space Available. Deluxe medical office space for lease. 2,500 to 21,000 square feet available. Excellent location, walking distance to Good Samaritan Hospital in the Master plan campus. Custom tenant improvements built to suit your needs. Site development work has begun - construction starts summer 2006. For more information please contact Roger Mayer, Crescent Realty, Inc. at 253-370-0286 or email rammayer@comcast.net.

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Pierce County Medical Society
BULLETIN

July, 2006

The Sound to Narrows "CHAMP" team. Left to right, back row: Aksel Nordestgaard, Mark Craddock, Ginny Craddock, Steve Elder, Jim Rooks, Sharon Jung, Harald Schoeppner, Joan Brookhyser, Pat Hogan, Lauren Colman, Jim Schopp, Henry Retailliau, Ron Taylor and Cordell Bahn. Left to right, front row: Darryl Tan, Willie Shields, Tom Herron, Loren Betteridge and Jos Cové

Story and more photos, page 7

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Pierce County Medical Society
BULLETIN

July, 2006

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President's Page

by Joseph F. Jasper, MD

Healthcare Community Collaborations

Joseph F. Jasper, MD

Pierce County Medical Society (PCMS) will be working on several projects with the major hospitals and the Health Department in the future. I have had some preliminary conversations with **Mike Newcomb, MD** of the Franciscan Health System, and **George Brown, MD** of MultiCare Health System. Our initial efforts will address electronic health records, attracting and retaining physicians to Pierce County, reducing "out-migration" of cases to Seattle, and the formation of a Medical Reserve Corps. We shall engage representatives from other organizations as needed and welcome their collaboration.

Increasingly, healthcare providers are moving to electronic record keeping. The exchange of both demographic and health information is necessary in providing continuity of care for patients. Electronic records have the potential to facilitate the transfer of information. We need a common data set for patient demographics and perhaps other aspects of electronic health records.

Pierce County needs to improve its ability to attract and retain new physicians in our great medical community. We have a Family Practice Residency and a Podiatry Residency in town. Madigan Army Medical Center brings a number of physicians to our area for a while. In years past, University of Washington and Madigan residents in some specialties would rotate through the hospitals. Having other specialty residents rotate through the county's hospitals or practices in Pierce County would likely help attract some to practice here. To accomplish improved recruitment our medical community should be able to support, educate and evaluate residents with a common infrastructure and without barriers.

Sadly, Pierce County loses a significant percentage of procedures to Seattle. Some patients and some physicians believe that medical care in Seattle will result in better outcomes. In most of these cases the same excellent care can be provided here. Coronary bypass surgery is one such example among others. There are some exceptions such as major burns and transplants. How do we stem the "out-migration" of cases? Likely, this will require cooperation of practitioners at every level and of the hospitals to promote the public image of the Pierce County healthcare community.

Recent natural disasters and the looming threat of pandemic avian flu have prompted renewed interest in forming a Medical Reserve Corps which would be organized under the Tacoma-Pierce County Health Department. However, a Medical Reserve Corps is a community-wide project with many issues to resolve. We must address the issues of recruitment, training, privileges, liability, organization and resources before a disaster results in chaos.

I am excited about the prospect of building *unified* and *effective* community-wide healthcare solutions. Our patients and community deserve no less. PCMS welcomes your input and ideas. ■

100,000 Lives Campaign Scores Big Patient Safety Gains

The Institute for Healthcare Improvement (IHI) has announced that the *100,000 Lives Campaign* has actually resulted in reductions in breakdowns in care in the hospital setting, preventing more than 120,000 patient deaths in the past 18 months.

Washington State was the first to have all of its hospitals sign on for the campaign. The WSMA was an early endorser of the campaign, and continues to work with the Washington State Hospital Association (WSHA) and other organizations on this effort. Hospitals have shared mortality data and study-tested procedures that prevent infections and treatment errors.

The best known of the six changes promoted by the campaign was to deploy rapid-response teams for emergency care of patients whose vital signs suddenly deteriorate. Common in emergency departments, the measure was designed to make sure the service is available around-the-clock to other units, and to encourage lower-seniority medical staff members not to be intimidated about calling for help.

Another change urged checks and rechecks of patient medications to protect against drug errors. A third focused on preventing surgical-site infections by following certain guidelines, including giving patients antibiotics before their operations.

Patient Safety/Error Reduction efforts remain integral to the WSMA's #1 priority - making Washington a better place to practice medicine and to receive care. Other patient safety/error reduction programs with the state hospital association will continue to be developed. Physician engagement at the hospital and medical practice level is very important. The WSMA urges you and your colleagues to capitalize on these opportunities as they arise. ■

Reprinted, WSMA Member Memo, 6/23/06

Applicants for Membership

Michael B. Kimmey, MD
Gastroenterology
Tacoma Digestive Disease Center
1112 Sixth Ave #200, Tacoma
253-272-8664
Med School: Washington University
Internship: University of Washington
Residency: University of Washington
Fellowship: University of Washington

Anne-Marie Lee, MD
Endocrinology
Endocrine Consultants Northwest
1628 S Mildred #104, Tacoma
253-565-6777
Med School: University of Florida
Internship: Mercer University
Residency: Mercer University

Pearl Ren, MD
PM&R/Pain Management
South Sound Neurosurgery
1519 - 3rd Street SE #101, Puyallup
253-841-8939
Med School: Jilin Medical College
Internship: Mercy Hospital & Med Ctr
Residency: Loyola University Med Ctr

2007 Priority Survey

You should have recently received a copy of the PCMS 2007 Priority Survey in the mail. President-Elect **Sumner Schoenike, MD** is preparing for his tenure as president and is very interested in feedback from the membership.

The survey asks members to prioritize the following issues:

- Access for Patients, Barriers to Care, Under/uninsured
- Changing Physician Workforce; Scope of Practice
- Emergency Preparedness
- Health Information Technology; EMR; Patient Safety
- Hospital Relations
- Medical Liability Reform
- Profession/Physician Unity
- Specialty Competition; Reimbursement; P4P

Ideas for how PCMS can maintain profession unity, queries about the PCMS *Bulletin*, and interest in becoming more active in PCMS are also included on the survey.

Respondents are also asked to list the top two inefficiencies or commonly wasteful expenditures that they see in medical practice, that if eliminated, would provide an immediate cost savings to the health care system.

If you did not receive a copy of the survey but would be willing/interested in providing your feedback, which can be done confidentially, please call PCMS 253-572-3667 and a survey will be faxed or mailed to you. ■

June General Membership Meeting Recap

Living a Healthy Lifestyle...One Day at a Time

Joe Piscatella is no ordinary Joe – as attendees at the June General Membership learned. After surgery at 32 years old for coronary arteries that were 95% blocked and a grim prognosis for life, he went to work doing extensive research to create a plan for a healthy, balanced lifestyle that he could live with. The results were dramatic and his physicians urged him to publish his plan.

Today, 29 years later, he has sold over 5 million books, founded the Institute for Fitness and Health, makes numerous television appearances, and has hosted three PBS specials. He maintains a very successful professional speaking schedule, and is currently the only non-physician member of the Institute of Medicine's Health Committee. Most importantly, he is alive, against the odds, because of his choice and commitment to living a healthier lifestyle.

CHOICE was the key word of the evening. Mr. Piscatella stressed that we all make numerous choices every day – some being more important than others. He believes the most important choices that we make every day in our life, affect our health; and they include:

- **Diet**
- **Exercise**
- **Smoking**
- **Stress**

He claims that many people know about healthy lifestyles. Most understand what they should do and why they should do it. But the disconnect between what people know vs. what people do is huge and puzzling, at best. He believes that much of this "disconnect" is caused by stress and the stressful lifestyles that most Americans live.

A glaring example is the pace of life and the way that chronic stress has changed our relationship with food. Americans no longer cook, they reheat. And, they no longer have a meal together, they eat at different times and they eat different things. Meals are usually out of cans or boxes or drive thru windows. The average American daily diet is 34% fat, 24% sugar and 5% alcohol. And, 40% of Americans eat no fruit, 40% eat no vegetables and 80% do not eat any whole grains.

He talked significantly about the role that fat plays in the diet. He corrected the age-old adage of "the sweet tooth" to "the fat tooth," explaining that new research shows that when your sweet tooth takes over, it is really your fat tooth wanting fat. He strongly recommended a fat "budget" for daily control of fat intake. Allowing 40 grams of fat each day forces people to make better choices, and be realistic about their daily intake. They don't have to give up the Oreo cookies they love, they can budget them into their accounting for

See "Healthy" page 6

Joe Piscatella (left) visits with one of his personal physicians, Dr. Kari Vitikainen, Tacoma cardiovascular surgeon

From left: Drs. Mike Kelly, PCMS Past President, Paul Schneider, PCMS Trustee and Jeff Nacht, PCMS Vice President visit after the meeting

PCMS President Joe Jasper, MD (center) visits with Drs. Ray and Vita Pliskow, radiologist and anesthesiologist respectively

Healthy from page 5

the day. Restricting fat grams forces people to eat whole foods as they are lower in fat than processed foods and of course, much healthier.

He touted Omega 3 Fatty Acids – good sources include fish/seafood, walnuts/almonds and flaxseed (he cautioned that one serving of nuts is about shot glass size). He also sang meat's praises, saying it is a great source of protein; you just have to choose the lean cuts such as loin or round.

He suggested that people learn to drink skim milk by slowly adding it to their higher fat variety and he warned about cheese, particularly females as they tend to eat a lot of the high fat food. Palm oil is now being called palm kernel oil but still needs to be restricted as does HFCS (high fructose corn syrup) which he cited as a dangerous trend. One of the biggest culprits he cited is the fat-free baked goods – while low in fat they are loaded with calories pointing to the necessity of paying attention to the entire food label, not just one aspect.

Other suggestions, or course, included restricting sodium to a maximum of 2,300 mg per day and incorporating exercise into your daily routine. If you exercise at least 30 minutes on Saturday and Sunday and then pick two days from 5 work days, then it is not so stressful during the work week.

His last recommendation was for a good night's sleep. Sleep is under-rated and a very important element to a healthy, stress-free lifestyle, he added.

Editor's Note: For a copy of Joe Piscatella's new book, "The Road to A Healthy Heart Runs Through the Kitchen," go to www.joepiscatella.com. ■

Dr. Mike Regalado, Puyallup ER physician and his wife visit with Joe Piscatella (left)

Drs. Kari Vitikainen and Art Knodel peruse handouts prior to the Piscatella presentation

CHAMP Sound to Narrows Team: All Gold

The bright gold CHAMP t-shirts were ablaze at the running of the 33rd annual Sound to Narrows on Saturday, June 10. The Coalition for Healthy, Active Medical Professionals (CHAMP) provided free t-shirts to all PCMS runners and walkers that signed up to participate, and provided Clif Bars, bananas, bagels and drinks at a finish line gathering.

Hoping to create a healthy medical community to serve as a role model for patients and the community, CHAMP encourages all medical professionals to work on improving fitness. Walking, running, biking, climbing, canoeing; any activity that includes movement and not necessarily at the speed of this year's finishers.....

Tom Herron, the first CHAMP finisher in just 46 minutes and 37 seconds was the 35th person to cross the line, running a very fast 6:16 pace. Dr. Herron is a Gig Harbor pediatrician. Another fast pediatrician, **Martin Goldsmith** finished the 5K (3.1 mile) run first in his age group in 20:59, a speedy 6:46 pace. Puyallup's **Marc Aversa**, family practitioner also finished in the six minute mile category with a 6:37 pace for an overall time of 59:17 and 76th place finish.

The seven minute/mile runners included **Stephen Elder** finishing in 55:34 at a 7:28 pace. Dr. Elder, a Tacoma anesthesiologist, was the 230th person of more than 6,000 to cross the line. Following Dr. Elder closely with two seconds separating them was **Chad Krilich** at 56:24 and **Aksel Nordestgaard** at 56:26, both running a 7:35 pace. Dr. Krilich is a family practice physician with CHC's downtown clinic and Dr. Nordestgaard is a vascular surgeon. **Jim Schopp**, Tacoma general surgeon had a great run at 59:23 at a pace of 7:59.

Right on their heels was PCMS Trustee **Harald Schoeppner** at 56:51, orthopedic surgeon **Jos Cové** at 57:11 and PCMS Past-President **Pat Hogan** in 57:58, running paces of 7:38, 7:41 and 7:47 respectively.

Eight minute milers included **Loren Betteridge** with an 8:02 pace bringing him across the line in just under one hour at 59:49. Dr. Betteridge was followed closely by retired surgeon, **Ron Taylor** with an 8:06 pace and finishing time of exactly one hour. Pediatrician **Darryl Tan** and ophthalmologist **Willie Shields** finished close at 1:02:47 and 1:02:58 respectively. Their paces were 8:26 and 8:27.

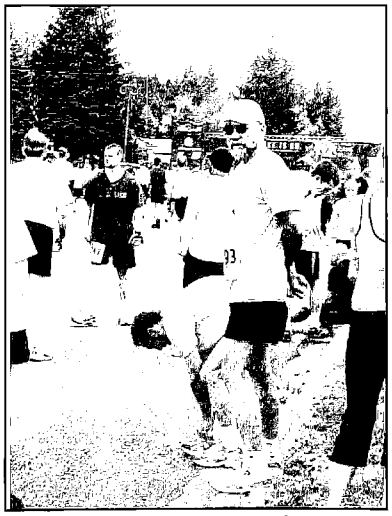
Other PCMS finishers (that we know about) include **Drs. Lauren Colman, Jim Rooks, Mark Craddock, Cordell Bahn, Henry Retailliau,** and **Jennifer Smith.**

Special recognition is certainly due to **Dr. Cordell Bahn,** retired surgeon for running EVERY Sound to Narrows since its inception in 1973. He is a member of the ever shrinking "every timers" club. Congratulations on your 34th STN run, Dr. Bahn.

And further congratulations are extended to the following physicians who bettered their time over last year's run – **Drs. Patrick Hogan, Jos Cové, Steve Elder,** and **Tom Herron**. Dr. Cové had the most significant improvement by decreasing 4 minutes and 45 seconds from his last year's finishing time.

Congratulations to all finishers of the 2006 Sound to Narrows and thank you to all CHAMP participants. And, if you were a participant in the 2006 Sound to Narrows event but were not included in this recap, please call the PCMS office and we will run additional participants that we missed in the next issue. Apologies are extended to those we missed. ■

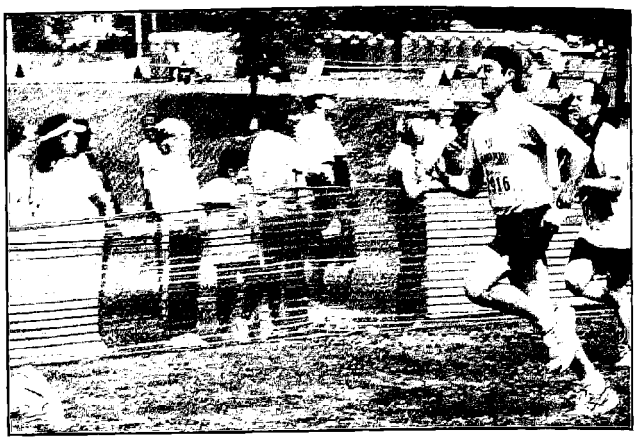
Darryl Tan, MD enjoys his music pre-run



Jim Rooks, MD anticipates the start

Steve Elder, MD heading to the start line

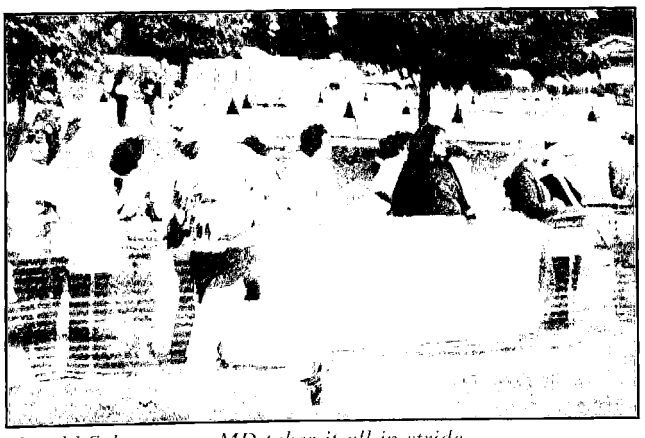
Loren Betteridge, MD makes it look easy



Chad Krilich, MD finishes strong

Pat Hogan, DO powers to the finish line

Jos Cove', MD fast and strong



Harald Schoeppner, MD takes it all in stride

CHAMP supporters gather for the News Tribune photographer and explain their fitness initiative

In My Opinion

by Michael J. Kelly, MD

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

Apology Not Accepted

Michael Kelly, MD

Presented for your perusal - a letter sent to Regence on June 22 addressing the recent controversy over their new product known as Regence Select. Many Washington and Pierce County physicians were slandered as a result of the promotion of this new insurance plan. Physician response to this outrage has been swift and varied. What follows is part of mine. MJK

Re: Apology in regard to Regence BlueShield's "Select Network"

Dear Ms. McWilliams and Dr. Robertson:

Ever since Joan E. Bargelt, senior professional relations representative for Regence BlueShield, visited my office on behalf of your company on June 8, with an "apology," I have been considering my response. My deliberations have been further fueled by press releases and public comments and by your own *"Dear Physician"* and *"Dear Boeing Member"* letters left by Ms. Bargelt and later circulated to physicians and certain subscribers. I have decided to not accept your apology.

To begin with, your company only apologizes for *"...any misunderstanding"* caused by the slanderous letter you sent to 8,000 Washington residents about their doctors. But there is no misunderstanding. There never has been any misunderstanding about the language, tenor and intent of that communication. You cannot apologize for something which does not exist. But there is much for which you can and should apologize.

You could apologize for suggesting that utilizing claims data would allow you to *"...raise the bar on health care quality and efficiency."* You could apologize for strongly suggesting that those physicians not included in the Select Network were deficient in their delivery of quality medical care. But this is not what your apology is about.

The most important factor fueling my refusal is the simple fact that you intend to once again roll out the Regence Select program July 1, 2007. I am baffled by your lack of insight. Let me explain: You want me to accept your apology concerning a present action which you fully intend to repeat once again in one year! This is similar to asking me to accept your apology for robbing my home now, while you announce your intent to do it again. This is a "sincere" apology?

Your apology can only mean something when combined with an announcement of your future intent to employ a transparent process, not a black box, in selecting your narrowed network. It would also mean something if you announce your conclusion that the use of claims data is insufficient to make determinations about a physician's performance.

It would further mean something if you announced the risk adjustment component of profiling systems must take into account the entirety of patient factors which must be considered for valid risk adjustment. Patient factors such as health plan benefit type or socioeconomic status, which may affect access and/or adherence to care, should be included in such risk adjustment and/or physician profiling processes. Multiple comorbidities and unresponsiveness to, or noncompliance with treatment, are other factors that are important to include.

As we have seen from your proposal, network redesign severs the long-standing relationships that chronically ill patients have with their trusted physicians who have treated their conditions for years. Such tiered and narrow network approaches add further complexity to the health care system for patients and risk undermining the patient-physician relationship when patients are restricted from seeing some physicians or are faced with choosing their doctors based on cost tiers.

Finally, let me say that I believe collaboration is still possible despite the ill will and rancor engendered by this new Regence product. I know that the WSMA and the Pierce County Medical Society stand ready to move forward with you in the same spirit mentioned as a motto in your television commercial (employing plastic people) which states, "Together we can take charge."

Sincerely,

Michael J. Kelly, MD, FAAFP

In My Opinion

by Stevens Dimant, 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.

All at Sea

Stevens Dimant, MD

Two elderly Texans at dinner were telling us a little casually that they had taken over 50 cruises. The Captain and others had also described to us an 80-year-old lady who was spending her tenth year on the QE2. His wife had explained that many of the 500 passengers found this life better than a retirement home. My wife and I, although not yet in that category, certainly enjoyed sharing this life of luxury – for three and a half months. A lady friend from Ontario had written to say, "Living like a peasant was difficult after being a queen for so long."

This remarkable journey on the MV Discovery had taken us through Antarctica, up the west coast of South American to Santiago and then due west through the Pacific Islands to New Zealand. The return home through the Panama Canal to visit our daughter's beach house in Belize was the last lap of our odyssey.

Although a relatively old ship, her lines were classical and the interior layout equally pleasant. We were not prepared for the fringe benefits of such a cruise. Elegant four-course meals or a buffet lunch in the open sunshine were preceded by breakfast in bed provided by the Filipino steward, always smiling. These crew members alone kept reasonable waistlines, but eating was only one of many on-board attractions. Nightly floorshows presented beautiful women with good voices while at the same time the movie theater also presented good shows, and to those with any residual steam there was a nightspot and casino before bedtime. Many of the daily lectures were excellent with faculty members from the Mayo Clinic giving daily talks, and I will remember the relevance of one entitled "The Sun, the Sea and the Skin."

We were a diverse group, not only from North American, but also from the U.K., Australia, New Zealand and Japan. We had a superb classical trio from Romania. The dance band were all Ukrainians, led by a furious drummer reminiscent of Gene Krupa were it not for his wearing ear mufflers as he actually read music. Afternoon tea in a viewing lounge was regular refreshment for most of us, and of course the bars were not unpopular, particularly on party nights. Yes, the 45 ports of call also figured in our activities, and it was the extraordinary itinerary that lured many of us onto the ship in the first place.

This article is not a travelogue, but reference must be made to the astonishing colors and wildlife encountered in Antarctica, followed by the drama of sailing west to the Pacific through the Beagle Channel, still in unbroken sunshine. In that channel, the towering Andes plunged down thousands of feet with huge glacier-carving icebergs, and as we turned north to the Chilean fjords, summer clothes appeared, and across the Pacific Ocean from Valparaiso, we pretty much stayed on the equator. From the prosperous beauty of New Zealand farmlands, we proceeded north through Melanesia

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The Health Status of Pierce County

Federico Cruz-Uribe, MD, MPH
Director of Health

Be a Mentor

Federico Cruz-Uribe, MD

The war in Iraq, our oil dependence, a weak economy, the healthcare morass, child abuse, meth addiction, there is no shortage of problems that confront us. But what to do about them? Big problems never have easy or simple solutions. In my job as the director of the local health department, I confront more of these tough issues on a regular basis than I would like to. So many times I just wish that there were straightforward solutions. Instead, we have many one-step-forward-and-two-step-back scenarios.

But I do want to share some good news with you. There are some programs out there that are simple and very powerful on their impact on big issues. Recently I was recruited to mentor a teen-age student at Lincoln High School. He had been admitted into the Washington education foundation program that focuses on getting high-risk kids into college. I was maneuvered/pressured to volunteer at a breakfast meeting that I had been invited to at a local Pancake House restaurant. There was a motivational speaker and several high school students who had gone through the program spoke on how it had helped them. I have to admit that I wasn't very impressed. It wasn't that what they were saying wasn't true but rather that I had heard it many times before and I was busy and needed to get to my next meeting. I was caught before I could get out the door and put on the spot. I was reminded that my own agency had funded this effort in the community because it worked. I found myself giving a little speech on how important this kind of effort was and volunteering to take a student at a local high school.

What I remembered when I was standing by the door was that mentoring was one of those rare interventions that does really work. Kids who struggle with their studies, with suspensions, with drug and alcohol use, and with sexual acting out, all do better when mentored by an adult. The positive impacts have been documented through multiple studies. A caring adult who will take the time just to listen and give advice can make an important difference in a child's life. The Gates foundation has committed $125 million to a scholarship program for Washington high school students. A key part of the program is the individual mentors assigned to each student in the program.

"We can worry and fret and complain about the big intractable problems we face in our community. We can also do something about them on a personal level."

I was one of those mentors. I was assigned to a student at Lincoln High School, Carlos, whom I was to meet with at a minimum of once a month for an hour in the school library. I am sure that he had a family name but I never did get it in conversation with him. He had black shiny hair that stuck up in spikes from the top of his head. He dressed neatly though his pants were baggy and he had several tattoos. But he had far fewer than my own son so he was in the ballpark for me.

We met in the school library on Monday mornings for an hour. Initially we met just for an hour or so a month. But as we got close to the time when he had to get his college applications together, we met once a week. We chatted about stuff. Mostly what it was like to go to college and then we worked on his applications. These were a struggle for him. There was so much documentation that had to be done. The financial aid applications took us many weeks to do. He had a series of essays that he had to write for each of the applications; each had to look and sound right. I helped re-write his efforts but it just didn't make sense to him. He had a story to tell about who he was and why he wanted to go to college. When I stepped back and didn't meddle and didn't worry about the grammar and sentence structure and shape of the paragraphs, I realized that he had a very powerful story to tell.

I was happy to just be encouraging and to keep reminding Carlos about

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deadlines. He needed to put answers down on paper in his own way. We did get everything in on time, and then we waited for word from the schools about his applications.

He was accepted into one of our state universities and will start school in the fall.

I tell you all this because I failed to mention one important part of this whole process. I enjoyed being a mentor! It wasn't just about the teen student. I learned a lot about Carlos's world and the paths and challenges that our kids face these days. I was humbled by his passion and drive, by his ambition to be the first in his family to go through high school and then go off to college. It was an honor for me to share a few hours with this young man. And it didn't take a lot of time, just some focus when I was with my student. I was a better person because of it all.

So, do I have a deal for you? The Washington Education Foundation, in partnership with the Gates Foundation, is looking for a few good men (and women). They need mentors for the fall as the new class of Achiever Scholars goes into place. It is easy and fun and remarkably it also provides a real service to these young people as they prepare themselves for college. We can worry and fret and complain about the big intractable problems we face in our community. We can also do something about them on a personal level. Think about it and consider contacting Robert Jones, Washington Education Foundation, 571-6673 or rejones@waed foundation.org

I am meeting my new student in the fall. ■

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 Problem with Pricing

Andrew Statson, MD

"First you destroy those who create values. Then you destroy those who know what values are, and who also know that those destroyed before were in fact the creators of values. But real barbarism begins when no one can any longer judge or know that what he does is barbaric."
"A Warsaw Diary" Ryszard Kapuscinski (1985)

The system is broken at every link along the chain. So declared *Reader's Digest* in its issue dated February 2006. A special report by Kerry Howley, titled "I Can't Afford to Get Sick," discussed the problems facing patients, physicians, insurers and employers, the broken links in the medical care chain.

We know the problems. We are living with them every day, in our offices, in our hospitals. Stooped under our own burdens, though, we seldom have the chance to glimpse at those of our patients, of their employers, and even less so, of their insurers.

"Few people are pitying the nation's health insurance companies," wrote Kerry Howley. Yes, indeed. In many discussions among ourselves, I heard stories about the millions in salaries and bonuses that high officers of this or that company were getting. Yes, but that is generally true of executives of most other companies. Perhaps they are paid too much, but I don't know how much they should be earning, and I suspect no other individual does.

The price of wages, as the price of every other good or service, is determined by the market, that is, by what we, the people, as customers, are willing to pay. If an insurance company pays its executives too much and has higher premiums as a result, we can buy a policy from another company, and cut the first one down to size.

