Pierce County Medical Society

BULLETIN

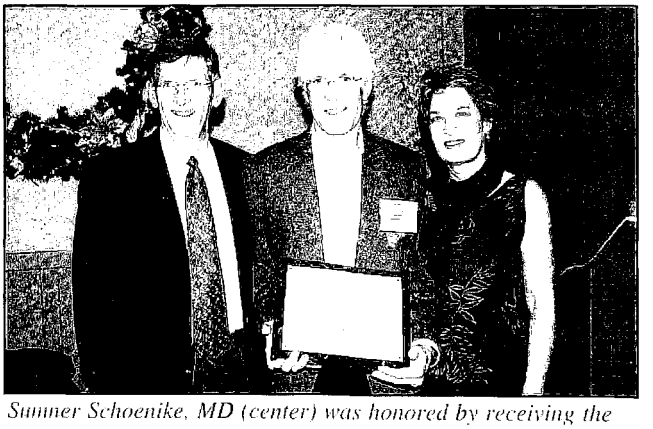
December 2009/January 2010

2009 Annual Meeting - Lots of Singing!

Dr. Stephen Duncan (left) was installed as 2010 President and presented his gavel by outgoing President Dr. David Bales

The Brothers Four did not disappoint!

See story and more photos page 5



Sumner Schoenike, MD (center) was honored by receiving the 2009 Community Service Award. His wife Jan and Dr. Paul Schneider, presenter of the award, flank him

INSIDE:

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

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Pierce County Medical Society

BULLETIN

December 2009/January 2010

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President's Page

by Stephen F. Duncan, MD

The First Question

Stephen F. Duncan, MD

As we start 2010, Healthcare Reform is on our mind. The congress is completing its job and soon there will be a bill on the president's desk for signature. What challenges the change in the delivery and payment of healthcare will bring are still unknown. It will take several years while the new law is implemented. I am certain there will remain much debate about the law and its implications.

I recently read *The Healing of America* by T. R. Reid. I would recommend it for its excellent description of the healthcare systems that are in place in the major industrialized countries. It also makes the case for the United States to make the difficult changes that are needed to provide health care to every U.S. citizen.

T. R. Reid refers to Professor William Hsiao, a Harvard economist. Hsiao asserts that before a country sets up a healthcare system it must first answer a basic ethical question. The question is: "Do the people in your country have a right to health care?" If they do not, it becomes acceptable to decide who gets health care and who does not. But if the people of our country determine that all citizens have the right to health care, it makes it imperative to do the hard work to find a solution that accomplishes just that. I wonder in the congress, where law making has been compared to the making of sausage, if the members have this basic ethical question in mind. It seems, as though they are content on arguing over who gets what from the $2+ trillion industry that is healthcare. Lets hope that in the end that compassion will win over self-interest.

I have been an advocate of putting forth this first question to help us begin the debate. The answer would be a guiding principle for the solution. I do not think the solution would come any easier but the imperative to come to a solution might be more compelling.

As we begin to learn the details of the new healthcare reform, I believe the ethical question still has a role in guiding our will to implement the new law. I for one will look forward to living in a society that provides affordable healthcare for each one of our citizens.■

The 2009 Annual Meeting - pure entertainment

The 2009 Annual Meeting saw a full house at Fircrest Golf Club as well as a full agenda of awards and raffles, welcoming of new officers and recognition and thanks for those completing their services and of course the featured entertainment of the Brothers Four. The atmosphere was fun and very festive in the beautifully decorated club and the singing brought the roof down!

Rave reviews continue for the Brothers Four...what a hit they were!!

The evening was highlighted by surprising **Dr. Sumner Schoenike**, the 2009 Community Service Award recipient. Dr. Schoenike received the award primarily for his unending contributions to our medical community. (See article page 7)

Mona Baghdadi, PCMS Foundation Board member introduced McKell Sansaver, artist for the 2009 Holiday Sharing Card and 8th grader at Jason Lee Middle School in Tacoma. McKell drew three tickets for winners of the raffle. The lucky recipients were Pat Palms (wife of **Kiyoaky Hori, MD**), **Keith Dahlhauser, MD** (newly elected PCMS Treasurer) and Lindsay Elliott, (guest of Rosemary Dye). All received a gift basket full of goodies and a $100 gift certificate to a local restaurant.

Dr. Dave Bales asked for a moment of silence in honor of each colleague that had died since last year's meeting. They included: **Drs. Robert Burt, John Colen, John Coombs, James Hazelrigg, Robert Kunkle, Charles Marshall, Anthony O'Keefe, Stanley Tuell** and **David Wilhyde**.

Dr. Bales thanked the physicians who served on the board during his presidential year including **Drs. Steve Duncan, Ron Morris, Jeff Smith, Bill Hirota, Maureen Mooney, Raed Fahmy, Mark Grubb, Debra McAllister, Gary Nickel** and **Cecil Snodgrass**. He also thanked the State Medical Association board members for their service, **Drs. Len Alenick, Richard Hawkins, Mike Kelly, Ron Morris, Nick Rajacich** and **Don Russell**. Prior to his parting words, he asked for immediate past-president Dr. Ron Morris to join him on stage for a special thank you. Presenting Dr. Morris with a parting gift he thanked him profusely for his five years of board service.

Introducing the new president for 2010, Dr. Bales asked Dr. Steve Duncan to join him on stage where he presented him with his presidential gavel. Dr. Duncan thanked Dr. Bales for his service to PCMS and presented him with a thank you gift as well as a plaque noting his exemplary leadership and commitment to PCMS. Dr. Duncan then asked the new trustees for 2009 to stand as he introduced them: **Drs. Jeff Smith, David Bales, Bill Hirota, Pat Vaughan, Keith Dahlhauser, Bruce Brazina, Raed Fahmy, Mark Grubb** and **Steve Konicek**. Dr. Duncan thanked his colleagues for their support and encouragement, noting that he looked forward to a prosperous and productive year. ■

See page 8 for more photos

Past Presidents L to R - Drs. Larry Larson, Bill Ritchie, Bill Jackson, Charles Weatherby, John Rowlands, George Tanbara, Pat Duffy, Bill Marsh, David Bales, Sumner Schoenike, Joe Jasper, Pat Hogan, Dave Law, Mike Kelly, Patrice Stevenson, Ron Morris and Jim Fulcher Attending but not pictured - Drs. Richard Hawkins and Gordon Klatt

Dr. David Bales (left) thanks Dr. Ron Morris for five years of service to PCMS, including the 2008 Presidency

Dr. Keith Dahlhauser, ophthalmologist, PCMS Treasurer and lucky raffle winner

2009 Community Service Award

Sumner Schoenike, MD honored as the 2009 PCMS Community Service Award recipient

Dr. Sumner Schoenike was honored at the December 2 PCMS Annual Meeting as the recipient of the 2009 Community Service Award. The award is given annually by the organization and recognizes a physician that has contributed volunteer time to the community. Volunteer time that often goes unrecognized and unappreciated.

Dr. Schoenike's volunteer contributions never quit. He never quits. He devotes himself to projects that he believes will benefit the community and consequently the people. He works tirelessly to accomplish what others would long abandon as impossible.

Friend and colleague **Dr. Paul Schneider** presented the award to Dr. Schoenike and his wife Jan at the meeting and the script, in it's entirety is below:

Sumner Schoenike, MD recipient of the 2009 PCMS Community Service Award

I am truly honored to present the Pierce County Medical Society Community Service award to one of our members who has distinguished himself through commitment, perseverance, integrity and hours of community service.

I don't wish to hold you in suspense while I outline his achievements and contributions; I would rather like to ask him to join me here so we can watch him squirm while I talk about his accomplishments.

Sumner Schoenike, will you and Jan please join me?

Sumner is a true renaissance man. He is a linguist, a poet, an artist, an organic gardener and a sailor in addition to being a highly competent and caring physician. His professional training includes a residency in pediatrics and additional training in pediatric psychiatry, pediatric preventative medicine and a Masters of Public Health. The medical students at OHSU three times recognized him for excellence in teaching.

I first came to really know Sumner 4- 5 years ago when he helped form a small group which subsequently became the Healthy Communities Pierce County project sponsored by the Medical Society. I recall mentioning to my wife Cathy at the time "this guy really gets it." Little did I realize how prescient he was in understanding the health needs of our community.

Sumner also recognizes a calling to leadership, especially as related to community health and equity for all persons. He has a vision of constructive action beyond the scope of his busy pediatric practice; he has demonstrated remarkable energy and sincere commitment to being an effective force for initiating change to benefit our community.

Sumner has represented us as a PCMS delegate to the WSMA annual convention for the last several years, participating on panels addressing access to care for the underserved. He has served us as a Board Member and president of the PCMS.

In Pierce County, Sumner has been tenacious in efforts to develop Project Access, a new initiative that will help assure a medical home and access to specialty care for the uninsured. Sumner's admonition that "we can do better" was instrumental to his campaign resulting in both health care systems providing funding for the first two start- up years of Project Access.

Recognizing the value to the underserved of the Community Health Clinic network, Sumner has been on the Leadership Team for their capital campaign. Fund raising is never easy work, but he understands the importance of the CHC network and has been a tireless worker for them. Significant contributions such as his led to the George and Kimi Tanbara Health Clinic in Salishan.

In recognition of his leadership role in the community, Sumner has been asked to sit on the Board of Directors of the Franciscan Health System

Sumner is quite unique in the scope of his involvement. He is dedicated to each individual patient, yet serves the

See "Schoenike" page 16

Annual Meeting from page 5

Newly elected trustees Drs. Steven Konicek and Bruce Brazina share a laugh

Newly elected treasurer Keith Dahlhauser and secretary Patrick Vaughan are introduced

Dr. Peter Shelley and his wife Andrea (left) visit with Dr. Carl Plonsky and his wife Kay

L to R - Drs. Joan Halley, Joe Jasper (President 2006) and Neville Lewis visit before the program

Dr. Charles Weatherby (President Y2K) with Dr. James Fry

Drs. Steven Litsky, Justin Cooper and Jeff Okey enjoy the social hour

New Board of Trustees will lead PCMS in 2010

Stephen Duncan, MD is a Puyallup family practitioner. He received his medical education from Indiana University and completed his internship and residency at Union Hospital in Terre Haute, Indiana. Dr. Duncan will serve as **President**.

William Hirota, MD is a gastroenterologist. He received his medical education from Georgetown University and completed his internship, residency and fellowship training at Walter Reed Army Medical Center. Dr. Hirota was elected **Vice President**.

Patrick Vaughan, MD practices orthopedic surgery in Tacoma. He graduated from Georgetown University School of Medicine and completed his internship and residency at Virginia Commonwealth University - Medical College of Virginia. Dr. Vaughan will serve as **Secretary**.

Bruce Brazina, MD, Trustee, practices palliative medicine. He graduated from Hahnemann University and completed his internship and residency at Geisinger Medical Center.

Mark Grubb, MD, Trustee, practices pediatrics in Puyallup. He attended medical school at Louisiana State University Medical Center and completed his internship and residency at Baylor College of Medicine followed by a fellowship at Texas Children's Hospital.

Gary Nickel, MD, Trustee, practices ob/gyn in Tacoma. He graduated from Bowman Gray School of Medicine of Wake Forest University and completed his internship and residency at Madigan Army Medical Center.

Jeffrey Smith, MD is family practitioner in Lakewood. He received his medical education from the University of Washington School of Medicine and completed his internship and residency at Swedish Hospital in Seattle. Dr. Smith is **President-Elect**.

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 as well as a fellowship at Colorado Health Science Center in infectious diseases. Dr. Bales is **Immediate Past President**.

Keith Dahlhauser, MD is an ophthalmologist. He received his medical education from the University of Iowa College of Medicine. He completed his internship at St. Mary's Health Services followed by residency at the University of Minnesota. Dr. Dahlhauser was elected **Treasurer**.

Raed Fahmy, MD, Trustee, practices cardiology in Tacoma. He graduated from George Washington University. He completed his residency training at Loma Linda University Medical Center and a cardiology fellowship at UCLA - SFVP.

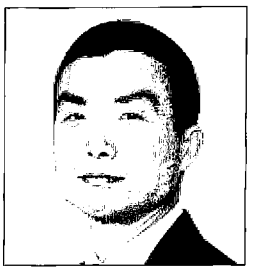
Steven Konicek, MD, Trustee, practices internal medicine in Tacoma. He attended the University of Washington School of Medicine and completed his internship and residency at University of Iowa Hosiptal & Clinics.

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.

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH;
Nigel Turner, RS, MPH; and Claudia Catastini, MA

A New Year's Resolution to Address HIV in Pierce County—Test Your Patients!



Anthony Chen, MD

December's holidays and feasting are behind us now, and some of us may be weighing new resolutions to exercise more, and eat healthier. We know how hard those resolutions can be, but can I suggest something to add to your list of resolutions that might be easier to implement? What about following CDC recommendations for routine HIV testing of everyone ages 13-64 years? Let me explain the background and also some changes in State law and resources that now make this easier for your practice.

In addition to food, family, festivities, and frantic shopping, December is International AIDS Awareness Month and December 1st is World AIDS Day. Most would rather not be thinking about such grim subjects as HIV and AIDS during that time of year, but we should be since HIV is here to stay in Pierce County.

Out of all Washington State HIV & AIDS cases, 11-12% are in Region 5 (Pierce & Kitsap Counties). There were 64 new diagnoses in 2008 and over 900 people are living with HIV in Pierce County; nearly 500 have died of HIV-related illnesses since AIDS was defined in 1982. In our county, HIV disproportionately affects the poor, minorities, homeless, and men who have sex with men:

* About half of new HIV cases in Pierce County, and almost 2/3 statewide occur among men who have sex with men (MSM). Among MSM in Washington State, there is one new HIV diagnosis each day.

* Blacks comprise a quarter of those living with HIV in Pierce County and the rate of infection for Blacks is more than five times that for Whites.

* The rate for Hispanics compared to Whites is about 1.5 times in Pierce County and 2-3 times statewide.

* Among women statewide, almost 40% of new HIV diagnoses occur in Blacks and the rate for Black women is 24 times that for White women.

"Physicians will welcome the news that in November 2009, the Washington State Board of Health made it easier to perform routine HIV testing."

* 20% of HIV positive people are homeless.

The societal, familial, and individual impact of HIV is profound. While we have drugs that prolong life, they can be difficult to take, have side effects, and are costly. The estimated lifetime cost of living with HIV has grown from less than $100,000 per person in the 1980s to more than $500,000. There is no price tag for the physical and emotional suffering.

Paradoxically, while HIV and AIDS have become household words and medicine has made great strides in treatment, people have lost their sense of urgency and become complacent in their prevention efforts.

Since 2006, the Centers for Disease Control and Prevention (CDC) have recommended routine HIV screening for:

* All patients ages 13-64 years seeking health care for any reason, without regard to known risks for HIV infection.

* All patients starting treatment for TB.

* All patients seeking treatment for STDs.

* All pregnant women, as early as possible during the pregnancy.

Screening should be repeated:

* Each year for patients at high-risk: injection drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

* At each visit for a new STD complaint.

* For patients and their prospective sex partners prior to initiating a new sexual relationship.

See "HIV" page 13

HIV from page 11

* For pregnant women at high risk (see above) or in an area of elevated incidence of HIV or AIDS, a second test during the third trimester (preferably before 36 weeks EGA)

* Based on the clinician's judgment.

Why has there been a shift away from previous recommendations for risk-based testing? First, it has not been effective. In contrast, routine screening protocols in pregnancy has decreased pediatric HIV incidence and routine screening of blood donation has essentially eliminated transfusion-associated HIV infection. Second, as HIV infection has become more widespread, the demographics have changed with more infections in young people, women, heterosexuals, and minorities who were not usually considered high risk.

Routine HIV Testing promises to detect hidden infections, improve health prognosis, and decrease community transmission of HIV:

* A quarter of those infected with HIV do not know they are infected. They may not take preventive steps nor will their partners know that they are at risk of infection.

* Infected persons often see medical providers for years before they are diagnosed. Earlier identification will lead to earlier treatment and improved prognosis.

* The quarter who are infected and unaware of their infection are the source of over half of the new infections. Those who think they have low risk often ignore prevention messages; in contrast, those who know they are HIV infected do change their behavior to reduce transmission to others. Treatment with antivirals also lowers viral load and infectivity.

Physicians will welcome the news that in November 2009, the Washington State Board of Health made it easier to perform routine HIV testing. Now, providers conducting HIV testing need only obtain informed consent (which can be a general consent for treatment or routine tests), inform the patient that an HIV test is included, and offer an opportunity to ask questions and decline testing. Time consuming pre- and post-test HIV counseling is no longer required! Also, the HIV test can be ordered by any appropriate clinic staff and results can be provided over the phone by any appropriate clinic staff; there is no legal requirement of education or license to order or provide an HIV test result.

You can see that this makes routine HIV testing much easier to implement in a practice. As we learned with vaccinations, standing orders that do not require physician evaluation or orders reduce physician workload, improve patient satisfaction, and increase compliance rates. Those with electronic medical records can build HIV testing into health maintenance modules, standing orders, or templates. As we learned in routine prenatal HIV testing, making HIV testing an opt-out means that in the majority of time, there is good acceptance and minimal discussion with the patient.

As you can see, implementing routine HIV testing is important and practical for your office.

I hope that you will make it a New Year's resolution so we can help address HIV infection in Pierce County.

Resources:

* For questions about implementing routine testing in your clinics, please contact Claudia Catastini, STD/HIV Program Liaison at 253-798-2841

* Refer patients to 253-798-6410 or http://www.tpchd.org/page.php?id=8 for information about HIV/AIDS, the needle exchange program, and where to get an HIV test.

* To learn more about and support the Pierce County AIDS Foundation http://www.piercecountyaids.org/about.html

* HIV Testing in Healthcare Settings http://www.cdc.gov/hiv/topics/testing/healthcare/index.htm

* CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

* CDC's HIV/AIDS page http://www.cdc.gov/hiv/

* HIV Infection: The Role of Primary Care. An article in the November 2009 American Family Physician http://www.aafp.org/afp/2009/1101/p946.html

* Find patient education information at http://familydoctor.org/online/famdocen/home.html by searching "HIV" ■

Dr. Stan Mueller, Washington Tree Farmer of the Year

The Washington State Tree Farmer of the Year for 2009 was announced at the WTFP luncheon, held during the WFFA Annual Meeting. The three nominees were: Bill and Erin Woods, Bob & Mariella Arnold and their Rapjohn Tree Farm, and Stan Mueller and his Mueller-Sack Tree Farm. The Mueller-Sack Tree Farm took home the State award. The 203 acres was certified as Tree Farm #90 the same year it was purchased by Stan Mueller and John Sack in 1976. At the time of acquisition, it was mostly pasture and alder. With lots of hard work and a three-stage conversion process, it is now a fine example of a Tree Farm. Congratulations!■

Applicants for Membership

Victor W. Chiu, MD
Ophthalmology
Cedar Medical Specialties, Pacific Northwest Eye Associates
2202 S Cedar #100, Tacoma
253-759-5555
Med School: University of Rochester
Internship: UC Irvine
Residency: University of Minnesota

Kieu N. Dang, PA-C
Dermatology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Training: University of Washington

Maria Gutierrez-Yach, MD
Ob/Gyn
Tacoma Women's Specialists
314 Martin L King Jr Way #104, Tacoma
253-272-5572
Med School: Loyola Stritch
Residency: John H. Stroger Jr. Hospital

Daniel J. Hahn, PA-C
Family Practice/Internal Medicine
Puyallup Clinic
800 S Meridian #A, Puyallup
253-845-6645
Training: Medex at Univ of Washington

Steven R. Kaptik, MD
Gastroenterology
Digestive Health Specialists
34503 - 9th Ave S #130, Federal Way
253-838-9839
Med School: Vanderbilt University
Internship: University of Colorado
Residency: University of Colorado
Fellowship: University of Tennessee

Amanda K. Kleven, PA-C
Dermatology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Training: Pacific University

Jason E. Love, MD
Pathology/Hematology
Western Washington Pathology
315 Martin L King Jr Way, Tacoma
253-403-4594
Med School: Ohio State University
Residency: University of Washington
Fellowship: University of Washington

Jocelyn J. Newman, MD
Dermatology
Cascade Eye & Skin Centers
11216 Sunrise Blvd E #3-102, Puyallup
253-848-3000
Med School: Univ of South Dakota
Internship: Virginia Mason Med Ctr
Residency: Mayo Clinic-Rochester

Roy J. Park, MD
Ophthalmology
Cascade Eye & Skin Centers
1703 S Meridian #101, Puyallup
253-848-3000
Med School: Jefferson Medical College
Internship: Thomas Jefferson Univ Hosp
Residency: University of Washington
Fellowship: New York Eye & Ear Infirmary

Schoenike from page 7

greater community.

He can chair a meeting or simply be a constructive participant.

He learns from the past and envisions a better future.

He sits on boards and spreads manure in the community garden.

Both boards and gardens flourish.

Most remarkably, in spite of the endless meetings and the stress of his work, that mane of hair will never require Rogaine.

Sumner has a passion for all people---to help them do better, have better and be better

It is with gratitude that I present the Pierce County Medical Society Community Service Award for 2009 to Dr. Sumner Schoenike. ■

COLLEGE OF MEDICAL EDUCATION

Endocrinology for Primary Care

This year's *Endocrinology for Primary Care* program will be held on Thursday, February 4, 2010 at Fircrest Golf Club under the medical direction of **Marc Aversa, MD**. The program begins at 8:00 am and adjourns at 3:15 pm. Six hours of Category 1 CME are offered.

This conference will provide a working knowledge of many common endocrinological problems. Emphasis will be placed on clinical diagnosis and practical treatment with attention to evidence-based medicine. Upon completion, participants should be able to recognize the signs and symptoms of most endocrinopathies; educate their patients regarding the basic concepts and natural history of these diseases; and participate with their patients and consulting endocrinologists in decisions regarding modern disease therapy and prevention.

This year's topics include:

- *Adult Endocrinology - The Prequel*
- *New Drugs for Diabetes*
- *Diagnosis and Management of Common Thyroid Disorders*
- *Reducing Macrovascular Disease in Type 2 Diabetes*
- *Cushing's Syndrome*
- *Endocrine Mechanisms of Weight Loss and Diabetes Resolution after Bariatric Surgery*

Call the College at 253-627-7137 to register or more information. The fee is $60 for PCMS members (active and retired) and $85 for non-PCMS members. ■

Continuing Medical Education

CME at Hawaii 2010, March 29-April 2, Sheraton Kauai Resort

This year we have selected the **spectacular Sheraton Kauai Resort** located on sunny Poipui Beach to host our *CME at Hawaii* conference. The exciting conference will be held **March 29-April 2, 2010.** Sixteen hours of Category 1 CME are offered.

We have negotiated exceptional rates for airfare, car rental and rooms. Our room rates are nearly 50% off those offered by the resort. Please book early to take advantage of these reduced rates through Jeanette Paul at Thomson Travel & Cruise. Her contact information is (253) 627-8221 or e-mail her at jeanette@ttc.travel. The College's reserved block of rooms will be released after February 12, 2010 and airline seats will be released after January 16, 2010. Book now!

This course is designed for practicing primary care providers, internists, physician assistant and specialists interested in expansion of their primary care knowledge and skills. The curriculum features a diverse selection of up-to-date practical topics in primary care medicine. Our approach is to combine the best evidence-based medicine with the day-to-day realities of patient care.

This year's topics and speakers include:

- *Update in Dermatology* - Brenda Kodama, MD
- *Hematology Cases for Primary Care* - Frank Senecal, MD
- *Robotics: Applications in Thoracic Surgery* - Baiya Krishnadasan, MD
- *Important Cardiology Clinical Trials* - Daniel Guerra, MD
- *First Line Treatments of Common Brain Disorders* - Patrick Hogan, DO
- *Sleep and Its Effect in the Practice of General Medicine* - Dale Overfield, MD
- *Solving Medical Mysteries: A New Approach to Unexplained Symptoms* - David Clarke, MD
- *The Walker Versus Non Walker in Pulmonary Arterial Hypertension* - Manuel Iregui, MD
- *Vitamin D Deficiency: A Newly Recognized Epidemic* - Ronald J. Graf, MD
- *Tales of a Pacific Northwest Rear Admiral* -Gordon R. Klatt, MD
- *Karotkoff and Systolic Hypertension: Getting to the Heart of the Matter* - Paul D. Schneider, MD
- *Colorectal Cancer Screening - A Moving Target!* - John Carrougher, MD
- *New Therapies for Inflammatory Bowel Disease* - Mark Hassig, MD
- *Update in the Treatment of Pelvic Organ Prolapse: To Mesh or Not to Mesh?* - John Lenihan, MD
- *Cardiovascular Demography in the Greater Puget Sound Area* - Raed Fahmy, MD
- *Update on Lung Cancer Clinical Management* - Moacyr R. Oliveira, MD
- *Aloha and Traditional Hawaiian Healing* - Kauila Clark
- *Ending Medical Apartheid; Patient Safety is Not a Solo Act* - John J. Nance, JD & Kathleen Bartholomew, RN, MN

Please call the College at 253-627-7137 or Jeanette if you have any questions or need more information. You can also find a copy of the program brochure online at www.pcmswa.org/col_cal.html.

We hope you will plan to join your colleagues and their families this coming spring for this very exciting CME course in Kauai! ■

Classified Advertising

POSITIONS AVAILABLE

Western Washington – Internal Medicine. MultiCare Health System, seeks BE/BC internal medicine physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or call 800-621-0301 for more information. Refer to Opportunity #5906, 5575 when responding.

Pediatric Opportunity-Puyallup, WA
A well-established, successful general pediatrics practice located in a growing community is seeking a BE/BC pediatrician to join the group in providing quality outpatient care and inpatient newborn care (hospital has pediatric hospitalists). Call is 1 in 7, and consulting nurse service screens all calls. Please visit www.BlazeNewTrails.org to apply online, email your CV to Provider Services at blazenewtrails@multicare.org, or fax it to 866-264-2818. For more information, call MultiCare Provider Services at 800-621-0301. Refer to Opportunity #5554 when responding.

OFFICE SPACE

Great location with plenty of parking, 13th and Union. Spaces of 800 square feet and 2,500 (divisable) remaining. Contact Carol 206-387-6633.

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

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BULLETIN

February 2010

New York University School of Medicine

INSIDE:

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

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

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by Stephen F. Duncan, MD

Membership is Our Business

Stephen F. Duncan, MD

PCMS has been very fortunate over the past several years. Even though the economy has had its ups and downs, our membership has stayed stable and even grown slightly. The viability of our organization is dependent upon our membership because the funding of our activities is dependent upon our dues. We have depended upon our numbers and have infrequently had to increase the dues amount. I wish to personally thank each and every one of you for your continued support.

Despite our lasting support, is the past sustainable? The following shows the number of dues paying members over the last 5 years.

2005 = 713 2006 = 723 2007 = 725 2008 = 694 2009 = 759 % Change over 5 yrs = +6.5%

When we compare our growth with the number of licensed physicians in Pierce County over the same time frame, we can see we have not been keeping up with the growth. There are many potential members.

2005 = 1519 2006 = 1566 2007 = 1598 2008 = 1671 % Change over 4 yrs = >10%

So where are the potential new members? Pierce County has large groups of employed physicians. We are fortunate to have the full support of the Franciscan Medical Group and we have about 35% of the Multicare Medical Group. But we have very little participation by the Group Health Permanente group despite 140 members and we have few of the civilian and active duty military physicians. There may be a new member of your group who has not taken the time to consider membership.

Recently, the Board of Trustees spent time considering this issue. We believe strongly that PCMS offers value for the membership dollar and we will be working over the next year to reach out to those physicians that have not taken advantage of that value. I would ask each one of you to look around. If you know of a colleague that is not currently a member of PCMS/WSMA, I would encourage you to invite them to consider membership. It will be good for them and good for our organization.

Over the next year, there will be opportunities to invite a colleague to a general membership meeting or even a baseball game. It is also an election year, a great time for those who are politically minded.

I hope to see you there.■

PCMS Foundation thanks generous contributors

The PCMS Foundation, via their 2009 Holiday Sharing Card project raised more this year than in the past ten years due to the generous, giving nature of Pierce County Medical Society members. A total of $19,340 was raised for grants to be awarded to Pierce County non-profit organizations. Funds were raised by contributions to the holiday sharing card, member contributions, raffle ticket sales at the annual meeting and miscellaneous holiday card sales. Thank you to everyone who contributed….

Grant recipients for 2009 included:

Crystal Judson Justice Center
Family Renewal Shelter
Hospitality Kitchen
Neighborhood Clinic
New Phoebe House
Pierce County AIDS Foundation
St.Leo Food Connection
Tacoma Rescue Mission
Trinity Neighborhood Clinic

Grant recipients are required to spend their grant money in Pierce County for direct services to residents in need of assistance. The Foundation has no administrative overhead; consequently all contributions are donated to 501(c)(3) organizations that are selected as grant recipients. Your contributions to the PCMS Foundation are tax deductible.

PCMS is grateful to the following physicians who contributed to the Foundation after the deadline to be listed on the holiday sharing card:

David Bales, MD
Anthony Chen, MD
Youl Choi, MD
Mark Craddock, MD
Clark Deem, MD
Ron Graf, MD
Deborah Hickey, DO
Peter Lee, MD
Bill Roes, MD
Maan Salloum, MD
Jennifer Smith, MD
Cecil Snodgrass, MD
Roger Wang, MD
Matthew White, MD
Tanya Wilke, MD
Keyi Yang, MD

PCMS again thanks everyone for their generosity and their participation in this important and meaningful project.■

2010 Survey reveals priorities of the membership

The 2010 priority survey conducted in November 2009 revealed that national health care reform and medical liability reform tied as the number one concerns for the majority of responders. Fifty-nine percent listed both issues as their top concern from a list of 14. The responses, listed in order of priority by percent were:

#1	National Health Care Reform	59%
#2	Medical Liability Reform	59%
#3	Reimbursement	54%
#4	Quality of Care/Patient Safety	43%
#5	Legislative Advocacy	43%
#6	Practice Viability	41%
#7	Access to Care/Barriers to Care/Under/uninsured	38%
#8	Professionalism/Physician Unity	35%
#9	Pay for Performance	29%
#10	Changing Physician Workforce; Scope of Practice	28%
#11	Hospital Relations/Pay for Call	27%
#12	Community Collaboration/Community Health/Prevention	22%
#13	Specialty Relations	14%
#14	Hospital Relations; Privileges	12%

Other concerns written in included access to electronic prescribing, preventive care, sham peer review, and impacts of hospital employed physicians on private practice.

When asked the three most important things that PCMS can do to help members, responses overwhelmingly leaned toward advocacy, continuing the CME programs, practice survival and physician unity.

Primary care comprised 40% of respondents that reported their specialty and 60% were specialists. We were also informed that 45% prefer to hear from us by mail, 43% by email, while 9% preferred fax and 2% preferred to read the *Bulletin*.

Thank you for responding to the 2010 priority survey. It helps the Board of Trustees set their work priorities for the year and lets us know how best to serve you.■

In My Opinion

by Edward Pullen, 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.*

Sound Advice vs. Celebrity Advice - Celebrities Far Ahead

Edward Pullen, MD

When it comes to on-line medical advice few physicians do more than complain. In the latest *Forbes* list of the Best Medical Blogs, they reflect, "The complaints of the average Dr. Blogger reveal similar concerns: that big pharmaceutical firms are pressuring patients to take expensive drugs that aren't needed, that medical malpractice insurance is increasingly pricey, and that trial lawyers will take them for all they have." None of these seem especially focused on giving our patients a good, balanced, relevant commentary on medicine today.

I have to say I was not even close to an early computer geek. I remember **Terry Utt** convincing me to use the new Macintosh in the late 1980's when I tried to keep my office checkbook register balanced. He seemed to "get it," but I barely managed. Yet by the mid 1990's it seemed to me that medicine was a serious laggard in using the digital tools every other industry was embracing. Our group decided to move from paper charts to an EMR. I thought we would be early adopters when we made this commitment in 1997, but I never dreamed that over a decade later many physicians would still be using paper records.

An EMR seemed like a safe haven though, compared to where medicine seems to be heading now. Everything is moving fast. In the last three years our practice has started many of the same types of communication tools used by HMO models of care. In an HMO model, provision of health care services is seen as a cost, not a means of revenue. In the fee-for-service model, where many of us live, anything except the only billable service we have, i.e. direct face-to-face patient care with a CPT code that third party payers reimburse for, is a cost to us with no direct revenue in return. Why then, should we even consider electronic communication? Good question. First let's look at outbound secure electronic communication. This still feels "safe." We have control of how much of it we do, and as long as patients cannot "communicate" back at us, it should be tolerable. So why do it?

1. **Patients like it a lot**. The "best patients" (insured, middle-to upper class, etc.) communicate with all the other professionals in their lives electronically, and naturally expect this from us too.

2. **Sometimes it is less expensive**, therefore reducing costs and increasing our bottom line. A simple example is sending a secure message with lab results and an explanation to a patient. Creating a paper letter uses paper, printing, postage, and significant "handling" costs. The cost of a few mouse clicks can save real money on every message sent.

3. **It is definitely faster**. This may reduce patient phone calls to the office for results that are in the mail, another savings.

4. **It sometimes is more secure**. You can send results directly to an individual, not just to the mailing address where anyone who has access to the mail can read it.

Patients sending electronic messages to us is a more frightening prospect. Using secure communications, HIPAA compliant inbound messaging is an option, allowing a secure response by the physician. We started this last year, with great trepidation by many of our physicians. Fears that patients would drive us nuts, bury us in "communication" and misuse the system generally were real. In addition we were "giving away" another non-billable service. "We gave away the phones, we can't give away this too," was a valid concern. So why do this?

1. **Patients want it**. In surveys of patients, many want to be able to electronically communicate with their physician.

2. **Proponents felt we could reduce costs by doing this**, by reduction of use of expensive resources like phone receptionists and phone nurses. Also vast amounts of labor is used to route information from inbound phone requests around the office to get physician input before routing the information back to the appropriate person to try to contact the patient in real-time to

See "Advice" page 14

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

National Children's Dental Health Month

Anthony Chen, MD

February is National Children's Dental Health Month and there is a lot that physicians can do to help improve children's dental health. While pediatricians and family physicians have the greatest opportunity to help, other specialists and those who interact with children in other capacities also have roles.

The understanding of dental health has changed even from when I was in medical school. We all have heard about the detrimental effect of sugary foods on teeth, but we now know that bacteria and how (not just what) children eat are important factors. Streptococcus mutans (Strep mutans) is now known to play an important role in tooth decay. Where does it come from? Mothers naturally transmit the bacteria to their children.

So for the earliest intervention, obstetricians and family physicians providing prenatal care can reduce children's cavities. Good oral hygiene and dental referral can decrease the pregnant mother's Strep mutans colonization and decrease bacterial load transmitted to the infant. We now know that periodontal disease in the mother increases the risk of preterm delivery and low birth weight, so that is the other area where maternal intervention makes a difference. Preterm and low birth weight infants are more likely to have enamel hypoplasia, which make their teeth more susceptible to dental decay.

What and how children eat are important. Oral bacteria ferment the carbohydrates in food, producing acid that demineralizes tooth enamel and can form cavities. Frequent or prolonged exposure to carbohydrates does not allow for the acid to be washed away or buffered by saliva, so how the food is consumed can be more important than the amount. Once you understand this, much of the advice given to parents during well child visits make sense.

To avoid pooling of milk in the mouth and prolonged contact with milk, we recommend holding infants for bottle and breast feeding and avoiding bedtime or nap bottles. We recommend introducing a cup at 6 months of age because we are aiming to have the child start weaning from the bottle at 12-18 months (when teeth will have erupted). Just as we advise against constant use of a sippy cup, we discourage continuous snacking or grazing which prolong tooth exposure to food.

