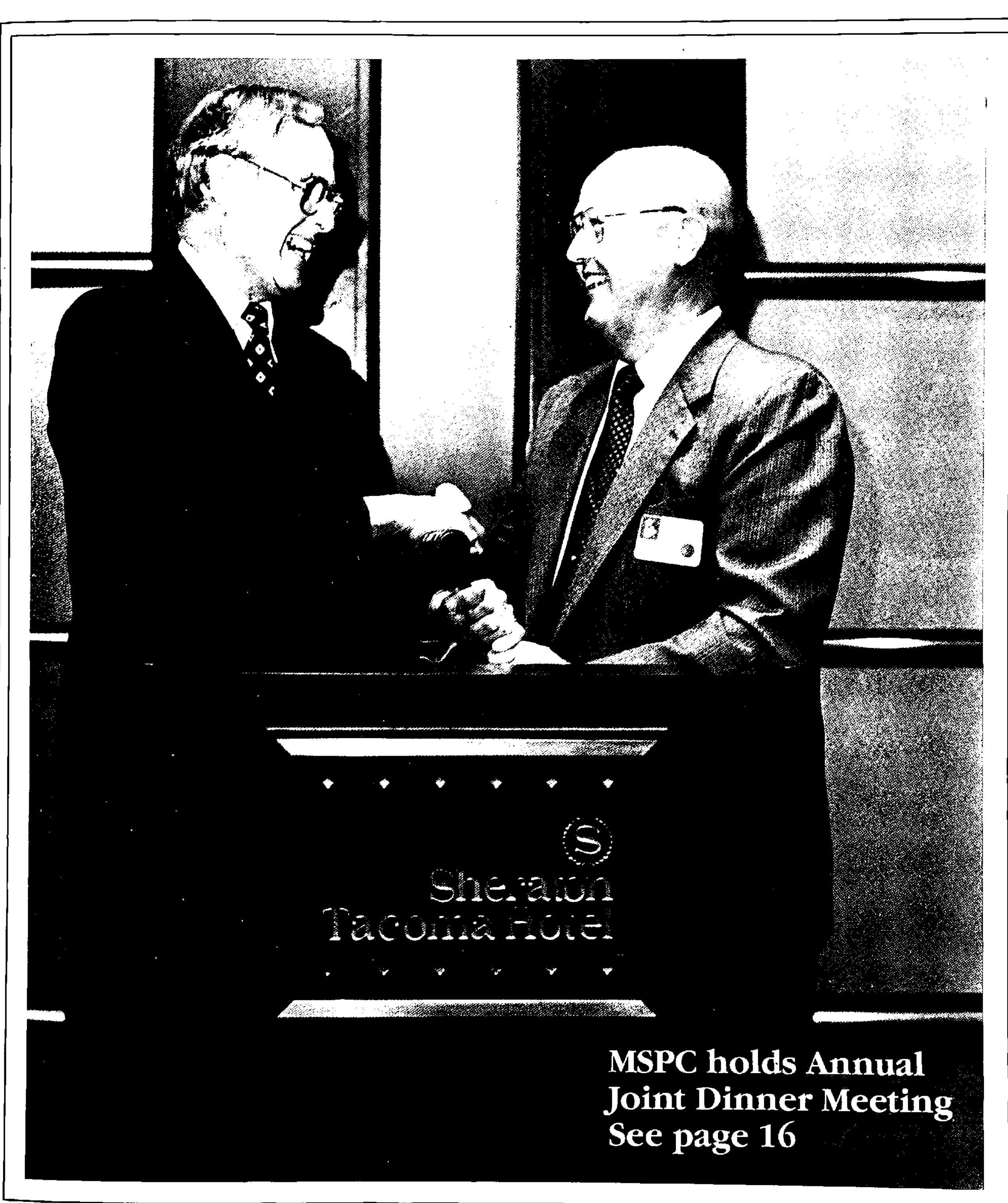
The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

January, 1985



MSPC holds Annual Joint Dinner Meeting
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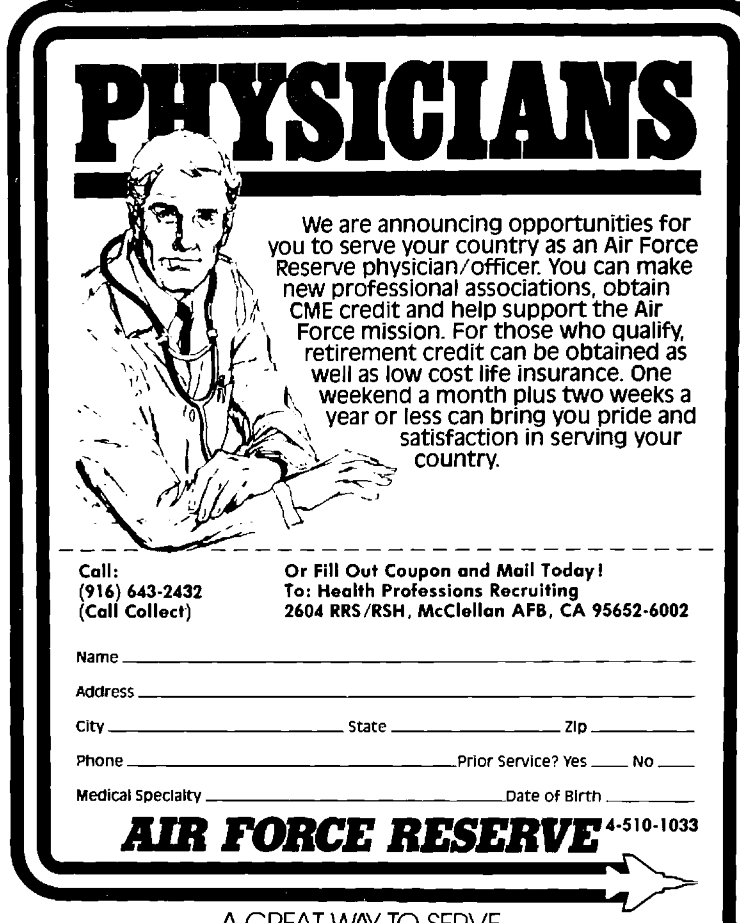

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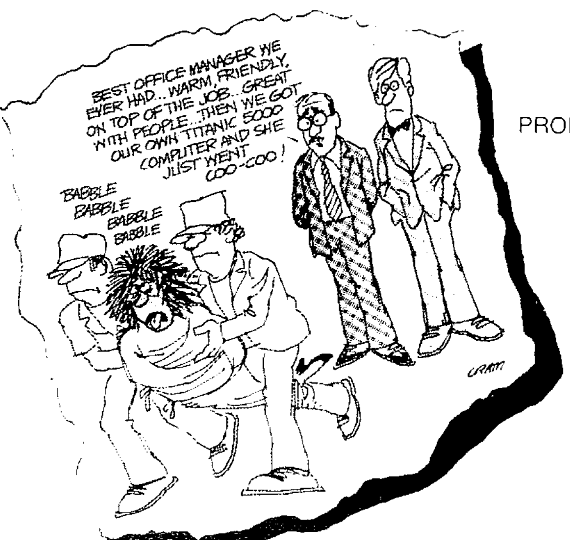

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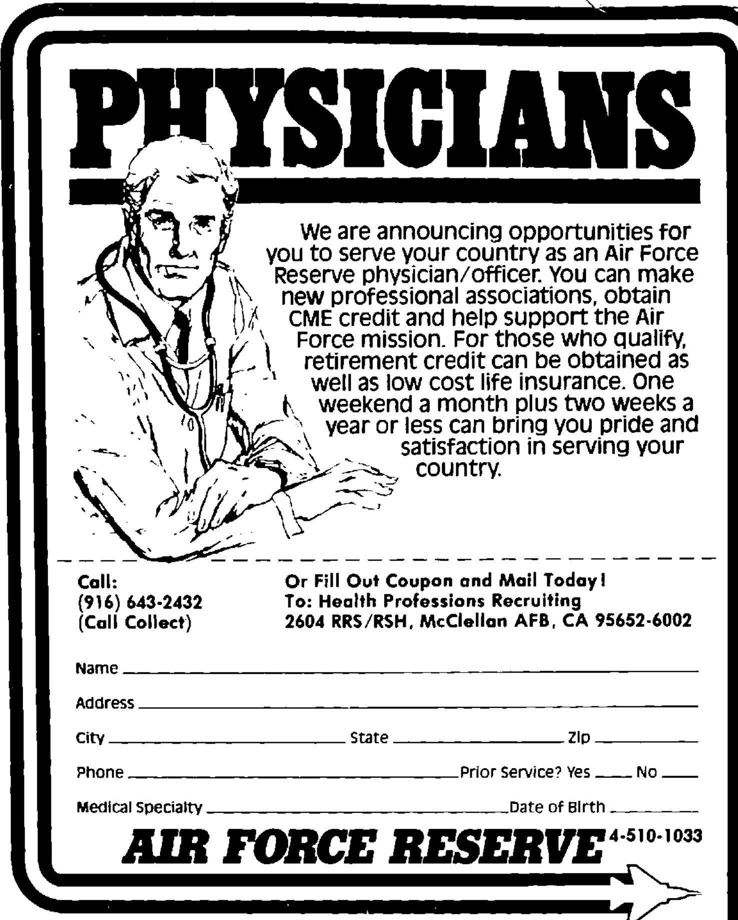

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Cover photo: Outgoing President Dr. James P. Duffy passing the gavel to 1985 MSPC President Dr. Guus W. Bischoff.

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Managing Editor: Douglas R. Jackman
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President's Page

Some thoughts on organized medicine

The "President's Page," what should it contain; "thoughts about organized medicine," "reports on what your Board is trying to do and is accomplishing which they perceive to be in your best interest" or "just a philosophical essay?"

I dislike writing essays, and so you will be spared glorious dissertations on all kinds of issues. For these I will rely on guest editorials.

Further, although I am opinionated, I have only a few opinions. One of these is the following:

Instead of being your fearless leader, I am starting this year full of trepidation. The reason for this is the attrition of membership through resignations, however small, and the failure of a number of applicants to join the Society, while still using it to gain membership on Medical staffs through the Society's credentialing mechanism.

As for myself, I am not a "joiner." I think I can understand their feelings, as they wonder, "what is in it for me?" However, at present, it appears to me that the main reason for joining has little to do with individual satisfaction, and more to do with the concern for the future of our medical care as a whole.

If we wish to maintain any resemblance of the type of care and delivery of medicine which we and our patients are accustomed to we'll have to convince our legislators that their approach surely is going to limit or deny any freedom of choice for their constituency regarding "health care."

Whatever one thinks of "organized medicine," it is because of its existence that legislation like the "Foreman-Kennedy" bill has not been passed. It is for this same reason that we have not yet joined the other health systems of the Western World.

How would you like a system which rations placement of physicians in society and geographical area, rations any type of non-emergent surgical care, has a total gatekeeper system for referral to specialists, delivers hospital care according to payment plans with first, second, and third class bed, and has mandatory retirement for physicians at age 65? (Some of this may not be all bad.)

Since I was recently exposed to the above and knowing the system as it had been previously, I can tell you it takes only a few short years to develop, if the consumer can be persuaded, by whatever group, that this is in their best interest.

One step further is national health insurance, and as the Director of Education of the Washington State Labor Council stated, the AFL-CIO is committed to passage of national health legislation.

In view of all this, I believe, that to steer away from what I hope is not the inevitable, one has to belong to a group, which because of its size has more clout in being a spokesman for us.

For the same reason, I believe that belonging to specialty societies alone is not enough, in view of self interest.

In conclusion, if you know a better way to react to stop the threats directed at you and your patients, other than through our county, state and national associations, please let me know and I will gladly offer you the space allotted me on the "President's Page."

—*G.W.C.B.*

LOCAL NEWSBRIEFS

WSMA Leadership Conference Focuses on Changing State of Medicine

AMA President Dr. Joseph Boyle headlined the WSMA Leadership Conference held at the Sea-Tac Marriott Hotel. Pierce County was well represented with a good turnout to hear an outstanding program.

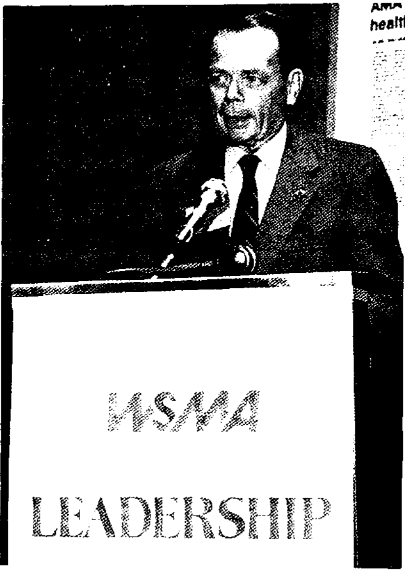
Calling the County Medical Societies the cornerstone of medicine and the state associations the integral part of the medical community, Dr. Boyle said, "Those who do not join AMA are asking your brothers and sisters to pay your share." "If you don't believe in your future," he told those present, "don't join the AMA."

Executive Administrator for Virginia Mason Clinic Austin Ross addressing the conference, told those present that "the industry was in the midst of rapid change." "We do not," he said, "really perceive the magnitude of the change."

Discussing the hospital/physician relationship, Ross emphasized that hospitals were in a strong bargaining position. "Physicians," he said, "will have to have agreements with the hospitals."

AMA Trustee Dr. John Dawson reviewed a June, 1984 AMA poll, which included, for the first time, a special Washington State segment telephone interview with 1,503 randomly selected U.S. adults and 400 Washington state residents.

The public's rating of cost as the main problem facing health care reached an all time high with the 1984 survey. Nationally 68% of the respondents rated cost as the number one problem. The complete survey will be carried in the February issue of *The Bulletin*.



AMA President, Dr. Joseph Boyle, speaking at the 1984 Leadership Conference.

Meet Your State Representatives, Jan. 24, Westwater Inn, Olympia

Mark your calendar for January 24. Spend an informative day in Olympia during the 1985 Legislative session. Meet the legislators from your home district between 10:00 A.M. and 7:00 P.M., January 24, at the Westwater Inn, Olympia. This is your opportunity to let the legislators know that the physician is interested in the legislative process.

Drs. Gil Roller, Chairman, MSPC Ethics/Standards of Practice Committee, and Lloyd Elmer, WSMA Board of Trustees, share notes on a presentation at the MSPC Leadership Conference.

Solo practice faces same fate as small farmer MSPC Meeting, Nov. 13

Over 120 physician members and hospital administrators attended the November 13 General Membership meeting to hear Dr. Turner Bledsoe, Medical Director, Group Health Cooperative of Puget Sound, speak.

Dr. Bledsoe's topic for the evening was "The Corporate Practice of Medicine." Dr. Bledsoe told the gathering of physicians that they were witnessing "a period of major upheaval" in medicine where the prospective payment system had dramatically changed the hospital scene, and physicians were experiencing a transition from a period of shortage to the present surplus.

Noting the evolution towards organizational practice in discussing the surplus and shortage issue, he spoke of the declining physician income; reduced insurance coverage and increased costs to insurer, insurance companies and employers; and the price-sensitive consumer, all of which are creating a trend toward organized practice.

The ultimate decision making process, he told the group, is the budget being the "dominating factor." Hospital management's number one priority, he emphasized, will be a balanced sheet, with management having a strong corporate loyalty and orientation to the corporation. In contrast, the medical staff's priorities are toward meeting the patient's needs, professional satisfaction and being the patient's advocate before being corporate loyalists.

Dr. Bledsoe urged physicians to learn management skills and understand the functioning of the organization. He recommended that physicians know how to analyze and manage a budget and spend time on administrative tasks. The "bottom line," he told the physicians, is the balance sheet with management staff becoming the dominant force and the quality of care being redefined.

In discussing characteristics of the for-profit organization, he pointed out that they usually have a national scope of operation and are less community oriented with a tendency to avoid indigent care. Growth pressure on the managers is intense and the competition is very aggressive.

Summing up his talk, Dr. Bledsoe told MSPC members that medicine was the "last industry" to feel the corporate transformation. It is his opinion that the solo practice faces the same fate as the small farmer.

Dr. Thomas Murphy elected to American College of Surgeons

MSPC member Dr. Thomas Murphy was elected to the Board of Governors of the American College of Surgeons during the Annual meeting of Fellows, October 25, 1984. His term will run until the conclusion of the 1987 Clinical Congress.

Beginning private practice in Tacoma in 1957, Dr. Murphy was among the first to practice cardiovascular surgery in Tacoma. He is considered one of the pioneers in this area of surgery. Dr. Murphy will serve as representative of the North Pacific Surgical Association. The Annual meeting of the Association was held in Seattle, November 9 and 10.

Dr. Murphy is a member of the Society of University Surgeons, American College of Angiology, American College of Chest Physicians and the Tacoma Surgical Club. He is on the faculty of the Department of Surgery, University of Washington Medical School.

AMA pamphlet for Medicare patients now available

Your MSPC office now has available in quantity for your Medicare patients the AMA pamphlet outlining, in layman terms, for Medicare participants the difference between the Federally enacted term, "participating and non-participating physician." The 3-fold pamphlet presents in a simple and straight forward manner the position of those physicians who have decided not to "participate." Call the MSPC office, 572-3667, for your pamphlet. (Bulk quantity available.)

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A *Memorial* for Dr. Charles P. Larson

October 4, 1984 marked the passing of Dr. Charles P. Larson. Tacoma and the medical profession lost a prominent, talented and productive figure in medical fields locally, as well as nationally.

My first recollection of Charlie was during our years of study at McBill University in Montreal. He showed an early interest in pathology and spent many extra hours in the pathology laboratories and in viewing post mortem examinations. He graduated in 1936 with the degrees of M.D.C.M..

I lost track of him after graduation until the war years, at which time both of us enlisted in the 50th General U.S. Hospital of Seattle. He was appointed Chief of Pathology and Laboratories. It was here that he demonstrated his organizational and medical abilities.

He ran a tight ship in his departments in the hospital; because of this, he could spend time as a member of commissions to study causes of death of prisoners of war and persons imprisoned in detention camps such as Dachau. He received honors and medals for this service. After the war, he served as Chief Pathologist at the Nuremberg war crime trials.

During the post war period, he became the father of Forensic Medicine and President of the American College of Forensic Pathologists. He showed interest in other fields as evidenced by being elected President of the National Boxing Association and later, President of the World Boxing Association.

He became director of Pathology and Laboratories at Tacoma General Hospital, a position he held until he retired. Furthermore, he developed a number of needed clinical laboratories in the Puget Sound area.

Although there are many people who have contributed dramatically to medical progress, there are very few who have accomplished as much as Charlie through his own hard work, personality and intelligence, without the help of grants and larger institutions.

He will be greatly missed by his friends and peers.

—*Edwin J. Fairbourne*

"Secrets of the Inner Ear" MSPC co-sponsors Conference on Hearing

A conference on hearing to discuss "function, assessment, problems and remediation" will be held Friday, January 25. Registration for the conference is $25.00 for S.N.O.W. members, $30.00 for non-members. Conference fee includes lunch, snacks, brochures, handouts and a bibliography.

The conference is sponsored by the School Nurse Organization of Washington in cooperation with the Medical Society of Pierce County, School Health Committee, Tacoma-Pierce County Health Department and the Crippled Children's Service. For information call Shirley Carstens 564-1561.

Guidelines Being Established for Reporting Child Abuse

Drs. Pat Duffy, Robert Lane, Guus Bischoff, Alan Tice and Terry Torgenrud met with representatives of the Washington State Medical Disciplinary Board, Children's and Adult Protective Services and Pierce County Prosecuting Attorney's office to discuss common problems, particularly reporting procedures dealing with child abuse.

As a result of the meeting, a Committee will be formed with representatives from each organization. Members of the Committee will provide input into the development of guidelines for reporting child abuse to establish better communication among the organizations concerned.

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Economic Outlook for Pierce County

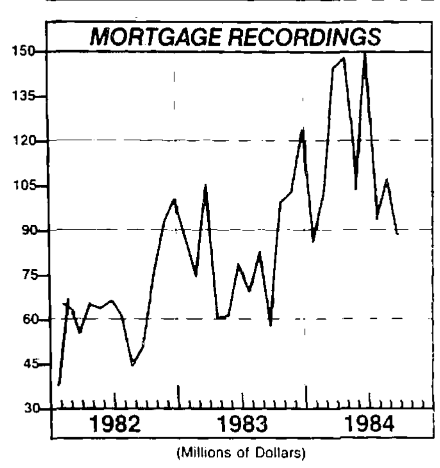
It has been apparent for some time now that a number of changes are taking place in Tacoma-Pierce County. While unemployment rates have run higher in Pierce County than in other places across the country during the last two years, the rate has dropped from a high of 14 percent in 1982 to a low of 9.5 percent in 1984. Retail sales are up while mortgage recordings are down.

According to the 1984 Survey of Business and Industry conducted by the Tacoma-Pierce County Economic Development Board, approximately 2,010 jobs are expected to be created during the next two years, with the majority of these jobs being in light manufacturing or the service economy. The impact on the medical community could be significant.

The December 3 issue of the *Seattle Business Journal* reported the "biggest 20 businesses in Pierce County" currently employ 16,300 people, or 9 to 10 percent of all Tacoma-Pierce County nonagricultural jobs. Of the top 20 private sector employers listed for Pierce County in the *Seattle Business Journal,* Multicare Medical Center was listed as the number one employer, employing 1,806 full time employees. St. Joseph Hospital was listed as fifth and Good Samaritan Hospital was listed as 12th.

The most "stable big employer" in Tacoma-Pierce County, according to the *Seattle Business Journal* is the health care industry, providing 22 percent of the jobs in the top 20 businesses listed.

Pierce County Economic indicators



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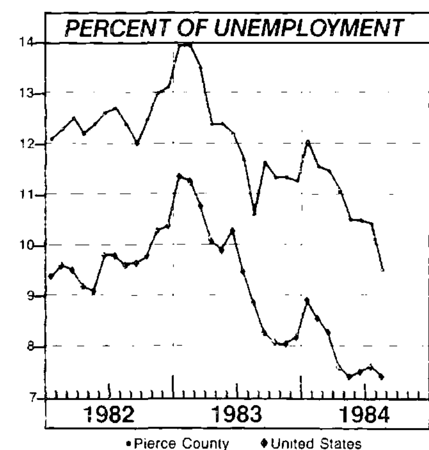

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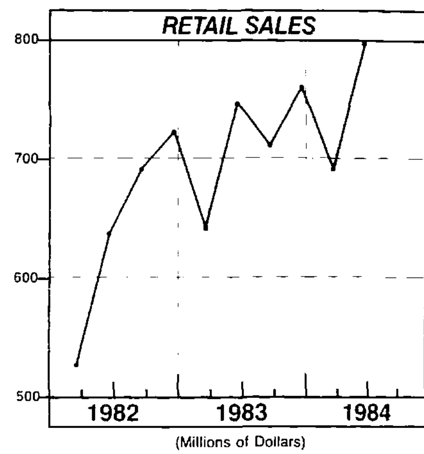

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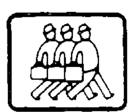

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A Step Back

In 1967 AMA dues went from $45 to $70. *The Bulletin* reported the increase in headlines saying, "Let's face it, AMA dues go up 25 bucks." Annual AMA dues went from $45.00 to $70.00 in January 1967, as the result of final action by the AMA House of Delegates at its meeting in Chicago in June, 1966. The vote was 168 to 46. The initial recommendation was made by the Board of Trustees in 1965 and approval had been voted by the House of Delegates at the 1965 meeting.

Open House for Medical Arts Hospital

Over 2,000 visitors turned out June 26, 1966, for an open house celebrating the opening of the Medical Arts Hospital, now Humana Hospital. *The Bulletin* reported the hospital as having 50 beds, air-conditioning with "completely modern equipment."

The opening of the hospital coincided with the beginning of Medicare, and in the first three weeks, according to *The Bulletin*, 50 percent of the patients were in the Medicare category.

The open house turn-out had been greater than what was expected. The visitors consumed some "40 gallons of coffee and over 4,000 cookies before the afternoon was over."

Dear Colleagues,

As I write this letter (in November, 1984) to my medical colleagues in Pierce County, I am reminded that November is National Diabetes Month, and I thought it particularly apropos at this time to inform you of the recent establishment of a branch of the Washington State Diabetes Association (affiliated with the American Diabetes Association ADA) serving Pierce County. This organization called the Greater Tacoma Branch of the American Diabetes Association (GTB-ADA) has been established to carry out the goals of the ADA in our community. This organization needs to be distinguished from the Pierce County Diabetes Association, a similar independent organization not affiliated with the ADA.

This organization is dedicated to seek out the needs of the diabetic patient, (as well as his or her family) and indirectly the needs of their health care providers (as they hope to provide comprehensive care to their patients) and fill those needs. Some of the currently recognized needs include the need for ongoing patient and physician education in diabetes related issues, the need for patients to associate with others with similar concerns, and the need to promote diabetes related issues in the community.

As part of this organizations educational effort, diabetic education discussions are held most first Tuesdays at 7:00 p.m. at Mary Bridge Hospital. Topics previously discussed recently were the "insulin pump" and "self monitoring of blood glucose." The next meeting is to be held on the 5th of February, 1985 (topic to be announced).

In March, the GTB-ADA plans a four part, weekly seminar entitled How To Deal With the Complications of Diabetes. Specific topics will be "Diabetes and the Heart," "Diabetes and the Eye," "Diabetes and the Kidneys," and "Diabetes and the Feet." These topics will be discussed by specialists in their respective subject.

We respectfully submit that the Greater Tacoma Branch of the American Diabetes Association can be of service to you and your diabetic patients. We hope that you and/or your patients will choose to find out more about our organization. Please call or have your patients call, Neil or Sandy Sappingfield at 206-531-8548, to find out more about our organization.

Sincerely,

Gary L. Treece MD, FACP, LTC, MC
Medical Advisor
Greater Tacoma Branch of the American Diabetes Association

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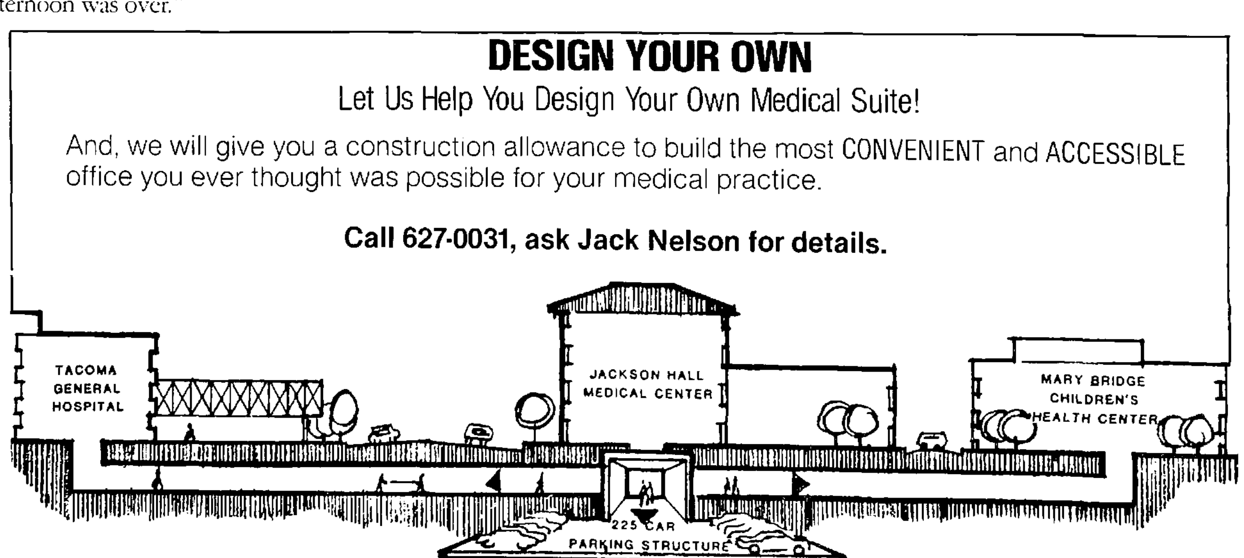

MSPC Membership Comments

The December issue of *The Bulletin* published the results of the 1984 Membership Opinion Survey. Continuing here are comments by MSPC members with regard to General Membership Meetings and in response to the 1984 Membership Opinion Survey questions: What issues do you feel the Society should be involved in. What issues do you feel the Society should spend less time with.

—*the editor*

Comments relevant to General Membership Meetings

Little in common with membership in general

Limited time. I focus on anti-smoking issues, which require lots of night meetings—I also have a family

Seems irrelevant to what I do day by day

I have so many PCMB/hospital meetings

Need to run on time and finish earlier in the evening

Too many kids

Too far to go

Scheduling difficulties

Skip most all evening meetings

No interest

No time

I cannot meet on Tuesday

Conflict with evening office hours

Day off–that's my family time

Illness in family

Day off

Didn't feel I could take the time

Meetings should be quarterly, short and well organized–we all spend too much time away from our families without wasting more

Inconvenient

Scheduled in ER at those times

Most meetings are boring

Family needs me at night more than MSPC

Individual conflicts re time

Semi-retired

Unable to attend meetings on Tuesday evenings

Not informed long enough in advance to plan

Inconvenience of night meetings

Too much emphasis on politics and competition

Schedule conflict–on call

I was very disappointed with two speakers whose titles sounded promising

Conflicts with other meetings

Variable, usually inconvenient locations

Sense of futility

Need 6-8 weeks notice to be off

Would attend more–but they conflict with other meetings

MSPC Membership Views: Issues the Society should be involved with.

Your views would be appreciated on issues you feel the Society should be involved.

Public information on DRG's; protesting poor decisions by PSRO groups

Improve image of physicians, policy poor

Basically attempting to prevent the government from dictating the practice of medicine without accepting responsibility for what it is doing

Nuclear arsenal

Against importing medical doctors from poor countries

Community health issues

Public stands on pollution, public health matters and smoking

United front opposing entrepreneural inroads by business people into medical care

Consider an advertising campaign

Should take a stand against nuclear war

Fee reduction re specialists

The Society should establish a fund to review and countersue in those cases where an unjustified malpractice suit has been brought against society members or unfounded charges are filed by the state, hospital or other agency. The Society has traditionally abandoned physicians falsely accused. Please note I have no quarrel with justified claims; however, it is difficult to support a Society that offers no help to its members.

Present involvement well balanced

Medical ethics, oversupply of medical doctors; reduce competitiveness and physician–physician antagonism

Should take more active role in policing "marginal" physicians

Costs of medical care

Nuclear risks

Overpopulation

Nuclear war threat, environment; health care for poor

CME

Quality care of patients

Third party reimbursement

Same as now

Public image–inform public of all the free work given, etc.

Stop abortion in Pierce County

Professional competence

Public responses/membership discussion on currentissues, i.e. free standing emergency centers, ER advertisements, fees

Economic and third party issues

Every practicing physician should be required to be a dues paying member

Health care to the poor, specifically surgical consult referral

Anti-abortion education–pro-life

Well covered

The Society wouldn't exist if it weren't for the requirement to be able to obtain malpractice insurance–basically a total waste of money

Malpractice

Consolidation of community resources, i.e., trauma, Ob, Peds., etc.

Much more aggressive standards/ethics with doctors monitoring

Increase communication among the members

Help impaired physicians

Medical trends

Organization of PPO's and HMO's

Doctor surplus

We should expose and criticize self-referral (x-ray exams, catheterizations, etc.)

We should alert public to chance of delayed Dx by seeking chiropractic treatment

More on health care delivery in U.S.

Motor vehicle safety education

Trauma center

Cost containment

Ethics

Continuing education and membership service are most important

Public health, health care delivery trends

Physician's fees

Get group dental coverage for Society members

Review of patient care delivered in nursing homes

Ethics of advertising/professional image in advertising

Representation of M.D.'s with other health areas

Vigorous campaign about chiropractic quackery especially directed at ancillary personnel

Can we reverse the "competitive era" trend?

PR for physician image–credentialing

Keeping patients from being lost to Group Health, other PPO's

Prevention of illness and injury

MSPC Membership Views: Issues the Society should spend less time with.

M.D. image enhancement

What you do is OK

Financial and management topics

The private practice of medicine

Office supplies

The "competitive era"

CME

Things that directly aid individual practices so doctors would not have to spend much money to hire office help, locate new offices, get supplies, etc.

Marketing and being a business–not a profession

Finding office help and patients for new physicians

Social functions

Individual marketing

Tel-Med–worthless, waste of money

Scientific

Paging service

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(Programming is subject to change—Individual notices will be sent preceding each program.)

Phone: 627-7137

(P) = Physician **(A)** = Allied Health

Location	Date	Program	Coordinator	
	JANUARY			
JH	4, 11, 18, 25	Update in Surgery	TGH	(P)
JH	23, 30, Feb. 6	Effective Meetings		(A)
JH	17	Ear/Nose/Throat in General Practice	Wulfestieg/ Rone	(P)
STJ	17	Marketing to Win	Vipperman	(A)
STJ	24	Law & Medicine	Malden	(P)
JH	17, 24	Money Management (Evenings)	Jackman	(P)
	FEBRUARY			
STJ	7	Telephone Assessment	Simms	(A)
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Pomeroy/ Bargren	(P)
HHT	13	Nursing Assessment—Geriatric Patient	Barton	(A)
	TBA	Hospital Budgeting		(A)
STH	15	Diabetes	Stonecipher	(P)
STJ	25, 26	Advanced Pediatric Life Support	Seward	(P/A)
	MARCH			
STJ	6	Right Brain/Left Brain		(A)
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
HHT	21	Prac. Solutions—20 Most Common Geriatric Prob.	Waltman	(A)
	21	Current Trends in Nutritional Therapy	Pelham	(P/A)
	TBA	Medical/Surgical Potpourri		(A)
	APRIL			
STJ	4, 5	Survival Skills for Nurses	Chilton	(A)
UPS	12, 13	Surgical Club	Martin	(P)
STJ	26	Death & Dying	Schmidt	(P/A)
	TBA	Symptom Mgmt. of Cancer Patients for Nurses	Boulet	(A)
	TBA	Adolescent Patient: Suicide, Pregnancy, Drugs	Ingraham	(A)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	9, 10	Cardiovascular Disease Review	Strait	(P)
	JUNE			
JH	27, 28	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Contracting: Professional Liability Exposure

By David E. Willett, Esq.
CMA Legal Counsel

All parties involved in contractual arrangements between insurers and physicians should understand that these arrangements for health care present new risks of liability. In this article we will discuss the liability of those who provide care, and the exposure of those providing peer review. We believe that everyone involved in contracting should be aware that the risk of suit increases in this new environment.

What Characterizes Contracting?

PPO or EPO arrangements significantly differ from traditional insurance coverage. One feature is agreement between the physician or other provider and the insurer, as to amount to be paid for specific services. From the professional liability standpoint, other features of these arrangements are even more significant. Benefit contracts commonly penalize patients who are treated by noncontracting providers. Many procedures cannot be performed on an inpatient basis, except with prior authorization. Both physicians and hospitals are required to comply with peer review decisions, made either by the carrier or by a peer review organization contracting with the carrier. These "peer review" or cost containment decisions may affect discharge, availability of diagnostic procedures, or various other conditions which influence the outcome.

Standard of Care:

Despite the impact of these conditions, or restrictions upon the physician's ability to treat a patient in his usual manner, there is no provision for a different or lower standard of care, in terms of obligation to the patient. Applicable standards of medical practice are the same, regardless of the insuring arrangement.

A carrier's refusal to authorize or pay for care which ought to be rendered, in good medical practice, does not of itself excuse the physician who fails to render or offer such care. Physicians must not assume that responsibility for the exercise of good medical judgment has passed to the carrier. That responsibility remains with the physician. The carrier may have an independent and equal responsibility, but a carrier's mistake will not excuse a physician who accepts the carrier's judgment.

Avoiding Liability:

We are certain that circumstances will arise where carriers will not authorize, or will otherwise obstruct, the provision of needed care. When this occurs, it is imperative that physicians *document* the circumstances. Equally important, physicians must explain the problem to the patient, describe the care which the physician believes is needed, and, insofar as possible, assist the patient either in resolving the dispute with the carrier or in finding an alternative source of care. Such situations may be resolved by the patient's agreement to pay for needed care or hospitalization directly. When contracting with insurers, physicians should pay careful attention to contractual provisions which may affect the physician's ability to make such separate arrangements.

Physicians who blindly accept erroneous carrier restrictions or decisions may be liable for the consequences. The carrier may also be sued, but this is small comfort to the physician, even if greater liability is ultimately assessed against the carrier.

Carrier Liability and Cross-Complaints:

Even physicians who acquaint their patients with the problem, exhausting all available "administrative remedies" without avail on the patient's behalf, may be sued. Some patients will believe that the physician did not do enough to provide the needed care. Even if the patient does not sue the physician, the carrier itself may try to lay blame off on the treating physician. We doubt that persons interested in PPO arrangements fully understand what a field day lawyers may have in a couple of years, if these arrangements are commonplace. Administrative mistakes or deficiencies which deny or limit care, affecting the outcome, place carriers and those involved in plan administration at great risk. These entities may be liable to the patient on theories of negligence, misrepresentation, breach of contract, and "bad faith." Punitive damages will be claimed. These cases will be so threatening to carriers that they will make every effort to contend that it was the physician's fault that authorization or some other relief was not made available. It will be contended that the physician inadequately described the problem, didn't call the right telephone number, or whatever. Thus, the threat to the physician is not only threat of suit by a patient, but the threat of a cross-action by the third party payor or peer review organization.

The Wickline Case:

A recent suit illustrates both carrier liability and the threat of cross-complaints. Many physicians have read the *Medical Economics* article of May 16, 1983, describing the *Wickline* case. Mrs. Wickline was a Medi-Cal patient who encountered complications after a bilateral aorta-femoral bypass graft. The Medi-Cal program authorized only four days' extension of hospitalization, when her physician believed that she should remain in the hospital for at least eight more days. Subsequent to discharge, the patient was readmitted and her leg amputated, apparently because a thrombus recurred in the right femoral artery. Mrs. Wickline sued the state, and the jury awarded her $500,000. This illustrates a carrier's potential liability.

Informally, we have heard that department of health services personnel have been critical that no cross-complaint was filed by the state against Mrs. Wickline's physicians, on the theory that they should have made greater efforts to obtain further authorization for extension of stay. I do not know whether this is true. At the trial, the state did try to blame Mrs. Wickline's doctors. I am sure that every carrier faced with such a suit will take a careful look at the physicians to see whether blame can be passed off, or at

least shared.

One of the assumptions being made by those who favor contracting is that less care will be rendered if no payment is available, and this will reduce the cost of care. Whatever benefits this prospect might have, it is probably inevitable that some necessary care will not be rendered. We do not think that courts will require patients to bear the burden, even though patients willingly choose this form of coverage. Courts will lean over backwards to protect patients. For instance, a very recent decision (*Ponder v. Blue Cross*) holds that the contractual exclusion of coverage for "temporomandibular joint syndrome" is unenforceable, because this term is not "comprehensible to lay persons." Even though the purpose of these arrangements is to limit and restrict care, any adverse consequences will be the concern of carriers or providers, rather than a risk accepted by patients.

Physicians will have to be particularly attentive to this risk. They will have to make special efforts to force carriers to authorize that care which should be provided under the contract. They will have to document these efforts for their own protection.

Who Pays the Bill?

Even where there is no personal injury, physicians may be sued by patients who suffer economic loss because of the physician's alleged failure to work within the PPO arrangement. Physicians who refer to non-contracting physicians, or who admit to non-contracting hospitals, will have to be extremely careful that the patient understands and approves of the consequences. Generally, the consequence will be additional unreimbursed expense to the patient. Where such referrals are necessitated by the carrier's failure to arrange for adequate resources, that will have to be documented, and it probably will be necessary to assist the patient in forcing the carrier to accept responsibility. A specific problem is likely to arise. Insurers designing PPO arrangements fail to recognize that physicians providing coverage for contracting physicians may not have contracts. The covering physician bills the patient but is paid even less than the contracting physician would receive. Unless the covering physician is willing to accept this payment, the patient who believes that there is no "balance bill" under PPO arrangements will get a balance bill. These patients may blame their own physicians for arranging coverage by non-contracting physicians and contend that this is a breach of their contractual responsibility. Fee disputes foment professional liability litigation.

Peer Review Liability:

So far, this discussion has dwellet upon the liability of treating physicians. It is also appropriate to discuss the liability of physicians who engage in peer review, to implement these cost containment programs. In past years, we have said that there is significant legal protection for physicians engaged in peer review activities. The activities we had in mind primarily involved service on medical staff or medical society committees. In most instances, this was retrospective review.

With the advent of contracting, the situation changes. Physicians are being asked to provide peer review to private parties, making decisions about ongoing care. In these different circumstances, physicians should understand that usual statutory protections may not be available. In addition, the stakes are higher. A physician making peer review decisions may actually affect the outcome.

Civil Code Section 43.7* provides conditional immunity to ". . . any member of a duly appointed committee of a state or local professional society, . . . a professional staff of a licensed hospital, . . . *any peer review committee whose purpose is to review the quality of medical . . . services*, . . . or any member of the governing board of a hospital in reviewing the

continued on page 19.

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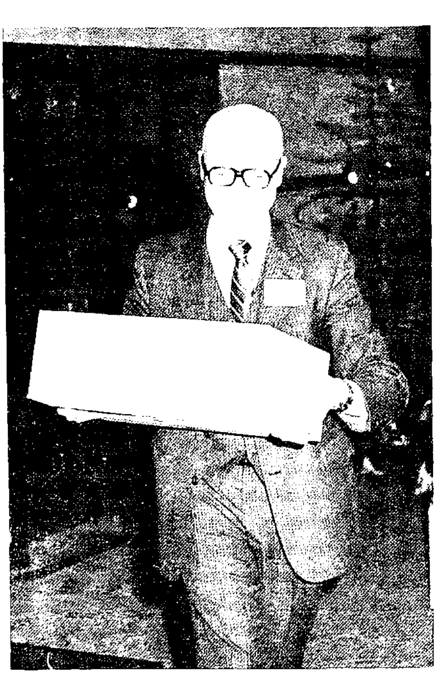
MSPC Holds Annual Joint Dinner Meeting

The Annual Joint Dinner Meeting with the MSPC Auxiliary, held at the new Sheraton Tacoma Hotel, December 11, attracted nearly 250 members and spouses.

Highlighting the evening was the installation of the 1985 Officers and Trustees, headed by Dr. Guus Bischoff, President; Drs. Richard Hawkins, President-elect; G. Bruce Smith, Vice President; Robert Osborne, Jr., Secretary-Treasurer. Trustees installed for 1985 were Drs. Marcel Malden, Barry Weled, David Clark and Charles Weatherby.



Dr. Robert Ferguson wins case of assorted wines donated by MSPC Board of Trustees to benefit the Student Recognition Fund.

MSPC member Dr. Thomas K. Jones buying raffle tickets from Auxiliary member Sandy Griffith.

MSPC Auxiliary members and Society members enjoy a relaxed moment before dinner.

Dr. George Tanbara receives "Apron Award" for 1985 from MSPC Auxiliary for his many contributions to the community and medicine.

A round of applause was given to outgoing officers, Vice President Dr. Richard Hawkins, Secretary–Treasurer Dr. Henry Retailliau and Trustees, Drs. Richard Bowe, Richard Gilbert, Gregory Popich and Alan Tice for the time and effort they had contributed to the affairs of the Society during 1984.

MSPC Auxiliary President Sharon Lawson presented the 1985 "Order of the Apron" award, an award symbolizing the highest tradition in community service, contributing to the community and medicine. It was no surprise when recipient Dr. George Tanbara received the award. All those present knew he was eminently qualified for the award. In presenting the award, Sharon Lawson outlined the many contributions Dr. Tanbara has made to the citizens of Pierce County.

Dr. Robert Ferguson was winner of the case of assorted wines and MSPC Executive Director Doug Jackman won a set of attractive hand woven place mats.

Entertainment for the evening was the Sumner High School Jazz Band under the direction of Mr. Steve Montague, who's music delighted the entire group.

In his parting remarks, outgoing President Dr. Duffy thanked the Board Members, Officers and Trustees for their help. He said the year had been a learning experience and a "great year."

President Dr. Guus Bischoff, in his inaugural comments, urged all physicians to become involved for their patient's welfare and their own future.

MSPC President Dr. James P. Duffy presenting award to Dr. Henry Retailliau. Standing in background (right) is Dr. Richard Hawkins.

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Sharon Lawson . . . . . *Trustee*

MSPC Auxiliary members sell raffle tickets at Annual Joint Dinner Meeting for Student Recognition Fund.

MSPC members (left to right) Drs. Robert Ferguson, Robert P. Craybill, Herb Kennedy enjoying the evening.

Home Health Care

The nation's health care bill last year was $360 billion. Cost for home care averages about $50.00 a day compared to an average of $300 for one day's stay in a hospital. Given the comparative costs, there is a growing trend toward home health care that is gathering momentum.

The fastest growing segment is the "high-technology, home therapy"-at home kidney dialysis, cancer chemotheraphy, parenteral nutrition and antibiotic therapy. The following article provides some insights into the advantages and services of home health care agencies here in Pierce County.

—the editor

What Is Home Care?

Home care is any or all of a full range of health care and social services offered to patients in their homes. From home birthing to hospice care, home care is for the ill, infirm or disabled who elect to be treated at home rather than in a nursing home or hospital.

What Is the Profile of the Home Care Patient?

Home care services are available to those patients who are confined to home under the supervision of a physician. The patient may need either temporary or long term care.

What Services Are Offered Through Home Care Agencies?

There are basically two types of services offered: health services and home chore services.

Home Health Services: Home health services are comprehensive, involving nursing, physical therapy, occupational therapy, speech therapy, dietary guidance, and medical social services. Normally, a home health nurse will design a plan of treatment with a physician based on the patient's needs and lifestyles. She will help assemble a team of the above professionals based on each case.

Homemaker-Homechore Services: These services provide the kind of personal care and assistance often required in addition to nursing and therapy. Activities can include bathing and personal grooming needs, helping practice self-help skills and general housekeeping services as required to keep the patient's environment safe. An aide will work with the home care nurse and implement her design for care.

How Many Home Care Agencies Are There In The Country?

It is estimated there are about 5,000 home health agencies and 5,000 homemaker/homechore agencies in the United States. The number of agencies has grown rapidly over the past several years as a result of government legislation, initially introduced by Utah Senator Frank Moss, that allows Medicare and Medicaid coverage for home health services.

How Are Home Care Services Paid For?

In many cases, most home care services are paid by Medicare, Medicaid, the Veterans Administration or other third party payers, such as commercial insurers. A home care agency can be more specific about coverage for each individual case. The agency most often handles billing and paperwork, sparing the patient the burden.

How Many People Are Served by Home Care Each Year?

It is estimated an average of four million people are served by home care each year.

How Do Home Care Costs Compare to Costs for Comparable Care in Nursing Homes and Hospitals?

Home care costs about one quarter as much as comparable care in a nursing home. An example is illustrative: a retired man received services over a three year period. He received counseling once a month, three housekeeping services a month, occasional nursing services, and two home delivered meals every day, seven days a week. The total home care costs were $10,000. Placement in a nursing home for the same care would have cost $40,000 for the same period.

Is Home Care the Right Choice For Everyone?

No, not everyone can be effectively treated at home. Some people need the kind of constant attention that can only be provided in an institution. However, home care is the overwhelming choice for people who are not in need of acute care, and it can often prevent or postpone institutionalization of the patient.

In addition, the US General Accounting Office has reported that up to 25% of the 1.2 million elderly now in nursing homes are receiving care excessive to their needs. They could live better and for much less at home with home care services.

For skilled and compassionate nursing care or therapy in the comfort of your home, turn to a certified home health agency. In Pierce County, the agencies are: Good Samaritan Home Health & Hospice, 848-6661; Hillhaven Home Health Services of Washington, 383-3901; Hospice of Tacoma/Associated Home Health Services; 383-1788; Tacoma-Pierce County Health Department,Home Health Services,591-6485 ■

Contracting: Professional Liability Exposure, continued from page 15.

quality of medical services." A "professional society" is defined as a medical organization having as members at least a majority of the eligible licentiates in the geographic areas of the particular society. As of January 1, 1984, CMA-sponsored legislation will cause medical specialty societies to be included within this definition. A further provision of Section 43.7 extends immunity to underwriting committees of professional liability insurers.

To obtain immunity under Section 43.7, the committee member must act without malice, make a reasonable effort to obtain the facts of the matter as to which he or she acts, and act in reasonable belief that the action taken is warranted by the facts known, after such reasonable effort to obtain facts.

In our opinion, Section 43.7 is broad enough to provide conditional immunity to those engaged in peer review activities which are incidental to contractual arrangements. However, the value of this protection may depend upon the facts. The physician will have to demonstrate that his or her actions were taken as a member of a peer review committee (rather than as a company consultant), and that he or she did all of the things Section 43.7 requires as a condition for immunity. If the court concludes that the physician did not make a reasonable effort to obtain the facts, Section 43.7 will be of no avail. If the court concludes that the action taken was not "reasonable," there will be no immunity. A decision which is inconsistent with good medical practice, measured against known facts, may not be regarded as "reasonable."

Challenges to peer review decisions may come from two sources. Patients hurt by such decisions may sue, claiming professional negligence. While the physician may contend that he has not assumed a relationship to the patient which would properly support liability, there is sufficient contrary authority that this is a serious threat. In addition, peer review decisions may affect the economic interests of other physicians or practitioners. They also may sue.

Confidentiality:

Physicians should understand that statutory protection against the discovery of peer review records may not be applicable to peer review conducted by certain entities. Evidence Code Section 1157 provides protection against the discovery of medical society or medical staff records. This section would not be applicable to other entities. Evidence Code Section 1157.5 extends the prohibition against discovery to ". . . the proceedings or records of an organized committee of any non-profit medical care foundation or professional standards review organization which is organized in a manner which makes available professional competence to review health care services with respect to medical necessity, quality of care, or economic justification of charges or level of care." Evidence Code Section 1157.5 is not applicable to actions involving a claim of a provider of health care services for payment of such services. The law does not define "non-profit medical care foundation or professional standards review organization." It remains to be seen whether the term "professional standards review organization" will be extended to include organizations which are not PSROs recognized under federal law.

It should also be remembered that neither Civil Code Section 43.7 nor Evidence Code Section 1157.5 are binding in federal courts, or in actions undertaken by federal agencies. This is particularly significant if antitrust claims are involved.

Insurance:

Physicians agreeing to make decisions affecting other physicians should have these concerns in mind. Appropriate and adequate insurance can provide some protection. However, physicians should not assume that their professional liability policies already provide needed protection. The definition of "professional activities" insured under the policy is important. Specific exclusions may also deny any coverage. Some policies exclude or qualify coverage for peer review activities. Others may exclude any coverage for antitrust claims.

Antitrust Liability:

A final ground of additional exposure by reason of participation in PPO efforts is antitrust exposure. Liability on antitrust grounds will depend entirely upon the structure of the plan, and the physician's role in implementing or overseeing its operation. Cases of this sort are just beginning to emerge, but accusations of price-fixing, boycott, attempts to monopolize, or other antitrust violations should be anticipated.

Conclusion:

It is important that the business community and insurers who are interested in contracting arrangements recognize that such arrangements, by their very nature and purpose, carry with them additional exposure to suit. It is even more important that physicians recognize this risk. In many cases, patients will not discriminate among various potential defendants. Even defendants themselves may bring others into such litigation. Those entering into these new arrangements should be aware of these risks. ■

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*Section 43.7 refers to California Civil Code.

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Hospital News

Multicare

Dr. McCravey Oversees Pediatric Intensive Care

Dr. Martha McCravey, who has served as a fellow in critical care of pediatric medicine at LeBonheur Children's Medical Center in Memphis, Tennessee, has accepted the position of Director of the Mary Bridge Pediatric Intensive Care Unit. She will assume the post in January.

Dr. McCravey is a graduate of the University of Tennessee College of Medicine. She finished her pediatric residency at the University of Michigan.

As Director of the Mary Bridge Pediatric Intensive Care Unit, Dr. McCravey will coordinate and integrate such areas as: 24-hour physician coverage of the PICU, cover group management, inservice education for nurses and physicians PICU nursing staff development, regional program development, transport program development and patient management and quality assurance. In conjunction with Dr. Paul Seward, the Director of Emergency Services, she will develop and promote Advanced Life Support Programs for physicians, nurses and paramedics in our community.

Under the leadership of Dr. Ted Walkley, the Mary Bridge Pediatric Intensive Care Unit has developed into a regional program which includes a transport team and cover group that provides 24-hour service to children in Southwest Washington who are critically ill or injured. Since inception of the Transport Team in February, more than 70 patients have been transported.

St. Joseph

Blood Pressure Clinic

St. Joseph's blood pressure research clinic, under the direction of Dr. Robert L. Reeves, is now in room 2D. The clinic helps those who need to control their blood pressure. Blood pressure checks are given Tuesday from 8:00 A.M. to noon and 1:00 P.M. to 3:00 P.M. Anyone interested in participating in the blood pressure research clinic may contact Dr. Reeves' office, 1-357-6689 or 1-357-6820, Monday, Wednesday, Thursday and Friday or St. Joseph Hospital, 627-4101, Ext. 5154, on Tuesday from 8:00 A.M. to 3:00 P.M. The blood pressure screening and monitoring is available to the community at no charge.

St. Joseph Receives Grant for Heart Research

St. Joseph Medical Director of the Coronary and Cardiac Surgery Care Unit, Dr. David G. Clark, recently accepted a $10,000 check from the South Tacoma Eagles.

The grant enables St. Joseph to fund a research project within the Coronary and Cardiac Surgery Care Unit. Anticipating two years to complete, the research project will evaluate the effectiveness of Exercise Echo Cardiography in patients with suspected coronary artery disease.

Principal investigator and research administrator for the project will be Dr. Clark. The $10,000 grant is part of $658,520 contributed nationally by the Fraternal Order of Eagles to the Max Baer Heart Fund, named in memory of former heavyweight champion, Max Baer.

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PROGRAM COORDINATORS:
Marcel Malden, M.D.
and
Vernon W. Harkins, J.D.

PROGRAM

8:15 **INTRODUCTION & WELCOME** .... *Marcel Malden, M.D.*

8:30 **INFORMED CONSENT: What is it? How to Obtain? How to Document?** .... *Don C. Pearson, M.D., J.D., Opthalmologist, Tacoma*

9:15 **VIGNETTES OF RECENT MALPRACTICE CASES** .... *Jack G. Rosenow, J.D., Attorney, Tacoma*

10:00 Coffee

10:15 **WHAT TO LOOK OUT FOR IN CONTRACTS WITH COMMERCIAL HEALTHCARE PROVIDERS** .... *John H. Lindberg, M.D., FACP, Internist, Seattle*

11:00 **WHEN & HOW CAN LIFE SUPPORT BE WITHDRAWN** .... *Honorable Robert H. Peterson, Pierce County Superior Court Justice*

12:00 Luncheon — **"The Rule of Justice or the Rule of Law?"** .... *Honorable Vernon R. Pearson, Supreme Court Justice, State of Washington*

1:45 **FAMILY LAW & THE PHYSICIAN** .... *Terrence F. McCarthy, J.D., Attorney, Tacoma*

2:30 **"EMBARRASSING" QUESTIONS IN THE COURTROOM & HOW TO DEAL WITH THEM** .... *Ross F. Burgess, J.D., Attorney, Tacoma & Marcel Malden, M.D., Neurologist, Tacoma*

3:15 to 4:00 Question/Answer .... *Moderator: Marcel Malden, M.D.*
Panel: Jack G. Rosenow, J.D., Ross F. Burgess, J.D.
Terrence F. McCarthy, J.D.

AUXILIARY NEWS

MSPC Auxiliary has panel discussion on "Substance Abuse in the Medical Family"

MSPC Auxiliary members listened to a panel discussion on substance abuse during their November luncheon and meeting. Panel members were adult psychiatrist Dr. Charles Leroy Anderson; Sandy Camp, RN, BSN, a volunteer teacher in the Substance Abuse Program at Oakbrook School; Dr. Roy Clark, Jr. who is a member of the WSMA Committee on "Personal Problems of Physicians"; and "Jo Ann," spouse of a recovered physician. Sharon Lukens moderated the panel discussion held after a delicious luncheon and business meeting.

During the business meeting, co-chairperson for the March fund raiser Mary Lou Jones reported her committee was busy contacting people for articles to be raffled off. The committee is working on getting one large item. Anyone wanting to donate an item or items for the March fund raiser is encouraged to contact Mary Lou Jones or Bernice Lazar. Profits will go to the Women's Support Shelter, Washington Women's Employment and Education and The Family: Birth to Three Support Program.

WSMA Organ Donor Chairperson Alice Hilger told MSPC Auxiliary members plans were in progress for duplication of organ donor posters that will be distributed throughout the state. MSPC Auxiliary voted to donate up to $500 for the project from the philanthropic fund.

Auxiliary members listened during the panel discussion to Dr. Anderson emphasize the need for parents to be concerned with their children's moral values from birth on. "We as parents and concerned adults," he said, "have to realize that children are not small adults. They are specifically different from adults –emotionally, physically and in concepts of morality. Changes occur as maturation proceeds."

Panel member Sandy Camp, also a physician's wife and mother, told the group about the program at Oakbrook pointing out that if children get three consecutive years of substance abuse education, there is a better chance to teach them how to avoid substance abuse.

The group listened as "Jo Ann" talked about her own experience with a substance using and over-using husband, saying she didn't realize what was going on until her husband hit his lowest point. They were able, she told Auxiliary members present, to get help through AA and Al-Anon. She said both she and her husband feel the Impaired Physician Program is very beneficial.

During the panel discussion Dr. Clark presented the AMA definition of an impaired physician. "It is," he told the group, "one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process, loss of motor skills or excessive use or abuse of drugs, including alcohol."

Dr. Clark outlined the way the WSMA Committee on Personal Problems of Physicians functioned, pointing out the "confidentiality of a contact is always adhered to." (The Hotline number is 1-800-552-7236, Seattle.)

Panel members emphasized a number of times the importance of parenting skills and the fact that parents and concerned adults have a responsibility to guide their children from birth on. It is, therefore, with pride that the Pierce County Medical Auxiliary has decided to invest both their financial and volunteer support to the Birth to Three Program in Pierce County.

Auxiliary News continued on pages 23 and 24.

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AMA-ERF Fund Raising: Pierce County still No. 1

AMA-ERF is alive and well in Pierce County. (Fund raising for research and medical school student assistance).

Gift wrap sales netted over $400.00. Greeting card sales in the area hospitals should show an equal profit.

A special thank you to all who volunteered to sell cards at Tacoma General, St. Joseph, Lakewood General, Good Samaritan: Rubye Ward, Alice Wilhyde, Mary Lou Jones, Martha Coombs, Bernice Lazar, Dorothy Grenley, Sandy Griffith, Bev Graham, Alberta Burrows, Margaret Grandquist, Shirley Kemman, Marilyn Bodily, Bev Law, Janet Fry, Karen Bloustine, Kris White, Mimi Jergens, Ann Fulcher, Sharon Ann Lawson, Dottie Truckey. Preparation, publicity and set-up was done by Tina Sobba. Thank you all.

The Holiday Sharing Card produced an astounding $13,200 for 1984. The Auxiliary would like to thank all the donors for their generosity and their foresight in helping to insure quality medicine for tomorrow.

—*Nikki and Jim Crowley, AMA-ERF Chairmen*

Gifts brought to the Annual Joint Medical Society-Auxiliary Dinner Meeting. Gifts were given to the women at the Pierce County Support Shelter. Gloria Virak puts her gifts under the tree.

Three-year-old Amy Morford, granddaughter of Dr. James and Mrs. Rubye Ward, sits comfortably on Santa's knee. Santa is Dr. Thomas J. Miskovsky.

At the recent Holiday party, physicians' children brought gifts to give to the children at the Pierce County Women's Support Shelter. The gifts will be used for both holiday and birthday times.

MSPC Auxiliary's case of assorted wine raffled off to raise funds for Student Recognition Award. $438.00 were raised from the raffle.

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Loss of a Spouse was Topic for November Auxiliary Board Meeting

MSPC Auxiliary's November Board Meeting was held at Lakewood General Hospital. WSMA Auxiliary President, Erselle Eade (King County) attended along with WSMA Auxiliary President-Elect Sue Dietrich (Clark County) and WSMA Auxiliary Southwest Regional Vice President Cindy Anderson (Pierce County).

Margaret Dahl, Chairman of the Board of Directors for Widowed Information and Consultation Services, spoke before the group on how to cope with the loss of a spouse. Sharing her own experience in coping with the loss of her husband, she emphasized that it was important to know where documents were kept, the financial status of your family and something about the tasks done by your spouse.

Auxi-Quad Luncheon scheduled, January 18

The semi-annual Auxi-Quad Luncheon will be held January 18 at the Washington State Historical Museum. General Chairman Dorothy Grenley along with her committee have planned a day steeped in Washington State history. Theme for the luncheon that begins at 10:00 A.M. with a tour of the museum is "From Promise to Achievement–100 Years of Sharing." Highlighting the tour of the museum will be exhibits of particular interest to lawyer, pharmacy, dental and medical groups.

No-host wine will be available from 11:00 to 12:00. Lunch will be served at noon in the Helen Long Room with a menu selected from the "Old Tacoma Hotel" menu, circa 1895-1906. Centerpieces featuring authentic photos of old Tacoma, prepared by the pharmacists' wives, will be the door prizes.

MSPC Auxiliary members may contact Joan Sullivan for reservations. Price is $8.75. Your check will be your reservation. Deadline for reservations is January 15. Guests are welcome. If you can, wear something reminiscent of the turn of the century.

AMA Auxiliary Leadership Confluence

The American Medical Association Auxiliary, Inc. Leadership Confluence held in Chicago, October 14-16, 1984, was a great learning experience for those hundreds of presidents-elect, who were able to attend. I wish to thank the members of the Medical Society of Pierce County and the Auxiliary in contributing towards my expenses.

The key note speaker, Sunday, Dr. James H. Sammons, Executive Vice President of AMA expressed the immediate concern of the AMA with the reasons for the legal action recently taken by the Association and the possible consequences to every practicing physician. Dr. Joseph Boyle, President of AMA reviewed those concerns at the final luncheon Tuesday, October 16th.

I would have liked to have been able to attend all 12 scheduled seminars but this would have meant extending the time an additional day or two. It was with difficulty that I chose the four seminars that I was able to attend, during pre-registration prior to my departure from Tacoma. Talks were scheduled at breakfast, lunches and after the two dinners. Goals of the AMA and the Auxiliary were also addressed. There was an exciting breakfast presentation by Marilyn Benveniste, author and consultant from Atlanta, Georgia, who spoke on Leadership Styles and Strategies. The two Sunday Workshops could have been extended to cover the entire confluence time but the four seminars I was able to attend was time well spent.

It was most interesting to discuss and listen during the too brief allotted time on Sunday, an Idea Exchange with other auxiliary presidents-elect. During meal periods, I arranged that I would always sit with "strangers" but after a brief moment, they were strangers no longer, but concerned women, seeking ideas and suggestions for a stronger local auxiliary.

The Washington State representatives (there were 10 of us) were able to meet briefly twice, to exchange impressions of seminars attended but most important, getting to know each other. I hope that kind of a sharing time for all Washington State presidents-elect can be arranged sometime in the spring. I've an idea about that, and if it works out, perhaps I can tell you about it in a later *Bulletin*.

—*Virginia Y. Miller*
President-elect

Requests for physician speakers increases

The Speaker's Bureau is getting an increasing number of requests for physicians to speak before groups. The groups using the service are varied, ranging from the public school system, health related interest groups, para-medical organizations, Remann Hall Detention Center, a radio station and, even a Grandmother's club.

We would like to extend our deepest thank you to all the physicians who have spoken before these groups. The comments we have received from each of these groups has been "terrific."

For those physicians who have not yet volunteered their services and would like to do so contact Sandy Henson at the MSPC office, 572-3667.

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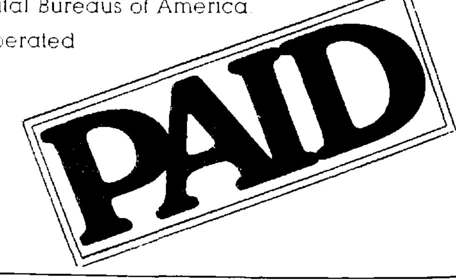

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MEMBERSHIP

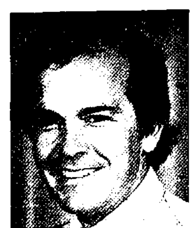
In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Mary Butcher, MD, *Family Practice.* Born in Chicago, IL, 9/28/50; medical school, Rush Medical College, Chicago, IL, 6/80; internship, Evanston Hospital, internal medicine, 7/80-7/81. Washington State License, 9/84. Dr. Butcher is currently practicing at 8509 Steilacoom Blvd., Tacoma, Washington.

Mark G. Constance, MD, *Family Practice.* Born in St. Joseph, MO; medical school, University of Iowa College of Medicine, 5/80; residency, Lincoln Medical Education Foundation (Univ. of Nebraska), 7/80-7/83. Washington State License, 9/84. Dr. Constance is currently practicing at 1720 East 44th Street, Tacoma, Washington.

Michael Dunn, DO, *Ophthalmology.* Born in Providence, RI; medical school, Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 1976; internship, Phil. College Osteo. Medicine, rotating internship, 6/76-7/77; residency, St. Francis Hospital Pittsburg, PA, 6/80-7/81, Scheie Eye Institute, Univ. of Penn, 6/81-7/82, St. Francis Hospital, 6/82-7/84. Washington State License, 9/84. Dr. Dunn is currently practicing at 3611 South "D" Street, Tacoma, Washington.



Blaine H. Johnson, II, MD, *Orthopaedics.* Born in St. George, Utah; medical school, University of Utah, Salt Lake City, Utah, 6/79; internship, Providence Hospital, Southfield, Michigan, 7/79-6/80; residency, Richland Hospital, Columbia, SC, 7/80-6/84. Washington State License 10/84. Dr. Johnson is currently practicing at 1002 "K" Street, Tacoma, Washington.

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For Sale—Medical Clinic and Practice in Parkland, 1,600 sq. ft., includes X-ray, minor surgery and large examining rooms. Contact J.J. Erickson, MD, P.O. Box 44488, Tacoma, WA 98444.

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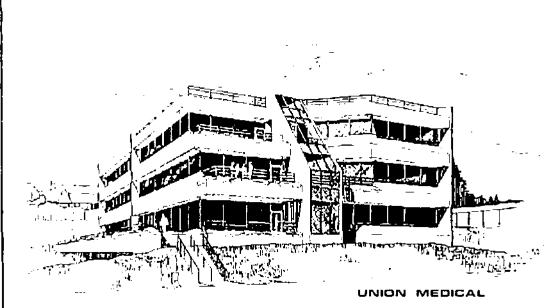

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Tacoma Community College is offering a course on "Medication Procedures for the Medical Office," (Course #HT-175). The course will begin January 21 and run through March 13, from 6:00 P.M. to 10:00 P.M., Monday and Wednesday.

Designed for medical assistants, the course provides the didactic instruction for medication administration as required by the new Washington State Law (RCW 18-135-030). Those successfully completing the course will be eligible to seek certification under a physician sponsor to administer medications.

Class size will be limited to 25. Participants may register in advance in Building 18 after January 7, 1985 or may register the first evening of the class on a space available basis only. For further information, call the Allied Health Division, 756-5163.

Patient Brochures Available

MSPC office has WSMA produced patient brochure available. The brochures were distributed at the recent WSMA Leadership Conference. Call the MSPC office, 572-3667 for samples and bulk orders. Brochure titles: *Good Health is a Two-Way Street, 16 Easy Ways to Cut Medical Costs, Communications Your Most Important Practice Builder,* and *We Want Your Visit to be Positive.* Also available: Physician Cost Control Check List, Medicare Assignment posters and a sample letter.

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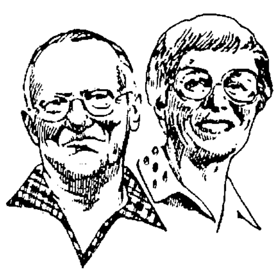

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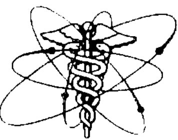

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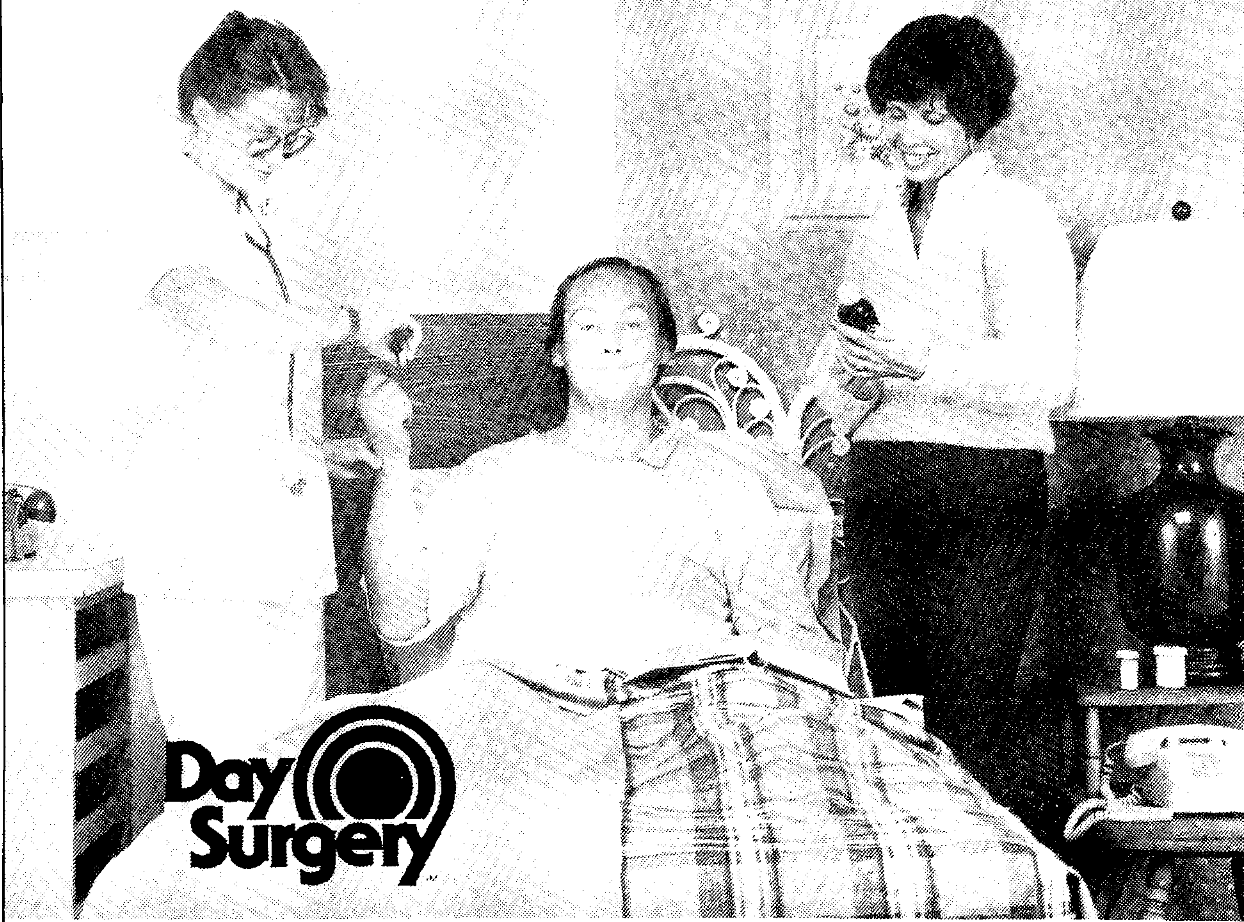

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The AMA Needs You

The message this month: Join the AMA. (Don't turn the page!) When we have discussed membership in the past, the emphasis has been on the AMA's work in the political arena. Our presence there is essential, but our motives are often suspect by the public. But our true influence and real credibility with Congress and the nation lies in our preeminence as a scientific organization.

I wish all physicians could attend one annual AMA meeting and see firsthand how the leadership, including our own John Dawson on the Board of Trustees, is anticipating trends and adapting to change. For example, the AMA has launched a concerted effort to bring our brethren in academic medicine back into the fold where they were once so prominent. Increasing federal cutbacks have forced institutions to rely more heavily on the private sector, and it has become more apparent that we have a real commonality of interests.

In line with this, the AMA has lured Dr. Roy Schwartz away from academia to become vice president for medical education and scientific policy. Dr. Schwartz, the former head of the WAMI program and more recently dean of the Colorado School of Medicine, is extremely bright, articulate and innovative. He predicts we are on the verge of a communication explosion. Things are already happening. *JAMA* is returning to a position of excellence, with increasing international circulation. The AMA cable health programs have been widely acclaimed. The AMA *Family Medicine Guide* has succeeded beyond all expectations, with the sale of over a million copies and its selection by the Literary Guild. The possibilities of AMA worldwide communication via satellite TV and video tape are mind boggling.

In the book *Megatrends*, Washington State is described as one of the five states that sets the trends for the other 45 states to follow. I would hope we would set the trend for AMA membership. I appeal to you as physicians and scientists to become AMA members and help keep the AMA the ultimate health authority for the nation. Without it, governmental pressures and both paramedical and quasi-medical usurpers will continue to erode the profession and reduce us to technicians or less.

—David S. Hopkins, M.D.

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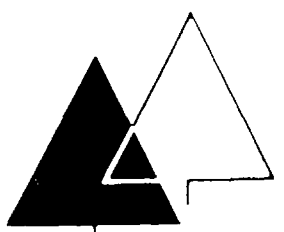

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The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

February 1985

Health Care Costs Public's #1 Concern

(see president's page and page 8)

Hospital Occupancy Rates Decrease

(see page 20)

Auxiliary Medical Fund Raiser March 17

(see page 19)

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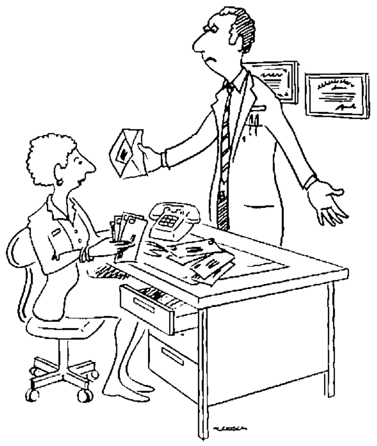

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President's Page

Statistical Considerations

As everybody is into statistics these days, I thought it might be appropriate to quote some. Probably at this point, everybody will be turning the page, as I normally would do. However, keep reading, some of the following numbers are surely thought provoking. You may not be aware of them.

Most of the countries in the Western world have percentages of G.N.P. for healthcare, which are higher or closely approximate the magic number of 10%, as in the U.S.A. In 1981, medical care represented 10.6% of consumer expenditures. Tobacco, alcohol and "recreation" combined accounted for 10.2%. Should one draw the conclusion that the latter is at least as important as one's health? Of course without the first, one could not "enjoy" the second.

Healthcare costs are increasing faster than the inflationary rate, but do we want to go back to the "good old days" when there were no cures or even palliative treatment for certain diseases? It appears to me that the general public will have to make a decision since we ourselves are committed to improve the quality of health and cannot ethically say "this is it and no further."

Between 1983 and 2025 the total population is projected to grow by about 30% with the elderly doubling to a total of 58 million or 19.4% of the entire population. At present 40% of the elderly are now older than 75. This is projected to increase to 45% while the "over age 85" group will triple from 2.5 to 7.5 million. As this group of the population utilizes a greater proportion of healthcare resources than the 19-64 group, there is no doubt that the utilization will correspondingly increase with its necessary costs. Who will draw the line?

The 1984 AMA Public Opinion Survey taken throughout the U.S.A., including Washington state, shows the greatest concern of those interviewed to be directly related to costs. The figure came to 66% for the entire group while 76% nationally of those over 65 view this as the main problem.

Right on top of this, however, 86% feel that medical care costs can be reduced without reduction in quality of healthcare, and I assume this would include access.

Another interesting statistic is that only 25% of the consumers feel that physicians are doing a good to excellent job in speaking out on the consumer's behalf, while 71% feel we do a poor to fair job. Not very complimentary, I would say. Combine this with the following questions and affirmative answers:

Doctors fees are reasonable 27%

Losing faith in doctors 68%

Doctors too interested in making money 67%

Doctors are active in trying to hold down the cost of care 21%

Doctors' availability to give adequate care to poor people 43%

Doctors' availability to give adequate care to the elderly 45%

Regarding the voluntary fee freeze, the poll shows considerable doubt in the public's mind as to the compliance by physicians.

Well, so much for numbers. I would urge you to read the entire survey beginning on page 8, as it does make for some sobering thinking as to how the public perceives us.

Finally, though having nothing to do with the above statistics, I would recommend the "Sounding Board" article in the *New England Journal of Medicine of December 1984* for some interesting reading.

—*G.W.C.B.*

LOCAL NEWSBRIEFS

MSPC Board of Trustees Meet

MSPC Board of Trustees held their monthly meeting December 5. It was recommended that the Medical Society of Pierce County extablish a support mechanism for members who are confronted with a malpractice suit. The recommendation was referred to the Executive Committee for further consideration.

MSPC Representative to the EMS Council Dr. James Fulcher reviewed for the Board recent action of the Council. Good Samaritan Hospital was approved as a Base Station Hospital for eastern Pierce County.

Terry Torgenrud, Chairman of the Public Health/School Health Committee, told Board members the 1985 goal for the Committee would be to secure legislation for fluoridation of the Tacoma water supply.

Drs. James L. Patterson, Douglas E. Robson, Henry F. Retailliau, Donald W. Shrewsbury and Robert Stuart were re-elected to the Board of Directors of Membership Benefits, Inc. The Board unanimously approved Dr. George Tanbara as recipient of the 1985 Order of the Apron award for his outstanding contributions as a volunteer to the community and medical profession.

The Board approved a $35,104 budget for the Pierce County Medical Library for 1985.

At the January 8 meeting of the MSPC Board of Trustees Board members asked that a mechanism be developed for members of the Society who are facing a malpractice suit. The Board recommended members have recourse to consultation with members who have faced malpractice to provide guidance and support.

The following applicants for membership were approved for membership into the Medical Society at the January 8 Board meeting: Drs. Michael W. Goerss, John C. Hill, Douglas S. Malo, Alan E. Shelton, Larry D. Stonesifer and Amy T. Yu.

Four Physician and Patient Brochures Produced by WSMA Available from MSPC

"16 Easy Ways to Cut Medical Costs," "We Want Your Visit to be Positive," (a patient satisfaction questionnaire); "Good Health is a Two-Way Street," (patient responsibilities); "Communications: Your Most Important Practice Builder," (for physician and staff). These all are available from the MSPC office in quantity. Call the MSPC office for samples or bulk orders, 572-3667.

Available for Locum Tenens?

The Medical Society of Pierce County office is establishing a file on physicians who are available for Locum Tenens. Physicians who are interested may call the Society's office, 572-3667.

Our apologies to Drs. Gil Roller and Lloyd Elmer who were incorrectly presented in the January issue of The Bulletin as attending the MSPC leadership conference. Drs. Roller and Elmer were, in fact, attending the WSMA Leadership Conference in Seattle, not an MSPC Conference.

"Where to turn. . ."

The Council on Aging has produced a very worthwhile brochure as a guide to services and activities for older adults. If you or your office staff often have difficulty referring your senior citizens/patients to the appropriate agency for assistance, this brochure has the answer your questions.

It has listings for home health services, housing, legal/consumer aid, meal programs, senior centers, social services and more.

Brochures are available at the Society's office. Call 572-3667 for a supply.

Local Newsbriefs continued on page 6

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Tel-Med continues to accept contributions

The Tel-Med Society's existence depends on the contributions of physicians, Allenmore Foundation, Pierce County Medical Bureau, Pierce County Medical Society Auxiliary. This is a valued community service. Let's keep it healthy. Your contributions are appreciated.

Sustaining Life or Prolonging Death: Topic of lecture

"Sustaining Life or Prolonging Death," will be the topic of a lecture by Dr. William Madden February 19, in the Board Room of Puget Sound Hospital.

Dr. Madden, a pediatric pulmonologist at Madigan Army Medical Center, serves on a medical ethics committee and advises the Physicians for Moral Responsibility, the sponsoring organization. Medical personnel and spouses are welcome.

1985 MSPC Committee Chairmen Appointed

Committees are the backbone of an effective and progressive Society. The following members have been asked and have agreed to chair the respective committees:

Budget/Finance . . . *Robert W. Osborne, Jr., MD (Vascular and General Surgery)*

Medical Education . . . *John Lincoln, MD (Family Practice)*

Committee on Aging . . . *Bryan M. Archer, MD (Family Practice)*

Continuing Medical Education . . . *David Brown, MD (Family Practice)*

Ad Hod Committee on Contracting . . . *Peter Kesling, MD (Obstetrics and Gynocology)*

Credentials . . . *Ronald G. Taylor, MD (Surgery)*

Editorial Committee . . . *David Hopkins, MD (Family Practice)*

Emergency Medical Standards . . . *Mark E. Jergens, MD (Emergency Medicine)*

Ethics/Standards of Practice . . . *Gilbert J. Roller, MD (Radiologist)*

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Marcus S. Gaspard (D)	753-7648	Donald C. Weber, MD
26th District		
Barbara Granlund (D)	753-7650	Richard F. Ambur, MD
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Lorraine Wojahn (D)	753-7652	Alan Tice, MD
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Stan Johnson (R)	753-7654	James D. Krueger, MD
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Olympia Telephone Numbers:
WSMA Olympia Office
(24 hr. answering for messages) . . . . (206) 352-4848
Lobbyist Message Center
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Public concern about health care costs growing

The public's worry over the cost of health care has increased significantly over the past two years, while concerns about access and quality have changed less. These findings and more are contained in the just released 1984 AMA Public Opinion Survey. While the survey results may not make for comforting reading, they do provide an invaluable planning tool for medicine's programs and responses to today's health care issues.

The public's rating of cost as the main problem facing health care reached an all-time high with the 1984 survey; nationally, 68% of the respondents rated costs as the number one problem.

The June 1984 AMA poll included for the first time a special Washington state segment. Telephone interviews with 1,503 randomly selected U.S. adults and 400 Washington state residents were conducted by an independent New York-based research organization. Data analysis was provided by the AMA's Office Survey and Research.

Cost Concerns Crystallize: The poll left little doubt that among health care issues cost has become the public's primary concern by a wide margin. It has been named as the main problem facing medicine since the AMA began its public polling activity in 1977.

"What do you feel is the main problem facing health care and medicine in the United States today?"

	US 1982	US 1983	US 1984	WA 1984
Cost	62%	65%	68%	66%
Quality	13	14	12	11
Access	8	6	5	4
Other	17	15	15	19

The major decrease in other responses, primarily by defection to cost, suggests crystallization of opinion on the issue. The Washington state data show a similar pattern.

Different age groups differ in their opinions somewhat. Washington individuals aged 45-65 are most likely to name cost as

the main problem, followed by those in the 35-44 age group. Fewer of those age 65+ view costs as the main problem in Washington, with 68% of that age group citing cost as the number one problem compared to 76% nationally.

"Do you believe medical care costs can be reduced without reductions in the quality of health care?"

	US84	WA84
Yes	86%	90%
No	11%	9%

The survey indicates that the public strongly rejects the argument that reductions in cost will necessarily cause reductions in quality. By overwhelming majorities, both Washington and national respondents believe that reducing costs can be accomplished without compromising quality.

Social spending priorities: The survey also assessed public opinion about the amount of social resources being directed to various sectors of the economy. Financial support for the elderly and education are the two areas seen by Washington residents as most in need of additional funding. These are followed by retraining for employed citizens, financial assistance for the needy, environmental protection and health care. In the 1978 AMA survey, health care headed the list as the sector most in need of additional funds.