The insurers have a problem similar to ours. They function under a heavy regulatory burden that raises their costs just as it does ours. I can only guess what effect that has on prices. The administrative costs of casualty insurance are about 5% of premiums. Before Medicare, before the extensive coverage of what I would call pay-as-you-go services, the overhead of health policies was less than 10%. Now, it is at least 25%, and probably more than that for the managed care and government programs.

In addition, the policies are made more expensive by legislative mandates to cover services which were not included in the past. We could eliminate the coverage for low cost services, more efficiently paid for out-of-pocket, and get rid of the mandates for coverage, so people could buy only what they needed. Insurance rates would drop by half. That is the direction in which employers, the large purchasers of insurance, are pushing.

Businesses large and small are suffering, too. Employers would rather have a healthy work force. Training replacements and substitutes is expensive, and for a time, the new workers are less productive. Yet insurance premiums have gone up every single year. That expense is forcing many companies to cut down on coverage, and to transfer more costs to their employees. The trend is inevitable if businesses are to survive, and workers are to have jobs.

We are the next link in the chain and our problems are similar to those of other businesses, with the added burden of price controls. Most businesses, even in the presence of strong competition, have some ability to raise prices. We don't. Our costs — malpractice premiums, health insurance, payroll, taxes, equipment, supplies — have increased steadily over the years, while our payments, if anything, have gone down. The resultant squeeze is forcing many among us to close our offices and to look for salaried positions, or to leave the practice of medicine altogether.

The patients have a different problem. There is no market to set the price, so the fees of hospitals and physicians are arbitrary. Insurers frequently disallow half or more of the submitted bills and we accept that. But when a service is not covered or the patient is not insured, we want to be paid what we charge. Patients perceive that as unfair.

What is fair? Perhaps we could give patients the opportunity to negotiate prices, or let them get a bid from someone else. We are stymied, because most contracts forbid us to charge insured patients more than what we charge others. Fine, but we should be able to discount our fees for uninsured

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services close to what we get for those who are insured.

So what is the answer? Kerry Howley gives three possible solutions to the problem of high costs. One is to reduce spending by having patients pay a bigger share, and at the same time, giving them more control over the choices of the services they get. Another solution is to reduce waste and duplication of services by computerization of the medical records. A third solution is to put more stress on prevention and disease management.

Of the above, patient choice of services and control over expenses is primary and most likely to succeed in the long run. But it must, like the Health Savings Accounts, allow patients to carry forward toward future expenses or retirement any money not spent.

One significant point about this report in "Reader's Digest" is that it did not mention single payer and government takeover. If we can get away from that idea, perhaps we can address the underlying problem that is destroying our system — the absence of a pricing mechanism.

Our current approach to pricing is the government system of cost plus profit. That may work for buying fighter planes, submarines and tanks. It is not the way to pay for consumer services. It is based on the Marxist fallacy that Price = Cost + Profit. The price derived in such a fashion is a meaningless number which does not reflect the value of the service.

Even though cost is the most independent of the three variables, with the incentive of a competitive environment rewarding good management and proper use of resources, it can be reduced significantly. However, when profit is calculated as a percentage of costs, the incentive to reduce them disappears. If we found a way to cut costs after we began work, we might be accused of overcharging the government, incur fines and be disqualified from future participation in government contracts. What's the use? Better leave well enough alone.

In the market, the price of a service is determined by the willingness of a buyer to pay it, which also means that the buyer, by voting with his money, ratifies the value of the service he gets. This price guides suppliers to direct their productive ability toward those services that are most likely to bring a profit and away from others, which do not pay enough to cover their costs. The result is the most efficient use of resources, designed to meet the demands of the customers, and to maximize the benefit to both buyers and sellers.

All three elements in the pricing equation are variables, and they are better expressed as Profit = Price - Cost. Profit is the variable depending on the two others. It is not a given, as in the Marxist equation.

When engineers consider the design of a new product, the first question they ask is, if they made it, for how much would it sell. Once they get a good estimate of what people would pay, they ask the next question, can

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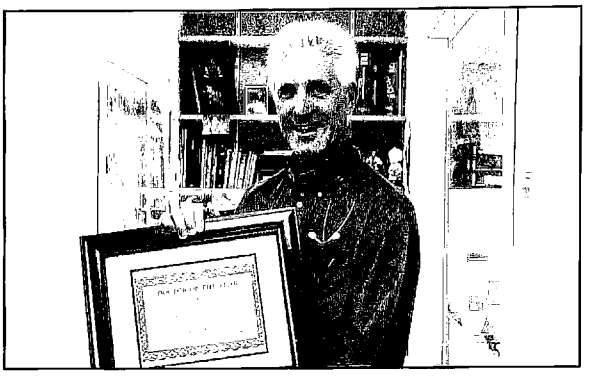
Sumner Schoenike, MD honored as Doctor of the Year

Sumner Schoenike, MD, Lakewood Pediatrician and PCMS President-Elect was honored recently by the Tacoma School District nurses having been selected as the Doctor of the Year for 2006. A surprise visit to his Lakewood Pediatrics office on Bridgeport Way to present him with the honor was successful. He was both honored and surprised!

Dr. Schoenike chairs the PCMS Public Health/School Health Committee that meets monthly at Mary Bridge Children's Health Center. He has worked diligently with this committee, comprised primarily of school nurses for the past six years. The Committee brings together school nurses from every district in the county with public health representatives and primary care physicians. The success of the committee is evidenced by the full-house attendance each month in spite of the 7:00 a.m. meeting time.

Issues undertaken during Dr. Schoenike's tenure have included implementation of the "Fall Back to School" series of educational presentations at Jackson Hall that have ranged from Immunizations to ADD/ADHD and Autism. Series attendance has grown and the program will be offered again this fall.



Sumner Schoenike, MD displays his award

School nurses are often in a precarious position between parents, school administrators, physicians or hospitals in directing the health of a child while in school. Under Dr. Schoenike's leadership the committee has recently dealt with issues surrounding both diabetic and asthma care at school, meeting with representatives from Mary Bridge Children's Hospital to discuss and understand the complexities of the issue from the other's perspective. "Dr. Schoenike is a master at providing us an avenue to collaborate and improve the health of our children," said Delois Brown, administrator of health services for the Tacoma School District and committee member. "We owe him a debt of gratitude for all he does for the school districts in our county," she added. ■

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and were continually impressed by the goodness of local people, despite their simple lives.

A 94 year-old gentleman told me he was responsible for raising funds to allow Tongans to attend New Zealand universities, and indeed one of his churches with a congregation of 250 had raised $15,000 for that purpose. Interestingly there was much personal warmth experienced throughout French Polynesia, and there the islands of Bora Bora and Moorea stand out as the most fabulous. And not to be overlooked are the astonishing 800-odd statues remaining on Easter Island and the personal encounters with the remaining descendants of the Bounty mutineers on Pitcairn Island. Although totally unlike our sailing excursion from Gig Harbor to San Diego years ago (and described here) this adventure was every bit as much fun. Moreover, it gets one's wife out of the kitchen and oneself back onto a boat for about the same length of time. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

SAVE THE DATES

Fall programs scheduled; annual calendar due out in August

Common Office Problems, Oct 13

The College's *Common Office Problems* CME has been scheduled for Friday, October 13, 2006, Fircrest Golf Club.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the medical practice.

Look for the registration brochure in the mail early September. ■

Infectious Diseases Update set for Nov 10

The annual *Infectious Diseases Update* is set for Friday, November 10, 2006 at the Fircrest Golf Club.

The program features nationally recognized authorities as well as our own infectious disease specialists and is hosted by the physicians of Infections Limited, who are: **Marina Arbuck, MD**; **Philip Craven, MD**; **Elizabeth Lien, MD**; **David McEniry, MD**; **Peter Marsh, MD**; and **Lawrence Schwartz, MD**.

Watch for a program brochure to arrive by mail in early October. ■

CME at Whistler set for Jan 24-27, make plans now!

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 24th to the 27th, 2007.

Reservation for the program's condos can be made by calling Aspens on Blackcomb, toll free at 1-877-676-6767. You must identify yourself as part of the COME group (group # 403699).

The Whistler course is under the medical direction of **John Jiganti, MD**. ■

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they manufacture it at a profit. Then, looking over their shoulder at the competition, they ask whether they can cut down the cost of production even more. Because if they can't, their competitors might.

In medicine, with cost plus reimbursement, we don't have a pricing mechanism. We advocate patient autonomy in making decisions about their medical care, but when it comes to decisions that involve spending money, that autonomy is taken away from them.

Value is subjective. Neither we, nor the insurers, nor the government, are qualified to determine the value of a service. Only the patients can do that, but that valuation cannot be true unless they vote and ratify the price with their own money. Until that happens, the economics of medical care will remain in disarray. ■

Classified Advertising

POSITIONS AVAILABLE

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@sound familymedicine.com. Equal Opportunity Employer.

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to *MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org.* "MultiCare Health System is a drug free workplace"

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 + incentive. Fax your CV to 253-847-9630.

Family Practice - Gig Harbor. Well established FP seeks enthusiastic associate in desirable Gig Harbor/Tacoma area. Office based. Minimal call. No OB. Full-time/Part-time/Locum option. Great opportunity. E-mail resumes to Dr. Finkleman at hazak@msn.com.

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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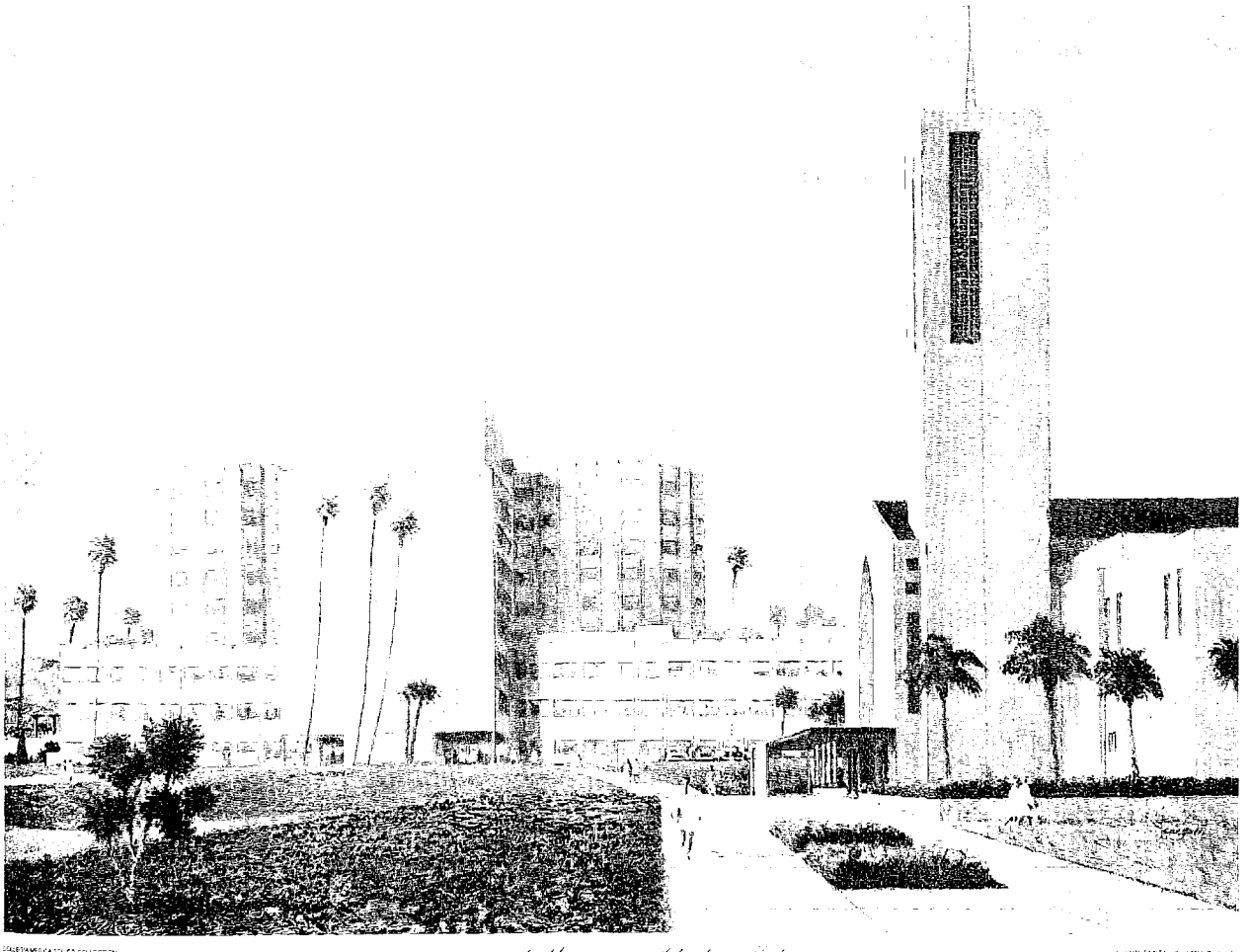
Pierce County Medical Society

BULLETIN

August, 2006



Loma Linda University School of Medicine

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Evidence Based Medicine – YOU can help!

Joseph F. Jasper, MD

We are being confronted with rapid changes in the way the medical field and third party payers are looking at the practice of Medicine. Pay for performance, Economic Credentialing, Electronic Medical Records and Evidence Based Medicine (EBM). One may feel like one has no influence over the outcome of these measures; i.e., that the measures will be implemented with or without our consent and cooperation. How does one preferentially gain control?

Let us look at EBM. Is one truly helpless? One can influence the interpretation of medical research. One can participate in research as part of a multi-center study or perform a single site study. The other avenue is to participate as part time faculty at a medical school, residency or fellowship. This is not as difficult as some may think. Every day physicians are amassing data, but in a disorganized fashion that is unusable by research standards. Many doctors have developed fairly unique approaches to a disease or other medical problem that may never benefit society at large. Why not share such knowledge and prove theories?

Another opportunity arises within specialty societies. Each society should provide its own interpretation of evidence based guidelines. These have proven quite useful with payers when the guidelines are properly constructed to follow the Agency for Healthcare Research and Quality (AHRQ) or Cochrane standards.

A third option is to participate on a committee that is reviewing evidence. These committees are frequently seeking volunteers including local private practicing experts. Without such input, decisions may not be made respecting appropriate standards of care in a specialty. The error will always be made on the side of non-coverage.

If we do not provide the studies needed to validate our treatment regimens and procedures, the payers will deny coverage. It is up to physicians both in academic settings and in the private sector to rise to this need and provide the evidence. Publish or perish no longer applies to academicians. Have you been thinking about an article you would love to write or a theory you would love to test? Now is the time.

Editor's Note: Dr. Jasper has participated in the production of EBGs for his specialty, which have been published in the National Guideline Clearinghouse, and has authored a number of published articles, some based on original research. He participates on the Noridian Carrier Advisory Committee and has assisted Labor & Industries by serving on ad hoc committees to decide coverage policies.

Negotiating with Payors and Regulators

Washington State Medical Association
Practice Management Seminar

Has your practice ever:

* Signed an unfavorable provider contract?
* Had a claim wrongfully denied?
* Had to make multiple attempts to get services authorized or get claims paid?
* Been audited for allegedly deficient coding and documentation?

If so, your practice is like virtually every other practice in the state. With downward pressure on reimbursement and increased emphasis on compliance, the need to be successful in your dealings with insurance companies will only grow. The training and skills you acquired to become a capable clinician or manager, likely have not prepared you to be an effective negotiator. This seminar will build your skill sets so that you can negotiate these complex yet essential issues with health insurers. You'll also learn about the role of regulators and how to protect yourself and the practice in your dealings with them.

This half-day program will introduce you, in very practical terms, to the art of negotiation and offer you specific techniques to improve your chances of getting the best outcome possible. You'll learn:

Strategy

* Identify what's really at issue
* Identify your strengths and vulnerabilities and the other side's strengths and vulnerabilities
* Avoid antagonizing the other side and harming your cause

The Process and the Players

* Determine who the real decision-makers are at the insurance company or regulator's office
* Understand their culture and earn their respect and trust

Contract Design

* Discover how insurance companies design their contracts, and the oversight role of regulators
* Focus on the contract provisions that most directly affect your practice
* Determine your leverage and use it to maximum advantage

Outcomes

* Remove the obstacles that may be stalling negotiations
* Know when you're leaving money on the table, and when to walk away from a negotiation
* Reach your goals while creating good relationships with insurance companies and regulators

Who Should Attend

Physicians and practice managers responsible for health insurance contracts and accounts receivable should participate in this important program.

The presenters will be Jeff Coopersmith, former Chief Counsel and Director of Enforcement at the Office of the Insurance Commissioner. He now heads Coopersmith Health Law Group, a law firm devoted exclusively to representing physicians, hospitals and individuals in their dealings with the health insurance industry and industry regulators; and Dwight Johnson, former Director of Provider Contracting for Regence BlueShield. He now directs provider contracting at Coopersmith Health Law Group.

The seminar is from 12:30 - 4:30 pm, **Friday, September 22**, La Quinta Inn & Conference Center, 1425 East 27th Street, Tacoma.

To register on-line go to www.wsma.org/memresources/seminars.html. Questions? Contact Beth Chapman by phone at 1-800-552-0612 or via e-mail at bkc@wsma.orgs. Cost for WSMA or WSMGA members is $149 per person, and may sponsor staff in the same practice for the member rate. Group discounts are available.

You can register On-Line on the WSMA's web site at http://wsma.org/memresources/seminars.html or by calling Beth Chapman at the WSMA, 1-800-552-0612.

In Our Opinions

by Len Alenick MD, Ken Feucht MD, Ron Morris MD and Jeff Nacht, 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.*

Should PCMS continue unification with the WSMA?

Editor's Note: For the last couple months, your Board of Trustees have been discussing the advantages and disadvantages of being a unified county society with the Washington State Medical Association. Unification means that to belong to one of the organizations, membership in the other is required. The consensus was to learn more about the issue, present these pro and con statements to the membership and solicit feedback, then regroup for a closer examination.

Counties that have staff or some organized semblance of a medical society that are unified include: Kitsap, Kittitas, Okanogan, Pierce, Snohomish, Spokane, Stevens, Thurston-Mason, Walla Walla, Whatcom and Yakima.

Counties that are not unified include Benton/Franklin, Chelan Douglas, Clark, King and Skagit Island. Both Whatcom and Yakima recently considered disunifying but their memberships said no. Snohomish and Thurston Mason both voted to unify in recent years. The largest county in the state, King, is not unified.

Please be sure and make your opinion on unification known by calling the medical society office, 253-572-3667 or by talking to one of your elected PCMS board members or WSMA representatives (they are listed in the masthead on page 2). The issue will again be addressed at the September Board of Trustee meeting where next steps will be decided.

Supporting unification

Our combined 40 years of experience on the local, state and national levels in specialty organizations and 29 years at the local, state and national levels in geographic organizations have taught us several things which directly relate to the importance of unification.

The greatest comfort and agreement on issues occurs with local people in one's own specialty which is the county specialty society. Slightly less comfortable is PCMS because different specialties see issues differently. Third is the state specialty society because different parts of the state may have unique issues. Fourth is WSMA which increases diversity by combining the geographic variable with the specialty variable. Fifth is the national specialty society which magnifies the geographic variable. The least comfort and agreement is the AMA which maximizes both geographic and specialty variables.

Len Alenick, MD

Ron Morris, MD

Experience has taught us that physicians need all six organizations. The camaraderie and nearness of a PCMS makes it ideal for local issues, CME and moral support.

Physician licensure and regulation is a state issue. It is

See "Unify" page 10

Supporting disunification

Medical societies were founded to further the art and science of medicine but over the years have shifted into becoming political entities. The WSMA is no exception. As a political entity, the WSMA should behave democratically, yet does not.

Consider:

1) WSMA leadership is not democratically elected.

2) WSMA Bylaws gives King County additional trustees, defying any sense of democracy.

3) WSMA often conceals activities and opinions from the general membership for political reasons.

The PCMS is currently a "unified" society which means you must belong to the WSMA in order to belong to the PCMS. Not every county society in this state is unified, the most significant disunified group is the King County Medical Society.

Ken Feucht, MD

Jeff Nacht, MD

Objections to disunification are easily countered:

1. A small loss of revenues from the WSMA could easily be replaced by an equivalent increase in PCMS dues from non-WSMA members.

2. There is a concern that the WSMA voice in Olympia

See "Disunify" page 10

Applicants for Membership

Clifton T. Baylor, MD
Pulmonary Disease/Critical Care
Pulmonary Consultants
316 ML King Jr Way #401, Tacoma
253-572-5140
Med School: University of Kansas
Intership: Kansas University Med Ctr
Residency: Kansas University Med Ctr
Fellowship: Tulane University Med Ctr

David M. Christensen, MD
Pediatrics
Mary Bridge Children's Hospital
311 South L Street, Tacoma
253-403-1453
Med School: Creighton University
Internship: Stanford University
Residency: Stanford University

Kathleen M. Manning, MD
General Surgery
Sound Surgical Associates
1322 - 3rd St SE #220, Puyallup
253-697-4140
Med School: Boston University
Internship: Stanford University
Residency: Stanford University
Fellowship: UC San Francisco

Carol Sarner, MD
Ob/Gyn
Pearl Place Women's Care
6002 N Westgate Blvd #230, Tacoma
253-761-2244
Med School: UC Irvine
Internship: Kaiser Permanente
Residency: Kaiser Permanente

Roberta Yoshimura, PA-C
Family Practice
Community Health Care
134 - 188th St S, Spanaway
253-847-2304
Training: Union College

John T. Verrilli, MD
Pulmonary Disease/Critical Care
Pulmonary Consultants
316 ML King Jr Way #401, Tacoma
253-572-5140
Med School: Albert Einstein
Internship: UC San Diego
Residency: UC San Diego
Fellowship: UC San Diego

Pierce County Medical Society

presents

MAGGIE HOOD, MD; FAAP

Pediatric Hospitalist; Mary Bridge Children's Hospital

sharing her Sri Lanka experiences

"Saving the World One Vitamin at a Time"

- one of the most rewarding 'travel trips' you will take -

- The "humanism" of participating in complex humanitarian emergencies
  - Meeting the needs of humans when nothing else matters
- The real life experiences in disaster relief / a different kind of medicine
  - Snapshots of Hurricane Katrina and wildfires in California

September General Membership Meeting

Tuesday, September 12, 2006 - *Social Hour* - 6pm; *Dinner* - 6:30 pm; *Program* - 7:00 pm

Landmark Convention Center - 47 Saint Helens Avenue, Tacoma (Roof Garden)

also on the agenda:

Nominating Committee Selections

- Selection of 4 at-large members to join the Executive Committee to form the 2007 Nominating Committee
- A Nominating Committee commitment entails ONE, one-hour meeting in early October
- The Nominating Committee serves to nominate candidates for 2007 trustee and officer positions

Register by phone, 253-572-3667, fax 253-572-2470, or mail to PCMS, 223 Tacoma Ave South, Tacoma WA 98402

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

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

☐ Visa ☐ MasterCard ☐ Am Express Expiration Date: _____ Signature: _____

Name: (please print or stamp) _____

Spouse/Guest(s) name for name tag: _____

To guarantee dinner, registration helpful by Friday, September 8. Thank you!

The parking lot across the street charges $3, but there is usually ample street parking at no charge

Physician income not keeping pace

By Damon Adams, reprinted from AMNews, July 24/31, 2006.

A new study on physician income won't help family physician leaders who are struggling to interest more medical students in their specialty instead of higher-paying ones.

The average net income for primary care physicians, after adjusting for inflation, declined 10% from 1995 to 2003 to $121,262, according to a national study by the Center for Studying Health System Change. The average adjusted net income for medical specialists slipped 2% to $175,011 during the same period.

"How do you blame a medical student [for not choosing family medicine] when they come out with this huge debt, the work effort and a reimbursement system that works against them?" said Rick Kellerman, MD, president-elect of the American Academy of Family Physicians.

Dr. Kellerman and other physician leaders said the study, released in late June, reflects what they are seeing: Income is sliding.

The study said the average net income adjusted for inflation for all physicians dropped 7% from 1995 to 2003, the last year studied in the survey. In contrast, income for non-physician professionals increased 7% during that time.

Yet medicine remains one of the best-paid professions, according to the study based on surveys of more than 6,600 physicians. At least half of all patient care physicians earned more than $170,000 in 2003, and the physician average net income was about $203,000.

Surgical specialists were the highest-earning physicians, with an average income of about $272,000. Strong growth in tests and procedures partly explained why medical specialists saw incomes grow at a faster rate than primary care physicians, who rely more on evaluation and management of patients to generate revenue, the study said.

The study also found that physicians are spending more time on direct patient care than they did in the mid-1990s. Physicians are moving into larger practices where more administrative staff and information technology allow doctors to spend less time on billing and other office tasks.

"Some of the management tasks physicians might have done are now being done by nonphysicians," said Paul B. Ginsburg, PhD, co-author of the study and president of the Center for Studying Health System Change.

Low reimbursements hurting income

Researchers said declining or flat fees from public and private payers were largely responsible for income declines. Medicare payment rate increases for physician services were 13% from 1995 to 2003 while inflation increased 21%, the study said.

Dr. Wilson said the government plans to cut Medicare

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The Health Status of Pierce County

Federico Cruz-Uribe, MD, MPH
Director of Health

Bacterial contamination found in oysters can lead to illness

A sporadic bacterial outbreak in Puget Sound has sickened several people across the state.

The bacteria, *Vibrio parahaemoly-ticus,* are found primarily in oysters but can infect other shellfish as well. The Washington State Department of Health tests samples for the bacteria each year from May to October. The samples show sporadic bacterial contamination in shellfish throughout South Puget Sound, Hood Canal and Willapa Bay.

Vibrio causes a variety of symptoms including diarrhea, abdominal cramps, nausea, vomiting, headache, fever, and chills. The symptoms usually appear about 12 hours after eating infected shellfish but can occur anywhere from 2 to 48 hours after consumption. The illness is usually mild to moderate and lasts for 2 to 7 days.

Thorough cooking will kill the bacteria and leave the shellfish safe to eat. The risk comes from eating raw shellfish, especially oysters.

During warm weather months the risk of infection by *Vibrio parahaemo-lyticus* is increased and shellfish should be thoroughly cooked to prevent illness, including shellfish purchased at the supermarket.

Shellfish currently on the market should be safe to eat, provided that they have been kept refrigerated or iced after purchase and are thoroughly cooked to 145° F.

The Office of Food Safety and Shellfish will continue to monitor bacteria levels in oysters throughout the warm weather months.

While many people think it's great to slurp a fresh oyster, they can expose themselves to a variety of health risks. **Shellfish currently on the market should be safe to eat, provided that they have been kept refrigerated or iced after purchase and are thoroughly cooked to 145° F.**

The general public should look at notification of closure for marinas and recreational beaches by checking the department's Biotoxin Web site (http://www.doh.wa.gov/ehp/sf/biotoxin.htm) or the biotoxin hotline at 1-800-562-5632. Harvesters should also look for and obey warning signs that have been posted at marinas and recreational beaches. ■

Disunify from page 5

will be diminished. However, consider that at present, if the WSMA is not representing your interests or disagrees with your representative PCMS Board of Trustees, then the PMCS Board has no choice but to support the WSMA position.