Some advice to parents simultaneously promote nutrition and dental health. Avoiding juices and sugary drinks help prevent both dental decay and obesity. Similarly, sweet and sticky foods high in refined carbohydrates (e.g., cookies, crackers, fruit leather or roll-ups) should be avoided in favor of whole grain and non-carbohydrate foods (e.g., vegetables, fruit, nuts, meat).

Cleaning teeth is an important part of dental health. For children under a year old, parents should clean teeth with a soft cloth or toothbrush without toothpaste. From 1-6 years of age, parents should perform or supervise brushing with a rice grain-sized amount of fluoridated toothpaste twice a day. Over 3 years old, if the child can spit, a pea-sized amount of toothpaste can be used. Children should brush with the parent's supervision until they can brush alone—usually around age seven. Once they are independent they should be brushing with fluoridated toothpaste twice a day. Swishing the mouth with water after snacks also helps.

Even physicians who do not take care of children can help. Make it a habit to examine your patients' mouths and discuss dental health. As I earlier mentioned the link between periodontal disease and pregnancy outcome, there are other links with medical disease (e.g., diabetes control). If your patient can improve his or her bad dietary or dental habits, chances are his/her children or grandchildren will benefit directly or through role modeling. Orthopedists and sports medicine specialists have opportunities to discuss with children and adolescents the need for mouth guards and the avoidance of sports drinks. If you are making a dental referral, inquire about dental insurance for the patient and family as well. If you need help to make a low-cost or Medicaid dental referral, call the Health Department's Low-Cost Dental Care Resource Hotline (253-798-6044 or 800-992-2456 ext. 6044) or access the referral guide at http://www.tpchd.org/files/library/da997569c42de55e.pdf.

Many of us also interact with children in other capacities, such as volunteering at school, leading boy or girl scouts, or coaching sports. There are age-appropriate dental health activities,

See "Dental" page 10

Dental from page 9

games, and crafts that children can enjoy. We can role model good eating and brushing habits.

So during National Children's Dental Health Month, let us all think of ways that we can keep smiles on children's faces and help them achieve the best dental health possible.

Resources

General resources for all physicians include the American Dental Association (http://www.ada.org/prof/events/featured/ncdhm.asp#fun) and the American Academy of Pediatrics (http://www.aap.org/ORALHEALTH/ncdhm.cfm) National Children's Dental Health Month pages, which have activities for children and publicity resources. The Health Department's oral health program including the referral guide is at www.tpchd.org/dental.

The American Academy of Pediatrics has many resources. General oral health information is at http://www.aap.org/healthtopics/oralhealth.cfm. The Oral Health Initiative is found at http://www.aap.org/commpeds/dochs/oralhealth/index.cfm. There is also an online curriculum (eligible for a maximum of 11.0 AMA PRA Category 1 Credits) called Protecting All Children's Teeth (PACT) which helps physicians become more knowledgeable about child oral health and more competent in providing oral health guidance and preventive care: http://aap.org/oralhealth/pact.cfm.

The Society of Teachers of Family Medicine also has a curriculum (eligible for 12.5 prescribed credits from the American Academy of Family Physicians) called Smiles for Life. Physicians can access the slide shows and materials (including pocket cards and applications for Palm or PocketPC handhelds) at http://www.smilesforlife2.org/home.html .

The absolutely best deal for primary care providers comes from the Washington Dental Service Foundation. It will come to your office to conduct a free, hands-on, 90 minute CME training (with lunch, too!) that includes recognizing early childhood caries, making appropriate referrals, and applying fluoride varnish treatment as part of well-child checks. Once trained, providers can be reimbursed for applying fluoride varnish and providing family oral health education. To learn more, go to http://www.kidsoralhealth.org/provider-index.html. To arrange training, contact: Dianne Riter at driter@deltadentalwa.com or 206-729-5507. The WDSF also provides brochures and educational materials for your patients. ■

IN MEMORIAM

ROBERT KLEIN, MD

1927 - 2009

Dr. Klein passed away on December 11, 2009 at the age of 82.

He received his medical degree from Leyden University Medical School in 1954 and completed his residency at Tacoma General Hospital. He was board certified in family practice and practiced in Tacoma for fifty years.

Dr. Klein was a member of Rotary Club International, Physicians for Social Responsibility, the Goodwill Games, Vladivostok Sister City, Doctors Without Borders and Heart to Heart Medical Missions and was the recipient of numerous humanitarian awards.

PCMS extends sincere sympathies to Dr. Klein's family.

Robert Klein, MD

Applicants for Membership

Faron J. Bauer, MD
Family Medicine
St. Anthony Prompt Care (FMG)
4700 Pt. Fosdick Dr NW #102, Gig Harbor
253-853-2050
Med School: UC Irvine
Internship: Swedish Hospital
Residency: Swedish Hospital
Fellowship: Tacoma General Hospital

Lance L. Bear, MD
Orthopaedic Surgery
The Orthopaedic Center (FMG)
1112 - 6th Avenue #300, Tacoma
253-272-2224
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Internship: University of Missouri
Residency: University of Missouri

Marlene A. Bednar, MD
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Northwest Neurology (FMG)
11311 Bridgeport Way SW #205, Lakewood
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Internship: Univ Hospitals of Cleveland
Residency: Metrohealth Medical Center
Fellowship: Univ Hospitals of Cleveland

Marjorie A. Bergsma, PA-C
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All Family Medicine (FMG)
11025 Canyon Rd E #C, Puyallup
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Training: Gannon University

Pierre Andre B. Dalumpines, MD
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253-985-6688
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253-864-0224
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Internship: Niagara Falls Mem Med Ctr

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Residency: University of Colorado

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Internship: University of Colorado
Residency: University of Colorado
Fellowship: Vanderbilt University

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11311 Bridgeport Way SW #307, Lakewood
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Internship: Metrohealth Medical Center
Residency: VA Boston Healthcare
Fellowship: Royal Alexandra Hospital

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Internship: Virginia Mason Med Ctr
Residency: Virginia Mason Med Ctr

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Health Center, Dayton OH

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Gig Harbor Medical Clinic (FMG)
6401 Kimball Dr NW, Gig Harbor
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Med School: Univ of the Philippines
Internship: Akron General Med Ctr
Residency: Akron General Med Ctr

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Residency: Queens Hospital Center
Fellowship: Univ of British Columbia

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Residency: University of Missouri

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Residency: University of Washington
Fellowship: UC San Francisco

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Med School: Oregon Health Sciences
Internship: Mayo Clinic
Residency: Mayo Clinic

Advice from page 7

get that information to them on the phone. Sometimes just a simple response by the physician routed directly to the patient is easier and cheaper.

3. **We already deal with the patient questions, we just use the phone**. Phone use requires real time two-way communication. Someone has to answer the phone (or use voice mail, with its own inefficiencies). Then someone has to get the answer to the question. Then someone has to call the patient back at a time when they are available. Lots of opportunities for frustration and expensive minutes spent doing this.

We have been doing this for a few months, and so far the workload for physicians seems no more than that needed to respond to the phone messages these replace, and it has been well received by patients and physicians alike.

What's next? Web sites are old hat. Should physicians be tweeting with their patients? I have no idea what's next, but I think the need for us to be open to use of technology to not just test and treat our patients (I see little physician community reluctance to use the latest test, device, drug, etc.) but to communicate with them will be needed for us to remain relevant. Oprah, Dr. Oz, and every celebrity with an opinion or anecdote is using TV and the internet to give medical advice. Now many of us in the mainstream of medicine are fighting to have our views heard too. I've recently decided to fight back in my small way. I started DrPullen.com a "Medical Blog for the Informed Patient." I'm trying to post commentary on current healthcare issues, mainstream op-ed type posts, and other posts of potential interest to the patients who rely on us for care. I hope to find a following by appealing to our core clients, Americans who use and rely on the mainstream medical care system. If you like, tell your patients and friends about this blog, and help get the mainstream voice out there to be heard. We need to not just complain about the way others are misusing modern tools of communication. We need to fight back by our own participation in these communication forums to remain relevant in this information age. ■

Dr. Pullen is a family physician with Sound Family Medicine in Puyallup.

Suck it up, America

We have become a nation of whining hypochondriacs, and the only way to fix a broken health-care system is for all of us to get a grip, says Dr. Thomas A. Doyle

Dr. Thomas A. Doyle is a specialist in emergency medicine who practices in Sewickley (tomdoy@aol.com). This is an excerpt from a book he is writing called "Suck It Up, America: The Tough Choices Needed for Real Health-Care Reform."

Emergency departments are distilleries that boil complex blends of trauma, stress and emotion down to the essence of immediacy: What needs to be done, right now, to fix the problem. Working the past 20 years in such environments has shown me with great clarity what is wrong (and right) with our nation's medical system.

It's obvious to me that despite all the furor and rancor, what is being debated in Washington currently is not health-care reform. It's only health-care insurance reform. It addresses the undeniably important issues of who is going to pay and how, but completely misses the point of why.

Health care costs too much in our country because we deliver too much health care. We deliver too much because we demand too much. And we demand it for all the wrong reasons. We're turning into a nation of anxious wimps.

I still love my job; very few things are as emotionally rewarding as relieving true pain and suffering, sharing compassionate care and actually saving lives. Illness and injury will always require the best efforts our medical system can provide. But emergency departments nationwide are being overwhelmed by the non-emergent, and doctors in general are asked to treat what doesn't need treatment.

In a single night I had patients come in to our emergency department, most brought by ambulance, for the following complaints: I smoked marijuana and got dizzy; I got stung by a bee and it hurts; I got drunk and have a hangover; I sat out in the sun and got sunburn; I ate Mexican food and threw up; I picked my nose and it bled, but now it stopped; I just had sex and want to

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Suck it up from page 15

know if I'm pregnant.

Since all my colleagues and I have worked our shifts while suffering from worse symptoms than these (well, not the marijuana, I hope), we have understandably lost some of our natural empathy for such patients. When working with a cold, flu or headache, I often feel I am like one of those cute little animal signs in amusement parks that say "you must be taller than me to ride this ride" only mine should read "you must be sicker than me to come to our emergency department." You'd be surprised how many patients wouldn't qualify.

At a time when we have an unprecedented obsession with health (Dr. Oz, "The Doctors," Oprah and a host of daytime talk shows make the smallest issues seem like apocalyptic pandemics) we have substandard national wellness. This is largely because the media focuses on the exotic and the sensational and ignores the mundane.

Our society has warped our perception of true risk. We are taught to fear vaccinations, mold, shark attacks, airplanes and breast implants when we really should worry about smoking, drug abuse, obesity, cars and basic hygiene. If you go by pharmaceutical advertisement budgets, our most critical health needs are to have sex and fall asleep.

Somehow we have developed an expectation that our health should always be perfect, and if it isn't, there should be a pill to fix it. With every ache and sniffle we run to the doctor or purchase useless quackery such as the dietary supple-

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COLLEGE OF MEDICAL EDUCATION

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March 5, 2010; Fircrest Golf Club

New Developments in Primary Care
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Internal Medicine Review
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We have negotiated exceptional rates for airfare, car rental and rooms. Our room rates are nearly 50% off those offered by the resort. Please book early to take advantage of these reduced rates through Jeanette Paul at Thomson Travel & Cruise. Her contact information is (253) 627-8221 or e-mail her at jeanette@ttc.travel. The College's reserved block of rooms will be released after February 12, 2010. Book now!

This course is designed for practicing primary care providers, internists, physician assistant and specialists interested in expansion of their primary care knowledge and skills. The curriculum features a diverse selection of up-to-date practical topics in primary care medicine. Our approach is to combine the best evidence-based medicine with the day-to-day realities of patient care.

Please call the College at 253-627-7137 or Jeanette if you have any questions or need more information. You can also find a copy of the program brochure online at www.pcmswa.org/col_cal.html.

We hope you will plan to join your colleagues and their families this coming spring for this very exciting CME course in Kauai! ■

Suck it up from page 16

ment Airborne or homeopathic cures (to the tune of tens of billions of dollars a year). We demand unnecessary diagnostic testing, narcotics for bruises and sprains, antibiotics for our viruses (which do absolutely no good). And due to time constraints on physicians, fear of lawsuits and the pressure to keep patients satisfied, we usually get them.

Yet the great secret of medicine is that almost everything we see will get better (or worse) no matter how we treat it. Usually better.

The human body is exquisitely talented at healing. If bodies didn't heal by themselves, we'd be up the creek. Even in an intensive care unit, with our most advanced techniques applied, all we're really doing is optimizing the conditions under which natural healing can occur. We give oxygen and fluids in the right proportions, raise or lower the blood pressure as needed and allow the natural healing mechanisms time to do their work. It's as if you could put your car in the service garage, make sure you give it plenty of gas, oil and brake fluid and that transmission should fix itself in no time.

The bottom line is that most conditions are self-limited. This doesn't mesh well with our immediate-gratification, instant-action society. But usually that bronchitis or back ache or poison ivy or stomach flu just needs time to get better. Take two aspirin and call me in the morning wasn't your doctor being lazy in the middle of the night; it was sound medical practice. As a wise pediatrician colleague of mine once told me, "Our best medicines are Tincture of Time and Elixir of Neglect." Taking drugs for things that go away on their own is rarely helpful and often harmful.

We've become a nation of hypochondriacs. Every sneeze is swine flu, every headache a tumor. And at great expense, we deliver fantastically prompt, thorough and largely unnecessary care.

There is tremendous financial pressure on physicians to keep patients happy. But unlike business, in medicine the customer isn't always right. Sometimes a doctor needs to show tough love and deny patients the quick fix.

A good physician needs to have the guts to stand up to people and tell them that their baby gets ear infections because they smoke cigarettes. That it's time to admit they are alcoholics. That they need to suck it up and deal with discomfort because narcotics will just make everything worse. That what's really wrong with them is that they are just too damned fat. Unfortunately, this type of advice rarely leads to high patient satisfaction scores.

Modern medicine is a blessing which improves all our lives. But until we start educating the general populace about what really affects health and what a doctor is capable (and more importantly, incapable) of fixing, we will continue to waste a large portion of our health-care dollar on treatments which just don't make any difference.■

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Classified Advertising

POSITIONS AVAILABLE

Western Washington – Internal Medicine. MultiCare Health System, seeks BE/BC internal medicine physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or call 800-621-0301 for more information. Refer to Opportunity #5906, 5575 when responding.

Pediatric Opportunity-Puyallup, WA
A well-established, successful general pediatrics practice located in a growing community is seeking a BE/BC pediatrician to join the group in providing quality outpatient care and inpatient newborn care (hospital has pediatric hospitalists). Call is 1 in 7, and consulting nurse service screens all calls. Please visit www.BlazeNewTrails.org to apply online, email your CV to Provider Services at blazenewtrails@multicare.org, or fax it to 866-264-2818. For more information, call MultiCare Provider Services at 800-621-0301. Refer to Opportunity #5554 when responding.

OFFICE SPACE

Great location with plenty of parking, 13th and Union. Spaces of 800 square feet and 2,500 (divisible) remaining. Contact Carol 206-387-6633.

Office space available to share.
Spanaway Medical office to share space and possibly staff of 2,800 sq ft office 1-5 days per week. Ideal for primary care or specialty. If primary care may be able to share patients. Contact Dr. Wayne Kim 253-536-2824 (office) or 253-988-7867 (cell).

EQUIPMENT

Equipment and furniture for sale. We are closing our surgery center and office and have top-notch equipment for sale. Please contact us at 253-564-2009 or email getsmart@msn.com to request a listin gor arrange a visit to see the items. We have an excellent c-arm, c-arm table, stretcher/gurneys, RF/IDET generator, patient monitors, a mobile OR light, mobile small exam lights, autoclave, spore test warmer, warming cabinet, crash cart, file shelves and cabinets, exam tables, x-ray view boxes, digital telephone, small refrigerators, various charis, desks, bookshelves and carts. Many of the items may be viewed on our website www.tacoma paindoctor.com.

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Tacoma, WA 98402

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Pierce County Medical Society
BULLETIN

March 2010

Jefferson Medical College of Philadelphia

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

March 2010

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President's Page

by Stephen F. Duncan, MD

So You Want a Change?

Stephen F. Duncan, MD

When I started practicing years ago, I was naïve to think that reasonable people got together to debate the pros and cons of the issues and compromised on practical and agreeable solutions to make good laws. If an individual wished to influence the debate all he or she had to do was participate with a logically, persuasive argument. In the 1990's when I became interested in tort reform in Washington, I learned quickly that this is not the case.

Recently the board of PCMS polled our membership to ask what were the most important issues for our members. Many responded that they wanted PCMS to help change laws that confound the practice of medicine today like tort reform and Medicare reimbursement. The fact of the matter, our society does participate in forums that attempt to influence the molding of laws that address the medical issues of the day. It is my belief that PCMS has a minor role in that debate.

What I have learned over the years is that laws are made by influence and pressure from groups and individuals. Money that is spent through lobbying and political action committees (PACs) provides access for the group that wishes to influence the political process. The individual voter has influence by expressing their opinion directly to their representative. For me this has been an inconvenience and frankly a challenge.

Recently, I attended Legislative Day in Olympia along with other members of PCMS and WSMA. I came away with some suggestions that could help those who wish to influence the making of laws for our State and Nation.

• First you need to give money to the PACs of organizations that advocate issues that you find important. This year $25 for our WSMA dues goes to WAMPAC. This money gives WAMPAC access to key state and national legislators to advocate for the house of medicine.

• If you wish to be more informed, I suggest you get on the mailing list of the WSMA *Monday Memo*. To do this sign up on the WSMA link http://www.wsma.org/news_events/wsma-monday-memo.cfm or e-mail Jennifer Hanscom at jgl@wsma.org. This weekly memo will inform you of the latest issues and urge you to contact your elected representative via e-mail, phone or letter. It will also tell you how to do it easily.

This brings me to my last suggestion. Over the years, I have met and talked to some of my state representatives through forums in my community. This does take a little bit of time but it has allowed me as an individual to express my views. I suggest you give your e-mail address to your state representatives and allow them to contact you to discuss issues that deal with medicine. This builds a relationship that gives them a contact in the medical community to get real time information about medical issues. It can give you a contact to give input to the issues you think important. Maybe next year you will set aside a day to spend with the WSMA in Olympia to lobby during the legislative session.■

Retail clinics: Struggling to find their place

Billed as a low-cost alternative to primary care, retail clinics are filling a niche but are finding it hard to turn a profit

If you want to know why retail clinic momentum slowed after a fast start, one industry veteran says, look no further than Minneapolis, the city where they were born 10 years ago.

The initial appeal of retail clinics in Minneapolis had little to do with the concept itself, but instead with the area's high concentration of insured and affluent working parents, said Chris Endres, senior director of Convenient-Care Strategies Group, a consulting group created by Memorial Hospital & Health System in South Bend, IN. So once retail clinics opened outside of areas with Minneapolis demographics, they struggled.

"One reason this industry has had massive closures is because Minneapolis was the Garden of Eden for research in this industry," Endres said.

Endres' theory was one of many presented in January in Minneapolis at the ConvUrgentCare Strategy Symposium, where retail clinic operators and those interested in entering the market met to share stories and advice on where the industry might be headed.

One place it's not headed is the stratosphere. From October 2006 to September 2008, the number of retail clinics — quick-care centers in pharmacies, grocery stores or big-box stores — grew from 200 to more than 1,000. CVS Corp., which bought retail clinic pioneer MinuteClinic, and Walgreen Corp., which bought Take Care Health Systems, were expected to expand even more. Wal-Mart Stores Inc. said it would open hundreds nationwide.

As of February, there were 1,197 retail clinics, an all-time high. But that was only eight more than in March 2009. CVS and Walgreen not only did not expand, they closed clinics. Wal-Mart became more circumspect on where and when to open clinics. Some hospitals and retail clinic chains dumped plans to open clinics in favor of stand-alone urgent care centers.

Attendees discussed theories about why the model wasn't working as well as they'd hoped: the seasonality of the business, oversaturation and the difficulty attracting patients outside of those who shopped at the host stores.

They also talked about what would define a successful retail clinic. While most venture capital-based operators pulled out of the market due to lack of profit, many hospital groups remain or are entering the market. Some groups see the clinics not as profit centers but as entry points into the health care system or as necessary expenses to ensure patient satisfaction.

"In the beginning, there was a lot of hoopla," said Tom Charland, CEO of Merchant Medicine, the retail clinic consultancy group that hosted the two-day symposium. "But the hoopla didn't reflect the reality of running a retail clinic. It's not as easy as it sounds."

By his own calculation, a retail clinic — normally a small operation staffed by a nurse practitioner — that is open 4,000 hours per year can break even with 8,000 patients. Most primary care physicians would find that pace, two patients an hour, financially unsustainable. "Ten thousand patients will get you squarely in the black," he said.

Charland used the example of MinuteClinic, where he started his career in the retail clinic business, to show how hard it is to get two patients per hour. In nearly every news release, MinuteClinic will state the number of patients served, which is topping 4 million, Charland said. Drilling that number down by the number of clinics and the number of hours they are in business, the typical MinuteClinic is treating only 1.1 patients per hour on average, he said.

On Feb. 8, MinuteClinic said it has served 6.2 million patients since its inception. It did not break down traffic per hour.

Avera St. Luke's in Aberdeen, SD, opened its first FastCare clinic in July 2009 at a local ShopKo. For the remainder of 2009, the only month it passed two patients per hour was in October — flu shot season — when it reached 2.3. It reported being down to 1.4 patients/hour by December.

In Springfield, MO, CoxHealth, which opened clinics in five Wal-Mart stores in 2009, had one store reaching 1.9 patients per hour, while most others hadn't reached even one patient per hour.

Clinics have struggled with fluctuations in traffic based on seasons. In March 2009, CVS announced that it was closing 90 MinuteClinic locations for the spring and summer and said they would reopen once the busier fall season arrived. But many of those locations have not reopened.

The hope of retail clinics was that shoppers would become patients, and patients would become shoppers. There is little evidence that is happening. "Store traffic does not equal patient traffic — no ifs, ands or buts," Charland said.

Some operators have been especially frustrated with Wal-Mart. In 2007, America's No. 1 retailer announced a goal of 400 retail clinics by 2010. But Wal-Mart had only 58 clinics as of Feb. 1.

Memorial Hospital & Health System in South Bend opened its first Wal-Mart retail clinic in 2006, and expanded to six locations. Endres said Memorial hoped that would lead to a national expansion with Wal-Mart. He said the clinics' financial performance didn't justify such a move.

After Endres spent six months researching cities with retail clinics, he said he decided the clinics needed to be operated by local hospitals in the markets they serve, with a flexibility in clinic size. Wal-Mart's model, which requires clinics to fit in a certain size and include standardization between locations, didn't allow for that, he said.

Today, Memorial operates one clinic inside Wal-Mart, but under its own brand, rather than under Wal-Mart's "Clinic at Walmart." Memorial also has

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Pierce County Medical Society

invites you and your spouse/guest to

The Physician Lifelong Learner Program

featuring

"The Nexus of Terrorism and Illicit Economies: Challenges for American Foreign Policy"

presented by:

– Bradford Dillman, Ph.D. –

- Terrorist groups make use of illegal activities like drug trafficking, arms smuggling, and money laundering to achieve their objectives.
- These activities are hard to monitor or stop, which makes it difficult to achieve the objective of "winning" the war on terrorism.
- This talk will include examples from Afghanistan/Taliban, Iraq/Al Qaeda, and Gaza/ Hamas to illustrate the challenges.

Tuesday, April 20, 2010 - *"Box" dinner* - 6:15 pm; *Speaker*– 6:30 pm

University of Puget Sound - 1500 North Warner, Tacoma (N Union & N 18th)

Wheelock Student Union Building (SUB) Room #101– Corner of 15th & Lawrence.

Directions: From 6th & Union, go north on Union to the first stoplight. Turn right on North 11th Street. Go past the field-house and at the first street you come to turn left. (This will be Lawrence Street, but it is not marked) Go straight and as you come to the end of the street, the SUB will be the round building ahead, slightly to your right. Park your car either in the lot to your right or on the street. Room 101 is on the east end of the building directly behind the main cafeteria seating. Signs will be posted.

Dr. Brad Dillman *is Associate Professor of International Political Economy at the University of Puget Sound. He received his BA from Ohio State University, and both his MA and MPhil and also his Ph.D. in political science from Columbia University. He teaches courses on the illicit global economy, Middle East politics, intellectual property rights, and international political economy. His past research focused mostly on Middle East politics and economic change, especially in Algeria and North Africa. His research in the last five years has centered on international smuggling and transnational crime. He is currently writing a new book on the illicit global economy, and his presentation will draw upon some of that work.*

The Physician Lifelong Learner Program is a series of informal, seminar based discussions on academic topics of interest. Please join us and feel free to bring your spouse or guests with you.

Attendance fee is $10 and includes a "box" dinner. Fee will be collected at the door - cash or check.
Please RSVP by phone, 253-572-3667, fax 253-572-2470, or email to PCMS: sue@pcmswa.org

RSVP helpful by Thursday, April 15. Thank you!

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two clinics inside regional grocery store chains.

Karen Bowling, CEO and co-founder of Solantic, a physician-run urgent care center chain in Florida that expanded to include three clinic sites inside Wal-Mart stores, said that, although the standalone Solantic locations are breaking even, "we're finding it much harder to turn a profit in Wal-Mart."

Attracting patients outside Wal-Mart shoppers is made difficult by the fact that the store does not allow outside signage, and Bowling recently learned how important outside signage can be. In a survey at Solantic's other sites, customers cited signs as the No. 1 method of finding Solantic, Bowling said.

Wal-Mart did not have a spokesperson available to comment before deadline. But the retailer is moving ahead with opening in-store clinics. In January, it announced a deal with Wuesthoff Health Systems, a Rockledge, Fla.-based hospital group, to open five clinics inside its stores.

Making it work

Despite its less-than-profitable numbers, CoxHealth is happy with retail clinics and its locations in Wal-Mart stores. The hospital system does not expect its clinics to turn a profit.

The clinics are filling a void in areas with a primary care physician shortage while providing a convenient option for existing CoxHealth patients and those looking for a primary care physician, said David P. Taylor, vice president of regional services for CoxHealth.

"We're set up to lose money," Taylor said. "But we're set

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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Clean Water for a Healthy World: World Water Day 2010

Anthony Chen, MD

When we each got up this morning, we turned on the faucet, knowing that clean water would come out so we could wash up, brush our teeth, or take a drink. March 22, 2010 is World Water Day and maybe we should give this a second thought.

I have always grown up with running water, but I remember visiting my grandfather's rural home and thinking it was fun to draw water out of the well. After lowering the bucket down with the rope, you had to give it a little flip of the wrist so it would turn over and catch the water; then you could show how strong you were by hauling the full bucket up. In later years, my grandfather got a big red pump with a long handle that was a different kind of fun for a visiting city kid. Eventually, that pump was neglected when the house was hooked up to running water.

Last year, I went to Honduras on a medical mission and was reminded that 1.1 billion people around the world lack adequate access to water and 2.6 billion lack basic sanitation. While we had running water where we stayed, I discovered that the soapy water (along with shaving cream, contact lens solution, and whatever else) from my sink ran out a pipe onto the ground outside. Some of the schools we used as clinics had running water, but others had cisterns by the outhouses. Many of the rural homes got water wherever they could find it and gastrointestinal complaints were common. Disparities to water access were evident in other ways. While tooth decay was rampant in rural areas, there was little in the capital where the water was fluoridated.

Around the world, millions of people (usually the women) walk miles and spend many hours each day collecting water. Without clean water, it is not surprising that each year 443 million school days are lost from water-related illness and 2.2 million people (1.8 million children) die from diarrhea. Americans are generally oblivious to these startling facts. From our perspective, water seems endlessly available. We wash our cars and water our lawns with purified, drinkable water which many others can only dream of. We think nothing of indulging in a nice hot shower that pumps 2 ½ gallons of water a minute down the drain.

Considering that the average adult daily water requirement is about 2 liters a day, we could keep 25 adults alive with a 5 minute shower, 50 adults with a 10 minute shower, or 80 adults with a bath (about 40 gallons in a bathtub). When both consumption and sanitation needs are combined, people around the world who do not have running water use about 5 gallons of water a day. In the United Kingdom, this number is about 40 gallons a day (of which 12-13 gallons is used just to flush toilets) while in the United States it is about 150 gallons a day.

Kofi Annan, United Nations Secretary-General, said, "We shall not finally defeat AIDS, tuberculosis, malaria, or any of the other infectious diseases that plague the developing world until we have also won the battle for safe drinking-water, sanitation and basic health care." The same can be said for goals to overcome poverty and hunger or to improve education and economic development.

Public health is involved in making sure that what you get out of the faucet is safe. Between the state and our local health department, we regulate large and small water providers. Since water, human health, and environmental health are all intertwined, stewardship is required from many sectors. For example, as part of our antibiotic resistance reduction efforts, we used to work with dairy farmers to reduce the amount of antibiotics routinely fed to cows. Obviously, whatever passed out of the cow through manure or urine would eventually end up in the water and environment. Similarly, fertilizer spread on lawns, leaking septic tanks, and pet droppings all contribute to excess nutrients and algal blooms in lakes and ponds. Weedkiller from lawns, chemical byproducts from factories, and oily runoffs from roads all threaten aquatic life and may threaten human health as well. We should each consider how we can be stewards in consumption and pollution.

So, on this World Water Day, visit http://www.worldwaterday.org/ and http://www.worldwaterday2010.info/ and think about what you can do locally and globally to ensure that there will be clean water for all. ■

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up to feed the system."

Hospital systems also see retail clinics as potential money-savers for themselves and patients by keeping minor cases out of emergency departments. In a statement announcing its Wal-Mart deal, Wuesthoff noted that although a typical emergency visit costs between $1,500 to $2,000, a retail clinic visit runs $55 to $65.

Other hospital systems are taking another look at urgent care centers, a model that pre-dates retail clinic models, as a precursor to opening in retail outlets.

Darin Jordan, MD, medical and operations director of Convenience Care for Central DuPage Hospital in Winfield, IL, said although the urgent care model is working for Central DuPage, the hospital is considering retail clinics, too.

The retail clinic model has a much faster build-out time, which would let the system get a jump on its competition, he said.

Other clinics are betting that expanding their scope will have some impact. Many are expanding to include wellness services as well as chronic disease management to help spread the business year-round.

It's too soon to tell how much of an impact that will have on break-even points.

Through all of the stories, tips and lessons shared by symposium attendees, one thing was apparent: The retail clinic model is evolving, and what works for one could be the thing that destroys another. ■

Reprinted from AMNews 3-1-2010

IN MEMORIAM

RAYMOND C. ELLIS, MD

1923 - 2010

Dr. Ellis passed away in Salt Lake City on his birthday, January 26, 2010 at the age of 87.

He received his medical degree from the University of Oregon Medical School in 1947. He completed his internship at Iowa Methodist and his residency at Raymond Blank Memorial. Dr. Ellis was a board certified pediatrician practicing in Tacoma for 45 years.

Dr. Ellis gave the first polio vaccination in Tacoma and served as the Chief of Staff at Mary Bridge Children's Hospital.

PCMS extends sincere sympathies to Dr. Ellis' family.

Raymond Ellis, MD

Applicants for Membership

Ramon Anel, MD
Nephrology
Northwest Nephrology (FMG)
1708 S Yakima #107, Tacoma
253-272-5881
Med School: University of Washington
Internship: Univ of the Philippines
Residency: Illinois Masonic Med Ctr
Fellowship: Illinois Masonic Med Ctr

John W. Fuchs, DO
Family Practice
Gig Harbor Medical Clinic (FMG)
6401 Kimball Dr, Gig Harbor
253-858-9192
Med School: Kirksville College
Internship: Tucson General Hospital

Donald L. George, MD
General Surgery
Gig Harbor Medical Clinic (FMG)
6401 Kimball Dr NW, Gig Harbor
253-858-9192
Med School: University of Montpellier
Internship: Maricopa Medical Center
Residency: Maricopa Medical Center

Amy Guttmann, MD
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Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
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Med School: Medical University of Ohio
Internship: Henry Ford Hospital
Residency: Henry Ford Hospital
Fellowship: University of Washington

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Lakes Anesthesia (FMG)
1313 Broadway Plaza #200, Tacoma
253-426-6306
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Residency: Northeast Regional Med Ctr

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Women's Pelvic Medicine
4545 Pt. Fosdick Dr NW, Gig Harbor
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Internship: Eisenhower AMC
Residency: Mass General Hospital

Mohit K. Mahajan, MD
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Sound Family Medicine
3908 - 10th St SE, Puyallup
253-848-5951
Med School: Krishna Institute
Residency: Central WA Family Medicine

Daren R. Mealer, MD
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Sound Family Medicine
3908 10th St SE, Puyallup
253-848-5951
Med School: University of Texas SW
Internship: University of Tennessee
Residency: University of Tennessee

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Plastic & Reconstructive Surgery
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6002 N Westgate Blvd #160, Tacoma
253-759-4522
Med School: University of Florida
Residency: Columbia's Mary Imogene Bassett Hospital
Fellowship: Washington University

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253-426-6306
Med School: University of Washington
Internship: Virginia Mason Med Ctr
Residency: Virginia Mason Med Ctr

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611 - 31st Ave SW, Puyallup
253-445-7100
Med School: College of Osteopathic Medicine & Surgery, Des Moines
Internship: Malcolm Grow Med Ctr
Residency: Malcolm Grow Med Ctr

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324 East Pioneer, Puyallup
253-841-2929
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Krista M. Tannery, PA-C
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253-851-6075
Training: Medex Northwest

Olmedo A.R. Tesoro, MD
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Lakes Anesthesia (FMG)
1313 Broadway Plaza #200, Tacoma
253-426-6306
Med School: University of Santo Tomas
Internship: Lenox Hill Hospital
Residency: St. Joseph's Reg Med Ctr
Fellowship: St. Vincent's Hospital

COLLEGE OF MEDICAL EDUCATION

CME at Hawaii, Mar 29 - Apr 2

This year's CME at Hawaii conference be be held at the **spectacular Sheraton Kauai Resort** located on sunny Poipui Beach. The exciting conference will be held **March 29-April 2, 2010.** Sixteen hours of Category 1 CME are offered.

Contact Jeanette Paul at Thomson Travel & Cruise for travel arrangements. Her contact information is 253-627-8221 or e-mail her at jeanette@ttc.travel.

Please call the College at 253-627-7137 or Jeanette if you have any questions or need more information.

We hope to see you in Kauai! ■

Continuing Medical Education

Upcoming CME Programs

New Developments in Primary Care
April 28, 2010; Fircrest Golf Club; 4 - 8 pm
This course in primary care medicine is designed for practicing internists, family physicians, physician assistants and specialists interested in expansion of their primary care knowledge and skills. Our curriculum will feature a diverse selection of up-to-date, practical topics in primary care medicine. Our approach is to combine the best in evidence-based medicine with the day-to-day realities of patient care. This conference was designed for the physician who has a hard time taking a full day away from patient care in the office.

Internal Medicine Review
May 21, 2010; Fircrest Golf Club; 8 am - 3:15 pm
This one day program will provide primary care physicians the opportunity to learn first hand from national and local leaders in their field. The goal is to provide a better understanding of several of the most common disease processes, in light of rapid scientific advances. This program is offered to members of the Tacoma Academy of Internal Medicine as well as local physicians and physician assistants.

Primary Care Conference
June 18, 2010; Fircrest Golf Club; 8 am - 3:15 pm
This one day course focuses on the latest updates and clinical challenges common to the primary care and internal medicine practice. Each year we strive to provide new information regarding etiology, diagnosis and management in a variety of general medicine areas. As in the past, the topics for the course were chosen with these selection criteria in mind: Suggestions from previous course attendees as well as areas where substantial changes have taken place during the past three years and on controversial subjects where medical opinions differ. ■

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POSITIONS AVAILABLE

Western Washington – Internal Medi-cine. MultiCare Health System, seeks BE/BC internal medicine physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or call 800-621-0301 for more information. Refer to Opportunity #5906, 5575 when responding.