"Do you think we as a society are spending too much money, not enough money, or about the right amount on . . ."

	Not Enough US84	Not Enough WA84
Financial support for the Elderly	70%	67%
Education	64	58
Retraining for Unemployed Citizens	53	53
Financial Assistance for the Needy	52	52
Protecting the Environment	52	50
Health Care	51	47
Defense	21	15

Washington residents who most likely feel that not enough is being spent on health care are those between the ages of 18–35 and over 65, and have incomes between, $10,000 and $20,000 per year. Nationally, individuals who often express a need for increased health care spending are between the ages of 18–34, are highly educated, or earn high incomes.

In Washington, as in the national findings, individuals over age 65 are least likely to say that more should be spent on financial support for the elderly.

Consumer Advocacy Rated Low: Existing groups and institutions in the health care sector are viewed as either unable or unwilling to speak out on behalf of consumers. According to the survey, this was true both nationally and in Washington state.

When asked who they think is doing a good job in speaking out on behalf of the consumer, only one in four Washington residents ranked physicians as doing an excellent job. In addition, Washington residents hold a particularly negative view toward the consumer advocacy of the federal government.

"Would you say . . . are doing an excellent job in speaking out on behalf of the consumer, a good job, a fair job, or a poor job?"

Continued on next page

	Excellent/Good		Fair/Poor	
	US	US	US	WA
Physicians	27	25	71	71
Non-physician health care professionals	46	49	49	45
Hospitals	34	33	63	62
Insurance companies	34	36	60	55
State Governments	20	16	75	77
The Federal Government	19	12	77	82

Opinion Split on Medical Malpractice: Washington respondents were more likely than the national sample to say that most malpractice suits are justified, and they are less likely to support a limit on awards. However, at the same time, they are significantly more likely to say that awards are too high. One possible explanation for the pattern of responses is the fact that Washington residents are better educated that the national population.

The results show a split in this state's public opinion over why physicians are sued for malpractice; 41% of Washington residents believe that people who sue for malpractice are "just looking for easy way to make money." A larger portion, 46%, feel that most suits usually are justified. In terms of awards, a plurality (49%) believes them to be too much, with 37% thinking they are "about right." A majority (53%) favors a limit on the amount that can be awarded in a malpractice case.

"Do you think people who sue physicians for malpractice are usually justified in bringing suit or are they just looking for an easy way to make some money?"

	US84	WA84
Usually justified in bringing suit	43%	46%
Just looking for easy way to make money	44	41
Not sure	13	14

"Do you think the amount of money awarded to patients by juries in malpractice suits is usually too much, not enough or about right?"

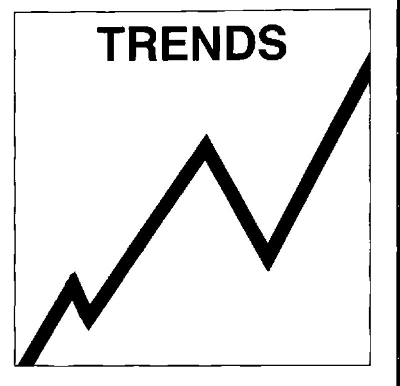
	US84	WA84
Too much	41%	49%
Not enough	7	4
About right	41	37
Not sure	11	11

"Do you think that there should be a limit on the amount of money that can be awarded to someone suing a doctor for malpractice?"

	US84	WA84
Yes	61%	53%
No	34	41
Not sure	5	6

Opinions of Washington residents vary markedly by age on whether suits are justified and whether there should be award limits.

Age	Washington 1984 stating justified	Washington 1984 supporting limit
18-34	58%	49%
35-44	41	45
45-64	38	57
65 +	29	66



Doctor Supply Assessed: The survey clearly indicates a national decline in the belief that there are too few physicians. In 1984 just 26% of Americans take this position, a decline of 12 points in just two years.

While physicians have been sensitive to the growth in their numbers–since 1970, the physician-to-thousand population ratio has risen from 162 to 217, an increase of 33%–until recently public opinion in support of more physicians has remained largely impervious to the increasing supply. That now appears to be changing.

"In this community, do you think there are too many doctors, too few doctors, or about the right amount of doctors?"

	US82	US83	US84	WA84
Too many doctors	7%	12%	12%	15%
Too few doctors	38	29	26	12
About the right amount of doctors	52	55	59	67

Image of Physicians Somewhat Negative: The 1984 AMA survey shows a trend toward increasingly negative public views toward physicians, particularly in the areas of fees, time spent in explanation, and access to care by the elderly.

Respondents gave physicians good ratings in areas such as patient care explanations, emergency accessibility, interest in patients, and scientific knowledge. Interestingly, Washington respondents aged 35-44 hold much more favorable views of physicians than their counterparts nationally in the areas of access and interest in patients.

"Please tell me if you agree or disagree with each of the following statements about medicine and health . . ."

	Agree		
	US 1983	US 1984	WA 1984
Doctors fees are usually reasonable	32%	27%	24%
People are beginning to lose faith in doctors	66	68	66
Most physicians are accessible in an emergency	56	53	58
Doctors are too interested in making money	66	67	62
Doctors usually explain things well to their patients	49	44	47
Doctors act like they're better than other people	35	38	33
Most doctors take a genuine interest in their patients	62	62	67
Doctors are active in trying to hold down the cost of care	22	21	23
Doctors are usually up to date on the latest advances in medicine	72	71	70
Poor people are able to get needed medical care	41	43	36
The elderly are able to get needed medical care	50	45	44

Nationally, individuals who are male, over the age of 65, or possess less education are more likely to agree that "physicians are too interested in making money." Those in the 18-34 age group are the least likely to believe that the poor and elderly are able to obtain medical care. Surprisingly, respondents in the 65 and over age group respond more favorable to these two issues.

On every item but one, the percentage of favorable responses toward physicians nationally has declined since 1983.

The fact that patients find physicians' fees unreasonable may be linked to the view that physicians don't do a particularly good job in explaining things (including fees) to their patients. Any program to improve public opinion of physicians must deal with fees, incomes and time spent in explanation.

Continued on page 10

Public Concern about Health Care Growing, continued from page 9

Washington respondents were less likely than national respondents to say there are too few physicians in their community. Only 12% of the Washington respondents believe there are too few, while a majority (67%) feel there is an adequate supply.

Health Care for the Elderly: A particular benefit of the 1984 survey has been the data provided regarding the elderly's view of health care issues generally and the Medicare program specifically.

The survey results indicate that the elderly who have direct contact with the Medicare program believe that quality and access to care under Medicare are virtually identical to that of the general population. At the same time, the balance of public opinion in both Washington and nationally is that quality is more of a problem than access for Medicare recipents.

"Would you say that under Medicare elderly persons have better access to health care than the general population, worse access, or is there no difference in this regard?"

	US84	WA84
Medicare has better access	20%	14%
Medicare access about the same	51	50
Medicare has worse access	22	26

Age	US 1984 Responding that Medicare Access is worse
18-24	28%
35-44	24
45-64	20
65 +	7

Those respondents most likely to have had direct experience with Medicare are least likely to believe that quality is lower, suggesting that opinion on this issue is based largely on misinformation.

"Would you say that the care available for the elderly through Medicare is of higher quality, lower quality, or about the same quality as that available to the general population?"

	US84	WA84
Medicare is higher quality	6%	4%
Medicare is about the same	59	60
Medicare is lower quality	28	25

Age	US 1984 Responding that Medicare Quality is Lower
18-34	35%
35-44	27
45-64	24
65 +	13

Of those aged 65 and over, 69% rated cost as the number one problem facing health care, compared to 83% for the 45-64 age bracket, 72% for the 35-44 age bracket, and 55% for the 18-34 age bracket. Twenty-seven percent of those aged 65 and over attributed the problem to the high cost of doctors generally, 10.2% attributed it to the high cost of hositalization.

Recognition of Voluntary Physician Fee Freeze: The public was asked about the March 1984 AMA and WSMA call for a voluntary physician fee freeze for one year. The survey indicates little knowledge of the fee freeze request and considerable skepticism regarding physician compliance, although Washington residents have slightly more faith in their own physician's compliance with the fee freeze request. Results showed little public support for the belief that a fee freeze will be effective in helping control costs.

"Recently the American Medical Association made a formal request to all physicians in the U.S. Do you happen to recall what this request was about? (if Yes) What was the request?

	US84	WA84
Yes, correct specification	15%	13%
Yes, incorrect specification	3	3
No	82	84

continued on page 11

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"In March, the American Medical Association called for all physicians in the U.S. to voluntarily freeze their fees. Do you think doctors in general will comply with this request?"

	US84	WA84
Yes	32%	31%
No	63	62

"Do you think your physician will comply with the request?"

	US84	WA84
Yes	47%	51%
No	41	34

"Overall how successful do you think a voluntary fee freeze by doctors will be in helping to control the rising cost of medical care?"

	US84	WA84
One of the most effective ways to control costs	18%	13%
Of some, though not major effectiveness	38	40
Of little or no effectiveness in controlling costs	41	41

Other issues: The survey also asked about advertising in medicine, specifically prescription drug advertising, to consumers. By a two-to-one margin, prescription drug advertising on television is opposed by the public. Opposition is even stronger in Washington than in the nation as a whole.

"Do you support or oppose prescription drug advertising on television?"

	US84	WA84
Support TV ads	34%	27%
Oppose TV ads	62	68

Regarding advertising by hospitals, clinics, and other medical organizations generally, more Washingtonians have seen or heard such advertising during the past several months than nationally, suggesting the greater prevalence of such advertising in this state than the nation as a whole.

"Have you seen or heard any advertising by hospitals or clinics during the past several months?"

	US84	WA84
Yes	41%	54%
No	58	46

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Membership Benefit Inc., Benefit Survey Results

The following is a compilation of responses to the Membership Benefit Questionnaire conducted in October 1984. The survey is intended to give the Membership Benefit Board of Directors input on future benefits the membership might like to see offered. The questions are written out below with answers ranked by percentages. The fourth question which solicited comments reflects the remarks made by the membership. Thank you for your participation, it allows us to help serve you better.

Would you like to see the following benefits ordered?	YES	NO	NEUTRAL
1. Discount costs on purchasing of office supplies? (Included here would be compatible pegboard accounting forms and equipment, filing system equipment, shelving, filing supplies, computer and regular business forms, and office stationery.)	73%	11%	16%
2. Discount on long distance telephone service, including in state and out of state calls?	59%	13%	28%
3. Discount costs on purchase of medical surgical supplies? (Included here–caps, gowns, tongue depressors, table paper, disposables, injectables, gauze sponges, lab equipment, etc.)	71%	10%	18%

4. Benefits you would like to see offered?

Professional House and/or Babysitting service, sponsored by Medical Society.
Dental insurance (A group as large as this should be able to get a good plan, individually we can't get any dental coverage.)
Discounts of air fare, major resorts or city hotels.
List of temporary fill ins to call if someone is sick.
Low cost responsive physician answering and paging system.
Integrating computer systems.
Malpractice Insurance premium discounts.
Discount on Attorney Fees.
Discount on Appliances, cars, air-travel, etc.
Locum tenens on prn basis or to take occasional calls etc.
None. I think it is deceptive to have a business association with PCMS like Medical-Dental whose interests are profit making.
Discounts are fine but there is usually no "free lunch" and what are we as a Society giving for this? If just purchasing power, it may work well.
Discount on computer office systems could interface.
Somehow–there should be some benefits for dues paying members–that non-dues paying physicians get for nothing.
Perhaps we need to recognize that we are now more like a business and less like a profession. A union has some merits!
I don't believe these business ventures are appropriate. I would rather hear of cooperative CME ventures with other areas of the country or world.
Dental program.
Benefits applicable to HMO members too.
Discount travel, tours, discount auto lease, purchase.
Insurance-stereos-tires-washers-dryers-anything of value.
Office & lab materials.
Discount printing–consumer reports on office equipment–audiometers, copiers, microscopes, spirometers, lab equipment, etc.
Rating of office equipment–durability, cost effectiveness, etc.–Medical as well as non medical (eg–Spirometer rating; photocopier rating)
Continue present ones.
I feel your present services are both excellent and appropriate.
I favor all above discounts if offered by the seller in return for MBI simply announcing it to members. If the discount is "paid for" by an exclusive "endorsement" (thus ignoring equal quality by competitors), or a kickback to the Society, it's unethical. ■

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...from your facility design?

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College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—Individual notices will be sent preceding each program.)

Phone: 627-7137 (P) = Physician (A) = Allied Health

Location	Date	Program	Coordinator	
	JANUARY			
JH	4, 11, 18, 25	Update in Surgery	TGH	(P)
JH	23, 30, Feb. 6	Effective Meetings		(A)
JH	17	Ear/Nose/Throat in General Practice	Wulfestieg/ Rone	(P)
STJ	17	Marketing to Win	Vipperman	(A)
STJ	24	Law & Medicine	Malden	(P)
JH	17, 24	Money Management (Evenings)	Jackman	(P)
	FEBRUARY			
STJ	7	Telephone Assessment	Simms	(A)
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Pomeroy/ Bargren	(P)
HHT	13	Nursing Assessment—Geriatric Patient	Barton	(A)
	TBA	Hospital Budgeting		(A)
STH	15	Diabetes	Stonecipher	(P)
STJ	25, 26	Advanced Pediatric Life Support	Seward	(P/A)
	MARCH			
STJ	6	Right Brain/Left Brain		(A)
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
HHT	21	Prac. Solutions—20 Most Common Geriatric Prob.	Waltman	(A)
	21	Current Trends in Nutritional Therapy	Pelham	(P/A)
	TBA	Medical/Surgical Potpourri		(A)
	APRIL			
STJ	4, 5	Survival Skills for Nurses	Chilton	(A)
UPS	12, 13	Surgical Club	Martin	(P)
STJ	26	Death & Dying	Schmidt	(P/A)
	TBA	Symptom Mgmt. of Cancer Patients for Nurses	Boulet	(A)
	TBA	Adolescent Patient: Suicide, Pregnancy, Drugs	Ingraham	(A)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	9, 10	Cardiovascular Disease Review	Strait	(P)
	JUNE			
JH	27, 28	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Orthopaedics and Sports Medicine in Primary Care

February 7, 8, 1985
Jackson Hall,
314 South 'K' Street, Tacoma

Thursday, February 7, 1985
Orthopaedics in Primary Care

Time	Session	Speaker
8:00	Welcome and Introductions	
8:05	**HAND/ARM**	*John D. Stewart, MD*
8:50	**SHOULDER**	*Gregory A. Popich, MD*
9:35	**PANEL—Question/Answer**	
9:55	**Break**	
10:10	**THE ACUTE KNEE**	*John H. Bargren, MD*
10:55	**FOOT/ANKLE**	*W. Brandt Bede, MD*
11:40	**PANEL—Question/Answer**	
12:00	**Lunch—No Host**	
1:15	**PEDIATRIC ORTHOPAEDICS**	*Don H. Mott, MD*
2:00	**SCOLIOSIS/SPONDYLOSIS**	*R. Charles Ray, MD*
2:45	**PANEL—Question/Answer**	
3:05	**Break**	
3:15	**ASPIRATION/INJECTION**	*Robert E. Ettlinger, MD*
4:00	**PANEL—Question/Answer**	
5:00	Adjourn	

Friday, February 8, 1985
Sports Medicine in Primary Care

Time	Session	Speaker
8:00	Welcome and Introductions	
8:05	**RUNNING INJURIES**	*Jeffrey L. Nacht, MD*
8:50	**TAPING AS TREATMENT**	*Bruce J. Snell, M.S., R.P.T., ATC*
9:35	**PANEL—Question/Answer**	
9:55	**Break**	
10:10	**NECK INJURIES**	*Thomas J. Miskovsky, MD*
10:55	**PANEL—Question/Answer**	
11:05	**PRACTICUM DEMOS:**	*Orthotics, Taping, Helmet Removal*
12:00	**Lunch—No Host**	
1:15	**FITNESS EVALUATION**	*Gary Chase, PhD.*
2:00	**THE FEMALE ATHLETE**	*Karen Nilson, MD*
2:45	**PANEL—Question/Answer**	
3:05	**Break**	
3:15	**CHRONIC KNEE**	*Pierce Scranton, MD*
4:00	**TEAM PHYSICIAN**	*James M. Foss, MD*
4:45	**PANEL—Question/Answer**	
5:00	**Adjourn**	

FACULTY:

JOHN H. BARGREN, MD
Orthopedist

W. BRANDT BEDE, MD
Orthopedist

GARY CHASE, PhD.
Physiologist,
Pacific Lutheran University

ROBERT E. ETTLINGER, MD
Rheumatologist

JAMES M. FOSS, MD
Family Practice

THOMAS J. MISKOVSKY, MD
Orthopedist

DONALD H. MOTT, MD
Orthopedist

JEFFREY L. NACHT, MD
Orthopedist

KAREN NILSON, MD
Medical Director, A. T.&T.

GREGORY A. POPICH, MD
Orthopedist

R. CHARLES RAY, MD
Orthopedist

PIERCE SCRANTON, MD
Orthopedist

BRUCE J. SNELL, M.S., R.P.T., ATC
Director of Training,
Tacoma Stars

JOHN D. STEWART, MD
Orthopedist

Registration: Paid pre-registration required before February 4, 1985

Fees: $ 95 Medical Society of Pierce County Physicians (both days)
110 Non-Medical Society of Pierce County Physicians (both days)
$65 Medical Society of Pierce County Physicians (one day)
75 Non-Medical Society of Pierce County Physicians (one day)
40 Residents (both days)

Yes, please register me for: ORTHOPAEDICS AND SPORTS MEDICINE IN PRIMARY CARE

Enclosed is $________ payable to CME **OR** Charge $________ to my: ☐ VISA ☐ MC

☐ **Entire 2-day program**
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The College of Medical Education does not discriminate on the basis of race, creed or religious sect.

The Diagnosis and Treatment of Type II Diabetes

Sheraton Tacoma Hotel
1320 Broadway Plaza, Tacoma
February 15, 1985

Co-Sponsored by: COLLEGE OF MEDICAL EDUCATION, Medical Society of Pierce County, Pierce County Hospital Council and American Diabetes Association, Washington Affiliate

No fee for seminar. Attending physicians will receive *The Physician's Guide to Type II Diabetes (NIDDM): Diagnosis and Treatment.* This practical manual was written by nine diabetologists with the assistance of two expert committees - one composed of other diabetes specialists and one comprising physician representatives of the organizations whose members will be primary users of the Guide. It is designed to be a ready reference manual rather than a text book.

PROGRAM (Program Coordinator: *Larry D. Stonesifer, MD)*

Time	Session	Speaker
12:00	*Complimentary Buffet Luncheon* (Pre-registration required)	
1:10	Introduction	*Larry D. Stonesifer, MD,* Endocrinologist, Tacoma
1:15	Definition, Classification, Pathogenesis and Diagnosis of Type II Diabetes Mellitus	*W. Kenneth Ward, MD,* Professor of Medicine University of Washington
2:00	Non-Pharmacological Management of Type II Diabetes Mellitus	*Larry D. Stonesifer, MD*
2:45	*Coffee Break*	
3:00	Pharmacological Management of Type II Diabetes Mellitus	*Clinton W. Young, MD,* Director, Diabetes Clinic, San Francisco Gen. Hosp.
3:45	Detection and Treatment of Complications of Type II Diabetes Mellitus	*Ronald J. Graf, MD,* Endocrinologist, Tacoma
4:30	Wine and Cheese Reception	*Questions and Discussion with Faculty*
5:30	*Adjourn*	

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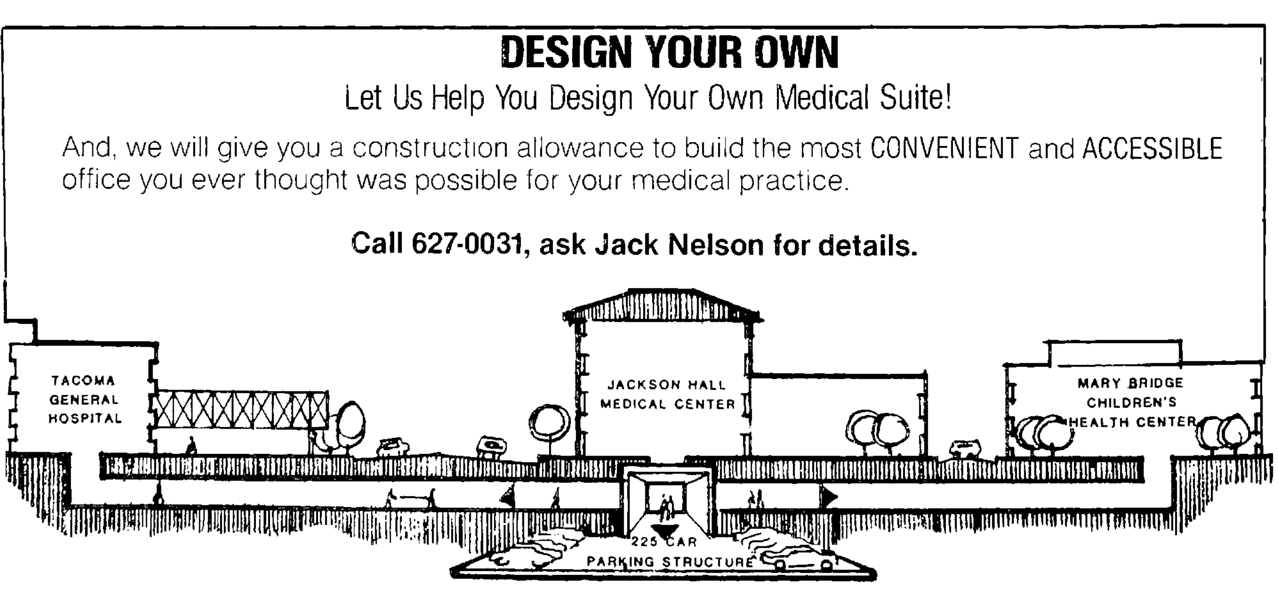

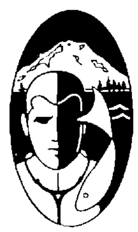

Medical Society/Madigan Army Medical Center

ANNUAL JOINT MEMBERSHIP MEETING

Join your colleagues from the Medical Society and Madigan Army Medical Center for dinner and an informative, entertaining program of four presentations (one hour AMA Category I credit will be awarded).

PROGRAM

- *"Medicine on the Modern Battlefield"*
  Major Sprague Taveau, M.D.

- *"The Role of Mask CPAP and Preventing Post Operative Adolescent Atelectasis"*
  Major Arthur Knodel, M.D.

- *"The Effect of Physical and Environmental Stress on the Soldier"*
  Captain Karl E. Friedl, PhD.

- *"The New Madigan Army Medical Center"*
  Brigadier General Darryl H. Powell, M.D.

DATE: Tuesday, February 12, 1985

TIME: No host cocktails 6:15 P.M. Dinner 7:15 P.M. Program 8:00 P.M.

PLACE: Tacoma Dome Hotel, 2611 East "E" Street

COST: Dinner, $14.50 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County,** in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Due to the special arrangements necessary for this joint meeting, reservations must be made no later than Friday, February 8.

REGISTRATION:

Yes, I (we) have set aside the evening of February 12 to join my fellow Society members and physicians from Madigan Army Medical Center at the Annual Joint Meeting.

___ Please reserve ___________ dinner(s) at $14.50 per person (tax and gratuity included). Enclosed is my check for $_______________.

___ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr: ______________________________

RETURN TO MSPC BY NO LATER THAN FRIDAY, FEBRUARY 8.

AUXILIARY NEWS

Auxiliary holds Auxi–Quad luncheon

The Pierce County Medical Society Auxiliary held its semi-annual Auxi-Quad luncheon, Jan. 18, at the Washington State Historical Museum. Dorothy Grenley and her committee did a superb job of coordinating the luncheon. Spouses and friends of the Pierce County dentists, lawyers, pharmacists and medical doctors spent an enjoyable day together.

Director of the Washington State Historical Museum, Anthony King and his crew set up exhibits for our groups. After the museum tours we were served a delicious meal that was prepared from an early Tacoma hotel menu. Music was provided by the Charles Wright Academy Chamber Ensemble. Speaker for the afternoon was John Rupp, Esq.

Marion Beale (Law Aux.), Dorothy Grenley, Sharon Lawson (Med. Aux.), Patience Powell (Pharmaceutical Aux.) and Judy Johnson (Dental Aux.).

Kit Larson & Edith McGill

Auxiliary members attend Legislative Day

A contingency of Pierce County Auxiliary members attended the annual Legislative Day in Olympia, Jan. 24.

The day's activities began at the Westwater Inn with discussions concerning medical issues. The group met their representatives at the capitol building. A reception concluded the day's activities.

Editors Note.

The Pierce County Medical Society Auxiliary was presented in error in the January issue of The Bulletin as the MSPC Auxiliary.

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Auxiliary News continued from page 18

Medical Fund Raiser March 17

Plan to attend the March 17 fund raiser. A champagne brunch will be held at St. Joseph Hospital from 11:00 A.M. to 2:00 P.M.

Mary Lou Jones and Bernice Lazar are co-chairpersons and have been busy getting a large variety and quantity of items for us to dream about holding winning tickets for. Raffle tickets are available for $1.00.

Some of the items to be raffles include a fur jacket, jewelry from Gundersons, computer lessons from Quantum Computer Stores, original art works and a large chest of gourmet items lined with a handmade quilt. Auxiliary members are donating items for the chest. (More articles are still needed. If you would like to donate contact Mary Lou or Bernice).

Profits from the fund raiser will go to: Women's Support Shelter of the YWCA, Washington Women's Employment and Education of Pierce County and The Family-Birth to Three Support Program.

We hope everyone will make this a profitable day for the Auxiliary and its philanthropic activities.

Health Fair, Feb. 15-17

The Health Fair will be held Feb. 15-17 at the Tacoma Mall. For the first time the Auxiliary will be using a booth created by WSMA's PACE program (Public Awareness Community Education).

The Auxiliary ***will need volunteers to work in the booth,*** and would like two doctors to take blood pressure and two more volunteers to explain the booth and hand out literature. If you or your spouse can help, call Sally Larson, 588-9839 after 6:00 P.M.

Auxiliary Note:
The date and time for the February meeting is the same, but the location has been changed. Check your February newsletter for specifics.

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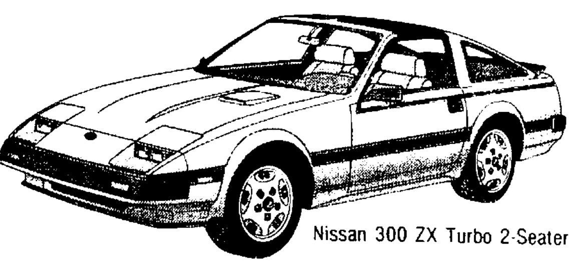
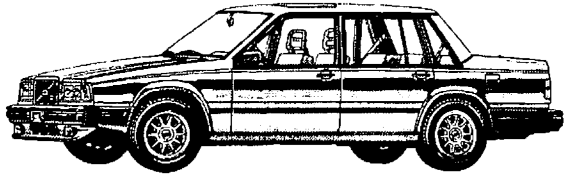

Nissan 300 ZX Turbo 2-Seater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Community hospital occupancy rates decrease

According to the most recent AMA Health Services Utilization Report, Dec. 1984, community hospital occupancy rates have decreased 7.4 percent to 70.3 percent over the last five months. Figure 1 from the report shows significant variations among regions for occupancy rates in 1984 that range from 80.6 percent in the Mid Atlantic to 56.7 percent in the West North Central.

According to the report, hospitals decreased their work force by 1.3 percent during the 2nd quarter of 1984 as a result of the decreased occupancy rate. The declining rates, says the report, suggest new trends in the hospital market.

In May the Health Care Financing Administration reported utilization in hospitals under the Medicare prospective pricing system (PPS) showed a continuing decline in length of stay (LOS). Length of stay for Medicare patients in PPS hospitals averaged 7.2 days, while Medicare patients in non-PPS hospital averaged 9.4 days, according to the report.

Figure 2 at the right shows significant LOS variations between regions. For the over population, LOS ranges from a high of 8.2 days in the Middle Atlantic states to a low of 5.4 days among the Mountain states.

Figures 3 and 4 compare average LOS between regions for infectious mononucleosis (IMN) and acute myocardial infarction (AMI). According to the report, these two diseases were chosen to illustrate that although service utilization rates for one illness may vary significantly between regions, other diseases or illnesses do not.

The average length of stay for IMN is fairly consistent between regions while that for AMI is highly variable across regions. According to the report, the magnitude of the variations within these two diagnoses has remained consistent over the two years indicated for each region.

In 1982, length of stay varied 4 days between regions for AMI, from a high of 15.1 days in the Northeast to a low of 11.1 days in the West. By comparison, length of stay varied 1.3 days between regions for IMN.

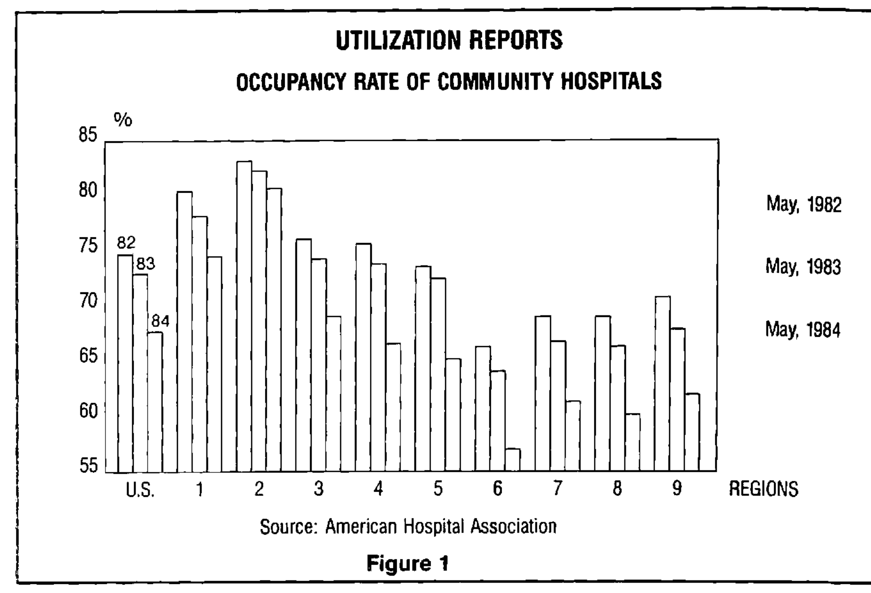

Figure 1

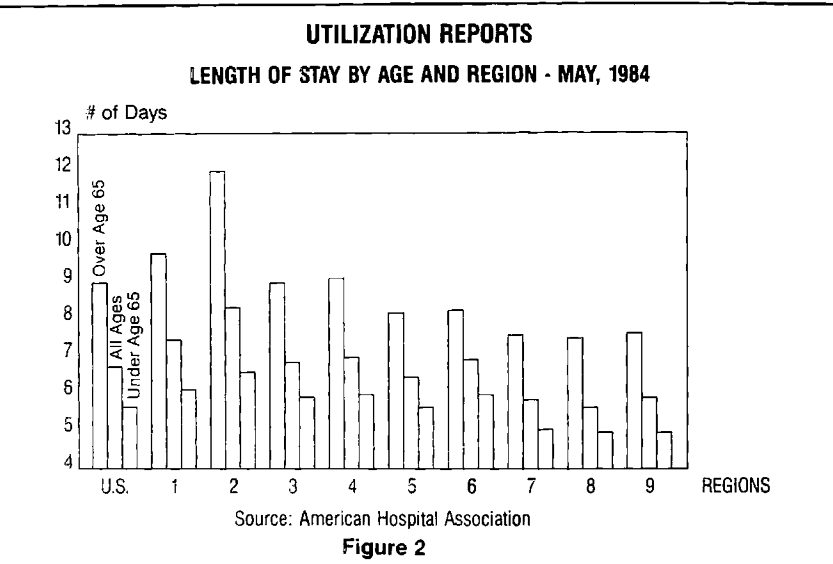

Figure 2

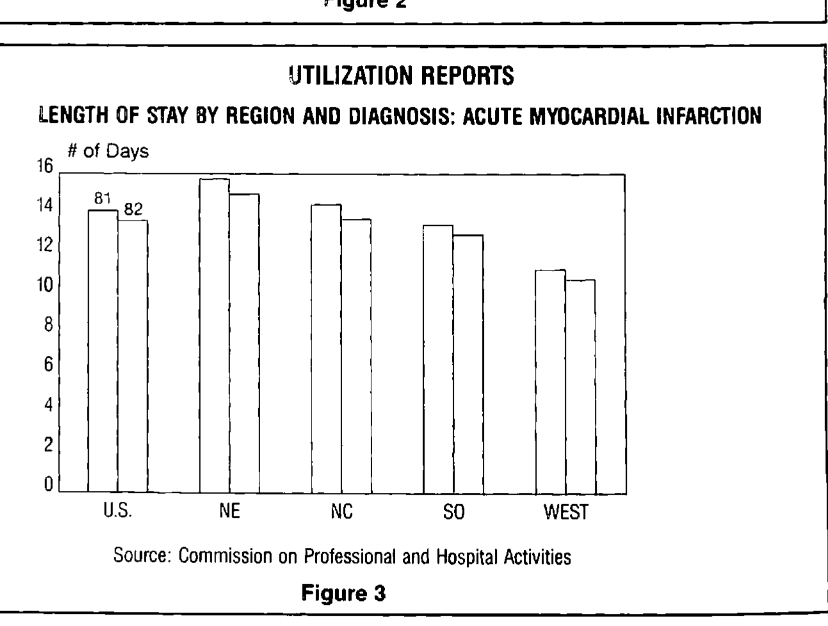

Figure 3

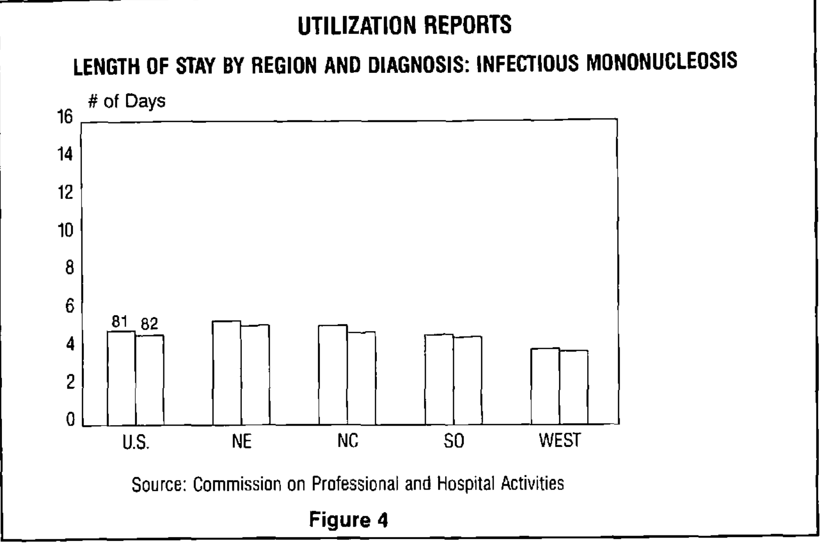

Figure 4

From Health Services Utilization Report, AMA, Dec., 1984.

Legend

1. New England: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut
2. Middle Atlantic: New York, New Jersey, and Pennsylvania
3. South Atlantic: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida
4. East North Central: Ohio, Indiana, Illinois, Michigan, and Wisconsin
5. East South Central: Kentucky, Tennesee, Alabama, and Mississippi
6. West North Central: Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
7. West South Central: Arkansas, Louisiana, Oklahoma, and Tennessee
8. Mountain: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, and Nevada
9. Pacific: Washington, Oregon, California, Alaska, and Hawaii

For further discussion on this and other issues see: *AMA Cost Effectiveness Bulletin, Vol. 3, No. 2, Dec. 1984.* MSPC Office.

NOTICE TO READERS

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaces, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 572-3667.

One–Day Seminar, March 29:

"Current Trends in the Medical and Rehabilitation Management of Stroke"

St. Joseph Hospital and Health Care Center is sponsoring a one–day seminar March 29, 1985, for physicians, nurses and allied health professionals: *Current Trends in the Medical and Rehabilitation Management of Stroke.*

Nationally knows neurologist, Dr. James Grotta, will join local physicians, Drs. Huddlestone, Overfield, and Bodily, in presenting sessions designed to increase understanding of current trends in the diagnosis and medical management of stroke. Nationally known physiatrists, Drs. Weber and Lehmann, will present sessions designed to improve understanding of the rehabilitation management of stroke.

Cost of the seminar is $50.00 for physicians, $35.00 for non-physicians. 8.5 prescribed, Category I credits will be available for physicians. The seminar is scheduled for 8 A.M. to 5 P.M., Friday, March 29, in Rooms 3 A–B at St. Joseph Hospital and Health Care Center, 1718 South I Street, Tacoma, Washington, 98405. Deadline for preregistration is Friday, March 22.

For further information, contact Sylvia Harlock, Ph.D., Assistant Administrator for Rehabilitation Services of Surinderjit Singh, MD, PMR, Medical Director, both at St. Joseph Hospital, (206) 591-6761.

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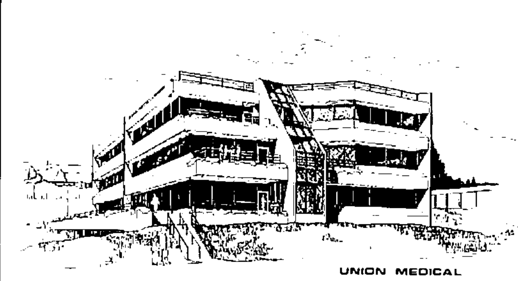

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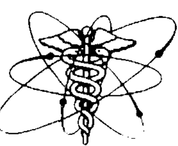

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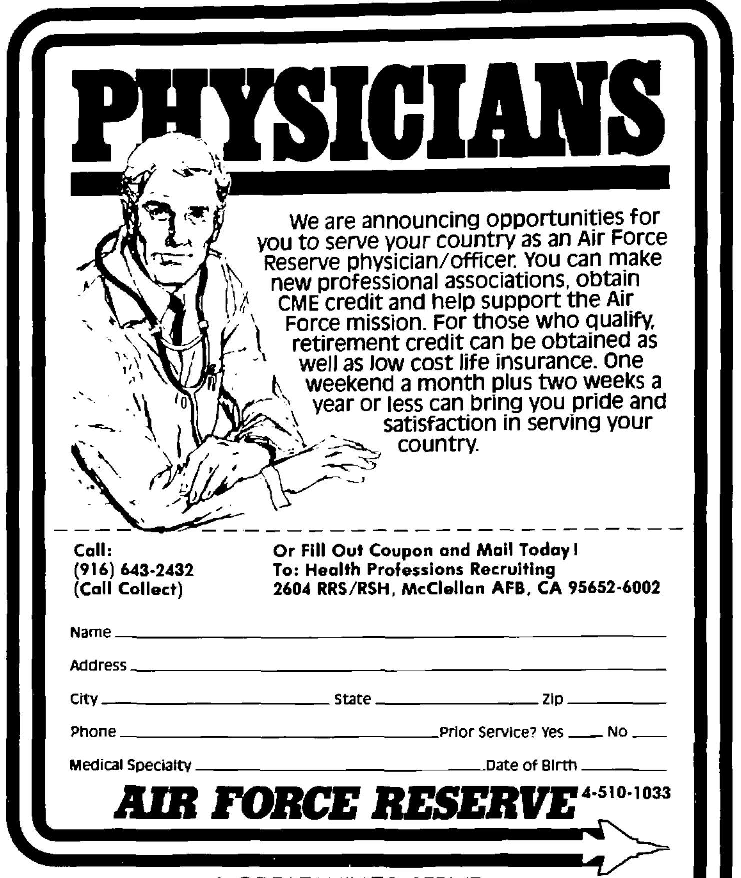

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Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
Pierce County Medical Bureau

One of the most frequent comments I have heard from fellow physicians when the topic of conversation turns to Pierce County Medical's Preferred Provider Plan is "we can't control health care costs without the cooperation of hospitals and other providers." This is certainly a valid concern and one that the Bureau has been aggressively addressing since Substitute Senate Bill No. 4403, "An ACT relating to health care costs," became effective in June of 1984. The bill encourages competition but also tightens regulatory control over rates.

The new law sets four major tasks for the Washington State Hospital Commission:

1) The setting of statewide hospital target revenues by October 1 of each year in advance of hosptial budget approvals;
2) The collection and maintenance of financial and patient discharge data necessary to monitor charity care and develop and all-payor system;
3) Establishment of a proposed unified hospital reimbursement system and
4) Approval of negotiated discounts from hospital rates.

Thanks to the substantial resources of the national Blue Shield Association and the concentrated effort of several Bureau staff members, hospital negotiations are currently in process. Local hospitals have been asked to formalize their relationships with Pierce County Medical Bureau by signing participation agreements, just as physicians traditionally have. Those hospitals may then choose to seek "preferred" status in order to provide care for patients who are covered by the Bureau's Preferred Provider Plan. These contracts between the hospitals and the Bureau will provide mutual benefits, not the least of which is a formal cooperative effort to control the cost of health care in our community.

Essentially, the agreements with hospitals are analogous to the Bureau's agreements with participating and preferred physicians and other providers. These contracts also will include provisions for utilization review, fair payment, and compliance with programs of preadmission certification, second surgical opinion and mandatory outpatient surgery when appropriate.

I am pleased to be able to report that hospital negotiations are proceeding as planned. In addition, those of you who are preferred may have already begun treating preferred patients as one major employer group has been covered by the Preferred Provider Plan since January 1. Please bear in mind that the Design Committee intended our Preferred Provider Plan to be flexible and dynamic; if you have comments or suggestions, be sure to forward them to either myself or Karen Kiehn, Manager, Alternative Delivery Systems.

Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
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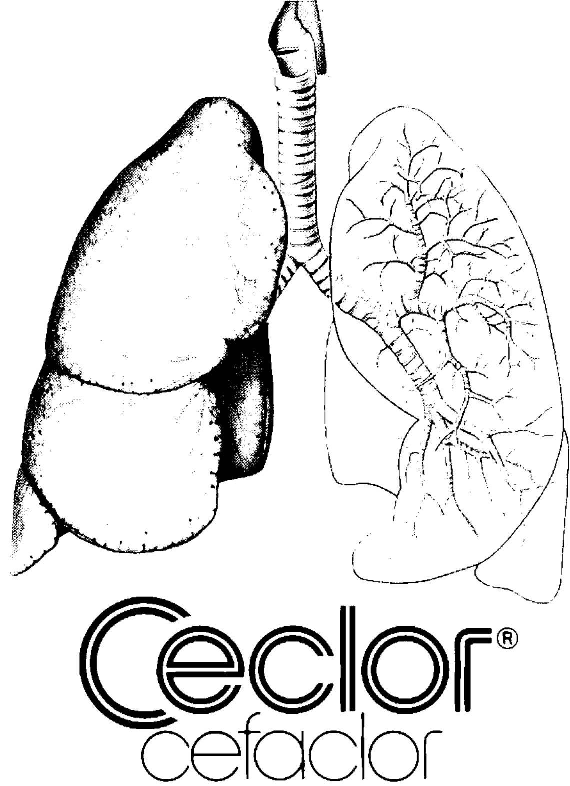
Consider the causative organisms...



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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings. IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out

Precautions. *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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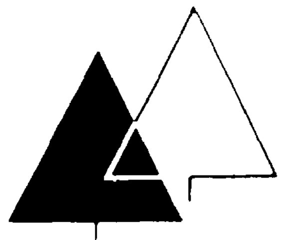

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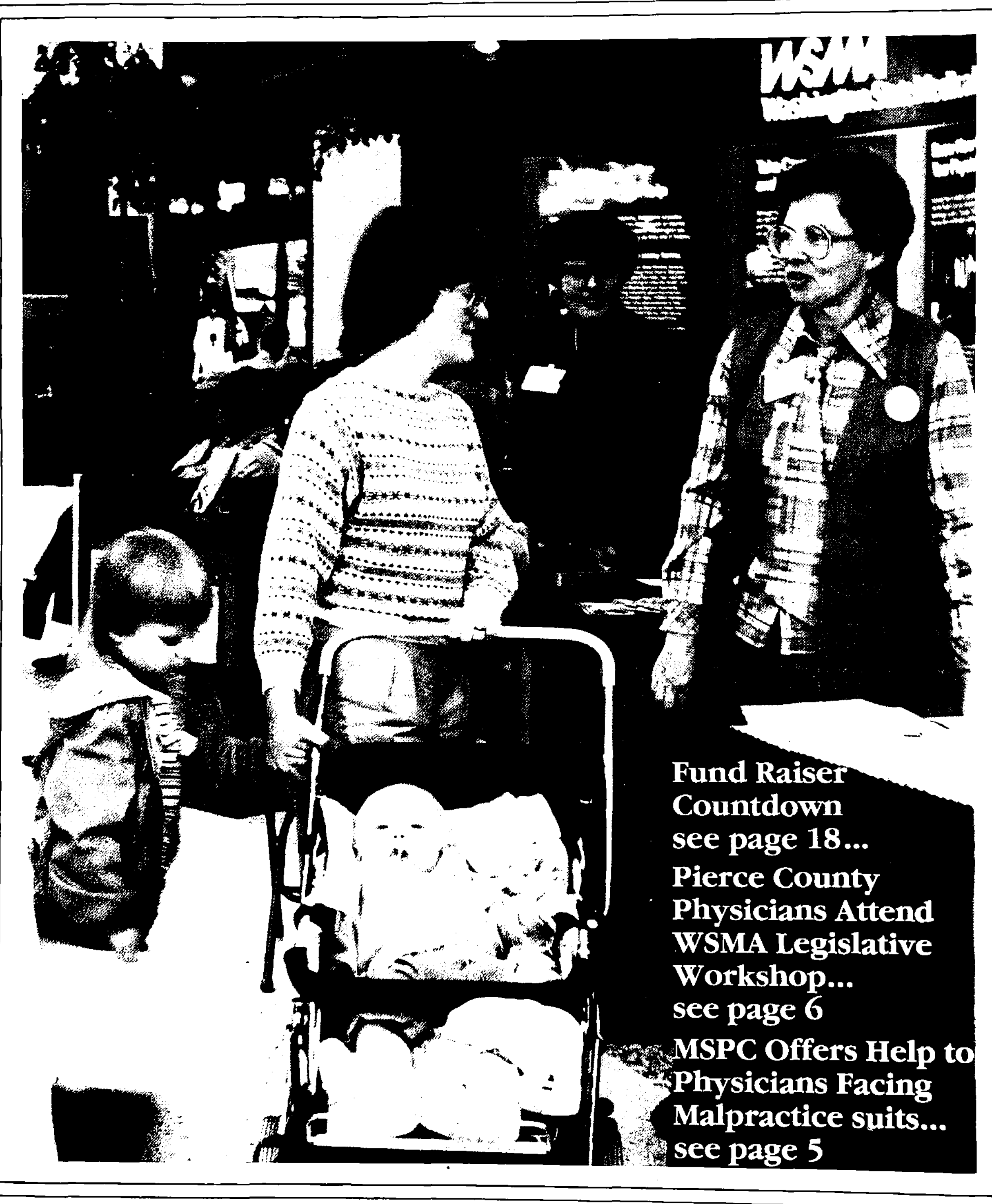
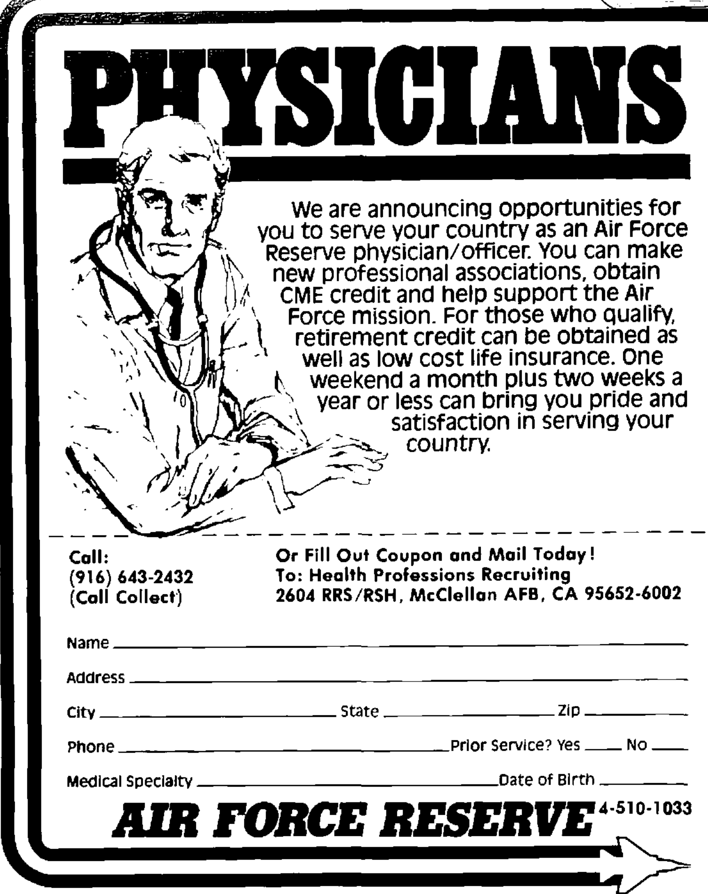
March, 1985



Fund Raiser Countdown see page 18...

Pierce County Physicians Attend WSMA Legislative Workshop... see page 6

MSPC Offers Help to Physicians Facing Malpractice suits... see page 5



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Cover Photo: 1985 Health Fair, Tacoma Mall, Tacoma, WA

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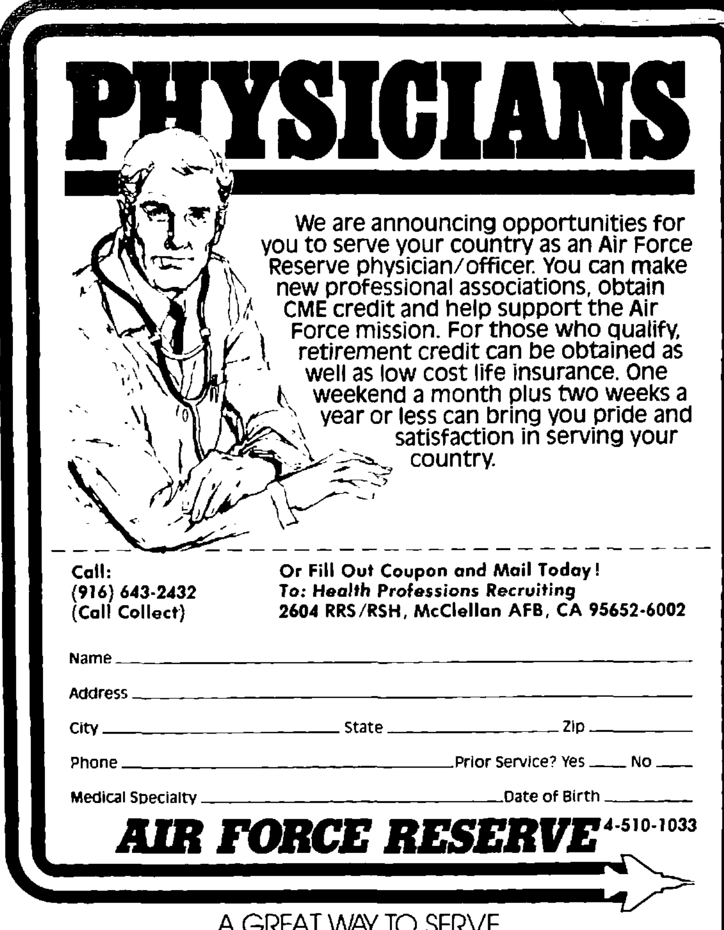

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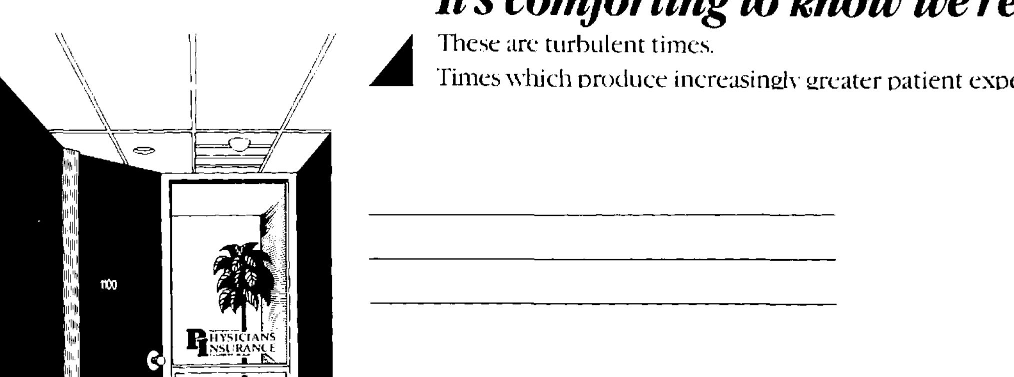

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*Cover Photo: 1985 Health Fair, Tacoma Mall, Tacoma, WA
Auxiliary members Cindy Anderson (left) and Helen Whitney (right) talking with a young mother at Health Fair booth. Photo by Sharon Lawson.*

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President's Page

Physicians' Opinion Survey

10:00 P.M., the telephone rings. A friendly voice says, "Did not wake you up, did I?" "Not at all," I answer, and follow with "Who is this," knowing full well that it is our Executive Director screaming for the copy of this page, as it is past the deadline for printing. Well, another night spent trying to get one of these articles together.

As you may remember in the last *Bulletin*, a public poll was conducted from which physicians were excluded. So here it is for our side. The following is from the Harris Poll, funded by the Equitable Life Assurance Society of the USA, and was related to "Physician Attitudes Toward Cost Containment." The overall conclusion was that physicians are less critical of the status quo, more likely to believe that the health care system is price competitive and less willing to accept alternatives to fee-for-service than consumers and other groups are.

For some of the specifics, the following: eighty-five percent of the physicians concur that government price controls to reduce health care spending are unacceptable; 2) Fifty-nine percent of the physicians think that the cost of hospitalization is unreasonably high; 3) Health Maintenance Organizations or Preferred Provider Organizations were unacceptable to a majority of physicians (this poll was taken in 1984 and I wonder if the latter is stil true.); 4) over 50 percent of the physicians find unacceptable the use of nurse practitioners, midwives and physicians' assistants instead of physicians, and 49 percent believe that this is not an effective measure of cost containment. Most physicians believe that reducing the use of "heroic" medicine would be effective in controlling health care spending. Thirty-one percent of the physicians say that aging of the population is the reason for soaring health care costs and 27 percent cite the use of expensive procedures to prolong life. Other reasons given were new medical technology and abuse of the health care system.

In general, younger physicians who have recently graduated are more receptive to changes in the health care system than older ones. The latter endorse changes that would shift additional costs to patients.

From a panel discussion on health care costs, "Who Will Provide the Cure," given at the American College of Hospital Administrators annual Congress on Administration, comments and projections from the panel were: Physicians will learn to use "diagnostic restraint" and the physician glut will help to reduce costs.

Well, there you have it. The public's and the physicians' poll. My own feeling is that the twain will never meet again, unless coerced by, probably, an impartial mediator, who I believe will be on the side of the not so silent majority.

Finally, I hope you all have read the thought provoking excerpt of a speech by Robert G. Petersdorf, MD, given at the George Washington University Medical Center. If not, a copy will be available by calling the Medical Society office.

—*GWB*

LOCAL NEWSBRIEFS

WSMA's Council on Professional Services working for better communication

WSMA's Council on Professional Services is establishing a mechanism to help arbitrate Professional Review Organization/Washington (PRO/W) actions as it administers the review program. The Council is also developing programs for better communication between PRO/W and practicing physicians.

WSMA leadership has met with PRO/W physicians and staff leadership to express member's concerns. PRO/W has announced a new policy to give physicians an opportunity to discuss a potential retrospective denial of hospital payment with a PRO/W reviewing physician before a final decision is made. PRO/W will make at least two telephone attempts to contact the attending physician to allow for any additional information regarding the patient's need for hospitalization.

Malpractice Suit???

MSPC Board of Trustees is establishing a mechanism for assisting members faced with a malpractice suit. Any member who has been faced with a malpractice suit and all its implications understands the impact this has on the physician.

If a member has experienced the trauma of a malpractice suit and would be willing to provide guidance and consultation to a fellow member, call Doug Jackman at the Medical Society office.

Talking to the community

(It is in the best interest of medicine that the general public hear medicine's side of the story. Editors note.)

Recently Drs. Bruce Buchanan and Richard Hawkins spoke before the Tacoma business community. Dr. Buchanan made a presentation before the Tacoma Rotary on the subject, "Can the Elderly Afford Health Care?" Dr. Hawkins addressed the Downtown Kiwanis on, "Is There Such a Thing as 'Affordable Health Care.'" Both talks were well received by the respective groups, and, as a result, close to 400 businessmen have a greater awareness of the many factors involved in the spiraling costs of health care.

Ethical Issues in Health Care

A seminar on Ethical Issues in Health Care will be held March 12, from 9:00 A.M. to 11:00 A.M. at the Executive Inn. The featured speaker will be Leo Greenwalt, chief executive officer for the Washington State Hospital Association.

The seminar is sponsored by the Council on Aging, the Area Agency on Aging and Senior Services of Washington. For information and to pre-register call the Council on Aging, 591-7219.

Editor's Note: Dr. Clark Deem's photo was run in error in the December issue of *The Bulletin* as Steven G. Buty, MD, applicant for membership. Our apologies.

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Pierce County physicians attend WSMA Legislative Workshop

James Symonds, MD (left) talking with Senator Talmadge, chairman of the Senate Judicial Committee.

Thursday, January 24, saw many Pierce County physicians attending the WSMA Legislative Workshop in Olympia. Key contact physicians took the opportunity to meet with Pierce County legislators to discuss some of the major issues facing the medical community and society today.

Immunization legislation seeking removal of the present 45 day grace period was high on the agenda. Health care cost containment, allied health care professional licensure, tort reform, smoking and the recommended managed state health care plan were among the other issues addressed.

Those at the Legislative Workshop attended legislative committee meetings and visited with legislators in their offices. Among the Pierce County doctors attending were: Drs. Lloyd Elmer, James and Henry Krueger, James Symonds, Alan Tice, Stan Tuell, Gregory Popich, Richard Hawkins, Robert Scherz and George Tanbara.

Gregory Popich, MD, MSPC Key Contact physician attending the 1985 WSMA Legislative reception, discussing the issues of the day.

Pamphlet on DRG Reimbursement available through MSPC

"Physician reimbursement under DRG's: Problems & Prospects" is the title of a new publication available from AMA. The pamphlet discusses the background and current status of medical reimbursement of physicians, and looks at the DRG system from the hospital and physician angles. It also gives AMA positions and activities. The pamphlet views the possible extension of DRG's to inpatient services and the ramifications as well. Copies are available on a loan basis from the MSPC by calling 572-3667.

Seminar on Hearing Disorders Receives High Marks

With the Tacoma/Pierce County Health Department and School Nurses of Washington as co-sponsors, the Medical Society Ad Hoc Committee on Tympanometry with co-chairmen Shirley Carstens, RN and Carl Wulfestieg, MD had over 100 registrants attend the seminar on January 26 and 27 at the Tacoma/Pierce County Auditorium.

School nurses from Richland, Vancouver, Forks, Longview and Seattle attended the Seminar and gave it extremely high marks.

The program reviewed anatomy, pathology and treatment, review of audiometry and prevention of hearing. The focus being on the school child's problems such as psychological aspects of hearing loss causes. The Ad Hoc Committee on Tympanometry is to be congratulated for organizing such a much needed and successful program.

College of Medical Education Receives Support

Thank you to the following individuals for their continuing support of the College of Medical Education.

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A quote from Dr. David S. Hopkin's January 1985 Western Journal of Medicine column; "The AMA will produce a TV show called "Medicine Today" on the lifeline cable network which will be seen in 22,000,000 homes. The AMA programs on cable TV this past year were so successful that over 7,000 laymen viewers called to ask how they could join the AMA. They apparently recognized the value of AMA better than some physicians."

Hope Amid Darkness

Editors Note:
The James R. Burt foundation was established by Dr. and Mrs. Robert R. Burt, following the death of their son, in the hope of helping others and to arrest the increasing magnitude of the problem of depression and suicide in our youth.

A two day seminar on understanding depression and suicide will be presented Friday, March 8th, 7:00 p.m. to 9:00 p.m. and Saturday, March 9th, 9:00 a.m. to 3:30 p.m. by the James R. Burt Foundation for Research & Treatment of Depression. Cosponsors include Cable T.V. Puget Sound; KIRO Inc.; Greater Lakes Mental Health Center; Tacoma School District #10; and Tacoma Community College.

It is a free, non-credit seminar designed to expand public awareness of the growing problems of depression and suicide among our youth, and although primarily developed for the professional person working with young adults, it is also applicable to other age groups.

Professionals will look at depression as a treatable illness, discuss kinds of depression, behavior patterns of the depressed, causes and effects, medical treatment, self-help and preventive measures including the role of diet, exercise and self-esteem. Depression in relation to suicide, myths-vs-facts about suicide, warning signals, professional help and community resources available will be covered. Opportunity for questions and answers from professionals.

Keynote speakers are: Patrick J. Donley, MD, F.A.P.M. Biological Psychiatry Northwest, Tacoma; Marsha Linehan, Ph.D., Department of Psychology, Director, Suicidal Behaviors Research Clinic, University of Washington; and Marie Thomson, RN, M.A., Tacoma.

An optional one continuing education credit is available through Tacoma Community College for attending the seminar and follow-up class March 16th, 8:00 a.m. to 12:00 p.m. by registering in advance and enclosing $38.20 with the registration. The seminar and follow-up will be held in the auditorium at Tacoma Community College.

For further information, call Program co-ordinator, Carolyn Bondy at 759-5168 or contact the Office of Continuing Education, T.C.C. at 756-5018.

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Physician's Cost Containment Checklist

Individual physicians can contribute significantly to efforts to contain health care costs. The checklist below includes many ideas you may wish to consider in drawing up a personal treatment plan for our health care system's economic problems.

Patient Care

The physician's medical practice is constantly being affected by increasing competition and other pressures. Many individual physicians are concerned about the impact of market forces on their practices that require them to be not only good medical practitioners but also effective organizers of resources. Below are some suggestions on how to make patient care more cost effective.

- Do you know the cost of the diagnostic tests and imaging procedures you order?

- Are you familiar with the cost of the medications you prescribe? Are you aware of competitive generic drugs which may offer your patient the same clinical effectiveness but at a lower cost?

- When you prescribe a test, procedure, or drug, do you explain to the patient why it is being prescribed, what you hope will be accomplished, the cost of the treatment, and whether a follow-up telephone call or office visit is required?

- Do you schedule diagnostic tests or procedures on an outpatient basis whenever feasible?

- Do you utilize the AMA's Patient Medication Instruction (PMI) sheets to enhance patient compliance in the use of drugs, to help in the prevention of adverse drug interactions, and to strengthen the physician–patient relationship? (For ordering information, contact AMA Order Department at 312/280-7291.)

- When referring patients to another physician, do you send along all reports on laboratory tests, x-rays, etc. which may be needed to avoid costly duplication?

- Do you obtain previous reports and laboratory results when a patient is referred to you?

- During your routine communications with patients, do you encourage the use of your office rather than the hospital emergency room for all but true emergencies?

- Have you developed a standard "return to work" form indicating the date the employee could return to work, level of effort the employee should expend (if not able to return to his or her previous job), and length of time before full activity could be resumed?

- Do you have an arrangement to provide physician coverage when you are unavailable so that patient will know whom to contact and not resort to use of the emergency room for minor problems?

- Do you or a qualified member of your staff provide your patients with information on self care? Do you explain the importance of compliance with treatment regimens, diets, etc. which you have prescribed?

- Have you considered using patient education pamphlets to explain procedures or treatments that are common in your practice, lifestyle issues, health care resources in your community, common medical conditions, etc?

The Business Aspects of Medical Practice

To assist physicians in making their practices more cost effective, the AMA has developed programs offering instruction on a variety of subjects such as efficient practice techniques, computer-based information on drugs, and paperless health insurance claims processing activities through the AMA/GTE Medical Information Network.

By managing the business side of their practices more carefully, many physicians have been able to hold down or reduce overhead expenses. These physicians have in turn passed these savings on to their patients. Some of all of the following suggestions may be helpful to you.

- Does your office use preprinted forms whenever possible to reduce the cost of letter writing? A recent survey by the Dartnell Institute of Business Research estimated the average cost of a dictated and transcribed letter to be approximately $7.60.

- Does your office complete insurance forms promptly? Studies show that insurance forms are often submitted weeks, even months, after the date on which a procedure was done. Consider the benefit of improving cash flow in your office by speedy processing of claims and statements. The new, revised AMA Health Insurance Claim Form is now available to facilitate payment of Medicare, Medicaid, CHAMPUS, and private health insurance claims. (For information on the types of forms available, contact AMA Order Department at 312/280-7291.)

- Is your staff familiar with the claims submission procedures of third party payers? A clear understanding of claims processing procedures will expedite payment and will save you and your patients time, money, and frustration.

- Do you inadvertently fail to record and collect on certain types of patient encounters such as hospital emergency room and consultation visits? Some physicians are slow, or even forget, to

bring this information back to the office for billing purposes. Patients who pay for office visits may be subsidizing those who are never billed.

- Does your office deposit patient payments on a daily basis? Doing so is good business management. A money market account can maximize the interest on your funds.

- Does your office take advantage of bulk purchase discounts on frequently used supplies and the supplier discounts that many firms offer on promptly paid bills?

- Do you know that the AMA's Department of Practice Management conducts workshops and serves as a resource for physicians? Programs offered include workshops on starting a practice, the use of computers in the medical practice, and marketing strategies for private practice. (For further information, contact AMA Department of Practice Management at 312/645-4791.)

- Do you or appropriate members of your staff discuss with our patients the proper utilization of health services and, in particular, procedures followed by your office?

- Have you considered providing a patient information booklet describing your appointment procedures, telephone call policy, insurance and legal form policies, office hours, fees, billing procedures, etc.? Patient information booklets can cut staff time and create goodwill with your patients. (The AMA provides information on "Preparing a Patient Information Booklet," available through the AMA Order Department, OP-441.)

Professional Association Involvement

Important changes can be effected through individual involvement in your state, county, and specialty societies. Rarely has there been a time when physician participation at all levels of organized medicine was more necessary.

- Are you aware of the cost effectiveness activities conducted by your professional associations? The AMA and an increasing number of state medical associations sponsor annual leadership conferences at which physicians can become exposed to current issues in the public and private sectors that have an impact on the cost of medical care.

- Are you familiar with your society's participation in a local health care coalition? Local health care coalitions bring together a broad spectrum of community and provider participants, and these voluntary groups have evolved as an effective mechanism to address such issues as accessibility, quality, and the cost effective use of health care resources.

- Have you contacted your society to find out how you can help to develop or contribute to a health care coalition or other cost effectiveness efforts? (For further information, contact AMA Department of Health Care Coalitions at 312/645-4717.)

- Does your society provide information on health care cost issues that you can share with colleagues and your patients?

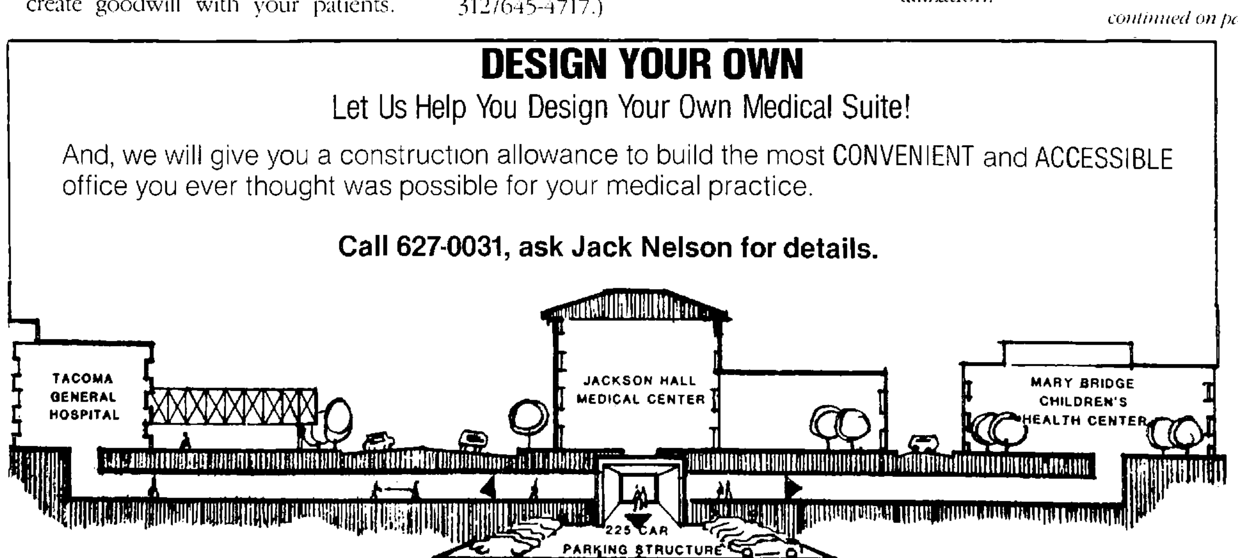
- Have you taken the time to become involved in your local society's activities–perhaps running for an office, becoming a member of a committee, encouraging membership of your colleagues at all levels of organized medicine? Active physician participation is essential to assure that high-quality medical care continues to be provided through the efficient utilization of resources.

Physician–Hospital Relations

Many office–based physicians spend a great deal of time in hospitals treating their patients–a trend that requires added attention to physician–hospital relations. The activities of the AMA's Hospital Medical Staff Section, and similar activities at the state level, encourage greater physician involvement in hospital decision–making at all levels to assure continued high-quality, cost-effective medical care. The AMA has published "A Guide for Formation of a Hospital Medical Staff Section" and offers consultation services to assist state medical associations in the development of statewide hospital medical staff sections. (For further information, contact AMA Department of Hospital Medical Staff Services at 313/645-4757.)

- Do you initiate early discharge planning when you know that our patient may need extended care facility or home health services following hospitalization?

continued on page 10



- Do you try to schedule admissions and discharges to avoid charges for extra days or weekend stays?

- Do you order preadmissions testing?

- Do you notify hospital administration when delayed or neglected tests or procedures necessitate a longer hospital stay for your patients?

- Are you aware of your hospital's policy concerning ordering combinations of diagnostic tests? Do you have the option of ordering tests individually?

- Do you routinely review copies of your patients' hospital bills? Do you notify administration when unnecessary duplications of procedures are ordered for your patients, or when items are billed incorrectly to your patients?

- Do you and your colleagues use your organized hospital medical staffs to suggest cost effectiveness efforts which medical personnel and hospital administration might initiate? For example:

  - Are cost and charges printed on order forms for laboratory tests and x-rays?

  - Are interns and residents at your hospital given a "cost containment orientation" and provided with information on the hospital's costs and charges for routine services (from room charges to the cost of an aspirin)?

  - Has the medical staff considered discussing an "economic case" during departmental meetings or holding periodic Economic Grand Rounds conferences? (For further information, contact AMA Department of Health Care Financing and Organization at 313/645-4868.)

  - Does the hospital publish a periodic newsletter for the medical staff on cost effectiveness issues? These can be used as a device to apprise physicians of the costs of frequently ordered services and to transmit ideas that can be implemented by the medical staff.

  - Does the medical staff representative to the hospital's board of trustees encourage cost effectiveness efforts which are consonant with quality patient care?

  - Does the medical staff work in concert with the hospital's pharmacists to encourage the ordering of the most cost effective drugs?

Cost Awareness in Medical School

It has been suggested that introducing cost awareness at an early level in a physician's training may encourage life-long habits in the cost effective use of medical services.

- Do you encourage inclusion of socio-economic information in the curriculum of your area's medical school and teaching hospital?

- Are medical students exposed to educational programs on the cost and usefulness of laboratory tests and x-rays, drug costs and the use of generic drugs, the most effective use of ancillary services, etc?

- Are students given the opportunity to discuss an "economic case" and to participate in Economic Grand Rounds conferences? ■

The American Medical Association continues to offer support to private sector initiatives designed to contain health care costs while protecting the patient's right to high-quality care.
Reprint from "Physicians Cost Containment Checklist," AMA, 1984

Notice to Readers...

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 752-3667.

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Runners' Diarrhea

By W. Michael Priebe, MD, and Jo Anne Priebe, RD, St. Joseph Hospital and Health Care Center, Tacoma, WA

Reprinted from American Journal of Gastroenterology, Oct., 1984

Many long-distance runners experience incapacitating diarrhea which may significantly hinder optimal performance during running. Yet, most physicians are unaware that this condition exists. The few anecdotal reports on RD in the medical literature do not provide detailed data on prevalence or clinical symptomatology. RD has been attributed to intestinal ischemia by some authors. To determine the prevalence, clinical symptomatology, and whether ischemia or other factor(s) may play a role in RD, a questionnaire was designed. 425 respondents who participated in the 1983, 10 km (6.2 mi), St. Joseph Heart Run provided data for analysis. Thirty per cent (125/425) of runners have experienced RD. Further analysis of 82 symptomatic participants provided the following clinical description: passage of semi-formed or watery stools occurred in 85%, associated abdominal pain below the umbilicus in 67%, rectal urgency in 63%, multiple stools (≥ 2) in 51%, large volume stools in 13%. Abdominal pain and rectal urgency were relieved by defecation in 72%. Diarrhea and/or abdominal cramps continued or began after completion of a run in 54%. Fecal incontinence with soilage was reported by 33%. Scant hematochezia was rarely observed by 12% of runners, some of whom had anorectal disorders commonly associated with rectal bleeding. Fifteen per cent of subjects had irritable bowel symptoms when not running. Lactose intolerance and high dietary fiber intake were present in 13 and 33%, respectively. Those runners who tried prophylactic antidiarrheal agents noted prevention or alleviation of diarrhea. The symptom relief with defecation, symptom onset or continuation after finishing a run, and prevention or alleviation of diarrhea with antidiarrheal agents suggest that running-induced alteration of intestinal motility rather than intestinal ischemia is the cause of RD. The frequent occurrence of defecation during running makes one wonder whether this form of exercise should be used as an adjunct in the treatment of simple constipation.

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Open Letter from the Office of the Pierce County Medical Examiner

Dear Doctors;

In the past, the Coroner's Office assumed jurisdiction over deaths in which the deceased was without medical care for thirty-six (36) hours preceding death and death is thought to be from natural causes.

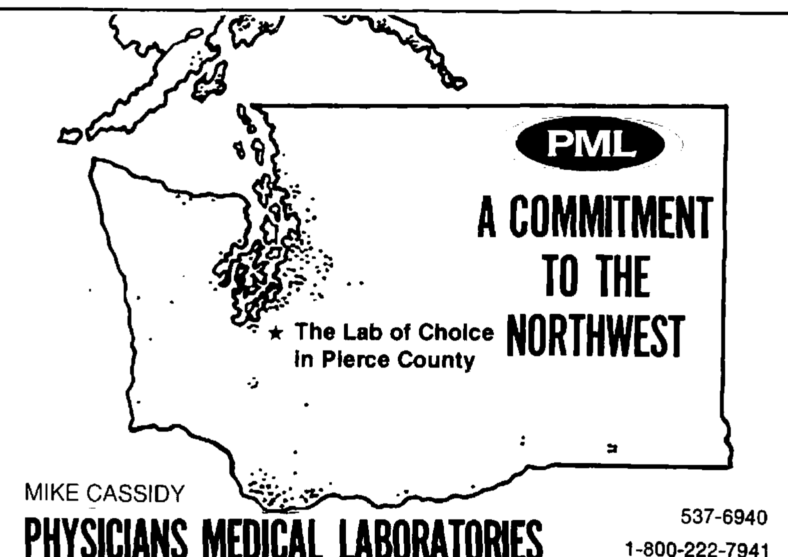
The Medical Examiner's Office applies a rather narrow interpretation of the legislative language "persons who come to their death suddenly when in apparent good health without medical attendance within the thirty-six (36) hours preceding death." If both conditions (lack of medical care and apparent good health) apply, the Medical Examiner's Office will take jurisdiction. If one or both conditions do not apply, the Medical Examiner's Office need not be notified. In all of these cases, a prerequisite is that the attending outside physician has knowledge and awareness of a patient's natural disease condition and is able to reasonably certify death.

Since the death certificate is a legal and not a scientific document, it is not necessary for the physician to demonstrate a specific anatomic lesion to determine the cause of death. For such a requirement, postmortem autopsies would be necessary in all deaths which are clearly unmanageable and beyond the resources of the Medical Examiner and the medical community. The requirement for certification is a statement of the general disease process which underlies and is *most likely* responsible for the mechanism of death.

Occasionally, we have encountered difficulties with physicians who state that they are uncertain why a patient died, although they have been treating the patient for years for a stable, although not necessarily a life-threatening condition; e.g., a hypertensive patient, quite well controlled, drops dead suddenly and in view of many witnesses. The physician may feel that the death is unexplained and needs an autopsy for specific anatomic diagnosis. The Medical Examiner will not take jurisdiction on such cases since the medical history provides a background for a reasonable cause of death, i.e., Hypertensive Cardiovascular disease.

The first year of the Medical Examiner's Office has been a challenging year for me. We have made many changes and anticipate many more to come. The response to the change from the community has been positive. The medical community, in particular, has been supportive and cooperative. This has made my job easier and is very much appreciated.

Sincerely yours,
Emmanuel Q. Lacsina, MD
Pierce County Medical Examiner



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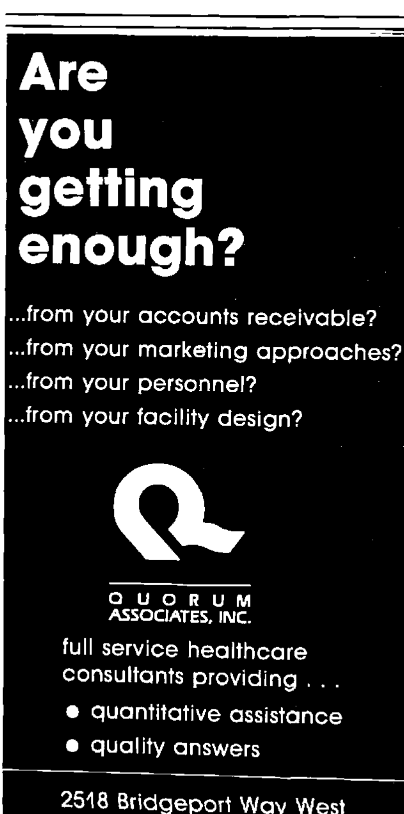

Encountering the High Risk Patient

By Brian S. Gould, MD

Sooner or later every physician breaks the law.

The reasons, of course, have to do with the dilemmas of patient care. Despite the best efforts of excellent physicians, there are always patients who do not seem to get well with orthodox therapeutics, or who persist in making extratherapeutic, but persuasive, demands of the treating physician. Typically, the medical "law breaker" ends up writing prescriptions for which there is little appropriateness or justification—at least in the opinion of more objective reviewers. If, as the attorneys are fond of pointing out, difficult cases make bad laws, then we might add its medical corollary: difficult patients provoke poor treatment decisions.

Of course it is not unknown for physicians who conduct their practices with a sufficiently "unorthodox" pattern to come to the formal attention of the enforcement authorities. When this occurs, the ensuing debate concerning what is "clinically appropriate" versus what is "legal" invariably provides tasty grist for the judicial mill. By the way, the side favoring the priority position of clinical considerations usually loses.

In the past several years we have witnessed growing anxiety among the ranks of physicians regarding the hazardous consequences they face from so-called misprescribing. For a number of years the California Medical Association and the California Society for the Treatment of Alcoholism and Other Drug Dependencies have co-sponsored a seminar at the CMA annual meeting focused on this problem. In 1985, our specific emphasis will be on what we have fondly been calling "the new high-risk patient."

Unlike his traditional clinical predecessor with the same name, this high-risk patient is not in jeopardy from disease. Rather, he is "high risk" because he poses a direct and significant threat to the professional well being of the physician attempting to treat him. These patients initially challenge the physician clinically; then personally; and, ultimately, legally.

Fortunately, like other toxic conditions, these can also usually be predictively identified and treated appropriately if one knows what to look for, understands the underlying pathophysiology, and is aware of the proper intervention techniques.

Central to the problem is the surprising fact that most physicians misunderstand the legal basis of medical care. The privileges granted by medical licensure are actually rather specific and limited ones. Broadly stated, under ordinary circumstances physicians are (having obtained appropriate consent, of course) empowered to utilize recognized medical therapeutics only for the treatment of adequately diagnosed pathological conditions. Therefore, prescribing without a diagnosis, or in excess of recognized norms, or in the absence of a pathological condition, may well place a physician's behavior outside of the practice of medicine, and therefore outside of the law, regardless of good intentions.

As an illustration, consider the patient who requests an amphetamine in order to "study" or "stay alert" on a long distance drive. His perceived need may be real, and one with which the physician is inclined to be compassionate, but legally there is no question that this falls outside of the practice of medicine because there is no pathologic condition being treated.

In other situations, special restrictions may also apply to the practice of medicine such as those associated with specific categories of therapeutics (the scheduled drugs), or to specific conditions (those applying to patients who are addicted).

We find that although physicians rarely object to these limitations when presented didactically, in gray area situations they may get confused and do the wrong thing anyway.

Chronic conditions almost always fall into this confusing "gray area." Pain, insomnia, tension, and stress are all notoriously associated with overprescribing. Published guidelines are often of little help when the physician is confronted by a compelling patient in severe distress. The physician's training and instincts create a readiness to assist through action. The customary action is to prescribe therapeutics. The therapeutics are usually also drugs of abuse.

In point of fact, it is not particularly difficult to seduce physicians into improper behavior by creating a climate that combines appealing personal characteristics

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with a high level of anxious "neediness." As a group, physicians are action-oriented, time-pressured, anxious to please, prone to believe whatever they are told by patients, and most of all, reluctant to say "no." If seasoned with appeals to the physician's sense of dedication, status, or vanity, success in obtaining medication is almost assured. ("Thank you, thank you, Dr. Gould. You are the only one who really understands and gives me the help I need." Patient leaves with 100 more codeine tablets.)

While it is beyond the scope of this brief article to outline a detailed approach to these most complex clinical problems, a few comments may be helpful:

1. Physicians should recognize that illicit drug traffic is big business, and that the diversion of medication from legitimate channels (ie, physicians) to the black market is a major source of supply. With several types of medication selling for $15 to $50 per tablet, simple arithmetic would indicate the business potential of visiting different doctors for the purpose of tricking them into writing prescriptions for non-existent ailments.

It is important to spend sufficient time with new patients to fully understand the nature of the ailment, the personality of the patient about to be treated, and the implications of the treatment plan. Quickly writing a prescription to dispose of a cranky or persistent patient is a dangerous habit and should be avoided.

2. Learn how to say no. There is no reason to initiate treatment prematurely or when there are significant reservations about its correctness. These are not life or death situations that require immediate responses. If they seem to, perhaps hospitalization for further evaluation is a better idea than a large prescription for a questionable drug.

Remember that the first rule of medicine says nothing about demonstrating our compassion or likability as physicians, but is rather a warning to restrain ourselves lest we do added harm.

Bona fide patients are seeking proper treatment. They can usually be dissuaded from insisting on quick relief if the physician is reassuring about his clinical interest in them and demonstrates willingness to evaluate their problem properly with effective therapeutics to follow. The patient who does not accept this measured approach should raise suspicions regarding his actual motives.