If we disunify, you will have the opportunity to choose to be a member of the WSMA, regardless of your PCMS membership status. We belong to the PCMS because they have done an excellent job of promoting educational conferences and membership meetings that generate professional interchange, while avoiding political controversy. The Board of Trustees, elected by our membership, answers only to its members and represents us with an understanding of local issues and local opinions. It would be preferable if physicians in Pierce County had the same ability to choose who represents them as physicians in King County do, and to be able to belong to the PCMS without being required to join the WSMA.■

Unify from page 5

vital to have a strong organization at the state level to set policy and ethical standards for the medical profession plus represent you to government which creates the spider web within which we are allowed to practice. WSMA is physician driven and patient focused in legislative advocacy, CME, practice development, performance improvement, and representational efforts. If there were no WSMA, the county societies would have to create it.

With Medicare, Medicaid, FDA and numerous other national issues where the federal government influences our ability to practice, the same can be said for the value of AMA in relation to WSMA. Unfortunately, AMA gets the least respect for your membership dollars.

Unification is good for both organizations and cements the shared goals in representing you. Our experience strongly supports maintaining unification.■

In My Opinion

by Kenneth Feucht, 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.

My best friend Arthur

Kenneth Feucht, MD

His name isn't really Arthur, but he's a real person. Arthur's portrait hangs in my office as one of the most prominent framed images on the walls; below that of my family, but above that of all of my degrees, awards, accolades and honors.

Arthur and I met during the first days of general surgery residency at Cook County Hospital in Chicago. I had just moved to Chicago from the Northwest and was a little overwhelmed. Arthur was the resident who always seemed to know better than anybody else what was going on, and had a natural clinical sense that took the rest of us years to acquire.

He was a technical master in the operating room from his first years. His bedside manner was calming, and always reassuring to patients. Arthur became the chief resident in our last year of man's best surgical residency program, and was esteemed and respected by staff and fellow residents alike. Arthur was a super-doctor, who spent 10 years completing training after medical school, with five years of surgery residency, two years of bench research, two years of fellowship and an additional year of subspecialty (pediatric heart surgery) fellowship before he could even start practice. He was the best of the best.

Arthur and I became best friends during our research years. We worked in adjacent rooms in the animal laboratory, and while I was attempting to discover the cure for cancer through the subtleties of human tumor growth in athymic (nude) mice, Arthur was placing bunny hearts in a Langendorf apparatus to determine the mysteries as to why our hearts tick. There were many 0200 night ventures of two young Faustian scientists feverishly attempting to bleed Nature of its secrets. We maintained our sanity with long chats on religion and the meaning of life, shared with our other friend Jack Daniels, drunk out of unused test tubes from our experiments.

I eventually went on to do a fellowship in surgical oncology, and Arthur did his fellowship in pediatric heart surgery. Afterwards, Arthur acquired a position at one of the most prestigious pediatric heart centers in the South where he had a thriving practice. However, academics grew wearisome and the desire for private practice grew strong. Arthur had a streak of altruism in his blood and throughout his life he always cared for the underdog, the downtrodden and the unfortunate. His practice in Gulfport, Mississippi was at first modestly lucrative, until declining reimbursements, malpractice crisis issues, overwork exhaustion and declining referral relationships with the cardiologists began to take a toll. He found that by doing a single laser treatment of a varicose vein he could take home more bacon than by performing a high risk medicare CABG and could sleep at night without the worry of an arbitrary lawsuit. Hurricane Katrina totally devastated his home, office and practice. After the big wind, one of the only structures that survived along the coast was a roadside billboard advertising his cosmetic vein surgery center.

Arthur thought about opening up a chain of cosmetic vein centers or doing hair-transplant surgery for alopecia. Both procedures pay better than cardiac surgery. Arthur struggled for many months at coming to terms with his identity. Eventually, he settled into a job working for a hospital in the North on a start-up cardiac surgery team where he is content again. His salary is adequate, the hospital covers his malpractice, and he takes business courses at night with the hope of eventually finding some means of supporting himself and family outside of being a physician.

Arthur's dilemma typifies the crisis that faces all specialties that are dependent upon hospitals for their practice. These specialties are often associated with exceedingly long work hours which demand major night decisions and weekend call, and include the care of high risk patients that are not only high medical risk but high malpractice risk. These physicians must endure the vagaries and obligations of hospital commitments, which one cannot escape without losing their hospital practice.

Arthur realized that he was a hospital-based physician, wishing to be an office-based doctor removed from hospital

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Arthur from page 11

obligations. Being caught in Mississippi, a state (like Washington) with low reimbursement and a horrible malpractice crisis, Arthurs' altruism about caring for the poor and underserved failed to justify the headaches, hassle, absence of appreciation and grief that he had to experience. Arthur desired to do what he did best (pediatric and adult heart surgery), which few (if any) could do as well as he could. His final solution will be to change identities, using business school to offer an alternate means of support for himself and his family.

Our community is witnessing the Doc Arthur phenomenon. As an example, my general surgery practice was approached by various vendors wishing to help us start lasering veins and shifting hairlines around, in the hope of providing a cash-basis service to our patients and thus increase our revenues. These vendors were promptly escorted to the door and given a sound boot. We have seen high quality physicians succumbing to the siren sound of these vendors offering cosmetic services or selling some form of snake oil to their patients. Tricks abound. Some offices have their patients stop by the "potions and elixirs" department on their way out the door, being cajoled into buying a small, worthless, but very expensive bottle of something, purchased simply because the specialist doctor recommended it.

This is what my chiropractor friends would routinely do, and it is a shame that physicians are doing the same thing. There is actually an ongoing lawsuit in this state related to this type of hucksterism, yet this practice is done because it falls outside of the roving eye of Medicare and insurance, and thus is directly billable to patients.

It is especially a shame that the environment of medicine now so easily demoralizes physicians. Why is it that so many of us went to medical school, and then competed fiercely to get into seriously demanding residencies, only to find that we are being treated like we aren't really wanted? Why is it that we have to resort to hucksterism or gimmicks to survive in the medical world? Why is it that the current medical environment quickly becomes repulsive to those that are the brightest and best? What are we going to do about this as a medical society?

If I had a child with a surgical heart problem, I would certainly choose Arthur to operate on the child over anybody else in the world. Yet, we've lost Arthur. How many more Arthurs will we lose before we wake up? ■

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.*

Abundance and Scarcity

Andrew Statson, MD

"And having looked to Government for bread, on the very first scarcity they will turn and bite the hand that fed them."
"Thoughts and Details on Scarcity"
Edmund Burke (pub. 1800)

In May, *The News Tribune* reported two items of medical news, a developing shortage of physicians in certain specialties, and an overcrowding in the emergency rooms.

That may have been news to them, but it certainly was not news to us. We have been talking about that for several years. Yet as recently as six months earlier, the *"Tribune"* denied that shortages existed.

Of course, six months earlier we had an election, with liability reform on the ballot. Reporting such a thing then would have been an inconvenient truth for the trial lawyers. Their line was that the physicians were just whining. The lawyers saw no shortages. They didn't want people to hear about them.

Those reports were followed by the inevitable question, why doesn't somebody do something about it. Usually the somebody who is asked to do something is the government. At this point, it is also convenient to forget that the government has been doing something about it for over forty years.

The main arguments advanced during the debate on Medicare and Medicaid in the early 1960s were that many people didn't have insurance and could not afford medical care, that the country needed to do something about it, and that once Medicare and Medicaid became law, the problem would be solved. Now the arguments are the same, and the offered solution is more of the same. This time, they say, we'll fix it for good, because everybody will be covered.

Yes, of course. Unfortunately, the shortages will not go away. Or the opposite, they'll get worse, as they are in every other country with national health insurance.

The shortages will not go away because we are not addressing their cause. We have adopted the doctrine of scarcity and no matter what we do, the shortages will remain. To get rid of them, we must change our way of thinking, and adopt instead the doctrine of abundance.

Stated briefly, the avowed goal of capitalism is profit, and the inevitable result is abundance. The avowed goal of socialism is equality, and the inevitable result is scarcity.

Why is that? The main characteristic of human society is the constant interaction between its members. Perhaps the best term for this interaction is trade, but in a sense much broader than its narrow, commercial meaning.

The interaction between people brings them together in a society. We exchange goods and services, yes, but we also exchange ideas and emotions. We support and assist one another when in distress. Those exchanges are the fabric of society. They make us social creatures. They join us in a cohesive unit. Without them, we would be unconnected strangers, passing one another through space and time, without any interchange among ourselves.

Yet society is a unit. In it, through our efforts, we produce goods and services, which we exchange for the goods and services produced by others, so we can better satisfy our needs. The more we produce, the more services we make available to others, the more we get in exchange. Society increases our productivity by joint effort, specialization and mass production.

Without that interchange, our life would be much harder, our survival less assured, and our standard of living much lower. The social structure which allows us to work and to trade without encumbrances is the most able to satisfy our wants. In sum, abundance leads to wealth, and that is the natural order of things in the absence of intervention.

As Bernard Shaw worded it so nicely, "We have no more right to consume happiness without producing it than to consume wealth without producing it."

The doctrine of scarcity, on the contrary, is based on the fear of abundance and advocates intervention to put obstacles both on production and on exchange.

There are many examples of it in industry, but I'll give you just one. Workers and businesses in the garment industry have deplored the cheap cloth-

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Abundance from page 13

ing imports flooding our country. The term itself, flooding, implies disaster, as if low cost clothes were destructive, as if we were drowning in them, as if they were impoverishing us.

If the garment workers could accept that they cannot compete with foreign workers using their hands, doing the stitching, they would move to the high end of the market, and use their skills and their minds to make high quality, one-of-a-kind products. Or they could do product design, make patterns for clothes and let the less skilled workers stitch them. Instead, they call for import quotas and tariffs. In sum, they deplore abundance and advocate scarcity.

In our field, the impetus for scarcity comes in the form of quality assurance and protection of the public. Someone misreads a Pap smear, and we get CLIA. Someone discharges an unstable patient from the ER, and we get EMTALA. Now that we have them, you can rest assured that nobody will ever misread a Pap smear, or discharge an unstable patient. Hmm, . . . did I hear a giggle? Those two interventions raised costs and eliminated services. In sum, they induced scarcity.

Most of us did various tests in our offices. Performing them barely paid for the time and reagents used, but it was a convenience to patients, and usually the results were available immediately, so we could begin treating right away. CLIA raised the cost of doing the tests and they became a money-losing activity. As a result, many of us dropped at least some of the tests we had been doing.

Perhaps our tests were not as accurate as those of the laboratories. Perhaps they were not perfect, but they were convenient, and helped us treat our patients. We did not do Lexus work; we did Honda Civic work. Why should that be a problem?

As a consequence of EMTALA, a number of smaller hospitals had to close their Emergency Rooms because they couldn't afford to keep them open. Many physicians dropped from the staff of hospitals that forced them to take ER call. And now, we have overcrowding of the ERs. Fancy that!

People act in what they believe to be their best interest. They look for reasonably good services at a reasonably low price. Every roadblock on their way to exchange their services for those they want to purchase from others increases their cost, reduces the availability, and leads to scarcity.

Scarcity is the result of intervention. We will not get rid of it until we remove the roadblocks imposed on us by intervention, reject the doctrine of scarcity, and adopt instead the doctrine of abundance. ■

Income from page 8

payments to physicians 37% over the next nine years, but the cost of caring for patients is expected to rise at least 22%. He said the cuts, combined with sliding physician incomes, paint a troubling picture of future patient care.

The makeup of the physician population changed between 1995 and 2003, with the proportion of medical specialists up from 32% to 38%. The proportion of primary care physicians and surgical specialists each dropped by about 3%.

The study and hiring experts say many physicians are showing preferences for specialties that provide better control over work hours.

"A lot of our doctors are saying, 'I want to watch my children grow up,' " said Kurt Mosley, vice president of business development for national physician search firm Merritt, Hawkins & Associates.

But there are encouraging signs for primary care doctors. From 2003 to 2004,

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Physicians and School Nurses support new "Asthma" treatment form

Editor's Note: A copy of the form is inserted in this month's edition of the Bulletin and may be copied, distributed and used. It can also be downloaded at pcmswa.org/pdfs/FORM Asthma.doc

There has been a groundswell of cheers over the new "Healthcare Provider Medication Request and Treatment Plan for Asthma" form recently released by the Pierce County Medical Society's Public Health School Health Committee.

The form stems from the new asthma legislation RCS 28A.210.370, which states that for students to self-administer medications at school, the health care practitioner will

- Prescribe the medication for use by the student during school hours and instruct the student in the correct and responsible use of the medication.
- Formulate a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours.

The plan must also be signed by the parent or guardian and kept on file at the school.

The Committee, chaired by pediatrician **Sumner Schoenike, MD** worked in earnest to devise a new, one page form that would fulfill all the requirements of the new law and hopefully improve communication and coordination for those involved in the child's health care, i.e. parents, physician and the school nurse.

Special recognition must be given to Carol Jones, RN, MS, Lead School Nurse at Peninsula School District for proposing the idea to the committee and drafting the form with the help of Shirley Carstens and **Art Vegh, MD**. Special thanks is also owed to **Dr. David Ricker**, pediatric pulmonologist, and Wendy Parsons from Mary Bridge for meeting with the committee and providing valuable input. ■

Health care workers should be immunized

The Advisory Committee on Immunization Practices (ACIP) strongly recommends that all health care workers be immunized against:

- Influenza - a flu shot every year.
- Hepatitis B
- Measles, mumps and rubella
- Tetanus, Diphtheria, and pertussis. There is a new vaccine available that protects against tetanus, diphtheria, and pertussis. The Tdap vaccine should replace one tetanus and diphtheria (Td) booster shot. This is a provisional recommendation, which becomes final when it is published in the CDC *MMWR*. (http://www.cdc.gov/mmwr/CDC.)
- Hepatitis A
- Meningococcal vaccination

Most of these immunizations have been recommended for almost ten years, but the Centers for Disease Control reports that only 36% of health care professionals get their flu shots.

Model good health choices for your patients and co-workers - get your immunizations!

For more information on immunizations for health care professionals, visit www.cdc.gov/nip or call 1-800-CDC-INFO. For information about specific vaccines or diseases, visit www.cdc.gov/nip/menus/vaccines.htm. ■

To contact a person for more information or assistance, email Nicole Pender at Nicole.Pender@DOH.WA.GOV. Ms. Pender is an adult and adolescent immunization coordinator for the immunization program CHILD Profile with the Department of Health.

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

SAVE THE DATES

Fall programs scheduled; annual calendar due out in August

Common Office Problems, Oct 13

The College's *Common Office Problems* CME has been scheduled for Friday, October 13, 2006, Fircrest Golf Club.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the medical practice.

Look for the registration brochure in the mail early September. ■

Infectious Diseases Update set for Nov 10

The annual *Infectious Diseases Update* is set for Friday, November 10, 2006 at the Fircrest Golf Club.

The program features nationally recognized authorities as well as our own infectious disease specialists and is hosted by the physicians of Infections Limited, who are: **Marina Arbuck, MD**; **Philip Craven, MD**; **Elizabeth Lien, MD**; **David McEniry, MD**; **Peter Marsh, MD**; and **Lawrence Schwartz, MD**.

Watch for a program brochure to arrive by mail in early October. ■

CME at Whistler set for Jan 24-27, make plans now!

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 24th to the 27th, 2007.

Reservation for the program's condos can be made by calling Aspens on Blackcomb, toll free at 1-877-676-6767. You must identify yourself as part of the COME group (group # 403699).

The Whistler course is under the medical direction of **John Jiganti, MD**. ■

Income from page 15

family physicians saw a 2% rise in median compensation to $156,011, while internists had a 5% hike to $168,551, according to a survey by the Medical Group Management Assn.

Internists and family physicians were at the top of the recruitment list for hospitals and medical groups for the first time this year since the 1990s, according to a review done by Merritt, Hawkins & Associates.

Some employers are offering incentives such as signing bonuses. And some experts believe primary care physician incomes will increase because they are in demand as fewer physicians have chosen to go into family medicine or general internal medicine.

"There's such a shortage of [primary care] doctors -- anything to sweeten the deal," Mosley said. ■

Classified Advertising

POSITIONS AVAILABLE

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@sound familymedicine.com. Equal Opportunity Employer.

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 + incentive. Fax your CV to 253-847-9630.

Tacoma - Busy Family Practice seeking BC/BE PCP for family practice and OMT. Excellent opportunity with competitive salary and benefits, full or part time. No call or OB. Fax CV to (253) 759-6056 or E-Mail to topgundo@qwest.net. Phone (253) 752-6965 Office Manager, Susan.

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to *MultiCare Health System Provider Services at providerservices@ multicare.org or fax your CV to 866-264-2818. Website: www.multicare. org.* "MultiCare Health System is a drug free workplace"

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

Medical Office Space Available. Deluxe medical office space for lease. 2,500 to 21,000 square feet available. Excellent location, walking distance to Good Samaritan Hospital in the Master plan campus. Custom tenant improvements built to suit your needs. Site development work has begun - construction starts summer 2006. For more information please contact Roger Meyer, Crescent Realty, Inc. at 253-370-0286 or email rammayer@comcast.net.

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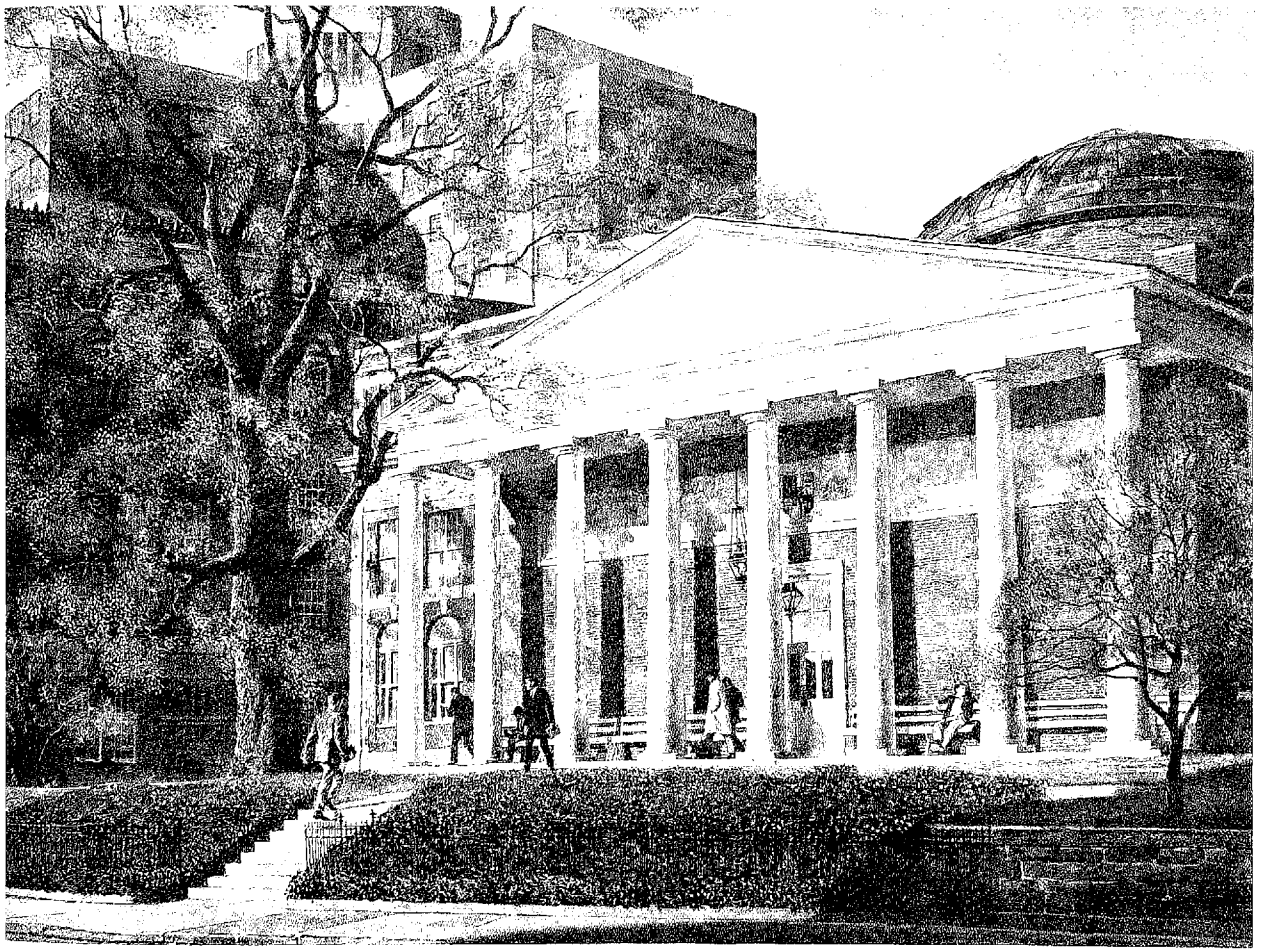
BULLETIN

September, 2006



University of Maryland School of Medicine

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

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Pierce County Medical Society

BULLETIN

September, 2006

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President's Page

by Joseph F. Jasper, MD

Pierce County – A Healthcare Community of Excellence

Joseph F. Jasper, MD

I thought I had arrived in medical training heaven. That was 25 years ago when I began training at Tacoma Family Medicine. I quickly discovered that our community has excellent primary care and specialty physicians with tertiary care and community facilities. With no other residents to teach, these experts lavished FP residents with teaching and mentorship. Today, I find Pierce County to be capable of fulfilling the needs of our patients' expert care needs. I tap into the best care available right here. I hope you do too.

The primary care we offer in Pierce County is marvelous. Our specialty experts are well credentialed and highly competent. For example:

- Coronary bypass, or valve replacement; coronary stent or aberrant conduction path ablation. Rapid assessment and intervention of acute myocardial infarction
- Brain surgery or gamma knife
- Cancer surgery, Oncology, Nuclear Medicine
- Spine decompression, fusion, or reconstruction and Interventional Pain
- Complex & routine orthopedic care
- Trauma care
- Pediatric surgery or ICU
- Electrodiagnostics and Physical Rehabilitation
- High Risk OB and Neonatal Intensive Care

These add to the long standing Pierce County excellence in Pulmonology, Neurology, Cardiology, Obstetrics & Gynecology, ENT, Ophthalmology, Dermatology, Endocrinology, Rheumatology, Gastroenterology, Nephrology, Urology, Vascular Surgery and Infectious Diseases.

Part of the perception of wellness for our patients will be through the convenience of care near home and the ability of family and friends to support them. This is all better accomplished in Pierce County rather than 45 minutes away.

We should be using our local resources. Increased frequency of referrals to local experts will increase their experience and quality of care. It is time to dispel the belief that Seattle provides better healthcare than is available here. The only exceptions are major burns, transplants, and limb reattachments. **Up to 30% of specialty care is unnecessarily sent to Seattle**. We have the power to change this by our referrals and our counseling of patients. I feel confident in our healthcare in Pierce County and hope that you are all proud of your excellence and that of your colleagues. ■

Americans may get medical money's worth

Excerpted from the Associated Press, Aug 30, 2007

Despite exploding costs, most Americans got sizable life-extending bang for their medical bucks over recent decades, says one of the most sweeping studies ever of health-care value.

That might come as a surprise to anyone who has ever shuddered over a medical bill, and the report itself raises doubts over how quickly costs have escalated.

The study calculated that Americans of all ages spent an average of $19,900 on medical care for each extra year of life expectancy gained over the last four decades of the 20th century. And that cost is worth it, the study authors say.

"On average, the return is very high," concludes leader David Cutler, a Harvard University health economist. "But it's getting worse for ... in particular, the elderly."

The federally funded study by researchers at Harvard and the University of Michigan has been published in the *New England Journal of Medicine*.

The researchers measured value by the cost of care that extends the average person's life by one year. The $19,900 spent for each extra year of life averaged over 40 years, would be widely considered a reasonable value. Many public and private insurers routinely pay for treatments that cost up to roughly $100,000 for each additional year of life.

The researchers attribute this relatively low cost for longer lifespan to things like cheap blood-pressure drugs that prevent heart attacks.

However, the study also outlines disquieting trends. It finds that inflation-adjusted costs from birth rose fivefold between the 1970s and 1990s, when the cost of an additional year of life span peaked at $36,300. That means each health care dollar of the 1990s, when expensive drugs made modest impact on

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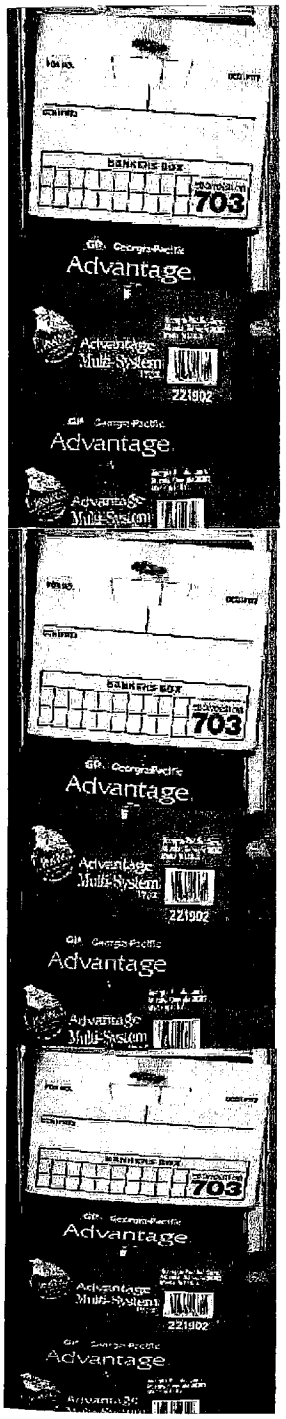
What To Do With Old Records!



- Store them in the backroom or basement?
- Store them at your home or garage?
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A Better Solution

We scan your patient's old records, convert them to PDF files, alphabetize for easy retrieval, and store them on USB external hard drives (an original and a backup).

1. Eliminates storage cost and inconvenience.
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6. Frees up office and storage space.

When you need to retrieve a patient record, simply plug the USB external hard drive into your computer's USB port. Immediately view the patient record and print what you need.

Which way would you rather have your patient records stored?

For a better storage solution…
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Garry Stutz
253.875.7995

Coalition for Healthy Active Medical Professionals

CHAMP

Pierce County Medical Society

METROPARKS TACOMA

PHYSICIANS AND MEDICAL PROFESSIONALS including office staff and families!

3(5K)MILE FUN Walk/RUN

Saturday, September 30th
9:00 AM
Pt. Defiance Park — Ft. Nisqually

BE AN EXAMPLE FOR THE COMMUNITY THAT EXERCISE IS MEDICINE: HAVE FUN IMPROVING YOUR LIFE
HAVE EVEN MORE FUN AND PARTICIPATE WITH YOUR CLINIC/PRACTICE AS A GROUP

This fun event will be a celebration of healthy lifestyles and will promote healthy people, families, workplaces and communities. Please join us for a new start or continuation of a healthier life, including improved fitness

Please join with your work colleagues, your family members, your friends or come to meet new ones at the 3 mile fun walk/run for health and wellness. REGISTER YOUR CLINIC AS A GROUP!!