OFFICE SPACE

Great location with plenty of parking, 13th and Union. Spaces of 800 square feet and 2,500 (divisible) remaining. Contact Carol 206-387-6633.

Office space available to share. Spanaway Medical office to share space and possibly staff of 2,800 sq ft office 1-5 days per week. Ideal for primary care or specialty. If primary care may be able to share patients. Contact Dr. Wayne Kim 253-536-2824 (office) or 253-988-7867 (cell).

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April 2010

University of California School of Medicine, San Francisco Medical Center

INSIDE:

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Pierce County Medical Society
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President's Page

by Stephen F. Duncan, MD

Access to Care

Stephen F. Duncan, MD

Despite all the recent debate about health care reform, care to patients without insurance in our community has been delivered through donated services of our hospitals, clinics and providers for decades. In 2010, Pierce County will see the initiation of new way to manage uninsured patients. Pierce County Project Access's mission is "to improve the outcome of volunteer, donated care to the low-income, uninsured patients in Pierce County."

Like similar programs operating in other counties in Washington, PCPA will bring added value to the process of managing low income, uninsured patients. By offering a clearinghouse for registration and tracking of patients, PCPA will be able to facilitate better outcomes. Patients will be expected to fulfill basic responsibilities. PCPA will be able to assure transportation, interpreter services, and access to lab and imaging services so that the patient will arrive at the doctor's office with the appropriate information. The program plans to develop some basic agreements between primary care and specialists around problem-based care so that evaluation and testing do not have to be duplicated. The program will track through a mock billing process the services that the patient receives so that recognition of such services can be reported to the participating providers and institutions. Access to ancillary services such as social services and physical therapy can be coordinated through PCPA.

Project Access is a 501(c)3 corporation with an independent board comprised of representatives from PCMS, Franciscan Health System, MultiCare Health System, TPCHD, and Community Health Care who have come together to provide start-up funds and support. Other partners include Sea Mar, NW Physician Network and Group Health. The ultimate goal is to serve the providers of donated care with a coordinated and more efficient system in which to manage the patients that are already in our waiting rooms. By standardizing workups, reducing duplication, and creating efficiencies, it is hoped that providers and patients will benefit. This spring a pilot project will be started to test the system and hopefully in late 2010 a more robust program will be place.

Throughout the year you will have the opportunity to meet Leanne Noren, PCPA's Director, who will be providing information and guidance in the initiation of this program. Pierce County Medical Society will be in the foreground for promoting this valuable project. ■

WA Physicians Launch Medicare Meltdown Petition Drive

The WSMA has joined several medical societies across the U.S. in launching an online petition drive. The petition urges Congress to fix the flawed payment formula that threatens care for Washington's 897,000 Medicare recipients, including senior citizens and people with disabilities, and 337,000 military family members covered by TriCare. Congress must replace it with a stable, fair funding mechanism that reflects the true cost of providing care.

Please sign the petition today at: http://www.ipetitions.com/petition/meltdown/.

Also visit the WSMA website to download materials for your patients. Go to www.wsma.org to download copies of "Ask Congress to Keep Doctors of Medicare Patients." The letter is a pdf that can be reproduced in color or black and white.

Washington physicians have told the state's Congressional Delegation that Medicare is breaking down and needs repair. With a 21.2% cut that was effective April 1, with no resolve, physicians are launching a petition drive with their patients to help prevent a Medicare Meltdown.

The petition urges Congress to fix the flawed payment formula that threatens care for Washington's 897,000 Medicare recipients, including senior citizens and people with disabilities, and 337,000 military family members covered by TRICARE.

Congress adjourned for its Spring recess without taking action to stop the significant cut in Medicare payments for physicians' services. Current payment levels don't cover the cost of many services now.

Each year Congress slaps a temporary Band-Aid on the problem, postponing a steep cut to a later date. The most recent cut went into effect on April Fools' Day, and Congress is expected to place another temporary patch on the problem soon. It will be the third patch this year alone and this system creates ongoing uncertainty that hurts patients and their doctors.

At press time, over 40 state medical associations have joined in the petition drive.

Washington's seniors, patients with disabilities, and military families deserve better than the on-again/off-again health plan Medicare has become and the only acceptable solution is for Congress to repeal the flawed Medicare formula and replace it with a stable, fair funding mechanism that reflects the true cost of providing care."

Physicians report their Medicare patients routinely ask them if they know of other physicians – both specialists and primary care – who will see and care for them. Finding doctors to care for new Medicare patients is a constant struggle, they say.

Physicians will be inviting their patients to join the grassroots effort to save Medicare by signing the online petition. Again, the petition is available online at http://www.ipetitions.com/petition/meltdown/. ■

Health Care Reform (HR3590) - key provisions that will affect physicians and patients

The Patient Protection and Affordable Care Act (HR3590) health reform legislation signed into law by President Obama on March 23 contains a number of key provisions for you and your patients. Some provisions may have an immediate impact on your practice and patients, while others will not take effect for some time. There are many significant benefits for patients including those who already have health insurance and those who do not.

Following is a summary with timeline of the most significant changes known at this time:

Within 90 days:

• A new federal health plan will be created for people with pre-existing conditions who have been uninsured for at least six months. It is unconfirmed at this point, but the plan likely will be operated through Washington State's Health Insurance Pool (WSHIP).

• Federal funds will pay at least 65 percent of the cost of enrollee health care services and the maximum enrollee annual out-of-pocket limit will not exceed $5950.

Beginning Oct. 1, 2010:

• All new individual health plans must include preventive services, with no out-of-pocket costs. Free preventive services for group health plans begin on the plan's renewal date. However, all health plans in effect before March 24, 2010 are considered grandfathered and are not required to include the free-preventive care benefit.

• No health plan can put a lifetime cap on benefits. (Caps of $1 million or $2 million are now common.)

• Insurers cannot refuse to cover a child's pre-existing condition.

• Young adults may be covered on their parents' plan until the age of 26, unless they get a job that has employer-sponsored insurance.

• Medicare enrollees cannot be charged a co-pay for preventive services.

This year:

• Medicare enrollees with prescription drug coverage (Part D) will receive a one-

See "Reform" page 10

Patrick Hogan, DO recognized as Health Champion

Dr. Patrick Hogan, Tacoma neurologist, was recently recognized by the Washington State Public Health Association as a 2010 Health Champion. The award recognizes individuals who have made the biggest, tangible impact on public health in Washington State that an individual could make through their actions, either cumulatively or in terms of one specific action/set of actions. Dr. Hogan has been a community health champion for decades, volunteering his time with many organizations, and promoting healthy lifestyles. He was honored particularly for his Freedom From Tobacco Program which he implemented in May 1992 to help people quit tobacco. It is a free, weekly support group housed at Franciscan Health System's Hospitals. He continues to attend regularly as a volunteer and devote his expertise and support to everyone in attendance.

Patrick Hogan, DO

Dr. Hogan has led many community initiatives that have impacted public health including ten years ago organizing CHAMP - Coalition for Healthy Active Medical Professionals, devoted to encouraging medical professionals to become more healthy and be better role models for their patients. He has been instrumental in the Healthy Communities of Pierce County Initiative that works to inspire communities to improve their own health through increased exercise and improved nutrition in response to the rising obesity epidemic and resultant diseases of inactivity.

He is a role model for good health, exercising and practicing good nutrition, and he is always eager to assist and encourage colleagues, patients and friends who also want to improve.

He took his mother's valuable advice to heart - no matter what you do in life, be happy and healthy. He also realized that he could help so many more people get well if he could help them quit tobacco. He visited another local support group in Lacey at St. Peter's Providence Hospital, and followed through with organizing the program in Pierce County.

Congratulations Dr. Hogan for a well deserved award. ■

2010 Physician Directory updates

Please make the following corrections to your 2010 PCMS Physician Directory:

HANNIGAN, NEIL R., M.D.
Change office address and numbers to:
1802 S Yakima #208, Tacoma 98405.....627-5755
Physicians only.....383-3104
FAX.....627-7385

REALICA, ROSS M., M.D.
Change office address to:
5016 Bridgeport Way W #A, University Place 98467

RYNES, RICHARD I., M.D.
Rheumatology
ROAD Clinic (FMG)
Change Lakewood phone to: 985-6490
Change Gig Harbor phone to: 985-6490
Change Gig Habor FAX to: 985-6488

TITOVA, DINA C., M.D., Ph.D.
Add Lakewood office:
11311 Bridgeport Way SW #214, Lakewood 98499.....985-6490
FAX.....985-6488
Change Gig Harbor phone to: 985-6490
Change Gig Harbor FAX to: 985-6488

WANG, ZHIQIAN "ROGER," M.D.
Change Lakewood phone to: 985-6490
Add Gig Harbor office:
4700 Pt. Fosdick Dr NW #111, Gig Harbor 98335.....985-6490
FAX.....985-6488

Please make the following correction under Medical Laboratories (page 314):

UNION AVENUE OPEN MRI
Change phone number to: 761-9482
Change FAX number to: 759-6252
Delete Gig Harbor, Lakewood and S. Cedar Tacoma addresses
Change mailing address to P.O. Box 2233

Please make the following correction under Podiatrists (page 339):

FENBERG, CYNTHIA A., DPM
Add phone number: 474-4353
Add FAX number: 474-5850

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

This is Public Health

Anthony Chen, MD

In Public Health, we provide such a broad range of critical services that it is sometimes hard for people to understand what exactly we do. April 5-11 is National Public Health Week so let me take a stab at it. Often, I wish it were as simple as Tacoma Power saying, "We provide the electricity that lights your house" or the fire department saying, "We prevent and put out fires."

At Tacoma-Pierce County Health Department, our Mission is: "To safeguard and enhance the health of the communities of Pierce County." This goes beyond ensuring safe food in our restaurants, clean drinking water, protection from infectious outbreaks, and clean air free from tobacco smoke. Our mission also includes: access to medical, dental, and social services; long term investments in our children and families to promote learning, prevent violence, and develop productive citizens of our county; and the development of healthy communities for healthy people. What a mouthful!

Dr Barry Levy, former President of the American Public Health Association, more eloquently answers the question "What IS public health?" (1):

In response to those who ask this question, I say that public health is a whole series of activities that are designed to promote health, to prevent disease and injury, to prevent premature death—to assure conditions in which we all can be safe and healthy. And I tell them that many public health activities are invisible—you do not see them, but you see their results throughout the day.

I tell them that all of us use the public health system daily, whether we know it or not. We get up in the morning, turn on the faucet, and know that our water is safe. That is public health—that is the result of public health. And, if we are fortunate, that water is also fluoridated—that, too, is public health. We sit down at the breakfast table and eat a more nutritious breakfast, and there are even "Nutrition Facts" on the cereal box. That, too is public health. We get into our cars (or, better yet, onto our bicycles) to go to work or school or elsewhere, and those cars are less polluting and safer, with air bags, seat belts, child restraints. Not only are these features present, but we and people across the country are more likely to use them. All of that is public health. And when we get to work, even though our workplaces still have many hazards, they are much safer today than ever before and much safer than those in many other countries. That, too, is public health.

Many other parts of our daily lives, such as our healthier exercise patterns, are the results of public health. Our access to comprehensive quality health care that provides not only diagnosis, treatment, and rehabilitation but also preventive services—that, too, is public health. All of the community-based preventive services that prevent disease and injury and promote and protect health are critical parts of public health. So are education, research, policy analysis and development, and the organizational infrastructure that supports it all.

All of this is public health, and most of it is invisible. We don't see it unless there is a crisis—an outbreak of foodborne disease (E. coli in the meat or hepatitis A virus in the school-lunch dessert), an increase in diabetes, a flood, an episode of community violence, or a war.

When I tell people what public health is, I sometimes add the Institute of Medicine's definition from The Future of Public Health report published approximately 10 years ago: "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy." It takes a society to practice public health.

For a contemporary, lively discussion, check out the website "This Is Public Health" at http://www.thisispublichealth.org/ (2). It has a video of students on the streets looking for all things public health. Another short, thought provoking video is at the website "Healthiest Nation in One Generation" http://www.generationpublichealth.org/ (3).

These two videos emphasize that public health improves the conditions that affect the health of all of us. Public

See "TPCHD" page 18

Tamper Resistant Prescription Pads/Paper

A new law signed by the governor in 2009 requires that prescriptions written in Washington be on tamper resistant paper or pads (TRPP) approved by the Washington State Board of Pharmacy. Beginning July 1 this year all medication prescriptions hand delivered to a pharmacy must have a new look. While the layout will be much the same as previous forms — with two signature lines for prescriber and patient information — the forms will include a "seal of approval." Prescribers, pharmacists, and patients can identify approved forms by the "seal of approval" printed in the lower right-hand corner of the prescription form.

The tamper resistant prescription paper and pads now in use won't comply with the new law. Only board-approved forms are to be used for hard copy given to a patient or patient designee, including prescriptions printed from an electronic medical record system.

A few helpful tips will assure prescribers are using the proper forms in the correct way. The seal of approval, for example, should always appear in the bottom right corner of the prescription form. The seal consists of a mortar and pestle watermark with the Washington State map centered over the top. The state is green thermo-chromic ink that changes from green to yellow when exposed to heat or friction, and goes back to green when cooled. Don't use tamper-resistant prescription paper or pads when faxing directly to a pharmacy. The fax machine may activate the pantograph, making it appear that the prescription is invalid or void.

It's okay for vendors to provide legitimate requestors with blank stock of the board-approved tamper resistant paper, with the seal, to be printed in the office. Remember, prescribers are always responsible to safeguard prescription pads and paper from theft. It's a good idea to check with your supplier to be sure tamper-resistant prescription paper or pads are board-approved. Check the Board of Pharmacy Web page (www.doh.wa.gov/hsqa/Professions/Pharmacy/default.htm) for a list of vendors that have received approval. Your supplier or print distributor may not be on the list if they are using products that have received prior-approval by the board. ■

Reform from page 5

time check of $250 to help pay for their medications in the coverage gap ("doughnut hole").

• Small businesses will not be required to continue coverage for their employees up until 2013, but they'll receive tax incentives if they do. If they pay for at least 50 percent of their employees' premiums, they can receive a tax credit equivalent to 35 percent of their contribution.

• Washington state will begin applying for federal grants to implement the new health reform law.

• Insurers can no longer drop patients from their health plans if they get sick.

In 2011:

• Drug manufacturers must provide a 50 percent discount to Part D (Medicare's prescription drug benefit) for brand name drugs beginning January 1.

• Effective January 1, Medicare and Medicaid patients will no longer pay any cost sharing for a number of preventive services.

• States can require insurance companies to submit justification for premium increases and can impose penalties for excessive increases.

In 2014:

• All insurers are required to cover people with pre-existing conditions

• U.S. citizens and legal residents cannot be denied private health insurance coverage for any reason

• All U.S. citizens and legal residents must obtain health insurance coverage or pay a minor tax penalty (although there are some exemptions)

• State based health insurance exchanges will begin operating, where people who do not have access to employer-based insurance can shop and compare the benefits and costs of private health insurance plans. These exchanges will create insurance pools that will allow people to choose among affordable coverage options. All insurance companies in the exchange must provide at least a minimum benefit package as well as additional coverage options beyond a basic plan. Federal subsidies through tax credits or vouchers will be provided to people who cannot afford the full cost.

• Medicaid coverage will be expanded to all eligible children, pregnant women, parents and childless adults under age 65 who have incomes at or below 133% of the federal poverty level.

In 2020:

• The coverage gap or "donut hole" in Medicare's prescription drug program closes. ■

Who's In Charge on Trauma Supervision?

The Physician, Says WSMA in Joining an Amicus Brief

WSMA has joined the University of Washington, the City of Seattle, and the Washington States Hospital Association in an amicus curiae brief in a case related to the rights associated with a physician supervising the work of a paramedic.

A brief synopsis – Following an incident on an emergency call, a paramedic physician supervisor determined that a paramedic had an anger management problem, failed to identify medically significant symptoms in the patient, and had abandoned the patient. The physician told the paramedic that he was no longer authorized to act as a paramedic under the physician's medical license. The paramedic was reassigned to work as a fire fighter, without reduction in pay. No action was taken to restrict or revoke his certificate.

The paramedic claimed that the physician's decision violated his property interest in his employment as a paramedic, he had a liberty interest in continued employment as a paramedic which was violated, and he suffered reputational harm. He also claimed that his right to due process had been violated, and the physician had tortuously interfered with his employment relationship.

The District Court granted the defendant's motion for summary judgment and denied the plaintiff's motion for partial summary judgment. The paramedic has appealed the District Court decision to the United States Court of Appeals for the Ninth Circuit.

Why WSMA is now engaged: Amicus Curiae Arguments: There are several important policy considerations beyond the arguments already made.

Reversal of the District Court decision:

• Could have wide-ranging adverse effects on the health care system in general, since it could lead to a physician being unable to discharge any "at will" health care professional dependant on the physician for employment (potentially including physician assistants, nurses, or any other licensed or certified health care professional) absent a "pre-deprivation" due process hearing;

• Cause patient care to suffer, since physicians and hospitals may justifiably become unwilling to hire or utilize licensed or certified health care professionals;

• Would undercut the public's interest in a strong EMS system if a Medical Director is unable to make a determination regarding the qualifications, competence, and suitability of paramedics under his or her supervision.

It is also arguable that:

• The entire emergency medical system is designed by law to be under the control of physicians, including who is chosen to work as the eyes, ears, and hands of the supervising physician;

• The professional judgment of the physician supervisor is sufficient due process in a decision made regarding the delivery of emergency medical care, since ultimately it is the physician's license on the line when that care is delivered; and

• There is no deprivation of liberty interests when information about the competence of a paramedic is communicated to professional oversight officials or entities – indeed, it is a priority of the Washington State Legislature that information flows from employers and supervisors to oversight officials and

See "Trauma" page 14

California Physicians must notify patients of licensing and regulating body

California physicians have until June 27 to post signs in their offices, or if they don't have an office to notify their patients in writing that they are regulated by the Medical Board of California and how to contact them for more information and/or complaints.

The Medical Board of California, the disciplinary and licensing agency for the state's 125,000 doctors claims the new regulation is designed to "inform consumers where to go for information or with a complaint about California medical doctors."

The notification must say, in bold, conspicuous type:

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 / www.mbc.ca.gov

The regulation is not popular with the California Medical Association because of the impact on the patient/physician relationship and because other professions are not required to post such information. All physicians who treat, test or diagnose patients must comply.

Any of the state's 125,000 physicians who treat, test, or diagnose patients must comply with the rule.

Under the new rule, physicians must provide the notice either by prominently posting a sign in a conspicuous area of their office, include the notice in a written statement, signed by the patient and kept in the patient's file, or include the notice in a statement on letterhead, or other documents given to the patient and be placed immediately above the signature line for the patient in specified type.

Texas, Georgia, Idaho are among other states that have similar requirements. ■

Applicants for Membership

Karin B. Hamilton, MD
Pediatrics
Harbor Pediatrics (FMG)
6401 Kimball Dr #104, Gig Harbor
253-853-3888
Med School: University of Wisconsin
Internship: Children's Hospital, LA
Residency: Children's Hospital, LA

Kavitha Krishnamani, MD
Family Medicine
St. Joseph Medical Clinic (FMG)
1708 S Yakima #110, Tacoma
253-627-9151
Med School: Madras Medical College
Internship: Central WA Family Medicine
Residency: Central WA Family Medicine

Donald D. Lillegard, MD
Anesthesiology
Lakes Anesthesia (FMG)
1313 Broadway Plaza #200, Tacoma
253-426-6306
Med School: University of Colorado
Internship: Mercy Hospital & Med Ctr
Residency: Mercy Hospital & Med Ctr

Kevin B. Martin, MD
Family Medicine
Sound Family Medicine
3908 - 10th St SE, Puyallup
253-848-5951
Med School: Case Western Reserve
Internship: Case Western Reserve
Residency: Case Western Reserve

Stacy L. Merrifield, DO
Family Pracitce
Sound Family Medicine
3908 - 10th Se SE, Puyallup
253-848-5951
Med School: Midwestern University
Residency: Tacoma Family Medicine

Angie K. Pham, MD
Anatomic & Clinical Pathology
Puget Sound Institute of Pathology
1001 Klickitat Way SW #205, Seattle
206-622-7747
Med School: University of Oklahoma
Internship: Loma Linda Univ Med Ctr
Residency: Loma Linda Univ Med Ctr

iPad stoking doctor interest in tablet computers

If the launch of the iPad has done anything, it has brought legitimacy to the tablet computer, a product that has long been considered the redheaded stepchild of computing.

It could be because of the buzz over Apple's latest offering, or because physicians who have grown to love their smartphones also recognize their limitations in a clinical setting. But more physicians than ever — more than 50%, according to a recent survey by Software Advice — say they are now considering buying a tablet. A separate survey by Epocrates, whose medical software has been a popular smartphone download, found that one in five physicians are planning specifically to purchase an iPad.

But experts say doctors shouldn't jump on the iPad bandwagon without exploring other options.

Despite the big splash from iPad, several other recently introduced tablets also should be considered, experts say. At January's Consumer Electronics Show in Las Vegas, more than a dozen tablets were unveiled. And if physicians really assess what characteristics they need in a tablet, Software Advice found that the iPad may deliver on only a few.

Software Advice, a free service that gives information on computer systems, surveyed 178 doctors, nurses, medical students and health IT professionals in early February to get an idea of what the ideal tablet for the health care industry would look like, and if the iPad would fit the bill. Out of 10 must-have features, the iPad delivered on four.

The survey found ease of use to be the No. 1 feature users sought in a tablet. Because of the touch screen format, which many have used on their iPhones, the iPad could deliver on ease-of-use concerns. But so could a touch screen tablet introduced by Hewlett-Packard Co. that is expected to launch later in 2010.

Richard Knight, president and CEO of Medical Business Systems, an Elmsford, N.Y.-based information technology consulting company, said the ability to point and click (or touch, as it were) to open an application is much easier than the process of manually opening each application, required on most tablets that mimic desktop computers. This is a primary concern for physicians who would be using the device on the go.

The other "must have" features physicians want, and that the iPad delivers on, are Wi-Fi access, lightweight hardware and an ergonomic design.

For many physicians who have integrated Apple iPhones into their workday, the fact that a tablet basically can do all an iPhone can but on a bigger screen is also a major draw. But there are many functions important to health care that the iPhone doesn't have — and the iPad won't, either.

Features deemed "must-have" in Software Advice's survey that the iPad will not include are: resistance to dust and liquids; fingerprint access; barcode scanning; RFID reader; voice-to-text dictation; and an integrated camera.

But just as developers have proven with the iPhone, if there's something you want the device to do, chances are someone will create an application to do it. The iPad's ability to run third-party applications will let users customize their devices to accomplish many of the tasks they want.

"The iPad is exciting for power mobile users or for physicians who want more detailed content or longer content on a portable device, so I see a strong potential there," said Monique Levy, senior director of research for Manhattan Research. Not only will physicians be able to read journal articles online on their devices, she said, but they also could use them to look at detailed graphics such as x-rays and access an electronic medical records system.

When it comes to medical software, however, the most commonly used programs are Windows-based and not available on an Apple platform. The technology company Citrix thinks it has solved this problem for iPad users. It created a virtual desktop to allow applications or programs — even those that are Windows-based — that live on a desktop computer to be accessed remotely. The company has an iPhone application that does the same thing, but it says the screen size of the iPhone has restricted the usability.

But, warns Chris Thorman, social media manager for Software Advice, remote access likely will cause the software to run much more slowly than if it actually lived on the devices themselves.

There will be at least one EMR program that will live on the iPad. Thomas Giannulli, MD, developer of iChart, an EMR for the iPhone, is working on an iPad version and hopes to launch it shortly after the iPad is made available in two months. Unlike other mobile EMR applications, iChart lives on the device, so the reliability of the cellular network won't impact its ability to function properly.

But even if the device has all the features you want or need, it still might be wise to wait, experts warn.

In the survey by Epocrates, which developed a mobile drug reference tool for smartphones that it plans to expand to the iPad, 9% of physicians said they planned to buy an iPad when it is released in March; another 13% plan to buy it within a year. But 38% said they are interested but will wait for more information before finalizing their decision.

Scott Testa, PhD, professor of business administration at Cabrini College in Philadelphia, said he thinks the 38% are doing the right thing. "I think it's important that they probably not be the earliest adopters." He advised waiting until Apple has "come out with the second version to make sure most of the bugs are worked out."

"Usually the first people who adopt these products go through a little bit more pain that those that wait a little bit," Testa said. "I think that's true for many technology products." ■

Reprinted from AMNews, Feb. 2, 2010

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bodies in order to assure that medical personnel practice with reasonable skill and safety.

This is a classic example of a seemingly narrow case that could have considerable spill-over into other areas of care – and why expanded legal efforts are warranted more than ever. For more information about this amicus contact WSMA's Legal Affairs Director Tim Layton at tim@wsma.org. ■

From WSMA's Monday Memo, 4/5/2010

Pierce County Medical Society

DOCTORS AND BASEBALL!!

Join your Pierce County Medical Society colleagues, friends and families for a night of baseball, BBQ and fun....

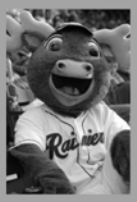
Thursday, June 24

6:00 p.m. gates open
6:30 p.m. barbecue starts
7:00 p.m. game time

Cheney Stadium

Experience one of Cheney Stadium's most popular spots to watch a Rainiers game, the Casino Party Decks. The decks offer an exclusive experience to groups of families and friends. Our private PCMS deck will be stocked with beer, wine, soda and ballpark fare! No waiting in lines or grabbing for your wallet, as our private concierge will be there to help. The deck offers great views of all the fantastic Rainiers action on the field, the Mariners stars of tomorrow and majestic Mt. Rainier.

Bring your family and friends and enjoy the night at the ballpark!!



For more information call PCMS
253.572.3667; Tanya or Sue

Bring your family and friends and come watch the Tacoma Rainiers play the Omaha Royals at Cheney Stadium.

Ticket price includes:

- Game ticket and PARKING
- Buffet of burgers, hot dogs, baked beans, chips, etc. (6:30 - 8 pm)
- Drinks: soda, bottled water, wine and beer (6 pm - 7th inning)
- Private entrance and concierge
- Family and group photos with the Rainier's Rhubarb the Reindeer

Cost: $32 per person (no charge for 3 years and under)

To Reserve Tickets:

BY MAIL: mail this form to PCMS
223 Tacoma Avenue South
Tacoma WA 98402

BY PHONE: call 253.572.3667

BY FAX: 253.572.2470

BY EMAIL: tanya@pcmswa.org

Name - PLEASE PRINT

Address

City and Zip

Phone

Email

Number of tickets: _____ **@$32 each**

Credit Card Info (or enclose check payable to PCMS)

☐ Visa ☐ Master Card ☐ Am Express

Card Number: _____

Expiration Date: _____

Signature

Health care reform calls for full disclosure of industry gifts

The Patient Protection and Affordable Care Act requires drugmakers, device manufacturers and other medical suppliers to report annually any "payment or transfer of value" to individual physicians and teaching hospitals. Payments or gifts worth less than $10 need not be reported, unless they total $100 or more during a calendar year.

Subject to disclosure are charitable contributions made on a physician's behalf, compensation for nonconsulting services, consulting fees, continuing medical education speaker or faculty fees, current or prospective ownership or investment interests, education, entertainment, food, gifts, grants and honoraria research, royalties or licenses, and travel.

Exempt from disclosure is anything physicians receive in their roles as patients, devices loaned for fewer than 90 days for physicians to evaluate, discounts, dividends or profits from stock ownership in publicly traded industry firms, educational materials that directly benefit patients or are intended for patient use, in-kind items used for providing charity care, items or services provided under contractual warranty and product samples intended for patient use.

The new law will be effective September 30, 2013. ■

COLLEGE OF MEDICAL EDUCATION

Upcoming CME Programs

Internal Medicine Review

May 21; Fircrest Golf Club; 8am-3:15pm

This one day program will provide primary care physicians the opportunity to learn first hand from national and local leaders in their field. The goal is to provide a better understanding of several of the most common disease processes, in light of rapid scientific advances. This program is offered to members of the Tacoma Academy of Internal Medicine as well as local physicians and physician assistants.

The continuing medical education activity will offer up to six Category 1 credits. Program Director is **Brian Mulhall, MD**.

Watch your mail for a program brochure and registration information.

Primary Care Conference

June 18, Fircrest Golf Club; 8am-3:15pm

This one day course focuses on the latest updates and clinical challenges common to the primary care and internal medicine practice. Each year we strive to provide new information regarding etiology, diagnosis and management in a variety of general medicine areas. As in the past, the topics for the course were chosen with these selection criteria in mind: Suggestions from previous course attendees as well as areas where substantial changes have taken place during the past three years and on controversial subjects where medical opinions differ.

The continuing medical education activity will offer up to six Category 1 credits. Program Director is **Kevin Braun, MD**. ■

Continuing Medical Education

New Developments in Primary Care - An Evening Conference

New Developments in Primary Care has been scheduled for Wednesday, April 28, 2010 and will be held at the Fircrest Golf Club. This will be an evening conference held from 4 pm - 8:20 pm. Heavy appetizers and beverages will be served.

This course in primary care medicine is designed for practicing internists, family physicians, physician assistants and specialists interested in expansion of their primary care knowledge and skills. Our curriculum will feature a diverse selection of up-to-date, practical topics in primary care medicine. Our approach is to combine the best in evidence-based medicine with the day-to-day realities of patient care. This conference is perfect for the provider who has a hard time taking a full day away from patient care in the office. Program Director for this conference is **Michael Bateman, MD**.

Topics and speakers include:

Vitamin D: Current Updates	Ian De Boer, MD, MS
Setting Limits on Narcotics: Having Effective Conversations with Patients	Daniel O'Connell, PhD
What's New in Hypertension/ Kidney Disease	Neil Hannigan, MD
Prediction of Cardiovascular Disease: Novel Risk Assessment Markers	Michael Bateman, MD

At the end of the conference, participants should be able to:

- Understand new developments in Vitamin D treatment.
- Understand the dynamics of patients requesting narcotics and describe and demonstrate an approach to setting limits more effectively in conversations with patients. Demonstrate how to practice the approach with a patient situation on videotape.
- Understand new treatments from new evidence today for best ways of treating hypertension and subsequent kidney disease.
- Update an review novel cardiovascular markers to review the current future tests to help screen form cardiovascular disease.

This conference offers a maximum of 4 hours in Category 1.

A program brochure/registration form was mailed mid-March, or to register or for more information call the College at 253-627-7137. The fee is $60 for PCMS members (active and retired) and $80 for non-PCMS members. (Registration after April 23 will be an additional $25.) ■

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health has always taken a holistic, ecological approach that addresses the entire environment. In its constitution written in 1946, the World Health Organization penned the definition "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." To achieve its objective, it specified among its functions "to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene" (4).

This approach is just as relevant in tackling infectious diseases as it is in tackling inequities in health outcomes. It is estimated that racial differences in health outcomes are only marginally due to genetics (10-15%) and access to care (10-15%). The majority (70-80%) are due to social and environmental factors. As Dr. James Marks writes (5):

In other words, as it relates to our health, our ZIP code may be more important than our genetic code, our school files may be more telling than our medical files, the time spent in our office at work may be more relevant than the time spent at our doctor's office and the places we play may be more crucial than those where we get treated.

In previous articles, I have spoken of the important partnership between public health and medical providers. Together, we work on individuals, populations, and the environment. You can see from the above discussion why public health can also seem very diffuse when we partner with others to impact education, urban design, economic development, crime and violence, transportation, and environmental quality. It is only in partnership that we will be able to achieve our vision of "Healthy People in Healthy Communities."

References:

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Classified Advertising

POSITIONS AVAILABLE

Western Washington – Internal Medi-cine. MultiCare Health System, seeks BE/BC internal medicine physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or call 800-621-0301 for more information. Refer to Opportunity #5906, 5575 when responding.

POSITIONS WANTED

Two experienced Physician Assistants interested in partnering with a clinic to start lifestyle clinic incorporating counseling on diet and exercise modification to treat chronic illness. Will pay rent and preceptor fee. Prefer Tacoma area, will consider other Pierce County locations. Please contact Rachel DeBoer at racheldeyoung@hotmail.com or Susan Fish at pegasus4787@comcast.net or phone Susan Fish 253-584-5723.

OFFICE SPACE

Great location with plenty of parking, 13th and Union. Spaces of 800 square feet and 2,500 (divisible) remaining. Contact Carol 206-387-6633.

Office space available to share. Spanaway Medical office to share space and possibly staff of 2,800 sq ft office 1-5 days per week. Ideal for primary care or specialty. If primary care may be able to share patients. Contact Dr. Wayne Kim 253-536-2824 (office) or 253-988-7867 (cell).

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Tacoma, WA 98402

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Pierce County Medical Society
BULLETIN

May 2010

PCMS activities bring members together for fellowship and fun.....

The Board of Trustees welcomed new members at a "New Member Reception" held at the PCMS office...

"Please do this again" was heard frequently at the recent "Grape Vine Social," a wine tasting event held at the Landmark Convention Center Roof Garden...

More photos and stories page 5

INSIDE:

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

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

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Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

May 2010

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President's Page

by Stephen F. Duncan, MD

ALOHA

Stephen F. Duncan, MD

For the past approximately 20 years, the College of Medical Education (COME) has sponsored a meeting in Hawaii on a biannual basis. The venue rotates around the islands and this year it was held at the Sheraton Kauai Resort, March 29-April 2. I have been fortunate to attend several of the events over the years and this year was one of the best. With the guidance of course director **Mark Craddock, MD** and program administrator Lori Carr, the courses have consistently been a great time for education, fellowship and family.

Despite what you might think, the participants were challenged by an agenda that included local Pierce County experts and nationally acclaimed speakers. There was also time to enjoy the wonder of Kauai. Kauai, the garden isle, has an array of cultural, recreational, historical and artistic activities. It also is a tropical paradise with many exotic plants and animals. And there is also the draw of the Pacific Ocean and the beaches.

Kauila Clark, a Traditional Hawaiian Practitioner, gave one of the most interesting talks. He shared with us the Aloha Spirit.

"A presence which can't be seen, touched or heard but is expressed from the center of one's being to all of creation, knowing the unknowable, expressing the universal, it is found in all things and it is the connection of all things, it is known as ALOHA." Kauila Clark

A-Akahai - meaning kindness, as expressed with tenderness

L-Lokahi - meaning unity, as expressed with harmony

O-Olu Olu - meaning agreeable, as expressed with pleasantness

H-Haa Haa - meaning humility, as expressed in modesty

A-Ahonui - meaning patience as expressed in perseverance

Pilahi Paki

When you are in Hawaii, you have the opportunity to slow down and look at the world a little differently. I wish to keep in mind the spirituality of the Hawaiian Healer as I return to the reality of the everyday work schedule.

I hope you will consider returning with me to the next Hawaii conference sponsored by the College in 2012. In the meantime, check out the other great CME opportunities from COME at www.pcmswa.org.■

PCMS welcomed new members at April reception

The PCMS Board of Trustees, leadership, and staff welcomed new members at a reception in April. The event was held at the PCMS building on Tacoma Avenue in the Stadium District of Tacoma.

The reception included drinks and hors d' oeuvres and provided an opportunity for new physicians to learn more about the Medical Society as well as the medical community. Meeting other physicians is important, as one member noted, particularly since there are not many opportunities for physicians to meet face to face anymore. While names and sometimes voices are familiar, faces are not, and this is one way to get to meet your peers.

