Pierce County Medical Society

BULLETIN

January, 2002

The 2001 Annual Meeting

Patrice Stevenson, MD passes the gavel and PCMS Presidency to Susan Salo, MD

Charles Weatherby, MD introduces Bill Roes, MD recipient of the 2001 Community Service Award

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INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

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2001 Annual Meeting - "Boomers to Busters"

Fun and festive, the 2001 Annual Meeting was held December 11th at the Tacoma Sheraton Hotel. Bringing together friends and colleagues, the meeting was well attended, providing social time, dinner, entertainment, education and overall, an opportunity for physicians and their guests to visit and enjoy themselves.

President **Patrice Stevenson, MD**, thanked the Tacoma Youth Symphony quartet for providing festive background music during the social hour and dinner. As every year, the quartet of high-school musicians displayed their talent by performing a selection of holiday music. Another annual tradition, gifts for children and mothers of the YWCA support shelter were brought by attendees and delivered the next day for residents with little hope of having many gifts at Christmas. A very big thank you to all who donated.

Dr. Stevenson called the meeting to order and invited everyone to purchase raffle tickets to benefit the PCMS Foundation. The Foundation, led by President **Lawrence A. Larson, DO**, distributes thousands of dollars in grants each year to local non-profit allied health agencies in Pierce County. This year's raffle winners were Virginia Delyanis, wife of **George Delyanis, MD**, and Mary Larson, wife of **Lawrence A. Larson, DO**, both winning gourmet baskets and **Arthur Smith, MD** winner of The Children's Home Society Fruit of the Month Club package.

Laura Yu-Blumenthal, daughter of **Amy Yu, MD**, was recognized as the artist of the 2001 Holiday Sharing Card. Laura is 11 years old and drew the poinsettias that adorned both the holiday sharing card and the Annual Meeting program cover. In lieu of accepting the cash prize, Laura requested that the money be sent to the Afghan Children's Fund.

Dr. Stevenson asked for a moment in silence in honor of colleagues that died during the past year. Unfortunately, there were many and they included: **Drs. Robert Truckey, Charles Denzler, Paul Bondo, Hugh Larkin, John Shaw, Gale Katterhagen, David Dye, Robert O'Connell, Ronald Johnson, Wayne Bergstrom, Maurice Origenes, Myron Bass, Arthur O'Leary, Ernst Randolph, Ralph Huff, Edward McCabe, Bernard Rowen, Robert Johnson, James Vadheim, Robert Freeman and Franz Hoskins.**

The guest speaker for the evening, Marilyn Moats Kennedy, gave an informative and very humorous presentation on understanding the demographics of the evolving work-

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A note from President Salo....

Susan Salo, MD

Looking at these pictures, I remember what a refreshing interlude our annual meeting was, with Marilyn Moats Kennedy's entertaining and provocative discussion.

I would like to thank each of you for the honor and opportunity to serve as Pierce County Medical Society president and to ask each of your assistance in making the year a successful one.

This year should be challenging and exciting. Some issues will be novel, some all too familiar. I fear division into special interest groups could be lethal; we must remember our common objective of a scientific basis for medical care.

I would like to use this year to review our society, to evaluate our present position and programs, and to expand or contract, add or subtract, in whatever direction will be most valuable to our membership.

Let us hope that 2002 will be a year that exceeds our expectations for success. ■

Dr. Susan Salo, newly elected 2002 PCMS President, and her husband Robert Bedoll

Dr. Bill Roes standing to accept the 2001 PCMS Community Service Award

2001 Annual Meeting from page 3

place in relation to generational differences (see related story, page 7). Ms. Kennedy's presentation "Boomers to Busters: How Generations Relate" struck a chord in the audience of primarily pre-boomers, boomers, and cuspers, all born before 1969. Her presentation provided useful insight into why what one person says is often not interpreted the same way by the person who heard it.

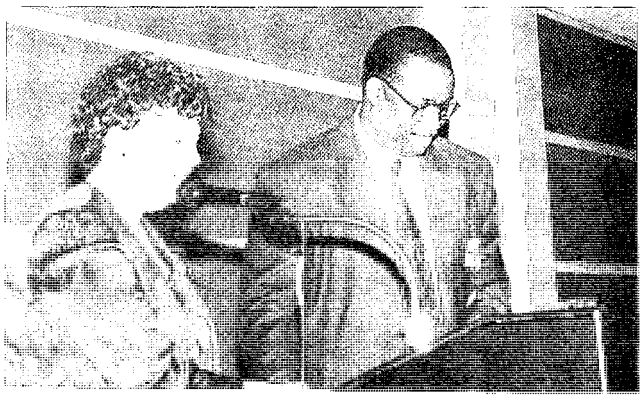
Highlighting the evening was the presentation of the Community Service Award to **Bill Roes, MD** (see related story, page 6). Introduced by friend and colleague, **Dr. Charles Weatherby**, Dr. Roes joins the ranks of previous award winners, **Drs. George Tanbara, Charles Weatherby, Terry Torgenrud, Gordon Klatt, Patrick Hogan, John VanBuskirk, David Sparling and Donald Mott**. Surprised and hopefully pleased, Dr. Roes thanked his colleagues for the honor and expressed his gratitude for the consideration.

With Dr. Stevenson noting that she would soon be entering the ranks of "past-president," she asked that those attending stand and introduce themselves. **Drs. George Tanbara** (81), **Pat Duffy** (84), **Richard Bowe** (87), **Bill Jackson** (88), **Gordon Klatt** (90), **David Law** (95), **John Rowlands** (96), **Larry A. Larson** (99), and **Charles Weatherby** (00) obliged.

She introduced Board of Trustee members and thanked them for their service and support during her presidential year and introduced the new board members for 2002, **Drs. Patrick Hogan (Secretary-Treasurer), Allison Odenthal, Joe Regimbal,** and **Matthew White** (see page 10). Before turning over the presidential gavel to Dr. Salo, Dr. Stevenson thanked Dr. Weatherby for his five years of service on the board including Secretary-Treasurer, Vice President, President-Elect, President and Immediate Past-President. She presented him with a gift and thanked him for his support of and involvement in PCMS noting that Dr. Weatherby was recently appointed to the PCMS Foundation Board of Directors.

Dr. Stevenson commented that it just seemed like yesterday when she dubbed 2001 "The Year of Transition." Highlighting the Society's accomplishments for this year, she reflected on the nation's "changes in priorities," realizing that "it is hard to place the same priority on many issues as we look to the value of a strong public health system." She thanked everyone for their support and involvement over the past year as she turned over the gavel to Susan Salo, MD, 2002 PCMS President. ■

Dr. Bill Roes, left, received a plaque and congratulatory handshake from Dr. Charles Weatherby



Dr. Patrice Stevenson thanked Dr. Weatherby for his many years of service on the PCMS Board of Trustees

Left, Dr. Ron Benveniste, Lakewood ENT, visits with Dr. Asuquo Esuabana, Tacoma family practitioner

From left, Drs. Larry Larson, Ron Benveniste, and President-Elect Jim Rooks visit during the social hour

2001 Community Service Award

by Jean Borst

William F. Roes, MD recognized for community service

"There are probably a dozen people working behind the scenes who deserve this award more than I do," **Dr. Bill Roes** commented. "But I really appreciate it – it's wonderful."

Dr. Roes, a family practice physician in rural Key Center, is this year's recipient of the PCMS Community Service Award, given annually to a member who has contributed time and talent to the community to improve the quality of life. He has joined the ranks of previous recipients including **Drs. George Tanbara, Charles Weatherby, Terry Torgenrud, Gordon Klatt, Pat Hogan, John VanBuskirk, David Sparling** and **Don Mott**. Dr. Roes is reserved about discussing his extensive community efforts and involvement and insists that he was recognized because, "I just happened to get more publicity than other members."

The honor was successfully kept under wraps until the presentation, and came as a shock to Dr. Roes. "It wasn't until Dr. Weatherby mentioned Trinity Clinic as he was presenting the award that I realized who he was talking about. I was very surprised."

Practicing medicine in a rural setting was never something Dr. Roes contemplated — it was what he always wanted to do. Raised in rural Wyoming, he came to the Key Peninsula in 1981 as part of the National Health Service Corps and began working at the Key Peninsula Health Center. (Dr. Roes arrived at just about the same time that long-time friend Dr. Weatherby came to the area and the Community Health Clinics were established.) Three years later, Dr. Roes became an employee of Key Peninsula Health Center, and in 1987 bought the center and established his family practice.

While Key Center is a small community, "is not really rural," Dr. Roes notes. "This isn't exactly Omak." He acknowledges the uniqueness of the small-town practice saying, "We see a lot of interesting and unusual things walk through the door that a practice in Tacoma or Seattle probably would not see. Emergency cases are not unusual, and in most instances we can help them," he said. Unlike most urban offices, his office has the capability to perform suturing and take x-rays; there is a fairly extensive on-site lab, and many medications are stocked. In 20 years, he has delivered one baby in the office and has had two codes. "Those kinds of things don't happen very often," he said, "but the possibility is always there."

"Managed care has increased workload and paperwork here just like everywhere else," he said, "But when I think about the people I'm seeing on a daily basis, I realize how fortunate I am and really can't complain. It's just something I have to deal with."

In contrast to an urban setting, Dr. Roes' patients are primarily older, poorer and have less access to care. The office also opens its doors once a week for well-child visits, offering immunizations and preventative care at little or no cost to patients. Dr. Roes sets aside Thursday mornings to make home visits to homebound patients.

William Roes, MD

Dr. Roes admits that he enjoys being *THE* community doctor. "I admit, it strokes the ego to have everyone know me and appreciate what I do here," he said. "It is also great to build such close relationships with my patients and the community." His involvement on the Peninsula runs deep. Dr. Roes was medical director for the fire department for ten years; president of the water society for five years. He was also "instrumental" in forming the Down Home Band, a group of musicians that performs at various Key Peninsula functions. "We formed the group to ensure that all Key Peninsula children had the opportunity in their lifetime to hear 'Stars and Stripes

See "Dr. Roes" page 6

Dr. Roes from page 5

Forever,' he joked. (Also among the illustrious group of musicians are **Drs. Jim Patterson, Joan Halley**, and **Andy Loomis**.) For 20 years, Dr. Roes has written a weekly medical column for the Key Peninsula News.

For the past 15 years, Dr. Roes has been medical director for the Rocky Bay Health Care Facility, a private facility for developmentally delayed adults. "That's just a natural thing to do," he says. "It is only five miles from the office, it's really a pleasant facility, and the residents are very special. It is also staffed by great people."

While his heart is in Key Center, Dr. Roes' involvement and dedication cross the span of the Narrows Bridge. For 12 years, he has been medical director of Trinity Neighborhood Clinic at 6th and Division, an all-volunteer effort that involves several Medical Society members.

Dr. Roes has been a PCMS member since 1981 and served as the Society's vice president in 1992. Among his accomplishments: Chair, Healthy Options Committee; PCMS Trustee; PCMS Delegate; President, Pierce County Chapter of American Association of Family Practitioners; Chair, Department of Family Practice, Tacoma General Hospital. He has also worked extensively with numerous medical committees associated with MultiCare and Northwest Physicians Network. He was Chief of Staff at Tacoma General Hospital in 2000 and President of the Medical Staff for Allenmore in 2001.

While he may be practicing medicine far from the madding crowd, Dr. Roes isn't insulated from the many changes and challenges of the medical profession. "Managed care has increased workload and paperwork here just like everywhere else," he said, "But when I think about the people I'm seeing on a daily basis, I realize how fortunate I am and really can't complain. It's just something I have to deal with."

As medicine changes and more and more physicians (both established and those new to the profession) leave Washington State, Dr. Roes expresses concern about who will fill the medical needs of rural communities in the future. Over the years, he has had several residents work at his office. "They really enjoy it, " he said, "but the fact remains that the money in medicine is elsewhere. And so many people are leaving the state to practice medicine. The rural setting just can't compete financially with other opportunities." For those physicians who are contemplating practicing medicine in a not-so-urban environment, Dr. Roes offers only encouragement. "Do it!" he said, "And be sure to come help me!"

In the meantime, Dr. Roes will continue doing what he always has and what seemingly comes so naturally — serving the Key Center community and beyond. ■

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service at Madigan Army Medical Center will be hosting the 18th Annual Physical Medicine and Rehabilitation conference on March 26-29, 2002 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will speak on Management of Chronic Pain including Alternative and Complementary Medicine, various topics on Musculosleletal /Sports Medicine, Pediatric and Adult Electrodiagnosis, Bioterrorism and issues unique to Physiatrists and other Neuromusculoskeletal healthcare providers. The conference is designed for Physiatrists, physicians in related specialties and all other professionals interested in updating their knowledge in neuromusculoskeletal medicine. The course program and other detailed information for registration will be published on the web in early January 2002 at www.hjf.org. Approximately 25 Category 1 CME credits will be provided. For interim information, please contact Shashi Kumar, MD or our secretary at 253-968-2020 or at shirley.birdsong @nw.amedd.army.mil

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

From Boomers to Busters

Annual Meeting speaker educates and entertains while explaining generational differences

Nationally known speaker Marilyn Moats Kennedy was the guest of honor at the 2001 Annual Meeting held in December at the Sheraton Hotel.

Ms. Kennedy is a business owner, author, career consultant and founder and managing partner of Career Strategies, a 24-year-old consulting firm in Wilmette, Illinois. Her presentation, "Boomers to Busters: How Generations Relate," was a humorous and entertaining approach to understanding the demographics of the evolving workforce.

Citing recent U.S. census statistics, Ms. Kennedy explained that there are currently four age cohorts in the workplace and a fifth coming on by the year 2005. These five age groups are categorized by the year of their birth and are identified as Pre-Boomers (born 1934-1945), Boomers (1946-1959), Cuspers (1960-1968), Busters (1969-1978), and Netsters (1979+).

All five groups share some traditional work values but differ on such important ones as the role of managers, employer/employee loyalty, telecommuting, technical competence and what constitutes a good day's work. Their lifestyle preferences and social values differ. Nowhere is this as acute as between pre-Boomer and Boomer managers and their younger subordinates. For example, older managers criticize younger workers' commitment because the young frequently want to limit the hours they work – time off for the younger group is more important, while money motivates the older two.

Telecommuting, is another generational expectation as is computer competence. Studies have shown that Pre-Boomers are about 50 percent computer competent while Boomers are only 32 percent competent. Many cross-generational spats arise from the fact that Busters, 80 percent computer competent, are impatient with people less technically savvy than themselves. Cuspers find themselves technically challenged while Netsters prefer state-of-the-art technology.

Communication is another issue that stymies some forty and fifty-something Boomer managers. They literally tear their hair out when they try to communicate what they consider ordinary ideas to a 20 to 30-year-old Buster. For example, when a Boomer says to a Boomer, "This needs to be done," both understand that this is an order, but nicely put. However, when a Boomer says to a Buster, "This needs to be done," the Buster hears an *observation*, not an order, and they quickly agree that it needs to be done, with no intention of actually carrying out the task. According to Ms. Kennedy, this fractured cross-generational communication must be overcome if people are to work well together. Knowing that what one person heard was not what the other person meant and understanding the differences in communication styles goes a long way in creating a compatible work environment.

In the medical work environment these communication differences are also apparent. For example, the Boomer nurse approaches a hospital patient with a soft, calming voice and reassuring words asking, "How did you sleep?" Then moves to "While I'm here let's take a little blood." The Buster or Netster nurse makes no chit-chat or attempt to make the patient feel at ease, but moves quickly to task and simply gets the job done. When Boomers were children their parents imprinted them with the need to be nice, well-liked, and cooperative. Their generation was large, crowded, and competitive. It was a win/lose world. "You must get along with other people" sums up their child-rearing philosophy. Busters and Netsters didn't hear that from their parents. They belong to much smaller generations. For many, computers are more absorbing than playmates. Their parents, perhaps as a reaction to the pressure on them to be popular when they were young, tended to encourage individualism. As a result, the generations clash in the workplace.

So what to do about all this chaos? Ms. Kennedy suggested packaging messages so that every hearer understands. Vary reward systems. Offer each group what they want most. Use written, verbal and interactive forms of communication. Encouraging all groups to complement and mentor each other is another useful technique. This encourages and allows each age group to learn from one another.

It makes being a manager more difficult in today's climate because they must recognize the diversity of workplace values and work to accommodate them. For a copy of Ms. Kennedy's handout explaining differences in generations, contact PCMS, 572-3666 or email us at pcmswa@pcmswa.org. ■

Fluoride Varnish: the Physician Role

Prevention effort is effective and simple with ample reimbursement

"Children's Dental Issues for Physicians" was recenlty presented by Rhonda Savage, DDS at the Multicare Pediatric Grant Rounds. One of the topics covered was the use of fluoride varnishes by physicians. Fluoride varnishes have been used in Europe and Canada for 20 years for treating caries. In this country the FDA has approved their use for hypersensitive teeth only, so use on caries is off-label. While not an FDA approved indication, fluoride varnishes have gained widespread acceptance in caries remineralization protocols and caries control in patients with rampant decay. Fluoride varnishes are most effective when the caries is at the "white spot" stage, rather than having progressed to a brown spot, or in the prevention of caries in high-risk children.

Caries are particularly a problem in low-income children, where families may not practice good oral hygiene nor be seeing a dentist. Since the physician is already seeing the child for well-child exams, there is opportunity to check the condition of the teeth during the exam, and have staff apply a fluoride varnish treatment. Application takes about 2 minutes, and only requires the fluoride varnish and a cotton swab.

