MSPC
NEWSLETTER
♦A publication of the Medical Society of Pierce County♦

VOL. 3, NO. 1

705 South 9th, Suite 203
Tacoma, Washington
572-3667

JANUARY, 1988

DR. JACKSON ASSUMES PRESIDENCY

Nearly 250 members and spouses attended the Annual Joint Dinner Meeting of the Society to see Dr. Bill Jackson assume the Presidency from Dr. Dick Bowe. Dr. Bowe thanked Mrs. Sharon Lukens and her Auxiliary Committee for an excellent job in organizing the festivities.

A five piece ensemble from the Tacoma Youth Symphony provided background music during dinner followed by a lighthearted speech by Mr. Mick Delaney, well known Seattle speaker.

Dr. Bowe presented plaques to departing Board members: Dr. Richard Hawkins, Immediate Past President; Dr. Ken Bodily, Vice President; Dr. Robert Whitney, Secretary-Treasurer; and Trustees Drs. Michael Halstead, Peter Marsh and Paul Schneider. Dr. Bowe thanked the departing members for their commitment to the Society and organized medicine. He noted the goals that he had set forth to improve communications with local media and with hospital administrators, to reinstitute the field day for physicians, dentists and attorneys and the Caribbean Cruise for members. He expressed appreciation for the support he had received from his wife Sara and staff of the Medical Society during the long and busy year .

Dr. Bowe then turned the gavel over to Dr. Jackson who said he was looking forward to celebrating the Society's centennial year as President and was concerned in maintaining the traditional values of medicine with emphasis on quality and access of care.

A.I.D.S IN PIERCE COUNTY

It was reported at the Public Health/School Health Committee Meeting that there are currently 45 cases of AIDS diagnosed in Pierce County since 1983. There are presently an estimated 60-70 persons with AIDS living in Pierce County.

The Medical Society and the Pierce County Medical Society Auxiliary have been very active in maintaining communications with all factions of the community working on this disease. Dr. Alan Tice, Chairman of the MSPC AIDS Committee also sits on the Pierce County AIDS Task Force and has represented the Society at meetings of the Pierce County AIDS Foundation and the South Sound AIDS Network.

Mrs. Sydna Koontz, Pierce County Medical Society Auxiliary has been very active in developing and publishing a Pierce County AIDS Resource Guide that has been distributed thoughout the County by the Health Department and the Medical Society. Mrs. Koontz has updated the resource guide which will be distributed in January. Mrs. Koontz and staff are also participants in the organizations mentioned above as well as Continuum of Care Committee and Committee on Housing for People with AIDS.

As of December 7, the Center for Disease Control (CDC) had received reports of 47,436 adults/adolescent cases of AIDS in the United States. In addition, 703 pediatric cases had been reported among persons under age 13, with a total of deaths occurring in 27,235 or 57% of these cases.

The Nursing Home Access Task Force appointed by Dr. Bowe and chaired by Dr. Paul Schnieder is

(Cont'd on pg. 6)

"PAR/NON-PAR"

The AMA is urging Congress to extend the period for physicians to make decisions under Medicare's Participating Physicians Program. Physicians must make a decision binding them for the full 1988 calendar year to be either a participating or a non-participating physician. Under current law the decision must be made no later than December 31, 1987. Due to uncertainties as to precisely how Physician Medicare Reimbursement will be affected by deficit reduction steps that Congress is taking, HCFA late last month made a last minute decision to abandon prior plans for carriers to mail out on November 23, its 1987 advisory letter to physicians on Medicare program changes.
Over the life of the Participating Physician Program, the physicians have been unable to obtain full or adequate information necessary to make a knowledgeable decision. Last year, the AMA was forced to court to get an extension of the sign-up period.

The AMA is asking that an extension of at least 45 days from the time physicians receive the carriers letter to make a decision. This is <u>essential</u> because of 1) the anticipated significant changes in the law that physicians will have to consider and 2) the necessity of physicians to cope with errors by carriers in providing physicians with their MAAC's.

PERSONNEL POLICIES APPROVED AND AVAILABLE

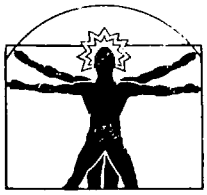
The Board of Trustees at their December 1st meeting unanimously approved a revised Personnel Policy Manual submitted by staff.

A copy of the manual is available upon request by members. They can be adapted to any office and it is highly recommended that every office have written policies.

By having access to a written policy manual, even the newest employees can be sure they are complying with the employers established ways of doing business. By explaining personnel procedures in advance, you are telling each staff member what to expect from any given situation. A few of the areas covered in the manual are: sick leave, maternity leave, employee benefits, office hours, job description, overtime, telephone usage, confidentiality, personal conduct, voluntary and involuntary termination, etc..

If you would like a copy of the manual, please call the Medical Society office at 572-3667.

Some of us can remember when all kitchen tools were cordless.



DIRECTORS NAMED TO MBI BOARD

Drs. Bob Whitney and David Law were named to the Membership Benefits, Inc. (MBI) Board of Directors by the MSPC Board of Trustees. MBI is a wholly owned for-profit subsidiary of the Society and oversees the Publication of the Pocket and Pictorial Directories, Bulletin, Newsletter and the Placement Service.

Dr. Whitney, Radiologist has just completed a two-year term as Secretary-Treasurer of MBI and the MSPC Board of Trustees and is intimately aware of it's operations. Dr. Law is an Internist and has been a member of the Society since 1983.

The MBI Board of Directors oversee the business operations of the subsidiary. MBI has been operating at a profit for the past two years enabling them to continue loan payments to the Medical Society. Membership dues have not been increased as a result of MBI's healthy financial position.

AMA PURSUES

The AMA has renewed its request for detailed information that reveals the precise reasons necessitating the sharp 38.5% increase in Medicare Part B premiums to become effective January 1.

When HCFA announced the need for this surprise premium hike, statements obtained by the press from some national spokespersons incorrectly attributed the need to imply irresponsibility of the profession in driving up Part B costs.

After the announcement was made the AMA asked William L. Roper, M.D., Administrator for HCFA for answers to specific questions intended to determine the precise reasons for the Part B increase so that all factors would be placed in proper perspective. Answers to the list of questions that the AMA posed have not been provided.

POSITIONS AVAILABLE

FAMILY PRACTITIONER NEEDED. Established practice available at Soundview Medical Plaza next to Puget Sound Hospital, due to retirement. Fully equipped office, new patient referral system, on-site lab and x-ray. Contact Hugh Hendrix 756-8579.

COMMITTED FAMILY PRACTICE PHYSICIAN needed by urban Native American community for challenging and fulfilling practice. Excellent medical community, ideal location with nearby mountains, beaches and cultural activities. Good benefit package. Send CV: Puyallup Tribal Health Authority, 2209 East 32nd Street, Tacoma, WA. 98404.

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part time for FP/IM/EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel M.D. at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

FAMILY PRACTICE/OCCUPATIONAL MEDICINE. Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy. Malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and a balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, WA 98121. (206) 728-6888.

IMMEDIATE OPENINGS. Full time and part time, positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Opportunities including ER in Olympia area. Call NES 1-800-554-4405 ask for Lois.

HAELAN MEDICAL EVALUATIONS is an independent evaluation facility specializing in comprehensive medical examinations. We have a growing need for Neurologists/Neurosurgeons to participate in individual and panel evaluations in the Tacoma area. The patient examinations are scheduled in our facility to correspond with the physician's available hours, Monday through Saturday. You are invited to join our growing number of physicians who provide evaluations to our rapidly growing referral base. For further information please call 627-0565, from 8:00 a.m. to 5:00 p.m. Monday through Saturday or feel free to come by and see the facility.

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(Cont. on pg. 12)

DECEMBER READINGS

The Medical Society of Pierce County welcomes the following who have made application for membership into the Society. 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.

DAVID R. BARRY, M.D., Family Practice. Born in Indiana, 5/9/42. Medical School, University of Kansas, 1968; internship, St. Francis Hospital, Wichita, KS, 7/68-6/69; residency, St. Luke's Hospital, 7/71-10/71. Washington State License, 1978. Dr. Barry is currently practicing at A-222 Allenmore Medical Center, Tacoma.

LAUREN K. COLMAN, M.D, Medical Oncology/Hematology. Born in Seattle, WA, 4/2/48. Medical School, University of Washington, 1975; internship, Madigan Army Medical Center, 7/76-6/77; residency, Madigan Army Medical Center, Internal Medicine, 7/77-6/79; graduate training, Madigan Army Medical Center, Hematology/ Oncology, 7/79-6/82. Washington State License, 1978. Dr. Colman is currently practicing at 314 So. K Street, Tacoma.

RICHARD W. KALE, D.O., Family Practice. Born in Idaho, 8/29/44. Medical School, College of Osteopathic Medicine, 1970 and Washington College of Physicians, 1971; internship, The Doctors Hospital, Seattle, 7/70-7/71; residency, The Doctors Hospital, Seattle, 7/71-7/73. Washington State License, 1972. Dr. Kale is currently practicing at 1901 So. Cedar, Tacoma.

HARLEY B. MORGAN, M.D., Child Neurology. Born in Wisconsin, 3/16/52. Medical School, Loma Linda University Medical School, 1977; residency, Loma Linda University, pediatrics, 12/77-12/80 and University of Minnesota, child neurology, 12/83-6/86. Washington State License, 1987. Dr. Morgan is currently practicing at 915 - 6th Avenue, Tacoma.

RONALD R. MORRIS, M.D., Family Practice. Born in Tacoma, WA, 9/13/50. Medical School, University of Washington, 1980; residency, Wilson Memorial Hospital, NY, 6/80-6/83. Washington State License, 1986. Dr. Morris is currently practicing at 1420 - 4th St. S.E., Puyallup.

MICHAEL OLEJAR, M.D., Internal Medicine. Born in Czechoslovakia, 3/17/34. Medical School, Ohio State College of Medicine, 1963; internship, USPHS, Staten Island, NY, 7/63-6/64; residency, University of California at San Diego, 7/65-6/67; fellowship. Tumor Institute of Swedish Hospital, Seattle, 7/67-6/68. Washington State License, 1965. Dr. Olejar is currently practicing at 3611 So. D Street, Tacoma.

PATRICIA L. RUCKLE, M.D., Pediatrics/Pediatric Neurology. Born in Loma Linda, CA, 10/24/49. Medical School, Loma Linda University School of Medicine, 1982; internship, Loma Linda University, pediatrics, 7/82-6/83; residency, Loma Linda University, pediatrics, 7/83-6/84; fellowship, Loma Linda University, Loma Linda University, Child Neurology, 7/84-6/87. Washington State License, pending. Dr. Ruckle is currently practicing at 1811 So. K Street, Tacoma.

LIBRARY CONSORTIUM CRUMBLES

The Pierce County Medical Library Consortium consisting of representatives from Pierce County hospitals and the Medical Society has been disolved. At the November meeting of the Hospital Council, members of the consortium voted to discontinue their financial support to the Library.

The withdrawal of support by all hospitals except Tacoma General has created a shortfall of approximately $23,000 in funding for the Library. A meeting is scheduled in early January between representatives of Tacoma General Hospital and the Medical Society to consider future funding of the Medical Library.

The Board of Trustees has sent a letter to the hospitals expressing its disappointment in their decision to withdraw from the consortium.

HCFA HOSPITAL MORTALITY DATA

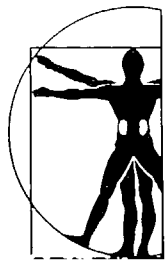
HCFA published mortality data on all Medicare beneficiaries who died within thirty days of a hospital admission. The mortality figures will be compared to an "expected" range of mortality predicted in a statistical model. HCFA argues that the information can be used to measure hospital performance and that these mortality rates will aid consumers in choosing among hospitals. The AMA and other health care organizations are concerned about the potential for misunderstanding and misuse of the data and the needless confusion they will cause the consumers.

The information is presented in alphabetical order by state and hospitals within the state. For each hospital, the information is presented for overall Medicare patient mortality and in each of 16 diagnostic categories (using DRG codes). The hospitals included in the HCFA analysis are short, acute care facilities.

The overwhelming concern expressed by AMA is that this data can not be interpreted or deciphered to measure quality or performance. Since severity of illness is not a factor in the HCFA model, there is great potential for patients misunderstanding of a hospitals "ranking."

(Cont'd from pg. 1)

reviewing the accessibility of nursing homes for not only persons with AIDS, but decubitus ulcers and patients with certain types of catheters. The Task Force anticipates meetings with nursing home administrators and legislators to review this difficult problem.



1988 OFFICERS AND TRUSTEES ELECTED

The Society realized a 46.7% return on the 1988 Officers and Trustees election ballot.

Dr. Bill Ritchie, Otolaryngologist and member of MSPC since 1969 was elected President-Elect. Dr. Ritchie follows in the footsteps of his father, Dr. C.B. Ritchie, who served as President of the Society in 1960. Dr. Ritchie served on the Board of Trustees during 1974-76, and has served on numerous, committees of the Society, Chief of Staff of Mary Bridge Childrens Hospital, 1981 and Chairman of the Board, Pierce County Medical Bureau, 1982.

Dr. DeMaurice Moses, Pediatrician of Puyallup was elected Vice President. A member since 1965 he has served as a MSPC Trustee in 1986 and is a member of the Ethics/Standards of Practice Committee. He has served as President of the Southwest Washington Pediatrics Society and Medical Staff of Good Samaritan Hospital. He was founder of the Hilltop Childrens Clinic, 1967. Dr. Moses was named Washington State Jaycee's Outstanding Young Man of the Year, 1968 and was recipient of the Tacoma Urban League Award in 1970.

Secretary-Treasurer for 1988 will be Dr. Robert J. Martin, Dermatologist.

Dr. Martin, a graduate of the University of Oregon School of Medicine, 1968 has been a member of MSPC since 1976. He has chaired the MSPC Interprofessional Committee since 1985. Dr. Martin has been very active in community affairs of the Gig Harbor Peninsula, particularly activities related to land use.

Three Trustees elected for 1988 were:

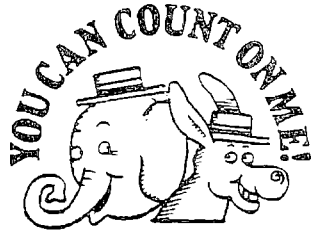
David S. Hopkins, M.D., Family Practice, Federal Way. Dr. Hopkins is a Past President of MSPC serving in that capacity in 1976. He served as a Delegate to the AMA in 1981-85 and is a member of the WSMA Congressional Liaison Committee. Dr. Hopkins, well-known for his writing skills is Editor of the Washington State Edition of the Western Journal of Medicine since 1978 and is also Editor of the Pierce County Medical Bulletin since 1972. He is presently serving as Chief of Staff and Member of Board of Trustees of St. Francis Community Hospital.

Dr. Bill Marsh, Family Practice, Puyallup and member of MSPC since 1978 has been very active in local and state levels of organized medicine. He served as Chairman of WSMA Hospital-Medical Staff Section, 1986 and Delegate to the AMA House of Delegates, Hospital Medical Staff Section, 1986-87. He served as President of Good Samaritan Medical Staff in 1985-86 and currently chairs the Quality Assurance and Bylaws Committees.

Dr. John Rowlands, Pulmonologist, graduate of the University of Washington School of Medicine in 1976. Dr. Rowlands, like his colleagues has been very active in local and state medical affairs. He served as Chief of Staff of Puget Sound Hospital in 1985 and President of the Tacoma Academy of Internal Medicine in 1986-87.

It was an extremely close vote and all of the candidates have the appreciation of the Society for their willingness to serve.

Rounding out the Board of Trustees membership is Dr. William B. Jackson, President; Dr. Richard Bowe, Immediate Past President; and Trustees, Drs. Gerald Anderson, Ron Knight and Eileen Toth.



INTERESTED IN COMPUTERS

The Medical Society Computer User Group continues to meet on the fourth Wednesday of the month at the Medical Society office at 705 So. 9th.

Some recent topics have been Hard Disk Management, The Basics of MS Dos, etc..

If you are interested in learning more about the rich variety of services available on AMA/NET.

One of the services provided AMA/NET subscribers is MEDLINE Search, the National Library of Medicines Biomedical Information Database, with Paper Chase, a literature search interface added June 15. It offers you easy access to the entire MEDLINE Database -- five million references in medicine, dentistry, nursing and health care management from 4,000 journals dating back to 1966.

Another service is DX Plane -- a diagnostic decision - support system developed by Massachusetts General Hospital. DX Plane is the only system of its kind available on a nation-wide on-line information network.

EMPIRES Database on AMA/NET has three interfaces tailored to suit your specific information needs. In addition to the traditional method of

COLLEGE OF MEDICAL EDUCATION

*** * * January Programs * * ***

January 21

LAW & MEDICINE SYMPOSIUM

Coordinators: Richard K. Spaulding, M.D.
David A. Bufalini, Attorney

February 5, 6

COMPUTERS IN MEDICINE

Coordinator: David Brown, M.D.

For further information contact:

College of Medical Education
705 South 9th #301
Tacoma WA 98405
Phone: 627-7137

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LEGISLATIVE GUIDE

(TEAR - OFF and KEEP)

YOUR LEGISLATIVE GUIDE

2ND DISTRICT

Senator Ken Madsen (D)
P.O. Box 370
Roy, 98580
843-2659 (H)
786-7912 (Oly)
Contact: Walter Arthur, M.D.

Rep. Randy Dorn (D)
Antonie Ave. N.
Eatonville 98328
832-3422 (H)

Rep. Marilyn Rasmussen (D)
33419 Mountain Hwy E.
Eatonville, 98328
847-3276 (H)
786-7824 (Oly)
Contact: James Symonds, M.D.

25TH DISTRICT

Senator Marcus S. Gaspard (D)
8220 191st Ave. E.
Sumner, 98390
863-3086 (H)
786-7648 (Oly)
Contact: William Marsh, M.D.

Rep. Daniel K. Grimm (D)
P.O. Box 1046
Puyallup, 98371
845-2408 (H)
786-7968 (Oly)
Contact: Michael Haynes, M.D.

Rep. George W. Walk (D)
11607-98th Ave. E.
Puyallup, 98373
848-6071 (H)
786-7948 (Oly)
Contact: Donald Weber, M.D.

26TH DISTRICT

Senator Bill Smitherman (D)
405 John Cherberg Bldg.
Olympia, 98504
752-6976 (H)
786-7650 (Oly)
Contact: William Jackson, M.D.

Rep. Ron Meyer (D)
4621 34th Ave. Ct. NW
Gig Harbor, 98335
851-8375 (H)
786-7964 (Oly)
Contact: Donald Shrewsbury, M.D.

Rep. Wes Pruitt (D)
6215 55th Ave. Ct. NW
Gig Harbor 98335
858-3154 (H)
786-7802 (Oly)
Contact: Paul Schneider, M.D.

27TH DISTRICT

Senator R. Lorraine Wojahn (D)
3592 East "K" St.
Tacoma 98404
472-6537 (H)
786-7652 (Oly)
Contact: Richard Hawkins, M.D.

Rep. Ruth Fisher (D)
1922 N. Prospect #9
Tacoma 98406
752-7926 (H)
786-7930 (Oly)
Contact: Michael Jarvis, M.D.

Rep. Art Wang (D)
3319 N. Union
Tacoma 98407
752-1714 (H)
786-7974 (Oly)
Contact: George Tanbara, M.D.

28TH DISTRICT

Senator Stanley C. Johnson (R)
7302 66th Ave. W.
Tacoma 98467
582-5465 (H)
786-7654 (Oly)
Contact: James Krueger, M.D.

Rep. Sally W. Walker (R)
4617 Bellview St. West
Tacoma 98466
565-4370 (H)
786-7958 (Oly)
Contact: Terry Torgenrud, M.D.

Rep. Shirley J. Winsley (R)
539 Buena Vista Avenue
Tacoma 98466
564-5494 (H)
786-7890 (Oly)
Contact: Joe Nichols, M.D.

29TH DISTRICT

Sen. A.L. "Slim" Rasmussen
5415 "A" Street
Tacoma 98408
472-4380 (H)
786-7656 (Oly)
Contact: Stan Tuell, M.D.

Rep. Brian Ebersole (D)
5716 Pacific Ave.
Tacoma 98408
472-9414 (H)
786-7996 (Oly)
Contact: Richard Hawkins, M.D.

Rep. P. J. (Jim) Gallagher (D)
125 South 72nd
Tacoma 98408
472-4501 (H)
786-7906 (Oly)
Contact: David Brown, M.D.

30TH DISTRICT

Senator Peter von Reichbauer (R)
P.O. Box 3737
Federal Way 98063-3737
786-7658 (Oly)
Contact: David Hopkins, M.D.

Rep. Jean Marie Brough (R)
1118 So. 287th Place
Federal Way 98003
839-6903 (H)
786-7830 (Oly)

Rep. Dick Schoon (R)
2669 So. 300th Street
Federal Way 98003
941-0313 (H)
786-7898 (Oly)

Legislative Mailing Address:
Senator/Representative _____
Legislative Bldg., Olympia, 98504

For urgent and quick messages to your legislator call the Legislative Hotline toll free, 1-800-562-6000. WSMA Olympia office, 1-800-562-4546.

NEW MEMBERS WELCOMED TO MSPC

The Board of Trustees at its December meeting approved the Credential Committee's recommendation that the following four applicants be approved for membership into the Medical Society. They are:

ALLEN M. CLARK, M.D., 3582 Pacific Avenue, Pathology; Jefferson Medical College, Philadelphia, PA, PhD, 1964, M.D., 1966; internship and residency, U. of Colorado.

THOMAS L. DUMLER, M.D., Diagnostic Radiology, 3402 So. 18th,; Washington U. Medical School, 1979; internship, Jewish Hospital of St. Louis; residency, Baylor College of Medicine.

STANLEY S. W. IP, M.D., General Surgery; 10109 Plaza Drive, S.W.; University of Toronto, 1982; internship and residency, Huntington Memorial Hospital, Pasadena.

DAVID T. ESTROFF, M.D., Pediatrics, Western Clinic; Hahnemann Medical College, 1976; internship, Emory University; residency, Oregon Health Sciences University.

JARED C. ROGERS, M.D., Family Practice, 11019 Canyon Rd. East; Southern Illinois U. of Medicine; internship and residency, Silas B. Hays Army Comm. Hospital.

WELCOME TO THE MEDICAL SOCIETY!!!

INITIATIVE 92/WSMA

While the euphoria lingers following the November 3rd election victory over the proponents of Initiative 92, the "No on 92 Committee," 300 Lenora Street, Box B261, Seattle, WA 98121, is continuing to accept contributions.

The expenses of the campaign were greater than anticipated and the level of contributions from the membership was not as great as expected. Your generosity would help remove this deficit. Many physicians and clinics have been very generous in helping support the Initiative 92 campaign. If you have not yet contributed to the campaign, please do so. Send your check to the "No on 92" Campaign Committee, 300 Lenora Street, Box B261, Seattle, WA 98121.

HEPATITIS A OUTBREAK

Ms. Allene Mares, Director, Communicable Disease Program Coordinator, Tacoma/Pierce County Health Department reported at the December 16, Public Health/School Health Committee Meeting that over 500 cases of Hepatitis A have been reported to date for 1987. Over 75 have been reported in December to date and it is anticipated that it will peak near 100 for December. The high month for last year was also December with cases ranging in the mid 90's. Only two of the 75 cases reported this month can be attributed to the outbreak in a south end restaurant.

MEDICAL SOCIETY PICTORIAL DIRECTORIES

Medical Society of Pierce County Pictorial Directories are now available by calling the Medical Society office. The Pictorial Directory features pictures of all physician members as well as office information and residence phone numbers.

Books are available to members at a reduced cost of $13.00 and to other allied health personnel for $30.00. Call 572-3709 and we will be happy to send you an order form.

PRACTICES AVAILABLE

RETIRING after 40 years of General Practice in Tacoma - Practice and equipment for sale - Bldg. for sale or lease. Excellent location - 2640 sq. ft. main floor, 730 sq. ft. basement. Contact - Dr. McPhee or Tom Markosky (business manager) Seattle - (206) 281-9149.

PRACTICE FOR SALE OR SHARE EXPENSES. Well established active family practice, located in rapidly growing area of Pierce County. Flexible terms. Contact Bill or Adrienne Morrison 848-6499 6 to 10 p.m.

GENERAL

MEDICAL EQUIPMENT AUCTION - January 20th, 6975 - 176th Ave. N.E., Redmond. Call 839-9696 ar 867-5415 for information or auction flyer.

RETIRING? Call us regarding your used office equipment. (206) 867-5415.

RETIREMENT LUNCHEON JANUARY 13

The MSPC Luncheon for Retired Members is scheduled for noon, Wednesday, January 13, at the Tacoma Dome Hotel.

Dr. Dumont Staatz, well known Tacoma Orthopedist will discuss his experiences in Bangladesh.

The luncheons have been very well received by retired members with attendance averaging between 50-60 at the quarterly meetings. If you are retired or anticipating retirement in the near future, plan on attending the January 13th meeting. It is a great time for meeting old friends.

MEDICAL SOCIETY ENDORSES SERVICES

The Medical Society would like to remind members that the Society does endorse the services of CEI (CM Computers) and Doctor's Exchange Answering Service. We highly recommend using the services of these companies, as they have been screened and checked as being reputable businesses and highly skilled at meeting the specific needs of physicians.

If you are thinking of computerizing your office, please call Gail Smith at CEI, 383-3657. For information regarding an answering service call Scott Hager, 272-4111. And, if you don't receive the service you expect, please call the Medical Society office and let us know.

FEDERAL GRANT AWARDED FOR EMERGENCY SERVICES

Mary Bridge Children's Hospital recently was awarded a federal grant for Emergency Services for children in the State of Washington. The grant, one of eight awarded this year by the Department of Health & Human Services Division of Maternal Child Health, is given to states to allow the improvement of pre-hospital and emergency services for children. Hawaii and Washington were the two states to receive the award for 1988.

The six elements of the grant include: 1) EMS training in pediatric emergency medicine, 2) Physician training in pediatric emergency medicine, 3) EMS-C data base, 4) Minority access to emergency care, 5) Public health referral system for EMS-C, and 6) cataloging of hospitals.

The grant is an important development for Mary Bridge. It has placed the Emergency Department in the forefront of a national movement that is developing pediatric emergency services.

If you would like more information regarding this grant, please contact Dr. Ted Walkley, Director of Pediatric Emergency Services at 594-1000.

SIGNATURES TO BE GATHERED

The Citizens for Better Dental Health (Fluoride) Committee under the chairmanship of Dr. Terry Torgenrud anticipates having petitions ready for distribution to all Doctors and Dentists offices in early January.

Signatures will be sought to have an Initiative placed on the November, 1988 ballot to fluoridate the drinking water of Tacoma.

ENTERTAINMENT 88 BOOKS AVAILABLE

Entertainment 88 books are still available, but going fast, thru the Medical Society office. The South Puget Sound edition is selling for $30.00 this year and features over 70 fine dining restaurants, over 40 casual restaurants and over 90 informal restaurants. Also included is over 60 sports offers and special events and over 300 hotels, airline discounts and West Coast Highlights.

The coupon book and membership card will allow you to take advantage of these two-for-one 50% off offers for the next year. The use of just one or two coupons easily pays for the cost of the book. Call 572-3709 to get your Entertainment 88 book.

QUIT SMOKING CLINIC FOR MEDICAL SOCIETY MEMBERS & STAFF

The Medical Society will be co-sponsoring a series of classes in January to help smokers with their New Year's Resolution to stop smoking. The seven session course, co-sponsored by the American Lung Association will cost $35.00 Pre-registration is required and space is limited. Please call the Medical Society office to register, 572-3709.

HAELAN MEDICAL EVALUATIONS is an independent medical evaluation facility specializing in comprehensive medical examinations. We have a growing need for Orthopedists to participate in individual and panel evaluations in the Tacoma area. The patient examinations are scheduled in our facility to correspond with the physician's available hours, Monday through Saturday. You are invited to join our growing number of physicians who provide evaluations to our rapidly growing referral base. For further information please call 627-0565, from 8:00 a.m. to 5:00 p.m. Monday through Saturday or feel free to come by and see the facility.

OFFICE SPACE

NEW MEDICAL - DENTAL BUILDING within sight of Tacoma Mall. Up to 2500 sq. ft. available. Reasonable lease. Contact Dr. Bird 475-8934.

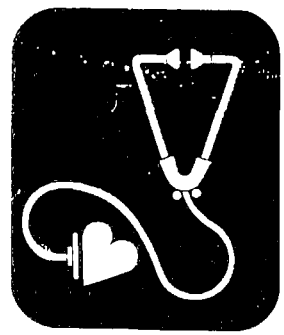
3000 SQUARE FEET of medical office space is available in the Hartland 2 building of Hartland Medical Center at 39th Avenue & 10th Street S.E. across from Fairchild Corp. on South Hill. The space can be subdivided and designed by the physician to fit his/her own professional needs. The complex already has Drs. Gross, Larsen, Whitney & Associates Radiology, South Hill Eye & Skin Associates, Apple Physical Therapy, Good Samaritan Outreach Services', Puyallup Valley Institute, and South Hill Family Medicine. If interested please contact: Dr. Rebecca Sullivan at 848-5951 or Al Sullivan at 593-6072.

NEW MEDICAL - DENTAL BUILDING. Lease or sell. Puyallup near hospital. 848-2359 or 848-7332.

MEDICAL - DENTAL OFFICE AVAILABLE. 2400 sq. ft. brick building near major hospitals, basement , excellent terms. Call Bruce Schmidt 473-0890 Com-Ind Realty.

SATELLITE MEDICAL OFFICE space available for sharing in Federal Way. Please call 927-4876 or 838-7980.

3700 SQ. FT. BRICK MEDICAL - DENTAL office building between Tacoma General and St. Joseph renovated within last 3 yrs. South 8th and "K" Street. Contact: Dr. Fuson at 473-5566.



AUXILIARY

VOLUNTEERING - ANYONE?

The answer to that question is usually "you've got to be kidding" accompanied by an incredulous lift of the eyebrow.

We're not kidding about the need to assist in the following two projects.

The undaunted one, Sally Palm-Larson, is again chairing the Health Fair to be held February 12, 13 and 14 at the Tacoma Mall. This year, she will be ably assisted by Dr. Eileen Toth. This involves a four hour shift at the MSPC/Auxiliary booth and it's time well spent. The medical community will again be projecting a concern for a healthful community. A call to Sally (588-0930) would be most helpful and would certainly make her job an easier one.

For a longer and more extended time commitment, the chair of the Fluoridation Committee (campaign to fluoridate Tacoma's Water Supply), Dr. Terry Torgenrud, has asked that 2-3 Auxiliary members join his group. As an involved committee membr, you will be fulfilling the three main purposes for Auxiliary, and what a great sense of personal accomplishment will be felt, should your efforts be politically successful. Call Bev Graham, Auxiliary President (752-3457) for further information.

Gloria Virak, Chair of the Finance Committee has announced that two community health related projects have been designated the 1987/88 recipients of the Auxiliary's Philanthropic award. The Neighborhood Respite Program sponsored by Catholic Community Services and PLU Wellness Clinic sponsored by Pacific Lutheran University have been notified by the Board, regarding the decision of the general membership. There are many deserving community health programs in Pierce County and it is always difficult to make these selections. Gloria and her committee are to be thanked for their time and effort.

WANTED: Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect. In almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime. You work without worrying whether the patient can pay or you will be paid, and you prescribe, not the least care, nor the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging opportunities for the student, the resident, and the practicing physician.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations. If you are currently in a residency program such as Orthopedics, Neurosurgery, Urology, General Surgery, or Anesthesiology, you may be eligible for the Army's Sponsorship Program.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine:
The practice that's practically all medicine.

CONTACT: **AMEDD Personnel Counselor**
Building 138, Room 116
Naval Support Activity (Sand Point)
Seattle, WA 98115
(206) 526-3548/3307

Medical Society of Pierce County
705 South Ninth Street, Suite 203
Tacoma, WA 98405

The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY February 1988

Medical Society of Pierce County Celebrates 100 Years! See President's Page

AIDS: Impact on Pierce County See pages 13 - 27

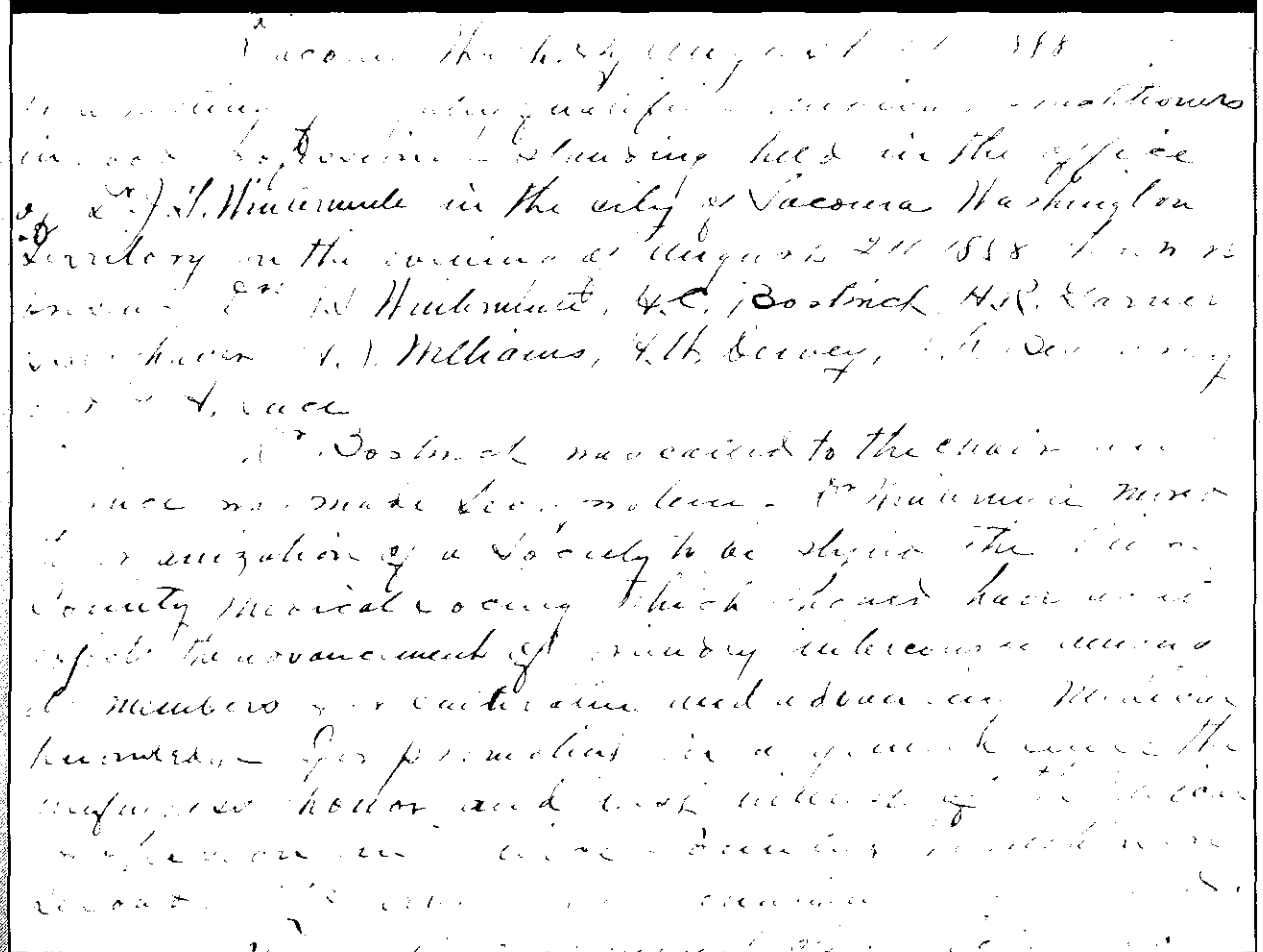


Photo: Washington State Historical Society, Tacoma, WA

Just because your patients feel bad is no reason they should be treated that way.

At Humana Hospital, we go to great lengths to help them feel as good as possible—as soon as possible.

What are some of the advantages you and your patients can expect when you admit them to Humana? For one thing, highly personalized attention to the needs of both of you. For [illegible] our smaller size permits more [illegible] and the involvement of [illegible] highly-skilled nurses [illegible] quick support for your [illegible] consultations [illegible] possible to help you [illegible] your practice. We've [illegible] to provide health care tailored particularly to adults. With special facilities and skills in geriatric care, diabetes education and treatment, male sexual dysfunction, gastrointestinal screening and care, cancer detection and treatment, pulmonary rehabilitation, spinal disorders, osteoporosis, and many other medical specialties. And, of course, we offer well-staffed and fully equipped Day-Surgery, Emergency, and Acute Care facilities. We promise you—both you and your patients will feel good about Humana.

Humana Hospital-Tacoma
Health care for grownups
South 19th at Union,
Tacoma, Washington 98405 (206) 572-2323

Humana®
Bringing the human being in need into the hands of a doctor.™

The Bulletin

The Official Publication of the Medical Society of Pierce County

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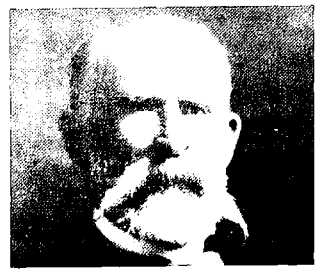
President's Page

Pierce County Medical Society Is 100 Years Old!



H. C. Bostwick
1888-89

W. Jackson, MD
1988-89

When I accepted the presidency I had no idea that the Pierce County Medical Society was organized in 1888 and would be entering its 100th year in 1988. Initially I anticipated girding my loins for the struggles ahead and focusing on future directions of the Society. On discovery of our centennial year, fantasies of looking backward for 12 months leapt to mind. Instead of mobilizing for the next Initiative 92 or attempting to untie the "Gordian Knot" of trauma care, I visualized recounting the fine accomplishments of yesteryears' physicians.

My search for historical information led me to the archival collection of past Medical Society records housed in the library of the Washington State Historical Museum in Tacoma. Contained in four large cartons are our links to our medical origins in Pierce County. These plain cardboard boxes cradle all of the handwritten minutes of our Society back to its inception, August, 1888. Sitting in that silent, old library turning the pages of those century old books, dusty and worn, history does come alive. The inked handwriting has a very personal feel. The character of the earlier physicians and the problems they faced are communicated in the first person.

As one reads through the years of minutes it is obvious that the issues of their day parallel many of our present day issues. Education, turf battles, licensing, entrepreneurism, advertising, legislative issues, public health issues, fees and ethics, the usual trappings of organized medical societies.

What stands out in stark contrast is the remarkable improvement in the quality of medical care. Our early predecessors had a relatively primitive understanding of disease, very few effective diagnostic techniques, and an abysmal lack of therapeutic modalities. The hospital lengths of stay were multiples of our present LOS record. The average longevity in the U.S. in 1900 (the earliest date available) was 47.5 years compared to a current average approaching 75 years.

The initial white settlers arrived in Pierce County around 1850; their commerce was primarily timber and farming. Significant developments were the unsuccessful Indian uprisings, the completion of the Northern Pacific railroad terminus in Tacoma in 1873, the arrival of a land developer, Col. McCarver in 1880, and the first newspaper, the Weekly Ledger. Our sleepy logging community of 300 citizens in 1880 exploded into a bustling frontier town of 15,000 by 1888.

The growth in turn brought physicians. The Tacoma Directory lists 22 physicians. Eight Pierce County physicians met at the office of Dr. Wintermute on August 24, 1888, for the purposes of forming a Society. A statement of purpose was made, they elected officers, and addressed the problem of unlicensed practitioners.

Their elected president was Dr. Henry Bostwick, a model capitalist, but somewhat weak in the arena of organizational medicine. Dr. Bostwick had risen to the rank of major as a surgeon in the Civil War. He migrated westward and arrived in Tacoma in 1874 at the age of 42. Despite finding time to open the first drugstore, become the first bank president, establish the Tacoma Board of Trade (to later become the Tacoma Chamber of Commerce), and serve on the Paddock Hospital board, the newly elected Medical Society President failed to show up after the first three meetings and never paid his dues. Although Dr. Bostwick made many significant contributions to the development of early Tacoma, other physicians assumed the role of nurturing our young society.

We have a rich history of service in Pierce County. Our records detail many examples of physicians who made service to our community a priority in their lives. Service to our hospitals, service to medical education in our community, exceptional service during epidemics, service during national wars, and service to many other community organizations. It is a heritage of which we can be very proud.

We owe a debt to Mrs. Mavis Kallsen for playing a significant role in the preservation of our history. When the Medical Society moved from the old Medical Arts Building our old records came to light. Mavis did a great deal of archival research in the 1970's and penned several excellent articles, several of which were recently reprinted in the Bulletin. She was recognized nationally for her work and received an award from the National Society of Archivists. Importantly she arranged to have our archives transferred to the Washington Historical Society Library in Tacoma. We thank you Mavis Kallsen.

There is a great deal of history of medicine in Pierce County which has not been recorded. If you spend a few minutes with any of our senior members discussing the history of Tacoma, one realizes that these physicians are a rich repository

President's Page, Continued

of unrecorded history, history which will disappear with them unless it is written down. Several living physicians' fathers practiced in Tacoma and they can remember the tales of early medicine their fathers passed to them.

I would like to take this occasion of our centennial to make a plea to our retired and senior members to record their memories of persons, interesting anecdotes, and institutions. This is an opportunity to preserve a passing history for future generations. We will be certain that your writings and any memorabilia will be preserved at the Historical Museum. If this endeavor interests you, please don't procrastinate, future generations will appreciate your efforts. Contact Mr. Doug Jackman or myself if you have any questions.

Finally, I would like to recognize and commend my predecessor, Dr. Richard Bowe, who has been a superb President. He opened lines of communications with Pierce County hospitals, the press, and our related societies. Dick spent endless hours attending committee meetings. He enthusiastically and prudently led us in dealing with our Society' lems. He organized the Phy Lawyer-Dentist Field Day a ranged a Pierce County M Society Caribbean cruise. We Dr. Richard Bowe.□

W. Jackso

Peer Review Organizations

The House/Senate Conference Committee met before Christmas on Budget Reconciliation and agreed peer review organizations will see numerous changes.

A provider or practitioner excluded from the Medicare program by a PRO will be entitled to a hearing before an administrative law judge prior to the effectiveness of the exclusion. PRO contracts will be authorized for three year periods with staggered expiration dates.

PROs will be prohibited from publicizing payment denials without first offering the provider or practitioner prior notification and opportunity for discussion. In establishing review standards, PROs will be required to take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and social factors that could adversely effect safety and effectiveness of outpatient treatment.

PROs will be required to perform substantial on-site review in 20% of the rural hospitals in the PRO's area. PROs will be required to meet several times each year with hospital medical and administrative staff about PRO review.

Fund Raising Efforts Directed to Doctors...

Caution Urged

Some unscrupulous fund raisers are approaching physicians urging them to advertise in a directory that would be used by union leaders to refer their rank and file members. Only those physicians advertising in the directory would be referred. Some callers have said, "If the doctor does not advertise he/she would not see any more union people in their office." If you are called by such a group, please call the Medical Society at 572-3667.

Dr. C. W. Harvey & the First Tacoma Home Phone

By Robert M. Monsen, DDS

A little known fact about the early days of the telephone in Tacoma is that a physician, Dr. C.W. Harvey had the first residential phone in the city. This private line ran from his house at North 2nd and E Street to Bonney's Drug Store on Pacific Avenue.

An advertisement in the "Tacoma Daily Ledger," Oct. 12, 1883 read: "W.P. Bonney, New Tacoma W.T., Wholesale and Retail Dealer, Drugs, Medicine and Chemicals.

The year was 1883. This was one year before regular phone service was established in Tacoma and only six years after its invention in Massachusetts by Alexander Graham Bell.

As the doctor for the Northern Pacific Railroad, Dr. Harvey had privileges at Fanny Paddock Memorial Hospital.

If a person were sick or injured they went to Bonney's Drug Store at 9th and Pacific and called Dr. Harvey on the telephone. He could decide whether or not it was necessary to see the person immediately at the drug store or to have that person go directly to the hospital. If he decided to see the patient at Bonney's Drug Store, he hopped on his bicycle and peddled downhill to Pacific Avenue. It was a good arrangement that lasted until the phone company started regular service. Dr. Harvey apprised the public of the fact that he had a phone by placing the following announcement in the *Tacoma Daily Ledger*. This clipping was dated February 21, 1884.

" C.W. Harvey MD, (Successor to A.M. Ballard, MD) -- Office - over Hampson and Bonneys Drugstore. Residence - On the northside of South Seventh Street, between C and D Streets.

Because of the easy access of the telephone at Bonney's Drug Store, many people went there just to see and hear this new-fangled gadget. Friends of Mrs. Harvey would walk to the drug store just to call on the phone and say hello to her.

"This is phone similar to Dr. Harvey's. This is Mrs. Henry Drum of Gravelly Lake in 1928."

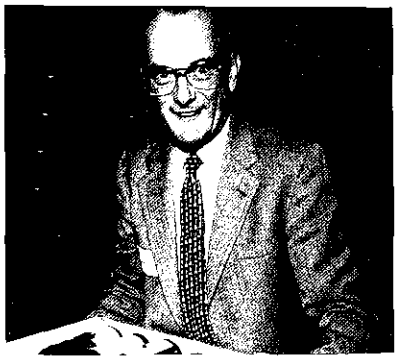
The Sunset Telephone company started regular telephone service in Tacoma, Washington territory on April 4th, 1884. There were twenty-two subscribers and of course Dr. Harvey was one of them. One amazing fact is that the *Tacoma Daily Ledger* barely mentioned this great milestone. Even though the editor of the paper had a phone, all that can be found is a one line announcement in the city news saying *"The local telephone system was set in operation yesterday."*

In 1886 Dr. C.W. Harvey was still one of the few (5) subscribers to have a residential phone. He was a real Tacoma Pioneer.□

Joint Annual Dinner Meeting Dec. 8, 1987

1987-88 officers and trustees gathered for a photograph following the dinner.
Back Row: (L-R) Bill Ritchie, Bob Whitney, Bill Jackson, Dick Bowe, Mike Halstead and Ron Knight.
Front Row: (L-R) Richard Hawkins, DeMaurice Moses, Eileen Toth Peter March, Bill March and Ken Bodily.

Outgoing President Dick Bowe and wife Sara were presented a token of appreciation by Bill Jackson, President for 1988.



Winner of the case of assorted wines donated by the Board of Trustees was Mrs. Betty Johnson. Dr. Bob Johnson carries the trophy away.

Pete and Pat Kesling share a laugh with David and Mary Anne Lee at the festive Annual Joint Dinner meeting held at the Tacoma Sheraton.

Proud winners of the gourmet basket were Dr. Dave Wilhyde and wife Alice

Dinnie and Mike Regalado with Jo and Roger Simms were among the nearly 250 members and spouses to enjoy the festivities Dec. 8.

Auxiliary President Bev Graham enjoys a moment at the Annual Meeting with (L-R) Betty Johnson, Judy Brachvogel, Bev Graham and Nadine Kennedy.

WSMA - At Your Service

Today's health care environment may be in a state of flux and the political environment might well be complex, but the medical PACs' (Political Action Committees) goals remain constant: to promote the improvement of governmental process and leadership by encouraging physicians to be more effective in governmental and political affairs.

Government is very much a part of the practice of medicine whether physicians like it or not. Every medical decision made is shaped by current health care policy, from "which lab tests to order for a patient" to "where does a patient belong during duration of treatment?"

Because someone other than a medical authority is often making these medical decisions, it is more important than ever that you, as a member of the medical community, take on the aggressive role of patient advocate. To be an effective force in government, you must become an active voice in politics.

Political party loyalty, responsibility and discipline are all from a bygone era. Today's elected representative votes along pragmatic lines, frequently crossing party boundaries to join like-minded legislators and turning an ear back towards constituents before going on record concerning an issue. In addition, each legislator is overwhelmed by issues and view points from all different directions and must rely on the thoughts and feelings of voters back home when staking out a position.

There are many special interest groups out in the political arena, all vying for attention. As each interest group speaks out on its own behalf, only a unified force made up of physicians and physician spouses can best represent the interests of the medical community and most important, the patient.

In 1961, the American Medical Association created AMPAC to advance the goals of medicine at the federal level. Currently, more than 57,000 physicians, spouses, and other members of the medical community support AMPAC yearly.

WAMPAC (Washington Medical Political Action Committee) was founded in 1962, and is an important player on the political scene. In conjunction with the other state medical PACs, WAMPAC forms the foundation for AMPAC's continuing success. WAMPAC is a separate segregated fund established by the WSMA and like AMPAC, operates on voluntary political contributions.

The 1987 WSMA House of Delegates adopted a recommendation of full support of WAMPAC by physicians and auxilians in order to further impact the political and legislative arenas. In 1986, only 45% of WSMA physicians belonged to WAMPAC, but the numbers are increasing - - especially with a major election year approaching, when physicians and auxilians more readily see the impact that can be had in the political arena.

WAMPAC has created a consistency and credibility with legislators by supporting friends of medicine and opposing those with an unfavorable posture towards medicine. WAMPAC sponsors highly visible and successful fundraising events for supportive legislators of both parties. This enables the individuals to build up their campaign chests while WAMPAC acts as host for a relatively small outlay. In 1986, 91% of the legislative candidates supported by WAMPAC were elected.

In 1986, WAMPAC was instrumental in electing three physicians and an auxilian to the state legislature. WAMPAC will be actively involved in 1988 with the re-election of those four legislators and is already committed to supporting a number of additional qualified physicians who plan to run. A special program is being devised to actively recruit more physicians and auxilians to run for office.

Your medical PAC contributions and subsequent participation in the political processes are really an investment in the medical profession, our patients and nation's health care system. Join WAMPAC/AMPAC and discover what you can do for the profession, your patients and yourself.□

Committee Volunteers

Our recent survey (see page 29) of MSPC member attitudes indicated a general satisfaction with the Society. We are known at the state level as being the most active and involved county medical society. The Society has 24 committees, several in which the Bylaws direct the composition.

Several responders to the membership survey indicated that they felt the Society was run by a few individuals. The Society is "by the physicians, of the physicians, and for the physicians." If you are truly interested in being involved, making a difference and contributing, please volunteer to serve on a committee.

Committees are the backbone of the organization. We need your ideas and involvement. Please review the following list of committees and check those committees you are interested in serving. Please return your request as soon as possible.

_____ *AIDS Committee ... (meets Monthly) Develops programs to assist medical community to understand and treat this disease.*

_____ *Bylaws Committee... (meets as needed) Considers and recommends amendments to Bylaws.*

_____ *Children's Protective Services... (meets as needed) MSPC/CPS joint committee to enhance communication between the organizations.*

_____ *College of Medical Education, Board of Directors... (meets quarterly) Responsible for setting policy for C.O.M.E.*

_____ *Continuing Medical Education Committee... (meets quarterly) Determines CME presentations and coordinates programs.*

_____ *Committee on Aging... (meets monthly) Created to enhance communications with senior citizen groups, providers, etc.*

_____ **Credentials Committee... (meets monthly) Reviews membership applications and submits recommendation to Board of Trustees.*

_____ *Editorial Committee... (meets as needed) Sets policy for Society publications.*

_____ *Emergency Medical Standards Committee... (meets monthly) Serves as an advisory to the Pierce County EMS system.*

_____ *Ethics/Standards of Practice Committee... (meets quarterly) Reviews, arbitrates questions of ethical conduct within the profession.*

_____ *Grievance... (meets every six weeks) Seeks to resolve disputes between physicians, patients and other parties.*

_____ *Interprofessional... (meets quarterly) Maintains communications between physicians, pharmacists and other professionals to solve problems of mutual concern.*

_____ *Legislative... (meets as needed) Presents medicine's viewpoint to members of the legislature and candidates for office. Monitors legislative activities and issues.*

_____ *Library... (meets quarterly) Governs the activities and budget of the Medical Library consortium.*

_____ *Medical-Legal... (meets monthly) Seeks to resolve disputes arising between respective members of the two professions.*

_____ **Membership Benefits, Inc. Board of Directors... (meets quarterly) Sets policy for the Society's wholly owned for-profit subsidiary.*

_____ *Personal Problems of Physicians... (meets as needed) Assists physicians whose practices may be affected by a drug, mental, or alcohol related impairment.*

_____ *Public Health/School Health... (meets monthly) Serves as a resource authority to a variety of community and health agencies.*

_____ *Fluoridation (Citizens for Better Dental Health) Committee... (meets monthly) Community effort to get the Tacoma water supply fluoridated.*

Name_____Phone #_____

Physician Dispensing

At the December 2, Medical-Pharmacy, Inter-professional Committee, a lively discussion was held regarding physician dispensing. It was noted by physician members that there is significant economic pressure upon physicians to dispense out of their office and that services are available which will make paperwork and regulations a minimal problem. It was the perception of members of the committee that physician dispensing has a built-in conflict of interest. The only benefit of such practice is convenience for the patient; the disadvantage being greater cost to the patient if, in fact, this is going to be an economic advantage to the physician. Also, the possibility of limiting the patient's access to medication in that physicians will not have the spectrum of medicines stocked and therefore may choose to use an available medicine rather than necessarily the best medicine. The AMA and the Washington State Medical Association have gone on record as discouraging physicians' dispensing because of possibility of conflict of interest and risk of breaching medical ethics. Any physician considering dispensing would be advised to consult with the Medical Society.

The second item of discussion is related to mail order pharmacies. The members of the committee again feel that mail order pharmacies have substantially greater risk with misprescribing and lack of control, i.e., contact between the physician and the pharmacist and between the patient and pharmacist. There were individual experiences among committee members of proventyl being put in lanoxin bottles. Quality control was less, with patients complaining that the mail order pharmacy sent many more prescriptions and a larger number of tablets than prescribed. These are problems experienced within a very small group of practitioners. If any of the practitioners within the Society have had similar negative experiences, please bring them to the attention of your Society Board of Trustees or the Medical-Pharmacy Inter-Professional Committee so that we may have a better perception of how great a problem this may be.□

Robert J. Martin, M.D.

Chairman
Inter-Professional Committee

U. S. Health Care at a Glance

Enrollment in Medical Schools and Residency Programs

Year	Medical School Enrollment	Total Resident Population
1980	65,497	61,465
1981	66,485	68,217
1982	66,886	70,523
1983	67,443	72,397
1984	67,090	75,125
1985	66,040	74,514

Source: Journal of the American Medical Association

Growth of Group Practice

Year	Total Groups
1969	6,371
1975	8,483
1980	10,762
1984	15,485
1987	17,556*

*Provisional
Source: American Medical Association, Division of Survey and Data Resources

HMO Growth

Year	Number of HMO Plans*	Number of Enrollees (thousands)*
1981	243	10,266
1982	265	10,831
1983	280	12,491
1984	306	15,141
1985	393	18,894
1986	595	23,664

*As of June of the year indicated
Source: Interstudy

Infant Deaths per 1000 Live Births

Year	Infant Mortality (Infants under 1 year)	Neonatal Mortality (Infants under 28 days)
1950	29.2	20.5
1960	26.0	18.7
1970	20.0	15.1
1980	12.6	8.5
1981	11.9	8.0
1982	11.5	7.7
1983	11.2	7.3
1984	10.8	7.0
1985	10.6*	**

*Provisional **Not available
Source: National Center for Health Statistics

Life Expectancy at Birth in Years, by Race and Sex

Year	All	Male	Female	Black	White
1950	68.2	65.6	71.1	60.7	69.1
1960	69.7	66.6	73.1	63.2	70.6
1970	70.9	67.1	74.8	64.1	71.7
1980	73.7	70.0	77.4	68.1	74.4
1981	74.2	70.4	77.8	68.9	74.8
1982	74.5	70.9	78.1	69.4	75.1
1983	74.6	71.0	78.1	69.6	75.2
1984	74.7	71.2	78.2	69.7	75.3
1985*	74.7	71.2	78.2	69.5	75.3

*Provisional
Source: National Center for Health Statistics

Physician Utilization: Average Patient Visits per Week

Year	Number of Visits
1982	130.9
1983	125.3
1984	120.4
1985	118.4
1986	118.0

Source: AMA Socioeconomic Monitoring System

PPO Growth

Year	Total Operational PPOs*
1980	13
1986	454

*Total Preoperational PPOs as of December 1, 1986: 52
Source: American Medical Care and Review Association

Growth in Hospital Beds, Admissions, and Outpatient Visits (thousands)

Year	Beds	Admissions	Outpatient Visits
1950	1,456	18,483	*
1960	1,658	25,027	*
1970	1,616	31,759	181,370
1980	1,365	38,892	262,951
1981	1,362	39,169	265,332
1982	1,360	39,095	313,667
1983	1,350	38,887	273,168
1984	1,339	37,938	276,566
1985**	1,318	36,304	282,140

*Not available
**Total U.S. Hospitals 1985: 6,872
Source: American Hospital Association

Growth of For-Profit Community Hospitals

Year	Number of For-Profit Hospitals	Percent of Total*	Number of For-Profit Hospital Beds (thousands)	Percent of Total*
1980	730	12.5%	87	8.8%
1981	729	12.5	88	8.8
1982	748	12.9	91	9.0
1983	757	13.1	94	9.2
1984	786	13.6	100	9.8
1985	805	14.0	104	10.4

*Total community hospitals
Source: American Hospital Association

Medicare and Medicaid Expenditures (billions)

Year	Medicare	Federal Medicaid	State and Local Medicaid
1970	$ 7.5	$ 3.0	$ 2.5
1975	16.3	7.9	6.2
1980	36.8	14.6	12.2
1985	72.3	23.2	18.6
1986*	76.0	24.2	19.3

*Preliminary
Source: Health Care Financing Administration

Physician Manpower: Number of Active Physicians per 100,000 Population

Year	Physician/ Population Ratio	Year	Physician/ Population Ratio
1950	142	1980	202
1955	144	1981	208
1960	142	1982	213
1965	148	1983	218
1970	161	1984	223
1975	180	1985	228

Source: American Medical Association Physician Masterfile

Female Physicians and Foreign Medical Graduates as a Percent of Total Physician Population

Year	Percent Female	Percent Foreign Medical Graduate
1980	11.6%	20.9%
1981	12.2	21.2
1982	12.8	21.4
1983	13.4	21.6
1984	14.0	21.5
1985	14.6	21.5

Source: American Medical Association Physician Masterfile

"U. S. Health Care at a Glance" continued from page 11

National Health Expenditures

Year	National Health Expenditures (billions)	As a Percent of Gross National Product
1950	$12.7	4.4%
1960	26.9	5.3
1970	75.0	7.6
1980	248.1	9.1
1981	287.0	9.4
1982	323.6	10.2
1983	357.2	10.5
1984	391.1	10.4
1985	422.6	10.6
1986*	458.2	10.9

*Preliminary

Source: Health Care Financing Administration

National Health Expenditures, by Type of Expenditure (billions)

Type of Expenditure	1984	1985	1986*
TOTAL	$391.1	$422.6	$458.2
Health Services and Supplies	375.4	407.2	442.0
Personal Health Care	341.9	371.3	404.0
Hospital Care	156.3	167.2	179.6
Physicians' Services	75.4	82.8	92.0
Nursing Home Care	31.7	35.0	38.1
Drugs and Medical Sundries	26.5	28.7	30.6
Other	51.9	57.8	63.8
Program Administration	22.6	23.6	24.5
Government Public Health Activities	11.0	12.3	13.4
Research and Construction	15.6	15.4	16.3

*Preliminary

Source: Health Care Financing Administration

1985 Physician Population, by Specialty and Major Professional Activity

Total Physician Population	552,716
Total Active and Classified with Known Address	497,140
Specialty:	
General Practice	67,051
Medical Specialties	159,567
Surgical Specialties	128,156
Other	142,366
Major Professional Activity:	
Patient Care	448,820
Office-Based	330,197
Residents	75,411
Hospital Staff	43,212
Medical Teaching	7,832
Administration	13,810
Research	23,268
Other	3,410

Source: American Medical Association Physician Masterfile

Average Physician Net Income, Professional Expenses, and Professional Liability Insurance Expense (thousands)

Year	Net Income*	Total Expenses	Professional Liability Insurance Expense
1981	$93.0**	$74.0***	$4.1***
1982	99.5	78.4	5.8
1983	106.3	85.9	7.1
1984	108.4	92.6	8.4
1985	113.2	102.3	10.5

*After expenses but before taxes
**Includes employee physicians
***For self-employed physicians

Source: AMA Socioeconomic Monitoring System

AIDS: IMPACT ON PIERCE COUNTY

Surgeon General C. Everett Koop has stated that "By the end of 1991, an estimated 270,000 cases of AIDS will have occurred with 179,000 deaths within the decade since the disease was first recognized." Many activities are taking place in Pierce County to help prepare the community for the increasing numbers of AIDS patients anticipated in the near future.

The Medical Society has asked the Tacoma-Pierce County Health Department AIDS Project to report on services now available through the Department. The Department is heavily involved in antibody testing, counseling and services, risk reduction counseling, educational services and case management.

The following articles will provide you with the services, policies and resources of the Department. You may pull the section out of the Bulletin and save separately.

The Society thanks the staff of the Health Department for gathering and writing the information that will prove very helpful to the medical community.

The Community-Wide AIDS Task Force

At its October meeting, the Board of Health for the Tacoma-Pierce County Health Department established a Community-Wide AIDS Task Force for Pierce County. This group is charged with studying local issues related to AIDS and developing policy recommendations to the Board of Health.

Task Force members were drawn from many segments of the community, reflecting the breadth of impact the AIDS epidemic will have. Following informational sessions about the disease and its status in Pierce County, the Task Force was divided into subcommittees. Community comments on draft recommendations will be sought before the Task Force presents its final recommendations to the Board of Health.

Staff assistance to the Task Force is provided by the Health Department. For information, contact Joan Brewster, Division Community Liaison.

AIDS Task Force members Joyce Hopson, Dave Alger and Alan Tice, MD, discuss medical and social issues for people with AIDS.

Members of the Community-Wide AIDS Task Force include:

Craig Larsen
Active Citizen

Alan Tice, M.D.
Infectious Disease

Rick Campbell
Hospital Administrator

Cathy Pearsall
School Board Member

Joyce Hopson
DSHS Secretary's Representative

Rick Erdtman, M.D.
Preventive Medicine

Dave Alger
Associated Ministries

Lyle Quasim
Active Citizen

William Chunyk
Quad C Convalescent Centers

Don Sacco
Pierce County Medical Bureau

Al Allen
Director of Health

Karen Lynch
Nursing Administrator

Greg Mykland
Tacoma City Council Member

Wendell Brown
Pierce County Council Chairman

Cathy Brewis
Tacoma News Tribune

Henry Haas
T-PC Bar Association

Harry Schmidt
Occidental Chemical Corporation

Fred VanCamp
Teamsters Local 599

Comments from the Director of Health

The following are excerpts from comments made to members of the Community-Wide Task Force on AIDS by Al Allen, Director, Tacoma-Pierce County Health Department, at the December 9, 1987 meeting of the Task Force:

As the Task Force begins its work, I want to offer a few comments from the perspective of a community Health Officer. I recently attended a conference on AIDS in San Francisco. It was designed for public health officials and gave me a chance to share ideas and information with people from around the country who wear the "Health Officer" hat.

Some ideas I brought away from San Francisco:

1. AIDS is BIGGER than any one agency. The exponential growth of this epidemic will strip us of our resources . . . . its impact will be felt throughout our community.

2. We all have a part in developing a coordinated response. We must carefully build bridges between medical and social service resources.

Director of Health, cont.

Because no one agency can shoulder this burden, we will need to collaborate to use our resources wisely.

3. Developing community policy about AIDS is essential to a coordinated response:

What we need are policies which guide our respective agencies and industries. From that guiding policy will extend the programs and specific services we need to respond to AIDS.

Let me share a story about two communities - one with a coordinated response and one without . . . .

We have all heard of Arcadia, Florida where the home of three boys was burned because no one wanted them in school. No real community education took place, fear reigned . . . and fear won.

Did you know there was another Arcadia? Arcadia, Indiana, spent two years working together - as a community - to decrease the fear around AIDS . . . and there was support - not a boycott - when a boy with AIDS started school there.

That positive response has been seen in other communities as well and seems always to be accompanied by:

- a community-wide effort
- a positive philosophy, and
- a leadership willing to speak out about AIDS and the community responsibility.

Pierce County has begun to respond in many ways:

- An AIDS Prevention Program has been built through local government contributions.
- We are reaching many people in need - although our capacity is strained . . . and
- We are working together in groups around the community to identify and meet the needs related to AIDS.

Al Allen, Director, Tacoma-Pierce County Health Department

While important, this community response doesn't address some key public health/public policy issues that will serve as a basis for the work of this Task Force. The issues can be illustrated by some real-life case stories.

Legal/Ethical Issues

AIDS is unlike any other disease. There are no ready answers for public health. For example: What do we do about a 16 year old female prostitute, who is HIV+ and known to be active downtown?

We have no statutes for short-term or long-term intervention, yet we recognize that her behavior represents a serious threat to the public health. Thus far, we have been able to resolve situations like this on a case-by-case basis. Yet we feel the need to approach this problem with a more suitable, systematic solution.

Education Issues

The only effective tool we have to fight the epidemic is education. It's not simple. For example: How do you reach the 21 year old heterosexual male whose self perception is that he is invincible? He is out of school, hangs out at bars, uses drugs and alcohol frequently, has many casual sex partners. How do we reach him and many others like him? And how do we effectively reach 25,000 to 50,000 gay men in our community? . . or "street kids"? . . . or IV drug users?

What will it cost to educate half a million residents . . . . and who will do it?

Medical/Social Services

AIDS will demand a more coordinated response from our medical and social service systems than any other problem to date. We are simply not equipped for the intense disability - and death - that this disease will bring to young people.

For example, we know of an unmarried couple in their mid-thirties, both HIV+. They are showing symptoms of AIDS. They have four children under age 6, an infant, possibly infected. They have problems getting public benefits; they get food from food banks, and money from odd jobs. What will happen when mom and dad get sicker? Who will provide babysitting; household help; food; home care; medical care and transportation; and, eventually, foster care?

Access to Care and Financial Barriers

AIDS is going to be extremely costly. The bulk of responsibility will fall to the local community and the state for financial support and benefit coordination. There is a great deal of planning to do.

This is a typical case. A 38 year old gay man who in the past earned a healthy income, but lost his insurance when he became too sick to work. Now his savings are spent. He gets Social Security, but that gives him "too much" income, making him ineligible

Director of Heath, continued

for medical coupons until he pays enough bills to qualify again. He never knows if or when he'll be able to buy antibiotics or see his doctor. He is caught in a "spend down" trap between state welfare and social security. He feels hopelessly entangled in a bureaucratic web that he's too weak to fight. He calls it his "punishment for working all those years . . "

These are hard issues. They are complex. And there are no ready answers.

But developing some answers is our task.

We are going to look at these big issues together and we are going to "write a book" about AIDS for Pierce County.

When our work is done, we will have these things:

First, a document. Our draft statements will be submitted to the Board of Health for its adoption and endorsement of community-developed policy. But, you can't measure the success of a task force by how much paper is produced. I hope when we are finished we will also have:

Understanding or agreement about major AIDS policy issues . . . . and, Community leaders willing to speak out about AIDS . . . who can advocate responsible policy.

As a Health Officer and member of this group, I'm counting on a successful endeavor. □

Effective Communication About AIDS

Physicians as Educators

Prevention through education is currently our most effective weapon against AIDS. The physician's role in this process is vital. Potentially, physicians can be the best source for communicating AIDS information to the public via their patients and families. Most persons trust the medical profession and turn to their physician for reliable information about health care issues, including AIDS.

While the general public believes that it is saturated with AIDS information, surveys indicate that most people are still ill-informed, particularly about their own risk. A recent study by the University of California at San Francisco found that people holding the greatest fear of AIDS had the least knowledge about the disease and the least desire to learn. Since fear is a significant barrier to learning, it seems logical to focus on alleviating it while delivering AIDS prevention information. Ralph Waldo Emerson one said "knowledge is the antidote for fear".

In the Waiting Room

Physicians can address their patients' fears and indifference by providing AIDS education material in several forms. Pamphlets can be provided in the waiting room or patient education area.

Posters can be placed in hallways, bathrooms and other visible sites. Audio-video tapes could be played periodically in the waiting room exposing not only patients but their families to accurate information.

For an AIDS message to be effective, educators have found it must contain three important components: 1) clear statements about how AIDS is transmitted; 2) how it is not transmitted; and, 3) where to get more information. Other elements which increase the capacity for effectiveness include appropriate delivery of messages which are realistic and factual. Threats, fear-inducing phrases or graphics, and the use of mis-information are not effective and will not encourage preventative, healthy behaviors.

(continued)

Effective Communication, cont.

Staff preview of all waiting room materials will insure that the content is congruent with the information you want your patients to receive. It will also help you effectively communicate, answer questions, and evaluate the learning conditions you've created.

In Conversation

Physicians can also provide opportunities for patients to inquire about AIDS during interviews, examinations or treatment. Leading questions are effective: "What did you think of the video in the waiting room?" Be prepared for questions about HIV transmission, assessment of risk, symptoms and testing.

To be an effective communicator about AIDS , a physician should first realize how his/her own personal fears or prejudices might create barriers towards educating patients. Avoid biased statements which might discourage a patient from discussing a behavior which genuinely puts them at risk. Reduce personal fears by staying informed with accurate and realistic information. Watch language traps which might bar communication (e.g. "as AIDS spreads into the general population . . . " (Are the persons already infected not part of the 'general population'?)

Be prepared to use explicit sexual or drug use terms and be prepared to use them when necessary. Talking about AIDS may be different than communicating other health care messages. Words and phrases which may have seemed inappropriate for a physician to use several years ago are now common place in prevention messages about AIDS.

In the Community

Another way physicians can become involved in AIDS prevention is through public speaking. Several Pierce County doctors have recently spoken to numerous community groups and schools, receiving enthusiastic response. Through these efforts, area physicians have demonstrated their concern with the growing

AIDS crisis and have provided our community with a credible resource.

In Our Schools

As a community leader and parent, a physician can also participate in the efforts to implement AIDS prevention education in our schools.

The AIDS Prevention Program educators have been working with Pierce County school districts to develop AIDS education goals, curricula, learning objectives, and lesson plans. School staff inservices, teacher training, parent and student presentations are among the priority activities of the Program.

For information about a speakers bureau, educational materials, or medical office staff inservices, contact the Health Education staff at the AIDS Prevention Program. □

Testing for the AIDS Antibody

The Health Department AIDS Testing Program

The Tacoma-Pierce County Health Department AIDS Prevention Program counsels and tests individuals for the AIDS antibody on a voluntary basis. Appointments are made through the AIDS Information Line (591-6060) using first names only. Waiting time for appointments is generally two weeks, although clients assessed at particularly high risk may be seen sooner. Each client sees an AIDS counselor who follows a well designed protocol which assures that they are informed about the disease, prevention and the meaning and limitations of the AIDS antibody test. Clients must return in person to receive the results of their test, approximately two weeks after the initial visit.

This program was modeled after similar efforts in San Francisco and other areas heavily impacted by AIDS. It follows guidelines developed by the Center for Disease Control which emphasize the educational benefits which accrue from counseling, rather than only testing.

Testing by Physicians

Pre-test counseling, including assurance of informed consent, should be accomplished prior to testing. The importance of this step should not be overlooked because of the potentially great medical and social impact of the test results on a patient.

Conditions for Testing

1. AIDS Antibody testing may be employed by a physician as a diagnostic tool in the presence of symptomatic infection in a variety of situations. Examples include severe manifestations of M. tuberculosis or severe herpes virus infections.

2. Testing can also be used for the diagnosis of an asymptomatic AIDS virus infection in a variety of persons who may be at risk of infections, such as:
- gay/bisexual men
- IV drug users
- sexual partners of the above
- sexually active heterosexuals (10 or more partners/yr)
- hemophiliacs

Guidelines for AIDS Antibody Testing

1. Anyone who desires to know his or her antibody status should have access to that information.

2. Informed consent, counseling and confidentiality must be available to everyone who seeks testing.

3. Informed consent for testing should be signed by the person to be tested.

4. Testing should NOT be used for generalized screening or as a precondition for employment, admission to a school or health care facility. Testing is appropriate for screening blood, semen, and organ donors.

5. The test results cannot be used to discriminate against persons in decisions regarding employment, education, housing or health care services.

6. Individuals engaging in high risk behavior should be referred to appropriate supporting services regardless of test results.

Counseling Considerations

While the relationship between knowledge of AIDS antibody status and behavior change is unclear, the following recommendations are suggested:

1. Individuals who engage in high risk behaviors, including sexual partners of those at high risk, should be encouraged to seek counseling, and begin risk reduction information and the option of testing.

2. Individuals who formerly practiced high risk behaviors and their current and previous sexual partners may consider counseling and testing to establish AIDS antibody status.

3. Seronegative individuals who continue to practice high risk behavior should be encouraged to seek continued counseling to modify risk in conjunction with periodical retesting.

4. Women at high risk of infection (current or former intravenous drug users or sex partners of intravenous drug users) should consider either postponing pregnancy or learning their antibody status.

5. Women of childbearing age who are or have been in the following categories, or have had the following sex partners, should consider counseling and testing before making childbearing decisions.
* have used IV drugs
* have engaged in prostitution
* have had sexual partners who are infected or are at risk for infection (bisexual men, IV drug users, or hemophiliacs)
* are living in communities or were born in countries where there is a prevalence of HIV infection among women.

• received a transfusion between 1978 and 1985 in areas where the HIV infection was prevalent (New York City, Los Angeles, San Francisco, New Jersey, Miami).

6. Individuals who have never engaged in high risk behavior should be counseled about prevention strategies and the means of transmission rather than being encouraged to opt for antibody testing.

Why Not Test Everyone?

Before considering mass screening of individuals at low-risk for AIDS, one should consider what the test results mean: A positive result on initial and confirmatory tests in someone at low-risk of HIV infection is by no means synonymous with infection, because of the possibility of false positive results.

Bayes' rule allows us to calculate the probability that a person with a positive test is infected. If the joint false positive rate is 0.005 percent, the test will yield false positive results in 5 of 100,000 people tested and ten true positives. The probability that infection is present in a low-risk patient with positive tests would be 67%. The example below compares results between high-risk and low-risk groups.

Before testing, one should also think about the ethics of screening and the social consequences of positive tests for HIV antibody. It is important to keep in mind the emotional impact that a "positive aids test" may have on the individual.

References:

CDC Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. MMWR 1987, 36: 509515.
New York City Department of Health City Health Information, Volume 6, #1, January 1987.
Policy Recommendations for Oregons Response,
HIV/AIDS Policy Committee, February, 1987.

Examples of HIV Antibody Test Results in High Risk vs Low Risk Populations

The following example demonstrates how a larger percent of the positive results of a test will be false in a low risk population than in a high risk population.

Assume that a test will be positive in all persons who are infected, and that it will be falsely positive in only 0.1 percent of persons who are not infected. This test is then used in two populations: One is a high risk group in which 20 percent are infected, the other is a low risk group in which only 0.1 percent are infected. The tables below show the results in each group.