The event was well attended and both new members and long standing members found the time spent very worthwhile.■

From left, Drs. George Wang, Murray Rouse, Justin Cooper, Bruce Brazina, Steven Litsky and Jeff Okey, PhD. Dr. Brazina serves as a PCMS Trustee

From left, Drs. Mark Grubb and Keith Dahlhauser, Treasurer and Trustee respectively, visit with Dr. Francis Mercado, Gig Harbor internist

More photos, see "New Members" page 13

"Grape Vine Social" - the first annual wine tasting a hit

On May 1, the roof garden of the Landmark Convention Center was the venue for the 1st Annual PCMS Grape Vine Social – a wine tasting event organized with the leadership and expertise of **Nick Rajacich MD**, Tacoma orthopedic surgeon. Three eastern Washington wineries, all physician owned, poured tastes as well as chatted with attendees about their wineries and the wine making process. The three physician owners were Drs. Hugh Shiels, orthopedic surgeon from Sunnyside with Cote Bonneville Winery, Palmer Wright, otolaryngologist from Yakima with Kana Winery, and Joe Gunselman, Spokane anesthesiologist, the owner of Robert Karl Cellars.

With a wonderful turnout of attendees, good food, great wine, door prizes and keepsake engraved wine glasses, everyone seemed to enjoy themselves. The consensus at the end of the evening was overwhelmingly in favor of a 'second annual' event.■

Keith Dahlhauser, Tacoma ophthalmologist, PCMS Treasurer, and lucky door prize recipient with guest Kathy Drake

Dr. Gary Pingrey (left) and Dr. Robert Stuart discuss their wine findings

More photos, see "Wine Tasting" page 13

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.*

Damn the Torpedoes

Andrew Statson, MD

"Nothing is so well calculated to produce a death-like torpor in the country as an extended system of taxation and a great national debt."
William Cobbett (1804)

One of the nurses in our Delivery Room wore a button that said, "Others promise, we deliver."

In March, Congress made a whopper of a promise, without having a clue as to how it will deliver. The Speaker offered this promise as a gift to the American people. Yes, it is a gift for which we, our children and our grandchildren will have to pay.

In the trade business, some stores offer what they call a gift with purchase. You buy something and you get something else extra. Others have sales in which you buy one item and you get a second one free, or at half price, or whatever. That was not the kind of gift The Speaker had in mind.

In a way, our rulers almost had to pass this bill. They are in a desperate situation and they had to resort to desperate measures. They cannot deliver on the promises they made in the past, among them Social Security and Medicare, all of which are in deep trouble.

This year the Social Security Fund will have to pay in benefits more than it collects in taxes. Medicare already did that last year. That shouldn't be a problem, they have balances in their Trust Funds, but Congress spent that money on other things over the years. What is left in the Trust Funds is a pile of Treasury bonds, promises which the Treasury was going to make good on when the need arose.

Well, the need has arisen, but the Treasury is empty. What to do? Oh, what to do?

Our rulers are in trouble, and they know it. And they are ready to break all the rules of good governance just so they can hold onto power a little longer. They are out of money, and they need a lot of it in a bad way. They basically have three options, none of them good.

The first one is to raise taxes, and that includes levies, assessments, charges, fines, mandates, premiums, up to and including requisition and confiscation of private property, if they can think of a nice way to justify it for the public good.

The health bill does exactly that, but no matter how powerful a government may be, it is limited in how much it can collect by force. Increases in the tax rate rapidly lead to a drop in economic activity, with the inevitable result of reduced tax receipts and a lower standard of living for all. The outcome of such measures is disappointing even in the absence of popular opposition to higher taxes, as expressed by the Tea Party Movement.

Then, there is the taking of private property, which the Supreme Court approved with its Kelo decision. That didn't work too well for New London, Connecticut. Just because it became legal didn't mean it would benefit the government.

Argentina recently gave us another example of taking by nationalizing the private retirement plans of its citizens. Granted, that is Argentina, but I have seen articles in our press advocating the folding the 401(k) plans into the Social Security system. It is something to look forward to, and it is all for the good of the people, you understand. With the market tanking, many people had a significant paper loss on their investments. If the government took them over, they would be "guaranteed." Yes, of course.

There is one little problem with that, apart for making people even more angry than they already are. The estimated total of the funds in the 401(k) plans is 3.4 trillion. Even if Congress took them over, they would barely cover the federal deficit for the next two years. Once that money is gone, what else are they going to take over?

The second approach to raising funds is borrowing. I am afraid we are close to the limit of our borrowing ability. In the past six months, the federal debt increased by about one trillion dollars. During that time, our international creditors have not increased their holdings of Treasury paper. If anything, they may have decreased them.

Japan and China, our two largest lenders, each hold a little less than 900 billion, about the same as six months ago. Russia, India, Taiwan, South Korea, haven't made any significant purchases, either. They have problems of their own. We can't count on them, and not even on China, in spite of the glittering statistics it puts out.

See "Torpedoes" page 8

Torpedoes from page 7

So where did that money come from? Who bought that trillion dollars of debt? Certainly not the American citizens. They have increased their savings, but just a little. They have reduced their debt, too, but mostly by defaulting on their loans, which were written off.

It looks like our banks were the big buyers, and why not? They borrowed from the Fed at 0.1% interest and bought Treasuries paying 1-4%. Most of the profits they had during the past year came from trading bonds and playing the interest rate spread, not from lending. So the money came form the Fed.

Fine, but what will happen when the Fed starts raising the interest rate? The value of the bonds on the banks' books will drop, just as did the mortgage securities they unloaded on the Fed not too long ago. And the banks might need another bailout.

The third, and final option, is the printing press. While all the activity mentioned above has been going on, the printing press has been running quietly in the basement.

Kevin Dowd, now retired, was a professor in economics at the University of Nottingham in England. He spoke at the Paris Freedom Fest on September 13, 2009. Here are excepts from what he said:

"I would suggest that the pension/social security system -- the system of intergenerational transfers in which the young get signed up by their elders, often before they are born -- not only resembles, but actually is an intergenerational Ponzi scheme, the biggest scam ever invented. And to you, young people here, I am sorry to say, if you want to see who the suckers of this Ponzi scheme are, just look in the mirror.

"The younger you are, the more you stand to lose. And the longer the scam goes on, the more it will cost you. To you, youngsters, I say: it's your choice how long you . . . put up with this. . . .

"You can play by the rules your elders would impose on you. You can expect to pay higher and higher taxes, work harder and harder to stand still, and get less and less back in return for yourselves -- a life little different from slavery -- and then the system will collapse anyway.

"Or, alternatively, you can fight back. There is no law of nature that says you have to honor checks that other people write at your expense. . . . You can repudiate those checks.

"Let's be blunt about what I am suggesting. I am suggesting that if default is inevitable, and if default is more damaging the longer it is delayed, then it would be a good idea to consider embracing it. We should lance the boil, as it were, and kill off the scam -- sooner rather than later."

The health bill, now law, is a small part of our problem. The balance sheet of a company lists its assets on the left, and the owners' equity on the right. I am sorry to say that, on the balance sheet of our nation, on the right, nothing is left, and on the left, nothing is right.

In the midst of our Me Generation, the ghost of King Louis XIV of France stands up on his soapbox and declares: "After us, The Flood." The French Sun King died in 1715. The policies he instituted bankrupted France and seventy-four years later, in 1789, the country exploded.

Our own Sun King was FDR. He died in 1945, sixty-five years ago. The policies he instituted are bankrupting the nation and have brought us to the condition we are in now. Will history repeat? Mark Twain gave a beautiful answer to that question. He said, "History does not repeat, but it rhymes."

Time is running out. The end of the socialist century is getting closer, and the powers that be plan to go out in style. To enjoy it while it lasts, let us all go to

THE PROMISED LAND

Damn the torpedoes, full speed ahead,
On borrowed time and borrowed money,
Neither mind the rocks, as we are led
To the Promised Land of milk and honey.

We shall be with goods replete
Far beyond imagination,
And bullet trains will compete
With magnetic levitation.

We shall catch the wind to sail,
We shall fly on solar power,
We shall ride the speedy rail,
Soar within the tallest tower.

We shall face no wants or sorrow,
For as long as we can borrow. ■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Keep Moving for a Healthier America

Anthony Chen, MD

When I was a medical student, I remember one classmate whose breakfast was usually a handful of whatever was in the secretary's candy basket. As a resident, there were many times when my breakfast was only marginally better: a doughnut from the doctor's lounge or the drug representative's display (back when they were allowed to have displays). Once we move from training to the real world, breakfast may be better, but lunch is often what we can squeeze between patients and paperwork.

When we look at what actually causes death in Pierce County, the top two (at almost 20% each) are Tobacco and Poor Diet and Physical Inactivity. We have made great strides against Tobacco with only 20% of adults and 5% of physicians smoking. You know the facts about Poor Diet and Physical Inactivity because you see it in your patients' bodies every day: children and adults do not eat healthy foods, do not exercise regularly and are paying the price. The result is hypertension, heart disease, stroke, diabetes, osteoporosis, and even other issues like mental health. The cost is $5 billion each year in medical costs, lost productivity, and worker's compensation.

In Pierce County, two thirds of adults are overweight or obese and one third of children are obese, with the trends continuing higher. Three quarters of adults do not eat much fruits or vegetables and one in five adults does not exercise. The average child gets less than 15 minutes of vigorous activity a day.

May is National Physical Fitness and Sports Month—and has also been called the Exercise is Medicine™ Month by the American College of Sports Medicine—so it is a great opportunity for us to encourage our patients to address their lifestyle and diet. Two-thirds of patients would be more likely to exercise if advised by their doctor and given additional resources; 25% look first to their physicians for advice on exercise and physical activity. There are many barriers for those in practice and we know that only 41% of physicians talk to their patients about the importance of exercise.

What about our own health? For me, I know that there are times I do better than others. There are many adjustments we can do to try to eat better and exercise more. This morning, I took the bus and walked the mile from the Tacoma Dome up Pacific Avenue to my office. While the ground was wet, the sun was shining from a blue sky. The cherry trees were blooming and flowers were popping out of their beds. Although my schedule does not allow me to take the bus every day, I find that when I do, it gives me time to think and more exercise than if I drive. I also find that walking, whether at home or around work, gives me more connection to the community. May is also National Bike Month and this year I need to figure out how I am going to bicycle to work.

I hope that the month of May gives you some opportunities to think of how physical activity and healthy eating fits into your patients and your own lives. Here are a few resources:

• At www.health.gov, there are guidelines for exercise broken down by age.

• Read about National Physical Fitness and Sports Month, including resource materials at http://www.fitness.gov/May%20Month/may_month_ toolkit.htm

• USA Track and Field and the American College of Sports Medicine's Exercise is Medicine™ Month site is at http://www.exerciseismedicine-physicians.org/.■

COLLEGE OF MEDICAL EDUCATION

Hawaii and CME, this year on Kauai, has largest crowd ever

The Hawaii and CME course held bi-annually in Hawaii was on the beautiful island of Kauai this year, March 28 – April 3 at the Sheraton Kauai Resort. Attracting the most registrants ever, the program had special features this year including speakers John Nance, national aviation safety expert and Kauila Clark, a unique, respected practitioner in the local Native Hawaiian community.

Local speakers from Pierce County Medical Society included, **Drs. John Carrougher, Raed Fahmy, Ron Graf, Daniel Guerra, Mark Hassig, Pat Hogan, Manuel Iregui, Gordon Klatt, Brenda Kodama, Baiya Krishnadasan,, John Lenihan, Moacyr Oliveira, Dale Overfield, Paul Schneider** and **Frank Senecal**. **Dr. Mark Craddock** served as program director. PCMS extends gratitude to all participants and especially to these speakers who contributed their time and talent to make the program so successful.

PCMS also extends thanks to both **Drs. Dan Ginsberg** and **John Lenihan** for contributing their photography skills. The next Hawaii and CME will be held in spring of 2012. ■

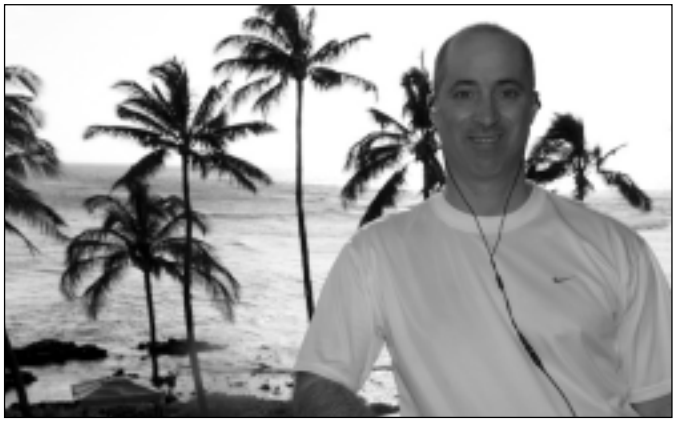
Dr. Gregg Ostergren (left) and Dr. Mark Yuhasz verify information during a break

From left, Drs. John Samms and Bill Roes - are we having fun yet?

Drs. Thomas Martin and Baiya Krishnadasan having a grand time

From left, Drs. Alex Mihali and Ron Graf enjoy lounging

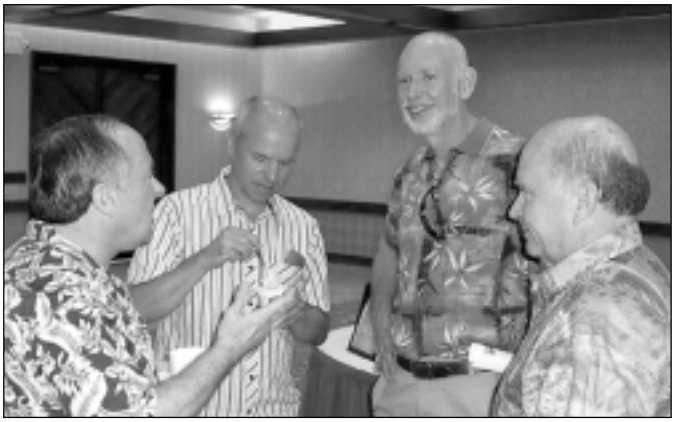
COLLEGE OF MEDICAL EDUCATION



Dr. Dan Ginsberg, Tacoma internist, above. Dr. Ginsberg and Dr. John Lenihan contributed these photographs from the Hawaii CME program

We hope that Drs. Dale Overfield (left) and Paul Schneider solved the issue they were discussing

Left, Dr. Stan Harris, retired surgeon, with endocrinologist Dr. Ron Graf. Dr. Harris served as PCMS President in 1997



From left, Drs. David Law, Jos Cove', Pat Hogan and David Lukens taking a break

Program Director Mark Craddock, MD (left) with popular Hawaii speaker Kauila Clark (center) and associate

New legislation calls for updated pain management guidelines

ESHB2876 recently passed by the legislature calls for pain management rules to be repealed and new rules to be adopted by June 30, 2011. The legislation was originally introduced to require mandatory CME for any physician prescribing pain medication.

The Medical Quality Assurance Commission (MQAC) is tasked with adopting new rules on chronic, noncancer pain management. It is to include dosing criteria, including an amount that must not be exceeded unless a physician first consults with a practitioner specializing in pain management. The legislation also states that the commission shall consult with the WSMA, the UW, the Department of Health and the Medical Director's Association in writing the new rules.

The legislation applies to all professions with prescriptive authority. ■

Applicants for Membership

Germaine R. Johnson, MD
Diagnostic Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: University of Pennsylvania
Internship: Virginia Mason
Residency: Wake Forest Babtist Med Ctr
Fellowship: University of Washington

New Members from page 5

Dr. Bill Hirota, Vice President, gets to know Dr. Victor Chiu, new Tacoma ophthalmologist

Dr. Sanjay Agrawal, gastroenterologist (DHS) and Dr. Steve Larson, gastroenterologist (TDDC) get to know one another

George Wang, MD, radiologist (left) visits with Dr. Steve Konicek, PCMS Trustee

Drs. Bill Hirota and Mark Grubb flank new member Francis Mercado, MD

Wine Tasting from page 5

Ophthalmologist Len Alenick with Davida Navarre, happy winners of one of the three door prizes

Dr. Sue Salo and her husband Robert Bedoll, also happy winners. Dr. Salo served as President in 2002

Pierce County Medical Society

DOCTORS AND BASEBALL!!

Join your Pierce County Medical Society colleagues, friends and families for a night of baseball, BBQ and fun....

Thursday, June 24

6:00 p.m. gates open
6:30 p.m. barbecue starts
7:00 p.m. game time

Cheney Stadium

Experience one of Cheney Stadium's most popular spots to watch a Rainiers game, the Casino Party Decks. The decks offer an exclusive experience to groups of families and friends. Our private PCMS deck will be stocked with beer, wine, soda and ballpark fare! No waiting in lines or grabbing for your wallet, as our private concierge will be there to help. The deck offers great views of all the fantastic Rainiers action on the field, the Mariners stars of tomorrow and majestic Mt. Rainier.

Bring your family and friends and enjoy the night at the ballpark!!

For more information call PCMS
253.572.3667; Tanya or Sue

Bring your family and friends and come watch the Tacoma Rainiers play the Omaha Royals at Cheney Stadium.

Ticket price includes:

- Game ticket and PARKING
- Buffet of burgers, hot dogs, baked beans, chips, etc. (6:30 - 8 pm)
- Drinks: soda, bottled water, wine and beer (6 pm - 7th inning)
- Private entrance and concierge
- Family and group photos with the Rainier's Rhubarb the Reindeer

Cost: $32 per person (no charge for 3 years and under)

To Reserve Tickets:

BY MAIL: mail this form to PCMS
223 Tacoma Avenue South
Tacoma WA 98402

BY PHONE: call 253.572.3667

BY FAX: 253.572.2470

BY EMAIL: tanya@pcmswa.org

Name - PLEASE PRINT

Address

City and Zip

Phone

Email

Number of tickets: _____ **@$32 each**

Credit Card Info (or enclose check payable to PCMS)

☐ Visa ☐ Master Card ☐ Am Express

Card Number: _____

Expiration Date: _____

Signature

COLLEGE OF MEDICAL EDUCATION

SAVE THE DATE CME at Whistler

The annual *CME at Whistler* course will be held Wednesday - Saturday, January 26-30, 2011 at a new location - the beautiful Fairmont Chateau Resort. We have negotiated a fabulous room rate of $219 a night.

CME at Whistler is a "resort" program, combining family vacationing, skiing, a resort atmosphere, and offering ten hours of CME credits.

This year's course will have dynamite line up of speakers discussing a variety of topics of interest to all physicians. **Baiya Krishnadasan, MD** and **Rick Tobin, MD** will be this year's program directors. ■

Primary Care Conference 2010

Primary Care 2010 will be held June 18, 2010 at the Fircrest Golf Club from 8 am - 3:15 pm. This one day course focuses on the latest updates and clinical challenges common to the primary care and internal medicine practice. As in the past, the topics for the course were chosen with these selection criteria in mind: Suggestions from previous course attendees as well as areas where substantial changes have taken place during the past three years and on controversial subjects where medical opinions differ.

The continuing medical education activity will offer up to six Category 1 credits. Program Director is **Kevin Braun, MD**. ■

Continuing Medical Education

Internal Medicine Review 2010

Internal Medicine Review 2010 has been scheduled for Friday, May 21, 2010 and will be held at the Fircrest Golf Club. Conference hours are 8:00 am - 3:15 pm. A hosted lunch will be served.

This one day program will provide primary care physicians the opportunity to learn first hand from national and local leaders in their field. The goal is to provide a better understanding of several of the most common disease processes, in light of rapid scientific advances. This program is offered to members of the Tacoma Academy of Internal Medicine as well as local physicians and physician assistants.

The continuing medical education activity will offer up to six Category 1 credits. Program Director is **Brian Mulhall, MD**.

Topics and speakers include:

The In's and Out's of Pneumonia Admissions	Ramona Popa, MD
Anemic Inpatients: What Labs Do I Need? Who Gets Blood?	Daniel Moore, MD
Long Term Adverse Consequences of Exacerbations of COPD	Arthur Knodel, MD
Acute, Severe Migraine Management	Traci Ryan, MD
Congestive Heart Failure	Rosemary Peterson, MD
Decompensating Cirrhosis	Brian Mulhall, MD

At the end of the conference, participants should be able to:

- Understand and discuss how to keep patients out of the hospital, when to admit, and understand antibiotic management and out-patient follow-up of patients.
- List the indications and criteria for blood transfusion.
- Order appropriate labs to evaluate anemia in the hospital setting and list which patients require urgent hematology consultation.
- List rationale for preventing ECOPD and approved medications for this indication.
- List optimal inpatient management to include use of non-invasive ventilation.
- Discuss the pathophysiology of acute migraines, initial outpatient approaches, criteria for admission and strategies for preventing recurrence after discharge.
- Discuss the various types and manifestations of congestive heart failure, signs of worsening disease, outpatient evaluation and management, criteria for admission and critical measure for inpatient management and return to home.
- Discuss the multiple variables in end-stage liver disease, the most effective strategies for outpatient management, the criteria for admission and the best strategies for inpatient management and careful transition back to the outpatient setting.

This conference offers a maximum of 6 hours in Category 1 CME credits.

You should have received a program brochure in the mail. To register by phone or for more information call the College at 253-627-7137. The fee is $35 form TAIM members, $60 for PCMS members (active and retired) and $85 for non-PCMS members. (Registration after May 14 will be an additional $25.) ■

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

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Western Washington - General Surgery. Fabulous Opportunity! Multi-specialty medical group seeks B/E or B/C General Surgeon. Practice is located in Covington, Washington, an ideal community nestled in a beautiful forest close to a large metropolitan area only 35 minutes southeast of Seattle. Join a State-of-the-Art clinic with in-house radiology, laboratory, ambulatory surgery center, breast services center, and urgent care. Primary care referral base and exploding population growth demands an aggressive physician willing to further develop this practice. 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 to apply online at http://blazenewtrails.org/, email your CV to blazenewtrails@multicare.org or fax your CV to 866-264-2818. "MultiCare Health System is a drug free workplace"

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Pierce County Medical Society
BULLETIN

June 2010

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INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

June 2010

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President's Page

by Stephen F. Duncan, MD

Are You Happy?

Stephen F. Duncan, MD

I once asked one of my colleagues, who was known by his peers to have one of the highest satisfaction scores from his patients, what does it take to make your patients happy? He said three amazing things. First, he said he rarely talked. By saying little, he let his patient talk; they told him what was wrong with them and they felt they had been heard. Second, he suggested helping the older patients with putting on their shoes and coats. In other words, be sure to touch your patients. Lastly, he believed in giving his patients what they wanted. Because he listened to them, they usually told him what they wanted. He did not mean to give patients unreasonable treatments but usually they wanted something and he believed they would be satisfied if they received it.

Over the thirty plus years I have practiced family medicine, I have found a few things that make my life better. When you think about it, seeing your 5,000th patient with a cold does not bring much glowing satisfaction in your life.

I observed one of my colleagues one day calling the spouse of a patient who had died. I asked him why he did that. He explained that it was a satisfying service he provided his patients. So years ago I began calling the surviving spouse, daughter, or son when one of my patients died for any reason. It has given me untold satisfaction. First it is the compassionate thing to do. But beyond that, I have heard some the most heart warming stories about the patients whom I have cared for and the care they received. In fact some of the most sincere compliments I have received have been from survivors telling me about the death of their loved one.

I have watched scores of doctors work years with dedicated staff and never say thank you. The men and women who work with you every day to appoint your patients, room your patients, or provide services to your patients deserve thanks. It is amazing what saying "thank you" does to someone who is putting their best into what they do. My support staff have more to do with making my patients happy than I do. I believe that remembering their birthday, getting to know a little about their family and interests, taking time to listen to their concerns is the least I can do for the great people I work with. Since I make way more money than they do, I also believe that giving some of it to them in the form of gifts is essential.

I have worked in several locations in my career from three provider clinics to 15-plus provider medical centers. No matter what the size of the building, it is possible to work all day with your patients and support staff and never interact with the other doctors who you practice with. I believe it is valuable to purposefully walk around the clinic and say hello to the other doctors who work with you. Some idle chat is just fun and relaxing.

Medicine has many rewards for those who practice it. Sometimes the non-clinical things I do in my practice bring the most satisfaction. ■

In My Opinion

by Mark Yuhasz, 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.*

Reducing Unnecessary Radiation Exposure in Medical Imaging

Mark Yuhasz, MD

Editor's Note: PCMS thanks Dr. Yuhasz for writing this article at the request of the Board of Trustees. The issue was brought to the board's attention as one that needed clarification in our medical community. Hopefully this information will prove useful to physicians concerned about radiation and imaging.

The advances in technology have made CT, nuclear medicine, and fluoroscopy effective tools in diagnosis of a wide variety of clinical conditions. Although this often translates into improved care for patients the downside is the ill effects of ionizing radiation - primarily carcinogenesis-making it an increasing public health concern.

On February 9th, the FDA announced an initiative to reduce unnecessary radiation exposure from three types of medical imaging procedures: CT, nuclear medicine, and fluoroscopy. They are advocating the adoption of the following two principles of radiation protection:

1. Appropriate use of the radiation procedure

2. Optimization of the radiation dose used during each procedure

The American College of Radiology is working with the FDA through its education and accreditation programs for facilities that offer these procedures to support the benefits of imaging while minimizing the risks. Diagnostic radiologists oversee operation of equipment by using the ALARA principle-as low as reasonably achievable. Equipment manufacturers are building in devices and techniques to minimize the amount of radiation to produce images which are of diagnostic quality. Bismuth shielding can be applied to the female breast before CT to reduce breast irradiation.

So what are the amounts of radiation involved? First, it is useful to know that in the U.S. each individual is exposed to about 3 mSv a year from background radiation-mainly from cosmic radiation and radon gas. A 2 view CXR results on an estimated dose of 0.16 mSV-a chest or abdomen CT gives 50 times as much at about 8 mSv. It's estimated that each dose of 10 mSv will increase the risk of malignancy on average by 1/1000 with a lag time of one to two decades. The risk of carcinogenesis is more than theoretical-data from atomic bomb survivors, adolescents who received multiple plain films for scoliosis surveys and radiation technologists all show increased risks of malignancy years after exposure. The WHO, CDC, and NIH have all classified ionizing radiation as a carcinogen. A threshold of 50 mSV cumulative dose has been set as identifying those patients who are at significant increased risk of radiation induced malignancy. The relative risk is still small given the roughly 40% individual chance of malignancy for each of us but spread over the entire population it's estimated that 1-2 % of cancers in this country (with a 50% case fatality rate) may be radiation induced.

What can we do to protect our patients? Clinical guidelines such as the Wells criteria and d-dimer assays for venothromboembolism may make the chance of venothromboembolism small enough that no imaging is required. It's been estimated that about one third of CT scans aren't indicated or can be replaced by tests that use less radiation. Anecdotally, the vast majority of CTPAs performed in our community are negative for PE. If imaging is indicated, techniques that don't use radiation such as ultrasound and MRI should be used whenever possible, especially in younger patients. About one third of patients who undergo CT get three or more scans so the patient should be asked and records checked to see if they're accumulating significant dose. Five or more CT scans of the chest or abdomen and pelvis in 2 years or less in a patient 50 years of age or younger is a red flag to try to reduce further exposures when possible.

Of special concern are those clinical situations which include younger patients who may receive many CT scans such as chest pain possible PE and those patients with renal stones. The former is of particular concern in females because it includes the relatively radiosensitive breast tissue. We know that breast irradiation is less with V/Q scans compared to CTPA and V/Q is as accurate a test particularly if the CXR is normal or nearly so. Unfortunately, the recent shortage of radioactive tracer agents makes this practical only in those at especially high risk(less than 30). Those with recurrent renal stone disease can be imaged with very low dose techniques and sometimes be followed with plain films (if their stones are visible on a KUB) and ultrasound rather than repeat CTs.

Imaging in pregnancy is another area where not only exposure to the fe-

See "Radiation" page 6

Medical practices not hiring; other health care jobs still growing

After months of adding new positions, hiring declined in physician offices in April. Demand for professionals in the health care industry as a whole, however, returned to prerecession levels, according to a pair of papers released in May.

The Bureau of Labor Statistics report on the employment situation, released May 7, found that physician offices lost 300 jobs after gaining 1,400 in March and 1,100 in February. Experts suspect that continuing uncertainty around Medicare's sustainable growth rate formula has left physicians wary about adding to the payroll.

"Many physicians, with a 21% Medicare cut pending, are very reluctant to hire new staff, and they may even be postponing replacing staff who leave," said David N. Gans, VP of innovation and research for the Medical Group Management Association.

But although physician offices may not be hiring much at the moment, the rest of the medical service industry is. Health care added 20,100 jobs in April, according to the BLS. This was far more than the 8,300 added in April 2009, but down from the 32,900 created in March of this year. Approximately 6,100 jobs were created in hospitals.

This job growth also is being reflected in a growth in online job advertisements.

The number of ads for health care practitioners and technicians, including physicians, grew 3,300 to 630,000 in April, according to the monthly report on the subject released May 3 by the Conference Board. This is on par with the number appearing before the recession began. Ads for medical support personnel increased 2,400 to 128,700. ■ *Reprinted from AMNews, May 28, 2010*

FTC Delays Red Flags Rule until end of year

The Federal Trade Commission (FTC) recently delayed the compliance deadline for the red flags rule until the end of this year. Enforcement was scheduled to being on June 1.

The rule will require creditors and financial institutions to develop identity theft prevention programs. The FTC considers physicians to be creditors when they accept insurance and bill patients after services are rendered for amounts that insurance does not pay, or if they regularly allow patients to set up payment plans after services are rendered. The law will require implementing policies and procedures on preventing, detecting and mitigating identity theft.

For the past two years the FTC has continued to delay while the AMA and other physician organizations have made the case to the FTC that physicians are not creditors like banks and lenders and the rules should not apply to them. The AMA recently filed a lawsuit asking a federal court to prevent the FTC from extending the rule to physicians. Hopefully, this extension is a positive sign that the lawsuit has prompted the FTC to reconsider their decision. ■

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tus is a concern but also the mother. The three most common scenarios are possible appendicitis, possible renal stone disease, and possible PE. For appendicitis, ultrasound or MRI should be the first test used if practical-followed by limited CT if the diagnosis is still in doubt. Repeat ultrasounds for the first 24 hours followed by plain films and then CT have been recommended for possible renal colic. For possible PE, CTPA results in less irradiation for the fetus especially in the critical first trimester.

In all these situations, the current real risk of not getting or delaying the diagnosis must always be weighed against the more remote risks of irradiation. ■

Special Feature

by Ann Gosch

A Doctor in the House?

Sumner Schoenike, MD

Editor's Note: The PCMS Board of Trustees recently voted to not endorse physician members running for the legislature. However, they do support providing information about candidates, regardless of party affiliation, to the membership so that each member will be better informed to make their own decision about supporting the physician candidate.

Physicians in some parts of Pierce and Kitsap Counties will have a choice on Election Day 2010: A choice to vote for a candidate who has experienced medicine and medical practice firsthand. **Sumner Schoenike, MD** is running for the state house and he is hoping to represent the citizens of the 26th Legislative District, which extends from Fox Island, Gig Harbor, and the Key Peninsula north to Port Orchard and Bremerton. He also hopes to represent the house of medicine in improving patient care and supporting physicians and their practices.

Dr. Schoenike, 62—who retired in May 2008, yet continues to practice on a part-time/limited basis—thinks that politics is a "natural fit for a pediatrician" like himself. "I have dealt with many of the same issues: kids, families, schools, community, and the problems that come from lack of education, unemployment, and the cycle of poverty." Identifying the problems is easy, he says, but finding solutions to complex issues with very limited resources will be extremely difficult. He quickly adds, I'm up to the challenge and the learning curve. It's the job that comes with being elected."

Evolution of an Ambition

When asked how he came to run for public office, Dr. Schoenike looks back to his work on Pierce County Project Access, a nonprofit organization of volunteer physicians who donate care to low-income, uninsured county residents. In the course of co-founding the organization, in late 2006, he worked with and was inspired by legislators who really cared about health care.

Throughout his civic and political involvements of the past decade—including being on the Board of Trustees of the Pierce County Medical Society since 2001—he's been "astounded at how welcoming legislators have been and how willing they are to changing their minds when presented with new data and reasonable arguments." He came to realize that legislators are not well-educated about medicine and they all bring their own knowledge and resources to the table.

"It was around our dinner table that I first floated the idea to my family that I might enter public life by running for state office. There was a deafening silence that followed." But little by little, he says, both his wife, Jan, and daughter, Celi, have come around to the idea and have become two of his strongest supporters.

Dr. Schoenike believes he can add something new to the legislative mix because of his medical background and experience in helping to create health policy in Pierce County. On the door-to-door campaign trail, he's found that it's good to be a nonpolitician—it makes people more likely to want to engage in conversation. "Doorbelling is much like practicing medicine. I listen to people (in this case voters) and together, we begin to develop solutions to problems."

The Health Care Debate

The most obvious problem that he's looking to solve in Olympia is the health care crisis. Schoenike believes that basic health care should be a right for all citizens, like basic education. Right now, he maintains, it is a privilege only for those who manage to have and to keep health care insurance.

The statistic that 47 million Americans are uninsured and have no access to health care except through emergency rooms is what got Dr. Schoenike involved in Pierce County Project Access. He believes that access is a huge problem and that the right to basic health care tops the list of attributes a fully functioning health care system must have. The others that he supports include:

- A ban on the rescission or denial of care by insurance providers.
- Reimbursement on the basis of outcomes.
- The standardization of medical processes.
- Administrative simplification and information integration.

See "Schoenike" page 12

Regence Foundation honors local medical director

The Regence Foundation recently it has honored **Mimi Pattison, MD**, medical director at Franciscan Hospice and Palliative Care in Tacoma, with a Sojourns Award in recognition of her leadership in advancing palliative care in the Puget Sound area.

The inaugural award includes a $50,000 grant to support continued advancements in palliative care, which Dr. Pattison will donate to the Franciscan Health System's Foundation to benefit the organization's comprehensive hospice and palliative services.

Palliative care is an approach to care that brings holistic relief and comfort to seriously ill patients and their families. Through Sojourns, The Foundation aims to help people with life-threatening and incurable illness to access high-quality palliative care in their own communities.

Dr. Pattison originated a screening question for physicians, nurses and other providers now used nationally for palliative care referral: "Would you be surprised if the patient you are examining died in the next year?" This simple and effective question resulted in a seven-fold increase in appropriate hospice referrals through the unique Palliative Care Outreach program in Franciscan's primary-medicine clinics.

The Palliative Care Outreach program earned national recognition in 2000 upon receiving the American Hospital Association's Circle of Life Award for innovation in end-of-life care.

In 1998, Dr. Pattison helped launch the first palliative care program in the Northwest at FHS, and was the first physician to practice palliative medicine in a Washington hospital. In addition to being medical director for Franciscan Hospice and Palliative Care, Pattison is vice chair of the Washington State Medical Quality Assurance Commission. ■

Reprinted from Business Examiner, 5-13-2010

Help Your Low-Income Patients Quit for Good

New Quit-Smoking Campaign Features Real People, Real Struggles to Quit

By Dr. Maxine Hayes, Washington State Health Officer

During the past decade, Washington has had tremendous success reducing tobacco use. Since the Tobacco Prevention and Control Program began in 2000, our state has nearly 30 percent fewer adult smokers. That equals about 295,000 people leading healthier lives.

Our toll-free Washington State Tobacco Quit Line (1-800-QUIT-NOW; 1-800-2NO-FUME in Spanish) is one reason we've been so successful at helping people quit. Calling the Quit Line is free and can double the chances of quitting successfully. Since the program began about 10 years ago, more than 125,000 people have called for help.

Still, smoking rates remain higher among people from low-income and low-education backgrounds. These people are just as likely to try to give up tobacco as smokers with higher incomes, but they're less likely to succeed.

That's why the state Department of Health continually develops new ways of reaching people who smoke with free resources and support to help them quit.

The agency recently created a multimedia "Dear Me" campaign to reach people from all walks of life with messages designed to motivate them to quit smoking. The campaign features real smokers writing letters to themselves about their addiction. The "Dear Me" letters highlight the effect tobacco has had on the writer's family, health, and livelihood. The videos—which are honest and, at times, emotional—convey the real, everyday struggle people go through when they try to quit tobacco.

One Dear Me letter reads as follows:

"Dear Me,

When you were 8 you begged mom to quit smoking. 4 years later you started. Now Jack is 7 and he begs you to quit. Mom is dying of cancer and all you have told the boys is that Grandma is sick. Shame on you!