3. Finally, all physicians should recognize the distinctions between the proper approach for chronic as opposed to acute conditions. The success rate of analgesics and sedatives is inversely proportional to the duration of therapy in most cases. Unfortunately, the failure of the treatment tends to justify its continuation. That is, because the treatment does not correct the underlying problem, the need for relief continues, and so the nonspecific remedy is continued endlessly. Any of us can fall into this pattern but should be able to recognize it eventually, and extricate ourselves. Often, consultation with another practitioner at this point is most helpful.

While provocative, we have found the concept of the hazardous patient to be a useful one for describing practice situations that are particularly stressful to the primary care provider. Our course at this year's Annual Session should be a lively one. Of course we hope to see everyone there.

Reprint: From San Francisco Medicine, Jan., 1985

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College of Medical Education
Continuing Education Programs Scheduled for 1984-85

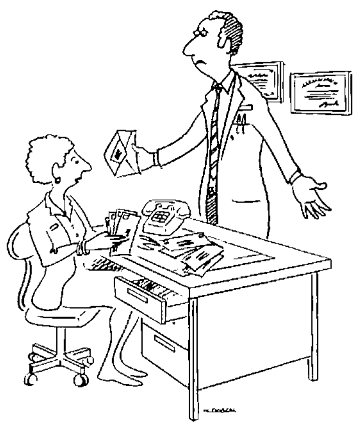
(Programming is subject to change—Individual notices will be sent preceding each program.)

Phone: 627-7137 (P) = Physician (A) = Allied Health

Location	Date	Program	Coordinator	
	JANUARY			
JH	4, 11, 18, 25	Update in Surgery	TGH	(P)
JH	23, 30, Feb. 6	Effective Meetings		(A)
JH	17	Ear/Nose/Throat in General Practice	Wulfestieg/ Rone	(P)
STJ	17	Marketing to Win	Vipperman	(A)
STJ	24	Law & Medicine	Malden	(P)
JH	17, 24	Money Management (Evenings)	Jackman	(P)
	FEBRUARY			
STJ	7	Telephone Assessment	Simms	(A)
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Pomeroy/ Bargren	(P)
HHT	13	Nursing Assessment—Geriatric Patient	Barton	(A)
	TBA	Hospital Budgeting		(A)
STH	15	Diabetes	Stonecipher	(P)
STJ	25, 26	Advanced Pediatric Life Support	Seward	(P/A)
	MARCH			
STJ	6	Right Brain/Left Brain		(A)
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
HHT	21	Prac. Solutions—20 Most Common Geriatric Prob.	Waltman	(A)
	21	Current Trends in Nutritional Therapy	Pelham	(P/A)
	TBA	Medical/Surgical Potpourri		(A)
	APRIL			
STJ	4, 5	Survival Skills for Nurses	Chilton	(A)
UPS	12, 13	Surgical Club	Martin	(P)
STJ	26	Death & Dying	Schmidt	(P/A)
	TBA	Symptom Mgmt. of Cancer Patients for Nurses	Boulet	(A)
	TBA	Adolescent Patient: Suicide, Pregnancy, Drugs	Ingraham	(A)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	9, 10	Cardiovascular Disease Review	Strait	(P)
	JUNE			
JH	27, 28	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137



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Fund Raiser: Final Count Down

It's final count down for the fund raiser, March 17. Have you purchased your raffle tickets? Have you made your Champagne Brunch Reservation? It's not too late to do both! Contact Bernice Lazar, 564-3034 or Mary Lou Jones, 565-3128 for raffle tickets.

Use the tear-out reservation form on the opposite page to make your reservation for the Champagne Brunch or your contribution to our annual fund raiser.

Don't Delay. Do it Today...

Your participation in this fund raiser will give support to several smaller local agencies which need our support to survive.

Student Recognition... ATTENTION Parents of Graduating Seniors

A special thanks to all who helped us raise $500 by purchasing raffle tickets at the December Joint Dinner Meeting.

Kris White, Student Recognition Program Chairman, reports the Auxiliary will again present the Student Recognition Award. Eligible are Pierce County high school seniors who are children of Pierce County Physicians.

Applications are available in the counselor's offices of the public and private schools in the county. The Student Recognition Committee stresses that the applicant's names are not known to the committee. The award is based on scholarship, leadership, service to the school and to the community.

Deadline to return applications is March 29. If you have questions call, Kris White, 851-5552, Gig Harbor.

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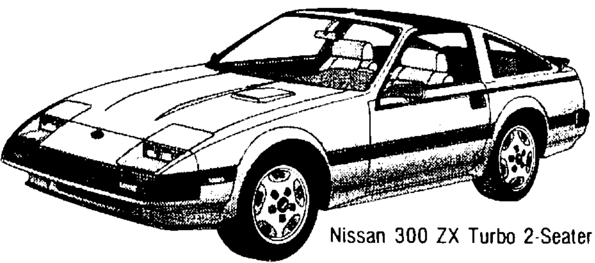

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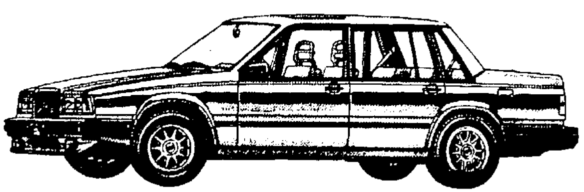

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HOSPITAL NEWS

Lakewood General

Alcohol and Chemical Treatment and Rehabilitation Program for Adolescents

Lakewood General Hospital will provide a greatly needed service for Pierce County and surrounding areas—an inpatient alcohol and chemical abuse treatment program, exclusively for adolescents.

According to Bruce M. Yeats, President/CEO of Lakewood General Hospital, "The new 26-bed unit, developed in the hospital annex, is scheduled for opening in February of this year." Yeats further stated, "This program, entitled 'New Beginnings,' will provide needed services to the chemically-dependent adolescents in the 11–18 year age group."

Recovery Centers of America, Inc., a subsidiary of National Medical Enterprises, will provide professional management and services for the new program.

Richard E. Paynter has been appointed Program Director. Active in the field of drug and alcohol treatment for the last eleven years, he previously served at Milam Recovery Centers and Riverton Hospital Care Unit.

Paynter stated, "Experiences in the past decade have sharpened society's awareness of the devastating effect of chemical dependency on our youth. An estimated 3,000,000 young Americans abuse alcohol extensively. Each year, 10,000 young lives are lost in alcohol-related accidents and alcohol is implicated in thousands of adolescent drownings, suicides, violent injuries, and deaths and injuries in fires."

New Beginnings rehabilitation program has been planned in response to the overwhelming concensus that there is a great need for hospital-based chemical dependency treatment for adolescents in our area.

The multi-disciplinary, three-phase program for the treatment and continuing recovery of adolescents with chemical dependency problems and related medical complications will be comprised of a primary care phase averaging three days, a rehabilitation phase which may last for 60 days, and after care extending for a minimum of one year after discharge. An average length of stay of 45 days is projected.

"By 'turning around' the lives of 200 or more youth annually, and the positive impact this will have on the entire community, Lakewood General Hospital feels pleased, challenged and motivated to provide this service," Bruce Yeats concluded.

Humana

Physical Therapy at Humana Adopts Hands-Off Approach

Humana hospital's new spine rehabilitation program is designed to get people back to work within three to five weeks. Patients work with physical therapists who set goals to improve their functional limitations, and counsel them on the proper ways to lift and move. The program is intensive, involving daily total body strengthening exercises, workouts on state-of-the-art exercise equipment and swimming.

Patients who do well in this program have gone beyond the acute stage for injuries, have tried other methods to get well and are mentally prepared to accept the rigors that lie ahead.

Humana's spine rehabilitation program accommodates 12 patients at a time who are admitted through doctor referrals only. After discharge, a patient's progress is monitored for three to 12 months.

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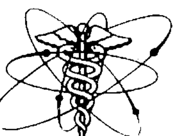

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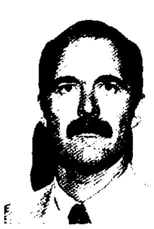
MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Paul Sargent, DO, MD, *General Practice.* Born in Hymera IN, 10/2/31: medical school, Chicago College of Osteopathic Medicine, Chicago IL, 6/61: Washington College of Physicians & Surgeons, Seattle WA, 7/65: internship, Standring Memorial Osteopathic, 7/61-6/62. Washington State DO License, 62; Washington State MD License, 65.



Lawrence R. Vidrine, MD, *Urology.* Born in Houston TX, 6/24/47: medical school, University of Texas, Galveston TX, 6/72: internship, University of Oklahoma Surgery, 7/72-6/73: residency, University of Oklahoma General Surgery, 7/76-6/77, University of Oklahoma Urology, 7/77-6/80. Washington State License, 9/84. Dr. Vidrine currently is practicing at 124 Tacoma Avenue South, Tacoma, Washington.

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General Surgeons needed for long-term practice opportunity in Western Washington community within 2 hours of Seattle-Tacoma. Training and experience in Vascular or Pediatric Surgery desirable. Practice support package possible. Send CV and references to Nancy Friedrich, c/o The Friedrich Group, 9284 Ferncliff N.E., Bainbridge Island, WA 98110.

Due to an increase in patient population and contractual business, Western Clinic is seeking existing or new practitioners who wish to join Western Clinic in the following sub-specialties: FP/Occupational Medicine, OB-GYN, ENT, Gastroenterology, Surgery, Orthopedics, Urology. Excellent opportunity to join a growth oriented medical group. All replies held in strict confidence. Please Send CV or letter of interest to: Executive Director, Western Clinic, P.O. Box 5467, Tacoma, WA 98405.

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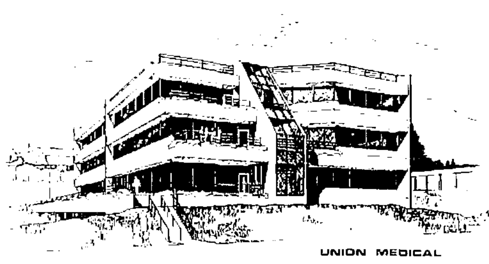

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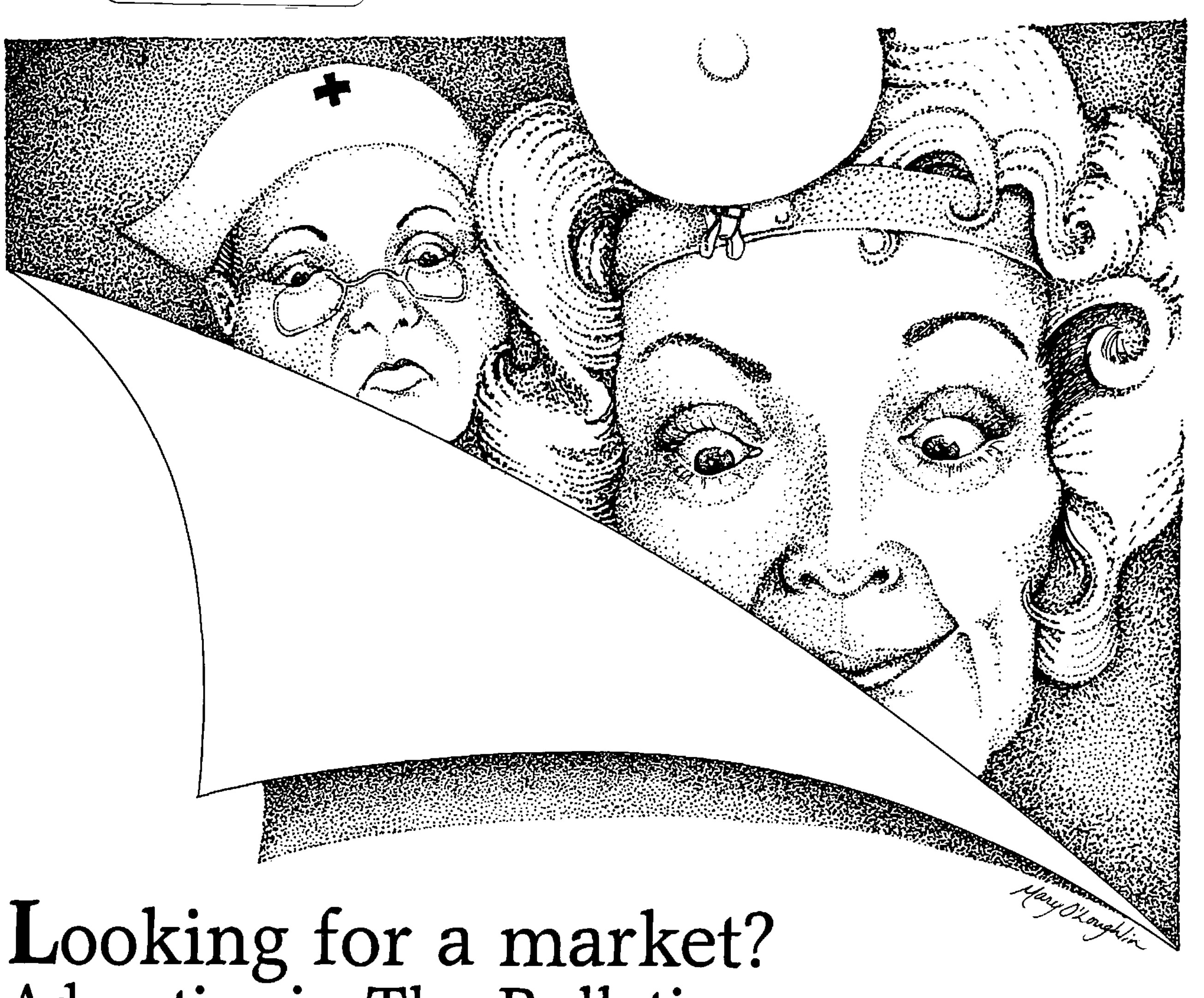

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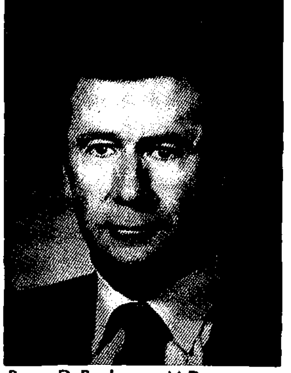
Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
Pierce County Medical Bureau

Pierce County Medical Bureau's new managed health care program is now ready for the acid test, introduction to the marketplace. Participating physicians, our local hospitals and other health care providers have been informed of the design of our Preferred Provider Plan. The Bureau's marketing staff seems confident that the employers who are the actual purchasers of coverage will be enthusiastic about the plan and are prepared to launch a comprehensive advertising, sales and service campaign that will be fully underway by April 1.

Your support of this effort will be critical to the long range success of this new plan, which will depend on the perceptions of your patients whose groups have enrolled. Helping them understand some of the plan's requirements, like preadmission certification, second surgical opinions and required outpatient surgery, will enhance their confidence in their coverage. Your support of this physician-designed plan will reassure your patients and contribute to the plan's success.

Part of the initial campaign to educate the public about the Preferred Provider Plan will promote the concept that the new I.D. card is accepted "in all the right places." Those of you who are Preferred Providers will receive specially designed graphic displays to identify your office as one of those "right places." Preferred hospitals will be identified in like fashion. Patients will be looking for providers who are preferred; it will be advantageous to utilize the display materials provided by the Bureau. Remember that preferred providers are expected to recommend other preferred providers.

It is hoped that your peers' knowledge of your preferred status will enhance your patient population base.

Hospice and Home Health Care

I recently received a reminder from the Bureau that hospice and home health care benefits are available as an alternative to hospitalization on almost all Pierce County Medical Bureau plans. Please consider using these cost-effective alternatives in appropriate situations. Many patients may not be aware that these benefits are available or may not realize the advantages these agencies can provide. I encourage you to become familiar with these programs so that you may more effectively educate your patients about them.

The Utilization Review Committee

There are several committees under the jurisdiction of the Bureau's Board of Trustees whose members deserve acknowledgment for their contributions of time and effort. I would particularly like to commend those who serve on the Bureau's Utilization Review Committee, because their task is seldom an easy one.

Although the Bureau's internal staff systematically analyzes computer data on all claims, it is the Utilization Review Committee that addresses specific provider problems. The Committee monitors and corrects specific practice patterns and establishes reasonable solutions to general problems of over-utilization.

Fellow physicians who have been involved in the utilization process have found it to be useful and highly professional. It is important for participating physicians to know that the Utilization Review Committee continuously addresses relevant issues with sensitivity and understanding about its collective responsibility.

Bruce D. Buchanan, M.D.
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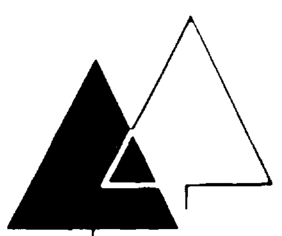

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The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

April, 1985

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The Bulletin *The official publication of the Medical Society of Pierce County*

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President's Page

WHY NOT?

If you have read the first blurb which I wrote in the Bulletin you may remember how I feel about the necessity of joining our three general medical associations. Thus far nobody's arm has been twisted as shown from the dues that have been paid to the Society's office.

The recent memo sent to those who are not members again attempts to explain some of the neccessities and advantages of belonging to the MSPC, WSMA and AMA. Granted this is a lot of money for most of us, but what is not a lot of money is that amount which we can pay to the Auxiliary for our wives' membership dues.

I could not believe that only about 224 out of 575 physicians have been willing to pay the $38.50, which is what it takes for our wives to become members of the Auxiliary. Of course, there are some of us who are luckier than others and have nobody to pay for, (no offense).

I can hear many spouses say "I don't want to become a member because I don't want to become involved." Personally, I am convinced that in all organizations only 15% is motivated for one reason or another, to do the work. As that 15% belongs already to the organization there should not have to be too many worries in the spouse's mind of having to become involved if not specifically wanting to do so. However, maybe there will be a few, who after seeing what is being done will become inspired volunteers.

To emphasize to you what our Auxiliary is doing I would like to mention again as Dr. Duffy did in the January *Bulletin*, a few notes of interest.

Our Auxiliary is the strongest, most active and best organized in the state (resulting in numerous Past State Presidents). It supports us in the medical profession in many ways. For instance, the Auxiliary has raised more money for the Educational and Research Fund, which gives us assistance for research and financial aid to medical students who need it, than any other of the Auxiliaries since the funds inception. They also organize the booth for the Health Fair at the Tacoma Mall and provide more volunteers for it than we do as physicians.

Regarding other philanthropic projects the following is a partial list of Auxiliary contributions:

1. Pierce County Women's Support Shelter
2. Handicapped Awareness
3. Tel-Med Tape Library
4. Good Samaritan Children's Unit
5. YMCA Handicapped Swim program
6. Catholic Children's Services
7. Mary Bridge Children's Hospital
8. Us and other projects. Regarding the Tel-Med Organization, Auxiliary volunteers spend at least forty hours a month at the switchboard.

Well, I hope the above will have convinced those of you who have not already done so, to part with $38.50 as the organization needs the dues and surely deserves it. (It is even tax-deductible.) I have asked Mr. Jackman to send a notice to those, who I hope will pay their wives' membership (for once I have paid).

By the way, this article is without the knowledge of the Auxiliary.

Finally, please consider your College of Medical Education. The courses they put on are generally outstanding and are certainly worth your support. Our own members who coordinate these programs work diligently for you and your benefit only. Many of the educational hours offered are free, which is something that is hard to come by these days. If you are mad about all of the above, please start a petition.

—GWB

NEWSBRIEFS

Tacoma Mall Health Fair Big Success

Hats off to the volunteers who contributed several hours working at the Medical Auxiliary/Society Health Fair booth at the Tacoma Mall, February 15, 16 and 17.

This activity provides tremendous visibility for the Society and its members. Yet, it was not possible to fill all the time slots because volunteers were not available. Those who manned the booth had their time extended to provide full coverage.

One visitor to the booth told Dr. Gerry McGowen, "You saved my life." His blood pressure had been checked at the booth last year and found to be abnormally high. He sought medical care and now has his blood pressure under control.

Volunteers who so graciously gave of their time and talent were:

Deanne Ames
Cindy and Charles Anderson
Marlene and Walt Arthur
Marylin Baer
Wibby and Guus Bischoff
Karen and Stan Bloustine
Nikki Crowley
Susie and Pat Duffy
Alice Hilger
Sally and Wayne Larson
Sharon Ann Lawson
Debby and Bob McAlexander
Gerry and John McGowen
Ginnie and Ray Miller
Jo and Gil Roller
Shauna and Chuck Weatherby
Alice Wilhyde
Helen Whitney

Congratulations and special thanks to Sally Larson, chairperson of the event, who spent many, many hours coordinating the volunteers and gathering the abundance of literature at the booth.

MSPC Board of Trustees Meeting Held, March 5

The MSPC Board of Trustees met on Tuesday, March 5. Following is a summary of the meeting.

College of Medical Education

Dr. Peter Marsh, representing the C.O.M.E. Board of Directors requested that the Medical Society continue funding the College at its present 1985 level of $6,776 on a permanent basis. The College is supported by contributions from the Medical Society and Pierce County Hospital Council. These contributions were scheduled to be reduced by 20% annually until the College was self-sustaining. The Board of Trustees voted unanimously to freeze the level of MSPC contributions to the College of Medical Education at the 1985 level.

Tacoma Mall Health Fair

The Board of Trustees discussed the difficulty in trying to get enough physician volunteers so that the Health Fair booth was manned at all times by a physician and an auxiliary member. While auxiliary volunteers were in abundance, physician volunteers were sadly lacking. The Board noted that the Health Fair gives the Society and its members extensive visibility in the community. Those who did serve in the booth found it rewarding with time passing quickly. The issue of volunteers will be discussed at the March Executive Committee meeting.

Medical Staff and Specialty Society Presidents participation at Board of Trustees Meetings

A study has been requested to consider the possibility of making Medical Staff and Specialty Society Presidents voting members of the Board of Trustees. The study is just getting underway.

Membership

The credentials Committee recommended that the following applicants be elected to membership into the Medical Society of Pierce County: Alan B. Berggren, Harold G. Brandford, Steven G. Buty, Elsie P. Claypool, Robert D Flack, Jean Goerss, John O. Goodin, Henry S. Krueger, Janice L. Strom, Jerry J. Sullivan, Estelle Yamaki.

The Board Approved the recommendation of the Credentials Committee.

Ethics Standards of Practice Committee

The Ethics Committee is drafting revised guidelines on telephone listings, advertising and the transfers of physicians' records.

Public Health/School Health Committee

The Public Health/School Health Committee has set its goal for 1985 to have the Tacoma water system flouridated. The Committee had a guest speaker to discuss the experiences of Spokane and Olympia in trying to get fluoridation.

Tort Reform Legislation

The Houe of Representatives Judicial Committee conducted a hearing March 5, on four bills WSMA supported. It was reported that there was little chance of the bills reaching the floor for a vote. On March 8, deadline for new legislation to pass through the committees, the four bills under consideration were not even brought up for a vote in the Judicial Committee. The legislation is, therefore, dead for 1985.

Single Designated Trauma Care Center

The Board of Trustees noted that a Request For Proposal for a Trauma Center has been sent out to all hospitals. The Proposal is due June 1. A team of experts from outside Pierce County (two surgeons, one pediatrician and one

continued on page 6

Newsbriefs continued from page 5

emergency physician) will make the decision based on certain criteria. One of the criteria being the recommendation of the MSPC Board of Trustees. The Board discussed the background of the previous decision reached in 1982 and the changes that have occurred in the interim. The Board was asked to consider the issue for further discussion at the May meeting.

Medical-Legal Committee

The Doctor-Lawyer Committee continues to resolve disputes between the professions. The Board recommends that if any member has suggestions for changes in the Memorandum of Understanding, the changes should be submitted prior to the May committee meeting.

Louis Harris offers insights on how physicians can aid relationships with their patients

The Louis Harris survey on "Americans and Their Doctors" outlines a series of steps that physicians can take to build "even more solid" relationships with patients.

Among them:

- Even clearer communication with patients can help foster more positive attitudes on the part of patients, enhance their loyalty, and improve their compliance—particularly drawing out patients' concerns and responding to their questions to their satisfaction. It also is important for physicians to be sure that patients understand what they have been told.
- Physicians should avoid dictating treatment decisions to patients. What patients really want is to feel that they are in agreement with their physicians on a course of action. By the same token, however, it is important to realize that some patients are looking to physicians to assert strong guidance in making a treatment decision and do not want to be left on their own to decide; they, too, want to feel that they have agreed on a plan with their physicians.
- Communicating an extravagant concern for the well-being of the patient should be one of a physician's top priorities in dealing with patients. Indeed, to the extent patients see physicians motivated as much by money as by an interest in helping patients, they become less loyal and less compliant. These findings suggest that physicians should review their scheduling and billing practices, the attitudes of their staff, and the nature of their discussions with patients about fees to reinforce patient's perceptions of the physician's commitment to quality care.
- Patients are more concerned with the perceived value of the care they pay to receive from their physicians than with the dollars per se. Fees are not the primary issue with patients as long as they are satisfied that they are getting enough of the physician's time and attention.

When and How Can Life Support Be Withdrawn?

Topic of General Membership meeting April 9, at the Doric Tacoma Motor Hotel will be "When and How Can Life Support Be Withdrawn?" Judge Robert Peterson who addressed the highly successful Medical-Legal Seminar in January on the same topic will be the speaker.

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Tort Reform Measures Die in Committee

The House of Representatives Judicial Committee effectively killed tort reform for 1985. House Bill 965 waiving the physician/patient privilege as soon as a suit is filed, House Bill 966 permitting evidence of agreements reached with other defendants, House Bill 967 permitting evidence of collateral sources (e.g., health insurance), and House Bill 968 allowing a defendant to make either a lump sum payment or periodic payments died in committee when they were not brought up for a committee vote. All four bills had broad bi-partisan support with over 30 legislators from both parties signing on as sponsors. The bills were referred to the House Judiciary Committee on March 5. Members of the Judiciary Committee were not asked to sign on as sponsors in an effort to free them from any precommitment.

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Emergency Medical Services (EMS) Seeking Physician

The Emergency Medical Services division of the Tacoma-Pierce County Health Department is seeking a physician to serve as medical advisor to the EMS Division and as Pierce County EMS Medical Program Director. Applicants may anticipate working approximately 85 hours a month in a paid consultant capacity providing medical direction and guidance to the EMS community. Resumes must be submitted to the EMS Division by April 30, 1985. Interviews will be held.

Position prerequisites are:

- Minimum three years emergency medical experience
- Active in the Pierce County EMS system
- Administrative experience (preferred)
- American College of Emergency Physicians member (preferred)
- American Board of Emergency Medicine Certified (preferred)
- Resident of Pierce County (preferred)

For information contact the Division of Emergency Medical Services, Tacoma-Pierce County Health Department, 420 South Fawcett, Tacoma, Washington, 98402, (206) 591-5747.

All Physicians! Plan to Participate in the 1985 PPA Census

In February 1985, all physicians in the U.S. were mailed a Physicians' Professional Activities Census form. Completion of the form assures accurate classification in official AMA records and in the American Medical Directory.

The PPA Census is conducted by the AMA every four years for the purpose of identifying the practice specialties and current professional activities of every physician in the country. All physicians, AMA members and non-members, are listed in the Directory, as well as those who are no longer in active practice.

Not completing the Census form may result in inaccurate classification in AMA records and in the Directory. Moreover, these classifications usually serve as the basis for the distribution of educational information from the AMA as well as complimentary journals and materials from pharmaceutical companies.

From: AMA - Office of Medical Society Relations, Feb. 4, 1985

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☐ **NEW! A Physician's Guide to Professional Corporations** (OP-168) $8.75. 1984. Should you or shouldn't you incorporate?
This helpful guide explains the tax and non-tax advantages and disadvantages of incorporating a medical practice in easy-to-understand language. The changes resulting from enactment of TEFRA are clearly detailed. Major sections of the publication include: Making the Decision to Incorporate, Professional Service Corporations: Advantages and Disadvantages; Operating a Professional Service Corporation; and Selection of a Corporate Retirement Plan.

☐ **NEWLY REVISED! Handling Patient Telephone Calls Effectively.** Audiocassette and workbook OP-181; Nonmember, $33; AMA member, $30. Extra workbooks OP-045; Nonmember, $6; AMA member, $5. Revised 1984. A must for every new medical office assistant and a good review for staff with years on the job. The audiocassette and accompanying workbook demonstrate, using vignettes of real-life situations, how to deal with patients who want medical advice, requests for medical information, irate patients, and emergencies.

☐ **A Physician's Guide to Gearing Up for Retirement** (OP-133) $39.95. Loose-leaf three-ring binder. 1983.

This manual is specially designed for use by the physician and his/her spouse in planning for retirement. It covers all the practical business aspects of closing a practice as well as the personal and financial aspects of retirement.

The manual is divided into six main sections:

- Gearing Up Psychologically
- Gearing Up Financially
- Gearing Up to Sell Your Practice
- Gearing Up to Close Your Practice
- Planning Your Estate
- A Gearing Up Wrap-Up

Included in each section are many helpful charts, worksheets, and sample forms.

☐ **Valuing a Medical Practice: A Short Guide for Buyers and Sellers** (OP-117) $5.00. Revised 1982. For those buying or selling a medical practice, this booklet guides you through the complex process of assessing the tangible and intangible elements that determine the worth of a practice, covering assets from earnings and equipment to leasing and goodwill.

☐ **Optimum Timetable for Starting Your Practice** (OP-216) $5.00. Revised 1983. This guide organizes, in calendar form, the various tasks required to open a private practice. Developed over the last five years with assistance from dozens of physicians, the timetable shows the steps that should be taken before opening the office to patients. Professional, personal, financial, and some legal areas are covered.

☐ **Planning Guide for Physicians' Medical Facilities** (OP-439) $4.50. Provides guidelines and general principles to help you determine the criteria for selecting a medical office that best suits your needs. Includes: basic planning before building; office construction—inside and out; office interior; and office condominiums.

☐ **Medical Collection Study Course.** Audiocassette and workbook OP-134: Nonmember, $33; AMA member, $30. Extra workbooks OP-135; Nonmember, $6; AMA member, $5. 1982. A listen-and-learn study course of infinite value to medical office assistants who collect overdue accounts by telephone. Includes basic collection approaches, standard formulas for incoming and outgoing calls, typical reasons for late payment, and motivating non-payers to pay up. Course emphasizes the lighter, more "human" aspects of medical collection.

Course package consists of audiocassette and workbook in carrier. Although the audio/workbook method is most effective, the workbook can be used without the tape as a course in itself.

☐ **New Doctor's Kit** (OP-458) $24.95. Contains: The Business Side of Medical Practice; Planning Guide for Physicians' Medical Facilities; AMA Publications List; Group Practice Guidelines; Current Procedural Terminology order form; Uniform Health Insurance Claim Form; Medicolegal Forms; Winning Ways with Patients; Judicial Opinions and Reports; Talking with Patients: Preparing a Patient Information Booklet; AMA membership information, Placement Service.

☐ **Group Practice** (OP-457) $10.00. Contains: Group Practice Guidelines; medicolegal reprints on such subjects as: professional liability, confidentiality, informed consent, etc.; samples of model legal agreements for a physician and employed associate, office sharing, medical partnerships, and forming a corporation.

☐ **The Business Side of Medical Practice** (OP-410) $9.95. This publication is a guide to basic management principles for the medical office. It includes discussions of how to set up a practice; selecting a location; financing; clearing legal hurdles; insurance; hiring and supervising personnel; appointment scheduling; medical records; billing and collecting; and patient relations.

☐ **Winning Ways with Patients** (OP-078) $1.50. Revised 1982. Twelve-page guide for medical office assistants on how to improve their patient relations skills in a variety of situations. Tips on courtesy are emphasized.

☐ **Preparing a Patient Information Booklet** (OP-441) $.75 Revised 1983. A guide for preparing a general information booklet for your patients on your specialty and type of practice.

☐ **Talking With Patients** (OP-450). $.30 Revised 1984. Provides proven psychological principles and specific examples on how to improve office-patient relations in telephone communications.

☐ **Patient Survey Questionnaire** (OP-121) $8.00 per package of 100 questionnaires. Revised 1982. This is a device for the physician to measure the satisfaction of his/her patients regarding different aspects of the practice.

☐ **Medicolegal Forms with Legal Analysis** (OP-109) $4.50. Sets forth general legal principles governing common interactions between patients, physicians, and hospitals. Contains appropriate forms to use in these situations. Cites court decisions and statutes.

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______	Valuing a Medical Practice: A Short Guide for Buyers and Sellers	OP-117	5.00	4.50	4.00	$______
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______	Winning Ways with Patients	OP-078	1.50	1.35	1.20	$______
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	AMA member		30.00	30.00	30.00	$______
	Nonmember		33.00	33.00	33.00	$______
______	Extra Workbooks	OP-045				
	AMA member		5.00	5.00	5.00	$______
	Nonmember		6.00	6.00	6.00	$______
______	Medical Collection Study Guide Course (cassette & workbook)	OP-134				
	AMA member		30.00	30.00	30.00	$______
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Legal Risks of Being a Physician

By Marcel Malden

The Law and Medicine Symposium was held at the St. Joseph Hospital Auditorium on January 24, 1985. There were close to 80 participants and they seemed to be about equally divided between physicians and attorneys. The meeting was lively, there was good audience participation and judging from the comments it was well received.

It is my intention to highlight some of the points made by various speakers. I do so with some anxiety, realizing that the papers presented were carefully prepared, were concise and hence it may be difficult to present them in a brief capsule form. This is particularly so with some legal points, the validity of which may depend on their precise wording. Thus I hope that my summary will be treated as information rather than as an exact presentation of principles.

Dr. Don Pearson spoke on issues of informed consent. His was a very thoughtful and detailed presentation. I especially enjoyed such statements as "Freedom implies the right to make stupid choices, not just intelligent decisions." Dr. Pearson, in common with other speakers, underlined the strong legal trend towards increasing personal autonomy in decisions involving individuals' health and treatment. This is so even though "*paternalists* may be more comfortable than equality."

In referring to the "Battery Principle" in relation to the acts of physicians he mentioned that "violation of personal integrity may occur even without damage flowing from the act." He underlined the physician's duty to inform the patients in lay terms about the nature of the diagnosis and treatment, and he underlined that this duty belongs to the doctor and that it cannot be delegated to someone else. This seemed to be an important statement, as it at present seems in some offices the duty is delegated by the physician to others. Dr. Pearson described medical/legal issues that may be faced in relation to the problems of informed consent and indicated that documentation of administration of informed consent is important. He also added that it may be even more important to document a patient's refusal of treatment than document consent. Dr. Pearson's description of the rights of minors was interesting and he mentioned that while minors cannot consent to psychotherapy, or amputations, they can be treated without parental consent for drug and alcohol abuse and for such venereal diseases as syphillis, and gonorrhea, but not for herpes, AIDS or clomidial infections. Further, he indicated that a minor can be "emancipated" by age of 16 if this minor is a parent, if he is in the military or if married. Apparently physicians can accept in good faith minors' statements as to their age and status of emancipation. He underlined that competent adults can refuse anything.

Ms. Judith Stone appeared in the place of Mr. Jack G. Rosenow and presented "Vignettes of Recent Malpractice Cases." She illustrated problems which may arise when physicians fail to obtain timely consultations, when they act outside their areas of competence, when they deal with "shy people" who tend to minimize their problems or when they get *ennui* to the multiple of varied complaints in people who are chronic and frequent visitors to their offices. She underlined the need for discretion in commenting on previous treatments and procedures where taking over a patient from another physician and the need for discretion and circumspection when discussing an established malpractice case with anyone. Ms. Stone has defended more malpractice suits in the last year or two in our area than anyone else and her talk was presented with good humor and with obvious understanding of the kinds of difficulties and problems that we as physicians find ourselves in.

Dr. John Lindbergh spoke about the difficulties that physicians face when signing contracts with commercial health care providers. He described the process of negotiations and the need to identify and describe such essential points of the contract as identity of the parties, legal characterization of agreement, description of the services of the physician and their availability, limits of outside activities, financial arrangements and the duration of the contract with description of the procedures for its termination. He mentioned the importance of recognizing the potential existence of "a key physician" and how important it may be to know how he is selected, what are his powers and what the relation of each physician is to this key person. Dr. Lindbergh gave reference to Publication 363-27M of the American Society of Internal Medicine for September of 1984. It is apparently available from the Society at 1101, Vermont Avenue NW, Washington D.C. 20005.

Judge Robert H. Peterson talked to us about "when and how can life support be withdrawn." His talk struck me as the most clear and lucid prsentation of what I have always seen as a very complex problem. Judge Peterson analyzed a number of key cases from several jurisdictions and then described the principles that govern in the State of Washington. Thus he described the principles that a competent person may refuse treatment. An incompetent person has the same right, but then acts through a properly appointed guardian. The physician should not be involved in the appointment of the guardian. In the State of Washington, the courts do not insist on the existance of so-called "ethics committees," but agree to the discontinuance of life supporting equipment when two nonattending physicians in appropriate specialties concur with the decision of the attending physician and when no family members protest. Judge Peterson referred to the "ethics manual" of the American College of Physicians which is now available in the booklet form, and which was originally printed in the Annals of Internal Medicine, 1984; 101: 129-37; 263-74. Judge Peterson also gave us a handout.

continued on next page

continued from previous page

The luncheon was excellent and the desserts calorifically most sinful. It seems that recently St. Joseph Hospital has excelled itself in the conference food preparation and presentation.

Honorable Vernon R. Pearson of the Supreme Court of the State of Washington then addressed the governing on "the rule of justice or the rule of law." It was a most thought-provoking presentation, offered with good humor and a sense of respect for all things human. Judge Pearson then presented us all with a "insoluable legal problem," appointed one "supreme court" from among attorneys and one from among physicians present. He then insisted that we make a decision and offer our reasons. The outcome was interesting in that the attorneys, "supreme court" divided about 50/50 on the issues and the physicians, "supreme court" decided unanimously in favor of the "human benefit of the petitioner" and not strictly in accordance with the laws, thus becoming "an activist court." What better way could there be of letting us "feel the problems" of the two professions.

Mr. Terrance McCarty spoke on the subject of the "Family Law and the Physician" and he particularly illustrated the laws that protect children and incompetent adults against abuse. He clearly stated that these laws override the privilege of confidentiality between the doctor and patient and clearly force the doctor to report any potential case of abuse to the proper authorities within seven days. The doctor has no discretion in this situation and if he or she fails to comply with the law, he becomes open to criminal prosecution. This is a risk which apparently is not covered by our malpractice insurance policies. Mr. McCarty indicated that it is probably better to report to Child Protective Services than to police.

Mr. Ross Burgess prepared the next presentation on "Embarrassing Questions in the Courtroom" and hopefully the examples will prove useful in actual proceedings. The question and answer period was lively and interesting.

The Doctor/Lawyer Committee of the Tacoma-Pierce County Bar Association and the Medical Society of Pierce County has felt very pleased with the attendance and hopes to offer seminars of interest to both professions in the future. ■

AMA Leadership Conference Held, Tapes Available

The AMA Leadership Conference was held Feb. 14–16 in Chicago. Many excellent speakers discussed the critical issues facing medicine today. Cassette tapes for most of the conference sessions are available on a loan basis from the Medical Society Office. Cassettes available are:

- **Today's Critical Issues: Four Views**
  The Honorable Richard D. Lamm, Governor of Colorado
  The Honorable David Durenberger, United States Senate
  Joseph F. Boyle, MD, President, American Medical Association
  Uwe E. Reinhardt, Professor, Department of Economics, Princeton University
- **Private Enterprise in Health Care: What's Coming**
  Addresses the future direction of investor-owned entities and the potential for private sector financing mechanisms to take over certain areas of government responsibility.
- **Health Care Rationing: Curse or Cure?**
  This session speculates on how medical care will be allocated as increasing restraints are placed on health care expenditures
- **Health Care for an Aging Society**
  This session explores the implications for physicians of the increasing number of elderly Americans on both financing and delivery of care.
- **The American Health Care Revolution**
  The views of Joseph A. Califano, Jr., former Secretary of Health, Education and Welfare and presently serving as a member of the Chrysler Motor Co. Board of Directors.

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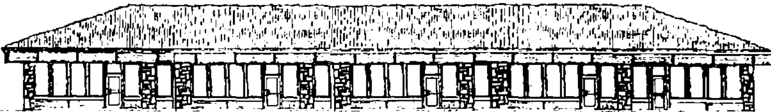

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April 12, 13, 1985 – University of Puget Sound – Thompson Hall – 15th & Union

Keynote Speaker – Wallace Ring, M.D.

8:15	**Continental Breakfast**	
8:30	**Welcome & Introductions**	William H. Martin, M.D.
9:40	*The Cost of Surgical Care*	Karen Kien, PCMB
9:00	*The History & Development of Ambulatory Surgery*	Wallace Ring, M.D.
10:00	*Anorectal Surgery in an Ambulatory Surgical Unit*	Gordon R. Klatt, M.D.
10:20	*Break*	
10:40	*Ambulatory Plastic Surgery*	Martin Schaferle, M.D.
11:00	*Ambulatory Urologic Surgery*	Robert O. Modarelli, M.D.
11:20	*Ambulatory Otolaryngology*	Donald W. Shrewsbury, M.D.
12:00	**Luncheon**	
1:30	Afternoon Introductions	Robert O. Modarelli, M.D.
1:35	*Patient Safety & Quality Control in Ambulatory Surgery*	Wallace Ring, M.D.
2:30	*Ambulatory Gynocologic Surgery*	Robert Z. McLees, M.D.
2:50	*Hernia Repair in an Ambulatory Surgical Setting*	
3:10	Break	
3:30	*Ambulatory Orthopedic Surgery*	John H. Bargren, M.D.
3:50	*Surgical Dermatology*	Sidney F. Whaley, Jr., M.D.
4:10	*Local Anesthetics; Agents, Techniques, Toxicities*	Michael R. Colpitts, M.D.
4:30 to 5:00	*Panel Discussion - Moderator:*	Robert O. Modarelli, M.D.

Program coordinator: William H. Martin, M.D.

College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—individual notices will be sent preceding each program.)

Phone: 627-7137 (P) = Physician (A) = Allied Health

Location	Date	Program	Coordinator	
	APRIL			
STJ	4, 5	Survival Skills for Nurses	Chilton	(A)
UPS	12, 13	Surgical Club	Martin	(P)
STJ	26	Death & Dying	Schmidt	(P/A)
	TBA	Symptom Mgmt. of Cancer Patients for Nurses	Boulet	(A)
	TBA	Adolescent Patient: Suicide, Pregnancy, Drugs	Ingraham	(A)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	9, 10	Cardiovascular Disease Review	Strait	(P)
	JUNE			
JH	27, 28	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Medical Society/Madigan Army Medical Center

GENERAL MEMBERSHIP MEETING

TUESDAY, APRIL 9, 1985

"WHEN AND HOW CAN LIFE SUPPORT BE WITHDRAWN?"

Honorable **Robert H. Peterson**
Pierce County Superior Court Justice

DATE:	Tuesday, April 9, 1985
TIME:	No host cocktails 6:15 P.M. Dinner 7:15 P.M. Program 8:00 P.M.
PLACE:	Doric Tacoma Motor Hotel 242 St. Helens Avenue
COST:	Dinner, $15.00 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County,** in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Due to the special arrangements necessary for this joint meeting, reservations must be made no later than Friday, April 5.

REGISTRATION:

Yes, I (we) have set aside the evening of April 9 to join my fellow Society members and physicians for the presentation "When And How Can Life Support Be Withdrawn?"

___ Please reserve __________ dinner(s) at $15.00 per person (tax and gratuity included). Enclosed is my check for $______________.

___ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr: ____

RETURN TO MSPC BY NO LATER THAN FRIDAY, APRIL 5.

MINET hookup becomes AMA membership benefit

American Medical News, Feb. 22, 1985 — American Medical Association members will not have to pay the $100 one-time subscription fee to the Medical Information Network (MINET), the AMA and GTE Telenet Inc. have announced.

Hook-up rights to the nationwide, computerized telecommunications network for physicians are now a free benefit of AMA membership. Physicians may use the network free during the first 30 days of their subscription while they familiarize themselves with the system.

Any physician with a computer terminal or microcomputer can access MINET, which now includes seven data bases designed or acquired by the AMA and collectively known as AMA/Net. AMA/Net offers subscribers an extensive computerized library of drug and disease information and alerts, as well as medical news and bibliographic references to clinical and socio-economic literature.

In addition, the network features the Massachusetts General Hospital interactive continuing medical education programs. These programs teach clinical problem-solving skills using patient care simulations.

The Drug Therapy data base, which provides MDs with unbiased information on the clinical use of more than 200 selected classes of drugs, is the most recent addition to AMA/Net. It was designed by the AMA Division of Drugs and Technology to complement the on-line version of the book, Drug Evaluations.

The Drug Evaluation data base, on the other hand, contains more comprehensive information on adverse reactions, precautions, drug interactions, toxicity, and dosage recommendations.

The AP Medical News Service, created by the Associated Press specifically for the AMA went on line at the end of last year. The service includes articles selected from the AP's national and internationl news reports. ■

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HOSPITAL NEWS

Puget Sound

Construction and Recent Growth Mark Puget Sound Hospital's Future

Since early 1982 more than seven million dollars have been spent on construction, renovation and capital equipment at Puget Sound Hospital. This large expenditure of funds has resulted in a new SCU, OR, recovery and holding area as well as the acquisition of major equipment. Included in the new Operating Room are the following: a state-of-the-art arthroscope with video camera, an Argon-Krypton laser, new lighting, new furnishings, and the only orthopedic table of its kind in our area. The addition of a laser and cysto room has greatly complemented our existing OR capabilities.

Much emphasis has been placed on the Hospital's Day Surgery Program. A waiting room has been designated for family and friends, while the furnishings and "mood" of the area have aided in the comfort level of patient and family alike.

The 9-bed Special Care Unit has the hard-wire monitoring system, and direct visualization of each patient attests to the design of the unit. Besides the Operating Room, Day Surgery area and Special Care Unit, other departments of the Hospital have undergone major construction and design changes. The Mental Health Unit has new furnishings, wall coverings, and cosmetic changes. The Emergency Room has a total facelift, including wall coverings, floor coverings, Herman Miller portable storage systems, new equipment, new admitting and waiting area. Respiratory Therapy boasts a complete stress testing/pulmonary function room containing the latest, most efficient equipment available.

The Radiology Department is scheduled for a total renovation, which will include a new Angiography Room as well as a permanent CT Scan area. Presently, Mobile CT Scan Services are provided daily. Physical Therapy will be moved to new quarters in the North Building.

The exterior renovation, which began in November, is progressing steadily. According to Bruce Brandler, PSH Administrator, "The exterior work is moving ahead of schedule. It's hard to believe because of the winter weather, but we've only lost minimum time due to poor weather. Projected completion is early May, and most of the landscaping has already been accomplished. The parking lot in the rear of the North Building has been redesigned and parking capacity is doubled."

When completed, the main entry way of the hospital will be covered to provide for patient, visitor, and staff convenience. The exterior, as well as having new window treatment and a new walkway between the buildings, will have dark paint to complement the brick treatment of the older section of the hospital.

St. Joseph

St. Francis Community Hospital of Federal Way names new assistant administrator

Craig Hendrickson, administrator of St. Francis Community Hospital of Federal Way, has announced that Sister Jude Connelly is the assistant administrator for the hospital.

The soon-to-be-built 110-bed hospital will be located on a 22-acre site on the northwest corner of south 348th and 9th Avenue South in Federal Way.

Sister Jude Connelly has a master's degree in hospital and health administration from Xavier University located in Cincinnati, Ohio. She graduated with a bachelor of science in nursing from the University of Oregon in Portland and has a diploma in nursing from St. Joseph Hospital, Tacoma. Sister Jude Connelly became a member of the Sisters of St. Francis in 1965. Her work experience includes education, pastoral care, staff nursing and administration.

While the architects' plans become firm and before construction begins, Sister Jude Connelly will begin the internal planning of the hospital which will include assisting with the development and planning of programs and departments.

St. Francis Community Hospital of Federal Way is a member of the Franciscan Health System.

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AUXILIARY NEWS

1985-86 Officers Nominated

Auxiliary members Gloria Virak, chairperson; Dorothy Grenley; Barr Mott; Dottie Truckey; Debbie McAlexander and Ginny Miller met and prepared the following slate of officers for 1985-86.

President Elect	*Suzanne Duffy*
1st Vice President	*Marie Griffith*
2nd Vice President	*Alice Wilboe*
3rd Vice President	*Carol Hazelrigg*
4th Vice President	*Alice Yeh*
Corresponding Secretary	*Sonya Hawkins*
Recording Secretary	*Mary Schaeferle*
Treasurer	*Helen Whitney*
Dues Treasurer	*Betty Virtue*

Auxiliary members participate in Birth to Three Program. Left to Right: Mrs. Ruth Grenley, Mrs. Virginia Miller.

Family Birth to Three Program

The Family Birth to Three Program provided additional training for Auxiliary volunteers in February. At this time Auxilians are involved in most aspects of the Family Birth to Three, the Hospital Visitor Program, Parents Support Group, Home Visitor and Board. Our support of parenting has grown from a small trickle to a stream. Join! Make the stream of volunteers flow.

Fun Day

Plan now to attend the May 17th Fun Day at Oakbrook. GOLF-TENNIS-BRIDGE-RUN or WALK! More details in next month's Bulletin.

Health Fair, Tacoma Mall. Dr. Pat Duffy taking blood pressure.

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MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Clark M. Waffle, M.D., Emergency Medicine. Born in Renton, WA, 12/17/51; medical school, Univ. of Washington, 1978; internship, Internal Medicine, Brown Univ.-Roger Williams General Hospital, Providence, Rhode Island 7/78-6/79; residency, Internal Medicine, Brown University, 7/79-6/81, Emergency Medicine, UCLA Medical Ctr. Los Angeles, California, 7/81-6/83. Washington State License, 1984.

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Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 752-3667.

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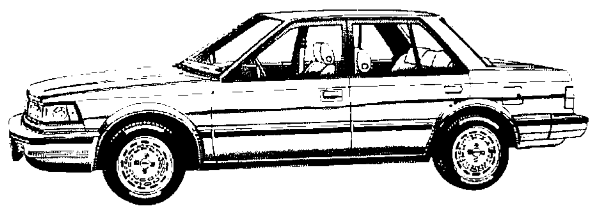

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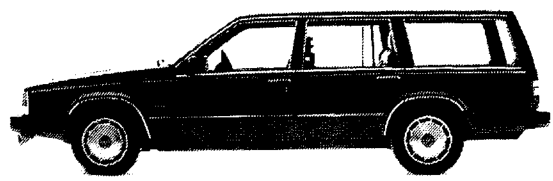

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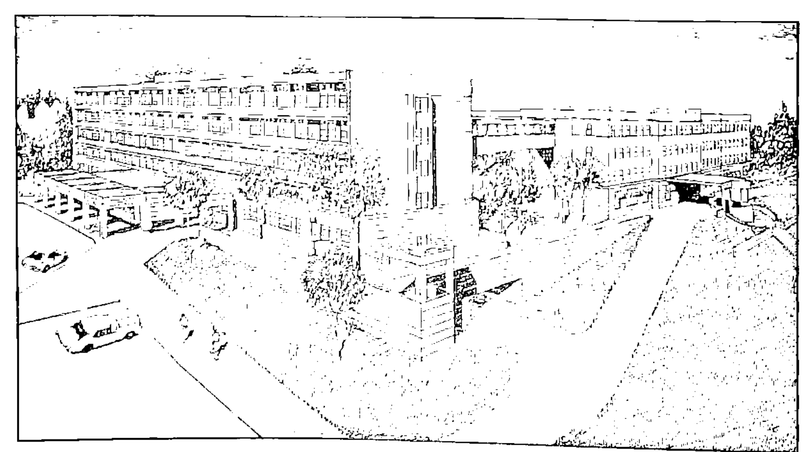

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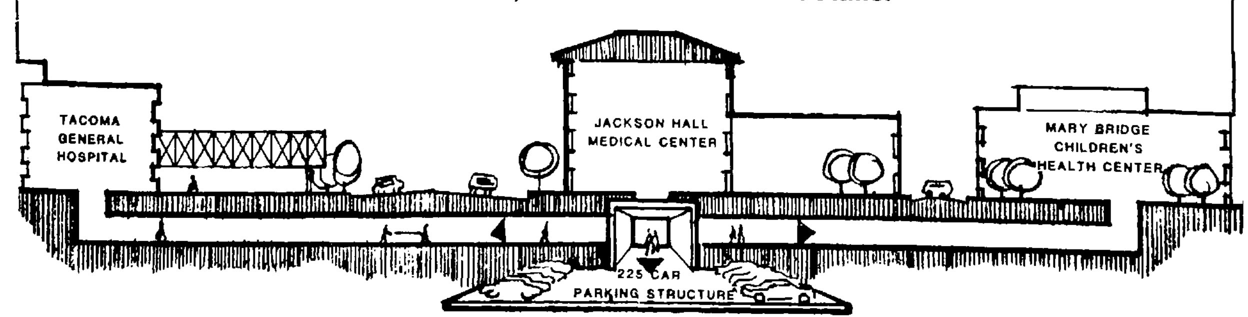

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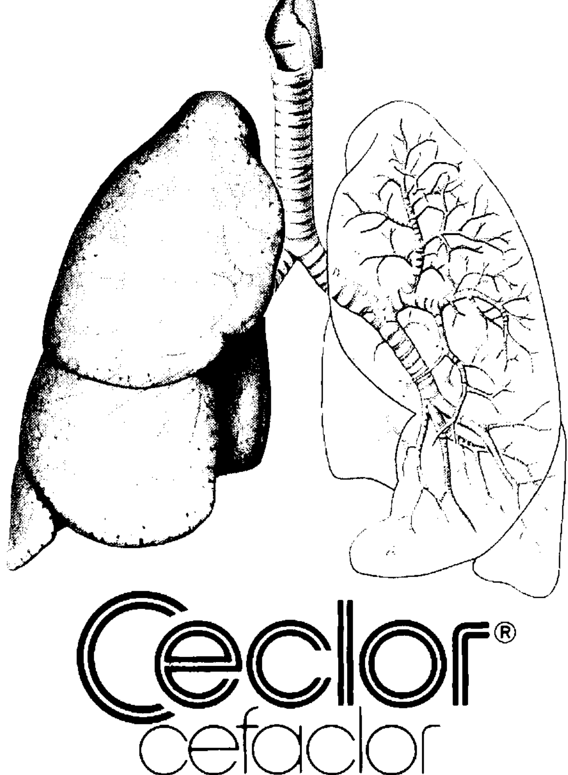

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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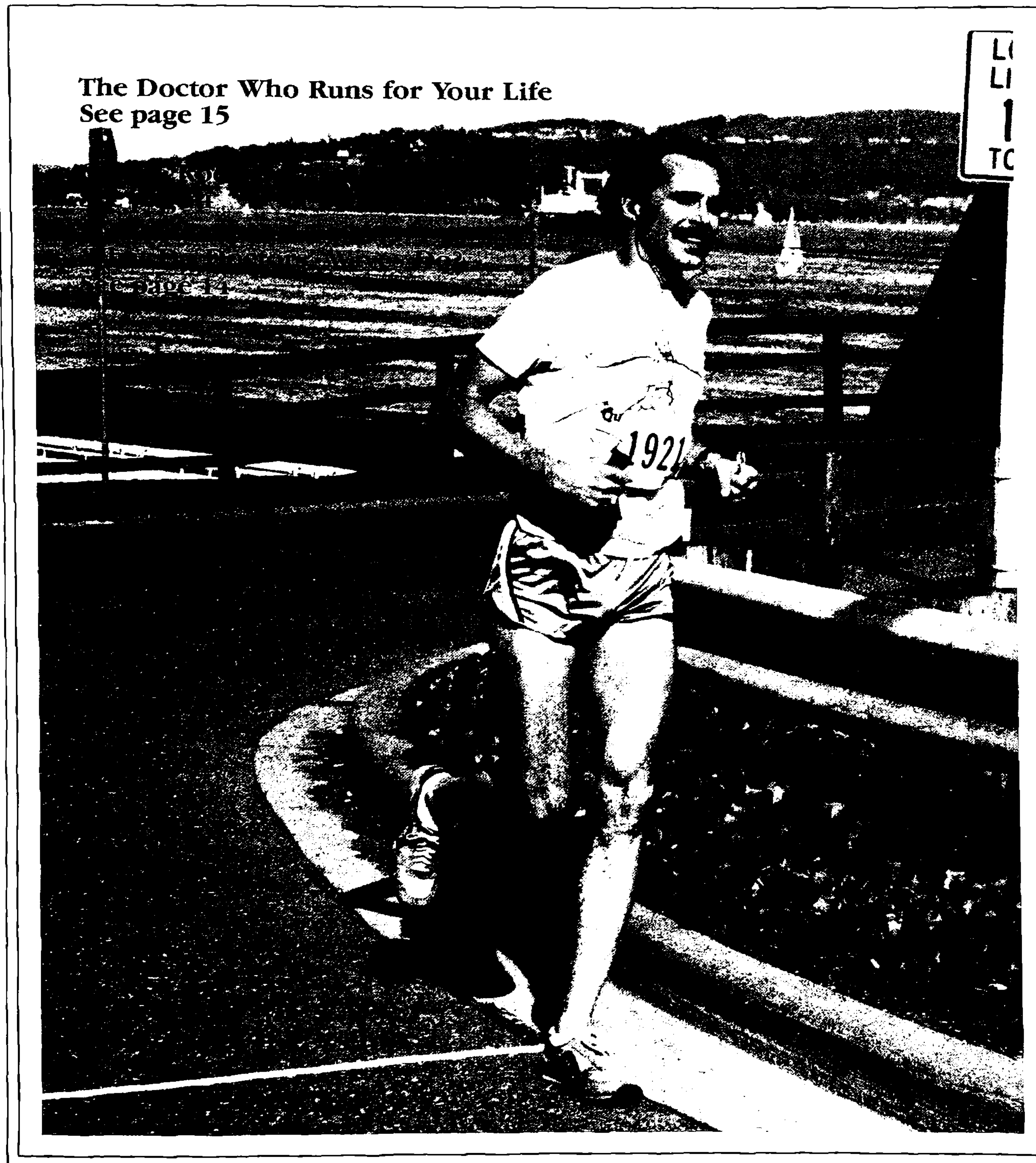

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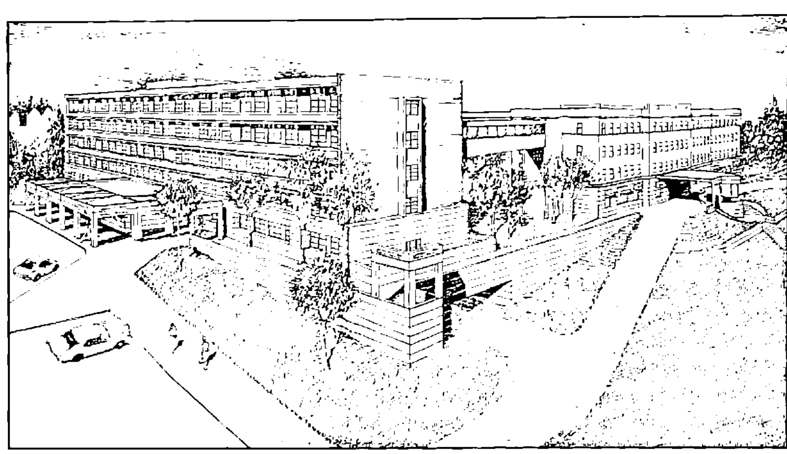

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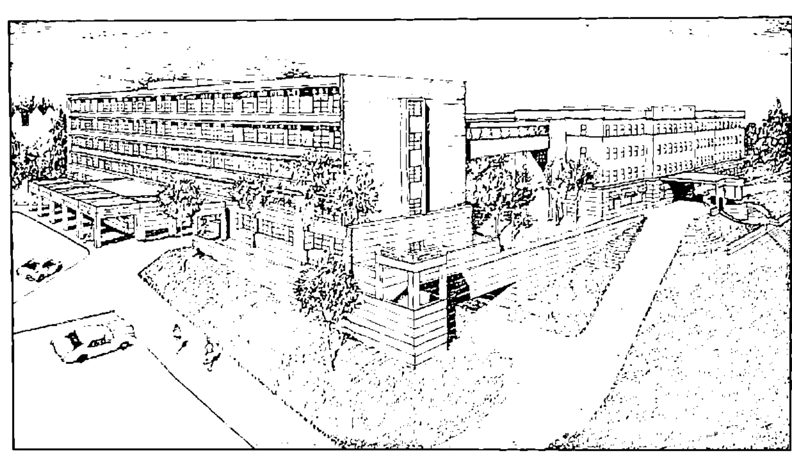

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Cover photo: Dr. Gordon Klatt prepares for his 24-hour run to help raise funds for the American Cancer Society.

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On the Rocks

Guest Editorial by Richard Hawkins, MD

The ship set out from port. Soon the captain was told of a blip on the radar screen directly in front of them. The captain asked that a message be sent, "Please alter your course ten degrees south." It was sent, and a message came back, "Please alter your course ten degrees north." This irritated the captain and he instructed that a message be sent. "Alter your course ten degrees south; I am an Admiral." It was sent, and a message came back, "Alter your course ten degrees north; I am a Seaman Second Class." Incensed, the captain directed that a message be sent, "I command that you immediately alter your course ten degrees south; this is a battleship." It was sent, and a message came back, "I suggest that you change your course pretty soon; this is a lighthouse."

This story was told by Governor Spellman when he addressed the Washington State Medical Association at its Annual Meeting last September. His point was that physicians and politicians, as they deal with each other on health issues, should work together rather than confront one another.

Medicine has built a firm foundation. There is not a country in the world with better medical knowledge, or the capacity to use that knowledge. Our doctors and hospitals have in place a well established method of taking care of people's medical problems; it has stood the test of time. We should be very secure and very proud to stand on the status quo, to maintain the fine system of medical care that has been established.

We in medicine have pretty good reason to think we know where we are going, and that we are going in the right direction. We do a darn good job of taking care of the medical needs of the country. The advances in medicine have been tremendous, and continue to lead us on to new frontiers. Shouldn't we keep on doing what we have been doing? "Stay the course," seems like a very appropriate phrase.

There is a lot of noise out there, among politicians and others, about the problems in the American medical system; and they do hit some pretty sensitive chords. Why don't people feel "cared for" by doctors and hospitals? Why is it so expensive? Are choices between therapies, when there are equally effective alternatives, always based on the best interests of the patient? Why do doctors make so much money? Why are there folks who cannot get medical care because they cannot afford it? There are strong feelings that our health care system does not do everything the right way.

So we seem to be in the midst of confrontation. What happens in confrontation?

There is the "run over them" approach — we are bigger and tougher and can run right over them; they'll have to do what we want.

There is the "stand firm" approach — we won't let them push us around; we know what to do.

There is the "to heck with them" approach — we don't need them; we can get along well without them.

You can see the analogy with the battleship and the lighthouse. But who is the battleship and who is the lighthouse? It doesn't really matter. We and they both have the capacity to be either, and should want to be neither. You can go full speed ahead on your course, and be shipwrecked on the rocks. Or you can stand your ground in the face of an onslaught, and find yourself smashed right between a rock and a hard place. Or you can remain steadfast and watch them sail past, leaving you high and dry, standing on the rocks.

There has to be a better way. ■

NEWSBRIEFS

General Membership Meeting, May 14

The May 14, General Membership Meeting promises to be one that will interest all the medical community. Johnny Cox, RN, PhD, Staff Ethicisit, Sacred Heart Medical Center, Spokane, will be the speaker. Dr. Cox addressd the WSMA Leadership Conference in November and was considered one of the outstanding speakers.

His presentation for the May 14 meeting is titled "Thorny Ethical Issues." Bring your spouse. His presentation is a topic of interest to all. See page 23 in this month's *Bulletin* for your registration form.

Committee on Aging meets with American Association of Retired Persons (AARP)

The Committee on Aging will meet with representatives of the three Pierce County Chapters of the American Association of Retired Persons at their May meeting. Efforts will be made to establish a dialogue with the elderly of Pierce County to gain a greater understanding of their concerns about health care today. The committee has met with representatives of most of the agencies in Pierce County that provide services to the elderly.

Auxiliary Brunch Big Success

Again, your Pierce County Medical Society Auxiliary organized and carried out a very successful fund raiser with their "Champagne Brunch," March 17. This was the first time for the Auxiliary to hold this type of an event. They were urged to make it an annual event by all those attending.

Chairperson Mary Lou Jones and her committee of volunteers are to be congratulated and thanked for their efforts.

ATTENTION PHYSICIANS

1986 Pocket Directory Information

Please be watching your mail for an information form regarding your Directory listing for the 1986 Pierce County Physicians and Surgeons Directory.

It is essential that you review and return this data as soon as possible to assure a correct listing in the 1986 Directory. The Directory is scheduled for distribution in October. Your cooperation will be appreciated.

Medical Society and Children's Protective Services Representatives working to develop guidelines

Medical Society and Children's Protective Services representatives met in March to discuss reporting procedures of child abuse incidents. The group is developing guidelines to improve communication between physicians and CPS. Once the guidelines are established they will be published in *The Bulletin*.

Community Health Forum held March 19

Washington State Medical Association and the Washington State Hospital Association held the first of several health forums scheduled across the state in

continued on page 6

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Newsbriefs continued from page 5

Tacoma, March 19. Nearly 75 people turned out at Curtis High School to hear a lively discussion on the health care issues facing society today.

Physicians, community leaders and hospital administrators expressed their views on a number of complex issues and difficult choices society will have to begin to make.

Luncheon Meeting for retired MSPC members to be held, May 22

A luncheon meeting for all retired members of the Society has been scheduled for Wednesday, May 22, at the Tacoma Dome Hotel. Colleague and MSPC member Dr. Kenneth Sturdevant will be the speaker. Dr. Sturdevant will speak on his experiences in Africa as a missionary.

All retired members of the Society will receive a registration form in the mail. Plan to attend, meet some old friends and colleagues and hear a very interesting presentation.

Gig Harbor Physicians Purchase Urgent Medical Care Center

Drs. Stephen Bergmann, Lowell Finkleman, Eric Luria, Dave Pomeroy, Jim Patterson, Bill Roes, John Samms, Richard Schoen and Phillip Schulze have purchased and are now operating Family Care Medicenter of Gig Harbor. According to Dr. Patterson, the physicians will continue to operate their own practices in the same manner as previously and will remain in the same locations. Family Care Medicenter will continue to operate in the "woods" on Kimball Drive as a walk-in, urgent medical care clinic. The clinic will be staffed with a combination of hired physicians and local, established physicians. Hours for the clinic will be from 9:00 A.M. to 9:00 P.M., Monday through Saturday and 11:00 A.M. to 7:00 P.M. on Sunday.

Dr. Patterson said it is the policy of the physicians to be responsive to physicians both locally and in Tacoma. "We have joined in a cooperative effort to guide and control medical care in the Gig Harbor Peninsula in a responsible manner.

"We will refer patients back to their primary physician for follow up care," he said, "and with the patient's permission send a copy of the visit notes to their primary care physician. We hope this will provide a service and convenience to the physician and patients alike."

Dr. Patterson said the physicians will also be "responsive to the needs of those patients without doctors, referring those patients who would be best served in an ongoing patient/physician relationship."

In addition, according to Dr. Patterson, the physicians will be working with local groups interested in medical care needs in the community in an effort to see that medical services become available as they are needed. "In order to be responsive to physicians," says Dr. Patterson, "we need to know if there are problems with patient care or communication. We welcome advice and criticism."

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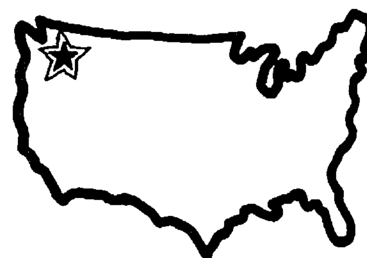

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Fluoridation of Tacoma Water System: Goal of Public/School Health Committee

Securing legislation on smoking in public places and the work place was the goal of the Public Health/School Health Committee in 1984. The goal was realized with the passage of the Clean Indoor Air Act.

For 1985 the committee is seeking to have the water system of Tacoma fluoridated.

Members of the committee will be meeting with the leadership of the Pierce County Dental Society to develop strategies for another successful campaign.

TEL-MED Assessed

An ad hoc committee consisting of MSPC members, auxiliary members, and the Tel-Med Board of Directors, met to discuss Tel-Med. One question before the committee was: "How does MSPC membership view TEL-MED?" A survey was sent out to all members. Of the nearly 600 surveys sent out, 173 have responded to date, for a 28.8% response rate.

The survey results are:

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2. Do you support the TEL-MED concept?	*89.2%*	*10.8%*
3. Do you feel TEL-MED infringes upon your practice?	*7.9%*	*92.1%*
4. Would you or do you recommend TEL-MED to your patients?	*73.2%*	*26.8%*
5. Does TEL-MED enhance the physicians image?	*73.0%*	*27.0%*
6. Have you donated to TEL-MED in the past?	*51.5%*	*48.5%*

It was the opinion of the committee that TEL-MED offered the physician an excellent opportunity to provide a real service to his patients by making the TEL-MED brochure available to them. The brochures are available in bulk quantity from the Society office. If the physician wants, he may put his personal stamp on the brochures.

Submit your resolutions to WSMA House of Delegates: August 1 deadline

The WSMA Annual Meeting is scheduled for Sept. 19-24. Now is the time to be developing resolutions for consideration by WSMA. Any WSMA member may submit resolutions for consideration. Deadline for submission of resolutions is August 1.

Medical Society Office Offers Referral List for Physicians

The Medical Society office has a referral list for physicians. Call the Society's office to make certain your name is on the referral list or to place your name on the list.

The referral list may be especially helpful for new physicians or those seeking to expand their practice. The Society's office answers over 300 to 400 calls monthly from individuals looking for a physician.

Notice: Change of Address

Dr. W. Gary Becker's listing in the 1985 Directory for Pierce County Physicians and Surgeons, appearing on page 8, shoud read:

adult and ped., allergy and pull. accepts all patients. out on Wednesday afternoons. Address: 2302 Union Avenue, Bldg. B, Suite 18, Tacoma, WA 98405. Phone: (206) 756-0112.

Dr. Hsushi Yeh's address and phone number appearing on page 92 of the 1985 Directory should read:

1311 S. Union, Tacoma, WA 98405. Phone: (206) 759-0404

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Study concludes implementation of Trauma Center will not significantly alter established patient distribution patterns

By
David Vance, MSHS Administrator
Emergency Medical Services Division
Tacoma-Pierce County Health Department

The Medical Society of Pierce County established a trauma subcommittee of the Emergency Medical Services (EMS) Standards Committee in late 1981 and 1984. This committee, chaired by Dr. Ken Bodily, considered the need for a trauma center in Pierce County and the consequent issues of facility and staffing requirements, the designation of a single facility vs. multiple facilities and the potential impact on non-designated facilities.

Dr. Bodily reported, in the April 1982 issue of *The Bulletin*, that studies from other parts of the United States clearly indicated the positive impact on patient care as a result of the designation of a trauma center. Dr. Bodily also reported the results of a study done by the trauma subcommittee which indicated that approximately one patient per day would fit the criteria of a patient who would be delivered to a trauma center.

The trauma subcommittee developed "Requirements For Trauma Hospital Categorization" which were based on recommendations from the American College of Surgeons and the American Medical Association. The requirements were published in the July 1982 issue of *The Bulletin*. Comments regarding the criteria were solicited from individual physicians and specialty groups.

The Board of Trustees of the Medical Society, at its October 5, 1982 meeting, approved the requirements for trauma hospital categorization/designation. The requirements were forwarded, on October 15th, to Dr. Bud Nicola, as chairman of the Pierce county EMS Council, with the recommendation that the Council adopt them and if adopted to proceed with the designation of a trauma center.

At its December 1, 1982 meeting, the Board of Trustees of the Medical Society again considered the general issue of trauma centers in Pierce County as well as the specific issue of designation of a local trauma center. As a result of research on the issue, including meetings with local specialty societies and a survey of the general membership, the Board recommended to the EMS Council that:

1. Designation of a local trauma center(s) in Pierce County is appropriate and would be of benefit to the community.
2. One level II trauma center should be designated and that multiple designation is not desirable.
3. St. Joseph Hospital should be the EMS Council's designation as the level II trauma center, based on discussions with specialty societies and in the general membership survey.

The Board recommended to the EMS council that multi-system pediatric trauma should be integrated into the total EMS trauma center system. The Board also forwarded the recommendations from the Southwest Washington Pediatric Society that the trauma center be closely affiliated with Mary Bridge Children's Health Center and that after initial stabilization of the pediatric patient at the trauma center, the patient should be hospitalized at Mary Bridge for continuing care.

The results of the general membership survey regarding the trauma center issue were published in the December 1982, issue of *The Bulletin*.

The EMS Council has subsequently considered the recommendations of the Medical Society and has adopted the requirements for trauma hospital categorization/designation. The decision was made to delay the trauma center request for proposals until after the EMS hospital base station system is established. The base station system is projected to go on line effective June 1985. As a result of the base station designation, the trauma center requests for proposals were mailed to Pierce County hospitals on February 1, 1985.

The trauma center request for proposals are due in the EMS Council office by June 1, 1985. During the month of June, a site evaluation team from outside Pierce county will review the proposals and visit the applicant facilities. The site evaluation team will consist of two trauma surgeons, one emergency room physician and one pediatrician. Names of prospective site evaluation teams members have been solicited from the Washington Chapters of the respective professional societies.

The trauma center RFP has established the Medical Society's recommendation as one of the criteria for designation of the trauma center. The EMS Council will be formally soliciting the recommendation of the Medical Society in the near future. The trauma center designation by the EMS Council is scheduled for this summer with implementation to take place several months later.

One issue which is commonly raised during the discussion of trauma center designation is the question of the number of patients which would be diverted to a trauma center. The potential disruption in established patient distribution patterns is of concern to many EMS provider agencies, but is perhaps most acutely felt by hospital administrators and medical staff who are sensitive to the perceived loss of patients.

The EMS Division of the Tacoma-Pierce County Health Department conducted a study to answer the question regarding the potential impact of trauma center designation on established patient

distribution patterns in Pierce County. In December, 1984, the EMS Division published the results of a report entitled "Pierce County Trauma Incidence Study." In this study, the admitting diagnoses of 52,382 patients seen in eight Pierce County hospital emergency departments were reviewed. The retroactive study period was March 1984, December 1983 and June 1983. A total of 150 patients were determined to meet the Pierce County "Criteria for Field Categorization and Triage of Patients to a Trauma Center." An additional 199 patients were determined to meet or marginally meet the criteria. The percentage of patients who were determined to meet or marginally meet the criteria compared to the total volume of patients seen in Pierce County hospital emergency departments was .666%. The study concluded that implementation of a trauma center for Pierce County, which is designated to receive all patients who meet accepted criteria will not significantly alter established patient distribution patterns. Copies of the study are available from the EMS Division office (591-5747).

The designation of a trauma center is just one of many changes that have occurred in the Pierce County EMS delivery system since the Medical Society and the EMS Council co-sponsored the EMS Medical Control Project in 1981-82. The Medical Control Project was the forerunner of the Health Department's EMS Division.

Communications systems, paramedic and EMT training, public information/education, CPR training, EMS systems management and related areas have all seen significant improvement as a result of the efforts of the Medical Society and the EMS Council. Emergency receiving centers and base station hospitals designation and the 911 phone system scheduled for implementation September 30, 1985, can also be attributed to the cooperative efforts of the Medical Society and the EMS Council. Pierce County is now recognized as a model for the evolution and development of EMS systems. It is important that the EMS council and the Medical Society maintain their cohesive efforts to improve the delivery of emergency medical care as we move toward the designation and implementation of a trauma center system.■

Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 752-3667.

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Wednesday, May 15
7:00 REUNION—Guest Lecture "THE ROAD BACK: TENACITY & HOPE"
Presented by: Robert H. Moser, MD

Thursday

8:00 **NEW CONCEPTS IN THE MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION** . . . . . *Bruce H. Brundage, MD*
9:00 **CORONARY ARTERY SURGERY** . . . . . *Nicholas T. Kouchoukos, MD*
9:45 **Break**
10:00 **WHO NEEDS CORONARY BYPASS SURGERY? Has Anything Changed Since CASS?** . . . . . *Melvin D. Cheitlin, MD*
11:00 **THE FUTURE OF AMERICAN MEDICINE A Clouded Crystal Ball** . . . . . *Robert H. Moser, MD*
12:00 **Lunch**
1:30 **HOW TO EVALUATE VALVULAR, MYOCARDIAL & GREAT VESSEL DISEASE BY CT SCAN** . . . . . *Bruce H. Brundage, MD*
2:15 **PROGRESS IN THE MANAGEMENT OF THE THORACTIC AORTA** . . . . . *Nicholas T. Kouchoukos, MD*
3:00 **Break**
3:15 **CORONARY ANGIOPLASTY: State of the Art** . . . . . *Douglas K. Stewart, MD*
4:00 **PANEL: QUESTIONS & ANSWERS!!**

Friday

8:00 **THE ELDERLY PATIENT: How Does Age Affect Cardiac Disease & Surgery for Cardiac Disease?** . . . . . *Melvin D. Cheitlin, MD*
9:00 **VALVE AND CORONARY ARTERY SURGERY IN THE ELDERLY** . . . . . *Nicholas T. Kouchoukos, MD*
9:45 **Break**
10:00 **THE ABC'S OF THE HEART FAILURE** . . . . . *Bruce H. Brundage, MD*
11:00 **BETA BLOCKING DRUGS AFTER MYOCARDIAL INFARCTION: Who, When & For How Long?** . . . . . *Melvin D. Cheitlin, MD*
12:00 **Lunch**
1:30 **NEW APPROACHES TO THE DIAGNOSIS & TREATMENT OF PERICARDIAL DISEASE** . . . . . *Bruce H. Brundage, MD*
2:15 **CHOICE OF HEART VALVE SUBSTITUTE** . . . . . *Nicholas T. Kouchoukos, MD*
3:00 **Break**
3:15 **OLD & NEW INOTROPIC AGENTS IN CONGESTIVE HEART FAILURE: What Does the Patient Get Out of Them?** . . . . . *Melvin D. Cheitlin, MD*
4:00 **PANEL: QUESTIONS & ANSWERS!!**

FACULTY

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St. Louis, Missouri

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Location	Date	Program	Coordinator	
	MAY			
STJ	1	Crisis - Crisis - Crisis	Ingraham	(A)
Holiday I	2	Telephone Assessment	Simms	(A)
JH	7, 14, 21, 28	Medical/Surgical Potpourri	AH Comm.	(A)
JH	14	Common Office Procedures	Klatt	(P)
Holiday I	15, 22	Hospital Budgeting	Johnson	(A)
JH	16, 17	Cardiovascular Disease Review	Strait	(P)
	JUNE			
JH	27, 28	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)
	JULY			
JH/MB		Advanced Pediatric Life Support	Seward	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
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Tacoma-Pierce County Board of Health Takes Action

The Tacoma-Pierce County Board of Health has established local regulations governing the storage, handling and disposal of infectious waste with the adoption of Resolution 712. The resolution authorizes the local Health Officer to develop guidelines to control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his jurisdiction.
Following is a reprint of Resolution 712 in full.

Infectious Waste Standards

SECTION 1
Definition
"Infectious Waste" means waste from medical and intermediate care facilities, research centers, veterinary clinics, and other similar facilities which may contain pathogens or other biologically active materials in sufficient concentrations that exposure to the waste directly or indirectly creates a significant risk of disease as determined by the organization's functioning Infection Control Committee. This may include but is not limited to contaminated:

a. Isolation wastes, cultures and stocks of etiologic agents;

b. Blood and blood products, pathological wastes, placentas & bloody OB waste, other wastes from surgery and autopsy, and lab wastes;

c. Sharps and dialysis unit wastes;

d. Animal carcasses and body parts, animal bedding and other wastes from animal rooms;

e. Discarded biologicals, and equipment.

SECTION 2
Medical Waste:
A. General. All medical waste shall be stored, handled, transported and disposed of as follows:

1. Storage of the waste on the medical premises shall be such as to prevent the dissemination of infectious waste into the environment, and storage sites are to be accessible to authorized personnel only. Containers shall be impervious, sturdy and labeled, or be in a particular color designated solely for contaminated articles or infectious waste. Storage areas shall be kept free of all insects and other vectors capable of transmitting diseases. Type of container and the length of storage time shall be determined by the functioning infectious control committee so as to prevent inadvertent exposure of personnel to articles contaminated with infectious material and prevent contamination of the environment.

2. All infectious waste shall be treated in an autoclave, incinerator, retort or other approved process to render it harmless prior to disposal at a solid waste disposal site for which there is a valid permit. The handling of infectious waste shall not be at variance with the current Federal Center for Disease Control (CDC) "Guidelines for the Prevention and Control of Nosocomial Infections," and WAC 173-301.

3. All sharps must be segregated from the general medical waste stream and stored in impervious plastic, glass or other containers capable of maintaining their structural integrity from the point of storage to deposition at permitted disposal site.

4. The Health Officer may prepare and print standards, regulations, procedures, and/or recommendations to be followed in handling, storage and transportation of infectious waste. These papers shall be available to interested persons upon request.

B. Disposal.

1. All non-infectious medical waste, including infectious waste which has been rendered harmless, shall be disposed of at a permitted incinerator or landfill or as otherwise approved by the Health Officer.

2. All human body parts, fetuses, and non-infectious pathological specimens shall be disposed of either by appropriate burial or incineration or other method approved by the Health Officer.

3. Liquid and liquified waste (e.g., blood, blood products, plasma, serum) known to be contaminated with infectious etiologic agents (e.g., hepatitis, malaria, congenital rubella, disseminated neonatal Herpesvirus hominis, dengue, Smallpox, Lassa fever, Marburg virus disease, Yellow fever, and Colorado tick fever) should be managed as infectious waste. If the above etiologic agents

are not known to be found in the liquid waste products, then the following procedure should be followed. Whenever possible or practical, waste materials should be properly disinfected prior to disposal. This would include autoclaving or chemical disinfection. Where this is not possible, the utmost care must be taken to insure the waste containment is secure for all handling through to disposal. If the practice is acceptable to the providing sewer utility, liquid waste may be disposed of by the release into a sanitary sewage system.

C. Infectious Waste Storage, Handling, and Transporting Procedures. All generators of medical waste must develop procedures for storage, handling, and transporting of infectious waste. Procedures must address:

1. Bed capacity and/or case loads.
2. Type of facility.
3. Types of waste.
4. Location of generation.
5. Transportation within the facility.
6. Methods of decontamination: autoclave, incinerator.
7. Frequency of disposal.
8. Quantity of total waste and quantity of infectious waste.
9. Storage area.
10. Bags and labels used to identify infectious waste.
11. Transportation to the final disposal area.
12. Training of exposed and responsible personnel.

This procedure shall be available for review by the Health Officer if requested.

D. Contingency Plan. Generators of all medical waste must develop a contingency plan for the treatment of infectious waste. Provisions must be made for an alternate treatment plan in the event of equipment breakdown with the incinerator, autoclave, or other approved method for rendering waste non-infectious prior to disposal. This plan shall be available for review by the Health Officer if requested.

Practice and Procedure
Postmortem Handling of Blood and Body Fluids

Whereas, the Tacoma-Pierce County Board of Health has established by resolution a Local Health Department, Boards, Officers, Regulations Chapter 70.05 RCW to define the powers and duties of the Local Health Officer; and

Whereas, said resolution authorizes the Local Health Officer to develop his own guidelines to control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his jurisdiction, and take such measures as he deems necessary in order to promote the public health; now, therefore,

The following rules of practice and procedure are hereby adopted:

(1) Generally, personnel should use the same precautions to protect themselves during postmortem handling of bodies that they would use if the patient were still alive; however, masks are usually not necessary unless aerosols are expected to be generated. Autopsy personnel should be informed of the patient's disease status so that appropriate precautions can be maintained during and after the autopsy.