In the high risk group, a very high percentage of the positive test results (99.6%) are from people who actually have the disease. In other words, only a very small percent of the positive test results will be in "false positives".

In the low risk group, very few individuals have positive test results. However, of those that are positive, only 50% actually have the disease. This means that of the 200 positive tests, 50% are false positive.

This statistical effect means that a positive test result has a different meaning for a high risk person than for a low risk person. In this example, the high risk person with a positive test has a 90% certainty that he or she is actually infected. On the other hand, the low risk person with a positive test has only a 50% certainty that he or she is actually infected.

Table I Expected HIV Antibody Test Results for a High-Risk Population Based on Assumption of 20% Infection Rate (20,000 of 100,000 people, 20 percent or 20,000 are infected)

TEST RESULTS FOR HIGH-RISK GROUP

HIV Antibody	POSITIVE	NEGATIVE	TOTAL
Present	20,000	-0-	20,000
Absent	80	79,920	80,000
TOTAL	20,080	79,920	100,000

Table II Expected HIV Antibody Test Results for a Low-Risk Population, Based on Assumption of .1% Infection Rate (100 of 100,000).

TEST RESULTS FOR LOW-RISK GROUP

HIV Antibody	POSITIVE	NEGATIVE	TOTAL
Present	100	-0-	100
Absent	100	99,800	99,100
TOTAL	200	99,800	100,000

Counseling Patients About HIV Status

Counseling is Critically Important

Counseling is a critical component of testing for HIV infection. Both before and after the test, counseling is considered beneficial for educational, emotional, behavioral, medical and public health reasons. The federal Centers for Disease Control (CDC) consider HIV testing without counseling would accomplish little to change behavior leading to HIV transmission.

Pre-test counseling is aimed at helping the individual understand the nature and purpose of the tests and the significance of the results. There are various levels of counseling, depending on the resources available and the risk of the individual concerned. Post-test counseling is directed toward increasing the person's understanding of HIV infection, changing behavior and encouraging contact notification.

Assessing the Risk

In order to assess whether or not an individual is at risk for AIDS and would benefit from testing, it is necessary to get as complete a sex and drug history as possible. As physicians recognize, symptoms associated with the AIDS virus may be descriptive of many other diseases or conditions. Although the development of these symptoms should be discussed, it may be more valuable to guide the discussion toward risk behaviors. Candid conversation may be initiated by reminding the patient that there are three main ways the AIDS virus is spread: 1) having sex with an infected person; 2) sharing drug needles and syringes with users of illegal drugs; and, 3) babies born to infected mothers.

If the patient is a gay or bisexual male, it is important to ask what type of sexual activity he has engaged in. The risk of infection may be higher in someone who is anal receptive rather than someone who engages in oral sex only.

It is also important to ask the client if they have thought about what this reaction might be if their test results are positive. If they respond in any way that sounds suicidal or homicidal, it's probably best not to test until further counseling can be obtained.

Safer Sex Education

All clients need information on safer sex. Often, men need instruction on proper use of condoms. A demonstration using two or three fingers to represent a male penis is useful to show how to squeeze the air out of the tip of the condom. Also, the use of lubricants such as KY jelly, particularly for anal intercourse is important. Women may need instruction in the use of spermicides. The ingredient they need to look for is Nonoxynol (at least 6%).

Explaining Testing

Patients should be counseled about the meaning of test results prior to testing. Patients need to be told that an AIDS antibody blood test does not diagnose the disease itself, but a positive test helps to confirm exposure to the virus in the majority of cases. They should be taught that the diagnosis of AIDS is based on the person's medical history, the results of a physical examination, and the presence of certain tumors or opportunistic infections or symptoms of progressive brain disease.

If an AIDS antibody test is positive, has been confirmed by a Western Blot, and there is a history of high risk behavior, then there is a high probability that it is a true positive and the person has been infected with the virus. However, patients must be told that a positive antibody status does not necessarily mean they will develop AIDS.

Sources
The New England Journal of Medicine, Volume 317, No. 4 □

For further information on AIDS contact the Medical Society of Pierce County 572-3666

Hotline Information CALL

National: 1-800-342-AIDS
State: 1-800-272-AIDS
Tacoma-Pierce Co: 591-6060

AIDS: The Impact of Diagnosis

A Powerful Diagnosis

A diagnosis of AIDS has potentially devastating psychological consequences. Many patients know - or soon learn - that seventy percent of all people with AIDS die within two years of diagnosis. Ninety percent of all adults with AIDS are in the "prime of life" - - between ages 20 and 49 - - when people are not commonly prepared to deal psychologically with death. All but a small minority of AIDS patients are homosexual and bisexual men or intravenous drug users - individuals who already may be stigmatized and subject to social and job-related discrimination. Such problems multiply with a diagnosis of AIDS.

Multiple Problems with AIDS Diagnosis

AIDS is an experience of multiples: multiple losses, multiple systems, and multiple stigmas.

Losses: Few other diseases produce as many losses - loss of physical strength, mental acuity, ability to work, self-sufficiency, social roles, income and savings, housing, the emotional support of loved ones, and loss of safety.

Systems: Seventy-five percent of those diagnosed with AIDS are unfamiliar with the public benefits system: social security, DSHS, homecare, hospital discharge, medical care, transportation, nutritional services. Often, needed resources don't exist or cannot be accessed because the AIDS client doesn't fit traditional criteria.

Stigmas: The stigmas toward homosexuality, addictions, welfare, disease and the handicapped contribute to the emotional and spiritual trauma of an AIDS diagnosis.

Need for Continued Support

A diagnosis of AIDS, ARC, or a positive HIV test result should be communicated gently and accompanied by referral to an informed, supportive resource to assist patients in coping with the implications of their diagnosis. Two resources presently available are the AIDS Prevention Program and the Pierce County AIDS Foundation. □

AIDS: The Impact on Health Care Providers

Care for people diagnosed with AIDS impacts the private physician greatly. Health care providers, while educated to respond to the medical, surgical and psychological needs of their patients, face three major challenges in helping people with AIDS:

1. **A New Disease**

First, we must learn to serve patients with a new and unfamiliar disease. We must treat and comfort people who face suffering and death. We must provide information, treatment and solace to others infected with HIV but with few or no clinical symptoms. For so many of their questions, the answer is often, "We don't know yet . . . "

2. **Lack of Effective Therapies**

Second, health care workers must provide intense care while coping with their own fears and their own pain in caring for patients who do not get well or whose outcome is uncertain. It is distressing to treat young people and to feel a sense of powerlessness because we have so little to offer patients. Adding to this strain is the need to respond respectfully and sensitively toward individuals who may be treated as "social pariahs".

3. **Complex, Time Consuming Care**

Third, there is an increase in provider and clerical time to coordinate care: completing disability forms, monitoring treatment plans, communicating with home health/hospice/and other agencies, and insurance case managers regarding denial of pay, third party payers with contracts, respiratory therapy, etc.

Community Resources Can Assist

While care of the AIDS patient can be complicated, the role of the health care provider is critical. One way to ease the impact of AIDS patients on a medical practice is to coordinate with community resources. For example, the Health Department's AIDS Case Management Program can provide support to both patients and physicians by helping to arrange necessary services and monitor health and service needs over time. □

The Need for a Collaborative Practice

AIDS is a rollercoaster of rising and falling levels of disability that may or may not parallel underlying pathophysiological processes. Some persons may be chronically ill for weeks or months before diagnosis is confirmed; others may experience an abrupt onset of severe Pneumocystis Carinii pneumonia, in which the respiratory impairment can be life-threatening and irreversible. This framework conceptualizes four levels of disability:

- apparently well
- chronically ill
- acutely ill
- terminally ill

In addition to unpredictable changes in general health, the natural progression of the disease toward less independence, it's life-threatening quality, the scarcity of resources, fear and prejudice all contribute to the complexity of managing patient care. This disease necessitates a comprehensive approach: The cornerstone of comprehensive care needs to be a collaborative practice.

San Francisco General Hospital has demonstrated the value and necessity of the multi-disciplinary team to maximize patient care. The physician, nurse, social worker, Shanti counselor or volunteer, psychiatrist, dietician, chaplain, and community agency staff can play an essential role in patient conferences and discharge planning.

Physicians and nursing staff are in a critical position to initiate referrals to hospital social workers and to community-based agencies. Early intervention by social workers or case management can provide a realistic assessment of needs and available resources. Their participation can also help build a collaborative care team which is responsive to a patient's fluctuating care and service needs over time.

Central to the collaborative team are the client, family and friends who act as active participants. For people living with AIDS, the best treatment builds on the person's ability to evaluate and make full use of their own coping skills. Treatment plans should capitalize on strengths, maintain hope and show continued human care and concern. □

AIDS Case Management

Scope of Case Management

Case management offers a system of support when transitioning from hospital care to community care. In addition, it supplements physician-directed care by helping patients access community-based services.

Case Management assures:

- comprehensive needs assessments
- referral to health and social support services
- education for clients, families, providers of care
- assistance in obtaining benefits
- advocacy for patient rights
- follow-up to evaluate status and needs as they change over time.

A goal of case management is establishing coordination and cooperation between the systems and people affected by AIDS/ARC: family, friends, physicians, social workers, volunteers, DSHS, social security, etc.

Health Department AIDS Case Management

Anyone living in Pierce County diagnosed with disabling AIDS-related Complex (D/ARC) or AIDS can be served by the Tacoma-Pierce County Health Department AIDS Case Management. For those who are HIV positive and not diagnosed with AIDS or D/ARC, the Health Department will make every attempt to refer them to the best community services for their needs. Along with case management, the Health Department is working with the community to develop a continuum of care resources so that we can adequately respond to the needs of people living with AIDS.

When a patient is referred for case management, the Case Manager will meet with the client in the office, at their home, or at the hospital. Together, they will explore the clients' needs, individual support system and the resources available. Then they develop a plan for obtaining the benefits and services needed. The case manager will follow through with the plan - giving information, being an advocate and helping when the client wants help. The case manager will stay in touch with the client as long as he/she wishes, and will respond to the individual's changing health status.

Referrals to the AIDS Prevention Program Case Management can be made Monday thru Friday, 8:00 a.m. to 5:00 p.m. at 591-6060. Char Bennett, CHN, will explore each situation and initiate a plan for case management services. This service is part of the Tacoma-Pierce County Health Department AIDS Prevention Program. There is no cost to the client.

Pierce County Responds to AIDS

A number of community based efforts are underway to respond to AIDS-related needs for education and service. The informal chart, on page 27 shows how this "AIDS Network" is developing. Program descriptions, contact persons and phone numbers are provided below.

Community-Wide Task Force

Eighteen community leaders were appointed by the Board of Health to study AIDS related problems in Pierce County. This group will develop policy recommendations for a community response to the AIDS epidemic. Contact: Joan Brewster, AIDS Prevention Program, Tacoma-Pierce County Health Department, 591-6060.

Continuum of Care Committee

Associated Ministries, in conjunction with the Health Department is creating this steering committee for a number of ad-hoc working groups. Participants are needed to identify possible solutions to AIDS related problems such as:

Financial Assistance
Housing
Legal Assistance
Emergency Assistance
Dental Service
Volunteer Training
Home Care
Long Term Care
Mental Health Service
Chemical Dependency
High Risk Education

Contact: Dave Alger, Associated Ministries, 383-3056

Pierce County AIDS Foundation

Patterned after the Northwest AIDS Foundation in Seattle, this group is allied with Associated Ministries. The Foundation is providing targeted education for high risk groups, emergency financial assistance to people with AIDS and is organizing development of a volunteer network and support groups. Contact: Patrick Rumrill, 383-2565.

South Sound AIDS Network

This group of service providers for PWA's meets each second Tuesday at 7:00 a.m. at the Homestead Restaurant. The meetings are open to anyone concerned about AIDS services and education. The network allows providers to share their activities and concerns, and keep abreast of developments in the community. Contact: AIDS Prevention Program, 591-6060

The AIDS Prevention Program

This Tacoma-Pierce County Health Department Program offers the following services: counseling, testing, education, case management, and community organization. Contact: 591-6060.

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Madigan Army Medical Center and **American Lake Veterans Administration Hospital** each have programs designed to offer medical services and support groups for people with HIV infections and PWA's, and education for long-term care providers. Contact: Madigan Army Medical Center - Janet Davis, 967-6118; American Lake VA Hospital - Joyce Moody, 582-8440; Long-Term Care Providers - Bonnie Nichol, 582-8440.

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The Medical Society of Pierce County, The American Red Cross, Planned Parenthood and AIDS Prevention Program offer public education on AIDS to community organizations, employers, and school districts. Contact: American Red Cross - Candace Carroll, 572-4830; Planned Parenthood - Martha Ann Watt, 572-2187; AIDS Prevention Program - Harry Jensen, Marian Williams, 591-6060.

*****

POCAAN-People of Color Against AIDS . . . Tacoma Urban League

Contact: Royce Brown, 383-3007.

*****

Tacoma Urban League
Contact: Loretta St. Andre, 572-5002.

AIDS and IV Drug Use

IV drug use is the only known risk factor attributed to three reported cases of AIDS in Pierce County. One case was an Intravenous Drug User (IVU); two others were sexual partners of IV drug users.

These small numbers are a marked contrast to reports from some East Coast cities where IV drug use is emerging as the predominant risk factor for AIDS. However, the number of local cases is expected to rise: Health Department staff in both the AIDS Prevention and Methadone Programs are aware of a number of IVDU's who test positive for HIV, some of whom have HIV-related symptoms. Only a small fraction have been tested.

Needle Sharing and Local Drug Use Trends

The lower incidence of HIV transmission here has been attributed to the fact that: 1) "shooting galleries" found on the East Coast are not common locally; and, 2) needles are more available, decreasing the necessity of needle sharing. However, nearly all IV drug users share needles with someone, generally "friendship groups" that may range from two to twenty people.

IV drug use locally consists chiefly of heroin, cocaine and methamphetamine. The consensus among treatment professionals is that there has been a shift away from poly-drug use and pharmaceuticals over the past five years as heroin and cocaine have become increasingly available and cheap.

A Heterogeneous Population

According to Dr. Richard Hawkins, M.D., Medical Director for the Methadone Maintenance Program, physicians may be unaware that some of the patients they treat use needles. IV drug users are a very heterogeneous population. Pre-conceived notions about who uses IV drugs are not reliable and stereotypes about behavior or appearance can be misleading. In addition, the practice of assigning hospital patients to physicians may increase the likelihood of becoming a primary care provider to IV drug users, who may be unlikely to have their own physician.

Drug Use History

Patients are understandably reticent to disclose their use of illicit drugs. Yet, routinely taken drug histories could help physicians identify individuals who are ready or willing to discuss their chemical dependency. A candid discussion could elicit referrals for treatment and an opportunity for patient education about the risks of AIDS.

Treatment Resources

A county-sponsored information and referral line for all types of chemical dependency problems can assist in providing referrals. The phone number is 572-CARE.

In addition, the following three programs provide outpatient treatment for IV drug use and have incorporated AIDS education in their treatment plan:

The Pierce County Alliance 572-4750
The Center 572-8200

These are county subsidized programs offering drug-free treatment for the client who is willing or able to give up opiates.

The Methadone Maintenance Program, Tacoma-Pierce County Health Department 591-6405
This program combines individual counseling with methadone to relieve opiate withdrawal symptoms, with a goal of reducing methadone dependency over time.

Education

The treatment centers above have developed intensive AIDS education programs. In addition to stressing abstinence, clients are taught how to protect themselves and others by cleaning their works and following safer sex quidelines. They are counseled and referred for HIV testing as appropriate. Instruction is offered in both group and individual settings and a survey is administered after three months to help assess the effectiveness of the AIDS education efforts.

For More Information

. . . . about AIDS and IV drug use, please contact:

Dave Bischof, Tacoma-Pierce County Health Department, Methadone Maintenance Program (591-6405)

or The AIDS Prevention Program (591-6060)

AIDS Information Sources

Hotline Information:

National:.....1-800-342-AIDS
State:.....1-800-272-AIDS
Tacoma-Pierce County 591-6060

Recommended References:

Abrams E.J., Patrias K. *AIDS Bibliography.* 1986-1987, National Library of Medicine, Specialized Bibliography Series No. 1987-2. June 1987.

Serologic and Immunologic Studies in Patients With AIDS in North America and Africa: The Potential Role of Infectious Agents As Cataetas in Human Immunodeficiency Virrus Drifxns, by Tomas C. Quinn, M.D., Peter Pisti M.D., and Joseph B. McCormack, M.D., et al, JAMA, May 5, 1987, volume 257, No. 19, p. 2617-21, editorial comment 2632.

Surviving and Thriving with AIDS: Hints for the Newly Diagnosed, edited by Michael Callan; 158 pages, published by the PWA Coalition, April,1987.

Legal Answers About AIDS by Mark Senak, Gay Men's Health Crisis, New York, 1987.

Pearce, R.B. , Abrams, D.I., *Entamoeba histolytica in homosexual men.* Letter to the Editor , New England Journal of Medicine, 316: 689-690. 1987.

AIDS among blacks and Hispanics: United States. MMWR, October 24, 1987.

HTLV-III/LAV: Agent summary statement. MMWR, August 29, 1986.

Recommendations for providing dialysis treatment to patients infected with HTLV-III/LAV. MMWR, June 13, 1986,

Recommended infection-control practices for dentistry. MMWR, April 18, 1986.

Recommendations for preventing transmission of infection with HTLV-III/LAV during invasive procedures. MMWR, February 14,1986,

Additional recommendations to reduce sexual and drug abuse-related transmission of HTLV-III/LAV. MMWR, February 14, 1986.

HIV antibody screening: an ethical framework for evaluating proposed programs. JAMA 256:1768, 1986.

Confronting AIDS: Directions for public health, health care and research. Institute of Medicine and National Academy of Sciences, National Academy Press, 1986

Palacios-Jiminez L, Shernoff M: *Facilitators Guide to Eroticizing Safer Sex. Gay Men's Health Crisis,* New York, 1986.

Bloom DJ, Shernoff M: *"I Can't Cope With My Fear of AIDS - Strategies for the 'Worried Well'".* Gay Men's Health Crisis, New York, 1986.

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Cole HM, Lundberg GD. *AIDS From the Beginning,* Journal of the American Medical Association, 1986.

Sande MA: *The case against casual contagion.* New England Journal of Medicine 314:380, 1986.

Acquired immunodeficiency syndrome: infection control and public health law. New England Journal of Medicine 314:931, 1986.

Recommendations for assisting in the prevention of perinatal transmission of HIV and AIDS. MMWR, December 6, 1985.

Recommendations for preventing transmission of HTLV-III/LAV by ocular fluids. MMWR, August 30, 1985.

Revision of the case definition of acquired immunodeficiency syndrome for national reporting - United States. MMWR, June 28, 1985.

Update: acquired immunodeficiency syndrome - United States, MMWR, May 10, 1985.

Update: acquired immunodeficiency syndrome (AIDS) - United States. MMWR, January 6, 1984.

Nichols SE, Ostrow DG. *Psychiatric Implications of Acquired Immune Deficiency Syndrome,* American Psychiatric Press. 1984.

Partial directory of clinical trials of experimental antiretroviral and immunostimulatory agents in patients with AIDS and ARC and agents in pre-clinical study for application in AIDS and ARC. American Foundation for AIDS Research.

MMWR:

Recommendations for prevention of HIV transmission in health-care settings. August 21, 1987.

PHS guidelines for counseling and antibody testing to prevent HIV infection and AIDS. August 14, 1987.

Update: AIDS - United States. August 14, 1987.

Publication of revised case definition for AIDS surveillance. August 14,1987.

Classification system for Human Immunodeficiency Virus (HIV) infection in children under 13 years of age. April 24, 1987.

Antibody to Human Immunodeficiency Virus in female prostitutes. March 27, 1987.

Human Immunodeficiency Virus infection in transfusion recipients and their family members. March 20, 1987.

Electronic Databases:

Electronic database systems provide very current information and are a useful resource for identifying references on selected topics. An office computer, modem and communications software are needed to use an electronic information system, which is purchased by subscription and fees for time spent on-line, accessing information.

One example is:
San Francisco General Hospital's AIDS Knowledge Base, which became available in October 1987, described below:

"This database presents current and comprehensive information about all aspects of the acquired immunodeficiency syndrome. Its format allows rapid access to specific topics, including epidemiology, pathogenesis, diagnosis, prevention and treatment strategies, and societal and psychological aspects of AIDS. It is designed for use by clinicians, researchers, nurses, public health personnel, administrators, educators, and all others working in this area. The AIDS Knowledge Base will be continuously updated as new developments and practices emerge."

This example was obtained through BRS/Colleague Information Technologies (1-800-468-0908).

AIDS Cases Reported in Pierce County

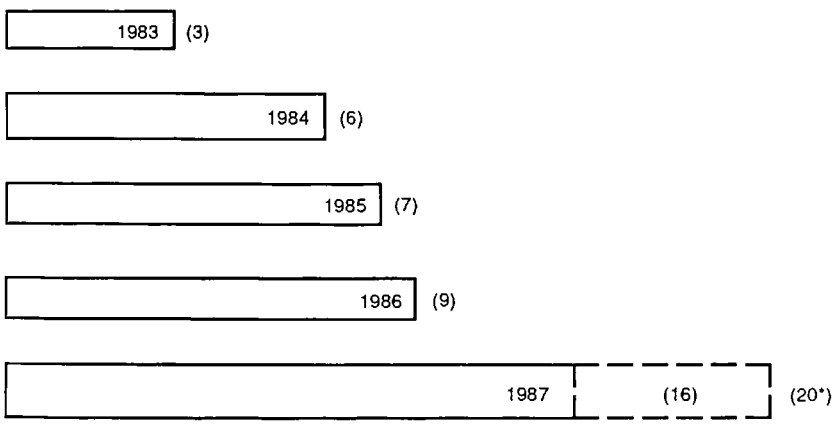
1983 through November, 1987

AIDS Reported Cases			Status		
Year	Number of Cases		Alive	Dead	Unknown
1983	3	7%	0	3	0
1984	6	15%	0	6	0
1985	7	17%	1	2	4
1986	9	22%	3	3	3
1987	16	39%	11	3	1
TOTAL	41		15	18	8
	100%		37%	43%	20%

Age Group			Risk Behavior	Cases	percent
20	0	0%	Gay/Bisexual	35	85%
20-29	18	44%	IV User	1	3%
30-39	15	37%	Transfusion	2	5%
40-49	1	2%	Undetermined	3	7%
50+	3	7%			
unkn	4	10%			
TOTAL	41	100%		41	100

Race			Sex		
White	34	83%	Male	39	95%
Black	4	10%	Female	2	5%
Am Indian	0	0%			
Hispanic	1	2%			
Asian/PI	2	5%			
Other	0	0%			
TOTAL	41	100%			

AIDS Cases Reported in Pierce County 1983-1987



(* includes 4 case reports not yet filled)

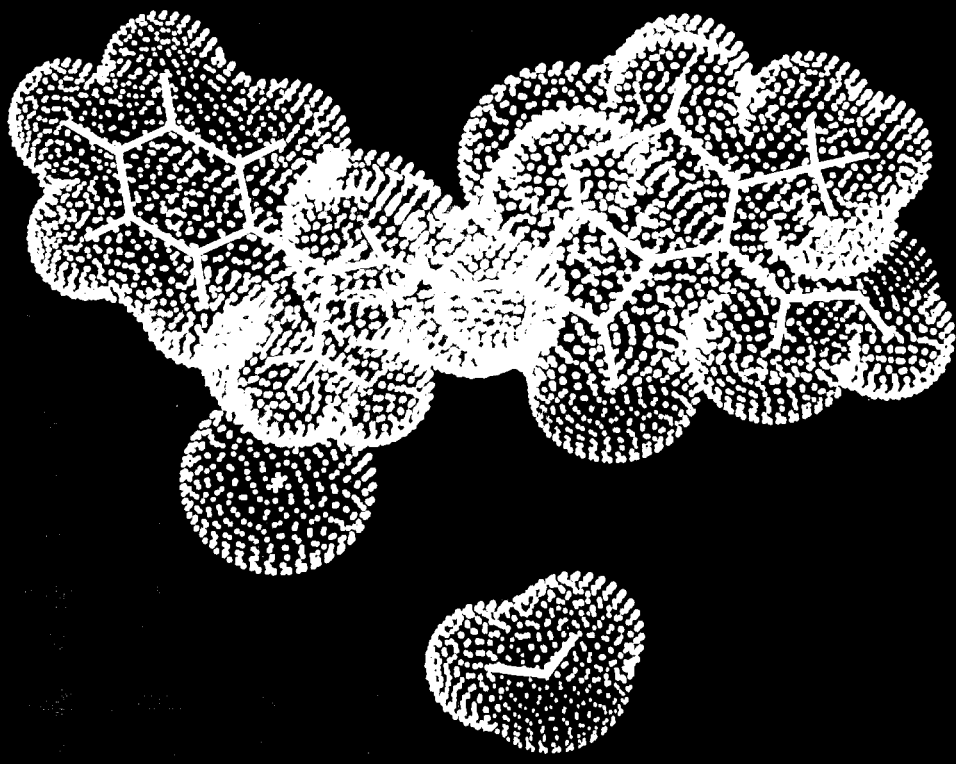
41	Reported
4	Not Completed
45	Total Cases

ANNOUNCING

NEW

[redacted]

cephalexin hydrochloride monohydrate



DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd by Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

Computer-generated molecular structure of cephalexin hydrochloride monohydrate

Medical Society of Pierce County Opinion Survey

In December, the Medical Society Office sent out nearly 700 Membership Opinion Surveys to help the Board of Trustees in planning for 1988 and the future. As we go to press (late December) we have received 160 responses. The following is a tabulation of those responses. In a future Newsletter or Bulletin the complete results will be printed with commentary.

1. In the future what level of emphasis should the Medical Society of Pierce County give to each of the following issues? (PLEASE RATE EACH ISSUE)

	Greater Emphasis	About the Same	Less Emphasis	No Opinion
a. A Designated Trauma Center	49	56	43	14
b. A more effective EMS system	55	73	23	12
c. The public image of the medical profession	97	59	3	3
d. Medical staff/hospital administration relationships	52	87	15	9
e. Accessibility of quality health care to P.C. citizens	46	99	15	4
f. Physician/patient relationship	36	110	12	4
g. Continuing medical education	36	105	19	2
h. Environmental public health issues	49	2	4	12

2. To which of these community organizations do you belong? Kiwanis 4, Lions 2, Rotary 12, Chamber of Commerce 24, None 105,

3. In your opinion, which of the words or phrases below best describes the current Medical Society of Pierce County (PLEASE CHECK EACH PHRASE THAT APPLIES)

Young 27	Innovative 15	Passive 32
Traditional 92	Dynamic 22	Competent 74
Effective 57	Old 24	Ineffective 21
Practical 66	Self-serving 23	Acts in the public interest 69
Low credibility 9	Democratic 44	
Run by a few 41	Aggressive 9	Bureaucratic 19
Liberal 0	Conservative 63	High credibility 80

SOME INFORMATION ABOUT YOU:

4. Your age: 18 35 years or less 66 36-45 50 46-55 27 65+

5. Your sex: 147 Male 7 Female

6. Have your number of practice visits increased or decreased during the last two years?

Decreased Greatly	Decreased Somewhat	No Change	Increased Somewhat	Increased Greatly
5	16	39	30	30

Is It Worth Dying For?

By Robert S. Eliot, MD, FACC

Dr. Eliot is Director and Chief Executive Officer, The National Center of Preventive & Stress Medicine, Phoenix, AZ.

The following is the text of Dr. Eliot's speech to the Sixth Annual AAMSE Conference in New Orleans, July 30, 1987. AAMSE gratefully acknowledges a generous educational grant from Marion Laboratories, Inc. Kansas City, supporting Dr. Eliot's presentation.

Today I am going to discuss "medicine for the twenty-first century." Some fourteen years ago I was the new chief of cardiology of a major medical school in the midwest, and I was lecturing on cardiac emergencies and developed one myself. Now at the age of 44 and chief of cardiology-that creates a certain credibility gap. It was even more of a credibility gap because my mother was 85 at the time and quite lively, and my father had been 79 when he died.

Also I had none of the classic risk factors. Therefore it brought to mind the comments my colleagues had been making about the whereabouts of my father when I was conceived! How could I possibly be the child of those parents with a heart attack at 44? As developments in the last few years have made clear, the answer was probably stress.

Many Changes

Many things have changed in your profession and mine. This was brought home to me a few weeks ago when I cut my hand through my hobby of model railroading. I showed the cut to my wife who is a dietician, and she made a diagnosis of a laceration in need of stitches.

As she was driving me to the hospital, I wondered what changes had taken place in emergency room medicine since my heart attack some 13 years before. As we entered the waiting room, I noticed two doors. One said Injury; the other said Illness. The decision was easy, I went through the one that said Injury.

But there were two more doors, labeled Appendage and Trunk. I called upon my knowledge of anatomy and recognized that a cut on the hand was an appendage so I went through the door that said Appendage.

To my surprise, I was again faced with two doors. One said Cut; the other said Bruises. Of course I chose Cut. Again two more doors. One said Bleeding; the other said Not Bleeding.

By then, I had been fooling around so long that I wasn't bleeding. I went through the door that said Not Bleeding and wound up in the parking lot. You should see the bill I got for that!

Not What But How

The bottom line is that it isn't what you do but how you do it that makes the difference. Now what I would like to do is to carry you along the path that led us to uncover the mechanisms of the stress reactions, and the ways to measure them, as well as some hints on management.

Here is an example of stress, where you have a drunk on one side of you who wants to recite all of his exciting experiences and on the other side a kid whose gastrointestinal system has been overloaded with pablum and is aimed at your left earlobe. Such is the not-too-friendly sky.

Our stresses are different now from what our ancestors faced. We've lived two and a half million years in the forest, a thousand years on the farm, 300 years in the factory, and only 30 years in high technology. The "fight or flight" reaction which we needed when facing sabretoothed tigers does not work for us now. The survival reaction is turned inward and becomes harmful.

Many individuals whom we see tell us that they feel they go from one combat zone to another. "I go to work on Monday to one combat zone; by the end of the week my family has forgotten who I am and home is like another combat zone." Perhaps as a result, 26% of sudden deaths occur on Monday and another 25% on Saturday. Sudden death is a major cause of death in this country (1000 Americans a day), and 27% die within 24 hours of an emotional crisis.

Take Aim

As I testified before Congress not long ago, more than half the nation's health bill is preventable. The optimistic side of the coin is that you and I deal more often with diseases of choice than we do with diseases of chance. Therefore our AIM today is to create an Awareness, because most of you are individuals very much like our patients who come to us from around the world; if they learn what the situation is and what they can do about it, they generally do it.

The I part is Involvement and Incentive, getting an individual into his/her own care. The M stands for Motivation and Management.

In order for this field to be considered legitimate, we have to understand mechanisms, we have to have objective measurements, and we have to have prudent, scientifically based management systems. The difference between stress and the

common cold is that stress can be a killer. But remember, it isn't over until the fat lady sings.

As Ernst Wynder said, "It should be the function of medicine to have people die young as late as possible." The kind of medicine that we have developed is more comprehensive than the sort of drum and bugle corps of nutrition and fitness that is so common in the world, for our goal is to help people to maximize their quality of life, their performance and their health. And that seems to be what motivates them to stay on the path.

Cape Kennedy

This became apparent to me when I first became involved in this field of stress medicine about twenty years ago when I was asked to be the cardiovascular consultant to Cape Kennedy (previously known as Cape Canaveral, then Cape Kennedy, and now Cape Canaveral again, thereby completing the Federal nitrogen cycle). The biggest ballgame being played at the Cape was our captured German rocket scientists against the Russians' captured German rocket scientists, to see which would be the first in outer space.

The problem I was asked to look at as a cardiologist was that young people, 28 to 35 years of age were dropping dead. There was no explanation. There was some question as to whether the deaths were "natural," and the CIA was concerned that they were being poisoned.

But before starting what ultimately was an eight-year search for the answer, I went to the leader of the Cape at the time to ask what was going on. He looked at me with all the warmth and humanity of a social worker at Auschwitz and said something like "Is this the doctor who is supposed to be out there keeping those schweinhunds from dropping dead?"

So we assumed they had a problem!

As well trained cardiologists we looked for these five things: high blood pressure, cigarette smoking, cholesterol, overweight, and diabetes; because we had been taught that, if we could eliminate those five risk factors, we'd all die of cancer. How can you possibly have a heart attack without the benefits of those things? However these factors did not account for what was happening to the people we saw at the Cape. We even asked the coroner, "Are they faking it?" The coroner said, "No, they're not faking it; they just haven't read the book."

Negative Incentives

As we attempted to find out what was going on, we found that these people were depressed. For some reason the aerospace engineers and technicians were not feeling too good about themselves. The real problem was an economic move on the part of Congress, who had set up a negative incentive plan such that every time a rocket was fired successfully, they would fire 15% of the people who made it happen. Sounds like an incentive system from Congress! It wasn't a matter of *whether* you would be fired, it was simply a matter of *when*. During the years that people were being fired, the incidence of sudden death was more than double the rate for the state of Florida, despite the relatively youthful population.

So it wasn't the hard work that was bothering them or putting in 16 hours per day. It wasn't firing rockets, it was firing people that upset them. These people were being fired into oblivion. They were forced to accept work such as repairing television sets, sacking groceries, and delivering newspapers. I kid you not: these were the three major occupations for these highly trained engineers at the Cape. They were losing identity, control, and self esteem. These are important factors.

Continued on next page.

Self Esteem

Each of us has an identity-who you are, how you see yourself, your self-image, what you want from life; and you want control over your identity to maintain your self-esteem. If you have all three, generally you can stay healthy, remain productive, and enjoy a good quality of life without being self-destructive. If something happens to such people, they can bounce back.

Apparently we had been looking for answers in the wrong direction. But we still had to find the mechanism involved. Two years of my training involved pathology, so we began looking at the coronary arteries post mortem and were surprised to see they were not blocked as you would expect in a typical heart attack.

What we did find was the rupture of muscle fibers in the heart. When that happens it produces a chaotic electrical storm, causing the heart to beat like a bag of worms. It then can't pump blood, and the result is sudden death. But what was producing this?

Over a period of ten years working with my colleagues in Nebraska, we demonstrated that giving animals doses of adrenalin could produce the same changes in a matter of five minutes. The changes could be prevented by agents that blocked the adrenalin.

So it seems that sudden death victims are like adrenalin junkies, literally shooting up on their own adrenalin for "fight or flight" reactions, although they could not run or fight. We are living in the bodies of our ancestors in a world that they never dreamt would exist, and our bodies may respond in the age-old pattern even when it is no longer appropriate. Instead of being life-saving, it can be suicidal.

Hot Reactors

Was it necessary for these walking time bombs to drop dead before we could find them? If they were shooting up on adrenalin, shouldn't we be able to see extreme levels of arousal? Indeed we could and found that one in five Americans are such "hot reactors." They may do well on the physical stress tests and seem healthy, but physical stress is expected and controlled, while mental stress is sudden, unexpected and uncontrolled.

The testing system has been designed for the astronauts. We couldn't send them into space with needles in them for three reasons: the needles might fall out and bleed; they might get infected; and also the astronauts had a tight union. So we had to develop a noninvasive system. This sophisticated system gives us the equivalent of a heart catheterization. We use it to determine what is happening while we challenge people with a standardized stress test. The stressors include mental arithmetic, putting a hand in icewater, and playing a competitive video game. The subject is placed in a room alone and wired up to various monitors. All the instructions are given via a videotape. The subject's reactions are measured by the monitors and fed into a computer that records the data at the rate of 160,000 bits per second. Thus we now have objective measurements of stress reactions.

It turns out that hot reactors are different in several ways. They have more risk factors for heart disease, more family histories of heart disease, and more health problems in general than cool reactors. Hot reacting is part of that critical mosaic that we all need to understand and deal with, so that indeed we can get a handle on that 55% of all illness that is preventable.

Portable System

To aid in finding hot reactors we have simplified our sophisticated laboratory and put it into a portable system. The portable stress laboratory can screen an individual in twenty minutes. It can be used anywhere as long as there is an electrical outlet and a telephone. The test can predict which individuals are most likely to be absent from work, most likely to have high blood pressure in three years (so they can be treated by education instead of medication).

When we take this unit into industry we can locate the hot spots in the workplace and then help them to cool off those departments, those areas, those individuals by teaching them rather than treating them.

Let me give you the highlights of a pilot program we did for the Million Dollar Round Table (MDRT). The MDRT members, who work under great pressure, were thought to be more at risk of disability and death than average. We took the portable lab to their annual meeting. As I mentioned to you, in the population at large, one in every five individuals is a hot reactor. In a screening test of 128 supposedly healthy volunteers from the MDRT group, 39% were found to be hot reactors, twice the national average, and 24% were hypersensitive and didn't know it.

Only about a third fell into normal categories. These people were supposed to be healthy, but two thirds were in need of sensible measures to improve the quality of their life, their performance, and their health.

Of the hot reactors, we randomly chose 13 to participate in a pilot study and put them through our program. In a day and a half we gave them an idea of where they were coming from, what they could do for themselves, and how to do it. They each were given a custom-tailored health portfolio. In other words, they had a rifle instead of a shotgun when they left. Further educational material was given by means of a 30-minute phone call a month later, in September; a three-day seminar in October; another in-depth phone call in November; and finally a one-day seminar in February.

During the six-month program, every single hot reactor cooled off. Three remained lukewarm. Blood pressure, both systolic and diastolic, came down. The resting heart rate fell by 10 beats per minute which means that their anxiety levels were lower and also that their fitness had increased. Their weight slipped about six pounds; their cholesterol came down to 17 points; anxiety indices dropped; as did depression and hostility.

Quality of Life

Their scores were higher on the quality of life index which we had put together to measure the individual struggles and support systems that a person has. Importantly, their

extroversion stayed the same. This is critical for salespeople and shows that this is not a laid-back form of medicine that turns them into corporate hippies. Furthermore, they reported that in the year following, their commissions increased from not less than 40% to over 200%. (The average increase for MDRT members that year was 15%.)

When I presented these results at two international conferences, my colleagues felt they represented a major breakthrough in our ability to deal with people's blood pressure, metabolism and behavior, while still keeping them productive.

What did we do? We didn't do anything, except provide an evaluation and a learning prescription. The participants did the hard part, the practice and the learning. They went to seminars; they listened to tapes; they became their own physicians.

Type A's

Does it have to do with type A behavior? What is type A? It is hostility; more and more, faster and faster. They "love" to wait in line and are "fun" to play tennis with, as compared to type Bs. No, the answer is not type A. Hot reacting and type A behavior are totally different.

When an individual interacts with the world, particularly if his expectations are not met, stress occurs at that interface. What we see on the surface is an overt behavior, but it may be a poor representation of what goes on underneath. Many old and crabby type A's have been to the funerals of younger type B colleagues. Type A is not a death sentence. It is an overt style of behavior, which oddly enough, does not correlate very much with the covert behavior, the physiology and metabolism.

Let's take a look at two bank presidents from different parts of the United States. They are both flaming type A's. They are what we call carrier type A's: when they walk into a room, everybody becomes type A. They spread type A like Typhoid Mary spreads typhoid. But here they are two minutes into playing a competitive video game, and they are as different as night and day. One stayed cool as a cucumber; the other showed a rise in blood pressure from 130/80 to 220/140, and the resistance against which his heart was pumping went up so much that we stopped the test because we were afraid he would have a stroke.

Basically this shows the difference between the way we act on the surface and the way we react underneath. We can look like a type A on the surface, and be hot below the surface. Or you can be hot on the surface and cool below. Or a person can look like a type B and be boiling inside. Or they can look like a type B and be cool inside.

Continued on next page.

These are the things that concern us: the prescriptions the brain writes for the body, the self-talks, vigilance, the six rounds of softening up process, the conversation that an individual has with himself or herself. Then comes the seventh round knockout punch.

It may relate to the cultural situation—the competitive pyramid of our culture versus the supportive system of the Japanese.

Is That All there Is?

A person may go along and look like a winner and then all of a sudden develop the "Peggy Lee Syndrome." This story may be a caricature, but such things really do happen. A man gets up in the morning and his water bed breaks and he doesn't even have a water bed. He looks for the clothes he wore to a party last night and there aren't any. He starts to do pushups but forgot where he had put the mousetrap. He goes downstairs and his son says "Hey, Dad, why doesn't Anita Bryant mind her own business?" He's eating breakfast and watching the bad news on television while hollering abstract goals for his children to follow throughout their life. He is eating his cornflakes in a hurry and the overhead is going up.

Then he starts writing orders on the blackboard for his wife to follow during the day, because he sure as heck doesn't want her to have a better day than he is going to have. He gets out on the freeway and his horn sticks behind a group of Hell's Angels.

At the office he finds Mike Wallace with a camera crew. They want to ask him about his weird Uncle Harold who has been breaking into the homes of Mormons, tying them up, and smoking and drinking in front of them.

Meanwhile his wife has gone out to get herself some identity, control, and self-esteem, but she hurries back to make sure that the children are not in jail. To the man, the family has become a sliding priority.

This evening he blasts in the door, converted into a veritable Godzilla. His wife worries what he might do to the children but then remembers her high school biology where they put the needle in the back of the frog's skull to pith it—separating the brain from the spinal cord. She thinks, "I could pith him, but then who would raise the children." But he has already found his own solution (alcohol). By 12 o'clock he is chemically pithed.

That is the Peggy Lee Syndrome, named for the depressing song she wrote, "Is That All There Is." When you listen to it, please sit next to a lamp where the cord is plugged in so if you begin to fade you can bite down on the cord immediately.

Let's stop for a moment for the simplest stress test in the world. Just give a YES or NO answer. Respond at the gut level and be honest with yourself. The question is, "Are you winning?" If you are winning, it is by your perceptions, your prescriptions that your brain is writing for your body. Then your computer tells you, "Yes, more is going right for me than is not."

If you stop and think, or ask a question, the answer may be NO. No matter what the answer was, today all of us can learn how to deal with stress better. We were not taught this in school, but we can learn. For stress can be either the spice of life or the kiss of death.

This was brought home to me when I was asked to speak to a thousand cardiologists in New York not long ago. They put me on the 46th floor of the Sheridan Center, and being the compulsive physician, I looked for the exit in case of fire. The floor I was on was being remodeled and I made the wrong turn and accidently entered a fellow's room. He was sitting in the bathroom with the door open in a marked state of thought. He was embarrassed and so was I. I said, "I'm sorry, I was just looking for the fire escape," turned around and walked out the door. Well, you guessed it, about ten seconds later he came running after me with his pants at half mast yelling "Where's the fire?"

Our Perception

So we all see things through our own window of perception. The goal is to be productive without being self-destructive and awareness is the therapy. It is important to balance things effectively, to change as little as possible to enable you to achieve what you want in life.

It all starts with the ABCs of an emotion. A, an event takes place. It doesn't have any meaning until you and I give it meaning which is B, the perception. And the C is the response, the physiology of your emotions.

For example, while I was in Saudi Arabia, I saw two brand new Mercedes crash into each other. The drivers got out and ran toward each other and I expected to see a small version of the Arab-Arab war. I didn't see that at all. Instead, they hugged each other. I asked the interpreter what was happening. He said, "They're saying isn't it nice that Allah arranged for us to meet this way." They walked off hand-in-hand to the Mercedes agency, got two more, and tried it again.

Now, if that had been your spouse and your ten-year-old Toyota, you probably wouldn't feel that way about it, even if no one was hurt and you had all the insurance in the world. That is because our perception of the event is different. We play different tapes in our heads. So it is not events that upset us. You upset yourself; I upset me. Most of the time. I'm not talking about major life catastrophes. Most of the things that bother us are small things, irritations that can occur 30 or 40 times a day. Those are the reactions that we can control.

You yourself can choose the price you are willing to pay for an upset on a one to ten basis. It is a matter of teaching one's brain to write health prescriptions. This means that we have more control than we ever thought we had.

Hot reactors are thin-skinned persons who pay a high price. When life's hammer blows strike they break like a china doll. Cool reactors are resilient and they bounce back like a rubber doll. Consider the difference between 9s and 10s for the thin-skinned and 2s and 3s for the thick-skinned. Why pay the price of hatred when a little dislike will do the job? Why go into orbit with anxiety (a 9 or 10) when a little nervousness will take care of it? Why rage and hostility (9 or 10) when anger and irritation are enough? Why suicidal depression

when a little sadness is more appropriate?

Cooling Down

We tell our patients to start with a 10 if that is where they are, but try to make it a 9 next time, and an 8 later on. Sooner or later you may bring it down to something that allows you to take the brakes off the "car" of life; it will feel better and go more smoothly. This is nothing new, for Shakespeare said, "There is nothing either good or bad, but thinking makes it so." And Abraham Lincoln said, "People will be about as happy as they will allow themselves to be." A pessimist is an individual who, when confronted with two unpleasant alternatives, selects both.

We can learn from the Japanese about dealing with anger. Phase 1: The next time someone is angry with you, smile at them. They will think you have totally "vegged" out. It is the most unexpected response to anger that you can imagine. If that doesn't work, try Phase 2: smiling and bowing. That is even more ludicrous. You can go home and try it on the children. You can say something like "So nice of you to put the cat in the toilet." For the cat it may be a 9 or a 10, but it need be only a 2 or 3 for you.

The great thing about this is that even if you don't actually try these things out, the muscles of the body will relax when you just think about them and laugh inside. Thus you can cool off your body either by doing it or by thinking about it.

Then in the event that Phase 2 doesn't work, bring up the heaviest artillery which is "Oh, terribly sorry, but not understand meaning of four-letter words and would you mind repeating, please." Then make them repeat over and over again. If their UPS tries to make a hostile delivery to your doorstep and you are not there, then the message goes back where it came from.

What can you do about it? How can you change behavior? The answer is very gradually.

Six-Months-To-Live Test

One way to help yourselves with stress is to reduce the number of stressful events in your life by taking the six-months-to-live test. If you had only six months to live, what would you really do? Write down the present activities and planned events in your life. Then divide them into three categories: things you have to do; those things you would like to do; and in category III, those things you would not do at all. I suggest you take some time to do the things that you have waited a lifetime to do, and eliminate category III.

You can change the way you see things, even if you can't change the world. In 60 seconds you can even change your view of the person you like the least, or the biggest stress carrier in your life. Just imagine that this person has a brain tumor. Suppose I tell you this person really has a brain tumor and can't control his behavior.

In that case you would probably feel sorry for the individual rather than mad at him. So if people act towards you as if they have a brain tumor, why treat them as if they didn't? It is an effective way of self-regulating, by reducing the overheated energies in your body.

Stress is like the tension on the strings of a violin. Too loose and you won't like the music; too tight and those strings could break. Therefore, each of us has to set the strings just right to make the right kind of music in our lives.

We need realistic goals, not the goals of our mother's bridge club, but our own personal goals. And we need to know where we're going or we run the risk of winding up some place else. Planning ahead is very important.

Granted, some things in life are important enough to get upset about: the loss of loved ones, and so forth. But most of the time, we are grieving for unimportant things that really aren't worth the energy.

Remember to plan for unexpected events. Most of you schedule yourselves from morning to night. To physicians who are probably the worst offenders, I suggest they schedule 15 minutes twice a day to do nothing. If they don't know how to do that, I suggest they schedule a fictitious patient — Letitia Blimptickle. The trouble with most of us is we don't know how to do nothing; we only know how to do something. But use those 15 minutes twice a day to evaluate and determine which things really deserve to be done that day and which things to say NO to. Use the word NO more often, for it's the most powerful lifesaver in the English language, to eliminate category III and to give yourself a chance to breathe and become more human.

Another trouble is guilt. Guilt is the most wasted of human emotions, and if a ball labeled guilt is sent your way, ask yourself, "Where is it written that I have to catch it?"

Learning To Play

Don't forget to play, for play is the oil on the wheels of life that makes it go smoothly. Play is made up of freedom, whimsy, spontaneity and laughter. We cannot work all the time. We need to have diversion, and it is increasingly important that we learn how to play and what kind of vacation to take.

I recommend frequent three-day weekends. I suggested this to one of my patients. He said, "Yes, that sounds good. My wife and I can go to Las Vegas." I said, "That's not what I mean. I mean a three-day weekend in the Christian Science reading room in Dismal Seepage, Nebraska." "But there's nothing to do there," he protested. "Yes, there is. Find out who she is; what she wants to do with her life; what her goals are. Then you'll find there is value in taking some time to smell the roses, for when you come back you will have a more fresh and clear perspective on life."

Take some time for aerobic exercise, for it does reduce anxiety and depression and increases self esteem. The famous cardiologist, Paul Dudley White, said, "Walk your dog, whether you have one or not." It is good exercise and one you can use all your life.

But exercise should be individualized according to your needs and your tastes and should be approved by your physician. Some people prefer a social type of activity, some like exercising in front of the TV, others enjoy a sport.

Other techniques such as muscle relaxation, yoga and biofeedback also can have a profound influence on health if they're used in the right way.

Be Your Own Physician

So, in summary become your own physician under the advice of your physician. Custom tailor your own personal health portfolio. Depend more on yourself for endorsement. Develop a coping portfolio that you can take with you wherever you go. And learn self-regulation, for it is the best medicine.

Remember, "I upset me, events don't. Therefore I decide how upset I'm going to be. I can set the price."

Cool off your self-talks. The most important conversations you'll ever have are with yourself. So when you're talking to yourself, watch your language.

Relax your muscles and your mind. Learn to slip life's psychological karate chops. Bounce, don't break, and use humor. It is the lotion on the sunburn of life.

Take time for love. The importance of love and its support cannot be overestimated. Since stress is most often a learned phenomenon, you can unlearn it. Therefore, ask yourself which of the things that I've talked about you can change, and pick one to begin with.

If you run into that stone wall, ask yourself, is it worth dying for? I don't think it is. If you can't fight, and can't flee, you can learn how to flow.

Each of you has a unique perception combining what you think, what you feel, and what you hear, into the most powerful medicine that there is: the words of your self-talks. For it is the power of these words that writes the prescriptions from the brain to the body. Those prescriptions determine the body's physiology and metabolism, and ultimately health, productivity and quality of life. You can control this most powerful of all medicines, and the power of your words can be used daily to keep you healthy, wealthy, and wise. So use it often, use it well, use it to help your coworkers, your friends, those you love, and use it in good health and good spirits. Let me leave you with the rules for my own prescription: 1. don't sweat the small stuff: and 2. it's all small stuff! □

Reprinted from:
Medical Executive/Summer, 1987

AMA-ERF

Lavonne Stewart-Campbell would like to extend a very special THANK YOU to all the families who contributed so generously to the AMA-ERF Holiday Sharing Card. As of December 1, 1987, with a few checks still outstanding, we were able to raise $12,215 for the AMA-ERF fund. A very special thank you also to the Santa's Helpers who hand addressed all those cards.

STUDENT RECOGNITION

As in the past, the Medical Society and the Auxiliary would like to acknowledge all of this year's graduating seniors. If you have a student graduating from high school, college, junior college, trade school, or a professional school this spring, please drop a line to Marge Ritchie at 4803 95th Ave. W., Tacoma, WA 98467. She would also like to know a little about the student's future plans. Please include the student's name, the school from which he/she is graduating, and his/her major areas of interest.

Congratulations to Marge Ritchie for her election to the University Place School Board. She will bring a lot of very special talents to this Board!

Classifieds

POSITIONS AVAILABLE

FAMILY PRACTITIONER NEEDED. Established practice available at Soundview Medical Plaza next to Puget Sound Hospital, due to retirement. Fully equipped office, new patient referral system, on-site lab and x-ray. Contact Hugh Hendrix, 756-8579.

COMMITTED FAMILY PRACTICE PHYSICIAN needed by urban Native American community for challenging and fulfilling practice. Excellent medical community, ideal location with nearby mountains, beaches and cultural activities. Good benefit package. Send CV: Puyallup Tribal Health Authority, 2209 East 32nd Street, Tacoma, WA 98404.

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part time for FP/ IM/ EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, MD at 5900 100th Street Southwest, Suite #31, Tacoma, 98499. Phone (206) 584-3023 or 582-2542.

FAMILY PRACTICE/ OCCUPATIONAL MEDICINE. Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy. Malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and a balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, WA 98121. (206) 728-6888.

IMMEDIATE OPENINGS. Full time and part time, positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Opportunities including ER in Olympia area. Call NES 1-800-554-4405. Ask for Lois.

PRACTICES AVAILABLE

RETIRING after 40 years of General Practice in Tacoma. Practice and equipment for sale, Building for sale or lease. Excellent location, 2640 sq. ft. main floor, 730 sq. ft. basement. Contact Dr. McPhee or Tom Markosky (business manager) Seattle, (206) 281-9149.

ACTIVE FAMILY PRACTICE and medical-dental building on South Hill of Puyallup. Guaranteed 5 year leases on rental portion of building. Physician agrees to continue working part time with new doctor. Contact Dr. Bill or Adrienne Morrison at 848-6499, 6 to 10 p.m.

OFFICE SPACE

NEW MEDICAL - DENTAL BUILDING within sight of Tacoma Mall. Up to 2500 sq. ft. available. Reasonable lease. Contact Dr. Bird 475-8934.

3000 SQUARE FEET of medical office space is available in the Hartland 2 building of Hartland Medical Center at 39th Avenue & 10th Street, SE, across from Fairchild Corp. on South Hill. The space can be subdivided and designed by the physician to fit his/her own professional needs. The complex already has Drs. Gross, Larsen, Whitney & Associates Radiology, South Hill Eye & Skin Associates, Apple Physical Therapy, Good Samaritan Outreach Services', Puyallup Valley Institute, and South Hill Family Medicine. If interested please contact: Dr. Rebecca Sullivan at 848-5951 or Al Sullivan at 593-6072.

NEW MEDICAL- DENTAL BUILDING. Lease or sell. Puyallup near hospital. 848-2359 or 848-7332.

MEDICAL OFFICE & STUDIO. 3125 sq. ft. office including 5 room and 250 sq. ft. conference room, good parking. 1500 sq. ft. studio. Call Bruce Schmidt at Com-Ind Realty 473-0890.

MEDICAL - DENTAL OFFICE AVAILABLE. 2400 sq. ft. brick building near major hospitals, basement, excellent terms. Call Bruce Schmidt. 473-0890 Com-Ind Realty.

SATELLITE MEDICAL OFFICE space available for sharing in Federal Way. Please call 927-4876 or 838-7980.

3700 SQ. FT. BRICK MEDICAL-DENTAL office building between Tacoma General and St. Joseph renovated within last 3 years. South 8th and "K" Street. Contact: Dr. Fuson at 473-5566.

NEW AND LARGE well equipped satellite medical office for share. South Hill Puyallup. Reasonable terms. 474-3329.

GENERAL

Shepard Ambulance, Inc., Tacoma Division is seeking a Medical Director to oversee emergency medical provider training programs and personnel. Ensure compliance with Pierce County EMS protocol. Review quality assurance programs. Candidate must have: knowledge of local EMS system, recent ER experience, cardial knowledge and skills with main emphasis towards ACLS. Submit resume to: Wayne Davis, 610 Tacoma Avenue South, Tacoma, WA 98402-2323, EEO, M/F/H/V.

RETIRING? Call us regarding your used office equipment. (206) 867-5415.

EQUIPMENT

HOLTER MONITOR. $500. Seralizer-blood chemistry equipment, $995 (original price $3500.00) 474-3329.

PEDIATRICS NORTHWEST:

THEY STARTED IN 1981 WITH TWO DOCTORS. AND, BABY, LOOK AT THEM NOW.

Doctors George Tanbara and Larry Larson started Pediatrics Northwest in the Connemara Building at 1811 South K Street.

Today PNW is eight specialists in four locations: Tacoma, Federal Way, Port Orchard and Gig Harbor. From left in the photo are Drs. Richard Ory, Bernard Bader, Larson, Tanbara, John Dimant, Daniel Niebrugge, Jan Gorton and Ross Kendall.

Last year the practice saw 32,000 patients.

How do you measure growth of a business like this?

"Only one way," says Dr. Larson, "our ability to meet the needs of the patients and families we see."

"Our practice demands multi-disciplinary expertise – the ability to manage the tough problems. Each of our doctors is a specialist: whether it be allergy, immunology, heart, stomach, blood, tumors or cystic fibrosis."

Pediatrics Northwest is also one of the few remaining practices anywhere which takes all patients based on their need – not their ability to pay.

"It is part of why people go into medicine," says Dr. Tanbara. "It is the shared philosophy of all the doctors in this practice."

What was PNW looking for in a bank?

"The same thing people look for with us," says Dr. Larson, "the type of treatment that everyone wants, but few get."

"We need a bank that's there when we need them." North Pacific was there. Another bank wasn't. Today North Pacific handles PNW's operating line of credit, corporate relationships and financing of medical equipment.

If you are looking for quality care, here are two numbers to call. Pediatrics Northwest at 383-5777.

And the Business Bank 472-3333.

NORTH PACIFIC BANK
THE BUSINESS BANK

Member FDIC

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 203
Tacoma, Washington 98405

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PCMS
NEWSLETTER
A publication of the Pierce County Medical Society

VOL. 3, NO.2

705 South 9th, Suite 203
Tacoma, Washington
572-3667

MARCH, 1988

WE ARE NOW THE PIERCE COUNTY MEDICAL SOCIETY

Revised Articles of Incorporation and new Bylaws were unanimously adopted at the February 9 General Membership Meeting. The revisions which were sent to the membership in January are the culmination of two years efforts by Dr. Stan Tuell and ably assisted during the time by Drs. Dudley Houtz and William Ritchie.

A major change is the name of the organization. We are once again the PIERCE COUNTY MEDICAL SOCIETY. We had once been the PCMS, but to avoid confusion with the Pierce County Medical Bureau the name was changed.

However, the confusion continued and the office has always received the Bureau's many phone calls and some mail. Also, the general public had a difficult time locating us in the telephone directory under Medical Society.

Other refinements are: greater due process is provided to applicants and members involved in the disciplinary process; physician's assistants may now become assistant members; an Associate Membership category for members of the military and government hospitals was established and many other changes.

LABOR AND AARP REPRESENTATIVES MEET WITH LEADERSHIP OF MEDICAL COMMUNITY

Representatives of several Pierce County labor unions led by Mr. Clyde Hupp, Secretary-Treasurer of the Pierce County Central Labor Council and Mr. Otho Smith, Executive Director, Washington State Chapter, American Association of Retired Persons and four of his representatives met with the Board of Trustees, Medical Staff Presidents, Specialty Society Presidents, WSMA and Auxiliary representatives Saturday, January 9, at the Tacoma Dome Hotel for a Medical Society Planning Session.

Please see pages 8 and 12 for a statement read by Mr. Hupp to the attendees.

Other labor representatives urged a joint effort between labor and medicine to counter the movements of the insurance industry and asked for an effort on the part of physicians to limit fees or have a sliding scale for the poor and uninsured. Mr. Terry Brossett urged that physicians have standards for provision of charity care such as hospitals. He stated that physicians do not communicate how much free care they do give.

Mr. Otho Smith, Executive Director, Washington Chapter, American Association of Retired Persons along with four other members of local AARP chapters met with the planning session at the Tacoma Dome Hotel. Mr. Smith noted that there are 550,000 members of the AARP in Washington with 150,000 in Pierce County and 27 million nationally.

The number one concern and issue of the AARP is "Quality of Care at an Affordable Price." Mr. Smith said "the AARP is concerned that the senior citizen is now paying more out of pocket than they were before Medicare."

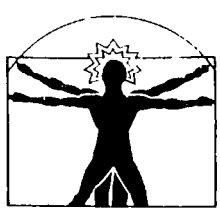
(Cont'd on pg. 6)

MEDICAL SOCIETY PERSONNEL CHANGES

The Pierce County Medical Society and its subsidiary, Membership Benefits, Inc. is in the process of making personnel changes. Sue Asher, Director of Membership Benefits Inc., will become Assistant Executive Director of the Medical Society. Sue will still direct the operations of Membership Benefits, but will work as an assistant to Doug Jackman in Medical Society activities. Sharon Bain will continue her Placement Service duties with a new title of Placement Coordinator.

Membership Benefits will hire a new, full-time Publications Coordinator to handle all the responsibilities of the publications department, including the monthly publications and annual Directory. The new publications coordinator will also be available to do any desktop publishing for members on a contracted basis.

The Society is looking forward to the above changes, allowing for a more professional, consistent publications look, in addition to the expanded staff for Medical Society committee functions



CARIBBEAN CRUISE A SUCCESS

Nearly 70 PCMS members and spouses enjoyed a week in the sun in mid-January in the Carribean and West Indies. The trip was the idea of 1987 PCMS President Dick Bowe.

The group boarded the Royal Carribean Cruise Ship, "Song of Norway" in San Juan, Puerto Rico and for the next seven days they visited the Islands of St. Martin, Antiqua, Martineque, Barbados and St. Thomas.

The "Song of Norway" kept the passengers busy with many activities or just relaxing in the sun. We won't report the results of the black jack tournament or the participants, but we can say that the group came home with olympic size medallions for placing second in the masquerade contest (dressed as M & M candies). Ask Dr. Pat Duffy for details.

Dr. Pete Kesling and his wife Patty walked away with the jitterbug prize and Pete won a beautiful leather jacket. Dr. Walt Arthur came home winner of the drawing for a submission of comments on the ships operations.

All travelers had a great time and plans are afoot for a trip next year. If you have any suggestions where you would like to go, please drop the Society office a note or call.

CORRECTION! CORRECTION!

In the January Newsletter a listing of the 1988 Board of Trustees failed to list Mrs. Beverly Graham, Auxiliary President as a trustee. The Auxiliary President sits on the Board, with voting privileges. Our apologies to Bev Graham who has made a real contribution to the Board.

The Editor.

"LIVING WILLS" AVAILABLE

Copies of a Living Will (Directive to Physicians) are available from the Medical Society office. Members of the American Association of Retired Persons told the Committee on Aging that this service would be most helpful to the senior citizens in the community.

Living Wills are hard to find, they said, and if they could be placed in the doctors offices it would have several advantages and provide an excellent service to the patients.

Please call the Society office for your copy.

LIBRARY SYSTEM BEING RESTRUCTURED

Discontentment with the structure of the Medical Library by the Medical Society Board of Trustees and members of the Hospital consortium has resulted in a reorganization of the system.

There has been no complaint with the operation of the library by Ms. Von Bruck or her staff.

Presently, the Library is a loosely structured, unincorporated body with uncertainty as to whom staff reports, budgetary responsibility, funding uncertainties and other difficulties.

Under the chairmanship of Dr. Wm. Dean, an ad hoc committee is taking steps to incorporate the Library as a separate system from Multicare Medical Center. Bylaws are being drafted that will have staff responsible to an independent Board of Directors representing the Medical Society, Multicare, the Dental Society and an at-large member from the community.

POSITIONS AVAILABLE

FAMILY PRACTITIONER NEEDED. Established practice available at Soundview Medical Plaza next to Puget Sound Hospital, due to retirement. Fully equipped office, new patient referral system, on-site lab and x-ray. Contact Hugh Hendrix 756-8579.

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part-time for FP/IM/EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel M.D. at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

FAMILY PRACTICE/OCCUPATIONAL MEDICINE. Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy. Malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and a balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, WA 98121. (206) 728-6888.

IMMEDIATE OPENINGS. Full time and part-time, positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Opportunities including ER in Olympia area. Call NES 1-800-554-4405 ask for Lois.

PULMONOLOGISTS (B.C./B.E.) needed to join expanding pulmonary group in Bellevue. Must have the ability to perform procedures relative to specialty and willingness to do Internal Medicine. Competitive salary, benefits and early partnership with progressive group. Females encouraged to apply. Send C.V. to: 1600 - 116th Avenue Northeast, #304, Bellevue, WA 98004.

PSYCHIATRIST - 3/4 time position available combining Mental Health Center (1 day/week) and model intensive residential treatment program (up to two days per week). Requires Board eligibility and interest in successful programs for the chronically mentally ill. Compensation and benefits to suit. Send resume to: Stephen Burr, V.P., Administrative Officer, Northwest Mental Health Services, 514 Auburn Way North, Auburn, WA. 98002.

PRACTICES AVAILABLE

RETIRING after 40 years of General Practice in Tacoma - Practice and equipment for sale - Bldg. for sale or lease. Excellent location - 2640 sq. ft. main floor, 730 sq. ft. basement. Contact - Dr. McPhee or Tom Markosky (business manager) Seattle - (206) 281-9149.

ACTIVE FAMILY PRACTICE and medical-dental building on South Hill of Puyallup. Guaranteed 5 year leases on rental portion of building. Physician agrees to continue working part-time with new doctor. Contact Bill or Adrienne Morrison at 848-6499, 6 to 10 p.m.

MARCH READINGS

The Pierce County Medical Society welcomes the following who have made application for membership into the Society. 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.

THOMAS M. BAKER, M.D., Hematology-Oncology. Born in Lake Forest, IL, 1/3/51. Medical School, Loyala-Stritch School of Medicine, 1976; internship, St. Joseph Hospital, Denver, 6/76-6/77; residency, St. Joseph Hospital, Denver, 7/77-7/79; graduate training, Madigan Army Medical Center, 1/81-1/84. Washington State License, 1982. Dr. Baker is currently practicing at 1811 So. K Street, Tacoma.

ESTELLE M. CONNOLLY, M.D., Plastic Surgery and ENT. Born in Hyannis, MA, 2/26/38. Medical School, University of Washington, 1964; internship, Baltimore City Hospital, 7/64-1/65 and Surgery 1/65-7/65; residency, Baltimore City Hospital, Surgery, 7/65-7/66 and John Hopkins Hospital, Otolaryngology, 7/66-7/67; fellowship, John Hopkins Hospital, Head & Neck, 7/68-7/70. Washington State License, 1976. Dr. Connolly is currently practicing at 3403 So. 19th, Tacoma.

DONALD F. DeVRIES, M.D., Internal and Nuclear Medicine. Born in Grand Rapids, MI, 12/08/48. Medical School, Wayne State University, 1978; internship, Southwestern Michigan Area Health Education Center, 6/78-6/79; residency, Southwestern Michigan Area Health Education Center, 6/79-6/81; graduate training, University of Cincinnati, 7/82-7/84. Washington State License, 1987. Dr. DeVries is currently practicing at 622 - 14th Avenue, Puyallup.

WAYNE M. DURAN, M.D., Emergency Medicine. Born in Los Angeles, CA, 11/7/50. Medical School, University of Washington, 1981; internship, Swedish Hospital, 7/81-6/82; residency, Swedish Hospital, 7/81-6/84. Washington State License, 1981. Dr. Duran is currently practicing at 27427 - 12th Place So, Kent.

LOREN C. FINLEY, M.D., Ob/Gyn. Born 7/19/53. Medical School, Oregon Health Sciences University, 1981; internship, Blodgett Memorial Medical Center, 7/81-6/82; residency, Blodgett Memorial Medical Center, 7/82-6/85. Washington State License, 1988. Dr. Finley is currently practicing at 1811 So. K Street, Tacoma.

ALFA B. GARCIA, M.D., Anesthesiology. Born in the Philippines, 4/23/47. Medical School, University of Santo Tomas, 1972; internship, Brackonridge Hospital, Pediatrics, 7/80-3/81 and Montefiore Medical Center, 7/82-2/83; residency, Montefiore Medical Center, Anesthesiology, 3/83-2/85. Washington State License, 1985. Dr. Garcia is currently practicing at Puget Sound Hospital, Tacoma.

KENNETH J. KIRKWOOD, M.D., Family Practice. Born in Tacoma, WA, 3/20/52. Medical School, Mount Sinai, 1978; internship, University of California, 7/78-7/79; residency, University of California, Ob/Gyn, 7/79-11/81 and San Bernardino County Medical Center, Family Practice, 7/83-6/85. Washington State License, 1981. Dr. Kirkwood is currently practicing at 10102 Bridgeport Way W., Tacoma.

(Cont'd on p.11)

(Cont'd from pg. 1)

The AARP is a strong supporter of the Natural Death Act now before the Washington State Legislator, Smith said. Board and AARP members discussed the strengths and weaknesses of a "living will." Physician members stated that it is important that patients discuss their wishes with family members and their physician. A discussion centering around a mechanism for receiving complaints and grievances was discussed. AARP members were urged to contact the Medical Society office in an effort to resolve any grievances with physicians.

Members of the AARP met with the PCMS Committee on Aging on February 5, to discuss further cooperation in areas of legislation and management of grievances.

VISIT OLYMPIA

Members of the Medical Society are urged to visit their legislator and the Capitol on Tuesday, March 8.

WSMA Olympia staff will brief us on current legislation. You will have the opportunity to sit in the House and Senate galleries and watch floor action.

We will meet under the Capital rotunda at 9:30 a.m..

EQUIPMENT

FAMILY PRACTITIONER STARTING PRACTICE - Interested in purchasing used office equipment. Will consider individual items or entire office full. Contact Dr. David Gillingham, evenings 531-1381.

LANIER DICTATING AND TRANSCRIBING machine with remote stations. Excellent condition. $1200.00. Call 1-206-867-5415.

1) HOLTER MONITOR - $500.00. 2) Seralizer - blood chemistry equipment for $995.00 (original price $3500.00). 474-3329.

PCMS TESTIMONY SWAYS DECISION ON SMOKING

At 9:40 p.m., Monday, January 11, Mr. Joe Ghilarducci, Chairman, Clover Park School Board asked for a vote on the motion "Tobacco products in any form shall be prohibited in all buildings, grounds and work sites associated with K-12 and banned in all buildings of Clover Park Vocational Technical Institute and appropriately posted with the effective date of September 1, 1988." The five members of the School Board had heard testimony all evening supporting and opposing the adoption of the policy.

Four members of the Medical Society testified in support of the policy. Dr. David Sparling told the Board that "we have a responsibility to protect our children's health and their children's health and that our curriculum will help to eliminate a health hazard."

Dr. Clyde Koontz spoke on behalf of his many pulmonary disease patients who now wish they had never started smoking. He emphasized how smoking is now a handicap for a young person seeking employment. By adopting the policy, he said, it offered the school to assume a leadership role on the issue.

Dr. Leonard Alenick testified that schools should be the role model for the community and that a non-smoking policy helps those addicted to quit smoking.

Dr. Charles L. Anderson stated it is a medical issue as well an economic and addictive issue.

The School Board voted three to one in favor of the No Smoking Policy which will go into effect September 1, 1988 rather than July 1, 1989 as originally proposed.

The Society expresses its thanks to Drs. Alenick, Anderson, Koontz and Sparling for playing a major role in having this policy adopted.

AARP REPS MEET WITH PCMS COMMITTEE

The "Natural Death Act", Living Wills, Assignment and the PCMS Grievance process were topics discussed in the February 5 Committee on Aging meeting with representatives of Pierce Co. Chapters of the AARP and Council on Aging.

AARP representatives suggested the placement of Living Wills in doctors offices where seniors could find them conveniently and be in a position to discuss them with their physician during the examination.

Finding a doctor who accepts assignment, especially upon referral to a consultant was said to be a major problem for senior citizens. Dr. David Munoz, Chairman, invited the AARP representative and Mr. Hal Rinehardt, Executive Director, Council on Aging to meet with the Committee on a quarterly basis.

Dr. Munoz and the guests are planning a forum for senior citizens to discuss the issues and areas of mutual concern. The groups plan to work together to meet with legislators next Fall.

DR. WALTMAN GUEST LECTURER

Pierce County Medical Society member Dr. Richard Waltman has been active lately as a guest presenter. Speaking for the Humana Corporation in Louisville, Kentucky, Dr. Waltman made two presentations at the Senior Health Care Symposium, "Principles of Geriatric Medicine" and "The Geriatric Program at Humana Hospital - Tacoma". Other presenters were Dr. Leo Cooney, Professor of Medicine at Yale University and Dr. Charles Beber, Professor of Medicine at the University of Miami School of Medicine. Dr. Waltman also addressed the Geriatric Research and Clinical Practice Conference sponsored by the University of Florida Colleges of Medicine and Nursing by discussing "Perioperative Care of the Older Patient".

POSITION STATEMENT ON MEDICAL CARE IN PIERCE COUNTY PRESENTED TO THE MEDICAL SOCIETY OF PIERCE COUNTY BOARD OF TRUSTEES RETREAT BY MR. CLYDE HUPP, SECRETARY-TREASURER, PIERCE COUNTY CENTRAL LABOR COUNCIL

JANUARY 9, 1988

It is appropriate to offer a thank you to President William Jackson, M.D. and Director Doug Jackman for providing this forum today, which allows a select number of delegates representing affiliates of the Central Labor Council to offer some input on our perception of medical care in Pierce County.

I do not, in any way, want to claim this statement as our consensus position, but, to the contrary, I want to encourage each individual to speak for themselves from their own knowledge and experience.

What I offer is an overview of the position of our federation on legislative action, health care legislation and Medicare, including initiative 92.

Over the years, labor has followed two paths to achieving progress for workers. First, through collective bargaining, it has sought wage rates that enable working people to support a family. It has also bargained for benefits to ease the burden of illness and accident, and provide sustenance in old age or disability.

Second, labor learned long ago that many of the goals of workers could best be achieved through legislation. It learned too, that gains made in negotiation could be lost through unfair, shortsighted laws. So labor makes its voice heard in the legislative councils at all levels.

A frequently asked question in regard to legislative effort is "What does labor want?"

Our national Secretary/ Treasurer, Tom Donahue, took a try at that last November. I quote: "There is no labor legislation agenda apart from other segments of our society. We have now, have had in the past, and will again have, legislative initiatives which incorporate our ancient hopes for better jobs, for education, for housing and health care, and we will follow our belief that workers and their children ought not be priced out of any of these matters. We will take our allies in those fights wherever we can find them, and we'll make headway on workers' concerns in whatever forum we can."

Several ideas have gained fashion during the Reagan Administration as the key to containing health care costs. They are: competition in the health care industry; placing a ceiling on tax-deductible contributions for health insurance plans; requiring the patient-consumer to pay more for their health care in the form of deductibles, co-insurance and co-payments.

They are based on the assumption that, if the health care industry is deregulated, and the marketplace is substituted for the judgement of professional practitioners in meeting the needs of their patients, costs will come down. The result has been the opposite and I think you know why.

As a result of that failure, and in desperation, we have seen the most irrational response by the administration. Penalties imposed through the tax code; unrealistic caps on fees for service; the infamous "Diagnostic Related Groups" prospective payment system.

Consequently, health care institutions and vendors of all variety are caught in the squeeze. You as physicians and we as representatives of workers are pitted inappropriately against one another.

The fact is that the medical care market is dominated by physicians. Any rational cost containment strategy must recognize this issue.

The doctor-patient relationship does exist. Patients do not shop for price once they become ill. They seldom dispute their doctor's advice. They are not inclined to look for a cheap hospital. In fact, they cannot check into a hospital like a hotel.

It is the doctor who decides whether a patient goes to the hospital. It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged. It is the doctor who orders diagnostic tests and prescription drugs. It is the doctor who decides how often the patient comes to the office. And quite properly so.