There are three vendors of fluoride varnishes. Duraflor is made by Pharmascience Inc., Montreal, Canada and distributed through Oratec, 1-800-368-3529. Duraphat is made by Colgate Oral Pharmaceuticals, 1-800-2-COLGATE. Cavity Shield is made by Omnii, 1-800-445-4486. Cavity Shield is available as a unit dose with the applicator; Duraflor will be available this way in January 2002; Duraphat is in a multidose 10 cc tube, which should treat 20 children. For local distributors, check the yellow pages under "Dental Equipment & Supplies."

Cost is variable, depending on the product, estimated to range from $1 - $3 per application. DSHS reimbursement is $18.93; DSHS will reimburse a physician for three applications per year, even if the child is receiving fluoride varnish applications from a dentist. The DSHS procedure code for application of fluoride varnish is 0122D. Reimbursement by private insurance depends on dental benefits of the individual's plan.

There is a good online course to learn more about caries in children. It is "Early Childhood Caries: A Medical and Dental Perspective." The address is http://www.pc.maricopa.edu/departments/dental/ecc. To obtain one hour of CME, the Group/User name is "flower" and the Password is "begonia." Also, there is a half-day conference, "Dental Medicine for the Primary Care Physician," at Children's Hospital in Seattle on Saturday, March 9, 2002. Call 206-527-5701 for more information.

For further questions call **Rebecca Sullivan, MD**, Executive for Medical Delivery Systems, Tacoma-Pierce County Health Department, (253) 798-6461. ■

Governor Locke will Address WSMA Legislative Summit

The focus of this year's Legislative Summit will be "Viability of Physicians' Practices." The Summit will be held in Olympia on Tuesday, January 29 at the West Coast Olympia Hotel. Governor Locke will speak at 9:00 am to discuss recent budget cuts and their effect on health care.

Later in the morning, WSMA will convene a press conference in the Capitol Rotunda to unveil the results of their 2nd Medical Practice Data Project and to share data on the continuing deterioration of physician practices and how this is affecting patients and communities. As the same time, WSMA will press state lawmakers to take a leadership role in fixing the state's health care system.

Registration forms were faxed to all WSMA members. A copy of the form can be downloaded from the WSMA Website at www.wsma.org under News and Events. The Summit is free for WSMA and WSMGMA members and $160 for non-members. For more information or to register, contact Susan Peterson at the WSMA Olympia office at 360-352-4848 or 1-800-562-4546 (e-mail skp@wsma.org). ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Environmental Tobacco Smoke

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT

Pierce County statistics regarding tobacco include some good news. In 2000, the prevalence of adult tobacco use was 21.9%, down from 24.4% (1993 - 1997 data). However, that means many adults continue to smoke, in their homes and in public places, exposing everyone to environmental tobacco smoke (ETS).

Federico Cruz-Uribe, MD

ETS is a mixture of smoke from burning tobacco products and smoke exhaled by the smoker. It contains about 4,000 chemicals, of which sixty are known to cause cancer. For that reason, in 1992, the Environmental Protection Agency declared ETS to be a Group A Carcinogen, for which there is no safe level of exposure.

ETS is linked to bronchitis, pneumonia and respiratory tract infections in people of all ages. For children whose parents smoke in the home, studies have shown significant health impacts, including increased rates of hospitalization for pneumonia, asthma, and bronchitis. ETS has also been associated with higher levels of middle ear effusions, acute nasopharyngitis, and sinusitis. A growing body of evidence links exposure to ETS to sudden infant death syndrome and to development of cancer as adults.

In addition to children, the other group of people heavily affected by ETS are those who work in the hospitality industry; waitpersons and bartenders who are non smoking but breathe ETS at work have been shown to have a 50% increase in risk of contracting lung cancer. For many young people, their first job is working in food service. If smoking is allowed, that first job can compromise their health for the rest of their lives.

ETS has been identified as the third leading cause of preventable death, following active smoking and alcohol. In Pierce County, approximately 140 people die every year as a result of ETS-related illnesses. By comparison, in this county, 95 people die from firearms and 60 from motor vehicle accidents annually.

The Tacoma-Pierce County Health Department has focused on decreasing ETS, particularly in public places, by promoting smoke-free food establishments. Currently, 66% of restaurants (excluding taverns) are smoke-free. We hope to increase that to 75% in the near future. During home visits, nurses also encourage parents to quit smoking, and volunteers in our asthma prevention program share information about the negative effects of tobacco on asthmatic children. But we can't do the job alone. Medical providers have the ability - and therefore responsibility - to change behaviors in their patients. Exposure to ETS is another area you can ask clients about and recommend they make different choices.

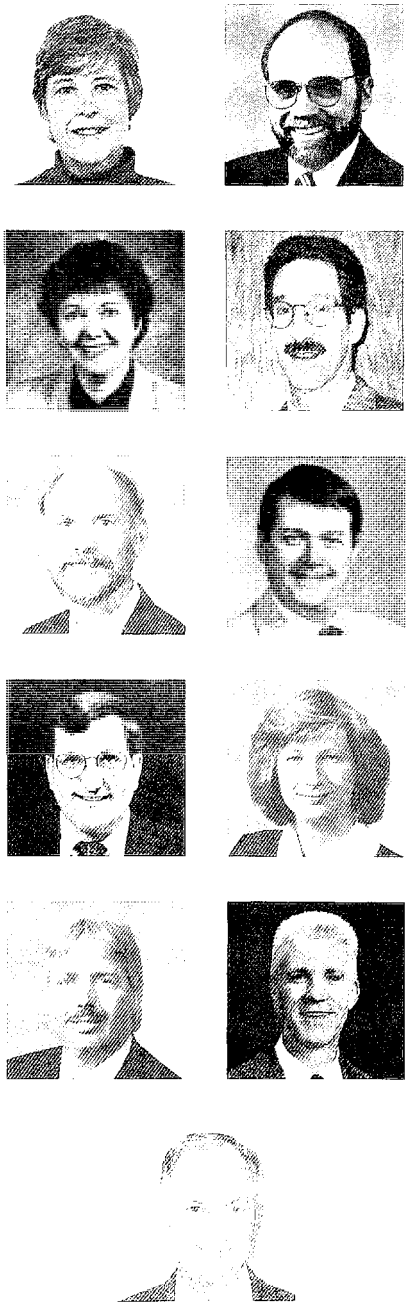
Here are some specific ideas:

- Take smoking histories from parents and guardians of children and talk with smokers about the hazards of ETS to children. Encourage parents to start tobacco cessation programs right away.
- If parents decide they cannot stop smoking, recommend that no smoking be allowed in the home, car, or near children.
- Ask all parents - whether or not they use tobacco themselves - to check with baby sitters, childcare facilities, schools, and other locations where children are present to avoid smoking.
- Recommend that anyone eating outside the home go to smoke-free restaurants.
- Ask adult patients, and teenagers, if they work in environments where smoking is allowed. Encourage them to ask their employer to establish a smoking policy that protects non-smokers from exposure to ETS.
- If legislation is introduced this year, as it was in 2001, that would ban smoking in restaurants and bowling alleys, encourage your representative to vote in favor of that law.

Nearly everyone is exposed to ETS to some extent. Since there is no acceptable level, let's collaborate to eliminate it altogether. Until smoking prevalence drops to 0%, we're all at risk.

With some of these recommendations, I realize that I am asking you to step out of your normal role as a physician. We need better public policy if we are going to really address the entire tobacco issue. A clear and aggressive stance by physicians both in and outside your office is critical. Please give this your fullest support. ■

New Board of Trustees will lead PCMS in 2002



From top, left to right, Drs. Susan Salo, J. James Rooks, Jr., Patrice Stevenson, Michael Kelly, Patrick Hogan, Stephen Duncan, Kenneth Feucht, Allison Odenthal, Joseph Regimbal, Sumner Schoenike, and Matthew White

Susan Salo, MD (President) is a family practitioner with Group Health in Tacoma. She earned her medical degree from the University of Washington School of Medicine and completed her internship and residency at St. Joseph Hospital in Flint, Michigan.

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

Patrice Stevenson, MD (Past-President) practices physical medicine and rehabilitation in Puyallup. She graduated from the University of Washington School of Medicine and completed her internship and residency at the VA Medical Center in Los Angeles.

Michael Kelly, MD (Vice President) is a family practitioner in Lakewood. He graduated from the University of Cincinnati College of Medicine and completed his residency at Oregon Health Sciences University.

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

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

Stephen Duncan, MD is a family practitioner with Group Health in Puyallup. He received his medical degree from the Indiana University School of Medicine. He completed his internship and residency at Union Hospital Family Practice in Terre Haute, Indiana.

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

Allison Odenthal, MD is a family practitioner in Tacoma. She graduated from George Washington University School of Medicine and completed her internship and residency at Silas B. Hayes Army Medical Center in Fort Ord, California.

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

Sumner Schoenike, MD, MPH is a Lakewood pediatrician. He graduated from Baylor College of Medicine in Houston. He completed a fellowship in psychiatry at Oregon State Hospital and received his MPH from the University of Texas School of Public Health.

Matthew White, MD is a family practitioner in Lakewood. He graduated from Jefferson Medical College in Philadelphia and completed his residency at the US Naval Hospital in Jacksonville, Florida.

Medicare relief efforts stalled

As the Bulletin went to press, physician hopes of Medicare relief looked dim. Congress was choosing to do nothing to stop the 5.4% cut slated for Medicare payments effective January 1, 2002. Bills to reduce the reduction to 0.9% were being denied opportunity for votes, even though a majority of members of Congress admitted that the payment system is flawed.

This cut will be the fourth Medicare payment reduction to physicians over the last ten years. Medicare payments to physicians will have averaged only a 1.1% increase per year since 1991. Compare this to the increase in physician practice costs, including liability premium increases of up to 200% and the ability to treat Medicare patients due to economic factors has to be scrutinized. Access problems have been reported in many states including Georgia, Arizona, New Mexico, Colorado, Maryland, California, Idaho and Washington.

It is being reported that there has been an agreement adopted by the House and the Senate requiring the Medicare Payment Advisory Commission (MedPAC) to present recommendations for a new payment update formula by March 1, 2002, however, support must continue for the 5.4 percent January 1 cut to be rescinded as promptly as possible. ■

PCMS Foundation thanks Holiday Sharing Card contributors

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

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

And a very big thank you must go to the volunteers who helped with all the work that accompanies such a project, particularly the preparation for mailing: **Mona Baghdadi, Mary Cordova, Nikki Crowley, Dr. Jim Crowley, Patty Kesling, Kris White, and Alice Yeh**.

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

Tarek and Mona Baghdadi
Dr. and Mrs. John Bargren
Jennifer and Tedford Cozart
Karen and Martin Graham
Deborah L. Hickey
Sherry Johnson
Lawrence A. & Mary Larson
Sharon Ann Lawson
Charles & Shauna Weatherby

Visit the new PCMS Website at www.pcmswa.org

Visit the new and improved PCMS website at www.pcmswa.org for Medical Society news and information!

Highlights include news and events, Health Department alerts, upcoming meetings, College of Medical Education courses and registration forms, and placement information. You will also find links to several sites including WSMA, local health resources, elected officials, and other local and national healthcare organizations.

PCMS publications are also being considered for publication under a "members only" category. The annual pharmacy directory, physician member directory and the monthly Bulletin are potential items that could be accessible for members.

Since its unveiling December 10th, www.pcmswa.org has processed one College of Medical Education registration, two applications for Society membership and three placement resumes. Members will soon be able to register for general membership meetings, retired physician luncheons and other events at the click of a mouse!

PCMS values member feedback and welcomes your comments on site content and design. To give your suggestions or for more information, visit www.pcmswa.org or call the Society office at (253) 572-3667. ■

Tax Levy to Determine Shuttle Service Cuts

The Pierce Transit Board of Commissioners has approved a resolution to be placed before the voters on February 5, 2002. This is a request for an additional three-tenths of one percent in local sales taxes authority.

The 0.3% tax increase will replace funding that was lost when the state Motor Vehicle Excise Tax was eliminated following the passage of I-695. "The tax would allow Pierce Transit to provide increasing levels of local bus service, Shuttle transportation for people with disabilities, vanpool services, and additional Park & Ride lots, at a rate that will keep pace with Pierce County population growth," according to Pierce Transit Public Relations Officer Lind Simonsen.

"If this measure doesn't pass, Pierce Transit will be forced to cut Shuttle transportation by 20 to 25% which in turn will affect many patients' abilities to get to medical appointments," added Simonsen.

Available reserve funds are set to run out at the end of 2002. Sales tax revenue is the only means available for additional funding. If the resolution passes, Pierce Transit would be the ninth transit system in the state to receive such funding from the public.

For more information on Pierce Transit's tax proposal, contact Customer Service at (253) 581-8000 or visit www.piercetransit.org. ■

New Publication for Physicians

Tacoma liability defense attorney Steven F. Fitzer, JD, has teamed with Angela M. Dodge, PhD, to guide physicians involved in malpractice lawsuits in their recently published book, When Good Doctors Get Sued.

The 128-page publication focuses on giving testimony about patient care, and includes techniques on how to give more thoughtful and succinct answers, maintain confidence and control, and cope with litigation stress and its impact on work and family. A summary pocket guide is also included.

For more information or to order a copy of When Good Doctors Get Sued, visit www.bookpartners.com or call Bookpartners, Inc. at (503) 554-1997. ■

"Pesticide Medicine" Course

The Northwest Center for Occupational Health and Safety and the Pacific Northwest Agricultural Safety and Health (PNASH) are pleased to present "Pesticide Medicine" March 8, 2002, Seattle, WA. This course is geared towards physicians, industrial hygienists, nurses, toxicologists, laboratory and management representatives, attorneys, health professionals, educators, safety and environmental health professionals. Professional credit available. Cost is $165 before February 15, 2002 and $195 thereafter.

Local and national experts on pesticide use, pesticide exposure, and pesticide health effects will cover topics relevant for practicing clinicians and other professionals who interact with people with pesticide exposure. A guest from the University of California at Davis will share his valuable expertise on measure pesticide exposure.

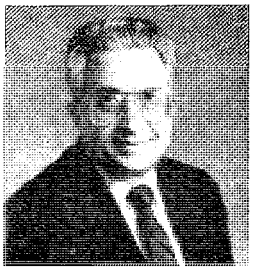
For more information about this course, call (206) 543-1069 or view http://depts.washington.edu/ehce. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Patient and Physician Satisfaction



Andrew Statson, MD

"He is well paid that is well satisfied."
The Merchant of Venice
Shakespeare (1596)

In their effort to recapture some credibility with the people, the insurance companies have decided to tie payments for medical services to patient satisfaction. I don't know how they propose to do that and I am not sure they know it either. It promises to be even more interesting than the mandatory second opinions, the pre-authorizations and all the other exercises in futility in which they have previously engaged.

In the usual medical practice, most patients are reasonably well satisfied with the care they get. Everyone of us sees a few patients per year who become disgruntled and go someplace else. The latest one in my practice was a young girl at 30 weeks of pregnancy, who already had been under the care of two or three other physicians. She came with the complaint of abdominal pain and was unhappy because she thought her previous physician did not believe she was hurting.

She had had a previous Cesarean section and the plan was to do a repeat section at 39 weeks. After two visits and several phone calls, she said she wanted to be delivered right now, at 33 weeks. "If you don't do my section now, I'll find someone else who would," she said. Her request would have been more tolerable, had it not been accompanied by profanities and swear words directed at my staff. Would an insurance company pay better had the request of this patient been granted? Should it?

Another, and more common situation is the patient who wants an ultrasound for her peace of mind, to be reassured that the baby is doing well and, "by the way, I want to know whether I have a boy or girl." When told that the insurance company would not pay for scans without a diagnosis to justify them, she says, "can't you make up something?" Would the insurance company pay more for the satisfaction of this patient? Should it?

> *"One of the employers of physicians in the area is reported as advising them to smile when they take care of the patients. That is nice, but the fact that it is necessary to tell it to the physicians means that they perhaps are not treated well enough to consider smiling without that special encouragement."*

Sometimes I see a patient who comes in with a long-standing history of pelvic pain, telling me she has endometriosis, has tried various treatments, but she is not yet ready for definitive surgery. After a negative clinical examination and discussion of her options for treatment, she requests a prescription for Percocet. As I refuse, she says, "That's ridiculous. That is why I came here in the first place. I am in pain," and she walks out of the office. Would an insurance company pay extra for the satisfaction of this type of patient? Should it?

Another pregnant patient worked for one of the large store chains. During her first pregnancy, she complained to her obstetrician that she was having contractions and he decided she had threatened pre-term labor rand recommended that she stop work, which she was happy to do starting at 24 weeks, while receiving a significant disability benefit. After several hospital admissions during that pregnancy because of cramps, she eventually delivered at term, following a two-day induction with prostaglandins and a

See "Satisfaction" page 14

Satisfaction from page 13

third day with oxytocin.

She came to me for her second pregnancy and presented with the same complaints. She wanted me to certify her disability, so she could stop work and collect her benefits. I told her she could stop work any time she wished, but I saw no medical reason for her to do so. Eventually she transferred care to someone else.

Of course, when the patients complain or are asked about satisfaction, they will not mention that they asked us to invent a diagnosis so they could get an ultrasound, they will say that they could not get an appointment promptly, that they had to wait a long time to be seen, that the doctor did not spend enough time with them, did not pay attention to their complaints, etc.