(2) **Blood and Blood Products Containing Known Etiologic Agents:** The principal hazard in blood and blood products (e.g., plasma, serum) is the possible presence of the hepatitis agent. Less common are the pathogens of other diseases (malaria, congenital rubella, disseminated neonatal Herpesvirus hominis, dengue, Smallpox, Lassa fever, Marburg virus disease, Yellow fever, and Colorado tick fever) in which the etiologic agent circulates in the blood. Therefore, if one of the above etiologic agents is known to be in the blood, this waste shall be managed as infectious waste.

(3) **Blood and Blood Products Free From Any Known Etiologic Agents:** If the above etiologic agents are not known to be found in the blood and blood products, through means of death or hospital Laboratory testing, then the following procedures should be followed. Wherever possible or practical, waste materials should be properly disinfected prior to disposal. This would include autoclaving or chemical disinfection. Where this is not possible, the utmost care must be taken to insure that the waste containment is secure for all handling steps through to disposal. Therefore, all waste blood products should be contained on the autopsy table and all drains connnected to the sanitary sewer. ■

What Do You Doctors Wives Do, Besides Socialize and Spend Money?

By Virginia Y. Miller

I was asked that question last May, by the woman who sat to my left at the Presidents' Council annual luncheon. I laughed, shrugged my shoulders and replied: "Actually, I do a great deal of both. I socialize with special friends of long standing and I spend money." (After all, if she ever talked to RLM, he'd tell her just that.)

My luncheon companion was not being malicious or cruel, and I realized that she was only echoing a popular misconception. I told her that doctors' wives were individuals, we were like every other woman with different personalities, talents and abilities. I went on to say that many doctors' wives were now working or going back to school to further their education, and I told her that I shared her surprise that this is so. I continued by saying that I had long been involved in community affairs with thousands of volunteer hours behind me and while I was still involved with the Social Concerns group in my church, a board member of Associated Ministries and with my orthopedic guild, I was in the process of learning more about the Medical Auxiliary, of their contributions of many volunteer hours as well as monies earned by them and donated to Health related, non-profit county groups: such as the Support Shelter at the YWCA, Respite Care, the Organ Donation Program, and Birth to Three.

I'm glad she didn't ask how long I had been a member of the Auxiliary and the follow-up question of why I was still learning.

Oh My! You're asking the question instead?

Again, a truthful answer. Like some of you, I've been a dues-paying-card-carrying-non-active-Auxiliary member for years. Like you, I attended a few meetings but became involved with other community outreach groups and paid little attention to auxiliary. The Auxiliary changed, expanded (and so did I in more ways than one) and the group became more involved with community affairs: I only became "hooked" as a volunteer when the Medical Auxiliary became involved with the Support Shelter. During this period in my life, I had new learning experiences, developed some delightful new friendships and *somehow*, four years later, became your president-elect.

It would be most helpful (and believe me, I need all the help you can give me) if the non-members of the Medical Auxiliary, and there are three hundred plus of you out there, would join with us and share your time, your talents and with your membership give us an additional delegate count and a firmer financial base. And, if you dues-paying-non-involved-members (my old category) would telephone me at 759-7434 and also offer to assist in planning for a more interesting, a more involved auxiliary, this not-quite-over-the-hill person might get enough strength, later in the year, to conduct a multi-faceted seminar on:

SOCIALIZING (I've joined the couples new gourmet group headed by Mary Schaeferle and have some marvelous new recipes and have met some great new people.)

SPENDING MONEY (Debbie McAlexander can tell you about saving and investing in her Financial Planning Group, but there is fun in spending. The Medical Auxiliary is funding some new county organizations. And -shhh- there's a new antique shop in the area.)

VOLUNTEER INVOLVEMENT (Bev Law has compiled a great deal of useful information on volunteer preferences and skills and I'll soon be an expert on expanding ones' volunteer hours.)

Oh yes, there is one last subject to be included:

"How not to Say 'maybe' when the nominating chairperson calls you."■

Virginia Miller is President-Elect, Pierce County Medical Society Auxiliary

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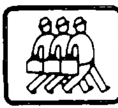

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The Doctor Who Runs for Your Life

By John T. Wrigley

Ever wake up in the middle of the night and feel like going jogging only there's nobody to go with? If this notion should strike you on the week-end of May 31st, cheer up! You can amble over to the track at the University of Puget Sound and join Dr. Gordon Klatt in *THE CITY OF DESTINY CLASSIC*, a 24-hour run against Cancer.

Dr. Klatt is a 42-year-old native of Stillwater, Minnesota who practices colon and rectal surgery in Tacoma and Federal Way. He has been an active participant of medical society affairs, serving on the Board of Trustees in 1982-83.

With his wife Trudy, his son David, 15, and 18 year old twin daughters, Julie and Lisa, he resides in the beautiful, peaceful environs of Brown's Point. It's here that he maintains his training routine for the main event.

As President of the Pierce Unit of the American Cancer Society he has made a pledge that just might put us all to shame: the commitment to start running at 6 P.M. on the evening of May 31st and continue going around the track until 6 P.M. the following day, June 1st; 24-hours of setting a pace that hopefully will rack up 100 miles.

If you're wondering how a doctor can find time to train properly for an endurance run of this magnitude, it's easy. You simply get up at 5 o'clock every morning and go for a one-hour run. During the long daylight hours of summer Gordon enjoys jogging the streets, but as the days shorten, and it's still pitch black at that early hour, he uses a track two blocks from home.

In October of 1983 he entered his first marathon, The Twin Cities Marathon in Minnesota. In November of the same year he achieved his best time in the Seattle Marathon having finished in 3 hours and 18 minutes. With his easy degree of modesty he did admit that Seattle was easier than Minnesota because it was all on level ground along Lake Washington. In March of 1984 he participated in the Emerald City marathon in Seattle and in July, the Olympia Marathon. Then, again in October of 1984, he ran in the Twin Cities Marathon.

In order to reach the goal of 100 miles in 24 hours, pacing must be perfect. This is Gordon's biggest concern. It's the key to finishing the race. To come out even he plans to jog three laps and then walk one. During this walking period body strength will be maintained with liquids including water and fruit juices. He'll also experiment with bananas and other fruits as energy producing sources for the long run.

Dr. Klatt received his medical degree from the University of Minnesota and has been a running advocate for the past 10 years or so. In addition to his daily morning jog he racks up 18 to 20 miles every week-end for a weekly total of 40 to 60 miles.

During this upcoming 24-hour run, the first in Tacoma areas, he will be looking forward to lots of encouragement from others. In fact the cosponsor, Humana Hospital, is arranging for 24-hour Marathon T-shirts to be given to anyone who pledges a minimum of $25.00 and joins Gordon in running for a minimum of half an hour.

In 1983 Dr. Klatt received $6,700.00 in pledges during his Seattle Marathon. This time his goal is $30,000.00.

Gordon looks forward to seeing all of you sometime during the run, because being cheered along and supported is mighty important for completing this undertaking. Right now you can make pledges toward the $30,000.00 goal by calling the American Cancer Society office in Tacoma at 383-1663.

So mark your calendar, because starting at 6 P.M. on May 31st and continuing for 24 hours Dr. Gordon Klatt, President of the Pierce Unit of the American Cancer Society will literally *RUN FOR YOUR LIFE* during the first *CITY OF DESTINY CLASSIC*, a 24-hour run against cancer. ■

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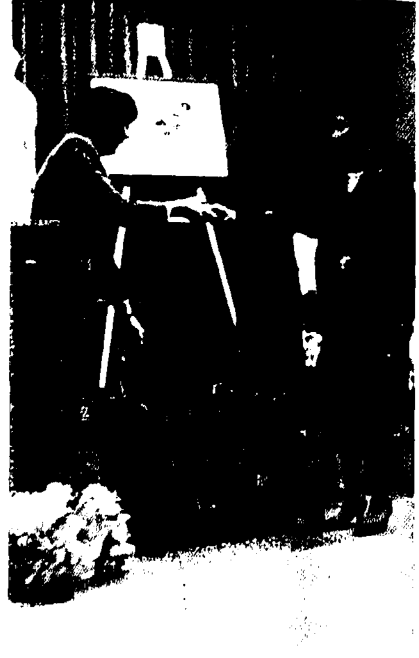
AUXILIARY NEWS

Champagne Brunch and Fund-Raiser Held at St. Joseph

The March "Champagne Brunch and Fund-Raiser" was held at St. Josephs Hospital. A huge thanks to St. Josephs Hospital for their strong support and use of their facilities. A special thanks to Mr. Dan Russell, Tim Harn and Herb Duncan, who tended to all needs. Thank you also to Chef James Barbie, who assisted us with the preparation and serving of the champagne brunch. Their generosity and co-operation contributed greatly to the success of the fund-raiser.



Auxiliary Raffle "Winners"

The winners of the PCMS Auxiliary Raffle included people from hospitals, the Health Department, the general community, physicians and spouses, as well as neighbors and friends of auxilians.

The blue fox fur jacket thrilled winner Delores L. Krull, admitting nurse at Tacoma General. The Lapis pendant pleased Neva E. Goetz, a neighbor of Ginnie Millers. Dr. and Mrs. William Sullivan were very excited that Joan held the winning number for the gourmet chest.

Trish Harrison was the happy winner of the lovely stained glass and wooden candle holder. Computer lessons were won by: Virginia Garred, Margaret Comfort, Beth Wyman, Michael Weis, and Jack Daniel.

The very special winners of the original art works, created by Carolyn Modarelli and Myrna Nagel were: Wanda Reid and Roger Russell. Maureen McClair was delighted by winning the hand knit sweater donated by Lavonne Campbell. Betsy Hoffman held the winning ticket for the modern oil painting, donated by Myra Vozenilek, MD.

Auxiliary Helps Fund Printing for Organ Donor Poster

The auxiliary has donated $500.00 toward the printing of the poster pictured on page 17. The poster will be distributed throughout Pierce Country and Washington State.

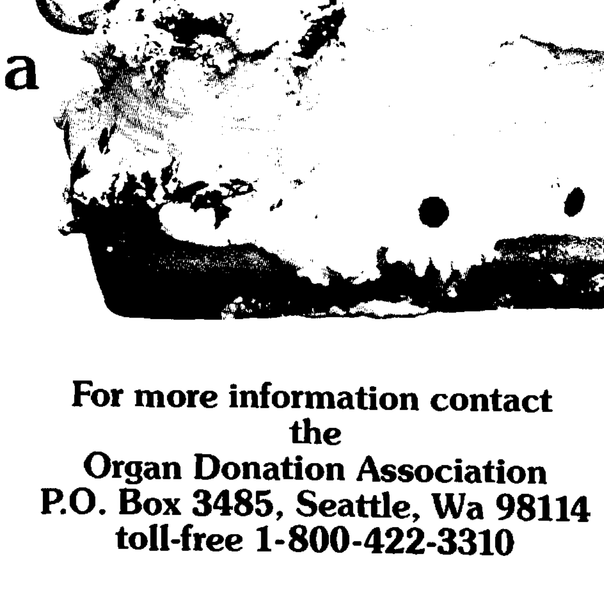
Alice Hilger, Chairman of the WSMAA organ donor program is pleased to report that Marilyn Baer and Judy Brachvogel, co-chairman of the PCMSA organ donor program, were able to obtain Donna Oiland to speak at the April meeting of the Medical Society of Pierce County. Ms. Oiland is Director of the Lions eye bank, located at the University of Washington. She spoke on organ donations. It is important that physicians and hospital personnel become more aware of the avenues for organ donations.

Auxiliary News, continued on page 18

Now Bryce can see his cake, and eat it too!

Bryce was born blind. At eight weeks of age, he received his first corneal transplant. At 11 weeks, he had a second operation. From two donors he had never met, Bryce received a miracle - his sight! Today there are hundreds of others who could benefit from the gift of an organ transplant. Kidneys, livers, skin and other organs are needed to help save and improve people's lives. Become a part of a future miracle...sign & carry a donor card.

Share the Gift of Life – Carry a Donor Card!



For more information contact the
Organ Donation Association
P.O. Box 3485, Seattle, Wa 98114
toll-free 1-800-422-3310

Auxiliary News cont. from page 18

Fun Day: May 17

The Auxiliary will have a Fun Day at the Oakbrook Golf and Country Club, Friday, May 17. Fun - games - relaxation - companionship are the order of the day.

The following activities have been scheduled:

Golf: 9:00 a.m.
Tennis: 9:30 a.m.
Bridge: 9:30 a.m.
Run or walk: 10:00 a.m.
Social hour: 11:30 a.m.
Luncheon: 12:00 noon

A program featuring the Curtis High School Swing Choir, under the direction of Robert Northrup, will follow the luncheon. The installation of the 1985-1986 Officers, by Cindy Anderson, S.W. Regional Vice President WSMAA, will also take place.

Pick your favorite "game" now, and call Kit Larson, 584-3802 for reservations. Reservations are to be made by May 13th.

Tel-Med News

Have you listened to these tel-med tapes?

- #63 *Early warning of heart attack*
- #6 *Breast cancer*
- #4 *I'm just tired, Doctor*
- #239 *Necessary immunizations for your child*
- #35B *Grief (done by Dr. Joyce Brothers)*
- #697 *Do you want to quit smoking?*
- #582 *Shortness of breath*

Call 627-6181 and ask for the tape by number. The Tel-Med switchboard is open from 10:00 a.m. to 8:00 p.m. Mon. - Fri. If you have any comments, call the Tel-Med board and the operator will be glad to take your comments.

Auxiliary Extends Thanks to Community

The Auxiliary would like to express their thanks to the following businesses and people for their generous donations to our recently held raffle:

Eiler Furs-(located in the Bon), for a natural Norwegian blue fox jacket.

Richard Talcott-(Talcott Jewelers), for a Lapis pendant.

John Ullis-(Quantum Computers), for free computer classes.

Myrna Nagle, for an original watercolor.

Carolyn Modarelli, for an original painting.

Dr. Myra Vozenilek, for a modern oil painting.

LaVonne Campbell, for a hand knit sweater.

Dr. and Mrs. Charles Anderson, for a stained glass candle holder.

Dr. and Mrs. Tom Jones, for the large wicker trunk for the gourmet items.

Dr. and Mrs. Anthony Lazar, for a handmade quilt with pillow to match, used to line the trunk. All of the members of the Auxiliary who donated the gourmet treats and wines for the gourmet chest.

To be singled out for special thanks are the following auxiliary members who worked many long, tireless hours on the fund-raiser and are thanked "heartily" for their vital contributions:

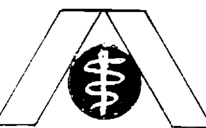
Mary Lou Jones and *Bernice Lazar* for months of planning and hours spent co-ordinating the champagne brunch and raffle.

Sharon Lawson, for much help and time volunteered.

Cindy Anderson, for designing and creating the "raffle" tickets and for the original design for the invitation to invited guests — done on her computer.

Helen Whitney, for designing the invitation that was sent to the auxiliary and society members; and the flyer in the auxiliary newsletter, promoting the raffle tickets.

Barbara Wong, for making the table decorations.



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St. Joseph

St. Joseph Hospital dedicates South Pavilion

The six-story South Pavilion of St. Joseph Hospital, 1718 South I Street, was dedicated on Sunday, March 17, at 2 P.M. in the main lobby of the hospital.

The public was invited to attend the ceremony.

The Air Force Band of the Pacific Northwest Woodwind Quintet provided the music for the ceremonies. The program included greetings by Pierce County Executive Joe Stortini and Mayor Douglas Sutherland, with the official welcome extended by Nat Penrose, chairman of the St. Joseph Hospital Board of Trustees.

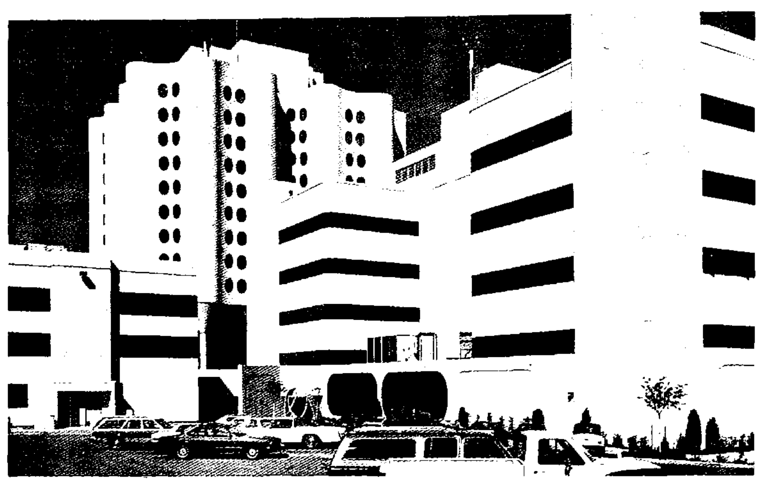
Tours of the South Pavilion were conducted after the ceremony. Refreshments were provided in the nearby cafeteria and dining rooms with the "Suite Life," a chamber ensemble, providing background music.

The South Pavilion features a 38-bed rehabilitation center to serve those who have suffered injury or illness. The majority of the patients have suffered head injuries or stroke.

The Physical Medicine and Rehabilitation Center is headed by Assistant Administrator Sylvia Harlock, Ph.D. The medical director is Surinderjit Singh, MD.

Also featured in the South Pavilion is a 12-bed Pain Management Program co-directed by Michael Jarvis, MD and Marcel Malden, MD. Chronic pain sufferers learn techniques to help them cope with their pain.

The new South Pavilion was completed in early January. Its completion marks the end of the major building construction phase at St. Joseph Hospital.■



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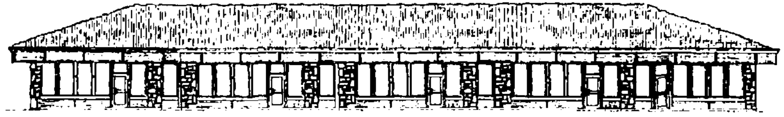

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Miscellaneous

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Physicians Needed

Tacoma: Associate wanted. Prefer Board Certified or eligible FP, EM, IM with interest in acute care for ambulatory/minor emergency center. Full or part-time with flexible scheduling. Partnership possible. Contact Roger Simms, MD at Firstcare Medical Center, 5702 N. 26th, Tacoma, 98407. (206) 759-6655.

General Surgeons needed for long-term practice opportunity in Western Washington community within 2 hours of Seattle-Tacoma. Training and experience in vascular or pediatric surgery desirable. Practice support package possible. Send CV and references to Nancy Friedrich, c/o The Friedrich Group, 9284 Ferncliff N.E., Bainbridge Island, WA 98110.

Ambulatory Care/Minor Emergency Ctr. Full/part-time for FP/IM/EM trained, experienced physician. Located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David Kennel, M.D., at: (206) 584-3023 or (206) 582-2542.

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☐ Physicians Needed ☐ For Sale ☐ Real Estate ☐ Miscellaneous

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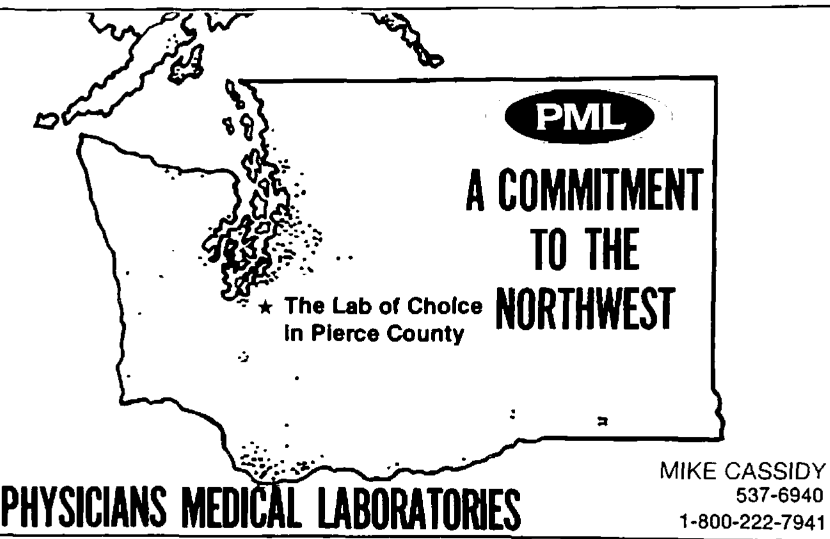

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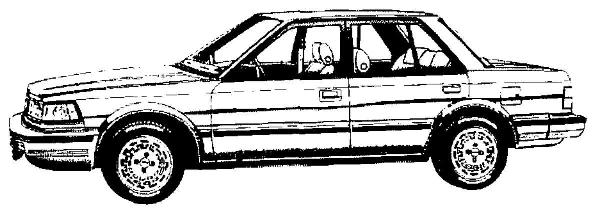

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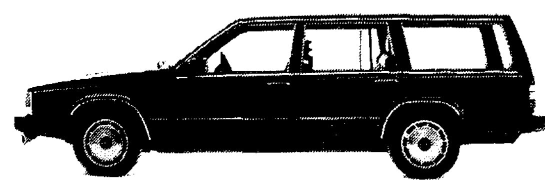

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MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Howard S. Clark, MD, *Anesthesiology.* Born in New York City, 4/22/55; Medical School, Northwestern University, Chicago, IL, 6/79; Internship, Northwestern University, Anesthesia, 7/79-6/80; residency, Northwestern University, Anesthesia, 7/80-6/82. Washington State License, 12/81.

Martha A McCravey, MD, *Pediatric Critical Care.* Born in Chattanooga, TN, 10/8/49; Medical School, University of Tennessee, Memphis TN, 6/75; Internship, University of Michigan Hospital, Pediatrics, 7/75-6/76; Residency, University of Michigan, Pediatrics, 7/76-6/78; Graduate Training, Lebonheur Childrens Medical Center, Memphis TN, Pediatric Critical Care, 7/82-11/84. Washington State License, 1/85. Dr. McCravey is currently practicing at 311 South L Street, Tacoma Washington.

Saroja K. Singa, MD, *Internal Medicine.* Born in India, 9/18/44; Medical School, Thanjavaur Medical College, India, 1968; Internship, Brooklyn Jewish Hospital, 7/79-6/80; Residency, Brooklyn Jewish Hospital, 7/80-6/81, Mary Immaculate Hospital, New York, 7/81-6/82. Washington State License, 2/81. Dr. Singa is currently practicing at Western State Hospital.

Alan B. Wood, MD, *Orthopedics.* Born in Glasgow, KY, 10/10/49; Medical School, Harvard University, Boston, MA, 6/75; Internship, University of Michigan Hospital, 7/75-6/76; Residency, University of Michigan, General Surgery, 7/76-6/78; Graduate Training, St. Joseph Mercy Hospital, Ann Arbor, MI, Orthopedic Surgery, 1/82-12/84. Washington State License, 1/85. Dr. Wood is currently practicing at 124 Tacoma Avenue South, Tacoma Washington.

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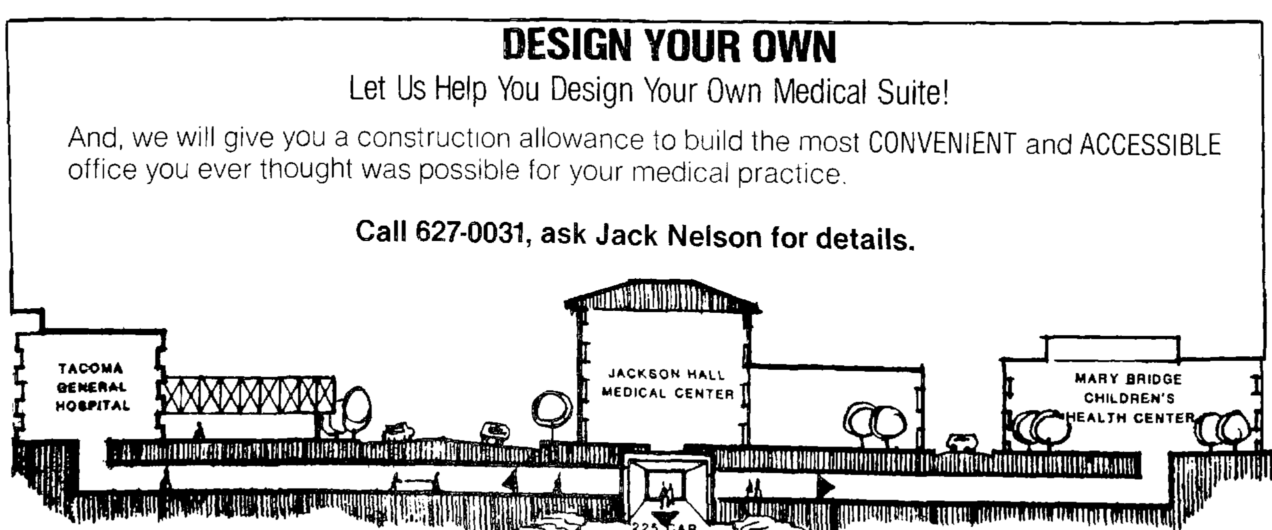


Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

GENERAL MEMBERSHIP MEETING

(Spouses Are Invited)

TUESDAY, MAY 14, 1985

"THORNY ETHICAL ISSUES"

Who Gets What's Left?
Who Decides?
Ethics and Rationing Health Care

Johnny Cox, R.N., PhD.
Staff Ethicist
Sacred Heart Medical Center, Spokane

DATE: Tuesday, May 14, 1985

TIME: No host cocktails 6:15 P.M. Dinner 7:15 P.M. Program 8:00 P.M.

PLACE: Doric Tacoma Motor Hotel
242 St. Helens Avenue

COST: Dinner, $14.50 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County**, in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Reservations must be made no later than Friday, May 10.

REGISTRATION:

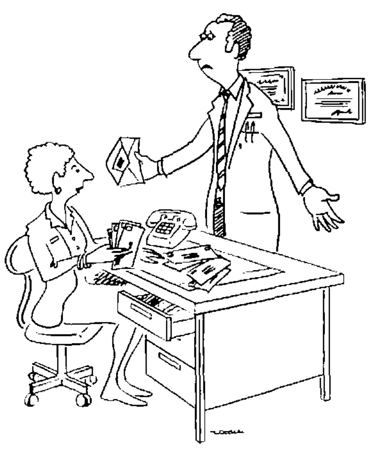
Yes, I (we) have set aside the evening of May 14 to join my fellow Society members and spouses for the presentation on "Thorny Ethical Issues."

__ Please reserve ___________ dinner(s) at $14.50 per person (tax and gratuity included). Enclosed is my check for $_______________.

__ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr: ____

RETURN TO MSPC BY NO LATER THAN FRIDAY, MAY 10.



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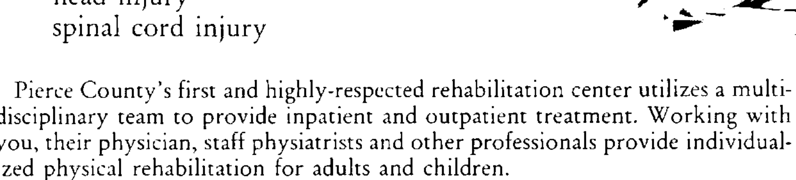

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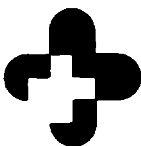

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The following information is
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THE YEAR IN RETROSPECT

Bruce D. Buchanan, MD.
Chairman, Board of Trustees,
Pierce County Medical Bureau

This is the last time I will address you as Pierce County Medical Bureau's Chairman of the Board. It provides me with the opportunity to be more philosophical than in previous editorials and to write from a more experienced and critical perspective.

At the outset, I will once again tell you that this is your Bureau. It is managed by a group of administrators who provide excellent support but it remains your organization. Some of you seem to, electively, lose sight of that fact.

The Bureau is no better or worse than we, as physicians, choose to make it. Physicians serve on policy-making committees that help to orchestrate the future direction the Bureau will take as well as outline the policies that are currently being implemented.

Please understand that, although personally addressing issues with the chairman provides communication, the way to implement change is by direct involvement as a physician member. Participants have no input into the policies of the organization. **Members** make changes by voting at the annual meetings and by serving on the various committees.

There is one important caution: each of us must rise above personal interests and address the issues objectively that affect the whole organization. A variety of specialty and subspecialty groups exist within the medical community, each of which has unique interests or areas of concern. Pursuit of these "individual interests," as a whole, creates a divisive element at the expense of the organization.

My purpose in writing this editorial is to speak with you as a concerned peer who, because of his position, has had the opportunity to see things from a broader perspective.

I have compared our Bureau to organizations throughout the country. We have the distinction of continuing to be a pioneer in the health care industry. Your Bureau does clearly serve your best interests.

Decisions that have been made about the direction the Bureau is taking have not been popular with some of you but they have been absolutely essential if the Bureau is to remain competitive in this and the next decade.

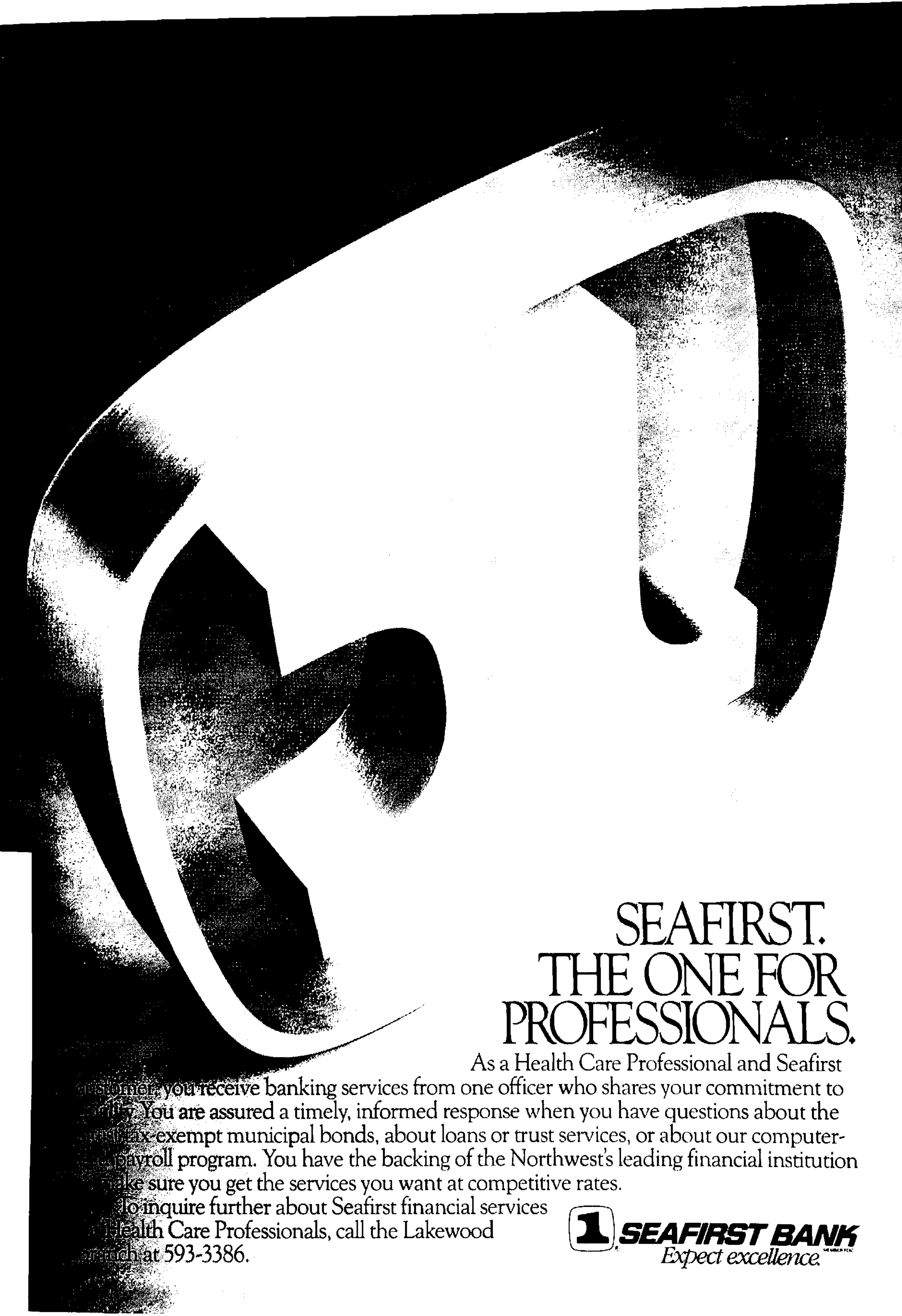
My tenure as chairman is concluded. I am pleased to pass on the responsibility to Roy Virak and look forward to diminished time commitments in the coming 12 months. On the other hand, I have experienced real satisfaction in attempting to provide leadership and represent your best interests this past year.

In conclusion, I will state that the Bureau is no better than each of you makes it. Its future is dependent on us as members and providers. Once again, I, like you, now have the opportunity to respond as a member rather than as chairman although the past chairmanship will color my input as a member. My hope is that, even without the chairmanship to enhance your perspective, each of you would contribute the insight that would best guide the Bureau's and, thus, each of our futures.

Thank you for the opportunity of representing your respective positions which, collectively, have been the heart of the decision-making process.

Bruce D. Buchanan, M.D.
Chairman, Board of Trustees
Pierce County Medical Bureau

*Paid for by **Pierce County Medical Bureau***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The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

June, 1985

MSPC Doctor/
Lawyer Committee
Resolves Disputes.
See page 10

Hospital/Medical
Staff Relationships.
See page 14

A letter to Physicians about SHUTTLE

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Sincerely,

Mary Ann Jackson

Mary Ann Jackson
Manager of Operations

The Bulletin *The official publication of the Medical Society of Pierce County*

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President's Page

As you will have noticed, at least if you read *The Bulletin*, you were spared my ramblings in the last one you received. I decided that as your president elect was writing a guest editorial, two of these would be too much of a good thing.

The question of reading the *The Bulletin* came to mind as nobody approached me regarding the nonsensical last sentence of my previous essay. Well, I am not to be blamed, as I was not able to proofread it and what was omitted from the sentence were the words, "For a recall vote." (I'm anxiously waiting.)

The reason for not being able to proofread the article was eleven days of gliding through knee-deep powdered snow and gorgeous woods and meadows at about tree line, resulting in unbelievable views of nature at its best.

However, one morning I was rudely brought back to earth by a cable news network editorial predicting socialized medicine not regulated by the U.S. Government, but by multi-million dollar corporations, with as an example: The new corporation created by the merger of the Hospital Corporation of America and the American Hospital Supply Corporation. Figures quoted boggle the mind.

An hour later, however, I was 3,000 feet higher. The lack of oxygen made me forget a prospect of the practice of medicine, which is slowly but surely given to us in the form of a "high colonic" with the instruction, "hold it as long as you can." As a matter of fact, I believe you will not be allowed to let it go.

I say, "you," as I myself, to quote Dr. Malden, "am in the twilight of my practice," and probably will be escaping, partially, that particular amount of unpalatable medicine.

To see what that part of the population to which I will belong is thinking, I signed up and am, at present, a card carrying member of the AARP (American Association of Retired Persons). Let me guarantee you that they have clout with Florida Congressman Claude Pepper as their principal spokesman in Washington D.C. What he had to say in a speech to the National Press Club should be heard by all physicians. Maybe it is obtainable, and if so, it would be worthwhile to have it printed in *The Bulletin*. In every AARP newsletter there are articles related to health care, often with political overtones.

By now you will have received the first MSPC newsletter through which we hope to bring issues that should get your immediate attention and which should not be delayed six weeks, as is now the case when you receive *The Bulletin*. For logistical reasons this is apparently unavoidable with the present format.

Accordinly, by the time you have read this you will have heard about the more pressing issues pertaining to your Society.

—*JWB*

When to withdraw life support systems topic of April 19 Membership Meeting

Over 100 MSPC members attended the April 19 General Membership Meeting to hear Judge Robert Peterson, Pierce County Superior Court Justice, review the Natural Death Act. During his presentation, Judge Peterson cited three Supreme Court cases from New Jersey, Massachusetts and Washington. Judge Peterson's presentation served to enlighten the members who were present on when and how they could legally withdraw life support systems.

Do you want a change in the system?

Now is the time to submit your suggestions and recommendations for change. Communicate your individual recommendations for the establishment of WSMA policy or programs through the introduction of a resolution. Submit your resolution to the Medical Society Office prior to August 1, 1985. The resolutions will be introduced at the Annual Meeting of the House of Delegates, September 19-22, Vancouver, Washington.

Health Care Medical Assistants must be certified

Effective March 27, 1985, all health care medical assistants must be certified with the Department of Licensing. A certification delegation form must be completed for each health care assistant you wish to register with the Department. Forms should be sent to the Department of Licensing, Health Care Assistants, P.O. Box 9649, Olympia, Washington 98504. At the present time there is no registration fee. If you were not sent a form or have questions, call the Medical Society Office. This certification is valid for a period of two years and is in lieu of national certification.

UPDate: Pocket Directory

You have recently received a questionnaire from the Society's Membership Benefits Inc. office asking for updated information for the 1986 Pierce County Physicians and Surgeons Pocket Directory.

It is imperative that you return the questionnaire to MBI by June 1, so that the information in the Directory is correct. A fee will be charged for any changes made after publication that are not the result of errors by MBI or the publisher.

Newsbriefs continued on page 6

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Newsbriefs continued from page 5

Dr. Surinderjit Singh again serves as AAEE Examiner

For the third consecutive year, Dr. Surinderjit Singh has been asked to serve as an examiner for the oral portion of the examination for the American Association of Electromyography and Electrodiagnosis (AAEE). The examination for active membership this year was held May 10 and 11 in Chicago.

Book offers suggestions for preventing malpractice suites

William O. Robertson, MD, has written a comprehensive book, *Medical Malpractice: Preventive Approach*, offering a case by case analysis of documented allegations of malpractice. Robertson discusses in detail in his book what might be done to prevent malpractice suits. The reader will find practical suggestions and guidelines for reducing both actual and perceived malpractice.

To order your copy, send $20.00 plus $1.50 postage and handling to the University of Washington Press, P.O. Box C-50096, Seattle, WA 98145-0096. Use number 0-295-96162-7 when ordering.

Physician Numbers Growing

Total M.D. population in the United States passed the half million mark for the first time, according to the new edition of the *Physician Characteristics and Distribution in the U.S.* The AMA publication reported 500,001,958 physicians for 1982, the latest year for which complete information is available. There were 470 for every physician that year, compared to a ratio of 703 to 1 in 1960. More than half (53.5%) of the M.D.'s were 44 years of age and younger. The proportion of female physicians to the total M.D. population doubled between 1963 and 1982, from 6.3% to 12.8%. Foreign medical graduates nearly doubled from 11.2% in 1963 to 21.4% in 1982.

Medical Malpractice Claims Jump

Physicians' risk of having a medical malpractice claim filed against them has leaped since 1980, when physicians experienced claims at an average annual rate of 3.0 per 100 physicians.

From 1980-84, an average of 8.6 of every 100 physicians had a claim filed against them, according to the Socio-Economic Monitoring System of the AMA Center for Health Policy Research.

The increase in the number of claims has led physicians to protect themselves through the practice of defensive medicine.

Although a large number of physicians had adopted defensive measures in the past, many adopted additional measures for the first time in 1984. Physicians in the survey said they maintain more detailed records, prescribe more diagnostic tests and treatment procedures, increase follow-up visits and spend more time with the patients.

"All these responses to increased professional liability risk directly contribute to higher health care costs," according to the latest issue of *SMS Report* (Volume 4 Number 2).

MSPC Professional Relations Committee

For Impaired Physicians

Your colleagues want to help
Medical Problems
Drugs
Alcohol
Retirement
Emotional Problems

Members of the Professional Relations Committee for Physicians

William A. McPhee	474-0751
Patrick Donley	272-2234
Ronald C. Johnson	841-4241
Jack P. Liewer	588-1759
Robert A. O'Connell	627-2330
Dennis F. Waldron	272-5127

AMA sets up Pro monitoring project

Interested in learning of individual physicians' and hospitals' experiences, both positive and negative, attributable to the new peer review system, the AMA has announced an innovative new program set up to monitor the health care delivered to Medicare beneficiaries

Under the Pro program both utilization and quality issues will be looked at by state-level PROs under contract to the Federal government. A percentage of all Medicare discharges will be reviewed with respect to a set of quality and utilization objectives contractually agreed to by each PRO with the Health Care Financing Administration (HCFA).

While the AMA is interested in all relevant experiences, areas of particular interest include: changes in length of stay, admission and discharge policies, preadmission certification procedures, utilization and quality review results, administrative relations between hospitals and physicians and the PROs, any demonstrable impact that PRO review may have on the cost or quality of care, and the results of any PRO efforts to review patients other than Medicare beneficiaries.

Physicians and/or hospital medical staffs interested in sharing this information with the AMA are encouraged to describe their experiences in a brief letter direct to:

AMA PRO Monitoring Project
Department of Health Care
Financing & Organization
American Medical Association
P.O. Box 10947
Chicago, ILL. 60610

All sources of information provided will be kept confidential. The date will be carefully analyzed and the results will be used by the AMA as the Association pursues further involvement with PROs, and as it develops new ways to assist physicians and medical staffs in dealing with this program.

Are you treating a patient with a new physical disability?

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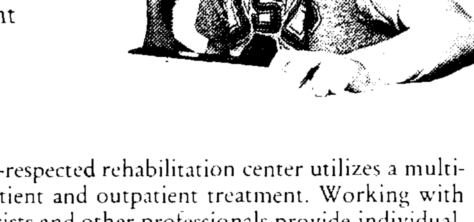

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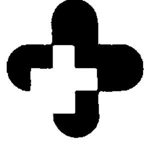

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Why Did You Enter The Practice Of Medicine??

The public basic beliefs about why physicians enter the practice of medicine should be a major target of any future campaign to enhance the professions public image, the AMA Group on Public and Federation Relations concluded after a survey of 1,000 U.S. adults.

The survey, which was conducted in cooperation with the American College of Emergency Physicians, found that a majority of Americans believe physicians do not spend enough time with patients (61%) and do not care about patients as much as they used to (54%). While 62% of the sample agreed that physicians incomes are fair, 44% said that men and women who become physicians are more likely to be motivated by a desire for money than by a desire to help people.

The 28% minority who said that physicians are motivated by desire to help people were more likely to have a positive image of physicians. That is, they were more likely to believe that physicians spent enough time with patients, that physicians still care about patients as much as they used to and that physicians' incomes are fair.

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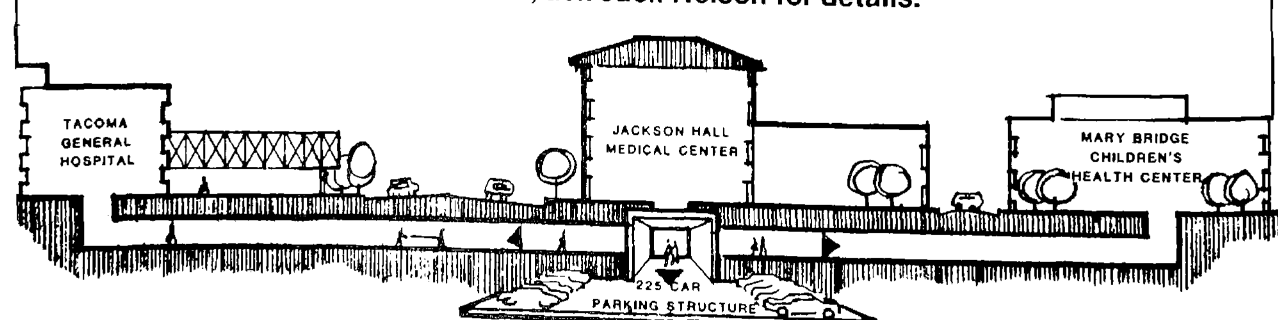

The need for tort reform

American Medical News, May 10, 1985.

From *The Washington Post*:

The number of medical malpractice suits filed in this country and the size of the jury awards are no longer matters of interest only to doctors. The cost, in terms of extremely high premiums and the practice of expensive "defensive medicine" designed to avoid suits, is passed on to patients and taxpayers. Some physicians in high-risk specialties and in certain areas of the country pay as much as $80,000 a year in malpractice premiums. Still, insurers report, they pay out more in claims under these policies than they collect in premiums.

Recently, an American Medical Association task force issued recommendations for addressing the malpractice problem. Public education and quality control within the medical profession were stressed. So was the need for tort reform — the revision of laws and procedures governing negligence litigation that would make the resolution of these cases faster, less burdensome, and fairer to all the litigants. In the mid-70's, when insurers first balked at providing this coverage, most states enacted some kind of tort reform, but many of these state laws are still being tested in the courts. In California, a leading state in terms of volume of suits and the sweeping nature of the reform, the constitutionality of the statute was resolved piecemeal, with the final state Supreme Court judgment handed down only recently.

THE CALIFORNIA LAW has three major provisions: Attorneys' fees in medical malpractice cases must be based on a sliding scale from 40% of the first $50,000 recovered down to 10% for awards over $200,000. Payments are made over the lifetime of the plaintiff, instead of in a lump sum, and cease when he dies. And recoveries for pain and suffering cannot exceed $250,000. Other states have adopted similar, though generally less stringent, forms of these controls and encouraged arbitration and the revision of statutes of limitations and rules of evidence.

The impact of these state laws is uncertain because some are still being tested. Indiana's reforms have worked well. Florida's have been the subject of continuous conflict in courts and in the legislature. Clearly, California will be the state to watch. The reforms have now been upheld by the highest court of the state, and they are major changes. If, over the next few years, they facilitate settlements, reduce litigation, and stabilize insurance premiums, the California rules will provide an effective model for other states.

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MSPC Doctor/Lawyer Committee Resolves Disputes

Results in established guidelines

By Marcel Malden, MD, FACP

For a number of years Bud Judd, as the Chairman of the Interprofessional Committee of Physicians and Pharmacists, reported in the *Bulletin* on the proceedings of his committee. When in January of 1984 I became the Chairman of the Doctor/Lawyer Committee, I thought that I would emulate his example regularly. Well, it is now April of 1985 and here is my first report! So much for good intentions.

The Doctor/Lawyer Committee really consists of two groups with two chairmen. One group is appointed by the Medical Society of Pierce County and the other by the Tacoma-Pierce County Bar Association. Since January of 1984 these two groups have assembled roughly once every six weeks with Mr. James Krueger conducting the meetings. Mr. Krueger has chaired the Bar-appointed committee for the past five years and has conducted all the affairs with the utmost skill and scrupulous fairness. Mr. Krueger's guidance and experience will be missed after all these years, as he has recently resigned.

The purpose of the Committee is to resolve disputes between physicians and attorneys. The Committee does not involve itself in any way with law suits, legal proceedings or investigations. It only responds to complaints of either attorneys or physicians. Most of these complaints concern the problems of fees and apparent lack of cooperation, communication and coordination.

The Committee reaches decisions on the basis of information provided by the involved parties, usually in writing. In the decision making process the Committee is guided by the *Memorandum of Understanding*, agreed to by the Medical Society of Pierce County and Tacoma Pierce County Bar Association. The decisions are not "legally enforceable" but have in the past been complied with on the basis of "moral persuasion." The original *Memorandum of Understanding* was formulated in 1979. It was rewritten in 1983 and then ratified by the Board of Trustees of the two Associations. The text of the *Memorandum* has been published in the August 1984 issue of the MSPC Bulletin (copies of the memorandum may be obtained from the office of the Medical Society of Pierce County). By agreement the *Memorandum* can be altered once yearly by proposals submitted to the Committee for its May meeting. The Committee's "jurisdiction" covers physicians and attorneys practicing in Pierce County only.

During 1984 and early 1985, several disputes were resolved with the result that some important guidelines were established.

In the first case the decision of the Committee indicated that a physician can charge a fee for a reasonable amount of time spent in preparation for a deposition and then the physician should bill the party who originally retained his services. If the request for the particular deposition came from the opposing party, then the physician should bill that party for the time spent in preparation and in the deposition.

However, a distinction must be made "between time spent in preparation to respond to the issues of the deposition and the time spent in assisting a party in preparation of its case." Thus time spent in preparation "to become a better informed witness for the benefit of one party" should be billed to that party, no matter who called for the deposition.

Put somewhat differently, the physician should bill "the party that prompts the physician's preparation for the testimony." In any one case these could be difficult issues to decide. In my experience they usually arise in medical malpractice cases and complex liability lawsuits, rather than in "simple" personal injury cases. The Committee spent months considering this case and trying to find the right wording for its opinion (#1984-1).

If in doubt a physician could ask the involved attorneys to agree to a formula prior to the deposition. The opinion in this case (and of course all others) is available for review and, if necessary, I would be glad to explain it as I understand it. Incidentally, in the same opinion the Committee affirmed "the good faith" right of an attorney to question the appropriateness of the physician's fees and the inappropriateness of a physician's attempt to charge an attorney for responding to such an inquiry.

In the second case the Committee decided that an attorney cannot refuse to pay for the time spent by a physician in preparation for the testimony, on the grounds that in the attorney's opinion the physician was not adequately prepared ("the time was not effectively spent"). This document (#1984-2) really complements and adds to the one previously described.

In the third case (#1985-2) the issue was "to what extent may a physician rely upon an attorney's assurances of payment of the physician's bill." The facts of the case were complex and the opinion is detailed and lengthy. The important portion of the opinion reads as follows:

> "In the event an attorney gives assurance of payment to the physician, which can be reasonably interpreted as personal assurance from the attorney of payment of the physician's charges, even for past or future treatment, the physician should be able to rely on such assurance and look to the attorney for payment."

In this particular case the attorney's letter did not actually make such a clear promise. In its opinion, in effect, the Committee said to the attorneys "please write clearly and state precisely what you will pay for and what promises you offer." To the physicians the Committee said "please read carefully what the attorney wrote and promised. If in doubt, question and obtain additional written clarification." I feel that this is a very important decision, as in the past I have seldom asked myself "what is actually promised and guaranteed" and now I shall be much more

careful and attentive to detail. The relationship between attorney and patient may change (the patient switches attorneys), different insurance carriers have different policies, there are differences between obligations incurred under personal injury protection clauses and under third party settlements. Further, some companies pay physicians for submitted bills directly, others mail checks to patients only and others still issue checks for endorsement by patients, physicians and attorneys. Some pay into the attorney's trust account.

Before closing, I would like to express my appreciation for the participation in the work of the Committee by Drs. R. O'Connell, R. Wilson, J. Foss, R. Spaulding, D. Attig and S. Jackson. The good humor, the understanding and the fairness of the attorney members of the committee make it easy to work with them.

Finally, I need to take a leaf out of the legal books and state "as used in the above article, the masculine gender shall be deemed to include the feminine, and vice-versa"! ■

Government Regulations and their Effects on Health Care

Since the end of World War II, physicians have had to deal with an increasing array of government regulations. Though most are well-intentioned, some have needlessly placed the burden of red tape on the greatest health care delivery system in the world — a health care system of the utmost quality with access for all.

Recently, quality and access have taken a back seat to attempts by the federal government to control the costs of health care. In fact, this overemphasis on costs has inadvertently set in motion forces that work against the best possible health care our nation's physicians can provide.

Recognizing that costs is an important issue, the American Medical Association in 1984 urged each of its members to initiate a voluntary one-year fee freeze for all patients regardless of their method of payment and to give special consideration to the unemployed, those not covered by any type of health insurance and those covered by Medicare. Despite this, the 98th Congress took under consideration a move to freeze Medicare reimbursement for physicians.

The House version of the bill called for a one-year freeze that would apply to current charge levels for services provided on an inpatient basis. In the Senate, another Medicare bill sought to freeze physician charges for all services provided to Medicare patients.

Later, a House-Senate Conference Committee decided to freeze Medicare reimbursement for physicians for fifteen months at the July 12, 1983 level and give physicians until October 1 to decide whether or not to sign a participating agreement to accept assignment in 100% of the Medicare cases seen. Physicians who did not sign the participating agreement would risk fines and possible removal from the Medicare program if they raised their charges above the pattern of charges for the second quarter of 1984.

The battleground then shifted to the courts when, in late September, the AMA, along with the Indiana State Medical Association and several Indiana physicians, filed suit in Federal Court challenging the constitutionality of the Medicare amendments. The AMA and its co-litigants argue that the government-imposed freeze on charges unconstitutionally restricts patients' freedom to choose their own doctors and interferes in the contractual relationship of Medicare patients with physicians who do not accept assignment. Further, the AMA believes that the changes in the Medicare law result in a two-tiered system with no rational basis for singling out part of the physician population for price controls.

Though the government's intentions are good, the move could end up cutting off access to care so needed by exactly the population it is seeking to help — the poor and the elderly.

The Medicare controversy is only one example of the trend toward increased government regulatory interference in the health care process. In recent years, the Executive Branch, Congress and the regulatory agencies affecting health care have proposed a host of measures that intrude on physicians' professional judgment and traditional physician-patient relationships.

Some of the issues include:

• ***Mandatory DRGs for Physicians***: In the 1983 Social Security Act Amendments, Congress attempted to insert a provision that would have mandated prospective pricing for physicians' services as well as for hospital charges. Owing to the efforts of the AMA, this provision never made it to the final amendments. Instead, Congress called for a study of modifications in the physicians' reimbursement system, with an eye toward basing physicians' payments on DRGs. The AMA was also the only health organization to actively oppose DRGs for hospital reimbursement;

• ***Mandatory Patient Package Inserts:*** In a move that would have eliminated physician control over informing patients about drug usage, the Food and Drug Administration attempted to require patient package inserts *at the point of drug sale.* In response, the AMA developed a Patient Medication Information program which provides physicians with leaflets to be given to patients to assist them in complying with their drug regimens. The PMI program helped prevent passage of the FDA ruling;

• ***Medicare Control of Organ Transplantation:*** This legislation would have given the Medicare program power to determine qualifications for physicians, facilities, patient selection and reimbursement conditions. The AMA successfully argued that this would have eliminated physicians' judgment in determining patient treatment.

These are instances where the AMA supports the interest of all physicians even though less than 50 percent of physicians support the Association through AMA membership. Consider how much better the AMA could represent the profession if all physicians joined. Consider too, what would happen if no one belonged. ■

Medical Ethics and Unionization:

Topics of discussion at General Membership Meeting

Neurologist Dr. Arthur Smith conversing with Jeena Surinderjit.

"Who get what's left?" This was the question Johnny Cox, staff ethicist, Sacred Heart Medical Center, Spokane, posed to those attending the May 14, General Membership meeting. Cox urged physicians to step forward and lead the way in establishing the standards that will guide the Society in making these very difficult decisions.

With dimishing funds and increased demands on physicians by society, solutions will have to be found. Cox said, "It is not a problem, but a dilemma."

Cox asked should we, "provide only those treatments that can be expected to yield benefits in proportion to the cost. If the burden becomes excessive, is it permissible to deny it?"

Questions, such as this, raise some of the most pressing ethical issues facing medicine today.

Dr. Nicol Iverson, Puyallup internist, briefly addressed the membership in discussing the need for a physicians' union. Dr. Iverson contends that organized medicine has been unable to stem the tide of regulations and control from the government, business and third party carriers. He told those present at the meeting that he believes, "the AMA and the WSMA have become impotent in their efforts to effect changes in the direction that laws are being made."

Johnny Cox, Ethicist, PhD, RN, speaking at the May 14 General Membership Meeting

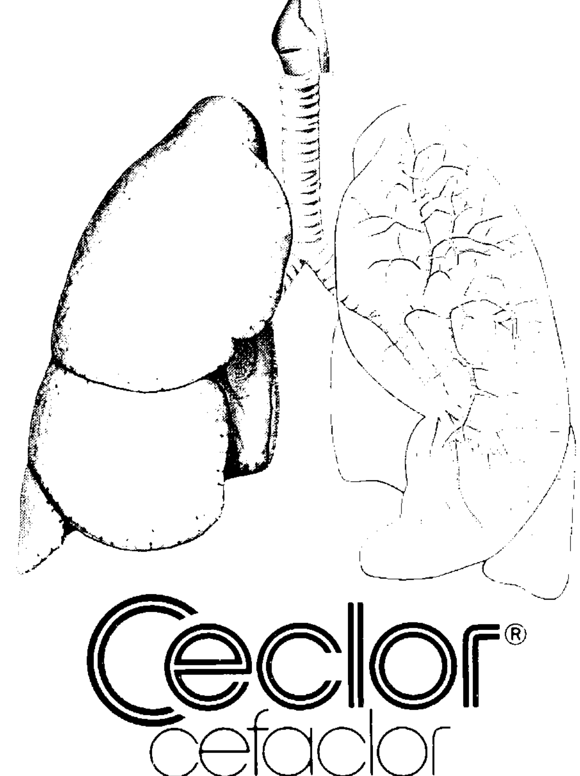
Over 30 physicians attend PRO/W meeting, May 16

Dr. Jack Peterson, Seattle internist representing PRO/W addressed approximately 30 physicians and hospital personnel in a wide ranging discussion on the role, function and responsibilities of PRO/W, pointing out that regulations concerning DRG's (468 product lines) are continually changing. (See cover photo).

Dr. Peterson emphasized that as far as PRO/W is concerned the attending physician is to take care of the patient first. He explained the types of hospital admissions that will be denied Medicare reimbursement and stressed the importance of documenting everything you do and why.

Input involvement from all physicians is being sought by PRO/W to provide them with assistance in developing criteria for reporting admission requirements, utilization review, etc. Dr. Peterson said it should be pointed out to all your Medicare patients that it is their insurance program that has been reduced and amended by Congress and not by physicians or hospitals.

Consider the causative organisms...



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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[051782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Hospital Medical Staff Relationships

By Ralph A. Johnson, MD

A recent article in the *Wall Street Journal* described a proposed merger between the Hospital Corporation of America and the American Hospital Supply Corporation.

Total revenue for these two firms was $7.76 billion in 1984. What impact this will have on hospitals and hospital medical staffs in this state, where we now have 12 investor owned acute care hospitals, is not known. But, we would all agree, the growth of proprietary, chain-owned hospitals will significantly shape the health care system — and soon.

This is one of many issues affecting the relationship between hospital governing boards, administration, and medical staffs.

The Need for Consultation

Hospital/Medical staff relations were recently analyzed by a task force of ten attorneys appointed by the AMA and the American Hospital Association. The resulting report examines the legal responsibilities, functions, and legitimate concerns of hospital governing boards, administrators, and organized medical staffs. It calls for greater consultation between hospitals and medical staffs to avoid conflicts and promote intra-institutional dispute resolution.

All of this is very noble, but it comes at a time when there is an underlying concern that the growing physician population, combined with cost containment, discounting, preferred provider organizations, and out-and-out competition between doctors and hospitals may force a hospital or physician to place economic survival ahead of quality cost-effective care.

To prepare for these changing times, physicians must have an accurate grasp of the economic, social and political pressures that are shaping the medical care delivery system. Hospital staffs must make decisions based on facts. It is from the hard facts and good data that policies and strategies to promote cost effective, quality medical care must be developed.

A Resource to Help

Is there a resource to help the hospital medical staff get good information to achieve a constructive working relationship between hospital medical boards and hospital administrators? The answer is yes.

The WSMA Hospital Medical Staff Section is creating a forum at the state level where medical staff representatives can discuss such issues as hospital bylaws, need for legal counsel, anti-trust issues, medical discipline and personal problems, cost containment, credentialing, risk management, confidentiality, and receiving good data.

Best Forum

The hospital medical staff may perhaps be the best forum for a well informed, dedicated medical community. It is most appropriate that the staff have access to the policy-setting bodies of the county, state, and national medical associations.

In Pierce County, the medical staff presidents meet with county society leadership on a monthly basis.

The AMA Hospital Medical staff has "roared" into existence with close to 2,000 medical staff physicians credentialed to represent 1,500 hospitals across the country.

The county, state and national medical societies, and our specialty societies have a long and effective history in representing the profession. Now is the time to move ahead in creating the state hospital medical staff section as a valuable resource to physicians.

Editor's note: *The WSMA Hospital Medical Staff Section met May 9 and will meet again during the 1985 Annual WSMA meeting, September 19-22 at Jantzen Beach. The AMA HMSS will meet June 13-17 at the Hyatt Regency Hotel, Chicago. For details contact the WSMA 1-800-552-0612.*

Dr. Johnson is a Tacoma surgeon who serves as Chairman of the WSMA HMSS Governing Council.

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What Price a Person

By Linda Carras, Director
Membership Benefits, Inc.

It is 5:00 p.m. Friday and you are feeling grateful man created weekends. Your receptionist of five years enters your office to announce she is leaving your practice for a better paying position. You wince and question whether depression might not be contagious. The symptoms hit you like lightening.

First there are visions of wrinkled resumes embellished with typographical errors in a heap on your desk. Voices of the past ring in your head, "Yeah, I could do his stuff. Uh huh, I sorta know what ya mean. I used to work in a laundromat with people and know all about money. Smack!" That wasn't a kiss you heard but bubble gum twisting under the tongue.

Your depression deepens into a hypnotic trance as you recall the disastrous results from training the one receptionist who never quite figured out insurance forms weren't designed as shelf paper for lining drawers.

You sigh and think, there must be an easier way of recruiting a capable employee, where the risks are reduced, less effort is expended and the payoff is positive. You are not alone. These same feelings were shared by a core of physicians at Allenmore Medical Center seven years ago and were the catalyst behind the creation of the Medical Society's Placement Service. The Placement Service is now a part of Membership Benefits, Inc. which is a subsidiary department of the Medical Society of Pierce County.

Your Placement Service is one of the best Medical Placement Agencies in Tacoma for several reasons: It serves you exclusively, understands your needs better than any other agency, and is more thorough and less costly than other agencies.

Fees are 50% below competition, positions are discreetly advertised, and we personally visit your practice. To assure quality selection extensive tests are administered, references are double checked and lengthy time is devoted to the screening process. No other agency can claim all of the above services.

In addition, we save you time and money. Calculate the cost of your time devoted to screening potential employees, add advertising costs for a couple weeks in the TNT, add the cost of developing comprehensive tests for each position, include the expense of hiring temporary help while you search for a permanent person and the sum is a reasonable investment. The cost is staggering when you add a training expense invested in the wrong employee who is eventually terminated. Turnover costs as much as $5,000 per position, according to the American Medical Association Practice Management Division.

The next time your valued employee terminates call us first. You will get the best applicants recruitable, you will get the previous knowledge of their skills and longevity, and you have professionals giving you prompt courteous service.

Survey Results

In an effort to continue offering the best placement service available Membership Benefits, Inc., recently completed a survey of member physicians. Following are the results: Positive comments far outweighed negative comments by more than three to one and have been condensed in the interest of space.

Some of the positive comments were: efficient, good response time, provided excellent employees, reliable, thorough screening, friendly, cooperative people, easy to talk to, honest and professional, understands my problems, weeds out unqualified candidates, works hard to find the right person for the job, makes our job easier, quick and responsive, best help provided through this service over last seven years.

Negative comments included: self interviewing is better, applicants do not have money to pay placement fee, background information is often incomplete, fee for service is too high.

94% of the physicians surveyed indicated they would consider using the placement service of the Medical Society in the future. 6% said no.

Of the physicians surveyed, 84% responded affirmatively that they knew the Placement Service was a subsidiary department of the Medical Society. 16% responded that they were unaware of this fact.

41% indicated that they knew, as a subsidiary, the Placement Service has a profit status intended to provide revenue for the parent organization. 59% responded that they did not know this.

24% of the physicians surveyed knew that the Placement Service fees were an average 50% lower than other agencies in Pierce County. 76% were unaware of this.

39% were aware that the Placement Service has its own board chosen from member physicians. 61% were unaware of this fact. 62% responded that they had used the Placement Service while 38% indicated that they had never used the service.

19% said they had given the Placement Service exclusive rights to job orders. 81% responded that they had not given the Placement Service such rights.

29% of the physicians surveyed indicated that they knew the Medical Society Placement screens more thoroughly than other agencies in Pierce County, 71% indicated they did not know this.

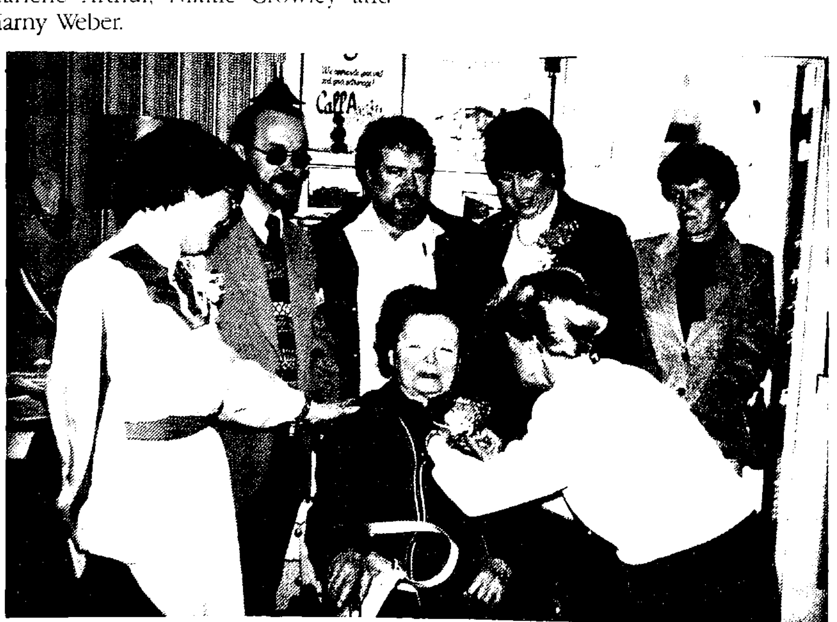
33% knew that the Placement Service will personally visit physicians' offices to better assess needs, 67% indicated they were unaware of this service.

36% of the physicians knew the Placement Service advertises their position opening free of charge, 64% were unaware of this. 23% of the physicians knew that the applicant pays the fee, and when the MD pays the fee, there is a 60-day guarantee extended. 77% were unaware of this.

52% of the physicians surveyed knew that the Placement Service conducts a complimentary salary and benefit survey for member physicians, 48% were unaware of this service. ■

Auxiliary Past Presidents attend luncheon in their honor

The Pierce County Medical Society Auxiliary recently held a luncheon at the Meeker Mansion, Puyallup, honoring the Auxiliary's past presidents. Pictured at the right are Auxiliary past presidents Jeanne Judd (seated), left to right standing, Gloria Virak, Helen Whitney, Jo Roller, Dorothy Grenley and Norma Smith. Other past presidents who were present at the luncheon but are not pictured were: Marlene Arthur, Nikkie Crowley and Marny Weber.



Susie Duffy is shown pinning a corsage on Jeanne Judd. Jeanne Judd was one of the former past presidents recently honored at a luncheon held at the Meeker Mansion in Puyallup. Left to right are Auxiliary members Sharon Ann Lawson, Nikki Crowley and Joan Sullivan. The two gentlemen pictured are with the Cabulance service at Good Samaritan Hospital, Puyallup. They graciously assisted Jeanne Judd and her wheelchair into the Mansion.

Auxiliary plans contest for summer fun . . .

If you are wondering how you are going to occupy the time and harness the energy of your "little darlings" this summer, the Auxiliary may have your answer. Plans are being made to have a contest for the best Holiday Card motif created by children from the medical community. The rules, medium, and ages are all being worked out by Caroline Modarelli and her committee. Further information will be published in the next issue of *The Bulletin* and the *NN* newsletter. (If you don't know what NN stands for, it stands for No name.)

You guessed it, another contest. This one is for grown-ups. There is no age restriction. Send your ideas for a name for the *No Name Newsletter* to the editor, Ruth Jackson (Mrs. Stanley M), 7513 87th Ave. S. 98498, Tacoma. (Madigan wives publish *The Heartbeat* monthly, so that neat name is taken up, otherwise the field is "wide open." And of course, there are prizes. Good ones at that.

Washington State Medical Association Auxiliary holds annual spring convention.

The Washington State Medical Association Auxiliary Annual Spring Convention met in Vancouver, WA., April 22-24, with Erselle Eade presiding. Attending as delegates from Pierce County Medical Society Auxiliary were Nikki Crowley, Alice Wilhyde, Norma Lloyd, Ginnie Miller and Sharon Ann Lawson, president. Cindy Anderson, SW Regional Vice-President, attended as a State Board member. There were 53 auxiliary members present, representing 17 state auxiliaries.

The opening session Monday afternoon, began with a welcome from Karen Sahlstrom from Clark County, the hosting auxiliary. Billie Brady, AMAA president, presented AMA greetings to the House of Delegates. Tracy Getz, a psychologist from the University of Washington, was very well received with his seminar on "Everyone Knows How to Listen, Don't They?."

County displays were set up Tuesday morning and while there was much interest shown to all displays it was noted by six attentive people that the informative display from Pierce County, prepared by Sharon Lawson, sparked the greatest interest. Many questions were asked, particularly the reasons and method for the spectacular amount raised from our AMA-ERF Holiday Card. Again this year this county received top award for the most money raised. Nikki Crowley, chairman, explained informally to many of the interested delegates, the procedures used. She emphasized again and again that it was only through the combined efforts of the entire medical community that $14,186.55 was raised (the next highest amount was $3,623).

Confluence, nominating, resolution reports were given, and during lunch an interesting slide show was presented by Marcella Morrison on "Being a Congressional Wife." Billie Brady gave a most informative (but chilling) report on Child Abuse.

Tuesday evening at the Installation Banquet, Dr. John Kennelly, Jr., WSMA president, was the speaker. Sue Dietrich, Clark County was installed as WSMAA president and Mary Skinner from Thurston-Mason as president-elect. Other State Board members were also installed including regional vice-presidents: Sharon Lawson will replace Cindy Anderson as SW Regional Vice-president. During the evening a singing gorilla (read on, there is more) provided by Dr. Kennelly, serenaded Estelle Eade, outgoing state president. Cindy Anderson provided further entertainment with a ROAST on some of the present and future State Board members and Sharon was included. (Cindy received some recognition along those lines the following morning.)

County reports were given Wednesday and information regarding the PACE program was ably presented by Tom Curry. There was also an Organ Donation Chairman Workshop presented by Jan McLean of King County and Alice Hilger, Pierce County Co-Chairman.

This was a challenging convention with valuable exchange of ideas from the other state auxiliaries. However, it wasn't all information giving and receiving. The fellowship experienced bound us closer together as auxilians. Next year it is hoped that more delegates from Pierce County will be able to attend. "Try it, you'll like it."

Virginia Miller

Open Letter

Dear Auxiliaries:

Auxiliary is people. People who are and share. People who have fun and get the job done. Whether the job is coordinating volunteers, staging a special event or remembering others – Auxilians are always there. Thanks to all of you for being there to make this a happy, busy year.

Sharon Ann Lawson

Membership Book being prepared

The Auxiliary Membership Book is currently being prepared. Chairperson of the 1985-86 Auxiliary Directory Alice Wilhyde is asking that if you have moved or have a new address or phone number, contact her at 572-6920.

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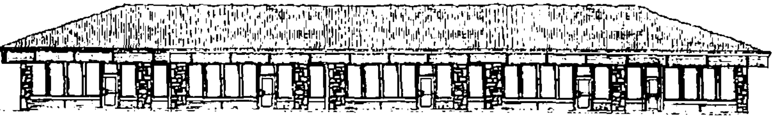

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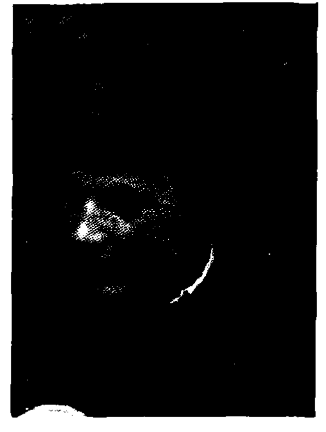
1985 Student Recognition Award Winners Announced

Each year an award based on scholarship and leadership is given to the most outstanding graduating son and daughter of a physician in private practice in Pierce County. The student recognition committee of the Medical Society Auxiliary has selected Susan M. Benveniste and Philip R. Beck to receive the 1985 recognition awards.

Susan M. Benveniste, a graduate of Curtis Senior High School, is the daughter of Dr. Ron and Karen Benveniste. She plans to study law at the University of Washington.



Philip R. Beck, a graduate of Charles Academy, is the son of Dr. Ronald and Ruth Beck. He will attend Stanford where he will major in Asian Studies (China).

Pierce County Auxiliary Members serve on WSMAA Board

Cindy Anderson and Alice Hilger were appointed to the State Board for Washington State Medical Auxiliary. Alice will continue to be co-chairman of the Organ Donation Committee. Cindy will serve as bylaws chairman. Sharon Ann Lawson was elected Southwest Regional Vice President. As part of her duties she will travel to all the county auxiliaries in the southwest with Sue Dietrich, WSMAA president.

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Good Samaritan

Good Samaritan Hospital completes two-month pilot project involving care of the elderly

One of 24 hospitals to participate in a nationwide program to demonstrate that hospitals can provide elderly patients enhanced inpatient services and ongoing coordinated care beyond the hospital walls, Good Samaritan recently completed a two-month pilot project. The program, Eldercare, is a three-year demonstration project funded by a grant from the Robert Wood Johnson Foundation, Princeton, New Jersey.

Ten patients were involved in the two-month pilot project with Good Samaritan's Eldercare staff.

"After working with these patients," says Susanne Marten, Eldercare project manager, "we are fine tuning our program and will begin to accept additional referrals next month."

Specific services Eldercare is prepared to provide include assistance in assessing the situation of older persons when a breakdown in their independent living pattern has occurred or is threatened; recommending and facilitating the use of appropriate community support services to maintain older persons in their homes while reducing strain on their families and others who provide support; conducting in-home functional assessments; monitoring health functioning and care needs with particular attention to medication compliance; reporting results of assessments, monitoring and intervention to physicians; helping to ensure continuity of care when multiple service providers are involved.

To provide these services, a resource coordinator and a registered nurse will be utilized. Their services and plan of care will be based on physician input and involvement with follow-up reports being submitted to the physicians. Concerned with long-term monitoring of chronic health problems, Eldercare will not offer intensive, skilled nursing care. This rather will remain a function of Home Health.

Participants in the Eldercare program must reside in the Good Samaritan Hospital area, be 65 years or older and not a permanent nursing home resident. They must need support and assistance in self-support and assistance in self-care and health care that exceeds the present or long-term abilities of the patient and/or care givers. In addition, their chronic health care needs must present a significant risk factor. There must be an inability to independently perform basic activities of living necessary to sustain functioning, health and/or safety in the home because of age, health conditions and/or cognitive impairment. ■

St. Joseph

"Charity Health Care: Society's Option or Obligation?"

One Day Conference, June 26, State Senator James McDermott to serve on panel

St. Joseph Hospital and Health Care Center will host a one day conference, "Charity Health Care: Society's Option or Obligation," Wednesday, June 26 from 8:00 A.M. to 3:30 P.M. at the Tacoma-Sheraton Hotel.

The purpose of the conference is to share information about charity health care needs in Pierce County and to find new ways to meet those needs. National, state and local perspectives will be presented.

Keynote speaker Walter McNerney, Professor of Health Policy Administration, Northwestern University, Evanston, Illinois, and past president of the National Blue Cross/Blue Shield Association, will speak in the morning outlining the national perspective on the health care industry.

Presenting the state perspective on charity health care will be panelists State Senator James McDermott along with Harry Morgan, chairman of the board, Puget Sound Health Care Purchasers Association; Alvin Thompson, MD, past president Washington State Medical Association and president of the Washington State Black Health Professionals; and Ron Kero, deputy director of the Washington State Department of Social and Health Services (DSHS) Division of Medical Assistance.

Following lunch, Florence Reeves, RN, project director of the Urban Health Initiative Project for the Tacoma-Pierce County Public Health Department and George Tanbara, MD, medical consultant for the Eastside Clinic and co-chair of the Family Clinic Board will discuss the local issues of charity health care.

Prior to the close of the conference, the audience will become participants, forming small groups to interact with regard to the issues presented during the conference day.

Seminar cost is $60 which includes lunch. Invited participants represent hospital administration, physicians, health care providers, business and public officials. Additional information may be obtained by calling St. Joseph Hospital Administration Office, 591-6605. ■

The AMA: Fighting the Professional Liability Crisis

The crisis in professional liability for physicians — after a respite of a few years — has resurfaced with a vengeance. In fact, the liability problem may be *worse* today than in the mid-1970s when medical malpractice insurance first began making headlines. At its most severe, the medical liability crisis of nearly a decade ago resulted in a shortage of coverage for physicians. Now the crucial insurance problem for physicians seems to be this: coverage is available, but premiums are going so high that some practitioners avoid them by *withdrawing their services* in whole or in part, or by taking early retirement. As a result, of course, patient access to medical care is restricted, and that makes physicians' professional liability *everyone's* crisis.

In battling this recurrent crisis, one of the initiatives of the American Medical Association is its Special Task Force on Professional Liability and Insurance. The first goal of the task force was to determine the severity of the liability problem, which is summarized in a report issued in the autumn of 1984. After the release of that report, the task force chairman, AMA Executive Vice President James H. Sammons, M.D., said:

> "What is now developing is a crisis in affordability for physicians. In the mid-1970s, when the first big wave of claims engulfed the medical profession, many commercial insurers deserted the market. New physician-owned companies were launched — companies that now provide protection to more than half the profession. Some commercial companies have stayed in the market, and a few others are moving back into it. Insurance is available, but its price is rising. The question is, how long can physicians afford to pay that price?"

The current escalation in physicians' premiums couldn't have come at a worse time, when the public's and policy makers' sensitivity about medical costs is at high pitch. All physicians have reason to be worried about the costs of professional liability. Consider these few points from the first report of the special task force and other sources:

- The number of 1984 claims against physicians' insurance is projected to reach about 40,000, up from 32,534 in 1983. There were 14,074 such claims in fiscal year 1976 — the midst of the "medical malpractice crisis."
- One survey indicates that, because of the ruinous insurance rates, 9 percent of ob/gyn specialists have given up the practice of obstetrics entirely and 20 percent avoid high-risk pregnancy cases.
- The loss in productivity among physicians who have taken early retirement rather than pay high premiums has been placed at *$250 million* annually, according to the AMA.

The end result, the AMA task force concluded, is a *professional liability system that is "ever more costly financially, and one that undermines physician-patient relationships and ultimately drains strength from the entire medical care system in the nation."*

What can be done about the professional liability crisis?

The AMA special task force has made a substantial start in its intensive and crucial effort. The task force's first report provides the information and perspectives necessary to carry out its mandate — *coordinating the AMA's activities with regard to professional liability* (including those of the AMA's Committee on Professional Liability) and developing a plan of action to respond to the crisis. Other important task force efforts:

- An assessment of the professional liability insurance market;
- A review of tort reforms;
- An evaluation of possible solutions needed for the plan of action;
- Compiling information on risk management in cooperation with the American Medical Assurance Co. (AMACO), the AMA's insurance subsidiary;
- Actively promoting state coalitions to address the issue of tort reform;
- Development of a pamphlet, for distribution in physicians' offices, to educate patients on professional liability;
- Creating a publication for physicians, including useful information on avoiding professional liability suits;
- Installation of toll-free AMA phone numbers to handle inquiries from physicians or the general public on professional liability. *Those numbers are: 800-552-1642 and, in Illinois, 800-821-5309;*
- Approval by AMACO of grants to study important medical liability topics.

Given that professional liability for physicians is a nationwide problem that varies according to individual state laws — and that it is a crisis facing *all* physicians — the AMA' s national leadership role is vital. And so is your support of the AMA on this front.

There are a number of reasons behind the medical liability crisis. Among those cited by the AMA task force are: the increasing complexity of medical technology (which has brought about some new procedures that increase risk of injury); high public expectations regarding medicine; a more litigious society; and a larger number of attorneys who are willing to file frivolous suits.

Yet, whatever will be the *solution* to the crisis, a good guess is that it will involve physicians working together. In the 1970's, when commercial coverage was difficult to obtain, physicians banded together to form their own insurance companies. Formation of many of these companies might well have been impossible had the AMA not formed AMACO to provide reinsurance. The AMA has shown many times on this and other medical issues, that a united, national front serves medicine well.

Moreover, the Association supports professional excellence in numerous ways, providing an important counterforce to actual malpractice. And through the special task force's clear examination of liability problems and its development of a practical agenda for action as well as through other activities in the professional liability arena, physicians stand the best chance of seeing this crisis end. ■

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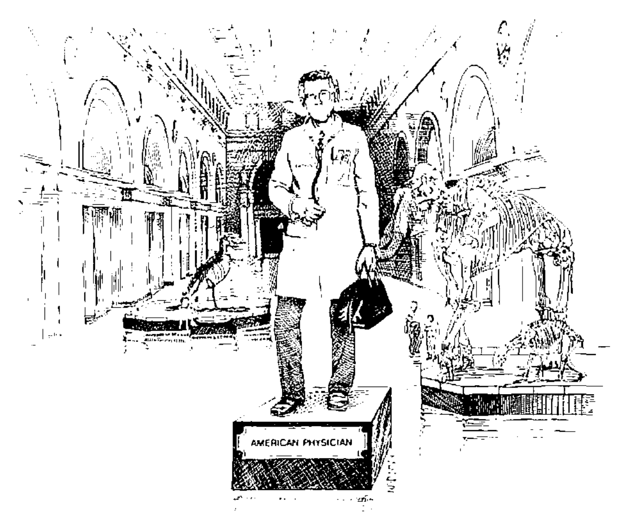
From an historical perspective: the AMA, June 4, 1894

Success is assured reported the *Pacific Medical Journal*, June 4, 1894. It is very gratifying at this very early date to assure our readers and members in the East that the American Medical Association meeting for 1894 promises to be a grand success. We are in receipt of enthusiastic letters from medical men in various parts of California, Oregon and Washington, informing us that they contemplate coming to San Francisco in June to attend the Association meeting and become members of the organization, reported the Journal. "We can assure them," said the Journal, "that everything will be in readiness on our part. The various committees are sparing no pains to provide literary feasts and social pleasures to all who may honor us with their presence. There will be grand dinners, balls, excursions on the bay and into the country, receptions, etc. etc. California has already gained laurels as hostess, and we can promise that she will do justice to her friends on the occasion of June 4, 1894."

The Pacific Medical Journal reported in June, 1894 that the AMA expected to "take in at least 1,000 new members from the west coast with the June 4, 1894 convention." According to the report, the AMA had at the time close to 5,000 members.



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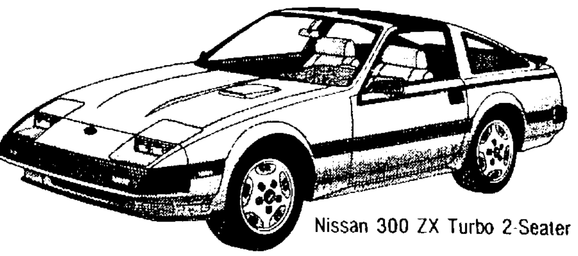

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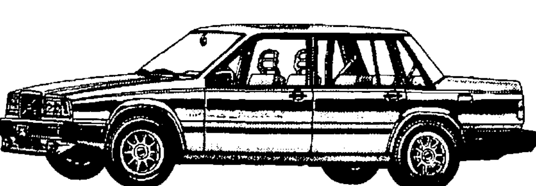

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In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Cameron S. Carter, MD, *General Practice* Born in West Australia, 10/23/55; medical school, University of Western Australia Medical School, 1979; internship, Royal Perth Hospital 6/80-10/80, Flinders Medical Centre, South Australia, 10/81-7/82; residency, Flinder Medical Centre, emergency/internal medicine 8/82-11/82. Washington State License 1984. Dr. Carter is currently practicing at 1110 Fryer Road, Sumner, Washington.

Nick W. Uraga, MD, *Occupational Medicine.* Born in New York City, New York 8/12/47; medical school, Creighton University, 1973; internship, USAF Medical Center 7/73-7/74; Washington State License, 1977. Dr. Uraga is currently practicing at 4505 Pacific Hwy E, Tacoma, Washington.