The course will begin at Ft. Nisqually and head through a scenic section of 5 mile drive, (closed to cars), and back to the Fort

This is a NON-scored event; however, times will be called at water stops along the route

This event is offered at no cost due to the sponsorship of Pierce County Medical Society and Metro Parks Tacoma

— WE LOOK FORWARD TO SEEING YOU!!! CALL PCMS FOR MORE INFORMATION, 253-572-3666 —

Registration Form Yes, please register me for the 3 mile fun walk/run for health and wellness at NO COST:

Name (please print) _____ Phone number: _____

I will be participating with a group (clinic, family, other), with the group name: _____
(all names may be faxed in on one sheet, if preferred)

YES, I would like to order a COOLMAX T-SHIRT with a CHAMP logo, at a fantastic price of $10 per shirt. Size: S M L XL

☐ I will pick up and pay for my shirt on event day (unless I pick it up at the PCMS office prior)
☐ I will mail my check and this form to PCMS, 223 Tacoma Avenue South, Tacoma WA 98402 (checks payable to PCMS)
Please FAX your registration form to PCMS 253-572-2470 (Call PCMS for any special arrangements prior to event day, 253-572-3667)

Medicare Physician Payment Reform

If Congress fails to act before they adjourn in October, Medicare will cut physician payments by about 5 percent on January 1, 2007, with cuts totaling as much as 37 percent through 2015. And while physician payments plummet, practice costs during the same period are expected to increase 22 percent. These cuts make no sense as millions of Baby Boomers begin to retire.

In Washington State, from 2007-2015, Medicare payments will be cut by $2.92 billion, with the first one in 2007 totaling $46 million. For individual physicians this means $18,000 per year. Data from the Bureau of Labor Statistics show that these payment cuts will have an impact on 56,791 employees in Washington.

Congress recently passed legislation reversing the physician payment cut of 4.4 percent that went into effect on Jan. 1, 2006, and setting the Medicare conversion factor at its 2005 level. Although payment rates for some localities and services are higher or lower than in 2005 due to geographic adjustments and other payment policies outlined in the 2006 Medicare physician payment schedule final rule, the legislation reversed the across-the-board cut due to the fatally flawed payment update formula.

The 2006 Medicare Trustees report forecasts a cut of about 5 percent in 2007 and cumulative cuts of more than a third by 2015. Clearly, the Medicare physician payment update system needs to be reformed. If it is not, Medicare payment rates in 2007 will have fallen 20 percent below increases in physicians costs since 2001.

Physician payment updates are driven by a flawed formula called the Sustainable Growth Rate, or SGR. Instead of the SGR, payment updates should be based on annual increases in practice costs, as recommended by the Medicare Payment Advisory Commission.

See "Medicare" page 12

Applicants for Membership

Salah N. Almohammed, MD
Pediatrics
Puyallup Valley Pediatrics
1322 - 3rd St SE #240, Puyallup
253-848-1572
Med School: Jordan University
Internship: JHS Jr Hospital of Cook Cty
Residency: JHS Jr Hospital of Cook Cty

Sibel Blau, MD
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Med School: Cerrah Pasa
Internship: Metro Health Medical Center
Residency: Metro Health Medical Center
Fellowship: Case Western Reserve Hosp
Addl. Training: Fred Hutchinson Cancer Research Center

Imelda D. DeVilla, MD
Internal Medicine/Geriatrics
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: Univ of Santo Tomas
Internship: Temple University/ Conemaugh Memorial Medical Center
Residency: Temple University/ Conemaugh Memorial Medical Center
Fellowship: University of New Mexico

Mark L. Hancer, PA-C
Tacoma Digestive Disease Center
1112 Sixth Ave #200, Tacoma
253-272-8664
Training: USC, Los Angeles

Paul T. Inouye, MD
General Surgery
Trauma Trust
315 Martin L King Jr Way, Tacoma
253-403-7537
Med School: George Washington Univ
Internship: Oregon Health Sciences Univ
Residency: Episcopal Hospital, PA
Fellowship: UMD, New Jersey

Xinsheng Micheal Liao, MD, PhD
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Med School: West China University
Internship: Roger Williams Hospital
Residency: Roger Williams Hospital
Fellowship: Fred Hutchinson Cancer Research Center

Gavind H. Niamatali, MD
Internal Medicine/Geriatrics
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: National Univ of Ireland
Internship: Conemaugh Mem Med Ctr
Residency: Conemaugh Mem Med Ctr

Kyung W. Noh, MD
Gastroenterology
Tacoma Digestive Disease Center
1112 Sixth Ave #200, Tacoma
253-272-8664
Med School: New Jersey Medical School
Internship: Mayo Clinic
Residency: Mayo Clinic

Robert D. McCroskey, MD
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Med School: University of Washington
Residency: Maine Medical Center
Fellowship: Univ of Wisconsin Hospital
Addl. Training: Univ of British Columbia

Daniel J. Moore, MD
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Med School: University of Texas SW
Internship: University of Texas SW
Residency: University of Texas SW
Fellowship: Georgetown Univ Hospital

Nanette G. Robinson, MD
Int Med/Hem/Onc
Rainier Oncology Professional Services
222 - 2nd St NE #B, Auburn
253-887-9333
Med School: McGill University
Internship: Indian University
Residency: Indiana University
Fellowship: University of Washington

Andrea L. Rose, MD
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Med School: University of Minnesota
Internship: Mt. Sinai Hospital
Residency: Mt. Sinai Hospital
Fellowship: Fred Hutchinson Cancer Research Center

Culbert M. Serrano, MD
Internal Medicine/Geriatrics
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Med School: USUHS, New York
Internship: Madigan AMC
Residency: Madigan AMC

Betty L. Stewart, PA-C
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Training: University of Washington

Sheri L. Wages, PA-C
Int Med/Hem/Onc
Rainier Oncology Professional Services
400 - 15th Ave SE #D, Puyallup
253-841-4296
Training: Rutgers University

Bicycle riders pedal 162 miles in Courage Classic

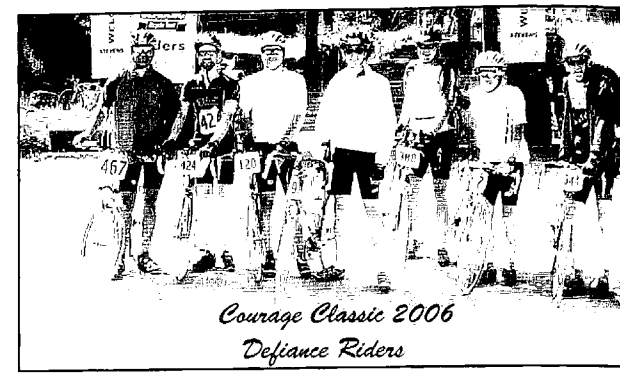
PCMS bicycle riders pedaled 162 miles over three mountain passes participating in the 2006 Courage Classic bicycle ride. The three day ride takes participants through Snoqualmie, Blewett and Stevens Passes. Rotary Clubs of Pierce County provide rest stops that provide food, drinks and other energy replacement every 15-20 miles along the way.

Beginning at North Bend over Snoqualmie Pass with an elevation of 3,022 to CleElum and on to Blewett Pass (elevation 4,102) and on to Leavenworth before heading to Stevens Pass (elevation 4,061), the 162 miles encompasses rolling hills, wheat fields, orchards, cliffs and some very steep terrain.

Pictures at right include PCMS members **Drs. Mark Craddock, Don Shrewsbury, Henry Retailliau** and **Harald Schoeppner**.

The Courage Classic benefits the Mary Bridge Children's Hospital and the Children's Trust Foundation as participants must raise a minimum of $400 to participate. Most raise much more however, realizing they are doing it for the kids!

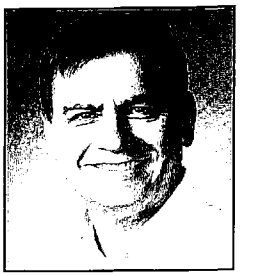
Next year's ride is scheduled for August 4-6, 2007 and those interested in preparing for next year's ride can visit the MultiCare Courage Classic website for early training and fundraising tips and can also register to participate.■



The Health Status of Pierce County

Federico Cruz-Uribe, MD, MPH
Director of Health

Creating a Healthy System



Federico Cruz-Uribe, MD

We are coming to a time for making decisions on the future shape of medicine. And of course no one has invited us, the medical providers, to the table. Maybe we've been too passive in the past, content to stand on the sidelines and critique the myriad of changes that have already taken place in medicine over the last twenty years. We haven't liked most of what we have seen: the bureaucratization of medicine; special interest groups controlling the central processes of medicine. We as physicians are often left to complain, sometimes in a principled manner and often just to grouse, as we have little influence on how things are going.

I have watched the health care debacle develop over the years and have waited to see if the feds or state would step forward to address the core issues. Sadly they have not. It is too difficult and feels too risky politically. The competing interests of their constituents have created a massive log-jam at both the federal and state levels. So they play around the edges making minor modifications to an obviously failing system.

We cannot change the power relationships based on money that abound in the health care field. Those in hospital systems, insurance companies, pharmaceuticals, and medical equipment manufacturing sit in a very different position than those of us on the patient care side. In the state/federal government debate about health care, elected officials address the needs of the constituencies that brought them into office; that constituent group does not include physicians in general. Controlling costs and protecting/rewarding friends are the drivers for the forces at play. Decision-makers receive continued pressure to curb expenditures. As a result, we see consistently dropping reimbursement rates.

I feel like I am on a bus that I need to get off of. I need to pull the cord and step off.

As your Public Health Director, I readily acknowledge that I work in the government-driven part of the health care system. But officials also ignore public health and fund us at pauper levels. When I look at how our government spends its health dollars, I am appalled, but felt I lacked levers to push for change. Politicians neither understand prevention nor are they connected to it in any substantive way. Their mental models involve disease and the care of people so afflicted.

The current vision of healthcare leaves providers, the public (both those served and those not served by the system) and payers (private business and government) deeply dissatisfied.

Sometimes hope comes in the form of mutual agreement about how hopeless everything looks. We may have reached the bottom together, which suggests there could be some good news in front of us. Health care has become so problematic that the existing system has failed all the key groups involved in health care. Can these groups come together and look to promote system change?

I think the answer is "yes," but at what level? State and federal governments drive health decisions and locals deliver the care. Can we on a local level influence the federal and state decision makers? Yes, through concerted efforts. Our community is truly where the rubber meets the road in health care and I see signs that local officials want to make changes.

Recently I went through a strategic planning process with the Tacoma/Pierce County Board of Health. We looked at those issues most affecting the health status of our community.

One of the top issues was access to effective care. After much discussion, centered on how much our little agency could impact the goliath of local, state and federal driven health care, it became apparent that access to effective care constituted the priority of the department. We realized we could not address the issues of chronic and/or communicable disease prevention without having a truly effective local care system.

We committed as an agency to take on this issue. The goal is not to study it and produce one more report but to position our community to actually change the health care system in Pierce County. We have hired a new

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System from page 9

manager at the department and are preparing to do the epidemiology of health care in Pierce County, asking:

- What works and what doesn't?
- Who is covered and who isn't?
- Are we getting healthier as a community?
- How much are we paying for all of this care?
- What does the public perceive as their health care needs and how does this match up to their actual needs?
- Who should be covered?
- How should health care be paid for?

I invite you as physician providers to join with the health department as we jump into this issue. There currently is no consensus around what to do about our health care morass. Please join me in trying to build that accord in Pierce County, and then to work together to create a much more effective system.■

Physicians victorious in medical staff court decision

With the AMA's help, the medical staff at a Georgia hospital recently won an important victory in court for physicians and their patients.

The Georgia Court of Appeals upheld a temporary injunction that restores the clinical privileges of 12 cardiologists on staff at Satilla Regional Medical Center, a ruling that defends the sanctity of medical staff bylaws and demonstrates the importance of attention to detail when drafting those bylaws. The AMA Litigation Center joined the Medical Association of Georgia in providing legal support to a group of cardiologists who were part of the hospital's affiliate medical staff.

At issue was whether a hospital can "close" its cardiology department without authorization to do so in the medical staff bylaws. After the hospital and the full-time cardiologists were unable to negotiate a suitable financial arrangement for expanding Satilla's cardiology services, the hospital entered into an exclusive contract for cardiology services with a group of physicians from Jacksonville, Florida.

After signing the contract, the hospital attempted to revoke the privileges of first the two full-time cardiologists and subsequently the ten affiliate medical staff cardiologists. This attempted revocation violates the medical staff bylaws and was opposed by the overwhelming majority of the medical staff. The cardiologists about to be terminated sought and were granted an injunction allowing them to retain their privileges, but the hospital then adopted a resolution stating that the cardiologists could not use the hospital's facilities. Essentially, the hospital attempted to evade the court's injunction.

In two separate lawsuits, the active staff cardiologists and the affiliate staff cardiologists secured temporary injunctions to defeat the hospital's ploy and retain their privileges while awaiting the case's outcome. On June 23, the Georgia Court of Appeals affirmed the injunctions.

In its decision, the court wrote that "there are no provisions in the medical staff rules and regulations that reserve the right for the hospital to automatically terminate privileges in order to implement an exclusive provider contract... the resolution did far more than simply restrict existing clinical privileges - it effectively terminated them altogether."

The court also wrote that "physicians with hospital privileges have responsibilities over patient care that justify affording them certain procedural precautions that must be complied with when implementing exclusive provider contracts."■

Medicare from page 6

Other Medicare providers are not subject to the SGR. In fact, hospital payments are slated to continue to rise by more than 3 percent a year under current law and payments to Medicare Advantage plans are estimated to increase by 7.1 percent in 2007.

The results of a recent AMA survey showed that 45 percent of physicians will either stop accepting or decrease the number of new Medicare patients they accept if Medicare payments are cut in 2007, seriously affecting access to care for America's seniors.

Take Action! Please take a minute to e-mail your Senators and Representative by composing a message to them now. Tell Congress to: (1) increase Medicare physician payments by 2.8 percent in 2007, and (2) replace Medicare's flawed payment formula with one that reflects increases in physician practice costs. ■

Reprinted from AMNews, August 28, 2007

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.

Patient Power

Andrew Statson, MD

"The market economy capitalism is a social system of consumer supremacy."
In "Money, Method and the Market Process"
Ludwig von Mises

Finally, our venerable elders at the Institute of Medicine concurred that patients should have some responsibility for their medical care. That came about in reference to their study of medication errors. They called it a paradigm shift, and to them it must be one.

Allow me to quote from their "Brief Report":

"The first step is to allow and encourage patients to take a more active role in their own medical care. In the past the nation's health care system has generally been paternalistic and provider-centric, and patients have not been expected to be involved in the process. But one of the most effective ways to reduce medication errors, the report concludes, is to move toward a model of health care where there is more of a partnership between the patients and the health care providers. Patients should understand more about their medications, and take more responsibility for monitoring those medications, while providers should take steps to educate, consult with, and listen to the patients."

Of course, the IOM still calls for additional government funding of more studies, for additional regulation, and for special accreditation in medication management, but allowing the patients to take a more active role in their own medical care is a big step away from their usual position that patients are passive recipients of care, that we do things to them they frequently don't want and probably do not need, and that when something bad happens, it has to be our fault.

Let us hope that this is the first of many steps that will take us away from our current trust in a paternalistic, omniscient, omnipotent and infallible government intervention.

According to estimates quoted by the report, at any one time about 80% of the adults take some kind of prescription medications, over-the-counter drugs, or dietary supplements, and 30% of the adults take five or more medications. I don't know how many billions of pharmacy purchases that implies, but considering the magnitude of that number, it should be obvious that somewhere along the line some mistakes will occur.

We in the surgical specialties don't write many prescriptions, but our colleagues in family practice and internal medicine probably write more than 500 prescriptions a week, 25,000 per year. Is an error rate of one per thousand excessive?

I am not saying that we shouldn't do everything we can to avoid mistakes, but no matter how hard we try, there will be a certain irreducible minimum, below which we cannot get.

The same is true of any kind of accident. Almost all car accidents, even in the presence of other contributory factors, can usually be traced to a human error. In our field, we hope that the pharmacists will catch our mistakes and call our attention to them, but they also are busy. They probably fill more than a hundred prescriptions during an eight hour work day. How can we expect them not to make an occasional mistake?

So we come to the last link in the medication chain -- the patient. That is where the buck stops.

Coincidentally, the August issue of *Reader's Digest* carries an article by Pamela Gallin and Joseph Vetter under the title "Gambling With Your Life." It deals with lab and imaging errors. They report a study of 120 clinical labs, which estimates that every year almost three million lab errors occur and probably more than 5% of the patients are harmed in some way. Another study estimates that 300,000 pathology specimens are misdiagnosed and 40% of these result in some harm to the patients.

Their advice to patients is to make sure the proper tests are done, and that the doctor got the result. The patients also may request a repeat test if the result is unexpected. Finally, the patients should keep copies of all their lab tests and imaging reports and should ask for another opinion if their questions are not answered to their satisfaction.

All that is very good, and it puts the final responsibility where it be-

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Patient from page 13

longs, in the patient's hands. We are not gambling with the patients' lives, but a case can be made that our medical care system is. In essence, the article is saying, "Buyer beware!"

Other recommendations involve double checking procedures in the lab, and multiple readers (at least two) of slides and scans. That will reduce the chances that something is missed. I think that most pathologists and radiologists already do such double checking on serious diagnoses, and the labs usually repeat a test that is out of line.

Two questions need to be addressed here. One is the cost. Yes, if two, or three, or five physicians reviewed every slide and scan, the chances of error will diminish, but who will pay for that? Medicare and other insurers are looking for ways to reduce payments, and certainly are not likely to increase them. But even if they did, we cannot eliminate errors completely. To pull a number out of my hat, with hundreds of millions of tests performed each year, can we reasonably expect that we can achieve an error rate of less than 1%?

The second question is about the role of the clinician in all this. When I was in training, many, many, many years ago, some of the old-timers occasionally said that all those tests are good, but when they don't fit with the clinical picture, someone will have to make the decision to treat or to abstain. Usually, that was the patient, on the advice of the clinician.

At that time, a clinician could still proceed with a treatment on a clinical basis, but how many of the physicians in practice today will dare to ignore a lab test based on their clinical judgment, even when they are convinced that it is wrong. That is because they know that their judgment might be wrong, too, and if so, nobody will back them up. They reason that if someone is going to be wrong, they would rather have it be the lab.

The purpose of all economic activity is to serve the consumers. They are the supreme arbiters of the services they get. The problem we have in our field is that even though our patients receive the services, they usually do not pay for them, or if they do, it is a token amount, not related to the value of the service. Medical consumers have no basis on which to make their purchasing decisions. Under such circumstances, the market discipline is blunted or totally obliterated.

No purchases can be made in a vacuum, and other parties have stepped in and taken over the decision-making process in the purchasing of medical services. The patients have relinquished their supremacy as consumers, and now we see the consequences.

So there we have it. In a sense, by turning over to others the financial responsibility for their medical care, the patients asked for what they got. It is now up to them to change the system if they wish. They have to reassert themselves if they want to regain control over the quality of the services they get, but that also requires them to assume the cost for their care. Do they want three physicians to read their scans, or is one enough? ■

Medical from page 4

cancer, bought a fifth as much real value as 20 years before, when cheaper medicines saved many lives.

Values deteriorated seriously for older people, the study finds. By the 1990s, 65-year-olds paid $145,000 for each additional year of life gained — a value that would be challenged for many individual treatments. These higher costs presumably come largely from end-of-life care that doesn't extend life very much.

Health policy chief Kathleen Stoll, of the advocacy group Families USA, said she believes the study suggests real value anyway. "Each increment of gain is more expensive now, but certainly very valuable to the person involved and their family," she said.

Others were troubled. "The fact that someone is writing this paper shows how desperate the health care system is to justify these out-of-control increases in health spending," said consumer advocate Dr. Sidney Wolfe, who heads health research at Public Citizen.

The researchers admit their calculations give only a partial picture of value. They started by calculating average changes in both medical spending and life expectancy for various age groups in each decade. Then they divided changes in spending by changes in life expectancy, yielding the cost per year of life gained.

But many factors extend life apart from medical care, like not smoking or keeping extra weight off. So the researchers turned to previous studies suggesting that about half of all gains in lifetime stem from medical care — and adjusted their findings accordingly.

Even the researchers acknowledge this adjustment could be off.

"It really doesn't tell you whether we are spending too much on what doesn't matter and too little on what does," said Dr. Harlan Krumholz, a cost-effectiveness expert at Yale University. Others worried about future costs. "The growth in medical spending is unsustainable over time — both in dollars and the benefits," said health care analysts. ■

COLLEGE OF MEDICAL EDUCATION

Common Office Problems set for October 13

This year's Common Office Problems CME will be held on Friday, October 13 at Fircrest Golf Club under the medical direction of **Mark Craddock, MD.**

This year's course will offer:

- Basics of Angiography
  - **Vinay Malhotra, MD**
- Helping Patients Change Behavior: Improved Treatment Adherence and Lifestyle Improvement
  - Daniel O'Connell, PhD
- Update on Contraceptives: What's Hot?
  - **John Lenihan, MD**
- Managing Falls Risks in Older Adults: Meeting the Challenge (Panel)
  - **David Munoz, MD**
  - **Jane Moore, MD**
  - **Lori Morgan, MD**
  - **Steven Teeny, MD**
- Update on Adult and Pediatric Immunizations
  - **Lawrence Schwartz, MD**
- Modern Treatment Options in Venous Disease
  - **Aksel Nordestgaard, MD**

You should have already received a registration brochure in the mail.

For more information, please call the College of Medical Education, 627-7137.

Continuing Medical Education

Dates	Program	Director(s)
Friday, October 13	Common Office Problems	Mark Craddock, MD
Friday, November 10	Infectious Diseases Update	Elizabeth Lien, MD
Wednesday-Saturday January 24-27	CME at Whistler	John Jiganti, MD Richard Tobin, MD
Friday, February 2	2007 Neurology Update	Pat Hogan, DO
Friday, March 2	Cardiology for Primary Care	Gregg Ostergren, DO
Friday, April 20	Orthopaedic/Gastroenterology 2007 Update	Nicholas Rajacich, MD John Carrougher, MD
Friday-Saturday May 11-12	Internal Medicine Review 2007	Joseph Regimbal, MD
Friday, June 8	Advances in Women's and Men's Medicine	John Lenihan, MD Loren Betteridge, MD

Classified Advertising

POSITIONS AVAILABLE

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@sound familymedicine.com. Equal Opportunity Employer.

Half-time Medical Director wanted, Steilacoom, Pierce County. Within the Department of Social and Health Services, the Special Commitment Center (SCC0 is recruiting for a Medical Director to provide medical supervision and direction to the medical/health services staff and contractors at the SCC. The SCC provides evaluation and comprehensive, rehabilitative therapy to civilly committed sexually violent predators (offenders) in a constitutionally sound environment that protects the safety and welfare of the public, staff and program residents. This position is located on McNeil Island, Steilacoom, Washington. The medical director will also provide direct medical care to individual SCC residents. This position will provide essential leadership to SCC staff who are responsible for monitoring the quality and appropriateness of medical care and other health-related services. The director will provide guidance on in-service training to SCC staff in health education and prevention services. As the chief consultant on medical care practices at the SCC, the director will oversee the agency's practices to assure current medical standards are met. For more information on this particular position and how to apply, please visit http://www1.dshs.wa.gov/hrsa/scc/Employment.htm or contact Tracy Sanford at (253) 617-6297. Applications are being accepted through October 1, 2006.

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 Paul Doty (253) 830-5450.

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Pierce County Medical Society
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Pierce County Medical Society
BULLETIN

October, 2006

PCMS representatives attend WSMA Annual Meeting in Spokane

Above from left, Drs. Ron Morris, Laurel Harris, Don Russell, Nick Rajacich, Federico Cruz, George Tanbara, Sumner Schoenike, Doris Page, Harold Boyd, Len Alenick and Patricia O'Hollaran

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

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

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Pierce County Medical Society
BULLETIN

October, 2006

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President's Page

by Joseph F. Jasper, MD

Triple Thoughts...

Joseph F. Jasper, MD

Gaul was divided in three parts, and so is this month's President's page.

Part I: Soylent Green

QUOTATION: "His pain was too great. He begged me for the simple mercy of death. And I could do nothing else but help him leave a world that had become a sleepless, tortured nightmare to him."

ATTRIBUTION: Robert D. Andrews, Screenwriter; Nick Grindé, Director; Dr. John Garth (Boris Karloff), Character. "Before I Hang" (Movie), defending himself at his murder trial (1940). Story by Andrews and Karl Brown (1897-1990).

Physician assisted suicide is again being discussed in our state, and may face another state initiative. I have been involved in some very desperate cases either related to cancer or non-cancer pain. I have been called to the bedside of a couple of hospitalized patients screaming with pain despite 50mg per hour iv morphine. I have faced patients in my office with pancreatic cancer pain with severe progressive abdominal and back pain. I have met patients with no surgical options left whose spinal pain, sciatica or headache has failed conservative treatment and aggressive medication management. Their lives are devastated by inability to socially interact, work, care for themselves or even rest. Suffering is intense. Common statements from these vulnerable people are, "I cannot go on living like this. I have suicidal thoughts. Please, do something to put me out of my misery." Fortunately, I have been able to help most of these folks find some relief and improve their quality of life. Frequently I hear from them afterward, "if you had not been able to help me I was planning to kill myself." Patients do not want to suffer; physicians and society cannot avoid this issue.

Physicians have a responsibility to heal the sick and relieve suffering. We need the tools and education to follow through with that responsibility. The better we are at relieving suffering, the less likely we will face a patient requesting assistance in committing suicide. What we do not need are barriers. A barrier to adequate pain control runs directly and abhorrently against an effort to avoid the perceived need for physician assisted suicide. Barriers do exist. As one example, Government cutbacks in reimbursement to physicians and facilities for implanted spinal drug infusions have forced most of us out of that "business" and thus access to a highly successful form of pain rescue has been severely restricted if not practically eliminated. That is the technique I employed to get the two hospitalized patients on MS drips out of the hospital and back into active lives. I'm sure similar examples exist for Oncology, Nephrology and Infectious Diseases. Formularies dictate what medications can be used and reimbursements are frequently below our costs. Regulatory boards are poised to string up a compassionate doctor for prescribing methadone when a patient dies of opioid complication. Patients, family, pharmacists, and even doctors have stigma against pain relieving medications and even some procedures.

Our charge is to provide comfort, not necessarily insist upon prolongation of life in a hopeless situation. For some patients there is no cure or they consciously choose not to cure their terminal illness. Efforts to provide comfort will sometimes hasten death, though not the intended goal. Informed consent of the patient, family and caregivers will help avoid wrongful accusations. Such treatment and outcome should not be viewed in the same light as active euthanasia. Legal protection for this humane practice seems reasonable and distinct from euthanasia, but will be difficult to enact. We count on such actions as not being investigated or as becoming easily dismissed.