Most, if not all of us do our best to satisfy our patients. We all know that the entrance to our office is also an exit. A patient may walk out at any time. There is no better expression of patient dissatisfaction than that. We also know that sometimes we cannot, in good conscience, agree to the request of the patients and we can only wish them well as they leave in search of a physician who would do what they want. Even then, we know that we could be wrong and the patients could be right in their quest for treatment.

Only when patients are assigned to a specific physician and can neither obtain satisfaction, nor change to someone else, that a problem arises. In those situations, it behooves the insurance companies to reassign the patient.

Business and consumer research firms have methods by which they try to assess customer satisfaction with goods and services for which people pay out of pocket. There is very little known how people would describe their satisfaction with goods and services for which they do not pay. When the services would not cost them anything, could it be that only perfection would by fully satisfactory?

Another factor in patient satisfaction is the attitude of the staff, physicians, nurses, medical assistants, bookkeepers, etc. When you walk into a store and get the feeling that the clerks don't care whether you are there and whether you buy anything or not, you are likely to walk out and never go back. What makes the clerks interested in helping the customers, in making them welcome? Frequently, it is the general attitude of the management, the way the clerks are treated, and how well they are paid.

One of the employers of physicians in the area is reported as advising them to smile when they take care of the patients. That is nice, but the fact that it is necessary to tell it to the physicians means that they perhaps are not treated well enough to consider smiling without that special encouragement. When people are tired, overworked and underpaid, they have very little energy to smile and hardly any incentive to do so. Of course, their attitude can be readily picked up by the patients and reflects on their employer, probably rightfully so.

The lack of physician satisfaction with the practice of medicine we currently witness is related both to inadequate compensation for our services and to a growing hassle factor, consisting of increased paperwork requirements, more and more restrictions on what we can do for our patients, and overwhelming demands on our time for things that have very little to do with patient care, but a lot to do with administration.

Patient satisfaction has always been our goal. It is new only to the insurance companies. Unfortunately we cannot treat our patients with the personal attention and concern we could give them some twenty or thirty years ago. We don't have the energy, the time, the staff or the facilities to do that. We have had to cut our overhead as much as possible. We are barely meeting our expenses now. We cannot afford to do more.

Yes, patients are less satisfied now than they were in the past. The insurance companies can do much better than survey and analyze the situation. They can pay better for the services we provide. Elimination of the hassles to practice medicine and better compensation for physicians would be much more effective in achieving patient satisfaction. It may be more expensive, even though that is debatable. A recent report stated that the cost of care in short-staffed ICU units was higher than in those well staffed. Such a step by the insurance companies is too much to expect. Things will have to get much worse before they get better. ■

IN MEMORIAM
FRANZ P. HOSKINS, MD
1915-2001

Franz Hoskins died in November after a long battle with prostate cancer. He did "real" doctoring, I did "niche" doctoring, but our lives came together closely at two intervals, more than enough for me to grieve at his passing. He was one of my heroes.

Franz's World War II exploits were covered in the *New York Times* and *News Tribune* obituaries and were well known by his contemporaries, but I didn't know about his past until I was consulted in 1979 to operate upon him for unstable angina. I have some trouble writing about this first "brush" in our relationship, as Franz's subsequent attitude about it differed widely from my opinion of the outcome. Four or five bypass grafts were required, and he bled excessively in the following hours. We talked at several points in those late night hours. As I looked worrisomely at his tube drainages and platelet counts, he would look up at me and assure me that everything was going to work out, that he'd been through a lot worse. I'd like to write that the bleeding stopped, but Franz tamponaded abruptly, early the next morning. I was fortunate to be there, but we had to reopen him *awake*, on the ward, when he arrested. Talking to an alert fellow physician patient while removing his sternal wires is not easily forgotten. We returned him to the OR, stopped the bleeding, and closed. Franz left the hospital a few days later. He developed hepatitis, undoubtedly from one or more of the many units of blood he had required. I know with certainty that he didn't feel well for years.

Even though after that I would bring my *mea culpa* out on multiple professional and social visits with Franz, he would congratulate me on a job well done, and call *me* one of *his* heroes for bringing him through that morning. We would visit on the wards or have lunch in the cafeteria, and Franz would sometimes drop in on us in the OR if I was operating upon one of his patients. It was at these times that he would open up about the war and his part in it. Statutes of limitations now allow me to say that sometimes things stopped for a minute in the operating room when he would tell about a near miss from a depth charge, or the famous under-sea appendectomy, when he, not yet a doctor, became the anesthetist, following a manual on how to keep someone asleep with open drop ether.

Then there was a long period of time when Franz dropped out of sight, and I found that he was essentially home - caring for his wife Noreen, in her terminal stages of a Parkinson-like palsy. That was his sole activity, outside of the office practice, for two or three years. We would chat some when he stopped in at the cafeteria for a quick lunch, but his dedication to her was total.

Later, we began to have a few dinners out, and the war stories would come out again. Franz was regarded with tremendous respect at Bangor, and here and there in his house were pictures of meetings and reception lines with Franz, front and center, in his dress uniform, replete with row upon row of ribbons. It was typical of him, though, that the picture he most enjoyed showing off was one of his 30-plus office nurse Esther Blodgett, manning the periscope on a "PR" submarine cruise and dive.

When I returned to Tacoma in 1992, Franz had been alone for some time and he convinced me that staying with him while I rearranged my life and practice would be good for both of us. It was indeed, and over that six week period we enjoyed many a good breakfast and evening together, talking over old and new times.

Franz battled with prostate cancer for the last five or six years. He kept scrupulous records of his treatment regimens, PSA levels and bone scans, and never seemed discouraged. He was always outward minded, and the final example of that was the dinner he and his friend Jackie Kane hosted for Jeanne and Jim Vadheim, Robbi and myself at the Lobster Shop a year ago. It was a fine evening and again the mood he set was one of gratitude to his friends and how fortunate he was to be feeling good and to be out with just us. Quite a guy indeed. It was a real privilege to know him and he is greatly missed.

Cordell H. Bahn, MD

Applicants for Membership

Mark A. Crowe, MD
Dermatology
Puyallup Dermatology Clinic
1706 S Meridian #140, Puyallup
253-841-2453
Medical School: University of Texas
Internship: William Beaumont AMC
Residency: William Beaumont AMC
Residency: Walter Reed AMC

Frederick W. Ehret, MD
Plastic Surgery
Pratt, Woodman and Ehret
2202 S Cedar St #300, Tacoma
253-627-2900
Medical School: Boston University
Internship: Boston University
Residency: Boston University
Residency: Harvard University
Fellowship: University of Washington

Phoebe F. Ho, MD
Ob/Gyn
Tacoma South Medical Clinic
2111 S 90th St, Tacoma
253-539-9700
Med School: U of Southern California
Internship: U of Southern California
Residency: Northeastern Ohio Univ

Jay K. Iyengar, MD
Pain Management
Cascade Interventional Pain Clinic
1901 S Union #A301, Tacoma
253-627-2666
Med School: Mysore Medical College
Internship: University of Connecticut
Residency: Richland Memorial Hosp
Fellowship: Univ of Iowa Hospitals

Andrew B. Kopstein, MD
Ophthalmology
Cedar Medical Specialties
2202 S Cedar St #100, Tacoma
253-759-5555
Medical School: Univ of Minnesota
Internship: Illinois Masonic Med Ctr
Residency: Loyola Univ Med Ctr

Stephen A. Koshel, PA-C
Orthopedic and General Surgery
Surgical First Assist, Northwest
5500 Olympic Dr NW, Gig Harbor
253-853-1596
Prof School: Kettering College
Physician Sponsor: **Ki Oh, MD**

Alison M. Pruim, PA-C
Dermatology
Tacoma Narrows Dermatology Clinic
1033 Regents Blvd #204, Fircrest
253-564-3367
Prof School: Wake Forest University
Physician Sponsor: **Robert Martin, MD**

Navdeep S. Rai, MD
Internal Medicine
Pulmonary Consultants
316 ML King Jr Way #401, Tacoma
253-572-5140
Medical School: Ohio State University
Internship: Cleveland Clinic
Residency: Cleveland Clinic
Fellowship: Cleveland Clinic

Kevin J. Roscoe, MD
Family Practice
Summit View Clinic
11019 Canyon Road E, Puyallup
253-537-0293
Med School: Albany Medical College
Internship: UC Davis Medical Center
Residency: UC Davis Medical Center
Fellowship: School of Aerospace Med

COLLEGE OF MEDICAL EDUCATION

Cardiology set Wednesday 1/9 & Tuesday 1/15

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

This year's Cardiology for Primary Care CME program will be offered on two evenings in two consecutive weeks in January, instead of the traditional 6-hour program on a Friday. This year's program is scheduled for **Wednesday**, January 9 and **Tuesday**, January 15 from 6:00 pm to 9:00 pm on both nights.

The program will begin with speakers on the 9th, three hours of CME and end with three additional hours of CME on the 15th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include:

- Congestive Heart Failure Management for Primary Care Physicians
- Appropriate Cardiac Testing
- ARBs and Their Role in Heart Failure and Cardiovascular Disease
- Rationale for the Aggressiveness of the NCEP - ATP III Guidelines
- Women's Cardiac Issues
- Managing Your Diabetic Patients' Cardiac Needs ■

Continuing Medical Education

First Primary Care Orthopedic CME set for February 8

A new COME program designed for the primary care physicians' attention to their patients' orthopedic problems is set for February 8.

The one-day program will feature speakers on evaluation, treatment and management, and include review of appropriate imaging, joint injections, referral protocols and more.

The course is directed by **Drs. Michael Bateman** and **Charles Weatherby**.

Topics planned include:

- Appropriate Anti-Inflammatory Therapy for Joint Disease
- The Knee and DJD
- The Aging Athlete and Osteoporosis
- Primary Care Evaluation of the Upper Extremities
- The Painful Spine: Evaluation and Management
- Primary Care Evaluation of the Lower Extremities
- Joint Injections for Primary Care?
- Pediatric Gate and Limp

Dates	Program	Director(s)
Wednesday; Tuesday January 9; 15	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 23-27	CME @ Whistler	Richard Tobin, MD John Jiganti, MD
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Classified Advertising

POSITIONS AVAILABLE

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

Washington State Division of Disability Determination Services. Medical Consultant positions available. The State of Washington Division of Disability Determination Services seeks psychiatrists to perform contract services in the Olympia Regional office. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Psychiatric Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits. **Requirements**: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/hr. Interested psychiatrists should contact **Guthrie L. Turner, Jr., MD, MPH**, Chief Medical Consultant, Acting at (360) 664-7361 or the respective regional manager: **Olympia**: Laura Wohl, Regional Manager (360) 664-7355.

Urgent Care Physician. The Puyallup Tribal Health Authority seeks a full time Urgent Care Physician for a busy Native American ambulatory clinic. Excellent benefit package. Doctorate of Medicine or Osteopathy from an accredited institution. Board eligibility in appropriate field. Licensed to practice medicine in the State of Washington. ACLS Certification. Urgent/emergent care experience preferred. Indian preference in hiring according to law. Please fax CV to PTHA (253) 593-3479 or call (253) 593-0232 x516 for an application packet.

Seattle/Tacoma. Medical Group seeks B/C or B/Q Family Practitioner or IM/Peds for Urgent Care float position. All clinics are located within 40 minutes of downtown Seattle. Experience the best of Northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. Live and practice where housing is still affordable and traffic is still manage-able. Excellent benefits and income guarantee. Three-year family practice or internal medicine residency in accredited U.S. residency program required. For more information, please e-mail CV to providerservices@multicare.org or fax to 253-403-5431. Check out our website: www.multicare.org.

GENERAL

Computer troubles? Call On Sight Computers (253) 318-0214. We handle repair, setup, upgrade and more. First hour free!

For Sale: Small office copier, Sharp Z57 II, $150. Fax machine, Sharp UX 114, $50. Both in excellent condition. 253-503-8187.

File your claims electronically with Advanced Medical Billing. 1-253-946-2264 or 1-253-905-7161.

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Transcription Specialists - We have years of experience in most medical specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and reasonable charges. Outstanding references. Call 925-3276.

OFFICE SPACE

Available now, new construc- tion. up to 1,800 sq ft remaining on first level, will provide tenant improvements. Close to hospitals on Union at 13th. Call **Dr. Lovy** at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examine rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Call (253) 863-3366 or (253) 272-4588.

Office Space For Lease. Sound- view Medical Plaza, located at 3611 South D Street, currently has office space available for lease to medical or general healthcare practices. We offer very competitive lease rates; spacious, updated facilities; shared reception; accessible support staff; excellent security, maintenance and janitorial services; and access to onsite radiology and blood labs. Our location, just off of Pacific Avenue, is adjacent to the Pierce County Health Department and Puget Sound Behavioral Health, and is easy access to and from freeways and on a bus line. For lease rates and more information, call Lindy Vincent at 798-4520.

Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

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BULLETIN

February, 2002

Photo by Sam Insalaco, MD

INSIDE:

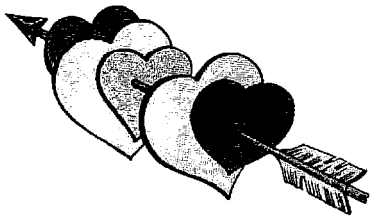
The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

February, 2002



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President's Page

by Susan Salo, MD

A Plea for Participation

Susan Salo, MD

This is our medical society. It is one of the most active in the state; I would like to make it the most responsive; most of all we need to make it the most useful.

Governance is supervised by a board of trustees which meets monthly except during the summer. The better I know these people, the more amazed I am at their vitality and at the energy and devotion to the Society as it exists and as it should develop.

We discuss membership: how well we meet and anticipate the needs of our members; how well our representatives function at the state and AMA level; how well our subsidiaries - the College of Medical Education, the PCMS Foundation, and Membership Benefits, Inc. - are fulfilling their functions; and how to meet our obligation toward furthering the health of the community.

We discuss ways of increasing membership and membership participation.

I personally think that members will be attracted to a vital, useful, effective organization and that increasing membership is more a benchmark - an indication of a successful program - than an independent goal.

In January our board met for a day-long retreat. After meeting with Dr. Sam Cullison, WSMA President, Len Eddinger, WSMA Director of Public Policy and Planning, and Bob Perna, WSMA Director of Medical Economics, who reviewed with us the present medical practice environment in Washington State, we reviewed our mission statement and addressed priorities for the next two years.

"Not surprisingly, practice viability was a tremendous concern to the members of the board and will be the major goal we would like to strive to accomplish."

Not surprisingly, practice viability was a tremendous concern to the members of the board and will be the major goal we would like to strive to accomplish.

But since this is an indirect goal - it is YOUR practice that must remain successful - we need your help. Tell us how to help you, your practice, your patients, your community. Please understand that some suggestions will be too cumbersome, too expensive, too divisive for us to attempt, but we need your suggestions and your advice.

We need your help and involvement. Participate in the CME programs and tell the COME how to make them even better. Visit the office, meet our director, Sue Asher, the staff and facility. Indicate your interest and volunteer for membership on a committee, the College of Medical Education board or the Membership Benefits, Inc. board.

Next month I will use this space to present our finalized mission priorities and work plan for 2002. For a review of our current organizational structure ....please see page 5.

We are a member-directed, member-driven, member-run society. I ask each of you for advice, guidance, and assistance.

Thank you. ■

2002 Board Retreat Recap

Retreat participants meet with WSMA leaders

A new year, a new agenda, and definitely a full plate. This is what the Board of Trustees were faced with at their January 5th retreat at Shenanigans Restaurant on Tacoma's waterfront. Board members, **Drs. Susan Salo, Jim Rooks, Patrice Stevenson, Mike Kelly, Pat Hogan, Steve Duncan, Allison Odenthal, Sumner Schoenike and Matt White** were joined by WSMA representatives, **Drs. Len Alenick, Richard Hawkins, David Law, Nick Rajacich and Don Russell** to learn about the current state of PCMS and determine future direction, specifically a 2002 work plan.

Learning about WSMA priorities was first on the agenda, however, as Sam Cullison, MD, WSMA president, reported their single focus for 2002 as helping members preserve their medical practices. The WSMA will concentrate on helping physicians maintain financial viability by fighting for adequate revenue and administrative cost reductions. "Given the budget woes of our state, administrative simplification is the most realistic goal," he said. Adding that, "We consider this year a crisis and we need to channel all of our efforts into this one project." With physicians evaporating from our state, many colleagues facing bankruptcy, and our state reimbursements so low, word is out on the street not to come to Washington to practice medicine, he explained. The most vulnerable practices are in rural settings or have a payer mix that includes over 22% from Medicare/Medicaid combined. Add soaring malpractice rates, it quickly becomes clear why the single focus.

While focusing on practice viability, WSMA will also look to strengthen their organization. "We are modifying the interspecialty council and they will be meeting monthly to help incorporate specialty society positions, our web strategies and email systems will be reviewed and we will reexamine the House of Delegate's meeting and other systems to ensure we are as productive and efficient as possible," he summarized.

Dr. Cullison also informed the board that he and colleagues had met with Governor Locke and he believes that medicine has finally made it on to his radar screen. The Governor agreed that there does need to be public discussions, and the citizens of Washington State need to decide what they want and what they are willing to pay for.