Kelly Wright, MD, *Neonatology.* Born in Ticonderoga, New York 6/3/49; medical school, University of Rochester School of Medicine & Dentistry, 1976; internship, University of Washington, pediatrics, 6/76-6/77; residency, University of Washington, Pediatrics, 7/77-6/79; graduate training, University of Washington, Neonatology 7/79-6/81. Washington State License, 1977. Dr. Wright is currently practicing at 315 South K Street, Tacoma, Washington.

Leo K. Min, MD, *General Practice/Nuclear Medicine.* Born in Korea, 7/29/45; medical school, Hanyang University, 1981; residency, Mount Sinai Hospital & Medical Center, Chicago IL Internal Medicine, 7/81-6/83, Oregon Health Science University Hosital, Portland, Oregon, Nuclear Medicine 7/83-6/85. Washington State License, 1985.

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MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 752-3667.

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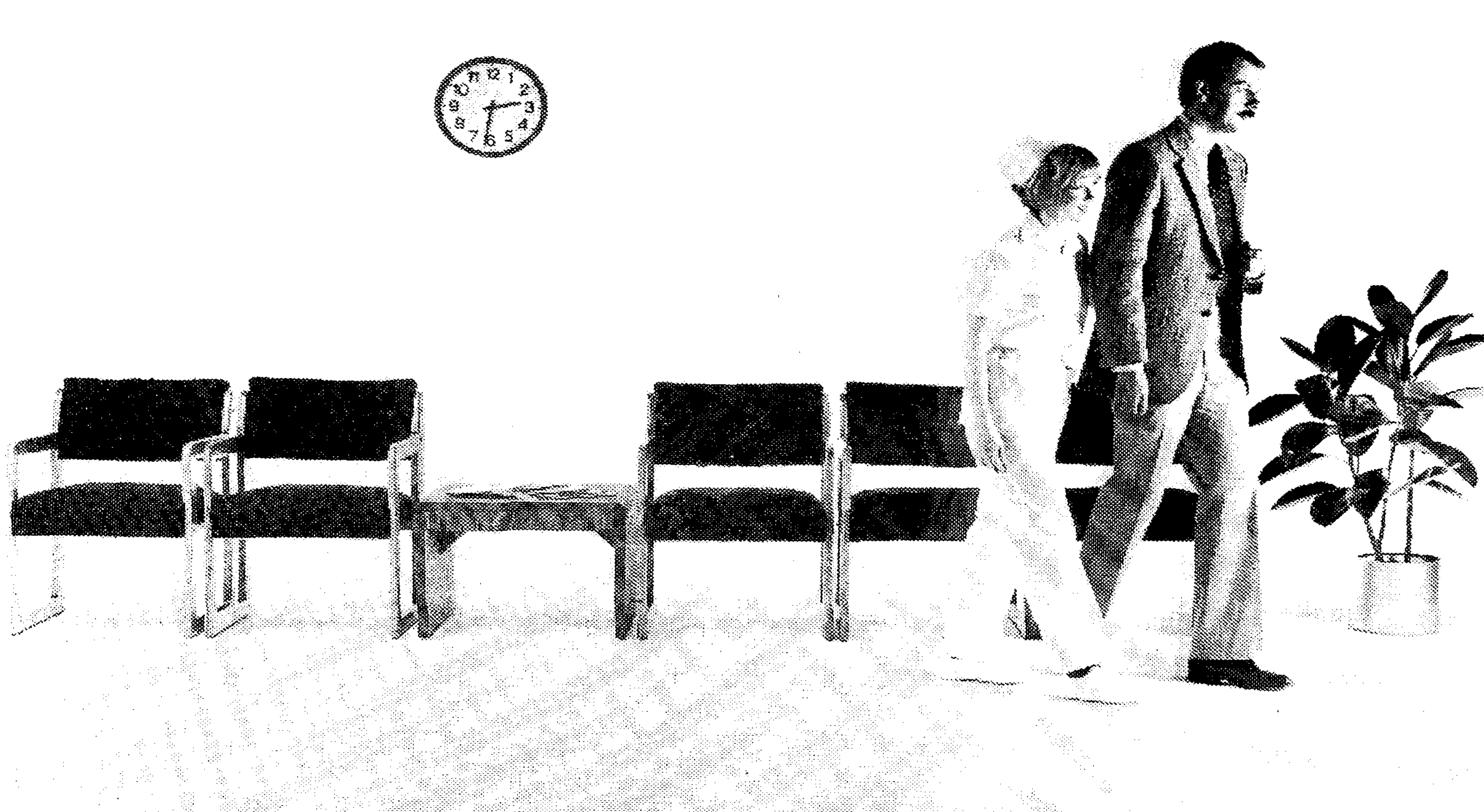

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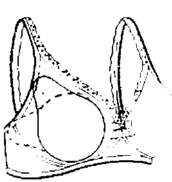

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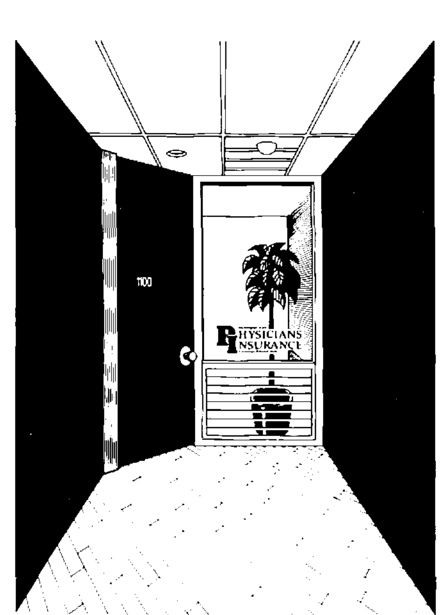

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Letter to the Editor

Dear Editor:

I think we doctors should recall the following quotation from Dr. William Hillary who, in 1750, wrote the following words: "If we once quit our reason for mystery, we must wander through endless mazes and dark labyrinths playing at hazard with men's lives and suffer ourselves to ramble to wherever conceited imaginations or whimsical hypotheses should lead us." This was writen in an essay by him entitled "A Rational and Mechanical Essay on Smallpox" in 1735.

In this day of acupuncture and Laetrile and a number of other nostrums, I think we should remember that as long ago as two hundred plus years the medical profession recognized that the imaginations of men were conjuring up improbabl and at times impossible solutions for the alleviation or cure of diseases. I am sure Dr. Hillary did not dream that after over two hundred years of advancement and enlightenment the same situation occurs, although it must be admitted in a more sophisticated and pseudorational fashion.

Rodger S. Dille, M.D.

"Snafus," Errors and Omissions

The May issue of The Bulletin incorrectly presented MSHS Administrator David Vance as Dr. David Vance. Our apologies to David Vance and to the Medical Society.

Our apologies to auxiliary members, Dorothy Grenley and Alice Wilhyde for inaccuracies in the spelling of their names in the April issue of The Bulletin.

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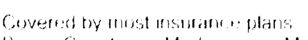

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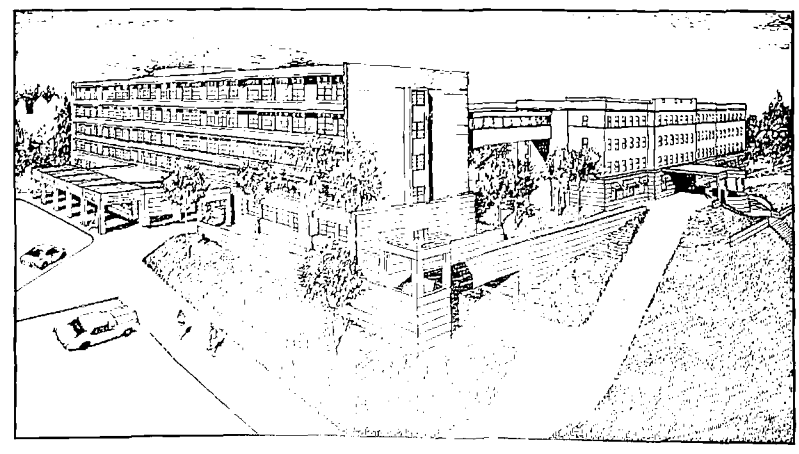

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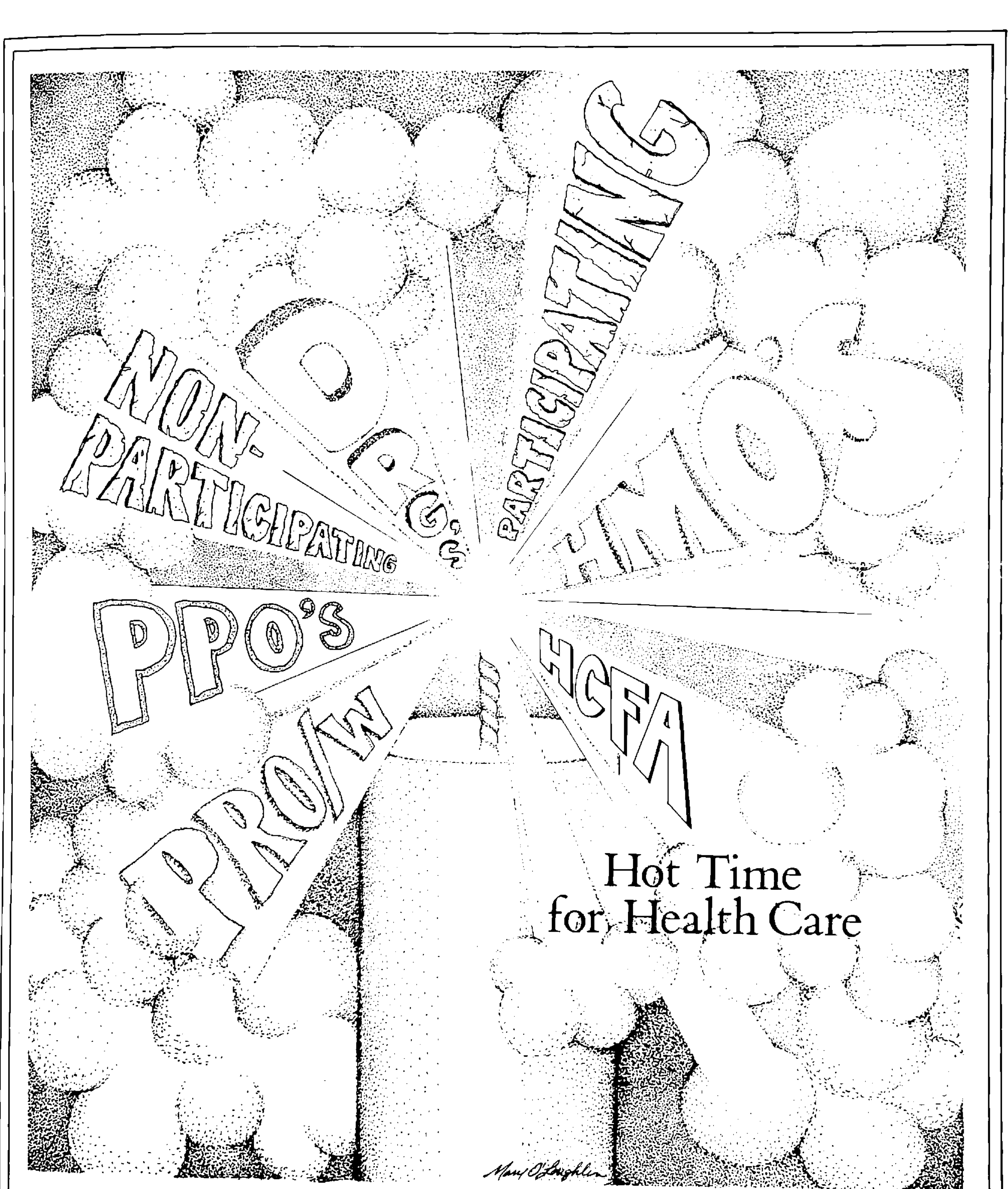

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President's Page

Well, here we are again after having escaped at least one *Bulletin* in view of the guest editorial. Anybody else? Please feel free to step forward and write your piece. I know there are many of you who want to let the world know what they think of it in very eloquent statements. However, somehow, they are not coming out of the woodwork and only make their thoughts known in their own circles, whether it be specialty societies, medical staff committees or various other boards. Believe me, if you write them in the *Bulletin*, we can all benefit.

As I was writing this first paragraph, the question arose in my mind where to go from here, and I decided to produce a "potpourri" of thoughts.

Before proceeding, however, I looked up in my dictionary of the English language to see if "potpourri" meant what I thought it did. Well, to my surprise, one of the explanations was: "A combination of various incongruous elements, with incongruous meaning; not corresponding, inharmonious, disagreeing and incompatible."

I hope you like the trivia thus far. Just keep in mind, you are responsible for me having to write this page. Moving back to "potpourri," which is French (not my foreign background), but apparently stemming from the Spanish (not mine either) "olla Podrida," which, back to French is divided into pot (from archaic French), meaning porridge and "pourri" which means "rotten" from the past participle of "pourrir" meaning to rot. Well I agree this is a "rotten" piece of literature thus far, and it is not getting any better.

So for the next incongruous element, the following, which is probably the only important thing I am writing this month. There is no doubt in my mind that without Doug Jackman the Society activities would be floundering in "quagmire." (I won't tell you what is said about it in the dictionary except that somewhere Middle Dutch was involved, and has to do with wetness and slime, which again has nothing to do with Doug.)

Of course, one can say there would be somebody else, but let me tell you, one does not find many people willing and able to tackle a job such as this one.

Doug stepped into some big footprints, as Tom Curry left an act which was difficult to follow. There is no doubt, however, that Doug has at least the same sized shoes or bigger in the way he is dealing with the problems which face him daily, and of which are not in the least, physicians' egos. Besides this, having looked at his calendar of meetings which he is attending, I don't understand why he stays as calm, cool and collected as he appears.

I had the privilege to join Doug in a backpacking trip, and I can't, because of the fun, remember the terrible aching and pain which an old body suffers climbing at a rate of 1,000 feet a mile.

I won't continue, as I know that Doug by now feels thoroughly embarrassed, but I felt you all should be aware of the superior individual who is your Executive Director.

Next, I would like to comment on the lack of interest most of you had in the meeting during which Johnny Cox, Ethicist from Sacred Heart Medical Center in Spokane gave a talk. His talk included considerable food for thought.

For instance, to repeat a few of his comments: "What we face today is not a problem, but a dilemma: we are shifting from optimal to adequate care; what should the standards related to medical problems in the society be, and why 'those' standards? Are we really trying to be in the forefront in deciding on the above or will we accept them by default?"

Or, how about: "Should we provide only those treatments which can be expected to yield benefits in proportion to the costs and number of patients, and when the burden becomes excessive, is it permissible to deny those?"

In many other countries these are the facts of life as I learned recently through first-hand experience and about which we all have read extensively.

It was really too bad not more of you were able to come, and I hope the reason for it was not apathy or lack of interest. Now for the last two items. First, I noticed that the Democratic Governor of New York was calling for a change in the laws related to the way malpractice awards, as well as attorney fees, are handled, and further, that the whole system should be overhauled. I wonder which of the other 49 governors will have the courage to ask for the same from their legislatures.

Finally, I remember that somewhere in the above I mentioned "Middle Dutch." Well, I have heard of the Amsterdam Dutch, the Rotterdam Dutch and the other type of Dutch, but Middle? Anybody able to shed a light?

—GWCB

Contracting Committee meets with PPO Administrators

The Ad Hoc Committee on contracting, under the chairmanship of Dr. Peter Kesling, has been meeting with adminstrators of several PPO's currently contracting with physicians in Pierce County. The Committee will prepare a report for the Board of Trustees.

The administrators of the plans were asked several questions that are important to the physician when contracting with a PPO. Neither the Committee nor the Society will directly, indirectly or otherwise endorse contracts. The Committee plans to provide an objective analysis of physician contracts.

The California Medical Association has had extensive experience with contract evaluation and has published a Physician's Contracting Handbook. Considered the state of the art resource document in providing invaluable assistance for physicians in understanding the vast range of legal implications associated with contracting, it discusses professional liability exposure, anti-trust and "101" questions to ask before signing a contract.

It is available through Sutter Publications. To order send $10.00 (prepaid postage and sales tax included) to Sutter Publications, Inc. Physician's Contracting Handbook, Sutter Publications, Inc., 44 Gough Street, San Francisco, CA 94103-1233.

Open letter to Medical Society Members: Good Bye and thank you from the Director of MBI.

It is with mixed feelings that I say, "Good bye and thank you," to all who have supported me and Membership Benefits, Inc. during my four and a half years of service. I am happy to share with you that the challenges facing me when I assumed responsibility for managing the Placement Service have been met. Membership Benefits, Inc. is now a financially healthy and viable service to member physicians.

Change is often accompanied by growth and pain, so it is with pleasure and the regret of leaving behind many friends that I move on to pursue new opportunities in my life. July 15, 1985 will be my last day working for the Medical Society of Pierce County.

Thank you for the privilege of working with all of you. It has sincerely been my pleasure and rest assured as I leave all my fond memories will go with me.

With gratitude,
Linda Carras

Newsbriefs continued on page 6

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"Cut the Cost, Keep the Care" Theme of AARP

Presidents of the three Pierce County chapters of the American Association of Retired People (AARP) met with the MSPC Committee on Aging in May stressing their theme: "Cut the cost, keep the care." AARP's primary objective is to reduce health care costs. Committee chairman Dr. Bryan Archer and committee members discussed critical issues such as, DRG's and their impact on care for the elderly. "Participating and non-participating" physicians as created by the Deficit Reduction Act for Medicare patients was explained.

A major problem with the current health care system pointed out by the AARP representatives was the number of errors found on hospital billings and the inability to understand the billings because of their complexity.

The Committee plans to meet with AARP representatives and hospital representatives to improve communications in these and other areas.

1985 Guide to Long Term Care in Pierce County now available.

The 1985 *Guide to Long Term Care in Pierce County* is now available for distribution. The booklet is designed to provide the latest up-to-date information about community support services, protective services, residential and nursing home/convalescent care facilities. In addition to discussing the long term care continuum, the booklet also includes sections on choosing and paying for long term care services.

The project reflects the cooperative effort of the Long Term Care Committee of Pierce County Area Agency on Aging, coordinated by Nick Cockrell, and of the committee members who were responsible for compiling, editing and seeking funds to publish the Guide.

The Medical Society has been provided with a supply of the Guides to be made available to interested physicians. You may contact the Society for your copy. Additional copies are available from the Council on Aging, distributor of the Guides, for $2.50 per copy (mailed) or $1.50 at the office, 223 N. Yakima. Phone: 272-2278.

AIDS impacts blood banking and transfusion therapy.

By S.J. Insalaco, MD, Medical Director, Tacoma-Pierce County Blood Bank

The Acquired Immune Deficiency Syndrome (AIDS) has had a tremendous impact on blood banking and transfusion therapy. As of April 30, 1985 there have been 145 cases of transfusion related AIDS occurring in both adult and pediatric recipients and 71 cases occurring in hemophiliacs. During this same interval over 12 million individuals have received blood.

To protect the quality of the nation's blood supply two major events have occurred. First, in March 1983 the FDA issued to all blood collection facilities voluntary deferral guidelines requesting high risk individuals refrain from donating. Since that time about eight million people have received blood and of those fifteen have developed transfusion related AIDS. Although this number will certainly increase, we are hopeful that the voluntary deferral guidelines have resulted in a substantial decrease in donations by high risk groups.

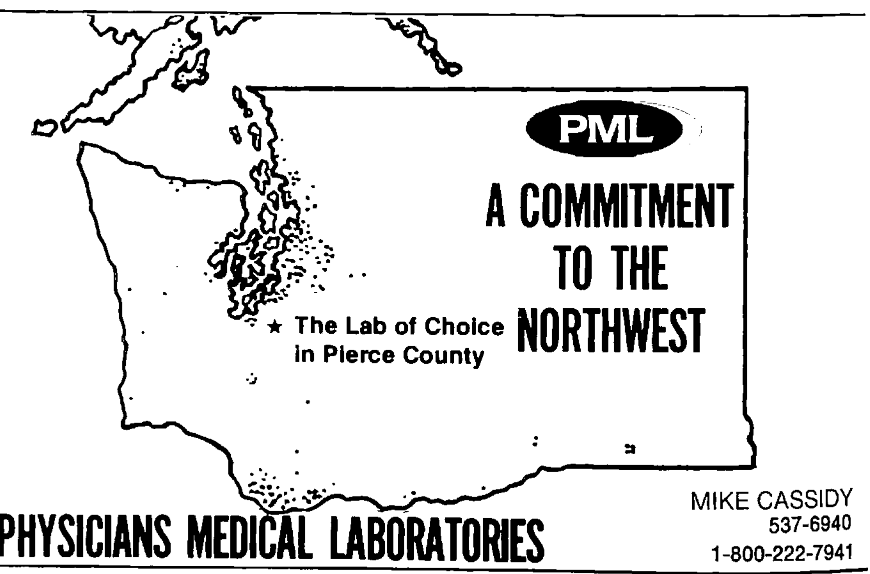
Second, on March 2, 1985 the FDA approved the HTLV-III antibody test. The test is licensed for the purpose of screening donor samples so that potentially infectious units can be eliminated from the blood supply. As of June 1, 1985 all blood and blood products in Pierce County have been tested and found to be negative for the antibody: positives units have been destroyed.

Although much maligned, the test is an excellent first generation test with high sensitivity and specificity and presumably will protect the nation's blood supply and reduce anxiety among blood recipients. However, despite the high specificity, a small but significant number of normal donors will have repeatably reactive tests without actually having the HTLV-III antibody.

In our region we are finding about 2 positives per 1,000 donors tested. In order to prevent donors from being falsely labeled as antibody positive, notification is being delayed until additional retesting including Western blot test is performed.

Many people are curious about their HTLV-III status because of promiscuity, extramarital affairs, homosexual experiences or previous drug usage. Despite the test, it is essential that we discourage these individuals from donating. Confidential testing is available through the Pierce County Health Department. Doctors' offices and commercial laboratories may send specimens to the Tacoma-Pierce County Blood Bank.

Finally, AIDS has educated the public and reminds the medical profession about the hazards of transfusion therapy. Blood, like any therapeutic agent has associated risks and benefits. We must be cognizant that blood is still a life saver and that more individuals die from blood loss than from blood transmitted diseases.■



HTLV-III Antibody Testing at Tacoma-Pierce County Health Department

By Michael Goerss, MD

The Tacoma-Pierce County Health Department now offers HTLV-III antibody screening through the Sexually Transmitted Disease Clinic. Patients need to make an appointment with the STD Clinic, since we require an informational session prior to the antibody test.

The Health Department has hired a full-time counselor to assist prospective patients decide whether to have the test, and if they elect to have the test, what the positive or negative results may mean.

The unprecedented step of pre-test counseling reflects the complexity of the problems engendered by the test. Most people inquiring about the antibody test think it will tell them whether they have AIDS syndrome or whether they will develop it. THIS ANTIBODY TEST IS NOT A TEST FOR AIDS. It merely detects the presence of antibody to the virus which appears to cause AIDS.

No one knows how many patients with positive antibody tests actually harbor virus or are infectious. Furthermore, no one knows how many of those patients who have HTLV-III virus will go on to develop AIDS. To date the only studies have been in seropositive high-risk individuals, primarily homosexual men, and show a risk of developing AIDS between 5-20%, with another 25% developing ARC (AIDS related complex). The CDC is following seropositive individuals with no risk factors to find their relative risk for AIDS, but those results will take years.

The test has some risks, too. Insurance companies and employers may require test results. Some AIDS patients have already lost insurance, jobs and housing, not to mention the social isolation this disease brings. Many people mistakenly assume a positive antibody test means AIDS.

For all these reasons, the Health Department has severe reservations about the antibody test. The test gives little useful information, and the social and economic risk of seropositivity is great. High-risk individuals should modify behaviors that spread virus whether they are seropositive or not, and low-risk individuals have no clear guidelines.

During pre-test counseling, patients hear these recommendations. Even with all these caveats, many people will want to have the antibody test. To prevent high-risk people from going to the Pierce County Blood Bank for the test, the Health Department offers the test at no charge. All results will be kept strictly confidential and divulged only in person to the patients themselves.

When patients return to the Clinic for their test results, the Clinic counselor will endeavor to explain what the test means. The meaning of the test result hinges on the risk status of the patient. In high-risk individuals, a negative test means very little and a positive test implies exposure to the virus. In low-risk individuals, a negative test implies no history of exposure to the virus, while a positive test, though hard to interpret, may be false positive. High-risk patients include homosexual or bisexual men, intravenous drug users, hemophiliacs, recipients of blood products, and sexual contacts of any of these groups.

In an effort to help AIDS patients, people at high risk for developing AIDS, and seropositive low-risk individuals, the Health Department will be sending a questionnaire to all physicians in Pierce County in the next few weeks. The questionnaire will be put together in a directory of AIDS Sensitive Physicians, similar to the Seattle Gay Clinic's directory. We will make these directories available to health care workers in Pierce County.

For more information about antibody testing at the Health Department, call Jack Jourden, STD Clinic Coordinator, Frank Chaffee, Testing Counselor, or myself at the STD Clinic (591-6407).

On a final note, the risk of transmission of HTLV-III to health care workers seems extremely small. Since 1983 the Centers for Disease Control in Atlanta has prospectively followed health care workers exposed to body fluids of AIDS patients (patients, not merely seropositive individuals). Two hundred sixty-nine health care workers with significant exposures to AIDS body fluids have had T cell ratios checked; all but nine were normal, and these nine returned to normal within six months. All health care workers tested for antibody to HTLV-III virus remained negative an average of ten months after their exposure. ■

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Organ Donor Association works to fulfill need.

By Donna Oiland, Executive Director, Lions Eye Bank, University Hospital.

Recent surveys indicate that 93% of all Americans have heard about organ transplantation. Unfortunately even though the subject of transplantation is constantly in the news the need for organs surpasses the number of donated organs each year.

Both the general public and health care professionals need to understand that every person is considered a potential donor and every citizen is encouraged to sign and carry an organ donor card. At the time of a death the suitability of organs and tissues to be donated is determined. Again, every person is considered a potential donor regardless of age or medical history.

The Organ Donation Association (O.D.A.) is a non-profit organization comprised of the various agencies concerned with the procurement of human tissue and organs for transplantation in Washington State and other parts of the Northwest.

Formed in 1976, the O.D.A. became the first organization of its kind to be established anywhere in the United States. The members of the O.D.A. include the Northwest Kidney Center, the Lions Eye Bank, Harborview Burn Center, the American Liver Foundation, the International Order of Odd Fellows and the Washington State Medical Association Auxiliary. The objectives of the O.D.A. include simplifying the process of becoming a potential organ donor, and, to create a united effort to educate the public led to the coalition of these agencies into one volunteer organization.

Together, representatives from these groups work to accomplish a goal: to increase the amount of tissue available for transplantation that can save and improve the lives of hundreds of citizens in the Northwest and elsewhere. The main activities of the O.D.A. include educational presentations, maintenance of a 24-hour, toll free information phone line and dissemination of information to the media and governmental bodies.

February 19, 1985 was a red letter day for the O.D.A. and citizens of the State of Washington. That was the date the Department of Licensing implemented the new procedure of inquiring if a person is an organ donor when they make an application for a new or renewal of their Washington State Driver's License.

The new system will work as follows: When a person applies for alicense renewal or a new license, they will be asked if they intend to be an organ donor. This question is presented during the inquiry about the need for corrective lenses and whether or not the driver is on any medication. If the driver gives a positive response, an ORGAN DONOR sticker is applied to the form used when taking their picture. The ORGAN DONOR designation will appear over the state seal located just left of the picture on the front of the permanent license. The applicant will then be given a sticky donor card to sign, have witnessed and apply to the back of the permanent license when it arrives a few weeks later.

Reports from the Department of Licensing indicated that anywhere from 29% to 42% of the applicants being asked about donation are responding positively. It is going to take time and public education programs before drivers understand how the procedure works. The Department of Licensing is helping by issuing news releases, doing radio interviews, arranging for public service announcements to be produced and made available to television stations and printing a brochure that will be available in each of the 57 licensing offices.

With the increase in public awareness comes the need for health care professionals, physicians, nurses, social workers etc., to understand the need for organs and tissues and the positive part donation can play in the healing process for the family of a donor. Lives of thousands of people will be saved or improved through organ and tissue transplantation when families of potential donors are routinely given the opportunity to make a choice about whether or not they wish to donate at the time of a death. The feelings of a father who wasn't reminded about donation at the time of the death of his child are expressed in his letter below:

Dear Doctors and Nurses:

The task of informing someone who has placed his hopes and dreams in your abilities as a physician, that a loved one has died must be the most difficult task a human being must face. The feelings of loss, of finality and of grief which you bring with the news of death is sometimes thrown back at you in emotional outbursts which will hurt you if you let them. Remember, it is our hurt, not our heart, speaking at that moment.

But please remember this also: at that moment, there is a tremendous comfort which you alone can give to this person. A comfort that will help this hurt. That will lessen the sense of finality. That will reduce the loss. It is the chance to grant permission for organ donation. Please inquire, and give those who grieve that option.

Unless you act, and ask, you cannot help this person. I know it is difficult, but you must be courageous.

Without your help, the wait for a needed organ will be longer for thousands, and death will remain a final act. Please help!

A father who was never asked.

The number for the ORGAN DONATION ASSOCIATION is 1-800-442-3310. If you wish to have pamphlets available in your office for your patients' information or if you or your patients have questions, please feel free to call.

Leasing Office Space: Questions To Ask Before You Sign On The Dotted Line

By George S. Conomikes

Typically, commercial leases run anywhere from three to 10 years, and the term is usually negotiable with the landlord. But it's as important to pin down when the lease will begin as to determine when it will end. Unless the space you agree to occupy is already vacant and remodeled to fit your needs exactly, all kinds of last-minute problems can occur. The current tenant may refuse to move out, construction may not be finished on schedule, disagreements may arise about whether you can gain early access to install fixtures and make your own improvements.

Your lease should clearly spell out what happens if the space isn't ready by the move-in date, and what adjustments in rent will be made by the landlord. Be wary of a clause that allows the landlord to provide you with "alternative" space if the new premises aren't ready on time. That remedy only compounds the problems and costs of moving. If you have any doubts about whether your new space will be ready on time, give yourself some leeway in moving out of your old premises. Otherwise you may find yourself operating out of a moving van while lawyers squabble over the fine print.

How much is the rent?

Rent, unlike almost any other cost of doing business, is a fairly inflexible part of your overhead. But making cost comparisons when you're looking for rental space can be tricky.

Commercial rents are generally measured by the annual cost per square foot of the space, but there are three common ways to calculate rent, every one of which uses square footage as the basis for comparisons.

Gross leases, once the most common standard for office space, simply require the tenant to pay a flat monthly amount; the landlord is responsible for all the expenses of operating the building, including taxes, insurance, and repairs. (Because of rising energy costs, many landlords now charge tenants separately for heat and electricity, which used to be part of most gross rents.)

Net leases require that tenants pay for some or all of the real estate taxes on a property, in addition to a base rent.

Your lease should clearly spell out what happens if the space isn't ready by the move-in date, and what adjustments in rent will be made by the landlord

Net-net leases go a stop further: Besides base rent and taxes, the tenant pays for insurance on the space he occupies.

How much will the rent go up?

Not very long ago, the cost of operating a building — particularly real estate taxes and energy costs — rose so slowly that an owner could catch up simply by raising his rents every time a new tenant moved in or when a lease expired and was renewed. Now, however, costs are so unpredictable that most landlords feel they need some protection in the form of escalation clauses, during the course of even a short lease.

One common type of escalation clause builds in regular step-ups in rent over the course of the lease; others pass on prorated increases in taxes, heat, maintenance and other direct costs. Another common escalation clause automatically raises rents according to the Consumer Price Index (CPI) or some comparable index of inflation. (Since the CPI generally overstates the impact of inflation, a tenant shouldn't agree to pay more than a portion of the annual CPI increase, especially if the lease already contains escalators for taxes and direct operating costs.)

Most landlords will negotiate the key elements in the escalation clause, including the base year. If you move in halfway through the local fiscal tax year, for example, your base year for taxes could be any of three years; the previous tax year, the present year, or even the next full year. The same holds true for heating costs and other elements of the owner's overhead. In particular, you should be careful about the base year if you move into a new building that may take a year or two to reach full capacity because the owner won't have a stable history of operating costs to use as a reasonable base.

Can you sublease?

Two years into a five-year lease, you discover you're bursting at the seams and it's time to find a new home. What happens next may depend on a rather delicate negotiation with your landlord over what kind of subleasing he considers "reasonable."

At the very least, you'll have to come up with a new tenant who meets the same standards that the owner applies to other tenants. You're not off the hook if you find a massage parlor willing to take over your space in a prestigious shopping mall, or a punk rock band that plans to use your office space for practice sessions. Moreover, if your subtenant decides to skip town, you're still responsible for paying the rent on the original lease.

Now, though, there's a new wrinkle to the traditional negotiations over subleasing privileges — the question of who keeps the profits if your new tenant pays more than you did for rent. In today's rental market, that situation occurs fairly often, and landlords are naturally eager to write leases that give them more control over subleasing arrangements.

Can you renew?

Once your present lease expires, a landlord has no legal obligation to offer the same (or other) space to you. Unless you've agreed on a renewal formula and have a clause that guarantees you'll get first rights to the space when your lease expires, you'll probably end up paying the prevailing market rate to stay on.

Normally, a tenant has to give written notice exercising his option to renew his lease, or it lapses automatically. (A year's notice is typical for long-term leases,

continued on page 10

while only three or four month's notice might be standard for shorter-term leases.) Some leases, however, are renewed automatically until you take steps to cancel them.

What happens if your landlord goes broke?

A few years ago, a doctor moved into a small, privately owned medical building and spent a fortune on renovations and built-in equipment. One morning a bank officer showed up and announced that the doctor's 10-year lease was void because the bank had foreclosed on the building. The doctor could stay at twice his original rent, or move within 30 days.

There's a new wrinkle to the traditional negotiations over subleasing privileges — the question of who keeps the profits if your new tenant pays more than you did for rent

The doctor could have protected himself either by making sure his lease contained a standard "recognition" or non-disturbance clause. If a landlord balks on this point, it may be a sign that he's on shaky financial ground.

Who's responsible for insurance?

In the rush to firm up a lease, insurance rarely gets the attention it deserves. The result is that many buildings — especially those with multiple tenants — are covered by a hodgepodge of overlapping and inadequate coverage. Not only is this costly, it also invites disaster. In case of fire or other major disaster to the building, it may take years before the various insurance companies manage to sort out the claims and decide what was and was not covered.

Landlords in general are expected to carry a comprehensive policy on the building that covers liability for common areas, such as lobbies, stairways and elevators, as well as providing casualty protection for the building itself. They also have the right to insist that tenants carry their own insurance to protect the landlord against claims that might arise from the conduct of their businesses (a visitor who trips on an office carpet, for example), and "contents and improvements" coverage that protects his investment in the property itself.

Making sure the policies dovetail, though, is really a job for a professional insurance agent or a lawyer with expertise in insurance. Your own insurance representative or attorney should review the building owner's policies, help close any dangerous gaps, and spot unnecessary expenses.

What building services do you get?

Just about the only way a landlord squeezed by inflation can cut his costs is by lowering thermostats and reducing maintenance. It's a good idea, therefore, to define in writing *precisely* what services you're entitled to get as part of your lease.

Electricity is often supplied as part of the building services you get, but a landlord may reasonably set limits if you

In the rush to firm up a lease, insurance rarely gets the attention it deserves. Many buildings are covered by a hodgepodge of overlapping and inadequate coverage

expect to install extra air conditioning.

Heating, ventilation and air conditioning (HVAC) are also usually the landlord's responsibility. Unlike apartment buildings, though, commercial space rarely offers 24-hour HVAC service. You

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should attach an HVAC schedule to the lease itself, and even specify what service is to be provided on state and federal holidays. (Normal HVAC service is usually available Monday through Friday, from 8 am to 5 pm, and Saturday from 8 am to 1 pm.

Cleaning services can make a big difference in the appearance your practice presents to patients, so you should request a specific schedule of how often the building will be cleaned and who is responsible for such housekeeping details as cleaning your restrooms and taking out the trash.

Who else can move in?

How would you feel if a business that moved in next door generated strange odors or loud noises? Or attracted unsavory people? To some degree, zoning laws protect businesses from "incompatible" neighbors, such as retail businesses in office buildings, or manufacturing in retail area. But you can also negotiate stricter limits with your landlord if you feel it's necessary.

Who pays for improvements?

Modern office buildlings generally provide allowances for improvements — new partitioning, lighting, carpets, paint, etc. — but there still remain wide variations in what individual tenants feel they need, and what individual landlords are willing to provide. No other area of a lease, in fact, is so open to negotiation and hard bargaining between landlord and tenant.

You're more likely to persuade a landlord to pay the bill for major renovation work if the changes you request will attract future tenants after you move

This bargaining is complicated by the high costs of even minor construction jobs. A single new electrical outlet, for example, may cost $100 to install; heavy-duty carpeting may end up running $20 a yard to lay down; carpenters, plasterers, and painters bill their time at anywhere from $15 to $30 an hour. If a building owner is also carrying the remodeled space rent-free during construction, the cost can be substantial.

You're more likely to persuade a landlord to pay the bill for major renovation work if the changes you request will attract future tenants after you move on. Unusual partitioning and carpeting or wallpaper with strange color patterns won't add to the value of the landlord's property. In fact, they may even have to be removed before he can put the space back on the market.

Agreements about renovations should be put in writing, preferably with a detailed floor plan and an estimate of costs from a contractor *before the lease is signed*. This document, called a "workletter," should also specify who *owns* any improvements. Unless you agree otherwise, anything a tenant attaches to the space he occupies — air conditioners, light fixtures, shelving, cabinets, even his own office and manufacturing equipment — will probably belong to the landlord.■

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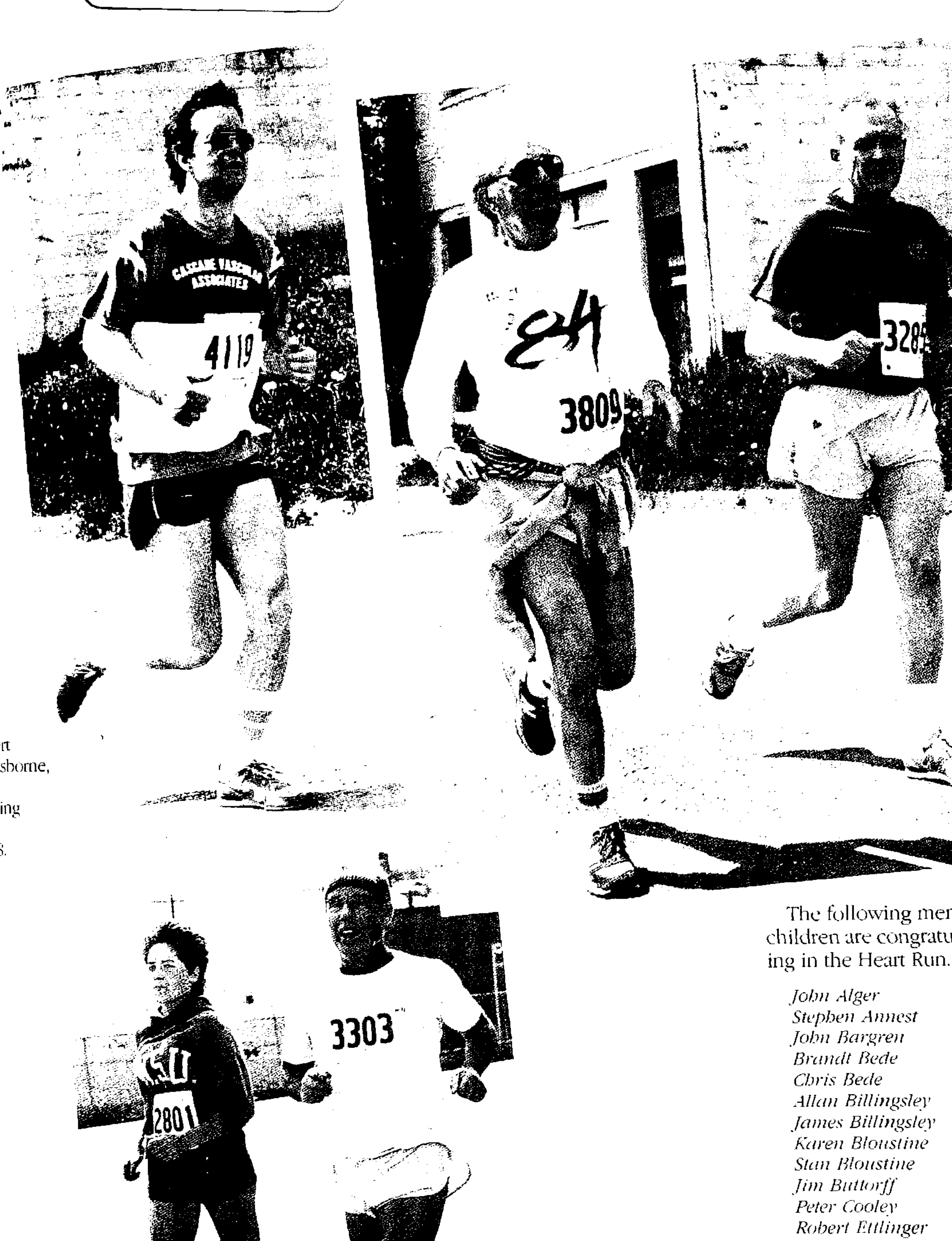
SETTING THE PACE

Doctors are running in many races in the county, setting the example for good health!

More than 2000 runners turned out May 11 for the 6th annual 10K Heart Run organized and sponsored by St. Joseph Hospital. The course is considered one of the most difficult of the many runs in the area.

Setting the pace for the medical community were over 25 physicians and family members. Dr. Ron Taylor, running in the 40-49 age category, finished a very admirable 72nd overall and 8th in his age group. Taylor also finished 10th overall in the Lakewood Super Summer Half-a-thon run May 18th. Drs. Craig Rone and Needham Ward finished 192 and 203 respectively in the Heart Run.



Left: Dr. James Billingsley, running time 56:15. Right: Dr. John McDonough, running time 56:17.

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Osborne,

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38.

Dr. Jack Naghe and his daughter Laure Naghe run in the 10K Heart Run.

The following members, spouses and children are congratulated for participating in the Heart Run.

John Alger
Stephen Annest
John Bargren
Brandt Bede
Chris Bede
Allan Billingsley
James Billingsley
Karen Bloustine
Stan Bloustine
Jim Buttorff
Peter Cooley
Robert Ettlinger
Penny Henry
Melvin Henry
David Hopkins
Gordon Klatt
James Komorous
Hugh Larkin
Larry Larson
David Law
Garth McBride
John McDonough
David Munoz
Laure Nagle
Jack Nagle
Robert W. Osborne, Jr.
David Pomeroy
Greg Popich
Craig Rone
Ron Taylor
Alan Tice

24-hours, $25,000 and 80 miles later, Dr. Gordon Klatt concluded his 24-hour run at the University of Puget Sound Track, Saturday, June 1.

Dr. Klatt, President, Pierce County Chapter, American Cancer Society, began his run at 6:00 P.M., Friday, in windy, blustery weather. Rain fell during the night, but Dr. Klatt preferred that to the original forecast of sunshine and 70 degree temperatures.

Dr. Klatt experienced muscle cramps, and heel blisters began to develop after 16 hours on the course. During the early morning after about 12 hours, Klatt's body began to feel the effects of the cool, damp weather. His blood pressure dropped considerably which caused some concern, and he experienced a degree of hypothermia.

A quick rubdown and warm soup reinvigorated him to finish the trial of endurance in quite good condition.

Dr. Klatt says his recovery was comparable to a marathon recovery. No special problems other than being a little tired and stiff.

Dr. Klatt extends his thanks to the medical community for its moral and financial support in contributing to this community effort. He says he never lacked for company during the 24 hours, even in the early morning between 3:00 A.M. and 4:00 A.M. when he had as many as 15 people running with him.

Photo by Carl Saytor

Dr. Gordon Klatt

Photo by Carl Saytor

Dr. G. Bruce Smith running May 18, in the Lakewood Super Summer Half-a-thon, 13.1 miles.

Dr. Stan Bloustine finishing the Lakewood Super Summer Half-a-thon.

AUXILIARY NEWS

May Fun Day!

Thanks go to Kit Larson and her committee for coordinating the Medical Society Auxiliary Fun Day, May 17, at Oakbrook Country Club. The weather cooperated and all members and guests that attended had an active morning participating in their favorite activity.

Chairpersons of the various activities were:

Helen Whitney - Chairperson for the tennis event.
Debbi McAlexander - Chairperson for the walking group.
Cindy Anderson - Chairperson for the run.
Ginny Miller - Chairperson for the bridge games.

It was a fun day. Everyone was a winner!

Thanks to these women for their splendid job, making it a great day.

After the morning events, a noon luncheon was served. A talented trio from the Curtis High School Swing Choir entertained during the social hour preceding the luncheon and during lunch. Following the luncheon, Cindy Anderson, Washington State Medical Auxiliary Southwest Regional Vice President installed the 1985-86 Pierce County Medical Society Auxiliary Officers.

Time for Auxiliary Dues

The Auxiliary year begins June 1. It would be appreciated if you could send your dues in as soon as possible to Betty Virtue, 71 Leschi St., Steilacoom, 98388. Dues are $38.50, the same as last year.

Remember, the more members we have, the more delegates we are entitled to have at the State and National Auxiliary conventions—which is important for our organization.

Auxiliary members take a look at local judicial system

Several members of the Auxiliary were treated to a tour of the Pierce County judicial system May 1. Led by Marilyn Beale, President of the Law League of Pierce County, Auxiliary members were able to observe three of the courts in the County City Building while court was in session. With Marilyn Beale answering all the Auxiliary members' questions, members came away with a new appreciation for the way justice is administered locally.

Auxiliary continued on following page

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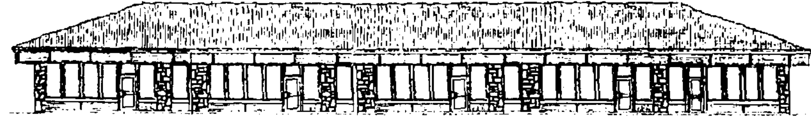

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What's In It for Me?

When I joined the Auxiliary almost 15 years ago, I was primarily a wife and mother, etc., etc., etc., and attended meetings sporadically. I felt my money was well spent, representing me even if I was absent. About three years ago an Auxiliary member suggested I become more involved and when the Auxiliary President called asking me to help on the Newcomer Committee I was ready. The seed had been planted; I was needed and wanted. I also had renewed confidence in my ability to participate and contribute with the assistance of my new "toys"—a pair of hearing aids to help correct a bilateral hearing loss.

I'm impressed with the quality of work of this organization; from Tel-Med and Organ Donation to Handicapped Awareness and the Family: Birth to Three program—just a few of the volunteer projects available. As an inactive member your dues help support the Auxiliary and total membership figures do carry weight, especially when legislation is involved. As an active member the benefits are without limits; new friends, ideas to exchange and explore, situations to share, a chance to learn and expand.

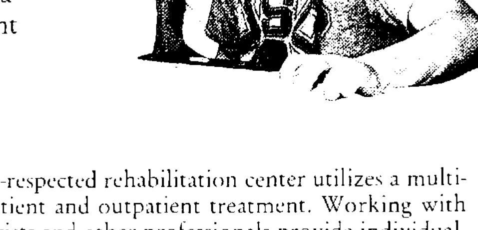
I'd like to share my 1984-85 membership fee bargain with you. In February, I was one of the "bees" at the Auxiliary Newsletter mailing work party at Rubye Ward's home. During the course of sticker-stamp-coffee and conversation, Rubye mentioned a report she had given to her Study Group about a new telescope lens being developed that will enable astronomers to look into the past, to "see the big bang" as it occurred approximately 15 billion years ago. Serendipity!* It literally blew my brain doors off. This little "pearl" was the catalyst that led to a three hour marathon dialogue with my 17 year old son (a first); not parent-to-child, but real person-to-person communication. We covered some pretty heady topics—space, reality, responsibility, decisions and judgement, knowledge (innate and acquired) and how to use it. It was three hours of 100% pure JOY. Granted, three hours doesn't allow for in-depth coverage—but what a beginning. Worth $38.50? You bet!—and a million more!

Whatever your reasons for not joining—RE-THINK—you just never know what you will find!

*Webster defines serendipity as "an apparent aptitude for making fortunate discoveries accidently."■

Alice Wilbyde, Membership Chairman

Are you treating a patient with a new physical disability?



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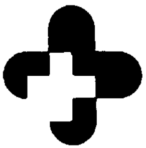

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HOSPITAL NEWS

St. Joseph

St. Joseph Hospital names new Vice President of Planning and Marketing.

Donna Proudfit has been named vice president of Planning and Marketing of St. Joseph Health Services at St. Joseph Hospital and Health Care Center, Tacoma, Washington. In the new created position, Ms. Proudfit will manage market research, strategic planning, service development, sales and community relations.

Ms. Proudfit comes to St. Joseph from La Crosse Lutheran Hospital, La Crosse, Wisconsin where she was vice president of Marketing. Prior to that, she was affiliated with St. Luke's Hospital, Cedar Rapids, Iowa.

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Physicians who would like to apply must have the following: a current medical license at least 15 years of service on a hospital medical staff with committee and leadership responsibilities, extensive clinical and patient care, management experience, strong oral and written, communication skills, excellent physical health.

Physicians who are interested in applying should send their curriculum vitae to:

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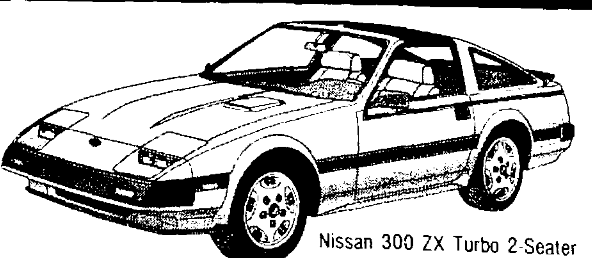
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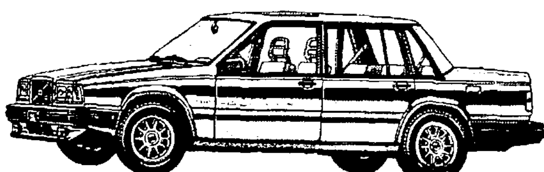
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The Cost Crisis in Health Care

The headlines are everywhere: "Congress Seeks to Cut Cost of Health Care," "Health Care Costs on the Rise for Most Americans," and so forth. It's gotten to the point that physicians may have to go back to school for accounting degrees in order to keep up with the changing economic realities of medicine.

Indeed, physicians have become quite aware that the cost of health care is more important than ever. In fact, a recent American Medical Association survey indicated that physicians see the cost of health care as the number one problem facing medicine. There is no question that physicians are interested in seeking a solution to the cost crisis, though not at the expense of their duty to their patients—a duty based on providing high quality care with access to all.

Nowhere is cost more of an issue than in Washington, D.C. Congress, the executive branch, and federal regulatory agencies are besieged daily by a combination of forces, all with their own agendas for "controlling the spiraling cost" of medical care. Unfortunately, there is not the same level of concern about the *quality* of health care in this country.

In recent years, hundreds of bills and regulations have been drafted in the name of health care cost containment. In the face of such mounting pressures, the government responded by getting more and more involved in legislating reimbursement methods, payment levels and even access to care.

American health care arrived at this point as a result of a government-backed societal push toward increased quality and access to care. The 50's, 60's, and early 70's, then, were a period of rapid economic expansion in medicine. The goal? Assurance that every American, regardless of race, creed or economic status, be guaranteed quality health care regardless of the cost.

Was the spending worth it? Did the nation meet its medical objectives? The brief summation of accomplishments below indicates a resounding yes:

- Americans' life expectancy has risen from 69.7 years in 1960 to 74.5 years in 1982;
- Infant mortality has been reduced to a record low of 11.2 per 1,000 live births, less than half the figure in 1960;
- Modern vaccines have been responsible for virtually eradicating polio, mumps and measles;
- Due to technological advances such as open-heart surgery, pacemakers and new drugs, deaths from heart disease dropped by 25%, and from stroke by 40%.

Clearly, health care American-style is unparalleled elsewhere in the world. Also obvious is the fact that these new procedures and technologies have placed a heavy economic burden on the public and private sectors.

How should this burden be resolved? Who should shoulder the responsibility for the rising costs of care? Certainly physicians, who actually account for only 20% of the rise in health care costs, can do only so much. Physicians, however, can and have taken an active role in trying to reduce the cost of medicine without sacrificing quality through support and involvement in programs sponsored by the American Medical Association.

In 1983, the AMA took advantage of its leadership role by putting forth a bold new agenda to address the problem of rising health care costs and to ensure that quality and access remained the cornerstones of American medicine. The Health Policy Agenda for the American people brings together representatives of about 150 organizations representing a wide range of health care interests.

In 1984, 159 broad-based principles were developed to address issues in six areas: medical science; education; health resources; delivery mechanisms; evaluation; assessment and control; and payment for services. Forty-one final policy proposals, based on these principles, will be published by mid-1986.

In addition, the AMA has encouraged the organization of voluntary coalitions of physicians, hospitals, insurers, and business and labor leaders to seek ways to contain costs at the local or regional level while maintaining accessibility to high quality care.

The AMA was also instrumental in establishing the National Commission on the Cost of Medical Care to seek cost solutions through a variety of means without decreasing the quality of care. Moreover, the Association publishes an annual *Cost-Effectiveness Plan* and the monthly *AMA Cost-Effectiveness Bulletin* that provides a communications network to members of state and county medical societies for cost-effectiveness reporting and information sharing.

The Cost-Effectiveness Network brings together physicians and hospital staffs to experiment with efforts at decreasing cost and increasing medical professionals' awareness of the means to do so. The AMA also sponsors annual conferences on this important topic.

The AMA has strongly opposed the "Kennedy-Gephardt" legislation that would set reimbursement caps on each hospital's total revenues, regardless of payor source. This legislation calls for a radical, untried system of reimbursement and an enormous bureaucracy, and would raise the spectre of rationing of health services.

The AMA also believes that a generally better-informed, healthier public can contribute greatly to the reduction of health care costs. For example, at meetings, members take stands on such topics as the use of air bags in automobiles, and labels on cigarette packages. The AMA then communicates these recommendations to the public and health policymakers.

No one segment of the health care system can solve the dilemma of rising medical costs—especially when those costs are reflective of an incredibly sophisticated, effective health care system like the one we enjoy in this country. Physicans, however, through their membership and support of the AMA, can take a leadership position in this effort to intelligently and compassionately control costs without unduly jeopardizing the quality of care which Americans expect and indeed deserve.

Report from AMA

"He flourished during the first half of the 20th century."

The American physician isn't extinct. But your freedom to practice *is* endangered. Increasing government intervention is threatening the quality of medicine – and your right to function as an independent professional. The government, responding to cost containment pressures from myriad sources, has taken a more active role in legislating reimbursement methods, payment levels and even access to care.

In your fight for survival, the American Medical Association is your best weapon. The AMA is the most influential force in health care. No other organization can so effectively reach the national policy-makers who will help determine your future and the future of medicine.

Join the AMA. We're your voice in Washington. And we're fighting for you – and your patients.

For more information, call the AMA collect (312) 645-4783, or return this coupon to your state or county society.

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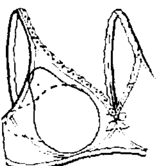

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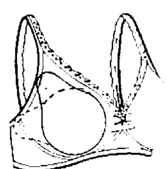

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Child Abuse: Reported cases continue to rise.
For story, see page 11

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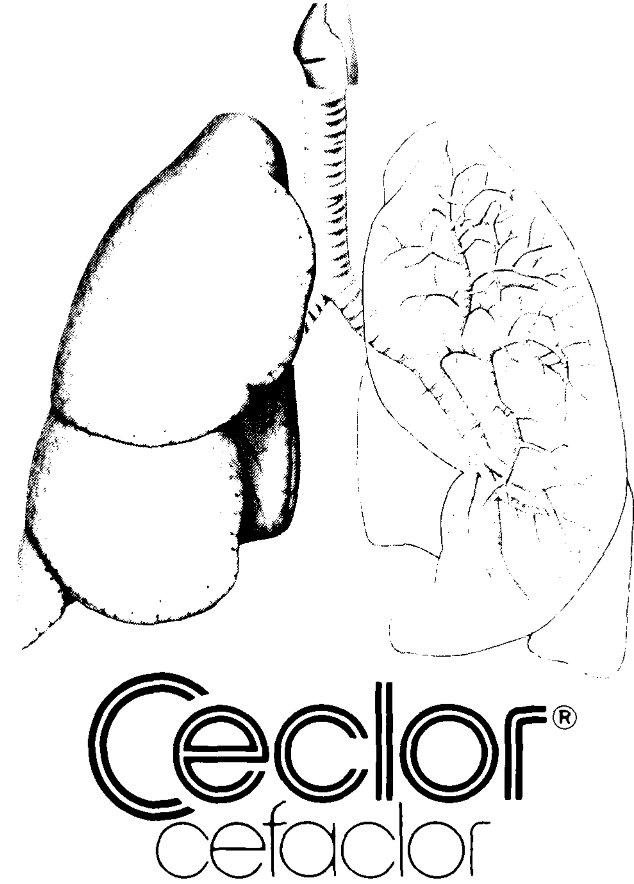

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, [illegible]).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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The Bulletin *The official publication of the Medical Society of Pierce County*

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JoAnn Johnson is the wife of Dr. Ralph Johnson. She has served as president of both the Pierce County and Washington State Auxiliary. During the 1984 election, she was a candidate for Representative from the 28th Legislative District.

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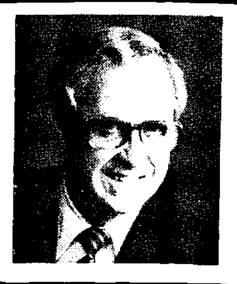
President's Page



In June, I attended a meeting which was organized by St. Joseph Hospital and Health Care Center in cooperation with the Pierce County Health Council and the Pierce County Hospital Council. The meeting was titled "Charity Health Care—Society's Option or Obligation." The objectives were to share information about charity health care needs in Pierce County and new ways to meet those needs.

To start with, the meeting was well organized and the quality of speakers, excellent. They represented a cross section of providers as well as consumer advocates.

The keynote speaker was Walter McNerney, FAHCA, Professor of Health Administration at Northwestern University and former President of the Blue Cross/Blue Shield Association. As it is impossible to include everything he said, I will only highlight some of his remarks.

For openers "there are about thirty to forty million people in the United States of America who are not able to pay for health care."

He then gave an overview of how we got to where we are now. As the Blues and insurers were losing about $300,000,000 and Medicare experienced a $2,000,000,000 deficit, the drive for cost containment was on with cutbacks in commitments to the aged and underprivileged.

To combat the deficit, the Federal Administration is trying to transfer responsibilities to states, who in turn are putting the heat to the public sector. It has been estimated that, if this would be possible, in the year 2010 the entire budget would be consumed by health expenditures.

The question then became, what to do? Answer: Get tough with M.D.'s and hospitals and as we're dealing with "mature health market", i.e., an overabundance of beds and M.D.'s, we are finding many increased options for the now sophisticated buyers.

As the risk is now more directed toward providers we find less use of hospitals, less M.D. loyalties, M.D.'s competing with hospitals, M.D.'s competing with each other, etc. What all of this is supposed to do, "is to wring the excess water out of the system."

An interesting statement he made was that in 1965 Medicare was sold because the aged were supposed to be underprivileged, as at that time one out of four were below the poverty line. In 1982 this had dropped to one out of seven and the question is, where is it now.

Regarding the underprivileged, 15% have no type of coverage and regardless of what has been done thus far they continue to receive less M.D. visits compared to the other sectors.

In general, the average employer can do only so much to help with community care (if they are willing to). M.D.'s are selecting, hospitals are selecting and government is selecting, which again results in less care to the underprivileged.

It seems that at present, both the government and the private sector are working towards overlapping care for payers and non-payers.

Professor McNerney concluded with some generalizations.

1. Employers are not to be counted on to donate to community care.
2. Carriers will not allow cost shifting.
3. The Federal Government wants out of the risk.
4. The states are trying to respond, as there are few alternatives, with price shopping, competition, taxing hospitals and M.D.'s for non-compensating care and not allowing cost shifting.

It's quite evident therefore, that if the states are to succeed, they will have to come forward with a "Public Policy Statement."

It was his feeling, however, regardless of what the states and the feds will do, it will not solve the problem for the underprivileged, and that voluntary programs will have to be included. Failure to respond to this by the private sector will lead to a total change in the system, and it will become a political football for someone.

Next on the program was Senator McDermott and three other speakers looking at the state perspective on charity health care. I don't feel that I have to quote Senator McDermott as he made the headlines in the TNT of 6/27/85 even though the TNT writer had not signed up for the meeting and presumably got her notes from another TNT representative who was sitting at the same table as I was. In that article it was stated that the Washington State Basic Health Care bill failed because of organized medicine. Granted that we lobbied against the proposed financing of it. But at the meeting, the Senator stated that the defeat was just as much due to business and other interests opposed to the bill. However, that part was not spelled out in the TNT.

In the afternoon local perspectives were given by Florence Reeves, R.N., Director of the UHI Project and Dr. George Tanbara. As by now you have had enough food for thought, I will stop here except for stating that problems were presented, but solutions were only touched upon and I was left with a feeling of frustration.

At the end of the meeting small discussion groups gathered to try and provide other suggestions for these solutions. The results of these discussions will be analyzed and forwarded to all participants. If and when this happens, I will include them in the *Bulletin*.

— *GWCB*

Risk Management: Topic for June 11 General Membership Meeting

Mr. Tom Kirschmeier, Manager, Risk Management Department, Washington State Physicians Insurance Exchange, addressed the June 11, General Membership meeting, noting that physicians in Washington State paid $65,000,000 in premiums in 1984. Average cost per paid claim in 1984 was $82,641. Kirschmeier further noted that the average number of months from incident to verdict in a jury case is 77 months, without a jury the average period of time is 55 months.

Interesting to note as to who really benefits from the malpractice judgements is that the patient receives approximately 30% of the settlement, the attorney 58%, the legal process and insurance companies 12%.

Mr. Kirschmeier listed the following steps in order to avoid a malpractice claim:

- Avoid diagnosing over the phone.
- Patients should be cautioned regarding drugs that may interfere with driving or occupation.
- Be sure of proper patient identity.
- No record is complete without all pathology and x-ray reports included.
- Do not fail to insist on x-rays when indicated.
- Check equipment frequently.
- Allergies and sensitivities to drugs should be prominently displayed on charts.
- Hostile, uncooperative and forgetful patients are more likely to sue. Document their files completely.
- Do not base an important diagnosis on clinical impressions alone.
- There must be no preventable delay in the diagnosis of cancer.
- Physicians under various circumstances are required by law to report certain conditions and situtations.
- Adequate and careful documentation is vital to the physician defense.
- Fraudulently altering records is against the law—do not erase. (Medical records generally take precedence legally over what the patient may recall.)
- "What a physician hears in a house stays inside."
- Write legibly.
- Records belong to the doctor—keep the original.
- Make certain insurance reports get written promptly.
- Be sure proper care was rendered before billing your patients.
- Be sure your patients understand what is involved before treatment.
- Be careful what you say.
- Obtain proper "informed consent."
- Do not abandon patients.
- Never guarantee a cure or warrant a result.

Mr. Kirschmeier emphasized that the key in avoiding a malpractice suit is to maintain good rapport with your patients and keep complete documentation.

Medical Society Services Available

The Society's Membership Benefits, Inc. service organization is ready to help member physicans establish and maintain successful practices. Services include:

- Employee staffing – Qualified applicants are available through the Placement Service for full-time, part-time, permanent or temporary job openings. Applicants are screened and qualified before being sent for an interview.
- Personnel related services – Salary administration guidelines, job description assistance, evaluations of employee related concerns are also available.
- Practice Management Services – For the new physician planning an office or for the established medical practice – are available through Management Resources, the MBI endorsed consulting service. Comprehensive bookkeeping service, purchasing assistance and additional services are also available.
- Collections – An ethical and effective collection service is offered through Puget Sound Collections, endorsed by the Medical Society and Membership Benefits, Inc. MSPC receive a 10% discount.
- Physicians Answering Service – Provides the physician with specialized trained staff focusing on the medical community. MSPC members receive 5% discount.

For additional information on these and other services to assist your practice call Membership Benefits, Inc., 572-3709.

County Health Department reduces immunizations

Terry Torgenrud, MD, Chairman, Public Health/School Health Committee

According to the Public Health/School Health Committee, immunizations furnished by the County Health Department to physicians will be reduced approximately 20 to 25 percent as a result of a drop in national and state funding. Physicians who plan to immunize children in their offices should be aware of this and plan to have adequate stock on hand.

This is especially essential during the coming year since the new Washington state law on immunizations specified that children will not be admitted at the start of the school year, if their immunizations are not up-to-date. Please take heed of this and make sure that you maintain your immunization supplies in your office so that we do not inconvenience our patients at the beginning of school this fall.

Organ Donor Hotline established. 800/24-Donor.

An organ donor hotline has been established for physicians, nurses and other health care professionals. The service is staffed by organ procurement specialists who are available 24 hours a day to direct organ donor referrals to appropriate local or regional organ procurement programs.

A major goal of the hotline is to reach hospitals that are not yet affiliated with a local or regional organ procurement program. Established in 1983 through the North American Transplant Coordinators Organization, the hotline is designed to supplement services presently provided by organ procurement programs and agencies across the country. The hotline number is 800-24-DONOR.

For additional information contact NATCO, c/o Shenandoah Valley Transplant Program, UOPA, Box 3198, Winchester, VA 22601.

Medical Society financial picture looks good

June MSPC Board of Trustees Meeting.

Greg Jordshagen, CPA, Simonsen, Moore and Olson, presented a report on the financial position of the Medical Society at the conclusion of 1984. Mr. Jordshagen in his 1984 report to the Board emphasized the importance of increasing the level of reserves. At the conclusion of 1984 the Society saw a swing of $22,000 added to the reserves. It was Mr. Jordshagen's view that the Medical Society's financial position improved considerably in 1984, and that Membership Benefits, Inc., through its inhouse management of publications (Bulletin/Pocket Directory) was now in a position to begin repaying its loan to the Medical Society. In past years it was necessary for the Society to subsidize MBI and its placement service.

In reports the Board learned: Pierce County Medical Bureau would be recommended to assume control of the Tel-Med operation.

A review of Pierce County Medical Library Policy in regard to individual and institutional fees had been completed. The Board discussed availability of Pierce County Medical Library resources to health professionals in the community. It was recommended to the Library Committee that sponsoring institutions, other than hospitals or the Medical Society, be required to pay a fee and that fee should be reasonable.

The Ad Hoc Committee on Contracting reported it would be preparing a report to the Board with results of its meeting with six administrators of the various PPO's being established in the Puget Sound area.

The EMS Committee recommended Dr. R.M. Nicola, County Health Officer, serve as interim EMS Program Director until that position could be filled. A decision on the position was expected to be made in June.

In other action, the Board reviewed two proposals submitted for approval by the Ethics/Standards of Practice Committee. Proposal #1: "Advertising and Publicity" was approved by the Board with noted corrections to the specialty listings recognized by the MSPC: Emergency Medicine, Infectious Diseases and Anesthesiology.

The Board discussed the proposed revision in Bylaws to be read at the June 11 General Membership meeting. Some concern was expressed regarding the revised nominating process, which presently requires the Nominating Committee to submit a slate of candidates of at least two for each elective office. The amendment would call for a slate of candidates of at least one nominee rather than two. A motion was made and seconded that "the Board recommend to the General Membership that the proposal relative to the nominating process." The motion failed with a four to four tie vote.

Physicians are advised to retain medical records indefinitely

Recent court decisions continue to erode the presumed protection of the statute of limitations. As a result physicians are advised to retain all medical records indefinitely. The recommendation is made for both the patient and physician's protection. Various court cases have demonstrated that for the protection of both parties medical records should be retained. The cost imposed by retention is less than the potential costs of destroying records prematurely, legal counsel points out. Further, scientific advances make it possible to predict what information will be necessary for a patient's future treatment.

Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 752-3667.

Medical Society of Pierce County now on FEDNET

The Medical Society of Pierce County became the 24th and newest county medical society to join the expanding medical society communication system, FEDNET, June 25. The system, provided as a service to the medical community through AMA, currently includes 28 state medical associations and 14 national medical specialty societies.

FEDNET was first established in November, 1983, two years after AMA and the General Telephone and Electronics Corporation entered into a contract to establish a high speed electronic system, making current scientific information instantly available to medical institutions and individual physicians.

In establishing FEDNET, a component network developed for medical society executives and their staff, it is now possible for state and county medical societies to receive up-to-date messages from AMA reporting major national developments, important actions of events or AMA actions or activities of general interest to society members. It is possible, as well, for any user on the network to send messages to another user or group of users. Each participant has their own mailbox, permitting sending and receiving confidential messages. MSPC's mailbox name is WSMA.MSPC.

The AMA plans to make FEDNET the primary method of communicating with the Federation. By the end of 1985, the AMA projects that well over 100 medical societies will be on the MINET-FEDNET system, enabling those on the system to receive or send quickly needed information from/or to the AMA and other medical societies.

The system provides for two way communication to establish statewide networks for large county medical societies and members of their boards, for active state specialty society chapters and officers and for members of national medical specialty society governing boards.

Serving the AMA's communications center for FEDNET is the Division of Medical Society Relations, whose mailbox name is AMA.MSR. It receives all incoming messages and inquiries directed to AMA staff from medical societies on FEDNET and coordinates the handling of prompt responses.

The AMA messages deal with a broad range of topics including late breaking legislative developments, legislative alerts, AMA statements for the news media, reports on AMA congressional testimony, information on significant scientific and legal developments, reports on significant medical society actions or programs and other areas of interest and concern.

For further information on MINET-FEDNET contact the Medical Society's Office, 572-3667. ■

Dr. Jack Nagle's name was printed in error in the July Bulletin, along with his daughter's. In showing the photo of Dr. Nagle running in the 10K Heart Run with his daughter, Laure, the photo caption should have read: Dr. Jack Nagle and his daughter Laure Nagle run in the 10K Heart Run.

"I taught my friend everything he knew. Last month, he died driving drunk."

"Eddie made me teach him everything I knew. How to throw a curve. Play the guitar. Last month he died driving drunk. I guess I taught him one thing too many. I taught him how to drink."

When John Weller sobered up and faced the truth about his friend's death, he also faced the truth about his alcohol problem. And he took the first step toward a New Beginning. At New Beginnings we're helping teenage alcoholics recover. One person at a time. One day at a time.

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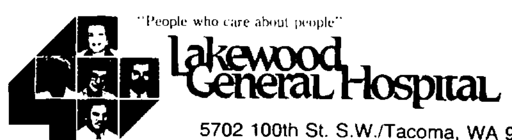

Haemophilus Influenzae Vaccine licensed for use in U.S.

Vaccine available at Tacoma-Pierce County Health Department

Haemophilus influenzae type b vaccine, also known as Hib, was licensed for use in the United States April 12, 1985.

H. Influenzae disease is the leading cause of bacterial meningitis (inflammation of the brain) disease in the United States. It accounts for approximately 12,000 cases per year, usually in children under five years of age.

Of the 12,000 children victims, 5 percent will die and in the survivors of the disease 25-35 percent will have neurological problems.

H. influenzae type b also causes other invasive diseases including epiglottitis (a life threatening respiratory condition), sepsis (blood infection), cellulitis (skin infection), arthritis (joint inflammation), osteomyelitis (bone infection), pericarditis (inflammation of the heart lining) and pneumonia.

Tacoma-Pierce County Health Department started giving the Hib vaccine on July 2. The vaccine will be given each Tuesday and Thursday afternoon from 12:30 P.M. until 4:00 P.M. Cost is $11.00 per dose.

The new vaccine is a purified polysaccharide. The 0.5 cc dose is to be administered subcutaneously.

The polysaccharide vaccines are among the safest of all vaccine products. Over 60,000 doses of Hib vaccine have been administered, only one serious systemic reaction was reported in a child who responded quickly to epinephrine injection.

Other side effects include fever of 101.3F or higher in less than 1 percent of recipients. Mild local and febrile reactions were common and appeared within 24 hours and rapidly subsided.

DTP can be given simultaneously with Hib at separate sites without increasing the incidence of reactions.

New Hib polysaccharide-protein conjugate vaccines are being developed and evaluated and may be of value for children under 18 months of age.

Who should have the vaccine?

1. All children who are 24 months of age.
2. Children who are 18 months of age, particularly in high risk groups such as:
   - A. Children who attend day care facilities,
   - B. Children with chronic conditions, such as:
     1. Sickle cell disease,
     2. children who have had their spleen removed,
     3. malignancies associated with immunosuppression, such as Hodgkins disease.

   These younger children may need a second dose of vaccine within 18 months after first dose to ensure protection. Additional information is needed to define the timing of the second dose more precisely.
3. Children over 24 months who have not received Hib vaccine should be based on risk of disease. Risk of invasive Hib disease decreases with increasing age over the age of 2 years.
4. Vaccine is **NOT** recommended for children under 18 months of age.
5. Insufficient data are available to base a recommendation for vaccine use in older children and adults with chronic conditions associated with increased risk of Hib disease.

For further information/questions contact: Tacoma-Pierce County Health Department, 3629 South D Street, Tacoma, WA 98408, 591-6452.

—*R.M. Nicola*, MD, MHSA, Director of Health ■

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Guest Editorial

By W. Ben Blackett, MD, JD

Dr. W. Ben Blackett is a member of the Editorial Committee for ***The Bulletin.*** *His editorial is the first in a series of Guest Editorials that will be published in* ***The Bulletin*** *by members of the Editorial Committee. We encourage others to submit their editorial comments for publication in* ***The Bulletin*** *as well.*
The Editor

I was recently asked to explain to one of the local hospital PRO employees why I had admitted a certain patient on Wednesday evening rather than Thursday morning for major surgery scheduled at 1:00 P.M. for Thursday. Upon challenging this, I was informed that afternoon surgeries were now required to be admitted that morning unless there were special circumstances justifying prior day admissions. This patient was an 80-year-old woman with the various infirmities that such age usually brings, but the rule itself seemed wrong.

The hospital spokesman laid the blame for the rule on Washington State PRO. But when I called Washington PRO, I was informed that there was and is no such rule for inpatient major surgery and it was suggested that the hospital was perhaps promoting the rule on its own behalf in order to avoid one day of care for which it would not be paid under the DRG formula!

Regardless of the source (PRO, HMO, hospitals or insurance companies) or motives, we should remember that it is our physician responsibility (and just good sense) to not accede to those money-saving measures which reduce the quality of patient care. There are some areas in which we can reduce medical costs without significantly reducing medical quality, but the line where cost reduction begins to include reduction in safety is both vague and real. And for going that extra test, that extra time spent, that extra care, if done enough times will inevitably result in some misdiagnoses and unrecognized complicating factors.

And when that mistake is made, I guarantee that your patient will not thank you for having saved him or her a few bucks. Also, in case you haven't noticed, there are lots of plaintiff attorneys waiting anxiously out there to make themselves some really big bucks by persuading a jury that you did not give your patient state-of-the-art care. ■

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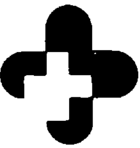

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A Dilemma: Shall We Laugh or Cry?

Commentary by Jo Ann Johnson, PCMSA Legislative Chairman

The irony, satire and humor of politics and government provides voluminous material for editorialists, cartoonists, and stand-up comics, and, perhaps, comic relief is a necessity from a process that invades every facet of our daily lives—from the sanctity of our homes to the operation of our businesses to decisions involving our social and moral values. And yet, how often do you hear the remark that people are vitally interested in legislation and judicial proceedings but will have nothing to do with politics or political campaigns. The past legislative session should serve as a prime example of how one process directly influences the other and we, as individuals, must accept the decisions we make in regard to our choices in these processes. Perhaps it is best to laugh rather than cry.

When the annual legislative session began in January, there was one over riding issue—The Budget—which had to be dealt with in order to reach a constructive approach to three major dilemmas facing the stable funding of State Goverment; namely the unfunded liability of the pension fund, the financing of our educational system, and the resolution of payment for comparable worth. In addition, the Industrial Insurance program which had been the target of unprecedented tax hikes—and again due for another increase—was in need of restructuring. An equitable tax base, overdue repairs on infrastructures, contamination of ground water and water quality were also items in need of attention. Increases for state employees' and teachers' salaries were also on the agenda. Six months later, on June 10, the Legislature returned for their special session and the agenda was still the same. Perhaps it is better to laugh than cry.

Legislation covering the issue of professional liability has been relegated to being a problem of a special interest group and has been essentially stalemated for years. In the meantime, we see liability premiums increase; we see increasing litigation; we see multimillion dollar judgment awards becoming common place; and we are beginning to see and hear about a potential loss of medical services in some of the specialty groups. Perhaps it is better to laugh than cry but if I were a young mother, or in need of emergency care, or just someone who values quality medical care, I think I would rather cry than to die laughing.

issue and a schizophrenic reaction to any possible constructive solutions. Who is really to blame? A litiginous society? A liberal judge and jury? Legal expertise based on contingency fees without any capitation on awards or costs? Powerful and knowledgeable legislators who control the political process during a legislative session? An insurance company who doesn't share actual revenue and costs figures? Medical "mistakes" that shouldn't have happened? A public perception of a rich doctor who can afford a $100,000 insurance premium—and is still liable for the same premium even after retirement? Unrealistic expectations of medical care? It is a true dilemma that the medical community is constantly striving to solve in a safe and sane fashion on every level—education, prevention, performance, review and individual integrity. And yet, perhaps, we should all cry, because everyone—doctors, lawyers, judges, juries, politicians, insurance, business, rich or poor—everyone may suffer.

Whether we laugh or cry, everyone has a dilemma. Everyone must help find a solution. ■

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Child Abuse: a national concern, a growing problem for doctors and the community.

There are no easy answers or simple solutions for physicians and communities faced with the increasing number of child abuse cases being reported across the country.

During 1984 there were 5,034 cases of child abuse reported in Pierce County. 1,076 of the cases reported were sexual abuse, 1,180 were physical abuse, 1,133 were physical neglect. The remaining reported cases were made up of various other forms of abuse. Of the cases reported 107 were reported by physicians; 290 were reported by hospitals.

The *American Medical News* covered the Los Angeles Virginia McMartin Pre-School case where criminal charges of sexual abuse were brought against seven teachers. In referring to the medical examinations Los Angeles pediatrician

continued on following page

Astrid Heger, MD, did on children involved, the *American Medical News* called it "unraveling a nightmare."

Based on a statewide average, there are 21 cases of child abuse per 1,000 families in Pierce County. 25 to 30 percent of all abuse reported is sexual abuse.

According to Child Protective Services Director Gene Zinck, sexual abuse covers a broad spectrum. It may involve the father, a mother's boyfriend, older children abusing younger children, aunts, uncles, other relatives, friends or acquaintances. It is more prevelant for female chidren to be abused than male children. In sexual abuse as in other abuse there is not only the physical trauma but also the emotional and pyschological trauma. "Children become distrustful, and often lack the ability to enter into close, meaningful interpersonal relationships after being abused," says Zinck.

Knowing, however, whether child abuse is on the rise is difficult to assess since many cases went unreported up until the last few years. Public education and willingness on the part of communities to assume responsibility has brought about a "tremendous rise in cases reported over the last 10 years," according to Zinck. Children, themselves, knowing that they have some element of community support, are also more likely to talk about being abused.

While reporting does not in itself solve the problem, it is a beginning. Ten years ago there were only 80 cases of child abuse a month reported in Pierce County. Today there are 400 to 500 cases a month reported, with one-third of those reported being sexual abuses.

The largest source for reporting abuse comes from the schools, according to Zinck. The second largest source comes from the medical profession. "I think," says Zinck, "that the doctors in Pierce County are doing an outstanding job in dealing with the issue and reporting abuse."

"They are an important part of our efforts. We need the benefit of their advice and counsel."

"I only wish," says Zinck, "that reports of child abuse would come in during the early stages of abuse, to help the family correct the behavior. Many abuse cases extend over long periods of time, and by the time the case is reported the child is severely damaged, emotionally and psychologically."

Child abuse is in itself a broad term. Like sexual abuse, those involved may be children abusing other children, parents abusing children, or friends, relatives, acquaintances abusing children. The abuse may extend from simple physical neglect to severe, intended physical and sexual abuse. It can be repeated parental spankings with cords, belts or other objects that leave bruises and may cause other physical injury. In the most severe cases, there is the desire to do as much damage as possible to the child. The abuser is completely out of control.

Medical neglect, while not as frequent a form of child abuse as sexual or physical abuse, occurs in cases where a child has not received medical care. The situation worsens and can even put the child's life at risk if medical treatment is not received.

Use of excessive alcohol, drugs, and poor diet during pregnancy is considered child abuse, in that it is a form of prenatal neglect. During 1984 66 cases of prenatal neglect were reported in Pierce County.

One of the most difficult forms of child abuse to really assess is the psychological and mental abuse inflicted on a child. There are no visible scars, no concrete evidence so to speak. It is only in the behavior of the child where the abuse is manifested. Babies may show delayed development. Young children may revert to baby behavior. They become frightened, untrusting and are often the loners. In older children the abuse often leads to runaways. 284 cases of mental injury and emotional abuse were reported in Pierce County in 1984.

While physical and medical neglect may come from low income strata of the society, for the most part, child abuse runs across economic stratas. Children of all socio-economic levels are victims of child abuse.

What can physicians do? According to Zinck, physicians can become more aware of the types of abuse. If bones are broken, they need to take a careful look at the type of fracture, the place of bruises. They can become more expert in listening to parents, observing the interpersonal relationship between parent and child. "Our primary responsibility," says Zinck, "is to protect the child."

Of the some 150 young Virginia McMartin Pre-School patients Dr. Heger examined, at least half, according to the *American Medical News,* were thought to have been seen by a family physician or a pediatrician for complaints related to the abuse. Parents said, however, that physicians did not examine the children for abuse even though they had complaints of rectal pain or vaginal discharge. Physicians who examined the children, according to the *American Medical News,* usually "suggested switching brands of bubble bath or diagnosed constipation or a urinary tract infection. Not a single physician ever said that he or she suspected sexual abuse."

"We need the help of the medical profession," says Zinck. "They need to be more accessible and make known their wishes, desires and involvement in cases of child abuse."

Legally a physician must report any suspicion of actual abuse. Failure to report can lead to legal action and sanction through law enforcement agencies.

"We need to recognize the responsibility we have for our area of expertise, to develop trust, confidence and respect for each other, and we must recognize the right to disagree," says Zinck.

In Pierce County, according to Zinck, child abuse is looked upon as a community problem. This attitude may be a beginning in helping families and children, both in many ways victims.

This year, Child Protective Services set up an experimental community team in an effort to be more effective in helping abused children and families alike. It is a multi-disciplinary approach, being field tested now, where a small number of reported cases are brought before a team made up of a medical doctor, currently Dr. Robert A. Padgett; a private practicing psychologist; a representative from the Child Protective Services Agency; a representative from the Pierce County Juvenile Court; a school representative and consulting treatment specialist.

After an evaluation, the team helps to develop a case plan that they believe will most benefit the family and the community. The team is composed entirely of volunteers from the community.

Facing the issue of child abuse is a painful process of awareness. But we can no longer turn our backs on the issue. While it is a national problem, it will, in all probability, best be solved through community awareness, concern and effort. ■

*Research for this article was conducted by Mary K. Tipton, MK Tipton Communication Services. The **Bulletin** would like to thank Child Protective Services Director Gene Zinck for his cooperation.*

Physicians are more aware of child sexual abuse: survey

Physicians say that they are more aware of the incidence of child sexual abuse today then they were before 1984, but some who suspect such abuse still are hesitant to report it, a recent opinion sampling conducted by *American Medical News* revealed.