The WSMA has decided to take a stance against physician assisted suicide. If this stand is to be successful, then we must be very good at providing relief.

The alternative is to have society thrust assisted suicide upon us. Seeing what payers and the government do to avoid increasing healthcare costs does make me very concerned that they may actually support assisted suicide. Soylent Green anyone?

See "Thoughts" page 4

Thoughts from page 3

Part II – Regence and Economic Credentialing

Remember my first President's Page in which I discussed key issues we face in the business and society of Medicine? One was economic credentialing. Current events – Economic Credentialing is the basis of the Regence Select panel selection. The WSMA and SPEEA (Boeing's professional engineer's union) suit filed against Regence Blue Shield of Washington. Physicians were not allowed to participate in a new plan called Regence Select. The reportedly libelous act Regence committed was to send a letter to patients stating their doctors were not only inefficient but delivered less than high quality of care. The doctors were excluded solely based upon economic claims data and not on the basis of clinical quality of care. The WSMA is handling this aggressively.

Our immediate past president, **Dr. Mike Kelly**, has stepped up to join in the suit and deserves our support, as do all the others. Those of us who know Mike appreciate that the quality of care he provides is exemplary. It was wrong for Regence to allege otherwise.

Curiously, another excellent physician switched his designation from specialist to primary care. In doing so, Regence reclassified him from being of high quality to not having enough quality to make the grade. Yet another puzzle is the doctor with offices in two counties. He is good in one county and inadequate in the other. His brain and talents must change at the border. Either that or there is something fundamentally flawed in the analysis Regence is using. Hmmm.

Certainly the Regence Select move foreshadows the future. Regence was the first payer in our region to do this, but will not likely be the last. Physicians have been placed on notice that if they want to continue to be credentialed they must practice efficiently, i.e. provide less costly care, without regard to quality or even outcome.

Part III – "The Walrus and the Carpenter" – by Lewis Carrol from *Through the Looking-Glass and What Alice Found There*, 1872

"O Oysters, come and walk with us!"
The Walrus did beseech.
"A pleasant walk, a pleasant talk,
Along the briny beach:
We cannot do with more than four,
To give a hand to each."

Physicians are being asked to participate in the development of evidence based medicine coverage decisions by third party payors including state government. Other organizations have arisen by the demand of employers seeking control of health care costs. Doctors in medical societies are being asked to help them as well. Should we or should we not participate? It seems many doctors are rushing to participate without recognizing the potential peril.

The eldest Oyster looked at him,
But never a word he said:
The eldest Oyster winked his eye,
And shook his heavy head--
Meaning to say he did not choose
To leave the oyster-bed.

But four young Oysters hurried up,
All eager for the treat:
Their coats were brushed, their faces washed,
Their shoes were clean and neat--
And this was odd, because, you know,
They hadn't any feet.

Four other Oysters followed them,
And yet another four;
And thick and fast they came at last,
And more, and more, and more--
All hopping through the frothy waves,
And scrambling to the shore

I suppose if we do not participate and unfavorable policies are developed, we will not be allowed to complain. However, despite our participation, we will likely be overrun by cost-cutting decisions based on this application of evidence based medicine. We will then be told, "but this decision that you complain of was made with the help of your fellow physicians."

The Walrus and the Carpenter
Walked on a mile or so,
And then they rested on a rock
Conveniently low:
And all the little Oysters stood
And waited in a row.

"The time has come," the Walrus said,
"To talk of many things:
Of shoes--and ships--and sealing-wax--
Of cabbages--and kings--
And why the sea is boiling hot--
And whether pigs have wings."

"But wait a bit," the Oysters cried,
"Before we have our chat;
For some of us are out of breath,
And all of us are fat!"
"No hurry!" said the Carpenter.
They thanked him much for that.

"A loaf of bread," the Walrus said,
"Is what we chiefly need:
Pepper and vinegar besides
Are very good indeed--
Now if you're ready, Oysters dear,
We can begin to feed."

"But not on us!" the Oysters cried,
Turning a little blue.
"After such kindness, that would be
A dismal thing to do!"
"The night is fine," the Walrus said.
"Do you admire the view?

"It was so kind of you to come!
And you are very nice!"
The Carpenter said nothing but
"Cut us another slice:
I wish you were not quite so deaf--
I've had to ask you twice!"

"It seems a shame," the Walrus said,
"To play them such a trick,
After we've brought them out so far,
And made them trot so quick!"
The Carpenter said nothing but
"The butter's spread too thick!"

See "Thoughts" page 20

Pierce County representatives participate in WSMA House of Delegates Meeting in Spokane

Pierce County physicians **Len Alenick, Harold Boyd, Federico Cruz, Laurel Harris, Ron Morris**, Katherine O'Halleron, **Doris Page, Nick Rajacich, Don Russell, Sumner Schoenike** and **George Tanbara** represented PCMS in Spokane at the Washington State Medical Association Annual Meeting mid September. The meeting was held at the beautiful, restored Davenport Hotel in downtown Spokane.

The meeting, highlighted by the changing of officers of the Washington State Medical Association was particularly meaningful to Pierce County as Dr. Ron Morris from Puyallup was installed as Secretary/Treasurer and now serves on the Executive Committee. Dr. Len Alenick was elected to become Vice Chair of WAMPAC, the political action committee of the organization. PCMS applauds Dr. Alenick and Dr. Morris for their participation and congratulates them for their accomplishments as well.

Another highlight of the meeting was the reception in honor of Andy Dolan, legal counsel for WSMA on his retirement. With about 75 people sporting "Andy Dolan faces" he was certainly surprised as he entered the beautiful Isabella ballroom. Andy is looking forward to spending time in Florida and Denver to be closer to his children as he retires at the end of the year. PCMS congratulates Mr. Dolan on his retirement and thanks him for his many years of excellent service and enlightening, entertaining presentations. He will be sorely missed.

This year the House of Delegates debated many issues. One of the most debated was the issue of physician assisted suicide. There was strong support for a resolution calling for the WSMA to take a neutral position in anticipation of an initiative that it be legalized. There was strong opposition as well. The resolution was eventually defeated primarily because WSMA has already adopted a resolution opposing physician assisted suicide and secondly because the debate centered around an initiative that has yet to exist and is supposition at this point.■

Pierce County attendees gathered for dinner Saturday night at the Davenport Hotel

PCMS Treasurer Dr. Laurel Harris (left) and Jan Schoenike (Sumner, MD) listen to Andy Dolan say farewell at his departing reception

The PCMS contingent met for a breakfast early Sunday morning to prepare for House discussion and voting

Andy Dolan, WSMA Attorney, gives his last talk for the WSMA at his farewell reception, as he will be retiring from his law practice later this year

September General Membership Meeting Recap

Maggie Hood, MD shares Sri Lanka experience

The September General Membership Meeting, featured guest speaker, Dr. Maggie Hood, pediatric hospitalist at Mary Bridge Children's Hospital sharing her Sri Lanka experiences. Dr. Hood visited Sri Lanka in January 2005, within 30 days after the tsunami with a team of workers that helped with medical needs as well as providing early interventions to counteract negative psychological outcomes- playing with children and families, providing emotional support and most importantly, listening and talking with them. Amidst the disaster, Dr. Hood was amazed at how happy the people were in spite of their misfortunes and meager living conditions. She saw beautiful people, and found real meaning and purpose in connecting with the children and families in Sri Lanka who certainly were grateful for the assistance and attention. Her photo journal presentation wowed attendees highlighted by the sheer beauty of the area in the midst of complete devastation.

During the business meeting, four at-large members were nominated to serve on the PCMS nominating committee along

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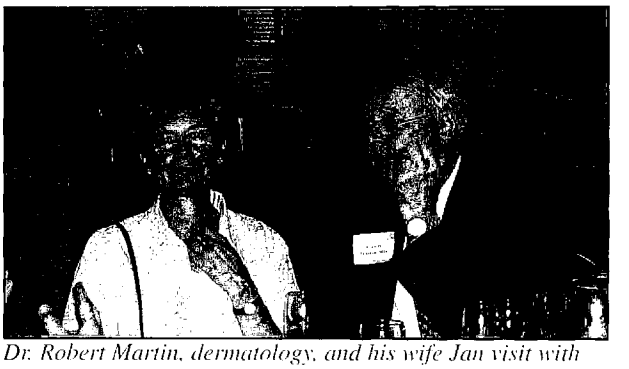
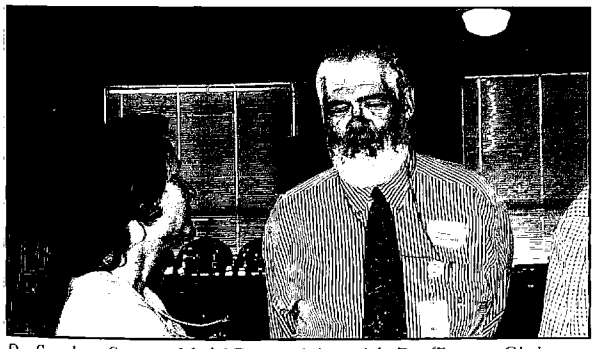
Dr. Joe Jasper, PCMS President, thanks Dr. Maggie Hood for her very enjoyable presentation



Dr. Robert Martin, dermatology, and his wife Jan visit with colleagues after dinner



Dr. Smokey Stover, MultiCare, visits with Dr. Teresa Clabots, pediatrician

Dr. Christopher Petty, left, recently joined K-Y Surgical, and Dr. Klatt, in Tacoma

Left - Dr. Cecil Snodgrass, Puyallup family practice with ophthalmologist Keith Dahlhauser, MD before the meeting

PCMS President-Elect Dr. Sumner Schoenike enjoys visiting with guest speaker Dr. Maggie Hood

GMM from page 7

with the PCMS Executive Committee. Nominees included **Drs. Jos Cové, Cecil Snodgrass, Don Trippel** and **Steve Duncan**. They will be joining, **Drs. Joseph Jasper, Patrick Hogan, Sumner Schoenike, Laurel Harris, Jeff Nacht** and **Nick Rajacich**. The Committee will meet in October to nominate a slate of candidates for officer and trustee positions which will be sent out to the membership by November 3. Ballots will be mailed no later than November 23rd for return to PCMS no later than December 7. Newly elected officers and trustees begin their terms at the Annual Meeting which will be held on Tuesday, December 12 at the Tacoma Sheraton Hotel. ■

Mark your calendar now for the

PCMS Annual Meeting
Tuesday, December 12, 2006
at the Sheraton Tacoma Hotel

featuring humorist and airline pilot

Dr. Jerry Cockrell
"Crew Resource Management - The Safety Parallels Between Pilots and Physicians"

and the installation of
Sumner Schoenike, MD as PCMS President
as well as officers and trustees

This is an evening you won't want to miss

Watch your mail for registration information

College of Medical Education Implements Honoraria/ Reimbursement Policy for Speakers

The College of Medical Education Board of Directors, led by President **John Jiganti, MD**, formulated a new honoraria and reimbursement policy for speakers at the College's annual CME programs. The board, at their June meeting, approved the policy effective for the September 2006 – June 2007 course year. It is the requirement of accreditation that the policy be implemented.

The policy is for both out-of-town as well as local speakers. Local speakers are defined as those residing in Pierce County.

Honoraria:

• Local speakers will be paid $250 to speak at a local College CME. They will also have the option to donate the money back to the College.

• Local speakers that speak at out-of-state College programs will have their registration fee waived in lieu of honoraria (ie: at Whistler and Hawaii programs).

• Out-of-town speakers will be paid honoraria in accordance with market cost as agreed upon by the course director, course administrator and PCMS executive director.

• Local speakers may be reimbursed at a higher level under special circumstances with the approval of the course director, course administrator and PCMS executive director.

Expense Reimbursement:

• There will be no reimbursement for local speakers for local courses.

• Out-of-town speakers will be reimbursed for conflict of interest, expenses as negotiated.

More policies are necessary to ensure identified needs, the essentials of CME, particularly in the arena of topic and area of interest. The College researches and assesses CME needs, secures programs, topics and speakers in alignment with identified needs, then secures funding for the program based on topic and availability of money. ■

Applicants for Membership

Tobias T. Lee, MD
Cardiovascular Dis/Interventional Card
Cardiac Study Center
1901 S Cedar #301, Tacoma
253-572-7320
Med School: Yale University
Internship: Boston Medical Center
Residency: Boston Medical Center
Fellowship: Beth Israel Deaconess MC

Erin J. Longley, MD
Family Medicine
Lakewood Clinic (CHC)
10510 Gravelly Lake Dr, Lakewood
253-589-7030
Med School: USC
Internship: Sutter Medical Center
Residency: Sutter Medical Center

Jorge M. Medina, MD
Diagnostic Radiology/Musculoskeletal
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: Universidad Central del Caribe
Internship: St. Elizabeth's Medical Center
Residency: Mt. Sinai Medical Center
Fellowship: Boston University Med Ctr

Christopher N. Petty, MD
General Surgery/Colo-Rectal
K-Y Surgical Associates
1307 South 11th Street, Tacoma
253-274-9732
Med School: University of Utah
Internship: Swedish Medical Center
Residency: University of Washington
Fellowship: University of Texas

Nicole A. Porter, MD
Anesthesiology
Tacoma Anesthesia Associates
3633 Pacific Ave #204, Tacoma
253-274-1668
Med School: University of Washington
Internship: University of Washington
Residency: University of Washington

The Health Status of Pierce County

Federico Cruz-Uribe, MD, MPH
Director of Health

Disease Reporting

Federico Cruz-Uribe, MD

Public health has been in the news lately. For the past week you could not turn on a television or radio or go to an internet news site and not see banner headlines. West Nile virus arrives in Washington State. E coli and spinach consumption. Carrot juice and botulism! These are important issues and they have been played up in the press. There has been a deluge of information thrown at the public. And during all of this, public health has needed to get out accurate information. Information based on a rigorous investigation of each case and each situation.

We are often cited for being slow and usually lagging behind the news channels in keeping the public informed. There is a reason for this: We also need to be accurate.

This is a tough position to be in as our society is addicted to the quick hitting story. Problem described, solutions identified, issue resolved. All-in-one heady story that lasts a few minutes in a broadcast. The classic Hollywood characterization is the show Law and Order. I admit that I really liked the show. It is so neat and clean and satisfying. A crime is committed. The police investigate. They identify the bad guys. The prosecutor indicts them. They go to trial and they are convicted and taken away.

I think part of the reason that I appreciate the show so much is that it so unlike what really happens. Criminal justice proceedings are often slow and cumbersome. Investigations take many weeks to months, even years. The perpetrators are often not identified. When identified, they are often not charged with the level of crime that they actually committed as a huge percentage plea bargain. And for those who go to court convictions for the guilty are not a foregone conclusion.

So what does this have to do with public health and all of the recent public health crises that have arisen locally and across the country? We have the same Law and Order kind of situation. We do have elegant disease control systems in place that can quickly identify an outbreak, put proven solutions on the table, educate the public in a timely manner so that those affected can get the services they need to protect their health and those of their families. But it usually doesn't work that way. We come up short.

For us in public health all of our elaborate and elegant systems don't work unless we get accurate and timely data from the care system. We truly depend on early identification of cases because providers and laboratories in the community communicate with us. They let us know about reportable cases as they are happening. When dealing with serious communicable diseases, time is of the essence. If we are to identify those affected we need to get out into the field and do our case contacts as early in the disease process as possible. This will allow us to implement preventive strategies that can spare our community a more widespread outbreak.

West Nile virus came to Pierce County this summer. We announced the cases just recently in September. The infected individuals were actually bitten in July. They were not reported until much later. Our control and education efforts were then delayed during a time when mosquito activity was highest. We were fortunate that we did not have any other cases.

The E coli contaminated spinach presents us with a similar situation. Our ability to protect the public depends on our public health system becoming aware of E coli infections as soon as they appear in our community. Every day of delay makes our control efforts that much less effective in protecting the public.

Every year I bring up the importance of disease reporting. Every year I remind the health care providers in our community how easy it is to communicate with us in the health dept. A phone call, a fax, an e-mail are all standard ways to get your patient information to us.

I hope the recent events involving West Nile virus and E coli infections are a reminder to you of how important your role is in protecting our community from the ravages of infectious disease. ■

To report a disease:
Call 253-798-6410, then press 0
or fax 253-798-7666

Information on our website:
http://www.tpchd.org/page.php?id=96

Retired Doctors' Wives Luncheon

The Retired Doctors' Wives will meet at a NEW LOCATION, The Tacoma Country and Golf Club, 13204 Country Club Dr SW, Tacoma 98498, October 25, 2006 at 11:30 am. Payment is by cash or by reciprocity with Fircrest or Oakbrook. They do not take credit cards. *Come join us!*

Please RSVP to:
Marlyn Baer (564-6374) or
Judy Brachvogel (564-4308)
by October 19.

WSMA's *Tomorrow's Medicine* Provides Data and Policy to Help Public Debate

A new report by the WSMA - *Tomorrow's Medicine* - is intended to help inform the public debate over the future of health care in our state. The report was released to the media, policy makers, community opinion leaders, and the attendees of the WSMA Annual Meeting mid September.

The first section of the report, *Where Are We Today?*, is based on quantitative data and analyses provided by the WSMA's Health Care Economics Department. The data is gathered from a wide variety of sources - public and private.

The second section *What Should Tomorrow's Medicine Look Like?*, injects a fresh perspective on the current discussions about health care. The WSMA chose to look beyond the immediate horizon. They retained the Washington Research Council (WRC) to survey opinion leaders regarding their vision for the future of medicine in our state five years out. The 36 respondents consisted of hospital administrators, practicing physicians, business advocates, labor leaders, medical school faculty, third party payers, policy analysts and state officials.

The remarkable degree of consensus was clear: Major improvements in health care will require systemic and cultural change, and physicians must help lead the way. They included:

- Physicians must champion quality care that is evidence based, safe and cost-effective.
- Physicians must work on behalf of the patients *and* communities they serve.
- Physicians are in a unique position to promote cooperation among all stakeholders in forging a better approach to the financing and delivery of health care by supporting the WSMA's guiding principles outlined in the final section of the report.

You can get a copy of the report from the WSMA website or call PCMS to mail you a copy. ■

IN MEMORIAM

ROBERT B. VOYNOW, MD

1928 - 2006

Dr. Robert Voynow passed away Tuesday, September 5, 2006 due to leukemia. He was 78.

Dr. Voynow received his medical degree from the University of Washington School of Medicine in 1955. His internships and residencies at Doctors Hospital, Children's Orthopedic, and Virginia Mason Hospital led to a fellowship and Board Certification as an anesthesiologist. He worked at St. Joseph Hospital in Tacoma from 1968 - 1988.

In lieu of services, Dr. Voynow donated of his body to the University of Washington School of Medicine where his donation and love of medicine will help educate the next generation of physicians.

PCMS extends condolences to Dr. Voynow's family.

Washington State History Museum presents a look at the century-long fight against tuberculosis in Washington

The Washington State History Museum presents "**The Battle against Tuberculosis in Washington**," a new exhibit running now through December 17, 2006 chronicling the struggle of doctors, medical researchers, and popular activists in the fight against this life-threatening disease. Sanatoriums, quarantines, Christmas Seals, patch tests, and even ping-pong balls have all been weapons in this ongoing struggle. With tuberculosis making a worldwide comeback, this exhibit speaks to an urgent contemporary issue. The exhibit has been produced in cooperation with the American Lung Association.

In conjunction with this exhibit, the History Museum offers several public programs that address the history and current relevance of tuberculosis. "One Breath at a Time: The Battle against Tuberculosis in Washington" is a free public program on Thursday, September 21, 2006, at 7 p.m. Guest speakers Drs. Wilbur Hallett, Jim DeMaine, and Jonathan Ostrow discuss the history of treatment in Washington sanatoriums before and after the introduction of life-saving antibiotics in 1947.

"Beating the Bacillus – New Commitments, New Opportunities: Ground-Breaking Research from the University of Washington and Washington State Epidemiological Report," is a free public program on Thursday, October 19, 2006, at 7 p.m. This discussion features Dr. David Sherman, Associate Professor of Pathobiology at the University of Washington, and Kim Field, President of the Board of Directors of the American Lung Association of Washington. Dr. Sherman presents current developments in research about the tuberculosis bacillus and how it has evolved, defying all treatment for centuries. Ms. Field speaks about tuberculosis, disease burden in the state of Washington, incidence rates and relative risks for the disease.

"Dr. Quevli and Son: Pioneers in TB Control and Christmas Seals in Washington," is a public program, free with paid admission to the museum, on Thursday, November 9, 2006, at noon. This lecture features the history of Dr. Christen Quevli Sr.'s pioneering contribution to tuberculosis control, including bringing the Christmas Seal campaign to Washington, in the early 1900s. Guest speakers will include Dr. Wilbur Hallett, tuberculosis expert, and Mrs. D. Knight, Quevli family biographer and granddaughter of Christen Quevli Sr., who will be displaying family artifacts.

"Lewis and Clark and the Pathogenic Encounter," is a public program, free with paid admission to the museum, on Thursday, December 7, 2006 at noon. This brown-bag lunchtime program features Washington State History Museum director David L. Nicandri discussing how pathogens, always a part of the human experience, formed a particularly poignant backdrop to the Lewis and Clark story in the Northwest.

The Washington State History Museum, flagship of the Washington State Historical Society, is located at 1911 Pacific Avenue in downtown Tacoma, just off I-5. The museum presents exhibits, programs, and events that bring to life the stories of Washington's history. For more information, including hours and admission rates, please call 1-888-BE-THERE (1-888-238-4373), or visit their web site, www.washingtonhistory.org. ■

In My Opinion

by Kenneth Feucht, 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.*

Economic Credentialing

Kenneth Feucht, MD

Dr. Joseph Jasper has requested various board members including myself to investigate various issues that interfere with the practice of medicine. I have been assigned the topic of economic credentialing (EC).

The AMA defines EC as "the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges." Most examples of EC do not fit this definition exactly and so it must be used as a loose term. For example, EC is being applied when a surgeon opens up his own surgery center, resulting in the hospital revoking that surgeon's hospital privileges, or when a family doctor that practices out of two hospitals, finding that one of the hospitals revoked his privileges.

Economic credentialing sounds like a terrible thing, especially when you are a physician who has had hospital privileges revoked for economic reasons. Most medical societies have issued statements condemning EC, including the AMA, the American Association of Physicians and Surgeons, and the American College of Surgeons. Many states have gotten involved in this battle; eleven states have declared EC illegal, whereas six states have ruled that EC is entirely legal. When doing a web search, one finds that the largest volume of informative sites regarding EC are legal firms. Interesting! Perhaps lawyers have much to gain by the various feuds between hospitals and physicians.

It is informative to first look at both sides of the EC battle. From the hospital perspective, they have the legal obligation to serve all who come. The emergency room is an open door and Hill-Burton regulations force the doors of all hospitals to remain open to all who come. The hospital has minimal recourse for the high consuming, no-pay or underinsured patient, and can not be selective based on ability to pay. Hospitals have had to pay ever increasing sums to attract nurses, physicians and other professionals into their employment. Hospital regulations are onerous, and visits of the JCAHO are an unpleasant and costly experience for the hospital.

Physicians equally are beset with problems. Our practices have been plagued by diminishing reimbursements, accompanied by increasing stress and work hours, depersonalization and absence of malpractice reforms. Our relation with hospitals is increasingly troubled by the "hassle-factor" - scheduled procedures that don't run on time, equipment that is not available, increasing demands on documentation, ward nurses and assistants that are overworked and not giving patients required attention, committees and meetings, etc., etc., all of which lead to outbursts of anger which are also heavily regulated. To escape the mess of the hospital, to improve declining revenues and to gain control over their schedules, physicians have turned to development of various outpatient facilities. Physicians will usually operate their facilities with far higher efficiency and lower expense than a hospital ever could. Unlike with hospital administrators, management decisions have a direct feedback on ourselves, effecting the amount of hassle and revenues we experience.

Hospitals and physicians are both caught by the EC battle in an effort to survive, and both sides have justifiable reasons for their thinking and behavior. Why should hospitals be friendly to staff physicians that are taking away the most profitable cases and working against the success of the hospital? Why should hospitals be forced to cater to a competitor, when that competitor is a physician? They shouldn't. Why should physicians be friendly to hospitals that are hiring competitors to us that operate in a special protected environment? Why should physicians behave civilly when a hospital fails to provide us a modicum of reasonable service and creates unbearable hassles for us even when we are trying to earn the hospital profits? We shouldn't.

Physicians could resolve the EC problem by fighting. We could engage hospitals with our bands of lawyers and sue them for restriction of trade. We could engage the state legislature to formalize laws against EC. Regardless of how the EC battle ultimately ends, all of us will lose. Hospitals will

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become increasingly economically unstable. Physicians will become increasingly embittered, and seek to either leave the state, retire early or retaliate against the hospital by other means. The only winners will be the lawyers, who will profit richly from our legal battles.

Let's not go there. Make love, not war. Hospitals and physicians must sit down with each other, realize that cooperation together will serve both of our interests and then re-invent the practice of medicine. Hospitals need to remove themselves from the notion that they can operate autonomously of physicians. Physicians need to remove themselves from the dream of autonomous private practice. We all need to eliminate the fantasy of "ideal-world" medicine and create new models of physician-hospital interactions.

A new model of health care will eventually take over, driven by economic, government and public forces. It remains to be determined what role physicians and hospitals may play in this brave new world of healthcare. If the healthcare industry doesn't acquire a unified stance against those outside forces, we will probably remain at the mercy of these outside forces for the "re-invention" of medicine. The fight over EC blinds us to the big picture, the even larger battles for the viability of healthcare. The battles for prevention of complete government control of medicine, tort reform and spiraling costs of healthcare need to be fought by hospitals in conjunction with physicians - not with us battling each other. ■

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.*

Health Savings Accounts

Andrew Statson, MD

"Power is always charged with the impulse to eliminate human nature, the human variable, from the equation of the action."
"The Tempur of Our Times"
Eric Hoffer (1967)

The Health Savings Accounts are the latest attempt to include the human variable in the economic equation of medical care. Their main accomplishment is the leveling of the field for the purchasers of insurance. Employers buy insurance with pre-tax dollars, while uninsured individuals have to spend after-tax dollars to pay for their care. The HSAs allow them to use pre-tax dollars.

The HSA, combined with a high deductible (HD) insurance plan, has the features both of a savings account and of an insurance policy. In that sense, it is similar to ordinary life insurance. It is portable with change of employment, the savings accumulate, and if the funds are not used, they become available to the beneficiary later in life.

Earlier this year, Deloitte Consulting LLP reported that in the two years since the plans became available, the premiums for the HD plans rose overall at one third the level of increase of the standard insurance policies. For individuals, however, sales data from ehealthinsurance.com show that premiums for the first six months of 2005 were lower by 19% relative to 2004.

That is understandable. The insurance companies offering the plans had little previous experience with HD policies and had to price them carefully. When the figures came in, they realized that they had overpriced the product.