Sincerely, Me"

Each "Dear Me" video concludes with the campaign's tagline, "No one can make me quit but me"—an empowering message that speaks to the personal determination it takes to quit smoking for good. Each video directs viewers to the Tobacco Quit Line for free support.

The "Dear Me" campaign includes radio ads that hit the airwaves statewide in April. Videos are also posted on Quitline.com. Visitors can watch a "Behind the letter" video that goes into greater detail about each person interviewed. People can submit their own "Dear Me" letters to be posted on the site, and find resources like the Quit Line number.

People who call the Quit Line are connected with a "quit coach" who asks them about their smoking history and helps them identify personal triggers that cause the desire to smoke. The coaches help callers develop a quit plan and set a quit date, and provide free nicotine patches or gum, if appropriate.

To reach more people from low-income backgrounds, the state's Medicaid program now provides support to clients through the Quit Line. The benefit covers Quit Line services and the cost of prescription medication, if appropriate. Medicaid reimburses physicians for smoking cessation referral visits, review of the Quit Line's prescription medication recommendation, and prescription writing and faxing. **All patients have to do is call the Quit Line at 1-800-QUIT-NOW to find out more**.

Today, many more people have quit smoking in Washington than there are current smokers. As a health care provider, you're in a unique position to help your patients quit tobacco — no matter their income. By simply referring people to the Quit Line, you can connect them with the support they need to quit.

The Tobacco Control Resource Center (www.tobaccoprc.org/TCRC/) has online information. Just click on "Tobacco Cessation and/or Quit Line Materials" to order Dear Me posters for your office.

Additional help for your patients who smoke is available at www.Quitline.com. ■

Online death filing starts in 2011

The Washington State Department of Health is releasing a new online Electronic Death Registration System (EDRS) to Pierce, Thurston, Mason, Benton, Franklin and Spokane counties in early 2011, with a statewide release to follow. EDRS is an internet-based death filing system for those who file death records in Washington State. EDRS streamlines the death registration process, improves the quality of the death data collected, improves communication among those who file, and uses the internet to make filing faster.

Everyone benefits with EDRS:

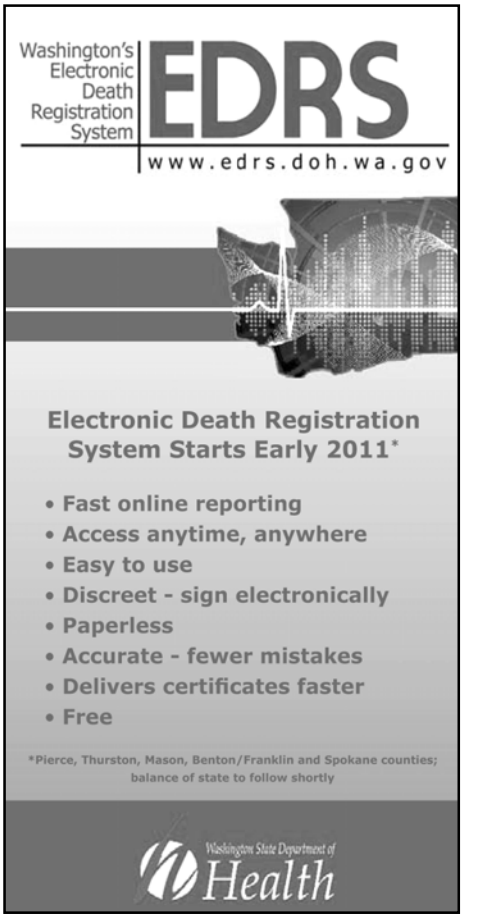
- Physicians will quickly complete a death record from any computer with internet access and file it with a single click. This paperless system does not require extensive computer knowledge. It streamlines communication between funeral directors and physicians and eliminates the need to fax or sign paper records. It offers a fast, easy, more accurate way to file.

- Families get death certificates faster and will do so from any local health jurisdiction across the state. EDRS delivers better service because delays inherent with paper processing are reduced.

- Funeral homes save time and money by collecting physicians' signatures electronically. They can view cases online and get death certificates faster.

- The people of Washington benefit by having immediate and accurate death data used to combat public health threats.

For information, contact Field Services at 800-525-0127 or EDRS@doh.wa.gov. ■



IN MEMORIAM

RICHARD E. MARTINDALE, MD

1929 - 2010

Dr. Richard Martindale passed away May 8, 2010 at the age of 80.

He received his medical degree from the University of Texas, Galveston in 1965 and completed an anesthesiology residency at Wilfred Hall Medical Center in 1969. Following 20 years of active duty with Air Force, Dr. Martindale settled in Puyallup where he served as a staff anesthesiologist at Good Samaritan Hospital until his retirement in 1991.

Dr. Martindale was a member of the Pierce County Medical Society and the Washington State Medical Association since 1976.

PCMS extends sincere sympathies to Dr. Martindale's family.

Richard Martindale, MD

Applicants for Membership

Mark C. Adams, MD
Vascular Surgery
Franciscan Health System
1717 South J Street, Tacoma
253-426-6322
Med School: University of Pennsylvania
Internship: University of Washington
Residency: University of Washington
Fellowship: University of Washington

Khashayar Dehghan, MD, PhD
Plastic & Reconstructive Surgery
Artistic Plastic Surgery Center, PLLC
3515 So. 15th Street, Tacoma
253-756-0933
Med School: St. Louis University
Residency: St. Louis University Hospital

Carolyn A. Wild, MD
Oncology/Hematology
Northwest Medical Specialties, PLLC
1624 South I Street #305, Tacoma
253-383-3366
Med School: University Health Sciences
Internship: David Grant Medical Center
Residency: David Grant Medical Center
Fellowship: UC Davis

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- Implementation of incentives and reimbursements for evidence-based prevention and wellness programs.
- A reworking of the tort system to limit the need for defensive medicine.

Dr. Schoenike believes that Basic Health, the state-funded health care plan for low-income uninsured citizens of Washington state, is extremely efficient, with an operating overhead of just three to four percent. He notes there has been talk of expanding the Basic Health Plan to become the platform for a public option in Washington State, should this align with national health care reform. If so, it is a system he would support.

Health care as it exists in America today, Dr. Schoenike believes, is unsustainable. "Doing nothing is not an option, so it all gets down to decisions about how [the system] will change to increase access and efficiencies and lower costs. I would love to be part of the thinking and decision-making about our changing structures and systems over the next five to 10 years," he said.

Join the Conversation

With health care now in the forefront of public policy debate, Dr. Schoenike says it's a great time for medical professionals to get more involved in the political process. And there are many ways to do so short of running for office. One of the most basic ways is by writing letters to elected officials, and Dr. Schoenike urges expressing your opinion before an issue becomes hot: "Get out in front of an issue, rather than being reactive."

"Legislators are absolutely dependent on people coming forward," he insists, "otherwise communication is left to the lobbyists and special interests, who are often not aligned with the best interests of the public." Dr. Schoenike emphasizes that to the extent that elected officials are not hearing from the public, they're not being effective.

Beyond letter writing, he says, you can "start dabbling" in the political process, as he did, through the Pierce County Medical Society, and see where it leads. "As physicians, we spend our time listening and discussing patient concerns, making diagnoses and, with the help of patients and their families, developing a therapeutic and follow-up plan. I intend to continue that same work as a legislator."■

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Baiya Krishnadasan, MD is the new program director for this Whistler program and has already been hard at work lining up a dynamite list of speakers to ensure this course meets your educational standards combined with quality skiing and family vacationing.

Details on how to book your rooms will be out shortly. If you have any questions or need more information please email Lori Carr at Lori@pcmswa.org or call the College of Medical Education at 253-627-7137. ■

The William O. Robertson Patient Safety Award was established to recognize and share innovative patient safety initiatives, especially in the ambulatory care setting.

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William O. Robertson, MD Patient Safety Award

Entries to receive the 2010 Robertson Award are being sought for small (5 or less physicians), medium (6-30 physicians) and large practice (31+ physicians). Entries must describe a patient safety program that has been implemented and must describe why the project was chosen, what system or process changes were accomplished, what cultural changes occurred, how barriers to implementing the project were overcome, and show evidence of improvement in the care provided.

The application form and information on past recipients can be found at www.wsma.org/medical_professionalism/patient_safety.cfm#robertson.

The WSMA established the William O. Robertson Patient Safety Award in honor of Dr. William O. Robertson who has been a champion for patient safety, risk management and quality improvement throughout his long and distinguished career.

Submissions and questions should be directed to John Arveson at jva@wsma.org, (206) 441-9762 or 1 (800) 552-0612.

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Northwestern University Medical School

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by Stephen F. Duncan, MD

Being A Professional

Stephen F. Duncan, MD

We hear the word "professional" used daily in a common way to describe an occupation: "professional wrestler" or " my profession is hair styling." Presently the term professional has been cheapened to mean, in the modern sense, nothing more than that one is paid to do a particular job or service. Classically there are only three professions: Divinity, Medicine and Law. A profession arises when a trade or occupation transforms itself through "the development of formal qualifications based upon education, apprenticeship, examinations, the emergence of regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights." (1)

In addition to having a body of knowledge and skills, control of the teaching of the body of knowledge and skills, and the means to certify and discipline members of the profession, a professional body is regulated by statute and forms local and national societies for the maintenance of the profession. A profession enjoys autonomy and usually is held in high esteem by society. Members of a profession are usually paid well and there are hidden inequities among the different members of the profession. A professional is one who engages in the service of others and is somewhat self-sacrificing.

One could argue that with the dilution of the term professional to mean nothing more than a salary for an occupation, the concept of a profession is one of a time gone by. Today with the loss of autonomy, greater regulation from without medicine, and the fragmentation of the delivery of medical care, maybe the medical profession should just be satisfied with its position in society. Sometimes it seems that there are forces in our society that are deliberately eroding the medicinal profession to gain the upper hand. They might wish to see physicians disengage and accept whatever government and the regulating bodies decide. I, for one, do not accept that fate.

Besides trying to provide the best care for our patients, we should be engaged in the organizations that provide the structure of professionalism. These include: the training of new doctors, participation in the specialty-based societies, involvement in the regulatory bodies of medicine, support of local, state and national medical societies and even engagement in the formation of laws both state and federal. It takes more that just going to the practice each day; it takes thoughtful work in all aspects of medicine.

The new members of our profession, as I understand according to surveys, are interested in how they might help in strengthening medicine. I invite you to get involved with the Society and/or any other aspect of the medical profession. If you call the Pierce County Medical Society and speak with Sue Asher, our director, we can put you in touch with other physicians that will help you get involved. ■

(1) Alan Bullock & Stephen Trombley, The New Fontana Dictionary of Modern Thought, London: Harper-Collins, 1999, p689.

Pierce County Project Access

by Leanne Noren, Executive Director

Collaboration in Volunteer Care: Pierce County Project Access

Leanne Noren

In the fall of 2006, Pierce County Medical Society physicians, under the leadership of then president-elect **Sumner Schoenike, MD** had a dream to improve access to healthcare for the low-income, uninsured in Pierce County. Pierce County Project Access grew from that vision. Today, it is an emerging network of physicians and ancillary providers who volunteer to provide care to the underserved in our community.

Pierce County Project Access has a robust board of directors with representation from Franciscan Health System, MultiCare Health System, Community HealthCare, Pierce County Medical Society, and Tacoma/Pierce County Health Department. Strong community support stems from many additional community agencies including SeaMar Community Health Center, Northwest Physicians Network, the free clinic network, Group Health, and independent physicians.

There are more than 100,000 uninsured residents in Pierce County. While many physicians already provide uncompensated care, there is no organized system, leaving the burden on individual office staff and creating uncertainty and risk for those providers who wish to do the right thing. PCPA is here to support you, the physician, and to help improve patient results through care management and availability of ancillary services.

Think of Pierce County Project Access as an extension of your office staff. We are people dedicated to coordinating your volunteer services. PCPA will manage the patient care from beginning to end. We do this through:

Enrolling Patients Based on Need

PCPA will verify financial status and county residency so that you can be assured that your volunteer service is reaching those who are in the most need and reside in this community. The eligibility requirements for a patient to enroll in PCPA are:

* Up to 200% federal poverty level
* Pierce County resident for at least 3 months
* Uninsured

Making Appropriate Referrals

PCPA uses workup standards to ensure that when a PCPA patient is scheduled for a specialist appointment they have already completed a conservative course of treatment from their primary

See "PCPA" page 12

PIERCE COUNTY PROJECT ACCESS

THANK YOU VOLUNTEERS!

David Coons, DO
Cynthia Edwards, MD
Doug Hassan, MD
John Jiganti, MD
Ashley Keays, DO
Chad Krilich, MD
Peter Krumins, MD
Mark Mariani, MD
Alexander Mihali, MD
Mark Murphy, MD
Viet Nguyen, ARNP
Allison Odenthal, MD
Janice Olson, MD
Nick Rajacich, MD
Don Russell, DO
Robin Sarner, MD
Bradley Schmitz, MD
John Stewart, MD
Keeley Sullivan, ARNP
Roseanne Thompson, ARNP
Patrick Vaughan, MD
Richard Waltman, MD
Jim Wyman, MD

As of 6/21/2010

Special Feature

by Ann Gosch

Public Service At It's Best

Stan Flemming, DO

"You need to be politically engaged if you want to help determine your own destiny—none of the people in the Statehouse understands health care from a physician's perspective." So says **Stan Flemming, DO** as he encourages his fellow professionals to get involved in the political process. If you don't want to run for office yourself, he says, you can get out and help those who do. "Find a candidate to support," he urges.

This year he might be referring to himself. The medical doctor who previously served as a member of the Washington State House of Representatives and as the first mayor of the City of University Place is now running for Pierce County Council, District 7. He is one candidate in a crowded field that will be whittled down to two in the August 17 primary. He's optimistic about his election chances, saying he's the only one who has served in public office. In fact, Dr. Flemming has a long record of service to the community—on the local, state, and national level.

Born to Medicine and the Military

Dr. Flemming is a nearly lifelong resident of Pierce County. Born in 1953 on the Rosebud Indian Reservation in South Dakota, he was just two weeks old when his family moved to Steilacoom. Both his parents were physicians and practiced in this area until his father retired and his mother died.

Young Stan did not go in a straight line from college to medical school, instead taking a detour into the military. His father was an Army officer; his mother was not happy. Once in boot camp, the newly enlisted private asked himself, "What have I done?!"

In the years that followed, he alternated between military service and his college education, eventually earning bachelor's and master's degrees—at the University of Washington and Pacific Lutheran University, respectively—and a commission in the Army. After joining the Reserve, he enrolled in Western University of Health Sciences, in Pomona, Calif., to complete his D.O. degree in 1985.

As part of his family medicine residency in Long Beach, Calif., he worked in a makeshift clinic in an abandoned church with the windows broken out. "This was a population that needed help and had nowhere else to go," he says. This experience inspired his career-long interest in public medicine.

His years in military, academic, and public medicine nearly led to his appointment as U.S. Surgeon General in 1995. Dr. Flemming was one of two finalists for the post.

He remained an Army Reservist until his recent retirement, at the rank of brigadier general. He was sent on medical missions that included two combat tours of duty and overseas service in Kosovo, Thailand, and Kuwait.

In the Tacoma area, Dr. Flemming practiced family medicine in community health organizations and private practice until 2005, when he joined Northwest Physicians Network as chief medical officer. NPN operates on the model of an Accountable Care Organization, with independent physicians providing coordinated care as an integrated delivery system.

Stepping In To Politics

Dr. Flemming's moonlighting career in politics began with a remedial educational tour of the Washington state capitol. "I knew nothing about politics," he said. "I couldn't even have told you the difference between a Democrat and a Republican, the right wing and the left wing." After a courtesy call to the speaker of the house yielded an invitation to run for office, Dr. Flemming upset a longtime incumbent to become the first Native American in the Statehouse, in 1992.

In 1994, when a ballot measure passed to establish the City of University Place in unincorporated Pierce County, Dr. Flemming was urged to run for office as the city's first mayor. "I was the only one around who'd held elective office," he says, while admitting he had no experience in "founding a city." He won the election and set out on the monumental start-up project. "We had 120 days to write and enact every law, establish a police department, a public works department—and we did it three days shy of the deadline," Dr. Flemming said. After his two-year term as mayor, he continued to serve on the City Council until January of this year.

He did not run for reelection, saying, "Anyone elected to public office is

See "Flemming" page 14

Nominations Requested for WSMA Judicial Council

The Washington State Medical Association is seeking nominations to fill open positions on the WSMA Judicial Council. Terms are for five years and members of the council are limited to one term or completion of one term.

The Judicial Council has a number of important functions including: Interpreting the Principles of Medical Ethics and Bylaws of the Association; Investigating general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public; Having jurisdiction over issues of membership and controversies between component medical societies or their members.

Qualifications of Proposed Nominees

The Bylaws provide that individuals proposed for the council must be current active members of the WSMA and must have been active members for ten or more years.

In addition, they should be colleagues who: Have demonstrated sound judgment and personal and professional ethics; Are committed to promoting the ethical practice of the art and science of medicine.

Election/Ratification Process

The Bylaws provide that the president-elect shall propose individuals for election to the council, that the Board of Trustees elects (by a simple majority), and that the House of Delegates ratifies the election (by a two-thirds vote).

Deadline for Response

Please propose your suggested nominee(s) to Dean Martz, MD, WSMA President-Elect, no later than August 13, 2010. A response form can be obtained by calling the Medical Society office at 253-572-3667. ■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Building Healthy Communities in Pierce County

Anthony Chen, MD

Since arriving 21 months ago, I have been engaging the Health Department in strategic planning. Some might say that sounds like a long time—and I, too, wish it could be done sooner—but I see strategic planning as an iterative process. Like quality improvement, there may be times when you take a big step or have a major accomplishment, but you are continuously working and refining.

One of our early milestones was aligning our vision with that of Healthy People 2010 (our nation's public health plan http://www.healthypeople.gov/): "Healthy People in Healthy Communities." Most people find it easy to define "Healthy People" but harder to define "Healthy Communities." We believe that we can achieve our vision if we achieve seven outcomes:

1. People are free of chronic disease
2. People are free of infectious disease
3. People do not die prematurely
4. People have access to affordable and comprehensive health care
5. People live in safe, nurturing communities
6. Communities have healthy physical and natural environments that encourage individual and community health
7. Economic stability, equality and social justice are created for all

An easy link to see is between Outcomes 6 and 1. For example, if we have communities with environments that encourage physical activity and have access to healthy foods, we will have less obesity, hypertension, heart disease, and diabetes. This has been the focus of Healthy Communities of Pierce County (http://www.healthypierce.org) and our ACHIEVE (**A**ction **C**ommunities for **H**ealth, **I**nnovation and **E**n**V**ironmental chang**E** http://www.ymcapkc.org/page.php?id=961) coalition. Our medical society members have been very engaged in both organizations and you may have read the recent news coverage about the successful pilot test of a healthier school lunch menu at the Peninsula School District. But Outcome 6 is much broader than that. Together, Outcomes 5, 6, and 7 make us look at broad measures of a community's health, which include the physical and social environment:

* Water quality
* Air quality
* Food safety
* Communicable disease rates
* Chronic disease and injury rates
* Healthy neighborhood features
* Poverty rate
* Income disparities
* Infant mortality disparities
* Access to affordable and comprehensive health care
* Equity in health services use
* Kindergarten readiness
* High school graduation
* Adverse Childhood Events (ACE scores)
* Social Capital

You can see that tackling all these things is about as complex as achieving world peace. We already are trying to address some of these areas. For example, our maternity support services and our collaborative work with African American churches (the Black Infant Health program) address Infant mortality disparities. Our early childhood interventions, parenting teaching, and nurse home visiting done in partnership with First Five Fundamentals, United Way of Pierce County, Pierce County Library, and the Family Support Partnership increase kindergarten readiness and social capital while decreasing Adverse Childhood Events.

As part of our strategic planning process, we are trying to better align with these measures and outcomes and to decide our share of each. In the next few months, we will have an idea whether there will be radical changes to what and how we do our work. We expect to be looking to our partners to help in this ambitious endeavor. In the meantime, I encourage you to learn more about healthy communities through these resources:

1. **Municipal Research and Services Center of Washington Healthy Communities page**: http://www.mrsc.org/Subjects/HumanServices/healthymain.aspx
2. **California Endowment's Building Healthy Communities initiative**: http://www.calendow.org/healthy communities/
3. **Department of Health's Active Community Environments and Healthy Communities Projects pages**: http://www.doh.wa.gov/cfh/nutritionpa/our_communities/active_community_environments/default.htm

See "TPCHD" page 12

Applicants for Membership

Curtis R. Allen, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Stanford Primary Care

Sonya A. Cottrell, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Medex Northwest

James E. Gee, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Oklahoma U Academy of Health Sciences

Paul H. Gibson, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Medex Northwest

Katie A. Lapsa, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: St. Francis University

Johny K. Lee, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: St. Louis University

Sandra Loyer, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Idaho State University

David L. Neiman, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: U of Texas at San Antonio

Andrew J. Poplawski, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: University of Utah

Brandon A. Swisher, PA-C
Family Practice
Sound Family Medicine
3908 - 10th Street SE, Puyallup
253-848-5951
Training: Medex Northwest

IN MEMORIAM

CHARLES J. GALBRAITH, MD

1926 - 2010

Charles Galbraith, MD

Dr. Charles Galbraith passed away May 27, 2010 at the age of 84.

He received his medical degree from St. Louis University in 1952 and completed a surgical internship and residency at St. Louis University Group Hospitals. Following two years as Chief of Surgery at the Veterans Hospital in St. Louis, he moved his family to Tacoma where for more than 30 years he practiced general thoracic surgery.

He was a member of the American College of Surgeons and served on hospital committees and boards in Tacoma including Tacoma Savings and Loan Bank.

Dr. Galbraith was a member of the Pierce County Medical Society and the Washington State Medical Association since 1959.

PCMS extends sincere sympathies to Dr. Galbraith's family.

PCPA from page 5

care provider. Volunteer Medical Directors screen each referral to ensure that it is appropriate and that the standards of care have been met prior to scheduling a specialist appointment.

Providing Enabling Services

Pierce County Project Access will provide transportation or interpretation services when needed so that you don't have to wonder if a patient is going to miss an appointment or if there will be a language barrier.

Providing Care Management Services

The Pierce County Project Access Patient Care Coordinators work with each patient one-on-one to coordinate follow-through on medical needs.

Providing All Needed Medical Services

Through our partnerships, we ensure that a full scope of services is

See "PCPA" page 14

TPCHD from page 9

4. **CDC's Healthy Communities Program**: http://www.cdc.gov/healthycommunitiesprogram/

5. **A Community Planning Guide Using Healthy People 2010**: http://www.healthypeople.gov/publications/healthycommunities2001/healthycom01hk.pdf

6. **National Association of County and City Health Officials' Building Healthier Communities Compendium Series**: http://www.naccho.org/topics/HPDP/chronicdisease/publications.cfm

7. **Robert Wood Johnson Foundation's County Health Rankings**: http://www.countyhealthrankings.org/health-outcomes

8. **United Health Foundation's America's Health Rankings**: http://www.americashealthrankings.org/ ■

COLLEGE OF MEDICAL EDUCATION

Upcoming CME Save the Date!

Friday, October 1, 2010
New Approaches to Common Medical Problems in Primary Care
Fircrest, WA
Program Director: **Mark Craddock, MD**

Friday, November 5, 2010
Infectious Diseases Update
Fircrest, WA
Program Director: **Elizabeth Lien, MD**

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

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Continuing Medical Education

SAVE THE DATE - CME at Whistler, January 26-30, 2011 at Beautiful Fairmont Chateau Resort

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education. Whistler offers alpine skiing, cross-country skiing, and many other winter activities at both Whistler and Blackcomb. You will also find many superb dining options and excellent shopping for the relaxed afternoon. Whistler is a great destination for families, as it offers many entertainment options and relaxation options.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. Nestled at the base of Blackcomb Mountain, the Fairmont Chateau Resort defines mountain luxury. With true ski-in and ski-out convenience, the classic elegance of this landmark Whistler hotel offers a modern alpine setting for unsurpassed guest service, exceptional dining, full resort amenities, and a world class spa. We have negotiated incredible room rates starting at $219 CDN per night. Details on how to book rooms at the negotiated rates will be available soon.

Baiya Krishnadasan, MD is the new program director for CME at Whistler and has lined up a dynamite list of speakers to ensure this course meets your educational standards, combined with quality skiing and family vacationing. Scheduled topics include: Sports Related Concussion; Surgical Management of Low Back Pain; Use of Ultrasound and Electromagnetic Navigation Aided Bronchoscopy; The Bicuspid Aortic Valve and Associated Aortopathy; Chronic Pelvic Pain; Update on Fibromyalgia Syndrome; Federal Requirements for DATA-Waived Physicians; Controlled Substances Federal Regulations Update; New Developments in PET/CT Imaging; Broken Heart Syndrome - Transient Catecholamine Induced Cardiomyopathy.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

If you have any questions or need more information please email Lori Carr at Lori@pcmswa.org or call the College of Medical Education at 253-627-7137. ■

PCPA from page 12

available to all of our patients, from office visits to hospital services.

Working with Pierce County Project Access, you will know that your volunteer efforts are maximized to the fullest. As a Pierce County Project Access volunteer, you determine how many patients you would like to see per year. Typically, a specialist will sign up for 6-12 patients per year, and for primary care providers, 2-3 is the average. Pierce County Project Access coordinates and ensures an equitable distribution of patients.

To address professional liability insurance concerns, the Washington State legislature expanded the "Good Samaritan Act," RCW 4.24.300, in 2004 to include any provider providing charity care to uninsured individuals, as long as the provider participates in a community-based program, such as Pierce County Project Access.

To quantify and measure the amount of volunteer healthcare provided, First Choice Health Network will provide mock billing. This data will document the value of donated services which will provide important information to lawmakers, healthcare organizations and the community.

The Franciscan Health System and MultiCare Health System equally provide current funding through September 2011. Pierce County Medical Society donates overhead and administrative services. Additional funding will be secured as the program grows and matures.

The Project Access model began in 1996 in Asheville, North Carolina. Currently, more than 90 active Project Access communities operate nationwide. There are seven counties in Washington State implementing Project Access: King, Spokane, Thurston, Clark, Pierce, Snohomish and Whatcom. Pierce County Project Access is a non-profit, 501 (c) (3) organization.

To test our processes, the pilot project is currently running with orthopedics. Expansion into other specialties is expected in the fall.

Please consider using Pierce County Project Access as your volunteer care partner. We are here to ensure your experience in providing medical care to the most needy is valuable and rewarding. Please contact us at 572-7265 or leanne@pcmswa.org. ■

Flemming from page 7

a public servant. He or she should do a job and then get out." He thinks that if you continue in a position too long, you start pushing an agenda rather than serving the people.

So he's hoping to move on to another position. Saying he has a "passion for public service," Dr. Flemming decided to run for Pierce County Council after receiving encouragement from the people in the community. "The overwhelmingly positive feedback really surprised me," he said. District 7 covers University Place, Fircrest, Fox Island, and the Gig Harbor and Key peninsulas.

Advocating for Access

The Pierce County Council's role in health care reform is limited, but Dr. Flemming has opinions about the bill recently passed in Congress. "We missed the opportunity to bring about reform," he says. "We need to change the reimbursement model and get away from fee for service." He also believes that administration needs to be more efficient, that we need to "reallocate dollars where they belong and put more money down on the front line."

Judging from his actions, his biggest concern may be access to care. "We need more family practice," he says, to serve the graying baby boomer population.

To this end, he was involved in the formation of a medical school in Yakima, Pacific Northwest University of Health Science, whose mission is to train primary care osteopathic physicians and other health professionals to work in rural and underserved communities. Drawing from his previous seven years' experience on the board of trustees of the Evergreen State College (two years as chairman), Dr. Flemming served as president of PNWU from 2007 to 2009. During this time he advocated for the university to the state legislature as it addressed the shortage of primary care providers.

As is apparent from his résumé, Dr. Stan Flemming believes that physicians must be integral to the life of the community. "The days of 'I'm taking care of my patients only' are long gone," he says. "My father always said that in everything you do, 'you're an asset or a liability.' I can look back and say I did something positive for my community." ■

Classified Advertising

POSITIONS AVAILABLE

Western WA - General Surgery. Fabulous Opportunity! Multi-specialty medical group seeks BE/BC General Surgeon. Practice is located in Covington WA, an ideal community nestled in a beautiful forest close to a large metropolitan area only 35 minutes southeast of Seattle. Join a state-of-the-art clinic with in-house radiology, laboratory, ambulatory surgery center, breast services center, and urgent care. Primary Care referral base and exploding population growth demands an aggressive physician willing to further develop this practice. 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 to apply online at http://blazenewtrails.org/, email your CV to blazenewtrails@multicare.org or fax your CV to 866-264-2818. "MultiCare Health System is a drug free workplace"

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or fax your CV to 866-264-2818. Refer to Opportunity #5906 or 7188 when responding.

OFFICE SPACE

Great location with plenty of parking, 13th and Union. Spaces of 800 square feet and 2,500 (divisible) remaining. Contact Carol 206-387-6633.

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Pierce County Medical Society
BULLETIN

August 2010

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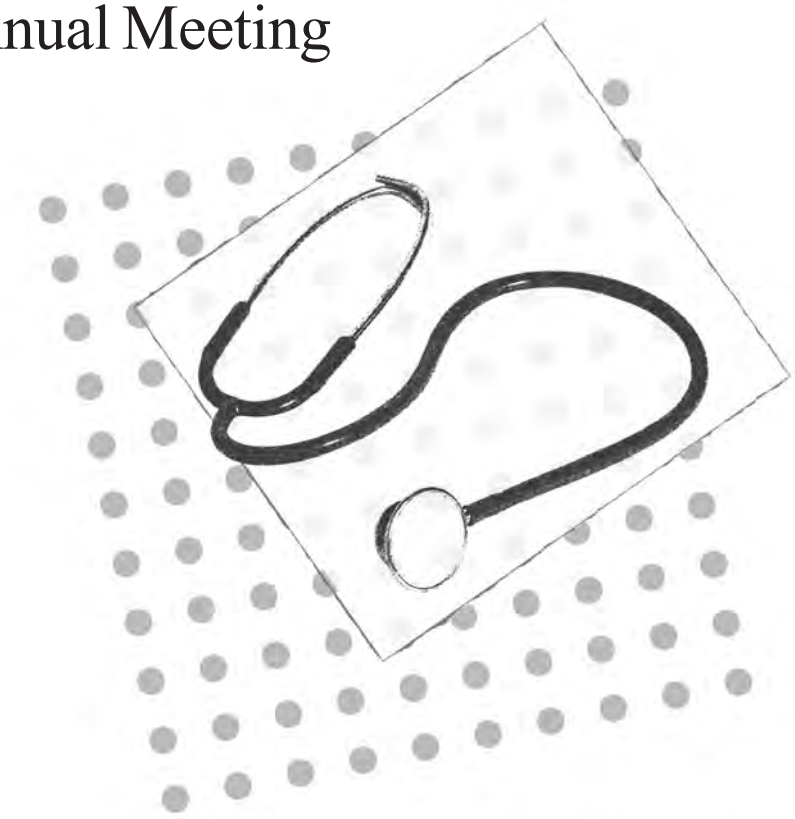

Celebrating Medicine

September 24-26
Tacoma, Washington

See page 11

INSIDE:

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

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

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Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

August 2010

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President's Page

by Stephen F. Duncan, MD

Patient Referrals - Changing With the Times

Stephen F. Duncan, MD

For as long as the PCMS history books tell us, referring patients to physicians has been a service provided for patients as well as physicians. Patients called PCMS requesting assistance in securing a physician and were given three names, with contact information, that fit the geographical, specialty or other criteria sought by the patient. **It worked well and was a valuable service for the public**.

Physicians notified PCMS if they wanted to participate in the referral service and they were able to receive new patients this way. When their practices were full they would notify PCMS to be taken off the list. When physicians closed their practices, or dropped patients from time to time, it provided an avenue for offering assistance for the patient in securing a new physician. **It worked well and provided a valuable service for members**.

Unfortunately, the patient referral service no longer works for patients or physicians in today's health care environment. And here's why….

* 60% of callers seeking physician referral are on Medicaid and 13% have no insurance. It used to be that community clinics, residency programs and even private physician offices would accept these patients in a timely manner. That is no longer the case as many clinics and practices are full and their wait times can be from six to 12 weeks, if at all, for these patients.

* 11% of callers request referrals for Medicare. It is difficult to find physicians that take new Medicare patients and with reimbursement cuts always looming, it is likely to get more difficult. As more practices close, more patients are left trying to find a spot in well established practices unwilling to accept new Medicare patients.

* 18% of callers seek treatment for chronic pain. While this doesn't sound like a great majority, they are the most difficult patients to refer as many times they are drug seekers who have been let go from a previous practice. And, while there are several interventional pain management physicians, these chronic pain patients are not seeking this method of treatment. They are referred to a primary care physician for treatment, but again many of these folks are uninsured or on Medicaid.

* It is impossible to track what physician or clinic is taking what type of patient at any time. Even for insured patients, most insurance companies have their specific provider lists. So, patients with insurance are referred back to their insurance companies for approved lists.

It quickly becomes apparent, as discussed recently by your Board of Trustees, that this service no longer serves the public or our member physicians. The demand is too great, the providers not adequate and the patient is referred in circles with no resolve. The clear majority of patients being referred to physicians are patients they either will not accept or do not want.

After much study and consideration, it was the decision of the trustees to work toward phasing out the referral service by the end of this year. Part of the plan will be to get the message out to the public and physicians that all patients will be referred to the "entity" that provides medical care coverage for them…ie: those with insurance to their insurance company, those on Medicare or Medicaid to community clinics or DSHS/CMS if they are unable to get an appointment, those on L&I to the Department of L&I, and those without insurance to community clinics and free clinics. We will also suggest that patients contact their legislators about their inability to find health care. It was agreed that this is an appropriate response as the Office of the Insurance Commissioner requires insurance carriers and plans to provide "network adequacy" for patients covered under their networks. As we work to phase out the current system, we are working on a website listing of referral information for patients seeking medical care as well as a phone message providing the same information.

We welcome and would appreciate your feedback prior to making this change and I invite you to contact me at 253.445.7151 or duncan.sf@ghc.org, our Executive Director Sue Asher at 253.572.3667 or sue@pcmswa.org, or any member of our Board of Trustees. ■

In My Opinion

by J. David Bales, 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.*

Effective Volunteering

J. David Bales, MD

One need only turn on the radio or television to be constantly reminded of how fragile our day to day routine is – earthquakes, floods, fires (even a small one closed I-5 North and Southbound only a few days ago!), and all of the manmade mayhem the world has to offer. Add to this the microbial and electronic onslaught and it is a wonder we have any peace of mind.

All of the "disasters" that befall us or others are accompanied by requests and encouragement for "preparation." Home escape plans, three days of food and water stored, sufficient medications, telephone or email lists of those to be contacted in emergencies are all recommended by the people and agencies who respond to these events on a regular basis. Personal preparedness or lack thereof can be life or death to us as individuals and families.

Preparedness at levels beyond the individual includes all levels of community – local, state, national and international. It seems to be our nature to want to help others if we ourselves are not affected by an event. Volunteering is a frequent response to tragic events such as 9-11, Katrina, or the Haiti earthquake. As with personal preparedness, effective volunteering takes some planning and preparation.

The outpouring of volunteers after 9-11 and Katrina inundated the agencies tasked to administer the emergency response. In 2003 President George W. Bush issued two directives that have had a profound impact on emergency response and management in the United States – Homeland Security Presidential Directive 5 (HSPD-5) and 8 (HSPD-8). These directives established a National Response Framework under the Department of Homeland Security and the National Incident Management System under the Federal Emergency Management Agency (FEMA).