Medicare has never lived up to its promise. If the government can find a way to sell arms to Iran, it ought to be able to find a way to provide care and comfort to its retirees.

Now, what can we do about it together. We supported Initiative 92 enthusiastically. You opposed it even more enthusiastically. Obviously, the voters said that it was not part of the solution.

Attempts to limit and reduce benefits under employer-employee plans are being resisted vigorously. Our members want more insurance, not less.

Catastrophic health care seems to be on the horizon and is a small step in the right direction.

Canada has had a universal comprehensive national health insurance program since 1965. Organized medicine has bitterly resisted this approach in the United States.
Actually, the Canadian plan is a Federal-Provincial plan. There is limited cost-sharing and deductibles are forbidden. In short, ambulatory care is free. According to the critics of such a plan for the United States, Canadians should be running to doctor's offices for their free care for unnecessary and trivial conditions.

(Cont'd on P.12)

AIDS PREVENTION PROGRAM 591-6060

PIERCE COUNTY SURVEILLANCE REPORT

Feb-88

Acquired Immunedeficiency Syndrome (AIDS)
PIERCE COUNTY SURVEILLANCE REPORT
(cases diagnosed in county)

1. Disease Category	Adults/Adolescents Cases	(%)	Deaths	(%)	Pediatric Cases	(%)	Deaths	(%)	TOTAL Cases	(%)	Deaths	(%)
PCP	21	(40)	11	(44)	0	0	0	0	21	(40)	11	(44)
Other Disease w/o PCP	24	(45)	10	(40)	0	0	0	0	24	(45)	10	(40)
KS alone	6	(11)	3	(12)	0	0	0	0	6	(11)	3	(12)
No Diseases Listed	2	(4)	1	(4)	0	0	0	0	2	(4)	1	(4)
TOTAL	53	(100)	25	(47)	0	(0)	0	(0)	53	(100)	25	(47)

2. Age	Cases	(%)
Under 13	0	0
13-19	0	0
20-29	25	(47)
30-39	21	(40)
40-49	2	(4)
Over 49	5	(9)
Unknown	0	0
TOTAL	53	(100)

3. Race/Ethnicity	Adult Cases	(%)	Pediatric Cases	(%)	TOTAL	(%)
White	37	(70)	0	0	37	(70)
Black	8	(15)	0	0	8	(15)
Hispanic	3	(6)	0	0	3	(6)
Asian/PI	2	(4)	0	0	2	(4)
Native Amer	0	0	0	0	0	0
Unknown	3	(6)	0	0	3	(6)
TOTAL	53	(100)	0	(100)	53	(100)

4. Patient Groups	Male	(%)	Female	(%)	TOTAL	(%)
Homosexual/Bisexual Men	35	(69)	**********		35	(66)
Homo/Bi/ + IV drug user	6	(12)	**********		6	(11)
IV drug user	1	(2)	1	(50)	2	(4)
Hemophiliac	3	(6)	0	0	3	(6)
Heterosexual contact	2	(4)	1	(50)	3	(6)
Transfusion	1	(2)	0	0	1	(2)
None of the above	3	(6)	0	0	3	(6)
TOTAL	51	(96)	2	(4)	53	(100)

5. PEDIATRIC	Male	(%)	Female	(%)	TOTAL	(%)
Hemophiliac	0	0	0	0	0	0
Parent at risk/has AIDS/HIV	0	0	0	0	0	0
Transfusion	0	0	0	0	0	0
None of the above	0	0	0	0	0	0
TOTAL	0	(100)	0	(100)	0	(100)

6. MORTALITY STATISTICS

Date Diagnosed	Number	(%) of total	Deaths	(%) per year
UNKNOWN	5	(9)	2	(40)
1982	1	(2)	1	(100)
1983	3	(6)	3	(100)
1984	5	(9)	4	(80)
1985	7	(13)	5	(71)
1986	10	(19)	5	(50)
1987	22	(42)	5	(23)
1988	0	(0)	0	0
1989	0	(0)	0	0
1990	0	(0)	0	0
1991	0	(0)	0	0
TOTAL	53	(100)	25	(47)

LET'S FLUORIDATE TACOMA'S WATER

The Citizen's for Better Dental Health Committee, better known as the Fluoride Committee has been very active in efforts to fluoridate the City of Tacoma water supply. Petitions are now available for signatures that will enable the issue to be put on the ballot in November. There will be 2,524 valid signatures required, or ten percent of the last councilmatic vote. An additional 20% needs to be collected to ensure validation, as only residents of the City of Tacoma who are also registered voters will be accepted. Signatures must be gathered by the first of June.

The committee is working with the Dental Society and the Dental Assisting and Dental Hygiene groups in Pierce County for distribution of educational information as well as the petitions. The Medical Society will be doing a special mailing to all members urging their support and soliciting their help in attempts to educate their patients and encourage support for the project. In 1987 the Medical Society Board of Trustees voted to support fluoridation of the water supply and the Better Dental Health Committee was formed from the Medical Society's Public Health/School Health Committee.

The project is currently endorsed by The Pierce County Medical Society, Pierce County Dental Society, Pierce County Nurses Association, Lakewood Hospital, Washington State Dental Association, Washington State Dental Hygiene Association, Pierce County Mt. Rainier Dental Hygiene Society, Pierce County Dental Assistants Society and other various groups.

If you would like more information about the Citizens For Better Dental Health Committee, or the fluoride issue, please contact the Society office at 572-3666.

PCMS MEMBERS TO SPEAK ON AIDS

The Medical Society held a speakers training session on February 4th to train members who are interested in giving public educational presentations on A.I.D.S. Fifteen members, from various specialties attended to learn not only about the disease, but also about how to give public presentations and what questions to anticipate.

The training was conducted by a panel of local experts, including three members of the Tacoma/-Pierce County Health Department AIDS project. Char Bennett, CHN addressed case management, Jim McGough, Ph.D. spoke on testing and counseling, while Jerry White discussed prevention and sensitivity to working with AIDS patients. Also on the panel were Dr. Alan Tice, Infectious Disease specialist; Gary Preston, M.A., from Multicare Medical infection control department and Sydna Koontz from the PCMS Auxiliary.

PCMS has already begun to receive requests for speakers from the community. If you know of any community group or organization that would like to have a speaker visit them, please contact the Society at 572-3667.

C.O.M.E. UNDERGOES CHANGE

Since October 1, the C.O.M.E. has been contracting its CME courses with Maxine Bailey, who had been the Executive Director of the College for nearly 20 years.

The Board of Directors is currently working to combine the efforts of the Board and CME Committee to eliminate duplication of efforts. The Bylaws are being revised and the composition of the Board will be altered as well as the funding mechanism.

The College has relied upon the Society and the Hospital Council consortium in the past for its financial support. A self-sustaining organization is the aim of the Board. The College underwent a reorganization as a result of less demand for allied health programs and an accompanying drop in revenues.

Medical Society staff will be administering the College and contracting the courses to individuals who will organize and coordinate them.

MARCH
READINGS

The Pierce County Medical Society welcomes the following who have made application for membership into the Society. 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.

THOMAS M. BAKER, M.D., Hematology-Oncology. Born in Lake Forest, IL, 1/3/51. Medical School, Loyala-Stritch School of Medicine, 1976; internship, St. Joseph Hospital, Denver, 6/76-6/77; residency, St. Joseph Hospital, Denver, 7/77-7/79; graduate training, Madigan Army Medical Center, 1/81-1/84. Washington State License, 1982. Dr. Baker is currently practicing at 1811 So. K Street, Tacoma.

ESTELLE M. CONNOLLY, M.D., Plastic Surgery and ENT. Born in Hyannis, MA, 2/26/38. Medical School, University of Washington, 1964; internship, Baltimore City Hospital, 7/64-1/65 and Surgery 1/65-7/65; residency, Baltimore City Hospital, Surgery, 7/65-7/66 and John Hopkins Hospital, Otolaryngology, 7/66-7/67; fellowship, John Hopkins Hospital, Head & Neck, 7/68-7/70. Washington State License, 1976. Dr. Connolly is currently practicing at 3403 So. 19th, Tacoma.

DONALD F. DeVRIES, M.D., Internal and Nuclear Medicine. Born in Grand Rapids, MI, 12/08/48. Medical School, Wayne State University, 1978; internship, Southwestern Michigan Area Health Education Center, 6/78-6/79; residency, Southwestern Michigan Area Health Education Center, 6/79-6/81; graduate training, University of Cincinnati, 7/82-7/84. Washington State License, 1987. Dr. DeVries is currently practicing at 622 - 14th Avenue, Puyallup.

WAYNE M. DURAN, M.D., Emergency Medicine. Born in Los Angeles, CA, 11/7/50. Medical School, University of Washington, 1981; internship, Swedish Hospital, 7/81-6/82; residency, Swedish Hospital, 7/81-6/84. Washington State License, 1981. Dr. Duran is currently practicing at 27427 - 12th Place So, Kent.

LOREN C. FINLEY, M.D., Ob/Gyn. Born 7/19/53. Medical School, Oregon Health Sciences University, 1981; internship, Blodgett Memorial Medical Center, 7/81-6/82; residency, Blodgett Memorial Medical Center, 7/82-6/85. Washington State License, 1988. Dr. Finley is currently practicing at 1811 So. K Street, Tacoma.

ALFA B. GARCIA, M.D., Anesthesiology. Born in the Philippines, 4/23/47. Medical School, University of Santo Tomas, 1972; internship, Brackonridge Hospital, Pediatrics, 7/80-3/81 and Montefiore Medical Center, 7/82-2/83; residency, Montefiore Medical Center, Anesthesiology, 3/83-2/85. Washington State License, 1985. Dr. Garcia is currently practicing at Puget Sound Hospital, Tacoma.

KENNETH J. KIRKWOOD, M.D., Family Practice. Born in Tacoma, WA, 3/20/52. Medical School, Mount Sinai, 1978; internship, University of California, 7/78-7/79; residency, University of California, Ob/Gyn, 7/79-11/81 and San Bernardino County Medical Center, Family Practice, 7/83-6/85. Washington State License, 1981. Dr. Kirkwood is currently practicing at 10102 Bridgeport Way W., Tacoma.

(Cont'd on p.11)

(Cont'd from pg. 1)

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ROGER M. ROPER, D.O., General Practice. Born in Eagle Grove, Iowa, 6/16/37. Medical School, Kirksville College of Osteopathic Medicine, 1976; internship, Suncoast Hospital, Largo, FL, 7/76-6/77. Washington State License, 77. Dr. Roper is currently practicing at 11225 Pacific Ave., Tacoma.

WAYNE E. SMITH, M.D., Anesthesiology. Born in Enumclaw, WA, 4/22/57. Medical School, Loma Linda University, 1984; internship, Loma Linda University Medical Center, 7/85-6/87; residency, Loma Linda University Medical Center, Anesthesiology, 7/85-6/87; graduate training, Loma Linda University Medical Center, Cardia Anesthesia, 7/87-11/87. Washington State License, 1987.

MARC A. STEINMETZ, M.D., Urgent Care/Industrial Medicine. Born in Alomagordo, NM, 12/7/53. Medical School, Indiana University, 1979; internship and residency, St. Francis Hospital, Peoria, IL, Emergency Medicine, 7/80-6/83. Washington State License, 1985. Dr. Steinmetz is currently practicing at 1930 Port of Tacoma Road, Tacoma.

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT
UPCOMING PUBLIC HEALTH ROUNDS

Some of the topics for upcoming PUBLIC HEALTH ROUNDS are:
Birth-To-Six; Communicable Disease Update; Cardiovascular Risk Reduction, Wood Stove Emissions, plus a presentation by Preventative Medicine at Madigan Army Medical Center.

DATE	TIME	LOCATION
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April 6, 1988	8:00-9:00 A.M.	Multicare Medical Center Across from Main Entrance

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Two important points:

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2. Doctors, therefore, can also shift the demand for care from the poor or poorly insured to the more affluent or well insured.

If that shift should become the case, doctors will surely become a target of both a backlash wrath of an indignant public and punitive legislation. I think you would agree that this is not in your best interest.

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What is in your best interest, I believe is your traditional claim of concern about the quality of care, the best possible health care for all Americans, including workers, children and retirees.

I urge you to join with us in seeking solutions rather than confrontations.

Thank you,

Clyde H. Hupp, Secretary
Pierce County Central Labor Council, AFL-CIO

Dr. Jackson, Dr. Ritchie, Dr. Priebe and Mr. Jackman had a follow-up meeting with Mr. Hupp and other labor representatives on February 9, to discuss access to care in Pierce County and other issues.

As a result of that meeting the labor and medical communities will be working together in several areas.

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JOGGERS AND RUNNERS

Run with your colleagues and represent the Medical Society in the American Cancer Society's 24 hour run to be held in May.

The Society would like to field a team of 6-10 runners who will alternate running during the 24-hour period. It should be a lot of fun.

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PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
- ***Retirement Potential***
- ***Post Exchange Privileges***
- ***Insurance Discounts***
- ***Continuing Medical Education****
- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

****All paid for by the U.S. Army Reserve.***

P.O. BOX 38
Madigan Army Medical Center
Tacoma, WA 98431-5038
206-967-5046

Many groups TALK about building a better America-
The Army Reserve WORKS at it.

OFFICE SPACE

NEW MEDICAL - DENTAL BUILDING within sight of Tacoma Mall. Up to 2500 sq. ft. available. Reasonable lease. Contact Dr. Bird 475-8934.

3000 SQUARE FEET of medical office space is available in the Hartland 2 building of Hartland Medical Center at 39th Avenue & 10th Street S.E. across from Fairchild Corp. on South Hill. The space can be subdivided and designed by the physician to fit his/her own professional needs. The complex already has Drs. Gross, Larsen, Whitney & Associates Radiology, South Hill Eye & Skin Associates, Apple Physical Therapy, Good Samaritan Outreach Services', Puyallup Valley Institute, and South Hill Family Medicine. If interested please contact: Dr. Rebecca Sullivan at 848-5951 or Al Sullivan at 593-6072.

NEW MEDICAL - DENTAL BUILDING. Lease or sell. Puyallup near hospital. 848-2359 or 848-7332.

NEW AND LARGE well equipped satellite medical office for share. South Hill Puyallup. Reasonable terms. 474-3329.

MEDICAL OFFICE - lease 1300 sq. ft. excellent terms. Puyallup location. Bruce at Com-Ind 473-0890.

HEALTH CARE CENTER. Sale or lease 1600-2500 sq. ft. 78th & Pacific. Plush oak finish. Call Bruce at Com-Ind 473-0890.

FEDERAL WAY - Established area of medical offices. 1375 sq. ft. $13 per s/f per year, triple net. Call owner, 228-0722.

MEDICAL OFFICE SPACE AVAILABLE in Federal Way. 2 blocks from St. Francis Hospital. Primary office space, shared space or satellite office. Reasonable. 927-8011.

GENERAL

EXCELLENT HOME perfect for inhouse practice borders Fircrest, within University school district. Custom built contemporary home, over 2,500 sq. ft. plus additional unfinished Zoned SR9. Call Barbara Wasser 759-1117 or 752-4764 Paragon Co.

PHYSICAL MEDICINE AND REHABILITATION SHORT COURSE MARCH 21-25 1988, Tacoma Dome Hotel, Tacoma. The office of the Surgeon General, United States Army, and Madigan Medical Center are pleased to co-sponsor the 5th Annual Physical Medicine Short Course. The course theme is, "Techniques and Technology in Rehabilitation Medicine," and will cover Cardiac Rehab, Pediatric Rehab, Prosthesis and Orthosis and Electrodiagnosis. The course is intended for physiatrists and physicians in related specialties and allied health professionals. Course is approved for 30 Category I CME credits. Application has been made for credits through AAFP. Fees -$50 for full course or $15/day. For further information or program brochure, contact Mrs. Sargent or Dr. Kumar at 967-6771/6442.

AUXILIARY

SHARON ANN LAWSON SET TO LEAD WSMAA IN 88-89

Pierce County will host the 57th Annual Washington State Medical Association Auxiliary House of Delegates Convention, April 20-22, 1988 at the Tacoma Sheraton Hotel. Pierce County is pleased to extend an invitation to all Medical Society members and spouses to attend the installation dinner of our own Sharon Ann Lawson, wife of Dr. Harry Lawson. She will be installed as WSMA Auxiliary President on April 21, 1988.

Let us acknowledge Pierce County's contribution to state auxiliary and demonstrate our unified support of organized medicine and this accomplished leader, our new state auxiliary president.

Sharon Ann will be the 4th Pierce County resident to hold this office. Alma Whiteacre (Mrs. Horace) of Tacoma was the first WSMAA President when state auxiliary was founded in 1932. Other state presidents from Pierce County include Mrs. Daniel H. Bell, 1936-37 and JoAnn Johnson (Mrs. Ralph A.), 1976-77.

Sharon Ann was raised in Collegeville, Pa. Following graduation from St. Joseph College, Philadelphia and teaching assignments in Pennsylvania and New York, she had the opportunity to teach for two years in Ghana, West Africa for Kaiser Aluminum. On returning to the States she received a Masters Degree in Librarianship for the University of Denver. Her post-graduate education also includes training in the Slinger-land method, a multi-sensory approach to teaching dyslexics to read, write, and spell. In addition to Auxiliary involvement, Sharon Ann has operated a tutoring service for dyslexic children and adults for the past seven years.

Prior to becoming President of PCMSA in 1984, she chaired and served on a variety of committees and projects. Sharon Ann previously served WSMAA as SW Regional Vice President, Nominating Committee Chairman, and was a member of the WSMAA delegation to AMA Auxiliary in 1984 and 1987.

Sharon Ann and her husband Harry enjoy skiing and sailboarding.

The installation dinner will be held Thursday, April 21 at the Tacoma Sheraton Hotel. A no-host reception begins at 6:30 p.m., steak dinner at 7:30 p.m.. Entertainment will be provided by the Curtis Senior High School Swing Choir, directed by Robert Northrop.

Reservations are due by April 10. Make checks payable to WSMA Auxiliary Convention Fund, $25 per person/$50 per couple. Mail to: Helen Whitney, 1736 Fairview Dr. S., Tacoma, WA 98465.

AIDS: WHAT ARE THE FACTS TODAY?

According to the Director of the AIDS Program at the Center for Disease Control in Atlanta, by 1991 the AIDS epidemic will increase so rapidly that it will move ahead of cardiac diseases as a leading killer of Americans.

In 1987, nationally, 400 cases of AIDS a week were reported.

What do these statistics mean to Tacoma and how does it affect the medical community and the physicians family?

On Friday, March 25 the Pierce County Medical Auxiliary will host a luncheon for members to learn more about this devastating disease.

Dr. Alan Tice, Infectious Disease physician in Tacoma; member of the Washington State Medical Association Task Force on AIDS and the Mayor's Task Force on AIDS, and Sandra Hellman, Washington State AIDS Program Consultant from Olympia will present an update on the disease.

A committee of Auxiliary members over the last 6 months has developed programs for its members, published a quarterly AIDS Resource Guide and participated in community meetings. Members of the Auxiliary committee include Judy Baerg, Karen Benveniste, Sydna Koontz,

Medical Society of Pierce County
705 South Ninth Street, Suite 203
Tacoma, WA 98405

PCMS NEWSLETTER

• A publication of the Pierce County Medical Society •

VOL. 3, NO. 3 | 705 South 9th, Suite 203 Tacoma, Washington 572-3667 | APRIL, 1988

SHARON ANN LAWSON TO ASSUME WSMAA PRESIDENCY

Sharon Ann Lawson, wife of Dr. Harry Lawson, will be installed as 1988-89 Washington State Medical Association Auxiliary President on Thursday, April 21, at the Sheraton Tacoma Hotel. The installation dinner is in conjunction with the 57th Annual WSMAA Auxiliary House of Delegates Convention, April 20-22.

Pierce County is hosting this year's convention, and all Medical Society members and their spouses are encouraged to attend the installation. Your presence will not only demonstrate unified support of Sharon Ann and her numerous accomplishments, but will also express Pierce County's contribution to state auxiliary and dedication to organized medicine.

A no-host reception will begin at 6:30 p.m., followed by a steak dinner at 7:30 p.m. Reservations are due by Sunday, April 10. Cost for the dinner is $25 per person and $50 per couple. Make checks payable to WSMA Auxiliary Convention Fund and mail to Helen Whitney, 1736 Fairview Dr. S., Tacoma, WA 98465.

ISSUES PRESENTED TO TNT EDITORIAL BOARD

Dr. Jackson and staff met with The Morning News Tribune Editorial Board on Thursday, February 25. The purpose of the meeting was to discuss some of the concerns of the Society, and the goals and objectives the leadership has set for 1988.

Issues discussed were access to care, AIDS, EMS System (i.e. pre-hospital care, trauma centers and rock concerts), fluoride and tobacco.

Dr. Jackson expressed concern regarding the number of cases that are seen in hospital emergency rooms when heavy metal concerts are held at the Tacoma Dome. The Society is recommending that the city be better prepared by increasing security and to better manage the large number of attendants at these events.

Of particular interest to the Editorial Board were the efforts of the Society to place an initiative issue on the November ballot to fluoridate the Tacoma water supply. The editors immediately recognized that this is a very controversial issue and would make good copy for future editions.

PCMS/PCMB WORK FOR PILOT PROJECT

The leadership of the Medical Society and Pierce County Medical Bureau met in March to determine if Tacoma could be one of five cities to qualify for a pilot project of the Basic Health Plan passed by the legislature in 1987.

The BHP has encountered many start-up delays. The program would help the working poor -- people too poor to afford private health insurance, but with incomes too high to qualify for Medicaid. It is estimated 42,000 would qualify in Pierce County.

(Cont'd on pg. 6)

ACCESS TO CARE

Dr. Ron Johnson, Family Physician, Puyallup and Medical Director of St. Leo's Neighborhood Clinic, addressed the Board of Trustees at its March meeting regarding access to care for the homeless and uninsured.

Dr. Johnson asked the Board to consider endorsing the concept of a referral system that would equitably distribute the responsibility for the care of those who are unable to pay for services.

The Board will review and consider referral system proposals at the April and May Board meetings prior to endorsing a program.

RETIRED MEMBERS LUNCHEON - APRIL 6

Mrs. Mavis Kallsen, wife of Dr. Robert A. Kallsen, and an archivist for the Washington State Historical Museum, will present "A History of Medicine in Pierce County" at the April retired members luncheon. Mrs. Kallsen wrote a series of articles for *The Bulletin* in 1975-76 describing the beginnings of medicine in Pierce County. The articles were rerun in 1985-86.

The luncheon will be at noon, Wednesday, April 6, at the Tacoma Dome Hotel.

The retired members luncheon is always an enjoyable get together of 50-60 retired members and their spouses, and an excellent opportunity to see your colleagues and share a few tales.

COUNTY EMS SYSTE BEING DEVELOPED

Dr. Robert Wachtel, Chairman, PCMS EMS Committee, and Drs. Paul Hildebrand and Ted Walkle are developing an EMS system to improve prehospital care in the county.

Dr. Wachtel has been meeting with county fire chiefs and other individuals and agencies involved in the EMS system. The Committee is aiming to complete a draf form of the system by May

PCMS MEMBERS SOUGHT AS MENTORS

Matching medical students (and their families) with established physicians and their families in a newly-created "mentor program" is another effort by the WSMA and Medical Auxiliary to help young physicians.

A pilot program, set this spring for King County, will be expanded to the rest of the state in the fall, according to WSMA Manager of Membership and Professional Services David L. Chivers. "We want to provide med students with a reality-based look on how the practice of medicine affects life," he said.

The program's steering committee seeks 30 King County physicians and their families who are willing to give the time to establish a friendship with a medical student and his or her family. A social occasion in April will introduce the pairings to each other.

Physicians will be matched to the students by medical specialty when requested and by other interests and hobbies, Chivers notes. The steering committee for the new program includes medical students, their spouses, Medical Auxiliary members, UW School of Medicine Director of Counseling Thomas R. McCormick and Tim Baldwin, M.D..

Prospective mentors must be WSMA members. Interested physicians may contact Sharon Ann Lawson at 564-6647 or the Medical Society office at 572-3667.

AN EVENING OF CAMARADERIE

The Pierce County chapter of the Washington Academy of Family Physicians will hold "An Evening of Camaraderie," Saturday, April 23, at the Tacoma Country and Golf Club. Dr. Sam Cullison, WAFP President, will be the keynote speaker.

A no-host cocktail hour will begin at 6:30 p.m., followed by dinner at 7:30 p.m.. The dinner is free for WAFP members. The fee for spouses/non-members is $25.

Reservations must be made no later than Wednesday, April 20. For reservations or more information, please call the Medical Society office at 572-3667.

FEEL ADVENTUROUS?

Would you like to spend two or three weeks in the northern most community in Alaska? Dr. Scott Kennedy, who completed his residency here last year is now practicing at Alaska PHS Hospital in Kotzebue, reports that the hospital is looking for family physicians who would like to do locum tenens. If you are interested, write R. Scott Kennedy, M.D., Alaska PHS Hospital, Kotzebue, Alaska 99752 or call (907) 442-3331. He also reports that the fishing is great! For additional information call the Medical Society at 572-3666.

RESOLUTIONS

Now is the time to consider resolutions to be introduced at the September meeting of the WSMA House of Delegates. Is there any action you would like WSMA to take regarding such issues as: PRO/W, HCFA, DSHS, smoking, fluoride, AIDS? If so, call the Society office and it will draft a resolution for you.

POSITIONS AVAILABLE

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full-/part-time for FP/IM/EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel M.D. at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS. Full-time and part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Opportunities including ER in Olympia area. Call NES 1-800-554-4405 ask for Lois.

PART-TIME PHYSICIAN NEEDED FOR FAMILY PRACTICE Wednesday and Thursday weekly and vacation coverage. No hospital coverage, no OB. Send resumes or direct inquires to: 3733 S. Thompson, Tacoma, WA 98408.

PSYCHIATRIST - 3/4-time position available combining Mental Health Center (1 day/week) and model intensive residential treatment program (up to two days per week). Requires Board eligibility and interest in successful programs for the chronically mentally ill. Compensation and benefits to suit. Send resume to: Stephen Burr, V.P., Administrative Officer, Northwest Mental Health Services, 514 Auburn Way North, Auburn, WA. 98002.

FAMILY PRACTICE/OCCUPATIONAL MEDICINE. Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy, malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and a balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, WA 98121. (206) 728-6888.

OPENING-MEDICAL DIRECTOR AT NEW BEGINNINGS OF LAKEWOOD HOSPITAL. New Beginnings is a 26 bed adolescent chemical dependency treatment center. If you are interested please contact Cathy Nugent, Assistant Administrator of Lakewood Hospital, 535-9609 or Rick Bialock, Program Director, New Beginnings, 582-4357.

To: Experienced General/Family Practice Physicians

Toying with the idea of a different life style?

Forget about hospital rounds, ER calls, night calls, committee meetings, utilization reviews, DRG's, chart signatures, and for that matter, your usual office administrative chores.

Join us at General Medical Clinics in Seattle and Tacoma to:

1) practice good outpatient medicine on a flexible schedule with good compensation,
2) embark on any project you once wished you had time for.

And have fun doing both for as long as you wish.

Give us a call at your convenience:

Bruce Kaler M.D.: 255-0056
Andy Tsoi M.D.: 537-3724

IMPORTANT NOTICE

March 22, 1988

Pierce County Medical Society
705 South 9th Street, Suite 203
Tacoma, WA 98405

Dear Colleagues:

I regret to inform you that prescriptions written by civilian health care providers will no longer be honored at army medical facilities beginning April 1, 1988. This curtailment also applies to lab tests and radiology procedures. These measures were imposed on Madigan and its support clinics by our headquarters, the U.S. Army Health Services Command, to redress in part a shortfall in the 1988 budget. This curtailment is expected to remain in effect until September 30, 1988. Should funds be reinstated to Health Services Command then these services will be promptly restored. I ask for your continued support during this difficult period. A cooperative effort to inform those military health care beneficiaries to seek remuneration for these services through CHAMPUS will do much to ease those patients' burdens. I hope that this situation will be short lived and we will once again be able to offer this very important service to our patients.

Sincerely,

Elmer M. Casey, Jr., M.D./s/
Col. Medical Corps
Acting Deputy Commander for Clinical Services

Personal Problems of Physicians Committee
For Impaired Physicians
Your colleagues want to help.
Medical Problems, Drugs,
Alcohol, Retirement, Emotional Problems

Committee Members

Patrick Donley, Chairman	272-2234
Robert A. O'Connell	627-2330
John R. McDonough	572-2424
William A. McPhee	474-0751
Ronald C. Johnson	841-4241
Jack P. Liewer	588-1759
Dennis F. Waldron	272-5127
Mrs. Marie Griffith	588-9371

APRIL
READINGS

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

DONALD A. BOUTRY, M.D., Ob/Gyn. Born in San Jose, CA, 06/11/57. Medical School, University of California, Irvine, 1984; internship, Santa Clara Valley Medical Center, San Jose, 7/84-6/85; residency, Stanford University, Ob/Gyn, 7/85-6/88. Washington State License, pending. Dr. Boutry will be practicing at 521 So. K Street, Tacoma.

IVAN COVAS-MALDONADO, M.D., Family Practice. Born in Puerto Rico, 10/15/53. Medical School, University of Puerto Rico School of Medicine, 1978; residency, University of Puerto Rico, 7/78-6/81. Washington State License, 1987. Dr. Covas-Maldonado will be practicing with the Community Health Care Delivery System.

DREW H. DEUTSCH, M.D., Radiology. Born in Rock Island, IL, 01/15/55. Medical School, University of Illinois College of Medicine, 1981; internship, Cedars-Sinai Medical Center, 7/81-6/82; residency, Cedars-Sinai Medical Center, internal medicine 7/82-6/84 and diagnostic radiology, 7/84-6/87; graduate training, Cedars-Sinai Medical Center, Body Imaging, 7/87-6/88. Washington State License, 1988. Dr. Deutsch will be practicing with Tacoma Radiology Associates.

MARY A. VAN ZYL, M.D., Pediatrics. Born in Portland, OR, 10/28/55. Medical School, Vanderbilt University Medical School, 1983; internship, pediatrics, University of Colorado, 6/83-6/84; residency, pediatrics, University of Colorado, 6/84-6/86; graduate training, Cornell University, pediatrics, 7/86-6/87. Washington State License, 1987. Dr. Van Zyl is currently practicing at Western Clinic in Gig Harbor.

APPEAL MADE FOR IMPROVING ACCESS TO CARE

Physicians in Pierce County contribute a tremendous amount of time and effort to patients for whom they receive no reimbursement. This has been the historic role of physicians in society.

The Medical Society office has a referral service that receives approximately 20-30 calls daily from patients. Some callers have insurance and the ability to pay and some do not. In 1982, the Board of Trustees revised the referral service policy to state that members wishing to participate in the service can do so openly if they agree to accept all referrals without regards to the patients ability to pay.

Here in Pierce County, the number of street people and "working poor" has multiplied. Some members of the Society are seeing many of these people as patients and have become overwhelmed by the numbers. Some of our members are not aware of the need for their services.

Increasing the number of participants in our referral service would help to spread the load more equitably among the medical community.

The four Community Health Care Delivery System Clinics are seeing approximately 11,500 patients per day and St. Leo's Clinic typically treats more than 50 patients each Monday and Thursday evening it is open.

The Medical Society office can be very flexible in making referrals to your office based on what you can accommodate. Let the office know the number of patients you can accept and we can control that number to your satisfaction.

The access to care issue has been deemed a number one priority by your Medical Society leadership, and we need your help.

(Cont'd from pg. 1)

Drs. Bill Jackson, Bill Ritchie and George Tanbara asked if PCMB could share the risk with physicians and hospitals to bring the program to Pierce County. Bureau officers will be meeting with BHP administrators in the near future.

RISK MANAGEMENT FOR MEDICAL OFFICE PERSONNEL

Your office staff can play a major role in reducing the risk of a malpractice claim. The following guidelines for office personnel will help to reduce the risk of a malpractice claim were provided by the Washington State Physicians Insurance Exchange & Association.

1. DO NOT PLAY DOCTOR. Although most staff members know that only licensed physicians can diagnose illnesses and treat patients, many do not know that well-intentioned remarks can be interpreted as medical advice. Since patients tend to take seriously anything they are told in a doctor's office, the staff should not volunteer medical opinions or comment on treatment.

   REMEMBER: An employee can be sued in a malpractice case, too.

2. STAY WITHIN THE LIMITS OF DELEGATION. All delegated duties should be performed under the doctor's supervision by an assistant qualified to carry them out. A protocol should be established if feasible and practical.

3. RESPECT PATIENTS' PRIVACY. Information about a patient should never be given on the telephone unless the identity and authority of the caller can be verified. A patient's written authorization for the release of information should always be on file before details of any medical treatment are disclosed. There will be instances where a written authorization is not practical. Use your common sense. Patient care is almost always of higher priority than patient confidentiality.

4. REMEMBER THAT PATIENTS ARE PEOPLE, TOO. Some assistants feel that being casual and calling a patient by his or her first name puts the patient at ease, which it does in some cases. However, some people resent such familiarity and bury their resentment. That resentment makes a lot of difference if the patient ever feels there is a reason for legal action against the doctor. Be careful about this type of familiarity.

5. ALWAYS FOLLOW THE DOCTOR'S ORDERS TO CONTACT PATIENTS. When an assistant is responsible for contacting patients about follow-up treatment, there should be a system for checking to see that the calls are actually made. A simple list checked at day's end is a good idea. Failure to report to the patient results of diagnostic tests and x-rays can make a malpractice case difficult to defend.

6. BRING LEGAL DOCUMENTS IMMEDIATELY TO THE DOCTOR'S OR MANAGER'S ATTENTION. When a physician waits too long to notify his/her insurance carrier or attorney about a summons, complaint or subpoena, a timely response cannot be made and a default judgement for the entire amount demanded in the lawsuit is at risk. An insurance carrier could try to deny coverage if the doctor is late in notification about a possible suit.

7. PUT IT ON RECORD. When a patient fails to come in for an appointment or cancels a scheduled test or follow-up visit, that fact should be noted on the patient's chart.

8. TELL THE DOCTOR WHEN A PATIENT COMPLAINS. Some patients are reluctant to complain directly to the doctor and instead vent their feelings to the office staff. Such complaints should be reported immediately to the doctor, who can decide whether or not to talk to the patient to prevent minor matters from becoming major ones.

CPS ROSTER

1949 South State Street NZ7-1
Tacoma, Washington 98405

CHILDREN'S PROTECTIVE SERVICES:
ASSESSMENT UNIT DETERMINED BY PARENTS' ZIP CODE
8:00 a.m. to 5:00 p.m.

597-3737 Assessment Unit For: Peninsula and Tacoma

98333	Fox Island	98395	Wauna	98406	North End
98335	Gig Harbor	98401	Downtown	98407	North End
98349	Lakebay	98403	North End	98416	U.P.S.
98351	Longbranch	98405	Hilltop	98465	University Place
98394	Vaughn				

Supervisor: Judith Donaghue 593-2561

593-2462 Assessment Unit For: Tacoma, Fife and Licensed Facility Investigations

98404	East Tacoma	98421	Port of Tacoma	98443	East Tacoma
98408	South End	98422	N.E. Tacoma	98445	Midland
98409	Hanitou	98424	Fife	98446	Collins

Supervisor: Ward Peterson 593-2560

593-2771 Assessment Unit For: Southwest Pierce County and Military Referrals

98303	Anderson	98438	McChord AFB	98498	Lakewood
98327	Dupont	98439	Tillicum	98499	Lakewood
98387	Spanaway	98444	Parkland	98501	Rt.12/Nisqually
98388	Stailacoom	98466	Fircrest	98558	McKenna
98433	Ft. Lewis	98467	University Place	98580	Roy/Yelm
		98491	Lakeview		

Supervisor: Ralph Noble 593-2912

593-2888 Assessment Unit For:
Southeast and Eastern Pierce County & Hospital Referrals

98301	Alder	98344	Kapowsin	98374	South Hill
98304	Ashford	98352	McMillin	98385	South Prairie
98321	Buckley	98354	Milton	98390	Sumner
98323	Carbonado	98360	Orting	98396	Wilkeson
98328	Eatonville	98371	Puyallup	98397	Longmire
98330	Elbe	98372	Edgewood	98398	Paradise
98338	Graham	98373	South Hill	98402	Downtown

Supervisor: Robert Harris 593-2298

FAMILY RECONCILIATION SERVICES (FRS) — 1-800-422-7556 Runaways & Families in Conflict

CHILDREN'S PROTECTIVE SERVICES (CPS) — 1-800-422-7517 Weekdays, After 5:00 p.m. and Holidays

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DAY CARE

Licensing - Day Care Centers.....593-2918
Licensing - Day Care Family Homes.....593-2525
Day Care Home Referral Listings.....593-2525
Day Care Subsidy - Child Care Payments.....597-3755

FOSTER HOME LICENSING
Licensing Inquiries.....593-2808

CHILDREN'S SERVICES SWITCHBOARD.....593-2600

Janet Durie, Area Manager.....593-2209
Larry Pederson, Acting Area Manager.....593-2458
Colleen Waterhouse, Acting Regional Administrator.....593-2711

9. ALWAYS RETAIN ORIGINAL RECORDS OR X-RAYS. You can make copies, but please keep all originals. If you do release original records or x-rays, document in the chart when, where and why the originals were released.

10. BEFORE SENDING A PATIENT TO COLLECTION, HAVE THE DOCTOR REVIEW THE FILE. In some instances, it might not be appropriate to send an unhappy patient with a bad result to collection.

11. IF A PATIENT IS GOING TO HAVE A LONG WAIT, LET HIM OR HER KNOW AS SOON AS YOU DO, THEN INDICATE HOW LONG YOU THINK THE WAIT WILL BE. When you are with the physician doing patient exams and you see that you are getting behind, let the reception desk know. SOME PEOPLE WOULD RATHER RESCHEDULE AN APPOINTMENT THAN WAIT -- PLEASE GIVE THEM THAT OPTION.

12. NOTIFY PATIENTS BY MAIL WHEN YOU ARE GOING TO TERMINATE THEIR CARE. The letter should explain to the patient that your office is no longer able to care for him or her, but that you will continue to provide interval care for a specified length of time. The length of time depends on the availability of other medical care. You can include the reason why your office is no longer available, but that is not mandatory.

13. CALL DAY-SURGERY AND OUT-PATIENT SURGERY PATIENTS THE DAY AFTER SURGERY. It is advisable (as well as helpful in building rapport) to initiate a call to these patients at home the day after surgery. The doctor, nurse or receptionist should call the patient just to see how he or she is doing. Again, chart the follow-up call in the patient's chart.

14. MAKE SURE THE PATIENTS IN YOUR OFFICE UNDERSTAND HOW TO OBTAIN CARE AT NIGHT AND ON WEEKENDS. A patient information brochure can help in this area.

These key factors provide an outline of the liability risks in a doctor's office. Encourage an understanding of these factors with new staff members, and review them at regular intervals with the entire staff.

FLUORIDE FOR TACOMA

Fluoridated water can prevent up to two-thirds of the tooth decay that otherwise occurs among children who drink non-fluoridated water from birth. The protection provided by fluoridation lasts a lifetime. Fluoride is safe, it is effective and it is also a natural substance found in varying degrees in almost all foods and water supplies. The Citizens for Better Dental Health Committee has been working to collect signatures in efforts to get the fluoride issue on the November ballot. The group's goal is to educate the voting public in Tacoma to ensure that the fluoride initiative will pass by a majority vote.

PCMS is actively involved in the fluoridation campaign, and members have been asked to help gather signatures from city of Tacoma residents who are registered voters. Please place the petitions you received in your waiting rooms and offices and encourage your patients, friends, and co-workers to sign. THIS CAMPAIGN NEEDS YOUR HELP!

If you would like more information about the Citizens for Better Dental Health Committee, the fluoridation campaign, or how you can help, please call the Medical Society office at 572-3667.

NEW TOBACCO TASK FORCE FORMED

The Pierce County Medical Society Board of Trustees recently appointed Dr. Gordon Klatt chairman of the newly formed Tobacco Task Force. Committee members include Drs. George Weis, Bruce Smith, Richard Hawkins, John Lenihan, Larry Larson, Vernon Nessan, and Irving Pierce.

The first meeting of the task force was held in March to determine goals and direction for the group. The group decided to target two priority areas -- hospitals and schools, and agreed to take a firm stand on both issues. The main goal of the Task Force is to ensure that all Pierce County hospitals are entirely "tobacco free" by January 1990. (The term tobacco free encompasses both cigarettes and chewing tobacco.) The group is committed to work closely with medical staff and physicians, who have patients who still smoke, to lend assistance and ideas for alternative programs when necessary. A general public relations campaign is also planned.

DO YOU TALK TO YOUR PATIENTS WHO SMOKE ABOUT THE HARMFUL EFFECTS OF THE HABIT??

WHEN WAS THE LAST TIME YOU TOLD A PATIENT THEY SHOULD STOP SMOKING??

DO YOU PERMIT SMOKING IN YOUR WAITING ROOM?

WSMA COUNCIL/COMMITTEES

WSMA is seeking members who are interested in serving on the following committees:

Adolescent Task Force
AIDS Task Force
Congressional Liaison Committee
EMS Standards Committee
Finance
Hospital Medical Staff Section
Judicial Council
Legislative (State) Committee
Liability Reform Steering Committee
Maternal and Infant Health Care Committee
Medicaid Advisory Committee
Pharmaceutical Committee
Senior Health Committee
Young Physicians Committee

COUNCIL ON PROFESSIONAL SERVICES

Grievance Committee
Medical Education Committee
Personal Problems of Physicians
Parental Task Force
Professional Liability/ Risk Management
PRO/W

If you would like more information, please call the Society office at 572-3667.

1988 DOCTOR/LAWYER/DENTIST FIELD DAY

The 1988 Tacoma-Pierce County Bar Associations Doctor/Lawyer/Dentist Field Day will be held Friday, June 10. Golf and tennis activities will again be held at the Tacoma Golf and Country Club and the Lakewood Racquet Club, respectively. Tee times are between 11 a.m. and 1:30 p.m. (Reserve tee times by calling Joyce, Tacoma Pierce County Bar Association, 383-3432.) Tennis will be from 1:15 p.m. to 5 p.m. A "Fun Run" (location to be determined) will begin at 4 p.m. Call Joyce (383-3432) after June 8 for location. Wrapping up the day's events will be a cocktail hour and prime-rib dinner in the Country Club's downstairs dining room, beginning at 5:30 p.m.

If you'd like to help organize the event, please contact Gary Ross at 383-3791. If you have questions, call Joyce Feely, 383-3432.

All the 1987 participants wish to extend a sincere "thank you" to the following sponsors who provided wonderful prizes and refreshments:

Norris, Beggs & Simpson
Evergreen Collectors
Davies Pearson, P.S.
Johnson, Lane & Crawford
U.S. West Cellular/Vector One
Tahoma Awning & Fabric Co.
Schwarz, Shera and Assoc., Inc.
Raisl & Stolz, CPAs
Rush, Hannula & Harkins
Raleigh, Mann & Powell, Inc.
Kane, Vandeberg, Hartinger & Walker
North Pacific Bank
Thompson, Krilich, LaPorte & Tucci, P.S.
Burgess, Kennedy, Fitzer & Stoomboni, P.S.
Gordon, Thomas, Honeywell, Malanca, Peterson & Daheim
Bonneville, Viert, Morton & McGoldrick

REGISTRATION FORM
1988 DOCTOR/LAWYER/DENTIST FIELD DAY
JUNE 10, 1988

Name_____ _____ _____ _____
(Last) (First) (MD/DDS/JD) (Day Phone)

Address_____ _____
(Street) (City & Zip) (Evening Phone)

_____ Please sign me up for GOLF:

____ Tacoma Golf and Country Club Member. Enclosed is $3.25
____ Non-member. Enclosed is $35.00
(Golf carts can be reserved for a fee through the TCCC pro shop, 588-0404)

_____ Please sign me up for TENNIS. Enclosed is $10.00
_____ Please sign me up for the FUN RUN (free).
_____ Please sign me up for the BANQUET. $25 per person.

Total Enclosed $_____

RESERVATIONS WILL BE MADE UPON RECEIPT OF PAYMENT. PLEASE RETURN REGISTRATION FORM/ PAYMENT NO LATER THAN WEDNESDAY, JUNE 8, TO: Ms. Joyce Feely, Tacoma-Pierce County Bar Association, 930 Tacoma Ave. S., Rm. 240, Tacoma, WA 98405. For info call 383-3432.

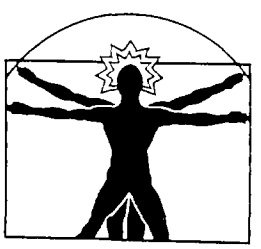
NO REFUNDS WILL BE MADE UNLESS CANCELLATIONS ARE DELIVERED TO JOYCE BY 4 P.M., JUNE 8.

AMA & PRO

In separate communications to government officials, the AMA has reiterated its concerns about evident PRO Program shortcomings and has called for elimination of the new PRO "bounty system."

In a letter to William L. Roper, M.D., HCFA Administrator, James H. Sammons, M.D., AMA's Executive Vice President, stated the belief that the PRO Program appears to be placing "an undue emphasis on reducing Medicare costs, as opposed to ensuring that beneficiaries receive high quality care." Dr. Sammons also indicated that the PRO Program is inconsistent in its physician reviewer decisions, pointing out that PROs were directed to place increased emphasis on quality issues when the second round of PRO contracts were awarded. The widespread and growing perception among physicians, however, is that the program continues instead to emphasize cost containment, often at the expense of care provided to Medicare beneficiaries, Dr. Sammons said. PRO determinations all too often are viewed by physicians as unreasonable he said, calling attention to the specific problem of inconsistencies among physician reviewers in many communities. "PROs should assure that all physician reviewers possess the appropriate degree of expertise and experience to render a sound opinion in the field reviewed," he stated. Physician reviewers must also be held accountable for rendering opinions based on careful and thorough review reflecting appropriate medical practice in the community, Dr. Sammons added.

In a second letter sent to Richard P. Kusserow, HHS Inspector General, Dr. Sammons called for ending the newly implemented PRO "bounty system through which high-level employees receive bonuses based on the number of PRO sanctions they impose and the amounts they recover in assessing financial penalties upon physicians. This patently unfair system "violates the due process rights of physicians by injecting a personal financial interest in favor of sanctions." Employees eligible for financial bonuses have the authority to exclude physicians from Medicare or impose substantial monetary penalties upon physicians, Dr. Sammons noted. Accompanying his letter was a copy of House of Delegates policy (Interim Meeting, 1987) urging the elimination of the financial bonuses plan.



LIBRARY RECEIVES WAFP SUPPORT

The Pierce County Medical Library received a $500 contribution from the Pierce County Chapter of the Washington Academy of Family Physicians. The presentation was made in recognition of the Library's important role in the medical community. The Family Physicians challenge all specialty societies to match the contribution.

PUBLICATIONS COORDINATOR JOINS STAFF

The Medical Society welcomes Jean Borst, who recently joined the Membership Benefits, Inc. staff as Publications Coordinator. Jean, who brings to the job several years experience in writing, editing and publication production, is responsible for all aspects of the Publications Department, including the *PCMS Newsletter*, *The Bulletin* and the annual and pictorial directories.

The Publications Department is currently putting in place a new desk-top publishing system, and will soon be able to offer desk-top publishing services to PCMS members on a contracted basis.

PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
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- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

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Many groups TALK about building a better America-
The Army Reserve WORKS at it.

PRACTICES AVAILABLE

PRIMARY CARE PRACTICE $29,500. Office building connected to St. Josephs Hospital. Tacoma - over $30,000 equipment included - view - 4000 records - 2 offices - 4 exam -lab - x-ray - surgery. 383-5437.

ACTIVE FAMILY PRACTICE and medical-dental building on South Hill of Puyallup. Guaranteed 5 year leases on rental portion of building. Physician agrees to continue working part-time with new doctor. Contact Bill or Adrienne Morrison at 848-6499, 6 to 10 p.m.

OFFICE SPACE

MEDICAL OFFICE - lease 1300 sq. ft. excellent terms. Puyallup location. Bruce at Com-Ind 473-0890.

HEALTH CARE CENTER. Sale or lease 1600-2500 sq. ft. 78th & Pacific. Plush oak finish. Call Bruce at Com-Ind. 473-0890.

FEDERAL WAY - Established area of medical offices. 1375 sq. ft. $13 per s/f per year, triple net. Call owner, 228-0722.

MEDICAL OFFICE SPACE AVAILABLE in Federal Way. 2 blocks from St. Francis Hospital. Primary office space, shared space or satellite office. Reasonable. 927-8011.

NEW AND LARGE well equipped satellite medical office for share. South Hill Puyallup. Reasonable terms. 474-3329.

NEW MEDICAL - DENTAL BUILDING within sight of Tacoma Mall. Up to 2500 sq. ft. available. Reasonable lease. Contact Dr. Bird 475-8934.

EQUIPMENT

MISCELLANEOUS MEDICAL OFFICE EQUIPMENT for sale including Mid Mark Power exam table. 867-5415.

LANIER DICTATING AND TRANSCRIBING machine with remote stations. Excellent condition. $1200. Call 1-206-867-5415.

1) HOLTER MONITOR - $500. 2) Seralizer - blood chemistry equipment for $995 (original price $3500). 474-3329.

GENERAL

EXCELLENT HOME perfect for in-house practice borders Fircrest, within University school district. Custom built contemporary home, over 2,500 sq. ft. plus additional unfinished Zoned SR9. Call Barbara Wasser 759-1117 or 752-4764 Paragon Co.

STOP PAYING RENT!! Invest in your business, 2 houses in Puyallup Valley recently zoned for professional offices priced to sell to $55,000 and $77,000. Call Carrie Henry or Linda Hundven at Landmark Properties Realty Inc., 848-7799.

AUXILIARY

MAY MEETING

We will be meeting with the Thurston and Mason County Auxiliaries May 20 at 10:30 a.m., for a tour of the Governor's Mansion, followed by a noon lunch at Carnegie's. But, leave your books at home - for this particular library is now an excellent restaurant. There are many neighboring shops and boutiques, and a public tour of the Capitol Building is available if you are interested.

Call Mary Lou Jones (565-3128) for further details. Carpooling information will be in the Auxiliary newsletter, The Pulse.

CONGRATULATIONS ER-AH GRADUATING SENIORS

Truly, we'd like to address your son or daughter by name. Be sure to call Marge Ritchie (564-4112), Student Recognition Chair, with the name of your proud senior and the school attended. The deadline for the May Bulletin is April 5, so don't put off tomorrow what should have been done yesterday.

TACOMA MALL HEALTH FAIR A SUCCESS

The Tacoma Mall Health Fair, held Feb. 12-14, was deemed a great success, according to health fair co-chairpersons Eileen Toth, M.D., and Mrs. Sally Larson. They reported that several hundred blood pressure tests were administered and numerous pieces of literature were distributed at the Medical Society and Auxiliary booth.

Dr. Toth, Sally Larson and Medical Society and Auxiliary members extend their appreciation to the following volunteers who contributed valuable time to help staff the health fair booth: Patty Kesling; Alice Hilger; Maryln Baer; Lon Annest, M.D.; Mary Lou Jones; Gerald Anderson, M.D.; Sharon Lawson; Cindy Anderson; Nikki Crowley; Ron Taylor, M.D.; Jennie Hinton, M.D.; Mark Gildenhar, M.D.; Jim Blankenship, M.D.; Hobart White, M.D.; Elizabeth Sanford, M.D.; John Bargren, M.D.; Nancy Rose; Alfred Chan, M.D.; Ron Graf, M.D.; Randy Lindblad, M.D.; Arthur Smith, M.D.; Todd Nelson, M.D.; Rubye Ward; Helen and Bob Whitney, M.D.; Ginnie and Ray Miller, M.D.; Karen and Ron Benveniste, M.D.; Debbie and Bob McAlexander, M.D.; Julie and Dick Hoffmeister, M.D.; Elaine and Tom Brown, M.D.; Grace and DeMaurice Moses, M.D.; and Wayne Larson, M.D..

This is the fourth consecutive year Sally Larson has helped organize the fair booth, a task that requires many hours to set up and dismantle the WSMA exhibit. The Society and Auxiliary is indebted to Sally and Wayne Larson for their major contributions over the years.

NOTARY SERVICE AVAILABLE

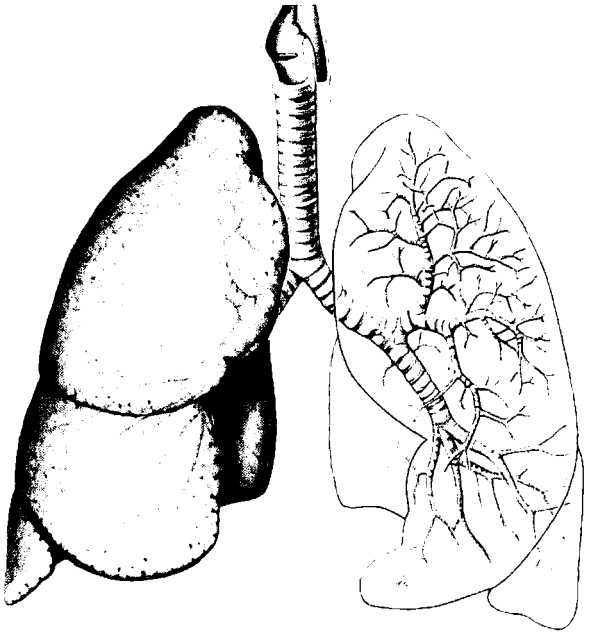
The Medical Society office provides Notary services to PCMS members free of charge. Call or drop by the office if you are in need of a Notary Public.

Medical Society of Pierce County
705 South Ninth Street, Suite 203
Tacoma, WA 98405

The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY May, 1988

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor 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.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL GROUP B TOXICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with nearly all broad-spectrum antibiotics. It should be considered in differential diagnosis of patients who develop diarrhea. Drug should be discontinued, appropriate antibiotic treatment initiated, and antibiotic-associated colitis

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mothers' milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. 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.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology:
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis, elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061787L]

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Lilly

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

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

The Bulletin

The Official Publication of the Medical Society of Pierce County

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President's Page

Issues for '88

Clearly the status quo of medicine is now that of continual change, a process occurring throughout this fast, forward world in which we live. This truth was highlighted at our Pierce County Medical Society Policy Planning Meeting in January and the February AMA Leadership Conference in Chicago.

Our continual challenge is to be involved in and to adapt rapidly to that change. As a Society, I know that we can and will meet the challenge!

The Pierce County Medical Society Policy Planning Meeting, held Saturday, January 9, was attended by the presidents of the Hospital Medical Staffs of Pierce County, the Pierce County Specialty Society Presidents, and the Medical Society Board of Trustees.

We spent the first hour with the leaders of the Pierce County Labor Council, representing 74 local unions and 24,000 members. The written opening comments from Mr. Clyde Hupp, Executive Secretary of the Labor Council, were reprinted in the March PCMS Newsletter.

Another hour of valuable discussion was held with state and local leaders of AARP (American Association of Retired Persons). This growing association has 27 million members nationally, 540,000 members in Washington state and 150,000 members in Pierce County. Mr. Otho Smith, Washington State AARP Executive Director, presented opening remarks.

We listened to both groups' perceptions of medical care in Pierce County, their medical care concerns and ways we might better serve their members. It became quickly evident that our guests were very knowledgeable about the intricacies of the health care system and were pleased to have the opportunity to participate in our planning process. There was absolutely no concern voiced about the quality of medical care in Pierce County. Their major concerns were primarily economic, centering around the possible loss of access to our medical system.

With both groups we identified several areas where we could jointly explore problems and propose mutually agreeable local solutions. Representatives of AARP are now regularly attending our Committee on Aging meetings, and we have held further conferences with the Central Labor Council.

After subsequent discussion, your leaders chose the following issues on which to focus our energies in the coming year:

1) Access to Medical Care - There is national and local concern for the growing number of persons who are inadequately insured against chronic care, catastrophic care, or —because of low income levels— "routine" medical care.

A) We support the Basic Health Plan's initial recommendations and are encouraging the placement of one of the state's pilot programs in Pierce County.

B) Education of the indigent and working poor about available medical resources will be pursued through representative organizations such as labor unions.

C) Legislative support of adequate funding of government health programs is essential, and we will be discussing the urgency of this issue with our elected Federal and State representatives.

D) Lastly, we as physicians must meet our historic and social obligations required by our privileged societal position. Shouldering the burden of medical care for the indigent is the responsibility of all of us, one which in all fairness we know should be equally shared. Many physicians in Pierce County have made the sacrifices by providing free or discounted medical care. There are a multitude of rationalizations for not treating the indigent, but the end result is displacement of our collective responsibility onto our colleagues. We must each re-examine our attitudes and responsibilities on this important social issue.

2) AIDS - Pierce County Medical Society, through its membership and Auxiliary, has participated on AIDS task forces at the state and local levels, provided trained physician speakers on AIDS to community groups, compiled a list of resources in Pierce County for AIDS victims, worked in concert with the Tacoma/Pierce County Health Department, and publicly supported funding for AIDS programs.

3) Development of a Prehospital Care EMS System - The PCMS EMS Committee, under the chairmanship of Dr. Bob Wachtel, is developing a system recommendation which will be presented to our community.

4) Fluoridation of the Tacoma City Water Supply - Despite the overwhelming scientific evidence of the value of water fluoridation in the prevention of cavities, focused opposition has prevented its application to the Tacoma Water Supply for at least 20 years. The Public Health/School Health Committee, under the chairmanship of Dr. Torgenrud, the Dental Society and the Medical Society Auxiliary will be circulating a petition for signatures to place this issue on the November ballot.

Continued on page 5

Presidents Page continued from page 4

Members of the Pierce County Medical Society will also be discussing this issue with members of the Tacoma City Council.

5) **Tobacco** - A tobacco task force, under the chairmanship of Dr. Gordon Klatt, will formulate policies to continue the fight against the use of tobacco in Pierce County.

6) **Trauma Care** - There is a wide divergence of strongly held opinions about the future direction of hospital trauma care in Pierce County and the value of a designated trauma center. Prospective studies to better measure our trauma care are being considered.

There are many issues in which we are involved, but our greatest focus will remain on these areas of concern. Networking is one of the most effective means of addressing these problems. Our priorities are shared by other community groups, and we will be developing coalitions for these efforts.

As members, I ask your enlistment in our joint efforts. There are many contributing physicians participating on Pierce County Medical Society committees. These committees are listed on the table of contents page. If you believe that any of these issues are of importance, we would value your personal involvement. Our Society and its influence are only as great as the degree and intensity of our membership involvement.□

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT UPCOMING PUBLIC HEALTH ROUNDS

Some of the topics for upcoming PUBLIC HEALTH ROUNDS are: Communicable Disease Update; Electromagnetic Radiation; Pelvic Inflammatory Disease; Smoking in Pierce County Restaurants; Attitudes About STDS Among Soldiers.

DATE:	TIME:	LOCATION:
May 11, 1988	8-9 a.m.	Lakewood General Hospital Conference Room
June 3, 1988	8-9 a.m.	Madigan Army Medical Center Madigan Annex Medical Auditorium

EVERYONE WELCOME

Strength in Unity

By WSMA President Ralph A. Johnson, MD

Working together, county medical societies, the state medical association, and specialty societies have established a successful and impressive record in Washington state. The defeat of a major B&O tax increase, landmark liability reform legislation, passage of the Basic Health Care Plan, defense of numerous attacks on tort reform and the defeat of Initiative 92 on the November ballot are all prime examples of what can be done when physicians work together.

At the national level, the American Medical Association, working with the state association and specialty societies, has built an equally impressive record. The AMA successfully defeated efforts to impose DRG payments on anesthesiologists, pathologists and radiologists. Over the past year, AMA action halted some of the more onerous provisions of the Health Care Financing Administration's Medicare review process and has introduced back into that process (thanks to the threat of lawsuit) the concept of due process. At this point, medicine has never been more strong or effective at the federal level.

Unity is more than a cliche; it is a prescription for our survival.

In an article in the January 22-29, 1988 edition of the American Medical News dealing with the issue of unity, AMA Board of Trustees Chairman, Allen R. Nelson, MD, noted, "there is little more destructive to a lobbying effort than disunity." He went on to add, "Unfortunately, there are divisions among physicians. Divisions that are growing wider. Divisions that can be exploited. Divisions that are being exploited."

Dr. Nelson also pointed out that disunity is what allowed Britain's doctors to be isolated and driven apart in 1949 when the national health service was established, concluding, "this disunity is due partly to the trend for specialty societies to set up lobbying arms—to concentrate on their own interests—weakening what should be a united effort to represent all interests in medicine."

Today, it is more important than ever for the profession to hold together. There is concern over Federal initiatives to reform physician reimbursement, and there is concern and some misinformation about the Harvard Relative Value Study issue. Problems that exist within our ranks must be resolved internally rather than externally if we are to preserve our unity.

In Washington state, our Interspecialty Council is a useful forum for each specialty society to discuss legislative priorities and to work for positions that we can all support. On April 9, the Interspecialty Council reviewed the status of physician payment reform and the Harvard Resource Based Relative Value Study Project. Hopefully, the dialogue for a unified position on this issue within our state has begun.

The WSMA House of Delegates is another way to achieve unity through the discussion and passage of resolutions introduced by county medical society and specialty society delegates. As KCMS Past President Dr. Joseph W. Eschbach said

Continued on page 7

Strength in Unity continued from page 6

on the President's Page in the November 1987 issue of the Bulletin of the King County Medical Society, "...this year I was struck by the marvelous system we have; the freedom to debate issues in a basically friendly environment. The four reference committees listened to the comments of any interested person regarding the many issues, reports, and resolutions, during one long morning. The House of Delegates, consisting of 115 geographical and 18 specialty delegates, then debated these items during nine hours, stretched over two days.

"Although these issues could have been resolved more quickly by more autocratic measures, the purely democratic process followed made it an exciting time to be part of the action. On one hand, the process might be criticized for too much nit-picking, but on the other hand, one can learn a lot about medicine this way: our ethics, our position on the issues, and the vision of what we must do as a profession in the future." The deadline for the 1988 House of Delegates resolutions is August 1, 1988.

We cannot allow ourselves to be divided and driven apart. In Britain, the labor government successfully split the specialists and primary care physicians apart in order to achieve its goals. We cannot let that happen here.

Don't think for a moment that unity is a vague concept or reflects a need to work on a national issue. Unity starts here, at home, with you and me.

Adlai Stevenson once said, "Astronomers of the world must cooperate because no man or woman can see the whole sky from one country." Likewise, we, too, must work together.

We have the talent to do the job. We need your support and unity to get it done.□

Taking a Little Time

By Richard E. Waltman, MD

I enjoy my practice very much, but recently I became so fatigued, both physically and even more so emotionally that I took the day off. Not the kind of day off that we usually have, which means seeing just a few patients rather than a full day and yet still filling the day with depositions, nursing home visits, phone calls, and paper work, but a *real* day off. Like *real* people have, with absolutely no work at all. A kind associate did my morning rounds, and I had absolutely no responsibilities or commitments for a full 24 hours.

I learned, or actually relearned a very good lesson. And I also had a very good time.

First of all I "slept in" until 7 a.m. instead of my usual 5 a.m. I next enjoyed the very special pleasure of not shaving. I had a spirited breakfast with my wife and two young sons, then sat down to read the paper over a cup of coffee while my wife drove them to school and went off to her office. I looked around and realized that I was alone in my own house probably for the first time in five years. Very interesting.

I cleaned up a bit in the kitchen, wandered into the living room and rearranged our cassette tapes. I walked out into the backyard and reminded myself of what a pretty place we live in.

I put out some birdseed, checked the progress of some young trees I had planted several seasons earlier, and I brushed the dogs. I went out front and cleaned out the accumulated papers, coffee cups, and other various items from my car. And I found a perfect spot to plant a new vine maple in the spring.

My wife came home, and we had lunch together on the back porch. We talked together at a more leisurely pace than our usual during-the-week encounters. We went upstairs and made love, with no telephone ringing and no little boys coming in to sleep in our bed. I knew even before that things were good with us, but after so many years it was good to really make sure.

After a nap (Oh how wonderful a nap is!), I went through a pile of journals I had been saving but would never read and managed to discard a few; I paid some bills, and went through the family photo albums. If you think you're not getting old fast try that tonight.

At three o'clock I picked up my 6-year-old and 7-year-old sons at school and took them out for ice cream. Although the prices were higher—and the people behind the counter much younger—everything else was much the same as it had been when I frequented such places on a regular basis. We sat down with our sundaes and had some serious "man talk." We stayed away from PPOs, DRGs, and ICUs and concentrated on the really important stuff. We talked about football, and basketball, and cars. We spoke of Larry Bird, and Babe Ruth, and four-wheel drive trucks. We got through Disneyland, the Super Bowl, and what it was like to go to college. I was frankly amazed at how worldly they had become, and I told them how much I cared about them. They said that they were having a good time and wanted to do it again. I absolutely loved it.

We came home, played a little ball, and then had dinner at dinner-time for a change. We had time after dinner to do some reading ("Make Way for Ducklings" is as good now as it was when I first read it years ago), play some computer games, and all got to bed at a reasonable hour. My wife and I even had time for a bedtime cup of decaf and a chat.

With the phone still disconnected I slept well that night, and got off to a good start the next morning. I felt a lot better, and for a while at least everything seemed to go a lot better. I am back on the old merry-go-round now, but I can still recall that very

Continued on page 8

Taking a Little Time continued from page 7

pleasant day and the good time I had. More important, when I came back to the office I took out the appointment book and scheduled out this kind of day every six weeks for the rest of the year.

Yes, I do enjoy my practice very much, and no, I wouldn't want to hang around the house every day. I know that I'd get very bored very soon, and I really cannot think of anything I'd rather do than practice medicine. But a day like I had does make you think. As physicians, we know best of all how fragile and delicate life can be. Yet we spend a lot of time telling our patients to slow down and enjoy life, although we rarely do it ourselves.

Yes, I shall continue to work crazy hours and still get up in the middle of the night for an admission, but every once in a while, while I still have the chance, I am going to take some time with myself, my wife, and my kids. I encourage you to do the same.□

Fifty Hours for the Poor

The following editorial appeared in the December 4, 1987 issue of the Journal of the American Medical Association

Doctors, lawyers, and the clergy belong to the classic learned professions, which are historically distinguished from trades and businesses. Although this distinction has blurred in modern times, one of the characteristics of a true profession remains its special relationship with the poor.

Edmund Pellegrino, director of the Kennedy Institute of Ethics, states that a fundamental difference between a business and a profession is that "at some point in the professional relationship, when a difficult decision is to be made, you can depend on the one who is in a true profession to efface his own self-interest."

The privilege to practice law or medicine has carried with it the obligation to serve the poor without pay. Doctors and lawyers today have tended to become overly concerned with their professional incomes and practice efficiencies, but they must not forget their higher duties. Many members of our profession have always cared for the poor who need legal or medical help. But their efforts are not what they should be, and there is abundant evidence of unmet needs. For example, 35 to 50 million Americans are now believed to be medically uninsured or seriously underinsured; access to health care is widely considered to be in crisis. For 68% of legal problems encountered by poor people, the services of a lawyer are not used, according to the American Bar Association.

The philosophical and ethical roots of the medical and legal professions are entwined with the public interest, service to the community, and caring for the poor. These professions maintain those values. In law, the official policy of the American Bar Association, adopted in 1975 states:

"It is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services without fee or at a substantially reduced fee in the following areas: poverty law, civil rights law, charitable organizations representation and administration of justice. It should always be provided in a manner consistent with the Model Rules of Professional Conduct. The organized bar should assist each lawyer in fulfilling his responsibilities in providing such services as as long as there is need, and should assist, foster, and encourage governmental, charitable, and other sources to provide public interest legal services."

In medicine, the American Medical Association's original code of ethics, written in 1846, emphasizes relief of pain and diseases without regard to danger or personal advantage and states that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded." In 1987, the American Medical Association House of Delegates approved as policy: "That the AMA urge all physicians to share in the care of indigent patients." Principle 3-6b of the Health Policy Agenda for the American People states that, "All health care facilities and health professionals should fulfill their social responsibility for delivering high quality health care to those without the resources to pay."

How many members of the legal and medical profession now deliberately care for the poor in a voluntary and uncompensated way? Many, but not enough. What percentage of their time is spent doing so? Much, but not enough.

Doctors and lawyers in our society have benefited greatly from the abundant opportunities made available to them from the fruits of our plenty. We believe that all doctors and lawyers, as a matter of ethics and good faith, should contribute a significant percentage of their total professional efforts without expectation of financial remuneration. This percentage will vary depending on time, setting, opportunity, and need, but all should give something. This is the proper behavior of a learned professional. We believe that 50 hours a year—or roughly one week of time—is an appropriate minimum amount.

There is a great tradition behind the giving of this gift. In the church, it is called *stewardship*. In law, it is called *pro bono publico*. In medicine, it is called *charity*. In everyday society, it is called *fairness*.□

George D. Lundberg, MD
Editor, *JAMA*

Laurence Bodine, Esq.
Editor and Publisher, *ABA Journal, The Lawyer's Magazine*, Chicago

Letters

To the Members of the Pierce County Medical Society:

I strongly support the goals of the state and local medical societies. Support for these goals can be shown in part by attendance at local and state meetings. I was unable to attend the past meeting of March 8. I chose to attend the local political caucus instead.

In my opinion, attendance at precinct caucuses is a very important medical society function. I feel it is very important for physicians to show a strong interest in regional as well as national political affairs. It is only by meeting and speaking with people that we an make our views understood by the general public. We have no excuse when we complain about what the local and national government is doing to quality medical care, if we don't take part in the process of selection of that government.

I find it inexcusable that the monthly medical society meeting was scheduled to conflict with the day designated as Washington State local precinct caucus night. This night is always the second Tuesday in March of the presidential election year. Unfortunately, this same conflict occurred four years ago, as well. I think it is time that the Pierce County Medical Society mark its calendar in advance, to prevent future conflicts.

It is vital that physicians exercise their responsibilities as citizens and attend the precinct caucuses. We should even attempt to be designated delegates to the county, state, and national conventions. All the contributions to PACs, and all the lobbying in the halls of government will be to no avail if we don't make the effort at the local grassroots level.

Carl W. Wulfestieg, M.D.□

Ed. Note: The calendar is marked for 1992.

Dear Medical Community:

Please accept my thanks for helping finance my trip to Leadership Confluence in Chicago, January 31 - February 2. The three days were filled with learning and excitement. This knowledge and enthusiasm will be shared with all of you. It was fantastic to be with other leaders in the country, sharing ideas and friendship.

The Auxiliary Board will incorporate as many suggestions as possible. We'll try hard to create some effective programs—offering meetings at varying times of days and days of the week, some "fun only" times, workshops, public forums, and other member ideas. We're in this together to deal with the mandated Medicare assignment, AIDS education, adolescent health issues, AMA-ERF, smoke-free environment, biomedical research, professional liability, et al.

Supporting each other as friends is so vital. One goal of Auxiliary is to help provide an opportunity for anyone to participate sometime during the year. Auxilians need to make commitments to ourselves and spouses, to fulfill our potential. We will make use of State and National officers to help train our leadership. By working as a "team" with physicians, Auxiliary will have a caring impact on the entire community.

Thanks again for sending me to Confluence and allowing me to be one of your leaders.

Kris White, President-Elect, PCMS Auxiliary □

The Bulletin *welcomes your comments and letters.*

3,000 Signatures Needed . . . Now

The Pierce County Medical Society and Dental Society have embarked on a campaign to fluoridate Tacoma drinking water.

After a two-year effort led by Dr. Terry Torgenrud and the Committee for Better Dental Health to have the Tacoma City Council take action (with no result), we are taking the Initiative route to have the issue on the November ballot.

We need 2,524 signatures to have the issue placed on the ballot. To guarantee that all signatures are valid, we are seeking a minimum of 3,000 signatures (Tacoma residents only), which must be submitted to the Tacoma City Clerk by June 30.

Today, about 120 million Americans in 8,000 locations (Fircrest, for one) drink from fluoridated water supplies, which either occur naturally or are adjusted to the optimal level for dental health.

The Medical and Dental Societies support fluoridation because it can prevent up to two-thirds of the tooth decay that otherwise occurs in children who drink nonfluoridated water from birth. Fluoridation costs about 20 cents per person annually.

In the last decade, studies have shown that fluoridated water benefits sufferers of osteoporosis. We will have more information on this aspect of the issue at a later date.

It has been 10 years since an effort was made to fluoridate the Tacoma water supply. At that time it became a very difficult and acrimonious struggle, and the issue went down in defeat.

The Board of Trustees and the Society believe this is an issue that needs to be won at the polls. Remember, it looked like the defeat of Initiative 92 was unlikely, yet it was defeated by a 66% vote. We can achieve the same kind of victory with this important health issue, and we can all play a role.

By obtaining 25 signatures to fill one petition sheet, you can contribute in a big way. Call the Society office today for another petition form, or volunteer to help in the campaign. A year from now, we want to be drinking fluoridated water.□

The Healthy Family: What Is It?

By Merville O. Vincent, MD

The following article appeared in the March 1987 issue of the Maryland Medical Journal

It is not possible to share the very latest details of research data on families or everything that is known about healthy families. Rather I have chosen to share some things that are believed to be important in making families healthy. Perhaps it will cause you to look at your family and your own role in your family.

Dr. Vincent is Executive Director, The Homewood Sanitarium, Guelph, Ontario, Canada. This article is excerpted from a speech given at AMA's Seventh National Conference: The Impaired Physician, in Chicago, April 1986.

In the past families were thought to have five major functions, all of which tended to hold the family together:

Economic—today everyone can get by on their own;
Protection—today we look to social agencies, police, and government for this;
Religious—today we have turned this over to the churches or denied its necessity;
Education—we've turned over to the school system; and
Status and job training—this is obtained much less from the family than from money, occupation, or looks.

Certain functions that were in the background of families in the past are now in the forefront. These are largely relational functions. Intimacy is of more concern than is protection. The end result is that if one feels lonely, isolated, or alienated in a marriage, solace may be sought elsewhere such as in work, alcohol, other relationships, or may result in depression, chemical dependency, or even suicide. Healthy families are important because they nurture the well-being of all their members.

We have considerable evidence that the quality of family life is extremely important to our emotional well-being, our happiness, and our mental health as individuals. We know that poor relationships within the family are very strongly related to many of the problems in society such as juvenile delinquency.[1]

In a similar vein, psychiatrist Armand Nicholi noted:

> If people suffering from severe non-organic illness have one experience in common, it is the absence of a parent through death, time-demanding job or absence for other reasons . . . what has been shown over and over again to contribute the most to emotional development of the child is a close, warm, sustained and continuous relationship with both parents. Yet, the accelerating divorce rate and several other trends in our society today make this most difficult to attain.[2]

Nicholi concludes that families are the vital cells that constitute the flesh and blood of our society. When one family disintegrates so does a part of our society.