Len Eddinger, Director of Public Policy and Planning with WSMA, gave an update on the legislative priorities for 2002, noting that "this year will be different," as there is no longer a tie, but a Democratic majority in the House of Representatives. "The session will be short (60 day) and will be difficult because of the budget deficits. They are anticipating deep cuts in hospitals, interpreter services and social services across the board. They are anticipating another 20,000 people to sign on to the BHP, due to the passage of the tobacco initiative, I-773, but there is uncertainty as to how these people will obtain health care even with the BHP coverage. Legislation to eliminate B&O taxes for physicians, to modify the ability to collectively negotiate by discussing money, and scope of practice issues will be reintroduced. Communications with Representatives Norm Dicks and Adam Smith continue regarding Medicare reimbursement reductions. Mr. Eddinger noted that last year physicians did an excellent job of communicating with their elected officials and he encouraged everyone to continue to do so.

With updated knowledge about WSMA and their priorities for the year, board members were informed about the state of PCMS (see page 5) and then went on to determine their working mission and goals for 2002. Their work plan will be finalized at the February Board of Trustees meeting and will be published in the March, 2002 issue of the *PCMS Bulletin.* ■

WSMA enters into agreement with legal council re: Aetna lawsuit

The WSMA has entered into a retainer agreement with a law firm representing the Connecticut State Medical Association (CSMS), and a number of other state medical associations, in legal action brought against Aetna. The firm is Milberg Weiss Bershad Hynes and Lerach, LLP.

The Aetna lawsuit seeks injunctive relief and damages for physicians. It asserts that Aetna has violated Connecticut's Unfair Trade Practices Act by:

- engaging in unfair and deceptive business practices;
- bundling of claims;
- retroactive downcoding;
- providing inadequate staffing to handle physician inquiries;
- violating timely claims payment rules and failing to pay interest on late claims;

See "WSMA" page 16

The State of PCMS

The Board of Trustees, at the January retreat reviewed the current state of their organization, from top to bottom including programs and services, staffing, governance and financial well-being with a critical eye to how the PCMS and it's subsidiaries could improve.

PCMS, a non-profit membership organization, 501(c)(6) was founded in 1888 with objectives to promote the art and science of medicine, the care and well-being of patients; to protect and to improve the health of the public and to serve and provide leadership for the membership of the Society, goals that remain to this day.

PCMS is governed by a Board of Trustees comprised of five officers and six trustees, elected by the membership. Nominees are selected by the Nominating Committee which is comprised of the officers of the organization and four at-large members nominated by attendees at the September General Membership Meeting. Trustee terms are two years and the board meets monthly, except for July and August.

PCMS is funded primarily by membership dues and is unified with the Washington State Medical Association. Unification requires joint membership in PCMS and WSMA (or WOMA for osteopathic physicians). Unification is a county medical society board decision and Pierce County (as most counties in the state) has continually maintained that unification strengthens the organization and is important for legislative and regulatory advocacy.

Standing committees of the Society include Bylaws, Credentials, Ethics, Executive, Finance, Grievance, Nominating and Program. Special committees include Public Health/School Health, AIDS, Membership and Investment while ad-hoc groups include Medical/Legal, Aging, Labor and Industries, etc. Activities and projects of the Society include but are not limited to patient referral services, practice management programs community coalitions, public health alerts in conjunction with the Health Department, physician advocacy, Immunization Coalition, Health Care Access Coalition, Retired Member luncheons, Women in Medicine meetings, Referral Coordinator meetings and working in conjunction with other organizations such as Tacoma Area Medical Managers, Pierce County Chapter of Medical Assistants, and others.

In 1978, PCMS formed a for-profit corporation, PCMS Membership Benefits, Inc. (MBI) for the purpose of providing a service for the membership and providing a source of non-dues revenue. Operation of a placement service for medical office personnel was formed. MBI is governed by a board of directors of at least five, but not more than ten, elected by the PCMS Board of Trustees. The Secretary/Treasurer of PCMS also serves as Secretary/Treasurer of MBI. The MBI Board meets four times annually.

The objectives of MBI are generally to carry out any lawful business or trade which may be necessary, useful or advantageous to the corporation, and to acquire real property and improvements. In 1985, after seven years of operation, the for-profit subsidiary found itself without money and having to borrow operating money from PCMS. By the end of 1985, the MBI Board of Directors determined that they didn't want a for-profit subsidiary that they had to subsidize, so they gave staff one year to solve the financial problem. By eliminating expensive publication contracts, rebuilding the placement service by increasing customer service, and closely monitoring income and expenses, the MBI's red bottom line began to fade. Adding numerous revenue sources including a temporary employment service in 1993, MBI has built their reserves, purchased the PCMS building, pays expenses to PCMS, and operates in a profitable mode. MBI is landlord to the Pierce County Dental Society, Pierce County Nurses Association and American Lung Association of Washington.

In 1969, under the direction of Dr. Marcel Malden, an independent organization was formed to offer accredited medical education to nurses and physicians. The College of Medical Education became an educational, non-profit organization to provide a local resource for continuing, local, medical education responding to local educational needs. As it remains today, the College provides the medical community an option to share and exchange expertise, increase competence and hence, improve patient care. In 1987 the College found itself floundering and in debt. With elimination of the state's CERP requirement for nurses, and increased hospital competition for CME programs, the College was unable to continue as it had for the previous 18 years. PCMS worked to reorganize the College, changing it's mission to physician education only and focusing on the educational needs of physicians who belonged to PCMS. With strong pharmaceutical support, the College is able to offer a minimum of ten Category 1 accredited programs each year.

Twelve members of the board of directors are appointed by the PCMS Board of Trustees, three by the College board and one member is appointed by each hospital system in Pierce County. College programs tend to be targeted toward primary care, but each year a program is offered in

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New Members

Peter G. Brown, MD
Neurological Surgery
Tacoma Surgical Neurology
1112 6th Ave #302, Tacoma
253-383-4379
Med School: Georgetown Med School
Internship: University of Massachusetts
Residency: University of Massachusetts
Residency: Medical College of Georgia

William E. Eggebroten, MD
General Surgery
Mt. Rainier Surgical Associates
419 South L Street #101, Tacoma
253-383-5949
Med School: Jefferson Med College of the Thomas Jefferson University
Internship: Fitzsimons Army Med Ctr
Residency: Madigan Army Med Ctr

Patricia Ferrer, PA-C
Dermatology
Cascade Eye & Skin Center
1703 S Meridian, Puyallup
253-848-3000
Prof School: U of Texas Med Branch

Gustavo S. Garcia-Arcos, MD
General Practice
Family Medicine of Fife
6040 20th Street E, Fife
253-922-5263
Medical School: Universidad Nacionar Autonoma De Mexico
Internship: Prince George Gen Hosp
Residency: Alexandria Hospital

Lori J. Morgan, MD
General Surgery
SW Washington Trauma Services
315 Martin L King Jr Way, Tacoma
253-403-7537
Med School: University of Washington
Internship: Stanford Univ Med Ctr
Residency: Stanford Univ Med Ctr
Fellowship: University of Pennsylvania

Nathan S. Ross, MD
Internal Medicine
Endocrine Consultants Northwest
1628 S Mildred #104, Tacoma
253-656-6777
Medical School: Brown University
Internship: Univ Hospitals of Cleveland
Residency: Univ Hospitals of Cleveland
Fellowship: Cleveland VA Hospital

Jennifer E. Smith, MD
Family Practice
Peninsula Family Medical Center
4700 Pt Fosdick Dr NW, Gig Harbor
253-851-5121
Med School: University of Washington
Internship: Montana Family Practice
Residency: Tacoma Family Medicine

A. Robert Thiessen, MD
Internal Medicine
Peninsula Internal Medicine Assoc
4423 Pt Fosdick Dr #200, Gig Harbor
253-853-2702
Med School: University of Manitoba
Internship: LA Cnty Harbor Gen Hosp
Residency: LA Cnty Harbor Gen Hosp
Fellowship: LA Cnty Harbor Gen Hosp

Alan B. Thomas, MD
Orthopaedic Surgery
Lakewood Orthopaedic Surgeons
5605 100th St SW, Lakewood
253-582-7257
Med School: Loma Linda University
Internship: Loma Linda University
Residency: Loma Linda University
Fellowship: University of Washington

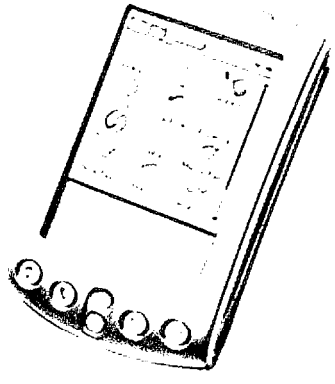
Melawati Yuwono, MD
Pediatrics
NW Pediatrics GI & Nutrition Assoc
311 South L Street, Tacoma
Medical School: Medizinische Hochschule Hannover
Internship: Neustadt Krankenhaus
Residency: Children's Hosp of Buffalo
Fellowship: Children's Hosp of Buffalo

Pierce County Medical Society

presents

The Handheld Computer and Medical Practice

featuring
David Acosta, MD, TFM Faculty
and
Chris Vincent, MD, Swedish FM Faculty



Learn how you and your practice can benefit from

- Drug Databases
- Medical Textbooks
- Medical Calculators
- How to choose the right handheld device and medical software for your practice
- Practice Management
- Prescription Writers
- Graphic and Text Writers

March General Membership Meeting

Tuesday, March 12, 2002 *Social Hour~6:00 pm, Dinner~6:30 pm, Program~7:30*

Landmark Convention Center Temple Theatre Roof Garden, 47 Saint Helens Avenue, Tacoma

Complimentary (FREE!) for all PCMS members and their guests!

Return this portion of form to: PCMS, 223 Tacoma Ave S, Tacoma, WA 98402; Fax to 572-2470 or call 572-3667

Name: (please print or stamp) _____

I will be bringing my spouse or a guest. Name for name tag: _____

Please reserve _____ dinner(s) at ***NO CHARGE, COURTESY OF NOVARTIS***

REGISTRATION REQUIRED by Friday, March 8th

If you register and later find you are unable to attend PLEASE call and cancel

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Whistler, B.C. and every other year in Hawaii. Programs and topics are generally selected based on an interest survey of the membership conducted every few years.

In 2000, with the demise of the PCMS Alliance, PCMS formed the PCMS Foundation to carry forward with the philanthropic work performed by the Alliance for many years. Raising money primarily via the Annual Sharing Card at Christmas, raffle sales at the Annual meeting, donations by physicians and their offices, the Foundation awards grants to local, non-profit agencies.

In 2001 grants were awarded to the American Lung Association, Family Renewal Shelter, Hospitality Kitchen, Trinity Free Clinic, Pierce County AIDS Foundation, Tone Transitional Center, The Neighborhood Clinic, and the PLU Wellness Center.

The Board of Trustees realized that PCMS is a stable organization, a property owner and landlord in Tacoma, with a long history of traditions and systems of governance. With a combined staff of seven, five full time and two part time, the organizations are lean. Calls to the office average 150 per day for all four organizations combined. Budgets target income of $974,617 for 2002, and combined reserves are $288,000. Funding sources are relatively diversified but are vulnerable to competition and/or the economy. PCMS is fortunate to have a strong base of non-dues revenue.

PCMS provides a diversified communication link to the membership, via mail, fax, email, PCMS Bulletin, PCMS Fax News, and the newly revised PCMS website. Links with office staff include participation in TAMM and PCCMA as well as practice management programs and employment agency services. Working relationships with other community agencies, such as Tacoma Pierce County Health Department, United Way and others are solid. PCMS holds a vital link to many non-profit agencies in Pierce County via the PCMS Foundation, granting over $14,000 annually to successful applicants.

The placement service realized over $400,000 in revenue in 2001, assisting over 105 satisfied medical offices with hiring, firing, employment laws, and other personnel related services while the College of Medical Education averaged 105 attendees per program, often at no cost.

General Membership Meetings, with average attendance of 91, offered programs on myriad subjects from retirement, electronic medical records, embezzlement, etc. to meetings and committees dealing with public health, immunizations, women's issues, contracting, insurance, etc.

There was no argument that services currently provided by PCMS and subsidiary organizations were significant and should be continued. The Board of Trustees will be solidifying the additional work priorities for 2002 at their February meeting and will present them in next month's issue of the Bulletin. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

A Plague on our Houses

Staff from the Tacoma-Pierce County Health Department have been conducting dental screenings of elementary school children across Pierce County for many years. The trends we see are disturbing. Significant numbers of school children with advanced and untreated dental disease are seen in every screening session we hold. We estimate that kids miss approximately 128,000 hours of school each year because of dental problems, a number that represents a huge education gap for a large number of children. Since kids with dental disease struggle with school and perform less ably than students with no disease, and since this group grows regularly, we are trying to expand our preventive activities. Primarily, we are adding more sites to do fluoride varnishes and dental sealants with high-risk kids. And, we are also working with the dental community to establish an expanded ABCD (Access to Baby and Child Dentistry) program that offers screening and prophylaxis in the dentist's offices. The state-sponsored ABCD program reimburses dentists at a higher rate to increase the availability of pediatric care in local dentists' offices.

Federico Cruz-Uribe, MD

But these two efforts are not enough. Limited funding does not allow us to provide fluoride varnishes and sealants to all the needy kids in Pierce County. We have one dental health staff person and are losing funding from our city, county and state funders. Currently there are not enough dentists to see the backlog of cases of children with significant disease.

There is, however, a third option for us: FLUORIDATION. Consistently, research has shown that fluoridation is the most cost-effective, practical and safe means for prevention of tooth decay. Schoolchildren who are lifelong residents of communities with optimal fluoride levels in drinking water had 61% less tooth decay than those who lived in communities with a low level of fluoride. The cost of fluoridation for a local water system is 72 cents/person/year. The cost of treating one cavity is $42. Extensive monitoring of children who have been raised in areas with fluoridated water systems show no long-term side effects besides occasional discoloration of teeth.

"Consistently, research has shown that fluoridation is the most cost-effective, practical and safe means for prevention of tooth decay."

It all seems so straightforward. We have a dental disease epidemic. We lack resources for intensive prophylaxis and there is a shortage of dentists. And, fluoridation works. But few water systems in Pierce County provide fluoridated water. What gives? Over the years much hype and bad information have been promulgated throughout the community. Somehow fluoride supplements to public water systems is suspicious. There are hidden side effects. There are hidden agendas to affect broad masses of people in some vague way. There are under the table profits illicitly coming out of the fluoridation movement. Paranoid conspiracies involving socialists or communists or international organizations are whispered about.

When debated openly and objectively these arguments become like many early morning fogs that dissipate with the steady rising of the sun. But often the volume and intensity of folks opposed to fluoridation make public officials reluctant to take on this issue. Not so in Pierce County. We want to start the dialogues needed and develop a plan of action.

We face a serious situation concerning the dental health of tens of thousands of our children. Both the Board of Health and I ask your support to have an objective and public dialogue on how to approach our dental health crisis. If fluoridation continues to be an essential part of our community plan after public discussion, we need your help both to reassure your patients of fluoride's safety and effectiveness, and to bolster our elected officials that this is the responsible way to go. An e-mail, letter or phone call to your local city or county elected official supporting fluoridation would be helpful. ■

New Jersey doctors get collective bargaining rights

Physicians can join together, but insurers don't have to negotiate with them
Similar provision have hurt physician bargaining efforts in other states, including Washington

New Jersey has become the third state in the nation to allow independent physicians to bargain collectively with managed care plans over the terms of their contracts.

Legislation signed into law January 8 exempts joint negotiating by physicians and dentists from antitrust laws as long as such activity takes place under close supervision by the state.

"We have been aching for some type of antitrust relief for years," said Angelo S. Agro, MD, president of the Medical Society of New Jersey. "Now it is up to physicians in our state to take advantage of the opportunities we have been fighting for and make them pay off."

Texas and **Washington** are the other states that give physicians the right to bargain collectively.

The New Jersey law allows doctors in that state to negotiate with health plans on such matters as the definition of medical necessity, utilization management procedures, quality assurance programs, clinical practice guidelines, dispute resolution and credentialing. Physicians also could negotiate payment issues as long as the attorney general found that the plan in question had substantial market power and that terms or conditions of the plan could pose a threat to quality and availability of care.

Doctors are not allowed to strike, nor can they negotiate to exclude nonphysicians from plans.

Plans unwilling to play

Like the laws previously enacted in Texas and Washington, the New Jersey act does not require insurers to join doctors at the negotiating table, raising questions about whether self-employed physicians will be able to exert any more leverage in contract talks with health plans than they did before. The experiences of physicians in Texas and Washington seem to provide little basis for optimism.

In June 2000, a group of 11 physicians in Henderson, Texas, applied to the state attorney general's office for permission to band together for contract negotiations with Blue Cross and Blue Shield of Texas - the area's dominant insurer.

The Henderson group was soon granted permission by Texas Attorney General John Cornyn to bargain collectively. He determined that physicians were locked into contracts with the Blues plan and that their practices couldn't absorb the loss of income they suffered as a result.

Cornyn also stated in his decision that the plan's "dominant position and its terms and conditions for physician compensation threaten to adversely affect the quality and availability of patient care in the Henderson area." He gave the physicians and the insurer a 60-day period to meet to negotiate.

But the Blues plan simply refused to sit down with the physicians, and that was the end of it. Since then, no other group of physicians has decided to pursue an application, said Michael Cushman, director of the Texas Medical Association's health care delivery department.

Like Texas, Washington also did not require insurer cooperation when it enacted its joint negotiation law in 1993.