In addition, the National Health Policy Forum reported on 4-11-2005 that out-of-pocket expenses for the HD plans were lower than what they were for the standard plans. Perhaps one explanation is that the deductible does not apply to preventive care, which is covered at 100%.

David Phelps, writing in the Minneapolis Star Tribune on July 13, 2006, reported that people who have HD plans are more likely to visit their physicians regularly for preventive care. They are also less likely to use the emergency room and have fewer hospital admissions than people with traditional coverage.

The above findings are from a three-year study by UnitedHealth, which sampled 55,000 workers. The same study reported that the cost to employers for HSAs declined by 3-5%, while increasing by 8-10% for the standard plans.

The UnitedHealth study suggests that "consumers are more discerning when they are confronted with prices and are less inclined to pay for expensive visits to the emergency room to treat something basic, such as a fever or an ankle sprain."

Another study in Minnesota, by Blue Cross and Blue Shield, also found that consumers with HD plans are more likely to use preventive services (39%) than those with open access plans (34%). The same study showed that premiums for traditional plans grew at a faster rate (11% versus 6%).

Several problems remain. Even though the regulatory burden of the HSAs is less onerous than that for the earlier Medical Savings Accounts or for the standard insurance plans, more hurdles need to be removed. For instance, individuals pay the premiums for the HD Policies with after-tax dollars.

On June 6, 2006, Nina Owcharenko, a senior policy analyst at the Heritage Foundation, wrote about the provisions of a bill, HR5262, the "Tax-Free Health Savings Act of 2006," which will make the HSAs better. The bill will allow individuals to pay their insurance premiums out of the HSA, meaning with pre-tax dollars. It will increase the maximum contribution limit to match total out-of-pocket expenses.

The bill includes provisions which will give additional preferential tax treatment to the insurance premiums for the HD plans. Owcharenko thinks that it would be more equitable if all health insurance products were treated alike by the tax code. She also suggests to eliminate the HD plan requirements altogether, and to allow individuals to use their HSA as a savings account for all health care expenses, including premiums, deductibles and other cost sharing requirements.

One potential problem has not been addressed, and so far does not seem to be of major concern. That is the 100% coverage for anything [illegible] deductible. Such coverage removes the

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patient's interest in watching for overcharging and for careful consumer decisions on big ticket items. That means that a hospital bill for twenty or fifty thousand dollars will not receive proper attention, except, perhaps, from the insurance company. Patient participation, say at 5%, or even at 1% of costs, will get their attention and lead them both to question the charges and to select an institution that would give them a better deal.

The unions and other proponents of socialized medicine are strongly opposed to the HSAs. They prefer equality, with its inevitable consequences of high cost and scarcity. Their argument is that people who require expensive care should seek first dollar coverage, no matter what the cost. Of course, that is fine when the government or the employers pay for it, but many self-employed workers and small businesses cannot afford the cost of such insurance, so they go without.

HSAs have helped. They became available in January 2004. A year later, three million people had signed up for them, one third of them previously uninsured. The premiums for the HD insurance are much more affordable, and people now can pay their out-of-pocket medical expenses with pre-tax dollars.

Another objection to the HSAs is that they will select the healthy and the wealthy. The standard insurance plans, stuck with sicker patients, will become even more expensive. Perhaps that may happen at the beginning, but as the plans age, so will the people in them, and their costs for high ticket items will go up.

Finally, the opponents claim that while HSAs can reduce the purchase of medical care that is inappropriate or of questionable value, they can also reduce the purchase of appropriate medical services and force people to delay treatment until their condition becomes serious.

That may be true when patients have no insurance and have to pay out-of-pocket, but the payments out of the HSA are not exactly out-of-pocket. The funds are sequestered into the accounts and can be used only for medical care. The patients must deposit a certain amount in their HSA every year to keep it open. They might as well draw on the account.

Even so, allowing patients to shop for medical care and to negotiate prices as they do for other consumer services will encourage physicians and hospitals to offer lower cost services, made possible by further specialization and by the economic use of staff, equipment and technology.

At the same time, the pressure on hospitals and physicians to publish an item by item fee schedule will increase and will allow patients to compare both the costs and the quality of services before they make their treatment decisions.

We currently have procedures and services, mostly in the cosmetic and dental fields, where costs are kept down by competition. The patients make personal arrangements for payment and are the judges of the quality and the value of the services they receive. The HSAs give them similar control over medical expenses. ■

Leadership Training for Physicians and Clinical Professionals

The University of Washington Department of Health Services and School of Medicine, through UW Extension, jointly sponsor the Certificate Program in Medical Management (CPMM). This program is specifically designed to help physicians, clinical professionals, and others with significant health care experience acquire practical business and management know-how and skills to enhance their effectiveness in everyday work situations. The program ultimately prepares participants for leadership positions in their organizations.

The Certificate Program consists of four courses:

1. Medical Practice Quality Measurement and Management (Autumn)
2. Strategic Management of Health Care Organizations (Winter)
3. Leadership and Change Management (Spring)
4. Health Services Financial Management (Autumn)

Classes are held Wednesday evenings 5:30-8:30 with the exception of Financial Management, which is held Monday evenings from 5:30-8:30. Continuing Medical Education credit is available to eligible participants for a total of 30 category 1 credits per course. An added benefit of the CPMM is that each course is transferable to UW's Executive Master of Health Administration (MHA) Program.

We are now enrolling for Strategic Management of Health Care Organizations, starting January 3, 2007. This course is taught by Dr. William Dowling, Professor and Chair, UW Department of Health Services, School of Public Health and Community Medicine. It focuses on the development and implementation of strategy and business development plans that enable organizations to adapt successfully to the changing health care marketplace. Upon completion of the course participants will:

- Develop a "strategic management" view of the health care manager's role, and draw on and integrate experience, knowledge and clinical perspective around this view of management.
- Understand the distinctive nature of health care organizations; the environmental, organizational, and people factors that affect their management; and the kinds of strategic issues health care managers typically face.
- Master conceptual and analytical tools for assessing an organization's external and internal environments, and for identifying strategies that fit the organization's situation.
- Apply organizational concepts and models to analyze the functioning and performance of health care organizations.

For more information, contact Bree Rydlun at 206-616-2947 or brydlun@u.washington.edu. For program and logistical details, visit the CPMM website at: http://www.extension.washington.edu/ext/certificates/mem/mem_gen.asp. ■

Thoughts from page 4

"I weep for you," the Walrus said:
"I deeply sympathize."
With sobs and tears he sorted out
Those of the largest size,
Holding his pocket-handkerchief
Before his streaming eyes.

"O Oysters," said the Carpenter,
"You've had a pleasant run!
Shall we be trotting home again?'
But answer came there none--
And this was scarcely odd, because
They'd eaten every one.

Humor

Please, take time away from the heady issues and visit some medical humor web sites:

www.qfever.com

www.placebojournal.com

www.plasticsurgeryhumour.com

www.ahajokes.com/medical_jokes.html ■

COLLEGE OF MEDICAL EDUCATION

Whistler CME January 24-27

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 24th to the 27th, 2007.

Reservations for the program's condos, *Aspens on Blackcomb*, can be made by calling Resort-Quest at 1-877-676-6767. **The group number to get our fantastic rates is #403699**. Our room rates this year are even lower at $214/one bedroom and $314/two bedrooms. You are encouraged to make your reservations soon to ensure space - at least by December 1, 2006 when any remaining condos in the block will be released.

A conference brochure will be mailed soon or visit www.pcmswa.org/col_abo.html for registration information. Please feel free to call Lori Carr 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 variety of subjects of interest to all specialties and is accredited for 10 hours of AMA Category I CME credits. The course directors are **Dr. Richard Tobin** and **Dr. John Jiganti**, and the speaking lineup will be better then ever. ■

Continuing Medical Education

Annual Infectious Diseases Update Friday, November 10, Fircrest

The annual Infectious Diseases Update is set for Friday, November 10, 2006 at the Fircrest Golf Club. The food, facilities and setting are perfect for continuing medical education.

The program is directed by **Dr. Elizabeth Lien** and is hosted by the physicians of Infections Limited and offers reviews and updates on a variety of clinical topics.

Speakers and topics include:

• A Fungus Among Us: Updates on Antifungals	Larry Schwartz, MD
• HIV Updates for the Primary Care Provider	Elizabeth Lien, MD
• Staphylococcus aureus: Management of a Problematic Pathogen	Mark Rupp, MD
• Bioterrorism: Always a Valid Threat	Marina Arbuck, MD
• Interesting Cases of Infectious Disease: A Discussion of Unusual Problems	Peter Marsh, MD
• Current Updates from the Health Department on Infectious Diseases	David Harrowe, MD
• West Nile Virus	Ramona Popa, MD

This is a popular program, please register early by calling the College at 627-7137 or visit www.pcmswa.org/col_reg.html for registration information. ■

Dates	Program	Director(s)
Friday, November 10	Infectious Diseases Update	Elizabeth Lien, MD
Wednesday-Saturday January 24-27	CME at Whistler	John Jiganti, MD Richard Tobin, MD
Friday, February 2	2007 Neurology Update	Patrick Hogan, DO
Friday, March 2	Cardiology for Primary Care	Gregg Ostergren, DO
Friday, April 20	Orthopaedic/Gastroenterology 2007 Update	Nicholas Rajacich, MD John Carrougher, MD
Friday-Saturday May 11-12	Internal Medicine Review 2007	Joseph [illegible]
Friday, June 8	Advances in Women's and Men's Medicine	[illegible]

Hematology Oncology Northwest, P.C. is pleased to announce the arrival of a new associate.

Bahman Saffari, M.D., Ph.D. was born in Tehran, Iran. He immigrated to the United States with his brother in 1978. He received BS and MA degrees in Biochemistry and Microbiology, respectively, from UCLA. He then attended the University of Southern California where he earned a joint *MD/PhD* degree. His doctoral dissertation described a number of significant molecular genetic alterations in uterine cancer. He completed his residency in Obstetrics and Gynecology at Los Angeles County-USC Medical Center followed by a Gynecologic Oncology fellowship at the University of California, Irvine. He has been honored by American Association for Cancer Research with Scholar-in-Training Award, and by the Organon and Ortho-McNeil Pharmaceuticals with Research Awards in Women's Health. Dr. Saffari relocated to the Pacific Northwest with his wife and three children and has joined the Northwest Medical Specialties in August of 2006.

His research interests in Gynecologic Oncology has included the identification of prognostic markers in uterine cancer and the discovery of a novel gene involved in the formation of uterine and ovarian cancers. His clinical research interests has focused on intraperitoneal chemotherapy and "targeted" biologic therapy.

Dr. Saffari is accepting referrals at the Jackson Hall office, 314 ML King Jr Way, Suite 201, Tacoma, Washington. Phone (253) 403-1029, Fax (253) 403-1714.

Classified Advertising

POSITIONS AVAILABLE

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@soundfamilymedicine.com. Equal Opportunity Employer.

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 Paul Doty (253) 830-5450.

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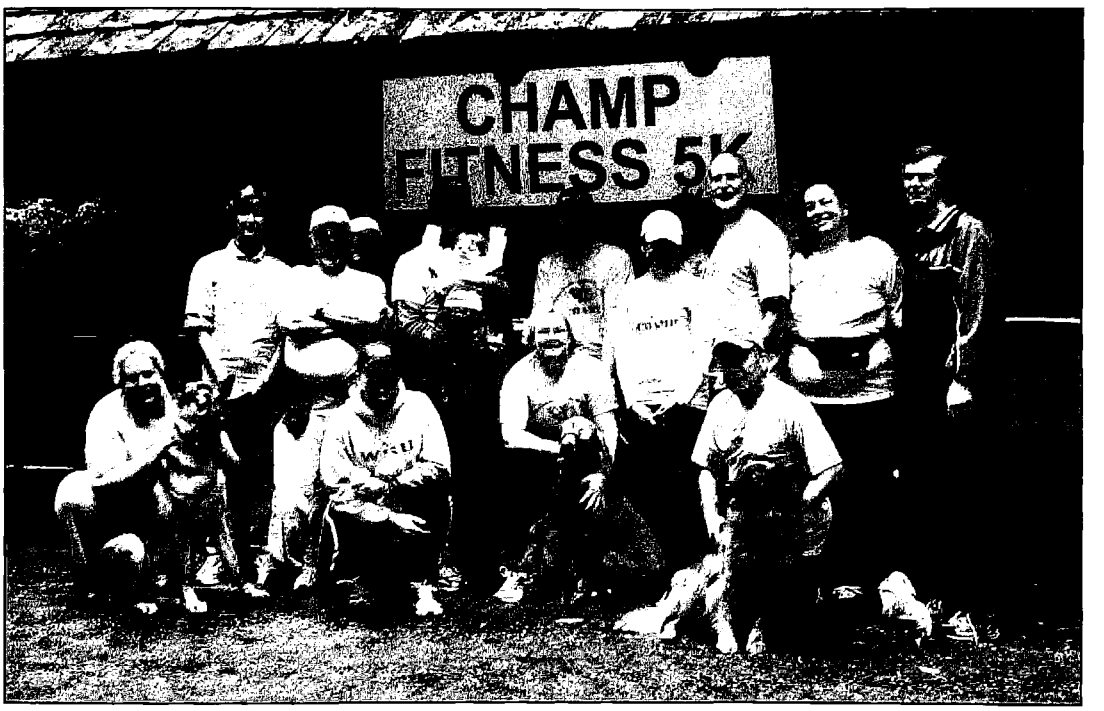
BULLETIN

November, 2006

2nd Annual CHAMP FITNESS 5K



CHAMP participants in CHAMP t-shirts, along with a few dogs and children had lots of fun at the September 30 PCMS CHAMP FITNESS 5K at Pt. Defiance Park

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Change & Threats

Joseph F. Jasper, MD

Invading hordes, plague, political and industrial revolution, holocausts and slavery: mankind has taken looming enormous change and threats many times over. Today we wonder how our nation will handle terrorism and avian flu. We worry if our children can compete when our economic and industrial global advantage becomes a past state. In our small businesses we wonder if we can survive years of reimbursement reductions, the consolidation of insurance companies into non-negotiating cartels, pay for performance monitoring and other increasing regulations. This all could lead one to a great sense of insecurity. Mankind has survived worse before, and we shall all get through this decade.

History has taught us that passivity sometimes works but more often leads to catastrophe. "The best defense is a good offense," is a commonly bantered strategy. In U.S. medicine, what do we have in our offensive war game? One is to remain engaged in the process as respected advisors – with the caveat of not playing the role of the oysters to our opponents' walrus and carpenter, as I alluded to in last month's President's Page. Thus we must have some teeth to our position. And so we may consider a few possibilities:

- Adapt practices to the changing times
  - Belt tightening, staff reduction, cheaper rent
  - Associate with larger group
  - Concierge practice, cash only practice
- Adapt lifestyles to the dropping profits
- Take political action
- Refuse to work at a loss or for inadequate compensation – the alternative is bankruptcy
  - Stop providing certain services, medically necessary or not
  - Refuse inadequate contracts
  - Change specialty
  - Retire early
  - White coat flu – since we cannot strike
  - Move to a better reimbursing state and city

As we take these options we must warn society of the potential impact on healthcare in the U.S. Presuming we are offering the best medical care in the world, holding off on services should have a negative impact. But will it?

A few years ago, I was in an audience of about 50 doctors listening to a Regence executive explain why our reimbursement rate was low compared to Idaho, or even Oregon. The answer was over-utilization. As part of the adaptation to impending changes, we do need to participate in the over-utilization discussions as open minded participants. Is the MRI a cost effective test that will change the likelihood of patient outcome? Perhaps the latest glitzy drug is not what the patient needs, despite what the TV ad and rep buying you lunch had to say. Implant A may work about as well as the twice as expensive Implant B. Perhaps we need to tell Mrs. Jones that we cannot perform her surgery until after she loses 100 pounds so we do not subject her to an expensive and doomed procedure. Sometimes we need to help a patient face their untreatable impairments rather than attempt heroic last ditch or low yield treatments. We have limited resources that would go a long way to help treatable patients.

The current Sustained Growth Rate Formula demands cutbacks in physician reimbursements as an attempt at controlling healthcare costs. Part of that formula is based on spending data suggesting over utilization. Unfortunately part of that formula is also based on irrelevant factors. We all must write to our legislators to get rid of the flawed formula. Expecting Medicine's leadership to accomplish this without grass root support will not work. The process of contacting your legislators is extremely easy via the internet. Log onto www.wsma.org, then click on the right Grassroots Poltical Action Center orange button. Fill in your zip code and then the action letter you would like to send and follow the simple steps to completion. It takes two minutes. The alternative is to return to the other aggressive bulleted options above.

Mankind will survive this decade's changes and disasters. As with every historical episode there will be survivors and those lost. We must act to be among the survivors.

Knowledge is power: Testing everyone for HIV status

New CDC recommendations call for streamlining HIV testing processes to facilitate widespread screening

Two important facts come to mind when thinking about HIV testing:

· Right now, more than 250,000 Americans are believed to be living with HIV, unaware of their infections.

· Nearly 40% of people with HIV are diagnosed within a year of developing full-blown AIDS, when it may be too late to benefit fully from treatment.

These numbers underscore the continued urgency of the HIV/AIDS epidemic and point to a clear course of action to address it. After all, knowledge is power.

People need to know their HIV-positive status so they can protect themselves and their partners as well as have access to new life-extending treatments and therapies as early as possible to give them the best chance at a future.

These are the realities behind new Centers for Disease Control and Prevention recommendations for HIV testing in the health care setting. The guidelines are a step forward in controlling the spread of this deadly virus.

The CDC begins with a straightforward ask — that HIV screening become a routine part of medical care for all patients between the ages of 13 and 64. The guidelines also include other provisions to streamline these efforts.

Previous recommendations, for instance, called for HIV testing in health care settings with high HIV prevalence — above 1% — and for all high-risk individuals. But physicians reported that such data often were not available and that time constraints made conducting risk assessments unwieldy. ■

Reprinted from AMNews, Oct. 23/30, 2006

CHAMP FITNESS 5K – We missed you...

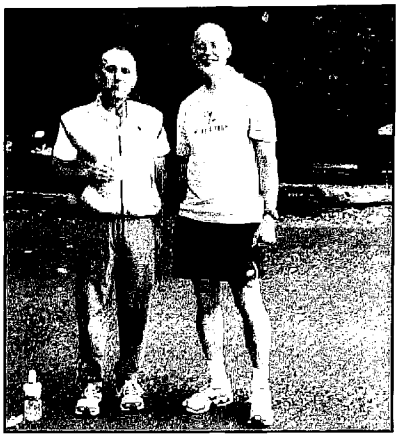
For those that attended the CHAMP FITNESS 5k at Pt. Defiance Park on Saturday September 30, it was a fun and invigorating start to the day. Physicians, both active members and retired, spouses, children, staff, friends, neighbors, and lots of dogs lined up to participate in the second annual event.

Starting at Ft. Nisqually the 5k (3.1 mile) course quickly merged to five mile drive, passing several beautiful look-out points of Puget Sound, Gig Harbor and the Narrows Bridge. With a finish back at Ft. Nisqually, participants enjoyed fruit, drinks, bagels and other refreshments before the drawing for gift certificates from Borders Books and Music. All finishers received free BMI wheels and Clif bars. The first male and first female finisher and four lucky exercisers who won the drawing, all received gift certificates from Borders.

The first annual CHAMP FITNESS 5K was also held at Pt. Defiance but started and finished at Owen Beach. The Ft. Nisqually staging area and course proved to be more popular with participants as the course was more scenic, and less cumbersome and hilly.

While only 50 people participated, there was no lack of fun and excitement as everyone did their own thing – walking, running, pushing strollers or being pulled by their dog. **Dr. Steve Pace**, Tacoma emergency medicine physician was the first to cross the finish line.

Start practicing now for next year. We hope to see you, with or without your friend, relative or dog at the third annual CHAMP FITNESS 5k. ■



Dr. Pat Hogan, right, event founder and director, with the first finisher, Dr. Steve Pace, Tacoma emergency medicine physician

With perfect weather and a beautiful setting, runners and walkers with dogs and strollers gather at the start line

Participants enjoyed drinks, fruit and bagels at the finish line as well as drawings and free gifts

Dr. Aksel Nordestgaard, Tacoma vascular surgeon with wife Lisbet and daughter after completing the course

Donna Jasper, wife of Joe Jasper, MD, runs toward the finish line with a staff member's daughter

Applicants for Membership

John C. Hung, MD
Orth Surgery/Sports Med
Advanced Orthopaedic Specialists
11212 Sunrise Blvd E #201, Puyallup
253-446-0750
Med School: Med College of Wisconsin
Internship: Med College of Wisconsin
Residency: Med College of Wisconsin
Fellowship: University of Illinois

Frederic Johnstone, MD
Orthopedic/Hand Surgery
Rainier Orthopedic Institute
3801 - 5th St SE #110, Puyallup
253-845-9585
Med School: Vanderbilt University
Internship: Madigan AMC
Residency: Madigan AMC
Fellowship: Walter Reed AMC

Jonathan M. Kell, MD
Diagnostic Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: University of Wisconsin
Internship: St. Joseph Mercy Hospital
Residency: SUNY Upstate Med Univ
Fellowship: SUNY Upstate Med Univ

Lynn C. Ostenson, MD
Internal Med/Palliative Care
Good Samaritan Palliative Care
407 - 14th Ave SE, Puyallup
253-697-1962
Med School: University of Washington
Internship: University of Arkansas
Residency: University of Arkansas

Allene Whitney, MD
Family Medicine
Community Health Care
1720 E 44th St, Tacoma
253-471-4553
Med School: University of New Mexico
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine
Fellowship: Swedish Family Medicine

In My Opinion

by H. Lester Reed, MD, FACP, MultiCare Health System; Kim Moore, MD, Franciscan Health System; Ron Morris, MD, Good Samaritan Hospital; and Don L. Mellor, Dept. of Defense and Homeland Security

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.

Pierce County Influenza Pandemic: What the Practicing Physician Needs to Know About Local Preparations

Scenario:

At 10:08 am on Tuesday morning, you hear through co-workers that an unusual number of people in Olympia have been reporting to the local emergency department with flu-like symptoms. Within 60 minutes the report has been expanded and it is broadcast on the local television that 700 people are waiting in the streets to enter the emergency department at Providence Saint Peters Hospital in Olympia. By 1:00 pm reports now include that 1,600 people are waiting at Good Samaritan in Puyallup, 2,500 are clustered outside Tacoma General and 2,000 more are gathering outside St. Joseph Medical Center. Most are complaining of fever and respiratory symptoms. Within 24 hours a rapidly increasing number of people are reporting to urgent care centers, physician offices and school nurses for the flu and they are asking for medication to treat and prevent the disease. A tone of hysteria and panic is settling over the community.

Introduction:

The disaster described above could occur. An influenza pandemic spreads quickly and widely as most people have no immunity to the new virus. The Pacific Northwest may be one of the first areas to observe clinical cases of pandemic influenza because of the flight pattern of birds from Asia. Within Pierce County the Center for Disease Control predicts that 25-30% of the population, or between 187,000 and 225,000 people in Pierce County alone, could be affected by a contagious outbreak such as an avian variant of influenza before the episode is complete. In this situation the care available to medical, psychiatric and surgical patients in Pierce County will be limited because of rapid exhaustion of the resources necessary to support the population. The crisis could last for weeks and recur in subsequent months as a second wave of influenza hits. Health care facilities will be overwhelmed with influenza patients at the same time that they are suffering shortages of health care workers and support staff because of the illness. Essential services such as public utilities, grocery stores and gas stations may be rendered non-operational because of staff shortages. Schools will close, public gatherings may be banned, and normal societal functioning as we know it will change drastically. What will you do, how will you assure safety of your family, who will you contact about your duties as a physician or provider?

County Preparations:

Dr. Federico Cruz-Uribe, Director of Health for Tacoma-Pierce County has raised this topic in the November, 2005 issue of the *Bulletin* and several times since. The Tacoma-Pierce County Health Department has been facilitating a group of meetings over the last eight months to prepare for an influenza pandemic, as well as other major regional catastrophes. With his direction, members representing Emergency Medical Services (EMS), local hospitals, the Department of Defense, State Health Department and state epidemiologists and legal services have been gathering and developing a plan for county health care in the event of such a crisis. It is time now for physicians to know that such a plan exists, how we can fit into the plan and how our role is integral to making it a success.

Personal Preparedness:

First, we must be personally prepared and feel that our families are safe in any type of disaster. This must be accomplished before we can effectively help others. The Washington State Health Department and Washington Military Department have prepared a useful "Disaster Preparedness Handbook"[1] (http://www.doh.wa.gov/phepr/factsheets.htm). This is a superb document for personal preparation and information about disasters of weather and other natural causes, bioterrorism and infectious agents. It describes in detail the checklists for a "disaster kit," it also lists emergency phone numbers, and outlines actions such as purifying water in different types of terrorist or natural disasters.

Local Preparedness:

When local hospitals become overrun and their resources and backup supply chains are predictably exhausted, emergency management systems would be activated both at the county level and the hospital level. This system is called the Incident Command System (ICS). A national training program makes this system the same for all national disasters and it clearly assigns an Incident Commander and chain of command in order to quickly assign authority and coordinate the response. It allows people to work within a structure that reports to a single leader and an organizational structure that can be expanded to the level of the crisis[2]. That leader may be your recognized CEO, COO or Chief Medical Officer initially

See "Influenza" page 16

Opioid dependence linked to worse outcomes in back injury patients

By Victoria Stagg Elliott

Patients with chronic back injuries who become dependent on opioids during the course of their treatments use far more health care services and are less likely to return to work than are those who do not abuse these drugs, according to a study presented at the North American Spine Society's annual meeting last month in Seattle.

"Don't be afraid to use opioids early in the course of the disease or for severe exacerbations," said Tom Mayer, MD, lead author and medical director of the PRIDE. Productive Rehabilitation Institute of Dallas for Ergonomics. "But with long-duration use, there are significant risks."

Dr. Mayer and his team followed 1,200 patients who completed the institute's rehabilitation program. They had been treated for an average of a year and a half before starting the program, and 1.3% were opioid-dependent before their injuries. This number increased to 14.3% during initial treatment but prior to entering the program, which requires participants to taper from the medications.

Despite the fact that the patients all finished their rehabilitation off the medications, earlier dependence clearly exacted a price. A year after finishing rehab, those who were dependent were 2.8 times less likely to have returned to work. They were also 2.1 times more likely to have sought additional health care services and 1.8 times more likely to have had additional surgeries.

"Opioid dependence disorder in these patients is almost an entirely iatrogenic issue, and patients may well have a poorer outcome," said Dr. Mayer. ■

Reprinted from AMNews, Oct. 23/30, 2006

IN MEMORIAM

GEORGE RANDOLPH BARNES, MD

1922 - 2006

George R. Barnes, MD died October 22, 2006 at age 84. Born and raised in Connecticut, he received his B.S. degree at Wheaton College and his M.D. degree at Yale University. A residency in pediatrics at Yale followed and he then served in the U.S. Army as a physician.