Research Findings

While there has been more research on pathology than there has been on healthy families, there is considerable research on healthy family functioning. These are the characteristics of healthy families most frequently mentioned in the literature I reviewed:

- The cornerstone is a good relationship between the marital partners.
- Good communication patterns
- Showing appreciation for one another
- Spending time together (including leisure time)
- Commitment to each other and the family group
- Parents and children who learn from each other
- Emotional closeness and shared activities in a context that permits individuality, privacy, differences
- A sense of trust
- Enjoyment of family traditions
- Shared religious core, values, and philosophy of life
- Teaching respect for others
- A sense of play and humor
- Balanced interaction among members without internal cliques or coalitions
- Fostering and sharing responsibilities
- Negotiating differences
- Teaching a sense of right and wrong
- Valuing service to others
- Flexibility and spontaneity in interactions
- Family members feel understood and are understanding
- Being reasonably self-sufficient
- Facing and solving problems, dealing with crises positively, and seeking outside help with problems.

Several of these characteristics of healthy families can be enlarged on with the medical family in mind.

A good relationship between marital partners characterizes healthy marriages. The research work of Jerry Lewis and his group once again established the importance of the marital relationship in healthy families. The better the marital relationship, the healthier the family.

Healthy marriages were characterized by flexibly shared power and deep levels of intimacy. Couples

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liked each other and were good friends; in a very close relationship, they were unique individuals. They could tolerate and relish their differences. They had good sexual relations. They were open with their feelings and had high levels of intimacy. When problems occurred they were quickly identified and resolved.[3]

A recent study on vital marriages indicated that marital partners possessed personality needs that promote sexual expressiveness, "otherness" rather than "selfness," determination, and high ego strength.[4]

Noting that the average duration of marriage in the US is 9.4 years, Jeannette and Robert Lauer[5] studied 351 couples married over 15 years. Three hundred of those couples considered themselves happily married. The top seven reasons given by both husbands and wives for their marriage lasting were

- My spouse is my best friend
- I like my spouse as a person
- Marriage is a long-term commitment
- Marriage is sacred
- We agree on aims and goals
- My spouse has grown more interesting
- I want the relationship to succeed

The authors noted three findings that run contrary to much common mythology. Couples with enduring marriages had not made a practice of fighting or expressing anger. Their motto was not "the family that fights together stays together." Second, they did not see marriage as a 50-50 proposition with a 50-50 divide on everything. There was a tendency for each person to emphasize periods of giving and periods of receiving. They seemed prepared to give more than they received in the relationship. The result appeared to be very close to equality of giving and receiving over the long run. Third, they tried to spend as much time together and share as many activities as possible. Preference for shared rather than separate activities was seen as a richness and fulfillment in the relationship rather than a loss of identity.

The healthy family spends time together including leisure time. Those families who spent time together genuinely enjoyed being together and structured their lives so it could happen. They realized it does not happen spontaneously. Togetherness was in all areas of their lives: eating meals, recreation, and work.

Time spent together is the basic requirement for the family that would develop the other characteristics of a healthy family. Authors of *American Couples* noted "in all four kinds of couples, we find that those who spend a lot of time away from each other—take separate vacations, have separate friends, dine apart frequently—have a lower survival rate." The same study concluded that a particular risk was the new marriage where the (working) wife is particularly ambitious; not that the wife grew dissatisfied with her marriage, but the more ambitious the wife, the more likely that the husband wanted the relationship to end.[6]

Time spent together allows some other things to happen that are important for families, such as the balanced interaction between all members of the family without the family breaking into cliques or coalitions at times of difficulty, or parents turning to a particular child to have their needs met. This shared time is where a sense of humor and a sense of play can happen, and these too are associated with family health.

Division of Time

Overworked parents expend so much energy and time to meet the needs of their occupations, their personal needs for success and status, as well as providing material and physical needs for their family that there is often little time left to be concerned about human needs such as love and sharing. The result is often tired, exhausted, burnt-out fathers and mothers. Conflict and anger result from this overload. There is little time for togetherness as a family. When there is very little time together, positive emotions are not expressed. There is only time to discipline, to complain, and to correct. Family interactions become tense and infrequent. Individuals seek refuge in their own interests: sports, TV, crafts, and other isolation chambers. Not that these activities are inherently bad, but they often become substitutes for interacting with family members. Other stresses include less time for togetherness between spouses on different work schedules, frequent separation of parents and children through the use of childcare institutions, and the insistence on instant gratification in family life.

Most of the characteristics of a healthy family involve time together. This necessitates setting priorities and taking charge of our lives. We only do this when we recognize its importance for us and our family. Then we set priorities, take greater control of our time and learn to say no. In the meantime many of us get into a pattern of being always busy, always hurried, always behind, always under pressure, and rarely saying no; then we feel trapped.

We all have the same amount of time, the question is: how are we going to use our time? We must control our work schedule so it does not routinely infringe on family time. We must expect the unexpected, therefore we cannot schedule our time too tightly. Stinnett (not a physician) stated all of us are busy and we sometimes feel like we have so many things to do that we are pulled in 1,000 different directions at the same time. The strong families experienced the same problems. One interesting action that these families expressed was that when life got too hectic—to the extent that they were not spending as much time with their families as they wanted—that they would sit down and make a list of the different activities in which they were involved.[1]

This was followed by hard decisions that deleted some of the activities.

Healthy families have good communication patterns. Members of healthy families spend time talking with each other, and this is closely related to the fact that they spend a lot of time together. They have good communication patterns, with

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shared thoughts and feelings and are also good listeners. In this way a person indicates that they value the sender, they value the message, and they value themselves even if they are differing with someone.

This communication occurs best in families that are not authoritarian, where power is shared but not abdicated by parents. Positive verbal and nonverbal communication is important. We all need to know that we are loved, valued, appreciated, accepted, and understood. Healthy families communicate this. At all ages we want to share our intimacies. Healthy families accept the reality and validity of other members' thoughts and feelings even if they differ from their own.

In addition to sheer busyness, television can be a major obstacle to communication in the home. This is at all ages and stages. It led one wife to comment that she was more worried whether there was life after dinner than life after death.

The healthy family shows appreciation. The healthy family shows appreciation for one another, they demonstrate empathy and unconditional love. They support, validate, and nurture each others' emotional needs. The individual is affirmed for whom he or she is and not for looks, money, accomplishments, or any form of productivity. This led family sociologist Urie Bronfenbrenner to define the family "as a group which possess and implements an irrational commitment to the well-being of its members."[7] The implications of this irrational commitment could be for me to go to a ballet with my wife or my wife to go to a hockey game with me. Alternatively it might lead to somebody washing someone else's socks and shorts for over 30 years or anyone changing anyone else's diapers.

David Mace, commenting on a study of families that function effectively, noted:

> The members of these families liked each other and kept on telling each other that they liked each other. They affirmed each other, gave each other a sense of personal warmth and took every reasonable opportunity to speak and act affectionately. The result, very naturally was that they enjoyed being together and reinforced each other in ways that made their relationships very satisfying.[8]

It is little wonder that William James said "the craving to be appreciated is a basic human need and the deepest principle of human nature."

When the physician fails to set priorities and has little time or energy left for family members, it is not surprising that the family perceives this as not being appreciated. Just as appreciation is often reciprocated in human relationships so is the lack of it reciprocated. Soon the doctor no longer experiences appreciation at home and finds that he is getting much more appreciation in his work. It is tempting to involve oneself even more in work, and the vicious cycle is compounded, often resulting in many unmet needs for everyone in the medical family. In the short run, there is actually more admiration with less responsibility in the medical activities than there is in the activities in the family. I would suggest in the long run there is potentially more reward in participating in a healthy family than there is in an excessive commitment to one's professional life with the cost being failed family relationships.

Healthy families develop a sense of trust. In healthy families, husbands and wives trust each other deeply. Children are gradually given more opportunity to learn trust. The family does not break trust for the amusement of others, which means that they do not tell secrets on each other or stories that humiliate one another. This is an expression of their caring and empathy. The family realizes that broken trust happens on occasion an can be mended. In such a family, both parents and children become trustworthy.

One reason successful parents often have unsuccessful offspring is because the parents are so busy that they can't give their children the time required to provide a trusting relationship.

Occupational or professional success may be a risk factor. Success leaves people with even less time for family. Physicians must repeatedly ask themselves if they have set reasonable priorities for their own

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family relationships. Only then will they keep promises for time-consuming commitments with their spouses and children. This doesn't necessarily end after the children have left the nest. My adult children in the last year let me know that I was spending too much time with my nose in a paper or journal when they were visiting. Healthy families promote high levels of both closeness and individuality. They learn that it is safe to express one's feelings openly. Note Jerry Lewis's description of fathers in healthy families:

> The fathers, all of whom were successful at work, invested much of themselves in their work. They described work satisfactions as primarily people-oriented, and many spent more than 40 hours per week on the job. As a group, however, they had a good deal of themselves left over for their wives and families. This point deserves emphasis because it is one of the clear differences between these families and families seen as less competent or faltering. This ability of the husbands to have energy and emotion available and to be significantly involved with their wives and children despite heavy investment in their work was striking.[3]

Children who learn to experience a high level of trust within the family tend to have higher levels of trusting relationships outside the family, and as Lewis implies, an individual or family that approaches others with the basic attitude is likely to receive a friendly response from others just as the untrusting and suspicious attitude toward others can also add a self-fulfilling outcome.

Healthy families often have a shared religious core. Healthy families tend to be religious, they share a religious core or values and philosophy of life. Commenting on this, Stinnett[1] states that research over the past 40 years has shown a positive relationship of religion to marital happiness and successful family relations. He went on to say, Of course, we know that there are persons who are not religious who have happy marriages and good family relationships. Nevertheless a positive relationship between religion and marriage happiness exists according to the research that we have had for many years. These strong families went to church together, often they participated in religious activities together; most of them, although not all of them, were members of organized churches.

These families often have a strong sense of family in which rituals and traditions abound. This encourages a sense of belonging, roots. Rituals around special religious occasions and holidays increase the sense of identity and belonging, so do special celebrations of birthdays or anniversaries. Part of this is getting together as a family. This also means that these occasions, which are partly

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religious and partly family, are important enough to parents that they arrange not to be on call or to say no to a particular responsibility so they can be available for such occasions.

Delores Curran[7] commented,

Faith in some transcendent belief is obviously a significant characteristic in establishing a healthy family in the eyes of my survey respondents, who work closely with many families. Not only was "a shared religious core" chosen for the top 15, but two other traits directly related to the professed role of the institutional church were prioritized there as well: "A sense of right and wrong" and "Values service to others." Taken together these three traits directly relating to religious beliefs are found in the top dozen of 56 possibles. This is impressive enough to cause us to pause and look closely at the relationship between religious belief and family health. But we have even additional reasons to do so when we add those traits which are implicit to religious ideals and which placed very high on the list: respect, trust, responsibility, and sense of family.

Since healthy families value service to others, physicians have the potential of being good role models here, if that is what they communicate at home about their practice, and if their practice does not keep them away from family to the extent that family members only resent their service to others and perhaps even question their altruism. this is a basic principle of most religions, the principle of AA, and of most people reaching out to their impaired colleagues. Perhaps the message for healthy families is that there appears to be truth in the dictum to "love God with all your heart, soul, and mind and your neighbor as yourself." The important addendum might be not to forget that your closest neighbors are your spouse and children.

Healthy families admit to and seek help with problems. Particularly in medical families it is important to be reminded that healthy families admit, expect, and face problems. They seek to solve problems rather than to avoid them, deny them, or hope they will go away without "our bothering" anyone or being embarrassed by any self-disclosure. Healthy families don't get locked into only one way of responding to all problems whether that one way be denial, anger, chemical dependency, overeating, violence, or withdrawal and isolation.

A Concluding Thought

No one has perfect families. I didn't come from a perfect family; I'm not the husband and father in a perfect family. I haven't used the word perfect, just HEALTHY. If some of the characteristics sounded like perfections, they have been so described only to point the right direction. When you don't know where you are going, it is impossible to get to your destination. These are some directions that we should be aiming if our goal is toward that ever-moving target of healthier families.

[1]Stinnett, N., "In Search of Strong Families." Stinnett, N.; Chesser, B.; and DeFrain, J. (eds.) *Building Family Strengths.* Lincoln: University of Nebraska Press, 1979.

[2]Nicholi, A.M., Jr., *Congressional Record,* May 3, 1983.

[3]Lewis, J., *How's Your Family?* New York: Brunner/Mazel, 1979.

[4]Ammons, P. and Stinnett, N., "The Vital Marriage: A Closer Look." *Family Relations* 29(1980):37-42.

[5]Lauer, J. and Lauer, R. "Marriage Made To Last." *Psychology Today,* June, 1985.

[6]Blumstein, P. and Schwartz, P. *American Couples.* New York: William Morrow and Co., Inc., 1983

[7]Curran, D. *Traits of a Healthy Family.* Minneapolis: Winston Press, 1983.

[8]Mace, D. "Strictly Personal: Expressing Affection in Families." *Marriage and Family Living* 62(1980):2-3.□

How To Select An Effective Office Manager

By Jack Valancy

Communicate what you expect the office manager to accomplish—then give her room to do the job

Every office, from a solo practice to a large group, needs an office manager—someone who keeps the business running smoothly and frees the physicians to practice medicine. Without an office manager, physicians would spend many hours on details, operating their practices below maximum potential.

To get a good office manager, you have to be a good manager yourself. That means defining what you want the office manager to do, granting her the authority she needs to do it, monitoring performance, and, most important, taking corrective action if she performs poorly. (With few exceptions, the people who work in physicians' offices are women. The use of the feminine pronouns is merely a reflection of this situation.)

In a hierarchy, every employee tends to rise to his level of incompetence — Laurence J. Peter

In medical practices, as in other organizations, promotions frequently are based on seniority alone. Whether it's out of loyalty *("She's been with us since the beginning")* or intimidation *("If we don't make her the office manager, she'll be angry or quit")*, physicians are inclined to ignore their misgivings. The promotion usually is accompanied by a hefty raise.

Sometimes this arrangement works well. In other cases, the practice witnesses the Peter Principle in action. Consider, for example, the assistant whose sharp tongue drives away both patients and staff; the bookkeeper so engrossed with the minutiae of record keeping that she fails to see the insurance clerk's mountain of unprocessed claims; or the transcriptionist so easily distracted by her new responsibilities that she can't complete her own work. There are other pitfalls.

An office manager can become intoxicated with her new title, delegating all her work to the staff, or she might become compulsive and try to do everything herself. Although promotion sets her apart, she might try to remain "one of the gang," failing to discipline staffers for the most egregious offenses. She might become a nit-picker, finding fault with the most innocuous behavior; or worse, she could play favorites among the employees.

Failure to act

It's easy to put the wrong person in the office manager's position. You never really know how someone will perform until she is actually on the job. However, failing to remove a person from a position when it's clear that she is not suited for it, is a serious mistake. Physicians who tolerate an ineffective office manager are likely to have a practice in turmoil.

Selecting an office manager

A good office manager has some crucial abilities and characteristics. She communicates clearly (orally and in writing), works well with others, perceives problems and develops solutions, sets and accomplishes goals, and teaches others to perform tasks properly. In addition, a good office manager balances loyalty to the practice with loyalty to herself. Workaholics can be destructive to themselves and their practices. She has an interest in improving her skills through continuing education. Finally, the good office manager displays grace under pressure.

Unless the practice is large, the office manager does not spend all of her time supervising and performing administrative tasks. She is likely to be a working office manager, dividing her time between management and non-management functions. In a practice with two employees, the office manager might spend only a few hours a week "managing." In an office with 10 employees, "managing" could take half of her time.

Promoting a current employee based on merits (rather than seniority) has several advantages. First, you know her personally; you are familiar with her abilities, and the quality of her work. Second, she understands the operations of the practice. Third, such a promotion gives her an opportunity for career growth. Your objective is to promote the person who will serve the practice the best in the future, not to reward someone for past performance in another capacity.

If you decide to look outside of your practice for candidates, be sure to check references carefully. Determine if the applicant has been successful as the office manager of a medical practice. Even if she has an advanced degree and professional affiliations, successful on-the-job experience is the proof of her ability.

Define the nature of the supervision and the authority the office manager will exercise. Make it clear whether she can hire and fire, grant raises, and discipline employees, or just make recommendations.

Resist the temptation to appoint two office managers if there is a deep division between your front- and back-office personnel. A power struggle between them might turn the practice into a battleground. Assign one person to the office

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manager position, and then assign one or more people to supervise certain areas. For example, an office manager with business office skills might supervise, train, assign work, and perform administrative functions for the practice's clerical staff, but handle only administrative functions for the clinical staff. Clinical personnel would receive direct supervision, training, and work assignments from a clinical supervisor (such as a head nurse), who would report to the physician(s) for professional guidance and to the office manager for administrative matters. Define exactly how the office manager and area supervisors will work together. Make sure everyone understands lines of authority and areas of responsibility.

Communicate, preferably in writing, what you expect the office manager to accomplish. Then give her room to do her job. Don't stand over her, but don't give her too much authority, such as allowing her to sign checks.

Monitor her performance by observing the results of her work. Meet with her formally and informally. Really listen to her; her reports should be taken seriously. She should keep you informed, but not burden you with details.

The office manager should have a quiet place to work. She should have use of an office for interviews and other private business conversations.

It is common for the other employees to test a new office manager. They may circumvent her and approach you directly. You must demonstrate that you will not permit her to be undermined. Except for allegations that she is acting unfairly or unethically, employee questions should be referred to the office manager.

Provide guidance to the office manager, bearing in mind that it might take several months for her to feel comfortable in her new position. A modest investment in formal supervisory training for the office manager will help her develop skills for working effectively.□

Consulting
Jack Valancy heads a health care management firm in Cleveland Heights, Ohio.

Reprinted from American Medical News, Nov. 20, 1987

AMA Looks at What Members Want

Marketing activities to help target programs, services...

When Clarence Avery, MD, started his practice in Oakland, California, in 1958, he joined his county and state medical society and the American Medical Association. Along with him, three-quarters of the physicians in the United States were AMA members.

It was his local society—the Alameda-Contra Costa Medical Assn.—that attracted him to organized medicine. "I was drawn to this area by what I read about my county society," he said. And county membership required membership in the California Medical Assn. and the AMA.

That was then.

In 1958, there were 175,730 physicians in an organization founded more than a century earlier " . . . to promote the science and art of medicine and the betterment of public health." The ranks had increased to 276,000, by the end of 1986, maintaining the AMA as the nation's largest medical organization. But other specialty societies—specifically medical specialty societies—have penetrated the AMA's once exclusive preserve, reducing its share of membership, by 1976, to less than half of the total physician population.

Current AMA figures show the AMA's "market share" at about 43.4% of the physician population, despite a record-breaking recruitment effort this year that netted, by the end of September, 12,700 more members than at the same time last year. Nevertheless, while the AMA's overall market share has remained relatively constant during the last few years, AMA leadership is concerned that for every 43,000 members it picks up in a given year, it loses 30,000 members. AMA officials call this the "churn factor"—the ongoing process of acquiring and losing members.

As dues revenues continued to decline relative to non-dues revenues during the past two decades, AMA officials re-asked the question: "Who needs us?"

They now say they have an answer. It follows from an 18-month self-examination, part of which included an admission of past misconceptions about the profession's needs.

The main misconception was that all physicians have a uniform set of needs that can be satisfied by existing AMA activities and services. Dr. Avery, who now practices in San Leandro, said, "Membership services, in my opinion, is what the national organization should be concentrating on." A professor Harvard Medical School, however, wrote an an AMA trustee saying, "The only 'service' I need from the AMA is representation, especially in dealng with the government and insurance sectors."

Now, says Executive Vice President James H. Sammons, MD, the Association has an activity that addresses the differing membership needs of various segments of the medical profession; it will be fully operational by the end of 1988.

That program, developed with The MAC Group, a Cambridge, Mass.-based management consulting firm specializing in marketing strategy, classifies potential members into market segments seeking either broad representation, or medical education and information.

This approach differs from past AMA membership recruitment philosophies, said James W. Coursey, VP for professional relations and membership. He added that it also differed from most other association membership recruitment.

Past approaches, he said, viewed potential members not according to professional needs but rather according to demographics - age, sex, specialty, and location.

Though not yet fleshed out in detail, said James S. Todd, MD, AMA senior deputy executive vice president, the new program is designed to "move the things the AMA does and has available into the mainstream of medicine at a faster rate and a more efficient rate than we have previously been able to do."

But he added that the new "marketing activity" also will include new "product lines in the context that corporate America talks about their products. But our products are not widgets."

Kenneth E. Monroe, appointed July 1 to the new AMA position of assistant executive vice president for marketing, is in charge of implementing the new marketing strategy. He said the MAC group's recommendations have given the AMA an excellent "roadmap" for achieving its marketing goals, and "now we're looking forward to moving ahead."

All AMA products and services "will be thoroughly examined," Monroe said. "This includes tangible products, such as books and conferences; intangible products, such as the development of policy on specific health care issues."

The complete reorientation of the AMA's activities is likely to take several years, Monroe said. He promised, however, that "we will evaluate every existing or newly proposed product or service on the basis of two distinct criteria: whether the product satisfies an identified member need and/or it makes a financial contribution to the Association. This evaluation will result in the dropping of some existing products or ideas and the classification of those that 'pass'

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into 'core' or 'non-core' products and services."

Several other new ideas are being put into effect, Monroe said. One will allow for the first time AMA members in the three market segments "to select from a number of product lines." This will enable physicians to set up tailored membership packages of equal value.

Monroe also explained that very detailed marketing plans will be developed for the individual membership segments. There are plans to develop similar plans for the other "stakeholders" of the AMA, including state and county medical societies, health care providers, the government, the public, and the media.

PHYSICIANS HOWEVER, are the most important target market, he emphasized.

AMA Deputy Executive Vice President Whalen M. Strobhar shares Monroe's views. Lacking in the past, he said, was emphasis on recognizing members' needs and wants and measuring their responses to AMA products and activities. "Although the Association has always had a direction, we needed some way to focus that direction," he said.

"The overall approach in the past has been to promote all we do to all physicians," he said. "There's been no discrimination." But he added, "Just to assume, for example, that everything we do is attractive to all female physicians is not totally correct."

At the core of the AMA's new program, he said, is a new "key objective" for the entire organization.

That objective, as stated in an AMA Board of Trustees report adopted last December, is: "to contribute to the professional and personal development of member physicians and to the betterment of the health of the public by developing and distributing information; by advocating health-related rights, responsibilities, and issues; and by representing the profession as a whole where the image, expertise, and national scope of the AMA prove useful."

Under the new AMA program, Strobhar said, "When individual department heads or unit managers (at the AMA) develop their program budgets, they as much as possible will put themselves into the heads of individual physician members within the various market segments. They will ask not, 'How does this satisfy the traditional thrust of our (departmental) activities?' but rather, 'Does what I have satisfy member needs as identified by market research?'

In trying to satisfy these needs, the MAC Group mailed surveys to 10,000 member and non-member physicians, analyzing the responses of 2,700. They also interviewed AMA trustees, House of Delegates members, AMA managers, and officials of other medical and non-medical associations. In addition, they reviewed AMA internal documents regarding membership activities, services, and products.

Those surveyed were asked to rate, for a total of 100 points, the relative importance of 10 benefits in an "ideal" medical society membership. These included:

- "Represents 'my' position to federal government."
- "Works toward enhancing the public image of physicians."
- "Makes available discounted products and services to members."
- "Provides medical information and education for physicians."

In addition, those surveyed were asked to rate the relative importance of a number of national issues affecting physicians.

MAC consultants used sophisticated techniques of "cluster" and "discriminant" analysis and found that:

- 62% of physicians are interested in broad representation, on issues such as physician liability, quality of physician services, ethics, third-party reimbursement, and standards for medical education.
- 14% of physicians are interested in economic representation, primarily on issues of physician liability, physician autonomy, and third-party reimbursement. Analysts noted that this segment has a higher incidence of male, office-based physicians who are involved in patient care, are surgery specialists, are new in practice, and are already members of the AMA.
- 23% of physicians are interested in medical information and education, which would include general and specialty journals; computerized medical information networks; and scientific conferences, courses, and seminars. In this segment, analysts found a higher proportion of female and hospital-based physicians, administrators, and government employes. Fewer in this segment are AMA members.

Coursey said results of this MAC study would now be used in determining "which of AMA's products

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One More Reason to Join AMA
continued from page 20

and services to keep, which to change, which to eliminate." This is a key feature of the marketing approach, he said.

"When most people mention marketing, they mean advertising—pushing the sales button," Coursey explained. "Marketing is a business philosophy, and it puts the customer—the member in our case—as the central focus."

Coursey said the new approach to membership at the AMA had been "evolving over the years," though the techniques of recruitment are "state-of-the-art."

"Either we're doing it or we've tried it and discarded it," he observed, listing direct-mail, telemarketing, research bases, and peer-to-peer programs as some of the methods the AMA has used in membership recruitment.

"We're extremely optimistic now," he said. "We believe we have an outstanding system in place and we have top management's enthusiastic support."

According to Dr. Sammons, this support will continue. "We've tried it a number of ways in the past," he said. "I think this may be the most efficient and easiest and best way. It's going to take a couple of years to get this fully in place and up and running. But it's going to begin to run very shortly. I think a coordinated activity in a structured formalized marketing sense will produce excellent results."

Dr. Sammons acknowledged past difficulties in recruiting members. "The AMA has had to overcome in recent years the drop-off that we had in membership following the Medicare and Medicaid fights that we had in the early '60s. You have to remember also that the AMA did not have any dues at all until the 1950s."

But, he added, "There are going to be freeloaders no matter what you do. . . . I don't know what's wrong with their educational background. But there's certainly something lacking if they don't understand the need for them to belong in organized medicine."

The new program, he continued, "will go a long way toward solving this problem. We're going to be much more aware of what doctors want from us and we're going to give it to them."□

—Arsenio Oloroso, Jr.

Terminating the Doctor-Patient Relationship

How to have a graceful exit

By Donna M. Moniz, JD

Circumstances arise in the practice of medicine and dentistry in which a doctor no longer wishes to take care of a patient. This can occur for many reasons such as the patient's refusal to cooperate with care, patient's objectionable conduct in the office, or unwillingness to pay bills. It is legally acceptable to terminate the care of such patients as long as certain guidelines are followed.

Generally speaking, doctors are free to choose which patients to treat and which not to treat. However, once a doctor undertakes the treatment of a patient, the doctor may not terminate that relationship arbitrarily without risking a charge of abandonment by the patient. Abandonment occurs when a doctor refuses to treat a patient who is in need of care without adequate notice and without adequate provision for alternative care.

Federal law, which controls Medicare, Medicaid and other federal programs, as well as the law of many states, specifically prohibits discrimination based on race, sex, religion or ethnic origin. Therefore no patient should ever be terminated from treatment or refused care for these reasons. To do otherwise would be illegal under most circumstances and unethical under all circumstances.

1. The first legal requirement for terminating a patient relationship is to give the patient notice, preferably in writing. This notice should either state in a kind way the reason for the termination or state no reason at all. It is not necessary to state a reason. It is necessary to give the patient ample time to locate an alternative doctor. Ideally, the doctor should make recommendations for specific practitioners known to be qualified. In the case of a patient who cannot pay a bill, a referral to a sliding-scale or free clinic would be appropriate. More than one choice should be given to the patient.

2. The second legal requirement is to take care of the patient until the patient has had an opportunity to find alternative care. This length of time will vary depending on the patient's condition, the region, and the other health care providers available. A serious illness which requires a specialist in an area where there are few would require giving the patient more time to obtain alternative care. A patient with routine problems in a big city with plenty of providers would need less notice. Generally anywhere from 5 to 30 days would be appropriate, depending on the situation.

Patients must always have the opportunity to obtain copies of their records so that the subsequent care provider will have full information about their condition and the care they have already received. The letter to the patient could inform the patient of that. For patients who truly cannot pay the copying charge, it would be advisable for the doctor's office to provide the copies anyway. If in spite of the letter a patient should present with an emergency condition and cannot safely wait for alternative care, then the doctor should certainly care for the patient. To do otherwise would seriously risk a malpractice suit.

SUMMARY CHECKLIST WHEN TERMINATING A PATIENT:

- 1. The reason for terminating the patient is a proper one.
- 2. The patient has adequate notice for the termination.
- 3. The patient is informed of alternative sources of care.
- 4. The patient's records are made available to the patient.
- 5. No derogatory comments about the patient are made.□

Donna Moniz is a malpractice defense attorney with the firm Reed, McClure, Moceri, Thonn, and Moriarty in Seattle, Washington.

Reprinted with permission from the Palmer Practice Management Report, *January 1988, Diane Palmer, executive editor.*

SAMPLE DISMISSAL LETTER

Dear _____

Because you have failed to follow my advice and treatment *(list other reasons as deemed appropriate)*, I must now inform you that I am withdrawing from further professional attendance to your medical needs. Since your condition requires further treatment, I urge that you place yourself under the care and treatment of another physician without delay. If you so desire, I shall be available to attend you for up to *(state length of time)*.

This should give you ample time to select a physician of your choice from the many practitioners in this city. With your approval, I will make available to this physician your case history and information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

NOTE:
Your editors have included this sample letter but suggest that you do not use it without the advice of personal legal counsel.

TACOMA-PIERCE COUNTY BAR ASSOCIATION
1988 DOCTOR/LAWYER/DENTIST FIELD DAY

FRIDAY, JUNE 10

SCHEDULE OF EVENTS

GOLF - Tee times are between 11 a.m. and 1:30 p.m. at Tacoma Golf and County Club. Request tee times by contacting Joyce at the Tacoma-Pierce County Bar Association, 383-3432.

TENNIS - 1:15 p.m. to 5 p.m. at the Lakewood Racquet Club.

FUN RUN - A free Fun Run will start at 4 p.m. (location to be determined). Please call Joyce (383-3432) June 8 for location.

DINNER AND COCKTAILS - A no-host cocktail hour will begin at the Country Club at 5:30 p.m., downstairs dining room. A prime rib dinner will follow at approximately 6:45 p.m. The cost is $25.

REGISTRATION FORM

1988 DOCTOR/LAWYER/DENTIST FIELD DAY

JUNE 10

RESERVATIONS WILL BE MADE UPON RECEIPT OF PAYMENT. PLEASE RETURN REGISTRATION FORM/ PAYMENT NO LATER THAN WEDNESDAY, JUNE 8, TO:

Ms. Joyce Feely, Tacoma-Pierce County Bar Association, 930 Tacoma Ave. S., Room 240, Tacoma WA 98405. For information, call 383-3432.

Name_____ _____
(last) (first) (MD/DDS/JD) (day phone)

Address_____ _____
(street) (city/zip) (eve. phone)

_____**Please sign me up for GOLF:**

_____**Tacoma Golf and Country Club member. Enclosed is $3.25.**
_____**Non-member. Enclosed is $35.**
(Golf carts can be reserved for a fee through the TGCC pro shop, 588-0404)

_____**Please sign me up for TENNIS. Enclosed is $10.**

_____**Please sign me up for the FUN RUN (free).**

_____**Please sign me up for the BANQUET. $25 per person.**

$_____**Total enclosed**

NO REFUNDS WILL BE MADE UNLESS CANCELLATIONS ARE DELIVERED TO JOYCE BY 4 P.M.,WEDNESDAY, JUNE 8.

SEE YOU ON THE 10!

Auxiliary News

NEW OFFICERS

At the March 18 meeting the PCMSA Board and the general membership approved the following slate presented by Susie Duffy, Immediate Past President, and nominating committee chair. Medical Auxiliary officers for the coming year are :

President-elect: Alice Wilhyde

1st Vice President, Program: Terri Stewart

2nd Vice President, Membership: Candy Rao

3rd Vice President, Historian/By laws: Debby McAlexander

4th Vice President: Betty Bahn

Recording Secretary: Joanne Iverson

Corresponding Secretary: Nancy Rose

Treasurer: Alice Yea

Due Treasurer: Helen Whitney

Kris White, incoming President, was installed April 21 at the Spring Convention of the Washington State Medical Association held at the Sheraton Tacoma hotel.

MAY MEETING

The Thurston and Mason County auxiliaries will be meeting with us, May 20, for a 10:30 a.m. tour of the Governor's Mansion. Lunch at Carnegie's will follow at noon. But, leave your books at home–for this particular library is now an excellent restaurant. There are many neighboring shops and boutiques to explore, and a public tour of the Capitol Building is also available.

Call Mary Lou Jones (565-3128) for further information. Carpooling information will be in Auxiliary newsletter, *The Pulse*.

Pearle Baskin: A Woman for All Seasons

By Rubye Ward

There are all kinds of benefits from being a member of the Medical Auxiliary. We help to fulfill some very special needs in the community's health services, but we also have an opportunity to form some special friendships. One such friend for me is Pearle Baskin. Pearle was Auxiliary president in 1947-48, though I didn't meet her until fairly recently. When I asked what she considered one of the contributions during her term, she told me that in spite of a great deal of opposition, sex education was introduced into the public schools.

The Baskins came to Tacoma in 1933, and Dr. Lester Baskin was affiliated with Western Clinic until his death in 1978. They both were active in community medical affairs and took leading roles in expanding cultural opportunities in Tacoma. Working closely with Eugene Lynden, conductor of the Seattle Symphony in 1936, they were able to bring fine classical music to Tacoma through the creation of the Tacoma Philharmonic. Because of Pearle's untiring effort on behalf of the arts, a concert was dedicated to her at the Pantages Center for the Performing Arts on April 30, 1983, and a reception was given in her honor.

Pearle and Lester worked with Francis Chubb, a professor at the University of Puget Sound, and architect Charles Rueger to establish the Tacoma Art Museum at the site of the old city jail. The Baskins initiated the opening by inviting people to attend an art lecture given by Chubb. They went to a great deal of effort planning the program, but the only attendees were the Baskins, the Chubbs and Mr. Rueger. It was a complete failure——but their spirits went undaunted. A few years later, Pearle and Lester, with assistance from others interested in the arts, were able to procure a former bank building as a new museum site, and money was raised to remodel the building. One of the museum's galleries is the Baskin Gallery.

Pearle and Lester traveled throughout Europe to add to their art collection. Because of Lester's interest in fine wines, they visited the wine sections of France, and one of their trips took them to the Chateau Mouton Rothschild. (On March 29 of

Continued on page 25

this year, the Tacoma Art Museum exhibited the striking wine labels created by 40 celebrated artists who were paid in wine, not money. Baroness Philippine de Rothschild was present at the preview to greet members of the museum.)

While in France, they met with Chagall at his estate. Modigliani's daughter, Jeanne, corresponded with Pearle for years, and during the last years of Jeanne's life, Pearle sent her money. It was a wry twist of fate that in March of this year, one of Modigliani's last paintings sold for $9 million at an auction of impressionist and modern art.

Jeff Smith, noted author and television personality, met Pearle when they were graduate students at the University of Puget Sound. The Baskins introduced him to his first wine, and in his book, *The Frugal Gourmet Cooks With Wine,* Smith inscribed, "To Pearle Baskin, my first inspiration." In his book, he devoted several pages to his deep and lasting friendship with the Baskins.

In June, 1977, UPS presented Pearle and Lester honorary doctorate degrees for their contributions to the arts. Dr. Esther Wagner of the university said of Pearle: "It is of particular pride and pleasure in this day of careful examination of women's roles in national life, to see her in this place. She has practiced a difficult art — she had a distinguished husband and stood by his side without ever standing in his light; she moved through life with him, but never striding before him nor pattering after him."

Pearle has enriched my life. Our paths might never have crossed had it not been for our mutual involvement in the Medical Auxiliary.

Pearle Baskin with 'Frugal Gourmet' Jeff Smith.

State Meeting Review (See Cover)

Sharon Ann Lawson, wife of Dr. Harry Lawson, was installed as 1988-89 Washington State Medical Association Auxiliary President, April 21, at the Sheraton Tacoma hotel. The installation was held in conjunction with the 57th Annual WSMA Auxiliary House of Delegates Convention in Tacoma, April 20-22. Conducting the installation ceremonies was Mary Strauss, AMA Auxiliary President Elect, who traveled from Hagerstown, Maryland to participate in the activities.

In her "Rings of Success/Partners in Caring" address to the delegates, Sharon Ann highlighted state auxiliary goals for the coming year, emphasizing that Auxiliary and Association are a team that will work with other organiztions to provide accurate information on health care.

In response to the WSMA resolution, passed in September, Auxiliary and Association will establish strategic planning to determine the optimal future relationship of the two organizations. They will also work to expand the medical student mentorship program.

To continue the "Rings of Success" story, state auxiliary will: focus on membership; take leadership training to county auxiliaries; organize a variety of regional meetings to provide opportunity for rap sessions or respond to specific requests for skills-development workshops; encourage attendance at state meetings to gain additional exposure to ideas and program development skills; and facilitate county president-elect participation in national leadership confluence.

The Pierce County Medical Society Auxiliary is very well represented in the leadership of WSMAA. In addition to Sharon Ann, two other PCMSA members are serving as WSMAA officers. Cindy Anderson is in her second term as Vice President. Elected Treasurer was longtime volunteer and past president of PCMSA, Helen Whitney. Helen served as president in 1977-78 and has used her computer knowledge to serve as dues treasurer for the county unit for several years.

Serving again as MedAux News Editor for 1988-89 is PCMSA President-Elect, Alice Wilhyde. Appointed chairwoman of the AMA-ERF drive was Susie Duffy, also a past PCMSA president, 1986-87.

Congratulations and best of luck to all of you!

MEMBERSHIP

MAY READINGS

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

WILLIAM H. BRAY, M.D., Ophthalmology. Born in Roseburg, Oregon, 12/27/54. Medical School, Creighton University, 1981; internship, Sacred Heart Medical Center, Spokane, Internal Medicine, 6/81-6/82; residency, University of Missouri, Ophthalmology, 7/85-6/88. Washington State License, 1982. Dr. Bray will be practicing at 2622 Meridian South, Puyallup.

DEBORAH S. HAMMOND, M.D., Family Practice. Born in Yonkers, New York, 4/28/49. Medical School, University of California, San Diego, 1976; internship, Sunnybrook Hospital, Toronto, 7/76-6/77; residency, Sunnybrook Hospital, 7/77-6/78. Washington State License, 1987. Dr. Hammond is currently practicing at 1213 South 11th Street, Tacoma.

KATHLEEN J. SACCO, M.D., Pathology. Born in Philadelphia, Pennsylvania, 7/19/44. Medical School, Hahnemann University, 1970; internship, Lankenau Hospital, Philadelphia, 7/70-6/71; residency, Saint Joseph Hospital, Chicago, Pathology, 8/76-12/78 and Lutheran General Hospital, Pathology, 1/79-7/80. Washington State License, 1988. Dr. Sacco is currently practicing at St. Joseph Hospital.

Personal Problems of Physicians Committee

For Impaired Physicians

Your colleagues want to help.

Medical Problems, Drugs, Alcohol, Retirement, Emotional Problems

Committee Members

Patrick Donley, Chair	272-2234
Robert A. O'Connell	627-2330
John R. McDonough	572-2424
William A. McPhee	474-0751
Ronald C. Johnson	841-0751
Jack P. Liewer	588-1759
Dennis F. Waldron	272-5127
Mrs. Marie Griffith	588-9371

WSMA: 1-800-552-7236

CLASSIFIEDS

POSITIONS AVAILABLE

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full-/part-time for FP/IM/EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, M.D., at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS. Full-time and part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Any state license. Opportunities including ER in Olympia area. Call NES 1-800-554-4405, ask for Jeanine.

PART-TIME PHYSICIAN NEEDED FOR FAMILY PRACTICE. Wednesday and Thursday weekly and vacation coverage. No hospital coverage, no OB. Send resumes or direct inquiries to: 3733 South Thompson, Tacoma, Washington 98408.

PSYCHIATRIST. 3/4-time position available combining Mental Health Center (one day/week) and model intensive residential treatment program (up to two days per week). Requires Board eligibility and interest in successful programs for the chronically mentally ill. Compensation and benefits to suit. Send resume to: Stephen Burr, V.P., Administrative Officer, Northwest Mental Health Services, 514 Auburn Way North, Auburn, Washington 98002.

FAMILY PRACTICE/OCCUPATIONAL MEDICINE. Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy. Malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and a balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, Washington 98121. (206) 728-6888.

EQUIPMENT

MISCELLANEOUS MEDICAL OFFICE EQUIPMENT for sale, including Mid Mark Power exam table, 867-5415.

LANIER DICTATING AND TRANSCRIBING machine with remote stations. Excellent condition, $1200. Call 1-206-867-5415.

WANTED TO BUY used medical *office equipment. Also used exam* tables. 867-5415.

SERALIZER-blood chemistry equipment - $995.00 (Original price $3500.00). Contact Dr. Rivera 474-3329.

PRACTICES AVAILABLE

PRIMARY CARE PRACTICE $29,500. Office building connected to St. Joseph Hospital. Tacoma - over $30,000 equipment included - view - 4,000 records - 2 offices - 4 exam - lab - x-ray - surgery. 383-5437.

OFFICE SPACE

MEDICAL OFFICES Several locations in Pierce County with terms to suit you. Bruce at Com-Ind 473-0890.

FEDERAL WAY - Established area of medical offices. 1375 sq. ft. $13 per s/f per year, triple net. Call owner, 228-0722.

NEW AND LARGE well-equipped satellite medical office. South Hill of Puyallup. $6.00 per square foot per year. 474-3329.

NEW MEDICAL - DENTAL BUILDING within sight of Tacoma Mall. Up to 2500 sq. ft. available. Reasonable lease. Contact Dr. Bird 475-8934.

ENTIRE MEDICAL OFFICE FOR SALE. 3 exam rooms. Excellent equipment. 867-5415.

GENERAL

EXCELLENT HOME perfect for in-house practice borders Fircrest, with University school district. Custom built contemporary home, over 2,500 sq. ft. plus additional unfinished, zoned SR9. Call Barbara Wasser 759-1117 or 752-4764 Paragon Co.

GENERAL PRACTITIONER experienced in Internal Medicine-Pediatrics. Seeks part-time position. Contact Dr. Washington at 931-4778.

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

GENERAL MEMBERSHIP MEETING

"Access to Care in Pierce County"

A Panel Discussion Moderated by Ronald C. Johnson, M.D.

DATE: Tuesday, May 10, 1988

TIME: 6:00 p.m. No-host cocktails
6:45 p.m. Dinner
7:45 p.m. Program

COST: Dinner, $14.50 per person

LOCATION: Fircrest Golf Club
6520 Regents Blvd.

Register now! Please complete the attached reservation form and return it with a check for the appropriate amount made payable to the Pierce County Medical Society, 705 South 9th Street, Suite 203, Tacoma WA 98405, or you may call the Medical Society office directly at 572-3667 to confirm your attendance.

Reservations must be made no later than Friday, May 6.

REGISTRATION FORM:

Yes, I/we have set aside the evening of May 10 to join my fellow Society members for the presentation on "Access to Care in Pierce County."

Dr._____

Please reserve_____dinner(s) at $14.50 per person (tax and gratuity included)

Enclosed is my check for $_____

RETURN TO PCMS NO LATER THAN FRIDAY, MAY 6
705 S. 9th Street, Suite 203, Tacoma WA 98405

New this year . . .

One more reason to join the AMA

Special benefit packages available with 1988 membership

A diverse membership has diverse needs, and the AMA is committed to addressing those needs. This year we're introducing something new when you join the AMA or renew your membership. In your AMA Membership Kit you'll have the opportunity to sign up for one of three *benefit packages* of publications, conferences, participatory panels, focused issue updates, etc., on topics related to the area you designate. Each package is tailored to address your particular interests:

- *Medical and scientific information and education* designed to enhance your practice, profession, and the public health.
- *Representation concentrated specifically on economic concerns*, such as professional liability and third party reimbursement.
- *Representation on a broad range of issues*, including not only economic concerns, but also quality of care, ethical issues, public health, and scientific issues.

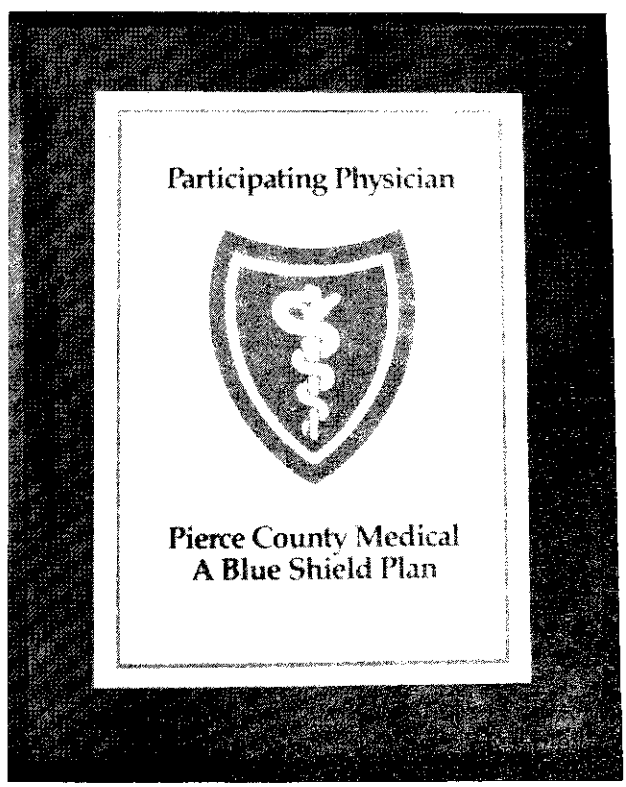
To receive your full range of benefits, select one and only one of these free packages by filling out the business reply card in your AMA Membership Kit.

Please look for the card in your AMA Membership Kit and return it promptly. Your new benefit package is one more way the AMA supports you as a physician.

James H. Sammons, MD
Executive Vice President

American Medical Association 535 North Dearborn Street; Chicago, Illinois 60610

When you hang your shingle, make sure it attracts the most patients.



PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
- ***Retirement Potential***
- ***Post Exchange Privileges***
- ***Insurance Discounts***
- ***Continuing Medical Education****
- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

****All paid for by the U.S. Army Reserve.***

P.O. BOX 38
Madigan Army Medical Center
Tacoma, WA 98431-5038
206-967-5046

Many groups TALK about building a better America-
The Army Reserve WORKS at it.

PEDIATRICS NORTHWEST:

THEY STARTED IN 1981 WITH TWO DOCTORS. AND, BABY, LOOK AT THEM NOW.

Doctors George Tanbara and Larry Larson started Pediatrics Northwest in the Connemara Building at 1811 South K Street.

Today PNW is eight specialists in four locations: Tacoma, Federal Way, Port Orchard and Gig Harbor. From left in the photo are Drs. Richard Ory, Bernard Bader, Larson, Tanbara, John Dimant, Daniel Niebrugge, Jan Gorton and Ross Kendall.

Last year the practice saw 32,000 patients.

How do you measure growth of a business like this?

"Only one way," says Dr. Larson, "our ability to meet the needs of the patients and families we see."

"Our practice demands multi-disciplinary expertise – the ability to manage the tough problems. Each of our doctors is a specialist: whether it be allergy, immunology, heart, stomach, blood, tumors or cystic fibrosis."

Pediatrics Northwest is also one of the few remaining practices anywhere which takes all patients based on their need – not their ability to pay.

"It is part of why people go into medicine," says Dr. Tanbara. "It is the shared philosophy of all the doctors in this practice."

What was PNW looking for in a bank?

"The same thing people look for with us," says Dr. Larson, "the type of treatment that everyone wants, but few get."

"We need a bank that's there when we need them." North Pacific was there. Another bank wasn't. Today North Pacific handles PNW's operating line of credit, corporate relationships and financing of medical equipment.

If you are looking for quality care, here are two numbers to call. Pediatrics Northwest at 383-5777.

And the Business Bank 472-3333.

NORTH PACIFIC BANK
THE BUSINESS BANK

Member FDIC

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 205
Tacoma, Washington 98405

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TACOMA WA 98405

PCMS
NEWSLETTER
A publication of the Pierce County Medical Society

Volume 3, No. 4 June 1988

Fluoride for Tacoma

The Citizens for Better Dental Health Committee is still seeking signatures to have the fluoride issue placed on the November ballot. A petition is included in this issue of the *PCMS Newsletter*. Petitions will be accepted by the county auditor's office for verification through July 1. If you have petitions in your office, please return them to the Medical Society office, 705 South Ninth Street, #203, Tacoma, 98405. If you would like more petitions in order to gather signatures, call the office at 572-3667. All petitions must be returned no later than July 1.

The Committee has been working diligently for this campaign. Fund raising among local physicians and dentists is planned, and efforts are being made to obtain grants from local medical and dental insurance carriers.

Numerous political and community groups are lending support. The broad base of the fluoride issue encompasses not only medical and dental professionals, but parents and senior citizens. Information about the benefits of fluoride is available through the Medical Society.

The Citizens for Better Dental Health Committee is growing as the campaign continues, yet the need for volunteer help will always remain. If you will be able to spend a couple of hours at the Tacoma Mall gathering signatures, work on a telephone tree, or help distribute educational materials, please contact Sue Asher at 572-3667. We welcome and need your help!

Board Adopts Statement on EMS System

The EMS Committee, under the chairmanship of Dr. Robert Wachtel, presented to the Board of Trustees a proposal for the reorganization of the EMS Structure in Pierce County. The Board adopted the recommended proposal at its May 3 meeting.

The statement, which outlines the concepts of an EMS system the Society can support in bringing about change, lists the following components as necessary to reduce the morbidity and mortality in the Pierce County EMS system:

- An EMS agency solely dedicated to administrating a pre-hospital care system should be created. The agency should be directed by a full-time medical program directory (MPD), certified in Emergency Medicine and experienced in pre-hospital care.
- A central dispatching agency should know the location of all available units and dispatch the nearest appropriate unit.
- Patient Care Protocols should be developed and enforced.
- The Base Station system should be expanded to ensure proper medical quality and control. Functions should include on-line medical direction and off-line functions of quality control and data collection.
- Any ALS unit dispatched should have the ability to transport. All agencies must adhere to those medical standards developed and approved by the MPD.
- Patients should only be transported to those facilities capable of providing the level of care necessary to treat the presenting condition.
- Fire districts and provider agencies should be responsible for the operational standards of the EMS system. All operations must conform to the medical standards set forth by the MPD.

Dr. Jackson and the Board of Trustees will work with other agencies and groups to have the proposal implemented as soon as possible. The proposal was developed by a subcommittee of the EMS Committee consisting of Drs. Robert Wachtel, Paul Hildebrand and Ted Walkley.

If you would like a copy of the proposal in its entirety, please call the Medical Society office at 572-3667.

New Look For Newsletter

There's something different about the *PCMS Newsletter*, and we hope you like it. This is the first publication produced on PCMS's new desk-top publishing system. We believe the layout and type is easier to read and generally more pleasing to the eye. As always, we welcome your comments about the *PCMS Newsletter* and *The Bulletin*. After all, these are your publications.

"Access to Care in Pierce County"

Members attending the May 10 General Membership Meeting at the Fircrest Country Club had the opportunity to learn a great deal about the availability of "Access to Care in Pierce County."

Dr. Ron Johnson, Family Physician in Puyallup and medical director of St. Leo's Neighborhood Clinic, moderated a panel discussion featuring providers of care to the poor, uninsured and under insured.

It was noted that there are an estimated 42,000 uninsured in Pierce County, and two-thirds of those people are employed. Medicaid covers less than half of the persons who are eligible at the poverty level (i.e., those making $5,500 per person per year or $12,200 per family of four per year).

Private providers, such as physicians, traditionally supply a large amount of free or partial-pay care, and, as a group, may be meeting 45 to 65 percent of the individual needs of the poor. In 1987, the Community Health Care Delivery System's four clinics provided services to 11,500 different individuals for 38,000 office visits. The Neighborhood Clinic -- a free clinic -- saw 3,300 patients last year.

As a solution to the increasing demand on the system, Dr. Johnson recommended the Medical Society endorse a proposed centralized community based referral program that would benefit providers in several ways:

- Financial eligibility screening and psychiatric screening would be done during the referral effort.
- A rotating system would be established to ensure equitable distribution of low-income patients among providers.
- Providers would have the convenience of communicating with predominately one source of requests for free or partial-pay care.

Subsequently, the benefits to patients would be enhanced:

- As a result of the screening measures, a greater number of physicians would participate in the program, therefore increasing access to care.
- Patients would receive appropriate levels of care before becoming acutely ill.

Participants in the panel discussion were: Linn Larson, MD, Tacoma Family Residency Program; Stuart Freed, MD, Family Practice, Tacoma; Florence Reeves, executive director, Community Health Care Delivery System clinics; and Maureen Howard, director, Martin Luther King Center.

An Equitable Referral System

Access to Care was designated the No. 1 priority at the January planning meeting of the Board of Trustees. One area that provides access for many Medicaid and no-pay patients is the Medical Society's Referral Office.

In 1983, the Board of Trustees adopted a policy stating members who want to be on the Society's referral list must accept Medicaid coupons. Naturally, the greatest demand is for primary care physicians. Since the Board policy was adopted, the list of family physicians, internists, pediatricians and obstetricians has diminished considerably.

When joining the Society, the primary care physician almost always agreed to be on the referral list. Within a few months, however, the physician would be inundated with Medicaid patients and subsequently ask to be removed from the list.

Today, there are 160 primary care physicians on the Society's

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The Pierce County Medical Society is a physician member organization dedicated to promoting the art, science and delivery of medicine and the betterment of the health and medical welfare of the community.

The PCMS Newsletter is published 10 times a year by PCMS Membership Benefits, Inc., for members of the Pierce County Medical Society.

We welcome and invite your letters, comments, ideas and suggestions.

Pierce County Medical Society
705 South 9th St., Suite 203
Tacoma, Wash. 98405
(206) 572-3667

Advertising and newsletter copy must arrive in the Society office by the 15th day of the month preceding the publication date. Advertisements in this newsletter are paid and not necessarily endorsements of services or products.

Continued

rolls. A total of 34 are on the referral list -- ten practice in Puyallup and eight are in Gig Harbor, areas where the demand is considerably less than in Tacoma, where approximately 10 doctors are on the list. The Society has 57 internists, 17 of whom are on the referral list; pediatricians total 35 in the Society, with 13 on the list.

Obstetrics is a major problem. Finding obstetrical care in Pierce County has reached the crisis level. It is not the inability to pay that deprives a patient prenatal care, but the availability of an obstetrician. There are 33 Ob/Gyns in the Society, only two of whom are on our referral list.

The referral desk receives approximately 15 to 20 calls daily. Not all calls are from Medicaid patients. Approximately 20 percent have insurance or the ability to pay.

A new policy is being reviewed by the Board of Trustees whereas a physician may inform the Society office that he/she will accept one or more Medicaid patients a month, or every other month, depending on the physician's comfort level.

The referral system will work on a rotating basis -- a caller will be given the next physician's name and address on the list and told to specify he/she was referred by the Society office when calling for an appointment.

You will soon be recieving a questionnaire regarding the referral system and your participation in it.

DSHS says there are 50,000 eligible Medicaid users in Pierce County, and a monthly average of 14,061 physician services are provided in the county. Please study the referral system, offer your comments and join to give Pierce County an equitable referral system.

Resolutions Due

Resolutions to be offered at the September meeting of the WSMA House of Delegates are to be submitted to WSMA or the Society office by *Friday, July 15*. This is an excellent opportunity to get your message to your colleagues and legislators and to seek change in some facet of the system you would like to see altered.

The Society office can help you finalize a Resolution if you need assistance.

College Of Medical Education Update

Numerous changes in CME activities and requirements have prompted reorganization of the College of Medical Education. Following the August resignation of Maxine Bailey, former executive director, the Medical Society accepted the administration of College affairs. All future CME programs will be coordinated through the C.O.M.E./PCMS office.

The Board developed new Bylaws, which merged the PCMS CME Committee with the Board of Directors. The Board currently has 22 members, comprised of six county hospital representatives, 12 PCMS members appointed by the PCMS Board and three at-large members. The PCMS executive director serves as secretary. Serving on the Board until January 1989 are: David Brown, MD, president; John Lincoln, MD, past president; Mark Craddock, MD, vice president; and Peggy Cannon, treasurer.

Other board members include: Drs. Mian Anwar, Peter Bertozzi, Wes Gradin, John Lenihan, David Munoz, Frank Senecal, Surinderjit Singh, Brett Rath, Alan Tice, Larry Price, Richard Tobin and Amy Yu. Hospital representatives include: Margaret Geering, Humana; Peggy Cannon, Good Samaritan; Sister Anne McNamara, St. Joseph; Robert Scherz, MD, Mary Bridge and Tacoma General; Connie Kirkpatrick, R.N., Puget Sound, and Dr. Stephen Tobias, MD, Lakewood.

The College will continue to be an accrediting body for Category I continuing medical education credits. A survey of the PCMS membership is currently being conducted to obtain information for program scheduling for the 1988-89 program year. At this month's Board meeting, the schedule of programs will be determined based on the information gathered.

If you are interested in the College or would be willing to help administer or participate in CME programs, please call Sue Asher at the Medical Society office, 572-3667.

Malpractice Support Group

When faced with a malpractice suit, the experiences a physician and his or her family, office and friends endure can sometimes be very traumatic.

Talking to others who have also experienced the pain of long drawn out court cases can help. Several Medical Society members have agreed to discuss their experiences with colleagues who are undergoing a first-time malpractice suit.

If you would like to discuss your situation with a colleague, please call Doug Jackman at the Medical Society office, 572-3667. You will be put in contact with a person who knows the problems you are experiencing.

PRO/W Responds To Article

In response to the *AMA & PRO* article that appeared in the April 1988 issue of the *PCMS Newsletter*, John C. Peterson III, M.D., Director of Medical Affairs, Professional Review Organization for Washington writes:

"Your description of communications between AMA and HCFA and OIG officials might have a negative effect on the perception of PRO/W in the eyes of physicians practicing in Washington state. You need to be aware that PRO/W has expended maximum effort, resources and energy to discount the presence of a quota or bounty system as applied to any aspect of the peer review program as it is applied in Washington, Alaska or Idaho. There has not been in the past, nor is there presently, any form of financial or any other sort of recognition of acclaim that is related to any portion of the cost containment or quality assurance activities as applied by PRO/W.

"PRO/W is currently working at a national level with AMPRA, the American Association of Medical Directors and the American College of Quality Assurance and Utilization Review Physicians to establish a uniform physician reviewer training and validation program. This should effectively address the issue of inconsistent physician review decisions in the PRO program. PRO/W has had a training and validation process for its physician reviewers for the past two years.

"Finally, the efforts and input to PRO/W from distinguished caring physicians from all parts of Washington state has allowed PRO/W to be an effective leader among the 46 PROs."

The Editor wishes to thank Dr. Peterson for his comments.

Notable

Singh Again Serves as Examiner

Dr. Surinderjit Singh, Cedar Medical Center, recently served as an examiner for the oral portion of the American Association of Electromyography and Electrodiagnosis examination for active membership. This is the fifth consecutive year that Dr. Singh has been asked to participate in the exam, which was held in Chicago, April 29-30.

Lecture Circuit

Dr. Joe Nichols, Orthopaedic Specialist, has been active on the lecture circuit. Last August, Dr. Nichols spoke on Medicare sanctions and PRO to the Board of Counselors at the American Academy of Orthopaedic Surgeons in Scottsdale, Arizona. He presented the same lecture at the Academy's national conference in Atlanta in February. In addition, Dr. Nichols has been appointed for a three-year term to the committee on health care delivery, American Academy of Orthopaedic Surgeons. Dr. Nichols currently practices at 1901 S. Cedar, Suite 202, Tacoma.

Members Serve at State Level

Drs. Joe Nichols, Ralph Johnson and Leonard Alenick are participants in two new Washington State Medical Association ventures.

Dr. Nichols is serving on the Health Care Quality Assessment Foundation, established to develop and implement methods of measuring and managing quality of care through a collaborative program. WSMA, Puget Sound Health Care Purchasers Association, Washington State Hospital Association and Seattle Area Hospital Council have formed the Foundation. Dr. Nichols is one of two WSMA members on the 11-member Board of Directors.

The WSMA Executive Committee has appointed a task force to continue meeting with representatives of the Medical Disciplinary Board and Department of Licensing to develop memorandum

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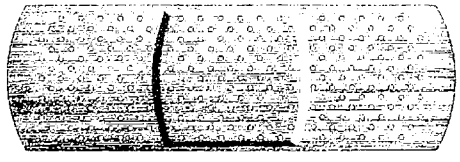
Basic Health Plan of Washington

Listed below are the preliminary benefits for the Basic Health Plan. BHP administration has developed these benefits, which have been mailed to potential managed health care plan bidders statewide. Upon receipt of comments, and a "costing out" of the basic package, BHP administration will issue a formal RFP to potential bidders in July. Operation of the initial test program, at a site to be determined, is anticipated in September.

SERVICE	CO-PAYMENT	LIMITATIONS
1. Physician	Yes, but waived for preventive services (probably $5)	Physician case manager must authorize all services.
2. Hospital	$100-$250/admission for inpatient	Semi-private room; must be preauthorized
3. Maternity	$100-$250/admission for inpatient	Prenatal care covered on enrollment; postpartum care after 6 mos; delivery 1 yr. after enrollment
4. Lab & X-ray	None	None
5. Emergency and out of area	$25-$50, waived if admission	Preauthorization required for all but true emergencies
6. Vision/Hearing	None, part of preventative services	Basic vision/hearing screening only, part of overall preventive exam
7. Ambulance	None	Emergency only, $75 max. per accident
8. Preventive Care	None	Based on industry norms

EXCLUSIONS (NOT all inclusive):
Custodial care, personal or comfort items; ER treatment for non-emergency conditions; experimental services, drugs or devices; non-medically indicated plastic surgery; non-emergency transportation; organ transplants; over-the-counter pharmaceuticals, except if included in formulary; sex transformations; eyeglasses; speech, occupational, physical therapy; durable medical equipment; dental; drugs; mental health and substance abuse.



Continued from Page 4

of agreement on operations and to seek statutory and/or regulatory changes where needed. Drs. Johnson and Alenick will serve on the five-member task force.

PCMS Speakers Active in Community

Several members of the Society's Speaker's Bureau have been speaking out on issues of community concern.

Three PCMS members recently spoke on the AIDS issue: Dr. Brian Berry was a recent guest on KOMO Radio; Dr. Mike Goerss was on KTAC Radio; and Dr. Bob Modarelli spoke to the Lakewood Junior Women's Club.

Editor's Note: *We know there are many other members who speak before groups or appear on television or radio programs. Please notify the Society office so we can recognize your efforts in our publications.*

Meeting Summary

A series of meetings held in April by Dr. William Jackson and Dr. William Ritchie addressed issues of concern to the Pierce County Medical Society.

In an April 7 meeting with Dave Hamry, president and CEO, and Ed Miller, director of physician affairs, Good Samaritan Hospital, discussion focused on physician/hospital relationship, PCM Library, College of Medical Education restructuring and Access to Care issues. Highlights of the meeting included:

- The hospital strives to maintain good working relationships with their physicians.
- Good Samaritan looks forward to working with the new nonprofit Pierce County Medical Library.
- Mrs. Peggy Cannon has been asked to serve as a representative on the College of Medical Education Board.
- The hospital has instituted a mandatory no doc patient program in its emergency room.

An April 14 meeting with Al Allen, MD, MPH, Director, Tacoma-Pierce County Health Department, was held to discuss grand public-health round meetings Dr. Allen's staff conducts at the county's hospitals. Dr. Allen is concerned with getting word to physicians in the county regarding the Health Department's activities and programs.

During an April 15 meeting with Terry Brossett, executive director, Local 123, Service Employees International Union AFL-CIO, PCMS learned the Central Labor Council has formed a Health Care Committee on which the Medical Society will be invited to participate. Other topics of discussion included:

Continued on Page 7

Personal Problems of Physicians Committee

For Impaired Physicians.
Your colleagues want to help.

Medical Problems, Drugs, Alcohol, Retirement, Emotional Problems

Committee Members

Patrick Donley, Chair	272-2234
Robert A. O'Connell	627-2330
John R. McDonough	572-2424
William A. McPhee	474-0751
Ronald C. Johnson	841-4241
Jack P. Liewer	588-1759
Dennis F. Waldron	272-5127
Mrs. Marie Griffith	588-9371

WSMA: 1-800-552-7236

Continued from Page 6

- The Society will be cooperating with the Central Labor Council in organizing various screening programs at the August 21 Solidarity Day activities at Cheney Stadium.
- Medical Society activities related to EMS and fluoridation of Tacoma's water supply were discussed. Brossett is very supportive of the fluoridation efforts and volunteered to have his members gather signatures.

Dr. Jackson and Dr. Ritchie have also met recently with: David Graybill, executive director, Tacoma-Pierce County Chamber of Commerce; Sharon Armstrong, administrator, Humana Hospital; and John Long, president and CEO, and Sister Anne McNamara, St. Joseph Hospital.

Medical Library Restructuring Approved

Reorganization of the Pierce County Medical Library was approved at the June 3 meeting of the Board of Trustees. Incorporation of the library was accomplished by an ad hoc committee chaired by Dr. Bill Dean.

Under the new Bylaws, the Library's Board of Directors will consist of two representatives from the Medical Society, two from Multicare Medical Center and three members at large.

The Library will contract with other hospital libraries for services it has traditionally provided. August 1 is the target date to begin operations under the new organizational structure.

Hazardous Chemicals

As of May 23, physicians having employees who may be exposed to hazardous chemicals must comply with the Occupational Safety and Health Administration's (OSHA) Hazard Communication Standard (HCS).

The HCS has been expanded to cover all employers, including physicians and certain others not previously included under HCS. Now, all employers must prepare a written communication program advising their personnel of chemical hazards that exist in their employment setting. Employers must:

- Keep warning labels on containers.
- Obtain material safety data sheets (MSDS), which must be made available to their personnel.
- Train all employees about their exposure to chemical hazards and proper safeguards.

Drugs in solid, final form for direct administration to patients are excluded by the HCS. Presently, liquid oral and injectable drugs are also excluded pending final determination by OSHA and the Office of Management and Budget (OMB).

The OSHA standard was published in the August 24, 1987 Federal Register (pgs. 31852-31886). Physicians wishing to consult with OSHA about interpretations of the standard should contact the OSHA office in Bellevue at 442-5930.

Personnel Manuals Available

Copies of the *PCMS Personnel Policies* manual are available upon request through the Society office. The manual can be easily adapted to any office.

Having a written policy manual ensures that every employee complies with an employer's established ways of doing business. By explaining personnel procedures in advance, you are telling each staff member what to expect in any given situation.

Areas covered in the PCMS manual include: the employee-employer relationship; compensation and reimbursement; employee leave; employee benefits; termination; and general information and guidelines.

If you would like a copy of the manual, please call the Society office at 572-3667.

Be Smoke Free!

A variety of programs and materials are available locally to those people interested in kicking the habit. Keep these programs in mind if one of your patients would like to quit smoking.

St. Joseph Hospital

St. Joseph Hospital's Smoking Cessation course is taught by a clinical hypnotist with extensive experience in addictive substances. The program uses a wide variety of techniques, including stimulus response, aversion therapy, record keeping, relaxation, exercise, hypnosis and others. For course information and schedules, call St. Joseph Hospital at 591-6709.

American Lung Association

The American Lung Association of Washington offers a variety of options and materials to persons interested in kicking the smoking habit.

- Self-help manuals
- Video cassette programs
- Freedom From Smoking Clinic
- Teen Cessation Program
- "Quit Kits," including information to help your on your way to a smoke-free lifestyle, are available free of charge.

For prices, schedule of courses and additional information, please call the American Lung Association of Washington office in Tacoma at 565-9555; or in Seattle, 441-5100.

American Cancer Society

The American Cancer Society offers self-help materials at no charge. For information, call Susan Richards at 473-1853. Susan also directs smokers to local record/video stores that carry the video "Fresh Start," or, invites them to visit their local American Cancer Society Chapter at 5412 S. Tacoma Way, to view the video.

Tobacco-Free Hospitals

Under the guidance of Chairman Dr. Gordon Klatt, members of the Tobacco Task Force have set January 1, 1990 as the target date to have all Pierce County hospitals tobacco free. Task force members agreed that adoption of a standard policy by all the hospitals would create public-wide acceptance and understanding.

In 1984, the Medical Society led the effort to secure a no-smoking policy in Pierce County public and work places. At that time, the Tacoma City Council was not interested in adopting a smoking policy. Efforts will be made to have a no-smoking policy adopted in all incorporated towns in the county.

June Calendar

June 3	Committee on Aging
June 7	Board of Trustees
June 8	Credentials
June 9	MBI Board of Directors
June 10	Doctor/Lawyer/ Dentist Field Day
June 11	Sound-to-Narrows Run/Walk
June 13	Medical-Legal Committee
June 13	C.O.M.E. Board of Directors
June 15	Public Health/School Health Committee
June 16	Grievance Committee
June 21	Executive Committee
June 22	Tobacco Task Force
June 23	EMS Committee
June 27-28	ACLS Conference
June 30	Fluoride Committee

1989 Directory

We need your help! *The 1989 Pierce County Physicians and Surgeons Directory* is in production and will be ready for distribution in December of this year. You will receive a form sometime in July that will enable you to verify or change information in your listing.

Remember, it is your responsibility to make certain the information provided on the form is correct!

Please return the information to PCMS Membership Benefits by the date indicated on the form.

You will receive your complimentary copy of the 1989 Directory sometime in December. If you would like to buy additional copies, an order form is included on the Directory Form.

New Prenatal Forms Designed

Washington State Physicians Insurance Exchange and Association has designed a new prenatal form to help promote consistency in obstetrical care and to increase the emphasis on dating and genetic issues. Physicians Insurance is offering the form to subscribers at no additional charge. Call or write Physicians Insurance, 1100 United Airlines Building, 2033 Sixth Ave., Seattle 98121-2891, (206) 728-5806.

AMA Update

Legislation

The initial draft of the President's fiscal year (FY) 1989 budget has been prepared. The budget will call for additional cuts in the Medicare program--$550 million in Medicare Part B and $770 million in Medicare Part A--on top of those made in the recent Reconciliation Act.

The draft budget contains a significant increase in funding for AIDS research, with proposed funding between $1.2 and $1.3 billion.

The Budget Reconciliation Bill (P.L. 100-203), passed by Congress and signed by the President in late December, contains more than 100 important health-related

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A MEMBERS-ONLY PROGRAM EXCLUSIVELY FOR PCMS PHYSICIANS

Do you have questions about proper office policies and procedures?
What are the most appropriate ways to deal with staffing problems?

THE MEDICAL OFFICE TODAY: ARE YOUR OFFICE POLICIES PROTECTING YOU?

Wednesday, June 29, 7 a.m.
Doctors' Dining Room, Humana Hospital

PCMS physician members are invited to join Sharon Bain, MBI Placement Coordinator, for an hour of informal discussion over coffee and donuts. There is no charge for the program. Sharon will cover such topics as:

- Establishing written policies for your office (policy manual handout)
- Procedures for screening, hiring and terminating employees
- Performance evaluations
- Employee counseling and discipline
- The importance of documentation

BRING YOUR QUESTIONS, IDEAS AND SUGGESTIONS.

Please return the attached registration form by Friday, June 24, to PCMS Membership Benefits, Inc.

REGISTRATION FORM

_____ Yes, I will attend **The Medical Office Today: Are Your Office Policies Protecting You?**, June 29.

Dr. _____ Office Phone: _____

I am attending the seminar because I would like to know more about: _____

_____

PLEASE RETURN BY FRIDAY, JUNE 24, TO:
PCMS Membership Benefits, Inc., Placement Service
705 S. Ninth Street, Suite 301, Tacoma, Wash. 98405

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provisions. The AMA was successful in lobbying efforts and scaled back the more onerous proposals generated by the various health committees. Significant achievements include: (1)Mandatory assignment, MD DRGs, and a yearlong physician-fee freeze were prevented; (2) The PRO program was amended to allow an Administrative Law Judge hearing prior to an exclusion going into effect; (3) Establishment of a financing mechanism for the vaccine compensation program created by Congress in 1986; (4) Medicare reimbursement changes: A grid system (MEI grid) will be used, awarding larger increases in payment for primary care services. A radiologic fee schedule will be developed and the clinical labs fee schedule will be reduced. In addition, MAACs for all services will impose a flat limit on charges, eliminating the weighted average.

Benefits

The AMA has announced two new members-only benefits. Mortgage Financing, created exclusively for AMA members, offers a fast, easy-to-use and competitively priced option to members looking to buy or refinance a home. Some advantages include: fast approvals (usually within 10 days); a convenient toll-free telephone number staffed by a team of mortgage professionals; financial incentives, including reduction of the origination fee one quarter percent to 1.75 percent; and relaxed underwriting guidelines for those with down payments of 20 percent or more... The second new benefit is the addition of National Car Rental to the AMA Members-Only Car Rental Discount Program.

Membership

AMA membership increased over 1986 in all categories. Year-end dues paying membership was 10,927 members, or 4.5 percent above the 1986 totals. Regular membership totaled 178,376, up 8,235; house staff totaled 38,760, up 1,941; and medical students totaled 36,587, up 751. The AMA achieved 104.1 percent of its 1987 membership goal of 243,800, compared with 103.1 percent of its 1986 goal of 235,600.

Publications

Copies of two publications are now available from the AMA. The 1987 edition of *Physician Characteristics and Distribution in the U.S.* describes present-day and historical information on U.S. physicians such as geographic distribution, national trends and population ratios.

Measuring Medical Practice: Statistics for the Physician, a publication of the AMA's Division of Health Policy and Program Evaluation, is designed to help physicians understand and respond to the increasing variety of statistical reviews of medical practice.

Headlines

Physicians have an ethical obligation to treat patients with HIV infections and to a large extent have lived up to this responsibility, the AMA informed the Presidential Commission on the HIV epidemic on March 17. Several members of the Commission expressed their gratitude to the AMA for its extensive AIDS-related activities and cooperation with the Commission.

The AMA, the American College of Obstetricians and Gynecologists, the National Cancer Institute, and the American Cancer Society recently announced guidelines regarding time intervals between Pap smears. The guidelines, which were developed during the past year and approved by the AMA House at the 1987 Interim Meeting, call for the screening to be performed not less than every three years.

TACOMA-PIERCE COUNTY BAR ASSOCIATION
1988 DOCTOR/LAWYER/DENTIST FIELD DAY

FRIDAY, JUNE 10

SCHEDULE OF EVENTS

GOLF - Tee times are between 11 a.m. and 1:30 p.m. at Tacoma Golf and County Club. Request tee times by contacting Joyce at the Tacoma-Pierce County Bar Association, 383-3432.

TENNIS - 1:15 p.m. to 5 p.m. at the Lakewood Racquet Club.

FUN RUN - A free Fun Run will start at 4 p.m. (location to be determined). Please call Joyce (383-3432) June 8 for location.

DINNER AND COCKTAILS - A no-host cocktail hour will begin at the Country Club at 5:30 p.m., downstairs dining room. A prime rib dinner will follow at approximately 6:45 p.m. The cost is $25.