Three-fourths (76%) of the physicians responding said they were more aware of the incidence of sexual abuse than in the past, while nearly one-fourth (23%) said they were not (see Table 1).

Nearly one-fourth (23%) of the responding physicians said that they had seen child patients in their practices in 1984 whom they suspected had been sexually abused. Forty-five percent said they had not, and another 32% said they see no children in their practices (see Table 2).

When asked if they had ever reported any cases of any kind of child abuse before 1984, more than one-third (34%) said they had. Sixty-four percent said they had not and 1.4% did not answer the queston (see Table 3).

Of the physicians who said they had reported child abuse of various types, physical abuse was by far the most often cited (52%), while only 5.4% cited sexual abuse and none cited emotional abuse only.

But several kinds of abuse often were present and were reported, the respondents indicated. Of those reporting abuses of children, 91.7% checked physical abuse, alone or in combination with either sexual or emotional abuse, or both. Forty-two percent said they had reported sexual abuse, alone or in combination with other types of abuse. Twenty-two percent reported emotional abuse, always with physical or sexual abuse, or both (see Table 4).

BECAUSE THE NUMBER of physicians who said they suspected they had seen cases of child sexual abuse in 1984 was larger than the number indicating that they had reported such cases in the past, several questions about adequacy of training to detect and deal with child abuses assumed greater importance when opinion sampling results were analyzed.

While two out of five physicians (41%) said they thought that their medical training adequately prepared them to detect child abuse, almost as many (38%) said it had not. There were a large number of "don't know" responses (17%), and 3% did not respond.

Even larger numbers of respondents—55%—said they had not received adequate training to prepare them to detect child sexual abuse. One-fourth (26%) said they had. As with the question about adequacy of child abuse training in general, a large percentage (18%) said they did not know, and about 1% did not answer.

When asked what percentage of child sexual abuse cases go undetected by physicians, respondents were about evenly divided, up to the range of 75% to 100% of cases. Twenty-seven percent said that 1% to 25% of such incidents were undetected by physicians; 23% said the percentage ranged from 26% to 50%; and 27.5% said 51% to 75% may be missed (see Table 5).

Thirteen percent said that as many as three-quarters to 100% of the sexual abuse cases were not recognized by physicians. About nine percent did not reply. "If you have seen a case of suspected child sexual abuse in your practice, but did not report it, please briefly explain why," the questionnaire said. Only a relatively small percentage of physicians (16%) responded, but their comments provided some possible insights into the reasons many practicing physicians are reluctant to allege child abuse, and specifically child sexual abuse.

Six percent said they thought that they lacked sufficient evidence to document the abuse. Four percent said they had personally intervened to resolve the problem, and another 4% said that the abuse had been reported by someone else. Only 2% said they had hesitated to make such a report because of the legal hazards involved.

"I could not be sure if it (the abuse) had in fact occurred and wished not to cause the child further problems," one physician said.

ANOTHER SAID there was "not enough evidence, so I chose to work with the family. There was family pressure not to report (the abuse)."

Two respondents said they had pre-

continued on page 14

Table 1

A great deal of public attention has been focused on child sexual abuse recently. Would you say that you are more aware of the incidence of child sexual abuse than you were before 1984?

Yes	76.1%
No	23.3%
No answer	0.5%

Percentages may not add to 100% due to rounding.

Table 2

During 1984 did you see any child patients in your practice whom you suspected had been sexually abused?

Yes	22.8%
No	44.8%
See no children	31.7%
No answer	0.5%

Table 3

Before 1984, had you ever reported any cases of child abuse?

Yes	34.1%
No	64.5%
No answer	1.4%

Table 4

If you did report any cases of child abuse before 1984, what kinds of abuse did you report? (Check as many as apply.)

Physical	52.0%
Sexual	5.5%
Physical/sexual	20.5%
Physical/emotional	5.5%
Sexual/emotional	2.7%
Physical/sexual/emotional	13.7%
Total reporting physical abuse	91.8%
Total reporting sexual abuse	42.5%
Total reporting emotional abuse	22%

Table 5

What percentage of child sexual abuse cases do you believe goes undetected by physicians?

1% - 25%	27.1%
26% - 50%	23.3%
51% - 75%	27.6%
76% - 100%	13.0%
No answer	8.9%

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ferred to handle the incidents with the parties involved, avoiding the official reporting process.

"To prevent further trauma to victim and family, I'd prefer to deal with the persons involved privately, if so warranted and if possible," one physician respondent commented.

'I met with the mother, grandmother, and aunt of a child," one physician said. The physician "determined who the molester was—and the family was able to have the process stopped."

One respondent expressed a certain frustration about dealing with the child sexual abuse problem. "What has happened on more than one occasion [is that] we have been sure of the abuse, without proof, and [so] . . . prosecution could not proceed."

Two who expressed reluctance about official reporting of suspected child abuse gave their reasons:

"[There is] embarrassment at confrontation [and] legal hazards. [Is there] lack of an adequate investigative team? [We must have] the ability to change things or assure protection" if there is a report and follow-up.

" 'Suspicion' (of child sexual abuse) covers a wide range—is it worth ruining a patient relationship for a 1% suspicion of minimal 'abuse'?"

AMN asked physicians what might be most helpful to them in dealing with child sexual abuse, listing several possibilities and providing an opportunity for physicians to suggest others. Most frequently checked (86%) was a diagnostic guide on child sexual abuse and a continuing medical education course on the subject (80%). Checked by more than three-fourths of the respondents was the availability of an interdisciplinary child abuse consultation team and an effective child protection service.

ADDITIONAL SUGGESTIONS from respondents included availability of a community resources guide; better knowledge of reporting procedures (how, to whom, the process to follow) and prevention; more education of law enforcement, social workers, and nonmedical people who may be involved in detecting and dealing with child sexual abuse; more articles in medical journals; audiovisual tapes on the subject; standardized diagnostic aids, such as explicit dolls; and more support for abortion rights, birth control, and sterilization.

As is always the case when free-thinking physicians are asked to express opinions on a subject currently receiving national attention, some give very candid responses. One internist said, "I see no children and I don't give a damn about this subject." Another said, "I believe that 'abuse' is being abused and that the basic principles of medical practice are [getting] lost in the fad."

The *AMN* Fever Chart opinion sampling is conducted periodically to obtain physician feedback on topics of current interest. Mail questionnaires are sent to 1,000 randomly selected physicians representative of the U.S. physician population. In this survey, 214 responses were received. The opinion sampling is conducted with the assistance of the AMA's Dept. of Survey Design and Analysis. ■

MSPC Ad Hoc Committee coordinates with Child Protective Services-Adult Protection Services

Report by Terry W. Torgenrud, MD, Chairman, Public Health/School Health Committee

For the past several months an ad hoc committee from the Public Health/School Health Committee has been meeting with representatives from Child Protective Services to form a liaison to help in any cases in which there is a problem, either with the physician, the legal system, or the case worker, in maintaining quality control in these situations.

At the present time, the dialogue has been excellent. There has been some good give and take, and if there is any problem that you have with Child Protective Services which you feel needs to be settled, please contact either Doug Jackman at the Medical Society or me, and we will attempt to help smooth the way in your situation. It has been the feeling of the Committee that the more communication that we have in a back and forth dialogue, the better our patients in the community will be served in handling many of these delicate matters.

Physicians required to report suspected adult abuse cases.

April-June Meetings of Ad Hoc Committee

The Child Protective Services–Adult Protective Services Medical Society subcommittee met in April and June, according to Dr. Alan Tice, member of the committee.

Drs. Terry Torgenrud and Tice met with Child Protective Services Director Gene Zinck, Colleen Waterhouse and Marilyn Collison from Adult Protective Services and Dr. Robert Padgett, consulting physician for Child Protective Services. Dr. Tice reported that among the issues reviewed were the following:

The need for better communication between the physician and case worker was stressed. Only early and effective contact can maintain the role of physician in the care of his or her patients and provide prompt insight into problems before they multiply.

From a physician's standpoint, it should be noted that the case worker is often out of their office when calls are returned. The situation can often be discussed with the case worker's supervisor, who should be in the office most of the time.

Child Protective Services and Adult Protective Services were assured of the Medical Society's interest in child and adult abuse and their willingness to assist whenever their patients are involved or member physicians have problems or questions with the agency.

Dr. Padgett emphasized the importance of a detailed and carefully recorded examination of children when abuse is suspected.

The Adult Protective Services now requires physicians to report suspected cases of abuse. This requirement became effective June 1, 1985. One of the major differences between Child Protective Services and Adult Protective Services is that the patient's consent must be obtained before any Adult Protective Services investigation. The only alternative to this is to appoint a guardian of the court to intervene on their behalf if they are thought to be incompetent. A summary of the most recent legislation follows on page 15.

How To Report Adult Protective Services Referrals

I. Who To Contact:
Adult Protective Services
Pierce East CSO
1004 East Main
Puyallup, WA 98372
(206) 593-8638 or 593-8647

II. What To Report:
Oral reports should include the following information:

a) The name, address, telephone number, birthdate or age of the adult being referred.
b) The name and telephone number of any relatives, guardian, care givers, etc.
c) The known nature and extent of the suspected abuse, neglect, exploitation, or abandonment.
d) Evidence of previous abuse, neglect, exploitation, or abandonment.
e) The name and address of the person making the report.
f) Other involved agencies.
g) Any other helpful information.

Written reports shall be made when the initial report is oral. These reports should include the above information and be mailed within *five* working days.

HIGHLIGHTS OF THE ELDERLY ABUSE LAW (EHB 1328) EFFECTIVE JUNE 1985

This bill created an Adult Protective Services law for vulnerable adults.

Some Definitions:

A vulnerable adult is:	any person 60 years of age or older who has the functional mental or physical inabilityto care for himself or herself.
Abandonment is:	leaving a vulnerable adult without the means or ability to obtain food, clothing, shelter or health care.
Abuse is:	any act of physical or mental mistreatment or injury which harms or threatens a person through action or inaction by another person.
Exploitation is:	the illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.
Neglect is:	a pattern of conduct resulting in deprivation of care necessary to maintain minimum physical and mental health.

Mandatory Reporting

Beginning July 1, 1985, the Elderly Abuse Law mandates social workers, DSHS employees and health care practitioners who have reasonable cause to believe that a vulnerable adult has suffered abuse, exploitation, neglect, or abandonment shall make an immediate oral report of the incident followed by a written report (within 5 days) to the Department of Social and Health Services. Unless there is a judicial proceeding or the person consents, the identity of the person making the report is confidential. They are also immune from liability resulting from reporting, or the testimony.

Responding To Referrals

The Department of Social and Health Services shall respond after receiving a report and provide appropriate protective services with the consent of the vulnerable adult.

"Consent" means written consent that is granted after the person has been fully informed of the nature of the services to be offered and that the receipt of services is voluntary.

Legal Responsibilities

The department may bring an action under Chapter 11.88 RCW (the guardianship statute) if it is determined that the vulnerable adult lacks the ability or capacity to consent.

The department can also seek an injunction to prevent interference with an investigation of abuse, abandonment, exploitation, or neglect.

Children's Protective Service Law

This law also changed the references in the Children's Protective Services law sections which involved adult developmentally disabled persons to read: adult dependent persons.

An adult dependent person is anyone over the age of 18 who has been found to be legally incompetent pursuant to RCW 11.88 (the guardianship statute).

AUXILIARY NEWS

Applications available for philanthropic funds

The Medical Society Auxiliary is accepting applications now for any service group that is health related and would like to be considered by the PCMSA as a recipient of their philanthropic funds. Marlene Arthur, Chairperson of the finance committee, has applications available. Her phone number is 845-5542. Deadline for accepting applications is Sept. 15th. Call Marlene for more information.

Children's Art Contest!

Here's a creative summertime project to occupy little heads and hands! The Pierce County Medical Society Auxiliary is sponsoring a Children's Art Contest. The winning design will be used for the 1985 Auxiliary Holiday Greeting Card (*and* 100 cards with "design only" will be given to the winner's family for personal use). The contest will be judged by a committee of PCMS wives who are members of Lakewood Artists.

Any child or grandchild of a Tacoma-area physician's family, *Kindergarten through Fourth Grade* is invited to submit one drawing, observing the following requirements:

1) Subject matter must be appropriate to the general purpose of a Holiday Greeting. The Committee will not be able to consider an entry with a religious theme.

2) Art work must be executed on white paper, 8½ x11 or larger. (In order to reproduce well for the holiday card, bright and darker colors are better than yellows or pastels. *No pencil or pastel chalk.)*

3) Child's name, address, phone number, and age must appear on *back of picture ONLY.*

4) Mail *unfolded* to:

PCMSA Children's Art
Contest Committee
c/o Carolyn S. Modarelli
7514 91st Avenue SW
Tacoma, Washington 98498

5) Deadline for entry: *August 30, 1985.* Winner will be notified shortly after September 15.

Please send your dues!

We would like to include your name in our auxiliary yearbook! The printers deadline for the book is August 6th.

Please send your $38.50 dues to: Betty Virtue, 71 Leschi St. Madrona Park; Steilacoom, WA 98388. Be sure to let Betty know if you have an address or phone number change.

1985-1986 PCMSA Executive Board announced

The following women have been elected to serve on the 1985-86 Executive Board of the Pierce County Medical Society Auxiliary.

President: Virginia Y. (Ginnie) Miller
President-elect: Susie Duffy
1st Vice President—Program: Marie Griffith
2nd Vice President—Membership: Alice Wilhyde
3rd Vice President—By-Laws & Historian: Carol Hazelrigg
4th Vice President—Arrangements: Alice Yeh
Recording Secretary: Mary Schaeferle
Corresponding Secretary: Sonja Hawkins
Treasurer: Helen Whitney
Dues Treasurer: Betty Virtue

Many thanks to the above women for volunteering their time and talent to our organization!

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Dual Identity: Physician/ Evaluator

By John Hey, MD

Reprinted by permission from Disability Digest, Jackson, Mississippi, Vol. 1, No. 3, April, 1985

During our medical training, there is conveyed to us the idea that the reporting of histories, physicals and general examinations, especially those relating to government programs, is a somewhat lesser activity than stamping out disease and caring for critically ill people. I must admit that I shared these beliefs when I first began doing disability examinations.

As a consultative physician, I often find that I am cast in the role of detective. If the patient truly has a disability and is deserving of assistance, then it is quite gratifying to help this person obtain the assistance. Sometimes the patient complains of one problem; but another more serious problem is uncovered, which is the cause of the patient being unable to do the work. Meticulous examination and documentation assure that both justice is done to the claimant as well as the society at large. This is especially important with dwindling resources and the need to make our government money go to the most needy and deserving.

I have been very much impressed with the range of pathology that presents itself through the disability program. Some of this is quite subtle and difficult to evaluate. Seeing these patients has sharpened my index of suspicion for many disease and disability states in my own patients that I would not have had, if I were not associated with the program.

One aspect of disability examinations, however, that I wish could be overcome is the lack of follow-up. After examining a person and investing time in his life story, I, as well as my staff members, often wish that we knew what finally became of him or her—whether he or she received assistance, was retrained for another career or was simply denied.

One factor I found that is very important is to try to communicate to the patient that I am not the judge, jury and executioner. I always try to emphasize to the patient that the decision will be made by others and, that we are merely gathering information to help in that decision-making process. For this reason, I always try to "bend over backwards" to put every thread of data, both positive and negative, that I can gather to help in insuring equity for all. Sometimes this does not work. I have had patients threaten to sue, threaten to broadcast over the town that I am in the business of getting people thrown out of government programs; and I have even had my life threatened—fortunately unsuccessfully! These instances are quite rare and, on the whole, they merely "spice up" a normal day's activity. ■

Physicians interested in obtaining information about becoming a consultative physician should contact:
John Peters,
Professional Relations Manager,
Office of Disability Insurance
P.O. Box 9303
Olympia, WA 98504
or call toll-free
1-800-562-6074, Ext. 4231.

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MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Ben R. Bryant, MD, *General Practice.* Born in Iowa, 7/14/20; medical school, University of Southern California, 1951; internship, Orange County General Hospital 6/50-7/51. Washington State License 1964. Dr. Bryant is currently practicing at 1215 South 11th, Tacoma, Washington.

Christopher A. Jordan, MD, *General Surgery and Colon & Rectal Surgery.* Born in Rockland, Maine, 7/26/53; medical school, University of Massachusetts, 1979; internship, Dartmouth-Hitchcock Medical Center, General Surgery, 6/79-6/80; residency, graduate training, St. Vincent Health Center, Colon & Rectal Surgery, 7/84-7/85. Washington State License, 1985. Dr. Jordan is currently practicing at 1901 South Cedar #204, Tacoma, Washington.

Joseph W. Regimbal, MD, *Internal Medicine and Geriatrics.* Born in Yakima, Washington, 10/05/54; medical school, University of Washington, 1981; internship, University of Washington, Internal Medicine, 6/81-6/82; residency, Internal Medicine, 6/82-6/84; graduate training, Geriatrics, 6/84-6/85. State of Washington License, 1985. Dr. Regimbal is currently practicing at 408 South K Street, #400, Tacoma, Washington.

Christopher J. Schmitt, MD, *Family Medicine.* Born in Dayton, Ohio, 8/18/53; medical school, St. Louis University, 1978; internship, Charity Hospital of New Orleans, 7/78-6/79; residency, LSU Family Medicine Residency, 7/78-6/81. Washington State License, pending. Dr. Schmitt is currently practicing at 1112 South Cushman, Tacoma, Washington.

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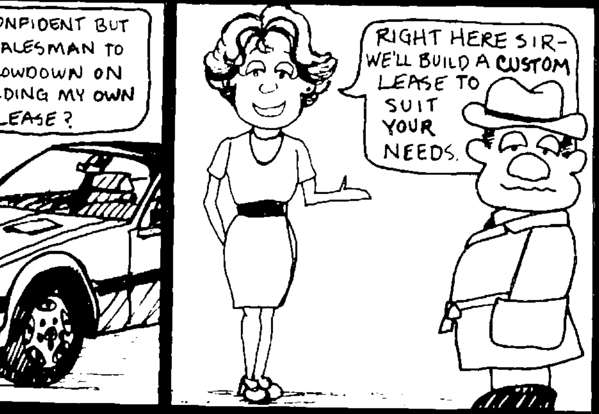

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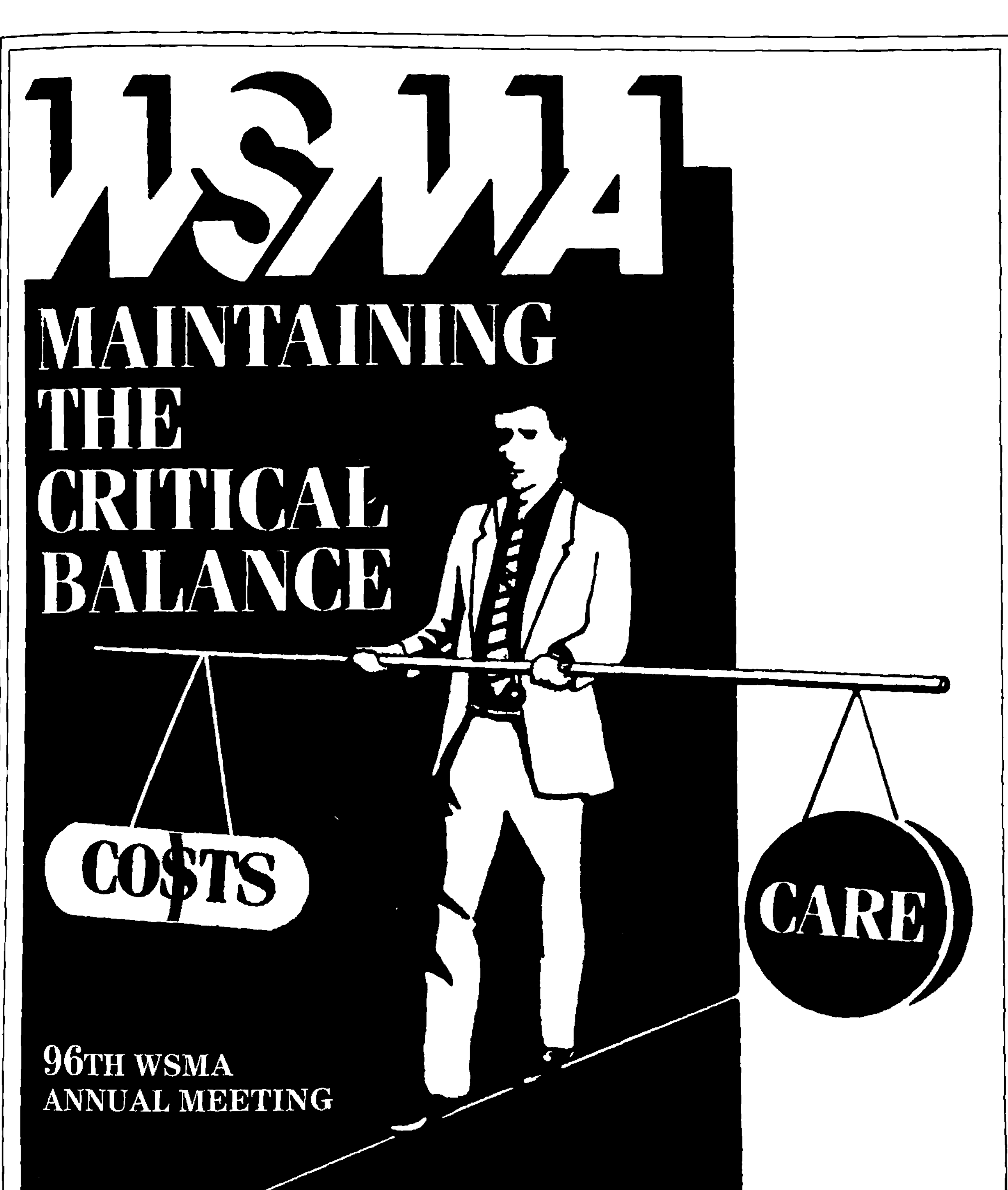
September, 1985



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President's Page
Guest Editorial

By Doug Jackman,
MSPC Executive Director

"Great economic and social forces flow with a tidal sweep over communities that are only half conscious of that which is befalling them. Wise statesmen are those who foresee what time is thus bringing, and endeavor to shape institutions and to mold men's thought and purpose in accordance with change that is silently surrounding them."[1]

John Morley could well have been writing about the tidal wave of change that has been pounding at the doors of medicine in the tumultuous 80's. He may have also been speaking of many physicians who are only half conscious of what is befalling them.

A surplus of physicians, diminishing health care resources, an aging population, advances in medical technology, professional liability and a proliferation of other problems are creating great change in the field of medicine today.

Yet, one senses a feeling of apathy, resignation and, perhaps, surrender among physician ranks to the forces that threaten to take away their professional freedom. It is difficult to comprehend how a group of individuals who have committed themselves to years of effort for the opportunity to practice medicine can sit back and watch the erosion of all they have worked for without some effort to oppose these changes or at least soften the blow.

Here in Pierce County nearly 90% or more of all eligible physicians belong to the Medical Society and WSMA. However, it is a different story when one looks at the number of physicians who belong to the American Medical Association. Only 44% of all eligible physicians nationally belong to AMA. In Pierce County the average rate of membership is comparable to that of the national average. When an AMA representative appears before a congressional committee he finds it difficult to be very persuasive when he cannot say he represents the majority of the physicians in the country.

Membership in WAMPAC and AMPAC stands at 23% for Pierce County physicians. Dues to WAMPAC are $50 and to AMPAC $20. This is considerably less than what many allied health professionals who have made great gains in the legislative halls in the past decade have been paying to support their political action committees. It is considerably less than what the trial attorneys have been contributing to the political process, and their success is reflected by it.

As distasteful as some of you may find participating in the political arena, the time has come for you to become a participant. It is necessary that you understand the enourmous influence legislative and congressional actions are having on the care of patients and the practice of medicine.

The MSPC is inaugurating a service beginning immediately. The Society office will collect stationery and letterhead of any member and hold it at the office. When that member wishes to write a letter to his or her congressman, they can call the office (572-3667) after hours and dictate a letter which will be typed, ready for signing and can be mailed by the office. If you would like to participate in the program, please send a few copies of your letterhead and stationery to the Society office.

The PCMS Auxiliary has done extensive work to develop a legislative phone tree that will also be in operation for the next Legislative Session.

One convenient way of becoming more knowledgeable on the affairs of state would be to plan on attending the WSMA Annual Meeting scheduled for September 18-22, Jantzen Beach. Two of the many issues that will be discussed are the impact on the quality of care resulting from cost controls and physician-hospital relationships, as well as an excellent scientific program. Try to attend.

[1] *Life of Richard Cobden*, John Morley, 1881.

NEWSBRIEFS

Tel-Med sold to Pierce County Medical Bureau

In 1977 Tel-Med was introduced to Tacoma. Offering at the time about 300 tapes that provided 3-5 minutes of accurate health information on the topics.

To bring the service to Tacoma was a major effort of the PCMSA. First President of Tel-Med Society Board of Trustees was Marie Henry. Some of those who led the effort for the Auxiliary were Jo Roller, Nikki Crowley, Helen Whitney, Cindy Anderson, and Stephanie Tuell.

In 1978, the Tel-Med switchboard received over 66,654 calls and publicity far and wide was generated by this opportunity to dial a number and receive 3-5 minutes of information that had been approved by a physician.

Tel-Med was financed then and continued to be by major contribution from MSPC members, Allenmore Foundation, PCMB and PCMSA. These individuals and organizations continued their strong support for Tel-Med through to the present.

During the life of Tel-Med, volunteers from the Auxiliary manned the switchboard from 10:00 a.m.-12:00 noon on a daily basis. It is estimated that nearly 5,000 volunteer hours were contributed by the volunteers. Based on receiving a minimum wage scale of $2.65 during the course of Tel-Med's existence, this would have accounted for approximately $14,000 in contributed manhours for our years of operation of Tel-Med. The annual budget of Tel-Med is approximately $15,000. A special thanks is extended to the volunteers who so generously gave of their time, providing a valued service for the community.

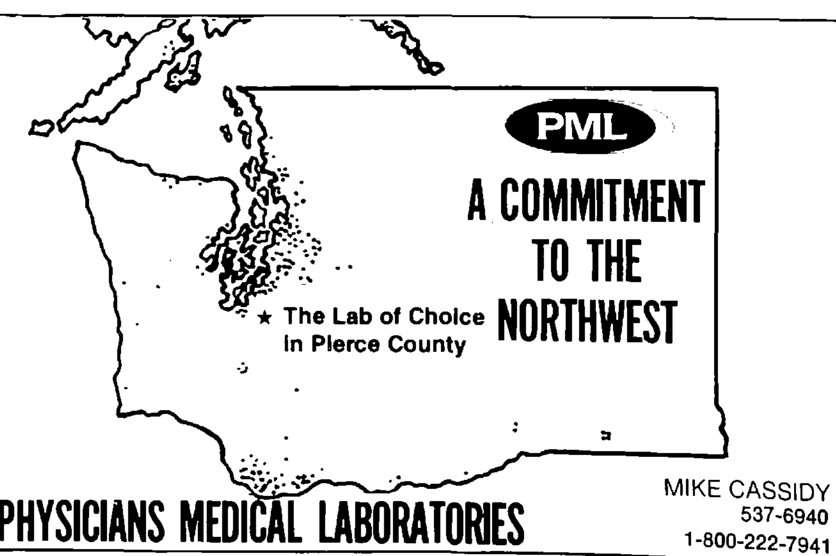
Despite numerous efforts, however, to increase activity on the switchboard, the call volume continued to drop. In 1980 call volume was 30,187. 1983, 17,476 and 1984, 14,680. In late 1984-85, Tel-Med Board of Trustees discussed some of the problems of Tel-Med other than diminishing call volume. The Board was concerned with continuing to solicit funds when the program was declining. Was such solicitation justified? It was becoming difficult to find volunteers to step forward and serve as officers on the Tel-Med Board. What were the alternatives available to the Board. Was the program worth continuing? Was it a valid community service?

An Ad Hoc Committee was appointed by the MSPC Board of Trustees. The recommendation of the committee was that physicians could play a more important role in making the public aware of Tel-Med. A survey of MSPC members and former officers of Tel-Med revealed overwhelming support for the concept and its value as a public service.

During a review of the alternatives, the Bureau expressed a possible interest in Tel-Med. PCMB had been a strong financial supporter since the inception of Tel-Med and had annually printed over 50,000 brochures for distribution. With financial resources, a marketing department and a wellness program to coincide with Tel-Med health education value, the Bureau's Board of Trustees accepted Tel-Med's offer to consider the purchase of the program.

The Bureau's Board of Trustees approved the purchase of Tel-Med and transfer of operation was completed by August 1. With the abundant financial and staff resources it was the consensus of the Tel-Med Board of Trustees that the Bureau could once again return Tel-Med to a valued, viable and active community service.

Newsbriefs continued on page 6.



MBI has new Director

Sue Asher has been named to replace Linda Carras as Director of Membership Benefits, Inc. Ms. Asher brings with her several years of experience in working with physicians as Program Director for the Puget Sound/Southwest Region of the Washington Lung Association.

A graduate of the University of Washington in Health Education, she has been a resident of Fircrest, Washington for the past three years. She is active in the community and is past president of the Fort Steilacoom Running Club.

Membership approves amendments to MSPC Bylaws.

In July a ballot was mailed to all active and honorary members seeking their vote on three proposed amendments to the MSPC Bylaws. The first amendment voted on dealt with the nominating process. The proposed amendment was intended to simplify the process by requiring the Nominating Committee to submit a slate of candidates consisting of at least one nominee, rather than two for each vacancy to be filled in election of officers. Additional nominations for any office may be also filed with the Secretary-Treasurer by petition.

Amendment No. 2 was concerned with providing a permanent Bylaws Committee. Amendment No. 3 was written to clarify the amendment process, making it more available to the membership. All three amendments passed.

MSPC member response to the balloting was outstanding. Your participation and interest is appreciated.

Physician supply continues to increase

Physician supply will continue to increase over the next two decades, reaching a total of 594,600 in 1990 and 706,500 by 2000, according to the U.S. Bureau of Health Professions.

Using data from the AMA Physician Masterfile, the bureau projected that although growth in physician supply would be slower than in the past decade, it still would outpace population growth. As a result the physician-to-population ratio will increase from 199 physicians per 100,000 population in 1981 to 235 in 1990 and 260 in 2000.

The supply of osteopathic physicians will grow even more rapidly than the supply of MD's. Although DO's will more than double by 2,000, however, they will comprise only 6 percent of the total physician supply.

Foreign medical graduates are projected to contribute less to the growth of active physicians during the next two decades than in the previous decade, but they will continue to comprise a significant percentage of total active physician supply.

About one of every five active physicians in 1990 and 2000 will have graduated from medical schools outside the United States and Canada. Women physicians will continue to increase substantially both numerically and as a percentage of total physician supply. By the year 2000, women physicians are expected to number approximately one-fifth of all active physicians.

From AM News Report, July 3, 1985

AMA Booklet Chronicles Outlook for Medicine.

The Environment of Medicine is the title of a new booklet published by the AMA's Council on long-range planning and development.

The booklet provides an up-to-date forecast of demographic characteristics, demand for health care services and supply of physician manpower. Some of the information included in the publication is that real expenditures on physicians services are projected to increase at a 4.4 percent annual rate between 1984 and 1987. 93 percent of the public respondents say that the length of time to see a physician is important in choosing a personal physician. More than 60 percent of the patients of the typical office-based physician were under 15 years old or over 65 years old.

Cost for the booklet is \$9.00 for members, \$10.00 for non-members. To order send a check or money order to:

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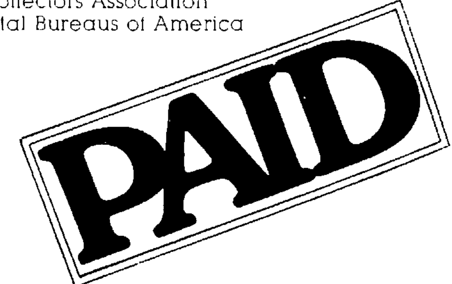

AMA product, Market Area Profile Service (MAP), helps physicians select medical practice sites.

The AMA has recently introduced a new product, the Market Area Profile (Map) Service. The service is designed to help physicians with medical practice site selection and development. Permitting physicians to precisely define any area under consideration, the service is the first and only source of integrated demographic, physician and hospital data for any area of the country.

According to the AMA, the MAP report package, which includes a comprehensive resource booklet to assist in interpreting the data, is being provided at a "very reasonable cost, with discounts for AMA members, residents and medical students."

The Map Service offers data for any location, of any size that a physician specifies. Physicians can request a MAP Service report package using a standard area definition, such as county, city or postal zip code, or they can request a "ring study."

In the ring study a physician can request information on any area defined as a specific radius, such as around a specific street intersection, giving physicians the capability to more accurately define their service area in relation to a specific office location.

The MAP Service report tells physicians how many people reside in a given area, if the population in the area is stable, decreasing or growing; what the characteristics of the population area and if such characteristics are expected to change, what the level of demand for a given specialty in the area is currently and what it might be in the future; how many physicians are located in the area and what their medical specialties are. In addition the service will show physicians to what extent there is a potential referral base for a given specialty, if hospital facilities are adequate to meet the needs of the physicians patients and what the medical staff characteristics of the hospitals in the specified area are.

For additional information on this service MSPC members may call the Medical Society Office, 572-3666, or contact:

Phyllis Kopriva, Director
Competition Action Project
Department of Physician Practice Service
American Medical Association
535 N. Dearborn Street
Chicago, Il 60610
Phone (312) 645-4719.

Virginia Mason Medical Center sponsors regional colorectal screening program.

Virginia Mason Medical Center in association with the American Cancer Society and KOMO-TV is sponsoring a free screening program to educate people about colorectal cancer.

Beginning Sept. 23, KOMO will air special nightly news reports discussing what colorectal cancer is, how it can be detected and how it is treated. According to Virginia Mason Clinic, an estimated 3 million people will have the opportunity to learn how to test for the symptoms of colorectal cancer. KOMO viewers will be given a phone number they can call to receive a Hemoccult II home test kit. Completed tests will be sent to Virginia Mason Hospital for processing. Individuals will be notified of the test results. In the case of a positive test result, individuals will be notified by letter, and a copy of the letter will be sent to the individual's personal physician.

AMA Patient Brochure helps build public awareness of professional liability

The AMA has recently published a patient information brochure on professional liability. Title of the pamphlet is "Doctor, Why Am I Hearing So Much About Professional Liability and Malpractice Today?"

The brochure was developed by the AMA Special Task Force in order to build public awareness of the effects the professional liability situation is having on the delivery of medical care.

"Public awareness of the effects of the professional liability situation on the delivery of medical care is essential if we are to tackle this critical problem," reports the AMA.

The brochure is available for purchase in packets of 100 through the AMA's order department. Each packet is $10.00, with a 10% discount for members. Publication number is OP 193. To purchase the brochure, write to:

American Medical Association
P.O. Box 10946
Chicago, IL 60610

Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 572-3666.

Physicians' public image declining

Physicians image continues to decline in socioeconomic areas, especially fees and income, according to a report of the Council on Long Range Planning and Development that was filed by the AMA House of Delegates.

Based on telephone interviews with 1,000 physicians and 1,500 randomly selected adults, the report said that in 1984, 67 percent of the public said that "most doctors are too interested in making money." This is an increase by 7 points since 1982.

Only 27 percent of the public believed that physicians' fees were reasonable, a drop from 42 percent in 1982.

In addition, the percentage of the public that agreed physicians took a genuine interest in their patients has declined from 68 percent in 1982 to 62 percent in 1984. As compared with 55 percent in 1982, only 44 percent of the respondents in 1984 agreed that physicians usually explained things well to their patients.

The public's views toward physicians' scientific knowledge remain strongly positive, however. 71 percent of the public respondents said they agreed with the statement that physicians usually were up to date on the latest advances in medicine. The public respondents' image of their personal physicians was sharply better than their image of physicians as a group. For example, only 32 percent of the 1983 respondents indicated that physicians' fees in general were reasonable, while 71 percent expressed the view that their personal physician's fees were reasonable. The data was collected by AMA Survey and Opinion Research, Larry J. Freshnock, PhD, director.

From AM News Report, June 25, 1985.

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In Memoriam

Dr. Sacide Morain died Friday, June 28, 1985. The following Memoriam in honor of Dr. Morian was written by Dr. Myra Vozenilek.

Sacide Morain was born in Istanbul, Turkey in 1927. She was a graduate of the American School for Girls, Uskudar, Turkey. In 1951 she received her medical degree from the University of Istanbul Medical School. She came to the United States in the fall of 1951.

After interning at D.C. General Hospital, she spent three years in internal medicine residency at George Washington University. Sacide then went to Glendale Hospital, a TB sanitarium in Maryland.

In 1957, she returned to Istanbul and started practicing. Gene Morain was stationed in Turkey with the United States Air Force. They met in the home of a mutual friend, married in 1959 and came to McChord Air Force Base in 1960. Gene was being discharged from the service and Sacide "interned" at St. Joseph hospital while preparing for the State Boards. They liked Tacoma, and in the fall of 1969 Sacide opened an office at the Lakewood Professional Village.

We both trained in Washington D.C., and got to know each other. A strong friendship developed over the next 20 years.

Sacide was a very serious person. Medicine was her main interest and hobby. This did not change even after she had to retire in the spring of 1982 because of illness.

Her other big love was Czech crystal. Many of the pieces in the Morain's collection are priceless. She took up cooking very seriously when she retired and when feeling well, liked to entertain her friends.

We will all miss her.

Cost efficiency- In or out of our hot little bylaws?

By Stanley W. Tuell, MD

The following Editorial by Dr. Stanley W. Tuell is the second in a series of Editorials published in the Bulletin by members of the Editorial Committee.

The Editor

Remembering that the word itself means getting a job done right—like rendering high quality medical care—at the lowest feasible cost, cost-efficiency is something that everybody from Iacocca to Dr. Spock has to be for. To be against it means you're in favor of waste.

So what's the problem?

Some doctors, though probably in favor of cost-efficiency, rise up in protest when we talk of telling each other, through our medical staff bylaws, that we should enforce the practice of cost-efficient medical care. "They're taking away our rights!" they cry.

The fact is, our "right" to spend health dollars without any limits has already been taken away. Haven't they heard of PRO's, DRG's, Utilization Committees, etc? If we don't write in some of our own rules about controlling the costs of the way some doctors practice medicine, rest assured that government, big business, and the consumer groups will move in and make the rules for us!

If ten doctors see that one doctor is wasting those dollars, should they work as a profession to try to control that waste? Or should they wait until the outsiders move in to do it in a more strict and less rational way.

Health dollars are limited. Consider this: For every dollar that a doctor wastes, there is one dollar less to spend on clinically essential quality care. Or even—one dollar less to pay a fee for a specific doctor's service. And when the doctor's fees are cut, partly because the profession refuses to impose cost-efficiency measures on each other, know what'll happen? The same doctors who didn't want us to put cost-efficiency into our bylaws will be standing up and shouting louder than ever:

"They're taking away our rights!"

Keep quality care in! Keep waste out!

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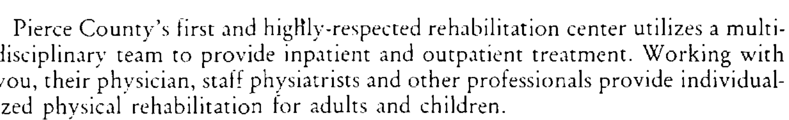

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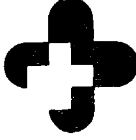

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WSMA Members Benefit From New Contract Evaluation Service

In July, the state medical association announced a free contract evaluation service for WSMA members. The new service is in response to physicians' need to make informed choices before entering into contractural agreements with alternate delivery systems.

Such a service was first proposed in a resolution submitted to the 1984 House of Delegates meeting by former Medical Society of Pierce County president Dr. James P. Duffy.

In a recent interview with WSMA Director of Economic Affairs, Ralph Mero, The Bulletin asked for details about this new service.

The Editor

The Bulletin: What will the contract evaluation service do for members?

Mero: The service wil analyze contracts submitted to the WSMA in regard to the quality of care, referral patterns, utilization review, billing procedures, professional liability, agreement termination, and reimbursement levels and procedures.

The Bulletin: Will the evaluation tell the physician whether or not to sign the contract?

Mero: Not directly. We intend to be very careful about legal aspects of antitrust and restraint of trade. The report back to the physician will be an objective written analysis that will spell out potential causes of concern so the physician can make an informed decision.

The Bulletin: Why is the service being offered now?

Mero: The number of alternate delivery systems (ADS's) continues to grow rapidly. Over 30 such organizations—HMO's and PPO's, primarily—are now or soon will be operational in Washington. More and more physicians are receiving contracts and are facing decisions that have great implications for their future practice.

The Bulletin: Who will review the contract?

Mero: Attorneys experienced in this type of contract evaluation. They are members of the legal staff of the California Medical Association. This arrangement was felt to be a real plus, given their particular expertise.

The Bulletin: How long does the review take?

Mero: We estimate 10 working days from our receipt of the contract.

The Bulletin: Is there a charge?

Mero: The service will be paid for by the WSMA and is free to WSMA members as another benefit supported by their dues. Nonmember physicians can submit contracts for evaluation, but for them the charge is $150.

The Bulletin: Where should the contract be sent for review?

Mero: To Contract Evaluation Service, WSMA, 2033 Sixth Avenue, #900, Seattle, WA 98121.

The Bulletin: Any recommendations on what a physician should do before seeking to have a contract evaluated?

Mero: First of all, read it thoroughly. Try to have the other party clarify any points you don't understand. Make sure you are capable of performing all that will be required by the contract, as any contract creates a legal obligation by both parties.

The Bulletin: Is there much room for negotiation?

Mero: Usually the original contract can be viewed as a draft or offer to negotiate the terms of an agreement. You should take the position that all provisions, not just price, are open to negotiation.

Remember, any contract that is entered into with a third party should be consistent with both the short-term and long-term goals of the physician and/or physician group. Further development of the practice can be seriously derailed if a contract is signed which runs counter to the goals of the practice.

Remember, also, that any other expressions—written or oral—that are made prior to, concurrent with, or subsequent to the signing of a written agreement are inadmissable in a court of law. The physician must make sure that when the contract is signed that it includes all issues which have been discussed and agreed to.

The Bulletin: Are there other things to weigh besides the specifics of the contract?

Mero: Beyond the contract there are three critical elements to take into account when you are deciding whether or not to sign on with an HMO or PPO. They are:

- The nature and integrity of the organization.
- Your individual career situation.
- The position and health of your medical practice in a changing medical economic market.

The Bulletin: What if the physician has follow-up questions?

Mero: We'll try to help, either by following up ourselves, or by referring the physician to competent legal counsel.

The WSMA is excited about this new service. It is another instance of our services being tied directly to the economic survival of our members.

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

GENERAL MEMBERSHIP MEETING

TUESDAY, SEPTEMBER 10, 1985

"WSMA & THE ISSUES"

★ Contracting ★ Professional Liability
★ Uncompensated Care ★ Public Image

John M. Kennelly, M.D.
President, Washington State Medical Association

DATE:	Tuesday, September 10, 1985
TIME:	No host cocktails 6:15 P.M. Dinner 7:15 P.M. Program 8:00 P.M.
PLACE:	Doric Tacoma Motor Hotel 242 St. Helens Avenue
COST:	Dinner, $15.00 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County,** in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Due to the special arrangements necessary for this joint meeting, reservations must be made no later than Friday, September 6.

REGISTRATION:

Yes, I (we) have set aside the evening of September 10 to join my fellow Society members.

__ Please reserve ___________ dinner(s) at $15.00 per person (tax and gratuity included). Enclosed is my check for $_______________.

__ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr: ______________________________

RETURN TO MSPC BY NO LATER THAN FRIDAY, SEPTEMBER 6.

Washington Physicians' Union

Commentary by Nichol T. Iverson, MD

Are you as happy about your practice of medicine as you were ten years ago? Do you envision a better climate for your practice ten years from now? My asnwer to these questions is a resounding NO. As a result of an article by Sanford Marcus, M.D. "Trade Unionism for Doctors—An Idea Whose Time Has Come" (NEJM, Dec. 6, 1984), a Washington State Federation of the Union of American Physicians and Dentists is here to stay. This article by Dr. Marcus describes the current scenario in which we live and is must reading for all physicians who are unwilling to be pawns of the government, giant medical corporations or third party medical carriers.

Ironically under a "conservative" administration, a group of Americans has been told what they can charge for their services, is subject to fines, and is being coerced into making medical and ethical decisions based on government regulations. This "group" does not operate bulldozers for a living, but is subject to an increasing responsibility to provide more service and technology for less money, and continues to be held more liable for its decisions than at any time in history. The American Medical Association was impotent in convincing the courts that the Deficit Reduction Act of 1984 violated the rights of physicians and patients across the land. Do we now sit on our collective "derriere" and accept these unprecedented laws and decisions or collectively lift our pens and refuse to write? Our signatures or lack thereof, represent our most powerful weapon to help direct the painful changes that we must ultimately face.

The stakes in this game are gigantic. Three hundred fifty billion dollars—approximately eleven percent of the gross national product is up for grabs. Physicians "grab" about ten percent of this total, yet are blamed for the whole cost. On the other hand multi-billion dollar corporations such as Hospital Corporation of America and Humana have run amok and have swallowed up community hospitals like hors d'oeurves. As these giants gain a large enough share of the market, they will be determining procedures, hospital staffing and will ultimately employ physicians. Although employment may seem like an anathema to many, the greater concern would be the lack of representation of the physicians and their patients, especially with regard to quality of care, ethical and moral issues, and utilization.

Another player in this game is the third party carrier. In Massachusetts a near monopoly exists with third party carriers, and physicians have been given "take it or leave it" contracts. Locally we see a barrage of PPO's, IPA's, HMO's, and other confusing ventures which are loaded with strange legal language, and all these programs raise doctors' anxiety levels, and usually physicians sign into these programs without proper legal advice. Several of the local insurance programs have been reviewed by the attorneys at the UAPD office in Oakland, and have all contained wording that may not be in the best interests of doctors and patients. (Who wrote the contracts?)

The Union of American Physicians and Dentists is not a panacea, but can provide us with some needed clout, legal advice at a bargain price—dues—and provide the collective strength to help shape the future of medicine. Unlike the medical societies, the union is protected by laws that allow for collective bargaining, and provides for proper and legal channels that will return some bargaining power to physicians. The AMA has been called a "union" by many, but cannot legally call for collective action without violating antitrust laws. Times always change, but without balanced input from physicians we may be very unhappy with our new lot in life.

Those interested in more information and especially application forms can contact me at the Puyallup Clinic, 800 South Meridian, Puyallup, 98371, or call 845-6645. Dues are $360 per year with a $25 initiation fee. Later this year Dr. Marcus will be addressing a meeting to help publicize our state federation, and to answer any questions that you may bring. This meeting will be well publicized to encourage as many physicians as possible to listen to what our union has to offer. The union also encourages all physicians to join their local and national medical societies—there is no conflict of interest between the union and the medical societies—each has its place. Remember, together we stand, divided we fall, and medicine is no different from any other service in America—you get what you pay for!

Nichol T. Iverson, MD is temporary president of the organizing committee of the Washington State Federation of the Union of American Physicians and Dentists.

AUXILIARY NEWS

First Fall Meeting, Sept. 27.

The first fall meeting of the year for the Medical Auxiliary is coming up Sept. 27 from 10:00 A.M. to Noon. The meeting will be held at St. Mary's Episcopal Church, 10630 Gravelly Lake Dr., SW., Tacoma. Topic of the meeting will be "Downtown Tacoma." A slide presentation will be given by Nancy Mendoza from Cornerstone Corporation.

Featured speakers will be Ginny Miller, president of PCMSA and Past President Sharon Lawson discussing "What Lies Ahead for Us."

We hope to welcome many familiar faces as well as new ones. This meeting is not reserved for new members, but for anyone who is curious enough to want to find out about us! Check us out. Program Chairperson Marie Griffith has arranged some interesting programs for us, from an outing to the Tacoma Art Museum—to a discussion on "Children, our most valuable resource."

We have collected specific information about the Tacoma area and put it in an Auxiliary Tote Bag. Each new member will receive one of these handsome creations at the coffee.

Karen Craven, Margaret Smith and Phyllis Pierce will contact new members in their area of the city, introducing them to neighborhood auxiliary members who in turn will help them get acquainted with Tacoma, We need all the help we can get—let's make it smooth sailing for our new medical friends!

Karen Craven
Newcomer Chairman

Philanthropic Funds Available

Don't forget, if you belong to a service or health oriented organization that would like to be considered by the Pierce County Medical Society Auxiliary as a recipient of their philanthropic funds, contact Marlene Arthur. She is the philanthropic chairperson for our auxiliary and has applications available. Her phone number is 845-5542. Deadline for accepting applications is Sept. 15.

Changing Role of Fathers: Topic of Fatherhood Forum, Sept. 21.

The Fatherhood Forum will be held Sept. 21 from 9:00 A.M. to 4:30 P.M. at Wilson High School, 1202 Orchard, Tacoma. Keynote speaker will be Dr. Michael Lamb who will speak on "The Changing Roles of Fathers." Dr. Lamb's talk precedes 30 workshops on issues such as "Changing Sexuality After the Birth of a Baby," "How to Use Sports to Communicate with Your Kids," "Your Family of Origin," along with a panel of men talking on the dilemma of career and family. There will be additional workshops, exhibits and much more.

The Forum is sponsored by Family: Birth to Three Parent Support Program and Good Samaritan Mental Health Center.

Volunteers are needed for the following committees to help with the Forum, **publicity, program planning, exhibits, hospitality, registration, set up** and **clean up.**

Cost for the Forum is $15 for individuals, $25 for couples.

For information contact:

Judy Best, Coordinator
Family: Birth to Three
Parent Support Program
FC3208
3629 South D Street
Tacoma, WA 98408-6897
(206) 591-6526.

Auxiliary News continued on page 14.

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Maggie Gray 584-6857
Judy Thompson 565-5192
Dena Hollowwa 584-1615

PCMSA Standing Committees.

YWCA — Support Shelter and Hospital Advocacy . . . . *Janet Fry*
FINANCE . . . . *Marlene Arthur*
PUBLIC RELATIONS . . . . *Ella Turner*
MERCHANDIZING . . . . *Carol Hazelrigg*
STUDENT RECOGNITION . . . . *Bev Graham*
LEGISLATION . . . . *JoAnn Johnson*
LONG RANGE PLANNING . . . . *Jo Roller*
MAILING . . . . *Pam Drouillard*
NEWCOMERS & BIG SISTER . . . . *Karen Craven*
Margaret Smith
TELEPHONE & RESERVATIONS . . . . *Rubye Ward*
Barbara Platz; Carol Lovy

NOMINATING . . . . *Sharon Lawson (Past President)*
SUPPORT . . . . *Ruthie Meier*
VOLUNTEER RESOURCES . . . . *Bev Law*
SPECIAL EVENTS . . . . *Nikki Crowley, (Chairman)*
AMA-ERF Holiday Card . . . . *Sharron Gilbert*
Card Design Contest . . . . *Carolyn Modarelli*
Children's Holiday Party . . . . *Anne Fulcher & Marilyn Bodily*
Holiday Dinner with MSPC . . . . *Nikki Crowley*
Fund Raiser . . . . *Debbie McAlexander*
Joan Sullivan
Mabelle Miller

Special Interest Groups making plans.

There are some exciting ideas and plans for this year's auxiliary members! The following special activities are being organized for our group. We hope that one or all of the following will appeal to you.

If you have any questions call the chairman of the group you are interested in or Ginny Miller (759-3343).

Special Interest	Chairman	Phone No.
Gilman Village (Nov.)	Dorothy Grenley	584-4421
Gourmet Group	Mary Schaeferle	627-2716
Doll House (Possible fund raiser?)	To be announced	
The P.S. Group (personal-sharing)	Marilyn Bodily	565-7224
Photography	Karen Benveniste	565-3211
Interior Design - Trip to Design Center	Nikki Buchanan	564-7686
Grape Vine Wreaths	To be announced	
The Fine Art of India Cooking	Jeena Singh	627-5844
Book Club	Carolyn Brand	564-1206
Updating an old Wardrobe (April)	Nordstroms at Nordstroms (Marie Griffith)	599-9371

*Finances and Investing

*If there is enough interest in this group, a group will be developed.

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St. Joseph

Dr. James Billingsley appointed Vice President

Dr. James G. Billingsley has been appointed vice president for Medical Affairs at St. Joseph Hospital and Health Care Center of Tacoma, according to hospital President, Daniel F. Russell.

In announcing the appointment, hospital President Daniel Russell cited an increasing responsibility to support physicians in the expanding specialty and general practice requirements at St. Joseph as well as administering a more complex credentialling procedure. St. Joseph Hospital has 667 physicians on its medical staff.

"With more and more physicians joining our hospital medical staff," said Russell, "it has become increasingly necessary to provide greater support to our doctors through the Office of Medical Affairs."

Todays St. Joseph Hospital has more medical specialty services in need of coordination and direction and Dr. Billingsley will be providing that guidance as well," said Russell.

Dr. Billingsley has served since 1970 in a part time role as medical director. A longtime medical specialist in pulmonary disorders, he will continue his active medical practice.

"I am pleased," said Russell, "that Dr. Billingsley has been able to adjust his work load to be able to give St. Joseph more of his time and talent."

"As an active practitioner, I feel I am better prepared to work with the medical staff members and committees, if I am subject to the same pressures and restrictions confronting them in their medical practices on a daily basis," said Dr. Billingsley.

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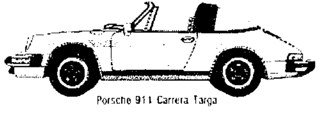
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Tacoma, Washington 98409
474-0651

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

ALFRED CHAN, MD, *Hematology-Oncology.* Born in Kwangtung, China 8/21/48; medical school, National Defense Medical Center, 1972; internship, Ohio Valley Medical Center, 1/74-12/74; residency, University of Conn. Medical School and Health Center, 1/75-6/76; New Hanover Memorial Hospital, 1/77-12/78; graduate training, UNC School of Medicine, North Carolina Memorial Hospital, 1/78-6/78; Madigan Army Medical Center, 3/81-6/84. Washington State License, 1982.

Don E. Gehle, MD, *Dermatology.* Born in Paxton, Illinois 3/25/38; medical school, University of Illinois College of Medicine, 1964; internship, Rockford Memorial Hospital, 7/64-6/65; residency, Madigan Army Medical Center, Internal Medicine, 7/68-6/69; Walter Reed Army Medical Center, Dermatology, 7/71-6/74. Washington State License, 1970. Dr. Gehle is currently practicing at 5900 - 100th Street SW #32, Tacoma, Washington.

Philip A. Vance, MD, *Family Practice.* Born in Kansas City, Missouri 4/4/54; medical school, University of Missouri, 1980; internship, St. Michael Hospital Family Care Center, 7/80-6/81; residency, St. Michael Hospital Family Care Center, 7/81-6/83. Washington State License, 1985. Dr. Vance is currently practicing at 3611 South D Street, Tacoma, Washington.

Frank S. Virant, MD, *Allergy/Immunology.* Born in Tacoma, Washington 1/5/54; medical school, St. Louis University, 1980; internship, University of Washington, pediatrics, 7/80-6/81; residency, University of Washington, pediatrics, 7/81-6/83; graduate training, allergy/immunology, 7/83-6/85. Washington State License, 1981. Dr. Virant is currently practicing at B6010 Allenmore Medical Center, Tacoma, Washington.

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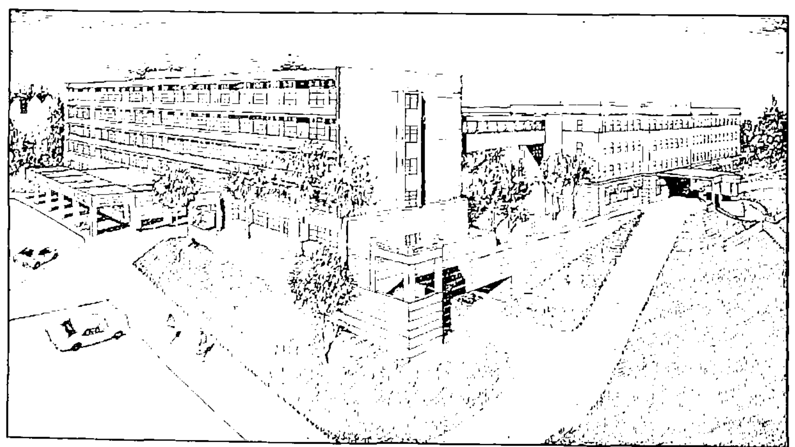

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MONEY MANAGEMENT FOR PHYSICIANS
Presented by Medical Society
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– September 24, October 1
7:00 A.M. to 9:00 A.M. — Jackson Hall

Presented by the Medical Society of Pierce County Accountants–Simonson Moore & Olson–This generic approach to money management will cover the practical aspects of financial planning including how to gain control of your finances, maximizing profits, planning for investments and tax deductions and aggressive tax strategies.

CARDIOPULMONARY RESUSCITATION
AN UPDATE FOR PHYSICIANS

September 24, October 30, November 27
7:00 A.M. to 8:00 A.M. — Jackson Hall

PRACTICAL SOLUTIONS TO COMMON OFFICE PROBLEMS AND PROCEDURES
Coordinators: James Foss, M.D.
Gordon Klatt, M.D.
Committee for Continuing Medical Education
Medical Society of Pierce County

October 24, 24 Wednesdays–all day
St. Joseph Hospital–Education Center

For family practice and general internists as well as interested physician assistants and nurse practitioners. This two-day program will include practical applicable solutions to common office problems and procedures in the following topics: Vertigo; Allergy; ENT Exam; Choosing Cardiovascular Drugs; Exercise Prescriptions for Adults; Upper Extremity Nerve Entrapment; Steroids & Non-steroidal Anti-Inflammatory Drugs; Injection/Aspiration of Joints; Skin Infections; Uncommon Presentations of Common Skin Problems; Dermatologic Procedures; Peptic Ulcer Disease; Diarrhea; Abnormal Liver Function Tests; Office Laboratory; Flexible Sigmoidoscopy; Bedside Use of Doppler; Vasectomy; GYN Office Procedures; Interaction with Lawyers; Computers in Office Practice.

LAW & MEDICINE SYMPOSIUM
Coordinator: Marcel Malden, M.D.
Medical–Legal Committee
Medical Society of Pierce County

January 16–All Day
St. Joseph Hospital–Education Center

This one-day course will provide information about the financial aspects of medical billing; medical records; medical malpractice; when no-code orders can be issued and a forum of court room practices and procedures loaded with practical information.

Preregistration is required for all above courses

FOR FURTHER INFORMATION OR REGISTRATION
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CONTINUING EDUCATION PROGRAMS SCHEDULED FOR 1985—86
P = Physician Course / A = Allied Health Course

	Date	Program	Instructor	Type
	SEPTEMBER			
		WSMA Annual Meeting		
JH	24, Oct. 1	★MONEY MANAGEMENT	JACKMAN	(P)
JH	25	★CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
STJ	26	TELEPHONE ASSESSMENT	SIMMS	(A)
STJ	30	GERIATRIC PATIENT—NURSING ASSESSMENT	BARTON	(A)
	OCTOBER			
JH	2, 9, 16, 23, 30	Tac Gen Clinical Conf-ELECTROCARDIOGRAPHY	NAGLE	(P)
JH	3, 10, 17, 24	POTPOURRI	AH COMMITTEE	(A)
STj	5	RIGHT BRAIN/LEFT BRAIN	McDONALD	(A)
STJ	21	DISCIPLINE & INSPIRING PRODUCTIVITY	SOLUM	(A)
STJ	23, 24	★COMMON OFFICE PROBLEMS/PROCEDURES	KLATT/FOSS	(P)
STAN	25, 26, 27	SURVIVAL SKILLS FOR NURSES (Retreat)	DEAN	(A)
JH	30	★CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
	NOVEMBER			
JH	1	3rd ANNUAL CANCER EDUCATION	KATTERHAGEN	(P/A)
JH	5	UPDATE-MED. OFF. PERSONNEL-INFECTION CONTROL	DUANE	(A)
JH	6, 13, 20, 27	Tac Gen Clinical Conf-INTENSIVE CARE	WELED	(P)
JH	7, 8	ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P/A)
JH	7, 14, 21	CARING FOR THE CANCER PATIENT	BOULET	(A)
STJ	8	★PRAC. SOLUTIONS TO GERIATRIC PROBLEMS	CLARK/LINCOLN	(P)
STJ	20	ETHICAL DILEMMAS	McCORMICK	(P/A)
JH	27	CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
STJ	TBA	AMBULATORY SURGERY	CHILTON	(A)
	DECEMBER			
STJ	5, 6	★ADVANCED CARDIAC LIFE SUPPORT	CRAD-DOCK/DUNN	(P/A)
	JANUARY			
STJ	14	ETHICAL DILEMMAS ASSOCIATED	McMORMICK	(P/A)
STJ	16	★LAW & MEDICINE SYMPOSIUM	MALDEN	(P)
JH	22, 23	CHRONIC PAIN & DEPRESSION	LURIA	(P)

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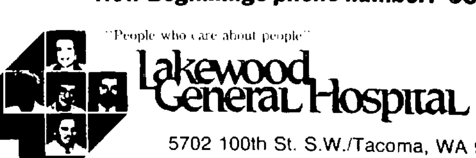

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These reports bring you information on what the AMA is doing, on behalf of the profession and the public, to influence decisions that will affect health care in the next decade and beyond.

The Cost Crisis in Health Care

The headlines are everywhere: "Congress Seeks to Cut Cost of Health Care," "Health Care Costs on the Rise for Most Americans," and so forth. It's gotten to the point that physicians may have to go back to school for accounting degrees in order to keep up with the changing economic realities of medicine.

Indeed, physicians have become quite aware that the cost of health care is more important than ever. In fact, a recent American Medical Association survey indicated that physicians see the cost of health care as the number one problem facing medicine. There is no question that physicians are interested in seeking a solution to the cost crisis, though not at the expense of their duty to their patients—a duty based on providing high quality care with access to all.

Nowhere is cost more of an issue than in Washington, D.C. Congress, the executive branch, and federal regulatory agencies are besieged daily by a combination of forces, all with their own agendas for "controlling the spiraling cost" of medical care. Unfortunately, there is not the same level of concern about the *quality* of health care in this country.

In recent years, hundreds of bills and regulations have been drafted in the name of health care cost containment. In the face of such mounting pressures, the government responded by getting more and more involved in legislating reimbursement methods, payment levels and even access to care.

American health care arrived at this point as a result of a government-backed societal push toward increased quality and access to care. The 50's, 60's, and early 70's, then, were a period of rapid economic expansion in medicine. The goal? Assurance that every American, regardless of race, creed or economic status, be guaranteed quality health care regardless of the cost.

Was the spending worth it? Did the nation meet its medical objectives? The brief summation of accomplishments below indicates a resounding yes:

- Americans' life expectancy has risen from 69.7 years in 1960 to 74.5 years in 1982;
- Infant mortality has been reduced to a record low of 11.2 per 1,000 live births, less than half the figure in 1960;
- Modern vaccines have been responsible for virtually eradicating polio, mumps and measles;
- Due to technological advances such as open-heart surgery, pacemakers and new drugs, deaths from heart disease dropped by 25%, and from stroke by 40%.

Clearly, health care American-style is unparalleled elsewhere in the world. Also obvious is the fact that these new procedures and technologies have placed a heavy economic burden on the public and private sectors.

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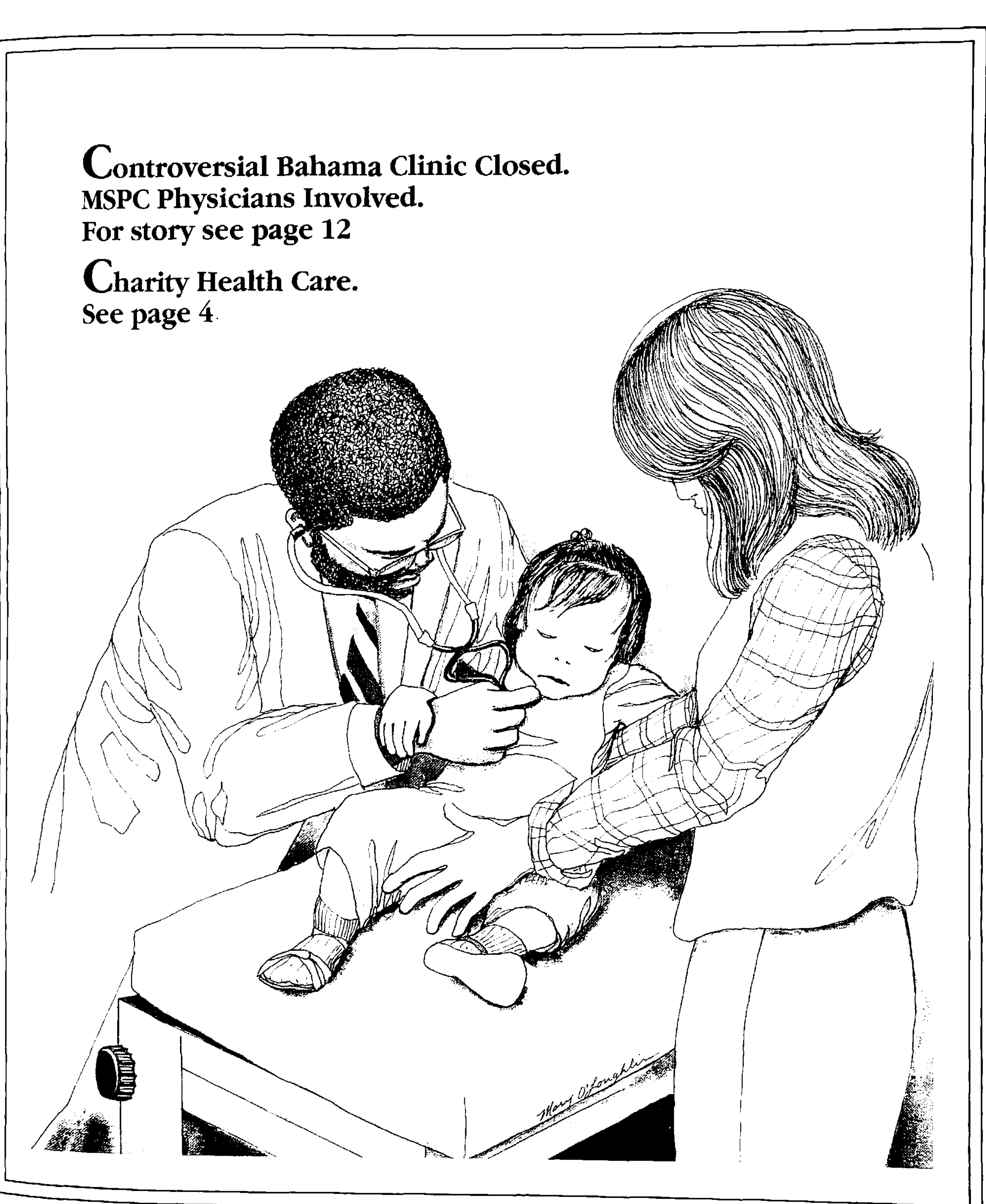
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

October, 1985

Controversial Bahama Clinic Closed.
MSPC Physicians Involved.
For story see page 12

Charity Health Care.
See page 4



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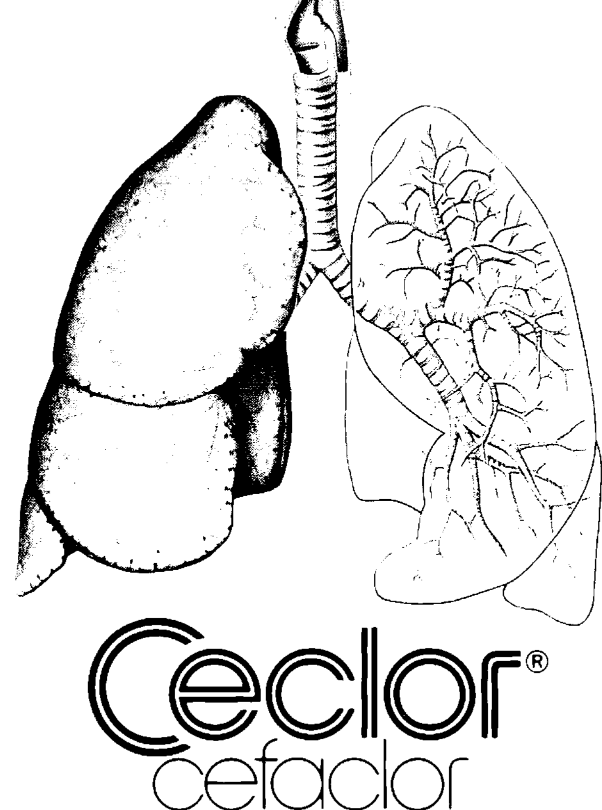

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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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The Bulletin *The official publication of the Medical Society of Pierce County*

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Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

Several months ago after having been at the conference on "Charity Care" organized by St. Joseph Hospital, I wrote I would let you know some of the conclusions reached by the small discussion groups. As they became available just before I went on vacation to my favorite place, I frankly did not look at them until the evening before this page was due, and accordingly, lucky for you, I will not editorialize.

The "Charity Care" issue was looked at from three different points of view:

I. The Providers' Perspective.
II. The Purchasers' Perspective.
III. The Consumers' Perspective.

Major issues from the Providers' point of view were:

1. Where does the responsibility lie for producing and administering a program to provide charity care? With the private sector, including institutions and physicians, or with the government: federal and state.
2. How does one go about collecting and monitoring data, as there will be a tremendous need for good utilization data, data to define charity care needs and data to determine if charity care has been provided.
3. Issues involving competitive bidding based on capitation as a means for providing Charity Care.

Responses to the above ranged from, a national health plan, to the Washington Basic Health plan, voluntary programs, spreading costs among all third party payers to requiring all providers to give charity care in order to get paying patients.

Viewing the problems from the Purchasers Perspective, they asked:

1. Who is to take the responsibility; corporate leadership or the government?
2. Should not charity care be shared equally by society as a whole instead of being seen as corporate responsibility.
3. There are difficulties in financing charity care programs due to the reluctance to allocate general revenues creating tax increases (society will have to be convinced.)

Responses to these issues by the discussants ranged from the state assuming financial obligations, or as stated before, society as a whole will have to recognize its responsibility.

To make the latter come true, the public will have to be made aware of the fact that those truly in need of *uncompensated care* are not "dead beats or welfare cheats."

Major obstacles to the above in Pierce County centered, in the opinion of the conferees, on a number of problems. To name a few: lack of public education, nobody wants to increase their charity load, lack of leadership in the business and health care communities related to provision of charity care.

Finally, "Charity Care" from the Consumers Perspective. Some of the major issues were perceived to be:

1. The lack of education of the consumer.
2. How can basic health care be made accessible.
3. Understanding the characteristic of those in need of uncompensated care.
4. Lack in integration and provision of continuity among existing resources.

Responses from the consumers' perspective were: education of the consumer, regarding himself as well as to the availability of existing resources, and health services for continuity of care.

Major obstacles to the responses in Pierce County were felt to be: lack of networking and lack of consumer care advocacy. Some consumers do not have any incentive whatever system is constructed.

As you can understand the above is just a cursory summary of the conclusions gathered by Esther Dillie, MA, Coordinator of Mission and Ministry, St. Joseph Hospital.

The immediate question now is what to do with the available information, and accordingly a discussion/strategy meeting has been planned for October 9th at St. Joseph Hospital.

It will be interesting to see if adequate momentum can be maintained to indeed improve the uncompensated care of those who really need it and who are unfortuate enough not to have the ability to find it.

— *GWCB*

MSPC Retired Physicians hold their first meeting.

Over 30 retired MSPC members turned out for their first meeting, May 22, to hear Dr. Kenneth Sturdevant relate his experiences while serving as a missionary in Africa.

The second luncheon meeting is scheduled for November 13, at the Tacoma Dome Hotel.

If you're considering retirement within the next two to three years, plan to attend. An informational session on the do's and dont's of retirement will be part of the agenda for the meeting. Take the opportunity to learn from someone who has actually experienced retirement, its pros and cons.

More information on the meeting will be published in the November *Bulletin*.

Second Printing of Physicians Cost Containment Checklist now available.

This booklet, describing practical ways physicians can reduce costs, is packaged in units of 10 copies. The cost is $5.00 a unit. AMA members receive a 10 percent discount.

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Washington State Legislature passes Clean Indoor Air Act.

The Washington State Legislature enacted the Clean Indoor Air Act prohibiting smoking in public places, July 28. By definition, public places "includes, but is not limited to any portion of a building or vehicle used by and open to the public." Smoking is permitted only in a designated smoking area.

Hallways of health care facilities may not be designated as smoking areas, the exception being nursing homes. A health care facility cannot be designated as a smoking area in its entirety.

For a copy of the new State law or more information, call the Medical Society Office.

Administrative activities consume an average of 2.4 hours of a physicians week, according to a survey conducted by the Socioeconomic Monitoring System of the AMA Center for Health Policy Research.

American Lung Association of Washington holds seminar: Dangers of Marijuana Smoking.

The American Lung Association of Washington will hold a free seminar on the dangers of marijuana smoking to the lungs, Oct. 11 from 8:00 A.M. to 3:30 P.M. The seminar is open to nurses, teachers, youth leaders and parents.

For information or to register, call the Lung Association, Tacoma 474-9547.

A Hot Little Correction

So what are "hot little bylaws?" I wondered that myself when I saw that phrase in the title of my editorial in last month's *Bulletin*. It was **not** a frivolous attempt at humor. The intended phrase was "hospital bylaws," but the word "hospital" turned into "hot little" in the tranmission through a telephone line to a secretary and to the printer.

I was lucky though. I had considered writing a piece on how much I appreciate our nurses. If that had been titled "Dr. Tuell appreciates our hospital nurses," and if the same secretary and printer had worked on the word "hospital"—I would have been kicked off the editorial committee!

Stanley W. Tuell, M.D.

MSPC member, Hugo Van Dooren re-elected to the American Psychiatric Association Board of Trustees.

MSPC member Hugo Van Dooren, chairman of the psychiatric service, Puget Sound Hospital, has been re-elected to the American Psychiatric Association Board of Trustees.

Dr. Van Dooren was first voted trustee of the Medical Specialty Society in 1982. The Society represents more than 30,000 psychiatrists nationwide. He served as the Washington State Psychiatric Association's deputy representative and representative to the AMA assembly of district branches from 1973 to 1979.

A clinical professor at the University of Washington and instructor at the Seattle Psychoanalytic Institute, he also has served as a member of the APA Committee on Confidentiality, Council on Psychiatric Psychiatry and Law and Council on Aging.

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Considering Retirement? Don't forget your patient records.

If you're planning on retirement, it is important to inform your patients concerning the disposition of your records: have they been transferred to another physician or are you retaining them.

Please inform the Medical Society office of the plans for your records, since it receives many calls from patients trying to locate their records.

Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 572-3666.

How many unproductive hours do you spend interviewing unqualified people?

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Pierce County Physicians get a sideline view of high school football games

For many years, Tacoma high schools (Bellarmine, Foss, Lincoln, Mount Tahoma, Stadium and Wilson) have been fortunate to have a dedicated core of local physicians monitor the health needs of their athletes.

These physicians have volunteered their services and have been on the sidelines at home football games of their respective schools and assisted coaches, trainers and athletes in areas of health care and injury prevention and treatment.

Ken Graham has been with the Wilson High School athletic program for 20 years; Stan Mueller and Jack Nagle have worked with Foss since its opening in 1976; George Race has assisted Stadium at least 10 years, as has Tom Miskovsky at Lincoln. Bob O'Connell served Bellarmine and Stadium some 30 years, but last year turned the job over to Hugh Larkin. Others who are equally involved but more recent in the program are Jeff Nacht and Richard Spaulding at Mount Tahoma, Walt Sobba at Lincoln, and Art Ozolin at Wilson.

These physicians enjoy their associations with the high schools and their coaches and athletes, but need assistance from other community physicians in maintaining this medical coverage. If several could share Friday nights at high school football games, it would lessen the time demands on any one physician, yet give the program proper medical coverage.

Interested physicians should contact the Medical Society of Pierce County. The job description is a brief one:

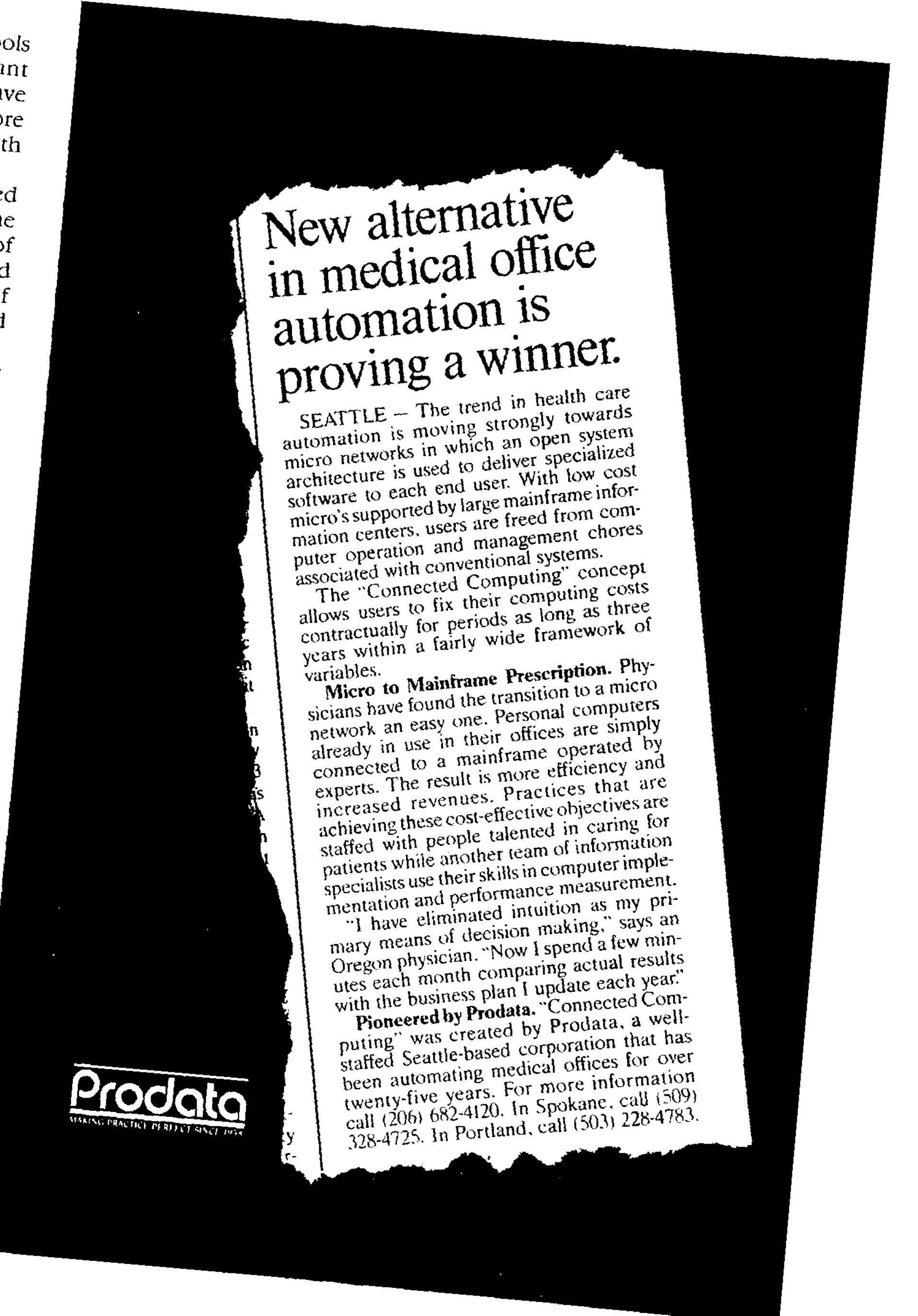
Attendance at a pre-season football practice to meet school athletic director, coaches, players and team trainer.

Attendance at high school varsity football games during course of season, September 13-November 5, with a possibility of state playoffs extending through December 7 (state finals) — can be shared with fellow physician. Games are generally scheduled on Friday nights at 7:30 p.m.

Act as a resource person for school athletic staff regarding athletic injury treatment and prevention.

Compensation offered are passes to all Narrows League high school athletic contests, sideline view of football games and an end of the season banquet with city coaches, trainers and athletic directors honoring the team doctors. An additional plus is the satisfaction of fulfilling a significant role in keeping our high school athletes as injury free and healthy as possible. ■

—Dan Inveen, Director of Athletics, Tacoma Public Schools



Practice Management.

By Mitchell C. Sollod, MD

Reprinted with permission from San Francisco Medicine, August, 1985

The Case for an Intercom

Time. Our most valuable commodity. Also patients judge us by the amount of time we spend with them. Each interruption in the visit diminishes the value of this time. When you want to consult another chart, need a piece of equipment or some medication, if you have to leave the room to get it, the patient feels short-changed. The solution is an intercom.

All intercoms have a central unit and stations. The central unit will typically be at the receptionist's desk. The stations will be in each exam room, the laboratory, or x-ray or cast room, and your office. Do not put an intercom in the reception area. Your staff should personally respond to the knock or doorbell there and personally usher your patient into the examination or treatment room. An intercom in the reception area provides a cold atmosphere.

You should buy an intercom with the hands-off response feature. When a telephone call is announced and your hands are in a patient's nether region, you can say, "I'll call back as soon as Mr. Jones is finished," without leaving Mr. Jones. Similarly in the cast room, x-ray or lab the no-hands-needed feature is necessary lest your staff become welded to the intercom by plaster or chemicals.

You buy either a separate intercom or one included in a telephone system. If you buy the phone with intercom each station must have a full telephone. This means your patients could use the telephone while you aren't there (although some systems have a lock-out feature). Additionally you'll be tempted to take calls in the room with Ms. Patient present. I think that annoys people. Finally, each full telephone costs more than a separate intercom station. You can plainly see why I favor separate systems rather than a combined phone and intercom.

The separate intercom plus phone system will cost more but you can install only the intercom units and change your phones much later if you need to change. You'll need fewer phones, too. Allowing 10¢ per trip for staff, 20¢ per trip for nurses, and $2.50 per trip (1 minute of active office time) for the physicians, I figured our intercom would pay for itself in 3 years. I was wrong. It paid off in 6 months on a dollar basis. It paid off instantly in more time with each patient, less hall traffic, and less scurrying about and tension.

Intercoms are a real winner. Every office and patient will benefit. ■

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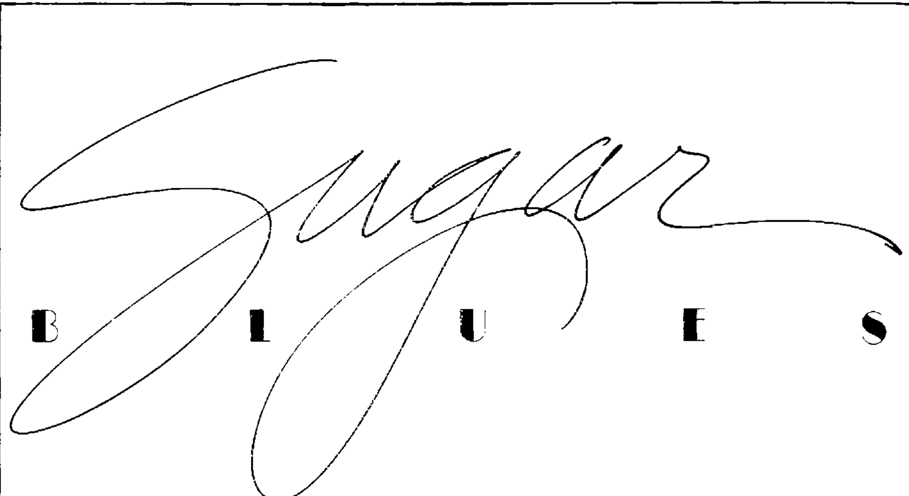

THE 10TH ANNIVERSARY CELEBRATION OF THE ST. JOSEPH HOSPITAL BALL

Music by the J. Barrett Band

Sheraton Tacoma Hotel Pavilion

Saturday, November 2, 1985
6:30 P.M. - 1:00 A.M.