Physicians' interest in pursuing negotiations with plans appears to have been dampened as a result.

"We can't even get to first base," said Len Eddinger, director of public policy and planning for the Washington State Medical Association.

The WSMA supports a measure that was expected to be introduced in the state Legislature in mid-January that would amend the 1993 law to explicitly allow negotiations about reimbursement and require insurers to negotiate in good faith with physicians.

Although the New Jersey law does not require insurers to negotiate in good faith, Dr. Agro said he hopes

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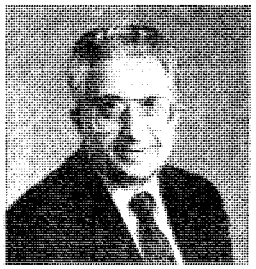
In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

The Double Edged Sword

"There are two tragedies in life. One is to lose your heart's desire. The other is to gain it."
George Bernard Shaw (1903)



Andrew Statson, MD

Assisted reproductive technology (ART for the intimate) is one of the few still relatively independent areas of medical practice. I mean that neither the patients nor the physicians have to depend on an insurance company to tell them what they may do and how to do it. In most states, the patients who seek these services have to pay for them out of pocket. When in vitro fertilization became available, the cost of the first course of embryo transfers was about $50,000.

The process required multiple examinations and consultations, including psychiatric evaluation and support services, laboratory tests, sonograms and several laparoscopies. The cost for repeat embryo transfers was almost the same until the development of cryopreservation, which brought it down to about $15,000. Since birth rates ran at about 15% per transfer, a couple still had to spend about $100,000 in the hope of achieving a live birth.

Over the years the cost has come down. It turned out many procedures could be dispensed with. The new techniques are less expensive, laparoscopy is no longer required and seldom done, egg retrieval is done under ultrasound guidance, so that now the costs for an initial embryo transfer is closer to $10,000, while repeat transfers cost about $6,000. The odds for live birth also have improved. A couple now can expect to pay not much more than $30,000 to achieve a live birth. That is the free market at work.

Doctor Howard W. Jones, Jr. is unusual in our field because he is not only an outstanding endocrinologist, but also an accomplished gynecologic surgeon. He is better known to the public as the founder of the Jones Institute for Reproductive Medicine and the director of the ART program in Norfolk, the first one in this country to do in vitro fertilization. In October, he wrote a guest editorial for the *OB.GYN. News*, in which he discussed the future of ART as he saw it. He expressed his concern about the high cost of ART. He wrote:

"Based on many talks I've had with third party payers in recent years, I'm convinced that in time more insurers are going to face up to public demand and start reimbursing for fertility services. That said, however, when the insurance industry finally does kick in more, it's going to have a far more active role in identifying who the "qualified providers" are, and there is going to be more work for less pay. We see this trend in states where payment is mandated. On the surface, such mandates may sound appealing, but in truth the compensation they provide often doesn't meet the costs of providing care."

Sounds familiar? There was something said about the Golden Rule, he who has the gold makes the rules. No surprises here. When the patients pay, they make the rules. When someone else pays, they are subjected to the rules, just like we have been. We, outside ART, having worked with insurance companies for a number of years, are painfully aware of this fact.

We, physicians, as advocates for our patients, were instrumental in the development of health insurance. Later, we supported the expansion of coverage to more and more people and to more and more services. Even now, we are concerned about the number of uninsured and many leaders of our profession actively advocate universal coverage. All along we thought that, since we were the experts, we would maintain control over the practice of medicine. We were wrong. We forgot about the Golden Rule.

There was a certain amount of self-serving interest in our push for expanded insurance coverage. On many occasions in the past, especially in emergent situations, we treated patients who had no resources and were unable to pay us for our services. We thought that if we could get everybody to have

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medical insurance, at least we would get paid. That was true, we did get paid. Only we didn't know then, as we know now, that the amount we receive would barely cover our expenses, so that frequently we would end up working just to cover our overhead. Now we are stuck. If it is any consolation, we are not the only ones.

The patients are stuck, too. They thought that if they got health insurance, it would pay all their medical expenses and they would be able to get any medical services they wanted. Now they face a health care system that is less and less responsive to their needs and generally unresponsive to their wishes. Their premiums are higher, their benefits, lower. While their cost for medical care and drugs continues to rise, their employers cannot afford to buy better coverage and some drop their health insurance altogether.

The insurance companies and the government are stuck as well. They promised coverage, but as demand exploded, the costs took off for the moon. The initial dream of a two billion dollar annual cost of Medicare turned into a hundred billion dollar nightmare. The cut in benefits by the insurance companies led to a significant popular dissatisfaction and resentment. As a result, insurance coverage became a political issue. The only thing legislation can do, unfortunately, is to increase the cost of doing business. Out of annual expenditures of 1.2 trillion dollars on health care, probably close to 400 billion dollars are spent on administration.

The operation of the government programs has to have a high overhead because of the way the government operates. The rules are more specific and more restrictive, the paperwork to comply with them more extensive, the authorization of expenditures more cumbersome. Those of us who spent some time in the Army had first hand experience of the process.

I am not criticizing it, that is how a responsible government must run. With the billions and billions of dollars sloshing around in government coffers, it has to be accountable. My point is that the overhead of such a system is too high. The heavy regulatory burden, an intrinsic part of all government operations, is choking the entire health care system. An independent private system, whether paid for directly, or supported by charitable contributions, would cost much less to run.

Let me digress for a moment. Our generation witnessed an unusual historical event, the implosion of one of the most oppressive totalitarian systems the world has ever known. This did not happen as a result of war, as the fall of the Nazis, nor of a revolution, as the end of the French kingdom. In spite of a massive police force, which controlled every aspect of life, the communist system just stopped working. Everybody there, from the lowest workers and peasants to the supreme leader, were caught in the works of an infernal machine and couldn't stop it, nor get off. Finally, the machine broke down. They system could not feed its people. The stores were empty, the workers went without pay for weeks and even months. What kept the country going was the underground economy and the black market.

Our current health care system is a similar infernal machine. All of us, patients, physicians, hospitals, insurance companies, government, are caught in the cogwheels. So far, no one has had the courage to admit the system is breaking down, nor the power to stop the machine. Fortunately, we live in a democracy. We will find a way out. What probably will happen is that most people will get medical care from high volume, low service, low overhead clinics and hospitals.

Those who want better care, personal service and convenience, will get it in private offices on a fee-for-service basis. We already see some medical groups in our area offering same day appointments and immediate 24-hour a day telephone availability of physicians for a select group of patients at a higher fee. The insurance companies will have to offer a product closer to the true meaning of insurance, perhaps 80% coverage for claims over a certain amount, say over 500 or 1000 dollars. That probably will be the only way people will be able to afford the premiums.

Fee for service medical care has always existed, even with the free government programs in the communist countries. Many people there went to the private offices of physicians and paid for their care, rather than go to government clinics. In some respects, that was part of the underground economy in Russia. Here it need not be underground. A parallel system of free market, fee for service care and a government sponsored care can coexist. That may be the best way for us to stop the infernal machine, which is destroying our health care system. ■

IN MEMORIAM
DON E. GEHLE, MD
1938-2001

Don E. Gehle, MD passed away on December 25, 2001 at age 63. Don's intellect never really considered retirement, but unfortunately his body did not agree. He went from his office to the hospital, and after 14 months of continuous medical care he succumbed to cancer.

Don E. Gehle, MD

Don was born in Paxton, Illinois, where he was raised and attended school through graduation from the University of Illinois College of Medicine in 1964. Don retained the Midwest ethic of hard work and integrity throughout his life along with a wonderful sense of humor and gift of story telling.

After an internship at Rockford Memorial Hospital in Illinois, Dr. Gehle was commissioned an officer in the US Army Medical Corps and pursued a career as an Army physician. His first military assignment was as a general medical officer in Germany, an assignment he and his family enjoyed greatly. After three years in Germany, he was diagnosed with Hodgkin's disease and treated successfully. His next assignment was Madigan Army Medical Center where he began an internal medicine residency. During his first year of residency he suffered a reoccurrence of the Hodgkin's disease which was again successfully treated with intense radiation therapy. Unfortunately this life-saving treatment probably produced the cancer which ended his life.

Don then began his career in dermatology with a residency at Walter Reed Army Medical Center. I first met him in 1973 when I had a temporary assignment to the Armed Forces Institute of Pathology and thus began a lifelong friendship. We served together at Madigan from 1974 until I left the service in 1976 at which time Don became Chief of Dermatology and served until his retirement in 1985. He then joined John McGowen, MD in practice in Lakewood and they were together until John retired in 1999 after which Don remained in solo practice until his forced retirement. Don's patients consistently comment on how much they appreciated and miss his compassionate care.

Don married his high school sweetheart, Joan, and they enjoyed 41 wonderful years together. They also shared a love of their three children, Mark, John, and Beth. To the very end Don cared for his wife and family, making sure Joan would have a present for her December 14 birthday and Christmas as well.

Don and I shared a love of our families, profession, and golf. Our lives paralleled each others in so many ways that we were truly brothers and I will miss him greatly, although Don will continue to golf with me in spirit.

Bob Martin, MD

Bargaining Rights from page 10

the state's doctors will be able to exert enough pressure to bring them to the table anyway.

If one or more groups of physicians apply for and receive permission to engage in joint negotiations with an insurer, and that insurer refuses, it could become a public relations problem for the HMO, he said.

"We think it would be an untenable (position) for the HMOs to stonewall if the state attorney general sees fit to allow negotiations with various groups around the state," he said. "I'm sure it won't help sell policies if it becomes know they're unwilling to negotiate on patient care issues even when the government and physicians say they should."

The New Jersey law also has an advantage over the Texas statute, according to MSNJ. It doesn't cap the percentage of physicians in a market who can negotiate, while the Texas law sets that limit at 10%, society officials said.

The AMA applauds the MSNJ for its success, said Donald J. Palmisano, MD, the Association's secretary-treasurer and a lawyer.

"Too long have insurers used their market concentration and market share to unfairly disadvantage patients and physicians," he said. "If insurers refuse to negotiate, then this will expose the insurers as entities that do not want to listen to reason, but instead want to exercise their monopsony power."

The AMA is working on a new collective bargaining bill that it hopes will be introduced in Congress. An earlier collective bargaining measure passed in the House but died in the Senate in 2000.

Joint negotiation bills have foundered in more than a dozen state legislatures due to concern that physicians would gain too much leverage and that such measures would lead to higher health insurance costs.

That was a complaint the insurance community used in its opposition to the New Jersey law.

"The virtually certain result would be higher costs for patients and for the health plans that pay for the health care they received," said the New Jersey Association of Health Plans.

Physicians gaining clout

The New Jersey collective bargaining law:

- Gives physicians the right to bargain collectively, through a representative they select, with insurers on many nonpayment-related subjects, including patient referral standards, group formularies and clinical practice guidelines.
- Allows doctors to bargain with plans on payment issues as long as the state attorney general has ruled that the carrier has substantial market power and its contract terms and conditions could hurt patient care.
- Requires that physicians submit a collective bargaining petition to the attorney general and pay a filing fee. The results of any collective bargaining agreements are also subject tot he attorney general's approval.
- Bars physicians from striking.
- Does not require health plans to join physicians at the bargaining table. ■

American Medical News, 1/28/02

Legislative Update

2002 State Budget (HB 2460 and SB 6387)

HB 2460 and SB 6387 are the Governor's supplemental budget proposals. The Governor's budget proposals include three items of concern to the WSMA:

- $28 million to increase reimbursement rates for selected Medicaid providers, including physicians and ambulance providers, in order to "address a serious problem with finding providers to accept Medicaid clients at the current reimbursement rates."
- Elimination of interpreter services for Medical Assistance clients and their physicians/providers.
- Elimination of the state's appropriation to local municipalities that was included in the 2001-2003 Biennial Budget.

It's important that all physicians call their legislators and stress the following:

- We must keep the $28 million to increase reimbursement rates for selected Medicaid providers.
- The budget must keep payment for mandated interpreter services, otherwise the network of physicians willing and able to treat Medicaid patients will continue to deteriorate.
- We must appropriately fund the state's public health system. We fear that the impact of these cuts to public health will be detrimental to the health system as a whole and eventually will have an adverse impact on physician practices. ■

B&O Tax Legislation (HB 2721)

HB 2721 would reduce the B&O tax for MDs, DOs and PAs. The bill would eliminate the Business and Occupations (B&O) Tax on revenues that physician practices receive from public payers such as Medicare, Medicaid and the BHP (a tax break that hospitals already enjoy).

WSMA's Position: Currently Washington State hospitals are exempt from B&O Tax on revenues from public payers. This legislation would give the same tax break to physicians practices. Such a tax break would help defray the impact of low government reimbursement.

Action: HB 2721 was referred to the House Finance Committee. ■

Collective Negotiations (HB 2360)

Currently Washington State law authorizes health providers (through processes defined by rule of the Department of Health) to collectively negotiate the terms and conditions of contracts with health plans, including the ability to meet and communicate for this purpose. This is a statutory legislative exemption from state anti-trust laws and provides immunity from federal anti-trust laws for a concerted activity that might be constrained by those laws. However, per se violations of state and federal anti-trust laws are not authorized.

In order to engage in collective negotiations, health providers must file a written petition with the department requesting approval, with the advice of the state attorney general, and the department must issue a written decision within 90 days whether the benefits of competition outweigh the advantages of negotiation. With the assistance of the attorney general, the department must actively supervise and periodically review the negotiations.

The Secretary of Health must charge a fee, not exceeding $10,000 for the filing of the petition, the opinion of the attorney general, and for the active supervision of negotiations, to defray the reasonable costs incurred in conducting the review.

- By rule, reimbursement for provider services may not be the subject of negotiations.
- There is no requirement for health providers and health plans to negotiate in good faith.
- There is no provision for voluntary mediation or arbitration in case of impasse.
- There is no express authority granted to the Insurance Commissioner to enforce any requirement of a health plan to negotiate in good faith.

HB 2360 changes the above by requiring that health providers and health plans bargain in good faith on all the terms and conditions of contracts, including reimbursement of provider services.

The bill, if passed, would be effective ninety days after adjournment of session.

WSMA's Position: House Bill 2360 is a top priority for the WSMA. Physicians need marketplace parity with plans. ■

HCR4423 Creating the Health Care Insurance Options Working Group

The first reading of HCR4423, "Creating the Health Care Insurance Options Working Group" was January 23, 2001. The bill, sponsored by representatives of the House Health Care Committee, and supported by Insurance Commissioner Kreidler, resolves that a Health Care Insurance Options Working Group be created to be composed of twenty-one members appointed as follows:

The Insurance Commissioner shall chair the working group and shall, in addition, be responsible for coordinating its administrative and ministerial duties.

The following members are to be appointed by the Governor:

- A representative of a major state corporation, selected in consultation with the Association of Washington Business;
- A representative of small businesses, to be selected in consultation with the Governor's Committee on Small Business;
- Three representatives of health care insurance consumers;
- A representative of organized labor, to be selected in consultation with the Washington State Labor Council;
- Three members selected to represent health care providers, including a hospital representative, selected in consultation with appropriate health care provider organizations;
- Two representatives of health insurance carriers;
- A representative of the health care insurance agents and brokers; and
- A Governor's representative.

Four members shall be selected to represent the Legislature, to be chosen by each of the four caucuses.

The Secretary of the Department of Social and Health Services, the Secretary of the Department of Health, and the Administrator of the Washington State Health Care Authority shall serve as ex officio members of the working group

It is further resolved that the Health Care Insurance Options Working Group hereby created be responsible for examining the health care insurance system in the State of Washington and for the development of recommendations for its improvement. The working group shall prepare a report including its findings and recommendations and transmit this report to the Legislature and the Governor no later than January 1, 2004. ■

WSMA from page 4

- wrongful denial of medically necessary services; and
- "offering" one-sided "take it or leave it" contracts.

This agreement allows the WSMA to share research on problems that physicians encounter in their dealings with Aetna, it does not obligate the WSMA to join the suit as a named plaintiff. This step was taken in accordance with the Board of Trustee's direction that research continue regarding problems that medial practices are having with plans. For now, the WSMA is an interested party.

If your practice has experienced any or all of the problems noted above, please contact (or have your practice manager contact) Bob Perna at the Seattle office at 1-800-552-0612 or 206-441-9762 (email rjp@wsma.org). ■

COLLEGE OF MEDICAL EDUCATION

Primary Care Orthopedic CME set for February 8

A new COME program designed for the primary care physicians' attention to their patients' orthopedic problems is set for February 8.

The one-day program will feature speakers on evaluation, treatment and management, and include review of appropriate imaging, joint injections, referral protocols and more.

The course is directed by **Drs. Michael Bateman** and **Charles Weatherby**.

Topics planned include:

- Appropriate Anti-Inflammatory Therapy for Joint Disease
- The Knee and DJD
- The Aging Athlete and Osteoporosis
- Primary Care Evaluation of the Upper Extremities
- The Painful Spine: Evaluation and Management
- Primary Care Evaluation of the Lower Extremities
- Joint Injections for Primary Care?
- Pediatric Gait and Limp ■

Continuing Medical Education

Internal Medicine Review 2002 scheduled for March 7 and 8

The Tacoma Academy of Internal Medicine's annual two-day CME program set for March 7 and 8 is open for registration. The program offers a variety of timely internal medicine topics and has been organized by **Tejinderpal Singh, MD**.