REGISTRATION FORM

1988 DOCTOR/LAWYER/DENTIST FIELD DAY

JUNE 10

RESERVATIONS WILL BE MADE UPON RECEIPT OF PAYMENT. PLEASE RETURN REGISTRATION FORM/ PAYMENT NO LATER THAN WEDNESDAY, JUNE 8, TO:

Ms. Joyce Feely, Tacoma-Pierce County Bar Association, 930 Tacoma Ave. S., Room 240, Tacoma WA 98405. For information, call 383-3432.

Name_____ _____
(last) (first) (MD/DDS/JD) (day phone)

Address_____ _____
(street) (city/zip) (eve. phone)

_____**Please sign me up for GOLF:**

_____**Tacoma Golf and Country Club member. Enclosed is $3.25.**
_____**Non-member. Enclosed is $35.**
(Golf carts can be reserved for a fee through the TGCC pro shop, 588-0404)

_____**Please sign me up for TENNIS. Enclosed is $10.**

_____**Please sign me up for the FUN RUN (free).**

_____**Please sign me up for the BANQUET. $25 per person.**

$_____**Total enclosed**

NO REFUNDS WILL BE MADE UNLESS CANCELLATIONS ARE DELIVERED TO JOYCE BY 4 P.M.,WEDNESDAY, JUNE 8.

June Readings

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

JOHN J. GALLUCCI, MD, Radiation Oncology. Born in Tacoma, 7/24/34. Medical School, Marquette University, 1959; internship, Madigan Army Medical Center, 7/59-6/60; residency, Oregon Health Sciences University, 7/62-7/66. Washington State License, 1988. Dr. Gallucci is currently practicing with Drs. Gross, Larson, Whitney & Associates.

ROGER B. LEE, MD, Ob/Gyn. Born in Oakland, CA 3/10/41. Medical School, Hahnemann Medical College, 1968; internship, Tripler Army Medical Center, 7/68-6/69; residency, Walter Reed Army Medical Center, Ob/Gyn, 7/69-6/72; graduate training, Walter Reed Army Medical Center, Gynecologic Oncology, 7/78-6/80. Washington State License, 1980. Dr. Lee is currently practicing with the University of Washington Ob/Gyn Department.

CARRIE A. THOMS, MD, General Surgery. Born in Appleton, WI, 9/18/56. Medical School, University of Colorado Health Sciences Center School of Medicine, 1983; internship and residency, Emory University Affiliated Hospital Program, Surgery, 7/83-6/88. Washington State License, 1988. Dr. Thoms is currently practicing with Dr. Ronald Taylor and Dr. Chris Jordan.

New Members

The Board of Trustees has approved the Credentials Committee recommendation that the following applicants be approved for membership into the Pierce County Medical Society:

David Barry, MD, Family Practice, Allenmore Medical Center, Tacoma

Donald DeVries, MD, Internal and Nuclear Medicine, Puyallup

Frank Ditraglia, MD, Rheumatology, Tacoma

Mark Grubb, MD, Pediatrician, Puyallup

Ronald Morris, MD, Family Practice, Puyallup

Michael Olejar, MD, Internal Medicine, Tacoma

Roger Roper, DO, General Practice, Tacoma

Marc Steinmetz, MD, Urgent Care/ Industrial Medicine, Tacoma

Correction Correction Correction

The May *Bulletin* inadvertently printed a photograph of 1986-87 President Dick Bowe on the President's Page. The photograph should have been that of Dr. Bill Jackson.

Editor's Note: *As a result of three errors in three prominent places in the May Bulletin -- (1) Cover: No caption for photograph of WSMAA President Sharon Ann Lawson; (2) Society's name was not changed on cover; and (3) Dr. Jackson's photograph was misplaced -- the editor contracted a severe headache from reading the help-wanted ads!*

PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
- ***Retirement Potential***
- ***Post Exchange Privileges***
- ***Insurance Discounts***
- ***Continuing Medical Education****
- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

****All paid for by the U.S. Army Reserve.***

P.O. BOX 38
Madigan Army Medical Center
Tacoma, WA 98431-5038
206-967-5046

Many groups TALK about building a better America-
The Army Reserve WORKS at it.

CLASSIFIEDS

CLASSIFIED AD RATES: 75 cents per word, 10-word minimum ($7.50). Advertisements must be received no later than the 15th of the month prior to publication. All classified ads require prepayment. Please send all payments to PCMS Membership Benefits, Inc., 705 S. 9th St., Tacoma WA 98405. Call 572-3709 for more information or assistance.

POSITIONS AVAILABLE

PHYSICIAN OPENING Ambulatory care/minor emergency center. Full/part time for FP/IM/EM trained, experienced physician Located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, M.D., at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

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LANIER DICTATING AND TRANSCRIBING machine with remote stations. Excellent condition, $1200. Call 1-206-867-5415.

LET US HELP YOU set up your medical-office practice. We can locate quality used equipment at a reasonable price. Call 867-5415.

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PRIMARY CARE PRACTICE $29,500. Office building connected to St. Joseph Hospital, Tacoma. Over $30,000 equipment included -- view -- 4,000 records -- 2 offices -- 4 exam -- lab -- X-ray -- surgery. 383-5437.

OFFICE SPACE

MEDICAL OFFICES Several locations in Pierce County with terms to suit you. Bruce at Com-Ind, 473-0890.

DELUXE AIR CONDITIONED ground-floor medical office, Lakewood Professional Village, adjoining three physicians in Family Practice, $10 per ft. per year, 581-0660, 582-4511.

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BROWNS POINT-FEDERAL WAY AREA 1250-5000 square feet available. Scenic Puget Sound area, growing suburban community with 35,000 people in a 1-mile radius. No Medical-Dental services available presently. Day Care Center on site. Good family traffic flow. Will provide all architectural, interior design and construction services. For information, call: 839-8001.

GIG HARBOR. SHARE SPACE OR SATELLITE OFFICE 1200 plus sq. ft., 3 exam rooms, X-ray room. Top of Pioneer Hill. Available now. Reasonable. 588-9779.

GENERAL

JEFFREY D. PATTERSON, M.D., Orthopedic Surgeon, is happy to announce the opening of his satellite office located in Lakewood at the Bridgeport 75 Professional Building, 7424 Bridgeport Way W., 584-8802.

MALPRACTICE LITIGATION Pierce County edition (1978-1988) $150. Contact C. Miller at 866-8247, P.O. Box 10010, Olympia, WA 98502.

Congratulations, Graduates!

The Pierce County Medical Society and the Auxiliary wish to recognize members' sons and daughters who are graduating this year. Each of these graduations represents a significant accomplishment and milestone in the student's life. We extend our congratulations and best wishes for the future to each one.

Trevin M. Anderson, son of Ron and Shaaron Anderson, is graduating from Bellarmine High School and is planning to attend the Univ. of Washington in pre-med.

Steven D. Baerg, son of Richard and Judy Baerg, is graduating from Bellarmine and will be going to college.

Sara Benveniste, daughter of Ron and Karen Benveniste, is graduating from Curtis High School and is planning to attend college.

Mark Campbell, son of Mick and Lavonne Campbell, is graduating from Charles Wright Academy and is planning a career in business/advertising.

Pat and Susie Duffy have two graduates in the family: **Jill Kathleen Duffy** is graduating from WSU with a major in Sociology. **Mary Margaret Duffy** is graduating from Sumner High School and is planning on going to WSU.

Kevin Graham, son of Ken and Bev Graham, is graduating from Wilson High School and will be going to college.

Thomas Hill, son of John and Judy Hill, is graduating from Bellarmine and will attend college.

Chad Kornberg, son of Jack and Peggy Kornberg, is graduating from Rogers High School and will be attending college.

Jeffrey Lindblad, son of Randy and Barbara Lindblad, is graduating from the Univ. of Washington with a degree in political science and will be going on to law school.

Robert and Debby McAlexander announce two graduations: **David E. McAlexander** graduated last December from Claremont-McKenna College with degrees in Economics and Accounting. He will attend Naval Aviators OCS in Pensacola, Florida. **James D. McAlexander** will graduate from the California College of Podiatric Medicine. He will be serving a residency at American Lake VA Hospital, Tacoma.

Daniel Murphy, son of Vince and Liz Murphy, is graduating from Western Washington University with a B.S. degree in Industrial Technology.

Peter Ozolin, son of Arthur and Aija Ozolin, is graduating from Bellarmine High School and will be attending college.

Bill Ritchie, son of Bill and Marge Ritchie, is graduating from Curtis High School and will be attending Western Washington Univ.

Kasey Luke Schmidt, son of Jon R. Schmidt, is graduating from Lakes High School and plans on a career in architectural engineering.

Dylan Ward, son of Needham and Diane Ward, is graduating from Bellarmine and will be going on to college.

David Whitney, son of Bob and Helen Whitney, is graduating from Stanford University, where he will be doing graduate work in computer science.

Stefanie Wulfestieg, daughter of Carl and Sue Wulfestieg, is graduating from Stadium High School and is planning to attend Harvard, Princeton or Swarthmore.

Pierce County Medical Society
705 South Ninth Street, Suite 203
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PCMS
NEWSLETTER
♦ A publication of the Pierce County Medical Society ♦

Volume 3, No. 5 July 1988

Mayor Sutherland Says "Yes" on Smoking Proposal

Dr. Bill Jackson, Dr. Bill Ritchie and staff met with Tacoma Mayor Doug Sutherland on June 2 to discuss community and Society concerns. A prominent topic of discussion was Tacoma's lack of no-smoking ordinances in public places or the workplace. In 1984, the county adopted a smoking ordinance at the urging of the Medical Society. The City Council at that time did not wish to consider any smoking legislation.

Mayor Sutherland, an acknowledged ex-pipe smoker, said the situation would be corrected, and he will introduce the ordinance to the City Council after a review by the City Attorney's office.

Other topics discussed were the current EMS system and the Society's concern for continued progress in the area of pre-hospital care; and the Fluoride Initiative, which the Medical and Dental society's are planning to have placed on the November ballot.

Also attending the meeting was Dr. Dan Gallacher, Tacoma dentist, who has been an outstanding volunteer on the Citizens for Better Dental Health Committee since its beginnings two years ago. Dr. Gallacher informed the mayor of the many benefits of fluoride, which the mayor acknowledged. Sutherland added, however, that he believes the populace should have the opportunity to express their wishes on fluoride through the ballot box rather than leave the decision to the City Council.

Drs. Jackson, Ritchie and staff also met early last month with Tacoma councilwoman Karen Vialle, who indicated strong support for the smoking ordinance proposal and the Fluoride Initiative. She is very knowledgeable about the EMS system and supportive of efforts to work with the fire districts toward continued progress and improvements in the system.

PTA, Labor Councils Endorse Fluoride Initiative

After hearing presentations on the benefits of fluoride from Dr. Bill Jackson, PCMS president, and Dr. Dick Sager, Pierce County Dental Society president, the Tacoma PTA Council endorsed the Fluoride Initiative at its June 8 meeting. The council represents all Tacoma schools.

In talking with the group, Drs. Jackson and Sager pointed out that the decayed, missing and filled teeth (DMF) rate for Tacoma was above that for the nation and areas where water supplies are fluoridated. Fircrest, which has had fluoridated water since 1958, showed a 60 percent improvement rate in a study conducted after 10 years of fluoridation.

In a study conducted by the Pierce County Health Council in the mid '70s, administrators, teachers and nurses said dental health was the highest health need among elementary school children.

Thanks go to Mrs. Jeanne Knutzen, president of the PTA Council, for bringing the issue before the council.

Mr. Clyde Hupp, secretary-treasurer, Pierce County Central Labor Council, informed Dr. Jackson that the Labor Council, representing nearly 80 unions and approximately 30,000 union members, has endorsed the Fluoride Initiative.

Petitions, Please!

Calling all petitions!

Please return all Fluoride Initiative petitions -- filled or unfilled -- to the PCMS Membership Benefits Office, 705 S. 9th St., #301, Tacoma, Wash. 98405.

The drive to fluoridate Tacoma's water supply is moving full steam ahead. The Citizens for Better Dental Health Committee has been very active in gathering signatures to put the issue on the ballot this fall. Dr. Terry Torgenrud, committee chairman, reports that several groups have come forward to endorse this very important issue. Most recently, the Pierce County Central Labor Council and the Tacoma PTA joined the list of organizations that support fluoride.

PCMS members have donated $825 to date, and the PCMS Auxiliary has donated $100. Total budget for the campaign is $56,308, of which $28,308 is targeted directly for education. If you have yet to donate to the cause, please send your checks to Citizens for Better Dental Health, 705 S. 9th St., #301, Tacoma, Wash. 98405. Contributions of any amount are greatly appreciated.

Gathering signatures is only the beginning. Volunteers as well as committee members are needed. Please call Sue Asher at the Medical Society office, 572-3666, and join our effort to bring better Dental Health to Tacoma.

Antitrust Immunity for Hospitals and Physicians Ends

The United States Supreme Court, in an opinion announced May 16, 1988, reversed the Ninth Circuit Court of Appeals' decision in Patrick vs. Burget. The opinion severely restricts the availability of the so-called "state action" antitrust immunity for hospitals and physicians conducting peer review. Fortunately, because Congress and the Washington state Legislature have recently taken steps to provide legal protection for physicians and hospitals conducting objective good faith peer review, the Patrick decision should have limited impact.

The Patrick decision arose out of an antitrust lawsuit by Dr. Timothy A. Patrick against Columbia Memorial Hospital in Astoria, Oregon, and various physicians who served on the hospital's peer review committees. Dr. Patrick alleged that the defendant physicians conducted a review of his practice with the specific intent to eliminate him as an economic competitor. A jury agreed and awarded Dr. Patrick damages of $650,000, which was trebled by the trial court as is required by the antitrust laws, as well as $110,000 in compensatory and punitive damages on Dr. Patrick's state law claims. The trial court also awarded Dr. Patrick $228,600 in attorney's fees, for a total judgement in excess of $2 million. The action by the Supreme Court will most likely result in the reinstatement of the award of damages to Dr. Patrick.

The U.S. Supreme Court in the Patrick decision was asked to decide whether peer review activities by hospitals and physicians in the state of Oregon were immune from the federal antitrust laws because of the so-called "state action doctrine." The state action doctrine immunizes certain anticompetitive acts of private parties when the challenged activity is "one clearly articulated and affirmatively expressed as state policy and the anticompetitive conduct is "actively supervised by the state itself." The Supreme Court in Patrick ruled that the Oregon statutes and regulations dealing with peer review did not provide sufficient "supervision" of peer review activities, as no state agency had the authority to review decisions of peer review committees and to disapprove those that failed to meet state policy.

Washington state law likewise requires hospitals to conduct peer review. State law, codified in Revised Code of Washington chapter 70.41, requires hospitals to establish programs to identify and prevent medical malpractice and to gather and verify information about physicians prior to granting them clinical privileges. The Washington state statutory scheme, like the Oregon state laws reviewed in Patrick, does not empower a state agency to review and disapprove hospital peer review decisions. Washington state law does not appear to provide sufficient "supervision" to meet the Supreme Court's test. It is therefore unlikely that hospitals and physicians will be able to avail themselves of "state action" immunity from the federal antitrust laws under the current Washington state statutory scheme. Fortunately, after the events that gave rise to Dr. Patrick's claim, Congress passed the Health Care Quality Improvement Act of 1986, which provides broad protection from both federal antitrust laws and state law for physicians and hospitals engaged in objective good faith peer review. These protections became available to Washington state hospitals and physicians on July 26, 1987, the effective date of Revised Code of Washington chapter 7.71.

"Fortunately, after the events that gave rise to Dr. Patrick's claim, Congress passed the Health Care Quality Improvement Act of 1986, which provides broad protection from both federal antitrust laws and state law for physicians and hospitals engaged in objective good faith peer review."

RCW 7.71 also restricts peer-review liability under state law. Previously, a physician who was adversely affected by a peer review decision could sue under the state Consumer Protection Act, which contains provisions similar to the federal antitrust laws. If successful, the physician could recover actual pecuniary damages, treble damages up to $10,000, plus attorney fees. RCW 7.71 now limits the amount and type of damages recoverable by a physician who is adversely affected by a peer review decision "that is found to be based on matters not related to the competence or professional conduct of a health care provider."

To avail themselves of the protection of the Health Care Quality Improvement Act of 1986, physicians and hospitals must ensure that the hospital's policies and procedures relating to review of credentials and privileges meet the requirements of the Act. For example, the physicians who conduct the actual fact-finding hearing involving the denial or restriction of a physician's clinical privileges must not be "in direct economic competition

Continued on page 3

The Pierce County Medical Society is a physician member organization dedicated to promoting the art, science and delivery of medicine and the betterment of the health and medical welfare of the community.

The PCMS Newsletter is published eight times a year by PCMS Membership Benefits, Inc., for members of the Pierce County Medical Society.

We welcome and invite your letters, comments, ideas and suggestions.

Pierce County Medical Society
705 South 9th St., Suite 203
Tacoma, Wash. 98405
(206) 572-3667

Advertising and newsletter copy must arrive in the Society office by the 15th day of the month preceding the publication date. Advertisements in this newsletter are paid and not necessarily endorsements of services or products.

Antitrust *(Cont. from page 2)*

with the physician involved." The Act also establishes certain procedural requirements for the conduct of the hearing and imposes detailed requirements for the reporting of malpractice payments and peer review actions.

If you have questions regarding the Patrick decision or the Health Care Quality Improvement Act, please contact Jeff Smith (attorney for PCMS), Chris Marsh, Pam Okano or Mary Petersen at Reed McClure Moceri Thonn & Moriarty.

This article was published in the *Health Care and the Law Newsletter*

Call for Surveys

A letter and survey regarding uncompensated care were recently distributed to members by PCMS President Dr. Bill Jackson, who reports numerous responses have been received by the Society office. "I'd like to thank everyone who participated in this information-gathering exercise," he said. "Your time and thought in completing the survey is much appreciated." Dr. Jackson added that results of the survey will be shared with members at a future date.

If you have not yet completed and returned your survey to the PCMS office, please do so as soon as possible. Thank you for your cooperation.

COME Administrator Joins PCMS

The Medical Society welcomes Les McCallum, new program administrator for the College of Medical Education. The new position is part of the college's reorganization.

Les's duties include assisting individual program directors in the coordination of COME courses. He will be working part time, replacing Maxine Bailey, COME's former executive director.

Les, 43, is a life-long Pierce County resident, with the exception of time spent obtaining his masters degree in Public Administration from the University of Southern California and a BA from the University of Redlands (California). A former college administrator, he previously served as the dean of Student Services at Pierce College.

The Medical Society recently accepted the administration of the college's affairs, including the adoption of new bylaws. Les will coordinate activities of COME from the PCMS office.

Les expressed excitement at becoming associated with the college and looks forward to assisting with COME's development of quality and timely programs for Medical Society members and other health professionals.

Election '88 -- Here's What You Can Do!

The general election will be held November 8, at which time we will be electing county councilmen, legislators, congressmen and a president. All of these key players will be making important decisions on health care that can affect you.

You can play an important role in this election by working for the candidates that will support what is best for your patients.

Get involved! All persons running for public office need help, be it through volunteer or financial contributions. People who help in campaigns have the opportunity to get to know the candidates and develop a rapport that increases their access to them when an important vote comes up. It doesn't mean that the legislator will owe you a vote, but you'll have his ear.

Volunteer to help a candidate this election. You will find it a fascinating, exciting and enjoyable process.

Hospice Benefits Under Medicare

By Joan H. Sells
Director of Communications
Associated Health Services

Since November 1983, the Medicare (Part A) hospital insurance program has included hospice care as a benefit. This means that people who have less than six months to live can receive a full scope of medical and home-support services for their terminal condition with no out-of-pocket costs.

Surprisingly, many physicians and their patients are not aware of this benefit. Of the 1,900 hospices in the country, only 404 are Medicare-certified and able to offer complete and comprehensive benefits.

Under Medicare, the hospice benefit is primarily a comprehensive home-care program that provides all reasonable and necessary medical and support services for the management of terminal illness, including pain control. Covered services include physician services under Part B, nursing care (following the attending physician's plan of treatment); medical equipment and supplies; prescription medications (for symptom management and pain relief); home health aide and homemaker services; physical, occupational and speech therapies; medical social services; and grief counseling.

When a patient receives these services from a Medicare-certified hospice, such as Hospice of Tacoma, Medicare pays almost the entire cost. A 5 percent co-pay on respite and prescription medications may be waived by the agency. As a cost-contained program, the provider cannot inflate the cost regardless of the amount of services. This is the introduction of a prospective payment system into home care. The accountability for cost, effective and efficient services, and quality of care is on the shoulders of the hospice agency.

According to Joey Hood, chief operations officer, Hospice of Tacoma, "It is a benefit that was taken away when the hospital DRGs were introduced and the home health-care regulations became more restricted, resulting in less care for the hospice patient."

When hospice care is mutually elected by the physician and patient, it allows both parties to be in control and focuses case-management responsibility on the hospice agency. This allows physician and patient to access all services through a single entry point.

"This consolidation of services is a tremendous time saver for the physician," said Dawn R. Rex, RN and hospice manager, Hospice of Tacoma. "Now, when we are given admitting standing orders, the patients can call us 24 hours a day, seven days a week for answers to their questions in non-emergency situations. In addition, we obtain equipment and prescriptions for them, thereby minimizing confusion and saving time."

Inpatient hospitalization for uncontrollable acute medical crises is also covered without a deductible, as is continuous coverage of skilled nursing care for up to 72 hours in lieu of hospitalization. Respite care also is provided for up to five days in an extended-care facility.

The Medicare hospice program is strengthened by the medical director's role. He or she provides program direction and supervision as well as ongoing quality control through biweekly conferences.

"Our hospice medical director, Dr. Stuart Farber, provides a physician's perspective and necessary support to the interdisciplinary team," Rex said.

Patients who are eligible for the hospice benefit under Medicare are those who require palliative rather than curative treatment, are within six months of death, have an accessible caregiver and are eligible for Medicare (Part A).

For more information about the hospice Medicare benefits, call Dawn Rex at Hospice of Tacoma, 383-1818, or refer to Social Security publication No. HFCA 02154.

Residential Alternatives for Seniors

Most doctors have patients who ask: "How do I care for an aging relative?" "Do we need a nursing home?" "Are there other alternatives?" "How can we afford good care?" "Are there any local facilities you could recommend?"

Fortunately, with some advanced planning, older people can now face the future with a variety of options and not become a burden to their children. While most people are aware of nursing homes as a long-term options, many do not realize that alternatives do exist. Some examples include:

Board and Care Homes, also known as congregate care or domiciliary housing. These facilities provide lodging, three meals a day and at least some assistance with personal care, such as dressing, arranging transportation and taking medication.

Retirement Homes. Like board and care homes, these are geared to independent older people in reasonably good health. They may be distinguished from board and care facilities by an entrance fee charged in addition to monthly rent, and less than full meal service. Popular variations include apartment high-rises in urban centers and retirement villages in remote areas.

(The chief advantage of the two aforementioned options is that they provide carefree living, with housekeeping and maintenance the responsibility of someone else. Another attraction is the potential for an active social life. Most complexes emphasize physical security, relieving residents from worries about crime.)

Low-Income Housing. These units are constructed by private developers using public funds or grants from federally sponsored housing programs. Prospective residents must meet a minimum age requirement, usually 62, and their incomes cannot exceed a stipulated maximum. Many of these buildings are situated in pleasant surroundings with security and some amenities. In fact, some retirement homes set aside a specified number of units qualifying under a low-income program.

Life Care Communities. These facilities provide living units and specified health care coverage for life in exchange for a sizeable entry fee and monthly charges. The advantage of life care is the combination of independent living with the security of knowing that nursing care is available at little or no extra cost.

Adult Day Centers. These facilities are an excellent option for elderly people who do not require round-the-clock attention and prefer to remain at home, but cannot manage their health and personal needs on their own. Day centers offer a variety of services including medication monitoring, grooming assistance, physical therapy, recreational and social activities, and one or more hot meals per day.

Home Health Care. This is a catchall phrase for services provided to seniors who wish to remain at home but who need assistance caring for themselves. Utilized on either a full-time or temporary basis, these services include: skilled nursing care; physical, speech and occupational therapy; grooming assistance; medication monitoring; meal preparation; and housekeeping.

These six options are only a few of the growing number of residential alternatives available to seniors today. Others not covered here include respite and hospice care, adult family homes, homesharing and integrated care communities, as well as nursing homes. It should be noted that the most desirable of these facilities have long waiting lists and substantial monetary requirements. With some careful planning, however, your patients can prepare for the challenge of selecting an attractive long-term residential option that best meets their needs.

This article was adapted from The Golden Horizons Retirement Guide: Washington State Edition, by Nanci Richards and Betsy Schneier. According to the authors, the guide is the only comprehensive resource combining explanatory text with a directory of facilities throughout Washington State. The book is priced at $18.95 and can be purchased at your local bookstore or by ordering from the authors at (206) 525-8160.

History and Physical Criteria

When patients are admitted to a convalescent or nursing facility, federal and state law requires that the attending physician complete, sign and date a current History and Physical. In order to be current, a H&P must be completed no earlier than five days prior to admission and no later than 48 hours after admission. A hospital H&P can be used if it is updated to reflect the status of the resident at the time of admission and signed and dated within the aforementioned time parameters.

A hospital progress note, signed by the attending physician, may serve as a H&P if the current status of the resident is reflected and the note is dated within the specified time guidelines.

A transfer summary, which must include all of the patient's current medications and treatments applicable at the time of admission, is also required.

Residents who are admitted from home must be seen by a physician prior to admission to obtain an order to admit and determine the resident's plan of care after admission to the facility. A H&P form, to be completed within the specified time parameters, is required, as is an admission physician's order sheet which must be completed, dated and returned to the facility on the day of admission.

Thank you for your cooperation.

News From WSMA

Student-Physician Mentor Program

Think back to the days you spent as a medical student. Did you benefit, or would you have benefited, from a close relationship with a practicing physician and his or her family? Now you have the opportunity to befriend a future physician and his or her family.

Recruitment is underway for physician families who are willing to serve as mentors to medical students and their families. The newly created "mentor program," conducted by the WSMA and WSMA Auxiliary, matches medical students with established physicians and their families. The next set of matches will take place October, soon after the school year begins.

The WSMA/WSMAA Student-Physician Mentor pilot program, conducted in April in King County, was a huge success. Fifty-three King County physician families participated and were matched to 76 students. It is hoped the mentor program will develop friendships and give future physicians a perspective of the medical profession not provided in the classroom.

Physician families offer students support, encouragement, council and advice. They serve as very special role models for students as they progress towards a medical career. Physicians are matched as students by medical specialty and, when requested, by other interests and hobbies.

Many medical students are enthusiastic about establishing a relationship with a physician family and are currently on a waiting list for the October program. With 150 new students planning to enter the University of Washington in the fall, there is a great need to start identifying prospective members now. The ideal goal would be to identify one student for each physician mentor. More information can be obtained by calling David L. Chivers, WSMA staff, at 441-9762 or 1-800-552-0612, or Ze Gerber, Mentor Program chair, at 454-5667.

Medical Student Governing Council

The five-position WSMA Medical Student Governing Council provides a liaison between the WSMA and the University of Washington medical-student body. The Governing Council sponsors "skills without stress" practice seminars that teach practice skills such as IM and subcutaneous injections and insertion of nasogastric tubes. The seminars have the approval of the school of medicine's administration and are well accepted by first- and second-year medical students.

WSMA-MSGC is in the process of planning Glaxo workshops to help students choose a specialty.

Two members of the WSMA-MSGC are designated delegate and alternate delegate to the WSMA House of Delegates. An additional student sits on the WSMA Board of Trustees. Students also serve as delegate and alternate delegate to the AMA Medical Student Section. These meetings are held twice a year in conjunction with the AMA Annual and Interim meetings. Sixteen medical students have been enthusiastic participants on WSMA councils and committees.

The WSMA is dedicated to increasing the strength of medical students in the activities and programs of the WSMA. The WSMA recognizes that the future of medicine lies in the hands of medical students, residents and young physicians and is committed to involving them as members as early as possible in their medical careers.

AMA Update

Policy Developments

The AMA will ask the nation's next president to create a Medicare Commission just as soon as he gets settled into office, according to Dr. James Sammons, AMA executive vice president. Sammons, speaking before representatives of the national news media, said the AMA will suggest that the proposed national commission function like the Social Security commission does in addressing Social Security Problems.

HCFA has reported that physicians have continued to accept Medicare assignment at record levels during the final quarter of 1987. It said the overall rate for accepting rose to 70.8 percent, 7.6 percent above the level attained for the comparable quarter only one year earlier.

Survey Results

Results from an annual physician opinion survey conducted by AMA's Issue and Communications Research area reveal that 78 percent of U.S. physicians favored withdrawing life support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it. Only 15 percent opposed withdrawing life support systems. These data closely mirror results of an AMA 1986 public opinion survey which reported 73 percent of the public favored withdrawal of life support and 15 percent opposed it. In addition, 67 percent of the physicians surveyed said they had been directly involved in treating a patient where the issue of the refusal or withdrawal of life-sustaining treatment arose, while

Continued on page 7

AMA *(Cont. from page 4)*

32 percent had not. Although a majority of physicians reported experience with refusal or withdrawal of life support, 54 percent of those surveyed were uncertain of their legal risks and responsiblities surrounding decisions to withdraw life-sustaining treatment. Forty-three percent were certain.

Head Start/ECEAP Requirements

This summer, more than 1,500 4-year-old children in Pierce County will be visiting their medical provider for a Head Start/Early Childhood Education Assistance Program (ECEAP) physical examination. Head Start Federal Performance Standards and ECEAP State Program Performance Standards require that all children enrolled in these programs have a hematocrit within six months of enrollment. ECEAP and some Head Start programs also require a tuberculin test within two years of enrollment.

It would be most helpful if you make sure all children coming to you for Head Start/ECEAP physical exams complete these requirements. This will enable the health team to do more timely follow up (all children with hematocrits below 34 receive nutritional counseling) and can save you and the family the time required to complete the tests on a return visit.

Living Wills Available

Maintaining a terminally ill patient's dignity without prolonging unnecessary suffering is one of the greatest legal and ethical challenges facing modern medicine today.

A living will responds to this dilemma by allowing individuals to express their desire to forego technical heroics should a terminal condition develop with no reasonable hope of recovery. Not only does such a document expedite a patient's wishes, it closes the matter to speculation, making the choice to maintain life-sustaining treatment in a terminal condition far less difficult for family members.

"Members of the American Association for Retired Persons expressed to the PCMS Committee on Aging that placing living wills in doctors' offices would be most helpful to senior citizens."

Members of the American Association for Retired Persons expressed to the PCMS Committee on Aging that placing living wills in doctors' offices would be most helpful to senior citizens.

Copies of a living will are available through the Medical Society office. Please call 572-3667.

Personal Problems of Physicians Committee

For Impaired Physicians.
Your colleagues want to help.

Medical Problems, Drugs,
Alcohol, Retirement,
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Ronald C. Johnson	841-4241
Jack P. Liewer	588-1759
Kathleen Sacco	591-6681
Dennis F. Waldron	272-5127
Mrs. Jo Roller	752-6825

WSMA: 1-800-552-7236

A Run in the Sun

PCMS members and their families were among the nearly 10,000 participants in the 1988 Sound to Narrows Race, Saturday, June 11. Sunny skies and 60-degree temperatures made it a perfect day for a run -- or stroll -- through Pt. Defiance Park.

Congratulations go to **Dr. Ronald Taylor**, who finished first in the age 45-50 division and 65th overall with a time of 43:28. Also among the 200 fastest runners were **Dr. Thomas Herron**, the 87th runner to cross the finish line, and his wife **Verna Herron**, who placed eighth in the women's age 30-34 division and 45th among the women participants. **Jennifer Blackburn**, daughter of Dr. Michael Blackburn, finished fourth in the age 14-18 division and and was the 71st woman to finish.

Also among the 12K finishers were:

Dr. Gerald Ames
Judy Baerg
Dr. John Bargren
Dr. Richard Bowe
Dr. Mark Craddock
Dr. James Foss
Dr. Kenneth D. Graham
Janet Halstead
Dr. Peggy Hosford
Dr. Sam Insalaco
Dr. James Komorous
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Janet M. Torgenrud
Dr. Terry Torgenrud
Kara Wulfestieg
Susan Wulfestieg

Solidarity Day

The Medical Society is working closely with the Pierce County Central Labor Council in organizing various screening programs for the August 21 Solidarity Day activities at Cheney Stadium. A sell-out crowd of 10,000 people will be attending the Tacoma Tiger's baseball game that day, and many will be interested in participating in the health screenings.

There is still time to sign up if you'd like to take part in the screening activities, which will be held from 11 a.m. to 2 p.m. At press time, the following health organizations had signed up to participate:

American Heart Association
American Lung Association
March of Dimes
Muscular Dystrophy Association
Multiple Sclerosis Society
Pierce County AIDS Foundation
Planned Parenthood
Poison Center

If you are interested in participating in this worthwhile event, please call the Medical Society office at 572-3667.

New Member

The Pierce County Medical Society welcomes new member **William H. Nicolaus, MD,** Anesthesiology, Puget Sound Hospital. Dr. Nicolaus was inadvertently excluded from the new-member listing in the June *PCMS Newsletter.*

July Readings

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

KIRK T. HARMON, MD, Internal Medicine. Born in Newton, MA, 8/20/58. Medical School, Cornell Medical College, 1984; internship and residency, University of Alabama, 7/84-6/85 and 7/85-6/87. Washington State License, 1988. Dr. Harmon will be practicing with Western Clinic.

THEODORE S. PABST, III, MD, General and Peripheral Vascular Surgery. Born in Chicago, IL, 10/11/54. Medical School, Northwestern University Medical School, 1980; internship and residency, University of Illinois, General Surgey, 7/80-6/81 and 7/81-6/86; fellowship, University of Arizona Health Sciences Center, Vascular Surgery, 7/86-6/88. Washington State License, pending. Dr. Pabst will be practicing with Dr. Robert Osborne Jr.

Telephone Dos and Don'ts

There's nothing nicer, when calling an office, than to be answered by a pleasant, efficient receptionist. So very important is the receptionist, for she is the one who most often gives the first impression of the office! Her telephone skills have great impact on creating the office image. Very often there is only one chance to make a good first impression.

What are some ways we can improve our "telephone personality?" Here are some "dos" and "don'ts."

DO:

1. Personalize the conversation as much as possible.
   - Use the person's name.
   - Mention something that indicates you know the person.
   - Identify yourself.
2. Both answering and ending the call are important in telephone etiquette.
   - Answering: First impressions are formed within the first few seconds. What impression do you wish to create?
   - Contrast: "Good morning, Dr. Moore's office. This is Mary Jane speaking," with "Doctor's office, hold."
3. If in doubt, double check any information that is important.

"Would you repeat that for me, please?" rather than, "What did you say?"

4. Take charge of as many calls as possible. Try to expand the areas in which you can assume responsibility. This will save paperwork, time and callbacks.

DON'T:

1. Overstep your bounds. Be sure you know the areas you have the authority to deal with and those which are not within your jurisdiction (reducing fee? recommendations of a medial/dental nature?) ("I will discuss your situation with Dr. Harry and will call you back this afternoon before 5 p.m. Where can I reach you?")

Continued on page 10

CLASSIFIEDS

CLASSIFIED AD RATES: 75 cents per word, 10-word minimum ($7.50). Advertisements must be received no later than the 15th of the month prior to publication. All classified ads require prepayment. Please send all payments to PCMS Membership Benefits, Inc., 705 S. 9th St., Tacoma, WA 98405. Call 572-3709 for information or assistance.

POSITIONS AVAILABLE

PHYSICIAN OPENING Ambulatory care/minor emergency center. Full/part time for FP/IM/EM trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, MD, at 5900 100th Street Southwest, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS Full-time and part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Any state license. Opportunities include ER in Olympia area. Call NES, 1-800-554-4405, ask for Jeanine.

FAMILY PRACTICE/ OCCUPATIONAL MEDICINE Full-time and part-time positions to staff ambulatory care facilities in the beautiful Northwest. Company has extensive network of rapidly growing medical centers, including physical therapy. Malpractice, health insurance, vacation and CME benefits. Opportunity for regular hours, light call and balanced professional and personal lifestyle. Competitive salary base plus incentive. Send CV to Deborah Phillips, Chec Medical Centers, 2200 6th Avenue, #225, Seattle, WA 98121. (206) 728-6888.

EQUIPMENT

MEDICAL EQUIPMENT for sale. Large selection, excellent prices, top condition. Call Linda, 867-5415.

APPRAISAL SERVICE for medical equipment. 867-5415.

ANTIQUE EXAM ROOM furniture. 867-5415.

SERALIZER blood chemistry equipment, $995 (original price, $3,500). Contact Dr. Rivera at 474-3329.

OFFICE SPACE

NEW AND LARGE well-equipped satellite medical office. South Hill of Puyallup. $6 per square foot per year. 474-3329.

BROWNS POINT-FEDERAL WAY AREA 1250-5000 square feet available. Scenic Puget Sound area, growing suburban community with 35,000 people in a 1-mile radius. No Medical-Dental services available presently. Day Care Center on site. Good family traffic flow. Will provide all architectural, interior design and construction services. For information, call: 839-8001.

GIG HARBOR. Share space or satellite office. 1200 plus sq. ft., 3 exam rooms, X-ray room. Top of Pioneer Hill. Available now. Reasonable. 588-9779.

ATTRACTIVE MEDICAL OFFICE SPACE available for rent on main arterial in Federal Way. Ideal for FP or medical specialty. 560 sq. ft. including 2 exam rooms, private office, work room, rest room. Also, shared business office space, in-office lab and spacious waiting room with established, board-certified Family Practitioner. Dentist and Optometrist in same building. Ample parking. Convenient to transportation, pharmacies and new hospital. Reasonable lease. Contact Dr. Kohler, 839-3480 or 927-3477.

JACKSON HALL MEDICAL CENTER, across from Tacoma General Hospital. Deluxe office space on top floor, recently redecorated. Windows on all sides, with water view. 1670 sq. ft. Available July 1. For information, call 627-1922.

DELUXE AIR CONDITIONED ground-floor medical office, Lakewood Professional Village, adjoining three physicians in Family Practice, $10 per ft. per year, 581-0660, 582-4511.

GENERAL

MALPRACTICE LITIGATION Pierce County edition (1978-1988) $150. Contact C. Miller at 866-8247, P.O. Box 10010, Olympia, WA 98502.

120-FT., LOW-BANK WATERFRONT HOME on Allen Point in Gig Harbor. Breathtaking, peaceful and exclusive. Spectacular Olympic mountains as backdrop. 3600 sq. ft., classic open concept, custom quality living. Four bedrooms, 20x34 master suite. Large passive solar family room. Much, much more. Pea Gravel Beach with oysters, clams and tidelands. $425,000. Contact Steve Peacock at Purdy Realty, 383-2404, or 1-851-9320 evenings.

Telephone *(Cont. from pg. 9)*

2. Argue or threaten. Anticipate calls that might be difficult to deal with, and work out ways to respond that will project an air of professionalism. ("I can appreciate how you feel.")
3. Breach the confidentiality rules. ("Please send your request in writing with a signed patient authorization form to release the information.")
4. Speak so loudly that patients in the reception area overhear the conversation.
5. "Yell" at other staff members to pick up a line until you put the caller on hold.
6. Take inaccurate or "sketchy" memos. Save time and money by taking complete information the first time. (Obtain caller's full name; check spelling of difficult names. Get telephone number and at what time caller can be reached. Include a brief description of the reason for the callback.)
7. Be a "CIA Agent" by asking needless questions. Become familiar with the doctor's frequent callers so you handle them appropriately.
8. Expect the caller to be articulate and gracious. You are the role model.
9. Take personal calls at work, unless urgent. Professionals handle personal calls during nonworking hours.

Excerpts reprinted with permission from the Palmer Practice Management Report, April 1988, Diane Palmer, executive editor.

PCMS Mailing Labels

Need to notify the medical community of changes in your practice? Adding a new physician to your group? Moving or retiring? Offering a new service of interest to other physicians? If so, contact the Society office for a current PCMS mailing list or labels, available to members for $25.

Our office staff is also available to stuff and label your bulk mailing and deliver it to the post office for a $55 fee, plus postage.

Let us know if we can be of assistance.

1989 Directory

We need your help! *The 1989 Pierce County Physicians and Surgeons Directory* is in production and will be ready for distribution in December of this year. Membership Benefits, Inc., is currently sending to all active and retired members a form to enable you to verify or change information in your listing. Remember, it is your responsibility to make certain the information provided on the form is correct! Please return the information to PCMS Membership Benefits by Friday, July 29.

You will receive your complimentary copy of the 1989 Directory sometime in December. If you would like to buy additional copies, an order form is included on the Directory Form.

Resolutions Due

Resolutions to be offered at the September meeting of the WSMA House of Delegates are to be submitted to WSMA or the Society office by *Friday, July 15.* This is an excellent opportunity to get your message to your colleagues and legislators and to seek change in some facet of the system you would like to see altered.

The Society office can help you finalize a resolution if you need assistance.

AUXILIARY

Weatherby Honored by Urban League

PCMS Auxiliary member Shauna Rae Weatherby, wife of Dr. Charles Weatherby, was honored May 26 at the Tacoma Urban League's 20th anniversary banquet.

Shauna is a RN and manager of the Sexually Transmitted Disease Clinic for the Tacoma-Pierce County Health Department. She was one of two honorees who received the league's Distinguished Citizen Award for volunteer work in the Tacoma community.

Also honored was the Reverend Oscar Tillman, an associate minister at Bethlehem Baptist Church.

According to Tom Dixon, president of the league's Tacoma affiliate, the honorees "are the epitome of the heart and soul of what the Urban League means by volunteer services."

Shauna, an organizer and member of People of Color Against AIDS Network and a member of the Governor's Task Force on AIDS., said about the honor, "I only wish I could do more," noting that an important concern is working with teenagers "to help them build self-esteem, to help them feel good about who they really are."

PCMS and the Auxiliary congratulate Shauna on receiving this distinguished honor.

PHILANTHROPIC FUND APPLICATIONS AVAILABLE

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, you may now obtain an application by either calling or writing to:

Mary Lou Jones
8217 22nd St. Ct. W.
Tacoma, Wash. 98466
565-3128

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Pierce County Medical Society
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The Bulletin

PIERCE COUNTY MEDICAL SOCIETY August 1988

Dr. Henry Clay Bostwick, first president of PCMS

Inside this issue:

AXID®
nizatidine capsules

Brief Summary. Consult the package insert for prescribing information

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions – No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high [illegible] mg of aspirin daily, increases in serum salicylate levels [illegible] nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day [illegible] times the recommended daily therapeutic dose) [illegible] carcinogenic effect. There was [illegible] [illegible] study in mice, there was no evidence of [illegible] although hyperplastic nodules of the liver were increased in the high-dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically [illegible] increases in hepatic carcinoma [illegible] numerical increase seen in any of the other [illegible] carcinoma in the high-dose animals was within the [illegible] for the strain of mice used. The female mice [illegible] maximum tolerated dose, as indicated by [illegible] compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – *Teratogenic Effects* – Pregnancy Category [illegible] [illegible] at doses up to [illegible] times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement [illegible] of the aortic arch [illegible] one fetus, and at 50 mg/kg it produced [illegible] distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Nizatidine is secreted and concentrated in the milk of lactating rats. [illegible] caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use – Safety and effectiveness in children have not been established.

[illegible]

Adverse Reactions: [illegible]

[illegible] determine whether these were caused by nizatidine.

Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Axid® (nizatidine, Lilly)

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Indianapolis, Indiana
46285

The Bulletin

The Official Publication of the Pierce County Medical Society

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Subscriptions: $20 per year, $2 per issue. Make all checks payable to Pierce County Medical Society.

On the Cover: *With the founding of the PCMS 100 years ago this month, Dr. H.C. Bostwick was elected the organization's first president. For more on PCMS's early players, see page 19.*

President's Page

Combating the Growing Drug Trade

The annual arrival of the summer sun and the seasonal diminishment of professional meetings is always cause for celebration. For the Medical Society president, it is also time for another President's Page report of quality and content. For those of us trained to the stilted jargon of medical chart communication, that is no easy task.

While we celebrate the arrival of the season, we must also turn our attention toward a rapidly growing problem in Pierce County that is not taking a summer vacation -- the drug trade. The relatively tranquil life we enjoy is being threatened by the tragic spinoffs of this societal disease. Street-gang activity, gun shot wounds, stabbings, assaults, theft, prostitution and corruption are drug-trade traveling companions arriving in Tacoma.

Driving the K Street corridor between hospitals at night is kin to pushing a shopping cart through a drug supermarket. The drug entrepreneurs, topped with colored baseball caps or scarves indicating their gang affiliation, are conspicuously stationed on several street corners. They wave you toward the curve and shout like a barker at a carnival. Open for business!

We all know these things happen in New York and Los Angeles, but not in Tacoma, Washington. If you have doubts, I invite you to drive K Street or Pacific Avenue after dark any night of the week.

The impact of the drug trade on the health care system in Pierce County is significant and growing:

- The large amounts of money involved breed turf wars and conflicts settled by violence (fortunately, these techniques are not used in organized medicine turf wars). Emergency rooms and surgical teams expend a great deal of time attempting to patch up the losers and innocent bystanders. The mixture of alcohol, drugs and automobiles provides a steady stream of broken bodies to emergency rooms.

- There is a dramatic increase of neglected and abused children who are recipients of the adverse effects of parental drug addiction.

- The combination of pregnancy and drug addiction frequently results in inadequate prenatal care, not to mention the direct adverse affects of drugs on the fetus.

- The scourge of AIDS is directly related to the drug trade and the sharing of needles.

- Addictive-disease centers and the required medical personnel are increasing rapidly to care for the growing number of clients.

- A significant proportion of indigent and uncompensated care expended in Pierce County is for those impoverished or afflicted by drug usage.

There has been steady progress in combatting other addictive diseases we humans fall prey to -- tobacco and alcohol. The outcome of our attempts to combat the drug trade, however, is uncertain. The politicians readily recognize the importance of this issue and are diligently portraying themselves as "more concerned, compassionate, and active" than their opponents. The suggested solutions include public education, increased enforcement and/or legalization. The transient euphoria associated with drug use, the acceptability of its use by so many levels of society and the billions of dollars to be made will make any corrective action difficult.

With no clear solution in sight, organized medicine will be called on to provide increased services for little or no compensation. It is essential that we educate our public representatives about the impact of the drug trade on health care resources in Pierce County and the necessity that government assume responsibility for the cost of this societal problem. We must frequently communicate these issues to other voting segments of society -- business, labor and retired persons. Lastly, we must act in the best traditions of medicine by providing medical services to those who need our help.

—— **WBJ**

* * * * * * * * * *

PCMS Committees in Action. In the results of last October's membership opinion survey, one of the comments that surprised me somewhat was the response of 41 out of 154 members who felt the Medical Society was "run by a few." The Board of Trustees, 12 members who are elected by the membership, do establish policy for the Society. The genesis of virtually all the Society's activities, however, stems from our extensive committee structure, comprised of many individuals representing all specialties and providing the Board of Trustees the ideas

Continued on page 5

President's Page
continued from page 4

that make this an active, progressive organization. The committee structure is the backbone of this organization, as is reflected by its reputation as the most active Medical Society in the state.

Out of the Public Health/School Health Committee, under the leadership of Dr. Terry Torgenrud, came the successful 1984 campaign to gain a smoking ordinance for Pierce County. A spinoff from the committee, Citizens for Better Dental Health Committee, is working to place the fluoride issue on Tacoma's November ballot. The committee has also established an AIDS Committee to strengthen community education efforts and physician involvement.

The Committee of Aging, under the able leadership of Dr. David Munoz, has established rapport with senior citizens, the providers of care to seniors, and representatives of the AARP and other groups.

The Interprofessional Committee, under the chairmanship of Dr. Bob Martin, maintains communication with the pharmacists, podiatrists and LPNs.

The Emergency Medical Standards Committee has played a major role in the Pierce County EMS system. Its chairman, Dr. Bob Wachtel, has been working closely with fire departments and fire districts. As a result, a major proposal has been presented to individual members of the Board of Health and will be addressed in a Board study session in July.

For the past three years, Dr. Marcel Malden has co-chaired the Medical/Legal Committee, which has resolved many issues between community physicians and attorneys.

The list of committees goes on and on: Personal Problems and Physicians Committee, Ethics and Standards of Practice Committee, Grievance Committee, the College of Medical Education Board of Directors, and the MBI Board of Directors that oversees the for-profit subsidiary of the Society.

My apologies to those who may have been inadvertently omitted from the Committee rosters. You all have my sincere thanks for your major contributions to the welfare of this very active organization.

— **WBJ**

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MD Has Role in Curbing Tobacco Use

The recently imposed ban on smoking on commercial airline flights of less than two hours' duration was accompanied by widespread publicity and has been hailed, appropriately, by foes of smoking as another milestone in the quest for a smoke-free environment by the year 2000.

Efforts to curb smoking in public areas also are receiving much attention, as is the AMA-backed effort to prohibit tobacco advertising.

Physicians can be justifiably proud of the efforts that medicine has undertaken to curb smoking. Smoking, however, continues to be one of the nation's most significant public health problems.

It is thus disturbing to note that not all physicians are making a concentrated effort on behalf of their patients.

Two statewide surveys done in Michigan and reported last year indicated that only 44 percent of smokers said they had been advised by a physician to quit. More than half of smoking patients who had had 10 or more contacts with a physician had been advised to quite. Young adults were the least likely to receive counseling, even though their addiction to nicotine might be less well entrenched.

In view of widespread data indicating that physician counseling can play an effective role in helping patients stop smoking, it behooves each MD to ask if he is doing all he can to help his patients who smoke to quit.

To help physicians do a better job of this, the AMA's Council on Scientific Affairs has developed a set of guidelines that merit careful consideration. They call on physicians to:

- Quit smoking and urge their colleagues to quit.
- Inquire of all patients at every visit about their smoking habits (and their use of smokeless tobacco).
- At every visit of patients who smoke, counsel them to quit.
- Provide smoking cessation pamphlets in the waiting room.
- Become aware of local smoking cessation programs, and of their techniques and success rates; where possible, refer patients to them.
- Participate in educational programs to help physicians help patients stop smoking.
- Speak to community groups about tobacco use and its consequences.

While many physicians express dismay and frustration with their inability to convince smokers to quit, the value of such activity is significant. Given the millions of smokers, even reductions of a few percentage points in the smoking population will produce significant reductions in the toll from tobacco-related diseases. □

This commentary appeared in the May 20 issue of AMNews.

A Physician's Dilemma

By James Swenson, MD, Madison, Wis.

The following editorial appeared in the May 13, 1988 issue of the Journal of the American Medical Association.

I read an obituary in the newspaper today. It concerned a 57-year-old physician who practiced in the hospital in which I worked. He was generally known to be a terror to work with, often rude and abusive of his colleagues. He had pulled out of a side street into the path of an oncoming car and had been broadsided. After reading the piece I wondered, was he a drunk?

I had very few encounters with this physician, but they had been uniformly bad. On one of my first, I had asked him to evaluate a patient in the emergency room. He had been abusive over the telephone and continued in a similar vein when he arrived in the ER. I had smelled alcohol on his breath but did not report it, whether because of an unwritten sense of "brotherhood" in the medical "fraternity" or out of fear of reprisal (I was new at the hospital, and he was well established), I don't know. Some time later, I again had occasion to request an emergency consultation of him. The same pattern was repeated, only this time when he arrived in the ER, he had obviously been drinking; he smelled strongly of alcohol and swayed a little as he verbally derided me.

I considered several questions at the time, none of which had a very good solution. If I smelled alcohol on his breath, should I have refused to let him see the patient? If I refused and he wasn't intoxicated (after all, I couldn't require him to submit to a blood alcohol test), would I then be open to a slander suit? On the other hand, if he was drunk and I said nothing, what would happen if he made some slip during surgery? Could I be held accountable, either morally or legally, for his misdeed? Last, what were my options for reporting this infraction?

At the time, I terminated our public discussion and told him we could talk at some more appropriate time. He examined the patient and eventually took her to the operating room, where he performed an appendectomy without complications. The next day I reported the incident to the hospital administration. I discovered that he had been previously reported by a nurse for having arrived in the ER with alcohol on his breath, but nothing had been done. There was some concern that alcohol was a real problem for this physician. The administration assured me that something would indeed by done this time. I told them I was considering reporting the incident to the state medical society, but they asked me not to, to keep this and "internal affair."

That was the last I officially heard of the incident, until I received a brief letter of apology from the physician, written, it said, at the request of the hospital administration. Alcohol was not mentioned. I was never again contacted regarding the "official" outcome of the case. The physician was removed from the on-call list for a time, and I heard through the grapevine that he had been required to seek professional counseling. Within a month he had returned to the on-call schedule, and I began to dread another encounter. In our subsequent one or two encounters up until the time of his death, although he was gruff, he was not rude and did not smell of alcohol.

Physicians live a high-stress existence and have access to many mood-altering drugs. The impaired physician has become recognized as a major problem in the profession only within the last 10 years. Many state societies have developed programs to confront and aid the impaired physician. I asked my state medical society about the procedure for reporting such a colleague but hesitated when it actually came to releasing names. I was told I could report a physician anonymously, but it would be "better" to give my name, so my "testimony" could be used in confronting the physician (especially if, during the investigation, no other colleagues were willing [or able] to report similar incidents). I shrank from "giving testimony," wanting to be involved but only to a convenient point. When asked not to report the physician, I probably breathed an unconscious sigh of relief.

We physicians seem to have learned to confront our patients but not each other. The public wonders if the profession is really able to police itself or if the judicial system is the only recourse to control unfit physicians. I had a chance to prove the public wrong but took the easy way out. Perhaps if I had had the courage to pursue this physician's case, he would have sought the help he seemed to need. Perhaps he would still be alive.

Physicians must take a more active role in policing the profession. Judicious reporting of colleagues must take place so they can start an appropriate rehabilitation program. Unless we take a more active role in this process, the public will have no option but to distrust our ability and willingness to seek out incompetence. I hope that the next time I can help to bring about a better outcome. □

Physicians Alert

It has been brought to the attention of the Pierce County Medical Society office and the Professional Pharmacists of Pierce County that there is an influx of persons obtaining prescriptions for the same controlled medication from many physicians and filling them at different pharmacies. These prescriptions are legal, so the pharmacists cannot legally use the Hotline and release information with the name of the patient or physician.

It is suggested that physicians be alert to persons coming into their offices, particularly late in the day, saying they have an emergency problem and enumerating medications they can take and are not allergic to. While it is sometimes difficult for physicians to make a decision in these cases, it is suggested you avoid Class II medications for pain, and prescribe, for example, Davocet-N 100.

The Pharmacy Hotline is in operation, but only to report stolen blanks, forced prescriptions and possibly a questionable person that frequents your office. You may access the Hotline by calling A & D Pharmacy at 472-4491. The whole county can be covered in one hour once the Hotline has been alerted.

Physicians are again reminded to keep prescription pads out of sight.

On to Portland

Joining 5,000 bicyclists on the increasingly popular Seattle-to-Portland bike ride, June 24-25, were Medical Society members Drs. Dick Bowe, Chris Miller, Joe Robinette, Greg Popich, Dave Wilhyde, and retired member Dr. Bill Mattson.

Approximately 1,500 participants elected to make the ride in one day. The two-day riders spent the first day in the Centralia-Chehalis area -- most of the Pierce County contingent tented on the football field of the Centralia Community College.

The riders enjoyed fabulous weather. One of the great benefits of the ride is that the Cascade Bicycle Club of Seattle provides sagwagons to carry the riders' tents, sleeping bags and other gear. Dr. Mattson, however, chose to carry all of his personal gear! Being one of the oldest riders on the course, he was an inspiration to all the riders.

If any members are interested in forming a weekend/evening biking group, please call the Society office at 572-3667.

Communicate in Writing

Physician-patient communication is vital. For the benefit of you as well as your patients, physicians are reminded of the importance of communicating in writing as well as verbally. There is no such thing as too much communication.

Hiring and Firing

Nearly two dozen Society members turned out June 29 to hear Sharon Bain, PCMS-MBI Placement Coordinator, discuss the many facets of personnel management in the medical office.

Sharon addressed questions heard frequently from members, and provided information packets containing: guidelines on the hiring and selection process, job descriptions, interviewing techniques, getting and giving reference information, performance reviews/evaluations, discipline, counseling, termination procedures, exit interviews, turnover problems, and the importance of documentation.

Those attending the free, 1 1/2-hour seminar were very impressed with the information provided and felt it to be a very valuable session. The program was so well received that it will be held again in Puyallup in late August or early September.

If any of these office issues are of concern to you, please call Sharon Bain at the Society office to register for the next conference.

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Taking a break during their bike ride from Seattle to Portland are (from left) Mr. Fred Sanchez; and Drs. Dick Bowe, Bill Mattson and Dave Wilhyde.

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Diagnosing Toxoplasma Infections

The Tacoma-Pierce County Health Department has offered recommendations to providers of perinatal care regarding the interpretation of tests used to diagnose toxoplasma infections.

It is recommended that tests suggestive of primary toxoplasmosis infections be: (1) Done in parallel to confirm rising titers and that sera be stored for confirmatory tests; (2) Confirmed with a Double Sandwich ELISA-IgM; and (3) Followed up with further testing on cord blood if primary infection is not ruled on in steps 1 and 2. Treatment in utero may reduce the impact of infection on the infant.

Please call the Society office, 572-3667, if you would like a copy of "Facts About Toxoplasmosis." ☐

Uncompensated Care: The Threat and the Challenge

By John Kitzhaber, MD

The following was presented at the Annual Meeting of the California Medical Association House of Delegates, March 5, 1988, Reno, Nevada. Dr. Kitzhaber is president of the Oregon State Senate and practices medicine in Roseburg, Oregon.

The growing crisis in uncompensated health care poses one of the most serious threats facing the medical profession today. If left unresolved, it will not only erode the health of our society and lead to an erosion of the clinical autonomy of physicians, but it will also undermine the very principles on which our health care system has been built. In addition, it will lead to increased regulation of the practice of medicine, and quite probably, to a government-controlled health care delivery system.

To understand this threat, the challenge it poses, and our critical role in its resolution, we must first consider the evolution of our American health care system.

The health care system we enjoy in this country was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer. We physicians were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered, and the cost was merely shifted to someone who could pay, through an incremental increase in their bill or in their insurance premium.

It is important to realize that this policy was no accident but was the result of conscious decisions in both the public and private sectors. In the public sector, the enactment of Medicare and Medicaid in 1964 extended coverage to the poor and the elderly. At the same time, there was a rapid expansion of private health insurance policies funded primarily through employment. This rapid growth of public and private third-party insurance coverage led to the belief that, in America, health care for the poor was free, when in fact it was being subsidized primarily by the government and by the business community.

Obviously, this rate of increase is not going to continue. While our health care system makes a great deal of sense in terms of a social policy, it makes very little sense in terms of an economic policy.

Thus, we created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they needed or wanted regardless of their income. Physicians could practice pure medicine, viewing their patients primarily from the standpoint of their health needs without concerning themselves about their ability to pay. But this system also encouraged utilization and led to the deeply held social belief in this country that health care is a right. Not surprisingly, this resulted in a dramatic increase in expenditures. The amount we spend each year on health care has grown from $75 billion in 1980 to nearly $500 billion today. More telling, however, is the growth of health care expenditures as a percentage of the gross national product: 7.4 cents on the dollar in 1970 versus about 11 to 12 cents today. If this rate of increase were to continue, by the turn of the century we would be spending 20 percent of the gross national product on health care and by about 2020, we would be spending 40 cents out of every dollar on health care.

Obviously, this rate of increase is not going to continue. While our health care system makes a great deal of sense in terms of a social policy, it makes very little sense in terms of an economic policy. Even a beginning student of economics recognizes that no single set of expenditures can continually grow at a rate faster than the rate of growth of the gross national product. Every dollar we spend on health care is a dollar that cannot be spent on something else. There are many other interests and priorities in which this country must invest.[1]

And while the prosperity we enjoyed over the past 20 years has allowed us to absorb these rapid increases in health care expenditures, it also masked the underlying fallacy of the way health care is financed in this country. By 1980, that mask had been stripped away when a number of factors combined to bring our ideal health care system into a collision with economic realities.

First, new medical technologies were being developed and being used -- at a tremendous cost -- because the system contained no financial restraints. Second, there

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has been a significant increase in the elderly as a percentage of the population. The elderly use more health care services than the non-elderly and have a higher incidence of chronic diseases. Both advances in medical technology and the aging population have increased the financial strain on the system.

Two additional factors forced those who had traditionally been subsidizing the cost of health care for the poor -- the business community and the government -- to reevaluate their ability to continue doing so. The first was the economic stagnation experienced in the United States at the beginning of this decade. While we could absorb the rapid increases in the cost of health care when the economy was growing, it was far more difficult to do so when productivity dropped. Our nation's annual productivity growth was a healthy 3 percent in the 1960s and 1970s but fell to 0.5 percent by 1979 and was actually negative in the early 1980s.

The federal budget deficit increased from about $73 billion to $211 billion in five years, and we liquidated all our foreign assets to become the largest debtor nation in the world. By the early 1980s, the government recognized that it could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit, or making deep cuts in other domestic programs. The government became interested in cost containment to balance the budget.

At the same time, this country entered the world market. American businesses began recognizing that they were no longer competing just among themselves, as the auto industry once did; they were competing with mainland China, West Germany, Japan, Italy and Canada. They realized they had to cut costs, particularly labor-related costs, in order to remain competitive with cheap labor industries abroad. They could not, for example, just pass the cost of health care on to their consumers and still remain competitive in a world market, particularly when American businesses had to carry the cost of health care on the books as a necessary expense and were competing with many countries that did not have to carry these costs because of nationally sponsored health care programs. The business community became interested in the need to contain costs to remain competitive.

This brought about very similar responses by both the government and the business community. The objective was simply to reduce the exposure to the cost of providing health care for the poor. It should be noted that the subsidy was not taken out of the system, it was merely shifted onto individuals and providers. Here is how it was done.

In 1983, the federal government enacted DRGs [diagnosis-related groups], which is a prospective reimbursement system that shifted economic risk onto providers. The federal government also began requiring first-day hospital deductibles for those on Medicare and increasing the Part B monthly Medicare premium that pays for physician services. This shifted costs onto the individuals. With Medicaid, the program for the poor, the federal government cut its match rate and shifted that to the states.

Today, our health care system is in transition. We are still ostensibly committed to the principle of universal access, but now the system is driven by economic factors, not by the social factors that drove it in the 1960s and the 1970s.

The first thing the states did was cut provider-reimbursement rates. Physicians currently average 45 to 50 cents on the dollar for taking care of someone else on welfare. That pushed costs and responsibilities onto the providers. When that did not balance the budget, the states increased the requirements for Medicaid eligibility, which pushed people off the program altogether. That shifted responsibility to the individuals. In the past 10 years, 800,000 women and children have been squeezed off Medicaid, and the program, which used to cover 65 percent of the poor, today covers less than 38 percent.The private sector reacted in exactly the same way, with increased involvement in health maintenance organizations, preferred provider organizations, and other prospective managed care plans that put providers at risk. Businesses increased copayments and deductibles for their employees that shifted costs onto the individuals.

The important point here is that these cost-containment actions reflected absolutely no social policy beyond that of cutting costs for the government and for the business community. There was a recognition that the amount of money that could be spent on health care for the poor was limited, but there was no consideration of the implications of those decisions on access to health care. The funding in the system was reduced but not what the public expected from the system.

Today, our health care system is in transition. We are still ostensibly committed to the principle of universal access, but now the system is driven by economic factors, not by the social factors that drove it in the 1960s and the 1970s. Providers are at economic risk. We are losing the ability to cost shift.

As I mentioned earlier, our ability to deliver on the principle of universal access has depended on cost shifting and the willingness of the business community and the government to subsidize the cost of care for the poor. While there is still supposedly a commitment to universal access, we are seeing a progressive shifting of the responsibility to pick up that cost. Between 1965 and 1980, that subsidy was borne by the government and by employers, who spread it out over taxpayers in general and over most of the workforce. Society was paying for what was essentially a social policy objective: universal access to health care.

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Because of the cost-containment measures that have occurred, however, that subsidy has been shifted onto providers, who have far less ability to absorb it. What used to be subsidized care for the poor is now showing up as uncompensated care. As physicians reach a point where they cannot absorb additional uncompensated care and still pay the bills, they push the costs onto individuals. And, today, if a person does not have insurance coverage and does not have money, that person is increasingly likely to lose access to the health care system, either because providers will not accept any additional indigent patients or the patient delays treatment because of an inability to pay.

This has dramatically changed how health care is financed in this country. Our health care system has traditionally had a bifurcated financing mechanism. On the one side is the public system, which is Medicare and Medicaid. On the other side is the private system, which is mostly employment-based policies and some individual policies. There has always been a little gap in between where some people slipped through the cracks. But as long as the government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and really contained only society's truly downtrodden.

Today, however, those two third-party payers, government and business, are trying to escape from the subsidy. As we see a reduction in government expenditures, the growth of copayments and deductibles in Medicare, and the increases in Medicaid eligibility, people spill off the public side into the gap. As competition in the world market increases, as we shift from a manufacturing to a service-based economy with large numbers of low-paid, non-unionized workers without health insurance coverage, and as premium rates go up, people spili off the private side and into the gap. Today, the gap is not narrow: it contains 37 to 40 million Americans. And they are no longer just society's truly downtrodden. Of those uninsured people, 70 percent are working full time or part time or are dependents of someone who is working. Those in the gap are generating 75 percent of the uncompensated care.

Why should we be concerned about this shifting responsibility to pay for the care of the poor?

Why should we be concerned about this shifting responsibility to pay for the care of the poor? We should be concerned because there are some serious social consequences affecting all of us, physicians in particular.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. And since market systems were not designed to foster social responsibility, it should not be surprising that no one is competing to care for the poor. Public health clinics are closing. We are seeing patient dumping from hospital to hospital, physician to hospital, and between physicians. There are treatment delays. And there are a growing number of people in the gap.

That leads to the second social consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two thirds of those mothers do not receive adequate prenatal care. Of the poor in America, 40 percent are children. Only a third of them are covered by Medicaid; the other two thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in cases

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of pertussis and increases in pediatric nutritional problems. There is case after case of people actually dying because of a lack of access to the system -- people dying of strokes because they could not get their blood pressure medication prescription refilled; people dying of heart failure and having myocardial infarctions because of a lack of routine checkups or medication; and people dying of perforated ulcers because of treatment delays.

The third and perhaps most serious social consequence is that we are mortgaging our own future. I think this is very important and would ask you to bear with me for a moment. As I mentioned, 40 percent of the poor in this country are children, and two thirds of them are in the gap with no insurance coverage. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we are expecting to fuel the economy and pay for a growing retired population. How are they going to do that in the face of $170 billion owed to foreign governments and nearly a $3 trillion national debt? How are they going to do that in the face of a $10 trillion unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security, and federal pensions, most of which are automatically indexed to inflation and do not have income eligibility requirements? We are asking them to do something that we have all refused to do: to recognize that increases in personal consumption have to be balanced with increases in productivity.

In the past 10 years, American workers have averaged a $3,100 increase per capita in personal consumption and only $950 of that has been paid for by increases in what each one produces. The remaining $2,150 has been paid for by cuts in domestic spending and investment and by foreign debt (P.G. Peterson, The Atlantic Monthly, Oct 1987, p 47). We are asking this group of people to be more productive than anyone in the history of this country and to probably take a reduction in their standard of living. Having asked them that, we are crippling them going in, by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is healthy and well-educated. That is a very, very serious implication.

There are also some disturbing professional implications. The first is that the growing problem of uncompensated care is catching physicians between what society expects from our health care system and economic realities. When the government and the business community moved to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals and without publicly or explicitly abandoning the idea of universal access because they shifted that subsidy onto the providers. But when physicians move to limit their exposure to this subsidy, and for exactly the same reason, they have to deny access to individuals. When physicians reach the point where they cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring.

As the problems of the poor intensify, state legislatures are going to begin to react. They are going to say, "If you physicians are not going to take care of the poor voluntarily, we are going to force you to do so."

That puts us in direct conflict not only with our professional ethics but with social expectations for the health care system. It casts us in a very unfavorable light. Many people still view physicians as we were seen in the halcyon days of the 1960s and 1970s when the economy was booming and incomes were rising. Most legislators are not physicians -- I am the only physician in the Oregon legislature. Many legislators do not understand the relationship between cost shifting and subsidizing care for the poor, and do not understand the implications of taking cost shifting away from providers.

The thought that a wealthy profession would be denying access to the poor is unacceptable to most legislators, a fact that puts physicians in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react. They are going to say, "If you physicians are not going to take care of the poor voluntarily,we are going to force you to do so." There are many ways that coercion can be accomplished.

As a condition of licensure, physicians can be forced to take care of a certain number of indigent patients. That bill was actually introduced in Oregon last year. A gross income tax can be applied to physicians' earnings to help pay for indigent care. That bill was introduced in Washington in 1985 and has been considered in Pennsylvania. These types of intrusive regulatory measures are being introduced in state legislatures across the country. Unfortunately, all they do is force physicians to assume the fiscal responsibility for taking care of the poor. They ignore the fact that society, while paying lip service to universal access, has made a decision to limit the amount of money that will be spent on health care. The problem remains unresolved. When someone convinces corporate America that a government-sponsored health care program will put them in a better position in terms of competition in he world market, then we will be looking at a nationalized health care

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program. In the short run, we are looking at increased regulation and an erosion in our own clinical autonomy.

What do we do about this problem? To solve this crisis in uncompensated care, we have to start by accepting three hard realities.

The first reality is that resources are limited. That is a difficult one for physicians to accept because they have never had to accept it. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars.

We have a national debt approaching $3 trillion that we must reduce. We have a huge defense budget that has been traditionally hard to pare down. We spend $450 billion a year on Medicare, Social Security and other federal pensions. At the same time, we are cutting aid to education and investments in road, bridges, sewers, and water systems. We are cutting civilian research and development. We are cutting all of the things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut. At the same time, however, we want to reduce government spending, we want good roads and schools, safe streets with criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, and clean water. And we want to do all that, of course, with lower taxes and higher wages.

Now, obviously, that does not work. There is a finite amount of money that this country can invest in health care versus the other things that we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality, which is simply that the rich are always going to have access to more health care than the poor. I think that is probably all right if what the poor get is adequate and if they are all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis on income, not necessarily on need or merit. We readily accept that in most instances. We do not expect public housing to look like the Ritz. We do not expect food stamps to be redeemed in expensive restaurants. But because of our concept of universal access, we have taken for grated that the poor should have access to all the health care services that are available to the rich. I would remind you that this is the only part of our system that operates on this open-ended economic principle. We have in effect rejected a multitiered system based on income, but in reality we already have that kind of a system. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available at home. The rich have had consultations and elective operations to which the poor have not had access. So what we have really is a poorly defined definition of what we think everyone has a right to and what perhaps they do not have a right to.

I think we would all agree that everyone should have a right to prenatal care, but we may argue whether or not the public should pay for an elective face-lift for everybody on welfare. The question becomes much more difficult, however, when we are trying to balance a transplant versus prenatal care.

We need a better definition of adequate health care to address that question. If we know resources are limited, if we know people with high incomes can buy more health care than people of lower incomes, and if we know that society cannot buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get. That means defining adequate health care and brings us to the third reality.

The third reality is the inevitability of rationing. This is also a very difficult concept for physicians to come to terms with, but when you define adequate health care, you also define what is more than adequate. And that provides the basis for the explicit rationing of health care. Before we overreact to this reality, I would suggest that rationing already exists in our system. We clearly already ration by income and by transportation barriers. More important, however, we ration inadvertently through legislative decisions because we lack any policy to guide how our health care dollars are spent. Rationing is the result of limits. If there is a limited amount of money in the health care budget and it is spend on one set of services, it is not available to be spent on another set of services. That is rationing.

We are spending huge sums on some and we are spending virtually nothing on others. We spend more per capita on health care than any other country in the world, yet 37

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million Americans have no coverage and many of them are losing access to the system. We spend $3 billion a year on neonatal intensive care while denying prenatal are to hundreds of thousands. We spend $50 billion a year on people in the last six months of their lives while closing pediatric clinics.[2]

That is like having someone in charge of a corporate truck fleet who adopts a policy that the oil in the trucks will not be changed until the engine blocks melt. The trucks won't be maintained but will be serviced only when there is a major breakdown. I doubt if you would endorse this policy for your car, nor would you employ anyone who did, but that is exactly how we spend health care dollars in this country. Rather than treating hypertension, we are treating people who have had strokes. We are rationing by default, unguided by any social policy. It is inequitable, inefficient, and we are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly is because we do not want to come to grips with our own limits.

To solve the problem of uncompensated care, with all of its ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system based on the three realities that I mentioned: limited resources, acceptance of the fact that the rich will always be able to buy more health care than the poor, and the need for rationing.

We have to recommit ourselves to universal access -- not universal access for everyone to everything -- rather, universal access for everyone to an adequate level of health care. That will put our system back on a sound economic foundation. It also means that we are going to end up in this country with a three-tiered system of delivery. In reality we already have a nondefined, implicit multitiered system: the medically indigent, Medicaid, workers with insurance, the wealthy. What I am suggesting is that we stop pretending it doesn't exist, accept its inevitability, and take steps to make it work equitably and efficiently. This would mean a government-sponsored tier for the poor, a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services.[3]

I want to reiterate one point. The government has a responsibility, in my mind, to pay for the poor but not for the elderly unless they are also poor. The government should pay for the poor regardless of their age. There is no reason Lee Iacocca needs Medicare, or Johnny Carson, or even my parents. Government-subsidized health care programs should have income eligibility requirements.

This is important because it is at the first, or public, tier that we have to come to grips with rationing. It is at this tier that we must set the socially acceptable minimum level of health care for this country. How do we get there?

Let me describe what is being done in Oregon, where we are attempting to resolve this problem. There are three elements involved: first, a clear social policy; second, a definition of adequate health care; and third, a universal insurance system to guarantee that people get access to that care.

Therefore, we first need a clear social policy to ensure that we spend our limited health care dollars in a way that is efficient and equitable.

Because of my time constraint, I will only cover the first two elements. Concerning universal health insurance coverage, however, let me say that while it is an essential component of the final solution, it is putting the cart before the horse. We need to recognize that the objective of our social policy of the 1960s and 1970s was, in fact, universal access. One of the reasons we are in trouble today is that we were, in the short run, able to cover everybody for almost everything. But unless we first define the level of care for which people are universally covered, we still have an open-ended system that we cannot afford.

Therefore, we first need a clear social policy to ensure that we spend our limited health care dollars in a way that is efficient and equitable. In Oregon, we have made an attempt to recognize our limits and to adopt such a policy. In the past legislative session, we discontinued funding for heart, pancreas, bone marrow, and liver transplants for people on welfare and used that money to extend preventive and prenatal services to a far larger group of people who had been in the gap. This constituted an explicit rationing decision. Let me go over the issue we were dealing with because, I assure you, it has not been an easy one to defend, politically or as a physician, although I firmly believe that it was the correct decision given the reality of limited resources.