Casino in the Rotunda

Proceeds to benefit the St. Joseph Diabetes Program

MSPC Committee for Continuing Medical Education winds up an outstanding year!

Special Report by David M. Brown, MD, Committee Chairman

The Committee for Continuing Medical Education of the Medical Society of Pierce County just finished its most successful year both in terms of total number of physicians attending our courses (1165) and in terms of total dollars generated for the College of Medical Education by those courses and generous individual donations by members.

The College sponsored eight courses for the Committee for Continuing Medical Education plus an additional three courses which were contracted by the Tacoma Surgical Club, the Tacoma Academy of Internal Medicine & Multicare Medical Care Center/Cardiac Study Study. The quality of the courses was uniformly excellent, judging both from the completed course evaluations and from my own experience of attending half the courses. I am going to briefly review last year's courses, while previewing the upcoming year at the same time.

The most popular course of the year for physicians was Dr. Jim Foss's "Practical Solutions to Common Office Problems." This 2-day course, attended by 88 physicians, offered expertise on a wide variety of problems which the office-based primary care physician faces daily. The topics were presented by local physicians and were extremely practical and interesting. The presentations were short and to the point, a fast paced, lively course from start to finish. The handout materials were abundant and a valuable addition to the learning experience.

Many of the participants expressed a wish for the course to be repeated this year. Drs. Foss and Klatt are enthusiastically coordinating the offering as the first program this Fall and have developed a completely new set of topics including office procedures as well. Scheduled for Wednesday and Thursday, October 23 and 24, the course will follow last year's format. Registration options are for the complete course or one to four half-days.

In November of 1984, Dr. David Munoz presented "The Geriatric Dilemma" course, which had an epidemiological and philosophical orientation. Forty-two physicians, nurses and health care specialists attended this course which included many excellent presentations. We are again offering a Geriatrics Conference in November coordinated by Drs. John Lincoln and Thomas Clark, who have put together a practical, clinical course. The presentors will include local, Seattle and University of Washington physicians. The date of this program is Friday, November 8.

On December 5 & 6, our semi-annual Advanced Cardiac Life Support Certification/Recertification course is again being offered. Last year it drew 73 participants, filling beyond capacity. This year Drs. Mark Craddock and David Munoz are coordinating the course.

In January of 1985 we presented "Otolaryngology for the Primary Care Physician" and the "Law and Medicine Symposium." The former was coordinated by Drs. Craig Rone and Carl Wulfestieg and included several practical, carefully prepared discussions. Topics presented were Sinusitis, Serous Otitis Media, Dizziness, Tonsillitis, Acute Otitis Media, and Neck Masses. Twenty-five physicians attended this course and many expressed interest in a repeat of

continued on page 17

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**CARDIOPULMONARY RESUSCITATION
AN UPDATE FOR PHYSICIANS**

September 24, October 30, November 27
7:00 A.M. to 8:00 A.M. — Jackson Hall

**PRACTICAL SOLUTIONS TO COMMON
OFFICE PROBLEMS AND PROCEDURES**

Coordinators: James Foss, M.D.
Gordon Klatt, M.D.
Committee for Continuing Medical Education
Medical Society of Pierce County

October 23, 24 Wednesday & Thursday
St. Joseph Hospital—Education Center
8:00 A.M. to 5:00 P.M.

For family practice and general internists as well as interested physician assistants and nurse practitioners. This two-day program will include practical applicable solutions to common office problems and procedures in the following topics: Vertigo; Allergy; ENT Exam; Choosing Cardiovascular Drugs; Exercise Prescriptions for Adults; Upper Extremity Nerve Entrapment; Steroids & Non-steroidal Anti-Inflammatory Drugs; Injection/Aspiration of Joints; Skin Infections; Uncommon Presentations of Common Skin Problems; Dermatologic Procedures; Peptic Ulcer Disease; Diarrhea; Abnormal Liver Function Tests; Office Laboratory; Flexible Sigmoidoscopy; Bedside Use of Doppler; Vasectomy; GYN Office Procedures; Interaction with Lawyers; Computers in Office Practice.

**PRACTICE SOLUTIONS
IN GERIATRICS**

Program Coordinator: John Lincoln, M.D.

November 8, Friday

9:00 A.M. to 4:40 P.M.

This one-day course offers practical guidelines for the management of specific medical problems in the elderly. Included will be a discussion of medical problems related to common cardiac, neurological, musculoskeletal diseases, disability and premature death due to fracture, suicide, complications of Alzheimer's disease and diabetes mellitus.

LAW & MEDICINE SYMPOSIUM

Coordinator: Marcel Malden, M.D.
Medical–Legal Committee
Medical Society of Pierce County

January 16–All Day
St. Joseph Hospital–Education Center

This one-day course will provide information about the financial aspects of medical billing; medical records; medical malpractice; when no-code orders can be issued and a forum of court room practices and procedures loaded with practical information.

Preregistration is required for all above courses

FOR FURTHER INFORMATION OR REGISTRATION
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COLLEGE OF MEDICAL EDUCATION
CONTINUING EDUCATION PROGRAMS SCHEDULED FOR 1985—86
P = Physician Course / A = Allied Health Course

	OCTOBER			
JH	2, 9, 16, 23, 30	Tac Gen Clinical Conf-ELECTROCARDIOGRAPHY	NAGLE	(P)
JH	3, 10, 17, 24	POTPOURRI	AH COMMITTEE	(A)
ST	5	RIGHT BRAIN/LEFT BRAIN	McDONALD	(A)
STJ	21	DISCIPLINE & INSPIRING PRODUCTIVITY	SOLUM	(A)
STJ	23, 24	★COMMON OFFICE PROBLEMS/PROCEDURES	KLATT/FOSS	(P)
STAN	25, 26, 27	SURVIVAL SKILLS FOR NURSES (Retreat)	DEAN	(A)
JH	30	★CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
	NOVEMBER			
JH	1	3rd ANNUAL CANCER EDUCATION	KATTERHAGEN	(P/A)
JH	5	UPDATE-MED. OFF. PERSONNEL-INFECTION CONTROL	DUANE	(A)
JH	6, 13, 20, 27	Tac Gen Clinical Conf-INTENSIVE CARE	WELED	(P)
JH	7, 8	ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P/A)
JH	7, 14, 21	CARING FOR THE CANCER PATIENT	BOULET	(A)
STJ	8	★PRAC. SOLUTIONS TO GERIATRIC PROBLEMS	CLARK/LINCOLN	(P)
JH	27	CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
STJ	TBA	AMBULATORY SURGERY	CHILTON	(A)
	DECEMBER			
STJ	5, 6	★ADVANCED CARDIAC LIFE SUPPORT	CRADDOCK/MUNOZ DOCK/DUNN	(P/A)
	JANUARY			
STJ	14	ETHICAL DILEMMAS ASSOCIATED	McCORMICK	(P/A)
STJ	16	★LAW & MEDICINE SYMPOSIUM	MALDEN	(P)
JH	22, 23	CHRONIC PAIN & DEPRESSION	LURIA	(P)
	FEBRUARY			
JH	6, 7	★ORTHOPEDICS & SPORTS MEDICINE IN PRIMARY CARE	CRADDOCK	(P)
JH	5, 12, 19,26	★Tac Gen Clinical Conf-GASTROENTEROLOGY	BAERG	(P)
	MARCH			
JH	6, 7	★ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P/A)
JH	15	★DAYS OF PEDIATRICS	SCHERZ	(P/A)
JH		★TACOMA ACADEMY OF INTERNAL MEDICINE	ROWLANDS	(P)
	APRIL			
UPS		★TACOMA SURGICAL CLUB	TAYLOR	(P)
JH	2, 9, 16, 23	★Tac Gen Clinical Conf-INFECTIOUS DISEASE	TICE	(P)
	MAY			
JH	15, 16	★CARDIOIVASCULAR DISEASE REVIEW	STRAIT	(P)
	JUNE			
JH	15, 16	★ADVANCED CARDIAC LIFE SUPPORT		(P/A)

★ *Category I for the physician*

For further information and registration
call 627-7137, College of Medical Education

MSPC Physicians Take Action

Interview by Mary K. Tipton

Closing of the Immunology Researching Centre, Ltd., advertised as a cancer research and treatment clinic, Freeport, Grand Bahama Island has brought widespread attention to the Tacoma medical community. Since July 12, Drs. Gale Katterhagen and Samuel Insalaco have been, if not front page news, major news throughout the country. The following is their story of the events that led to the closing of the clinic.

The Editor

Between May 21 and 24, a patient undergoing cancer treatment at the Immunology Researching Centre brought to the Tacoma-Pierce County Blood Bank 18 vials of serum for testing. According to Dr. Insalaco, Medical Director of the Tacoma-Pierce County Blood Bank, the patient took the serum to the Tacoma-Pierce County Blood Bank for testing because an acquaintance undergoing the same treatment at the Immunology Researching Centre had developed Hepatitis B.

Tests were completed between May 28 and 31. All 18 vials of the serum tested positive for Hepatitis B. Because individuals with Hepatitis B are at high risk in carrying HTLV-111 antibodies as well as the AIDS virus, Dr. Insalaco decided to test for HTLV-111 antibodies. 8 of the 18 serum samples showed positive results. On June 4, the State Lab tested the serum, reporting the same results. The serum was forwarded to the Center for Disease Control in Atlanta, Georgia. The tests were further confirmed when the Center was able to grow the AIDS virus from the serum samples.

Concerned with the results he had found, Dr. Insalaco contacted Dr. Katterhagen. Together they prepared a letter for publication in the *New England Journal of Medicine*. Mailed out June 10 by express mail, the letter was returned unpublished, July 9 with the comment. "I am sorry that we will not be able to print your recent letter to the editor. Space available is very limited."

The letter published in its entirety on page 14, argues that the "immuno-augmentative therapy" patients were receiving at the Bahama clinic is an "unproven cancer treatment method and potentially capable of inducing or transmitting AIDS."

Asked how he felt, Dr. Insalaco said he was a "little disappointed, and figured that it was the end of the issue." It wasn't, however, the end of the issue. Dr. Katterhagen called *The Cancer Letter* and talked with editor Jery Boyd. Boyd made the decision to publish the results of the tests in the newsletter. The story was picked up by the wire service, July 11, and run in the *Miami Herald* as front page news, July 12.

According to Dr. Katterhagen, on the afternoon of July 12, the Prime Minister of the Bahama Islands met with officials of Panamanian Health Organization to discuss their concerns. The Bahamian Government instructed clinic personnel to stop treating patients, allow scientists to review the records of the patients and examine the clinic's quality control. The clinic refused to comply with the request. Five days later, according to news reports, the clinic was closed down.

Since the clinic's closing, newspapers throughout the country have been running the story. The Los Angeles Herald ran an AP report July 30, from New York, headlined "1,000 may have been exposed to disease by Bahama's Clinic." According to the AP report, the *New England Journal of Medicine* had published a report in Sept., 1984, from Dr. Gregory Curt, Assistant Director of the Division of Cancer Therapy of the National Cancer Institute, stating products from the Bahama clinic were contaminated with hepatitis virus and bacteria and had caused at least 16 serious cases of bacterial infection in patients undergoing treatment at the clinic."

Despite the obvious, Dr. Insalaco says the Center for Disease Control in Atlanta has received numerous letters from senators and congressmen pressuring for the re-opening of the clinic.

A class action suit has been initiated by a group of clinic patients against the U.S. Government. The suit alleges the U.S. Government "acted irresponsibly and has a personal vendetta against Dr. Lawrence Burton, on record as both Director of the clinic and Director of Research for the clinic. Named in the suit is Margaret Heckler, Secretary of Health and Human Services.

"In reality," says Dr. Insalaco, "I think the clinic will probably open again somewhere else." According to Dr. Insalaco, sources suggest that Dr. Burton tried to open a clinic in British Columbia, Canada, where he was turned down before going to the Bahamas.

In hopes of keeping the clinic closed, Dr. Katterhagen says, as Chairman of the Subcommittee of a National Cancer Advisory Board, he will be making a strong statement on unorthodox cancer treatments such as those administered at the Immunology Researching Centre during the Sept. 27 meeting of the National Cancer Institute in Chicago.

According to Dr. Katterhagen, however, the decision to close the clinic was made not because of unproven or unorthodox treatment of cancer patients, but because of international notoriety and the overwhelming threat of spreading AIDS.

While the clinic was a major source of income for the Bahama Government, bringing in close to $24 million in tourist trade a year, according to major sources, Dr. Kattenhagen contends it had become an embarrassment for the Government.

The implications of Dr. Insalaco's initial test results raise a number of serious issues for the entire medical community. Because the records of the clinic are currently unavailable, there is no way of knowing just how many Americans or citizens from other countries have been treated at the Bahama

clinic.

According to Dr. Katterhagen, the clinic has been treating AIDS patients since 1983. The Center for Disease Control in Atlanta was able to grow the pure AIDS virus 2-times out from the vials of serum sent to the center from Washington, according to Dr. Katterhagen.

Statistics show an alarming rise in AIDS cases in the United States alone since 1983. Cost for treating patients with AIDS runs close to $125,000. It could, says Dr. Katterhagen, medically bankrupt this country.

"We have no way of knowing how many patients at the clinic have brought back vials contaminated with the AIDs virus since 1983," says Dr. Katterhagen.

According to Dr. Insalaco, between 1983 and 1985, approximately 1,000 cancer patients were injected with serum from the clinic.

In an effort to stop the possible spread of AIDS, Dr. Curt has sent a letter to the Center for Disease Control in Atlanta asking for follow-up tests on American cancer patients.

The U.S. Government has sent a letter to the Chief Medical Officer of the Grand Bahamas requesting the records of all U.S. patients under Dr. Burton's care.

The best the medical community can do at this point, according to Dr. Katterhagen, is become aware of any patients who might have gone to the Bahamas for medical treatment, and test them and their families for AIDS. "We need to assume a leadership role. We are not addressing the issue," he says.

"We have a chance here, he says, "to take a leadership role, and show that we are concerned about public health issues."

The Immunology Researching Centre, Ltd. was established in 1977, after Burton was unable to receive FDA approval for his cancer treatment in the United States. Burton claims the FDA was procrastinating, saying, "All attempts for Food and Drug Administration approval had to be abandoned when, after six months of FDA submission of questions and IRF submission of answers, the question list had metamorphosed from five questions to three and one-half pages of questions accompanied by the FDA declaration that there would be no approval by the FDA for the initial clinical trials until all the questions were fully answered."

In 1974, three years before Burton established the Immunology Researching Centre, Ltd., he set up the Immunology Research Foundation in Great Neck, New York.

According to information from the Bahama clinic, the National Cancer Institute expressed interest in Burton's treatment after an article had been published in *New York Magazine*. The National Cancer Institute, however, recommended that Burton carry out his experiments with a human control group. Burton declined to do so, saying it would be unethical to administer the treatment to one group of cancer patients and not the other.

In the late 60's, the American Cancer Society approached Burton, offering a $15,000 grant for one year with the stipulation that he give his flow sheets to the National Cancer Institute, the American Cancer Society and Sloan-Kettering. Burton refused the offer.

It was also during this period that Burton tried to publish a paper on his treatment of tumorous mice. He sent the paper to *Cancer Research*. The Editor, Dr. Shimkin, contacted Burton saying that he wanted to reproduce the experiments before publication. Burton told Shimkin the procedure requested was a "highly unusual step tantamount to plagiarism." Shimkin returned the paper to Burton unpublished.

Patients checking themselves in at the Immunology Researching Centre are instructed to bring a "companion and

continued on next page

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MSPC Physicians Take Action, continued

complete medical records," along with medical supplies and "appliances."

Information from the clinic instructs patients to plan a stay from six to eight weeks. Patients are further told "It is imperative that all patients have a helpful adult companion accompany them during the stay to aid and be a companion."

Since there are no in-hospital beds at the Centre, all patients are told they must stay at hotels or apartments with kitchen facilities. "This," says information from the clinic, "is a very necessary part of the patient's therapy."

Patients are instructed to come "prepared to pay the current fee for treatment at the Clinic in U.S. dollars." Fee for the cancer treatment given at the clinic runs close to $5,735.00 Air travel and living expenses for the term of the recommended stay is reported to be $3,350.00. According to clinic estimates, patients should plan to spend at least $9,085.00 for the six to eight week stay.

The $9,085.00 figure, however, does not include tests, medical or hospital care outside of the clinic that clinic patients might require while receiving their treatment.

Clinic information instructs the patients to have "funds available for all expenses while staying on the island," recommending patients to have their funds "wire-transferred pre-paid from their home town bank to a corresponding bank in Freeport."

As for accommodations, patients are told there are a "variety of efficiency and larger housekeeping apartment facilities available at different rates depending on the season and proximity to the ocean and prime tourist areas.

The *Tacoma News Tribune* addressed closing of the clinic in an editorial, August 30, suggesting the clinic not only posed a serious health threat but "capitalized on the desperate hopes of cancer patients."

What the medical community must now come to grips with, in view of the fact that access to patients' records may be the only means to stop the very real threat of spreading AIDS, is the question: when, or, does a physician's responsibility to the community at large take precedence over the confidentiality between physician and patient.

This issue will, no doubt, continue to be of concern as the story of the clinic unfolds, and the medical community attempts to come to terms with public opinion and the current AIDS epidemic. ■

Immuno-Augmentative Therapy and Possible Transmission of AIDS

Immuno-augmentative therapy is an unproven cancer treatment method championed by Lawrence Burton, Ph.D. at a clinic in Freeport, Grand Bahamas. The method, as described by Dr. Burton, consists of augmenting the body's immune system by injecting specific serum protein fractions obtained from cancer patients and reportably outdated regional donor blood. The sera is pooled, fractionated, diluted and then given back to the patient according to a treatment plan developed by clinic personnel.[1]

The National Cancer Institute previously examined these sera and found heavy contamination which included pseudomonas and Hepatitis B surface antigen.[2] In addition, the Centers for Disease Control has reported cutaneous morcardiosis at the injection sites[3].

Recently, the authors had opportunity to examine and test the diluted sera from two patients who are receiving active treatment from Dr. Burton's clinic. Eighteen specimen vials were tested for HBsAg and antibody to HTLV-III. Using the Abbott, HBsAg Auszyme EIA method all were weakly reactive. Most significantly, eight of eighteen sera tested as either repeatably reactive or repeatably borderline by two independent laboratories using the Abbott HTLV-III EIA method.

This preliminary evidence would indicate that immunoaugmentative therapy is potentially capable of inducing or transmitting AIDS. We feel this is a significant public health observation that justifies further immediate investigation.

S.J. Insalaco, M.D.
Tacoma-Pierce County Blood Bank

J.G. Katterhagen, M.D.,
Director of Oncology
Multicare Medical Center
Member-National Cancer Advisory Board

1 - Immunoaugmentative therapy. Cancer research and treatment. Freeport, Grand Bahamas: Immunology Researching Centre, 1984: 10-1 (IAT Information Center patient brochure.)

2 - Curt GA. Warning on Immunoaugmentative Therapy. New England Journal of Medicine 1984; 311:859.

3 - Cutaneous nocardiosis in cancer patients receiving immunotherapy injections—Bahamas. MMWR 1984; 33:471-7.

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The Bulletin would like to ask that you take a minute to complete the following survey. . .

to help us gear the magazine toward your interests. When you have completed the survey, tear out and mail to: Readership Survey, The Bulleti[n] Medical Society of Pierce county, 705 So. 9th, Suite 203, Tacoma, WA 98405. Thank you!

1. How long have you been a member of the Medical Society of Pierce County?
   - ☐ Less than 1 year
   - ☐ 1–3 years
   - ☐ 4–6 years
   - ☐ more than 7 years
   - ☐ not a member
2. Are you a member of the American Medical Association? ☐ Yes ☐ No
3. How many of the past 12 issues of The Bulletin have you read?
   - ☐ Less than 5
   - ☐ 7
   - ☐ 12
4. What do you read first? ☐ Newsbriefs ☐ President's Page ☐ Features
5. Do you find the table of contents helps you ☐ locate articles ☐ determine what to read
6. How long do you spend reading each issue?
   - ☐ less than ½ hour
   - ☐ 1–2 hours
   - ☐ 2–3 hours
   - ☐ 3 hours or longer
7. How long do you keep each issue?
   - ☐ discard when I finish
   - ☐ 3 to 6 months
   - ☐ 6 months to 1 year
   - ☐ 1 year or longer
8. Do you refer to old issues for articles of your interest? ☐ yes ☐ no
9. Which of the following news items in The Bulletin do you find most interesting?
   - ☐ President's Page
   - ☐ News Features
   - ☐ Membership News
   - ☐ AMA News Features
   - ☐ Newsbriefs
   - ☐ Hospital News
   - ☐ College of Medical Education Scheduling
   - ☐ Editorial Commentary
   - ☐ Auxiliary News
10. Would a Calendar of Events be useful to you? ☐ yes ☐ no
11. Do you find the classified section helpful? ☐ yes ☐ no
12. Have you advertised in the classifieds? ☐ frequently ☐ occasionally ☐ never
13. Which of the following news items to you find least interesting?
    - ☐ President's Page
    - ☐ News Features
    - ☐ Membership News
    - ☐ AMA News Features
    - ☐ Newsbriefs
    - ☐ Hospital News
    - ☐ College of Medical Education Scheduling
    - ☐ Editorial Commentary
    - ☐ Auxiliary News
14. Please list some subjects you would like to see in future issues of The Bulletin.

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15. Please list some of your leisure activities.

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16. Additional reader comments.

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College of Medical Education Report, continued from page 9

the topic in the future.

The "Law and Medicine" was coordinated by Dr. Marcel Malden and was attended by 64 attorneys and physicians. This course is becoming a traditional favorite in Tacoma and will be offered again this January.

Also planned for January is an offering on "The Various Manifestations of Depression," coordinated by Dr. Eric Luria. The Committee expects this course will have a broad appeal considering that all primary care physicians and many subspecialists spend a great deal of time managing depression. Emphasis will be on the newer techniques for evaluation and treatment of this frustrating problem.

"Orthopaedics and Sports Medicine in Family Practice" was held in February last winter and will be again in 1986. This 2-day course was attended by 43 physicians, which disappointed Drs. Mark Craddock, David Pomeroy and John Bargren, the course coordinators. The Committee has determined that the sparse showing was due in part to the late mailing of the brochure. The content was excellent, filled with many demonstrations of examination techniques, and small-group hands-on instruction in taping and strapping techniques and the evaluation of running shoes and orthotics. With the quality of the course assured from last year's experience, we expect that the attendance may well double this year with a more timely brochure mailing.

The extremely popular Advanced Pediatric Life Support course in February was attended by 129 physicians & nurses with another 30 applicants turned away due to room and time constraints. Coordinated by Dr. Paul Seward, the same course will be offered again this November and March 1986.

March of 1985 featured the Tacoma Academy of Internal Medicine's Annual 2-day Meeting which was predictably well attended. This will again be available in Mid-March.

Last April the Tacoma Surgical Club presented their annual Symposium and Dissections. The topic was Ambulatory Surgery with 78 physicians attending the lecture component and approximately 250 visiting the Dissections. The Surgical Club is already at work on the April 1986 program.

This April we will present a one-day course on Home Health Services, the fastest growing area in Health Care, to enable physicians to become familiar with who is offering services to our patients in the changing health care environment. This will be somewhat like a guided tour of our local community resources and should prove quite interesting with Dr. J. Gale Katterhagen coordinating the course.

In May, Dr. Gail Strait presented his Annual Cardiovascular Disease Review which was attended by 246 physicians, nurses and health care personnel. Dr. Strait will present this excellent course again in May 1986.

Tacoma will also be hosting the Washington State Academy of Family Physicians' Annual meeting and program at the Tacoma Sheraton Hotel in May 1986.

We will wind up the year in June with the Advanced Cardiac Life Support course, again coordinated by Dr. Jim Dunn. Jim has done a wonderful job coordinating this program five times in the last two years and we especially applaud and acknowledge this ambitious undertaking.

The Committee would like to thank all the Medical Society members for your continuing support both as instructors and attendees at the courses. We are pleased that we have been able to meet the C.M.E. needs of so many physicians in Pierce County as well as the outlying areas. We appreciate your input and always welcome new ideas for courses or ways to improve upon the ones we currently offer.

I would also like to thank Maxine Bailey and Peggy Dodge of the College of Medical Education for their excellent staff support. It is interesting to note that the College produced 49 conferences last year for physicians and nurses with a total enrollment of 2,926 for the academic year September '84 to July '85. ■

AUXILIARY NEWS

October Auxiliary Meeting scheduled.

Friendship, friendship, such a perfect blendship! That's what our Pierce County Auxiliary strives to be. This month we are inviting the Madigan Medical wives to attend as our guests.

The meeting will be held October 28, at the Tacoma Art Museum. Sarah Little will speak on "Fashions through the Ages."

A well known industrial designer, Little is a former editor of House Beautiful and a major design consultant for such companies as Revlon, Neiman Marcus, R.H. Macy & Co., 3M, General Mills, Corning Glass and Proctor & Gamble.

Her collection at the Tacoma Art Museum includes an extensive design library and a wide collection of items of culture, ranging from art objects to body covering to food oriented appointments from many parts of the world.

Come and meet old friends, make some new ones and learn about a renowned Tacoma resident and find out what she is contributing to the world of design.

The meeting will begin promptly at 10:00 A.M. A film on the Sarah Little Design Center will be shown at 10:15 A.M. Ms. Little will speak at 10:30 A.M. A brunch will be served at 11:30 A.M. Tours of the museum will begin after brunch.

Holiday Sharing Card in the works for this year.

Sharron Gilbert and her committee will soon be sending letters to all Pierce County Physicians telling them about this year's AMA-ERF Holiday Sharing Card. A card will be sent to all MSPC members with an enclosed list of contributors. It is a nice way to remember others while helping the medical school of your choice. All funds are payable to AMA-ERF. Your donations are tax deductible.

Design of the card was chosen from a recently held children's art contest. The entries were submitted by children and grandchildren of Pierce County physicians.

Pierce County has been number one in donations for many years. Let's be number one again this year!

President Elect to attend Leadership Meeting.

Pierce County Medical Auxiliary President-Elect Susie Duffy will be attending a leadership confluence meeting in Chicago in early October. The annual meeting is for county president-elects of auxiliaries from throughout the United States.

Membership Booklets now available.

If you have paid your 1985-86 auxiliary dues by mail, you will soon be receiving your Membership Booklet. Check to see that your address and phone number are correct. If they are not, please notify Membership Chairman Alice Wilhyde at 572-6290. She will make the corrections.

Dues are still being accepted! Just send $38.50 to Betty Virtue, Dues Treasurer, 71 Leschi St., Madrona Park, Steilacoom, WA 98388. Betty will be more than happy to send you a membership booklet upon receipt of your dues.

Finance Committee will meet to select recipients of philanthropic funds.

The Auxiliary Finance Committee will be meeting in October to select recipients for the 1985-86 philanthropic funds. The Committee received nine applications. The Committee will report the selections at the Board meeting in November. Selections will be announced at the general meeting November 15.

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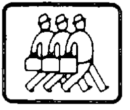

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Applicants are: New House, St. Leo's Center for the Handicapped, Fadeout, Fife Alcohol Drug Education Outreach, Equest, Children's Home Society of Washington, Neighborhood Clinic, WWEE, Washington Women's Employment and Education, Christmas House, YWCA, Women's Support Center, Good Samaritan Hospital's Rural Family Support Project and Lifeline.

Most applicants relate to our county, state and national emphasis on health education and improvement of health and quality of life for all people. Comments on the applicants are to be directed to Marlene Arthur, Finance Chairperson, after Oct. 8, at 845-5542. Your comments and the applications will be reviewed by the Committee before October 31, 1985.

Sponsor a Spouse.

Auxiliary president Ginny Miller recently put into action a suggestion from a panel at the AMAA House of Delegates meeting held in Chicago in June. The suggestion was: "For Resident Spouse/Medical Student Spouses—have a special liaison at the county level; consider a section for them in the newsletter; invite to board meetings; try "sponsor a spouse" where a regular member pays dues for a resident spouse for a year.

Ginny contacted several Auxiliary board members and polled them on their feelings concerning the subject. It was deemed a worthwhile project. Five volunteered to be a sponsor, and individually pay the spouses dues for 1985-86. The sponsor will also contact the spouses during the year, offering assistance when possible.

Ginny has sent a letter to the 12 residents and spouses, welcoming them to our community. They are in family practice at Tacoma General Hospital. The first year residents are: Drs. William F. and Katherine S. Hennessey, Dr. Linn M. Larson and Dr. David J. Hagen (wife Debbie). Second year residents are: Dr. Anne E. Biedel (husband James), Dr. Stuart D. Freed (wife Sally), Dr. Stephen (Harry) Herdman and Dr. R. Scott Kennedy. Third year residents are: Dr. Debra D. Pohlman, Dr. Paula L. Schulze, Dr. Scott D. Tarleton (wife Paula) and Dr. Steffen R. Tolles (wife Carol).

We welcome these residents and their spouses to our medical community. A special welcome to Debbie, James, Sally, Paula and Carol.

The enthusiasm of the Auxilians is to be commended for endorsing and acting promptly on this project.

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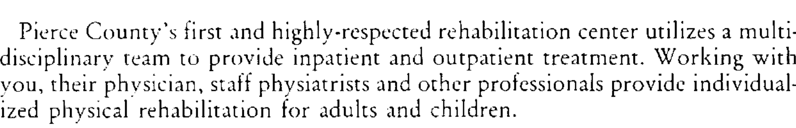

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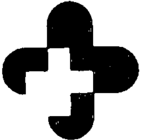

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HOSPITAL NEWS

Good Samaritan

Good Samaritan Hospital's "Rural Family Support Project" receives praise from child abuse experts.

A program established three years ago at Good Samaritan Hospital in an effort to reduce the number of "failure-to-thrive" babies in Eastern Pierce County is beginning to receive national attention.

The program called the Rural Family Support Project was developed by Good Samaritan Outreach services, a division of Good Samaritan Community Healthcare.

Funded through grants from the Bishop Foundation, the Forest Foundation, the Skinner Foundation, the Dupar Foundation and the Puyallup Methodist Church, the program is designed to provide a network of support for parents considered "high risk" or potential child abusers.

Trained volunteers work with new mothers while they are still in the hospital, talking with them about their home situation and support systems.

"We give them support as a friend," says volunteer Lois Schmitt. "You can tell if they need some help when you talk with them," she says.

According to Matthew Quinn, Director of Community Health Services, the number of "failure-to-thrive" babies has been significantly reduced during the three years the project has been in effect.

St. Joseph

Med Flight Stationed at St. Joseph Hospital.

Inauguration of a new helicopter service based at St. Joseph Hospital has brought specialized medical services one step closer to residents of southwest Washington.

Med Flight, owned and operated by Jet Helicopters in Boise, Idaho will be utilizing the available heliport at St. Joseph Hospital. Fully equipped as a flying emergency room, Med Flight can transport two medical personnel, a pilot and two patients up to 150 miles away at a cruising speed of 130 to 150 miles per hour. Specially trained staff will be available to transfer patients from outlying referring hospitals 24 hours a day, seven days a week. Upon receiving a call, Med Flight can be in the air within 10 minutes from dawn until dusk and within 30 minutes from dusk until dawn.

Special protocol is being established to maintain close contact with the patient's community physician in order to ensure continuity of care during the flight and after arrival at St. Joseph.

Equipment such as cardiac monitoring and defibrillating equipment, oxygen and suction, intraveneous fluids, intubation and ventilation equipment, splints and medications are available.

Med Flight Director is Dr. James Billingsley. He encourages those interested in more information to contact him at 591-6767.

St. Joseph Hospital: 94 years of health care

With the modern hospital buildings and state-of-the-art equipment, it is hard to visualize the long history of St. Joseph Hospital.

Founded in 1891, St. Joseph Hospital was a converted rooming house at the southwest corner of South 18th and I street. In addition to its 10-beds, the hospital also had a small chapel and living quarters for the sisters who cared for its patients and ran the hospital.

The first campus consisted of a woodshed and a two story laundry building, where, as the story goes, sisters slept when their living quarters in the hospital were used for patients. The second story of the laundry was a dormitory and living quarters for a chaplain and an intern or two.

In 1897, the first real hospital building was constructed partly with funds donated by the community, which sisters went out and begged for. That hospital, a wood frame structure, was built on the northeast corner of South 19th and J Street (the present location of the doctors parking lot) and had verandas, a tower and was three stories tall. The building was used until 1915 when the long red brick building was constructed on I Street.

The three story building became the St. Joseph's Hospital School of Nursing until it closed in 1973. The building stood for several years thereafter and was used primarily as an office building as well as meeting rooms and classrooms. In 1979 it was demolished to make room for another parking lot.

1985

Edwin C. Yoder Honor Lecture

WERNER U. SPITZ

Werner U. Spitz is currently the Chief Medical Examiner for Wayne County, Michigan. He also serves as the Professor of the Department of Pathology at Wayne State University School of Medicine. He speaks three languages fluently, including German and French. Dr. Spitz served as a consultant to the Rockefeller Commission on CIA Activities within the United States, investigating the circumstances surrounding the assassination of President John F. Kennedy. He is the author of 70 scientific publications and editor of a medical/legal textbook: *MEDICOLEGAL INVESTIGATION OF DEATH* — Guidelines for the Application of Pathology to Crime Investigation.

Guest Speaker

Werner U. Spitz, M.D.

Friday, November 15, 1985

St. Joseph Hospital and

Health Care Center

PHYSICIAN LECTURES

10:00 A.M. "Medical Examiners in the Medical Community"

12:15 P.M. Complimentary Luncheon

1:15 P.M. "Mysteries in Forensic Medicine"
— Honor Lecture —

NURSING/PARAMEDICAL LECTURE

3:30 P.M. "Answers to Medical Questions"

For tickets and further information, contact the Medical Director's Office, **591-6767**

AMA Efforts Toward Cost-Effective Health Care Deserve Your Support

Editorial

It is ironic that, in an era of deregulation, defederalization and renewed recognition of the ability of the marketplace to determine the most efficient and effective solutions to problems, pressure to control health care costs through regulation has grown so strong that it threatens the professional independence of physicians. The federal government has chosen to impose a number of cost-containment measures that are pushing America ever closer to a rationed health care system. The Medicare fee freeze and the move to arbitrarily price physicians' fees through imposition of diagnostic-related groups (DRGs) are just examples of a trend toward central, bureaucratic control of the health care system.

Fortunately physicians have a powerfully ally in the fight to maintain our professional independence: the AMA—the unified national voice of physicians.

The AMA has an excellent record in defeating legislative proposals that would have strengthened the trend toward central control of health care. Some examples:

- Legislation that would have allowed the Secretary of Health and Human Services to establish patient, physician and facility criteria for any medical technology or procedure, including organ transplantation;
- Mandatory prospective pricing of physician services through DRGs, as orginally included in the 1983 Social Security Act Amendments;
- A House of Representatives proposal that would have required physicians either to accept assignment under Medicare for all inpatient services or lose their hospital privileges.

Were it not for the efforts of the AMA, those proposals could be realities today.

Yet, in its concern for quality health care, the AMA has not been insensitive to the financial contraints many patients face. The Association has taken positive and important steps toward reducing health care costs while maintaining access to high-quality care.

The AMA exercised responsible leadership by initiating a one-year voluntary physician fee freeze. An overwhelming majority of physicians agreed to abide by this freeze.

Furthermore, the AMA was instrumental in initiating the Health Policy Agenda for the American People, a cooperative effort of 150 organizations seeking a long-term, consistent approach to medical issues facing the nation, including cost effectiveness. The focus is solid planning—not panic over costs. The AMA also has encouraged local and regional coalitions of physicians, hospitals, insurers and community leaders to explore cost-containment strategies that don't threaten the quality of care. In addition, the AMA publishes the annual Cost Effectiveness Plan and the AMA Cost Effectiveness Bulletin.

All these efforts have the goal of achieving true cost-effective health care. That is a far better, albeit more challenging, approach than is evident in many of the simplistic "solutions" offered by non-physicians, largely involving imposition of untested, national controls on the medical profession and the public.

Another important issue is the increasing incidence of medical malpractice litigation. Malpractice suits, many of them clearly frivolous, have contributed to the rising cost of medical care. Professional liability is one of the most serious problems facing medicine today. The number of medical malpractice claims is skyrocketing. One survey indicates that the median indemnity paid by physician-owned carriers increased by 500 percent between 1979 and 1983. Another survey indicates that 9 percent of ob/gyn specialists have given up practicing because of high insurance premiums—reaching $70,000 a year.

On the liability front, the AMA is seeking solutions through its Special Task Force on Professional Liability. The task force is setting priorities and coordinating Association activities on this issue.

Moreover, the Association's recommendations to the public on such topics as automobile air bags and labels on cigarette packs have an aggregate effect of decreasing medical costs by promoting healthier lifestyles.

Clearly, the national legislative agenda of medicine is expanding. As the one medical association that transcends state and specialty boundaries, the AMA is uniquely suited to pursue that agenda.

I strongly urge you to support the AMA, as well as your county, state and specialty societies, to help keep medicine in the control of physicians, not bureaucrats. Let's make sure that our health care system—truly the envy of the world—will continue to progress into the 21st Century. ■

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Frederick J. Carlock, MD, *Anesthesiology.* Born in Ohio, 2/26/50; medical school, Wayne State University, 1981; internship, Internal Medicine, Sinai Hospital, 7/81-6/82; residency, anesthesiology, Sinai Hospital, 7/82-6/84. Washington State license 1986. Dr. Carlock is currently practicing at Good Samaritan Hospital.

Christopher J. Harris, MD, *Urology* Born in Ohio, 12/15/48; medical school, University of New Mexico, 1976; internship, Urology, Naval Regional Medical Center, 6/76-6/77; residency, Urology, Naval Regional Medical Center, 8/78-8/82. Washington State license 1985. Dr. Harris is currently practicing at 124 Tacoma, Ave., Tacoma, Washington.

Theodore K. Inouye, MD, *General Surgery.* Born in Hawaii, 5/19/54; medical school, University of Washington 1980; internship, Surgical, University of Hawaii, 7/80-6/81; residency, Surgical, University of Hawaii, 7/81-6/82; graduate training, Surgical, Kaiser Foundation Hospital, 7/82-6/85. Washington State license 1985. Dr. Inouye is currently practicing at 1420 4th Street S.E. Suite #C, Puyallup, Washington.

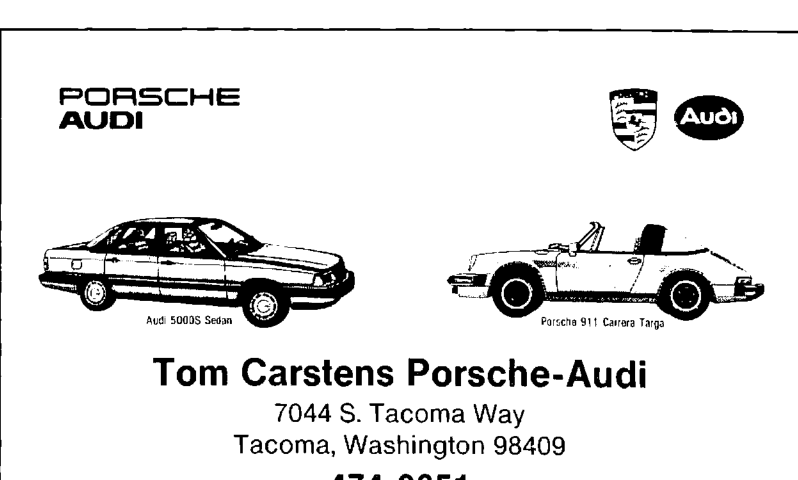
Martin Mendelson MD, *Family Practice,* Born in New York, 4/16/37; medical school, State University of New York, 1976; internship, Family Practice, Emanuel Hospital, 7/76-6/77; residency, Family Practice, Emanuel Hospital, 7/77-6/79; Washington State license 1986; Dr. Mendelson is currently practicing at The Tacoma Family Residency Program.

Kevin P. Schoenfelder, MD, *Orthopedic Surgery.* Born in Iowa, 2/28/52; medical school, University of Minnesota, 1979; internship, Surgical, University of California at San Francisco, 6/79-6/80; residency, Orthopedic Surgery, University of Washington, 6/80-6/84; graduate training, Spinal and Pediatric Orthopedic Fellowship, University of Hong Kong, 1/85-6/85. Washington State license 1986. Dr. Schoenfelder is currently practicing at 1624 South I Street, Tacoma, Washington.

Frank M. Senecal, MD, *Oncology/Hematology.* Born in Massachusetts, 3/9/51; medical school, Indiana University, 1977; internship, Medical, University of Washington, 7/77-6/78; residency, Medical, University of Washington, 7/78-6/80; graduate training, Hematology/Oncology Fellowship, University of Washington, 7/82-6/85. Washington State license 1986. Dr. Senecal is currently practicing at St. Joseph Hospital, Tacoma, Washington.

Patrice N. Stevenson, MD, *Physical Medicine and Rehabilitation.* Born in Puyallup, 12/21/55; medical school, University of Washington, 1982; internship, Rehabilitation Medicine, Wadsworth Veterans Administration Medical Center, 7/82-6/83; residency, Rehabilitation Medicine, Wadsworth Veterans Administration Medical Center, 6/83-6/85. Washington State license 1985. Dr. Stevenson is currently practicing at Good Samaritan Hospital, Puyallup, Washington.

Gary V. Trupp, MD, *Obstetrics/Gynecology.* Born in California, 6/10/53; medical school, Loma Linda University, 1981; internship, Obstetrics/Gynecology, Pontiac General Hospital, 7/81-6/82; residency, Obstetrics/Gynecology, Pontiac General Hospital, 7/82-6/85. Washington State license 1986. Dr. Trupp is currently practicing at 10206 E. 96th Avenue, Puyallup, Washington.



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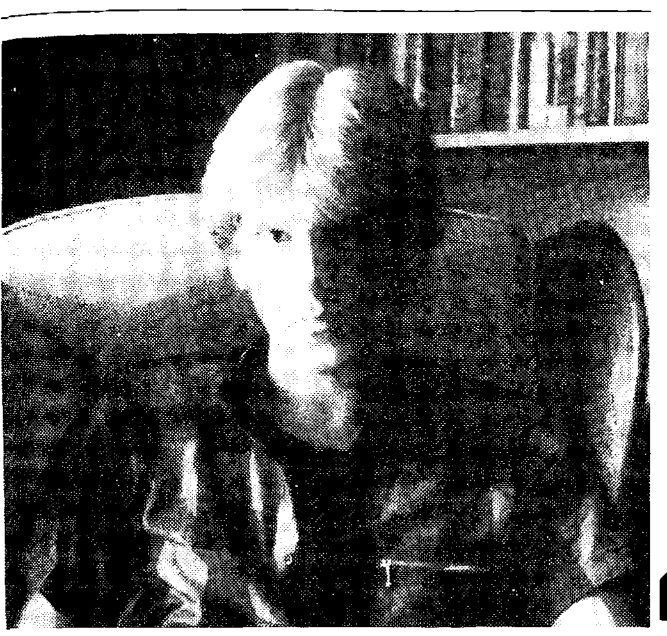

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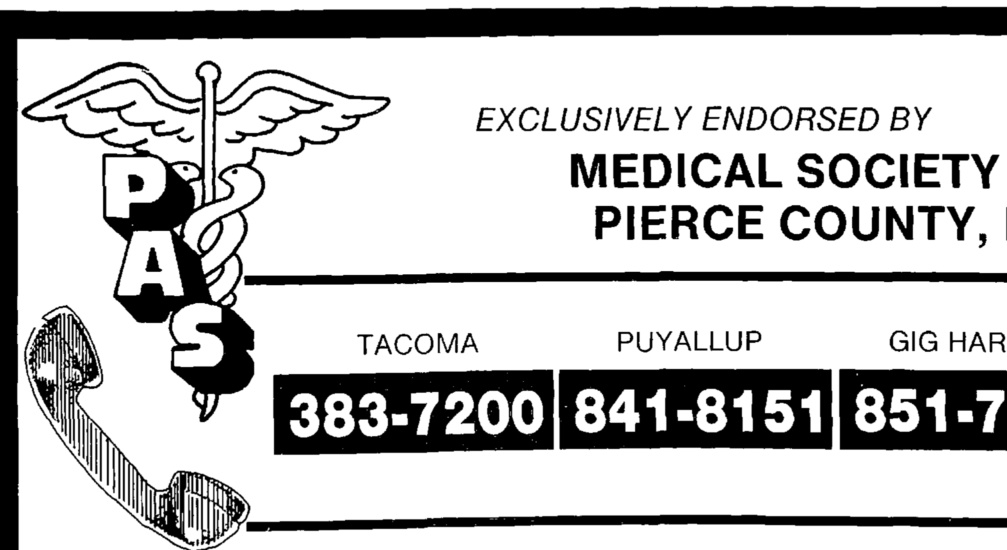

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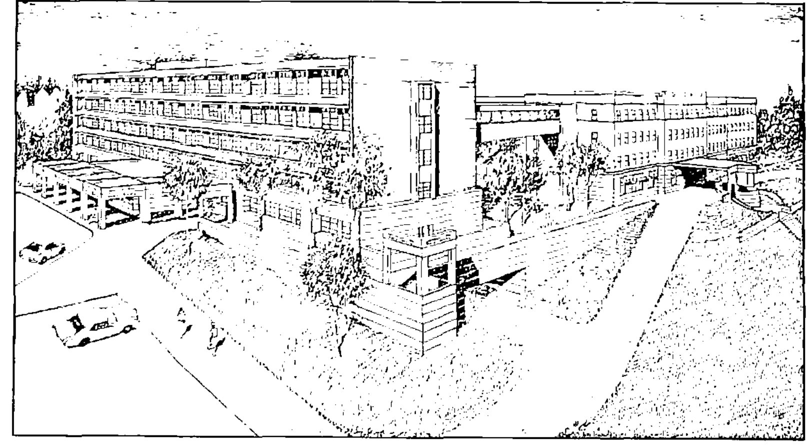

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The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

November, 1985

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1985 Edwin C. Yoder Honor Lecture

WERNER U. SPITZ

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The Bulletin *The official publication of the Medical Society of Pierce County*

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Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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NEWS BRIEFS

In Memoriam

Carol, wife of Dr. David Hopkins, died, Sept. 18, 1985. She is survived by her husband Dave and four sons, Steve, Bruce, Brian and Jeff, to whom the Society extends its deepest sympathy.

The following Salute to Carol Hopkins appeared in the Sept. Issue of the PCMSA Newsletter.

Some people have a style of their own, which is probably more of an outlook on life than it is specific things they say or do. Carol Hopkins has an enviable style of her own, which is evident both in times of celebration and adversity. We all think of her as cheerful, friendly, pretty and smiling. The fact that she has persevered in a family of all boys indicates a considerably buoyant nature. No pun intended.

Certainly the Medical Auxiliary is grateful to Carol for the many jobs she has performed. She has arranged numerous events, including style shows and dinners. She has helped out on the state level and sometimes she has taken on tasks others shied away from. She has not sought the spotlight but served steadfastly in the supportive area that makes the Auxiliary function well. Carol's value to the group is not based solely on her organizational ability or her considerable social skills, which alone are impressive, but rather because she offers encouragement to others, and she has helped others in important ways. This is a consequence of her own outlook on life, which is firmly based on a belief in God, in His infinite love and His tender interest in all of us.

General Membership Meeting, Nov. 12

A tour of China by neurosurgeon Dr. Stevens Dimant will highlight the November 12, General Membership Meeting. Dr. Dimant and a group of neurosurgeons toured several universities in China. Dr. Dimant will relate his experiences and show a series of slides.

WSPIA Vice-President of Marketing Tom Fine will lead a discussion on **"Claims Made"** liability insurance now being offered by Washington State Physicians Insurance Association.

MSPC Board of Trustees approves statement on unionization.

The September meeting of the MSPC Board of Trustees approved a statement on physician unionization which reads as follows: "The Society does not endorse any movement, but does support the physicians' right to organize to insure the quality of care for their patients."

The Board reviewed correspondence from a member asking the Society to clarify the relationship hospitals presently have with physicians, particularily in regard to joint ventures and employment. A letter will be written to the hospitals for clarification.

Medical Society staff was asked to investigate the possibility of forming a "Women in Medicine" Committee.

The EMS Committee reported that Dr. Clark Waffle had been appointed EMS Program Director, replacing Dr. Mark Jergens, who resigned after serving two and a half years as Director.

The Public Health/School Health Committee told the Board it had set as its goal the fluoridation of the Tacoma water supply. Members of the Committee will be meeting with City and County leaders to seek their support and advice.

The Credentials Committee recommended to the Board that the following applicants be approved for membership.

Cameron Carter, MD
Howard Clark, MD
Alan B. Wood, MD
Michael Cherkassky, MD
Martha A. McCravey, MD
Kelly Wright

The recommendation of the Committee was unanimously approved.

PCMSA President Ginny Miller reported that the Auxiliary had undertaken a program to sponsor spouses of medical residents by paying their dues for PCMSA, WSMAA, and AMAA. The Auxiliary is also making an effort to involve the spouses in all phases of Auxiliary activities.

Congratulations!

Tom Curry, former Executive Director of MSPC has been named Associate Executive Director of the WSMA. Tom, who left MSPC to become WSMA Director of Public Affairs, received the good news at the WSMA Annual Meeting. Harlan Knudson, Executive Director, will be directing the legislative activities of the Association in Olympia.

Front Cover: October Bulletin

The front cover of the October Bulletin, illustrated by Mary O'Loughlin, was taken from a slide, courtesy of the Tacoma-Pierce County Health Department. The doctor illustrated from the slide is Dr. Charles Weatherby while he was working at the Lakewood Clinic.

The Bulletin would like to extend a thank you to Florence Reeves, UHI Project Coordinator, Tacoma-Pierce County Health Department for her efforts in getting the slide, and to Mary O'Loughlin for a fine illustration on very short notice.

MSPC Retired Members Luncheon coming up, Nov. 13

The Society held its first meeting of retired members in May of this year. The meeting was very successful and enjoyed by all those attending.

A second meeting of the group is planned for Wed., Nov. 13. Those who have retired and those members who are contemplating retirement should plan to attend.

On the agenda is a discussion of the plans WSMA has to establish an organizational structure for retired physicians within the WSMA and county societies. The goal of the organization would be to promote the welfare of retired physicians, recognizing and utilizing their varied experiences and talents, benefiting the physicians, patient care and organized medicine.

Those attending will also enjoy hearing Dr. W. Ben Blackett describe his experiences with the 1984 Mt. Everest expedition with an exciting and exceptionally beautiful slide presentation.

Physician Shortage.

The MSPC office maintains a referral service for members who have agreed to be on the referral list and agree to accept medical coupons. The size of the list is becoming smaller and smaller. What is happening is that those physicians on the list become overwhelmed with welfare patients.

A recent study conducted at the office over a two month period indicated that 60% to 70% of those requesting referral assistance had insurance or the ability to pay. If you can see a few more patients a month, please call the office. 572-3667.

See related story on page 12.

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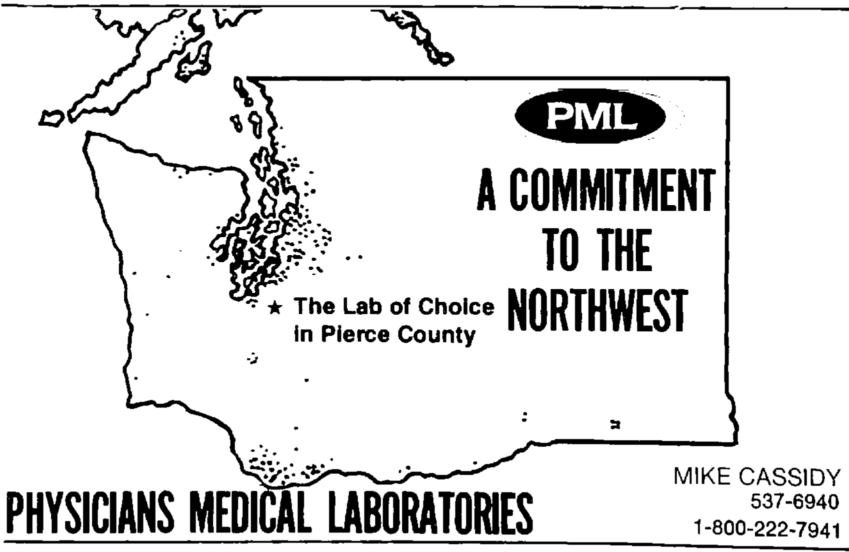

WSMA holds 96th Annual Meeting.

Dr. Stanley Tuell, Speaker of the House of Delegates for 17 years, discussing a parliamentary procedure.

Highlights

Dr. Stanley W. Tuell honored.

Dr. Stanley W. Tuell was honored for serving an unprecedented 17 consecutive terms as Speaker of the House of Delegates. Before assuming the position of Speaker of the House, Dr. Tuell served six years as a Pierce County Delegate.

A crystal decanter and a bound volume of all House action taken during Dr. Tuell's 17 years as Speaker were presented to Dr. and Mrs. Tuell during a dinner given in his honor. A bronze plaque of Resolution #21, passed unanimously, was also presented. The Resolution reads as follows:

WHEREAS, Stanley W. Tuell, MD, Tacoma has served as Speaker of the House of Delegates of the Washington State Medical Association since 1969; and

WHEREAS, the 1985 WSMA House of Delegates will mark Dr. Tuell's retirement from the position of Speaker of the House of Delegates after 17 years; and

WHEREAS, Dr. Tuell has been an advocate for accuracy and quality in the proceedings of the House and its official reports; and

WHEREAS, Dr. Tuell dedicated himself to upholding the rules of order of parliamentary procedure and provided guidance to others on the subject, and;

WHEREAS, Dr. Tuell has served as a valuable member of the WSMA Board of Trustees and Professional Liability Committee as well as being a leader in his county society and specialty society: THEREFORE BE IT

RESOLVED, that the Washington State Medical Association recognize Dr. Tuell for his many years of outstanding service as Speaker of the House of Delegates and extend its thanks to him for his contribution and leadership on behalf of the medical profession and the state of Washington.

MCPC has 100% representation!

Once again, MSPC was one of the few delegations with 100% representation at the 96th Annual WSMA meeting, Sept. 18-22, 1985, Jantzen Beach, Oregon.

The Society was ably represented by the following delegates and alternates: Drs. G.W.C. Bischoff, R. Hawkins, G. Bruce Smith, J. McGowen, M. Malden, C. Weatherby, C.L. Anderson, K. Bodily, T. Clark, N. Iverson, J. Krueger, G. Tanbara, R. Vimont, L. Elmer, R. Scherz, Ralph Johnson and G. Roller.

The MSPC expresses its appreciation to the delegates and alternates who took time out of their busy schedules to attend and represent MSPC.

Tacoma selected as meeting site for WSMA's Centennial Meeting in 1989!

Noting that the first meeting of the WSMA after the state of Washington achieved statehood was held at the Tacoma Hotel, Oct. 24, 1889, Dr. Tom Clark, Alternate Delegate, presented to the WSMA Annual Meeting site selection committee the many advantages of conducting the Centennial Meeting in Tacoma. The Committee agreed and designated Tacoma as the 1989 meeting site.

The 1987 Annual Meeting is also scheduled to meet in Tacoma.

Front Row, left to right, Drs. George Tanbara, Ken Bodily, Richard Hawkins, Richard Vimont, Bruce Smith. Back Row, left to right, Drs. James Krueger, Gerry McGowen, Guss Bischoff, Charles Weatherby, Gil Roller, MSPC Executive Director, Doug Jackman.

Dr. Charles Weatherby, MSPC delegate, stating his point at the WSMA House of Delegates meeting.

Dr. Tom Clark presents to the site selection committee the many virtues of meeting in Tacoma

Pierce County Physicians Elected to WSMA Leadership.

The following Pierce County physicians were elected to leadership positions at the WSMA 96th Annual Meeting.

Ralph A. Johnson, MD, AMA Alternate

Richard Hawkins, MD, Vice Speaker

Robert Scherz, MD, WSMA

Currently serving, Trustee Lloyd C. Elmer, MD, term expires, Sept. 28, 1986

Proposals generate discussion.

Physician Recompense discussed.

One of the more discussed resolutions before the House was the "Principles of Physician Recompense." The resolution introduced by Dr. Alvin J. Thompson, Seattle, was directed to the issue of cognitive versus procedural fees.

Following a great deal of discussion, the House voted to refer the issue to the WSMA Council on Professional Services for further consideration and to immediately undertake study and development of the concepts of case management fees and "gatekeeper" compensation. The AMA delegation was instructed to take a similar request to the AMA delegates.

The House also adopted a resolution endorsing additional cooperative efforts between members of its Personal Problems of Physicians Committee and the Washington State Disciplinary Board. The resolution was adopted in an effort to move toward a goal of contracting with a common entity. The resolution outlines appropriate chemical and behavioral monitoring on physicians judged by either group to be "chemically impaired."

Living Wills.

The House adopted a policy position to encourage each member of WSMA and respective families to prepare and sign a "living will" or, if preferred, arrange for designation of "durable power of attorney."

continued on next page

Cost of health care from a business perspective

Harry E. Morgan, Chairman, Health Care Purchasers Association of Puget Sound, presented the "business perspective" on the cost of health care during the WSMA Annual Meeting.

According to Morgan, business had no interest in health care 10 years ago. "Weyerhaeuser," he said, "was paying out $4 million in premiums for salaried employees and $16 million for hourly employees." Ten years later the cost to Weyerhaeuser increased to $20 million for salaried employees and $60 million for hourly employees. "Business now," he said, "has an interest and commitment to reduce costs."

Morgan suggested that doctors take the leadership role to monitor control of incompetent physicians, and get data to evaluate quality care. "Doctors are still held with esteem in the public eye," he noted, "and have the ability to mold the system, and business would like to assist in the transition."

Jeffery O'Connell, Professor of Law, University of Virginia, and author of "The Law Suite Lottery—Only Lawyers Win," told the gathering of physicians that lawyers have made a mess of malpractice liability insurance."

As presently conceived, O'Connell says tort reform ill-serves the patient. His advice to the medical community was to direct legislative efforts toward serving the patients rather than toward the self-serving legislation organized medicine has been advocating for the past 15 years.

Drs. Gil Roller, Mike Halstead, Guus Bischoff enjoying a break at the 96th WSMA Annual Meeting.

Front Row, left to right, Drs. Richard Vimont, Charles LeR. Anderson. Back Row, left to right, Drs. Mike Halstead, Guus Bischoff, Bruce Smith.

WSPIA Goes to "Claims Made."

Ted Linham, president, Washington State Physicians Insurance Association and W. Maurice Lawson, MD, Chairman WSPIA Board of Directors reported during the WSMA Annual Meeting that WSPIA would be introducing a new professional liability policy for Washington State physicians, "Claims Made Plus," a claims made policy without the usual long-term uncertainties of the reporting endorsement "tail" premium.

The major difference between Occurrence and Claims Made coverage is, what triggers coverage for a loss, the incident (Occurrence) or the reporting of the incident (Claims Made).

An occurrence policy covers an incident occurring during the policy period, regardless of when the claim becomes known. A Claims Made policy period only covers claims that are reported or become known during the policy period, providing that a prior Claims Made policy was also in effect on the date of the incident.

For example, an incident takes place on 7/1/86, and a claim is made as a result of that incident in 1988. The Occurrence policy in effect in 1986 will cover the loss. Under Claims Made, the policy in effect in 1988 covers the loss made that happened in 1986.

Linham reported that since the inception of WSPIA in 1982, 511 cases have been initiated with 121 resulting in actual law suits. To date $2.2 million has been paid.

Linham and Lawson reported that the Board of Trustees was reluctant to go toward "Claims Made." However, it was necessary to maintain coverage from

the reinsurer, and it does provide stability.

As a final note, Linham pointed out that WSPIA would be eliminating its premises liability coverage, effective Jan. 1, 1986. This is something that should be noted by all WSPIA holders.

Note: Tom Fine, WSPIA Vice-President of Marketing will be attending the MSPC Nov. 12, General Membership Meeting to explain "Claims Made" in greater detail.

Mandatory reporting of unprofessional conduct and tort reform generates debate.

Resolution 8, requiring mandatory reporting of unprofessional conduct generated considerable debate on the floor. By a 67 to 47 vote, the House of Delegates adopted the resolution, calling for a policy requiring physicians to report observation of unprofessional conduct by other physicians to the Medical Disciplinary board, except under specified exempting circumstances.

The House of Delegates rejected a resolution calling for WSMA to support the principles of a state income tax and work toward the adoption of same at the meeting of the next legislative session.

Tort reform and tort reform legislation dominated much of the conversation and discussion in the House. After much discussion the Board adopted a resolution which directed WSMA to immediately budget to design and plan an initiative to pursue tort reform through the initiative process if the major effort in the House of Delegates directed that WSMA launch a major effort for tort reform in 1986.

Dues Increase

The WSMA Board of Trustees recommended to the House a dues increase of $100.00 for WSMA dues in 1986. The recommendation was approved by the house unanimously. The Board felt the increased funding was necessary to achieve tort reform legislation in '86. As noted in the latest MSPC newsletter, a major effort is planned.

Notice to Readers. . .

MSPC members who are interested in contributing articles of interest and pertinence to *The Bulletin* are urged to do so. The editor reserves the right not to publish any article submitted, based on space available and pertinence of the topic. Articles should be limited to four double-spaced, typewritten pages or 1,000 words. Exceptions to this may be made by prior arrangement with the editor. Call the managing editor for information on article submission, 572-3666.

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WSMA President addresses Sept. General Membership Meeting.

Commenting on major issues confronting the medical community and the direction WSMA will be taking with regards to certain legislation, WSMA President Dr. John Kennelly addressed the MSPC General Membership Meeting, Sept. 10, at the Doric Hotel.

Emphasizing that large corporations now becoming involved in medicine are not interested in the patient, but in controlling costs, he told MSPC members it was imperative for physicians to become patient advocates.

Dr. Guthrie Turner, Director, DSHS Medical Assistance and Dr. Ron Spangler ponder a question while attending the September General Membership meeting.

Ms. Sue Asher, newly appointed Director, Membership Benefits Inc., relates a recent bike trip to Drs. Ben Blackett and Sidney Whaley.

Drs. Ralph Johnson, James Early and Gilbert Roller take part in a serious discussion at the September 10 General Membership Meeting.

During his address he noted that the relationship between the physician and the hospital is changing dramatically. Where they were once in effect partners, they are now competitors.

Commenting on the "crisis" in medicine, Dr. Kennelly noted that the word has the same characters as change in Chinese, and change, he told MSPC members at the meeting, offers opportunities. Physicians must be ready and able to grasp those opportunities, or they will be passed by, he said.

Fearful that physicians' efforts to unionize in Pierce County would further dilute the energy and resources of the medical community, Dr. Kennelly told the members he shared the concerns and frustrations of physicians who would like to see the energy and commitment channeled into organized medicine's efforts, pointing out that unions cannot do anything for the self-employed physicians that organized medicine cannot do.

Dr. John Kennedy, Seattle urologist and President, Washington State Medical Association, discusses current issues with Drs. Ralph Johnson, and Guus Bischoff, past and current president of MSPC respectively.

Drs. W. Ben Blackett and MSPC President Guus Bischoff talk over some of the issues of the day.

Charity Health Care: Where Do We Go From Here.

Rising health care costs and the continuing upward spiral in liability insurance coupled with decreasing Federal assistance has placed increasing demand for charity health care on the physicians and hospitals in Pierce County.

At the present time there are four community clinics in Pierce County that have been funded through Federal grants since 1980 to service the health care needs of those unable to pay full fee for services. There is one physician for each clinic along with seven full time nurse practitioners and one part time nurse practitioner. The clinics have between 3,800 and 5,100 visits a year. Federal limit is 6,000 visits a year.

"Since the economic recession of 1981," says Florence Reeves, UHI Coordinator, Tacoma-Pierce County Health Department, "we have seen an increasing need for health care as employers caught up in the economic slide have been forced to lay off many long time employees. These people are the new poor. They may not only need health care, but also counseling on what is, in fact, available to them."

While the Tacoma-Pierce County Health Department has seen some leveling off during the last year, the impact is still clearly felt.

"Ideally," says Reeves, "we should have two physicians in each clinic. We would then begin to meet the demands for medical care in this community. But, I don't know if anyone can fund this."

"There is a mentality," says Reeves, "that does not want to accept charity. There is a nominal fee for services, regardless of complexity of the health problem in an effort to retain some element of dignity for those who need the services.

"Seventy percent of those we see," says Reeves, "pay at the time of visit."

Forty MSPC physicians are currently donating their services on a regular basis upon request.

"MSPC member Dr. George Tanbara," says Reeves, "has never turned down a single patient in his life, as far as I know."

Despite the dedication of these doctors, the demand for servicing the health care needs of the poor in Pierce County continues to place a heavy burden on the medical community. Federal funding has leveled off. Liability insurance has nearly tripled in two years. Fixed maintenance costs have increased as hospitals in Pierce County continue to contribute large portions of laboratory and X-Ray services for out patient care.

"Maintaining both the quality and quantity of health care is my concern," says Reeves.

"Many doctors," she says, "are taking care of some of these people we never hear about. Still there are more who come to a public agency in need of health care.

"But," says Reeves, "physicians volunteering to help out is not the answer. We don't have enough space, enough back up support, enough supplies, medication or on site diagnostic support for this. We need to have doctors take people in their office. It would become much less expensive if more doctors would do this.

"With funding diminishing and the cost of health care increasing," says Reeves, "Our ability to service people who need on going medication has decreased. As a result, the patients direct resource to wellness has decreased.

"We are not performing as many emergency procedures as we were even three years ago. We can no longer afford to give out as many medical supplies for home care as we used to, which places an additional burden on those seeking our services, since they must come up with the resources themselves."

According to Reeves, no well physicals are given at the clinics. "These are luxuries," she says. "The first time we see someone they are usually ill.

"The most we were ever able to do was allow one visit per day per clinic on an appointment basis."

The majority of those who come to the clinic with acute illnesses are from 18-years-old to 44-years-old. During the first half of 1985, 3,525 young adults ranging from 20 years old to 34 years old came to the clinics for health care. The total number of patients seen at the clinics was 5,185.

Of special concern for the Tacoma-Pierce County Health Department's Charity Health Care Program, according to Reeves, is getting good prenatal care for women living at the poverty level.

"We cannot," she says, "meet the demand for low income maternity care."

The problem, according to Reeves, is not the lack of generosity on the part of obstetricians, but the high cost of insurance. Liability insurance for obstetrics has climbed from $4,000 in 1983-84 to $13,000 in 1985.

"Many of the women," says Reeves, "need high risk obstetrics care. There are a disproportionate number of women at this economic level who require special care," she says.

"They are under nourished, come in very late in their pregnancy, are often very young. Many end up with caesarean sections the first time."

The biggest threat, according to Reeves, is the loss of midwifery insurance. Currently the clinics are staffed with one full time and one part time midwife who sees 15 patients per month and about 180 a year.

While the current budget for the Tacoma-Pierce County Charity Health Care Program is a little over $1 million, the cost to simply maintain the program has forced cut backs. "We're not even able to offer as many office visits as we have in the past," says Reeves.

"Patients feel more satisfied that they are having their care met when we can

provide the support services," says Reeves. "They equate quality with service. But '86 may be the year of patient dissatisfaction."

Because the clinics will not be able to provide as much care as they have in the past, the community will be in need of greater care. The greatest impact, according to Reeves, will probably be felt by hospitals with emergency care.

For the first time this year, according to Reeves, the program is going to the open market for hiring a physician. Salary range will be between $51,000 to $60,000 per year, plus $600 a year for continuing education.

What it means for a physician, however, according to Reeves, is less autonomy and a sizable patient load. There is more stress and greater need for follow up care.

"Physicians," says Reeves, "feel the stress of what it is to be poor. In working with charity health care they find themselves limited by what they can do economically. They are as poor as their patients." ■

Funding Sources for Charity Health Care Program: 1986

Federal Government	$794,000	54.8%
County	$ 83,000	6.4%
City	$ 93,000	6.6%
United Way	$118,000	9.4%

Total proposed budget for 1986 — $1,492,887.

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4th ANNUAL CANCER CONFERENCE DIETARY PREVENTION OF CANCER: NEW FACTS AND DIRECTION.

Nov. 1, Friday — Jackson Hall
Breakfast: 7:45 A.M., Lecture 8:00 A.M. to 9:00 A.M.
Category 1 approved - 1 hour credit.

PRACTICAL SOLUTIONS IN GERIATRICS
Program Coordinator: John Lincoln, M.D.

November 8, Friday
St. Joseph Hospital Ed. Ctr.
9:00 A.M. to 4:40 P.M.

This one-day course offers practical guidelines for the management of specific medical problems in the elderly. Included will be a discussion of medical problems related to common cardiac, neurological, musculoskeletal diseases, disability and premature death due to fracture, suicide, complications of Alzheimer's disease and diabetes mellitus.

ADVANCED PEDIATRIC LIFE SUPPORT

Nov. 7 & 8, Thursday & Friday, 8:00 A.M. to 5:00 P.M.
Jackson Hall

This two day program includes lectures, discussions, workshops and testing on respiratory distress, obstruction and failure; shock; cardiac dysfunction and dysrhythmia; cardiopulmonary arrest; local trauma; child abuse; environmental injury including poisoning and neonatal resuscitation. Guest faculty member is Dr. Thom Mayer, Director of Emergency Medicine, N. Broward Hospital, Ft. Lauderdale, FL and author of *Emergency Management of Pediatric Trauma.*

CARDIOPULMONARY RESUSCITATION AN UPDATE FOR PHYSICIANS

November 27, Wednesday, 7:00 to 8 A.M.
Jackson Hall — No Fee

Pre-registration required

CLINICAL APPROACHES TO PULMONARY MANAGEMENT
Program Coordinators:
Robert L. Huck, MD
W. Harry Lawson, MD

Dec. 4, Wednesday — Holiday Inn, 1425 E. 27th, Tacoma, Education Grant. No Fee. Category 1, 6 hours. This program will have guest faculty members Dr. John E. Hudgkin, Clinical Professor of Medicine, University of California, Davis, CA, and Archie F. Wilson, MD, PhD, Professor of Medicine & Physiology, Chief Pulmonary and Critical Care Medicine, Dept. of Medicine, University of California, Irvine, CA. Program includes discussion on aerosol bronchodilators, pharmacological & respiratory therapy in patients with COPD, excercise in pulmonary patients and oxygen therapy.

ADVANCED CARDIAC LIFE SUPPORT
Program Coordinators:
Mark Craddock, MD,
David Munoz, MD

Dec. 5, 6, Thursday, Friday, 8:00 A.M. to 4:40 P.M., St. Joseph Hospital, Tacoma. Category 1, 13 hours credit. AMA, AAFP, ACEP, CERP, CEU. This two day program, beginning with registration Thursday morning includes discussion on Myocardial Infarction, Sudden Cardiac Death, Defibrillation & Synchronized Cardioversion, Monitoring & Dysrhythmia Recognition, Cardiovascular Pharmacology I & II, Airway Control and Ventilation, Acid Base, Resuscitation of Children, Medicolegal Aspects of Cardiopulmonary Resuscitation & Emergency Care, and Intravenous & Invasive Techniques.

LAW & MEDICINE SYMPOSIUM
Coordinator: Marcel Malden, M.D.
Medical—Legal Committee
Medical Society of Pierce County

January 16—All Day
St. Joseph Hospital—Education Center

This one-day course will provide information about the financial aspects of medical billing; medical records; medical malpractice; when no-code orders can be issued and a forum of court room practices and procedures loaded with practical information.

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CONTINUING EDUCATION PROGRAMS SCHEDULED FOR 1985—86
P = Physician Course / A = Allied Health Course

	NOVEMBER			
JH	1	★3rd ANNUAL CANCER EDUCATION— DIETARY PREVENTION OF CANCER	KATTERHAGEN	(P/A)
JH	5	★UPDATE—MED. OFF. PERSONNEL—INFECTION CONTROL	DUANE	(A)
JH	6, 13, 20, 27	★Tac Gen Clinical Conf—INTENSIVE CARE	WELED	(P)
JH	7, 8	★ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P)
JH	7, 14, 21	CARING FOR THE CANCER PATIENT	BOULET	(A)
STJ	8	★PRAC. SOLUTIONS TO GERIATRIC PROBLEMS	CLARK/LINCOLN	(P)
JH	27	CARDIOPULMONARY RESUSCITATION (CPR)	ROMINES	(P)
STJ	TBA	AMBULATORY SURGERY	CHILTON	(A)
	DECEMBER			
HOL. INN	4	★CLINICAL APPROACHES TO PULMONARY MANAGEMENT	HOCK/LAWSON	(P)
STJ	5, 6	★ADVANCED CARDIAC LIFE SUPPORT	CRADDOCK/ MUNOZ	(P/A)
	JANUARY			
STJ	14	★ETHICAL DILEMMAS ASSOCIATED WITH MODERN TECHNOLOGY	McCORMICK	(P/A)
STJ	16	★LAW & MEDICINE SYMPOSIUM	MALDEN	(P)
JH	22	★DEPRESSION—THE MASK & THE MASQUERADE	LURIA	(P)
JH	TBA	MARKETING		(P/A)
JH	TBA	CRITICAL CARE NURSING—TIMELY TOPICS	DALTON	(A)
	FEBRUARY			
JH	6, 7	★ORTHOPEDICS & SPORTS MEDICINE IN PRIMARY CARE	CRADDOCK	(P)
JH	5, 12, 19,26	★Tac Gen Clinical Conf-GASTROENTEROLOGY	BAERG	(P)
	MARCH			
JH	6, 7	★ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P/A)
JH	15	★DAYS OF PEDIATRICS	SCHERZ	(P/A)
JH	13, 14	★TACOMA ACADEMY OF INTERNAL MEDICINE	ROWLANDS	(P)
	APRIL			
JH	TBA	★HOME HEALTH AND THE PHYSICIAN	KATTERHAGEN	(P)
UPS	15, 26	★TACOMA SURGICAL CLUB	TAYLOR	(P)
JH	2, 9, 16, 23	★Tac Gen Clinical Conf-INFECTIOUS DISEASE	TICE	(P)
	MAY			
JH	15, 16	★CARDIOVASCULAR DISEASE REVIEW	STRAIT	(P)
	JUNE			
JH	15, 16	★ADVANCED CARDIAC LIFE SUPPORT		(P/A)
	JULY			

★Category I Credit II for Physicians

Preregistration required for all courses.

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College of Medical Education, 627-7137

Pierce County still involved in research on viral hepatitis.

The Centers for Disease Control continue to identify Pierce County as one of four "Sentinel Counties" in the U.S. involved in research on viral hepatitis. Currently there are three ongoing research projects: hepatitis surveillance, case control study, and chronic non-A, non-B hepatitis study. The Tacoma-Pierce County Health Department has been collecting indepth data on reported hepatitis cases since 1979. The results of these data for fiscal year 1984 are shown on the chart to the right.

Since 40% of reported hepatitis B and 36% of hepatitis non-A, non-B cases do not have a known or possible source for acquiring infection, additional funding has been granted from Centers for Disease Control to do a case control study gathering data which may further describe the "unknown sources" for both types.

Also, the incidence of chronic disease associated with a hepatitis non-A, non-B infection has not been well studied. The Health Department in collaboration with CDC and the other sentinel counties will be following all patients diagnosed with hepatitis non-A, non-B for a period of two years. If the patient shows evidence of abnormal liver function during that period, a referral will be made to a gastroenterologist for an evaluation to rule out chronic disease.

The Health Department strongly urges physicians to report hepatitis cases to facilitate data collection for all three studies. To report a case, call the Hepatitis Program at 591-6535.

Type		Rate per 100,000
Hepatitis A	22	4.5
Hepatitis B	39	8.0
Hepatitis NANB	54	11.1*
Unspecified	2	
Total Reported Cases	117	24.1

**Pierce County has the highest incidence rate of NANB among the four counties.*

Demographic Characteristics of Cases

	Hepatitis A	Hepatitis B	Hepatitis NANB
Age			
0-9	4	0	0
10-19	1	4	5
20-39	13	26	25
40-49	3	2	3
50 +	0	1	14
Sex			
Male	13	27	26
Female	8	6	21
Race			
White	17	29	42
Black	1	2	1
Asian	2	1	2
Other	1	1	2

Epidemiologic Characteristics of Cases

Number (%)	A	B	NANB
Day care contact	8 (38)	2 (6)	1 (2)
Contact with case HAV	6 (29)	NA	NA
Travel to Mexico	8 (38)	1 (3)	1 (2)
Raw shellfish consumption	4 (19)	11 (33)	11 (23)
Food handler	2 (9)	3 (9)	4 (8)
Contact with case HBV or NANB	NA	3 (9)	5 (11)
Medical/dental employment	3 (14)	3 (9)	2 (4)
Hemodialysis associated	1 (5)	0	1 (2)
Blood transfusion	0	0	13 (28)
Hospitalized (without transfusion)	0	2 (6)	3 (6)
Dental work	5 (24)	7 (21)	9 (19)
Other percutaneous exposures	0	6 (18)	9 (19)
Drug abuse	2 (9)	2 (6)	5 (11)
Patient or employee at mental institution	0	0	1 (2)
Prison inmate	1 (5)	1 (3)	1 (2)
Homosexual activity	0	14 (42)	0

Medical School Enrollment Down: 3rd Year.

AMA News Release, Sept. 26, 1985.

First-time enrollment in United States medical schools has decreased for the third year in a row, while the numbers of female applicants, students and graduates continue to increase. The trends are reported in Friday's *Journal of the American Medical Association*, which is the 85th annual medical education issue.

Anne E. Crowley, PhD, of the Office of Educational Directories at the AMA, observes that although total enrollment is down, the number of applicants to medical schools increased by more than 700 during 1984-85, reversing the decreasing trend of the past few years. She suggests this may be explained in part by the practice of deferred acceptance; some medical schools allow accepted students to delay enrollment. Of the 35,944 applicants, 17,194 students were accepted by at least one school for enrollment in fall 1984.

"For 1984-1985, women accounted for 35 percent of applicants, 33 percent of the entering class, 32 percent of total enrollment, 30 percent of MD graduates, and 25 percent of residents in graduate medical education programs," Crowley says. She notes that seven years ago, more than one third of specialties had no women in training, but in 1984 there were women residents in all programs except vascular surgery.

The numbers and percentages of medical students from minority groups have not changed much during the last few years, according to the report. Total minority enrollment in medical schools for 1984-1985 was 15.7 percent—5.5 percent blacks, 5.0 percent Asians or Pacific Islanders, 1.9 percent Puerto Ricans, 1.6 percent Mexican-Americans, 1.4 percent other Hispanics, and 0.4 percent American Indians or Alaskan natives.

Approximately 2 percent of students enrolled in U.S. medical schools are non-U.S. citizens, Crowley notes. Seventy-five percent of these students

continued on page 23

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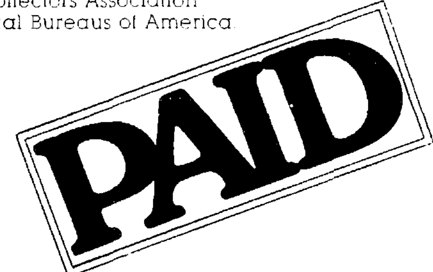

AUXILIARY NEWS

Childrens' Holiday Party, Dec. 6.

PCMSA Annual Childrens' Holiday Party will be held Dec. 6 from 4:00 P.M. to 5:30 P.M. at University Place Presbyterian Church. Plan now to bring your children and/or grandchildren.

Chairperson Marilyn Bodily and Ane Fulcher have planned a fun filled afternoon. There will be activities for all.

Children are asked to bring a wrapped gift for a child with a note on the gift stating what's in the package. These gifts will be taken to the Women's Support Shelter for distribution throughout the year to children there. This has been done annually at our Childrens' Holiday Party and is greatly appreciated by the children at the Women's Support Shelter.

Auxiliary Board Meeting, Nov. 4

Note: Change of Location

The November 4 Auxiliary Board Meeting will be held at Ginny Miller's home at 9:30 A.M. Special guest will be WSMAA President Sue Dietrich, WSMAA President-elect Mary Skinner and WSMAA S.W. Regional Vice President Sharon Lawson. A no-host lunch will follow the morning meeting.

Stefan Kirk winner of Children's Art Contest.

Five-year-old Stefan Kirk, son of Dr. and Mrs. George Kirk of Tacoma is the winner of the 1985 AMA-ERF Holiday Card Contest.

The drawing submitted by Stefan is a very original and charming snowman, complete with stethoscope and black bag. Stefan and his family will be receiving 100 holiday cards for their personal use, featuring his design.

Auxiliary members enjoyed the bright color, variety and originality of all the entries at the Newcomers Coffee in Sept. It was suggested that the Children's Art Holiday Card Contest become an annual tradition.

Holiday Sharing Card: It's not too late!

It's not too late to send your tax deductible contribution to AMA-ERF for the Holiday Sharing Card. However, donations must be in by November 1, so time is running out!

This is an effortless way to send holiday greetings to your colleagues and to support the Nation's medical schools and students. Mail your check today to Sharron Gilbert, AMA-ERF Chairman, 13510 94th St., KPN, Gig Harbor, WA 98335.

November Auxiliary Meeting

The November Auxiliary meeting will be held at the home of Nadine Kennedy. The program for the afternoon is titled, "Women in Transition." Three Auxiliary members, Priscilla Bosch, Peggy Smith and Ella Turner will share with us some of their experiences in beginning new careers. Ruthann Reim of the Individual Development Center, Tacoma, will discuss career/life decisions. Social time begins at 10:30 A.M. The program is at 11:00 A.M. with a luncheon at 12:00 P.M.

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New alternative in medical office automation is proving a winner.

SEATTLE — The trend in health care
automation is moving strongly towards
micro networks in which an open system
architecture is used to deliver specialized
software to each end user. With low cost
micro's supported by large mainframe infor-
mation centers, users are freed from com-
puter operation and management chores
associated with conventional systems.
The "Connected Computing" concept
allows users to fix their computing costs
contractually for periods as long as three
years within a fairly wide framework of
variables.
Micro to Mainframe Prescription. Phy-
sicians have found the transition to a micro
network an easy one. Personal computers
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experts. The result is more efficiency and
increased revenues. Practices that are
achieving these cost-effective objectives are
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specialists use their skills in computer imple-
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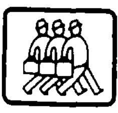

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Multicare

Clinical Oncology Program receives recognition.

The Southwest Washington Clinical Oncology Program (CCOP), led by Dr. Gale Katterhagen and Dr. Ronald Goldberg, has been recognized for two years of quality research.

Based on the quantity of patients served (some 150 thus far) and the quality of reports submitted, the CCOP has been accepted as a full group member in the Southwest Oncology Group, the San Antonio based organization that supplies cancer research protocols. This allows Dr. Katterhagen, director and co-principal investigator of the CCOP, to sit on the Board of Governors for the Southwest Oncology Group. Katterhagen also serves as director of Multicare's Marion Cheney Olrogg Regional Cancer Center.

Based at Tacoma General Hospital, the Clinical Oncology Program involves 11 area hospitals. Kaiser Permanente Hospital, Portland, Oregon, is the most recent addition to the program, joining in August '85.