The program offers 12 Category I CME credits and is available to both Academy members and all other area physicians. The program will be held at St. Joseph Hospital, Lagerquist Conference Center, Rooms 1 A&B.

To register or for more information please call the College at 627-7137.

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

- Antibiotic Resistance
- Insulin Resistance and Diabetic Dyslipidemia: Emergency Perspectives on the Role of TZD's
- Heart Failure
- Post Prandial Glucose and It's Relevance to Cardiovascular Mortality
- Screening for Skin Cancer
- New Technologies in Physical Medicine and Rehabilitation
- The Spectrum of Inflammatory Joint Disease: Update 2002
- Cancer Screening
- New Hypertension Treatments
- Practical Pain Management
- Update on the Treatment of Post Menopausal Women
- Osteoporosis: Present and Future and New Paradigms
- The Rational Use of New Generation Antidepressants: Maximizing Efficacy and Minimizing Side Effects
- Alzheimers Disease: Burden, Progress, and Hope ■

Dates	Program	Director(s)
Friday, February 8	Primary Care Orthopedics	Michael Bateman, MD Charles Weatherby, MD
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Classified Advertising

POSITIONS AVAILABLE

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

Washington State Division of
Disability Determination Services. Medical Consultant positions available. The State of Washington Division of Disability Determination Services seeks psychiatrists to perform contract services in the Olympia Regional office. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Psychiatric Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits. **Requirements**: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/hr. Interested psychiatrists should contact **Guthrie L. Turner, Jr., MD, MPH**, Chief Medical Consultant, Acting at (360) 664-7361 or the respective regional manager: **Olympia**: Laura Wohl, Regional Manager (360) 664-7355.

Urgent Care Physician. The
Puyallup Tribal Health Authority seeks a full time Urgent Care Physician for a busy Native American ambulatory clinic. Excellent benefit package. Doctorate of Medicine or Osteopathy from an accredited institution. Board eligibility in appropriate field. Licensed to practice medicine in the State of Washington. ACLS Certification. Urgent/emergent care experience preferred. Indian preference in hiring according to law. Please fax CV to PTHA (253) 593-3479 or call (253) 593-0232 x516 for an application packet.

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lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

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have years of experience in most medical specialties. We guarantee accuracy, fast turnaround time, free pickup and delivery and reasonable charges. Outstanding references. Call 925-3276.

Office Space For Lease. Sound-
view Medical Plaza, located at 3611 South D Street, currently has office space available for lease to medical or general healthcare practices. We offer very competitive lease rates; spacious, updated facilities; shared reception; accessible support staff; excellent security, maintenance and janitorial services; and access to onsite radiology and blood labs. Our location, just off of Pacific Avenue, is adjacent to the Pierce County Health Department and Puget Sound Behavioral Health, and is easy access to and from freeway and on a bus line. For lease rates and more information, call Nelsa Brodie at 798-4551.

GENERAL

Lake Steilacoom - One water-
front lot plus six large sites with lake access. Custom construction by "Zetterberg Homes" starting at $369,500. Call Elaine at 253-597-0038 or 1-877-377-2809.

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service at Madigan Army Medical Center will be hosting the 18th Annual Physical Medicine and Rehabilitation conference on March 26-29, 2002 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will speak on Management of Chronic Pain including Alternative and Complementary Medicine, various topics on Musculosleletal /Sports Medicine, Pediatric and Adult Electrodiagnosis, Bioterrorism and issues unique to Physiatrists and other Neuromusculoskeletal healthcare providers. The conference is designed for Physiatrists, physicians in related specialties and all other professionals interested in updating their knowledge in neuromusculoskeletal medicine. The course program and other detailed information for registration will be published on the web in early January 2002 at www.hjf.org. Approximately 25 Category 1 CME credits will be provided. For interim information, please contact Shashi Kumar, MD or our secretary at 253-968-2020 or at shirley.birdsong @nw.amedd.army.mil

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Pierce County Medical Society
BULLETIN

March, 2002

Many doctors wore white coats and stethoscopes to the rally and press conference in conjunction with the WSMA Legislative Summit, including PCMS members (front row, center, from left) Drs. Charles Weatherby, Sandra Reilley and Carl Wulfestieg

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INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
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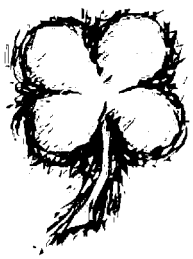
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

March, 2002



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President's Page

by Susan Salo, MD

Susan Salo, MD

Hello, again

Last month I promised a synopsis of the mission priorities and work plan for 2002.

Every January, the officers and the trustees of your medical society spend a Saturday devoted to an assessment of the current state of the medical environment and of the society's position and future therein.

At this year's retreat we reviewed our purpose, drafted a mission statement, and set priorities for the near future.

Our working mission statement: **"Pierce County Medical Society is a focal point for physicians, to become interconnected for the purpose of optimizing community medical care while promoting healthy medical practices."**

Several of our priorities relate to ongoing programs and positions. Continuing and expanding social forums and information dissemination, and aligning and coordinating (when appropriate) with WSMA and AMA will continue.

New projects include: replacement of the credentials committee with a new membership committee, with a more complete welcoming and incorporating role toward new members; a PCMS brochure introducing member services to new physicians and prospective members; and development of a policies and procedures manual for the Board of Trustees and PCMS staff. The staff is currently engaged in further developing the website (have you checked it out yet?) and in tracking docs in the community—who joins, who drops, and why.

"The staff is currently engaged in further developing the website (have you checked it out yet?)"

The most urgent concern of the trustees—and of the WSMA as well—is the viability of physician practices. In this area, which logistically feasible actions by the Medical Society will be effective? We are investigating increased involvement in political advocacy in items relating to practice viability. Since this is the focus of the WSMA this year, cooperation to prevent duplication of efforts will result in the highest yield. Several of our recent General Membership meetings have had very practical office management relevance (March's topic is hand-held computers in medical practice), and arranging funding to defer the cost of these meetings is increasing attendance.

This review of our current projects has impressed on me what a busy year 2002 promises to be! Wish us luck and call us with your suggestions! ■

PCMS Foundation announces grant recipients

Thanks to the generosity of PCMS members, the PCMS Foundation Board of Directors recently named ten Pierce County social service agencies as recipients of grants totaling $13,500. Foundation Board members **Drs. Lawrence A. Larson and Charles Weatherby**, along with Nikki Crowley and Mona Baghdadi, selected the following organizations for funding: American Lung Association, Community Health Care, Family Renewal Shelter, Hospitality Kitchen, Neighborhood Clinic, PLU Wellness Center, Phoebe House Association, Pierce County AIDS Foundation, Tone Transitional Center, and Trinity Free Clinic.

Lawrence Larson, DO

Charles Weatherby, MD

Each applicant must submit a detailed application along with supporting documents specifically outlining how the funds will be spent, the number of people that will be helped and how the money will benefit the organization overall. Proof of 501(c)(3) status is required.

Funds will be used for the following purposes by the selected agencies:
American Lung Association - Asthma Camp
Community Health Care - Patient and staff education
Family Renewal Shelter - Shelter and medical clinic
Hospitality Kitchen - Meals for homeless
Neighborhood Clinic - Supplies
PLU Wellness Center - Supplies and patient education
Phoebe House Association - Shelter and housing
Pierce County AIDS Foundation - Essential needs, home delivered food
Tone Transitional Center - Medical needs for homeless
Trinity Free Clinic - Prescription drugs

The PCMS Foundation receives grant money from the Holiday Sharing Card, raffle sales at the annual meeting and individual and medical practice donations. The Foundation Board of Directors is looking for additional ways of fund raising and would appreciate your ideas and suggestions. The Foundation was formed in 2000 after the demise of the PCMS Alliance. ■

2002 Physician Directory at printer

The ever popular, physician directory, published annually by PCMS is now at the printer.

Typically the 300-plus page book takes approximately six weeks to print, so the books will hopefully be available by April 15.

This year production was more difficult due to the new additions to the book. After consideration and approval by the PCMS Membership Benefits, Inc. Board of Directors numerous changes were made including the addition of email and website addresses. Clinic affiliations were approved and a new section for those that wanted to list all of their medical providers in their offices under their clinic name, as an advertisement for $20, was made available. A new midwife section was added also.

PCMS members receive one complimentary copy that is mailed to their home address. All other books are available to members at cost, and are distributed as requested per their order. PCMS distributes 4,500 copies of the book to the Pierce County Medical Community each year. ■

Frustrations abound over vaccine shortages

Representatives from the Food and Drug Administration, the CDC and the Agency for Healthcare Research and Quality, along with the pharmaceutical industry, distributors, physicians and pharmacy organizations should all be at the table to figure out how to strengthen future supplies. Patients need to be considered, because once you have lost the opportunity to vaccinate, will it present itself again, or will they be visiting their local supermarket who may have received supplies earlier than the physician.

Shortages exist for eight childhood disease antigens, including those used in the measles, mumps and rubella (MMR), invasive pneumococcal disease (pneumococcal 7-valent conjugate), diphtheria, tetanus and pertussis (DTaP), and chicken pox (varicella) vaccines, according to the CDC's National Immunization Program.

Recent strategies discussed by invested representatives included

–Creating additional stockpiles of vaccines that could be tapped during shortages

–Increasing funding and liability protection for manufacturers who bear the cost of developing the vaccines and for the physicians who administer them

–Requiring manufacturers to provide adequate notice before they halt production of a vaccine

Physicians can play an important role by explaining to parents and policy-makers how crucial it is to resolve the shortages. A national advertising campaign is needed on the importance of vaccines, according to Jerome Klein, MD, professor of pediatrics at Boston University. Guidelines to ration supplies and ensure that patients most in need receive the vaccines' help.

The complex nature of vaccine manufacturing is a problem from the industry's perspective. Vaccines require the use of biological organisms, viruses and bacteria which will not grow or respond on demand. Production time is lengthy and purity and potency tests are strict. Decisions by manufacturers to discontinue production is also a factor.

"It will always be a challenge to produce 80 million doses of flu vaccine by October 31 because manufacturers are producing a new vaccine based on virus strains selected early in the year.

While the challenges remain, a collaborative effort will be needed, but the effort would be worthwhile as vaccinations have resulted in freedom from disease for millions. ■

Excerpted from AMNews, 3/4/02

Some vaccines are in short supply. Here's why:
Measles, mumps and rubella (MMR) - Manufacturing difficulties.
Chicken pox (varicella) - Manufacturing difficulties.
Invasive pneumococcal disease (pneumococcal 7-valent conjugate) - Increased demand.
Diphtheria, tetanus and pertussis (DTaP) - One of only two manufacturers of tetanus toxoid stopped production; the remaining manufacturer can't meet demand.

PCMS participates in WSMA Legislative Summit

Approximately 230 physicians gathered in Olympia for the 2002 WSMA Legislative Summit in late January. Representing PCMS were **Drs. Leonard Alenick, Marc Aversa, Federico Cruz-Uribe, Richard Hawkins, Joseph Jasper, Ralph Johnson, David Law, Nick Rajacich, Sandra Reilley, Catherine Richardson, Don Russell, Susan Salo, Rebecca Sullivan, George Tanbara, Mark Tomski, Guthrie Turner, Charles Weatherby, and Carl Wulfestieg.**

Physicians gathered to hear and discuss priority issues for the 2002 legislative session as well as to participate in the noon "rally and press conference" seeking to draw attention to the perilous condition of the health care system. Summit guest speaker, Governor Gary Locke, thanked WSMA members for their dedication to medicine and to the community. When asked about the state's 2002 budget cuts, the governor shared with the group his commitment to leading a dialog with physicians, hospitals and employers both large and small, emphasizing that "today's healthcare systems demand creative solutions."

'Washington's Ailing Health Care System: Continued Decline, Guarded Prognosis,' was presented at the conference, highlighting numerous problems with the current health care system. From economics and administrative hassles, overcrowding in emergency departments, medical malpractice, and specific concerns with Medicare and Medicaid, all are outlined in this report. (For your copy, call PCMS, 572-3667).

Cynthia Markus, MD, JD representing the Washington Chapter of American College of Emergency Physicians reported on the recent findings of their survey of emergency department directors. She reported that 91% of small hospitals and 100% of large hospitals reported that they have an overcrowding problem with 76% of large hospitals reporting a frequency of two to three times per week or greater.

After the press conference, attendees spent the afternoon visiting with their legislators, attending various committee meetings or touring the capitol campus. ■

In Recognition of Doctors: A History of March 30th

The first Doctors' Day observance was held on March 30, 1933 by the Barrow County Auxiliary in Winder, Georgia. The idea of setting aside a day to honor physicians was conceived by Eudora Brown Almond, wife of Dr. Charles B. Almond, and the recognition occurred on the anniversary of the first administration of anesthesia by Dr. Crawford W. Long in Barrow County, Georgia in 1842. The Auxiliary immediately adopted the following resolution:

"WHEREAS the Auxiliary to the Barrow County Medical Society wishes to pay lasting tribute to the Doctors, therefore, be it RESOLVED by the Auxiliary to the Barrow County Medical Society that March 30, the day that famous Georgian Dr. Crawford W. Long first used ether anesthesia in surgery, be adopted as 'Doctors' Day,' the object to be the well-being and honor of the profession, its observance demanding some act of kindness, gift or tribute in remembrance of the Doctors."

The first observance included the mailing of cards to the physicians and their wives, flowers placed on graves of deceased doctors, including Dr. Long, and a formal dinner in the home of Dr. and Mrs. William T. Randolph. After the Barrow County Auxiliary adopted Mrs. Almond's resolution to pay tribute to the doctors, the plan was presented to the Georgia State Medical Auxiliary in 1933 by Mrs. E.R. Harris of Winder, president of the Barrow County Auxiliary. On May 10, 1934, the resolution was adopted at the annual state meeting in Augusta, Georgia. The resolution was introduced to the Women's Auxiliary of the Southern Medical Association at its 29th annual meeting held in St. Louis, Missouri, November 19-22, 1935, by the Auxiliary president, Mrs. J. Bonar White. Since then, Doctors' Day has become an intergral part of and synonymous with the Southern Medical Association Auxiliary. Through the years the red carnation has been used as the symbol of Doctors' Day.

On March 30, 1958 a Resolution Commemorating Doctors' Day was adopted by the United States House of Representatives. On August 1, 1989 the SMA Auxiliary, under the direction of President Mrs. David Thibodeaux, dedicated a bronze marker honoring Mrs. Almond on the grounds of the Court House in Winder, Georgia. In 1990, legislation was introduced in the House and Senate to establish a national Doctors' Day. **Following overwhelming approval by the United States Senate and the House of Representatives, on October 30, 1990, President George Bush signed S.J. RES. #366 designating March 30 as "National Doctors' Day":**

WHEREAS society owes a debt of gratitude to physicians for the contributions of physicians in enlarging the reservoir of scientific knowledge increasing the number of scientific tools, and expanding the ability of professionals to use the knowledge and tools effectively in the never ending fight against disease and

WHEREAS society owes a debt of gratitude to physicians for the sympathy and compassion of physicians in ministering to the sick and in alleviating human suffering: Now, therefore be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That -

1. March 30, 1991 is designated as "National Doctors' Day"; and

2. the President is authorized and requested to issue a proclamation calling on the people of the United States to observe the day with appropriate programs, ceremonies and activities. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

TACOMA-PIERCE COUNTY
HEALTH
DEPARTMENT

Direct Observed Therapy

One of the oldest programs we have at the Health Department is our tuberculosis control program: TB skin testing, case finding, identification of contacts and either treatment or prophylaxis for those infected. A few years ago we adopted Direct Observed Therapy (DOT) as the primary approach for care of our TB patients. This greatly improved the efficacy of our control efforts. With DOT we actually visit the patient every day (or as often as they are to receive treatment) to assure that compliance occurs with the treatment regimen.

Federico Cruz-Uribe, MD

In the past - prior to DOT - our compliance rates in TB control were a study in frustration. Many of our patients have multiple psychosocial problems that make them complex patients as the very least. Forgetting appointments, not making appointments in the first place, forgetting to take their medications, miscommunication of what they actually have taken. These all added up to a difficult and costly TB control effort. Much of this changed as we visited the patients on a regular basis. Compliance rates soared. Importantly, we began to see fewer antibiotic resistant organisms developing locally.

Drug resistance, however, continues to be a challenging problem. The number of cases that we manage with multiple drug resistant organisms has steadily risen. This has come about because we are getting an increasing number of refugees from Latin America, Africa, Central Asia and Russia where resistant organisms are much more common. The cost of caring for these clients is much higher, double or even triple the expenses of an uncomplicated case.

Needing to take another step in looking at how we could be more effective and still control costs, we decided to make changes. Central to our control efforts was the need to continue to have regular weekly even daily contact with our patients to monitor their efforts with their meds. The solution we came up with involves the use of small (inexpensive) video monitors that are attached to the patient's phone by which we have daily contact with each patient. After a short discussion with them, we walk them through their daily treatment regimen. We actually watch them take their pills. The pick up on the monitors is quite clear. From a staffing and administrative perspective, a very significant amount of staff time and travel expense is saved. Clients find this a very comfortable form of interaction with our staff. Relationship building continues between our staff and the patients and their family members. This has made our program much more cost effective even as we deal with much more complex cases of drug resistant TB.