The question was not whether transplants have merit; clearly they do. The issue was not whether in the short run we could find some additional money to buy a few more transplants for people on public assistance; clearly we could have. The issue was simply that if we were going to put additional money into health care, where was the best place to spend the next available dollar? Did it make more sense and was it a better use of limited public funds to buy high-tech services for a group of people (those on Medicaid) who already had access to virtually everything available in the private sector, or to extend services to a larger number of people who were in the gap, many of whom did not have access to any health care whatsoever?

We felt it made more sense to serve the larger number of Oregonians. Thus, the policy adopted in Oregon is one of universal access to adequate health care, and we have made that the first priority for spending the additional dollars that we can get into our health care budget. That still leaves the second element; defining adequate health care. Oregon's definition at this point does

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not include major organ transplants because we have made a decision that they are of a lower priority than preventive care. But we do need a more complete decision.

Before I describe to your the process we are using in Oregon to arrive at that decision, let me say that once you get a definition of adequate health care and array your health care services on a priority basis, you are changing, in a fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus, and it goes like this. We have one heart and three potential recipients. Do we give that heart to a 17-year-old unwed mother of three on welfare, do we give it to a 35-year-old man serving time for rape and armed robbery, or do we give it to a 40-year-old corporate executive?

This scenario raises the kinds of imponderable ethical and moral questions that society, almost by definition, cannot resolve on an individual basis.

This scenario raises the kinds of imponderable ethical and moral questions that society, almost by definition, cannot resolve on an individual basis. But once we develop a definition of adequate and array our health care services in a priority order, we shift that debate from an individual focus to a societal focus. We are no longer debating which service should be given or denied to which person, we are debating which priority of unding should be given to each service, given the reality of limited resources. Because shociety has made the decision to limit the amount of money it spendson health care, society needs to make the decision on how to spend that money. In addition to providing basic health care to a far larger number of people, this approach also takes physicians out of the squeeze and allows them to contisnue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. In Oregon, we are working with a group called Oregon Health Decisions, founding in 1982 by Ralph Crawshaw, MD, a Portland psychiatrist. It is a private, nonprofit group dedicated to educating Oregonians on the health policy choices and confronting them with the consequences of those choices. It was the first such group in the country. Now 14 states have similar organizations, including an active one in California.

We have appointed a steering committee of which I am the chair. We are breaking down everything on which Oregon currently spends its health care dollars. We are making a decision package for each service with a summary document that describes the number of people getting the service and the cost, the number of people not getting the service and the economic and health implications of not giving them that service, and then the cost to extend the service to everybody in the unmet-need population.

The plan over the next few months is to arrange this list in a tentative priority order and take it out to town hall meetings around the state of Oregon where citizens can actually get involved in working through the trade-offs and choices necessary to set up a priority list of health care choices, given the fact of limited resources. We will bring that information together this fall to generate a final list that will be submitted to the legislature.

Once the health care resources are arrayed in that kind of priority list, we come to the second step, which is to integrate this information with the legislative budget process. This requires that funding go to the first item on the priority list for everybody in the population for whom the state has responsibility. Going down the list, the second item is fully funded before moving to the next, then the third, the fourth, and so on, until the available money is exhausted.

This process puts accountability into the system. If, for example, a state legislature decides to cut $20 million out of the health care budget, it will not longer be an abstract accounting exercise, but will mean deleting specific services for specific

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Looking Back...

A Glimpse at PCMS 100 Years Ago

This month marks the 100th anniversary of the Pierce County Medical Society. To commemorate the occasion, we searched our files and came across a few items that illustrate the early beginnings of PCMS and portray the Society's founding fathers.

The following are excerpts from a series of articles called "The Ark Speaks," written in 1975-76 by Mavis Kallsen, wife of Dr. Robert A. Kallsen, and former curator, PCMS Archives.

In the Beginning

The PCMS started with a gathering of eight friends, at the invitation of a Doctor James Wintermute, who was appraised of the fact that a similar gathering was about to take place in King County the same evening.

In the year 1888, Tacoma had survived the great depression of 1833 and was in a period of booming expansion. The population rose from 735 in 1883 to about 17,000 five years later. The early settlers had come here to farm and raise stock but discovered that clearing their lands of timber was more profitable than using the land, with Tacoma the handiest shipping point on the Sound.

In 1888 in Washington Territory, the physician had a lot of competition in the practice of medicine from the pharmacists and other 'doctors' who did surgery and dispensed drugs in the twilights zone of Territorial licensure. Many of Pierce County's busiest doctors never even bothered to register with the County authorities. There was probably a lot of political graft in licensure then anyway. This really galled Doctor James Wintermute.

Doctor Wintermute introduced at the first meeting of the PCMS a complaint against a Doctor McLennan, who was apparently very successfully practicing medicine in Tacoma without credentials. At the next three meetings he pressed the same topic. The problem must have been

Dr. James Wintermute

resolved then, and the PCMS didn't meet for the following six months due to a lack of quorum.

Doctor Wintermute maintained his stance on credentials and was part of the group who wrote the licensure laws when the State constitution was written in 1889. He later helped develop the Public Health Service and the health codes for the city of Tacoma.

In November 1896, Doctor Wintermute was shot and killed on Pacific Avenue by an irate patient who claimed the doctor's prescribed medicine actually made him sicker.

The Medicine Man

Commencing January 1882, it was required by law that all those practicing medicine in Washington Territory register with the County authorities. The first physician to register in Pierce County was Doctor Charles Hadley Spinning, the legendary canoe and saddle doctor. He was never a member of the PCMS, but his influence predicated the concept of the Society (to best serve the health needs of the County) for three decades prior to the Society's inception.

Spinning was appointed the first physician to serve the Puyallup Agency. He continued in that capacity for 10 years. Three reservations were included in this Agency: the Puyallup, the Nisqually and the Squaxin. The Spinning family lived on the Puyallup Reservation. From there he made his rounds attending the medical needs of the widely scattered population by horseback, canoe and rowboat.

At that time, there was only one other physician in Pierce County...Doctor Wirtz at Fort Steilacoom, who limited his care to surgery within the confines of the Fort. Doctor Spinning was physician to the whole civilian population, Indians and settlers, of Pierce County, except for a few itinerant practitioners passing through, for that decade.

In 1872, Doctor Spinning left the Reservation and devoted his time to the several farms he had acquired in the County. He continued to practice medicine and to farm, while moving from one locality to another in Pierce County, until his eighty-ninth year. In 1911, Doctor Spinning

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died at the home of his daughter in Prosser.

Doctor Spinning was not a surgeon, and was opposed to the letting of blood, as practiced by the allopathic physicians of that day. He practiced a kind of naturopathy, using natural remedies and herbs. In fact he was a doctor by political appointment only, having left with the wagon train for Oregon four months short of graduation from Cincinnati Eclectic Medical College.

Early in 1890, the Legislature of the State of Washington enacted a law requiring all those practicing medicine in the State to be licensed by the State Medical Examining Board. Doctor Spinning, by then in his seventies, continued to deliver babies and prescribe medicine undaunted, without submitting to examination by the State Board. He was an institution by then, much loved by the community and honored...even by many of the doctors.

The PCMS, in a gallant gesture of professional courtesy, overlooked Doctor Spinning's activities as they scoured Pierce County searching out and prosecuting all those "irregular and illegal" practitioners within the area.

A Founding Father

It was by invitation from James Wintermute that the eight doctors met in Wintermute's office to launch the PCMS, but on the ballot for president, Doctor Wintermute got only one vote. The man who got seven votes on that ballot was ... Doctor H.C. Bostwick.

Early in 1874, Henry Clay Bostwick arrived in New Tacoma, Washington and established one of the town's first businesses, a drugstore on the corner of 7th and Pacific. Doctor Bostwick also engaged in the practice of medicine.

In the summer of 1880, Doctor Bostwick invited his old friend from Kansas City, A.J. Baker, to come look at the town with the view of starting a bank here. They bought a lot at the corner of 10th and Pacific and erected a frame building containing a vault said to be the best in the Territory. The bank was opened for business in October, 1880, under the name of the Bank of New Tacoma, capital $50,000, President H.C. Bostwick.

In 1881, smallpox was reported from so many localities throughout the U.S. as to cause widespread apprehension and an appropriation was wade by Congress of $100,000 for relief. Early in October of that year it appeared in New Tacoma, took hold with violence and quickly spread in all directions. This was at the peak of the building boom, with a large amount of the Bank of New Tacoma's capital out in loans.

By that time, New Tacoma had four physicians. Three of them, Doctors Bostwick, Miles and Ballard, pronounced the malady to be chickenpox and the fourth, Doctor F.B.H. Wing declared it to be smallpox, expressing alarm on account of the contrary opinion.

The New Tacoma Board of Town Trustees at their meeting of November 2, appointed Doctor Wing as Health Officer and empowered him to remove to the pest house all persons affected with contagious and deadly diseases.

As days and weeks passed, though people continued to die of the supposed chickenpox, the three doctors who stood in favor of the chickenpox theory, were not ready to admit their error. Doctor Wing labored alone in attending these patients.

The town of New Tacoma was shut off completely. Trains ran through with windows closed. Puyallup and Steilacoom organized shotgun quarantines by constructing barricades across all roads from Tacoma. Behind the barricades were armed men. Weeks passed with no money in circulation.

Doctor Wing worked day and night in his efforts to stamp out the scourge. Doctors Bostwick, Ballard and Miles probably never attended a smallpox patient and there is no record of heir having made this diagnosis during the epidemic. Of the town's population of 1,000, Doctor Wing treated over 70 cases of smallpox, 12 of whom died.

Doctor Wing, exhausted by the prolonged anxiety and continuous vigil he had maintained over those stricken by the disease, registered int eh office of the Pierce County Auditor on January 13, 1882, in obedience to an act of the Legislature requiring such registration by all those practicing medicine in Washington Territory after January 1. The following day, January 14, 1882, Doctor Wing dropped dead in his office.

Doctor Bostwick and the Bank of New Tacoma survived the smallpox

Dr. C.E. Case

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epidemic. Whether out of ignorance or in greed he had ignored his medical training at a time when he could have been most useful can only be conjecture. But the Doctor hadn't been idle during the epidemic...he had called 20 friends together to organize Tacoma's first commercial organization...the New Tacoma Board of Trade. Three years later this organization's name was changed to the Tacoma Chamber of Commerce.

Doctor H.C. Bostwick was the first president of the Pierce County Medical Society.

Another Key Player

The year following the organization of the PCMS in August, 1888, a great influx of human resources came to Tacoma in what was the biggest social, cultural and economic boom in the city's history. Of the many talented physicians and surgeons who arrived here in that year, 1888-89, probably the one man who did most to influence the course of medical history in Pierce County was the hard-working, hard-playing and totally lovable Charles McCutcheon.

For the years 1891-1897, Doctor McCutcheon served as secretary-treasurer of the PCMS, and we have his complete record of the meetings held by the Society those years...handwritten in his sometimes-legible script.

Charles McCutcheon was the first superintendent of the second Fannie Paddock Hospital and remained there as resident physician for the rest of his life. He established the first school of nursing in the State of Washington in 1895, conducting the classes himself as there wasn't money to hire an instructor. In 1889, his paper on "State Laws to Regulate the Practise of Medicine" was submitted to the State constitutional convention and was the basis for those statutes. He served as president of the short-lived Tacoma City Medical and Surgical Society, which established the fee bill adopted by the PCMS in 1891.

A gathering of PCMS members and their wives at the Tacoma home of Dr. Charles M. McCutcheon.

Hero or Villain?

The history of medicine in Pierce County as documented in our archives runs a close parallel to the old frontier type melodrama. It has its romance, its pathos, its heros and villains. But in the instance of Doctor C.E. Case, there is not clear definition of his role. He always wore a black hat...though, in at least one scene he emerged as the hero. At the time of the Great Streetcar Disaster, the Fourth of July, 1900, it was C.E. Case who labored in surgery for a heroic 24 hours attending the injured at St. Joseph Hospital. Five years later it was C.E. Case who fired the first volley in the great battle of the Contract Practice in the PCMS...but paradoxically, he came out blazing both barrels at the "good guys."

At the PCMS meeting of January 17, 1905, a completely new topic for discussion appeared. Grant Hicks had just been installed as president and made a little speech. In the next entry the old ledger reads simply. .."Doctor Case made a few remarks on Contract Practice"... and then, "Doctor Quevli made a short address as retiring president, calling upon the members to assist the new president in advancing the interests of the Society."

What C.E. Case referred to as Contract Practice was a system which had originated in the community years earlier as the first working arrangement for pre-paid medical care in the nation. It began as a contract between the St. Paul and Tacoma mill and the hospitals, for full medical care for their employees, paid for in advance. From this beginning, the contract concept mushroomed, so that by 1905, almost a third of the population in Pierce County was covered by some kind of pre-paid medical arrangement, often contracted by their social groups, or "lodges." Doctor Curran described Contract Practice then as an "intricate proposition." The contracts were outside the existing laws and took as many forms as there were doctors who practiced contract medicine...some bordering on flagrant quackery.

By November of that year, C.E. Case had become impatient with the sidestepping and evasion of the issue, and determined to settle the matter of Contract Practice once and for all...to throw the rascals out!

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He made his broadside attack in the letter reprinted here...

I herewith charge Doctors James R. Yocom, George C. Wagner, Grant S. Hicks and any and all other members of this society who are now doing contract work or so called lodge work, except of course Railway Contract work, Government, State, County or Municipal contract work, with violation not only of a resolution recently passed by this society by also with the subversion of this society's wishes and intentions relative to the doing of contract work and the abrogation of hospital contract work. The above named members of this society, namely James R. Yocum, George C. Wagner and Grant S. Hicks, did most shamefully abuse the society's confidence when they bid for or solicited the contract work given up by the two hospitals of our city...and did, in the most undignified, underhanded, treacherous, indecent, vicious and ungentlemanly manner appropriate to themselves these contracts, thus subverting the will and desire of this society. I therefore pray your honorable body to cite each and every contract physician or surgeon before your body to show cause why they should not be expelled from this society.

C.E. Case had fired his volley at the fellow in the white hats. Grant Hicks was then president of the PCMS. Doctors Yocom and Wagner had held offices in the PCMS intermittently for 15 years and were held in high esteem by their colleagues. Doctor Case refrained from naming the fourth physician in that partnership, A.J. Coleman, possibly because Dr. Coleman was also a licensed attorney.

Nevertheless, the problem of Contract Practice had to be solved in some way or the PCMS would not survive. In an ironic twist of circumstances...as the history of the PCMS unfolds...Doctor C.E. Case may have been a hero after all.

When Doctor C.E. Case's vitriolic charges ruptured the burlap and let the issue of Contract Practice out of the bag and into dispute in the PCMS, Doctor Wagner left the country for two years for a healthier climate, and Grant Hicks quit industrial medicine and limited his practice thereafter to a specialty he was especially gifted for... the treatment of women. The young doctor Curran, who had been an associate of Yocom's for two years, quit the practice of medicine for the time being and went back to the woods to become a logger.

Doctor's Case's charges erred in his use of the term "ungentlemanly," but perhaps the context of his charges approached validity. The inherent prejudice against organization of any kind within medicine and the abuses of the contract concept by those mercenaries engaged in Lodge Contract work had long before arrived at the flash point within the PCMS.

Doctors McCutcheon, Yocom, Wagner, Hicks and Coleman had instituted a most human plan and administered it quite professionally. Industrial medicine was a fact of life, as was the necessity of maintaining the hospitals. The economics of Pierce County were peculiarly adapted to the idea of pre-paid healthcare and this is where the idea was first put to use.

Climb Every Mountain

An illimitable interest in the value of human life and an involvement in the art of living seem to be characteristics of the medical family, and this capacity to live interestingly has produced a number of outstanding women within the membership of the WSMA Auxiliary. Prominent as the first of these was the State Auxiliary's first President, Alma Whitacre, who was also the first 'girl guide' in the United States to lead mountain climbing expeditions as a park service professional.

When World War I depleted the part service staff, Alma applied for a position as mountain guide, and got it. For nine months of each year she taught algebra and geometry at Stadium High School, and for the remaining three months she led climbing parties up the mountain.

Alma Whitacre, first WSMA Auxiliary president.

Alma's career as a professional mountain guide and math teacher came to an end when she married a Tacoma physician, the handsome widower Doctor Horace Whitacre. It was another challenge and a new climbing expedition...to marry a man whose previous wife had been so successful as a wife and in the community as well.

In an altogether different style, Alma achieved her own success as the Doctor's wife. Her own interest was in aiding the newly emerging woman in the labor force of the community. She was instrumental in the establishment of the local YWCA, to offer a home for young women looking for jobs here during the twenties, and later headed the fund drive for the large YWCA complex on St. Helen's, where thousands of young women found shelter during the depression years and during World War II.

When the Doctor was president of the WSMA, they worked together to establish the WSMA Auxiliary. The organizational meeting for the State Auxiliary was held in Whitacre's home, and Alma was elected its first president. She traveled from county to county assisting in the organization of the various Auxiliary units throughout the state, and for the remainder of her long and vigorous life she continued an active interest in the organization. □

Code/No Code:

The Problems, the Solutions

Obviously, the decisions that must be made when an elderly patient faces a medical crisis are difficult ones for everyone -- patient, loved ones, doctors, hospitals, and health care professionals alike. When a satisfying, although restricted, life is possible if treatment is successful, the decisions are easy: You do everything you can. But when someone has had a medical crisis and is in failing health with little hope for recovery, when all the painful, costly, possibly degrading though heroic measures may gain no more than a few extra days or weeks, or, maybe months for a patient who is probably miserable and often unconscious, the decisions are more difficult and individuals may vary widely in their preferences -- if, indeed, they are given a choice.

Modern Maturity, June-July 1988

When a patient's quality of life or potential for recovery is poor, often the decision is made by the patient, the family and the physician that steps will not be taken to intervene or resuscitate that person should a medical emergency arise. Unfortunately, in many cases, the decision is not made ahead of time, or, necessary documentation of the patient's wishes is either unavailable or nonexistent.

An issue continually arising in today's medical community is the need to establish an effective code-status system, particularly for nursing home patients. The issue prompts a variety of difficulties and responses among physicians, paramedics, family members, hospitals, nursing home personnel, and, of course, the patients. The PCMS EMS Committee and Committee on Aging has taken a hard look at this issue in an effort to improve the system. As a result, a consensus was reached that physicians need to take a greater leadership role in this area. The burden of responsibility rests most heavily upon the physicians and nursing home administrators to include clearly documented forms and instructions on a patient's chart. It is a physician's major moral commitment to the elderly to have code/no code orders on chart and unified policy developed that no one in a nursing home is without code instructions.

Last year, the committees developed do not resuscitate (DNR)/do not intubate (DNI) orders for paramedics in the field (see item, next page). Board and committee members agree that developing the protocols does not address all of the problems of this complex issue, but it is a beginning.

The Bulletin recently invited comment from the following PCMS physician members closely involved with the code\no code situation: Dr. Paul Hildebrand, Emergency Room Physician, St. Joseph Hospital; Dr. David Munoz, Internal Medicine and Geriatrics specialist and chairman of the PCMS Committee on Aging; Dr. Robert Wachtel, Emergency Room Physician, Tacoma General Hospital, and PCMS EMS Committee chairman; and Dr. Clark Waffle, Emergency Room Physician, Good Samaritan Hospital, and Medical Program Director, Pierce County EMS System. Here are their comments.

DR. HILDEBRAND: "I believe the main problem is a failure to discuss the situation with the patient and enable that patient to make arrangements ahead of time. When it has been determined that someone has a life-threatening illness and their quality of life is not good or the prospects for quality of life are poor, it is the patient's right to know his or her options for the future. Granted, the opportunities are just not there for people to get together and discuss the situation and make a decision. No one is to blame, really, it's simply a matter of everyone doing a better job of communicating. In essence, we have to go back to basics. The physician and patient need to educate one another."

DR. MUNOZ: "I agree. There is not timely discussion of the code/no code situation between the physician and the individual and the individual and the family members. The patient and family need to know everything that can happen. The physician with a no code patient should play out the scenario with the family."

DR. WACHTEL: "The physician needs to present his or her patient with options. It's important to talk about death and provide the patient with all the components needed to make a decision. Too often, a patient's wishes are not determined. Sometimes the physician is reluctant to discuss the issue for moral or legal reasons. But, I believe it is vital to discuss death, and the process should begin with the patient's initial evaluation."

DR. WAFFLE: "The burden is on the physician. He or she has to make a commitment to be honest and open with the patient. The decision is very personal and

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involves multiple factors -- the patient's feelings, his or her potential for recovery or enjoyment, the family's thoughts, the physician's preference. All these areas need to be addressed and all the players need to feel comfortable."

DR. WACHTEL: "The greatest problem we're facing today is the lack of documentation about a patient's wishes or desires. Patients, particularly those in nursing homes, should be pre-coded. That information should be included right along with all other patient information. Without that pertinent information, a situation will arise that will tie up time, people and resources unnecessarily and the outcome may be against the patient's wishes."

DR. HILDEBRAND: "A patient may arrive in emergency who, in fact, has a no-code status. But, there is no documentation present and no family member available, so intervention is done. It turns out that we see the patient for an hour and then a specialist comes in and the patient may end up on ventilation for months. Later we find out that the patient shouldn't have been resuscitated. That documentation has to be present."

DR. MUNOZ: "That patient is being exposed to astronomical costs and debilitation, and innumerable resources are being expended. In the absence of information, procedures are often expensive and poorly applied.

"People also must recognize the financial problems and consequences. Cost of care is largely ignored in these situations. If a patient is unable to walk and feed him or herself, the cost of care will be an additional $100 a day."

DR. WAFFLE: "Nursing homes by far pose the greatest problem, simply because of the shear volume of patients. Some have been very good about establishing a system, but there are problems. For instance, a physician at the nursing

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Do Not Resuscitate/Intubate Guidelines for Paramedics in the Field

It is anticipated that every paramedic will perform to the best of his/her ability when called to the scene of an illness or injury. However, full resuscitation should not be initated if:

1. Do Not Resuscitate(DNR)/Do Not Intubate (DNI) orders are written, present at the scene, and signed by the private physician and the patient (or his/her guardian).

2. The DNR/DNI orders must contain proper signatures, appropriate dates, and a clear statement as tot he expected level of resuscitation.

3. There is no one at the scene that requests resuscitation, the EMS Supervisory Physician does not request resuscitation, and the paramedic is comfortable with not resuscitating the individual.

The paramedic will contact the appropriate EMS Supervisory Physician immediately upon seeing a DNR/DNI standing order. Further patient care will be at the direction of the EMS Supervisory Physician.

The recommended forms for the DNR/DNI orders are:

DNR:
Patient's name: _____
Physician's name: _____
Date of order: _____
Termination date of order: _____

In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated for the above-named individual.

It is understood that any request by any individual to proceed with resuscitation will nullify this order.

Patient's (or guardian's) signature: _____

Physician's signature: _____

* * * * * * * * * * * *

DNI:
Patient's name: _____
Physician's name: _____
Date of order: _____
Termination date of order: _____

In the event of an acute or impending respiratory failure endotracheal intubation to provide sustained assisted ventilation shall not be performed for the above-named individual. Wherein DNI does not prohibit emergency management to prevent or reverse acute airway obstruction with oral or nasal airways or treatment of transient respiratory insufficiency with oxygen or short trials of assisted ventilation with positive pressure, ventilation equipment or bag-valve-mask device.

It is understood that any request by an individual to proceed with resuscitation will nullify this order.

Patient's (or guardian's) signature: _____
Physician's signature: _____

Code/No Code
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home is not always available to lend support. And, many times, code status is not determined ahead of time."

DR. WACHTEL: "The nursing homes are definitely a primary problem, and that is where there is an immediate need for change and improvement. Patients should all have definitive code status. Some nursing home patients should definitely be full code, but others with no or low quality of life with multiple medical problems, should have a no code status. Each case, of course, should be weighed individually. That is why it is so vital to have specific documentation."

DR. MUNOZ: "Due to the nature of my practice, there is a high morality rate, and therefore, I've been very aggressive in educating family and patients in regards to documenting the patient's wishes. For every patient of mine confined to a nursing home, I send a letter to the family members or guardian that directs personnel to withhold and/or terminate life support measures. The form is then placed with the patient's documentation. As physicians become more comfortable, they will be more assertive in documenting this information. There is a need for patient education as well. I encourage patients to obtain a durable power of attorney for health matters, which designates someone to act as guardian for the patient in relation to health-related issues and decisions. I feel that it is better than a living will in that the living will is only appropriate when there is a terminal condition present and death is imminent."

DR. WAFFLE: "Once again, I turn to the physician to carry the burden. EMS will honor any type of do not resuscitate (DNR) order, even if it's written on a napkin, just as long as the information is spelled out and agreed upon by physician and patient. That order needs to be present and available.

"Patients need to be educated about how to use the 9-1-1 system. The patient or family members need to know when to call and when not to call. When a less-than-terminal condition is present, the family is sometimes hesitant to call 9-1-1 because they fear resuscitation. They need to be educated as to what death looks like. On the other hand, 9-1-1 might be called because the family wants confirmation that the patient is dying -- they don't want resuscitation, only assurance. We will provide medical care and transportation to the hospital without resuscitation."

DR. HILDEBRAND: "The situation is improving. I feel that hospice, home health and nursing home administrators are triggering improvements and better communication. We simply need a more definitive system than now exists."

DR. MUNOZ: "Were seeing more advances. WSMA provides information on legislation, there is more information disseminated about durable power of attorney. PRO/W is more involved in the issue. We find that it comes up more in committee meetings."

DR. WACHTEL: "Hospice has come a long way in disseminating information among those who need it. The group has been very influential and has become well known because it is not just a physician group, but a citizen group. The living will is more well known and more readily accepted. Physicians and their patients are becoming more accepting of death and more comfortable in discussing death. The issue is coming up more in specialty conferences, but is not brought up in study and meeting groups enough. That should change. We need to talk more about what to treat and what not to treat when there is a no code order."

DR. WAFFLE: "The improvements have not been drastic -- its a slow process. Physicians are more comfortable with death and dying and are beginning to set up programs to deal with the issue. There is a better awareness of the EMS system -- we've incorporated the ability for patient's to call 9-1-1 for help, but not for resuscitation. There is an understanding that ther can be non-life-threatening situations with terminally ill patients."

DR. MUNOZ: "We must have further clarification of the issues. It's vital to have more clinical data available to make these decisions. It's feasible and necessary to build an information data base on the code/no code situation.

"I also believe it is important that society more readily address the issue. Education needs to improve through audio-visual aides, television and movies. It's too important an issue to ignore." □

Principles for Determining Code Status of Patients in Nursing Homes

Nearly two million Americans reside in the 19,000 nursing homes in the United States, and this number is expected to grow for another 30 years. Many nursing home residents are short termers and may be expected to return to independent living, but perhaps two thirds of the residents admitted to nursing homes will spend the rest of their lives there.

Cardiopulmonary resuscitation was developed to attempt reversal of untimely and unexpected sudden death. The application of cardiopulmonary resuscitation in the care of chronically ill persons with permanent and often multiple organ system failures requires a different kind of analysis.

At the end of life the application of general medical care must also be individualized. General medical care includes antibiotics and drugs, surgery, cancer chemotherapy, and artificial hydration and nutrition must be individualized for each nursing home patient.

Acknowledging the concept of timely death in individual patients, the following principles and practices are presented to guide physicians and other care givers in nursing home care.

Principle:	**Practice:**
The principle of autonomy assures the patient the right to choose between options of care at the end of life.	Physicians should consult with patients about such matters as code status and mechanical supports. Adequate information should be provided in a nonjudgemental fashion to allow patients to make informed choices.
Advance directives in the form of living will are legal in Washington and are helpful guides to caregivers.	Physicians and other caregivers should make living wills available to patients early in their course when they are maximally competent in making choices.
Physicians should respect choices of individuals to forego even life-sustaining treatment.	Physicians should respect the patients' choices. If the physician disagrees significantly, he may withdraw from care for the patient after providing written notice and allowing sufficient time to obtain another physician.
When in doubt about the appropriate course of action, the physician should presume in favor of life.	When the patient's desires are not known, are unknowable, and the physician has no previous knowledge of the patient's situation, the physician should act to support life.
When the patient is not competent to choose a course of action, the physician should seek to act as the patient would have chosen by seeking substitute judgement for the patient.	Often patients have declared to family and other caregivers in the past how they would choose care for themselves at the end of their lives. If the patient is no longer competent, his/her prior desires should be respected if they can be discovered.
Although the patient's desires are primary, the physician is not required to follow them in certain circumstances:	
• The patient requests unethical treatment, such as assistance in suicide, unapproved drugs, or treatments.	• The physician should inform the patient of his ethical responsibilities with respect to such issues.
• The patient requests a treatment that violates the moral or religious beliefs of the physician.	• Examples of such treatment include abortion, a patient request for withdrawal of life-sustaining procedures or a request for no code status.
• The patient wishes to draw on a limited resource	• The physician should share his notion of the

Principle (cont.)	*Practice (cont.)*
Patients lacking full decision capacity should be consulted to the degree feasible.	A patient's orientation and memory may be poor but he/she may be very decisive about certain decisions, likes and preferences. The patient's desires should be given close consideration.
Unpleasant information should not be withheld from patients simply because it is unpleasant.	The physician should provide information to patients to allow them to participate in informed deision making. This can and should be done without removal of hope for cure, but with the promise of humane and compassionate treatment regardless of diagnosis or unpleasant information being provided.
When the patient is totally unable to participate in decision making and there is no way of knowing the patient's prior desires, the physician must bring to bear his special technical knowledge and at the same time be careful not to substitute personal bias for his best judgement.	In this difficult setting it is always preferable when all caretakers and family are in agreement. The physician may need to initiate and lead a discussion amongst the involved parties in order to achieve a consensus.
The drive to sustain life can conflict with another possibly more venerable principle of medicine -- the relief of suffering.	When further intervention has only the prospect of prolonging the dying process, the physician may opt for the relief of suffering.
For patients in a persistent vegetative state with no hope of recovery, it is morally justifiable to limit antibiotics and artificial nutrition and artificial hydration as well as other life-sustaining treatments, allowing the patient to die. The physician should be guided by the need to provide the most humane kind of treatment.	Careful efforts to know patient's prior wishes should be made and this course of action requires the understanding and agreement of the family and other caregivers. It is ethically permissible to withhold artificial nutrition and artificial hydration provided by vein or gastric tube, and it is ethically acceptable not to treat intercurrent illness except with measures required for comfort.
No code status never means the withdrawal of care and support.	Continuation of care and support must be explicitly expressed to the patient and other caregivers and documented in the record.
Withholding or withdrawing life-sustaining treatment allows even greater attention to the relief of suffering.	Orders should direct action for the relief of pain, thirst, dyspnea, anxiety, fear and other kinds of distress and may take priority over correcting physiologic parameters in the dying patient.
The preeminence of the patient's choice does not preclude the physicians from making and sharing with the patient a personal judgement about what the patient should do.	The physician should share his/her judgement with the patient, but alternatives should also be made apparent. Statements such as "You have no choice" and "You must..." are rarely appropriate even though they may reflect the physician's strong judgement and opinion.
Code status should be determined and indicated on the medical record or patients in nursing homes. Slow codes and codes after telephone calls are not acceptable standards of care.	A patient and a patient's family have the right to understand the code policies and practices in an institution and participate in a decision as to their application.

Neither these principles, nor any principles, can be adequate to cover every possibility. They are designed to provide assistance in the majority of cases encounterd in nursing home care.

Reprinted from the Bulletin of the King County Medical Society, October 1985. □

Physician Use of the HIV-Antibody Test

By Renslow Sherer, MD

The following commentary is reprinted from the January 8, 1988 issue of the Journal of the American Medical Association.

In 1985, I was the primary physician for a young man whose life was ruined by the inappropriate disclosure of a positive human immunodeficiency virus (HIV)-antibody test. A physician ordered the test without consent and notified the local health department of the positive result. The health department notified the individual's employer and he was promptly fired. These events became common knowledge at his workplace and in his rural Midwestern town and he was shunned. His landlord asked him to move. Ten days after testing, the life he had known for the past 10 years was permanently ruined and he left town. With the loss of his job came loss of health insurance and insurability; he has been unable to obtain health or life insurance since then.

In this case, no purpose was served by obtaining the HIV-antibody test. The patient had been diagnosed with acquired immunodeficiency syndrome (AIDS)-related complex -- which has a 95 percent correlation with HIV infection (R. Sable, MD, and R. Sherer, MD, unpublished data, August 1985 [1,2]) -- six months earlier at Cook County Hospital. He was aware of his diagnosis and its implications. He had been following safe sex guidelines for the preceding 18 months and had never donated blood or semen.

This is but one example of the potential harm to an individual that can result from HIV-antibody testing. Loss of jobs, insurance or insurability, and housing and social ostracism have all been reported following disclosure of test results or even disclosure of seeking the test. [3,4] The adverse psychological impact of testing positive is well documented [5,6]; suicide attempts and major depressive illness have been described. [7,8] As in the case above, these consequences may be immediate, severe, and irreversible. Finally, there is evidence that a false sense of security may occur after a negative HIV-antibody test and that unsafe behaviors may result.

An Adjunct to AIDS Education and Prevention

In light of these risks, physicians have a profound responsibility to educate themselves about the meaning, appropriate use, and potential adverse consequences of the HIV-antibody test before ordering a single test. Most important, physicians must learn the nature and content of pretest and post-test counseling and be able to provide such counseling (either directly or via referral), including a frank discussion of the potential risks and the availability of anonymous testing (where available) at counseling and testing sites. Such counseling will guarantee that the primary purpose of the HIV-antibody test is an adjunct to AIDS education and prevention will be fulfilled. Physicians must also be aware of the critical need for strict confidentiality safeguards for this information. One may best approach the issue of confidentiality personally to appreciate its sensitivity. If this positive test result belonged to a member of your family or to a loved one, how would you want it to be handled? Who should share that information? Physicians should remain skeptical of even the strictest confidentiality safeguards, especially in hospitals and offices, where such safeguards are commonly unenforced and are extremely difficult to guarantee.

Some states have established laws to assist the public health goals of testing and counseling and to mandate confidentiality protection. In Illinois, it became the law as of Sept. 21, 1987, that every HIV-antibody test must be accompanied by written informed consent and appropriate counseling (unless otherwise stipulated by law). Unlawful disclosure of that information is a misdemeanor with a maximum fine of $5,000.

An article in the January 8, 1988 issue of JAMA by Henry et al [9] reports a lack of informed consent or counseling or both in 90 percent of persons testing for HIV antibody by physicians. Pretest counseling, which includes information on HIV transmission and explicit recommendations on its prevention, was not provided to 188 of 275 people tested. From the personal perspective of these patients, as well as a public health perspective, these tests were valueless and represent lost opportunities for education and prevention of HIV transmission. As important, 18 of these 188 people were seropositive; an unknown number may have been falsely negative. Because these test results are now part of the medical records of these patients, the adverse consequences of the test may still affect these individuals.

HIV Infection is Not AIDS

The authors report that five (20 percent) of the 25 persons with HIV infection were mistakenly recorded by physicians as having AIDS, though in fact they had stage I HIV infection, i.e., asymptomatic infection. How many hundreds or thousands more physicians will repeat this error?

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HIV-Antibody Test
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Rather than a 50 percent chance of an illness-free period of seven years, patients may be mistakenly informed that they have an average of 10 months to live and a 90 percent likelihood of death within two years. Widespread misrepresentation of the HIV-antibody test as an "AIDS test" by the media, physicians, and others reinforces this occurrence. As the authors suggest, physician education regarding AIDS is still widely lacking. Physicians and hospitals should consider guidelines to limit the use of the HIV-antibody test to qualified physicians with experience in AIDS care and HIV testing, as well as development of specific AIDS education programs for physicians.

Another form of misuse of the HIV-antibody test has been the premature disclosure of unconfirmed enzyme-linked immunosorbent assay (ELISA) results. Henry et al report that in six (2 percent) of 275 HIV-antibody tests given (representing 24 percent of the 25 positive tests) physicians erroneously interpreted positive ELISAs as positive for HIV antibody despite negative Western blot tests. No description is given of the consequences of this error, but the possibility of patients being misinformed is sobering. Despite false-positive rates of the ELISA of 1 percent [10,11] and a positive predictive value of a positive ELISA of less than 30 percent in the general population, [10] some physicians inform patients of ELISA results pending confirmatory tests. This is analogous to a physician informing a patient that a biopsy specimen "might be malignant." Human immunodeficiency virus-antibody test results should be shared with patients only when all of the pertinent information is available, including the results of confirmatory tests and consultation with specialists if necessary. Recommendations for behavior changes that prevent HIV transmission should be reasonably based on identified risk behaviors alone and not limited to the time of testing.

Counseling and Consent with Every Test

In summary, the HIV-antibody test is in no way "routine"; the use of this word in relation to this test is inappropriate and should be discouraged. Every HIV-antibody test should be preceded by written informed consent, which includes a detailed explanation of the test and its meaning, the reason for ordering the test, and its potential adverse consequences. In addition, explicit counseling regarding AIDS and HIV transmission and its prevention should accompany every test, as well as notice of the option of anonymous testing (where available) at counseling and testing sites. Confidentiality safeguards are essential, but the physician's ability to guarantee them with certainty in hospitals and offices is limited and should be honestly portrayed as such to patients.

Within the context of the principles outlined herein, the physician's responsibility is to encourage voluntary HIV-antibody testing for people at risk. False-positive ELISAs are common in low-risk populations; physicians should be skeptical of positive results and insist on confirmatory tests. Unconfirmed positive ELISAs are sometimes misinterpreted and misrepresented to patients by physicians both as true-positive and as indicating a diagnosis of AIDS. This occurrence of false-negative tests in early HIV infection and in some individuals for many months reinforces the limitations of testing and mandates thorough counseling and recommendations for behavior change in all at-risk individuals irrespective of test results. The clinical use of HIV testing is limited by the lack of discrimination between asymptomatic and symptomatic infection; T-cell studies and specialty consultations may be helpful. In light of the potential adverse consequences, physicians may preferentially recommend that individuals at risk seek out HIV-antibody testing in an anonymous context (where available) at counseling and testing sites. Physicians who offer the test should provide adequate pretest and posttest counseling and attend to the need for strict confidentiality regarding that information. □

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Uncompensated Care
Continued from pg. 18

individuals off the bottom of the priority list. The debate becomes far more focused. If someone wants to re-fund the transplant program, clearly they either have to knock something else off the priority list -- and they must make a choice, a clinical choice and a political choice, between those two health care services -- or they have to rob another program or raise more money (increase taxes).

The final point with this type of system is that if it is done on the basis of sound clinical information, money can actually be saved. A California obstetrics-access study suggested that the cost of treating an indigent woman for prenatal care and delivery was $1,000 and the cost of treating a low-birthweight infant was $28,000, up to six figures. The study suggested that if prenatal care were provided to all the indigent women who needed it, $22 million a year could be saved in the health care system.

That is money that can be used to add services on the priority list, such as major soft organ transplants. It could be used to raise provider reimbursement to a reasonable level and thus remove the current economic disincentive to treat the medically indigent and those on Medicaid, or it could be used for roads. In any event, the debate becomes much clearer and more focused. Accountability is inescapable.

What is the role of physicians in resolving this problem? The first and most significant role we have to play is that we must come to grips with our own limits. We have to recognize that health care resources in America are, in fact, limited. If the leadership of professional medical organizations is going to publicly refuse to recognize that health care resources are limited, how can we expect the public to accept that, and how can we expect state legislatures to recognize that as well? If we are not willing to recognize this ourselves, we are inviting all of the ominous social and professional consequences that uncompensated care is bringing our way. As a first priority, therefore, physicians must recognize and accept limits in health care, express that view publicly, and talk it over with each other and with their patients.

Second, through our professional organizations we need to adopt policies on how to expend limited public health care dollars. Your society or association may already have such a policy, but, if not, I would suggest one that states that the first priority should be to extend an adequate level of care to everyone. Then, and only then, should we indulge ourselves in the debate over how to spend what is left in the budget.

This means, of course, that we must also get involved in the definition of adequate. Physicians are really the only group in this country with the qualifications to provide sound clinical information to the state legislature. We need to say:

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"Yes, we are going to have to ration health care in this country. It is inappropriate and unethical for physicians to do the rationing; society needs to do it. And if you, the legislature, are going to ration health care, here is a list of priorities that make sense clinically. This makes sense in terms of marginal costs and marginal benefits. This makes sense in terms of probable outcome." Physicians have to provide that input. Then we have to support legislative decisions that make responsible resource allocation choices. We have to do that publicly, in our community, and at the legislative level.

This, then, is the threat and the challenge of uncompensated care. The solution, I believe, is a partnership between public policymakers at the state legislative level and leadership in the community. If left unresolved, this problem of uncompensated care is going to result in an erosion in our social commitment to universal access to health care and a deterioration of health for a growing number of Americans, with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system, which will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We need not accept this outcome. In fact, we cannot accept this outcome. With the active involvement and leadership from the medical community, we can meet this challenge and restore some rationality and equity and economic stability to our health care system.

I ask you to join me in meeting that challenge. ☐

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MEMBERSHIP

August Readings

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

WILLIAM L. BENSON, MD, OB/Gyn. Born in Grand Forks, North Dakota, 9/14/41. Medical school, University of Iowa College of Medicine, 1966; internship, University of Oregon Medical School, 6/66-6/67; residency, Tripler Army Medical Center, 2/69-2/72; fellowship, Armed Forces Institute of Pathology, Gynecologic Pathology, 7/74-7/76. Washington State License, 1981. Dr. Benson is currently OB/Gyn department chief at Madigan Army Medical Center. He will begin practice at Western Clinic September 1.

ROBERT W. GIRVIN, MD, Ambulatory Care. Born in Seattle, 11/24/55. Medical school, New York University, 1982; internship, Virginia Mason Hospital, 6/82-6/83; residency, Virginia Mason Hospital, 6/83-6/85. Washington State License, 1983. Dr. Girvin is currently practicing at Thunderbird Redi-Medical Center.

DAVID W. McENIRY, MD, Internal Medicine/Infectious Disease. Born in New York City, 6/19/51. Medical school, University of Virginia School of Medicine, 1977; internship, University of Iowa Hospitals/Clinics, 6/77-6/78; residency, University of Iowa Hospitals/Clinics, 7/78-6/80; graduate training, New England Medical Center, infectious disease, 7/82-6/84. Washington State License, pending. Dr. McEniry is currently practicing with Drs. Alan Tice, Peter Marsh and Philip Craven in Tacoma.

GREGORY W. RURIK, MD, Pediatrics. Born in Chicago, 1/24/59. Medical school, Washington University (St. Louis), 1985; internship, Stanford University, 6/85-6/86; residency, Stanford University, 7/86-6/88. Washington State License, 1987. Dr. Rurik is practicing with Pediatrics Northwest.

MARK S. YUHASZ, MD, Diagnostic Radiology. Born in Bethlehem, Pennsylvania, 7/15/56. Medical school, University of Pennsylvania School of Medicine, 1983; internship, Allentown Affiliated Hospitals, 7/83-6/84; residency, University of Arizona, 7/84-6/87; graduate training, University of Arizona, 7/87-6/88. Washington State License, 1988. Dr. Yuhasz is practicing with Tacoma Radiology.

New Members

The Board of Trustees has approved the Credentials Committee recommendation that the following applicants be approved for PCMS membership:

Thomas Baker, MD, Hematology/Oncology, Tacoma

William Bray, MD, Ophthalmology, Puyallup

Loren Finley, MD, OB/Gyn, Tacoma

Deborah Hammond, MD, Family Practice, Tacoma

Kathleen Sacco, MD, Pathology, Tacoma

Wayne Smith, MD, Anesthesiology, Tacoma

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Application deadline is Thursday, September 15, 1988

PCMS
NEWSLETTER
♦ A publication of the Pierce County Medical Society ♦

Volume 3, No. 6 September 1988

City Council Authorizes Sept. 20 Fluoride Vote

At its August 2 meeting, the Tacoma City Council unanimously authorized a September 20 city vote on a proposal brought forth by the Medical and Dental societies to add fluoride to the city's water supply. The 8-0 vote to place the issue on the ballot followed an intensive campaign by the Committee for Better Dental Health, in which over 5,000 Tacoma residents' signatures were gathered.

Mayor Sutherland commended the societies for "having done the footwork," and remarked "go get 'em!" in his closing comment to Committee Chairman Dr. Terry Torgenrud, who -- along with Dr. Bill Jackson and Dan Gallagher, D.D.S. -- testified in favor of the resolution. Councilwoman Karen Vialle also applauded the societies for bringing this significant health issue before the public.

The Council had the option of enacting or rejecting the initiative. Had they elected not to take action for 30 days, the issue would have been delayed until the 1989 general election. Councilmen Greg Mykland and Tom Stenger voted in support of the ballot measure, but expressed reservations on adding fluoride to the water supply and said the voters should have the opportunity to express their preference on the matter.

In a July 11 editorial, The Morning News Tribune gave the fluoride initiative a ringing endorsement, stating, "Tacoma shouldn't stay in the unfluoridated backwater of rampant decay."

Many volunteer hours have gone into the effort to gather signatures and place the issue on the ballot. As we go to press, the Committee is meeting weekly to lay out a strategy for the last weeks of the campaign. Doorbell ringers and volunteers to staff the phone trees are needed in these last few days of the campaign. If you can make the time, please call the Medical Society office at 572-3667.

Candidates Interviewed

Dr. Bill Jackson and a team of PCMS physician members and Auxiliary representatives interviewed legislative candidates during August in order to discuss the concerns of the medical community and to hear the candidates' views on these vital issues.

All of the candidates have expressed a sincere desire and interest to meet with Society and WAMPAC representatives.

The Medical Society strongly urges members to support the candidates of their choice through personal and financial involvement and commitment. During the candidate interviews, we found that very few physicians are involved in any of the campaigns or in any facet of the organizations. To have a voice in the legislative process, you have to get involved.

Puyallup Addresses Fluoride, Smoking Issues

Dr. Gordon Klatt and PCMS staff met recently with Puyallup's Mayor Ron Crowe and City Manager Gary Holt to discuss smoking ordinances and the possible fluoridation of Puyallup's water supply.

The city officials are complying with the State Clean Indoor Air Act and maintain quality no-smoking policies in city buildings and work environments. Dr. Klatt urged the passage of a city ordinance that would prohibit distribution of free "sample cigarettes" at the Puyallup Fair. Many minors take advantage of the opportunity to obtain cigarettes, and for some, it is their first chance to start smoking. Mayor Crowe and Mr. Holt expressed a strong interest in discontinuing the distribution.

To initiate the process of fluoridating Puyallup's water supply, the city officials requested that a letter be sent to them recommending fluoridation. A letter was subsequently forwarded to Mayor Crowe, which included an offer of assistance from the Medical Society.

Please encourage your patients, friends and colleagues to vote

YES on Proposition 2, September 20!

Come to the House of Delegates

When the WSMA House of Delegates meets September 15-18 in Yakima, the Medical Society will introduce 11 resolutions concerning such matters as: involvement of physicians in determining the criteria for nursing home inspections; community support for the Basic Health Plan; the need for all infants of addicted parents to be staffed by knowledgeable physicians and placed away from addicted parents; Health Department vaccines; Sickle Cell Disease; seatbelts and motorcycle helmets; Medicare supplement insurance; Medical and Osteopathic Disciplinary Boards; sales tax increase on all tobacco products; and greater education on infant mortality.

WSMA priorities are established by the House of Delegates at its annual meeting. The issues are debated in the reference committees and in the House of Delegates. Attendance at the meeting will give you an opportunity to see and hear what is happening regarding the RBRVS, the Omnibus AIDS bill, PRO/W, DSHS, Medical Disciplinary Board and many others.

Come see democracy in action and get a great education in the process. It will be a worthwhile trip -- try to make it. Call the Society office at 572-3667 for more details.

EMS Update

EMS Committee Chairman, Dr. Bob Wachtel, and Dr. Bill Jackson, PCMS President, have been making a strong effort to bring about change in the current county EMS system and pre-hospital care.

In May, the Board of Trustees approved a statement calling for a full-time medical program director (MPD) with expertise in EMS to head the system. Drs. Wachtel and Jackson have been meeting with representatives of the county fire districts, ambulance owners, Tacoma Fire Department, P.C. Hospital Council, and Emergency Nurses Association to strengthen the system.

Meetings have been held with individual members of the Board of Health to explain the objectives of the reorganization proposal.

There is unanimity among providers that the system should be changed and strong medical control is necessary. Some differences do exist, however, regarding the role of the health department in the new structure. Most of the differences appear to be negotiable.

Currently, Dr. Jackson and Dr. Paul Hildebrand are sitting on a committee appointed by County Executive Joe Stortini to review ambulance ordinances that were adopted on an emergency basis.

The Board of Health will hear the EMS Council's proposal for reorganization at its September 7 meeting.

Library Undergoing Changes

The Library Committee continues to make strides in upgrading the organizational structure of the Pierce County Medical Library, according to Dr. Bill Dean, committee chairman. Numerous changes are taking place which are expected to further enhance this quality library system.

The library has been incorporated as a 501(C)(3) under the IRS code, subsequently making it a tax-exempt organization.

The Board of Directors is now composed of two representatives from the Medical Society, two representatives from the Multicare Medical Center and three at-large members.

Recruitment for a head librarian is currently underway, and the personnel committee will begin interviewing candidates in the near future. Current library staff members are eligible and encouraged to apply.

The Board of Directors has announced that it will be contracting with other hospitals for services currently provided and may contract for additional services in the future. The Board has also been studying contracts that other library systems have with hospitals in order to determine the level and cost of services to be provided.

Pierce County physicians are fortunate to have a first-class, high-quality library system, a luxury not available to the majority of their colleagues in other parts of the state.

Tremendous Response to Basic Health Plan

Over 125 PCMS members have signed a letter of intent to participate in the Washington Basic Health Plan. As a result, a physician and hospital provider network of sufficient size and scope would be available to provide health care to the 5,000 Pierce County residents expected to enroll in the plan.

In response to a proposal sent to PCMS members in mid-July by the Society and the Pierce County Medical Bureau, one or more members in nearly every specialty represented in the Society expressed an interest in participation, a clear indication of the social conscience of our membership.

The purpose of the Basic Health Plan is to provide access to the necessary, basic and affordable health care services for uninsured people with incomes below the 200 percent poverty level who are not eligible for Medicaid. The plan is an effort to demonstrate the benefits of providing health care to those who, when given

Continued on page 3

The *PCMS Newsletter* is published eight times a year by PCMS Membership Benefits, Inc., for members of the Pierce County Medical Society. We welcome and invite your letters, comments, ideas and suggestions.

Pierce County Medical Society
705 South 9th St., Suite 203
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(206) 572-3667

Advertising and newsletter copy must arrive in the Society office by the 15th day of the month preceding publication date. Advertisements in this newsletter are paid and not necessarily endorsements of services or products.

BHP *(cont. from page 2)*

affordable options, choose to insure themselves and their families.

BHP is a landmark $15 million demonstration project, administered by an independent state government agency, designed to provide coverage for as many as 30,000 low-income, uninsured Washington residents. The plan was created by the passage of HB477 during the 1987 legislative session. The plan will offer a basic package of health care benefits in up to five areas of the state through capitation agreements with a variety of managed health care systems.

People under 65 who do not qualify for Medicaid and earn less than 200 percent of the federal poverty level for their family size will be eligible to enroll in the plan if they live in one of the five service areas. Enrollees will pay reduced monthly premiums based on their family size and income. The difference between premiums and amounts paid to managed health care systems will be subsidized by the BHP through state revenues.

Planned benefits will include physician, hospitalization, emergency, lab and X-ray services, emergency ambulance services and preventive services such as childhood immunizations and prenatal care. Some services will require co-payments.

As reported in the August 16 edition of the Morning News Tribune, the Pierce County Medical Bureau is one of eight health-care systems that made a bid to help launch the Washington Basic Health Plan. While a Pierce County site is not a certainty, Thomas Kobler, director of the plan, said it stands a strong chance. Sites will be selected based on the capability of the program bidders, as well as the needs of the communities, he said. "Our list has always depended on where the providers are interested and the services available," Kobler said.

Other bidders include Columbia Health Services of Vancouver, Snohomish County Physicians Corp., the Good Health Plan of Washington from Seattle, Group Health Cooperative of Seattle, Group Health Northwest of Spokane and County Physicians Services Inc. of Port Angeles.

Following selection of an initial site, participating managed health care systems are expected to begin providing services to members within that area in October. Four more sites will be phased in before July 1989.

The Society has reason to be proud of its members who stepped forward to participate in a plan that would help many less fortunate communities.

To assist Medical Society members in planning for the coming year, the College of Medical Education (COME) has announced its 1988-89 program schedule. A complete calendar, including course descriptions, was recently sent to members. Remember...MARK YOUR CALENDAR!

1988	
Nov. 2, 3	Common Office Problems
Dec. 8, 9	Advanced Cardiac Life Support
1989	
Jan. 12	Pharmacology in Medicine
Jan. 19	Law and Medicine Symposium
Feb. 1	AIDS
Feb. 10	Office Gynecology
March 9, 10	Tacoma Academy of Internal Medicine
March 22, 23	Orthopedics and Sports Medicine
April 14, 15	Tacoma Surgical Club
April 26, 27	Computers in Medicine (Clinical Applications
May 17	Neurology
June 26, 27	Advanced Cardiac Life Support

Sept. General Membership Meeting

Why did the Attorney General's office decide to investigate and file charges against the Central Washington Hospital and Wenatchee Valley Clinic, alleging violations of anti-trust statutes? Why did the clinic agree to a settlement that would provide free medical care worth nearly a million dollars and consent to roll back fees?

What will be the impact of the Supreme Court's decision to overturn the "Patrick" or "Astoria Clinic" case on peer review in Washington state?

John Ellis, Deputy Attorney General, will address these issues at the General Membership Meeting, Tuesday, September 13, at Fircrest Golf Club. Attorney General Ken Eikenberry may accompany Ellis, campaign schedule permitting.

No-host cocktails will be served at 6 p.m., dinner is scheduled for 6:30 p.m., and the program will start at 7:45 p.m.

A September General Membership Meeting notice and reservation form can be found on page 13 of this PCMS Newsletter. Reservations are due to the Medical Society office by Friday, September 9.

Field Day a 'Shining' Success

The 1988 Doctor/Lawyer/Dentist Field Day, held June 10, was deemed a rousing success by all who participated. Despite threatening rain clouds, the event came off without a hitch and under (unexpected) sunny skies.

Congratulations go to the following doctors who were awarded prizes in the golf event at the Tacoma Golf and Country Club: Dr. Jay Winemiller, low gross; Dr. Robert Martin, low net, first place; dual-winner Dr. Dick Bowe, low net, second place, and closest to the pin; Dr. George Madsen, low calloway, first place; Dr. Bill Jan, low calloway, second place; and Dr. Hugh Larkin, high gross.

In the tennis competition, held at the Lakewood Racquet and Tennis Club, Dr. Larry Larson won the "A" flight.

All of the participants in the 1988 Field Day wish to extend a sincere "thank you" to the following sponsors who provided prizes and refreshments for the players:

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See you all in '89!

Physician Payment Reform Reviewed

The WSMA Interspecialty Council met recently to review the state of physician payment reform and the Harvard Resource Based research program.

The AMA's interest in the development of new Relative Value Scales -- representing relative values of physician services, one to another -- began in 1984. It remains AMA's conclusion that a schedule of physician payments, based on an appropriate RVS, and allowing for balance billings, could provide a rational and acceptable basis for physician reimbursement under Medicare -- particularly in comparison to such alternatives as physician DRGs.

Since 1984, the AMA Board of Trustees has reported to the House of Delegates at each of its meetings on the course of AMA efforts to develop a new RVS. The RVS study is being conducted by Harvard University, with the AMA as a subcontractor.

The major objectives of the study are to produce resource-based relative value scales for 17 medical and surgical specialties and subspecialties accounting for substantial Medicare expenditure and to review that RBRVS with a broad-based group of interested persons.

Funding from HCFA covered the development of RVS's for 12 specialties and subspecialties: anesthesiology, family medicine, internal medicine, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, pathology, radiology, general surgery, thoracic surgery and urology. Five specialties provided funding from other sources to participate in the project: allergy and immunology, dermatology, pediatrics, psychiatry and rheumatology.

The resource inputs upon which the RBRVS is built are: time, intensity, practice costs, and opportunity cost of training. Data on time and the elements of intensity -- which together make up total work -- were collected through a national physician survey. Components of intensity were: mental effort, judgement, knowledge and acumen; physical effort and technical skill; and stress and iatrogenic risk to the patient.

In addition to time and intensity, total work was estimated directly by the surveyed physicians. These direct estimates were the primary basis on the RBRVSs calculated. Statistical analysis of the data on total work, time and intensity had indicated that the direct measure of total work was strongly associated with the measurements of its components, and hence could be used directly in the RBRVS.

Harvard is near completion of the technical stage of the project, in which data is collected, reviewed and analyzed.

A consultive conference was held in March to obtain reactions to the study and its results. Approximately 150 representatives from medicine, academia, business, government, third parties and consumers heard oral presentations and discussions of the methods and preliminary results of the study. One important conclusion of the meeting is that researchers need to do extensive "sensitivity analyses" and need to see whether changing their assumptions produces important changes in the results. They plan to include such analyses as part of their report to HCFA.

Harvard will not extend its findings to specialties that have not been intensively studied in this current project. However, the most recent budget reconciliation bill requires the Secretary of Health and Human services to extend the RVS to additional specialties: cardiology, nephrology, neurology, neurosurgery, nuclear medicine, oncology, psychiatry, plastic surgery, pulmonology and radiation therapy.

AMA position and policy will be required on the RVS study itself, as well as its possible implementation and a

Continued on page 5

Payment *(cont. from page 4)*

new Medicare payment system. These will be based on a careful review of the study by AMA staff, the Board of Trustees and House of Delegates.

The review will carefully consider the methodology of the RVS study and will estimate the likely effects of the RVS on beneficiaries, physicians, and the Medicare budget. AMA will work closely with others in reviewing the study, including state medical associations, specialty societies, the Physician Payment Review Commission and HCFA.

The AMA will: work with the federation to ensure that timely and accurate information on the RVS is available to all concerned parties; integrate federation views into AMA policy development; and build common perspectives within medicine on Medicare Physician Payment.

It was stressed that physician payment reform is likely to proceed regardless of whether or not the adminstration or Congress embraces the Harvard RVS study per se. Members of the Washington Delegation have clearly stated to WSMA leadership that they see Congress moving to: (1) further cut Medicare expenditures; (2) reform payment methodology, and (3) insure some type of beneficiary protection. Significant action in Congress on physician payment and general Medicare reform is anticipated in 1989 with the earliest possible implementation expected to be January 1990.

The potential for disunity within medicine is high. Attendees were reminded that it is not the RVS per se, but rather the conversion factor if an RVS is implemented, that will be critical. Medicine must negotiate the issue with maximum unity, or specialty societies will be "picked off" one by one. The AMA is strenuously lobbying the continuation of physicians' freedom to balance bill.

A full report on the Harvard study is expected at the WSMA 1988 Annual Meeting in Yakima, September 15-18. If the AMA work on the study has not progressed sufficiently to give the December AMA House of Delegates an opportunity to thoroughly review the issue, a special meeting of the AMA-HOD is likely to be called after the first of 1989.

Emergency Medical Responses in Physicians Offices

By John K. Murphy, PA, ET-P, Lakewood Fire Department

Acute medical emergencies are a rare occurrence in most medical offices, and, depending on the type of practice, medical emergencies are not the usual office standard.

When you have an emergency situation in your office and you call 9-1-1, a number of procedures occur. First, access to emergency care is gained through the 9-1-1 telephone system. The call is answered by a call receiver/dispatcher who will ask questions to determine the emergency situation. The call receiver/dispatcher will then notify the closest fire department engine company, staffed with firefighters/Emergency Medical Technicians (EMTs) and the paramedic-staffed Fire Department Medical Rescue unit. At present, only the city of Tacoma, Lakewood, University Place and Summit/South Hill fire departments have paramedic-staffed medical rescue units. All fire departments, however, have EMT-staffed engine companies.

Finally, a private transport ambulance, staffed with a paramedic and EMT driver, will be dispatched to complete the emergency response.

All agencies, responding with red lights and sirens, will come to your office to attend to the patient.

Overkill? Perhaps...

Emergency Medical Services (EMS) will respond with this configuration when unknown medical situations or other life-threatening situations arise. When the occurrence is a medical "urgency" (non-emergent emergency), the closest engine company and local ambulance will respond to the request for medical aid.

How do you control this equipment and manpower resource?

First, be specific as to the emergency. If it is a cardiac arrest, then the manpower is helpful. If it is a stable gastrointestinal bleed that requires transporting the patient to the hospital, then manpower is not needed.

Second, the 9-1-1 emergency dispatchers are not affiliated with private ambulance companies. If you want a specific ambulance company, you must call them on their private lines. If they respond with red lights and sirens, however, they must notify the fire district where the call originated. This may prompt a fire department response. Remember, the ambulance company may have a long response time as they could be on another call and may not be the closest emergency medical agency.

Finally, if you have a medical emergency within your office and the paramedics arrive, they may act under your orders only if the requests do not exceed the existing Pierce County protocols. If you give an order that contradicts the protocol (page 15, PCEMS Protocols), then the paramedics must contact their base station physician for clarification of the order. You may be asked to converse with the base station physician concerning the care of the patient.

Please remember, the EMT/firefighters and paramedics are

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Emergency *(cont. from page 5)*

experts in field medicine. We are all in the patient care business. While you may not be used to dealing with this level of medical provider, the patient will receive the best care possible during the resuscitation and transport to the hospital.

For more information on the Pierce County EMS System and Medical Protocols, contact the EMS office at 420 S. Fawcett, Tacoma, or call 591-5747.

1988 Salary Survey Results

In July, Membership Benefits, Inc. mailed its 1988 Salary Survey questionnaire to all PCMS members. We were very pleased with the response and would like to take this opportunity to thank everyone who participated in the project. We believe the information provided will help you in hiring new staff and reviewing current staff for salary increases.

If you would like a confidential copy of the survey results mailed to your home address, please contact the Society office at 572-3709.

September Calendar

Sept. 6, Board of Trustees
Sept. 7, Grievance Committee
Sept. 8, MBI Board
Sept. 8, PCMS Caucus for WSMA Mtg.
Sept. 9, Committee on Aging
Sept. 12, Medical-Legal Committee
Sept. 13, General Membership Mtg.
Sept. 14, Credentials Committee
Sept. 15, Tobacco Task Force
Sept. 15-18, WSMA Annual Meeting
Sept. 19, COME Board of Directors
Sept. 20, Executive Committee

Sept. 20, Primary Election (Vote YES on Fluoride!)

Sept. 21, Public Health/School Health Committee
Sept. 22, EMS Committee
Sept. 28, AIDS Committee
Sept. 29, Fluoride Committee

AMA Update

Trends

Based on current trends, the active U.S. physicians population is expected to rise from 519,411 in 1986 to 633,200 in the year 2000, an increase of 21.9 percent, the AMA's Center for Health Policy Research predicted in a new monograph released in June.

Approximately one-fourth of U.S. physicians then will be women.

Approximately one-fourth of U.S. physicians then will be women. More physicians will work in general internal medicine than in any other specialty. Other specialties expected to experience high levels of growth are emergency medicine (55 percent), pediatrics (35.8 percent), anesthesiology (35.4 percent), radiology (27.3 percent), and obstetrics/gynecology (22.7 percent). The projections indicated a moderate growth of 5.6 percent in the total number of foreign medical graduates (FMGs), due to an increase in the number of U.S.-born FMGs. A 1.2 percent decline in alien FMGs is anticipated.

To order the report, *Physician Supply and Utilization by Specialty: Trends and Projections*, contact the AMA's Order Department, P.O. Box 10946, Chicago, Illinois 60610-0946. The

Continued on page 7

AMA *(cont. from page 6)*

publication number is OP-237. Copies are $24 for AMA members; $30 for non-members.

Patient Medical Instruction

Patient Medical Instruction (PMI) sheets are now available exclusively from the U.S. Pharmacopoeial Convention. AMA, which introduced the PMI program in 1982, strongly encourages members of the profession to obtain PMIs (now available on 90 percent of drug classes) to enhance patient compliance in drug use, increase the effectiveness of drug therapy and to strengthen the patient-physician relationship. Currently, there are 83 different PMIs available in pads of 50 sheets. Both the AMA and the USPC welcome inquiries and suggestions regarding PMI content and format. To place orders, call 1-800-227-USPC. For additional information regarding PMIs, call the AMA at 1-800-645-4557.

Legislation

Most of the nearly 100,000 clinical laboratories operated in physician offices likely would be forced to close after 1990 unless a provision contained in OBRA '87 is either repealed or substantially modified, the AMA told a House subcommittee in early July.

AMA President-elect Alan R. Nelson, MD, testified before the Subcommittee on Health and Environment of the House Energy and Commerce Committee, which held hearings on lab regulation. It is essential, Dr. Nelson stressed, that MDs not be precluded from providing their patients with office-based clinical lab services, which afford diagnostic timeliness, improved access, and patient convenience.

Under a provision of OBRA '87, all clinical laboratories providing more than 5,000 tests a year would be required to meet existing independent clinical laboratory requirements, including personnel standards, starting in 1990. Physician offices currently are exempt from this requirement.

At the 1988 Annual Meeting, the House of Delegates adopted a statement outlining mechanisms to assure the quality of in-office testing. It supports development of national quality assurance standards for physician office laboratories, based on factors such as proficiency testing, quality control, and continuing education.

Medicare Participation Increases

The percentage of physicians participating under Medicare surged by 21 percent from 1987 levels, according to HCFA reports. The percentage of participating physicians jumped from 30.6 percent in 1987 to 37.3 percent for this year. Since the "participating physician" program was implemented in 1985, the percentage of physicians electing to participate has generally held at around the 30 percent level. The new figures reflect a dramatic change. Although there have been no surveys or other research to explain the rise, logic strongly suggests that government's strong bias toward the "pars" through incentive programs that provide greater economic rewards, in conjunction with persistent punitive measures (fee freezes, MAACs and lower Medicare reimbursement levels) directed toward "non-pars" have achieved desired federal results -- driving more physicians to becoming pars. Many former non-pars indicate the hassle of trying to deal with the continuous changes and bureaucratic headaches simply isn't worth the effort and valuable time. Another important factor leading to increases in participation has been pressure placed upon non-pars by the American Association of Retired Persons (AARP) in its persistent communications to the elderly.

Government's tactics have given pars increasingly significant economic advantages. Non-pars currently receive 4.5 percent less on their prevailing charges than do the pars. That differential will be stepped up to 5 percent next January.

Within the Federation there have been tremendous statewide variances in the profession's willingness or reluctance to sign up as pars, although HCFA data has shown that on a case-by-case basis assignment is now being accepted on about 73 percent of all claims -- an all-time high. Alabama is the state having the greatest percentage of pars (73.5 percent). Idaho has the lowest rate (14.9 percent). Other states with high percentages of participating physicians are Kansas (60), Rhode Island (55), Tennessee (54.9), Hawaii (53.7), West Virginia (53.2), Utah (50.4), California (48.5), Nevada (46) and Massachusetts (45.9). At the low end of the spectrum are South Dakota (17.6), Montana (19.9), Wyoming (20.1), Connecticut (22.8), Oklahoma (22.9), Minnesota (23.4), Colorado (24.9), New Mexico (25.9), Texas (26) and New Hampshire and New York (28.4).

Individual physicians desiring a copy of this brief summary of state-by-state participation rates and national results of prior enrollments may send a Medmail message to AMA.MSR. Be certain to include your name and mailing address.

A Question of Professional Liability

A summary question eliciting physicians' views on the current professional liability situation was included on the AMA's 1988 Physician Opinion Survey.

"In the past year, do you believe the professional liability situation in medicine has gotten better, gotten worse or stayed the same?"

Physician Opinion 1988	
Gotten better	5%
Gotten worse	67%
Stayed the same	27%
Unsure	1%

Even though concern about professional liability as the main problem facing medicine continued to decline in this year's survey, it would be incorrect to assume that physicians have become complacent about the current liability situation. Over two-thirds of physicians reported that professional liability concerns had indeed worsened in the previous year. Only 5 percent gave the opposite response. It appears that physicians believe strongly in continuing tort reform efforts to improve the liability situation.

The demographic breakdowns showed that non-members of the AMA were more likely than members to believe the liability situation had gotten worse, as were foreign physicians over U.S. MDs. Solo practitioners were more likely to express negative sentiment about the current situation, compared to group practice physicians.

Geographically, negative responses ("gotten worse") were highest in the West South Central region (81 percent) and lowest in the Pacific states (52 percent).

Public Response

The public's perception of medical malpractice suits was measured by two questions on the 1988 survey, each asking about the fairness with which the judicial system handles such cases. Results indicate that American adults are more likely to believe the system is fair to plaintiffs than to defendants in these suits.

"Now thinking about lawsuits in which patients sue doctors, do you feel the court system's handling of medical malpractice cases is fair to the patients who are suing, or not?"

Public Opinion 1988	
Yes	51%
No	21%
Unsure	28%

"What about the doctors who are being sued? Is the court system's handling of medical malpractice cases fair to them, or not?"

Public Opinion 1988	
Yes	26%
No	46%
Unsure	28%

A substantial proportion of respondents said they were unsure about how to answer these questions. Still, half the sample said the court system's handling of medical malpractice cases is fair to the patients who bring suit, while only a fourth said the physicians being sued are treated fairly.

Respondents 65 years of age and older were less likely than younger adults to see the system as fair either to patients or to physicians. Those with annual incomes under $20,000 and those with less than a high school education were less likely than respondents with higher incomes and more education to see the system as fair to patients, but no income or education differences emerged when the question referred to physicians. Similarly, men were more likely than women to say the cases are fair to patients (57 percent to 46 percent), but male-female responses were virtually identical with regard to doctors (27 percent to 26 percent). New England residents were by far most likely to consider the system fair to patients (77 percent) but were only very lightly more likely to see it as fair to physicians (32 percent).

Medical Professional Liability

The 10 Most Frequent Allegations Resulting in Claims, 1985-86

The following data is based on the claims experience of those physicians who have medical professional liability coverage with the St. Paul Insurance Companies. In 1986, the St. Paul Companies insured approximately 55,000 of the nation's 569,160 physicians. A total of 14,004 medical professional liability claims were filed with the St. Paul Companies from 1985 to 1986.

Type of Allegation	
1. Surgery: postoperative complications	1,864
2. Improper treatment: birth related	903
3. Failure to diagnose: cancer	704
4. Surgery: inadvertent act	553
5. Failure to diagnose: fracture-dislocation	444
6. Improper treatment: drug side-effect	419
7. Surgery: inappropriate decision	383
8. Failure to diagnose: pregnancy problems	376
9. Failure to diagnose: infection	347
10. Improper treatment: fracture-dislocation	340

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$15.00 Floor level reserved	_____	$375.00 = _____
Jr/Sr price	_____	$250.00 = _____
$10.50 Premium reserved	_____	$262.50 = _____
Jr/Sr price	_____	$162.50 = _____
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Jr/Sr price	_____	$137.50 = _____
	Total	= _____

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Section _____

Row _____

Seats _____

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AIDS: The Role of the Primary Care Physician

By King K. Holmes, MD., PhD,
Chief of Harborview Medical Center's Department of Medicine,
Professor and Vice-Chairman,
University of Washington Department of Medicine

This editorial appeared in a recent volume of University of Washington Medicine.

Which physicians should take care of patients with acquired immunodeficiency syndrome (AIDS)? Vaccines and curative antiviral therapy are not on the immediate horizon. Academic medical centers in some U.S. metropolitan areas are already overwhelmed by patients with AIDS. Special AIDS clinics are swamped and cannot alone cope with the growing number of cases. More and more IDS clinics are popping up in hospitals around the country. Some are directed by infectious disease specialists, but many are directed by general medicine internists or others involved in primary care medicine. Infectious disease specialists are skilled in managing opportunistic infections and are learning about the use of new antiviral drugs for human immunodeficiency virus (HIV) infections. However, they have no unique qualifications in management of opportunistic neoplasms or neuropsychiatric disorders, in delivery of long-term primary care, or in case management of complex social needs. Furthermore, infectious disease specialists are vastly outnumbered by the rapidly expanding numbers of persons with HIV infections. Thus, the growing consensus is that primary care physicians, including both generalists and specialists, will play a central role in managing HIV infections. Primary physicians are experienced in coordinating subspecialty consultations for multisystem diseases and in managing the complex, long-term psychosocial needs of patients with progressive, fatal illness. To effectively manage technical aspects of treating AIDS, physicians will need ready access to new information on diagnosis, treatment and case-management issues.

A recent grant from the Health Resources and Services Administration will enable an AIDS Educational Training Program to be established in Washington, Oregon, Alaska, Montana and Idaho. It is one of four AIDS training programs funded in the United States and will be directed by Dr. David Johnson, associate director of WAMI Regional Programs, and Susan Kaetz, deputy director of the AIDS Training Program. It will have satellite training offices affiliated with Area Health Education centers in Washington, Alaska, Montana and Idaho. Oregon primary care physicians will be reached through the University of Oregon Sciences Center. The new regional program will train primary care practitioners and allied health personnel in the medical, psychiatric and psychosocial aspects of AIDS and related conditions, thereby increasing the number of primary providers who are willing and able to manage and counsel AIDS patients.

1989 Directory is Coming

Production of the 1989 Pierce County Medical Society's Physicians and Surgeons Directory is in full swing. Directory listing and reservation forms were sent out in July and should have been returned to our office last month. If you did not receive a form, or have not returned the form sent to your office, and need to make changes to your 1988 listing, please contact the Society office as soon as possible! If we do not receive a form from you, we will not be responsible for the information printed in the book.

If you did return your form, and any information on your listing has changed, now is the time to let us know. We will be going to press soon!

Personal Problems of Physicians Committee

For Impaired Physicians.
Your colleagues want to help.

Medical Problems, Drugs, Alcohol, Retirement, Emotional Problems

Committee Members

Patrick Donley, Chair	272-2234
Robert A. O'Connell	627-2330
John R. McDonough	572-2424
William A. McPhee	474-0751
Ronald C. Johnson	841-4241
Jack P. Liewer	588-1759
Kathleen Sacco	591-6681
Dennis F. Waldron	272-5127
Mrs. Jo Roller	752-6825

WSMA: 1-800-552-7236

The Employment Reference

By Sharon Bain, MBI Placement Coordinator

The increase in employment reference defamation suits in recent years gives rising concern among employers about their own practice of giving employment references. The law has generally recognized that a qualified privilege exists between former and prospective employers as long as the statements made are in good faith, are for a legitimate purpose and are without malice. Reliable reference information is one of my greatest tools in evaluating applicants as possible employees for our member physicians. This information is essential in determining a person's overall suitability for a specific position. There are times, however, when a written reference is very complimentary, while a verbal reference from the same employer proves quite unfavorable. Why? Employers sometimes fear retaliation from former employees when providing a written reference. Also, it is believed that a verbal reference is more difficult to establish as defamatory. A simple way to avoid this problem is to regularly review and evaluate your employees on their work performance, attendance, attitude, etc. If your staff is routinely evaluated and counseled in these areas, you should have substantial written documentation when the time comes to provide an honest reference.