Funding for CCOP's third year of research on new drugs and new surgical and radiotherapeutic techniques for cancer patients began in September. A fourth year of funding is assured. With the addition of Kaiser Permanente Hospital, and increased local participation in the program, some 300 patients are expected to enter into investigational studies this year.

Four data managers, three of whom are headquartered at Tacoma General Hospital and one of whom works in Portland, are responsible for collecting follow-up information on these patients.

Valerie Graves (seated) and Carolyn Mitchell, data managers in Tacoma General's CCOP office, examine research protocols.

Testifying: A physicians legal obligation?

According to a recent publication of the Washington State Physicians Insurance Exchange and Association, physicians are under no legal obligation to testify, under any circumstances, as an expert concerning another practitioner's medical care, nor do they have to give a reason for choosing not to testify. There is a duty to testify concerning a physician's own treatment, but only as to factual matters, not as an expert witness.

When reviewing the case as an expert witness, the publication suggests physicians not give informal opinions without reviewing the records because the details of a case may be enhanced and exaggerated by the attorney.

"Do not shoot from the hip. It is unfair to review a physician's care without the benefit of all medical and hospital records. You should ask for a copy of the physician's deposition when it becomes available. By reviewing all relevant material, there is a much better opportunity to make a reasonable assessment."

Medical malpractice is not to be condoned or covered up, however, the publication suggests physicians "understand the standard care concept in a malpractice case, and try to put themselves in the defendant physician's shoes."

"Do not let your professional ego interfere with an unbiased evaluation," says the publication. "Be aware that the law recognizes different schools of thought as to course of treatment, and allows for an honest mistake in judgement."

According to the publication, encouragement for a malpractice case is frequently given by the subsequent treating physician, not so much from what is said, but how it is said. Attorneys often refer to this as "medical jousting."

Attorneys and/or insurance companies often find themselves defending lawsuits in cases where a subsequent treating physician or an evaluating physician has "implied" or "hinted" that there has been some negligence or indicated that he/she would have done it differently.

"Just because you would have treated a condition differently does not mean the defendant physician is negligent," says the publication.

Improving medical care is a frequent justification given by doctors for testifying as plaintiff's experts. Unfortunately, malpractice suits do little to improve the quality of care or remove marginal physicians from practice. Most of the improvement seems to appear only in expert's and plaintiff attorney's incomes.

To improve medical practice, it may be wisest to utilize the resources of your county society, state association, hospital staff or the Medical Disciplinary Board. ■

From: Progress Notes. Washington State Physicians Exchange and Association, August, 1985.

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Effective Marketing on a Shoestring Budget

You don't need to go broke to implement a program.

From LACMA Physician, Sept. 9, 1985.

Undertaking a program of marketing a practice is a task which, although not to be taken lightly, need not become a monumental project. Marketing, put simply, is an ongoing process of determining the patients' needs, determining what patients perceive as needs, and matching the services accordingly. Any plan should involve strategy, implementation and monitoring of results.

Following is a number of suggestions which physicians can implement into the practice, if it is determined that those areas are in need of strengthening. The areas are availability to patients, patient relations, promotion, pricing and referrals. These suggestions are generally well-accepted within the medical community and have been used by many other physicians. The important thing is to use those which pertain to the practice, and monitor the results after implementation.

Availability to Patients

- Institute non-traditional office hours, including evening, early morning and weekend hours.
- Make house calls (nearly one-third of the nation's physicians currently do).
- Send reminders for annual health care visits. This could be set up to coincide with the patient's birthday, so that he receives a combination birthday card/check up reminder.
- Provide child care services, either in the practice or at a reputable service nearby.
- Consider making your home telephone number available to patients.

Patient Relations

- Send new patients a welcome letter thanking them, along with a patient information booklet.
- Office staff should acknowledge patients immediately upon their arrival.
- Handle phone calls courteously. Avoid putting calling patients on hold. Office staff should never say doctor is "busy" when patients call to speak to the doctor.
- Provide amenities for the waiting room, such as interesting and up to date reading material, refreshments (coffee, juice, etc.), and educational materials.
- Schedule appointments to allow adequate time with each patient. Surveys indicate that patient satisfaction is directly correlated with the amount of time the physician spends with the patient.
- Explain the necessity of all lab tests and x-ray examinations which you order, and the billing procedures for such examinations.
- Call patients after examinations, where appropriate. Also, call patients with good lab results as well. Patients appreciate knowing all is well.

Promotion

- Become active in the community, and get to know respected community members, including clergy and pharmacists (they are asked for physician referrals often).
- Volunteer to speak before community groups, school groups, neighborhood associations, etc.
- Give free health screenings at community centers.
- Prepare a patient information handbook and distribute it effectively.
- Dispense small health-related items which patients can take with them as a gift from your office.
- Write letters to the editor of your local newspaper about topics on which you are competent to speak.

Pricing

- Price yourself effectively. Choose a pricing strategy that is not only fiscally sound but also sensitive to the financial needs of your patients.
- Develop credit policies, put them in writing and make sure your patients know about the policies.
- Accept-credit cards.
- Help patients file insurance forms. This will let them know you care, and will insure that the forms are filled out correctly.
- Provide written fee schedules to patients upon request.

Referrals

- Contact a consultant in a personal manner and with respect. Writing an order and letting the nurse make the call is not sufficient.
- When initiating a call to a consultant, be on the line. Do not keep the other physician waiting; this is sure to cause resentment.
- Don't dump troublesome patients on consultants just to get rid of them.
- Try to be as accommodating as possible in meeting the needs of both the referring physician and the patient by seeing the patient promptly.
- Develop a written information sheet for the physicians who refer to you. Detail the goals, policies and procedures by which you handle referral patients, and list the various services you offer to referring physicians.

Many of the ideas expressed in this article are nothing more than common courtesies and common sense. However, some physicians might have forgotten or overlooked the value of such effortless ideas as making eye contact with patients, addressing them by name or thanking them for a referral. The key word in dealing with patients is care. ■

Medical School Enrollment Down, continued from page 17

come from 18 Far Eastern countries, 25 countries in Central America or 20 European countries.

The total number of students expected to graduate in 1985 was estimated at 16,347, and 58 percent of these had accepted residency positions in the primary care specialties. The total number of residents in training continues to increase; in September, 1984, there were 75,125 residents on duty in 96 percent of accredited programs. More than two fifths were in family practice, internal medicine or pediatrics.

The report also includes financial information for the 1983-1984 fiscal year. Tuition and fees for medical schools increased by 13 percent from the previous year but remained a small fraction of total revenues. Revenue from service income has nearly tripled between the years 1970-1971 to 1983-1984, from 12 percent of total revenue to 33 percent. Conversely, revenue from federal sources represented 44 percent of the total in 1970-1971 but less than 25 percent in 1983-1984. Financial assistance to medical students increased 10 percent from 1982-1983, with the most notable increases in so-called "loans of last resort," which increased by more than half. "The average education debt of graduating seniors in 1983-1984 was $26,883, an increase of more than 12 percent from the previous year. More than one third of graduates had debts of more than $30,000."

The report notes that during the 1984-1985 school year, 58,767 full-time faculty provided instruction for 67,090 students enrolled in medical schools. Crowley adds, "It should be noted that medical school faculties were also responsible for providing some instruction for 68,000 other health professions students, for conducting continuing education courses for practicing physicians, and for medical research, as well as for the care of patients in the teaching hospitals."

Relative Value Scale for physicians being developed

Under contract with the Health Care Financing Administration, Harvard University is developing a Relative Value Scale for physician's services. The contract was scheduled to become effective Sept. 15, 1985. Under the proposal, the AMA will be a subcontractor.

The Association will provide advice on the project's overall objectives, directions and research methodology. With the cooperation of the national medical specialty societies, it will recruit physicians to be involved in the study.

The Association also will analyze and tabulate physicians' practice costs. HCFA's interest in the project stems from a desire to determine whether fee schedules based on an RVS might provide a workable method for reimbursing physicians under Medicare.

"The AMA is pleased to have a key role in the development of this RVS," said AMA Executive Vice President James H. Sammons, MD. "This repesents a real opportunity for all physicians to be in a leadership role on the reimbursement issue."

The project is expected to run for 30 months. ■

Practice Management
You're Late, You're Late, for a Very Important Date!

By Mitchell C. Sollod, MD

Reprinted from San Francisco Medicine, June 1985.

DEAR ABBY: My doctor is always late. I have tried taking his first appointment of the day, but invariably he is at least 45 minutes late getting started.

I've tried making later appointments, but it's even worse; in addition to starting late, he falls behind. I'm a working person, and time off costs me money. Where does he get off wasting my time and costing me money?

He's a very good doctor and I like him, but I am fed up. Don't tell me he's out saving lives; he's a dermatologist! What should I do?

—MAD IN MINNEAPOLIS

DEAR MAD: Knowing that the doctor is chronically late, telephone his office and ask his nurse how far behind he is before you leave for his office. If his nurse isn't cooperative, scratch this dermatologist. It appears that you're itching to change doctors, and I don't blame you.

(From "Dear Abby," *San Francisco Chronicle,* March 31, 1985.)

Notice he *starts* 45 minutes late! Do you have 3 emergencies per week which delay you? If you're not in your office by your starting hour, change it to conform to reality. Your staff can tell you what is good for your patients and you. Perhaps you should allow 15 minutes every 2 hours as catch-up because of telephone interruptions and the need to call back patients.

To protect the people who'd be delayed by someone who was late before them, consider a modified wave schedule. Two patients scheduled on the hour and none on the last appointment slot of that hour (eg, 2 p.m., 2 p.m., 2:15, 2:30, none, 3 p.m., 3 p.m., etc). This minimizes patient delays and allows you to be efficient and timely.

How about Mr. Komplane whose procedure takes 15 minutes but whose complaints take ½ hour? Schedule him ½ hour or he'll ruin your day, your other patients' days, and your practice. For the chronically late Mrs. Tardee, give her an appointment time 10 to 15 minutes before you plan to see her. Of course she'll then be prompt, sigh.

As "Mad" says, "I'm a working person, and time off costs me money." Once people recognize that you are prompt, they too will be prompt. You want to consider your patients' time, money, and resources. This will lead to their satisfaction with your practice and you.

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Urlich Birlenbach, MD, *Internal Medicine.* Born in West Germany, 4/26/52; medical school, Universidad Autonoma de Guadalajara, 1980; internship, Resurection Hospital, Chicago, 7/80-6/81; residency, St. Joseph Hospital, Chicago, Internal Medicine, 7/81-6/84; Chief Resident, St. Joseph Hospital, 6/84-6/85. Washington State License, 1985. Dr. Birlenbach is currently practicing at 7424 Bridgeport Way West, Tacoma, Washington.

William P. Brennan, MD, *Cardiology/Internal Medicine.* Born in Seattle, Washington, 10/5/53; medical school, University of Washington, 1980; internship, University of Utah, Internal Medicine, 6/80-6/81; residency, University of Utah, Internal Medicine, 6/80-6/81; residency, University of Utah, Internal Medicine, 7/81-6/83; Cardiology Fellowship, University of Utah, 7/83-6/85; Angioplasty Fellowship, Sequoia Hospital, Redwood City, California, 7/85-10/85. Washington State License, 1985. Dr. Brennan is currently practicing at 126 Auburn Avenue #401, Auburn, Washington.

Terryl R. Collins, MD, *Pathology.* Born in Vancouver, Canada, 10/15/46; medical school, University of Chicago, 1980; internship, Loyola University Medical, 6/80-6/81; residency, University of Chicago, 7/81-6/82, University of Washington, 7/82-6/85. Washington State License, 1985. Dr. Collins is currently practicing at 215 South 36th & Pacific, Tacoma, Washington.

James A. Nowogroski, MD, *General Practice/Industrial Practice.* Born in Aberdeen, Washington 4/9/45; medical school, University of Washington, 1971; internship, Hennepin County General Hospital, Minneapolis, Minnesota, 6/71-6/72. Washington State License, 1972. Dr. Nowogroski is currently practicing at 10109 Plaza Drive SW, Tacoma, Washington.

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Physicians and public continue to view health care costs as main problem facing medicine!

Health care costs continue to be viewed by physicians and the public as the main problem facing medicine today, according to a report of the Council on Long Range Planning and Development filed by the AMA House of Delegates.

Based on telephone interviews with 1,000 physicians and 1,500 randomly selected adults, the report said 68% of the public respondents and 50% of the physician respondents ranked costs as the greatest problem.

Since 1982, however, the trends in public and physician attitudes on costs have diverged. The level of public concern over costs has persistently increased. Physicians' concerns about costs, on the other hand, have decreased while their concerns about government regulation have increased.

While physicians in the 1984 survey no longer ranked costs as the most important problem facing health, a substantial majority (69%) indicated they had become more sensitive to cost considerations of medical treatment decisions.

A slight majority (56%) of physicians said they would favor modifying current standards of medical care to include an increased emphasis on cost considerations.

By a large majority, both physicians (71%) and the American public (86%) believed the costs of health care could be reduced without compromising the quality of services. The data were collected by AMA Survey and Opinion Research, Larry J. Freshnock, PhD, Director. ■

Medical Society of Pierce County

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GENERAL MEMBERSHIP MEETING

TUESDAY, NOVEMBER 12, 1985

"NEUROSURGEONS IN CHINA"

A tour of the Universities of Peking, Shanghai, Soochow, Canton and Hong Kong
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— also —

WASHINGTON STATE PHYSICIANS INSURANCE ASSOCIATION

"WHAT'S AHEAD FOR '86"

Mr. Tom Fine

DATE: Tuesday, November 12, 1985

TIME: No host cocktails 6:15 P.M. Dinner 7:00 P.M. Program 8:00 P.M.

PLACE: Doric Tacoma Motor Hotel
242 St. Helens Avenue

COST: Dinner, $12.00 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County,** in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Due to the special arrangements necessary for this meeting, reservations must be made no later than Friday, November 8.

REGISTRATION:

Yes, I (we) have set aside the evening of November 12 to join my fellow Society members.

__ Please reserve ____________ dinner(s) at $12.00 per person (tax and gratuity included). Enclosed is my check for $______________.

__ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr: ______________________________

RETURN TO MSPC BY NO LATER THAN FRIDAY, NOVEMBER 8.

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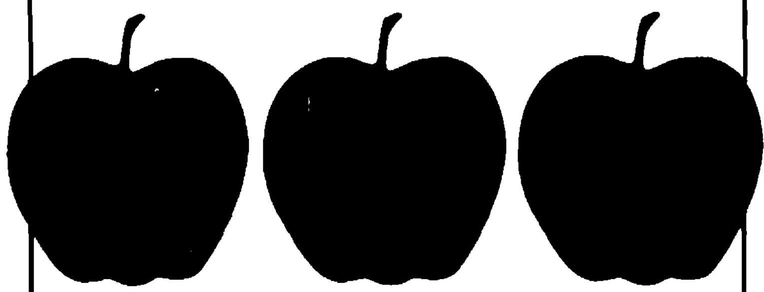

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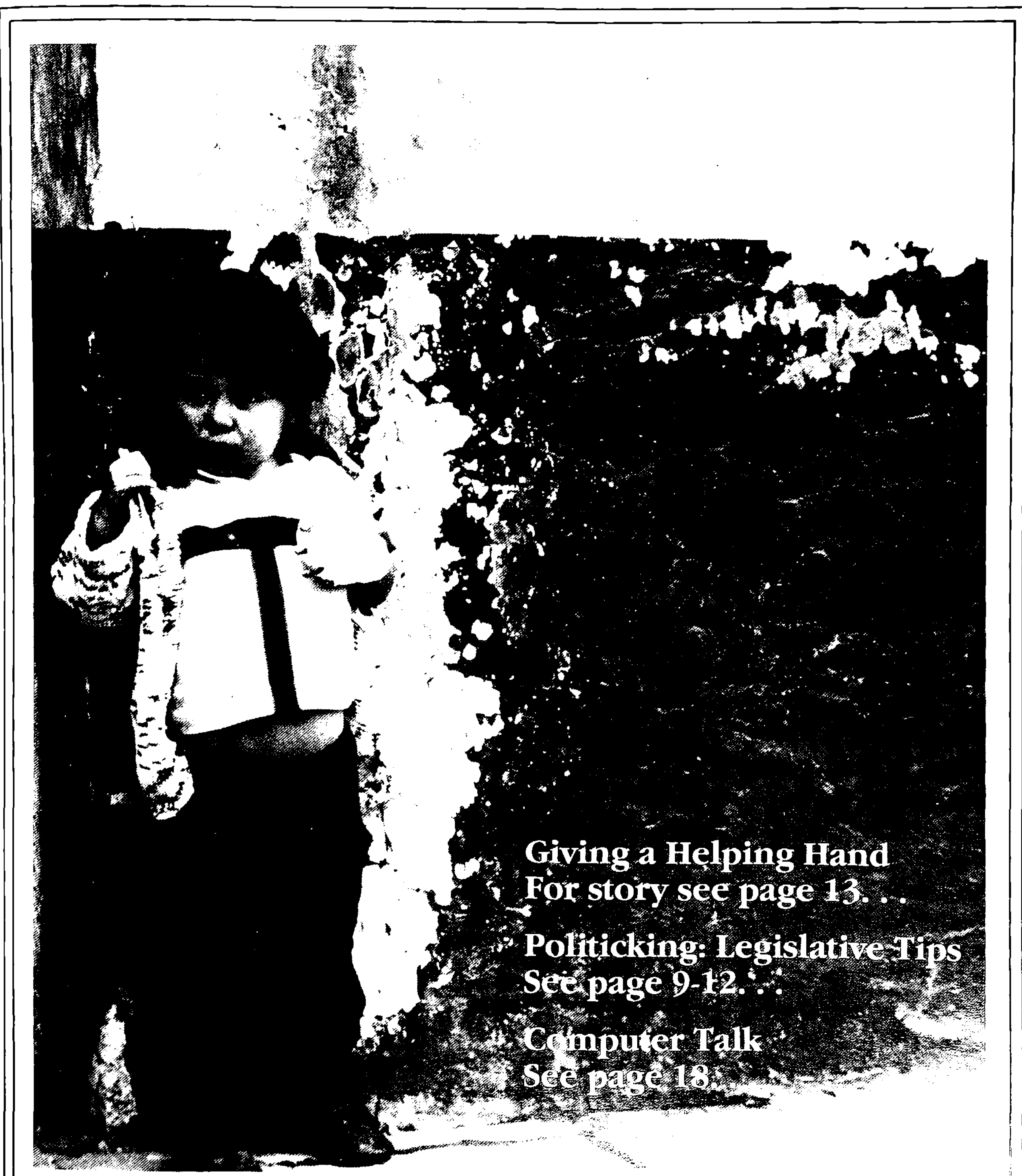
MEDICAL SOCIETY OF PIERCE COUNTY

December, 1985



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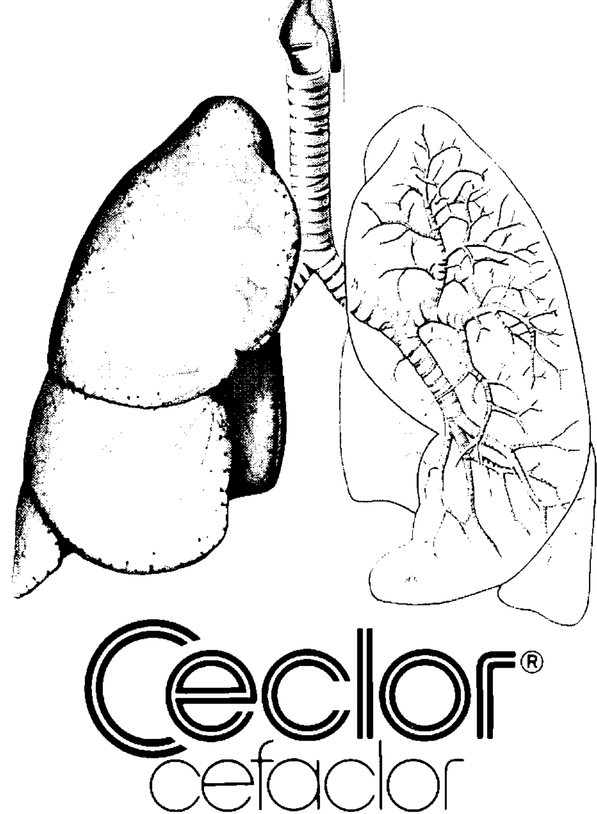

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Indications and Usage Ceclor (cefaclor Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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The Bulletin *The official publication of the Medical Society of Pierce County*

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Cover Photo: Courtesy Dr. Robert Osborne.
Child receives treatment at Salvation Army clinic
in Mexico City.

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President's Page

T.G.I.Y.E. This is not any foreign language, but stands for what most of us are likely to say every Friday, except for me this is the end of the year.

Well, what can I say, or rather write. I am not inclined to ponder or make predictions about the future and the past is as well known to you as it is to me.

I feel, however, that in ways this has been a frustrating year. Not because of the tremendous amount of work done and accomplished by those people who are involved, but rather due to having become aware of the lack of interest of the majority of our society members. We are lucky, that in Pierce County we at least have a monetary commitment from the majority of practicing physicians, which is even lacking in other areas of the state and nation; it is, however, frustrating to see that there is not even interest in a social gathering in spite of the fact that our meetings only happen a few times a year. I know we all can produce excuses as to why we do not attend. However, if any outsider other than the speaker, who often does not belong to the Society, would be able to come to the meetings, I wonder what they would think about our commitment.

We have about 570 members and for the November General Membership meeting only about 70 made reservations. At the special meeting in June, regarding the risk management and important bylaw changes pertaining to the election of your Board, a grand total of 13 showed up. These figures speak for themselves.

However, there are those who do feel committed and who put in a tremendous amount of work for the benefit of all of us, including the nonmembers of the Society.

I do not feel that I want to single anybody out, but thanks and appreciation should be given to all of those who are on committees and who have spent long hours of their time for the Society and on many occasions in the public interest and welfare in general.

I would further like to include those whose activities benefit us, though not necessarily through the Society. As stated before, I will not mention their names as you yourself are well aware of who they are, but I personally am grateful to them as otherwise, I'll guarantee you, the situation would be chaos, and more difficult than it is even now.

I know your next Board is a strongly committed one and I hope that we as members will support them adequately so they will not feel frustrated during their efforts on our behalf. (One can always hope.)

I know this has not been a statement of joy, but why write about wine and roses when they are not exactly present in great quantities.

Again, I wish to thank all of you who worked for the Society in whatever way.

— *GWCB*

NEWSBRIEFS

MSPC Annual Meeting, Dec. 10

Installation of Officers and Trustees— Seattle Humorist Stan Boreson to highlight evening events

Installation of 1986 officers and trustees will highlight the Annual Joint Dinner Meeting, Thursday, Dec. 10. The new Holiday Inn has been selected as the site for an always joyous occasion. A raffle of three cabbage patch dolls, a case of assorted wines and other prizes will be part of a gala evening.

Seattle area television personality Stan Boreson will be the featured after dinner entertainment. He is a consummate entertainer-singer and humorist. When Boreson takes the stage the audience is treated to a never-ending, hilarious session of songs, parodies, gags, skits and one-liners.

Plan to attend. No host cocktails will begin at 6:30 p.m. A holiday buffet dinner will follow at 7:15 p.m. with the program beginning at 8:15 p.m. For your reservation form, see page 25.

Dr. Stanley Mueller, Orthopedic Surgeon, will be moving his practice from 212 South J Street, Tacoma to 2420 Union Ave. South, Suite 300, Tacoma 98405. Dr. Mueller's phone number will be (206) 756-0888; answering service phone number is 272-3166. He will be in his new office beginning Jan. 2, 1986.

Correction Notice: The Donor Hotline Number is 1-800-422-3310.

MSPC/WSMA preparing groundwork for Legislative Session

WSMA/MSPC Malpractice Reform Campaign is taking shape. Community Action Teams (CATs) have been organized for each legislative district. CATs will meet with local legislators, promote local coalitions with others concerned about the need for personal injury compensation reform and work to gain positive local news media coverage of the issues.

The Community Action Teams will be meeting with local legislators along with other individuals and organizations interested and impacted by the growing problem of liability coverage.

The movement for malpractice reform is not designed to protect negligent physicians; nor is it designed to limit the legal rights of patients who have legitimate claims. In fact, central goals of the reform movement are to:

- Reduce injuries to parties.
- Provide reasonable compensation to the injured patient.
- Accelerate the resolution of patient claims.
- Reduce the enormous legal cost of these claims.
- Reduce the cost of professional liability insurance.
- Make individuals responsible only to the extent of their fault.

If you would like to participate and have not been called, please contact the Medical Society Office.

The Medical Society office has received notice that an Alpha Epsilon Delta fraternity pen was found at the Terrace Retirement Center. The owner may call Mr. Zimmerman, 759-4640.

Volunteers needed for Phone Tree

One of the most powerful tools an organization can have during a legislative session is a phone tree. It allows the organization to get information quickly to hundreds of members throughout the county, who can then respond to their individual legislators.

We are asking for volunteers for the upcoming legislative session. What is involved when belonging to a Phone Tree is minimal. Periodically, throughout the Legislative Session you will receive calls from an 'Activator' in your district who will give you information or brief messages to convey to your legislators. You will also be given a toll-free number you can call to relay the message to your legislator. It doesn't take much time, and it will affect the actions of your legislator and other governmental officials.

Because of the urgency of the '86 session, we are in great need of more activators. Being an activator means you agree to call the six or eight people on your list each time the Phone Tree is used. The message you convey is always kept simple and will not require extensive background in legislative issues to pass it on.

Do say you'll help! If you are willing to be an activator, call the Medical Society office. We will then mail you the list of people you will be contacting.

Dr. Kenneth Graham's office address is incorrect in the 1986 Directory for Physicians and Surgeons. The correct office address is Allenmore Medical Center, A-240, Tacoma, 98405. Dr. Graham's correct phone number is 383-4551.

MSPC Physicians receive honor

In recognition of their outstanding work in the field of medical radiology, Drs. Vernon O. Larson and William L. Rohner have been named fellows of the American College of Radiology, a national association of over 20,000 diagnostic and therapeutic radiologists and physicists dedicated to improving health care through the science of radiology. The honor was bestowed in a ceremony at the annual meeting of the American College of Radiology, Montreal, Canada.

A graduate of the University of Iowa College of Medicine, Iowa City, Iowa, Dr. Rohner is currently associated with St. Joseph Hospital, Tacoma General Hospital and Puget Sound Hospital.

Dr. Larson is a graduate of the University of Washington School of Medicine, Seattle, Washington. He is currently with Good Samaritan Hospital, Humana, Lakewood General, Mary Bridge Children's Hospital and the Veterans Administration Hospital, American Lake.

Physician to Population Ratio expected to increase.

The physician to population ratio is expected to increase 17% by the year 2000. The 10-member Task Force on Physician Manpower, which the AMA Board of Trustees created in response to Substitute Resolution 47 (A-85), has concluded that a short term increase in the number of practitioners relative to the population appears to be inevitable.

Even dramatic changes, such as reducing the number of students entering medical school or barring foreign medical graduates from residency training in the United States, would have a limited impact on physician supply in the next 15 years. The Association's physician manpower policies will be appraised at the 1986 Annual Meeting of the House of Delegates. The manpower task force, under the chairmanship of Charles N. Aswad, MD, plans to complete its deliberations in time to guide the delegates' discussion.

From: AMA Newsletter, Oct. 16, 1985.

MSPC Professional Relations Committee

Your MSPC Professional Relations Committee offers help for impaired physicians. Anonymity and confidentiality are assured through this local self help group. For help call 572-2470; or if you prefer call the WSMA Hot Line number, 1-800-552-7236. Your colleagues want to help.

MSPC Professional Relations Committee members

William A. McPhee 474-0751
Patrick Donley 272-2234
Ronald C. Johnson 841-4241
Jack P. Liewer 588-1759
Robert A. O'Connell 627-2330
Dennis F. Waldron 272-5127
Joseph F. Kramer 845-9511
John R. McDonough 572-2424

MSPC Member testing political waters

Dr. Mark Jergens, emergency physician, St. Joseph Hospital, is campaigning for a position on Fire District #5 Board of Commissioners in the Gig Harbor area. Dr. Jergens is Chairman of the MSPC EMS Committee and served for over two years as Program Director of the Pierce County Emergency Medical Services.

The Board of Commissioners is responsible for overseeing budgetary and planning aspects of the district administration. Win or lose, Dr. Jergens is to be complimented on entering the political arena.

Child Abuse and Neglect Community Services Conference

The 1985 Child Abuse and Neglect Community Services Conference will be held Dec. 6, from 8:30 a.m. to 5:00 p.m. at the Executive Inn, Fife. Cost for the conference is $10.00, which includes lunch and beverages.

Goals of the Conference will be to focus on new directions for the future and to share with the service-providing community the work that the Pierce County Child Abuse and Neglect Director's Task Force has completed.

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Pierce County Medical Library Hotline

Dear Patrons:

Recently, we have sent you letters asking for special monetary contributions to the Pierce County Medical Library. The December issue of this Bulletin affords us another opportunity to ehance our efforts for maintaining high-quality library services to this medical community. The Medical Society of Pierce County and the eight community hospitals comprising the Pierce County Medical Library Consortium have asked us to hold our budget for 1986 at the 1985 level. Therefore, we have to try and generate the difference of five to seven thousand dollars.

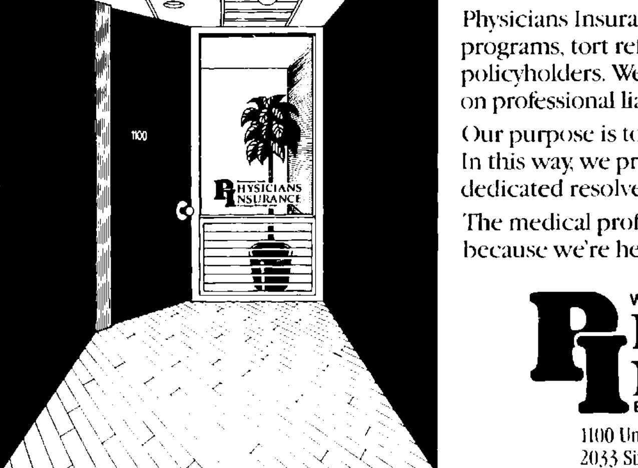
As many of you know, we have, since 1974, provided comprehensive library and information services to meet your expectations and diverse needs, from high-quality collections to computerized literature searches, to linkage with local, regional, and national networks including electronic mail delivery. In addition, thanks to Doctors Apa, Kapela, & Eggen, Inc., DBA/AKE Laboratories, we continue to provide a daily free courier service.

To be able to continue library services at the existing level of excellence we urgently need any tax-deductible contribution you care to make. Your help will be greatly appreciated!

Marion von Bruck
Coordinator of Library Services
Pierce County Medical Library Consortium

Today and tomorrow...

It's comforting to know we're here.



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Crisis! Crisis!

Editorial

By W. Ben Blackett, MD

Is it a crisis when the storm is coming, the hull is leaking and the bilge pumps aren't working, or only when the boat finally sinks?

Is there any point in debating whether the crisis is when the trend warns of a disaster or only after the disaster occurs? The fraternity of trial attorneys sees no crisis to the medical profession or to the public in the trend of medical negligence recoveries and insurance rates. But (and this is hearsay and not admissable) I heard that at a recent county bar association meeting—a county just north of Pierce—several ATLA attorneys referred to lawyers increasing professional insurance rates as a crisis.

The re-insurance industry thinks it is having a crisis. Some underwriting results of the re-insurance industry nationally are shown below:

Industry Cash Flow From Underwriting (in Billions)

Year	Amount
1977	$14.4
1978	15.1
1979	11.8
1980	7.2
1981	3.3
1982	(3.4)
1983	(4.1)
1984	(11.0)

The losses by lines of business show that the problem is not confined to medical professional liability (although that is the worst class).

1984 Combined Ratios

Line	Ratio
Total Property/ Casualty Industry	117%
Personal Auto Liability	113%
Personal Auto Physical Damage	100%
Homeowners Multiperil	106%
Workers Compensation	122%
Commercial Auto	134%
Commercial Multiperil	135%
Other Liability	152%
Medical Malpractice	170%
Total Reinsurance Industry	127%

If certain risks become too great and too unpredictable one can hardly blame the insurance industry for dropping lines of business that threaten it with bankruptcy. The change to claims made insurance is simply the reinsurance industries' strategy for staying in business. If truly effective tort law reforms can be made and sustained, claims made insurance should actually be less expensive than the present occurrence form and some plaintiff trial attorneys may choose another line of work.

If the sheep are dying is it a crisis for the wolf? Maybe I'll ask the Bhagwan.

Wall Street Journal carries story on for-profit hospital chains

In a headline story, Oct. 10, 1985, the Wall Street Journal related the tale of events taking place on Tuesday night, Oct. 8, when Hospital Corporation of American officials told analysts that the companies net income, while up 10% in the third quarter from a year earlier, would be flat for the fourth quarter and that next year's profit is likely to be about the same as that of 1985. American Medical International followed with an announcement of a 38% drop in net income for the fiscal fourth quarter.

Health care stocks plunged. In one day, the four major hospital chains lost more than 1.5 billion in market value. The news represented a radical shift for an industry built upon 20% annual earnings, gains and predictable growth.

The Wall Street Journal went on to report that a "revolution is moving through the country's health care system, and to cope with it, the nation's for-profit hospital chains have embarked on a major restructuring campaign."

"How these companies deal with the new environment, not only will determine the industries' future, but also will influence the structure of the U.S. health care system for decades to come."

Dr. Paul Ellwood, Jr., architect of the health maintenance organization movement, is quoted as saying, "There will be ten giant national firms providing 50% of the medical care in this country by the mid 1990's." Dr. Ellwood has been hired as a consultant by the largest hospital chain, Hospital Corporation of America, after the companies' disclosure that its growth now is sharply lower than it has been.

If you would like a copy of the article, call the Medical Society office, and it will be sent to you.

Politics on a Grass Roots Level: It Can Make the Difference

"All politics is applesauce," Will Rogers once said. To the uninitiated, that may very well be true. The entire maze of politics may present itself as a maelstrom of confusing processes, bill numbers, committees and a raft of issues which seemingly never end, and worse yet, change all the time. Confronted with the prospect of entering into any meaningful lobbying effort, it is little wonder that most people shy away from getting involved in the active political arena.

However, the issues themselves remain —issues which have a definite impact on the practice of medicine today. Of course, organized medicine has its own lobbyists working in the legislature to further the cause of medicine and act as a patient advocate. But a great deal of the support comes from physicians getting involved in the process. This support may be in the form of donations to organized medicine's political action committees or becoming a key contact to a legislator in a district. There are many things physicians may do to become involved on a grass roots level.

Getting your political point of view across to your legislator is not the difficult task many constituents think it is. A well-stated point of view in the form of a letter can carry more weight in how the legislator votes than many people think. Legislators value the opinions of their constituents, and weigh the opinions expressed to them carefully. It is also usually a safe assumption that the opposing point of view has already let the legislator know its position; therefore, the importance of writing when an important issue comes up increases.

There are several points to keep in mind when communicating with your legislator. First of all, know who your legislator is. When writing, make sure the letter is timely. A letter received just prior to a vote will be fresher in the legislator's mind than one received a month before a vote. In the same vein, a letter received after a crucial vote is moot.

A letter which is written by a well-informed individual lets the legislator know that the author is serious about the legislation, and the legislator may take the letter more seriously. Identifying a bill by name, number and author, when possible, also makes it that much easier for the legislator to figure out what you are talking about, therefore wasting less time.

It is usually best to open the letter with

continued on next page

Here's A Sample Letter To A Legislator

Jane Smith MD
1925 Tacoma Avenue
Tacoma, WA 98466
Nov. 7, 1985

Senator John Doe
Legislative Building
Olympia, WA 98504

Dear Senator Doe:

I am writing to urge your support of SB 000, a bill which is of great importance to our patients as well as physicians and organized medicine.

For the past four years, patients have needed some protection against government intervention in the areas covered by SB 000. In particular, the financially disadvantaged patient stands to gain a great deal from passage of this piece of legislation.

Quality of care should always be the main issue when dealing with the health and welfare of our society. SB 000 will strike a mighty and much-needed blow in favor of quality care. In addition, the costs for the state, over the long run, will be greatly diminished from current levels.

I would like to take this opportunity to thank you for your recent vote against SB 999. Thankfully, the damage, confusion and unfairness it would have brought about has been staved off, at least for now. I am passing along word of your vote to my colleagues.

Sincerely,

Jane Smith MD

Politics on a Grass Roots Level** **continued from page 9

your position on the bill, identifying it as completely as possible. Use the rest of the letter to give your reasons for holding your particular point of view. The reality is that the legislator may not always have the time to fully read each letter. If you state your position clearly at the onset, your opinion will be noted without anyone having to search through the letter. Also, stating your position at the beginning will reinforce the reasons throughout the rest of the letter.

Keep in mind that a personal letter is much more effective than a form letter or a photocopy with your signature on it. Write the letter on your own letterhead, and put your feelings in your own words. Sign the letter by hand. Make sure your return address appears on the letter as well as the envelope, since envelopes are often separated from the letters and discarded.

When stating your reason for taking a particular position, do so clearly and concisely. Avoid rambling sentences. State how the legislation would affect patient care first; then discuss its impact on the physician.

Do not use threats or ask for the impossible. Doing so will render the letter ineffective.

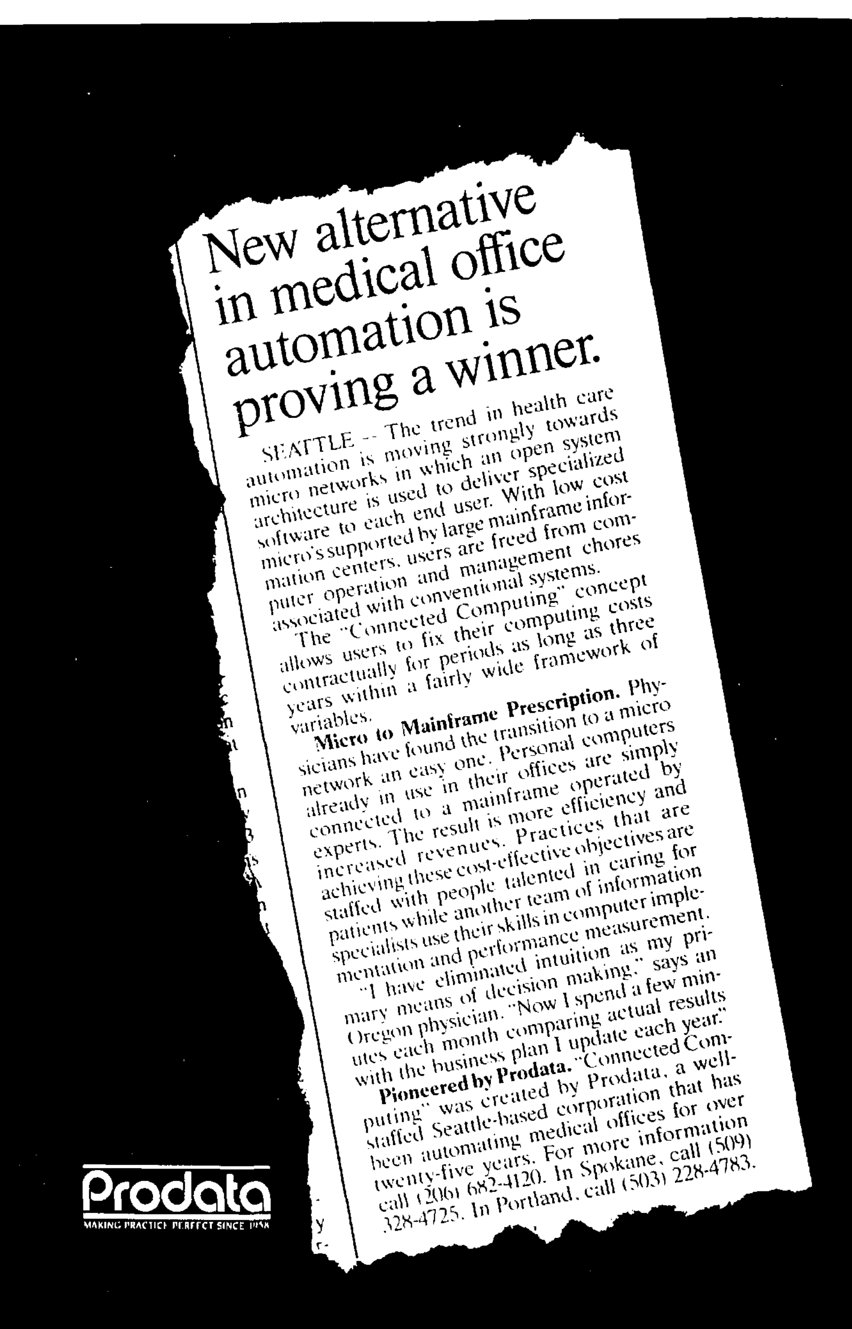
Thank the legislator for reading the letter. Keep up a regular correspondence with the legislator—it will pay off in the future with added clout on important issues.

If you need any assistance writing the letter, contact the Medical Society office for background information on bills, current status and other pertinent information. Send a copy of the letter to the Medical Society office, which keeps track of the lobbying efforts made to each legislator.

Another effective way of communicating with the legislator is by mailgram. It's quick, easy, inexpensive and very effective. The content will be shorter than that of a regular letter, but most of the other pointers for writing a letter apply. This service is provided by Western Union, and may be billed one of three ways: to the calling number, to your home telephone number or to a major credit card. The telephone number is 1-800-325-6000.

Perhaps the easiest way to get your opinion across to your legislator is by telephone. This type of lobbying is very effective and requires very little effort. Determine who your legislator is and call his or her office. Give your name, hometown, name and number of the bill you are giving an opinion on, and state briefly your position on the bill and what action you would like your legislator to take. If talking to a legislative aide, ask him to pass your position along to the legislator. Do not engage in a lengthy conversation giving all your reasons for why you feel that way about the issue. This is not the proper forum for that. If you need information on the current status of a bill, either the legislator's office or the Medical Society office can provide the necessary information. ■

Material for this section was taken from *LACMA Physician*, October 7, 1985.



The Ethics of Politicking

Whenever the physician enters the arena of political activism, whether it be on a limited basis or wholeheartedly getting involved, there are various ethical considerations to be aware of. These considerations range from basic protocol to realistic expectations, things which can and should be said to things which should never be said. If there is ever a question if something is proper, contact the Medical Society office. If that is not possible, use common sense, prudent judgment and don't say anything that may be regretted later.

One of the cardinal rules in dealing with legislators is never make threats. They can destroy achievements which have taken months or years to accomplish

One of the cardinal rules in dealing with legislators is never make a threat. Threats ruin any kind of future relationship one might otherwise enjoy, and can easily tear down achievements which have taken months or years to accomplish. The best bet is to try and achieve goals through positive means.

In the political process, medicine is under a microscope, as the saying goes. Legislation dealing with medical issues commands headlines, and the lobbying activities of medicine's proponents are well documented. It is important to be nothing less than completely truthful, factual and as scientific as possible in all dealings with legislators.

Money and politics are a very touchy combination. Whenever the two mix, great care must be taken to avoid "sticky" situations. Political contributions cannot buy an issue. When a donation is made, the only reasonable expectation one may have would be possible increased access to the legislator, and that is at the legislator's discretion. Money is only one factor in the overall lobbying effort. It is important, but is not a substitute for diligence, effort and awareness. **It is a felony to ask for a commitment on a specific legislative issue in return for a monetary contribution.**

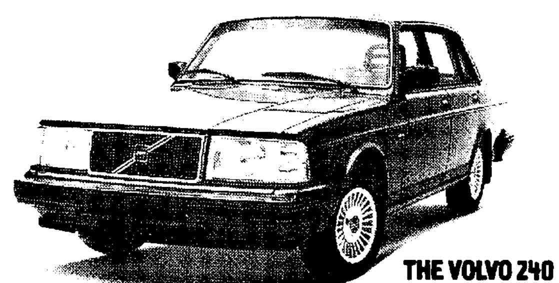
When the legislator indicates that he will most likely vote a certain way on an issue, that is not a hard and fast commitment. With any issue which comes up for a vote, there are generally advantages, political and otherwise, for the legislator to vote either way. It is necessary to understand that there are times when the legislator must be "gracefully" released from a commitment on a vote. For instance, Assemblyman John Doe says he will vote yes on your bill, although he had a tough time deciding since there were also good reasons why he should vote no. As the vote is being taken, it appears the bill you were backing is going to lose by a very wide margin. In this instance, it would be much wiser politically for Assemblyman Doe to vote no, in order to get more value out of his vote.

When lobbying your legislator, particularly if you are doing so in a key contact role, keep organized medicine's position separate from your personal position, if they differ. When acting in a capacity of lobbying under the organized medicine banner, represent only those positions.

Another important point to remember is that when contact is made with the legislator, it shouldn't always be to ask for something. An effective lobbyist will be there in good times and in bad, when he has something to offer as well as something to ask for. When your legislator votes with you or goes the extra mile, don't forget to send along a thank you message. It takes only a moment, but the goodwill it generates is immeasurable.

Loyalty and your personal word are two of the most important tools a lobbyist has. If you say you are going to do something, follow through with it. If it becomes impossible for you to do it, explain why to those to whom you made the commitment. Politics can be a very unforgiving game, and the players can have very long memories. ■

From *LACMA Physician*, October 7, 1985.



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Most people would be happy to build a car with an average life expectancy of 15.6 years.*

But Volvo engineers are harder to satisfy than most people. That's why, for 1986, they've made improvements in the Volvo 240. Improvements that include heated front seats, more comprehensive rustproofing and a re-styled body aimed at bringing the aerodynamics of the 240 to a new low.

Which is another reason why it's high-time you stopped by our Volvo showroom for a test drive.

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Your Legislative Guide . . .

Senators	Olympia Phone Number	Key Physician Contact
2nd District		
R. Ted Bottiger (D)	753-7602	Don Pearson, MD
25th District		
Marcus Gaspard (D)	753-7648	Donald C. Weber, MD
26th District		
Win Granland (D)	753-7650	Richard F. Amber, MD
Lorraine Wojahn (D)		Alan Tice, MD
28th District		
Stan Johnson (R)	753-7654	James D. Krueger, MD
29th District		
A.L. "Slim" Rasmussen (D)	753-7656	Stanley W. Tuell, MD

Legislative Mail Address:
Senator ______________________
Legislative Building
Olympia, WA 98504

Representatives	Olympia Phone Number	Key Physician Contact
2nd District		
Wayne Ehlers (D)	753-7824	James K. Symonds, MD
Ken Madsen (D)	753-7912	Walter M. Arthur, MD
25th District		
George Walk (D)	753-7948	W. Dale Overfield, MD
Dan Grimm (D)	753-7968	Michael Haynes, MD
26th District		
Linda Thomas (R)	753-7964	Gregory Popich, MD
Bill Smitherman (D)	753-7802	William B. Jackson, MD
27th District		
Ruth Fisher (D)	753-7930	Michael Jarvis, MD
Art Wang (D)	753-7974	George Tanbara, MD
28th District		
Sally Walker (R)	753-7890	Terry Torgenrud, MD
Shirley Winsley (R)	753-7958	Joseph Nichols, MD
29th District		
P.J. "Jim" Gallagher (D)	753-7906	
Brian Ebersole (D)	753-7996	Richard Hawkins, MD

Legislative Mail Address:
Representative ______________________
Legislative Building
Olympia, WA 98504

Olympia Telephone Numbers:
WSMA Olympia Office
(24 hr. answering for messages) . . . . (206) 352-4848
Lobbyist Message Center
(Capitol Building "Ulcer Gulch") 754-3206

For urgent and quick messages to your legislator call the Legislative Hot Line, Toll Free 1-800-562-6000, and leave your message.

Giving a Helping Hand

Two weeks after the devastating earthquake that rocked Mexico City in September of this year, a 21-member medical team from Tacoma arrived to help with the disaster. Only a few in the team spoke Spanish. Those who did helped as interpreters.

Susan Averill, a registered nurse at St. Joseph Hospital was responsible for organizing the medical team that included Drs. Robert Modarelli, Biff Fouke, Peggy Goldman, Rogelio Ruvalcaba, Robert Osborne and Charles Williams. All six doctors volunteered their time.

For Averill, however, getting approval from the Mexican government was no easy task. The Mexican government does not allow physicians from a foreign country to practice medicine without a sponsor. After many frustrating hours on the telephone, she finally found a sponsor with the Salvation Army who was in the process of setting up an alcohol and drug rehabilitation clinic in Mexico City when the earthquake hit.

The team left for Mexico City knowing only that they were replacing a medical group from Seattle. With communication networks knocked out there was no exchange of information before they took off.

Knowing there were risks and knowing they would be out of touch with families and friends while they were in Mexico City, why did they go?

In answer, says Dr. Robert Modarelli, "We were treating genuinely sick persons. You practiced medicine like you dreamed about when you were a kid. It was a real helping situation."

During the earthquake, two major hospitals had collapsed, killing most of the doctors and nurses working in them. Initial reports from government sources put the death toll from the earthquake at 10,000. As the magnitude of the disaster became clearer, news sources indicated the death toll could reach 100,000. Rescue workers told Dr. Biff Fouke they estimated between 50,000 and 100,000. Medical team member Dr. Robert Osborne suggested there may be

PHOTO BY ROBERT OSBORNE, M.D.

Entrance to Salvation Army clinic in Mexico City where Tacoma medical Team treated patients after earthquake disaster.

as many as 300,000 people left homeless.

Rescue crews from other countries arrived in Mexico City shortly after the earthquake. "The devastation was overwhelming," says Dr. Osborne, "we have never experienced anything of such magnitude in this country. It completely overloaded the system."

"At one point," says Dr. Osborne, "the Mexican government even considered tearing down the buildings damaged in the earthquake without looking for dead, the problem was so immense."

Still digging through the rubble to recover the dead when the medical team was preparing to return to the United States, the Mexican government, according to Dr. Osborne, was faced with taking down 1,500 buildings.

"The government was accused of not wanting to rebuild some of the poorer sections of the city that were damaged," said Dr. Osborne, "but to try and rebuild some of the areas would take years."

While there was no apparent major health problem as a result of the earthquake, the unrecovered bodies in buildings, according to Dr. Osborne, were a concern. Fearing that some would wash into the sewer system, the Mexican government was burning some of the buildings and spraying and fumigating others. According to Dr. Fouke the Central part of Mexico City had sustained the most extensive damage. "I was shocked and confused when we first arrived," said Dr. Fouke. "We didn't really see the worst areas for a couple days."

Drinking water was trucked into areas around the clock in an effort to keep a major epidemic from breaking out. In the more visible parts of town Red Cross tents and food lines were present.

Most of the adobe houses in the area of the clinic had been structurally damaged to the point that they were unsafe to be in.

"The people," says Dr. Osborne, "simply moved into the streets. They made elaborate tents out of virtually nothing. In the evening you would see them washing their clothes in the streets."

According to Dr. Modarelli, over 1,000 were living in the streets around the clinic.

"They didn't want to go back into their houses. They were afraid. We felt the same fears they felt."

The clinic, set up in Morelos, one of the poorest and reputedly roughest sections of the city, was in the basement of a church. A corner was roped off with

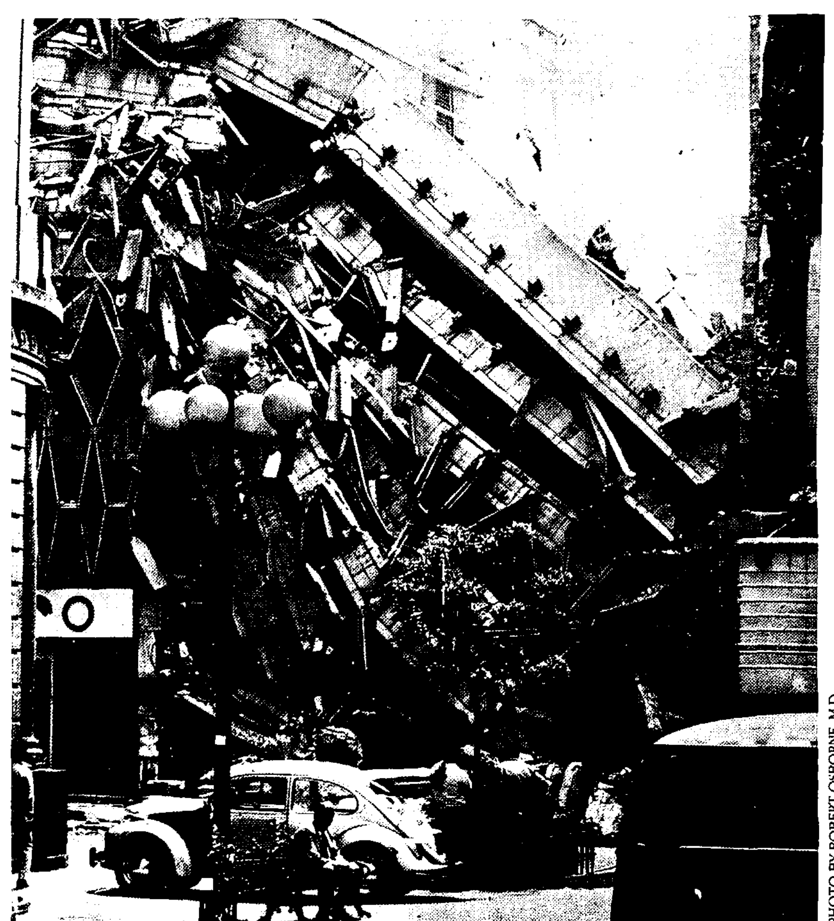

PHOTO BY ROBERT OSBORNE, M.D.

Nine story building collapses from earthquake.

Mexico City residents collecting water for drinking after earthquake.

blankets for examining rooms. Doctor and patients sat down in pews. The Salvation Army ran a soup kitchen for medical team members and anyone who came into the clinic.

Working a 9:00 a.m. to 6:00 p.m. shift and seeing about 180 patients a day, the medical team provided routine health care.

At first, according to Dr. Modarelli, women and children came. Then gradually the men started showing up for medical care. "The people were angry because they felt neglected," said Dr. Fouke. "There was very little relief service, except for water. The sense of depression was overwhelming."

"What we needed the most," said Dr. Modarelli, "were drugs, antibiotics, vitamins, anti-anxiety medication, antacids, aspirin, codeine. We had no charts, no records. We took what we could get and made do with what we had."

"It was pure medicine," said Dr. Fouke. "You relied completely on your diagnostic skills."

During the first few days of the earthquake, everyone worked around the clock. "Some of the Mexican doctors were exhausted when we arrived," said Dr. Osborne, "but the need for immediate emergency care had passed. Patients were coming into the clinic because they were more frightened than injured."

PHOTO BY ROBERT OSBORNE, M.D.

Morelos. Fearing that their houses would collapse, residents moved into streets after the earthquake.

PHOTO BY ROBERT OSBORNE, M.D.

Mexico City workers clearing debris from earthquake.

Collecting drinking water from portable drinking tanks set up by the Mexican Government.

Inside Salvation Army clinic patients wait for medical treatment.

Makeshift tents put together by Morelos residents whose houses were no longer safe for living in.

A routine day at the clinic.

"We talked to them and listened," said Dr. Osborne. "They just wanted to talk. There was no one down in the area who had been to see them."

"It was band-aid therapy," says Dr. Modarelli, "but I still think it was a worthwhile effort. I do think we saved some lives. Acutely we could have done nothing. But I think we came when we were needed the most. We did a lot of preventative medicine, catching early stages of dehydration, teaching, educating."

When the medical team was preparing to leave, families from the neighborhood, living in their makeshift tents with little hope of ever seeing their homes rebuilt, came to the clinic with gifts to express their appreciation.

A small hand-carved wood plaque given to Dr. Modarelli with the following inscription perhaps best expresses the universality of human compassion and caring:

"You know that I'll never forget you because of all of the good you've done will never be forgotten."■

Research and interviews for this article were conducted by Mary K. Tipton.

Placement Fee: Who Benefits?

By Sue Asher, Director,
Membership Benefits, Inc.

"Oh my gosh, you're fees are outrageous." "Why do you charge so much—I hate to see these people have to pay." "I just can't afford to pay that much money to find a job." "You're suppose to be a benefit to us, not charge us more."

Just a sampling of the comments that I have heard regarding our placement fees since beginning my position as Director of Membership Benefits in late July. Admittedly, I had a difficult time disagreeing with these opinions at first, but a little research, coupled with an insight into the system, has changed my perception. The Medical Society Placement Service really makes sense and I can honestly explain and defend our placement fees to employers and employees as well.

First, a review of our contract. Every applicant who registers with our service signs a contract that obligates them to pay a placement fee upon accepting employment thru a referral made by us. The placement fee for permanent full and part-time positions is 80% of the gross monthly income. (Salary of $1,000/fee = $800.) We extend a ten percent discount if paid entirely by the first billing, a seven percent discount is extended for bankcard charges. We will provide a payment plan within the first sixty days with no finance charge or extend payments beyond sixty days with an interest rate of 1½ % per month.

Our paramount interest is to match employers with employees successfully.

We are willing to work with people and be flexible in collecting fees. Our paramount interest is to match employers with employees successfully.

An examination of other employment agencies in Pierce County gives interesting comparisons for discussion. For example, the chart to the right shows an average minimum and maximum of current fees:

The current trend is to base the placement fee on the yearly salary, by a percentage. For salaries over $15,000 the average fee is fifteen percent. This translates to a fee of $3,000.00 for a position that pays $20,000, annually. Compare this to the Medical Society fee of 80% which equals $1,328.00. Cheap at half the price! The point not to miss is that fifteen percent sounds far less or at least more reasonable than 180%. However, the calculations can be equal or even greater. The fee for fifteen percent of a yearly income of $20,000 equals the fee for 180% of the monthly income of the same salary, and believe it or not, it is the going rate.

The applicant that signs the contract to pay the fee is responsible for that fee. The employing physician is not responsible to pay the employment fee on full or part-time permanent positions.

This makes using the Medical Society Placement Service quite attractive because we can do the work for you at no charge.

This makes using the Medical Society Placement Service quite attractive because we can do the work for you at no charge. And the "work" can be an involved, time consuming project. The advertising and recruiting will be done for you. The testing, screening and reference checking will be done for you. Scheduling the interviews will be done for you. You're only left with making the choice of who you want to employ.

Employers that list their positions as "fee negotiable" with agencies don't eliminate potential candidates who are unable or unwilling to pay a fee. "Fee negotiable" means that the employer is willing to work with the employee and negotiate the payment of the fee. Many physicians are electing to pay the placement fee for newly hired office staff, realizing it attracts more qualified applicants. The fee can be paid in advance or can be paid by reimbursement—which means after six months to one year's employment the physician will pay back the employee for the placement fee. This system is attractive for both parties—applicants are most interested in "fee paid" positions and it gives a guarantee to the employer of minimal longevity.

Employer paid positions offer a sixty-day guarantee which means that if the employee quits or is terminated within the first sixty days, the Medical Society Placement Service will replace that employee at no charge or will refund the fee to the physician. Another attractive benefit of our services.

We are able to attract many applicants to our Placement Service because our fees are very reasonable, because many physicians are willing to pay the fees, and because we recruit for a very specific field. Applicants can be registered with the Placement Service and know that we will contact them when an appropriate position becomes available with no obligation. It saves them the embarrassment and anguish of trying to sell themselves where they are not wanted.

continued on page 19

Gross Monthly Income	Fee Percent	Range of Fee	(Our Fee)
Under $500.	80%	Up to $450	(Up to $450)
$800-$900	100%	$800-900	($640-720)
$1,100-$1,200	130%	$1,430-$1,560	($880-960)
$1,500-up	180%	$2,700-up	($1,200-up)

Some Things I've Learned at Great Expense About Computers

By Brian S. Gould, MD, SFMS
Publications Committee

*In response to the **Bulletin** readership survey in which a number of physicians requested articles on computers, the following is the first in a series of articles that will be published in the upcoming months on computers. The Editor.*

By now it is likely that every American with even the slightest personal interest in computers has either purchased one or at least familiarized himself with one in anticipation of doing so. Which means that at this point we are writing an introductory guide for the hard-core resisters—those of you who are left do not care. In fact, you probably are not even neutral on the subject. If you have held out this long, it is likely more a reflection of antipathy than disinterest. Relax. It is OK to feel that way. In fact, we even agree with you. Remember Steward Brand's favorite adage ". . . All panaceas become poison." We are here to help you retard that process. The awakening of that wonderful "post-computer society" promised to us is undoubtedly being retarded by the obstacles to general computer literacy imposed by the excesses of faddishness. If salespeople would stop trying to sell and your friends would stop trying to impress, you could learn more about these machines—as you already know you one day must.

Therefore, as a service to our community, we have decided to share a few secrets with the expressed purpose of making the black box more approachable if not comprehensible. Tools should not come wrapped in so much doctrine. A clear set of instructions would be quite sufficient. After all, the fact that you do not know how telephones work has not stopped you from using them your entire life. Believe it or not, we can adopt much the same attitude for the computer and apply it with great success. Where hype was, let irreverent knowledge now be.

Stop trying to learn about computers and learn something about computing.

The conventional wisdom for novices is to analyze their needs, pick software, and then let that choice direct their hardware options. As beginners jump into planning computer purchases, we are reminded of the little old lady who finally purchased a car "just to go to church in bad weather." Once she learned how to drive, though, she traveled to places she had never considered before she had the means to get there. Your first task is not to choose a system, or even a single function. Nor is it to learn binary mathematics, programming, or how the things work. All of that is as relevant to the purchase of equipment as a course on the internal combustion engine would be to our lady choosing her first automobile. What does matter is learning to drive. Only then can you say whether you like it or not, and make an estimate of how much of it you are going to do.

Consequently, we are enthusiasts of the concept of "learner systems." Bear in mind learner systems are not euphemisms for cheap toys. It is impossible to learn about fine photography with an instamatic. On the other hand, prematurely investing thousands in a top-of-the-line camera system is likely to lead to frustration and regret. There is too much complexity and too many choices before you are ready for them. In the unlikely event that you do figure it all out and learn something, chances are that once you know what you want in equipment, it will be different than what you have.

Therefore, consider the strategy of staging your purchases to correspond to your level of knowledge. In the beginning keep it simple. A system capable of handling your business billing and accounting is almost certain to be over your head and accounts for much of the bewilderment expressed by non-technically oriented physicians.

Begin your education with word processing.

Operating a standard word processing program is one of the most delightful ways to learn computing we know. Seeing words move around on a screen just as they do in your head is nothing short of wonderful. In the meantime, you are learning basic computer driving. And it is relatively easy. Of course there are new words and symbols to memorize, but anyone who can pass neuroanatomy will find the most difficult word processing program to be readily conquerable.

If, on the other hand, you do not like word processing—it seems to offer no advantage to your work; it does not delight you with its displays of paragraphs dematerializing to reappear elsewhere at your command; if a keyboard feels uncomfortable to your fingers—then go no further. It is unlikely you will like anything about computing, and it is better left to support staff to handle. Not everybody likes to drive either.

Do not let anyone convince you that "Easy to learn" is the same as "Easy to use."

This is one of the larger frauds being perpetrated on the unsuspecting public. Don't fall for it. Of course it is easy to be intimidated by dozens, perhaps hundreds, of strange and meaningless codes and controls required to operate a new piece of software.

It is not important that you be able to operate the program within 15 minutes of acquiring it. You will be living with those endless menus, help prompts, and hardware crutches, and the time delays they introduce, long after they are needed. Once proficiency is gained, the hardware and the software should become as "transparent" as possible so the focus is only on the task at hand. For programs that are used frequently and depended on, it is much "easier" to go directly to the desired command if it is known. Wordstar, which is acknowledged to be one of the more complicated word processing programs around, takes a long weekend to learn. But after that, it will do anything you are ever going to need a word processor to do, and will do it efficiently.

continued on next page

In computer operations, pleasure is proportional to speed.

This is a corollary point to the one above. Do not let anyone tell you that a 25-second wait to perform a short save to disk "doesn't matter." It does. Every time you must stop your flow to wait for the machine or the software, the tool is getting in the way of the task. Those half minutes of nothing add up. And, although no microcomputer is yet instantaneous, there are significant differences in real operating time for identical tasks. Get demonstrations, and get the fastest equipment you can afford.

Finally, do not let anyone kid you; there is a "standard" for small computers.

And IBM is its name. At this point, there is no longer any doubt that any new development in the microcomputer world—new software, new equipment, new concepts—will be introduced for the IBM user base first, and in some instances, exclusively. This is a lesson that has been painfully learned by many manufacturers and countless small users. In fact, the standard has become bigger than IBM itself, as it has learned whenever it has attempted to deviate from it itself.

As with all other tools, there is a great value in standardization. This extends to languages, sizes, formats, and all other details that either will be transparent because they fit together, or will be major problems because they do not. The IBM PC format (now available from dozens of manufacturers besides IBM) is at present the one guaranteed method of assuring that everything you need will be available and fit together properly when you need it. (And yes, we are aware of Apple's claims when we say this; and no, we do not own IBM equipment ourselves, but have spent many extra hours learning solutions to myriad problems we have because of it.)

Forewarned is, as we like to say, forearmed. But with a steady approach, computing, like driving, is more fun because it meets more of your needs and preferences. Besides, whoever said it would be easy. ■

Reprint from San Francisco Medicine, August, 1985.

Placement Fee: Who Benefits continued from page 17.

Physicians that utilize the Medical Society Placement Service are helping to support the Medical Society of Pierce County.

Physicians that utilize the Medical Society Placement Service are helping to support the Medical Society of Pierce County. MBI (Membership Benefits, Inc.) is a subsidiary of the MSPC which operates the Placement Service, publishes the Pocket Directory, the monthly Bulletin, and the Newsletter. MSPC and MBI are dependent upon one another for support and funds. Supporting the Placement Service helps to keep Membership dues as low as possible for MSPC members.

Everything considered, it behooves physicians to utilize the Medical Society Placement Service. We specialize in understanding the needs of a medical office, we have new staff members who are enthusiastic and dedicated to helping offices find their ideal employees, and we are also able to assist with other personnel matters when necessary. Visiting your office, meeting your staff, and getting to know you personally enables us to send more appropriate candidates to your office. Think about it, call us, 572-3709; we'll really appreciate the opportunity to serve you. ■

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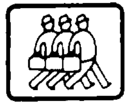

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CONTINUING EDUCATION PROGRAMS SCHEDULED FOR 1985—86
P = Physician Course / A = Allied Health Course

Location	Date	Program	Director	Course
	DECEMBER			
HOL. INN	4	★CLINICAL APPROACHES TO PULMONARY MANAGEMENT	HOCK/LAWSON	(P)
STJ	5, 6	★ADVANCED CARDIAC LIFE SUPPORT	CRADDOCK/ MUNOZ	(P/A)
	JANUARY			
STJ	14	★ETHICAL DILEMMAS ASSOCIATED WITH MODERN TECHNOLOGY	McCORMICK	(P/A)
STJ	16	★LAW & MEDICINE SYMPOSIUM	MALDEN	(P)
JH	22	★DEPRESSION—THE MASK & THE MASQUERADE	LURIA	(P)
JH	TBA	MARKETING		(P/A)
JH	TBA	CRITICAL CARE NURSING—TIMELY TOPICS	DALTON	(A)
	FEBRUARY			
JH	6, 7	★ORTHOPEDICS & SPORTS MEDICINE IN PRIMARY CARE	CRADDOCK	(P)
JH	5, 12, 19,26	★Tac Gen Clinical Conf-GASTROENTEROLOGY	BAERG	(P)
	MARCH			
JH	6, 7	★ADVANCED PEDIATRIC LIFE SUPPORT	SEWARD	(P/A)
JH	15	★DAYS OF PEDIATRICS	SCHERZ	(P/A)
JH	13, 14	★TACOMA ACADEMY OF INTERNAL MEDICINE	ROWLANDS	(P)
	APRIL			
JH	TBA	★HOME HEALTH AND THE PHYSICIAN	KATTERHAGEN	(P)
UPS	15, 26	★TACOMA SURGICAL CLUB	TAYLOR	(P)
JH	2, 9, 16, 23	★Tac Gen Clinical Conf–INFECTIOUS DISEASE	TICE	(P)
	MAY			
JH	15, 16	★CARDIOVASCULAR DISEASE REVIEW	STRAIT	(P)
	JUNE			
JH	15, 16	★ADVANCED CARDIAC LIFE SUPPORT		(P/A)

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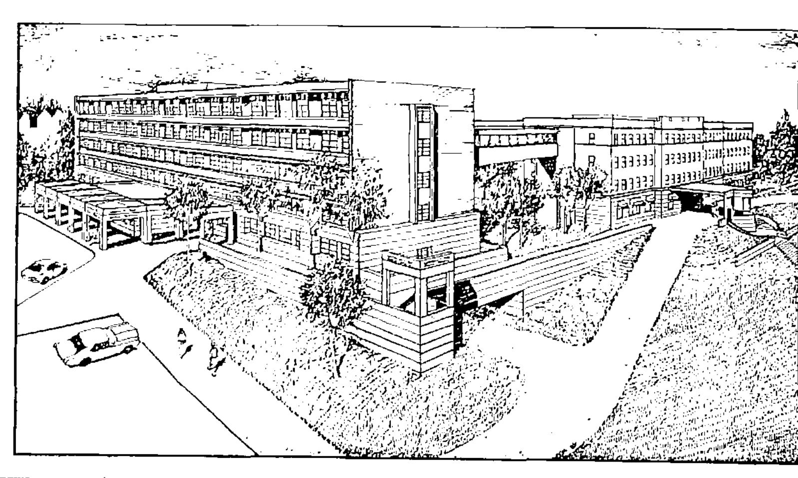

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LAW AND MEDICINE

January 16, 1986—St. Joseph Hospital, Education Center, 3rd Floor, South Pavilion, Tacoma

8:15	Welcome and Introduction
8:30	**MEDICAL RECORDS: PROBLEMS OF DISCLOSURE, CONFIDENTIALITY, MAINTENANCE, ETC.** Jack Rosenow, Attorney — Tacoma
9:30	**LESSONS FROM RECENT MALPRACTICE CASES II** Judith Stone, Attorney — Tacoma
10:30	Coffee Break
10:45	**PITFALLS IN PRESENT MALPRACTICE POLICIES** Phillip Sloan, Attorney — Tacoma
11:45	Lunch Presentation at Lunch: **THE PROS & CONS OF CONTINGENCY FEES IN OUR LEGAL SYSTEM** The Honorable Vernon Pearson, Supreme Court of the State of Washington
1:30	**A PLAINTIFF'S ATTORNEY LOOKS AT WAYS OF PREVENTING MALPRACTICE — Pitfalls of Informed Consent** William Rush, Attorney — Tacoma
2:30	**THE ANATOMY OF A PERSONAL INJURY CASE** Sam Pemberton, Attorney — Tacoma
3:30	Coffee Break
3:45	Questions & Answers
to	Panel: Moderator, Marcel Malden, MD
5:00	and the presentors

Program Coordinator: Marcel Malden, MD

(Applies to both programs)

CREDIT: 7 hours

AMA— As an organization accredited for continuing medical education, the College of Medical Education, Inc., certifies that this offering meets the criteria for seven hours in Category I for the Physician Recognition Award of the American Medical Association and for the relicensure requirements of the Medical Examiner of the State of Washington.

AAFP— This program has been reviewed and is acceptable for seven (Prescribed) hours by the American Academy of Family Physicians.

REGISTRATION: Preregistration is required.

Fees: $70 Medical Society of Pierce County Physicians
75 Non-Medical Society of Pierce County Physicians
65 Physician Assistant and Others
0 Medical Residents

Address all inquiry and registrations to: **COLLEGE OF MEDICAL EDUCATION,** Medical Society of Pierce County, 705 South 9th, #203, Tacoma, WA 98405, Phone: 206-627-7137

DEPRESSION: THE MASK & THE MASQUERADE

January 22, 1986—St. Joseph Hospital, Education Center, 3rd Floor, South Pavilion, Tacoma

8:30	Welcome & Introductions	Eric W. Luria, MD
8:35	**PREVALENCE OF MISSED DIAGNOSIS OF DEPRESSION**	Wayne J. Katon, MD
8:45	**RECOGNITION & DIAGNOSIS OF DEPRESSION**	Nicholas G. Ward, MD
9:30	**CURRENT BIOLOGICAL MODEL OF DEPRESSION**	Donald L. Dudley, MD
10:15	Break	
10:30	**THE DEPRESSION MASQUERADE: PAIN, ANXIETY, SOMATIC COMPLAINTS**	Wayne J. Katon, MD
11:15	**DEPRESSION IN CHILDREN & ADOLESCENTS**	Robert E. Sands, MD
11:45	Question/Answer	
12:00	Lunch	
1:00	**THE WHAT, WHEN & HOW OF ANTI-DEPRESSANT SELECTION**	Philip G. Lindsay, MD
1:45	**ALTERNATIVE & ADJUNCTIVE TREATMENT MODALITIES**	Eric W. Luria, MD
2:20	**THE PAIN-DEPRESSION SYNDROME: WHAT IT IS & HOW ANTI-DEPRESSANTS MAY BE HELPFUL**	Philip G. Lindsay, MD
3:15	**COGNITIVE THERAPY OF DEPRESSION**	Barry S. Anton, Ph.D.
3:45	**TREATMENT OF REFRACTORY DEPRESSION**	Nicholas G. Ward, MD
4:30	Question/Answer	
4:45	Adjourn	

Program coordinator: Eric W. Luria, MD

AUXILIARY NEWS

February Art Auction

The Pierce County Medical Society Auxiliary is having an Art Auction on February 14, 1986. The Robert Sills Gallery of North Hollywood is presenting this premium art. Mr. Sills, the most efficient and fluent of auctioneers, will personally conduct the auction.

The auction will be held at Charles Wright Academy, 7723 Chambers Creek Road West. Preview is at 7:00 p.m. Auction at 8:00 p.m. Tickets will be available in the near future for the function. Wine and hors d'oeuvres will be served.

There will be a Door Prize drawing for a signed and numbered lithograph by Salvador Dali, which the Sills Gallery is graciously donating.

This is a great opportunity to furnish your office, brighten up that drab wall or hall at home, purchase a Valentine gift for your "honey" or plan ahead for next Christmas. There is a wide price range offered. Our monetary percentage from the auction depends on the amount of art sold. Please come, bring your friends, art collectors, art dealers. All are welcome to make this evening a huge success!!!

Brunch With Jeff Smith!

The "Frugal Gourmet," Tacoma's own Jeff Smith, will be speaking at our January 17th meeting. We will meet at Oakbrook Country Club at 9:45 a.m. The brunch will begin at 10:15, with program to follow.

Jeff has promised that his talk will be both informative and fun. We are fortunate to be able to offer this program with his writing and television taping keeping him very busy.

Plan now to attend. Guests are welcome. Reservations are required. Please send your check, payable to PCMSA, for $12.00 per person, to Alice Wilhyde, 515 North C Street, Tacoma, WA 98403, no later than Jan. 10, 1986.

Children's Holiday Party

HO! HO! HO! Santa will visit the Children's Holiday Party on Friday, Dec. 6, at the University Place Presbyterian Church. This fun-filled afternoon will be a treat for all the children, (and adults). There will be crafts to make, a magician to entertain, and goodies to munch.

Again, we are asking each child attending to bring a present for a child at the Women's Support Shelter. These gifts are much appreciated and used throughout the year for birthdays and special holidays.

Plan to attend and bring your children and grandchildren to the party which will be held from 4-5:30 p.m.

1986-1987 Nominating Committee

Sharon Lawson, chairman, has announced that the following auxiliary members are serving on the 1986-1987 nominating committee: Sonya Hawkins, Kris White and Kit Larson, from the PCMSA board, and Judy Baerg, Nadine Kennedy and Marny Weber from the general membership of the auxiliary.

Nominations for offices will be announced at the January Board Meeting and the February General Membership Meeting. Elections will be held at the April General Meeting, with installation of new officers at the May meeting.

Dues/Membership

Please send your membership dues, $39.50, to Betty Virtue, 71 Leschi St. Madrona Park, Steilacoom, 98388, as soon as possible. The number of delegates Pierce County is allowed at the spring Medical Auxiliary Convention, is determined by the number of members we have, and the more delegates Pierce County has, the more we can influence medical legislation, practices, and projects.

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President Elect Attends Leadership Conference

The AMA Auxiliary Leadership Conference was held October 6-8, at the stately Drake Hotel, Chicago. The purpose of the meeting was to train state and county elected officers. A stimulating set of informal rap sessions, regarding County Idea Exchange and a Membership Workshop took place Sunday.

From the outset I was among 500 women with a purpose, a great sensitivity and a real interest regarding medical doctors, their families, the auxiliary and the community. Throughout our discussions they would ask, "What's wor ng in New York? In Alabama? In Was ington?" Monday's and Tuesday's schedules involved twelve "break out" sessions on varied and interesting topics, from which delegates could select six.

As I reflect on the knowledge I gained at the conference, I am evermore impressed by the real concern of auxilians across the country for their medical spouses. I hear them saying the chosen profession of our spouses is under growing pressure, rapid change and we, as auxilians have a more important role to play. Not because we are women, this time, but because we are spouses to the medical doctor, we must make time to support our medical society and our community in health related and legislative issues. We must look deeper into our ranks to increase our memberships. While increasing numbers of our doctors' spouses are employed, and therefore, must limit their active participation in the auxiliary, we nevertheless very much need their support through their annual dues of $38.50. Payment of dues lets our politicians know that there is strong support for the Medical Society and its Auxiliary in their efforts to obtain appropriate legislation and improved health care. Please urge your spouse to assist us, so we may further assist you, in this important way.

Conference keynote speaker Dr. James Sammons, quoting former President Richard Nixon, remarked: "If you do not get about the business of politics, you'll have no business to get about." Sen. Paul Laxlat said of Nancy Reagan in the Nov. McCall's magazine interview: "She is the President's chief protector and she has tremendously valid political instincts. She's a highly intelligent woman with a lot of street smarts. When asked, 'If Ronald Reagan owned a shoe store would you be pushing shoes?' She replied 'Absolutely!' " As chief protectors of our medical spouses, can we do anything less? We must be supportive, pay our dues (or perhaps the doctor will for you), and become active supporting the Medical Society of Pierce County.

Thank you for allowing me the privilege of representing you at the AMA Auxiliary Conference. It truly leaves me with a feeling of "Red, White and Blue."

Susie Duffy
President Elect PCMSA

PCMS Auxiliary President reports on WSMA Convention

Sees need for grass roots politicking.

The Washington State Medical Association and Auxiliary met Sept. 19, 21 at the Thunderbird, Jantzen Beach, Ore. for their Fall Convention. Pierce County Auxiliary representatives were Ginnie Miller, President and Susie Duffy, President-Elect. Also, from the county were two local members of the State Auxiliary Board, Sharon Ann Lawson, immediate Past President who is now SW Regional Vice-President and Cindy Anderson, By-Laws Committee.

Thursday, Sept. 19th, after the registration process, time was spent in attending various sessions. Of particular interest was the Safety Restraint Program, presented by Elaine Ruddell, State coordinator. At the request of Sue Dietrich, President, we attended different Reference Committee hearings to gather information to help us with future Auxiliary action at the Legislative level. The vast scope of the many issues involved, are indeed awesome to contemplate, let alone to effectively and intelligently approach and combat. The term "combat" is used deliberately, for it does appear to this here-to-for uninformed (certainly on all legislative issues) president, that matters have moved to the field of combat. Furthermore, it does seem to me, that too many physicians continue to ignore the warning sounds of impending havoc in this area. (Doug Jackman, Director of MSPC addressed this subject in his editorial in the Sept. issue of the *Bulletin*

Friday morning, Renee Pavey moderated a seminar on Coping with Malpractice in the Medical Family. I did not attend this meeting as I had heard a physicians' wife relate her own terrifying experiences. Michael J. Buschmohle, President of Applause Associates and an active member of American Society for Training and Development and the Pacific NW Personnel Management Association, presented a graphic and most interesting seminar "Speak With Power." Friday afternoon, presidents and presidents-elect, met with Sue Dietrich, President and Mary Skinner, President Elect, dealing with some of the possible legislative issues in the immediate future and the direction we, as Auxiliary members need to take. Informational folders were given to all those attending. On a personal note, I was surprised to find a copy of an article (mine) "What Do You Doctors Wives Do Besides Socialize and Spend Money?" that appeared in the April *Bulletin* was included. In view of the changing role of Auxilians in the future, it is possible that a sequel to that article may be written in spite of the fact that the "public" and editors of the *Bulletin* have not demanded (nay—whispered—that this be done). It is hoped that all those attending physicians who listened to those informed speakers in the various Reference Committees, will become more attentive, concerned and above all, *active* with the legislative processes, especially those issues that directly involve the practice of medicine. It was noted that other areas are affected with higher insurance rates, i.e., teachers, private and public schools, as well as industry. There is a beginning grass-roots movement for all groups to unite for a combined effort to become better educated and to become more effective.

I appreciated the opportunity to attend this convention and suspect that the term "grass roots" means Pierce County — as well as the other counties in the state of Washington. This is, however, a national problem — with international implications. Awe inspiring indeed!

Ginny Miller

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Norman A. Gosch, MD, *Family Practice.* Born in Omaha, Nebraska, 12/06/36; medical school, University of Nebraska College of Medicine, 1962; internship, St. Lukes Hospital, 7/62-7/63; Masters in Public Health, U.C. Berkeley, 9/71-6/72. Washington State License, 1985. Dr. Gosch is currently practicing at 301 South 320th Street, Federal Way, Washington.

Manuel P. Posadas, MD, *General Practice.* Born in Philippines, 12/12/46; medical school, University of Canto Tomas, 1972; internship, Veteran's Memorial Hospital, 3/71-3/72; residency, Notre Dame De Lourres Hospital, 6/72-5/73; San Juan de Dios Hospital, Surgery & Obstetrics, 6/74-5/76. Washington State License, 1985. Dr. Posadas is currently practicing at 2607 Bridgeport Way W., Tacoma, Washington.

Paul A. Swinehart, Jr., MD, *Anesthesiology.* Born in Spokane, Washington, 01/19/52; medical school, Creighton University, 1979; internship, University of Washington, 6/79-6/80; residency, University of Washington, Anesthesiology, 7/80-6/82. Washington State License, 1980. Dr. Swinehart is currently practicing at 314 South K Street, Tacoma, Washington.

Gary R. Taubman, MD, *Internal Medicine/Gastroenterology.* Born in Hastings, Nebraska, 05/08/53; medical school, Oregon Health Sciences University, 1980; internship, Oregon Health Sciences University, Internal Medicine, 7/80-7/81; residency, Oregon Health Sciences University, Internal Medicine, 7/81-7/83; Gastroenterology Fellowship, University of Utah Medical Center, 7/83-7/85. Washington State License, 1985. Dr. Taubman is currently practicing at 521 South K Street, Tacoma, Washington.

Kenneth E. Trnka, MD, *Cardiology.* Born in Marshfield, Wisconsin, 02/02/50; medical school, University of Wisconsin Medical School, 1976; internship, St. Joseph Hospital, 6/76-6/77; residency, St. Joseph Hospital, Internal Medicine, 7/77-7/79; cardiology fellowship, Fitzsimmons Army Medical Center, 7/79-7/81. Washington State License, 1980. Dr. Trnka is currently practicing at 1901 South Cedar, Tacoma, Washington.

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Please complete the attached reservation form and mail it, with a check for the appropriate amount, to the Medical Society office. Or call the Society, 572-3667, to confirm your reservation.

Reservations are requested by Wednesday, December 4, 1985

1985 Medical Society/Medical Auxiliary Annual Joint Dinner Meeting

I (we) have set aside the evening of December 10, 1985 to join members of the Medical Society of Pierce County and Pierce County Medical Auxiliary at their Annual Joint Dinner Meeting and Installation of Officers.

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