We are now trying to build on our successes with TB control and apply it to HIV treatment. Working with newly diagnosed HIV infected patients, we are planning to put them on once daily regimens. Our goals are the same with the HIV patients as with the TB patients: We want to establish high levels of compliance and build an on-going relationship with the patients to help them along as they adjust to their seropositivity. We look to touch base regularly with them to encourage their efforts to stay healthy and also to prevent spreading the virus to anyone else. There is a dual purpose: treatment and disease control. TB treatment is time limited - six months to a year to get through their primary regimen. With HIV it is more open ended as there is no cure and treatment needs to be ongoing. It is all the more important then for the patients to get accustomed to regular routines with their meds. Treatment skills and disciplines have to be developed if the patients are to be successful long term. We see the telemedicine approach as giving us another tool to assist the patients in being successful. I suspect that there will be an increasing number of clinical situations where tele-medicine can be applied. Especially when distance and transportation are barriers to accessing care. Management of chronic disease may also be an area where tele-medicine will be cost effective. If physicians are interested in seeing our equipment and watching some on-going treatment encounters, please feel free to call us at the Tacoma-Pierce County Health Department (235-798-2899) and we will set up a time for you to come for a demonstration. ■

Legislative alternative to DSHS's TSC remains alive

At press time, the Comprehensive Prescription Drug Education and Utilization legislation remained alive. This legislation would enable the Health Care Authority (HCA) to contract with one or more qualified entities to determine, based on scientific evidence, which drugs within given therapeutic classes would be essentially equal in terms of safety and efficacy. WSMA and organized medicine supports the legislation, which would develop a new state program to try to control its prescription drug expenses, while the pharmaceutical manufacturers are fiercely fighting it.

This legislation was developed with the input of WSMA and the WSPA (Pharmacists).

It was designed to eventually eliminate the constant hassles for physicians created by DSHS's Therapeutic Consultation Service (TSC) and prior authorization.

Physicians participating in the program will have the ability to provide an instruction to "dispense as written" if they feel a non-preferred drug is necessary to their patient. DSHS will develop systems to retrospectively review all prescribing patterns and look for those who prescribe non-preferred drugs frequently and will provide education to these physicians. This will reduce the "hassle factor" for all physicians and all prescriptions.

Physicians will be able to choose not to participate in the program, but would then remain subject to existing prior authorization requirements.

For more information on SSB 6383 and HB 2431 call PCMS, 572-3667.■

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

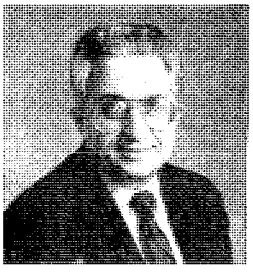
Confidentiality Assured

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Guns and Butter



Andrew Statson, MD

"War involves in its progress such a train of unforeseen and unsupposed circumstances that no human wisdom can calculate the end. It has but one thing certain, and that is to increase taxes."
Thomas Paine (1787)

When the war in Vietnam heated up, President Johnson decided not to scale down his social programs and came up with his guns-and-butter policy. He claimed that our economy was strong and we should be able to finance a war abroad and continue paying large social benefits at home. The result was a virulent inflation, which prompted President Nixon to devalue the dollar, to repudiate the Bretton-Woods Monetary Agreement and to suspend the convertibility of dollars into gold. By the time the inflation was tamed, the dollar had lost 80% of its value.

At its peak, the war in Vietnam cost us about one million dollars a day. The war on fanaticism is going to be more expensive. During the first hundred days, we already spent ten billion dollars. That does not include the billions more promised to friendly and not so friendly governments to help them ferret out terrorist cells and to buy their cooperation.

Even though fanaticism is a threat to the entire Western civilization, America will carry the heaviest load in this battle, just as it did in most wars of the twentieth century. Unless we are willing to accept going back to living in caves, traveling by foot or on horses, scratching the land with primitive tools, having starvation and disease as constant companions and hoping for an early death to relieve us from our suffering; unless we agree to relinquish music and dance, literature and art, our culture and our heritage, we have to fight this war with all our strength and all our resources. General Douglas MacArthur put it best, "It is fatal to enter any war without the will to win it." That is a lesson we should have learned from the bitter experience in Vietnam.

The price is going to be high and we will pay it, if not with taxes, then with inflation, probably with both. Our state is faced with a budget shortfall and the other states have the same problem. The federal government is back to deficit spending. More money will be spent on security, less will be available for social services and health care. We will have more guns and less butter. The use of guns is within the purview of the government and is its proper function. The production and consumption of butter is a function of the market.

Businesses will spend more on security, mostly because they depend on electronic data storage, transmission and processing. These areas remain vulnerable. Travel is vulnerable and so are deliveries of goods. The time and resources spent on security for air travel are the most obvious business costs we have incurred. Businesses will see their profit margins shrink. They will have less money to spend on health insurance.

Some companies already have revised their budget for health care expenses, moving from defined benefit contribution plans. Business intends to pay a certain amount toward the health care needs of its employees, but to let them shop for it and pay by themselves any amount they spend in excess of the contribution of their employers. Other employers have found health insurance unaffordable and have dropped coverage.

All that is happening when our health care system is suffering from insufficient funding. Things look grim, indeed. We are approaching a time of crisis, if we are not there already. If we can rise to the challenge, that crisis will also be an opportunity. We have to call on our Yankee ingenuity to rescue us. I know what I am about to propose is the opposite of what our profession has tried to achieve for years. I know that it is very unlikely to ever come to be. What we have wanted to achieve has not worked, either. The current economic condition of our practices and hospitals is witness to that. It is time to

See "Guns" page 10

Guns from page 9

look at other options.

After studying various statistical reports that had contradictory figures on just who is spending how much on health care, I decided to make a few wild guesses, hoping I wouldn't be too much off the mark.

Out of 1.2 trillion dollars a year, about 200 billion are paid by patients, out of pocket. The rest is about equally divided between private insurance and government programs. The cost to administer these programs is of the order of 250 billion, while 750 billion dollars are paid out as benefits. Assuming that the average claim payment is 150 dollars, the number of claims must be five billion. The cost of administration must be about 50 dollars per claim. Add the cost to us for training, keeping records, coding and billing. That must be well over ten dollars per claim, for a total of over 50 billion. So we spend 1 trillion to buy health care worth less than 700 billion dollars. The total burden on our economy for running the health care system must be over 300 billion.

So how do we get more money for health care? Going to our legislators, hat in hand, and begging, as we have done so many times in the past, is not likely to work. We heard about "the scarcity of dollars." Our only hope is to somehow reduce the administration costs.

At the basis of most of these costs, including the costs of drugs, is government regulation. For instance, pharmaceutical companies spend hundreds of millions of dollars to obtain FDA approval to introduce a new drug into the American market. Many drugs, available in other countries, never make it to the United States because of these costs. Those that do, cost more, because the companies have to recover their expenses. The regulatory burden on hospitals, clinical laboratories and physician offices is just as heavy. The only effective way to simpler administration is to cut down or eliminate completely the government control over health care. A tall order, to be sure.

Let me bring up something happening to the airlines. In the past, passengers were passive subjects, under the control of the staff. They did not get involved in case of highjacking. When the goal of highjackers, however, claimed the lives of those on board and of others on the ground, the parts of the equation changed. The first to realize that and do something about it were the passengers on the plane that crashed in Pennsylvania on September 11. Since then, passengers have been instrumental in subduing the shoe bomber and others who have threatened to cause trouble. Safety of the plan became the passengers' business. They took control. Wasn't that better and cheaper than having sky marshals on board?

We need control over health care expenditures. The cheapest way to achieve that is to hand it over to the patients. It's their health care. They should have the right to decide what to get and how much to pay for it. To do that, they must participate in the cost, so that their money is at stake, too.

The first step would be to reduce insurance costs by eliminating 90% of the processing. The cut-off would be in the range of $300-500. All claims below that amount would not be covered. Above that, the patients would pay 20%. Instead of processing five billion claims, insurance would handle 500 million. With simplified rules, their cost should be at most 20 billion dollars. With overhead at 8%, the total premiums should be 250 billion, or 900 dollars per person per year, 75 dollars per month. Insurance would become affordable if not for all, at least for most people in the country. Teaching institutions and charitable organizations would provide care to those unable to pay for it.

How business and government would participate in the purchase of insurance for people is for them to decide, but they must relinquish control over how the money is to be spent. That control can only be in the hands of the patients. The patient participation in paying for it will assure their vivid interest in the costs of care.

That may be a possible solution, but don't hold your breath. At least I can dream, can't I? ■

Physical Medicine and Rehabilitation Conference

Physical Medicine and Rehabilitation Service at Madigan Army Medical Center will be hosting the 18th Annual Physical Medicine and Rehabilitation conference on March 26-29, 2002 at Sheraton Hotel, Tacoma, Washington. Several nationally renowned speakers will speak on Management of Chronic Pain including Alternative and Complementary Medicine, various topics on Musculosleletal /Sports Medicine, Pediatric and Adult Electrodiagnosis, Bioterrorism and issues unique to Physiatrists and other Neuromusculoskeletal healthcare providers. The conference is designed for Physiatrists, physicians in related specialties and all other professionals interested in updating their knowledge in neuromusculo-skeletal medicine. The course program and other detailed information for registration will be published on the web in early January 2002 at www.hjf.org. Approximately 25 Category 1 CME credits will be provided. For interim information, please contact Shashi Kumar, MD or our secretary at 253-968-2020 or at shirley.birdsong

IN MEMORIAM
HERBERT C. KENNEDY, MD
1924-2002

Herbert C. Kennedy, MD passed away January 31, 2002 at the age of 77.

Born and raised in Indiana, he received his B.S. and M.D. degrees from Indiana University, and was a lifelong fan of IU basketball. Internship and residency were served at the University of Oregon. His college education was interrupted by Army service in World War II, during which he served in Europe under combat conditions, receiving the Bronze Star and Combat Infantry Badge.

Herbert Kennedy, MD

Herb began his practice of urology in 1956 in the Medical Arts Building in downtown Tacoma. In 1966, together with a number of other physicians then in the building, he moved to the newly built Allenmore Medical Center, of which he was one of the original physicians. From 1982 until retirement in 1992 he was Chief of Urology at American Lake V.A. Medical Center and staff urologist at Madigan Army Medical Center, where he enjoyed his teaching role in the urology residency program. He was a clinical instructor in the Department of Urology at the University of Washington School of Medicine from 1959 to 1992. He was a member of the Pierce County Medical Society, Washington State Medical Association, American Medical Association, American Urological Association, NW Urologic Society, Society of Government Service Urologists, and Tacoma Surgical Club, of which he was president in 1981-82. He was a past-president of the medical staffs of Allenmore, Doctors, and Puget Sound hospitals.

Herb was a quiet and compassionate physician, a loving, guiding and lasting influence for his family, and touched many lives. He was a good friend to me, to his colleagues and to his patients. He was academically sound, surgically skilled, morally straight, and never lost sight of the fundamental tenets of medicine. Herb gave every patient he ever cared for his very best. No more can be said of any doctor.

Robert Ferguson, MD

IN MEMORIAM
CHRIS C. REYNOLDS, MD
1907-2002


Chris Reynolds, MD

Chris Reynolds, MD was born July 25, 1907 in Kansas and died January 25, 2002 in Tacoma. After receiving his medical degree from Northwestern Medical School in Illinois, he completed his internship at Tacoma General Hospital in 1937. Prior to becoming a physician, he earned his BS and MA degrees from Kansas State Teachers College and taught high school for three years.

Dr. Reynolds was a PCMS member for 65 years and served as president in 1961. He practiced family medicine until 1969 and then became an emergency room physician. In 1980 he became medical director of the Rehab Center at Puget Sound Hospital prior to his retirement in 1986.

He served as president of Pierce County Medical Bureau and Washington State TB Association, as a member of the Governor's Council on Alcoholism, and Chief of Staff of Tacoma General, Allenmore, Medical Arts and Doctors' Hospitals in addition to memberships in numerous professional organizations. He was affiliated with Mason United Methodist Church, Phi Chi Medical Fraternity, Young Men's Business Club, Knife and Fork Club and Comus Dance Club. Dr. Reynolds will be missed.

PCMS extends sympathy to his wife Jerry and their family.

In My Opinion....

by Teresa Clabots, MD

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

The Global Referral

Teresa Clabots, MD

Alice was in my office. She did not look well. She was only one month old, but she had a fever of 102 rectally and an inflamed left eye with large swelling where the left puncta was. Her mother was grossed out from the amount of pus that her left eye was weeping. When I explained to the mom what I was looking for (yet at the same time not really explaining what I was worried about) - dehydration, irritability (shock, meningitis), and other sources of infection. The mother started crying and quickly disintegrated. I explained to her, as I gently pulled the infant from her arms, that I needed to do a quick spinal tap and bladder tap to rule out sepsis, as all infections were potentially lethal. I was trying to be as calm and efficient as I could while convincing her to sign the consent without forcing her.

I glanced at the boy in the corner. He was quietly trying to ignore the whole situation. He looked up from his book and I noticed that his left eye was a little droopy. But now was not the time to worry about that while his sister needed the septic workup. I took her to the trauma room and with the help of my well-trained pediatric nurse, I tapped her.

I returned her intact with a few more band-aids (over her spine and bladder) and the mother tearfully asking, "will she be okay?" I was about to respond and reassure her when I remembered what the attorney at the Business Management Insurance seminar had just said. "Don't make promises." Don't tell people they will be okay. That's an implied promise." I came out with the answer he had suggested. "We will do our best." The mother broke down.

I sent the baby by ambulance to the local pediatric hospital. After duct probing, three days of IV antibiotics, negative blood, spinal and urine cultures, she was released home on oral antibiotics and eye drops, having successfully recuperated from her eye surgery.

I noticed on the schedule the night before that Alice was scheduled to be seen the next day. I called the mother and requested that she also bring the brother (who was long over due for a health examination). I told her I was concerned about his eye and she said that she had noticed that his eye was a little bit different. She brought him the next day and I breathed a sigh of relief as he walked in. Yes, it was a little bit different. Was it that the eyelid was shifted? Was it facial asymmetry? Was it that his globe was bigger? Was it that it seemed to be a little proptotic? Could it be hyperthyroidism or unilateral Graves disease? I had never seen anything quite like it.

I had just attended a course on referrals and I had heard about a "global referral." I did not want my call team to be hassled all weekend long by referrals for admission, imaging studies, blood work, consultations, etc., etc.

I brought the other physicians in my office to examine him. I called the local ophthalmologist who recommended that we do a CT scan, which came back abnormal with a retrobulbar lesion, suggestive of a hemangioma.

To me, a "lesion" is cancer until proven otherwise. So I called the oncologist who looked at the CT scan and reported, "Oh, it's got to be a hemangioma. It will thrombose and regress."

I called an ENT physician and I said, "I have a kid with something behind his eye. Can you take a piece of tissue?" He said, "Absolutely not, no one in town will do that. You need to send him to Seattle." This process had taken three days. The mother called me saying that the child was in excruciating pain and could I see him on an urgent basis on Friday afternoon. "Of course," I said. It was 2:30 pm and there was snow on the roads in Tacoma.

I looked at the boy in my office and I could not believe what I saw. In three days the eye was popping out of the socket. I called the ENT physician at Children's in Seattle and said, "This boy is in pure agony. What can you do? Will you accept him as a transfer and control his pain until you figure out what he has behind his eye?" He said, "Of course we will." I had just attended

See "Referral" page 14

Referral from page 13

a course on referrals and I had heard about a "global referral." I did not want my call team to be hassled all weekend long by referrals for admission, imaging studies, blood work, consultations, etc., etc. I couldn't imagine spending Saturday getting every request for every procedure. I wrote for a global referral and faxed it to headquarters.

I waited ten minutes, picked up the phone and called. "It's 3:30 on Friday afternoon. I am sending this kid to Children's and he has already left by car to beat the Friday traffic. I need a referral to Seattle Children's Hospital immediately and I need a GLOBAL referral." The girl on the other end of the line replied, "We don't give global referrals." I said, "You'll give it for this patient." She said, "Why should I?" I said, "Because, it is 3:30 on Friday and I am documenting that his vision right now is 20/20 and when he goes blind in that eye because it has popped out of its socket and has ripped his optic nerve, you will be liable for his blindness!" She said, "I will call you right back."

I waited and waited and waited. An hour passed. I picked up the phone and called the medical director. I said, "I have an urgent situation here and I need a global referral." He said, "That's not my department." I said, "You're the medical director and I am appealing to you to authorize this urgent referral to Children's Hospital in Seattle. We can't provide these services and this kid is going to lose vision in that eye if we don't fix it right away." He said, "Have you talked to a referral coordinator?" I said, "Yes, I have talked until I am blue in the face and it has been an hour and I have not received a response."

Thirty minutes passed. It was time to close. As the office staff was going home, the fax machine sputtered. The global referral was approved.

I breathed a sigh of relief for the weekend and on Monday called Children's to see what they found out. He had been in the ICU all weekend for pain control. He had a biopsy and because they didn't believe the pathology on the first biopsy, had a second biopsy. The biopsy results were not good.