Some employers have set a policy whereby they will only confirm dates of employment, job title, etc. This may lessen their risk, but may be overly cautious. I feel we all need the opportunity to thoroughly investigate -- for legitimate purposes -- the employment history of prospective employees. Because we desire to keep this privilege, we must be responsible and consistent in giving employment recommendations.

All statements given regarding employment references must be true. We must always refrain from making a personal statement about things we do not know for certain, especially if the information is potentially damaging to the employee or could be perceived as irrelevant to employment. Never make a statement orally or in writing about a person that may be regarded as "acting with malice." (Washington courts define acting with malice as knowledge of, or reckless disregard to, the falsity of a statement.)

Washington law stipulates that to win a defamation claim, a former employee (the plaintiff) must be able to establish four essential elements:

- The employer giving the unfavorable reference is at fault.
- The employer engaged in an unprivileged communication.
- The statement was false.
- The false statement damaged the former employee (plaintiff).

If the employer demonstrates the existence of qualified privilege, then the burden rests with the plaintiff to prove the privilege was abused.

An employer can lose the qualified privilege in two ways:

(1) If an employer furnishes defamatory information irrelevant to the prospective employee's employment decisions -- this could be considered to have exceeded the employer's privilege.

(2) If the employer acts with malice, i.e., stating it was believed that the employee in question was a thief when there is no proof to substantiate the claim.

It is important to designate a specific person in your office to provide reference information, to ensure references are given properly and according to office policy. This person must understand the necessity of following proper guidelines. Be absolutely sure that he or she can be trusted never to express an opinion based on any personal bias toward the employee. Perhaps the physician himself/herself will want to handle references directly to be fair in assessing the person's assets and liabilities. After all, a good receptionist may lack the talent for bookkeeping but could still be highly recommended for a reception job. Centralizing the source of reference information in your office will offer consistency and help protect you from possible defamation action because statements given will meet the criteria defined as qualified privilege. A restrictive approach -- giving only employment dates, etc. -- may be a safe way to proceed. However, as long as the statements you make are true and you are speaking directly about a person's work performance, you

Continued on page 11

Employment *(cont. from page 10)*

should be alright. We do not want to lose the privilege of sharing valuable information to assist in selecting the person best matched to the job. Always use documented facts regarding poor work performance to avoid passing along a possible problem to an unsuspecting physician. Please be certain to check with your own attorney for his/her advice on the best way to handle employment recommendations in your office.

Too Little Spent on AIDS Research?

Last year, the federal government spent more than $502 million on AIDS treatment, education and research. Nevertheless -- and despite President Reagan's recent $1.3 billion request to fund AIDS research -- more than half of 1,000 people surveyed recently in a SRI Gallup Poll believe that the federal government is spending too little to fight the dreaded killer.

Poll results showed that the more-educated respondents favor more AIDS spending: 64 percent of postgraduates cite inadequate funding, compared to 48 percent of those with less than 12 years of schooling. In addition, higher-income people are more likely to cite insufficient spending.

This year, the U.S. Public Health Service estimates that the AIDS bill will rise 89 percent -- to $951 million.

(LACMA Physician/July 18, 1988)

The Benefits of Letters

Look at some of the letters you've sent out recently. Are they clear, attractive, friendly? Do they indicate that your practice is well-organized and carefully run? Do they project a sincere interest in your patients?

Effective business letters will ensure an ongoing rapport with patients. And keeping current patients happy is just as important as finding new ones -- often more important, since few practices can stay in business without repeat services.

The examples included here will help you handle promotion of your services and show you how to say "thank you" to loyal patients. They will promote name recognition and encourage future care.

Letter writing tips:

Here are some suggestions for improving your letters:

- Start your letter on a positive note. Don't keep good news a secret. And when the news is not so good, try to soften it with something positive.
- Don't say too much. Overwritten letters waste your time as well as your reader's.
- The tone and the style of your letters reflect on your practice. Be sure yours promote a professional image.
- Talk directly to your reader. Use "you" as often as possible without sounding repetitive. Your patients are not interested in your problems. Tell them what your going to do for them.
- Use "I" if you are writing in your own name. Use "we" if you are writing as a representative of a practice that employs you.
- Be specific. Include facts and figures whenever possible. Do not leave your patients guessing.

Answer mail promptly -- the same day if possible. Your patients are waiting to hear from you. Your response is important to them, and they deserve a quick one. Finally, add a personal touch whenever possible. Your patients will appreciate communications that do not sound like form letters.

(Excerpts reprinted with permission from the Palmer Practice Management Report, July, 1988, Diane Palmer, executive editor)

Code/No Code Clarification

In the August issue of *The Bulletin*, the article *Code/No Code, The Problems, the Solutions*, Dr. David Munoz was quoted on page 25 (1st column) as saying, "For every patient of mine confined to a nursing home, I send a letter to the family members or a guardian that directs personnel to withhold and/or terminate life support measures." The quote should have read, "For every patient of mine confined to a nursing home, who does not have a Living Will, and is not otherwise competent to make his wishes known, we send a letter or contact the family and/or guardian reviewing their diagnoses and the fact that CPR and other life support measures will not be expected to measurably add any significant quality of life or survival for that individual patient. If the patient is competent and able to make their wishes known, we review their situation with them and either have them sign a Living Will, appoint a durable power of attorney with health provisions or otherwise document their wish that no extraordinary measures, CPR or other such treatments be undertaken."

Fleet Footer Forgotten!

Race enthusiast Julia Mueller, wife of Dr. Stanley Mueller, was not listed among the participants in this year's Sound-to-Narrows race (June PCMS Newsletter). This was Mrs. Mueller's 12th year as a Sound-to-Narrows runner.

Correction!

In the August issue of The Bulletin, a photo caption on page 10 identified "Fred" Sanchez as one of the Seattle-to-Portland bicyclists. Mr. Sanchez's first name is Felix.

September Readings

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

C. STEVEN SETTLE, MD, Physicians Medicine and Rehabilitation Electrodiagnosis. Born in Cincinnati, Ohio, 1/19/50. Medical school, University of Cincinnati, 1976; internship, Highland General Hospital, 7/76-6/77; residency, Univ. of Washington, 7/78-6/81. Washington State License, 1982. Dr. Settle is currently practicing with Electrodiagnosis and Rehabilitation Associates of Tacoma.

SANDRA F. REILLEY, MD, OB/Gyn. Born in Fairbanks, Alaska, 12/4/53. Medical school, Univ. of Washington, 1985; internship, University of Washington, 7/85-6/86; Washington State License, 1986. Dr. Reilley will be completing her residency at the University of Washington in June 1989.

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

GENERAL MEMBERSHIP MEETING

"Anti-Trust Implications of the Wenatchee Valley Clinic's Joint Venture with Central Washington Hospital"

Also...

"Peer Review and the 'Patrick' Case"

John Ellis, Deputy Attorney General

DATE: Tuesday, September 13, 1988

TIME: 6:00 p.m. No-host cocktails
6:30 p.m. Dinner
7:45 p.m. Program

COST: Dinner, $12.00 per person

LOCATION: Fircrest Golf Club
6520 Regents Blvd.

Register now! Please complete the attached reservation form and return it with a check for the appropriate amount made payable to the Pierce County Medical Society. A pre-addressed envelope has been included for your convenience, or you may call the Medical Society office directly at 572-3667 to confirm your attendance.

Reservations must be made no later than Friday, September 9.

REGISTRATION FORM:

Yes, I/we have set aside the evening of September 13 to join fellow Society members for the presentation on **Anti-Trust and Peer Review.**

Dr. _____

Please reserve _____ dinner(s) at $_____ per person (tax and gratuity included)

Enclosed is my check for $_____

RETURN THIS FORM TO PCMS NO LATER THAN FRIDAY, SEPTEMBER 9

PHILANTHROPIC FUND APPLICATIONS AVAILABLE

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, you may now obtain an application by either calling or writing to:

Mary Lou Jones
8217 22nd St. Ct. W.
Tacoma, Wash. 98466
565-3128

APPLICATION DEADLINE IS THURSDAY, SEPTEMBER 15, 1988

CLASSIFIEDS

CLASSIFIED AD RATES: 75 cents per word, 10-word minimum ($7.50). Advertisements must be received no later than the 15th of the month prior to publication. All classified ads require prepayment. Please send all payments to PCMS Membership Benefits, Inc., 705 S. 9th St., Tacoma, WA 98405. Call 572-3709 for information or assistance.

POSITIONS AVAILABLE

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part time for FP/IM/EM trained, experienced physician. Located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, MD, at 5900 100th St. SW, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS. Full-time and part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Flexible scheduling. Any state license. Other opportunities including ER in Olympia area. Call NES 1-800-554-4405. Ask for Jeanine.

EXTENSIVE OCCUPATIONAL/FAMILY PRACTICE network of rapidly growing medial centers in Pacific Northwest has excellent FT/PT opportunities throughout California and Washington (Seattle/Tacoma). Regular hours and a balanced professional/personal lifestyle. Attractive salary/incentives/benefits/malpractice. Current state license. Prior occupational/family practice experience. Join our dynamic team of professionals. Contact: Director, Personnel, Readi-Care/Chec, 446 Oakmead Parkway, Sunnyvale, CA 94086. (408) 737-8531 or (800) 237-3234.

INTERNAL MEDICINE. Lakewood Hospital, South Puget Sound, recruiting for associates in Internal Medicine, is a 95-bed acute care, surgical, medical, and obstetrical hospital which has a new facility due for '89 completion. Lakewood is the "Lakes District" of South Puget Sound, surrounded by the Olympic Mtns., the Cascades and Mt. Rainier which provide outstanding water and moutain recreational activities. BC/BE respond to Genie Latta, Physician Recruitment, Lakewood Hospital, 5702 100th St. SW, Tacoma, WA 98499-0998, (206) 588-1711.

OBSTETRICS/GYNECOLOGY. Lakewood Hospital, South Puget Sound, recruiting for associates in Obstetrics/Gynecology, is a 95-bed acute care, surgical, medical, and obstetrical hospital which has a new facility due for '89 completion. Lakewood is the "Lakes District" of South Puget Sound surrounded by the Olympic Mtns., the Cascades and Mt. Rainier which provide outstanding water and mountain recreational activities. BC/BE respond to Genie Latta, Physician Recruitment, Lakewood Hospital, 5702 100th St. SW, Tacoma, WA 98499-0998, (206) 588-1711.

FAMILY PRACTICE. Lakewood Hospital, South Puget Sound, recruiting for associates in Family Practice, is a 95-bed acute care, surgical, medical, and obstetrical hospital which has a new facility due for '89 completion. Lakewood is the "Lakes District" of South Puget Sound surrounded by the Olympic Mtns., the Cascades and Mt. Rainier which provide outstanding water and mountain recreational activities. BC/BE respond to Genie Latta, Physician Recruitment, Lakewood Hospital, 5702 100th St. SW, Tacoma, WA 98499-0998, (206) 588-1711.

PRACTICE OPPORTUNTITIES available immediately for BC/BE Family Practice physicians in the charming "Bavarian" village of Leavenworth, Washington. No OB. Physicians will be employed by the hospital district. Competitive compensation package. Cascade General Hospital and

Continued on page 15

Classifieds *(cont. from page 14)*

Rehabilitation Center has 20 acute care beds and an active 13-bed rehabilitation unit staffed by a physiatrist. FPs will provide backup coverage. Leavenworth is located in central Washington state in the Cascade Mountains. The service area population is approximately 6,500. The area offers abundant, excellent, outdoor recreational opportunities and a rural lifestyle. Send CV to Patty House, Virginia Mason Consulting Services, P20-HRS, P.O. Box 1930, Seattle, WA 98008, or phone (206) 223-6351.

EQUIPMENT

APPRAISAL SERVICE for medical equipment, 867-5415.

USED MEDICAL OFFICE EQUIPMENT for sale, 867-5415.

WANTED TO BUY used medical office equipment, 867-5415.

PRACTICES AVAILABLE

GERIATRIC/FAMILY PRACTICE for sale. Beautiful Puget Sound. Good practice with excellent growth potential. Turnkey situation with all necessary medical supplies and office equipment. 18K. P.O. Box 111042, Tacoma, WA 98405.

OFFICE SPACE

MEDICAL OFFICE SPACE for lease in University Place, 1665 sq. ft. Improved to your designs. Smaller offices also available. 383-5500.

JACKSON HALL MEDICAL CENTER, across from Tacoma General Hospital. Deluxe office space on top floor, recently redecorated. Windows on all sides, with water view. 1670 sq. ft. Available July 1. For information, call 627-1922.

BROWNS POINT-FEDERAL WAY AREA: 1250-5000 square feet available. Scenic Puget Sound area, growing suburban community with approximately 35,000 people in a 1-mile radius. Limited Medical-Dental services available presently. Day Care Center on site. Good family traffic flow. Will provide all architectural, interior design and construction services. For information, call: 839-8001.

ATTRACTIVE MEDICAL OFFICE SPACE available for rent on main arterial in Federal Way. Ideal for FP or medical specialty. 560 sq. ft. including 2 exam rooms, private office, workroom, restroom. Also, shared business office space, in-office lab and spacious waiting room with established, board-certified Family Practitioner. Dentist and Optometrist in same building. Ample parking, convenient to transportation, pharmacies and new hospital. Reasonable lease. Contact Dr. Kohler 839-3480 or 927-3477.

LEASE/OPTION. Modern medical office Lakewood Professional Village (adjacent new Lakewood Mall); 1 block Lakewood Hospital; 1100 sq. ft. plus abundant storage; reasonable rental; 581-0660 or 582-4511.

GENERAL

MALPRACTICE LITIGATION, Pierce County edition -- King County edition available (1978-1988). Contact C. Miller at 866-8247, P.O. Box 10010, Olympia, WA 98502.

IMMACULATE 4-BEDROOM executive home in Gig Harbor has golf course, tennis and pool. $1250 mo. Non-smokers. No pets. Call 533-7750 or 538-1328. Ask for Steve or Joan.

FOR SALE OR LEASE. 2 Victorians, suitable for office space, near hospitals. Peggy, 752-6696.

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT
UPCOMING PUBLIC HEALTH ROUNDS

Some of the topics for upcoming Public Health Rounds are: Electromagnetic Radiation, AIDS Omnibus Impact, Influenza; Addicted Newborns

DATE:	TIME:	LOCATION:
Thurs., Sept. 15, 1988	8-9 a.m.	St. Joseph Hospital Conference Rooms 2 B&C 2nd Floor of Tower Bldg.

EVERYONE WELCOME!

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PCMS
NEWSLETTER
♦ A publication of the Pierce County Medical Society ♦

Volume 3, No. 7 October 1988

FLUORIDE WINS ! !

The dream of fluoridated water for the City of Tacoma has finally come true!

Sixty percent of Tacoma's voters said "yes" to fluoride at the polls, September 20. At press time, 9,681 yes votes and 6,692 no votes had been cast, with 661 of 682 precincts reporting, not including absentee ballots. The results insure passage of Proposition 2 regardless of how the remaining votes are cast.

Citizens for Better Dental Health, a subcommittee of the Medical Society's Public Health/School Health Committee, was formed in January 1986 under the chairmanship of Dr. Terry Torgenrud. The committee's one goal was to fluoridate the city's water supply --it proved to be an arduous one.

At the Tacoma City Council Meeting, July 8, 1986, Dr. Torgenrud addressed the Council, asking for support of fluoridation. Following the Council's inaction, the committee had no option but to go the initiative route to place the issue on the ballot. After gathering 5,000 signatures, the committee accomplished its goal in July of this year when the City Council moved to place the fluoride initiative on the primary ballot.

Many volunteer hours led to the success of the fluoride campaign. Significant contributions were made by the committee members, including PCMS members **Drs. Torgenrud, William Jackson and Robert Ettlinger**; and **Dentists Dan Gallagher, Mike Gage, Karen Sorenson, Eugene Choy** and **John Deviny**. Other committee members included **Patty Wolcott, MPH, R.D.H., Mary Lou Jones** (PCMS Auxiliary), **Janell Cole, R.D.H.**, and PCMS staff members **Sue Asher** and **Doug Jackman**.

Special thanks go to PCMSA members who helped gather signatures, made phone calls prior to the election, and performed other campaign tasks. Many thanks to **Bev Graham, Mary Lou Jones, Julia Mueller, Kay Plonsky, Rubye Ward, Kris White, Helen Whitney, Alice Wilhyde**, and **Alice Yeh.** Thanks to Dental Society Auxiliary members **Pat Berg, Judy Gage, Sue Hartman** and **Sue Wohlford**. Other volunteers that deserve recognition include **Grace Fredericks, Sue Jackson, Mary Marlin, Gay Morgan-Colyer, Marilyn Walton, Betty Drost** and PCMS staff member **Kim Reed**.

A big thank you also goes to all the financial supporters. Cash and in-kind contributions from physicians, dentists, attorneys and numerous organizations was vital to the passage of Prop. 2.

Last, but not least, many thanks to all the PCMS members, their staff members and patients for supporting this endeavor. Many members passed out information and encouraged their patients to vote "yes" for fluoridation. Your participation made the difference.

Sept. 20 -- A Momentous Day

Tuesday, September 20 will long be remembered as a momentous day in Pierce County Medical Society history.

Passage of Proposition 2, which called for fluoridation of Tacoma's water supply, culminated a two-and-a-half-year effort by the Society's Committee for Better Dental Health.

Earlier the same day, the Tacoma City Council adopted Ordinance #24207, which will regulate smoking in public places and in the work place. (In July, Drs. Bill Jackson and Bill Ritchie met with Mayor Doug Sutherland and asked for support of a smoking ordinance comparable to Pierce County's no-smoking ordinance.)

Under the ordinance, each non-city employer who operates an office in the City of Tacoma shall, within three months of adoption of the ordinance, implement and maintain a written smoking policy which shall provide protection to the non-smoker. The preferences of non-smoking employees shall prevail over those of smoking employees. The ordinance also requires restaurants to provide no-smoking food-service areas, and states that smoking will not be permitted in elevators, public conveyances, health care clinics, public meetings or libraries which are open to the public.

Dr. Jackson testified before the City Council September 20 and applauded their actions and speed in responding to the Society's request for an ordinance.

PCMS on the Air

Dr. Bill Jackson, PCMS President, took to the airwaves in September, appearing on KIRO's Jim French Show and KKMO's "Brunch with Barb" program to discuss the fluoride initiative.

Wayne Aho, an opponent of the fluoridation of Tacoma's water supply appeared on the show to debate the merits of fluoridation with Dr. Jackson. Aho is remembered in Tacoma for his alleged conversations with space aliens.

Continued on page 2

PCMS *(cont. from page 1)*

The KKMO program was such a hit that Dr. Jackson and Dan Gallagher, DDS, were invited to return September 16. Dr. Gallagher is a long-time volunteer member of the Committee for Better Dental Health.

Dr. Terry Torgenrud, chairman of the committee, and Dr. Gallagher appeared on the "Art Pophan Show" on KTAC, September 13, to debate the issue with Aho and Fircrest dentist, Geroge Grobbins.

WSMA Annual Meeting

AIDS, physician reimbursement, nursing, long-term care, PRO/W, specialty based fee profiles and numerous other topics were discussed and debated at the 99th annual meeting of the Washington State Medical Association, House of Delegates, in Yakima, September 15-18.

WSMA is governed by the House of Delegates, comprised of elective delegates from each county medical society, state specialty societies, and members of the WSMA Board of Trustees. All legislative power of the WSMA -- including the power to alter, amend or appeal the constitution and bylaws -- is vested in the House of Delegates. Each county society has one delegate for every 50 active WSMA members; PCMS has 12.

The Pierce County delegation was represented by Drs. Bill Jackson (PCMS President), Eileen Toth, Bill Marsh, Dick Bowe, Bill Ritchie, Bob Martin, David Hopkins, Charles L. Anderson, Tom Clark and Jim Krueger. Also in attendance were the Society's representatives to the WSMA: Drs. Ralph Johnson (WSMA President), Alenick (AMA Alternate Delegate), Hawkins (Vice Speaker), and Bob Scherz and Charles Weatherby (Trustees).

PCMS Auxiliary was also well represented by Sharon Lawson (WSMAA President), Kris White (PCMSA President), Alice Wilhyde, Helen Whitney, Susie Duffy and Cindy Anderson.*

Dr. Richard Vimont represented the Senior Physicians of Washington, and Drs. Larry Larson and John Kemman, who sit on the Subscribers Committee of the Washington State Physicians Insurance Annual Meeting, held concurrently.

Discussion and Debate

Various issues sparked interaction among the delegates, but the following resolution created considerable discussion: "Physicians shall maintain the right not to perform an elective or cosmetic procedure on a patient on the basis that the risk to the health care team is, in the physicians opinion, substantial and outweighs the benefit to the patient. Further, a physician shall maintain the right to ethically refuse treatment on the basis of noncompliance in the event that the patient refuses to undergo any testing deemed by the physician to be necessary to provide adequate diagnosis or treatment or to arrive at a decision regarding treatment based upon those risks." The House of Delegates rejected the resolution.

Referred to the Executive Committee was a resolution that states: "Any such person who fails to so inform the other person with whom he or she has sexual contact is guilty of assault in the second degree." The resolution was referred to the WSMA Board of Trustees for legal evaluation.

Discussion in the Reference Committees and on the House floor preceded adoption of a resolution that WSMA support the family physicians of King County in an effort to have King County Medical Blue Shield stop using specialty based fee profiles.

Johnson Bids Adieu

Among his many accomplishments during his year as WSMA President, Dr. Ralph Johnson, Tacoma surgeon, witnessed the defeat of Initiative 92 and a serious review of the Medical Disciplinary Board being done. In his final address to delegates and guests, which was met with several standing ovations, he stressed "unity," urging all facets of medicine to come together, work in a collaborative fashion to offset the attempts by government to "divide and conquer."

Dr. Johnson has served in many capacities at the county, state and national levels. He was Society President in 1978, served on the Medical Disciplinary Board, was first president of the newly created hospital medical staff section in 1986, WSMA vice president for three years, and AMA delegate for several years.

Auxiliary Shines

Sharon Lawson addressed the House and introduced the presidents of the county medical auxiliaries. Mrs. Lawson and Auxiliary members received rousing applause for the many activities PCMSA has undertaken in support of organized medicine. The Auxiliary's theme for this year is "Rings of Success."

Governor Voices Support

Among the highlights of the meeting was Governor Booth Gardner's address to the delegates, in which he stated his personal commitment to the Basic Health Plan in prinicple and said he would see that the plan has every opportunity to succeed. Many members of the Pierce County delegation attended the governor's reception and discussed with Gardner a variety of health care issuues.

*It should be noted that neither the Medical Society nor the Auxiliary reimburse any delegates for expenses incurred while attending the Annual Meeting.

Candidate Interviews Continue

PCMS is conducting several interviews to hear local candidates' views, which in turn are being communicated to Society members.

Pierce County Executive

The County Executive, elected by the voters, is the chief executive officer of Pierce County responsible for supervising and managing all administrative officers and executive departments as established by the Pierce County Charter or created by the County Council. It is the Executive's responsibility to execute and enforce all ordinances and state statutes within the county, and to manage all revenues and expenditures.

Drs. Bill Jackson and Bill Ritchie and PCMS staff met with County Executive candidate Larry Fault on August 31 to discuss current issues confronting the medical community.

Faulk's opponent is incumbent Executive Joe Stortini.

During the August 31 meeting, Faulk continually referred to the lack of leadership exhibited by his opponent. Faulk added that under his leadership, the county would realize the full potential of its vast resources.

In discussing the Pierce County EMS system, Faulk expressed his familiarity with Maryland's Prince George County law enforcement and Emergency Medical System, which has been considered a national model. He said he would work for such a system in Pierce County. To achieve such a program, he urged a cooperative effort among the fire districts, Medical Society and all providers.

Faulk's highest priority would be to institute a nationally recognized public safety program that includes hiring more deputies, giving them the best training, and paying them competitively and out of basic funding. Faulk said Pierce County's property and violent-crime rate has been increasing, and added that in 1986, Pierce County had the second-highest crime rate of the nine urban counties in Washington.

Joe Stortini is seeking his second term as County Executive. He was first elected as a County Commissioner and County Executive under the new charter in 1985.

In meeting with Drs. Jackson and Ritchie, Stortini outlined a recommendation to create a committee of health care personnel that would meet frequently with county leadership to keep them better informed on health issues. At present, members of the Board of Health must rely on the Health Department for all their information.

Stortini acknowledged that effective changes need to be made in the present EMS System, and he is anxious to work with the medical community to bring about those changes.

Stortini outlined four major issues he will focus on in the next four years if re-elected: transportation, land use, waste, and water and air pollution. He emphasized the importance of maintaining Pierce County as a place dedicated to family values, and stressed the need to keep and improve the county's parks and focus on environmental issues.

Board Approves '89 Budget

PCMS members will not see an increase in dues in 1989, according to the 1989 budget adopted at the September 6 Board of Trustees' meeting.

Expenditures of $187,311 and income of $192,149 is forecast for the next year based on a projected active membership of 574. Individual dues will remain at $285, $75 of which supports the Medical Library.

The Society's reserve level will increase to nearly $95,000 or 68% of the basic operating expense.

The improved financial position lies in the Society's maintenance of costs and expenses at the 1988 levels and the financial success of Membership Benefits, Inc., the Society's for-profit subsidiary. MBI has realized increased profits as a result of its Medical-Dental Placement Service and Publications area. MBI is now totally self-supporting, contributes significantly to support the Society, and is now in a position to reimburse the Society for staff time and services.

Non-dues income now accounts for 31.9% of the PCMS budget, which permits the Society to grow without increasing dues.

In other Board actions...a staff retirement plan has been approved...the decision was made to write a letter to the Pierce County Judiciary expressing the Boards concern for Tacoma's drug problem and its impact on society...the Board urges members to individually support the Tacoma Stars.

Hepatitis B Screening

Transmission of hepatitis B virus (HBV) from mother to infant during the perinatal period represents one of the most efficient modes of spread of infection and often leads to severe long-term sequelae. Infants born to mothers positive for hepatitis B surface antigen (HBsAg) have a 70 percent to 90

Continued on page 4

MARK YOUR CALENDAR . . . for November!

COMMON OFFICE PROBLEMS

November 2 - 3, 1988, Jackson Hall, 314 S. K Street, Tacoma

Wednesday, November 2

Pediatric Update

8:00	Allergic Rhinitis in Children	Frank Virant, M.D.
8:45	Pediatric Asthma	Lawrence Larson, D.O.
9:30	Break	
9:45	Otitis Media and Middle Ear Effusion	Carl Wulfestieg M.D.
10:30	Pediatric Dermatology	Dan Wikland, M.D.
11:15	Chronic Abdominal Pain in Children	Ross Kendall, M.D.
Noon	Lunch (No Host)	

Internal Medicine Update

1:00	Polymyalgia Rheumatica and Temporal Arteritis	George Krick, M.D.
1:45	Lab Review of Rheumatologic Disease	Robert Ettlinger, M.D.
2:30	Break	
2:45	Drug Management of Parkinson's Disease	Thomas Kimpel, M.D.
3:30 to 4:15	Ophthalmology Review	Clark Deem, M.D.

Thursday, November 3

Cancer Update

8:00	Cancer of the Breast	John Zielinski, M.D.
8:45	Cancer of the Colon	Gordon Klatt, M.D.
9:30	Break	
9:45	Cancer of the Prostrate	William Dean, M.D.
10:30	Skin Cancer	Sidney Whaley, M.D.
11:15	Review of Cancer Chemotherapy	Robert Thiessen, M.D.
Noon	Lunch (No Host)	

Update on Procedures (Small Group Sessions*)

1:00 to 4:20	A. Flexible Sigmoidoscopy	Gary Taubman, M.D.
	B. Plastic Suturing Techniques	Martin Schaeferle, M.D.
	C. Vasectomy	Lawrence Price, M.D.
	D. Dermatologic Procedures	Joseph Langlois, M.D.
	E. Fine Needle Aspiration Techniques	John Zielinski, M.D.

FEES: $210 PCMS Physicians (both days)
60 PCMS Physicians (individual sessions)
280 Non-PCMS Physicians (both days)
70 Non-PCMS Physicians (individual sessions)
140 Physician Assistants (both days)
0 Residents (both days)

☐ Entire 2-day program
☐ Wednesday morning
☐ Wednesday afternoon
☐ Thursday morning
☐ Thursday afternoon

Yes, please register me for COMMON OFFICE PROBLEMS, Nov. 2, 3, 1988.

Enclosed is $ _____ or Charge $ _____ to: ☐ VISA ☐ MC
Name: _____ Card No: _____
Address: _____ Expiration Date: _____
Specialty _____ Name on Card: _____
Phone No. _____ Signature: _____

Make check payable and mail to: College of Medical Education, 705 S. 9th, Suite 301, Tacoma, WA 98405. Phone (206) 627-7137.

HIV *(cont. from page 3)*

percent chance of acquiring perinatal HBV infection, and 85 percent to 90 percent of those infants who are infected will become chronic HBV carriers.

The Advisory Committee for Immunization Practices (ACIP), in consultation with the American College of Obstetrics and Gynecologists and the American Academy of Pediatrics, issued recommendations June 10, 1988 focused on reducing perinatal HBV infections.

Recommendations

1. All pregnant women should routinely be tested for HBsAg during an early prenatal visit. This testing should be done at the same time that other routine screening tests are ordered. In special situations, such as when acute hepatitis is suspected, when there has been a history of exposure or when the mother has risk factors such as IV drug abuse, an additional HBsAg can be ordered later in pregnancy.

If an HBsAg test has not been done, or if the results are not available at the time of delivery admission, the test should be done at that time.

2. Infants born to HBsAg-positive mothers should receive HBIG and hepatitis B vaccine. HBIG (0.5 ml) should be administered intramuscularly (IM) once the infant is physiologically stable, preferable within 12 hours of birth. Hepatitis B vaccine, either plasma derived or recombinant, should be administered (IM) in three doses of 0.5 ml each. The first dose should be given concurrently with HBIG, but at a different site. If vaccine is not immediately available, the first dose can be given within seven days of birth. The second and third doses should be given one month and six months after the first. Testing the infant for HBsAg and its antibody (anti-HBs) is recommended at 12 to 15 months of age to monitor the effectiveness of therapy.

3. Household and sexual contacts of HBV carriers, identified through prenatal screening, should be tested to determine susceptibility to HBV infection and, if susceptible, should receive hepatitis B vaccine. Screening and

Continued on page 5

HIV *(cont. from page 4)*

vaccination of susceptible contacts should be done by the family's pediatrician, primary health care provider, or the physician evaluating the clinical status of the pregnant woman.

4. Obstetric and pediatric staff should be notified directly about HBsAg-positive mothers. Coordination of prenatal, hospital-based obstetrical services, and well-baby care must be established to assure proper follow-up and treatment.

Submitted by the Tacoma-Pierce County Health Department. Adapted from MMWR 1988; 37:341-346.

Bosses Night

Tuesday, October 25 is bosses night out, as physician-office staff members show their appreciation by treating the doctors to dinner and entertainment.

"Bosses Night," an annual event sponsored by the Pierce County Chapter of the American Association of Medical Assistants, will be held at the Fircrest Golf Club. A no-host cocktail hour will begin at 6:30 p.m., and dinner will be served at 7:30 p.m. The cost of the event is $12.50.

This year's entertainment will be provided by comedian Audrey Loomis.

Invitations and registration materials have already been mailed to all Medical Society member offices. For more information, please contact Dixi at 383-3325.

Reservations must be made by Friday, October 21. Don't miss out on the fun!

Health Rounds

Topics for the Public Health Rounds scheduled for Wednesday, October 12, are: Addicted Newborns, Behavioral Risk Survey, Sensitivity of Mammographs, and Toxoplasmosis.

The program will be held from 8-9 a.m. at MultiCare Medical Center, Jackson Hall, across from the main entrance.

October Calendar

Oct. 4 **Board of Trustees**
Oct. 5 **AIDS Committee**
OCt. 6 **Nominating Committee**
Oct. 7 **Committee on Aging**
Oct. 11 **General Membership Meeting**
Oct. 12 **Credentials Committee**
Oct. 13 **Grievance Committee**
Oct. 17 **Doctor/Lawyer Committee**
Oct. 18 **Executive Committee**
Oct. 19 **Public Health/School Health Committee**
Oct. 27 **EMS Committee**

Notable

Dr. Surinderjit Singh has been asked to continue serving on the Quality Assurance Committee of the American Association of Electromyography and Electrodiagnosis

PCMS Celebrates 100

On August 24, 1888, eight physicians met in the home of Dr. James Wintermute to form the Pierce County Medical Society. At that time, it was determined that the Society should have as its objects the advancement of friendly interaction among its members for cultivating and advancing medical knowledge for promoting in a general sense the usefulness, honor and best interests of the medical profession in Pierce County.

One hundred years later, the Society numbers 730 active and retired members.

To honor PCMS's centennial celebration, Dr. Bill Jackson, PCMS president, hosted a gathering of past presidents, the Board of Trustees and medical staff presidents at his home August 24. It was a lovely summer evening, very much enjoyed by all who attended.

Legislation and the Elderly

Dr. Antonio Sanchez, research analyst, House of Program Research, Washington State House of Representatives, met with the PCMS Committee on Aging September 9 at the invitation of Dr. David Munoz, committee chairman.

Dr. Sanchez reported that long-term care is the Health Care Committee's No. 1 issue for 1989. As with all legislative programs, funding is a major difficulty. Sanchez said Washington will seek additional assistance from the Federal Government.

Sanchez also noted that nursing home care may not be the most appropriate option. A successful Oregon program that provides adult family homes will be reviewed by the Legislature and given serious consideration.

Pam Fortin, director, Area Agency on Aging, and Patty Reinkensmeyer, supervisor of Adult Health Programs, Tacoma Pierce County Health Department, also participated in the committee meeting.

Smoke-Free in 2000

Dr. Bill Jackson, PCMS president, testified before the Pierce County Board of Health September 7 in support of a resolution to make Pierce County smoke-free by the year 2000.

Dr. Jackson cited the many anti-smoking activities the Society has been involved in. In 1984, PCMS spearheaded the campaign for a no-smoking ordinance in Pierce County, and is currently recommending that all hospitals (and their patients) in the county be smoke-free by January 1, 1990. At present, the Society is seeking a City of Tacoma ordinance to limit smoking in public places and work areas.

Dr. Jackson noted that each year, over 1,000 Pierce County residents die prematurely from a history of tobacco use.

Entertainment '89 Books Available

Beginning this month, the Medical Society will be selling the South Puget Sound Edition of Entertainment '89 through the Membership Benefits, Inc. office.

Entertainment '89, which sells for $30, features over 400 "50 percent off" and "two-for-one" offers for fine dining and family restaurants, live theatre, movies, sporting attractions and special events throughout the Northwest. You can also take advantage of car-rental and airline discounts, attractions and getaways up and down the West Coast. The hotel directory offers hotels throughout the U.S., Canada and Europe. Through Condo Rentalbank, you can rent condominiums at popular resorts and vacation spots.

Enjoy fine dining at some of your favorite spots, including Grazie Ristorante Italiano, Hogan's Bay Company, Tacoma Salmon House, Pyong's Classic Chinese Cuisine plus many more. If you'd like a more casual or informal setting, choose from a number of different eateries.

Take in the Tacoma Stars, Seattle Supersonics, a day at Longacres, bowling, tennis and skiing. You can also enjoy special events at a Tacoma Actors Guild production, the Tacoma and Seattle symphonies, and the Pantages Theatre. Or see a movie, take a tour, or visit a special attraction. You can enjoy all this for only $30!

To purchase your Entertainment '89 book, please call Membership Benefits, Inc. at 572-3709. We will be happy to reserve you a copy.

COME Correction

The annual Law and Medicine Symposium is scheduled for Thursday, January 19, 1989. The 1988-89 COME Program Schedule recently mailed to members incorrectly listed the symposium date as Wednesday, January 18, 1989.

New Members

The Board of Trustees has approved the Credentials Committee recommendation that the following applicants be approved for membership into the Pierce County Medical Society.

Kenneth J. Kirkland, MD, Family Practice, Chec Medical Center

Roger B. Lee, MD, Ob/Gyn, Tacoma General Hospital

Mary A. Van Zyl, MD, Pediatrician, Western Clinic

We welcome you to Pierce County and the Medical Society.

October Readings

The Pierce County Medical Society welcomes the following physicians who have applied for Society membership. 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.

WILLIAM D. POLLARD, MD, General Surgery/Vascular. Born in Gilman City, MO, 5/13/37. Medical school, Univ. of Oregon, 1956; internship, Bryan Memorial Hospital, 1967; residency, Fitzsimmons Army Medical Center, 1978; graduate training, Letterman Army Hospital, 1980; Wash. State License, 1988. Dr. Pollard is practicing at Soundview Medical Center.

Skiing Adventure

Dr. Bill Jackson, PCMS President, invites Society members to dust off their skis and make plans to attend a medical seminar and skiing holiday in Switzerland, January 20 through February 4.

The first week of the trip is dedicated to a medical conference, sponsored for the 15th year by the Plymouth District Medical Society of Massachusetts. Week two, attendees can enjoy an array of winter sports, including some of the best skiing in the world.

For more information, please contact Dr. Toshio Akamatsu at 572-4619 (home) or 591-6649 (St. Joseph Anesthesia).

PCMS Committees

In the August issue of *The Bulletin*, the following information was inadvertently omitted from the listing of Society committees and boards.

Membership Benefits, Inc. Board of Directors

Dr. Robert B. Whitney, President
Dr. Mark R. Gildenhar
Dr. David E. Law
Dr. Robert J. Martin
Dr. Kevin Schoenfelder
Dr. John D. Stewart

Legislative Committee

Dr. Gregory A. Popich, Chairman
Dr. Kenton C. Bodily
Dr. Richard G. Bowe
Dr. David M. Brown
Dr. Richard Hawkins
Dr. Michael T. Haynes
Dr. David S. Hopkins
Dr. William B. Jackson
Dr. Michael J. Jarvis
JoAnn Johnson
Sharon Ann Lawson
Dr. William G. Marsh
Dr. Joseph C. Nichols
Dr. Gilbert J. Roller
Jo Roller
Cathy Schneider
Dr. Paul D. Schneider
Dr. Donald W. Shrewsbury
Dr. Michael J. Spiger
Dr. George Tanbara
Dr. Alan D. Tice
Dr. Terry Torgenrud
Dr. Donald C. Weber

1988-89 COME Program Schedule

1988	
Nov. 2, 3	Common Office Problems
Dec. 8, 9	Advanced Cardiac Life Support
1989	
Jan. 12	Pharmacology in Medicine
Jan. 19	Law and Medicine Symposium
Feb. 1	AIDS
Feb. 10	Office Gynecology
March 9, 10	Tacoma Academy of Internal Medicine
March 22, 23	Orthopedics and Sports Medicine
April 14, 15	Tacoma Surgical Club
April 26, 27	Computers in Medicine (Clinical Applications)
May 17	Neurology
June 26, 27	Advanced Cardiac Life Support

Building a Strong Staff

By Jack Valancy

A strong staff helps your practice run smoothly; a weak staff impairs it. The kind of staff you have depends on who you hire and your management skills. You can build a strong staff with formal job descriptions, competitive compensation packages, fair personnel policies and procedures, careful recruiting, thorough training, high job performance standards, and respect.

Job Descriptions

When physicians find themselves with employees who are not suited for their jobs, it's often because the jobs were not clearly defined in the first place. Each position in your practice should have a formal five-part written job description, covering:

- Job title.
- Job summary.
- Supervisor and/or supervisory responsibilities.
- Qualifications.
- Job duties.

Compensation: Salary and Benefits

Paying low salaries and minimal benefits is usually false economy. Good employees who can earn significantly more elsewhere leave the practice, while those with mediocre performance remain. This is not to say that you must match the compensation packages offered by other employers, such as hospitals. Employment in your practice may offer important non-economic benefits, such as regular hours and pleasant working conditions. To be competitive, however, you must enable your employees to earn a decent living.

Establish a formal written salary structure for each position based on its relative contribution to the practice. Individual compensation should be determined by performance and tenure, with the emphasis on performance.

Personnel Policies and Procedures

Routine matters like overtime, vacation, sick time, and office attire can develop into dilemmas if you don't have a system for handling them. Treating each employee request individually is very time-consuming and often futile. Prepare fair, written personnel policies and procedures to assure that everyone is subject to the same rules.

Recruiting

Advertise. Recruit a good selection of qualified candidates from which to choose. Run a brief classified ad in your area's major newspaper. Include your telephone number to make it easy for applicants to get in touch with you. While you, or our office manager, will talk with many people who are not qualified for the job, you will also speak with several who are qualified. You'll hear from fewer people, both unqualified and qualified, if you ask applicants to mail their resumes to your office rather than call. Fewer people still, will reply to a box number.

You can also make people aware of a job opening in your practice by word of mouth. Hiring friends (or friends of friends), or relatives can be uncomfortable if things don't work out well. Observe two guidelines: 1) Consider only people who are qualified for the job, 2) Don't hire anyone you can't fire.

Employment agencies can help you find candidates for a vacancy. they earn their fees when the candidate is hired. Better employment agencies screen candidates against job qualifications carefully. You make the final decision, however, and bear the consequences.

Screen. While you're on the telephone with the applicant, ask about her qualifications. If you determine that she meets them, ask her to send a

Continued on page 9

Staff *(cont. from page 8)*

resume, and if she's still a promising candidate, schedule an interview. If an applicant does not meet the job's qualifications, tell her so tactfully.

Interview. Your two objectives are to learn more about the candidate's qualifications and to educate her about the job. Allow at least a half hour to educate her about the job. Conduct it in a private office and permit no interruptions. Let the applicant talk but don't allow her to monopolize the interview. Ask her about her employment history with open-ended questions.

Give the candidate your full attention, observe her manner. Would you feel comfortable working with her? Having her represent your practice?

If you still think she is a strong candidate, give her a copy of the job description and review it together, point by point. If, as you review the job duties, you question the candidate's ability, ask, "Do you think you would have any trouble with this?" Review the compensation package and the practice's personnel policies and procedures, too. As you discuss each point, ask if it is acceptable to her.

Finally, ask, "If you were offered this job, is there any reason you could not perform it as described?" This is the time for the applicant to inform you of any special considerations.

Testing. You can test an applicant's skills by asking her to complete sample tasks you have prepared in advance. Tests should simulate actual working conditions as much as possible.

Check references. Ask the candidate to provide the names of her references in writing, and grant permission to contact them. If possible, speak with the applicant's most recent immediate supervisor. Verify the dates of employment, position, and job duties, and ask about her job performance and how well she got along with others. Determine why she left her previous job and if the employer would hire her again. Finally, ask, "Is there anything else I should know that would help me with my decision?"

Training

Good training can turn an underachiever into a staff member who makes a valuable contribution to the practice. Realizing an employee's potential should not be left to chance.

Outline a step-by-step training program for each new employee. Assign the responsibility for training her to an experienced employee. On the first day:

- Introduce her to the physicians and her coworkers.
- Review her job description, compensation and the personnel policies and procedures manual.
- Initiate her personnel folder and complete all necessary paperwork.
- Let her observe in the area where she will be working.
- Give her a small assignment so she will feel that she has accomplished something on her first day.

Written procedures are excellent training materials. Provide each employee with her own copy. Perform training during a quiet time in the practice. Go slowly. Teach one procedure, or portion of a procedure, at a time.

Job Performance Evaluation

Monitor each employee's job performance continuously and conduct a formal, written job performance evaluation with each employee every year. Reward good performance. Do not tolerate poor performance.

Small allowances to capitalize on an individual's strengths are acceptable, but making major compromises to avoid an individual's weaknesses can undermine the practice. Try to help the employee improve her performance. However, if she is unable or unwilling to carry out all of her job duties well, you must find someone else who can.

Treat People Well

Contrary to popular belief, money does not motivate people to do a good job. The greatest motivators are:

- Achievement
- Recognition
- The work itself
- Responsibility
- Advancement

Tell each person on your staff that her contribution is important to the practice. Express your appreciation for good individual and team performance. Solicit suggestions for improvements.

CLASSIFIEDS

POSITIONS AVAILABLE

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part time for FP/IM/EM trained, experienced physician. Located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, MD, at 5900 100th St. SW, Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS. Full-time and part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Flexible scheduling. Any state license. Other opportunities including ER in Olympia area. Call NES 1-800-554-4405. Ask for Jeanine.

EXTENSIVE OCCUPATIONAL/FAMILY PRACTICE network of rapidly growing medical centers in Pacific Northwest has excellent FT/PT opportunities throughout California and Washington (Seattle/Tacoma). Regular hours and a balanced professional/personal lifestyle. Attractive salary/incentives/benefits/malpractice. Current state license. Prior occupational/family practice experience. Join our dynamic team of professionals. Contact: Director, Personnel, Readi-Care/Chec, 446 Oakmead Parkway, Sunnyvale, CA 94086. (408) 737-8531 or (800) 237-3234.

Continued on page 10

PRACTICE OPPORTUNITIES available immediately for BC/BE Family Practice physicians in the charming "Bavarian" village of Leavenworth, Washington. No OB. Physicians will be employed by the hospital district. Competitive compensation package. Cascade General Hospital and Rehabilitation Center has 20 acute care beds and an active 13-bed rehabilitation unit staffed by a physiatrist. FPs will provide backup coverage. Leavenworth is located in central Washington state in the Cascade Mountains. The service area population is approximately 6,500. The area offers abundant, excellent, outdoor recreational opportunities and a rural lifestyle. Send CV to Patty House, Virginia Mason Consulting Services, P20-HRS, P.O. Box 1930, Seattle, WA 98008, or phone (206) 223-6351.

PSYCHIATRIST. Pt.-time contract psychiatrist. Board eligible. General outpatient, non-state priority patients. Consultation and trng. w/exp. multi-disciplinary staff. Psychiatric and medication eval. South King Co. location (approx. 20-30 min. from Seattle or Tacoma). 10 hrs. avail. @ $50 - $55 range. C.V. to Steve Herndon, Dir. CCS, Valley Cities Mental Health Center, 2704 "I" St. N.E., Auburn, WA 98002. PH: (206) 854-0760.

LOCUM TENENS FAMILY PRACTICE OR INTERNAL MEDICINE. Position available with a multi-specialty group in their satellite clinic in South King County. Can lead to permanent position. For details, call Elouise Gusman, 1-800-535-7698, or collect 504-893-4879.

FAMILY PRACTICE OR INTERNAL MEDICINE. Position available with a multi-specialty group in their satellite clinic in South King County. Excellent practice situation. For more details, call Elouise Gusman, 1-800-535-7698, or collect 504-893-4879.

EQUIPMENT

APPRAISAL SERVICE for medical equipment, 867-5415.

RITTER POWER EXAM TABLE -- $2,500. Mid-Mark Power Table Model III -- $4,000. Hamilton Power Hi-Lo Exam Table -- $1,700. Call 867-5415 for more info.

FOR SALE: Danam SA-1000 8 Parameter Hematology analyzer with printer. Ideal for a 1-2 physician office. Startup Reagents and training included. 627-1534, ask for Gloria.

PRACTICES AVAILABLE

GERIATRIC/FAMILY PRACTICE for sale. Beautiful Puget Sound. Good practice with excellent growth potential. Turnkey situation with all necessary medical supplies and office equipment. 18K. P.O. Box 111042, Tacoma, WA 98405.

OFFICE SPACE

MEDICAL OFFICE SPACE for lease in University Place, 1665 sq. ft. Improved to your designs. Smaller offices also available. 383-5500.

ATTRACTIVE MEDICAL OFFICE SPACE available for rent on main arterial in Federal Way. Ideal for FP or medical specialty. 560 sq. ft. including 2 exam rooms, private office, workroom, restroom. Also, shared business office space, in-office lab and spacious waiting room with established, board-certified Family Practitioner. Dentist and Optometrist in same building. Ample parking, convenient to transportation, pharmacies and new hospital. Reasonable lease. Contact Dr. Kohler 839-3480 or 927-3477.

ST. FRANCIS COMMUNITY HOSPITAL: Pre-designed and custom suites available in the new St. Francis Medical Building, located adjacent to St. Francis Community Hospital in Federal Way. Class "A" building construction with tenant improvement allowance available. Ample and convenient parking. View of Mt. Rainier. Partnership and lease options available for interested physicians on the active staff of St. Francis Hospital. For information, call Laure Nichols, 591-6803.

ST. JOSEPH MEDICAL PAVILION: Class "A" medical space with superb water and mountain view tied via skybridge to St. Joseph Hospital, Tacoma. Now under construction, this building will be completed by late Spring 1989. Custom space with tenant improvement allowance available. Partnership and lease only positions available to physicians on the active staff of St. Joseph Hospital. Convenient parking, outpatient surgical center, lab and radiology facilities located within building. For information, call Laure Nichols, 591-6803.

POSITIONS WANTED

POSITION DESIRED. Experienced physician (age 51) desires relocation to Tacoma area. Board eligible in Internal Medicine and Gastroenterology. Currently in twentieth year with large multispecialty group in Northern California. Contact Rodney L. Thomson at 1674 Filbert Ave., Chico, CA 95926. Phone (916) 895-1900.

GENERAL

MALPRACTICE LITIGATION, Pierce County edition -- King County edition available (1978-1988). Contact C. Miller at 866-8247, P.O. Box 10010, Olympia, WA 98502.

Pierce County Medical Society

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

GENERAL MEMBERSHIP MEETING

"The Future of Tacoma"

The Honorable
Mayor Doug Sutherland

DATE: Tuesday, October 11, 1988

TIME: 6:00 p.m. No-host cocktails
6:30 p.m. Dinner
7:45 p.m. Program

COST: Dinner, $14.50 per person

LOCATION: Fircrest Golf Club
6520 Regents Blvd.

Register now! Please complete the attached reservation form and return it with a check for the appropriate amount made payable to the Pierce County Medical Society. A pre-addressed envelope has been included for your convenience, or you may call the Medical Society office directly at 572-3667 to confirm your attendance.

Reservations must be made no later than Friday, October 7.

REGISTRATION FORM:

Yes, I/we have set aside the evening of October 11 to join fellow Society members for the presentation on **"The Future of Tacoma."**

Dr. _____

Please reserve _____ dinner(s) at **$14.50** per person (tax and gratuity included)

Enclosed is my check for $_____

RETURN THIS FORM TO PCMS NO LATER THAN FRIDAY, OCTOBER 7

Pierce County Medical Society
705 South Ninth Street, Suite 203
Tacoma, Wash. 98405

BULK RATE
U.S. Postage
PAID
Tacoma, Wash.
PERMIT NO.
605

The Bulletin

PIERCE COUNTY MEDICAL SOCIETY November 1988

Inside this issue:

THE LOWER RESPIRATORY TRACT—

More vulnerable to infection in smokers and older adults

Experience counts

Ceclor® Pulvules® 250 mg
cefaclor

think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci)
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS. PENICILLIN AND CEPHALOSPORINS SHOW PARTIAL CROSS ALLERGENICITY. POSSIBLE REACTIONS AMONG THESE AGENTS ARE:
Administer cautiously to allergic patients
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic associated colitis
Precautions:
• Discontinue Ceclor in the event of allergic reaction to it
• Prolonged use may result in overgrowth of nonsusceptible organisms
• Positive direct Coombs' tests have been reported during treatment with cephalosporins
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal: mostly diarrhea, 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
• Hypersensitivity reactions: rash, maculopapular eruptions, pruritus, urticaria, and serum sickness-like reactions that have included erythema multiforme (rarely, Stevens-Johnson syndrome), anaphylaxis, generalized eruptions of the above skin manifestations accompanied by arthritis/arthralgia, and frequently fever, 1.5%
[illegible] days after initiation of therapy. Serum sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following [illegible] with dosages totaling [illegible] have been reported. Acute generalized exanthematous pustulosis (reported to occur [illegible]
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia
Abnormalities in laboratory results of uncertain etiology
• Slight elevations in hepatic enzymes
• Transient fluctuations in leucocyte count (especially in infants and children)
• Abnormal urinalysis; elevations in BUN or serum creatinine
• Positive direct Coombs' test
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

[illegible]

Additional information available from
Eli Lilly and Company, Indianapolis, Indiana 46285

PV 2351 AMP

Lilly

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

CR-5012-B-849345

The Bulletin

The Official Publication of the Pierce County Medical Society

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President's Page

The Privilege of Medicine

William B. Jackson M.D.

At our last Medical Society meeting, Tacoma's Mayor Doug Sutherland shared his perspectives on Tacoma, the past, present, and the future. Those of you unable to attend missed an excellent presentation. He discussed the good, bad, and the ugly of Tacoma. The ugly and the bad being the challenging drug problem and the intractable dilemma of the homeless.

His vision of Tacoma's future is exciting! Increasing Pacific trade, downtown development, low unemployment, creative planning with emphasis on the environment, and refurbishment of the old train station were mentioned by Major Sutherland. The future will probably exceed our expectations.

As President, you hear discussion from your colleagues weighted toward the negatives of our professional existence. We're forced to focus on the problem trees in this forest of ours. It is easy to lose sight of the remarkable privilege that our society confers upon physicians.

Physicians as a group are consistently placed at the top of the most admired or status lists. The title of doctor is held in high regard; regard for our years of education, our dedication, our sense of service, and the complex science we practice. American physicians as a group are extremely well compensated. Despite governmental encroachment on our practice we continue to enjoy unusual personal autonomy.

We can be practitioners, researchers, administrators, or teachers. The list of specializations from which to chose grows yearly. The demand for physicians continues to allow for remarkable mobility and a wide range of choices as to our practice location. If you like drama, stimulation, excitement, and challenge, the practice of medicine can provide all of these.

If your life quest is job security, medicine is an excellent choice. We have so many amazing, effective diagnostic and therapeutic tools of which our predecessors never dreamed of having or using. The list of advantages and privileges are many.

Perhaps, the greatest benefit of our profession continues to be the richness of the human experience we enjoy. To be allowed to play such an important and eminent role in the lives of so many is an uniquely rewarding experience.

The debit side of the balance sheet unfortunately is significant and growing. The long years of training and mounting debt while your nonmedical cohorts are achieving financial success; the frequent long hours of work under stressful situations; keeping up with a science which is growing and changing at breakneck speed; patient expectations of miracles and perfection; increasing attacks on our control of medicine by government, and by third parties; the increasing costs of malpractice insurance and threat of legal suits; PPO's, HMO's, HCFA and other alphabet organizations which impact our professional lives.; the growing uncompensated care and discounted care making economic success increasingly difficult; hospital and organizational audit committees looking over our shoulders to second guess our actions; an endless array of committee appointments claiming our energies; meeting the challenging demands of simply supervising a small business; are all a steady stream of demands detracting from patient care and our personal lives.

The debit side of our ledger has grown significantly over the last few years and has resulted in a significant decline in medical school applications, a sensitive professional leading indicator. Does the credit side of a medical career exceed the debit side enough to warrant the choice of a medical career. If your goals are solely financial or the pursuit of a tranquil life, perhaps not.

If you still retain some of the idealism of your youth and it is personally important to make a positive contribution to the world in which you live, the answer remains clearly, yes.

Being an incurable optimist, I believe the future of medicine continues to be bright. The first 100 years of the Pierce County Medical Society's History are notable for the many physicians who were willing to make the voluntary contributions necessary to protect the values we enjoy today. We owe a debt to our past and an obligation to medicine's future. We must provide the energy necessary to maintain a leadership role in our community, to protect the quality and integrity of medicine, and to insure that our patients interests are not subjected to economic or political priorities.

Thank you for the honor of serving as your president.

William B. Jackson M.D.

THANKS TO FLUORIDE COMMITTEE MEMBERS

The Citizen's For Better Dental Health Committee was honored at the October General Membership Meeting of the Medical Society. President William Jackson introduced Dr. Terry Torgenrud, chairman of the committee and thanked him for his successful effort that culminated in passage of Proposition 2.

Dr.Torgenrud has chaired the committee since its inception three years age. Dr. Torgenrud thanked all his Medical Society colleagues and the Medical Society staff members for all their efforts and for all their support including financial contributions. He noted that the physicians donated as much to the campaign as the dentists which is unusual as most fluoride campaigns are heavily funded by dentists.Dr. Dan Gallagher, a Tacoma Dentist was a very active member of the committee and helped with just about every project. He attended City Council meetings, put up yard signs, wrote letters, and helped gather signatures. Dr. Gallagher's primary interest was in radio interviews and he was responsible for arranging them and was featured twice on "Brunch with Barb".Dr. Mike Gage, a Tacoma city resident, and dentist practicing in Tacoma was in charge of organizing the yard signs. He spent many weekend hours coordinating these efforts. He was also very active in other arenas such as gathering signatures, writing letters, and soliciting funds. Dr. Gage and his wife Judy also helped with the phone tree calling it a "remark able educational experience."Patty Wolcott was thanked for being the "technical" advisor. Patty was the information behind every committee member and her involvement was invaluable. Patty, an employee of the TPCHD, has a strong dental background, being a Registered Dental Hygienist as well as having a M.P.H. degree.John Deviny, D.D.S., dental instructor for the Pierce College Dental Hygiene Program provided "experience" for the committee. Dr. Deviny had worked on the Olympia Committee for fluoridation and often told us what not do do, as Olympia's efforts were not successful. Dr. Deviny was also responsible for endorsements, helped gather signatures, and was a real asset to this committee.Mary Lou Jones, a member of the PCMS Auxiliary, did a remarkable job for this committee. She worked diligently on gathering signatures and was solely responsible for organizing the phone tree for the 10,000 most frequent voters in Tacoma. The entire Auxiliary was very helpful thanks to Mary Lou's involvement and leadership.Janell Cole is a registered dental hygienist who practices in Puyallup but lives in the City of Tacoma. Janell was very helpful in gathering signatures, distributing literature and the phone tree. Her recruitment of volunteers for the phone tree included her husband, her mother and father, and two of her friends who all participated under duress. Dr. Torgenrud thanked Dr. Eugene Choy, a Federal Way resident and Puyallup dentist for all his support. Dr. Choy was very helpful with media releases and offered his office staff to help make phone calls

News Briefs Continued

for the phone tree.Bob Ettlinger, a PCMS member was the committee's link to the senior population. Dr. Ettlinger wrote articles and letters to the editors discussing fluoride and the prevention of osteoporosis. Bill Jackson, PCMS President, last but certainly not least was thanked for all his support and efforts toward this campaign. Dr. Jackson joined the committee late but contributed lots of ideas, enthusiasm and energy. He was featured on many radio shows, spoke at the City Council meetings, gathered signatures, helped with endorsements, yard signs, and just about everything else. Dr. Torgenrud commended him on his accomplishments as PCMS President as well as his involvement with the fluoride committee.The Citizens For Better Dental Health committee members are all to be congratulated for their successful efforts.

It was definitely a grassroots team effort, and a successful one for the dental health of Tacoma.

Major Sutherland Addresses Membership Meeting

Major Doug Sutherland spoke to nearly 100 members and guests at the October 13 General Membership Meeting on " The Future of Tacoma." Sutherland addressed what he called the "good, bad, and the ugly," of Tacoma.

The major problem and the ugly side of Tacoma is the drug problem it is facing today. The Mayor noted that within the last 8-10 months Tacoma has had and an "explosion" of activity. The movement northward out of southern California of the street gangs "Bloods and Crips", for bigger and better profits from drug dealing has overwhelmed the authorities. "A big unknown was," he said, "who was purchasing all the drugs.?"

The drug problem is the most severe difficulty the city faces today and no one has the answers to correct the situation. The Legislature will be asked to pass some juvenile legislation and their involvement in the drug scene, which would help the police curb some of the problems.

Sutherland noted the " bad" of Tacoma as being the number of "homeless" people in Tacoma. A survey conducted two years ago revealed that 40% of the homeless persons were high school graduates and 22% were college graduates. The city is seeing more and more complete families. He said, " there is a need to get them back into the job market."

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News Briefs Continued

The "good" points in favor of Tacoma and its future were; the Indian Land Claims settlement is nearing resolution and will no longer be an albatross to the city; plans for Union Station are finalizing for the State Historical Museum; new buildings can be expected to be built on the current vacant lots on Pacific Avenue and where Grayhound Bus Depot is located and I-705 will be dedicated and provide a new, more appealing entry into the city from the freeway.

Mayor Sutherland emphasized that the city will not make rapid progress, but that continued and steady growth can be projected for the next 5-10 years. He believes that it is necessary that the city identify with its own quality and character.

Dr. Jackson, thanked Mayor Sutherland for his assistance in passage of the city's smoking ordinance which was adopted by the City Council on October 4 and the quality of his leadership for the city during his two terms in office.

AIDS Course and Omnibus Bill

The AIDS program scheduled for Wednesday, February 1, 1989 by the College of Medical Education will satisfy the new AIDS education requirements. The AIDS Omnibus Bill passed by the legislature during the 1988 session requires physicians and health care professionals to receive AIDS education and training for licensing.

Although the Bill requires AIDS training for 1989 license renewal, the state Board of Medical Examiners, the governing authority, has yet to establish specific requirements. It appears the proposed rules shall be developed and presented to the Board during their November meeting. Final adoption requires a hearing and is slated for the Board's January meeting.

According to John Keith, the assistant attorney general assigned to the Board, the regulations will likely require 7 hours and include training in AIDS epidemiology, testing, counseling and infection control. Curricular topics will also likely include clinical manifestations and treatment, legal and ethical issues and psychological issues.

Physicians requiring relicensing in early 1989 will likely receive an extension for their AIDS education training. The College of Medical Education AIDS program set for February 1 is most timely and will completely fulfill the AIDS education requirements. The program, currently in its final stages of preparation will feature nationally recognized AIDS expert Constance B. Wofsy, M.D., CoDirector of the Division of AIDS Activities, University of California at San Francisco/ San Francisco General Hospital. The program coordinators are Drs. Alan Tice and Peter Bertozzi.

The AIDS program is scheduled for one day at the Tacoma Sheraton and will carry 7 hours of AMA and AAFP Category I credits. The program will also include AIDS experts from Harborview in Seattle as well as presentations by Pierce County Medical Society members Drs. Insalaco, Komorous, and Tice.

Registration forms and program brochures will be available in early December.

Law and Medicine Symposium, James M. Dolliver, Washington State Supreme Court Justice is slated to keynote the annual Law and Medicine Symposium scheduled for Thursday, January 19, 1989.

The day long program, to be held at St. Joseph's Hospital, will also feature latest issues regarding "bad baby" litigation. Joel Cunningham, J.D., of Williams, Kastner and Gibbs of Seattle, will discuss the latest defense issues while Paul Luvera, J.D., a successful personal injury attorney from Mt. Vernon will discuss plantiff issues.

Marcel Malden, M.D., will speak on "Once More With Feeling: Records, Money, and Time". Legal and Medical discussions regarding AIDS with emphasis on regulations from the 1988 Legislature AIDS Omnibus Bill are also planned.

Eric Rassmussen, from Multicare is scheduled to speak on Hospital risk management.

The program coordinators are Douglas Attig, M.D., and Clarke Johnson, J.D.

The Law and Medicine Symposium program is developed by the Medical/Legal Committee.

The committee is made up of representatives of Pierce County Medical Society and the Tacoma Pierce County Bar Association. The College of Medical Education will manage the symposium.

The program will be accredited for 8 hours Category I credit with the AMA, as well as AAFP and CLE accreditation. A program brochure and registration forms will be available in early December.

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SOCIETY TAKES POSITION ON COUNTY EMS SYSTEM

The Board of Trustees, at its October 4 meeting, discussed in depth the current conflict existing in the County EMS System between the Tacoma Fire Department and Health Departments EMS Division. The Board endorsed the Society taking a position that "the system is in need of reform and the present EMS System has unfortunately not lived up to the promise and goals envisioned by the EMS Task Force".

The Board had no desire to enter into personality issues, but to urge the Board of Health to take positive steps to correct the system. Dr. Jackson, President, appeared before the Board of Health at its October 5 meeting and expressed the views of the Society that the "present EMS System lacks expertise, coordination, communication, leadership and credibility. The EMS Council, EMS Division of the Health Department and the Medical Program Director are not functioning in a coordinated effective manner". He stressed that the citizens of Pierce County deserve a better Emergency Medical System. Jackson commented that conflicts among the EMS participants will continue until reform occurs. He reiterated the Medical Society's desire to continue to restructure the system, and that the system should have strong medical leadership provided by a full time physician program director with EMS expertise.

The medical program director must have adequate independence and authority to establish and supervise medical standards.In an appearance before a meeting of the Executive Board of the Pierce County Fire Chiefs Association on October 6, Dr. Jackson outlined the Society's position. The Fire Chief's Association endorsed the Society's position and will work with the Society in generating reform and restructure of the system.

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SENATOR WOJAHN ADDRESSES COMMITTEE ON AGING

Senator Lorraine Wojahn (D), 29th District, and long time Pierce County Legislator spoke to the Committee on Aging and representatives of the three Pierce County Chapters of the AARP, Retired Teachers Assoc., and Puget Sound Council of Senior Citizens who had been invited for the meeting.

Senator Wojahn addressed some of the issues that would be coming before the 1989 session of the Legislature. Due to a new ruling that elderly, mentally ill patients cannot be placed in nursing homes has placed the legislature in a difficult position.

The Senate Committee on Health Care has not devoted a lot of time to other issues, the Senator noted.She reported that the Senate had passed by a large margin, a bill that would create a Department of Health separate from the Department of Social and Health Services. This has been a goal of the Washington State Medical Association for the last two sessions of the legislature. Wojahn urged members of the Society to work on their district Representatives on this issue. Health matters have been relegated to secondary importance to social issues. Currently there is no overall person in charge of health matters at the state level. A separate Department of Health would correct this inequitity.

The Senator reported the lack of nurses in state institutions is having a serious impact on the care and availability of services to the mentally ill.

Wojahn recommended the removal of the current B & O Tax, stating that it is a regressive tax and institute a personal income tax and a corporate profits tax. This led to a good, informative discussion on the current tax structure in the state.

Senator Wojahn received several suggestions from members of the Committee and AARP representatives on the issue.

Letter to the Editor

Dear Sir: I think we doctors should recall the following quotation from Dr. William Hillary who, in 1750, wrote the following words: "If we once quite 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 written in an essay 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 improbable 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.

Sincerely yours,
Roger S. Dille, MD

Notable

Physician Honored

Dr. William B. Jackson, PCMS President, was named a fellow of the American College of Radiology (ACR) during ceremonies at the ACR annual meeting in Cincinnati, Ohio, September 27. Selected for his outstanding contributions to the field of radiology, Dr. Jackson was named as one of 136 new fellows by the College's Board of Chancellors. Fellowships in the College are awarded for significant scientific or clinical research in the field of radiology, or significant contributions to its literature. Criteria for selection also includes performance of outstanding service as a teacher of radiology, service to organized medicine and an outstanding reputation among colleagues and local community as a result of long-term superior service.

Dr. Jackson has practiced in Pierce County since 19--.

Physician Featured

An article written by Dr. Richard Waltman was featured in the September 23-30 issue of the AMNews. "Taking a Little Time" was originally featured in the May 1988 issue of The Bulletin

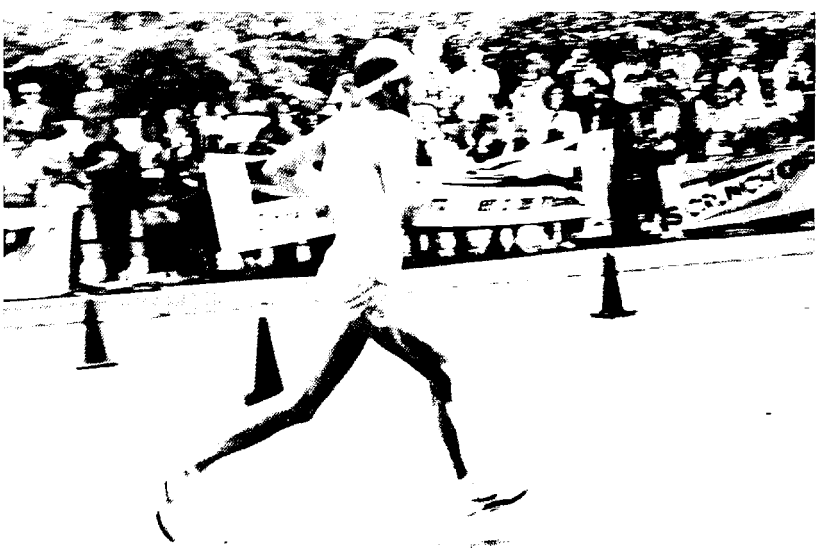
Dr. Waltman, is chairman of the Credentials Committee and a family physician.

Marathoner

Dr. Ronald Taylor, general surgeon and long-time PCMS member, recently toured the Portland Marathon in two hours and 45 minutes. Ron finished fourth in his age category and 42nd overall. His finish time in the 26.2-mile race was a tremendous accomplishment for any runner—an average of six minutes and 29 seconds per mile. Congratulations Ron, on a great run.

1989 Directory

The 1989 Pierce County Physicians and Surgeons Directory will be distributed in late December. **If you have any vital changes on your listing, you must notify the MBI office, 572-3709, no later than Friday, November 4. We will go to press after this**



Ron Taylor Portland Marathon 9-25-88

Pierce County Medical Society

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3660

LUNCHEON MEETING FOR RETIRED MEMBERS AND SPOUSES

Wednesday, November 9, 1988

"A History of Medicine in Pierce County"

with

Mrs. Mavis Kallsen

DATE: Wednesday, November 9, 1988

TIME: Lunch: Noon
Program: 12:45 p.m.

COST: Lunch, $9.50 per person

LOCATION: Tacoma Dome Hotel
(Hickman South Room)

Register now! Please complete the attached reservation form and return it with a check for the appropriate amount made payable to the **Pierce County Medical Society.** A pre-addressed envelope has been included for your convenience, or you may call the Medical Society office directly at 572-3667 to confirm your attendance.

Reservations must be made no later than Friday, November 4.

REGISTRATION FORM

Please reserve _____ lunch(es) at $9.50 per person (tax and gratuity included).

Enclosed is my check for $ _____.

Dr. _____

AMA Update

Membership Jumps

The AMA Division of Membership reports the following membership and dues revenue information for 1988 through the end of May. Year-to-date 1988 dues-paying membership is 7,335 members (3.7 percent) above the same period in 1987.

Legislation and Policy

An open letter to the presidential candidates from James H. Sammons, MD, executive vice president of the AMA, appeared August 16 in the Washington Post.

Dr. Sammons lauds AMA's "tremendous accomplishment" in achieving reforms for organized medicine.

Dr. Sammons outlined a bipartisan agenda that would "assure the American people high-quality health care at reasonable cost." Headlined as "The AMA's Political Prescription," the piece highlighted many issues including Medicare reform, professional liability and AIDS.The AMA's victories in the 100th Congress span Medicare reform, smoking bans, AIDS legislation, liability protection and more. In a recent report, Dr. Sammons lauds AMA's "tremendous accomplishment" in achieving reforms for organized medicine. The "victory profile" was prepared by the Department of Congressional Affairs.

AMA's Medical reform recommendations include expanded acute care coverage for all individuals below the poverty level. A Board of Trustees report, approved at the recent Annual Meeting, suggested program revisions establishing national standards for Medicaid eligibility and minimum benefits. The report has been forwarded to the Health Care Financing Administration.

Expansion of Medicaid was also proposed in recent AMA testimony in the House of Representatives regarding the problems of the uninsured and underinsured.

AMA comments on the unrelated business income tax (UBIT) were made in a letter to Rep. J.J. Pickle, chairman, Subcommittee on Oversight, House Ways and Means Committee. Among other points, the letter expressed opposition to UBIT's potential effect on pro bono activities of tax-exempt organizations. AMA lobbyists have met regularly with Treasury Department officials to discuss UBIT and possible alternatives to the measure.

To assist Medical Society members in planning their continuing medical education plans for the year, the College of Medical Education 1988-89 program schedule is printed below. A complete calendar, including course descriptions, is available through the COME office, 627-7137. Remember...**MARK YOUR CALENDAR!**

1988	
Nov. 2, 3	**Common Office Problems**
Dec. 8, 9	**Advanced Cardiac Life Support**
1989	
Jan. 12	**Pharmacology in Medicine**
Jan. 19	**Law and Medicine Symposium**
Feb. 1	**AIDS**
Feb. 10	**Office Gynecology**
March 9, 10	**Tacoma Academy of Internal Medicine**
March 22, 23	**Orthopedics and Sports Medicine**
April 14, 15	**Tacoma Surgical Club**
April 26, 27	**Computers in Medicine (Clinical Applications)**
May 17	**Neurology**
June 26, 27	**Advanced Cardiac Life Support**

Making the Difference

By David L. Anders, M.D.
Augusta, Georgia

Material for this section was taken from the JAMA, July22/29, 1988, p548.

The following editorial appeared in the July 22/29, 1988 issue of the Journal of the American Medical Association.

My afternoon patients started with Mr. Lorenz. Age: 35 years. Complaint: lower back pain. Before seeing him, I flipped through his chart. I couldn't quite recall his face but I did remember his visit several months previously for a mild upper respiratory tract infection. It had been during my first month of practice after residency.

As I entered the examining room where he waited, I suddenly remembered him very well. He was polite, articulate, and healthy and was concerned about staying that way. The ease with which he stood as I entered the room assured me that his back pain couldn't be very severe."Welcome back," I said, shaking his hand.

"Thanks. Before I forget, I want to let you know I am wearing my seat belt now."

"Great!" I exclaimed, partially for his encouragement but also from a sense of personal pride and sudden rejuvenation.

I remembered talking with him about screening examinations and risk reduction during his previous visit. The program director in my residency (a preventive cardiologist) had made a strong impression on me concerning the importance of reiterating screening and preventive methods with every patient at every encounter. I recalled spending a little extra time with Mr. Lorenz, even discussing seat belts, because he seemed so genuinely interested in his health. His major identifiable risk had been a failure to wear his seat belt. He had conceded an unexplainable, unjustifiable reluctance to do so, adding that his wife frequently reminded his to "buckle up." I had spoken with her several days after his first visit, when she called for the results of his serum cholesterol screening. She specifically thanked me for mentioning seat belts to her husband. She had not been optimistic he would change, however.

But now I had done it. I had actually intervened and persuaded a patient to wear his seat belt. One doctor really can make a difference, I thought. Patients really do pay attention to physicians. It had all been so simple, so painless: just a few more seconds at every meeting to remind patients about seat belts, tobacco, alcohol, cholesterol. What an impact that could have over 30 or 40 years of practice!

Now, as a I stood there basking in the glow of this success, Mr. Lorenz continued. "I knew Rex Lee." Instantly my throat and stomach tightened with a nauseating wave of adrenergic release. I had known Rex too. He was a talented, gregarious, young internist who taught me when I was an intern. A few weeks earlier he had been in a car accident and was thrown from his vehicle. He died shortly thereafter, a tragedy intensified by the brilliance and youth of its victim.