Academic medicine called George to the University of Iowa where he was a Professor of Pediatrics, and later after a radiology residency, a Professor of Radiology. He was awarded teacher of the year as a pediatrics professor. Recruitment to Children's Hospital in Los Angeles, California followed and finally, at the urging of Dr. William Rohner, George entered private practice in Tacoma in 1968.

For over 15 years George enjoyed an exceptional practice of radiology with Tacoma Radiology Associates. Always interested in pediatric radiology, he was instrumental in helping Dr. John Mulligan and Dr. Rich Knudsen develop neonatology services in our community. He served on many hospital committees and on many community organizations, lectured frequently and always sought to share his wonderful knowledge and skill with others.

Following retirement in Tacoma, he was recruited to the University of Arizona Medical School as a Professor of Radiology. He finished his career there as a respected clinician, beloved teacher and the recipient of many teacher of the year awards.

He was a quiet, loving man of faith who cherished his friends and family. He and his wife, Ellie, enjoyed 62 years of marriage and only recently had moved back to Tacoma to be near most of their children and grandchildren.

George was like a brother to me and certainly a friend to be cherished by all who knew him. He will be sorely missed.

Gil Roller, MD

The Health Status of Pierce County

Protect yourself and your patients from the flu

by Nicole Pender, DOH

As a healthcare professional, you are committed to protecting your patients' health as a top priority. One way you can help your patients stay healthy is by getting your yearly flu vaccination. Getting vaccinated also protects you from the flu and prevents spreading the disease to your family.

Flu vaccinations have been recommended for healthcare workers for several years, yet many professionals are still not getting vaccinated. In fact, only 42 percent of healthcare professionals receive a flu vaccination each year, despite the recommendations and information on why it's so important to get vaccinated.

Healthcare professionals are able to spread disease to their patients even when they have no symptoms. This is one reason why it is extremely important for healthcare professionals to get an annual flu vaccination.

There are two flu vaccines available; the flu shot and the nasal spray flu vaccine (FluMist). The nasal spray vaccine is composed of live, attenuated flu viruses, and is recommended for healthy people, ages 5-49 years, that are not pregnant. The flu shot contains inactivated, or killed flu viruses. Healthcare professionals that work with patients who have severely weakened immune systems should get the flu shot.

There are many misconceptions about flu vaccinations. The following information contains answers to commonly asked questions about flu vaccines. Hopefully this information will motivate you to get vaccinated, and also help you educate your patients about flu vaccinations.

Q: Can flu vaccines give me the flu?

A: It is not possible to get the flu from a flu vaccination because it is made from killed or weakened viruses that are no longer able to cause disease. Some people may get a mild fever or experience muscle aches for 1-2 days after vaccination. These are normal reactions to the vaccine that happen when the immune system starts responding to the vaccine.

Q: I do not usually get the flu, so why should I get vaccinated?

A: Anyone can benefit from getting a flu vaccination. Flu vaccinations reduce the chance that a person will get the flu. Even if you do not usually get the flu or are not one of the groups at high risk for complications, you can spread the flu to people who have a greater chance of becoming seriously ill from the flu.

Protect yourself, your patients, and your family. Get your flu shot!

For more information about the flu and flu vaccines, visit: www.doh.wa.gov/cfh/immunize/flu_updates.htm

If you are a healthcare employer or administrator, you can access tools to plan a flu vaccination clinic for your employees at: www.withinreachwa.org/forprof/IACW/Influenza.htm

Nicole Pender is the Adult and Adolescent Immunization Coordinator with the Washington State Department of Health Immunization Program CHILD Profile. ■

Washington State Medical Association &
Washington State Medical Group Management Association
Practice Management Seminars

*** CPT AND ICD-9 CODING REVIEW ***
*** MEDICARE BILLING AND PAYMENT ISSUES ***

--- Two Separate Programs ---

Wednesday, December 6, 2006

King Oscar Convention Center, 8820 South Hosmer, Tacoma WA

Morning: CPT and ICD-9 Coding Review 8:30 a.m. - 12:30 p.m.

Understanding the intricacies of coding determines whether your practice gets paid accurately and is protected against allegations of fraud and abuse! Expand and refine your knowledge of CPT and ICD-9-CM coding by participating in this interactive coding program. The need has never been greater for physicians, coders and administrators to code, document and bill correctly. Attend this program and embrace coding changes and coding challenges with new information, knowledge and resources. Get the latest on these issues: CPT & ICD-9 changes for 2007; Understanding Modifiers focusing on -59 and -25 Modifiers; Correct Coding Initiative (CCI), Bundling/Unbundling; General Coding Updates

The Presenters: **Bob Perna, FACMPE** is the Director of Health Care Economics for the Washington State Medical Association; **Arlene J. Smith, CPC** is the Health Insurance Coding Specialist for the WSMA.

Afternoon: Medicare Billing and Payment Issues 1:30 p.m - 5:00 p.m.

The numerous changes introduced into the Medicare program have confused many physicians' practices, even prompting errors in billing. Working in close collaboration with Noridian Administrative Services, we bring you this hands-on education program on Medicare. Seminar registrants will receive with their registration confirmation an Assessment Tool to pose questions to the presenters! Get the latest on these issues: Understanding Medicare Coverage Policies; Billing Appropriately and Effectively; Compliance

The Presenters: **Richard W. (Dick) Whitten, MD**, is Noridian's Contractor Medical Director for Washington. **Linda Windley, CPC** is Noridian's Director of Provider Education for Medicare in Alaska, Oregon and Washington.

To register on-line go to www.wsma.org/memresources/seminars.html. Questions? Contact Beth Chapman by phone at 1-800-552-0612 or via e-mail at mailto:bkc@wsma.org.

Seminar Tuition: WSMA and WSMGMA members can attend the morning Coding Review program only for $189 per person, or the afternoon Medicare program only for $99 per person, or attend both programs for a discounted fee of $274 per person. Non-members: call for rates. Cancellations received on or before five full business days prior to the seminar receive a full refund. Cancellations thereafter receive a refund less a $50 cancellation fee.

Nominating Committee selects nominees for 2007

The PCMS Nominating Committee has confirmed their slate of nominees for 2007 trustee and officer positions. Nominated for one year officer positions are:

- President-elect: **Ron Morris, MD**
- Vice President: **David Bales, MD**
- Treasurer: **Jeff Nacht, MD**
- Secretary: **Steve Duncan, MD**

Nominees for two-year Trustee positions, 2006-2008 include:

- **Ed Pullen, MD**
- **Jeff Smith, MD**
- **Don Trippel, MD**

The nominating report will be sent to the membership, followed by ballots that must be returned to the Society office by December 5.

If elected, those nominated will be joining those remaining on the Board of Trustees who will be completing their terms in 2007. They include:

- President: **Sumner Schoenike, MD**
- Past President: **Joe Jasper, MD**

and Trustees:

- **Harold Boyd, MD**
- **Leaza Dierwechter, MD**
- **Harald Schoeppner, MD**

Those leaving the Board of Trustees in December 2006 include **Dr. Patrick Hogan**, past president and **Drs. Ken Feucht** and **Paul Schneider** both completing trustee terms.

New trustees take office immediately following the annual meeting which is Tuesday, December 12. ■

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

Get Your NPI Now!

CMS (the Centers for Medicare & Medicaid Services) urges physicians to get your National Provider Identifier (NPI) "before the rush" to avoid delayed or rejected claims, which CMS warns could be the case if you haven't signed up for an NPI in advance of the **May 2007 deadline**. Do it now!

Every physician who submits electronic claims must apply for an NPI in time to be **using it by May 23, 2007**. The 10-digit number, which is already in use by Medicare, does not expire or change and will replace all other identifiers that doctors and private payers currently use. To get your NPI you can:

1) Apply online (https://nppes.cms.hhs.gov/),

2) Call the NPI Enumerator, a special contractor hired by CMS, at 800-465-3203 and request a paper application form to complete and mail back, or

3) Give permission to a CMS-approved Electronic File Interchange Organization to obtain an NPI for you. These groups are able to process many NPI requests at one time and may be appropriate for large medical practices and hospitals. ■

Source: Centers for Medicare & Medicaid Services

In-store clinic operator pulls out of Oregon market

Despite the outcome in Portland, experts predict today's 180 in-store clinics across the country will jump to 2,000 in 2009

By Tyler Chin, reprinted from AMNews, Oct. 23/30, 2006

Take Care Health Systems LLC, a major operator of in-store clinics, has exited the Oregon market after concluding it couldn't earn a profit there. But observers don't expect the news to cool off the red-hot growth of in-store clinics across the country.

On September 28, the Conshohocken, Pennsylvania-based company closed clinics it operated out of half-a-dozen Rite Aid drug stores in Portland, Oregon.

"What we found after operating there for close to a year was that there wasn't as much of an access to [care] problem as in other markets," said Lauren Tierney, a spokeswoman for Take Care Health Systems. "In turn, there was a lack of patient demand, which made it unsustainable for the business model."

Along with Kansas City, Kansas, Portland was one of two markets Take Care Health Systems selected in July 2005 to test the concept of using nurse practitioners to treat minor conditions on a walk-in basis at retail sites.

The concept has become one of the hottest trends in health care in the past year as retailers such as Wal-Mart Stores Inc., Walgreen Co. and Target have increasingly leased space to clinics staffed by physician extenders. The stores have made the move to enhance customer service, and drive sales of prescriptions and nonprescription goods. Based on the expansion plans of major operators in the field, some experts estimate there will be 2,000 clinics in 2009, up from about 180 as of early October.

Rite Aid continues to be committed to the in-store clinic concept. The Camp Hill, Pennsylvania company, which recently announced it will open nine clinics in California, plans to partner with another company to reopen clinics in Oregon. ■

Want patient referrals?

The Pierce County Medical Society has operated a patient referral line for many years. Our office receives many calls each day from patients seeking medical care from physicians of various specialties. It is becoming increasingly difficult to find appropriate referrals for many callers, particularly primary care.

If you are willing to accept new patients, and want to have patient referrals made to your office, please let us know. It is helpful to know restrictions you place on your practice, but we particularly need physicians who will accept Medicare and/or Medicaid patients.

We normally give two or three names to patients so the choice is theirs regarding selection of a physician, but this process is becoming more difficult. We want to give accurate and timely referral information to the public and would appreciate a call from you.

Call PCMS and ask for Michelle, 253-572-3667. Your participation will be appreciated. ■

Influenza from page 7

but rather a person who has been pre-assigned and trained to take command in these circumstances. Emergency information will be delivered over commercial radio stations such as KIRO 710 AM, KVI 570 AM, KTTH 770 AM, and KOMO 1000 AM. In this type of scenario, the Pierce County Executive in conjunction with Dr. Cruz-Uribe can direct care and commandeer resources for the safety of the population. The rules for medical liability change in a disaster and the government assumes a much larger role when actions of physicians are under the direct orders and programs of government officials. Within Pierce County, in this type of scenario, we have determined that there would be three new levels of care:

• TIER 1: This care is delivered at the physician office and over 30 designated urgent care and larger clinic sites in Pierce County. The Tier 1 locations are called Remote Triage Sites. These offices and larger clinics are being contacted about preparations to deliver first line care. The goal at these sites is to deliver consistent information and guidance about the management of influenza. Additionally, providers in these areas will triage patients dependent upon their severity of illness. The patients will then be directed to their home, a Level 2 or a Level 3 facility. The concept of triage can be emotionally and clinically difficult, but is necessary to provide optimal care for all patients. Triage levels will include the following categories: emergent (red), urgent (yellow), stable (green), and expectant (black). Expectant patients are not expected to survive and arrangements will be made to provide them with hospice care in a humane fashion. This may happen at Tier 1, Tier 2 or Tier 3 sites.

• TIER 2: These sites would be called Alternate Treatment Sites and they would include schools, the Tacoma Dome and other public areas that have been predetermined. These sites are being prepared to support patients with medical needs that can be met in a specialized setting. The Tier 2 sites would include focused and specialized care for influenza patients who need intravenous fluid therapy, antibiotics, supportive care and antiviral medications as determined by protocol when they are available. These sites would be staffed from a variety of resources. Admission packets and documents have been developed for Tier 2 and order sheets similar to current order sheets used for our hospitals have been developed.

• TIER 3: These sites would include the traditional hospitals in our region. Care in these sites would be dramatically changed. These changes would include the discontinuation of elective procedures and surgeries and discharge to home or skilled nursing facilities all patients who do not require ongoing inpatient care. Hospital based teams would expand and beds would be re-designated to collect together and identify the cohort of pandemic influenza patients. Prioritization of mechanical ventilators and mechanisms for acquisition of additional ventilators would need to be quickly determined. Hospital personnel would be rapidly vaccinated and/or provided with antiviral prophylaxis or treatment as recommended by the Department of Health and Human Services and the state health departments. For more details about protocols regarding prioritization of vaccine and antiviral drugs please see the DHHS website (http://www.hhs.gov/pandemicflu/plan/appendixd.html).

Local Procedures and Contact Information for Physicians:

When such a scenario happens, providers should carry their identification badge with them to ease access to health care facilities due to increased restrictions. Emergency privileging procedures will be facilitated when providers have their current identification badges. The table below lists the major hospital systems in the area and the emergency contact information that will publish their operating status and instructions for physicians with privilege at that site.

See "Influenza" page 18

- Cut and save -

Hospital System	Incident Command Contact Information Line	Internet Access for Information
Franciscan Health System: St. Joseph, St. Clare	253-426-6664	www.fhshealth.org
Madigan Army Medical Center	253-968-3653	www.mamc.amedd.army.mil/wrmc
MultiCare Health System: Good Samaritan	253-697-4000	www.goodsamhealth.org
MultiCare Health System: Tacoma General, Allenmore and Mary Bridge	253-403-8677	www.multicare.org
Washington Military Department: Emergency Management	800-562-6108	www.emd.wa.gov
Washington State Department of Health	800-525-0127	www.doh.wa.gov

COLLEGE OF MEDICAL EDUCATION

2007 Neurology Update

The *2007 Neurology Update* CME is scheduled for Friday, February 2 at St. Joseph Medical Center in Tacoma. The course is under the medical direction of PCMS Past-President **Dr. Patrick Hogan**.

The one day program will focus on updating the primary care physician on diagnosis, management and referral of neurological disorders.

Mark your calendar now and watch your mail for registration information and a course brochure. It is anticipated that the course will fill, so early registration is advised. ■

Cardiology for Primary Care

Cardiology for Primary Care – a one day CME course will be held on Friday, March 2 at Fircrest Golf Club in Fircrest. The course director will be **Dr. Gregg Ostergren**.

The program is designed for the primary care physician and will include updates on cardiac evaluation and testing and treatment with an understanding of the expanded treatment duties of today's primary care doctors.

Watch your mail and this *Bulletin* for specific program content – both speakers and topics which will be available soon.

Register for both programs by calling the College at 253-627-7137 or going to the College page at the PCMS website www.pcmswa.org. ■

Continuing Medical Education

CME at Whistler...Snow is Looking Good!

The annual Whistler and CME course will be held Wednesday through Saturday, January 24th to 27th, 2007. Make your reservations now as everyone is anticipating a busy, busy ski season.

This year's course has a dynamite line up of speakers discussing a variety of topics of interest to all physicians. **John Jiganti, MD and Richard Tobin, MD,** course directors, have done an outstanding job of scheduling speakers and topics, including:

- A Fungus Among Us: Update on Antifungals - Lawrence Schwartz, MD
- HIV Update for the Primary Care Provider - Elizabeth Lien, MD
- Staphylococcus aureus: Management of a Problematic Pathogen - Mark Rupp, MD
- Bioterrorism: Always a Valid Threat - Marina Arbuck, MD
- Interesting Cases of Infectious Diseases - Peter Marsh, MD
- Current Update from the Health Dept. on Infectious Diseases - David Harrowe, MD
- West Nile Virus - Ramona Popa, MD

The program has been accredited for 10 hours of AMA Category I Continuing Medical Education Credits. After the course the participant will be able to:

Identify new therapies for fungus infections; Review the progress made on HIV infections and discuss the adverse effects of anti-retroviral treatment medications; Understand the pathogenesis of disease due to Staphylococcus aureus; be knowledgeable about the major mechanisms of resistance in Staphylococcus aureas; and understand the importance of antibiotic resistance; Recognize and learn clinical presentations of infections from biological weapons, and identify and discuss which biological weapons are most likely to be used in a bioterrorism attack; Discuss and appreciate the breadth and scope of clinical infectious disease cases; Recognize and diagnose West Nile Virus infection.

Reservations for the program's condos, Aspens on Blackcomb, can be made by calling ResortQuest at 1-877-676-6767, booking code #403699. You must identify yourself as part of the College of Medical Education group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by December 1, 2006, when any remaining condos in the block will be released. ■

Dates	Program	Director(s)
Wednesday-Saturday January 24-27	CME at Whistler	John Jiganti, MD Richard Tobin, MD
Friday, February 2	2007 Neurology Update	Patrick Hogan, DO
Friday, March 2	Cardiology for Primary Care	Gregg Ostergren, DO
Friday, April 20	Orthopaedic/Gastroenterology 2007 Update	Nicholas Rajacich, MD John Carrougher, MD
Just Added! Friday, May 4	Radiology for the Non-Radiologist	Andrew Levine, MD Gordon Benjamin, MD
Friday-Saturday May 11-12	Internal Medicine Review 2007	Joseph Regimbal, MD
Friday, June 8	Advances in Women's and Men's Medicine	John Lenihan, MD Loren Beveridge, MD

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Plugging Into the System:

Physicians can join the reserve corps of physicians who can be deployed in time of disaster by visiting http://www. medicalreservecorps.gov/ HomePage or contacting The Pierce County Medical Reserve Corps. [Phone (253) 798-3538 ext 7665, 3629 South D Street MS 109, Tacoma WA 98418]

Summary:

Will you be ready to support yourself, your family and your community? The information provided in this review is designed to alert you to actions that you can take and to those structures that have been put in place to help you perform more effectively as a healthcare provider. We all hope that we never need to activate such a program but if we need to, being prepared will help our community minimize any impact of a natural disaster, terrorist incident, or pandemic.

References:

1. *Disaster Preparedness Handbook: An emergency planning and response guide*. Washington Military Department, Washington State Department of Health. January, 2005. http://www.doh.wa.gov/phepr/actsheets.htm. (Last accessed 7/06); 1-800-525-0127 for disabled persons.

2. Incident Command System IS-100 Incident Command System Introduction, http://training.fema.gov/emiweb/ (last accessed 10/06) ■

Classified Advertising

POSITIONS AVAILABLE

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@soundfamilymedicine.com. Equal Opportunity Employer.

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 GP, FP, IM. Contact Paul Doty (253) 830-5450.

Seattle, Washington. Multi-specialty medical group seeks B/C FP, IM/Peds or ER physician for a f/t urgent care position. All urgent cares are located within 40 minutes of downtown Seattle. As a MultiCare Medical Group physician, you will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. Take a look at one of the Northwest's most progressive health systems. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org. Please refer to opportunity #479-495. "MultiCare Health System is a drug free workplace"

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

Nurse Practitioner/Physician Assistant – Certified. Full-time opening for a nurse practitioner or physician assistant to provide quality healthcare to patients of all ages in one of our Urgent Care Centers located within 40 minutes of downtown Seattle. Experience in urgent care and family practice is preferred. Candidates must be qualified for licensure & certification in Washington State as a PA or NP. You will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. You'll live the Northwest lifestyle and experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Please email your CV to MultiCare Health System Provider Services at providerservices@multicare.org or fax your CV to 866-264-2818. Website: www.multicare.org. Please refer to opportunity # 483-556 and 593. "MultiCare Health System is a drug free workplace"

OFFICE SPACE

Satellite office space available in Lakewood. Tuesdays plus two Saturdays per month. More days negotiable. Please call Cathie at 253-581-1943 or email cathirosa@aol.com.

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Pierce County Medical Society

BULLETIN

December, 2006

Happy Holidays

2006 Holiday Sharing Card
Artist: Jason Lee Middle School Student, Jasmin Feriante

You won't want to miss the 2006 Annual Meeting! Details inside - page 4

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

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions 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, 2006

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President's Page

by Joseph F. Jasper, MD

Thanks for an Interesting Year

Joseph F. Jasper, MD

During my term as PCMS President in 2006, our society has discussed many topics. We discussed Economic Credentialing as a growing problem in the USA only to have it crop up a few months later in Washington State with Regence Select. We have raised awareness about the pitfalls of coverage decisions using evidence-based medicine, patient out-migration, physician recruitment difficulties, referral patterns, sham peer review, pay for performance, lack of due process in MQAC, disaster preparedness, and inter-communicability of health databases and electronic records. All the while the CHAMP program continued. PCMS was well represented at the WSMA, AMA and various regional meetings. It has been a very interesting year.

Some significant accomplishments occurred with PCMS participation. We have an improved school health asthma form. **Drs. Schneider, Schoenike, Hogan** along with **Drs. Jane Moore** and **Mark Craddock** established the Gig Harbor Healthy Community project to promote fitness and other healthy choices at the neighborhood level. We hope that this will become a model for similar programs in every Pierce County community. The Healthy Communities Project is in cooperation with the Tacoma-Pierce County Health Department. We brought MultiCare and the Franciscans together on a variety of topics to benefit our doctors and patients including information technology communications, physician recruitment and out-migration, resident rotations and disaster response. PCMS has updated our web site - www.pcmswa. org. Paperwork reduction has been one of my mandates. We have saved over 500 bucks this year alone in copying – think digital! Our number of enrolled members has increased as have our coffers.

Our board is comprised of specialist and primary care doctors, private practice, solo, group and hospital employed physicians; a good cross representation. I am very impressed by the effort of some of our members in community health and other PCMS activities. The uncompensated work of these individuals holds great promise for the future of Medicine in our county. I have challenged them and received their thoughtful response, which made this year a stimulating one. I thank the board and staff of PCMS for their support and work over the past year. ■

Pierce County Medical Society

invites you and your spouse/guest to join us for the

2006 ANNUAL MEETING

Passing of the gavel from President Joe Jasper, MD to Sumner Schoenike, MD
Saying goodbye to Patrick Hogan, DO for his 7 years of Board service
Introduction of the 2007 officers and trustees

Presentation of the Community Service Award
Raffle Drawings and Holiday card sales to benefit the PCMS Foundation
Please bring an unwrapped toy (child) and/or a wrapped gift (woman) for YWCA Shelter residents

and a very special presentation by

Captain Jerry Cockrell, Ph.D.

psychologist... aviator... humorist

Crew Resource Management

-the safety parallel between pilots and physicians

Dr. Jerry Cockrell's down-home, hilarious anecdotes will charm, educate and entertain you at this year's annual meeting. Dr. Cockrell, a former 737 Captain with over 20,000 flying hours, holds a Ph.D. in psychology and education, is an authority on safety, and serves as expert witness in regard to human factors in numerous aviation accident areas. He toured and taught for the Air Safety Foundation for many years and is a National Accident Prevention Counselor appointed by the FAA in Washington D.C. His aviation humor, always a crowd pleaser, is sure to make you laugh.

Tuesday, December 12, 2006;	**Sheraton Tacoma Hotel—Ballroom;**	**1320 Broadway Plaza, Tacoma**
Social Hour: 6:15 p.m.	**Dinner: 7:00 p.m.**	**Program: 7:45 p.m.**

Please return by Friday, December 8 to PCMS, 223 Tacoma Avenue South, Tacoma WA 98402
You may fax to 253-572-2470 or call 253-572-3667 for more information

Please reserve _____ dinner(s) at $40 per person. Enclosed is my check for $ _____

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☐ Visa ☐ MC ☐ AM Signature _____

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We look forward to seeing you!

Dr. Sumner Schoenike passes committee chair to Dr. Jane Moore

At the November 17 meeting of the Public Health/School Health Committee, **Dr. Sumner Schoenike** passed the leadership of the committee to **Dr. Jane Moore**. Dr. Schoenike, a Lakewood pediatrician, has chaired the committee since April 2000 and Dr. Moore, a Tacoma family practitioner has been a member since 2004.

The committee brings together school nurses, physicians and public health representatives in efforts to provide better health care to students in Pierce County. The committee stems originally from two PCMS committees – the public health committee and the school health committee. They merged in the 1970s finding much overlap in their work projects.

Past committee chairs have included **Drs. Joe Wearn, Lawrence Schwartz, Terry Torgenrud, David Sparling** and **George Tanbara**.

Drs. Sumner Schoenike and Jane Moore in a ceremonial "pass"

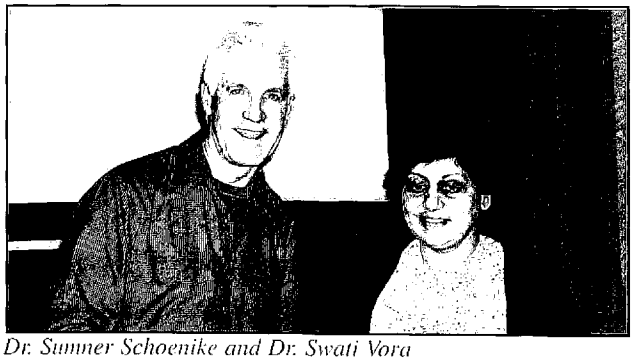
The two most recent accomplishments of the committee include development of the Health Care Provider Medication Request & Treatment Plan for Asthma form used by physicians and schools in coordinating care of asthmatic students and the continuing education series in November featuring Drs. David Estroff, **Tom Charbonnel** and **Swati Vora** giving updates on immunizations and seizure disorders. ■

Public Health/School Health Committee education program highlights immunization and seizure disorder updates

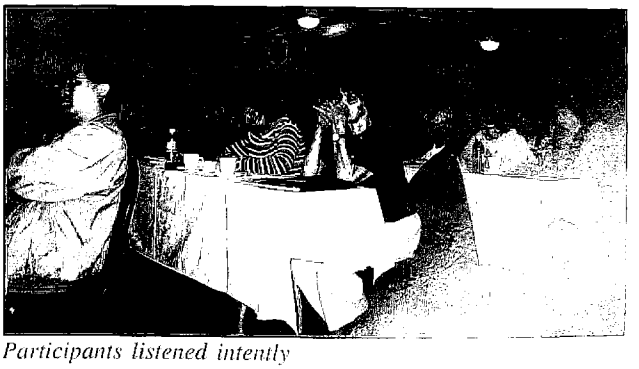
The Public Health/School Health Committee of PCMS held their annual education offering at the Landmark Convention Center on Saturday, November 17. With a dual focus this year, the program concentrated on the latest information regarding immunizations and on an overview of neurological issues with emphasis on seizure disorders. The program, attended by a mix of school nurses, public health representatives and physicians received excellent evaluation marks by attendees.

This is the first year the program was held on a Saturday as normally programs are offered in one hour increments at 7:00 a.m. in the morning. This format was experimental to see if it was more convenient for physicians to attend on a Saturday rather than a busy work day morning. Attendance was lower for the Saturday morning than for most programs scheduled on a workday morning.

The series of education programs was designed to provide continuing education as it relates to the school health setting, but more importantly it was hoped that the classes would provide an avenue for school nurses and physicians to interact, become familiar with one another and build relationships that would ultimately result in better health care and management of health care issues in the school setting.