The "All Hazards" approach ties together a complete spectrum of incident management activities from terrorism, major natural disasters, and other major emergencies. It allows communities to increase the speed, effectiveness, and efficiency of incident management. Recognition of the threat of pandemics resulted in HSPD-21 which established a National Strategy for Public Health and Medical Preparedness (Strategy). All-Hazards are categorized as Natural, Man-Made Technological and Man-Made Terrorism. These hazards require a unified and coordinated national approach to planning and domestic incident management.

One means of physician preparation for "All Hazards" includes the Medical Reserve Corps. This organization was chartered in 2002 by the White House and remains one of the simplest means of becoming registered as an Emergency Worker. This includes an application form, current identification, proof of licenses and certification, and a state police background check. Once registered, the time commitment can be as much or as little as you want to give.

Advantages to registration and participation include liability coverage by the state at no cost when serving at a recognized MRC event or action; up to date licensing and credential maintenance for immediate participation at a declared emergency; and ongoing training in emergency response. The only mandatory training is the basic Incident Command System structure and function and this can be done online in about an hour – it is the same structure and function as the Hospital Incident Command System and the basic level may be required for future hospital credentialing. Being a registered emergency worker may play a significant role in defense of individual liability when a mass casualty event results in lowered standards of care.

Further information on the Pierce County Medical Reserve Corps can be found on their website https://pierce wamrc.samariteam.com/default.sapx . The Documents tab has an enrollment packet that can be submitted online. Incident Command System training is available through FEMA's Emergency Management Institute online at http://training.fema.gov/IS/NIMS.asp. The AMA also has online training in National Disaster Life Support at the Basic and Core level and on site training for Advanced Disaster Life Support and has initiated a journal Disaster Medicine and Public Health Preparedness. Articles include commentary on the impact of the Medical Reserve Corps in disaster response. Go to www.ama-assn.org and search for National Disaster Life Support or go directly to the training site www.ndlsf.org.

Being prepared applies to all of us and one of the easiest ways to get there is through the Medical Reserve Corps.■

New AMA Report Finds 95 Medical Liability Claims Filed for Every 100 Physicians

Findings bolster AMA call for federal and state medical liability reform

A new report from the American Medical Association (AMA) paints a bleak picture of physicians' experiences with medical liability claims and bolsters the case for national and state level reform. A key finding from the report is that, among physicians surveyed by the AMA, there was an average of 95 medical liability claims filed for every 100 physicians, almost one per physician.

The report has data not available anywhere else, including information on medical liability claims' impact by age, gender and practice arrangement for physicians. Highlights in the report include:

* Nearly 61% of physicians age 55 and over have been sued.

* There is wide variation in the impact of liability claims between specialties. The number of claims per 100 physicians was more than 5x greater for general surgeons and ob/gyns than it was for pediatricians and psychiatrists.

* Before they reach the age of 40, more than 50% of ob/gyns have already been sued.

* Ninety percent of general surgeons age 55 and over have been sued.

"Even though the vast majority of claims are dropped or decided in favor of physicians, the understandable fear of meritless lawsuits can influence what specialty of medicine physicians practice, where they practice and when they retire," said AMA Immediate Past-President J. James Rohack, M.D. "This litigious climate hurts patients' access to physician care at a time when the nation is working to reduce unnecessary health care costs."

The number of medical liability claims is not an indication of the frequency of medical error, as the physician prevails 90% of the time in cases that go to trial. While 65% of claims are dropped or dismissed, they are not cost-free. Average defense costs per claim range from a low of over $22,000 among claims that are dropped or dismissed to a high of over $100,000 for cases that go to trial. This leads to increased costs for physicians and patients.

"The AMA supports proven medical liability reforms to lower health care costs and keep physicians caring for patients," said Dr. Rohack. "The findings in this report validate the need for national and state medical liability reform to rein in our out-of-control system where lawsuits are a matter of when, not if, for physicians."

The report includes data from the AMA's 2007-2008 Physician Practice Information survey of patient care physicians and other sources. ■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH;
David Harrowe, MD, MPH;
and Nigel Turner, RS, MPH

Pertussis Still Rears Its Ugly Head

Anthony Chen, MD

In the United States, infants have been routinely immunized against pertussis since the mid-1940s. While the number of cases has plummeted and the classic "whooping cough" is rarely seen, the disease is still very much with us.

In Pierce County, we have had ten confirmed cases in the first six months of 2010, with four (plus four more suspected cases) in the last five weeks. California is undergoing its largest pertussis epidemic in 50 years: as of mid-June, 910 cases have been reported (four times as many as were reported at this date in 2009) and five infants under three months of age have died.

The greatest morbidity and mortality from pertussis occurs in infants under six months of age and 50% of infants under 12 months are hospitalized. Make sure to point this out to parents who are declining or delaying DTP immunization! Infants may suffer direct complications such as necrotizing bronchiolitis, pneumonia, and pulmonary hypertension or secondary complications from coughing such as pneumothorax, subdural hematoma, hernia, and rectal prolapse. Similarly, adolescents and adults may suffer pneumonia, pneumothorax, urinary incontinence, rib fracture, syncope, seizures, stroke, and other complications. One local case suffered posttussive syncope and was involved in a car accident.

In the past decade, we have come to appreciate the significant variation in pertussis symptoms, especially as immunity from vaccination or infection wanes after 4-12 years. The classic illness has three phases beginning with a 1-2 week nonspecific catarrhal phase of rhinorrhea, sneezing, and irritated cough. Fever may be mild or absent. In the second, 2-6 week paroxysmal phase, there is a paroxysmal cough followed by inspiratory "whoop." This is often absent in patients under 6 months and in immunized older children and adults.

"Physicians in Washington are required to report all suspected and confirmed pertussis cases to the Health Department: in Pierce County, please call (253) 798-6534."

Infants may present with apneic episodes with minimal cough or other respiratory symptoms. Older children and adults may only have a persistent cough or paroxysms of coughing with posttussive vomiting. It has been estimated that pertussis accounts for 13-20% of coughing illnesses among adolescents and adults. The third, convalescent phase lasts 2-6 weeks but may exceed 6 months.

Pertussis spreads via respiratory droplets and is highly contagious, infecting 80% of susceptible household contacts. Individuals with asymptomatic infection or mild disease are still infectious. While treatment during the catarrhal phase may alter the course of illness, later treatment and postexposure prophylaxis is still very important in controlling spread of illness.

Pertussis should be included in the differential diagnosis in patients with:

* Coughing illness lasting greater than two weeks;
* Cough of any duration with paroxysms, posttussive vomiting, or posttussive inspiratory whoops; or
* Coughing illness of any duration if the patient resides with high-risk individuals (e.g. women in third trimester of pregnancy, infants under one year of age) or is a healthcare worker.

Laboratory diagnosis is imperfect but polymerase chain reaction (PCR) and/or culture of nasopharyngeal swabs are the preferred methods. Collection is very particular: specimens must be taken with a metal shaft Dacron or Rayon swab from the posterior nasopharynx and not from the anterior nares, throat, or sputum. Do not forget to wear personal protective equipment during collection! For PCR, submit the swab in a dry tube. For cultures, streak then cut and leave the

See "TPCHD" page 8

TPCHD from page 7

swab on a charcoal transport media slant. After three weeks of coughing, patients are considered noncontagious, and diagnostic tests often are negative. The bacterium is hard to culture and antibiotic treatment may render the culture negative while the PCR remains positive. Direct Fluorescent Antibody (DFA) and serology tests are not recommended for diagnosis. Physicians in Washington are required to report all suspected and confirmed pertussis cases to the Health Department: in Pierce County, please call (253) 798-6534.

The preferred treatment for pertussis is a macrolide antibiotic: azithromycin (for 5 days), erythromycin (for 14 days), or clarithromycin (for 7 days). For infants < 1 month, azithromycin is recommended. Trimethoprim-sulfamethoxazole (for 7 days) is an acceptable alternative to the macrolides for patients greater than two months. Postexposure prophylaxis is recommended to all household and close contacts of index cases who have been coughing less than three weeks. Agents and dosing regimens are the same as for treatment.

Prevention is paramount in keeping pertussis rates at their relatively low levels. We need your help in ensuring that children continue to receive their DTP series. Parents of infants with vaccine hesitancy or who subscribe to the misguided alternative delayed immunization schedule are leaving their children unprotected at the time of highest risk for complications from pertussis. In a past issue, I had suggestions on how to communicate that vaccines are safe, effective, and needed and that the risk of vaccine adverse effect are much lower than risks of disease complications.

Adolescents and adults should receive a one-time Tdap booster. This is especially important since adolescents and adults transmit much of the disease at a time when their immunity is waning. Regardless of your specialty, take the opportunity to ask your patient or review their record. **Of course, if you and your office staff have not received your Tdap booster, do so now!**

I hope this article has helped raise your awareness about pertussis in our community. Like so many other conditions, pertussis often does not present in the way we learned in class—that is what helps keep medicine interesting!

Recommended Reading:

DOH information for providers including epidemiology, diagnosis, treatment, and even how to collect specimens: http://www.doh.wa.gov/notify/guidelines/pdf/pertussis.pdf.

DOH fact sheet for patients: http://www.doh.wa.gov/EHSPHL/factsheet/pertussis.htm.

CDC guidelines for treatment and postexposure prophylaxis of pertussis: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5414a1.htm.

For those who have never seen pertussis, visit www.youtube.com and search "pertussis cough video."■

Nixed Medicare consultation codes force doctors to make cutbacks

Patient care is impacted as practices report laying off staff and reducing services in response to Medicare's new policy

Thousands of physicians say they have been forced to adopt a number of damaging cost-cutting measures as a result of Medicare discontinuing its use of consultation codes, a policy adopted by the Centers for Medicare & Medicaid Services that took effect on Jan. 1.

Consultation codes are used most frequently by specialists after patients are referred to them by primary care physicians. Starting this year, Medicare eliminated the use of all consultation codes except telemedicine consults. It directed physicians instead to bill for the visits using only evaluation and management codes that apply.

According to a June 18 letter sent to CMS by the American Medical Association and more than 30 other physician organizations, the agency predicted that no specialty would see Medicare revenues decline by more than 3% because of the change. CMS also had stated that another goal was to reduce confusion and administrative burdens associated with filing consultation codes.

But the AMA said the policy has had the opposite effect. According to a survey of approximately 5,500 physicians, the vast majority of specialists have seen their revenue stream drop after the change — most by more than 5% — and three out of every 10 already have reduced services to Medicare patients or are contemplating other cost-cutting steps that will impact care.

Such is the case for Lawrence Martinelli, MD, an infectious diseases physician in Lubbock, Texas.

Dr. Martinelli works in a three-physician practice that acts as a referral center for the surrounding area. He estimates that his practice will lose nearly 8% in net revenue this year as a result of the elimination of the codes. The practice also has had to let go of two mid-level medical staff and a biller since March.

"The elimination of the inpatient consultation codes has hit us pretty hard," Dr. Martinelli said. "There is work being done that's just not being accounted for. It's increased the overall level of angst that we're all experiencing at this time of turmoil."

Unintended Consequences

The AMA and the specialty organizations that signed the June letter have asked CMS to reconsider the policy as the agency works on the Medicare physician fee schedule for 2011.

In addition to the general cost-cutting steps that will affect Medicare patients, some survey respondents said they are likely to make changes that will discourage the kind of care coordination that CMS has been seeking in Medicare, the groups said. This includes specialists providing primary care physicians with written consultation patient reports.

Another unintended consequence involves prolonged services for hospitalized patients. The current procedural terminology system on which Medicare codes are based count both face-to-face time with the patient and time spent on the hospital floor. But CMS now recognizes only face-to-face time and not other services, such as reviewing charts, or talking with families and other medical staff.

"In effect, Medicare is denying payment for these services and further discouraging coordination of care between professionals," the letter states.

Yet another issue created by the elimination of the consultation codes involves the identification of new patients. While consultation codes do not distinguish between new and established patients, the office visit codes doctors must use in their place do make this distinction, with Medicare paying more for new patients.

But many practices focus on a narrower range of services than Medicare recognizes in its current list of specialties and subspecialties. So a patient seen by two subspecialists in the same group with very different areas of expertise, but who are in the same category on Medicare's list, will be seen as an established patient and not as a new patient.

The American College of Physicians initially had supported the elimination of the consultation codes when CMS first proposed it in 2009. But the organization said that was only in an effort to address the difficulty of billing such codes and the heightened chance of audits that come with the strict definition of what constitutes a consultation. The ACP also signed the June letter to CMS, but it has not asked the agency to rescind the policy outright because that would not resolve the audit concern, the group said.

CMS said the money that would have been paid out for consultations would be redistributed to boost pay for other evaluation and management codes, including ones typically used by primary care physicians. But the organizations signing the letter complained that inadequate budget neutrality adjustments have meant that shift has not occurred entirely as planned.

The Effect On Patients

Specialty organizations are weighing in on what the code elimination means for their members. They say its effect is going to translate into less access for patients.

The American Academy of Neurology estimates that nearly 75% of its

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Overdose deaths involving prescription pain meds climbing

The number of people dying from an overdose of prescription pain medication is growing in Washington. From 2003 to 2008, the state death rate increased 90 percent. And in 2007, 447 people died; in 2008 it was 505.

There was a similar increase in hospitalizations. The number of drug overdose hospitalizations involving prescription pain medications increased from 572 in 2007 to 646 in 2008.

"Too many people treat these powerful drugs as casual medications," said State Health Officer Dr. Maxine Hayes. "This stuff isn't aspirin, and it should be handled with care."

In Washington, the death rate per 100,000 population for overdose from prescription pain medications was highest in Stevens, Clallam, Spokane, Grant, and Snohomish counties. The death rate for Stevens was 18.6 per 100,000 population compared to 6.8 per 100,000 population in King County.

These types of medications are being prescribed much more often since the late 1990s. With that increase came greater misuse and abuse. From 1995 to 2008, Washington had 17 times more deaths from accidental overdose involving prescription pain medications. These types of deaths have surpassed automobile crashes as the leading cause of injury death in the state for residents ages 35 to 54. There is evidence that the risk of overdose is higher for those on higher doses of pain medication.

Patients with valid prescriptions must be careful with their prescription pain meds — and the need for caution grows with higher doses. It's important to keep medications in a safe place so others can't get to them. Always follow the directions and consult with your health care provider if you have any questions or concerns about prescriptions. If you can't reach your health care provider, talk to your pharmacist. Taking these powerful drugs with alcohol, illegal drugs, and other prescription medications can be dangerous — and even deadly — unless done under a doctor's care.

Information for health care providers, parents, and patients is on the Department of Health website. The Take as Directed (www.doh.wa.gov/hsqa/TakeAsDirected/default.htm) page is a resource to help people learn about this serious issue and help prevent death. It has information for health professionals about how to effectively and safely prescribe these medications. Parents can also find tips to keep their children from abusing prescription drugs, and advice on where they can turn if they think their teen needs help.

Properly dispose of all unused and expired prescription medications. Several drug take-back programs exist across the state. Find a location (www.medicinereturn.com/return-your-medicines/return-your-medicines/return-locations) in your community.

A brochure has been created for health professionals to educate their patients about how to safely use prescription pain medication (http://here.doh.wa.gov/materials/safe-use-of-prescription-pain-medication/33_PainMeds_E10L.pdf). It shows possible signs of an overdose — abnormal vital signs, sleepiness or confusion, and shortness of breath — and what to do when you observe an overdose. The recently passed Good Samaritan Law allows immunity for anyone who is either experiencing an overdose or witnessing one (www.atg.wa.gov/pressrelease.aspx?&id=25810). Call 9-1-1 to get care as quickly as possible.■

Reprinted from WSDOH News Release, 7/14/10

WSMA Annual Meeting, September 24-26 in Tacoma

The theme of this year's WSMA Annual Meeting *is Celebrating Medicine*. This year's opening session keynote address will feature Dr. Carl Hammerschlag, speaking on "Healthcare at the Crossroads: Sustaining Our Healing Spirit."

The WSMA Annual House of Delegates meeting is an opportunity for physicians around the state and across all specialties to come together to set the policies and goals for the Association.

The policy "heart" of the meeting will be reference committee meetings on Saturday morning, followed by the House of Delegates session on Sunday. It is the House that sets the broad policy course for the WSMA.

There are two opportunities for debate on every item of business brought before the House. The first comes during the reference committee hearings that are open to every WSMA member. Following these hearings, each of the three reference committees prepares a report recommending specific action and takes these recommendations to the entire House of Delegates on Sunday morning for its final action.

The annual meeting is not just about setting WSMA policies, although this is a large part of the meeting. It also provides educational and networking opportunities for all physicians.

On Friday and Saturday a variety of scientific sessions will be available, all providing additional CME Category I credit.

For those attending the WSMA Annual Meeting for the first time, there is a Young Physicians/First Timers Reception on Friday evening.

The WSMA's Annual Meeting brings Washington State physicians together in a forum like no other. If you would like to participate this year in Tacoma, please call Sue at the PCMS office, 253-572-3667. ■

Program-At-A-Glance

Friday, September 24

7:00 am	Exhibits Open
7:00	Meeting Registration Open
7:30	WSMA EC Meeting
7:30	AMA Delegation Meeting
7:55	Addiction Medicine
8:00	Risk Management
9:00	Allergy, Asthma and Immunology
9:00	Thriving in Changing Times
9:30	WSMA Board of Trustees
11:30	WAMPAC Board Meeting
Noon	Box Lunch in Exhibit Hall
1:00 pm	**House of Delegates Opening Session**
4:00	Primary Care Caucus
5:30	Reception: Young Physicians and First-time Attendees
6:30	**Presidents' Banquet and Inauguration**

Saturday, September 25

7:00 am	Exhibits Open
7:00	Meeting Registration Open
7:00	Reference Committee Members Orientation Breakfast
7:30	Ophthalmology
8:00	**REFERENCE COMMITTEES** 8:00 **Reference Committee C** 9:00 **Reference Committee B** 10:00 **Reference Committee A**
8:00	Public Health Forum
11:30	Senior Physicians Program/Luncheon
Noon	**WAMPAC Luncheon**
Noon	WAEPS Physicians' Luncheon
1:30 pm	Advances in Women's Health
2:00	Health Care Economics
2:00	Essential ENT for Primary Care
4:00	County Medical Societies Forum
4:00	Public Health Officers Society Meeting
5:30	Reception: "Physicians in the State House"
5:00	Exhibits Close

Sunday, September 26

7:00 am	King CMS Caucus Breakfast
7:00	Pierce CMS Caucus Breakfast
7:00	SW CMS Caucus Breakfast
7:00	Snohomish CMS Caucus Breakfast
7:00	Eastern CMS Caucus Breakfast
7:00	WSMA Past Presidents' Breakfast
7:00	Meeting Registration
8:00	**HOUSE OF DELEGATES**
Noon	Adjourn

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members responding to the AMA survey have seen revenues fall by more than 10% since January, and nearly 40% have had to reduce staff.

Joel Kaufman, MD, a neurologist in Providence, R.I., has seen colleagues struggle because of the codes' elimination. "One of the keys to neurology is to spend the time with patients," Dr. Kaufman said. "Taking a good history is critical, so devaluing our time undermines the service. Ultimately, it means some patients are not getting the care or attention that they should."

The American College of Cardiology noted that the patients who need the most help will feel the effects the most.

"The decision ... has made it harder than ever for cardiologists to be appropriately paid for managing complex patients," said ACC President Ralph Brindis, MD, MPH.

The American College of Rheumatology estimates that the elimination of the codes has negatively affected 80% of practicing rheumatologists who responded to the AMA's survey.

"By removing consultation codes, CMS is stating that the advanced training and unique specialty care provided by rheumatologists is not valued," said ACR President Stanley B. Cohen, MD. ■

Reprinted from AMNews, August 20, 2010

WSMA Collaborates to Form Clinical Performance Improvement Network

The Washington State Medical Association has joined with the Puget Sound Health Alliance and the Washington Academy of Family Physicians to create the Clinical Performance Improvement Network (CPIN), an educational program designed to assist physician practices focus efforts on quality improvement. The collaborative effort will be led by Lance Heineccius, WSMA's director of performance improvement and lead technical staff for the newly revised WSMA Foundation for Health Care Improvement.

The goal for CPIN is to offer opportunities for medical practices to collaborate with one another, sharing best practices, proven innovations, tools, and resources to stimulate accelerated and efficient implementation into practice settings. The initial target audience will be medium and small-sized primary care practices in the Puget Sound region, with a focus on evidence-based care, especially for chronic conditions and preventive services. The program plans to expand statewide in 2011.

CPIN will offer learning network events bimonthly or quarterly, either in person or via web conferences. The sessions will be scheduled for early morning, over the lunch hour, or at other times to accommodate individuals with busy practice schedules. Event duration will range from 60-90 minutes, with the general format being formal presentations on a range of topics from local or national provider organizations, with ample time reserved for discussion and networking (for in-person meetings). CME credit will be available.

Plans are underway to present an initial CPIN learning session in Tacoma the morning of September 24, 2010, in conjunction with the WSMA annual meeting which begins later that day. Please check next month's PCMS *Bulletin* for details on the specific topic, time and location of this inaugural event. For additional information, please contact Lance Heineccius at Lance@wsma.org or call (206) 956-3657. ■

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Friday, November 5, 2010
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Program Director: **Elizabeth Lien, MD**

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

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SAVE THE DATE - CME at Whistler, January 26-30, 2011 at Beautiful Fairmont Chateau Resort

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education. Whistler offers alpine skiing, cross-country skiing, and many other winter activities at both Whistler and Blackcomb. You will also find many superb dining options and excellent shopping for the relaxed afternoon. Whistler is a great destination for families, as it offers many entertainment options and relaxation options.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. Nestled at the base of Blackcomb Mountain, the Fairmont Chateau Resort defines mountain luxury. With true ski-in and ski-out convenience, the classic elegance of this landmark Whistler hotel offers a modern alpine setting for unsurpassed guest service, exceptional dining, full resort amenities, and a world class spa.

We have negotiated incredible room rates starting at $219 CDN per night. Please visit www.fairmont.com/whistler or call the Inhouse Reservations Department at 1-800-606-8244 to make reservations. You will need to mention you are with the College of Medical Education in order to receive the contracted group rates.

Baiya Krishnadasan, MD is the new program director for CME at Whistler and has lined up a dynamite list of speakers to ensure this course meets your educational standards, combined with quality skiing and family vacationing. Scheduled topics include: Sports Related Concussion - The Silent Epidemic; Surgical Management of Low Back Pain - Outcomes and Shortcomings; Use of Ultrasound and Electromagnetic Navigation Aided Bronchoscopy; The Bicuspid Aortic Valve and Associated Aortopathy; Chronic Pelvic Pain - What Works?; Fibromyalgia Syndrome - An Update for Primary Care Physicians; Federal Requirements for DATA-Waived Physicians; Controlled Substances Federal Regulations Update; Molecular Imaging 2011 - New Developments in PET/CT Imaging for the Primary Care Physician; Broken Heart Syndrome - Transient Catecholamine Induced Cardiomyopathy.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

To register for this program or if you have any questions, please call the College of Medical Education at 253-627-7137. ■

Health reform tasks could overwhelm agencies, former federal official says

HHS, CMS and other departments must issue more than 40 health reform regulations, some of which will be complex and controversial

Federal employees responsible for drafting and enforcing health reform regulations have an enormous task ahead of them, according to Gail Wilensky, PhD, an economist and former director of the agency now known as the Centers for Medicare & Medicaid Services.

The Patient Protection and Affordable Care Act contains a daunting list of tasks that will overhaul how health care is delivered in the U.S., Wilensky said at a July 9 Alliance for Health Reform event on implementing the act.

The national health reform law includes the phrase "the secretary shall" more than 1,000 times, each of which refers to a new task for the Health and Human Services secretary. "The secretary is going to be very, very busy," said Linda E. Fishman, the American Hospital Association's senior vice president for public policy, analysis and development.

HHS, CMS and other agencies must finalize more than 40 rules mandated by the health reform law, including standards for how health insurance exchanges will operate, how much health insurance coverage is required to satisfy the individual coverage mandate, and how tighter restrictions on health insurance plans will roll out, according to a report released on April 13 by the Congressional Research Service, Congress' research arm.

CMS and HHS also are experiencing a wave of retirements, which means they are losing important institutional knowledge, said Wilensky, now a senior fellow with Project HOPE, an international health foundation. "That makes all of this much more challenging."

Simply implementing the health reform law's hospital value-based purchasing program by 2012 — which will establish Medicare incentive pay for hospitals — will be difficult, Wilensky said. The forthcoming rule will compare in complexity and controversy to the rule implementing Medicare's resource-based relative value system in the early 1990s, which now governs Medicare pay. The RBRVS rule drew more than 100,000 comments from stakeholders, and the Medicare agency had to respond to each issue raised in the comments.

"What is going on now is so much more complicated," Wilensky said.

The Congressional Research Service report is available online (www.nga.org/files/pdf/1004crsppaca.pdf). ■

Reprinted from AMNews, July 28, 2010

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Pierce County Medical Society
BULLETIN

September 2010

INSIDE:

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Pierce County Medical Society
BULLETIN

September 2010

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President's Page

By the Numbers

Stephen F. Duncan, MD

Years ago I received a degree in mathematics and taught math in high school for a short time before beginning my medical education. Numbers have always held a special place in my life and in fact numbers can tell a compelling story.

I recently read an article in the *News Tribune* that 47% of taxpayers paid no taxes in 2009. On NPR, I heard a piece that said there are 40 million people in the United States who receive food stamps and there are an additional 20 million people who are eligible. In 2009, the federal poverty level for a family of four was $22,050.

According to the National Debt Clock found on Google, the national debt is slightly over $13 trillion and climbing. This is over $80,000 for each American worker or about $40,000 for each person living in our country.

The state of Washington, according to the numbers in July 2009, had an estimated population of 6,664,195. In 2014, the health care reform legislation passed this year will potentially add 460-520,000 covered lives to the care of our health care delivery system in Washington alone. These will mostly be paying at Medicaid rates. Nationally the average panel of patients for a family physician is about 2000 in 2010. It will need to expand to about 2400 in 2014 even without the increase in covered lives that health care reform will supply.

The Medicare Trust reported to congress in 2007 that by 2013, 45% of the funding for Medicare will come from general tax revenue and before the end of the next decade (2020), the trust fund will be depleted. Law requires this warning and the dates can be argued but the crisis cannot be averted without increased revenue or decreased benefits for Medicare.

Some experts say that numbers do not lie. Others say numbers tell a story. I am approaching retirement and thank God I will not have to deal with all of this. But then I realize that Oh My God I will be one of those who will need healthcare in the years to come. You do not have to be a mathematician to calculate that the numbers do not add up.

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.*

Project Homeless Connect

Chad Krilich, MD

Three years ago I was approached by Justin Schumacher about an opportunity to participate in a county-wide event that would help provide services to people in our community who need it most. Since that time, we have experienced a lot. There has been a change in our presidency that has led to some changes in how we will be providing care for our patients. In addition, we have had many people speak out in regards to inequities. Take for example our own $30,000 bottle of insulin[1] in Pierce County. On October 14, 2010 we will be heading back to the Tacoma Dome to provide services to those with the greatest need at Project Homeless Connect.

This event has served thousands each year in the exhibition center. The services provided are not just medical. Patients obtained access to services including food, shelter, vision, dental, and even haircuts.

Clients were shuttled in from areas throughout the county. By the end of the day, we had not solved the problem of homelessness or access to care. Rather, we gave those without, a fresh start and increased awareness of the problems within our county.

We are fortunate to live in an area where we have a medical community that is engaged with care for the underserved. This event at the Tacoma Dome has occurred because of the volunteerism of many. Last year each large health care employer was represented by physicians, mid-levels, and nursing staff who cared for our homeless patients. In 2010, we are looking forward to the engagement of others as well.

Now in our fourth year, we better understand who this population is. Thanks in large part to the work done by our local health department, we have some information to share. Our patients at this event on average were in their 40s and more than 50 percent were Caucasian. Many called Tacoma their home. About 12.5 percent, obtained their care from the emergency room. Many received their care at other clinics and providers, or received no care at all. About 18 percent reported tobacco use and 3 percent reported alcohol use.

Through the years, we have come to know who we are treating and gathered a better understanding of what we are treating. Most commonly, our patients have been seen for complaints related to musculoskeletal issues. Less frequently, patients reported needing to be seen for hypertension; ear, nose, and throat; or a check-up on related issues. Still, about 20 to 26 percent of the time our patients were hypertensive (BP > 140/90).

Even understanding this population better, we fell short of having an ideal treatment plan. Yes, we were able to provide medications. Last year we provided approximately 250 prescriptions. The most common medications provided were ibuprofen and albuterol. In providing these medicines, many times it was only for a 2- to 4-week period. But, the major challenges arrived with follow-up. Generally, more than 50 percent of patients required follow-up. As our outreach team spoke with clients who returned, we learned that many are unable to pay a co-pay for a sliding-fee visit. In addition, our access points for patients needing these services continued to constrict with the ever decreasing reimbursement for medical services.

As we continue to hear the rhetoric of what happens on a national level regarding health care, we should reflect on the work that has been accomplished by the Project Homeless Connect team. Most recently the book, "The Healing of America" by T.R. Reid exemplified some of our thoughts. There he reflected on his journey inside and outside of the U.S. health care system. You may not agree with Otto von Bismark that a "rich society must care for the poor."[2] But as U.S. citizens we face the reality of 22,000 Americans dying each year because they cannot afford medical care.[3] Ultimately, Mr. Reid leaves us with the sobering quote from Uwe Reinhard, an expert on health care economics, who states, "every nation's health care system reflects that nation's basic moral values."[4] Fortunately in Pierce county, we have people who are willing to step up for the cause.

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Pierce County Project Access: Benchmarks of Success

Leanne Noren

What are successful benchmarks of any new project? How do you measure those benchmarks at the onset of a new project? Using your mission as a compass, you map a pilot project.

The mission of Pierce County Project Access is to improve the outcome of volunteer medical care for low-income, uninsured patients. The compass points of recruitment, retention and expansion for our pilot project became the basic benchmarks of success.

Recruiting volunteer providers to launch the pilot program in orthopedics and primary care was our first goal. The pioneers of the first specialty field were hands-on in fine-tuning work-up and referral procedures. Twenty-three volunteer providers were ready to test the system during the summer.

Staff successfully created and launched an outreach program to ensure a smooth screening, enrollment and referral system between clinics, emergency departments and participating volunteer providers. We are close to our pilot goal of 15 referrals. To date, 13 referrals were made from Community Healthcare Clinics, free clinics and Franciscan Emergency Departments resulting in six patients enrolled. Four patients have been appointed.

Recruiting is the first measure of success. Retaining volunteer providers is the second measure. How do you know if you are retaining members? Feedback. When a provider tells you they get what you're doing and you've made their life easier, you know the system you have in place works.

Jeanie, of Tacoma Orthopedic Surgeons, understands Project Access. She knows a referral from PCPA means any patient referred to their office is qualified, and will come to their appointment prepared. Jeanie has learned that PCPA will give each referred patient 360-degree care…from their initial contact through any follow-up.

Every step is covered to ensure the volunteer providers, and their staff, can give the patient their full attention. Jeanie is already getting the word out that if a referring clinic or ED wants her to take uninsured or DSHS patients, they need to call PCPA.

Pierce County Project Access is going viral. The word is getting out that PCPA is here and ensures appropriate referrals, education and care management for the most vulnerable citizens of Pierce County. The third benchmark, expansion, is already happening. GI, Ophthalmology, Neurology and Oncology specialties are on board for October and beyond.

It is our vision that every Pierce County resident will have access to medical care. In partnership with you, and the community, our board and staff are creating a network of volunteers who donate care with dignity and respect to the most vulnerable in Pierce County.

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Why Does Socialism Fail?

"They pretend to pay us and we pretend to work."
Soviet workers

Andrew Statson, MD

Why? Because socialism gives the wrong incentives. People learn from experience that the socialist system pays them less than the value of their labor, and in return they get even by producing less. We need to learn how they do that, so that we can function better in the coming medical care environment.

To find out why socialism fails requires a more detailed look at how it functions, but to better understand that we first need to look at capitalism and see why it works.

Recently the talk that capitalism has failed became louder. Even Mr. Sarkozy, the supposedly conservative president of France, joined the chorus. Such claims reveal a deep misunderstanding of what capitalism is, and of how and why it works.

Capitalism has not failed. On the contrary, it was and still is doing exactly what it should be doing. It is cleaning house. It is getting rid of the mismanaged and bankrupt companies, of the underworked and overpaid union members, of the inefficient, stifling and burdensome work rules, and of the bloated and corrupt bureaucracies.

While it is doing that, the central banks and the governments all over the world are using everything in their power to stifle it and to prevent it from accomplishing its task. In the end capitalism will succeed, but it will take longer, the world economy will sink deeper and the people will suffer even more.

Capitalism is usually thought of as the economic system of the free market. It allows the market to function unfettered, so that the participants, as producers and as consumers, can freely trade with one another to their mutual advantage. Yes, but capitalism is much more than that.

It is also the political system of individual freedom. It enables every individual to fully develop and put into practice all his skills and abilities, and to work as hard and as long as he wants. It enables everyone to use his mind and his imagination to develop better and cheaper ways to produce or to bring to market the goods already being made, or to innovate and introduce goods nobody had thought of before. Capitalism does that by giving everyone confidence that he will be rewarded for his success, and that the product of his labor will be his to dispose of as he sees fit.

Alfred L. Flude said it better than I could, in his "Notes of an Idler," in the *Saturday Evening Post* of Burlington, Iowa, on March 24, 1894. At the same time he showed the spirit of America as it was at the end of the nineteenth century, the spirit that made this country great:

"My dear boy, you who are first beginning the battle of life by learning some trade, the world wants you and is ready to pay you for your work. It will pay you promptly and well if you are of service to it, or it will pay you poorly and slowly if your work is deficient. We are fond of laying all our misfortunes and poverty on the 'cold world,' because we know the world will never deny it, and it is so much more comfortable to lay blame upon someone else rather than bear it ourselves. But I tell you, my dear boy, the world wants you and will pay you liberally if you are of the right stuff."

Finally, and perhaps most importantly, capitalism is a moral system. Trade cannot exist without a minimum of trust. When I buy a car, I trust that if something is wrong with it, the seller will make it good. If I deposit money in a bank, I trust that it will honor the checks I draw on my account. Capitalism punishes the untrustworthy. Those who swindle others by selling shoddy merchandise or giving poor service cannot survive in the free market. There is no bail-out.

The essence of capitalism is that everyone gets what he has earned. His property is his, and so is the product of his labor. He is free to trade it with others, or to give it away, if he so desires.

The essence of socialism is that one gets what one has not earned. This is a disconnect between work and reward. The incentives to work are weak at best, when not totally absent.

You have heard the claim that medical care was a right. Since the bill passed, that claim has been softpedaled. Now they are talking

See "Socialism" page 12

Homeless from page 5

If you are interested in contributing or participating in this work, please do not hesitate to contact Lois Lux: llux@tpchd.org. Thanks to our many volunteers for making this work possible.

1. Cameron, Dave MD. "The $30,000 bottle of insulin. We all pay the price for failure of our health care system." The Tacoma News Tribune. 9/20/09

2. Speeches of Otto von Bismarck, Bavarian State Library, Munchener Digitalisierungszentrum (MDZ), p. 165

3. Urban Institute, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Unisurance on Mortality (2008). Available online at www.urgan.org/Uploaded PDF/ 411588_unisured_dying.pdf.

4. Reid, T.R. The Healing of America: The Quest for Better, Cheaper, and Fairer Health Care. The Penguin Press. New York. 2009

Most ED patients willing to wait longer to avoid non doctor care

Nurse practitioners and physician assistants account for at least 10% of outpatient visits and increasingly are being used to handle patient care in emergency departments, according to previous research.

But a new survey said 80% of patients expect to see a physician when they come to the ED. Fewer than half would be willing to see an NP or PA for an ankle injury — they would rather wait two more hours to be cared for by a physician.