A brief silence passed.

"So now I wear my seat belt.

"One doctor really can make a difference.

Aging and the Humanities

By Jay S. Luxenberg, MD

The following article appeared in the July 1988 issue of San Francisco Medicine, a publication of the San Francisco Medical Society.

A physician who has been ill or hospitalized may find a new, higher degree of empathy toward his patients. Similarly, having children can make managing parental anxiety in a pediatric practice more bearable. A large part of many physicians' practices involves dealing with the interactions between diseases and the aging process. Although we are all getting older, the emotional and physical manifestations of aging are impossible to experience first-hand ahead of schedule. Instead, literature allows us to vicariously experience a state that we can only hope to reach someday. I teach young physicians in the equally neophyte field of geriatric medicine. In geriatrics the curriculum is still in a state of rapid evolution, and the areas of expertise that separate geriatrics from internal medicine and family practice on one hand and psychiatry on the other are just being delineated. I suggest to the fellows in geriatric medicine, as well as to all physicians, that we turn to sources other hand medical textbooks to develop the wisdom needed to provide health care to elderly persons that will maximize their pleasure to be alive.

Starting with nonfiction, I recommend Robert N. Butler's Pulitzer Prize winning "Why Survive? Being Old in America." This expose dramatically reveals many of the roadblocks our society allows to interfere with a happy old age. Simone de Beauvoir's "Old Age" gives a cross-cultural picture of aging, and David Hackett Fischer's "Growing Old in America" puts our own attitudes and institutions concerning aging in historical perspectives.Perhaps more accessible, yet less likely to be in the syllabus of a course on aging would be the Barbara Meyerhoff's sterling work of anthropology "Number Our Days," a study of the community of elderly Jews in Venice, California. This type of books allows one to observe individual elderly persons in the context of a rich culture, and shows how physical illness interacts with the premorbid personality and the circles of family and friends. It is an axiom of geriatric medicine that inter-individual variance of physiological parameters increases with aging, and a lesson from this type of book is that there are tremen-

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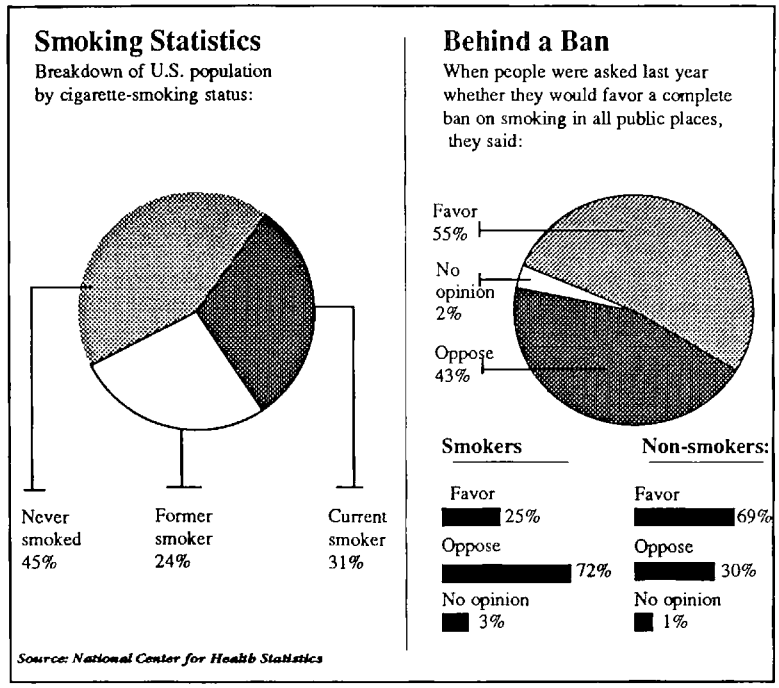
cial, and psychological challenges of aging.

Another way to study aging is reading the biographies of people that have achieved successful and happy old age. My favorite example of this genre is the last volume of Dumas Malone's six-volume biography of Thomas Jefferson, "Jefferson and his Time." This volume, "The Sage of Monticello," chronicles Jefferson's life from the end of his presidency at age 65, through his astonishingly productive "retirement," his illnesses, family problems, and his death at age 83. Although Jefferson remained brilliant and lively throughout his life, the impact of age was very much evident and Malone captures this with grace and poignancy.



As useful as nonfiction is in teaching about aging, there are elements of the aging process that seem only to be captured in fiction.

Here the choices are even wider; we can all think of a favorite character in a novel, play or short story that illustrates an aspect of aging, providing a chill of recognition and an insight that serves us in good stead in clinical practice. Many authors have devoted entire works to themes of aging, including Thomas Mann's "Death in Venice" and the complementary "The Black Swan." Short stories by mature authors such as V.S. Prichett and Eudora Welty often contain vignettes that bring alive older persons. M.F.K. Fisher has an excellent collection of short stories, "Sister Age," tied with a theme of aging. There are lessons to be learned about aging from works of fiction ranging from "The Canterbury Tales" to such current fiction as Saul Bellow's "More Die of Heartbreak."

In summary, it has been said that medicine is equal part art and science. Aging can be beautiful and ugly, dignified and embarrassing, lonely and yet universal. The science of caring for the elderly is contained in many medical textbooks, but the art of geriatrics can only be enhanced by studying the humanities.

HIV Testing/Counseling Requirements

By Joanne Peterson

Requests for HIV testing are increasing. Physicians must be aware of new requirements concerning confidentiality and counseling which are now part of the Omnibus AIDS Bill. The bill was passed by the Washington State Legislature in July 1988.

Pre-test counseling is required and the Washington Administrative Codes specify the information which must be given during this session. Post-test counseling is necessary whenever a test result is positive and is desirable even with negative test results. The goals of both sessions are education and behavior modification to decrease changes of exposure to the virus and/or transmission to others. Counselors should undergo training given by DSHS or the Seattle-King County AIDS Project.

Once the patient has made an informed decision to be tested, he/she should be advised of his/her options for testing:1. private physician; 2.county health department; clinics; 3. some planned parenthood clinics; 4. DARMIC Laboratory, a private company specializing in counseling and testing, primarily of low-risk individuals at 2000 116th Ave N.E., Bellevue, 455-1967, with satellite draw sites in Tacoma and Seattle; 5.Harborview STD Clinic, 223-3590; 6. Seattle-King County AIDS Project, 296-4999, emphasizing services for individuals who are at high risk of exposure.

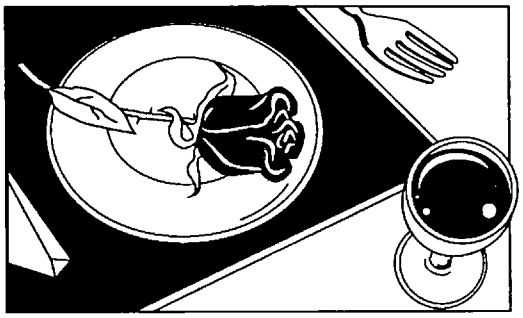
Confidentiality and/or anonymity, as well as informed consent, are of utmost importance. A patient must be given information regarding informed consent and then be allowed to decide which of the testing options best meets his/her personal needs. It may be that the person feels more comfortable being tested in a place other than the physician's office, but may want to return to the physician for further care. It is critical that HIV positive persons be referred immediately to appropriate support services for both health care and counseling.

Pierce County Medical Society
705 South Ninth Street • Suite 203 Tacoma, Washington 98405 • Tacoma (206) 572-3666

You are cordially invited to join the

Pierce County Medical Society
and
The Pierce County Medical Auxiliary
at their
ANNUAL JOINT DINNER MEETING

CELEBRATING 100 YEARS



Sheraton -Tacoma
Hotel
1320 Broadway Plaza

Tuesday, December 13, 1988
Cocktails (no host) 6:30 p.m.
Dinner 7:15 p.m.
Program 8:15

$25.00 per person, $50.00 per couple
(Price includes wine, tax, gratuities)

Reservations are requested by Wednesday, December 7, 1988

I (we) have set aside the evening of December 13, 1988 to join members of the Pierce County Medical Society and the Pierce County Medical Auxiliary at their Annual Joint Dinner Meeting and Installation of Officers.

Please reserve _____ dinner(s) at $25.00 per person/$50.00 per couple.
Wine, tax and gratuity included. Enclosed is my check for $ _____

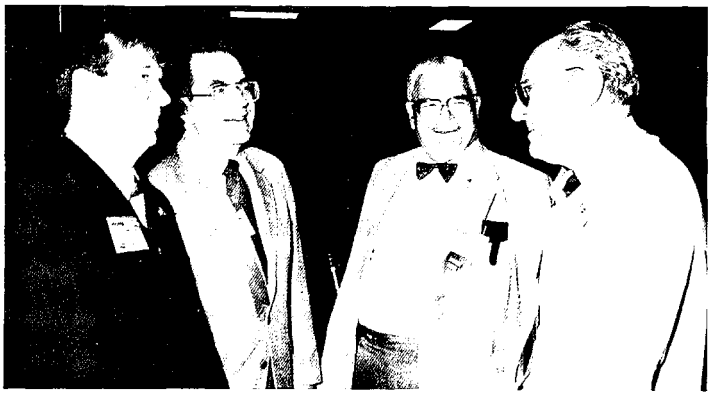
Dr. _____
(please print)

Please make check payable to Pierce County Medical Society
Return to the Society by Wednesday 7, December ,1988

WSMA CONVENTION

Dr. Ralph Johnson, WSMA President meets with Booth Gardner.

President of WSMA and WSMAA , Dr.. George Schneider and Sharon Ann Lawson share a smile as Dr. Schneider presented a check to the Auxiliary for the Teen Health Forum.



Dr. Richard Hawkins, WSMA Vice-Speaker, Ralph Johnson, Immediate Past President, David Williams, WSMA Speaker of the House, and Dr.George Schneider President WSMA, share a laugh in Yakima.

Pierce County Delegates to the Annual meeting had a front seat to the proceeding at Yakima-- they are: Drs., Bill Jackson, Eileen Toth, Charles Weatherby, Bill Ritchie, Charles Anderson, and Bob Scherz.

YAKIMA 1988

PCMS representative to the WSMA Board of Trustees, Dr. Charles Weatherby talks to Dr. A. Robnett and Governor Booth Gardner on a matter of importance.

Dr. Bill Marsh, PCMS trustee sat on Reference Committee 'B' to hear many of the issues brought before the House of Delegates.

n Yakima are Drs. Bill Jackson, Eileen Toth,

Make your investment in our youth today!

The purpose of the conference is to increase the number of adolescents making **responsible personal health choices**. This educational program targets the middle school student who is making decisions that will affect the quality of his /her adult life.

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WSMAA Teen Health Forum

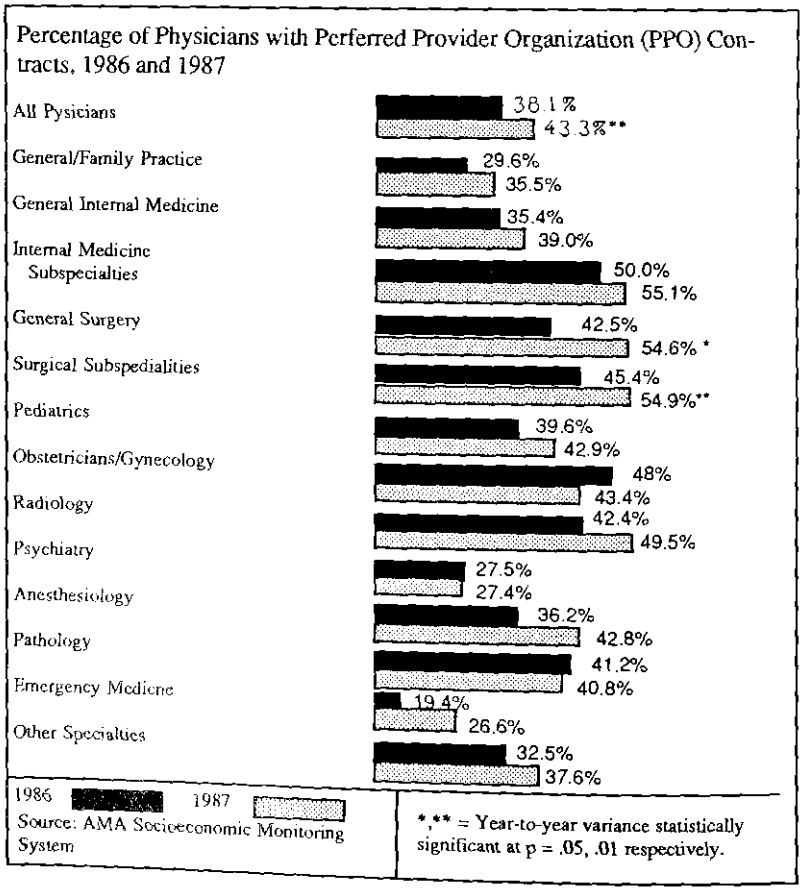
Physician Involvement with PPOs

The following commentary is reprinted from the September 5, 1988 issue of the SMS Report published by the American Medical Association.

The number of physicians who had contracts with preferred provider organizations (PPOs) increased from 38.1 percent in 1986 to 43.3 percent in 1987. Analysis by specialty group, Figure 1, shows that:

- General surgeons and physicians in surgical subspecialties experienced the largest increases in the percentage reporting contractual agreements with PPOs. 54.9 percent of surgical specialists and 54.6 percent of general surgeons had contracts with PPOs in 1987, representing increases of 12.1 and 9.5 percentage points respectively over the previous year.
- 43.4 percent of obstetricians/gynecologists had contracts with PPOs in 1987 compared with 48 percent in 1986. However, the decline was not statistically significant.
- In 1987, 55.1 percent of internal medicine subspecialists had a contract with a PPO, the highest percentage among all specialty groups. In contrast, only 26.6 percent of emergency medicine physicians and 27.4 percent of psychiatrists had such contracts.
- PPOs are becoming a more common phenomenon in medical practice but still account for only a small part of physicians' practices. For those respondents who indicated that they had a relationship with a PPO, SMS included questions on the percent of practice revenues that came from such arrangements. Overall, this percentage increased from 10.2 percent in 1986 to 12 percent in 1987. Specialty analysis, Figure 2, indicates that:Although the percentage of obstetricians/gynecologists with PPO contracts declined in 1987, the average percent of revenues from PPOs increased. In 1986, obstetricians/gynecologists earned 11.9 percent of their revenues from PPOs. In 1987, the average increased to 16.4 percent, the largest increase among the specialty groups.The percent of revenues from PPOs increased among all specialty groups except pathologists and emergency medicine physicians. Pathologists experienced a 2 percentage point decline in revenues from PPOs and emergency medicine physicians' revenues from PPOs declined 5.7 percentage points.
- Obstetricians/gynecologists, anesthesiologists and general/family practice physicians earned the highest percent of revenues from PPOs in 1987, 16.4 percent, 15.6 percent and 13.4 percent respectively. Psychiatrists, emergency medicine physicians, and surgical subspecial-

Continued on page 21



Physician Involvemnt with PPO's continued from page 20

ists earned the lowest percent of revenues from PPOs, 7.7 percent, 8.8 percent and 9.8 percent respectively.This review of physician involvement with PPOs indicates that it is a growing phenomenon that accounts for a relatively small portion of most medical practices. Future surveys will investigate the magnitude of the fee discounts negotiated by PPOs.

'89 World Medicine Games

For the past 10 years, The World Medicine Games have brought together several thousand physicians, dentists and pharmacists—representing over 50 nations—to engage in friendly competition in a variety of sporting disciplines. In the past, The Games have been held primarily in European countries and Morocco, attracting enthusiastic participation of the medical communities of Italy, France, Japan, the U.K., West Germany, Yugoslavia, Canada and many other nations.

In 1989, however, The World Medicine Games will be held on North American soil for the first time. Montreal is preparing to greet the world's medical community for one week in July, and is expecting large contingents of Soviet, European and North American athletes. Strong U.S. participation is encouraged in the numerous sporting events planned, including judo, swimming, track and field, tennis, cycling, soccer, and golf.

The Games encourage a spirit of participation and individual achievement; it is therefore important to realize that the majority of participating athletes enjoy amateur status, and will compete against their peers in appropriate age categories on a personal and non-national level. The top three athletes in each category will be honored with gold, silver and bronze medals.

A symposium on sports medicine — highlighted by internationally renowned leaders in the field — will be held concurrently with the Games. Symposium topics and guest speakers will be announced at a later date.

If you have questions or would like more information about this exciting international event, please write: ASSOCIATION DE MEDECINS DE LANGUE FRANCAISE DU CANADA, 1440 Rue Ste-Catherine Ouest, Suite 510, Montreal, Quebec H36G 2P9; or call (514) 866-2053, between 9 a.m. and 5 p.m. EST.

Medically Unnecessary Services

Medically unnecessary services are those services which are determined not to be covered by Medicare because they are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member.

The Omnibus Budget reconciliation Act of 1986 (OBRA), Section 9332 (C), "Prohibition Against Billing Nonassigned Services Which are Determined to be Medically Unnecessary" applies to non-participating physicians who do not accept assignment on the claim. Physicians billing services to another nsurance plan under the indirect payment procedure or because the Medicare beneficiary has primary coverage under another plan, i.e., claims where Medicare is the secondary payer, will not be affected by this change in the statutes.

A nonparticipating physician who provides on an unassigned basis services which medicare determines not to be reasonable or necessary for the treatment of illness or injury may request a review of Medicare's determination within 30 days of the notification. The physician may not bill the beneficiary for the service(s) determined not to be medically necessary, or if money has already been collected by the physician, it must be refunded.

This provision of OBRA applies to medical necessity denials and to so-called "medical necessity reductions." In the case of a medical necessity reduction, a nonparticipating physician who does not accept assignment must refund to the

Continued on page 23

Medically Unnecessary
Continued from page 22

beneficiary any amounts he or she collects that exceed his or her maximum allowable actual charge (MMAC) for the less extensive service or procedure.

Medical Necessity Determination

Many of the medical necessity denials and conditions for determining coverage vs. denial are published by the Health Care Financing Administration. These include items which are never covered as well as some which have specific conditions for coverage. See accompanying sidebar item, which includes a list of action codes used for Medicare medical necessity denials as well as guidelines regarding the frequency of some services. Services exceeding these guidelines are reviewed on an individual basis for medical necessity based on the documentation submitted with the claim.

Defining Medical Necessity

To be considered medically necessary, items and services must have been established as safe and effective. That is, the items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment
- Necessary and consistent with generally accepted professional medical standards (i.e., not still be experimental or investigational)
- Not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier
- Furnished at the most appropriate level which can be provided safely and effectively to the patient.

Notification When Services are Deemed Medically Unnecessary

If Medicare deems services not medically necessary, the beneficiary will be notified via the appropriate action code message (see sidebar) and the following wording on the Explanation of Medicare Benefits (EOMB):

"If the doctor should have known that Medicare would not pay for the denied services and did not tell you, you may be entitled to a refund of any amounts you paid. If you do not hear in 30 days, contact your doctor's office."

"If the doctor should have known that Medicare would not pay for the more extensive service and did not tell you, . . .

"If the doctor should have known that Medicare would not pay for the more extensive service and did not tell you, you may be entitled to a refund of any amount you paid which is more than the doctor is allowed by law to charge under Medicare for the less extensive service. If you do not hear in 30 days, contact your doctor's office."

At the same time, the physician who provided the service(s) will be notified with a letter from Medicare accompanied by a listing of medically unnecessary services that identifies the specific claim(s).

Physicians Right to Appeal

Nonparticipating physicians have the right to appeal Medicare's coverage determination in an unassigned claim if services were denied or reduced because they were deemed not medically necessary. The request for a review must be made within 30 days of the receipt of Medicare's notification. A review may be requested on both:

a. The carrier's coverage decision. This will generally required additional information why the physician believes the service(s) should be considered reasonable and medically necessary.

b. The determination that a refund is necessary. In this case, thephysician should submit evidence why he/she thinks the beneficiary is financially liable for the service(s) or why the physician believes he/she does not have to refund the money the beneficiary has paid.

Time Limits for Making Refunds

Under 1842(1), a refund of any amounts collected must be made to the beneficiary within the following time limits:

1. If the physician does not request review of the initial coverage determination with 30 days of the receipt of the initial notice, the refund must be made to the beneficiary within 30 days after the date the physician receives notice that the services are not covered.
2. If the physician requests review of the initial determination within 30 days of receipt of the initial denial notice, the refund must be made to the beneficiary within 15 days after the date the physician receives the notice of review determination (if unfavorable).

Situations When a Refund is Not Required

1. The physician did not know and could not reasonably have been expected to know that payment may not be made for the services because they were not reasonable and necessary, or
2. Before the service was furnished, the beneficiary was informed that Medicare payment could not be made for the specific service because it would not be covered, and

MEDICAL UTILIZATION REVIEW SCREENS

The following prepayment utilization screens are used by Medicare to identify services that potentially exceed established medical necessity guidelines. Therefore, claims which exceed these screens are individually reviewed to determine the medical necessity. At that time, all documentation submitted with the claim will be used to substantiate the medical necessity of the service furnished.

HCFA Required Screens	Claim is Reviewed to Determine the Medical Necessity if More Than:
1. Concurrent Care	1 physician treats the patient for the same condition(s) concurrently
2. Chiropractic Care Codes: A2000-A2999	12 treatments are furnished in 12 months
3. Nursing Home Visits Established Patient Codes: 90430-90470 M0040-M0045	1 routine visit billed per month
4. Hospital Visits Codes: 900240-90280	31 visits billed per 1 month or per 3 months
5. Office Visit - Comprehensive	1 per 6 months
6. Therapeutic Injections Codes: 90782-9079	12 injections per 12 months
7. Holter Monitor Codes: 93258-93263	1 procedure per 6 months
8. Mycotic Nails Codes: 11700-11711	3 services per 6 months
9. Skilled Nursing Facility Visits - Established Patient Codes: 90340-90370 M0030	12 visits per 3 months
10. Office Visit - New Patient - Comprehensive Code: 90020	1 visit per 12 months
11. Urological Supplies Codes: A4341-A4346	2 items per month
12. Contact Lenses Codes: V2500-V2599	4 contact lenses per 12 months
13. Routine Foot Care Code: T1060	2 services per 3 months for systemic condition

Carrier Assigned Screens	
1. Initial Hospital Care - Comprehensive Code: 90220	1 service per 3 months
2. Office Calls Codes: 90030-90070	5 visits per 1month 12 visits per 3 months
3. EKG Codes: 93000-93010	3 procedures per 6 months
4. Skilled Nursing Facility Visits - New Patient Codes: 90300-90320	1 visit per 12 months
5. Nursing Home Visits New Patient Codes: 90400-90420	1 visit per 12 months
6. Chest X-Ray Codes: 71010-71035	3 X-Rays per 1 month
7. Joint Injections Codes: 20600-20610	3 injections per 6 months
8. B12 Injections	1 injection per month

Code: J3420

ACTION CODES

When Medicare determines services to be not medically necessary, the following messages are shown on the beneficiary's EOMB to explain the reason for the denial. The appropriate code from this listing will also be shown in the very right-hand column on the "Medicare Part B Listing of Medically Unnecessary Services" to advise you of the reason for Medicare's determination.

Code	EOMB
AI (DRUGS)	Medicare does not pay for drugs that are not approved as effective by the food and drug administration.
AR (MED NEC)	Medicare covers only one visit per month to a nursing home unless special need is shown by your doctor.
AT (DRUGS)	Medicare does not pay for this injection for the condition and/or illness stated.
AV (MED NEC)	Procedures whose effectiveness has not been proven are not covered by Medicare
AW (MED NEC)	An office visit charge is not covered with this service unless the office visit was required because of an emergency.
AX (MED NEC)	Medicare does not pay for similar services by more than one doctor during the same time period under ordinary circumstances.
AY (MED NEC)	Medicare does not pay for more than one visit per day for your condition.
AZ (MED NEC)	Medicare does not pay for similar services by more than one doctor of the same specialty during the same time period.
BG (MED NEC)	Medicare does not pay for acupuncture.
BT	A full office visit charge is not covered (MISC) when an injection is the only service provided.
B5 (MED NEC)	Medicare does not pay for this many services within this period of time for this condition.
DP	This injection exceeds dosages for which (DRUG) Medicare will pay.
EP (MED NEC)	Medicare does not pay for this many tests/ procedures or visits for this condition unless unusual circumstances are documented.
N2 NEC)	Medicare paid less because a less extensive (MED procedure would have been adequate for the condition reported.
P1 NEC)	Medicare does not pay for this service for (MED the reported condition.
70 (SURG)	Charges for a surgical assistant are not covered by Medicare for this procedure.

after being so informed, the beneficiary agreed to pay the physician for the service.

Please keep in mind that Section 9332(c) OBRA applies only to non-assigned physician services which are denied or where the level of service is reduced because they were deemed not medically necessary. The physician can continue to bill the patient for services that are denied because they are excluded from Medicare, e.g., routine physical exams, dental services, cosmetic surgery, etc. Therefore, it will be important to submit the adequate information with the initial claim.

Should you have any questions or comments, please contact Marilyn Williams, Professional Relations Representative, Pierce County Medical Bureau, at 597-6483.

Continued on page

Building a Strong Staff

By Jack Valancy

A strong staff helps your practice run smoothly; a weak staff impairs it.

The kind of staff you have depends on who you hire and your management skills. You can build a strong staff with formal job descriptions, competitive compensation packages, fair personnel policies and procedures, careful recruiting, thorough training, high job performance standards, and respect.

Job Descriptions

When physicians find themselves with employees who are not suited for their jobs, it's often because the jobs were not clearly defined in the first place. Lack of definition leads to choosing the wrong candidate, then to misunderstandings about job duties. You can't make a good hiring decision without first creating a job description. Each position in your practice should have a formal five-part written job description, covering: Job title

Job summary

Describe the job in one or two sentences. Supervisor and/or supervisory responsibilities. Each employee should have only one direct supervisor, even though she may work with several people.

Qualifications

Specify the education, skills, and experience needed to perform the job well. Job duties. Each numbered item is a brief and clear description that begins with a verb, such as answers, prepares, schedules. Do not describe‹j‹ procedures.

Compensation

Salary and Benefits Paying low salaries and minimal benefits is usually false economy. Good employees who can earn significantly more elsewhere leave the practice,while those with mediocre performance remain. This is not to say that you must match the compensation packages offered by other employers, such as hospitals. Employment in your practice may offer important non-economic benefits, such as regular hours and pleasant working conditions. To be competitive, however, you must enable your employees to earn a decent living. Establish a formal written salary structure for each position based on its relative contribution to the practice. Individual compensation should be determined by performance and tenure, with the emphasis on performance.

Personnel Policies and Procedures

Routine matters like overtime, vacation, sick time, and office attire can develop into dilemmas if you don't have a system for handling them. Treating each employee request individually is very time-consuming and often futile. No matter what you do, everyone will feel shortchanged. Prepare fair, written personnel policies and procedures to assure that everyone is subject to the same rules.

Recruiting

It takes time to find the right person for a position, but it's worth spending the time so you don't have to do it all over again in a few months

Advertise

Recruit a good selection of qualified candidates from which to choose. Run a brief classified ad in your area's major newspaper. Include your telephone number to make it each for applicants to get in touch with you. While you, or our office manager, will talk with many people who are not qualified for the job, you will also speak with several who are qualified. You'll hear from fewer people, both unqualified and qualified, if you ask applicants to mail their resumes to your office rather than call. Fewer people still, will reply to a box number.

You can also make people aware of a job opening in your practice by word of mouth. Hiring friends (or friends of friends), or relatives can be uncomfortable if things don't work out well. Observe two guidelines: 1) Consider only people who are qualified for the job, 2) Don't hire anyone you can't fire. Employment agencies can help you find candidates for a vacancy. they earn their fees when the candidate is hired. Better employment agencies screen candidates against job qualifications carefully. You make the final decision, however, and bear the consequences.

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Screen.

While you're on the telephone with the applicant, ask about her qualifications. If you determine that she meets them, ask her to send a resume, and if she's still a promising candidate, schedule an interview. If an applicant does not meet the job's qualifications, tell her so tactfully.

Interview.

Your two objectives are to learn more about the candidate's qualifications and to educate her about the job. Allow at least a half hour to educate her about the job. Conduct it in a private office and permit no interruptions. Let the applicant talk but don't allow her to monopolize the interview. Ask her about her employment history with open-ended questions, such as:
"Tell me about your current and previous jobs." "What did you like most and least about them?" "Why are you interested in this job?" "If I were to talk to the people you've worked for, what would they be likely to say about you?" Give the candidate you full attention, observe her manner. Would you feel comfortable working with her? Having her represent your practice? If you still think she is a strong candidate, give her a copy of the job description and review it together, point by point. If, as you review the job duties, you question the candidate's ability, ask, "Do you think you would have any trouble with this?" Review the compensation package and the practice's personnel policies and procedures, too. As you discuss each point, ask if it is acceptable to her.

Finally, ask, "If you were offered this job, is there any reason you could not perform it as described?" This is the time for the applicant to inform you of any special considerations.

Testing.

You can test an applicant's skills by asking her to complete sample tasks you have prepared in advance. Tests should simulate actual working conditions as much as possible.

Check references.

Ask the candidate to provide the names of her references in writing, and grant permission to contact them. If possible, speak with the applicant's most recent immediate supervisor. Verify the dates of employment, position, and job duties, and ask about her job performance and how well she got along with others. Determine why she left her previous job and if the employer would hire her again. Finally, ask, "Is there anything else I should know that would help me with my decision?"

Training

Good training can turn an underachiever into a staff member who makes a valuable contribution to the practice. Realizing an employee's potential should not be left to chance. Outline a step-by-step training program for each new employee. Assign the responsibility for training her to an experienced employee. On the first day: Introduce her to the physicians and her coworkers. Review her job description, compensation and the personnel policies and procedures manual. Initiate her personnel folder and complete all necessary paperwork. Let her observe in the area where she will be working. Give her a small assignment so she will feel that she has accomplished something on her first day. Written procedures are excellent training materials. Provide each employee with her own copy. Perform training during a quiet time in the practice. Go slowly. Teach one procedures, or portion of a procedures, at a time. Continuing education will keep your employees' skills sharp. Books, periodical, self-study courses and seminars can help improve performance. The practice should pay for all training costs

Job Performance Evaluation

Monitor each employee's job performance continuously and conduct a formal, written job performance evaluation with each employee every year. Reward good performance. Do not tolerate poor performance. Small allowances to capitalize on an individual's strengths area acceptable, but making major compromises to avoid an individual's weaknesses can undermine the practice. Try to help the employe improve her performance. However, if she is unable or unwilling to carry out all of her job duties well, you must find someone else who can. Transfer or discharge the poor performer.

Treat People Well

Contrary to popular belief, money does not motivate people to do a good job. The greatest motivators are:
Achievement Recognition
The work itsel fResponsibility
Advancement Tell each person on your staff that her contribution is important to the practice. Express our appreciation for good individual and team performance. Solicit suggestions for improvements. Treating people with basic human respect costs nothing and pays big dividends.

Jack Valancy heads a health care management firm in Cleveland Heights, Ohio.

Health Care in Tacoma - Pierce County

A Tacoma Market Survey, sponsored by the Morning News Tribune, focused on health care in Tacoma-Pierce County and South King County. Two thousand adults (18 years and older) in Pierce County and 400 in South King County were surveyed in October and November of 1987 via telephone interviews using a standardized questionnaire. The Bulletin will report various results of that survey in the next few issues.

The following responses pertain to hospital care:

Hospital mentioned for emergency care:

Tacoma General (MultiCare)	27%
Good Samaritan (Puyallup)	17
Madigan	15
St. Joseph Hospital	15
Lakewood General	7
Humana	5
Puget Sound Hospital	2
Auburn General	2
Group Health	1
Mary Bridge	1
Enumclaw Memorial	1
Veteran's Hospital	1
Valley General	1
St. Francis Community Hospital	1
St. Peter's Hospital	*
Swedish Hospital	*
University	*
Harborview	*
Virginia Mason	*
Children's Orthopedic	*
Other	1
Whichever doctor says	*
None/would not go to hospital	*
None in particular/no response	3

Hospital mentioned for major surgery/illness:

Tacoma General (MultiCare)	30%
St. Joseph Hospital	18
Madigan	14
Good Samaritan Hospital	10
Lakewood General	4
Humana	3
Group Health	2
Valley General	1
Virginia Mason	1
Swedish Hospital	1
Auburn General	1
Mary Bridge	1
Veteran's Hospital	1
University	*
Enumclaw Memorial	*
St. Peter's Hospital	*
Harborview	*
St. Francis Community Hospital	*
Children's Orthopedic	*
Other 2 Whichever doctor says	2
None	*
None in particular/don't know	7

Hospital mentioned for minor surgery/illness:

Tacoma General (MultiCare)	25%
Good Samaritan	16
Madigan	15
St. Joseph Hospital	13
Lakewood General	6
Humana	6
Group Health	2
Puget Sound Hospital	2
Auburn General	1
Enumclaw Memorial	1
Valley General	1
Mary Bridge	1
Veteran's Hospital	1
St. Francis Community Hospital	*
St. Peter's Hospital	*
University	*
Swedish Hospital	*
Harborview	*
Other	3
Whichever doctor says	1
None	1
None in particular/don't know	5

Reasons for choosing that hospital for emergency care:

Location	31%
Quality of care	20
Insurance coverage	18
Hospital reputation	6
Know someone there	6
Physician referral	5
Habit/experience	5
Cost/lower cost	4
Specialized services	3
Staff specialists	2
State-of-the-art equipment	1
Quick, fast service	3
Other	3
No response	3

Reasons for choosing that hospital for major surgery/illness:

Quality of care	23%
Insurance coverage	17
Location	14
Hospital reputation	10
Physician referral	9
Know someone there	6
Staff specialists	6
Habit/experience	5
Cost/lower cost	4
State-of-the-art equipment	3
Specialized services	3
Quick, fast service	*
Other	3
No response	3

Reasons for choosing that hospital for minor surgery/illness:

Location	25%
Quality of care	21
Insurance coverage	17
Physician referral	8
Hospital reputation	8
Know someone there	6
Cost/lower cost	4
Habit/experience	4
Staff specialists	4
Specialized services	3
State-of-the-art equipment	2
Quick, fast service	*
Other	3
No response	3

Continued on Page 29

Health Care in Tacoma
Continued from page 28

Primary source used by Pierce County adults for information on hospitals and hospital care:

Friends/relatives	39%
Doctor/clinic	15
Newspapers	10
Television	6
Magazines	6
Work/employer/job	4
Personal experience	3
Radio	2
Insurance company	1
Flyers/direct mail	1
Other	3
No response	11

MEDIA SOURCES ONLY

Newspapers	41%
Television	24
Magazines	23
Radio	9
Flyers/direct mail	3

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Your colleagues want to help.

Medical Problems, Drugs, Alcohol, Retirement, Emotional Problems

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Jack P. Liewer	588-1759
Kathleen Sacco	591-6681
Dennis F. Waldron	272-5127
Mrs. Jo Roller	752-6825

WSMA: 1-800-552-7236

Correction

The Board of Trustees has approved the Credentials Committee recommendation that **Kenneth J. Kirkwood, MD.**, Family Practice, Chec Medical Center be approved for membership. Welcome to Pierce County and the Medical Society.

Fluoridation Update

The anti-fluoridationists have started their fight in Pierce County. Citizens For Freedom of Choice, as they call themselves, are being led by Wayne Aho, and they contend the media coverage regarding fluoridation was misleading. In spite of this issue making headlines since July of 1986, this group says it didn't realize that fluoride would be on the September 20th ballot and they blamed the Morning News Tribune for not making more prominent notice of this change. The City Council voted at its August 2nd meeting to place the issue on the September ballot to save the city about $60,000.00 since it already had a proposition in September.

Mr. Wayne Aho and his supporters attended the City Council meeting on October 4th and were given ten minutes to express their concerns. Their ten minutes were utilized by John Lee, a family physician from Mill Valley, California who informed the council of three major points regarding fluoride.

1.) The dose recommended (1 part per million) is excessive

2.) The toxicity reports on fluoride are in the biochemical literature, not the public health literature

3.) The proof of fluoride's effectiveness is not conclusive-it is a "myth" that fluoride works

Dr. Lee went on to report that he sees "fluoride toxicity" in his patients all the time and a 1970 study of death certificates by Dr. Erickson from CDC indicated that areas drinking fluoridated water had a 8.8% higher death rate from cancer, 12% higher death rate from heart attacks, and 9% higher death rate directly attributed to fluoride of 4.9%.

He claims fluoridation is losing in most areas of the world including Canada and Europe, that it is only a "cadre of beaurocrats" supporting fluoridation was a "good idea 45 years ago" and that the time for fluoride has "come and gone".

His summary statement included the question " what does it take for a rational person to abandon his fluoride mind-set".

As it stands now, Tacoma's water will be fluoridated. The final vote in September was 12,719 Yes votes and 8,441 No votes for a 60% majority. The only action that will stop this from happening is if Aho's group gathers signatures (10% of the last councilmanic vote) and places the issue back on the ballot. This could happen as it did in Seattle ten years ago. Fluoride prevailed, however, as Seattle voters twice favored fluoride for their water supply.

The Citizens For Better Dental Health Committee is continuing to work on the fluoride issue. They realize the importance of education now more than ever and urge your continual help and support. Please remember to mention to your patients the importance of fluoride not only for better dental health, but for better bone health.

Computer User Group Meetings Resume

The Society's Computer User Group will be meeting on the last Wednesday of each month at the Society's office on South 9th. At the November meeting the creation of clices from computer applications "Harvard Graphics" will reviewed by Dr. Sid Whaley.

Future topics for programs will be DOS-shell, DO WE GO TO 386? and many others. Join your colleagues for an evening of informative colleaguial learning .

Auxiliary News

For Kids

The medical community and the Superintendent of Public Instruction are co-sponsoring a teen health forum for eight- and ninth-grade students. "Choice, Not Chance," to be held April 11, 1989 at Central Washington University in Ellensburg, is a state-wide, physician-involved, day long event, which will focus on AIDS, teen suicide, and eating disorders. These topics are part of the existing health curriculum for middle schools. Conference follow-up by physician and school staff at individuals schools is part of the overall meeting plan.

Two students and one faculty member from each junior high school will be bussed to the day-long event, where they will register and have the opportunity to browse through free materials provided by exhibitors. The keynote address will set the tone for the day: a need to be receptive to accurate information which will facilitate responsible decision-making which will, in turn, make for healthy adult lives. Following the keynote speech, members of a physician panel will present overviews of their workshops. Students, school faculty and conference presenters will then have time for one-on-one table talk over lunch and another chance to view exhibitors' materials.

Six breakout sessions — two sessions for each topic — will be held in the afternoon. One group will work with staff and natural helpers to develop specific ways to take conference information back to their schools, while the second group, lead by physicians and other health professionals, will receive information and extensively discuss the topic. After an hour, the two groups will be switched to enable attendees to participate in both sessions. At the end of the second session, individual leaders will bring the conference day to a close. Final schedule and program will be sent to schools prior to conference for advance registration.

The teen health forum is an opportunity for you to serve and/or support your community. Please help. If you would like to participate in the conference as a presenter or volunteer, please call Kory Diemert at 1-800-552-0612. A solicitation envelope has been included in this issue of The Bulletin. Your donation is needed to make our conference a success. Thank you.

AMA-ERF

The American Medical Association Education and Research Foundation (AMA-ERF) was established over 35 years ago to help support quality medical education. Since 1950, the Foundation has distributed over $45 million to medical schools; guaranteed over $95 million in loans benefitting more than 40 thousand medical students, interns and residents; and supported numerous research projects.

As in the past, the Sharing Card project is our major fundraiser for AMA-ERF. The solicitation letter will be mailed soon. To have your name included on the list of donors, contributions must be received by Nov. 1. Don't delay! By the way, volunteers are needed for the mailing party; the early part of December. Give me (588-6175), or Judy Ip (581-8570) a call if you can help.

Choose your private card from the Christmas catalog of Francoise Greeting Card Company. This is a project with No Auxiliary investment, yet a high yield as AMA-ERF receives 40% of each order. The catalog may be perused, and your order taken, during regular hours at the office of Leonard B. Alenick M.D., 5900-100th St. S.W.#33. After- hours appointments can be arranged. Invite your friends, neighbors, office personnel and spouses to come, too.

Some small gift items can be purchased, as well, at Board and General meetings. We have gold "Rings of Success" pins (or tie tacks) for $5. We hope everyone will purchase one to show the unity of purpose of local, state, and national medical organizations. " The Heart of the Matter memo pads and packages of postalettes are useful at any time. They are priced at $1 each. Be sure to stop by.

Gail S. Alenick
Pierce County
AMA-ERF Chairman

Dues

State, national, and county $55.
For newcomers $40
(state reduction of $10
county reduction of $5)
not new, but joining PCMSA for the first time $50
Please make out check to PCMSA and send to :
Helen Whitney
1736 Fairview Dr. S.
Tacoma, Wa. 98465

THANK YOU, 1988 ADVERTISERS!!

The Pierce County Medical Society wishes to extend its sincere thanks to the following people and organizations who have advertised in our 1988 publications -- *The Bulletin* and the *PCMS Newsletter*.

Allenmore Medical Center

Alternative Care of Tacoma

Baby Diaper Service

Mrs. Connie Bacon

BFI Waste Management Systems

Catholic Community Service (CCS)Caregivers

The Doctors' Exchange

The Friedrich Group

Andre Gilmore

Group Health Cooperative of Puget Sound

Bill Hazelett Saab

Humana Hospital

Dr. Harold B. Johnston

Eli Lilly & Company

Lynlee's

Beverly McCullough-Gosch

Manor Care of Meadow Park

Metabolic Associates Optifast Program

North Pacific Bank

W.H. Opie

Persing, Dyckman and Toynbee

Physicians Insurance

Pierce County Medical Bureau

Prodata Systems

Professional Service for the Injured

Puget Sound Collections

St. Joseph Hospital

Se Re Co Associates

South Hill General Medical Clinic

Swanson McGoldrick Realty

Tacoma Modern Office Expo

Toppfast Puyallup

Topping Motors

U.S. Army

U.S. Army Reserve

Union Avenue Pharmacy

Dr. Gentry Yeatman

Thank you for your continued support!

Classifieds

POSITIONS AVAILABLE

PHYSICIAN OPENING. Ambulatory care/minor emergency center.Full/Part time for FP/IM/EM trained, experienced physician. Location in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, M.D. at 5900-100th St. S.W., Suite #31, Tacoma, 98499. Phone (206 584-3023 0r 582-2542.

IMMEDIATE OPENINGS-Full time & part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Flexible scheduling. Any state license. Other opportunities including ER in Olympia area. Call Nes 1-800-554-4405 ask for Jeanine.

OCCUPATIONAL/FAMILY PRACTICE. The Pacific Northwest's leading outpatient medical provider has career opportunities for primary care physicians to join an expanding 150-person medical group. Full/part-time openings throughout CALIFORNIA AND SEATTLE-TACOMA, WASHINGTON. Prior outpatient/ occupational experience preferred. ATTRACTIVE PACKAGE INCLUDES: competitive base salary Plus incentive program, malpractice insurance, comprehensive benefits, 401 (k) Plan, vacation/sick/ holiday/CME. Opportunity for advancement for energetic, hard-working physician committed to quality health care. Join our dynamic team of ReadiCare Professionals. CONTACT: Robin Smith, Director Personnel, ReadiCare/CHEC, 446 Oakmead Parkway, Sunnyvale, Ca. 94086, 408/ 737-8531. 800/237-3234.

EQUIPMENT

FOR SALE: Danam SA-1000 8 Parameter Hematology analyzer with printer. Ideal for a 1-2 physician office. Startup Reagents and training included. 627-1534 Ask for Gloria.

APPRAISAL SERVICE for Medical Equipment, 867-5415.

Mid-Mark power table model III $4000, call 867-5415.

AUDIOMETER- Tympanometer $1000, Call 867-5415 for more information.

OFFICE SPACE

PHARMACY SPACE AVAILABLE 720 sq. ft., $1080 per month, Physician Medical Center, Next to St. Joseph Hospital. Contact Elmer Davis at 572-6730.

ST. FRANCIS COMMUNITY HOSPITAL: Pre-designed and custom suites available in the new St. Francis Medical Building, located adjacent to St. Francis Community Hospital in Federal Way. Class "A" building construction with tenant improvement allowance available. Ample and convenient parking. View of Mt. Rainier Partnership and lease options available for interested physicians on the active staff of St. Francis Hospital. For Information, call Laure Nichols, 591-6803.

ST. JOSEPH MEDICAL PAVILION: Class "A" medical space with superb water and mountain view tied via skybridge to St. Joseph Hospital, Tacoma. Now under construction, this building will be completed by late spring 1989. Custom space with tenant improvement allowance to physicians on the active staff of St. Joseph Hospital. Convenient parking, outpatient surgical center, lab and radiology facilitiesl located within building. For information, call Laure Nichols, 591-68.3

MEDICAL OFFICE SPACE for lease on University Place, 1665 sq. ft.- improved to your designs-smaller office also available. 383-5500.

GENERAL

TYPING: Letters, medical drafts have typewriter. Call 272-5459 or 272-1336.

PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
- ***Retirement Potential***
- ***Post Exchange Privileges***
- ***Insurance Discounts***
- ***Continuing Medical Education****
- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

****All paid for by the U.S. Army Reserve.***

P.O. BOX 38
Madigan Army Medical Center
Tacoma, WA 98431-5038
206-967-5046

Many groups TALK about building a better America-
The Army Reserve WORKS at it.

PIERCE COUNTY MEDICAL SOCIETY
705 South 9th, Suite 203
Tacoma, Washington 98405
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PCMS
NEWSLETTER
♦ A publication of the Pierce County Medical Society ♦

Volume 3, No. 8

December 1988

Night of Fun, Festivities and Seriousness

The Annual Joint Dinner Membership meeting scheduled for Tuesday, December 13, Sheraton-Tacoma Hotel promises to be an evening of collegiality for all attending the always enjoyable evening. The Stadium High School Quintet will entertain before and during dinner.

Social hour will begin at 6:30 p.m., dinner will be served at 7:15 and the program will begin at approximately 8;15.

Dr. Bill Jackson, President will turn the reins of the Society over to President Elect Dr. Bill Ritchie. Dr. Ritchie follows in the foot steps of his father Dr. C.B. Ritchie, who served as President of the Society in 1960.

New officers an trustees will be inaugurated into office. Departing Officers and trustees will be honored. Those leaving the leadership positions are:

Vice President
DeMaurice Moses, M.D.
Secretary-Treasurer
Robert J. Martin, M.D.
Past President
Richard G. Bowe, M.D.
Trustee
Gerald W. Anderson, M.D.
Trustee
Ronald W. Knight, M.D.
Trustee
Eileen R. Toth, M.D.

The Society Board of Trustees is vitally interested in the drug situation in Tacoma and its impact on the Society as well as the medical community. Dr. Jackson has asked Tacoma Chief of Police, Ray Fjetland and Pierce County Prosecuting Attorney John Ladenburg to speak on the magnitude of the drug problem in this community and county.

Join your colleagues and spouses for an unforgettable evening.

PCMS Election Underway

Ballots have been sent for the election of 1989 PCMS Officers and Trustees. the Nominating Committee met on October 6 and had a wide array of possible candidates to select from. The Society is fortunate that it has so many member capable of assuming leadership roles.

The Committee nominated the following:

President-Elect
Gordon R. Klatt, M.D.
Colon-Rectal Surgery
Vice-President
James K. Fulcher, M.D.
Emergency Medicine
Secretary-Treasurer
William G. Marsh, M.D.
Family Practice
Trustees (3)
David E. Law, M.D.
Internal Medicine

Trustees (Cont.)
Anthony S. Lazar, M.D.
Radiology

James L. Patterson, M.D.
Family Practice

William F. Roes, M.D.
Family Practice

Rob R. Roth, M.D.
Pathology

Andrew N. Statson, M.D.
Ob-Gyn

The Society is very appreciative of the candidates who have offered their time, effort and commitment to leading the Society as rapid change continues to require the medical community to be more active in the community and politically.

The ballots must be returned to the Society office by December 7 to be counted.

EMS UPDATE

Dr. Bill Jackson, PCMS President and Dr. Bob Wachtel, Chairman of the EMS Committee and recently elected chairman of the Pierce County EMS Council met with County Executive Joe Stortini on November 14 to discuss redesigning the current Pierce County EMS system.

Also attending the meeting were representatives of the Pierce County Fire Chiefs Association,

Continued Page 2

Continued EMS Committee From Page 1

Tacoma Fire Dept., and City of Tacoma.

The Board of Health at its November 9 meeting had passed a resolution to create a " Blue Ribbon Panel" to make recommendations to the Board on restructuring the Pierce County EMS system.. Foremost on the Society's agenda is a system that will be under the control of a Medical Program Director who has expertise in emergency medicine. The EMS administrative staff would report and be accountable to the Medical Program Director. Improved coordination between the providers of pre-hospital care would result with centralized authority.

Mr. Stortini received suggestions from those present for the composition of the "Blue Ribbon Panel". Dr. Wachtel will represent the Society.

Harvard RBRVS Study

Washington-based representatives from 34 national medical specialty societies were advised on October 26 at a meeting held at AMA 's Washington office, that the AMA has no preconceived notions about the conclusions of the Harvard RBRVS study. The AMA and many of the specialty societies testified at hearings on October 28 held by the Physician Payment Review Commission (PPRC) which, along with the Department of HHS, will make recommendations next year on how a relative value system could be used in effecting a more rational policy for physician reimbursement under Medicare and in giving government greater predictability in federal budget planning.One of a continuing series that AMA has convened with specialty societies on the RBRVS study and the many Executive Vice President, led discussions.

Dr. Todd reminded the participants that the AMA, up to this point, has been committed only to supporting completion of the Harvard study.

During the next two months it will be devoting priority attention to synthesizing the Federations opinions and concerns about the study and its possible methodological shortcomings. Dr. Todd stressed that the current status of AMA in government policy development on the RBRVS is "so fluid that it is almost liquid" . AMA supported conduct of the study since it was preempted from doing so on its own because of anti-trust implications. AMA supported establishment of an indemnity physician payment system as a means of achieving greater equity. One of AMA's primary concerns, Dr. Todd said, it is that the government might act precipitously in enacting some kind of reimbursement plan based on the RBRVS. It is absolutely essential that government make a thorough assessment before proceeding to implement any plan, Dr.Todd said.

Basic Health Plan To Commence In Pierce County

Donald Sacco, President, Pierce County Medical Bureau (PCMB) notified physicians who had volunteered to participate, that Basic Health Plan staff in Olympia were very interested in implementing the Plan in Pierce County.

The Basic Health Plan requires that primary care providers act as health care managers. Procedures are being developed for referrals, hospital admission, and utilization management. PCMB and Plan staff are currently working together to develop a mutually satisfactory contract for service delivery effective January 1, 1989.

Mr. Sacco reported that many issues remain to be resolved. To succeed, Mr. Sacco said, "Provider education and communication will be especially critical to a successful program. Informational meetings for Basic Health Plan providers and office staff will be scheduled for later this year, assuming contract negotiations are successful."The Medical Society worked closely with PCMB in an effort to secure Pierce County as a demonstration site for the Basic Health Plan that will provide insurance coverage for an estimated 5,000 enrollees who presently are without coverage.

Pharmacology In Medicine Course Set For January 12

Pharmacology in Medicine; a one day Category I course designed to give a critical appraisal of drugs in medical practice is set for January 12, 1989 in Jackson Hall.

The course sponsored by the College of Medical Education, will compare the benefits, cost, side effects, and interaction among several drug groups including outpatient antibiotics, over the counter drugs, antihypertensive drugs, analgesics, sedative/hypnotic drugs, and drugs used in AIDS treatment.

The course is coordinated by Drs. David Munoz, Frank Senecal, and Henry Retailliau.

MD's Can Take "tour"of AMA/NET

by Rebecca Voelker
AMN staff

A guided "tour" of AMA/ NET, the computerized medical information network sponsored by the American Medical Association, is now available to physicians at no cost.

The tours are made possible by "AMA/NET Preview," a new software program that allows computer users to view AMA/NET's list of services and watch a demonstration of how to use them.

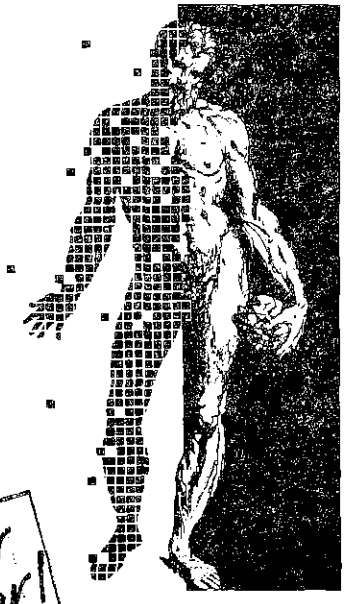
Physicians interested in taking the tour need only a computer terminal, telephone, and a modem, which allows the user to connect to AMA/NET through telephone lines. The demonstration program is accessible with almost any computer model.

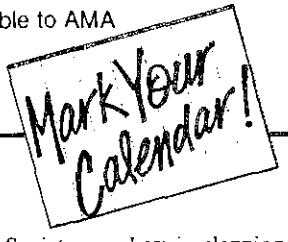
"It's a quick and easy way for physicians to take a look at what's available and see how it could be useful in their practices, " said William Yasnoff, M.D., medical director of AMA/NET.

In ADDITION to literature searches that have access to more than 5 million references, AMA/ NET also offers:

- A drug interaction database to aid in the care of patients taking multiple medications prescribed by more than one physician.
- A diagnostic assistance program with more than 4,700 signs and symptoms and more than 2,100 diseases or conditions.
- Immediate access to medical and legislative news from the Associated Press and the AMA Washington Report.
- An electronic communications networks allowing transmission of computer messages among AMA/ NET subscribers.

AMA/NET is available to AMA members for a $135 per year or $12.50 per month subscription fee. Non-AMA members pay $160 per year or $15 a month. Besides the subscription fee, there is an hourly rate for each service used on AMA/ NET. Additional information is available by calling (800) 426-2873.





To assist Medical Society members in planning their continuing medical education plans for the year, the College of Medical Education 1988-89 program schedule is printed below. A complete calendar, including course descriptions, is available through the COME office, 627-7137. Remember... **MARK YOUR CALENDAR!**

1988	
Dec. 8,9	**Common Office Problems**
1989	
Jan. 12	**Pharmacology in Medicine**
Jan. 19	**Law and Medicine Symposium**
Feb. 1	**AIDS**
Feb. 10	**Office Gynecology**
March 9,10	**Tacoma Academy of Internal Medicine**
March 22, 23	**Orthopedics and Sports Medicine**
April 14, 15	**Tacoma Surgical Club**
April 26, 27	**Computers in Medicine (Clinical Applications)**
May 17	**Neurology**
June 26,27	**Advanced Cardic Life Support**

NOTABLE

Award Winning

"The Geriatric Patient and Delay of Elective Surgery" an original paper presented by Dr. Richard Waltman, was one of five award - winning presentations at the 40th Annual Scientific Assembly of the American Academy of Family Physicians.

Dr. Waltman's paper was one of 24 selected from over 100 entries to be delivered at the session for scientific paper presentation. Of the 24 papers that were presented, Dr. Waltman's paper was chosen as one of five prize-winners. Dr. Waltman received a cash award and presented his paper a second time before the general assembly of the national conference of family physicians.

"The Geriatric Patient and Delay of Elective Surgery" has been accepted for publication in *Geriatric Consultant.*

Dr. Waltman is in private practice of family medicine and geriatrics in Tacoma. He has been a member of the Medical Society since 1981.

Mavis Kallsen Addresses Retired Members Luncheon

Nearly 50 retired members and spouses turned out November 9 to hear Mrs. Mavis Kallsen, speak on the first 50 years of the Medical Society in Pierce County. Mrs. Kallsen, is an archivist, who has worked in The Washington State Historical Museum.

In 1976 Mrs. Kallsen wrote several articles for the Society's Bulletin describing the first medicine practiced in Pierce County and the very beginning of the Medical Society. She has written a fascinating account of the early leaders of the medical community and the growth of the Pierce County Medical Bureau.

The articles were reprinted in the Bulletin in 1986.

President of Good Samaritan Hospital Honored

Dave Hamry ,of Good Samaritan Hospital in Puyallup, has been named 1988 recipient of the Joe Hopkins Memorial Award by members of the Washington State Hospital Association (WSHA). Mr. Hamry has been the president of Good Samaritan Hospital since 1970 and has had broad experience in working with hospitals in this state.

Auxiliary News

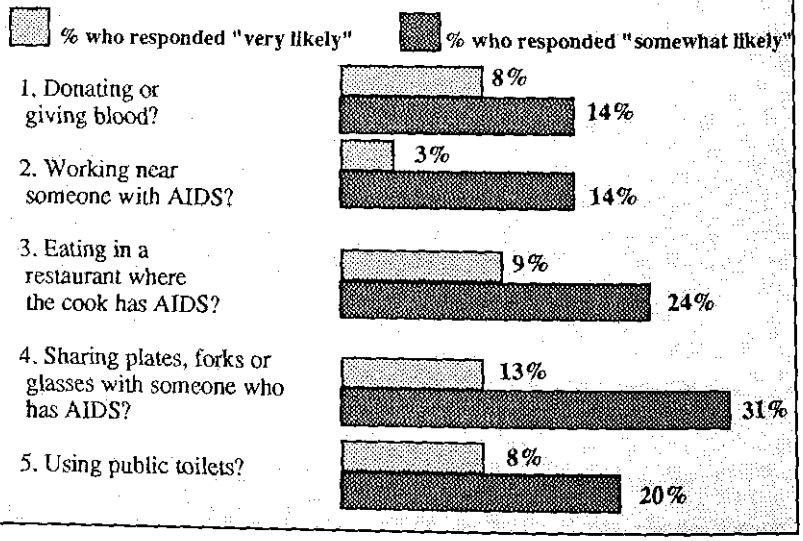
Mrs. Donald (Marny) Weber has been appointed Southwest Regional Vice President on the WSMA Auxiliary board. Thank you Marny for your many years of continued service.

Dues are still continuing to be collected if you have forgotten. Helen Whitney would be happy to receive them.

The Teen Health Forum needs your support. For further information on this outstanding undertaking please contact the WSMA office 1-800-552-0612. Kory Diemert will be happy to direct your question. This project especially needs your financial support.

Misconceptions about AIDS continue

Despite nationwide efforts to educate the public about AIDS, research shows that the myth of transmisssion through casual contact still persists. In a study conducted by the federal Centers for Disease



PHYSICIANS

Your
Army Reserve Personnel Counselor,

MAJOR PAUL H. LAWHON, MSC

Would like to talk to you about the following opportunities in the United States Army Medical Department:

- ***Part-Time Income***
- ***Retirement Potential***
- ***Post Exchange Privileges***
- ***Insurance Discounts***
- ***Continuing Medical Education****
- ***Attendance at A.M.A. Conferences****
- ***Training at U.S. Army Hospitals****

****All paid for by the U.S. Army Reserve.***

P.O. BOX 38
Madigan Army Medical Center
Tacoma, WA 98431-5038
206-967-5046

Many groups TALK about building a better America-
The Army Reserve WORKS at it.

NEWSNOTES

RBRVS Report Has Begun

The important process of analyzing Harvard's Resource-Based Relative Value Scale report has begun. After the report's release, the AMA rushed copies to state medical associations and 77 specialty societies. Representatives of those societies and over 450 county medical societies were invited to meet November 13 in Chicago to review the report. Other important dates include: December 4-7 AMA House of Delegates consider RVS at Interim Meeting; March 31, 1989-- PPRC reports to Congress on RVS; July 1, 1989-- HHS report due on RVS/fee schedule; January 1,1990-- earliest possible date for RVS implementation.

Computer user Group Meetings Resume

The Society's Computer User Group will be meeting on the last Wednesday of each month at the Society's office on South 9th. At the November meeting the creation of slides from computer applications " Harvard Graphics" will be reviewed by Dr. Sid Whaley.

Future topics for programs will be DOS-shell, DO WE GO TO 386? and many others. Join your colleagues for an evening of informative collegial learning .

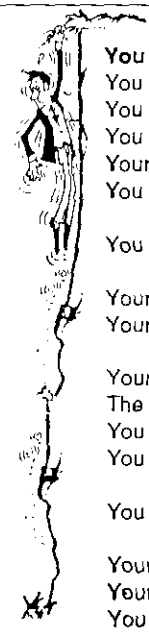
Upcoming Public Health Rounds

Topics for the Public Health Rounds scheduled for December 15, are Hepatitis A & Food Handlers, Changing Risk Factors for Hepatitis B Occupational Disease in PC, and Health Issues related to Clandestine Drug Labs.

The program will be held from 8:00 -9:00 a.m. at Humana Hospital, Doctors' Dining Hall (Continental Breakfast Served). Al Allen, Director of Health Tacoma-Pierce County Health Department will be the facilitator.

SOCIETY CELEBRATES 100TH WITH OPEN HOUSE

The Society hosted an estimated 240 guests at an open house at its offices on South 9th to celebrate 100 years since its inception August 28, 1888. Dr. Bill Jackson, President, members of the Board of Trustees and Auxiliary members greeted members and guests. Among those visiting the office were Dr. Kenneth Sturdevant, retired Puyallup general practitioner, who joined the Society in 1937 when there were approximately 100 doctors in the county and five in Puyallup. City leaders joined members and guests from the AARP, amd many other organizations and professions. It was a warm and sociable evening celebrating the 100th birthday of the organization.



Rotten Day

You Can Tell It's Going to BE A Rotten Day When. . .

You wake up face down on the pavement
You call Suicide Prevention and they put you on hold.
You see a " 60 Minutes" news team waiting in your office.
Your birthday cake collapses from the weight of the candles.
You want to put on the clothes you wore home from the party there aren't any.
You turn on the news and they're showing emergency routes out of the city.
Your twin sister forgot your birthday.
Your car horn goes off accidentally and remains stuck as you follow a group of Hell's Angles on the freeway.
Your boss tells you not to bother to take off your hat.
The bird singing outside your window is a buzzard.
You wake up and your braces are locked together.
You walk to work and your dress is stuck to the back of your pantyhose.
You call your answering service and they tell you it's none of your business.
Your blind date turns out to be your ex-wife.
Your income tax check bounces.
You put both contact lenses in the same eye.
Your pet rock snaps at you.
Your wife says, "Good morning, Bill" and your name is George.

Author unknown...but troubled.

The Living Will and Durable Power of Attorney

To date, Washington is one of 38 states to have passed laws authorizing residents to provide instructions to family and physicians about what should be done- or not done- in the event they are unable to make or communicate a decision about their medical treatment. Although these instructions have come to be known as "living wills," they are really not concerned with dying, but rather with the nature and extent of treatment in the event a person is terminally ill. A living will does not always provide the ultimate solution to a difficult problem, but it can help. " For one thing, it can unite a family whose members might otherwise have different interpretations about how an ill member of the family really feels about death- and it can help a doctor make a decision," says Monroe T Gilmour, M.D., an American Association of Retired Persons board member.

A living will is essentially just one medical treatment decision, although it can, if you stipulate, give instructions about the disposition of vital organs after death.

Most states require that at least two people— preferably not members of your family — witness the signing of the living will and some states require that it be notarized. It's recommended that you give copies to your physician (to include with your medical records), clergy, lawyer, and anyone to whom you give your power of attorney. And do remember that a living will can be revoked (usually by a simple oral statement) at any time. Then it will be up to the patient's designated "attorney" and physician to make the final decision, acting on whatever advance directives you have given them.

To ensure that the advance directives contained in a living will are carried out, it is recommended that a patient also execute a durable power of attorney for health care. All states have provisions for giving another person the power of attorney to act on a patient's behalf. But, the problem with a regular power of attorney, which usually designates someone to manage financial affairs, is that it is invalid if the patient becomes incompetent. The durable power of attorney for health care specifically resolves that problem.

A durable power of attorney is more flexible than a living will and allows the patient to detail his or her precise wishes concerning treatment. The patient may desire different actions regarding withdrawal of life support and food and hydration , and might specify that all treatments be used to prolong life.

In a durable power of attorney, it is advisable to appoint a "primary agent" to represent the patient, but is good practice to select one or more "successor" agents in case the primary agent is unavailable. The spouse is usually designated the primary agent, with an adult child, brother or sister or a close friend as successor agent(s) to represent the patient in a medical situation.

The important thing for a patient to remember is to pick someone he or she has confidence in and then through long conversations, make sure he or she understands the patient's wishes. It is also a good idea for the patient to reaffirm his or her feelings from time to time so the agent can assure the doctor that he or she has talked with the patient recently about the question of medical treatment, etc. It is also recommended that the document be witnessed by at least two people and notarized.

Living Wills Available

Copies of the Living Will are available by calling the Medical Society office (572-3667). An excellent brochure published by WSMA that answers common questions about Living Wills in Washington State is also available at the Medical Society or WSMA.

"Medical Jousting" Physicians Insurance Advises Caution

Physicians sometimes encourage nonmeritorious malpractice cases, often inadvertently, by medical jousting. Medical jousting may be defined as criticism by one physician of another physician's treatment of a patient based upon incomplete knowledge of the facts or a failure to appreciate the potential for harm. Such criticism is frequently hastily made and may be offered overtly or by innuendo. It may be stated to the patient, the patient's family, or a plaintiff's attorney.

Medical jousting is often not so much what is said , as how it is said. A subsequent treating or evaluating physician may " imply" or " hint" that there has been some negligence or indicate that he or she would have provided treatment differently. Simply because a subsequent physician may have treated a given patient differently does not mean the prior treating physician was negligent.

Legal Standard of Care

It is important to understand the concept of standard of care in a medical malpractice case. The law recognizes different schools of thought as to courses of treatment and diagnoses, and allows for honest mistakes in judgement. Your professional ego should never interfere with an unbiased evaluation. Avoid blunt questions such as " Who did this to you?" or " How did this happen?" It is unfair to make an assessment of another physician's care without knowing all of the facts and circumstances. Try to put yourself in the position of the physician you are tempted to criticize. Obviously there is a much better opportunity to make a reasonable assessment after reviewing all relevant medical records.

An Additional Risk

Of note is that as a policy holder with Physicians Insurance, your professional liability insurance does does not cover your liability for slander. The current policy exclusion states: "This insurance does not apply to liability of any insured resulting from libel, slander, defamation or making statements which harm the reputation of a person . .. or violate the right of privacy of a person, other than a patient of the insured..."

"Medical jousting can lead to malpractice cases, serious business for all concerned, and the possibility of civil suit against you also exists."

Medical malpractice is never to be condoned or covered up; however, challenging another physician's care should not be done lightly. Think carefully before rendering opinions about patient care provided by your colleagues.

Supreme Court Justice Set For Law and Medicine Program

"They Never Call For Lawyers at the Football Game", is the title of the Law and Medicine Symposium address by keynoter, the Honorable James M. Dolliver. Judge Dolliver is a Justice on the Washington State Supreme Court.

The annual program, developed by the Pierce County Medical/Legal committee, is slated for January 19, 1989 in St. Joseph Hospital's South Pavilion Conference Center.

Committee members and coordinators of this years symposium Douglas Attig, M.D. and Clarke Johnson, J.D., have gathered quality regional speakers on timely subjects facing both physicians and attorneys.

The following program is scheduled:

Law and Medicine Symposium
Thursday, January 19, 1989

8:15	Welcome and Introduction	
8:30	AIDS: Fact or Fiction	Hunter Hansfield, M.D. Medical Director AIDS Education and Training Center School of Medicine University of WA.
9:30	AIDS the Law: What it is and What it will be	Mary Tennison, J.D. Asst. Attorney General State of Washington
10:30	Break	
10:45	Aggressive Claims Management	Eric Rassmussen General Counsel and Director of Risk Management Multicare Health System
11:45	Lunch Keynote Speaker "They Never Call for Lawyers at the Football Game"	The Honorable Judge James M. Dolliver Wash. State Supreme Court
1:30	Once more with feeling: Records, Time, and Charges	Marcel Malden, M.D.
2:30	Bad Baby Cases: Lessons Learned	Joel Cunningham, J.D. Attorney, Seattle
3:30	Break	
3:45	Malpractice-Plaintiffs Perspective	Paul Luvera Attorney, Mt. Vernon
4:45 to 5:15	Questions and Answers	

Physician Education

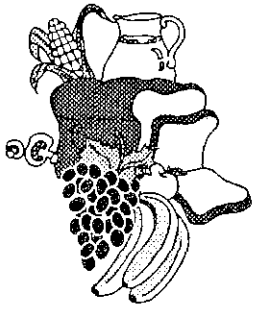
A teleconference on Health Legislation— 1988 Wrap-up and a Look towards 1989 airs December 12 at noon (EST) on the Hospital Satellite Network. Current legislation impacting on medical practice will be reviewed...Regular programming on American Medical Television (AMTV) will debut Sunday, January 8, 1989.The two-hour programming block, airing at 10:00 a.m. (EST) on cable TV's Discovery Channel, will address clinical, ethical, regulatory and socioeconomic issues of vital interest to practicing physicians.

Good Samaritan Hospital Offers Low-cost Lunches

Good Samaritan Hospital food services department will provide a low cost lunch to older citizens from 1-3 pm on the first Saturday of each month.

Cost for people 55 and over is $2, and those younger than 55 are welcome to eat for $5.00 plus tax.

The menu will consist of roast



turkey, cranberry sauce, mashed potatoes with gravy, bread dressing, buttered corn , salad with dressing, dinner roll dessert and a beverage.

The lunches will be served at the Good Samaritan Cafeteria on the the second floor of the hospital. Parking is available on the 13th Avenue S. E. side of the hospital. The hospital is located at 407-14th Ave. S.E. Puyallup. For more information call at 848-6661, Ext. 1541.

CLASSIFIEDS

POSITIONS AVAILABLE

PHYSICIAN OPENING Ambulatory care/ minor emergency center. Full/ Part time for FP/IM/EM trained, experienced physician. Located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, M.D. at 5900-100th St. S.W., Suite #31, Tacoma 98499. Phone (206) 584-3023 or 582-2542.

IMMEDIATE OPENINGS- Full time & part-time positions and directorship in Tacoma acute illness clinic. Hourly rates plus excellent malpractice. Flexible scheduling. Any state license. Other opportunities including ER in Olympia area. Call NES 1-800-554-4405 ask for Jeanine.

OCCUPATIONAL/ FAMILY PRACTICE. The Pacific Northwest's leading outpatient medical provider has career opportunities for primary care physicians to join an expanding 150-person medical group. Full/ part-time openings throughout CALIFORNIA AND SEATTLE-TACOMA,WASHINGTON. Prior outpatient/occupational experience preferred. ATTRACTIVE PACKAGE INCLUDES: competitive base salary Plus incentive program, malpractice insurance, comprehensive benefits, incentive program, malpractice insurance , comprehensive benefits, 401 (K) Plan, vacation/ sick/holiday/CME. Opportunity for advancement for energetic, hard-working physician committed to quality health care. Join our dynamic team of ReadiCare professionals. Contact: Robin Smith, Director Personnel, ReadiCare/ CHEC, 446 Oakmead Parkway, Sunnyvale, CA. 94086, (408) 737-8531, (800) 237-3234.

EQUIPMENT

APPRAISAL SERVICE for Medical Equipment, 867-5415.

MID-MARK power table model III $4000, call 867-5415 for more information.

FLEXIBLE SIGMOIDOSCOPES, Tympanometer/ Audiometer, Diathermy machine. Call 867-5415 for more information.

DIASONICS DRF 400C dedicated cardiac imaging system, real time-4 years old- well maintained, call 867-5415.

MARKET FORGE surgeons scrub station never installed-new $5800 asking $3000. Call 687-5415.

OFFICE SPACE

PHARMACY SPACE AVAILABLE, 720 sq. ft., $1080 per month, Physicians Medical Center, Next to St. Joseph Hospital. Contact Elmer Davis at 572-6730.

OFFICE SPACE suitable for General Practice of Dermatology approximately 1100 sq. ft. $500 per month. Locations 1212 South 11th Street. Call Mr. Chris Mercurio, 565-1411 (evenings).

PROFESSIONAL OFFICE space for lease, 1600 sq. ft., University Place, 863-7926.

ST. FRANCIS COMMUNITY HOSPITAL: Pre-designed and custom suites available in the new St. Frances Medical Building, located adjacent to St. Francis Community Hospital in Federal Way. Class "A" building construction with tenant improvement allowance available. Ample and convenient parking. View of Mt. Rainier Partnership and lease options available for interested physicians on the active staff of St. Francis Hospital. For information, call Laure Nichols, 591-6803.

ST. JOSEPH MEDICAL PAVILION: Class "A" medical space with superb water and mountain view tied via skybridge to St. Joseph Hospital, Tacoma. Now under construction, this building will be completed by late spring 1989. Custom space with tenant improvement allowance available. Partnership and lease only position available to physicians on the active staff of St. Joseph Hospital. Convenient parking, outpatient surgical center, lab and radiology facilities located within building. For information, call Laure Nichols, 591-6803.

MEDICAL OFFICE SPACE for lease on University Place, 1665 sq. ft.-improved to your designs-smaller offices also available. 383-5500.

AVAILABLE COMPACT MODERNISTIC fully furnished office in Plaza Medical Center facing the new Lakewood Mall. Ideal for part-time or full-time specialists, call 582-4900.

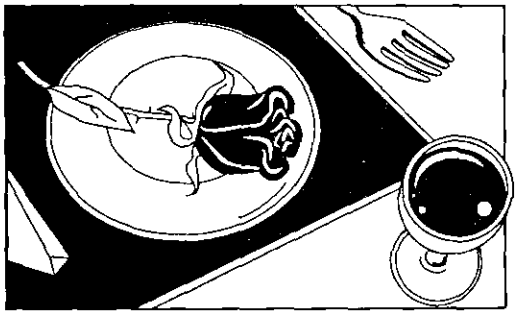
Pierce County Medical Society

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Tacoma (206) 572-3666

You are cordially invited to join the

Pierce County Medical Society
and
The Pierce County Medical Auxiliary
at their
ANNUAL JOINT DINNER MEETING

CELEBRATING 100 YEARS



Sheraton -Tacoma
Hotel
1320 Broadway Plaza

Tuesday, December 13, 1988
Cocktails (no host) 6:30 p.m.
Dinner 7:15 p.m.
Program 8:15

$25.00 per person, $50.00 per couple
(Price includes wine, tax, gratuities)

Reservations are requested by Wednesday, December 7, 1988

I (we) have set aside the evening of December 13, 1988 to join members of the Pierce County Medical Society and the Pierce County Medical Auxiliary at their Annual Joint Dinner Meeting and Installation of Officers.

Please reserve _____ dinner(s) at $25.00 per person/$50.00 per couple.
Wine, tax and gratuity included. Enclosed is my check for $ _____

Dr. _____
(please print)

Please make check payable to Pierce County Medical Society
Return to the Society by Wednesday , December 7 ,1988

Pierce County Medical Society
705 South Ninth Street, Suite 203
Tacoma, Wash. 98405

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