Dr. Sumner Schoenike and Dr. Swati Vora



Participants listened intently

Update: South Sound Health Communication Network

The Network will have its two-year anniversary at the beginning of 2007. The secure communication platform, co-sponsored by the Pierce County Medical Society and Northwest Physicians Network, is the first physician-led, truly community-based connectivity solution in the country. We have learned a lot about the communication needs of small practices and the ways a solution like this can be of tangible value for improving care coordination. It significantly reduces communication chaos with incoming and outgoing patient information in the typical small practice.

There are currently 1,631 individuals (including 238 patients) using The Network to send and receive patient information from their desktops in this fully secure Web-based environment. Physicians and their staff all over Pierce County are using this platform to communicate with each other, make referrals, receive lab and radiology results, schedule patient visits and respond to prescription refill requests. Seasoned users are discovering simple and effective ways to use The Network's functionality to improve office workflow. It can be used to reduce the load on the receptionist's phone, as well as streamline the care coordination process when it involves physicians and services across the community.

Physicians who have access to the Franciscan Elysium Web-based clinical messaging system are only one click away to viewing their patient's data from The Network's dashboard. Medical Imaging Northwest delivers results through The Network to the physician's or nurse's desktop, as does Quest Labs. The Network is working with LabCorp to provide the same results delivery. E-prescribing solutions will be added in early 2007. The goal is to assemble the majority of incoming data streams typically used by a practice with tools and templates that make care coordination, communication and referrals faster, easier and more reliable. Further, this all comes from one location in the dashboard.

The recent acceleration in health IT adoption across the country has also brought with it confusion, skepticism and unproductive claims about providing the "best solution" for a practicing physician. The last two years has illuminated the real role of The Network for the community physician. All hospital systems already have or will soon have very rich results delivery portals for physicians whose patients use their inpatient and outpatient services. Provision of these services requires a significant investment in information technology at the source. Any physician in the community who uses the hospital's services can access these convenient portals.

The Network forms the connectivity platform that connects physicians with each other, with patients and patient data providers across the entire community. Its purpose is to make data movement coming into and going out of the small community-based practice easier, more timely, reliable and less expensive than the current modes of phone, pager, fax, snail mail and sticky notes. One practice has already documented a real savings to the bottom line of about $4,000 per physician in the first 12 months' use of The Network. This compares favorably with The Network's annual subscription fee of $480.

In the Puget Sound area, about 40% of the physicians practicing medicine are in small practices of one or two providers. Another 30% are in groups of three to five. Most practices of this size do not have operating margins capable of significant IT investments. The majority of physicians' technology needs are therefore largely ignored by the current push to adopt health information technology. While EMR use is the direction in which medical practices will evolve, there is much that can be done short of an EMR to improve information handling coming into and leaving the office while reducing some of the administrative expense associated with this level of inter-office communication across the community. This is the role of The Network.

If you would like more information about The Network, please call Sue Asher at 253.572-3666 or Rick MacCornack, Ph.D. at 253.207.4341.

There are currently 1,631 individuals (including 238 patients) using The Network to send and receive patient information from their desktops in this fully secure Web-based environment.

December 31 is the Deadline to Change Your Medicare Participation Status

December 31 is the deadline to change your Medicare participation status for 2007. You must write to each carrier to which you submit claims, advising of your termination effective January 1, 2007. This written notice must be postmarked prior to January 1.

Physicians may also choose to opt out of the Medicare program entirely and are bound only by their private contracts with their patients. Remember, once you opt out, you cannot opt back in for two years.

For more information on making these decisions, visit the Noridian Medicare website: https://www.noridianmedicare.com/p-medb/enroll/participation/open_enrollment.html ■

Correction

On page 18 of the November 2006 issue of the Pierce County Medical Society *Bulletin*, an incorrect phone number was listed for the Pierce County Medical Reserve Corps. The correct number should be 253-798-7665 ext 3538. ■

WSMA Sets Legislative Priorities for 2007

The Washington State Legislature convenes on January 8 with larger Democratic majorities in both the House and Senate. It will be a 110 day session. In the House, Democrats have a 30 member majority (64D-34R), and in the Senate a 15 member majority (32D-17R).

At its November 4 meeting, the WSMA Board of Trustees adopted the following legislative priorities:

1. **Access to Medical Assistance (Medicaid) and the Basic Health Plan (BHP)**: The WSMA's number one priority is to improve access to both Medicaid and the BHP. The WSMA seeks to have Medicaid and BHP reimbursement (currently below the cost of providing many services) pegged at 80% of the UMP (Uniform Medical Plan) for all services except those to low-income pregnant women and children, which would be paid at 100% of the UMP rate.

Both upgrades carry hefty fiscal notes - the Medicaid increase is $704 million in combined state and federal funding for each year of the 2007 - 2009 biennium; the fiscal note for the BHP enhancement is $86 million per year. No one is underestimating the task ahead, but the shift worker at the Speedy Mart deserves the same access to care as a state senator.

2. **Mental Health Parity**: During the 2005 session, mental health parity for insurance coverage passed with strong bipartisan support and was directed at the large group market - groups with more than 50 employees. The Washington Coalition for Insurance Parity, of which the WSMA is a member, is proposing full parity in the 2007 session - for both the individual and small group market.

3. **Medical Discipline**: The WSMA is in discussions with the governor's office on moving the Medical Quality Assurance Commission (MQAC) out of the Department of Health, making it a freestanding entity. The Governor would continue to appoint the members of the Commission, but the Commission would hire its own staff and control its budget. In addition, the WSMA has proposed that the adjudication phase of discipline be conducted by an entity other than the Commission, and that a new mechanism for handling lower level problems be created.

4. **Expansion of Certificate of Need (CoN)**: A bill from the 2005 session established a task force to evaluate the appropriateness, and possible expansion, of the Certificate of Need

See "Legislative" page 10

— TRICARE —

Is your practice having difficulty with delayed or denied claims dealing with TRICARE? Have you limited or stopped seeting TRICARE patients? If so, please contact the Pierce County Medical Society office with specific examples. Additionally, please report your experiences with TRICARE to WSMA via their ICAR services www.wsma.org/memresources/reference1.html. For futher information, contact Bob Perna at WSMA 1-800-862-1118.

Legislative from page 9

(CoN) program. The task force has recommended that the Legislature expand the CoN program into such physician services as ambulatory surgery centers, freestanding radiological service centers, diagnostic imaging centers and PET/CT scanners. The WSMA will continue their long record of opposition to the CoN program and will continue its opposition during the 2007 session.

5. **Licensing Ambulatory Surgery Centers (ASC) and Physician Office Surgery (POS)**: It is anticipated that the Legislature may want to take up the issue of licensing ASCs and POS. The WSMA will work with the Freestanding Ambulatory Surgery Centers Association of Washington on both of these potential measures (to oppose or make them acceptable). The POS bill will likely propose to license on the basis of the level of anesthesia that is administered to the patient.

6. **Scope of Practice**: If any scope of practice bills will be considered next session, the WSMA will exercise its long-standing opposition to expansion by alternative provider groups.

7. **Specialty Hospital Ban**: The WSHA is expected to again introduce legislation to require all hospitals to have an emergency department and cover all specialty services 24/7. This effectively kills the development of specialty hospitals in the state. The WSMA will continue to oppose this legislation.

8. **Public Health Funding**: The WSMA will again support legislation to provide dedicated funding for the state's public health services.

9. **Diagnostic Imaging Self-Referral**: Legislation to restrict referrals for diagnostic imaging if the referring physician has an ownership interest in the diagnostic imaging equipment may be submitted in 2007. There was such a bill in 2005, but not in 2006. The WSMA will oppose such a bill if it is introduced.

For questions or more information contact Len Eddinger, Senior Director, Legislative and Regulatory Affairs, at 360.352.4848 or 1.800.562.4546 (email len@wsma.org). ■

In My Opinion

by David Kilgore, 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 Imaginary Safety Net

David Kilgore, MD

Author's Note: This was written during my sabbatical last year, during which time I worked for a migrant community health center near the Mexican border, although it also reflects sentiments from my previous work in our local community health care system and seeing underserved patients in the residency program.

The nursing note for my next patient stated simply, "Follow-up of nose injury." Randy (not his real name) was a young man, new to the clinic, so there was no background information available from the chart. I knocked on the door, stepped into the small examination room, and introduced myself to a short, unshaven young man with a bandage covering the end of his nose. I learned he was involved in a fight three nights ago and that his assailant had "bitten him on the end of his nose." He had been treated at the local emergency department and had been referred to a plastic surgeon for follow-up. Upon calling the surgeon's office for an appointment the next day, however, he was told that because he had no medical insurance, he would need to bring $500 cash up front just to be seen for the first appointment. When he called the ED back to complain, they gave him the number of our community clinic. Randy looked at me angrily. "I make minimum wage, Dude - no way I have that kind of money lying around. What am I supposed to do?"

I've cared for underserved populations my entire professional life, and his is an all too familiar story. The safety net for uninsured patients, such as it exists in the United States, stretches paper thin between emergency departments and community clinics. The buck stops with us, if it stops at all. When poor people have nowhere else to turn, they come to us. After almost 20 years of seeing the results of poverty and lack of access to care, I still never know what to expect behind the next exam room door.

I reached forward and gently began to peel back the bandage. Many times patients are referred to plastic surgeons for fine-tuning of cosmetically important wounds, like facial lacerations. Surgeons have the extra training to do subtle wound improvements or scar revisions to help obtain the best cosmetic results. This young man seemed like a rough-and-tumble sort of guy - when I reviewed his basic medical history, he proudly regaled me with his various physical exploits that resulted in several broken bones, three amputated fingers, and various bodily scars. I was a little surprised he would be concerned about having a plastic surgeon attend to a scar on his nose, but then again, it was his face and he had a right to the same level of care as his insured brethren.

His problem, however, wasn't with a scar across his nose. His problem was that he no longer had a nose. Pulling back the last layer of bandage, I stifled a gasp. In the middle of his face, between his eyes and mouth, was a jagged wound. There was a small remaining upper bridge of nose jutting down, but the fleshy end was traumatically missing - bitten off.

As horrific as it was, the wound at least showed no signs of infection. I rebandaged it, instructed him about further wound care, then promised him that the clinic's outreach worker would get to work on trying to find a plastic surgeon who would see him - for what? For free? Not likely. He had the classic dilemma of the working poor - an injury or condition that wasn't a life-threatening emergency but still clearly needed treatment. His low-income job offered no health insurance but paid him just enough to disqualify him for Medicare coverage.

Our outreach worker sighed when I gave her the referral request. She added his chart to the towering pile on her desk, muttering her suspicions out loud. "What was he doing that night anyway? Did he provoke the fight?" In other words, what was his responsibility for his current predicament? Is he simply paying for his poor choices? I often struggle with how judgments of the health care community can sometimes make it more difficult to render compassionate care, whether subtly with sarcastic comments and nonverbal behavior, or overtly with substandard or denied care. And this is a slippery slope to start down. Who among us has not done something stupid that resulted in an injury, however small? Are injuries that happen to insured people somehow immune to judgment and more worthy of society's [illegible]. The

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Safety Net from page 11

choices of many to overeat and not exercise are resulting in an epidemic of diabetes, hyperlipidemia, and vascular disease with very expensive consequences: Are these patients therefore to blame and not deserving of coverage for their medical treatments?

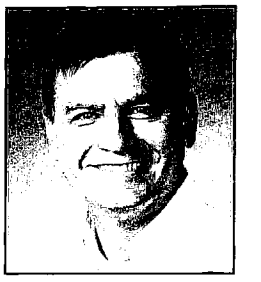
During a follow-up visit, Randy asked me to check his shoulder, also injured in the fight, and I noticed persistently elevated blood pressure readings as well. I diagnosed a torn muscle in his shoulder and new-onset hypertension - problems that at least I could treat, although in limited ways due to his lack of insurance. An MRI scan would have been helpful to confirm his torn shoulder muscle, but he simply laughed at the $800 he would have to come up with. Physical therapy would have been helpful in his recovery, but instead I printed out self-guided exercise instructions in lieu of the $600 bill he again couldn't afford. I had samples of blood pressure medication I could give him, but he insisted on postponing important baseline laboratory tests of his kidney function and electrolytes until he covered his rent that month.

On his third visit, I learned we had succeeded in getting Randy an appointment at the county surgical clinic 60 miles away, at some distant time in the future. He still wore a gauze bandage over his wound, even though it was healing well, to shield himself from stares from passersby. His blood pressure was down, and his shoulder was feeling better. As I prepared to leave the room, he reached out and vigorously shook my hand. "Thanks, Doc. You've done more for me than any of them fancy hospitals." I was initially embarrassed by his effusive gratitude, but later, as I sat finishing his chart, I found myself feeling sad and angry. I reflected on all the care he would have received had he been insured. As community clinic physicians, we do what we can but know it's often not enough. We know that some care is better than no care, but we carry the burden of knowing what care and treatment someone with insurance would have received. At times, and especially early in my career, I have been proud of carrying that burden, of being part of a safety net for the neediest. At other times, and more so lately, I wonder if my very participation in this system plays a darker role - a complicit role - of enabling the disparity of care to persist, of helping to provide false reassurance that we actually have a safety net that provides adequate care to all in need. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD, MPH
Director of Health

Let's Stop Complaining About our Health Care System



Federico Cruz-Uribe, MD

Has the time come for us to truly change our health care system? For years and years I have been to meeting after meeting where the central focus has been on how dysfunctional our current system is. Over and over I hear: the system is inaccessible to so many in need, it is expensive, and it is stressful for both user and provider. For me as a public health person it is ineffective from a population health perspective, that is, as we spend more and more money on health services our communities as a whole are not getting healthier.

Have we become comfortable just complaining? Discussions of changing the system in any fundamental way have in the past led to passionate and divisive conversations that didn't go anywhere. Each side entrenched themselves in their sacred positions and were not willing to look at any alternatives. Yes, there has been a steady stream of legislative bills floated over the years, but they are mostly bills that deal with little nibbles around the edges. How do we adjust the benefit package? How do we alter eligibility? How do we adjust the rates of reimbursement?

None of these approaches deal with the fundamental problems of our current system. Shortchanging or overpaying providers will not make cost-effective services more available to those in need. Making fewer or more people eligible for care will not lessen demand for care. Adding or deleting services that you are eligible for will not control costs. All of these maneuvers are doomed to fail until we realize that they are all linked together and that real solutions mean changing all three in an inter-related way.

POINT #1: There is no getting around the fact that we need to have community-wide risk sharing. All of the members of our community must be covered by whatever system we have in place, otherwise the continual games we play with cost shifting will continue. It is not such a big step. We do it now but we do it covertly and, inefficiently and ineffectively and expensively. We wait until people are crippled by disease then we put them on the government dole and pay for all of their rehabilitative and maintenance care. The classic case: refuse to pay to prevent or control diabetes but pay for the kidney transplants and cardiac bypasses from that come from this chronic disease when left untreated.

POINT #2: A defined package of services that are covered by a new health care system needs to be established. Now, everyone is treated differently, depending on whether you are insured and if you're insured what kind of insurance you have. If a large company or the government employs you, you get a certain kind of coverage. If you work for a small employer or are self employed, your coverage is probably very different. This wouldn't matter except that health outcomes are very different for people with the same health problems but who belong to these different classes of coverage. I don't think anyone can defend the basic unfairness of this situation. It leads to health disparities that are a true embarrassment for our community. Poor people and unemployed people and people of color sicken and die more often than their neighbors and co-workers who happen to have a different insurance status.

POINT #3: Deciding what services are available to every member of our community is very important and must not be left up to experts but rather must come out of a community dialogue. A dialogue in which the citizens of our communities speak for themselves about what should be covered and what shouldn't. It is critical to have a system that is basically fair and supported by the vast majority of our community. This will not happen if someone else is making all the decisions about the system.

I am not sure where a community process will come out, but common sense will need to prevail as the differences between need and desire will come up again and again. I suspect that we will all initially demand as much care as we want. Then, when we realize that we have to pay for it, we will start getting realistic and look at the care we actually need. The discussions about what we want and what we need are two very different discussions. It is essential to have those discussions

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Applicants for Membership

Erin M. Lenza, PA-C
Dermatology
Peninsula Dermatology & Laser Clinic
4700 Pt. Fosdick Dr NW #305, Gig Harbor
253-851-7733
Training: MEDEX PA Program/UW

Kevin E. Sanders, MD, PhD
Radiation Oncology
Tacoma/Valley Radiation Oncology
314 ML King Jr Way #11, Tacoma
253-627-6172
Med School: University of Illinois
Internship: Alameda County Medical Ctr
Residency: M.D. Anderson Cancer Ctr

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

The Seen and the Unseen

Andrew Statson, MD

"What man wants is simply independent choice, whatever that independence may cost and wherever it may lead."
Fyodor Dostoevsky (1864)

Some 160 years ago, the French economist Frédéric Bastiat wrote an essay under the title "What is Seen and What is Not Seen." In it, he debunked a common fallacy among non-economists, known as the broken window theory. It should not be confused with the eponymous theory in sociology.

The latter states that an act of vandalism, when not corrected rapidly, invites more vandalism. A building may remain intact for a long time, but once a window is broken and not replaced, another window will be broken soon afterwards, and then another, and another. It is as if a broken window gave permission for more disfigurement and destruction.

The economic theory claims that a broken window is good for business. You have to replace it, so you call the glazier, and the money you spend will change hands several times and will keep the economy going.

Yes, that is what we see. What we don't see is that if your window had not been broken, with the money you gave to the glazier you could have bought that shirt you wanted. While the glazier benefited from the broken window, it was at the loss of the shirt maker. The general effect on the economy remains the same, except that you also would have had the shirt. If breaking windows created prosperity, then why not break more windows?

Unfortunately, the advice of Bastiat was forgotten, and during the twentieth century breaking windows was not enough. Many people expounded on the idea that war stimulated business and was good for the economy. Why go to war? We can blow up our own buildings, if that were true. Just think of the business that would create.

At every step life presents us with choices, and what we do is always instead of something else. We usually can see the result of the choice we have made, but we cannot see, and can only guess, if we thought about it, what result the choice we did not make would have produced.

When the question is about what we ourselves choose to do, it affects only us and a few people around us. A bad choice would not do much harm. When such a choice is made for us by the people in power and affects our community, or the entire nation, a bad choice can hurt a large number of people.

One example in our field is the effect FDA decisions have on our patients. The approval process for new drugs intends to make sure that the drugs on the market in this country are safe and effective. Laudable goal.

The problem is that all drugs are poisons. They all have good effects and bad. But it is more complicated than that. Patients are individuals, and the effect of every drug varies from one patient to another. It is almost impossible to make a drug that is safe for everybody.

We all know a number of drugs that came on the market with the promise of great benefits, to be pulled out a few years later because of undesirable side-effects. So the process of approval cannot claim that it protects us from unsafe drugs. That is an impossible task. All drugs can be unsafe for some patients.

What we don't see about the approval process is its cost, and the effect of the delayed introduction of new drugs. Drugs are withheld from patients who could benefit from them for several years, and when introduced, they are more expensive.

The National Bureau for Economic Research published a paper by T. J. Philipson et al. in October 2005 reviewing the effect of the fast track drug approval process, enacted in 1992. They estimate that the more rapid access to beneficial drugs has improved the quality of life and prolonged the survival of our patients. They suggest that three to six times more "life years" were saved than lost by the quicker approval of drugs. According to their estimate, the rapid access to beneficial drugs saved between 180,000 and 310,000 life years. They also consider that if every risky drug withdrawn in that period was the fault of the rapid access act, it would be

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blamed for the loss of 56,000 life years.

One may dispute these figures, but we all know a number of widely used preparations which were withdrawn from the market, even though beneficial to most patients, because of rare side-effects observed in a few patients. The rare incidents made the news and were seen by all, while the many benefits remained hidden from public view.

The dictatorial powers of our legal system do not allow drug induced side-effects, but disease induced suffering is just fine, because it is "natural."

Another example is the current problem with pertussis. We had a vaccine that worked, but caused serious complications in a few children. Of course, there was an outcry, a lot of indignation among the lawyers, and the old vaccine was withdrawn.

A new, safer vaccine came on the market. It was not as effective, but that seemed to be acceptable. Information on the long term results is coming in.

In the past four years, the incidence of pertussis has increased 8.3 fold among adolescents and 7.5 fold among adults over the age of 20. I suspect this represents the number of cases diagnosed and reported. The true picture may be different. The disease in adults is atypical and difficult to diagnose. Not everybody with a cough gets a culture. Probably many patients are treated appropriately, but not diagnosed as having pertussis, and therefore, not reported.

Now we are told to give booster immunization to all those between 11 and 64 years of age. The main problem, however, remains in the transmission of the disease to infants, who have incomplete immunity. I have not seen any report on how many children became seriously ill or died from the disease, compared with those who became sick from the old vaccine.

I admit that I am stepping outside my field on this topic and I don't have the answer. I may be wrong, so I'll put it as a question: Was the tradeoff between the old vaccine and the new worth it, now that we see what was unseen then? ■

COLLEGE OF MEDICAL EDUCATION

College implements new course fee schedule

The College of Medical Education Board of Directors at their November meeting voted to implement a nominal fee schedule for their local College CME Category I accredited programs. The new fees, effective January 2007 will be $35 for PCMS members and $50 for non-members. Programs range in credit from six to 14 hours.

While the College Board has been able to offer no-cost programs for many years, continually rising costs, from facilities to accreditation fees, made the decision inevitable. Adding to the decision was the increased difficulty in securing educational grants.

In reviewing other CME programs, locally as well as nationally, the College was one of the very few remaining providers of accredited CME that did not charge for their programs. ■

2007 Neurology Update

The *2007 Neurology Update* CME is scheduled for Friday, February 2 at St. Joseph Medical Center in Tacoma. The course is under the medical direction of PCMS Past-President **Dr. Patrick Hogan.**

The one day program will focus on updating the primary care physician on diagnosis, management and referral of neurological disorders.

Mark your calendar now and watch your mail for registration information and a course brochure. It is anticipated that the course will fill, so early registration is advised. ■

Continuing Medical Education

CME at Whistler...Make plans now!

The annual Whistler and CME course will be held Wednesday through Saturday, January 24th to 27th, 2007. Make your reservations now as everyone is anticipating a busy, busy ski season. Download the conference agenda and registration form at **www.pcmswa.org** under the COME link.

This year's course has a dynamite line up of speakers discussing a variety of topics of interest to all physicians. **John Jiganti, MD and Richard Tobin, MD,** course directors, have done an outstanding job of scheduling topics and speakers, including:

- Congestive Heart Failure - Raed Fahmy, MD
- Sepsis Update for the Primary Care Physician - Ann Lee, MD
- New Advances in Diabetes Management - Ron Graf, MD
- Gamma Knife: Neurosurgery With a Scalpel - Daniel Nehls, MD
- New Antidepressants for Chronic Pain - Allen Bott, MD
- Updates in Plastic Surgery - Frederick Ehret, MD
- Surgery for Emphysema - Michael Mulligan, MD
- Target Therapy in Oncology - Moacyr Oliveira, MD
- Common Dermatitis in Internal Medicine - Jessica Kim, MD
- Stroke Intervention - Brian Kott, MD

The program has been accredited for 10 hours of AMA Category I Continuing Medical Education Credits. After the course the participant will be able to:

Review and update current treatments and new advances in congestive heart failure; Review and discuss recent advances in diagnosis and treatment of sepsis; Understand and discuss the role of new therapies in the management of diabetes; Understand the Gamma Knife and highlight its clinical uses; Understand and choose an antidepressant based on its mechanism of action for use in neuropathic pain; Understand and discuss the most recent updates in plastic surgery techniques available in Pierce County; Understand the range of options and appropriate referral thresholds for surgical management of emphysema; Understand target therapy and know the diseases where target therapy is applied; Recognize and discuss common dermatitis in internal medicine; Understand the changes in the approach to stroke, and learn the role of neuro-interventional radiology in stroke treatment.

Reservations for the program's condos, Aspens on Blackcomb, can be made by calling ResortQuest at 1-877-676-6767, booking code #403699. You must identify yourself as part of the College of Medical Education group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by December 1, 2006, when any remaining condos in the block will be released. ■

Dates	Program	Director(s)
Wednesday-Saturday January 24-27	CME at Whistler	John Jiganti, MD Richard Tobin, MD
Friday, February 2	2007 Neurology Update	Patrick Hogan, DO
Friday, March 2	Cardiology for Primary Care	Gregg Ostergren, DO
Friday, April 20	Orthopaedic/Gastroenterology 2007 Update	Nicholas Rajacich, MD John Carrougher, MD
Just Added! Friday, May 4	Radiology for the Non-Radiologist	Andrew Levine, MD Gordon Benjamin, MD
Friday-Saturday May 11-12	Internal Medicine Review 2007	Joseph Regimbal, MD
Friday, June 8	Advances in Women's and Men's Medicine	John Lenihan, MD Loren Betteridge, MD

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so that we can move on and support what comes out of the dialogue.

Though we often couch the failings of our current system in terms of cost and of unnecessary disease, it is important to step back and realize the huge amount of suffering that goes along with an inadequate health care system, the daily struggles with chronic pain, immobility, and an inability to function at a reasonable level. When it all gets summed up, it quickly becomes overwhelming for any one person. More than any of us can handle or even attempt to appreciate.

The bottom line for me in getting or not getting involved in a change process is that by not addressing the problems of our health care system, we are failing our community, we are failing our neighbors, we are failing our own families. And ultimately we are failing ourselves.

I think it is time to act. ■

Classified Advertising

POSITIONS

Family Practice Opportunity. Sound Family Medicine, a physician-owned multi-location family and internal medicine practice with 19 providers, in Puyallup, Washington, is adding a physician to our practice. We are seeking a physician who is interested in growing with our clinic, as we become the leader in family care in the Puyallup and Bonney Lake areas. Sound Family Medicine is committed to providing excellent, comprehensive and compassionate family medicine to our patients while treating our patients, our employees, our families, and ourselves with respect and honesty. We are an innovative, technologically advanced practice, committed to offering cutting edge services to our patients to make access more convenient with their lifestyles. We currently utilize an EMR (GE Medical's Logician) and practice management with Centricity. Interested candidates will be willing to practice full service family medicine, obstetrics optional. We offer an excellent compensation package, group health plan, and retirement benefits. Puyallup is known as an ideal area, situated just 35 miles South of Seattle and less than 10 miles Southeast of Tacoma. The community is rated as one the best in the Northwest to raise a family offering reputable schools in the Puyallup School District, spectacular views of Mt. Rainier; plenty of outdoor recreation with easy access to hiking, biking, and skiing. If you are interested in joining our team and would like to learn more about this opportunity please call Julie Wright at 253-286-4192, or email letters of interest and resumes to juliewright@soundfamilymedicine.com. Equal Opportunity Employer.

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 GP, FP, IM. Contact Paul Doty (253) 830-5450.

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 + incentive. Fax your CV to 253-847-9630.

OFFICE SPACE

Satellite office space available in Lakewood. Tuesdays plus two Saturdays per month. More days negotiable. Please call Cathie at 253-581-1943 or email cathirosa@aol.com.

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