The survey of 507 ED patients at three teaching hospitals in Pittsburgh and Dallas found that, even for a minor complaint such as a cold symptom, only 57% would agree to see a nurse practitioner and 53% would see a physician assistant, according to the study in the August *American Journal of Bioethics*. Patients also preferred to see a fully trained physician compared with a medical resident, but not by as wide a margin as their desire to avoid nonphysicians.

Given their strong preferences for care from physicians, patients deserve greater disclosure about who is providing care and what the level of training is, said study lead author Gregory L. Larkin, MD, professor of emergency medicine at Yale University School of Medicine in Connecticut.

"If we are going to advertise ourselves as a high-quality health care system, we should be trying to think of patients as health care customers more than we have," Dr. Larkin said. "We have been handing down these alternative providers to patients without any level of informed consent whatsoever. We inadvertently mask the fact that they aren't really physicians, adorning them with long white coats, small name tags and high-end Littmann stethoscopes. It's very hard for the unsophisticated patient to tell who's caring for them."

Who takes care of patients?

The American Hospital Association has a policy stating that patients have a right to know who is caring for them and what their training is. American Medical Association policy says the word "physician" should be used only to reference medical doctors.

But Dr. Larkin said many physician extenders fail to introduce themselves properly.

"They'll simply go into, 'Hey, how are you doing today?' " he said. "Patients' self-reported interest in choice has been slaughtered on the altar of economic expediency."

Everyone agrees that patients deserve to know who is caring for them and should be allowed to request a physician's care, said Connie M. Ulrich, PhD, RN, associate professor of bioethics and nursing at the University of Pennsylvania School of Nursing.

"It's common courtesy that the health care professional introduces him or herself, so I see that as a basic primer of communication with patients and that is taught in nursing schools and medical schools," said Ulrich, who contributed a commentary to *American Journal of Bioethics* in response to Dr. Larkin's study. "Any time we can be transparent, we should be."

Ulrich said some nonphysicians may fail to identify themselves fully in a busy emergency department, but there is little evidence to show it happens most of the time.

"Does the public feel they're properly informed about the health care provider who is caring for them?" Ulrich said. "I don't think we have that data."

A fifth of the patients surveyed did not understand the levels of training and education associated with the roles of nurse practitioner, physician assistant and medical resident. In those cases, the patients were provided objective definitions that mentioned that nonphysicians' care is less costly.

But Ulrich said patients may still not understand the contribution to care made by nonphysicians.

"We get into this turf battle between physicians, nurse practitioners and other providers when the main purpose should be to meet the needs of the patient," she said. "With the way health care costs are increasing and how much our aging and chronically ill patients will need to receive care in a much broader, interdisciplinary fashion, we need all these different skill sets to be able to do that."□

Reprinted from AMNews, 8/30/10

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about rationing, cutting down on services, as they will have to do because they are running out of money. The more they socialize our economy, the less money they'll have, so the more services they'll have to cut.

That means the so-called right to health care is not really a right, but a privilege, to be bestowed upon the patients by the authorities. They'll decide who can have what treatment. All that the patients will be able to do is beg for their care, unless, of course, they know someone who knows someone who can exercise some pull on their behalf.

In the Army I was stationed at a small base hospital. If you asked me, I'd say that we took good care of our patients. We did the best we could with the resources we had. We were busy most of the day, but we were not overworked by any means.

Yet compared to private practice, our attitude toward work was different. The patients were a captive audience, and they had to take the situation as it was. Occasionally someone would complain to his commanding officer, and we'd get a call, and maybe go the extra mile for that one patient, but that was rare.

We served a large retiree population, and our clinic was booked three months in advance. I asked my superior whether we could do something to shorten the waiting time for appointments. He said no, we couldn't. According to Army regulations we had to allow so much time per visit, so we couldn't see more patients per hour. We couldn't extend the clinic hours, either. He said that if the patients had an emergency, they should go to the ER. The others, if they wanted to be seen sooner, could go to a civilian doctor and pay out-of-pocket. Besides, if we shortened the waiting time, more patients will want to come to our clinic, the waiting time will lengthen again, and we will end up just seeing more patients and working harder. Why bother? Why, indeed!

I don't have to tell you that if I ran my office the way we ran that clinic, I would have never made it. The capitalist economy functions at the convenience of the consumer. Its goal is to satisfy him. The consumer is king. The socialist economy, on the contrary, functions at the convenience of the system.

Socialism gives no incentive to do a good job, to excell, so that one can deservedly earn more. Instead, the incentive is to do the least one can get away with, and since the system doesn't pay well, to try to do some work on the side and get paid under the table. It doesn't matter if the place you work for does not produce quality goods. The consumers have no choice.

Even though supposedly capitalistic, Wall Street shares that kind of reasoning. When the bonds which Citi,

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COLLEGE OF MEDICAL EDUCATION

CME at Whistler, January 26-30 Register now!

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education. Whistler offers alpine skiing, cross-country skiing, and many other winter activities at both Whistler and Blackcomb. You will also find many superb dining options and excellent shopping for the relaxed afternoon. Whistler is a great destination for families, as it offers many entertainment options and relaxation options.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. We have negotiated incredible room rates starting at $219 CDN per night. Please visit www.fairmont.com/whistler or call the Inhouse Reservations Department at 1-800-606-8244 to make reservations. You will need to mention you are with the College of Medical Education in order to receive the contracted group rates.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

To register for this program or if you have any questions, please call the College of Medical Education at 253-627-7137.

New Approaches to Common Medical Problems in Primary Care, October 1, 2010 Register Now!

New Approaches to Common Medical Problems in Primary Care will be held on Friday, October 1, 2010 at the Fircrest Golf Club under the medical direction of Mark Craddock, MD. Course hours are from 8:00 am to 3:15 pm and offers a maximum of 6 AMA PRA Category 1 Credits.

This one day conference will provide comprehensive updates of selected topics in general internal medicine and primary care which are critical to the practicing physician. Teaching methods will include lectures, case presentations and questions and answers with faculty. Practical and evidence-based approaches to treatment will be included. This course is appropriate for family practice, general practice and internal medicine physicians and will also be of great interest to physician assistants.

Topics and speakers include:

BP Variability: Hype or a Game Changing Paradigm Shift?	Dmitri Vasin, MD
Carotid Stenting: Current Data and Indications	Brian Kott, MD
Pulmonary Arterial Hypertension Treatment Updates	Babith Mankidy, MD
Bariatric Surgery Update for 2010	Jeff Hunter, MD
Communication & Relationship Skills: A Secret to Avoid Many Malpractice Claims	Randy Schumacher
New Updates on Female and Male Incontinence	Brian Anderson, MD
Changes to the Death Registration Process	Marena Kerr, EDRS

At the end of the conference participants should be able to: • Identify patients at risk for stroke due to high BP variability and implement medication changes to minimize this risk. • Understanding treatment options available for carotid disease, symptomatic and asymptomatic. Discuss current data and indications for treating carotid disease with minimally invasive endovascular stenting. • Discuss and analyze communication and relationship skills that if not properly implemented with patients could account for over 25% of intent to file claims seen in medical suits today. • Discuss and review new updates in diagnosis and treatment of pulmonary arterial hypertension. • Define the prevalence of morbid obesity. Discuss associated co-morbidities, indications for surgery types, surgical procedures and metabolic effects and results including complications. • Understand discuss new treatments options for both female and male incontinence. • Learn to access and utilize the New Electronic Death Registration System to report deaths in Washington State.

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is $90 for PCMS members (active and retired) and $130 for non-members. A $25 late fee will be charged after September 24, 2010.

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BofA, AIG, G'Sachs and all the others were selling and insuring turned out not to be as good as they had claimed, they turned to the state to save them.

The authorities blamed it all on capitalistic greed. Well, no. Left alone, capitalism would have closed them up and cleaned them out. By now their assets would have been taken over by strong, profitable companies, the losses written off, and the economy would be booming again. It was greed, all right, naked greed. It was backed by the confidence, based on previous experience, that in the end the state would bail them out, as in fact it did. Some call it crony capitalism. Others describe it as privatizing gains and socializing losses, also known as heads, I win, tails, you lose.

As an example, the only one that didn't get bailed out was Lehman, and when their actual losses were tallied, they amounted to about six billion, less than ten percent of the sixty to eighty billion that were projected initially, in the depth of the panic. That says something about the accuracy of the projections.

Recently a colleague posted on Sermo (www.sermo.com) a personal experience in Canada. While visiting her in-laws in Toronto, her two-year old boy developed a fever and a rash. She didn't think it was serious, but she wanted to be reassured by consulting a pediatrician. That was on a Thursday night. She called a few clinics and an ER. They had no pediatrician on duty. The next day she called four pediatric offices, and nobody wanted to see her child. They were either fully booked, or closed on Friday, or whatever. In sum, it was not convenient.

This is not to blame the pediatricians in Toronto, or to say that they are uncaring. This is how the system functions. This is what it makes them do. They have worked under it for many years, and unconsciously, without even being aware of it, they have adopted the attitude of all workers under a socialist system. The system pretends to pay them, and they pretend to work.

Yet the most serious problem with socialism is that it establishes multiple power structures, in which officials can use their authority over others to control their lives, including meting out the goods and services the people receive, be they food or medical care. That means they have control over life and death.

A number of psychological studies have shown that under such circumstances even the most normal, emotionally balanced and fair individuals can become tyrannical to the point of harming those who depend on them for their survival.

Doctor Philip Zimbardo, who had carried out such studies at Stanford, called it "The Lucifer Effect" in a book by that title. In one experiment he randomly assigned a group of college student volunteers to play the role of guards or prisoners in a mock prison environment. The experiment was to last two weeks. He had to terminate it after six days because these intelligent, educated, wholesome, moral young men were transformed into cruel and sadistic guards or emotionally shattered prisoners.

We humans are extremely adaptable. We can work in a great variety of environments, and most of the time we can expect to do well while doing good. There is one situation, however, in which I am not sure whether even a saint could escape becoming a monster, and that is when wielding power over fellow human beings. Lord Acton was right. Power tends to corrupt, and absolute power corrupts absolutely.

There is a lesson for us here, and I am sure you can work it out for yourselves. Our time is coming. Until the system finally crumbles, we as physicians will be faced with people who will have power over us and who will control our actions, but we also will be in a situation where we will have authoritarian power over others, namely our patients. How are we going to handle it? □

Western WA - General Surgery. Fabulous Opportunity! Multi-specialty medical group seeks BE/BC General Surgeon. Practice is located in Covington WA, an ideal community nestled in a beautiful forest close to a large metropolitan area only 35 minutes southeast of Seattle. Join a state-of-the-art clinic with in-house radiology, laboratory, ambulatory surgery center, breast services center, and urgent care. Primary Care referral base and exploding population growth demands an aggressive physician willing to further develop this practice. 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 to apply online at http://blazenewtrails.org/, email your CV to blazenewtrails@multicare.org or fax your CV to 866-264-2818. "MultiCare Health System is a drug free workplace"

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails @multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or fax your CV to 866-264-2818. Refer to Opportunity #5906 or 7188 when responding.

Physicians - Mobile Medical Examination Services, Inc. "MEDXM", a Healthcare service company is looking to contract with physicians in Tacoma to perform in home patient health assessments and screening. Ideal candidate must be licensed and able to be credentialed in their perspective state. MEDXM has been providing In-Home Health assessments and Screening in patient's homes for the past 20 years. No treatment or prescriptions. Come and join the fastest growing segment of the Healthcare industry. If you are looking for permanent part time or full time assignments with excellent pay and a flexible schedule, this would be a great fit. Please forward your C.V. to sy@medxm1.com.

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BULLETIN

October 2010

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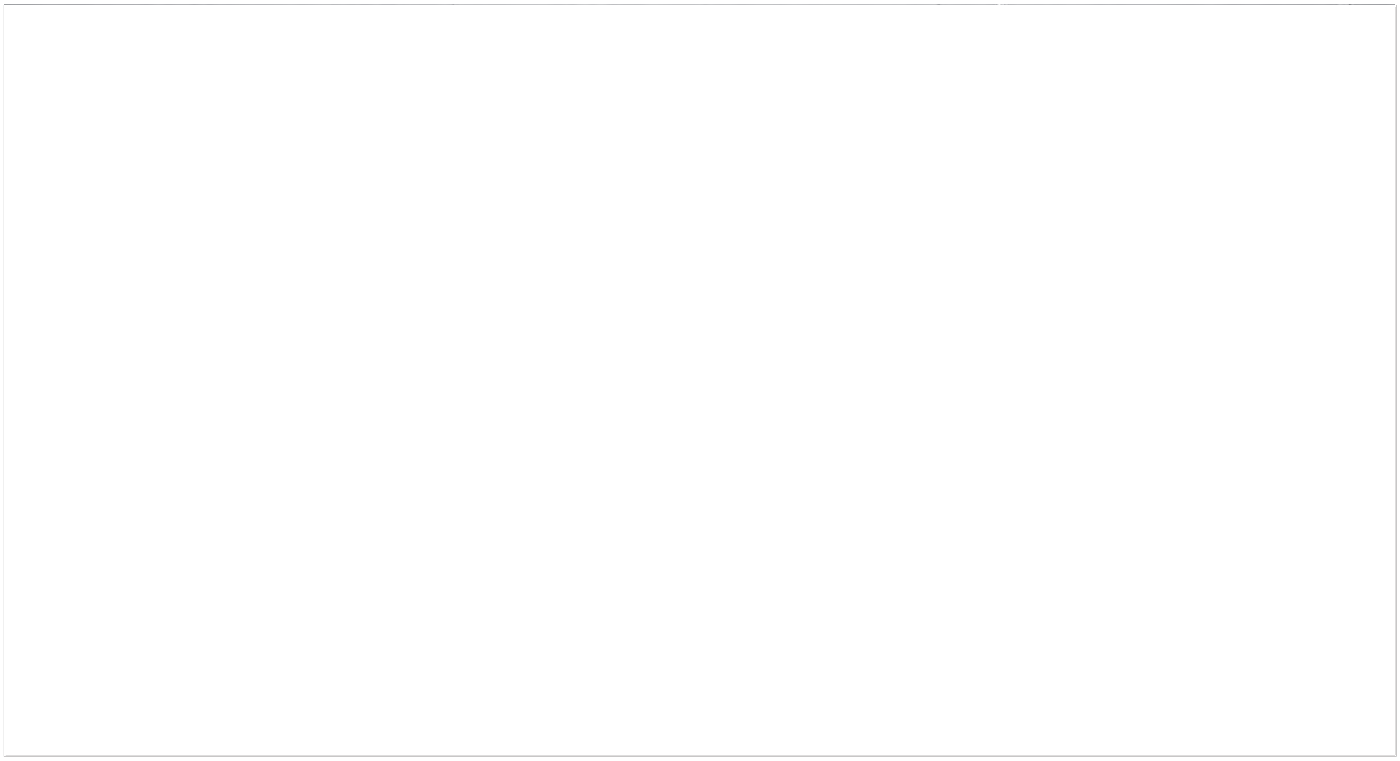

Left to right: Drs. Keith Dahlhauser, Bill Hirota, Steve Konicek, Pat Vaughan, Bruce Brazina, Mike Kelly, Dan Ginsberg, Dave Bales, Anthony Chen, Smokey Stover, Don Russell, Ron Morris and Richard Hawkins. Seated from left: Drs. Len Alenick, George Tanbara, Steve Duncan and Nick Rajacich

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INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

October 2010

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President's Page

Where Are We Now?

Stephen F. Duncan, MD

A year ago **Dr. David Bales**, Past President PCMS, lamented on this very page about the "current Health Care Reform debate." At that moment in time, the congress and the nation was divided on the whether our country should pass legislation that would reform our present health care delivery system and extend coverage to many of the uninsured.

As of today, we have that new legislation and what do we have to show for it? Since passage of HR 3590, the Patient Protection and Affordable Care Act (Public Law 111-148), what changes have we seen? If you have not already noticed, there has been implementation of some changes in most of the health insurance plans over the past several months. Changes in age limits for dependent children coverage, removal of preconditions, loss of maximum limits on coverage and the like are already being mandated to insurance companies. We have seen some jockeying for funding for EMR implementation and for reimbursement of costs of retiree medical benefits. Just like in Pierce County, all over the nation delivery systems are consolidating under hospitals and large groups in attempt to prepare for the fight over funding and well paying patients. We have seen the advance of the Accountable Care Organization (ACO) and we are not even sure we know what it is. Now we enter the election season and you can bet there will be much talk about the wisdom and affordability of the new law.

In David's piece entitled "A Physician's Lament" he expresses a frustration over the lack of discussion of doing "more and better with less resources." The campaigns this fall will remind us that there is not enough money to fund the new bill so increased taxes and/or decreased services will be needed. My lament is that the congress will not solve this important dilemma but will leave it to the doctor and the patient to figure it out in the exam room. With hundreds of thousands of new patients in our state alone qualifying for health care benefits at the bargain price of Medicaid rates, which group or delivery system will be advertising to take them on as affordable patients.

It is my opinion that each one of us is required to be engaged in the process. As our practices consolidate into larger groups and the health care dollar becomes smaller, it will beg the question of how are we going to deliver services in a more efficient and efficacious manner? Patients and doctors will have the conversations of determining what services will best use their heath care dollar best. And as David stated paraphrasing Ghandi, "we have to become the change we seek in the world."

Making the case... to improve immunization rates among adults

by Maxine Hayes, MD, MPH, State Health Officer, Washington State Department of Health

It is truly amazing how often adult immunizations are overlooked. Every year in the United States, between 40,000 and 50,000 adults die from vaccine preventable diseases. As a health care provider, it is important to make sure you know the latest adult immunization schedule. Updates to the schedule happen every year.

The world of immunizations is always in a state of change. Over the last couple years, licensed vaccines to treat diseases such as shingles, human papillomavirus (HPV), and meningitis have become available. Yet adult immunization rates remain low. This is especially true for newly licensed vaccines.

According to the 2007 National Immunization Survey (NIS), approximately two percent of all adults over 60 years of age reported having received the shingle's vaccine. Ten percent of eligible adult women 18 to 26 years old had the HPV vaccine. Two percent among adults 18 to 64 years old received Tdap, a combined tetanus, diphtheria and acellular pertussis vaccine. Approximately twelve percent of adults 18-49 have received both doses of hepatitis A vaccine, and about twice as many have gotten the three dose series of hepatitis B vaccine.

The most success in adult immunizations is with pneumococcal and influenza vaccination. As of 2008, the pneumococcal and influenza vaccination rates in Washington State for adults 65 and over are 70 and 71 percent respectively. These percentages reflect how far we've come and how much we still need to do to reach the *Healthy People 2010* goal of 90 percent.

Why are adult immunization rates so poor?

A lack of understanding and misinformation among healthcare providers and the public can potentially create a negative impact on adult immunization rates. A survey published in 2008 in the *American Journal of Medicine* on Barriers to Adult Immunization showed:

* Most consumers believe that a healthy person does not need vaccines.

* Most consumers indicated that they were likely to receive a vaccination if their healthcare provider recommended it.

* Healthcare professionals are not routinely following recommended immunization practices for adults. Almost 50 percent of surveyed healthcare providers did not rely on the CDC/ACIP guidelines.

* Missed opportunities—

"Every year in the United States, between 40,000 and 50,000 adults die from vaccine preventable diseases."

Healthcare professionals are less likely to discuss immunization during sick visits. Mild acute illnesses, even those presenting a slight temperature, are not a contraindication for immunization.

The National Vaccine Advisory Committee (NVAC) suggested several reasons:

* Misperceptions about the risks of vaccine-preventable diseases in adults.

* Vaccine safety and efficacy.

* Size of target population.

* Lack of regulatory and/or legal requirements.

* Reimbursement.

* Lack of coordinated adult immunization programs.

To address this issue, in 2008, the committee put together an Adult Immunization Working Group. So far, the group has been tasked with the following:

* Assess public health adult immunization activities in United States Department of Health and Human Services and other federal programs.

* Identify gaps.

* Recommend improvements in the areas of program implementation, coordination, evaluation, and collaboration across agencies.

Once these tasks are completed, the group plans to address adult immunization delivery in the realm of private health care.

What you can do to increase adult immunization rates in your practice!

* Review the most current recommendations on adult immunizations.

* Discuss the immunization schedule with your adult patients at every visit. A copy of the schedule is available at: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/2010/adult-schedule.pdf

* Learn how standing orders can work in your setting.

* Follow- up with patients who need to be vaccinated by utilizing a reminder- recall system.

To learn more about adult immunization issues, I encourage you to read:

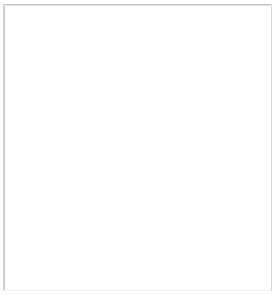
* Trust for America's Health in conjunction with Infection Disease Society of America and the Robert Wood Johnson foundation— *Adult Immunization: Shots to Save Lives*. http://healthyamericans.org/assets/files/TFAH2010AdultImmnz Brief13.pdf

* The 2009 National Vaccine Advisory Committee approved Adult Immunization Recommendations. http://www.hhs.gov/nvpo/nvac/adult.html

* The 2009 Clinical Practice Guidelines by the Infectious Diseases Society of America. http://www.journals.uchicago.edu/doi/pdf/10.1086/605430

* "Barriers to Adult Immunization." *The American Journal of Medicine* (2008) 121, S28–S35. http://www.immunizeadultga.org/docs/Barriers_to_Adult_Immunization.pdf.

Early Detection of Cancer This and Every Month



Anthony Chen, MD

October is Breast Cancer Awareness Month and it is only one reminder of the clinical preventive services that physicians need to provide for their patients throughout the year. As with any other health observance, this month is an opportunity to raise awareness, promote detection and prevention, and encourage development of a personal action plan. To learn more about Breast Cancer Awareness Month, visit http://www.nbcam.org/. You can also get a toolkit at http://www.healthfinder.gov/nho/PDFs/OctoberNHOtoolkit.pdf.

Breast cancer is the most commonly diagnosed cancer and second most common cause of cancer deaths among women in Washington and the nation (http://www.doh.wa.gov/hws/doc/CD/CD_BCN2007.pdf and http://www.cdc.gov/cancer/breast/statistics/index.htm). Since 1990, mortality has been decreasing due to the combination of increased screening and improved treatment. Public awareness of breast cancer is extremely high, but that does not always mean women are getting the proper preventive screening. Additional barriers may be attitudinal, financial, or operational.

Multiple organizations and many websites provide educational materials and encourage women to get mammograms. However, shifting a patient's attitudes of perceived importance, discomfort, or inconvenience may require a sensitive dialog with her medical provider or referral to one of the many patient support or advocacy groups in the community.

There are multiple resources to help overcome financial barriers. Most insurance policies cover mammograms and health care reform will expand that requirement. We are fortunate our county's health care systems and some other providers have internal resources to help their patients in need get screening mammograms. Those not eligible for those resources may qualify for services from the Tacoma-Pierce County Health Department's Breast, Cervical, and Colon Health Program (BCCHP). Low income, uninsured women aged 40-64 years can receive routine clinical breast exams and mammograms through BCCHP; BCCHP also has limited funding to provide diagnostic studies for follow-up of suspicious findings. Since 2000, BCCHP has been able to offer treatment services for breast and cervical cancer for patients diagnosed through the program. For information about the BCCHP Program, medical providers can call the program at (253) 798-4971 or visit our website at http://www.tpchd.org/page.php?id=33. Patients can contact the program at (253) 798-6410. Patients diagnosed with cancer who need help navigating the system can consult the list of Pierce County Navigators http://www.tpchd.org/files/library/36756506d1d2f4d5.pdf.

Recommendations for breast cancer screening are not without controversy and have continued to shift over the years. Professional organizations and advocacy groups have differed in their cutoffs for age and frequency of mammography. In November 2009, the US Preventive Services Task Force (USPSTF) (http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm or http://www.annals.org/content/151/10/716.full.pdf) caused an uproar among advocacy groups because its new guidelines recommended screening mammography every two years for women aged 50 to 74 years and recommended against teaching breast self-examination. Both of these recommendations are different than the guidelines I learned during my training and years of practice, but result from the progression of the evidence base and an increased recognition of the negative impacts of additional testing generated by false positive findings.

The last set of barriers, operational, can be very challenging. To begin with, since recommendations are age-based, how are the doctor and patient reminded of the need to initiate or repeat mammography? In the paper chart or electronic record, is there a list of preventive services or a prompt on the physical exam form? On the billing side, is the doctor aware of whether the study will be covered by the patient's insurance before ordering the test?

Often, patients are seen for acute or chronic care and not for a preventive care visit. While research has shown that doctors usually do not deliver preventive care during illness visits, two routine strategies used by clinicians

See "TPCHD" page 14

Prescription Monitoring Program

The Department of Health received two federal grants to support the Prescription Monitoring Program; the Harold Rogers Grant from the U.S. Department of Justice, Bureau of Justice Assistance, and the National All Schedules Prescription Electronic Reporting (NASPER) Grant from the U.S. Substance Abuse and Mental Health Services Administration.

The funding allows the Department to re-start the important work they began in 2007. The Prescription Monitoring Program was suspended in December 2008 due to the state revenue shortfall. They will develop rules, identify a contractor to collect the data, and provide important information to healthcare practitioners, regulatory authorities and law enforcement.

Unintentional opiate deaths linked to prescription drugs ballooned from 24 in 1995 to 505 in 2008. A prescription monitoring program collects controlled substance prescription data from pharmacies. The data is compiled into a central data base for reporting. Practitioners and other authorized users can view the information and use in making patient treatment decisions.

On-going funding for the program is uncertain at this time. The Department of Health believes the program is an important tool in protecting patients. They will proceed with implementation and work with stakeholders to find funding to sustain the program.

For more information, go to http://www.doh.wa.gov/hsqa/pmp/pmp.htm. You can join the "Interested Parties List" to receive updated information about the program: http://listserv.wa.gov/cgi-bin/wa?A0=PRESCRIPTION-MONITORING&X=17A8BE0EB1A449A152

New law part of fight to keep kids away from cigarettes

by Mary Selecky, Washington State Secretary of Health

It's tragic to see a teen with a cigarette in hand.

To teenagers, smoking may be a way to "look cool" among their peers or to rebel against their parents or society. To me, it's an unhealthy and addictive habit that could affect their health for years to come, and may cause an early death.

That's why the new Federal Drug Administration regulations on tobacco products, which recently took effect, are crucial. The 2009 Family Smoking Prevention and Tobacco Control Act is designed to curb access to cigarettes and lessen the appeal of smoking. This ultimately will reduce the number of young people who become addicted.

The tobacco industry is masterful at tempting each new generation with aggressive marketing and new products. Cigarette marketing is more likely to cause them to take up smoking than peer pressure. According to the Journal of the American Medical Association, **advertising is directly responsible for one out of every three kids who try tobacco**.

The FDA now requires stronger, more graphic warning labels on packaging and prohibits branded giveaways with tobacco purchases. It restricts tobacco sponsorship of athletic, musical, or cultural events – a tactic tobacco companies have long ussed to associate their brand with hip, young trends. The new law also bans the words "light," "low" and "mild" from advertising and labels of tobacco products. For years these simple words have falsely implied these products have lower health risks.

To reduce access to tobacco, the law restricts the use of vending machines and eliminates cigarette sales in packages of fewer than 20. Washington already bans distributing free samples of smokeless tobacco, but these regulations extend the ban to cigarette sampling.

The new law is a powerful weapon in the fight against youth smoking. But we shouldn't underestimate the tobacco industry. It will not roll over and give up. Already, tobacco companies are giving cigarette packages a colorful makeover by replacing the words light, low or mild with attractive colors like silver, gold or blue. Marlboro Lights will now be known as Marlboro Gold Pack, a name no doubt tested by marketers to make sure it appeals to young folks thinking about taking up the habit.

To combat the tobacco industry's desperate tactics, we must ensure that the FDA regulations are enforced, and that youth know the truth about this deadly product. Our kids are smart. I'm confident that if we empower them with information, most will make the right decision.

The good news is we take tobacco prevention seriously in this state and we've made tremendous progress. Since the state Department of Health Tobacco Prevention and Control Program began in 2000, youth smoking has dropped by about 50 percent. There are now 65,000 fewer youth who smoke in the state.

But we still have our work cut out for us. Across the nation, more than 3,500 kids under 18 try their first cigarette each day, and 1,000 become daily smokers. **In Washington, nearly 45 kids try their first cigarette every day**.

We cannot let our guard down. The tobacco industry spends about $146 million in our state each year to market a product that addicts, sickens and kills its users. The industry knows that 90 percent of adults who smoke started when they were young.

I encourage everyone who sees potential violations of the new federal regulations to report them by calling 1-877-CTP-1373 and press 3. We must enforce the new FDA regulations, which remedy some of the most blatant attempts to target youth, and combat any new tactics designed to attract our kids to an addictive and deadly product.

The future of our health and the future of our children ride on it. □

Dewey Stephens, DO

Physician shortage projected to soar to more than 91,000 in a decade

Nationwide physician shortages are expected to balloon to 62,900 doctors in five years and 91,500 by 2020, according to new Assn. of American Medical Colleges work force projections.

That's up more than 50% from previous estimates.

AAMC officials attribute the widening gap to increased demands from the aging baby boomer generation and expansion of coverage by 2019 to 32 million uninsured Americans under the health system reform law.

"As you get more people put in the ranks of the insured, that is going to make the shortage get worse a lot more quickly," said Atul Grover, MD, PhD, AAMC chief advocacy officer. "We have much less time to address these issues."

To counter shortages, the AAMC is urging federal officials to lift limits on Medicare funding for residency positions, which have been capped at 100,000 slots since 1997.

The Dept. of Health and Human Services estimates that the **physician supply will increase by just 7% in the next decade and decrease in specialties such as urology and thoracic surgery**. During the same period, one-third of practicing physicians are expected to retire and the number of Americans 65 and older is projected to grow 36%, according to figures released Sept. 30 by the AAMC Center for Workforce Studies.

"These are great challenges," said Patricia Hicks, MD, director of the pediatric residency program at The Children's Hospital of Philadelphia and professor of clinical pediatrics at the University of Pennsylvania School of Medicine. "It's critical to increase the number of residency training programs."

Supplying the work force

A 15% increase in residency positions would produce an additional 4,000 physicians annually, said Dr. Grover, assistant clinical professor of medicine at George Washington University School of Medicine and Health Sciences in Washington, D.C. "You can't just pull freeze-dried doctors off of shelves; it takes some time to train them," he said.

HHS announced recently that it was releasing $167.3 million in grants to create an additional 889 primary care residency slots by 2015. Though the funding will help, it's only a fraction of the thousands of new positions needed to counter future shortages, Dr. Grover said.

During the past decade, new medical schools have opened and existing schools have expanded class sizes, but "there hasn't been a parallel increase in residency positions," said Thomas Ricketts, PhD, MPH, co-director of the American College of Surgeons Health Policy Research Institute and professor of health policy and management at the University of North Carolina at Chapel Hill School of Medicine.

In addition to training more doctors, there needs to be a focus on finding ways to use the existing physician work force more effectively by collaborating with other health care professionals. "We can do better with the physician supply we have to meet needs," Ricketts said.

Financial barriers to subspecialty fellowships also need to be removed, Dr. Hicks said. Many young physicians complete residency training with large amounts of debt that make it difficult for them to consider a fellowship.

Blaming future shortages on health system reform isn't really accurate, said George Rust, MD, MPH, professor of family medicine and director of the National Center for Primary Care at Morehouse School of Medicine in Atlanta.

"The uninsured have always had needs — we just weren't meeting them. Now there will just be more paying patients," Dr. Rust said. "All of us are going to have to learn to work more effectively." □

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Internship: Univ of Colorado Hospitals
Residency: Univ of Colorado Hospitals
Fellowship: University of Kansas

PCMS members participate in WSMA Annual Meeting in Tacoma

PCMS members **Drs. Anthony Chen, Dan Ginsberg, Ron Morris, Smokey Stover**, and Board of Trustee members **Drs. Steve Duncan, David Bales, Bill Hirota, Keith Dahlhauser, Pat Vaughan, Bruce Brazina** and **Steve Konicek** joined WSMA Representatives **Drs. Len Alenick, Richard Hawkins, Mike Kelly, Nick Rajacich**, and **Don Russell** in representing Pierce County at the WSMA Annual Meeting September 24-26 at the Murano Hotel in Tacoma. All served as Delegates and had voting privileges on the House of Delegates floor.

There was debate and discussions on many resolutions ranging from chronic pain management to health care economics. Several resolutions were adopted, several not adopted and many amended - thanks to the hard work of reference committees prior to the House of Delegate voting.

The 2010 Business Plan for the association was approved and includes the organizational priorities which are:

* Make Washington a better place to practice medicine and to receive care.
* Support a medical practice environment that serves the needs of the public and profession.
* Strengthen the ability of the WSMA to provide value to its members.

There was discussion on medicine's organizational relationships including strong support for county medical societies and the state medical association to work collaboratively regardless of unification status. An adopted resolution calls for both county and state organizations to mutually support membership in both organizations and work to communicate the value of both. Investigation of consolidation ideas, services and membership efficiencies for a savings to members was also adopted.

PCMS extends a huge thank you to all delegates for their personal contribution of valuable time to participate in the WSMA Annual Meeting.

Drs. Tanbara and Chen honored

Drs. George Tanbara and **Anthony Chen** were honored on Friday, October 1 by the Northwest Asian Weekly Foundation at their annual Pioneer Dinner. Every year the Foundation presents an event that recognizes Asian American pioneers in a certain field - people who are passionate trailblazers in their careers, who are paving the way for the next generation. The theme for this year's awards was health care.

The mission of the Northwest Asian Weekly Foundation is to provide training and education to a culturally diverse population of young people. This is accomplished through programs designed to increase self-esteem, practical skills and understanding.

Congratulations to Drs. Chen and Tanbara.

COLLEGE OF MEDICAL EDUCATION

CME at Whistler, January 26-30 Register now!

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education. Whistler offers alpine skiing, cross-country skiing, and many other winter activities at both Whistler and Blackcomb. You will also find many superb dining options and excellent shopping for the relaxed afternoon. Whistler is a great destination for families, as it offers many entertainment options and relaxation options.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. We have negotiated incredible room rates starting at $219 CDN per night. Please visit www.fairmont.com/whistler or call the Inhouse Reservations Department at 1-800-606-8244 to make reservations. You will need to mention you are with the College of Medical Education in order to receive the contracted group rates.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

To register for this program or if you have any questions, please call the College of Medical Education at 253-627-7137.

Infectious Diseases Update November 5 Register Now!

This year's *Infectious Diseases Update* will be held on Friday, November 5, 2010 at Fircrest Golf Club under the medical direction of **Elizabeth Lien, MD**. The program begins at 8:00 am and adjourns at 3:15 pm. Six hours of Category 1 CME are offered.

This clinically-oriented course is designed specifically for the primary care and internal medicine physician interested in an update on the diagnosis, treatment and prevention of common infectious diseases of adults. It will provide a comprehensive overview of infections seen in the ambulatory practice with an emphasis on areas of controversy and new developments in this field.

This year's topics and speakers include:

• Zoonoses and Communicable Diseases	Ramona Popa, MD
• Serious Head and Neck Infections	Lawrence Schwartz, MD
• Pertussis and TPCHD Update	Anthony Chen, MD
• Infectious Disease Potpourri	David McEniry, MD
• What's New in HIV for Primary Care Providers	Elizabeth Lien, MD
• Necrotizing Fasciitis	Olympia Tachopoulou, MD

At the end of the conference participants should be able to: List animal host of different zoonoses and identify risk behaviors in contracting the disease; Recognize clinical features of zoonosis in humans; know appropriate diagnosis tests and treatment; The listener will become familiar with current diagnosis and therapeutic options for invasive infections involving head and neck structures; Understand the CDC's recommendations to integrate HIV screening into routine primary care and review and discuss the current complexities in HIV treatment; Understand catheter associated urinary tract infections. Review and understand the knowledge of current epidemic of Clostridium difficile colitis; Understand and review the recent epidemiology of pertussis and discuss the clinical aspects of pertussis and how it effects our community; Discuss Clinical case examples, risk factors, newer presentations of necrotizing cellulites.

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is $90 for PCMS members (active and retired) and $130 for non-PCMS members. A late fee of $25 will be charged for registrations received after October 31, 2010.

Upcoming CME Programs

March 25, 2011	*Pain Management Symposium* (6 AMA PRA Category 1 Credits)	Tacoma, WA
April 21, 2011	*New Developments in Primary Care* (4 AMA PRA Category 1 Credits)	Fircrest, WA
May 27, 2011	*Internal Medicine Review* (6 AMA PRA Category 1 Credits)	Fircrest, WA

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have been identified to initiate a discussion about prevention. Some doctors use the close of the medical encounter to make arrangements for follow-up preventive care or give reminders about immunizations or screening tests; of course, this underscores the need for a prompt in the medical record. Others take several steps during the conversation to switch from talk about the patient's presenting problem to advice about relevant health habits. So a complaint about coughing can be the opportunity to revisit smoking cessation; a complaint about abdominal pain or vaginal discharge in a woman can be a reminder for pelvic exam and Pap smear. This prevention discussion and subsequent physician recommendations are among the strongest motivators for patients, whether for mammogram, smoking cessation, Pap smear, colonoscopy, or other preventive services.

Once the recommendation is made and referral written, there still needs to be a check on follow-up. Some clients make personal choices not to complete their breast cancer screening and may or may not discuss this with you. Especially in this economy, patients may lack or have lost their insurance coverage. If the test is done, the patient needs to be notified of results and reminder for follow-up entered in the medical record.

You can see that everything I said about mammography is similar to other clinical preventive services. So when you hear that October is Breast Cancer Awareness Month, January is Cervical Cancer Screening Month, April is National Cancer Control Month, and November is Lung Cancer Awareness Month, make sure that you think about all other prevention recommendations and whether your practice is set up to have these discussions and help ensure your patients are getting the services they need.

Western WA - General Surgery. Fabulous Opportunity! Multi-specialty medical group seeks BE/BC General Surgeon. Practice is located in Covington WA, an ideal community nestled in a beautiful forest close to a large metropolitan area only 35 minutes southeast of Seattle. Join a state-of-the-art clinic with in-house radiology, laboratory, ambulatory surgery center, breast services center, and urgent care. Primary Care referral base and exploding population growth demands an aggressive physician willing to further develop this practice. 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 to apply online at http://blazenewtrails.org/, email your CV to blazenewtrails@multicare.org or fax your CV to 866-264-2818. "MultiCare Health System is a drug free workplace"

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or fax your CV to 866-264-2818. Refer to Opportunity #5906 or 7188 when responding.

Great location 13th & Union. **3rd floor** - Rainier view. 2,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic, Tacoma, 1100 sq. ft. sublease $100/d. University Place, 1000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Pierce County Medical Society
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Tacoma, WA 98402

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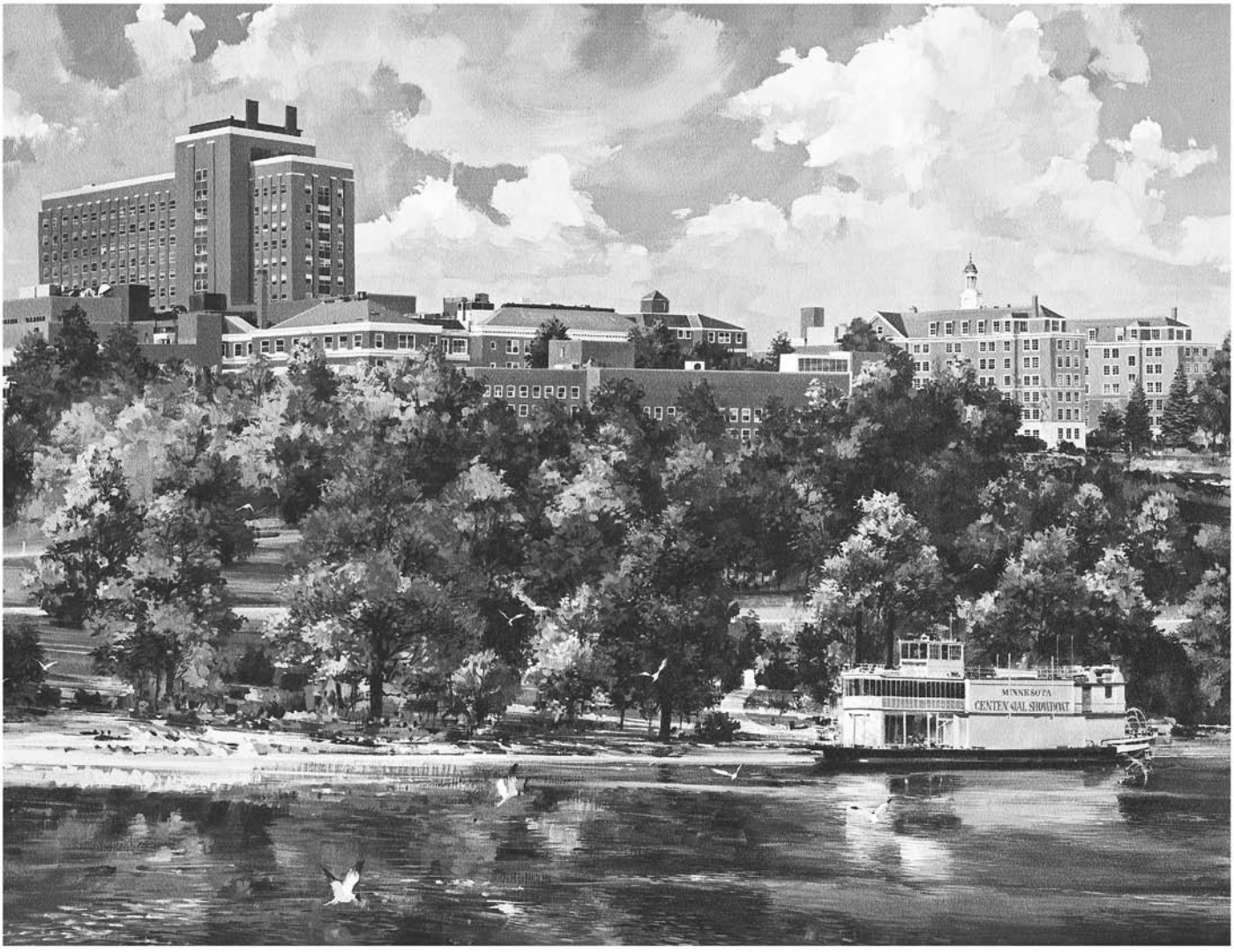
Pierce County Medical Society
BULLETIN

November 2010



University of Minnesota Medical School

INSIDE:

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

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

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Pierce County Medical Society
BULLETIN

November 2010

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President's Page

by Stephen F. Duncan, MD

To Be Thankful

Stephen F. Duncan, MD

As we approach the twilight of the year, fall and the holidays, I would like to pause to reflect on the last twelve months. As many before me have stated, it is difficult to believe that my term as President of PCMS is drawing to a close. I have had the distinct privilege to serve members of the greatest profession.

This past year has been filled with great accomplishments. We had one of the best WSMA Leadership Conferences at Lake Chelan this spring. Our society enjoyed social outings that included wine tasting in May and Rainier's baseball in June. In late September, our delegation represented PCMS at the House of Delegates of the WSMA at the annual meeting in Tacoma.

Our society has been blessed with continued membership growth. It has been a focus of the board this year to improve membership and to begin to focus the society on those functions that have greater value. I believe we have made improvement on membership support from the larger medical groups in the county. We discontinued the longstanding referral service that the staff of PCMS had maintained for years because it failed to have value for the members. Pierce County Project Access got its beginnings this year under the leadership of its board and Leanne Noren. We made recommendations for change in the organization of the College of Medical Education to hopefully maintain its ability to provide local CME for the near future. Thanks to the work of Sue Asher, Executive Director, and her staff, the PCMS website will be up on the web before the end of the year. And the board has rewritten the Bylaws of our organization. They were antiquated and were last revised in the 1990's. We have modernized them to fit the present and the future. We will begin the approval process soon.

At the opening session of the WSMA House of Delegates, Dr. Carl Hammerschlag told stories that made me realize that the members of the medical profession are more than service providers. We are healers, called to serve our patients more than just provide medical care. I have had the opportunity in the past to work with many different groups but none more caring and dedicated than those who make up the house of medicine of Pierce County. I wish to particularly thank those who have served on my board and the staff of PCMS for a rewarding year. ■

Please join us for a humorous and entertaining evening

Pierce County Medical Society
2010 Annual Meeting

Spouses/Guests invited...

Open up & say "Ha!"

Brad Nieder, MD

Some call him the Funny Doctor. Some call him the Phunny Physician. Still others call him Ethyl. To most, though, he's known as the Healthy Humorist. He's Dr. Brad Nieder a hilarious doctor and speaker who entertains, inspires, and enlightens audiences across the country with his unique blend of health care comedy and wellness advice. Dr. Brad presents "Laughter IS the Best Medicine."

Laughter is quite effective at reducing stress, managing pain and boosting the immune system. In the workplace it can enhance communication, aid creativity, and improve productivity. When Dr. Brad speaks, it's contagious!

As a freshman at Stanford University, he became a founding member of the SIMPS improv comedy troupe. During medical school at the University of Colorado, Brad frequently performed standup comedy throughout Denver for both live audiences and yes …. cadavers. As a general practitioner living in Denver, some would say he's a specialist in Healthy Humor!

- *Passing of the gavel from President Stephen Duncan, MD to Jeffrey Smith, MD*
- *Introduction of the 2011 Trustees*
- *Thanking David Bales, MD for six years of service*
- *Raffle drawings and holiday card sales to benefit the PCMS Foundation*
- ***Please bring an unwrapped toy for a child and/or a gift for a woman for YWCA Shelter residents***

Wednesday, December 1, 2010	**Social Hour: 6:00 p.m.**
Fircrest Golf Club	**Dinner: 7:00 p.m.**
1500 Regents Boulevard, Fircrest	**Program: 8:00 p.m.**

Please return by Friday, November 26 to PCMS, 223 Tacoma Avenue South, Tacoma WA 98402
You may fax to 253-572-2470 or call 253-572-3667 for more information

Please reserve _____ dinner(s) at $40 per person. Enclosed is my check for $ _____ Or, charge my credit card:

_____ Expires: _____ ☐ Visa ☐ MC ☐ AM Signature _____

My name for nametag (please print) _____ My spouse/guest name for name tag _____

Thanks….. look forward to seeing you!!

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH; Allison Cox, MA; Frank Dibiase, MA, RS; Elizabeth Pulos, PhD, MPH; and Joby Winans, MDiv

What Next Beyond the Great American Smokeout?

Anthony Chen, MD

The 35th annual Great American Smokeout will take place on Thursday, November 18, 2010. The purpose of the event: to challenge smokers to go smoke-free for twenty-four hours and maybe stop using tobacco permanently.

The Centers for Disease Control and Prevention (CDC) estimates that among smokers, 70% want to quit and 40-45% had tried to quit the previous year. Yet physicians know that discussions with smokers often result in arguments and excuses. Sometimes it seems easier to avoid the fight, but a challenge to stop for one day – "just try it!" – could be the start of something healthy.

At Tacoma-Pierce County Health Department, we continue to message about the adverse effects of smoking, try to prevent children from taking up the habit, and enforce the Smoking in Public Places Act (I-901 or RCW 70.160). We are also considering "what else?" What can we do next in our community to further reduce exposure to tobacco smoke?

Adult smoking rates have declined. In 2008, 17.8% of adults in Pierce County smoked; in 2009, the number dropped to 16.9%. Nevertheless, more than 100,000 people in Pierce County continue to smoke and threaten their own health and the health of those around them. We are concerned that smoking rates in children have flattened and started to increase between 2006-2008 after showing steady declines since 2002; in fact, in 2008 a higher percentage of 12th graders (21%) smoked than adults.

As physicians, we know the health risks to smokers: cancers and pulmonary, cardiovascular, and oral disease. Tobacco use remains the leading cause of preventable death in the United States; even without causing death, smoking greatly impacts disease morbidity. Secondhand smoke or environmental tobacco smoke (ETS) is concerning; as stated in the 2006 U.S. Surgeon General's report, there is no safe level of exposure to tobacco smoke. In children, ETS exacerbates asthma, upper respiratory infections, and otitis media. In adults, ETS is also associated with cancers and cardiovascular disease. It continues to amaze me that bans on smoking in public places have shown dramatic, immediate benefits: Helena, MT, for example, had a 40% drop in admissions for acute myocardial infarction (MI) in the six months that a smoking ban was in place compared to a 45% increase in surrounding areas without the smoking ban. Across the United States and Europe, acute MIs drop an average of 17% after a smoking ban with increasing benefit over time.

While the Smoking in Public Places Act protects people in restaurants, bus stops, and other public areas, it ironically may not protect them where they live. What are the risks to non-smokers who live in buildings with people who smoke? A study on the transfer of tobacco smoke in multi-unit housing in Minnesota found that the flow of air between units in apartment buildings ranged from 2 to 19% (median = 5%) of total air, depending on building construction and age. Other studies have found that half to two-thirds of the air in an older multi-unit residence can infiltrate from neighboring apartments. A Harvard School of Public Health study of multi-unit low-income housing developments found that nicotine was detected in 89% of non-smoking units, with levels sometimes as high as if one cigarette per day were smoked in the home. While nicotine was the marker measured, remember that many other harmful chemicals are present in cigarette smoke.

In Pierce County, 23% (about 60,000) of all households rent an apartment in a building with two or more rental units. While a 2007 survey indicated that 30% of landlords in Pierce County reported having some type of smoke-free policy, a new survey just completed by Health Department staff indicates that less than 10% now prohibit smoking inside apartments. That means a lot of people breathe tobacco smoke in their homes every day—even though the majority (over 80%) do not smoke themselves. A 2007 study by the Washington State Department of Health showed that 86% of renters and—ironically—54% of smokers prefer to live in smoke-free housing. The housing market is obviously not giving renters the choice of a healthy home environment.

See "TPCHD" page 12

Thank You to PCPA Partners and Volunteers

During this season of thanksgiving Pierce County Project Access would like to thank our partners and volunteers for donating care to the low-income residents of Pierce County!

Health Systems
- Franciscan Health System
- MultiCare Health System

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Pierce County Project Access

by Leanne Noren, Executive Director

Pilot Project a Success

Leanne Noren

The pilot phase of Pierce County Project Access is complete. We scheduled the first four months of this program as a pilot to evaluate our process and to learn and improve as we move forward.

In summary, our pilot data showed us that:

* PCPA received 20 referrals from five different sources
* Five patients from those 20 referrals were enrolled in the program; Nine were in process for enrollment at the end of the pilot phase
* PCPA patients had a 0% no-show rate!
* 65% were below 150% of the Federal Poverty Level
* 50% were between ages 18-44 and white, non-Hispanic residents of Tacoma
* 35 providers enrolled as volunteers (includes individual providers and clinics) with 65 pending
* 13 primary care providers, 14 specialists, and 8 allied health providers
* Total annual capacity as of October 1, 2010 was for 136 patients

The pilot project proved to be necessary and a very useful learning tool for our staff and the program. We learned how to work with the Referral Coordinators at different clinics to get complete patient applications which will move through the administrative process better. We also discovered how to work with different departments within the hospital setting to identify and refer appropriate patients from the ED. We've tried to understand the barriers and difficulties that patients encounter when trying to enroll in the program and make that process as easy as possible.

The medical community has welcomed Project Access with open arms. Volunteer providers from all sectors have easily and openly agreed to volunteer and our current capacity is beyond need. Physician "champions" for Project Access are critical to our success. Their ability to recruit their colleagues is a very valuable asset to this program and ensures success as we grow into new specialties. Provider recruitment works best through word of mouth and colleague to colleague. Thank you to the Provider Engagement Committee for all of the hard work they have put in toward volunteer recruitment. As we move forward in the next quarter we are expanding into ophthalmology, GI, and neurology. Oncology, gynecology and general surgery will soon follow.

Additionally, the Board of Directors has been successful in many areas as this year comes to a close:

* Successfully transitioned from a Steering Committee to a Board of Directors
* Secured two additional years of funding
* Completed a strategic plan
* Formed functioning and successful Ad Hoc Committees
* Demonstrated success as they lead this community toward an organized and coordinated means of delivering volunteer care

With the holiday season upon us, the staff and board of Pierce County Project Access want to express our gratitude to our volunteers for the compassionate care being shown to the uninsured. Thank you to for selflessly donating your time, talent and treasure for the most vulnerable in our community. ■

Applicants for Membership

Melanie P. Berg, MD, MPH
Family Medicine
Community Health Care
11225 Pacific Ave S, Tacoma
253-536-2020
Med School: New York Medical College
Residency: UW Family Medicine

Debra L. Campbell, PA-C
Family Practice
Community Health Care
101 E 26th St, Tacoma
253-597-4550
Training: Butler University

Nyen V. Chong, MD
Thoracic Surgery
St. Joseph Cardiothoracic Surgeons
1802 S Yakima Ave Ste 102, Tacoma
253-272-7777
Med School: Jefferson Medical Univ
Internship: Penn State University
Residency: Penn State University
Fellowship: U Massachusetts Med Ctr
Addl Training: U Pittsburgh Med Ctr

Donella S. Curcio, PA-C
Dermatology
Cascade Eye & Skin Centers
5225 Cirque Dr W Ste 200, Univ Place
253-564-3365
Training: Barry University

Evelyn X. Fu, MD
Ophthalmology
Cascade Eye & Skin Centers
5225 Cirque Dr W Ste 200, Univ Place
253-848-3000
Med School: Case Western Reserve
Internship: Kaiser Permanente
Residency: Cleveland Clin Cole Eye Inst
Fellowship: CA Pacific Medical Center

Timnit Ghermay, MD
Interventional Radiology
Medical Imaging Northwest
7424 Bridgeport Way W #103, Lakewood
253-841-4353
Med School: University of Michigan
Internship: Mercy Health Partners
Residency: University of Michigan
Fellowship: University of Michigan

Sean D. Ghidella, MD
Orthopaedic/Hand Surgery
Puget Sound Orthopaedics
7308 Bridgeport Way W #201, Lakewood
253-582-7257
Med School: Georgetown University
Internship: Madigan AMC
Residency: University of Rochester
Fellowship: Walter Reed AMC

Craig R. Hampton, MD
Cardiothoracic Surgery
St. Joseph Cardiothoracic Surgeons
1802 S Yakima Ave Ste 102, Tacoma
253-272-7777
Med School: Univesity of Minnesota
Internship: University of Washington
Residency: University of Washington
Fellowship: University of Washington

James P. McMahon, PA-C
Tacoma Digestive Disease Center
1112 Sixth Ave #200, Tacoma
253-272-8664
Training: University of Detroit Mercy

Jon D. Mortensen, PA-C
Community Health Care
10510 Gravelly Lake Dr, Lakewood
253-589-7030
Training: MEDEX

Carolyn L. O'Brien, PA-C
Dermatology
Cascade Eye & Skin Centers
5225 Cirque Dr W Ste 200, Univ Place
253-848-3000
Training: Grand Valley State University

Susan L. Powell, MD
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Community Health Care
134 - 188th St S, Spanaway
253-847-2304
Med School: University of Washington
Residency: Alaska Family Practice

Kathryn M. Tonder, MD
Family Medicine
Community Health Care
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253-847-2304
Med School: UC San Diego
Residency: Tacoma Family Medicine

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At the Health Department, we are considering how we can encourage an increase in the available smoke-free multi-unit homes. There are obvious advantages to both landlord and tenant when smoke-free policies are implemented and we need to work with stakeholders to find strategies that work without unintended consequences. In addition, we will continue to support policies that encourage smokers to quit and ensure that young people do not start using tobacco.

In the meantime, you can help by encouraging smokers to put their packs aside, even if only for one day. The Agency for Healthcare Research and Quality (AHRQ) suggests that physicians routinely **Ask, Advise, Assess, Assist,** and **Arrange**:

*** Ask about tobacco use at every visit**. Implement a system in your office that ensures that tobacco-use status is obtained and recorded at every patient visit.

*** Advise all tobacco users to quit**. Use clear, strong, and personalized language. For example: "Quitting tobacco is the most important thing you can do to protect your health."

*** Assess readiness to quit**. Ask every tobacco user if s/he is willing to quit at this time.

*** Assist tobacco users with a quit plan**. Give advice on successful quitting, encourage use of medication, and provide resources.

*** Arrange followup visits**. Schedule followup visits to review progress toward quitting. Or, if a relapse occurs, encourage a repeat quit attempt.

For those of you who enjoy working with young children, consider using the Tar Wars tobacco-free education program developed by the American Academy of Family Physicians in your local school (see resources below). Working together on this issue, I think we can keep chipping away at the smoking rate in Pierce County and protecting all people from the harmful effects of tobacco smoke.

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See "TPCHD" page 18

"Blue button" technology pushed to give patients instant access to medical records

Proponents say Web-based entry will save physicians time and hassle from gathering information for patients. But technical and privacy concerns must be addressed

As members of the public-private Connecting for Health collaborative met last winter, several people spoke offhandedly about how great it would be if there were some simple way for patients to download all of their health records from the Web.

That way, patients would have easy access to their own health information, and physicians wouldn't have to spend so much time putting together records requests. The people at the meeting even came up with a term to describe what they imagined: the "blue button."

Only nine months later, that concept has gone from what-if to reality. Even though, technically, what's being used isn't a button, and it isn't blue.

Two federal organizations have implemented virtual blue-button icons on their patient portal websites that, when clicked, give patients the real-time ability to download their own health information. Meanwhile, the concept is gaining steam in the private sector.

The Dept. of Veterans Affairs and the Dept. of Health and Human Services' Centers for Medicare and Medicaid Services worked together to develop their own versions of the blue button on their respective patient portals, MyHealth.va.gov and MyMedicare.gov. Because both organizations serve different roles — the VA provides health care while HHS manages payment for care — the two blue-button programs offer different things. The VA has a complete medical record for each patient, and CMS provides claims information. But gauging from the response, both provide a service patients find useful.

Both departments did soft launches of the system over the summer. By the beginning of October, more than 60,000 veterans used the VA's systems to access their medical records, and more than 5,600 Medicare beneficiaries used CMS' blue button to access their claims records.

"CMS has long been interested in helping beneficiaries be more engaged in their health care," said Lorraine Doo, senior policy adviser of eHealth standards and services for HHS. The blue button was a way of letting the patients know what data CMS has on them, she said.

Experts say most physicians aren't yet ready to add their own version of the blue button to their websites. For one thing, the physicians' electronic medical record systems probably don't have the capability to provide a blue-button link between their EMRs and their sites.

Still, members of Connecting for Health and others are pushing for widespread adoption of the blue button as physicians face "meaningful use" requirements, passed under the 2009 economic stimulus package, that give patients the right to receive their medical records electronically upon request. The blue button would be a convenient way for physicians to satisfy this requirement, as they could direct all patients with Internet access to the Web to obtain the information.

"The time is fairly opportune to increase awareness for this potential," said Josh Lemieux, director of personal health technology for the New York-based Markle Foundation, which sponsors Connecting for Health. The American Medical Association is one of the collaborative's members.

Driving demand

According to results from an October survey conducted by Connecting for Health, 70% of the public and 65% of doctors agree with the blue-button concept.

Many EMR systems allow for patient portals that provide access to patient records in a read-only format. But they do not allow records to be downloaded or uploaded to another system, such as a personal health record.

Stage 1 meaningful use requirements for EMRs say only

See "Records" page 14

Records from page 13

that systems must allow for patients to receive electronic versions of their records. (Meeting meaningful use allows physicians to collect incentive payments under Medicare and Medicaid.) But the rules do not specify how those data are delivered, said Sue Reber, spokeswoman for the Certification Commission for Health Information Technology, one of three organizations named by the HHS Office of the National Coordinator for Health Information Technology as an official EMR testing and certification site.

"In most cases, it is not a blue button, because in general the request is going through the physician, and they are going to create that kind of electronic copy for the patient," she said.

Because patients are being asked to share in making more of their health care decisions, having the ability not only to access the information but also to download it will become increasingly important. As demand for data access grows, the demand to make access easier also will grow, Lemieux predicted. Eventually, vendors will feel pressure from those demands and create blue-button applications, he said.

After the VA and HHS launched their blue-button systems, Markle and the Robert Wood Johnson Foundation held a contest for developers to submit ideas for applications that convert data downloaded from one of those sites into useful health tools. Taking the top prize in October was Adobe, which developed an application that converted health data into a pdf file that could be shared with physicians or caregivers.

"Downloading your information is only the first step to making use of it," said Carol Diamond, MD, MPH, managing director of Markle's health care program, in a prepared statement. "The real winner of this challenge is the consumer, because so many different approaches and ideas emerged to help patients put their information to good use."

Privacy concerns

Despite the growing interest from the public, however, there hasn't been much of a demand for widespread adoption of the blue button, in part because many people haven't thought to ask for electronic copies of their records.

The Connecting for Health survey found that 83% of the public have never asked for their records in electronic format. And the majority of physicians surveyed said patients rarely (27%) or never (67%) have asked for electronic records.

Lemieux thinks the lack of interest could be because the concept of downloading medical records as easily as one would download a song is too foreign for most people to grasp. Patients are used to a process of making a formal request for their records, paying a nominal fee per page to have them printed, then waiting several days to receive them. The idea of reducing that process to the act of pushing a button seems too simple — and dangerous, he said.

More than 80% of both the public and physicians said privacy safeguards were an important part of any federally funded health information technology program. Concerns include making sure the person accessing the records is authorized to do so, and making sure the records aren't harvested by machines developed to "data scrape," or crawl websites to obtain aggregated data.

A policy paper — whose member co-signers include the AMA — published by Connecting for Health in August addresses many of those concerns, with recommendations for privacy controls that can be implemented into any blue-button system.

The controls include "challenge response tests" that ensure the person accessing the information is a human — similar to when a user is asked to type in a string of letters to access a webpage; authentication systems to help ensure that a person logging in is authorized to do so and that he or she understands the possible security implications of downloading that information; and pop-up warnings the patient must read and acknowledge by clicking "OK" before the records can be downloaded. But, the policy paper warns, the pop-ups can't be too intrusive or even too scary looking, or people won't use it.

With its set of specific recommendations for how blue buttons could be implemented in a safe and secure way, Markle is calling on HHS to make it a priority in its health IT efforts. The organization also is calling on private organizations to include blue buttons in any new system procurement contracts. ■

Reprinted from AMNews 11/1/10

Insurers, employers talk quality while targeting physician pay

More health industry authorities believe that improvements in standards or costs can't come without reforming how doctors are reimbursed

Health insurers and employers are pushing what they call "physician payment reform" in an effort to keep costs down and quality up.

Simply put, "physician payment reform" is a catch phrase that refers to paying physicians based on quality measures and episodes of care, rather than a fee-for-service system. It's not a new idea. But physician payment reform — intended to be a step up from terms such as "pay-for-performance" — is gaining traction as more authorities in the health industry declare that no improvements in quality or costs will come without fundamentally changing how doctors are reimbursed.

"How we pay is probably the next real big issue we have to focus on. Payment reform has to be a big part of our future agenda," Cristie Travis, executive director of the Memphis Business Group on Health, an employer coalition. She was speaking at an Oct. 13 news conference for the release of the National Committee on Quality Assurance's annual State of Health Care Quality report.

The 162-page report, which looked at claims data from more than 1,000 health plans representing 118 million Americans, declared that spending more money on health care did not automatically lead to better health. "We must contain costs and create a system based on value, not volume," NCQA President Margaret E. O'Kane said at the news conference, where she was joined by health plan and other payer representatives.

In a phone interview after the news conference, Travis told *American Medical News*: "We see the physicians as, to be honest, the pivotal providers that have an impact on the cost and quality of care." But she added that measuring performance and giving physicians their scores won't do enough.

"Performance measurement and public reporting alone are not going to be sufficient to get the types of improvements we want. We really need to realign how we pay," Travis said.

Not a brand-new idea

Talking about changing the way physicians are paid to promote better and more efficient use of health care is an idea that has been tried before.

Capitation — paying physicians on a flat per-patient, per-month rate, rather than paying per encounter — was a big idea in the 1980s and 1990s. It took root in some areas, but died out in most places as physicians rebelled against a system they said rewarded them for merely keeping costs down, not keeping quality up.

The NCQA does not lay out a specific strategy on using physician payment as a way to increase quality. Instead, the report noted that a nuanced approach was needed to find a way to deliver health care efficiently — and well.

Because the NCQA report focused on health plans and payers, physician organizations were not speaking at its news conference. However, doctors were on the minds of those who were there.

"We think the future for quality improvement efforts is working with physicians," said Jeffrey Kang, MD, chief medical officer for Philadelphia-based insurer Cigna.

Later at the NCQA news conference, Dr. Kang talked about the need for health plans to decide on uniform measures and methods for determining the relative quality of a physician.

"There is an emerging consensus between all payers that we have to agree to a common set of metrics. We need to send the same signal to the doctors in terms of what quality means," he said.

Some payers, including Blue Cross Blue Shield of Massachusetts, have tried to revisit capitation but pair it with pay-for-performance and more precise quality measures. That new model has been referred to as global payment, and the Massachusetts Legislature could consider a bill in 2011 that would install such a system in the state.

Other health plans have tried to influence physician payment through tiered networks, in which physicians rated as higher quality are put in a plan that is less expensive for members to access, giving those physicians a larger potential pool of patients.

Meanwhile, government agencies are discussing how to set up accountable care organizations, in which physicians and hospitals group together to track care for a large, specific group of patients — and get paid a bonus if they reach certain quality measures. Beginning in 2011, physicians who report quality information to Medicare can receive a bonus.

Quality measurements differ

The problem physicians most commonly have with these efforts is with the accuracy, fairness and validity of the measurements health plans use to assess doctor quality. The American Medical Association-led Physician Consortium for Performance Improvement has developed more than 270 quality measures.

But physician organizations say that instead of using true quality data, payers have used only insurance claims data to populate quality reports. Then there's the challenge of appropriate risk adjustment, and the problem of how to assign care when more than one physician in a practice cares for a single patient.

See "Pay" page 16

Doctors visited by 20 drug reps a week

A sales representative working for a drug or device manufacturer walks into a physician office once every other hour, according to an ongoing survey of more than 237,000 practices accounting for 680,000 U.S. doctors.

Twenty-three percent of physician practices refuse to see reps, about the same number that had a no-reps policy in February 2009, said the report from SK&A, an Irvine, Calif., firm that maintains profiling information on more than 800,000 prescribers. There has been a rise in the proportion of practices that will see reps only with an appointment, from about 40% in February 2009 to nearly half in the most recent survey, released in October. The remainder of practices placed no restrictions on detailers' visits, which happen about 20 times each week.

Physicians working in practices with low patient volume, owned by hospitals or with a larger number of doctors are less likely to see reps, the report said. For example, 13.3% of one- or two-physician practices had no-reps policies, compared with 42.2% of practices with 10 or more doctors. ■

Reprinted from amednews.com 10/25/10

Pay from page 15

Research funded in part by the U.S. Dept. of Labor and released by the RAND Corp. in 2010 showed that quality rating programs misclassify physicians as often as 22% of the time. The research supports physicians' concerns about quality reporting and pay-for-performance programs already in place.

For that reason, physicians say pushing insurers to base what they pay doctors on these kinds of quality measurements could be disastrous. Some state medical societies are trying to get insurers to back off flawed rating programs that could be used as precursors to new payment schemes.

For example, the California Medical Assn. in September sued Blue Shield of California over the insurer's Blue Ribbon quality designation program, which physicians said was misleading. The CMA had been a part of a consortium working with Blue Shield before dropping out. Blue Shield said it stands by its data.

Physicians' frustration with quality reporting and payment reform in some cases is heightened by accompanying demands on their finances and time.

However, payers said physicians should understand that as pressure to contain health care costs goes up, so will scrutiny of how doctors get paid.

Travis said it's fair for a physician to ask if, say, they are getting a return on their investment in information technology. But she said it's also fair for payers to ask if they are getting a return on their investment in physicians.

"I think it would be unreasonable to ask a physician to invest in an infrastructure they didn't know they were going to get paid back for," she said. "It's equally wrong to ask an employer or health plan or consumer to pay more if they don't know if they're going to get more for their money." ■

Reprinted from AMNews Oct. 25, 2010

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This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. We have negotiated incredible room rates starting at $219 CDN per night. Please visit www.fairmont.com/whistler or call the Inhouse Reservations Department at 1-800-606-8244 to make reservations. You will need to mention you are with the College of Medical Education in order to receive the contracted group rates.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

To register for this program or if you have any questions, please call the College of Medical Education at 253-627-7137. ■

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Resources

1. American Cancer Society Great American Smokeout home page: resources and tools, including a guide to quitting smoking, a cigarette cost calculator, and an eCard to ask for support in quitting: http://www.cancer.org/Healthy/StayAwayfromTobacco/GreatAmericanSmokeout/index

2. The Agency for Healthcare Research and Quality (AHRQ): Helping Smokers Quit: A Guide for Clinicians: http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm

3. Quitline: 1-800-QUIT-NOW (1-800-784-8669) or http://www.quitline.com/

4. Washington State Department of Health Smoke Free Washington: http://www.smokefreewashington.com/

5. CDC Smoking & Tobacco Use: http://www.cdc.gov/tobacco/

6. CDC Tobacco Use and the Health of Young People: http://www.cdc.gov/HealthyYouth/tobacco/index.htm

7. Smoke Free Homes website - The Professional's Toolbox: http://www.kidslivesmokefree.org/toolbox/

8. Tar Wars: A tobacco-free education program for kids from the American Academy of Family Physicians: http://www.tarwars.org/online/tarwars/home.html

9. Washington State Tar Wars Coordinator: http://www.wafp.net/programs/tarwars/Washington-State-Tar-Wars-Coor.aspx ■

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POSITIONS AVAILABLE

Western WA - General Surgery. Fabulous Opportunity! Multi-specialty medical group seeks BE/BC General Surgeon. Practice is located in Covington WA, an ideal community nestled in a beautiful forest close to a large metropolitan area only 35 minutes southeast of Seattle. Join a state-of-the-art clinic with in-house radiology, laboratory, ambulatory surgery center, breast services center, and urgent care. Primary Care referral base and exploding population growth demands an aggressive physician willing to further develop this practice. 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 to apply online at http://blazenewtrails.org/, email your CV to blazenewtrails@multicare.org or fax your CV to 866-264-2818. "MultiCare Health System is a drug free workplace"

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails @multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or fax your CV to 866-264-2818. Refer to Opportunity #5906 or 7188 when responding.

Madigan Healthcare System. Community Based Clinic Puyallup & Lacey, Washington. Patient Centered Medical Home Practice. Exceptional civilian opportunities to join a first class Family Medicine team for a board eligible or board certified Family Physicians in a in outpatient settings. The U.S. Army is implementing Patient Centered Medical Home Model Clinics in Lacey and Puyallup, Washington to serve active duty families. Join a team that is committed to moving patients toward healthy lifestyles. Excellent benefits are available including competitive salary, malpractice, health, life and disability coverage, dual retirement plan including the civil service variation of a 403b, and CME allowance. Contact our Medical Provider Recruiter @ (253) 968-4994 or send CV to henry.laguatan@us.army.mil or apply on-line @ http://careers-civilianmedicaljobs.icims.com/jobs/job

OFFICE SPACE

Great location 13th & Union. **3rd floor** - Rainier view. 2,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic, Tacoma, 1100 sq. ft. sublease $100/d. University Place, 1000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

TACOMA/PIERCE COUNTY

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

Contact Paul Doty
(253) 830-5450

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

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