He had retro-orbital rhabdomyosarcoma. ■

Applicants for Membership

Roman L. Kutsy, MD
Neurology
Neurology and Neurosurgey Associates
915 6th Ave #2, Tacoma 98405
253-383-5056
Med School: Perm State Medical School
Internship: Albany Medical Center
Residency: Albany Medical Center
Fellowship: University of Washington

Peter B. Shelley, MD
Ophthalmology
32123 1st Ave S #A-3, Federal Way 98003
235-927-7799
Medical School: U of Pennsylvania
Internship: Letterman Army Hospital
Residency: Letterman Army Hospital
Fellowship: Children's Hospital

Victoria M. Silas, MD
Orthopedics
316 ML King Jr Way #312, Tacoma 98405
253-627-7143
Medical School: U of Massachusetts
Internship: U of New Mexico Hospital
Residency: U of New Mexico Hospital
Fellowship: LSUMC - Children's Hospital

Whistler CME program - education AND vacation

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

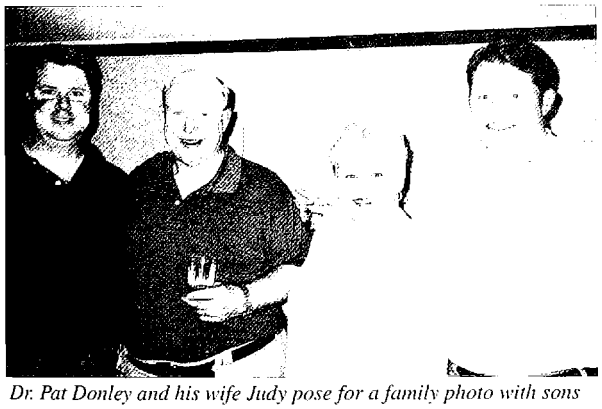
Pierce County physicians that attended the program, held at the British Columbia ski resort, were joined by other physicians from around the country. The program is not only known for excellent CME opportunities, but for family vacationing, as well.

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

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

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

Whistler speaker and Tacoma ENT Dr. Carl Wulfestieg addresses conference attendees



Dr. Pat Donley and his wife Judy pose for a family photo with sons Kevin (far left) and Todd (far right) during the reception

Dr. Gregg Ostergren (left) and Dr. Ron Graf chat before riding the Wizgard chair to the top of Blackcomb Mountain

Dr. Kirk Harmon (right), course speaker, answers a question from Tacoma surgeon Mark Ludvigson, MD

Drs. Matt White (left) and Carl Wulfestieg are set to challenge Blackcomb Mountain

Sons of Tacoma orthopedist Peter Krumins, MD, Benjamin and Stuart, prepare for the slopes

Tacoma internist Dr. Dave Law waits for his skis before tackling Blackcomb Mountain

Dr. Robert Wright, Puyallup general surgeon, makes a point on the value of anti-reflux surgery

Dr. Ian Lawson (left) and co-course director and speaker Dr. Rick Tobin prepare for the inviting slopes

Dr. Tom Herron, Gig Harbor pediatrician, and his wife Verna enjoy the pre-conference reception goodies

Dr. Ralph Katsman, Tacoma gastroenterologist, responds to questions from the audience

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Hawaii CME registration remains open

Space is still available to join your colleagues and their families for spring vacation on beautiful Hawaii during the College's "resort" conference April 8-12, 2002.

Reservations can be made on a space available basis by calling the Hapuna Hotel at 800-882-6060. You must identify yourself as part of the College of Medical Education group.

To help with airline reservations to Maui, the College is working with Marilyn at Olympus Travel 253-565-1213. For additional information or a program brochure, call the College at 253-627-7137. ■

Internal Medicine Review offers timely subjects, March 7 and 8

The Tacoma Academy of Internal Medicine's annual two-day CME program set for March 7 and 8 is open for registration. The program offers a variety of timely internal medicine topics.

To register or for more information please call the College at 627-7137.

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

- Antibiotic Resistance
- Insulin Resistance and Diabetic Dyslipidemia: Emergency Perspectives on the Role of TZD's
- Heart Failure
- Post Prandial Glucose and It's Relevance to Cardiovascular Mortality
- Screening for Skin Cancer
- New Technologies in Physical Medicine and Rehabilitation
- The Spectrum of Inflammatory Joint Disease: Update 2002
- Cancer Screening
- New Hypertension Treatments
- Practical Pain Management
- Update on the Treatment of Post Menopausal Women
- Osteoporosis: Present and Future and New Paradigms
- The Rational Use of New Generation Antidepressants: Maximizing Efficacy and Minimizing Side Effects
- Alzheimers Disease: Burden, Progress, and Hope ■

Allergy, Asthma & Pulmonology CME - May 3

The College's CME program featuring subjects on allergy, asthma & pulmonology is set for Friday, May 3 at the St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

A brochure with details regarding the conference is scheduled to be mailed in late April.■

Women's Medicine CME - May 17

The third annual CME program on Advances in Women's Medicine is scheduled for May 17, 2002. The conference will be held at St. Joseph Hospital.

The course is a one-day program addressing a variety of timely subjects relative to contemporary medicine for women. Designed for the primary care physician, this CME program will feature issues related to diagnosis and treatment advances in treating illness in women.

John Lenihan, MD, the course director, promises presentations on timely subjects with "outstanding" national speakers. ■

Dates	Program	Director(s)
Thursday-Friday March 7-8	Internal Medicine Review 2002	Tejinderpal Singh, MD
Sunday-Friday April 7-12	CME at Hawaii	Mark Craddock, MD
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Classified Advertising

POSITIONS AVAILABLE

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

Washington State Division of Disability Determination Services. Medical Consultant positions available. The State of Washington Division of Disability Determination Services seeks psychiatrists to perform contract services in the Seattle and Olympia Regional offices. Contract services include the evaluation of mental impairment severity from medical records and other reports, utilizing Social Security regulations and rules. Psychiatric Medical Consultants function as members of the adjudicative team and assist staff in determining eligibility for disability benefits. **Requirements**: Current Medical License in Washington State. Board certified desirable. **Reimbursement**: $57.01/hr. Interested psychiatrists should contact **Guthrie L. Turner, Jr., MD, MPH**, Chief Medical Consultant, Acting at (360) 664-7361 or the respective regional manager: **Olympia**: Laura Wohl, Regional Manager (360) 664-7355 **Seattle**: Han Njuyen, Acting Regional Manager (206) 654-7216.

Family Practice physician needed. Exciting opportunity for energetic family practice physician in Tacoma, WA. Female Ob/Gyn wishes to office-share or partner with F.P. Great office location and beautifully remodeled office. Great patient base to quickly build a practice. Call and ask for Penny (253) 470-7777 or send CV to (253) 460-0959.

OFFICE SPACE

1,500 sq. ft. remaining at 1310-A South Union. New construction, view, tenant improvements included. Call **Dr. Lovy** at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examine rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

Office Space For Lease. Sound- view Medical Plaza, located at 3611 South D Street, currently has office space available for lease to medical or general healthcare practices. We offer very competitive lease rates; spacious, updated facilities; shared reception; accessible support staff; excellent security, maintenance and janitorial services; and access to onsite radiology and blood labs. Our location, just off of Pacific Avenue, is adjacent to the Pierce County Health Department and Puget Sound Behavioral Health, and is easy access to and from freeways and on a bus line. For lease rates and more information, call Nelsa Brodie at 798-4551.

GENERAL

For Rent: Lake Chelan large waterfront condo, sleeps six, all amenities (235) 572-7543.

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

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Pierce County Medical Society
BULLETIN

April, 2002

PDA Experts Share Their Knowledge...

(Above) From left, Drs. Jennifer Smith, John Lenihan, David Acosta and Joe Regimbal are joined by PCMS Vice President, Dr. Mike Kelly, who introduced them to the audience

(Right) From left, a vendor representative answers questions while Drs. Edgar Steinitz, William Lee, and John Bargren hope to learn more about personal data assistants

See story and more photos page 3

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

April, 2002

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March General Membership Meeting Recap

"The Handheld Computer and Medical Practice"

Tacoma's Landmark Convention Center was a hub of activity, as approximately 140 members and their guests gathered for the March General Membership Meeting. The program, "The Handheld Computer and Medical Practice," proved to be a hot topic for physicians and their guests.

Attendees were welcomed by PCMS President **Susan Salo, MD**. She introduced new members **Drs. Kevin Roscoe** and **Peter Shelley,** and physician assistants **Alison Pruim** and **Stephen Koshel**.

Dr. Salo passed the microphone to PCMS Vice President and Program Chair, **Mike Kelly, MD**. Dr. Kelly introduced keynote speakers Chris Vincent, MD, Swedish Family Medicine faculty member, and **David Acosta, MD**, Tacoma Family Medicine faculty and PCMS member. Dr. Kelly noted that Drs. Vincent and Acosta coordinate and teach handheld computer courses at their respective residency programs. He also introduced PCMS members **Drs. John Lenihan, Joe Regimbal** and **Jennifer Smith**, panel members who would later relate personal experiences with using their handheld computers.

For members without handheld computer experience, Dr. Vincent explained that a PDA (personal data assistant) is a handheld device, much like a mini-computer but not a scaled-down version. Citing a recent survey, he shared that 15% of physicians used handheld computers two years ago and 20% will use the devices in two more years, adding that he personally believes that number will be much higher come 2004.

According to Dr. Vincent, the core functions of a handheld computer include an address book, calendar, task manager or "to do" list, memos and E-mail. "I find the calendar to be a useful tickler tool for patient reminders, and the memo feature is great for storing lecture notes," he said. He added that while these functions are similar to those of a laptop or PC, the PDA is mobile and pocket size, giving the user the flexibility to operate it almost anytime, anywhere.

Dr. Vincent gave an overview of the many types of handheld computers and their operating systems and how they can be used within a medical practice. "There are several choices of

See "March GMM" page 4

Dr. John Lenihan (left) shows the possibilities of a handheld computer to Dr. Eric Luria

Dr. Charles Weatherby (left) marvels at Dr. Lenihan's demonstration of his PDA

Dr. Chris Vincent (center) answered many questions and gave demonstrations after his presentation

A vendor representative and Dr. Srini Sundarum explore the potential of a handheld computer

March GMM from page 3

handhelds for your office. Making the right choice is critical, and should be based on needs specific to your practice. Medical software applications range from drug databases to medical textbooks, as well as calculators, practice management tools, prescription writers, and graphic and document viewers," he said.

Drs. Vincent and Acosta demonstrated several software programs including a pregnancy wheel, a billing program, and a medication dosage and interactions program, all effective in reducing errors and saving valuable time. Dr. Acosta said that his office has noticed a dramatic decrease in billing discrepancies and an increase in reimbursements. "It is amazing how much we captured costs with our billing database that includes correct diagnoses and ICD-9 codes," he said, adding, "You don't need a computer background to use this type of database."

Stressing the need to research handheld computer options, Dr. Acosta explained that there are thousands of programs of varying quality from medical and financial to formulas and entertainment, many at low cost, many offering free trials. "You will accumulate many of these trial programs until you find what works for you," he said.

In closing, Dr. Vincent emphasized that medicine changes quickly, and has an ever-expanding knowledge base. PDA technology changes even more quickly, sometimes daily, and with the right software, PDAs can store a vast amount of updated medical information. The key is for each individual to find the program that suits them best.

Following Drs. Vincent and Acosta's presentations, panel members Drs. Jennifer Smith, John Lenihan and Joe Regimbal gave their personal testimony as to the ease of using a handheld computer. "You don't have to be a 'techie' to use a PDA," declared Dr. Smith. While seasoned users, Drs. Lenihan and Regimbal questioned their ability to function without them.

To request a copy of the handouts distributed at the meeting, including helpful websites for choosing the right handheld computer for you and your practice, call the PCMS office, 572-3667 or send an e-mail to pcmswa@pcmswa.org. ■

From left, Drs. Mike Newcomb, President-elect Jim Rooks and Past President Jim Early visit before the meeting

Dr. Anthony Lahrs, right, shares his knowledge of handheld computers with, from left, Dr. George Noble, Dr. William Martin and his wife Karyl

Retired Members Luncheon Meeting Recap

Retired Physicians Welcome Master Gardener

Neither snow nor wind put a damper on the spirits of over forty retired physicians and their guests at the Retired Member Luncheon in March. The event took place at the Fircrest Golf Club where members enjoyed lunch and visiting with friends and former colleagues.

Dr. John McDonough moderated the program. After a few announcements, he asked for remembrances of physicians who had died since the last meeting. A moment of silence was held for **Drs. Robert Johnson, James Vadheim, Franz Hoskins, Don Gehle, Chris Reynolds, Herbert Kennedy and Herbert Zimmerman.**

He introduced Janet Sears, Washington State University Master Gardener and Volunteer Program Coordinator. Ms. Sears is in charge of training and scheduling over 400 Master Gardener volunteers in Pierce County. Accompanying Ms. Sears was Dr. Ray Maleike, WSU Horticultural Consultant.

Ms. Sears shared the history of the Master Gardener and Volunteer Programs, as well as her personal love of gardening. "I am an avid gardener and want to share that passion with others."

Although many in the audience shared her interest, most admitted that they lacked the skills to successfully tend to a garden. "I looked at my thumbs before coming today, and neither one is green," confessed Dr. McDonough. Another member asked, "How do you grow a green thumb?"

"The most important thing is to be able to identify an unhappy plant, and to learn to watch for plant problems. If you can do that, you have a green thumb," explained Ms. Sears.

"Whether you are a passionate veteran gardener with decades of experience or a new and eager beginner into the world of gardening, there are always a few things we all seem to do: we have noble, honorable intentions and high aspirations but unrealistic goals," she continued. She described a

See "Retired Luncheon" page 16

L to R, Nadine Kennedy, Keaty Gross and Helen Florence enjoyed "catchng up"

Dr. John McDonough and his wife Jane discussed gardening tips with friends after lunch

Many attendees visited with friends and former colleagues after the meeting

L to R, Florence Rigos, Rena Link and Jo Roller visited after an informative presentation on gardening

East Pierce County Physicians Meet with Senator Jim Kastama

Drs. Mark Aversa, Doug King, Bill Knittel, Terrel Michel, Ed Pullen, Don Russell, Susan Salo, Cecil Snodgrass, Rebecca Sullivan, Mark Tomski and **Robert Wright** had breakfast with Senator Jim Kastama (D 25) at Good Samaritan Hospital to discuss their concerns regarding the current state of medicine in Washington State.

They shared their concern about medical practice viability, focusing on increasing expenses and decreasing reimbursements but primarily the administrative hassles and burdens that drive up their costs by taking so much time. "It now takes five FTEs to support one physician where it used to take 2.5," they explained. They very clearly and frankly warned him of the fallout should the legislature pass a budget that cuts reimbursement for interpreter services, explaining that nobody should be mandated to provide a service that costs more to perform than what you are paid.

Other discussions included liability concerns and tort reform, insurance companies, pharmaceutical costs, budget woes, the economy and many others.

Hearing the group's concerns, the Senator explained that things are in a desperate situation in Olympia. "Washington does extremely poorly in times of recession," he said.

Senator Kastama pledged to speak with Insurance Commissioner Mike Kreidler and encourage the Commissioner to further these discussions with PCMS members. ■

Senator Jim Kastama (lt) presents his views to the group, including Drs. Doug King and Terrel Michel (rt)

Dr. Mark Tomski (left) listens as Dr. Don Russell points out his concerns with the current state of medicine

Letter to the Editor

Orbital services available in Tacoma

I want to clarify that the article I submitted in the March *Bulletin*, regarding the "Global Referral" actually happened in 1995. Pierce County has orbital services available, Drs. David Pratt, Troy Woodman and Fred Ehret practice in Tacoma. Dr. Pratt since 1996; Drs. Woodman and Ehret joined him in 2001.

I apologize for not providing factual clarification with the original article.

Sincerely,
Teresa Clabots, MD

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Preventing Antibiotic Resistance in Pierce County

The rising cost of health care associated with antibiotic resistant infections (ARIs) has serious implications for the long-term care and management of patients presenting with common and sometimes serious infections utilizing our national health system.

In Pierce County, *Staphylococcus aureus* isolates resistant to methicillin rose from 8% in 1995 to 25% in 2000. In 2001, the number of reported methicillin-resistant *Staphylococcus aureus* (MRSA) cases exceeded 696, among the county's population of 700,000.

Responding to public health concerns, the Tacoma-Pierce County Health Department assembled a 40-member Interdisciplinary Antibiotic Resistance Task Force to address the increasing occurrence and prevalence of antibiotic resistant infections in our community.

The Education Subcommittee of the Task Force has prepared a hands-on manual entitled "Controlling Antibiotic Resistance." The manual is designed to assist health care personnel in a variety of settings to diminish the emergence and transmission of resistant infections while caring for, or transporting patients.

For more information about the "Controlling Antibiotic Resistance" manual, contact the Health Department at (253) 789-4779, or visit our antibiotic resistance website at www.tpchd.org/antibioticresistance. ■

Community Resources

Once a year we like to point out some of the resources that the Health Department provides to our community. If you would like more information, or to participate in some way with the programs identified here, please call the number listed.

Communicable Disease Control

Antibiotic Resistance Bacteria Control: This collaborative approach to preventing the increase in bacteria resistant to antibiotics continued in 2001 with production of a manual for providers on using antibiotics. For more information, contact Monica Raymond, RN (253) 798-2873. For a copy of the manual, call (253) 798-4779.

Bioterrorism Preparedness: Since September 11, 2001 health department staff have worked with local, state and federal officials to prepare a plan in the event of a biological, chemical or nuclear terrorist event in Pierce County. Information for physicians from the CDC and state Department of Health on disease surveillance and treatment has been posted on the TPCHD website: www.tpchd.org. For more information, contact Cindy Miron, RN (253) 798-6556.

Childcare Program Assistance: Staff responded to calls and established training programs to provide information on safety, disease control, and illness prevention techniques to more than 550 childcare centers in Pierce County. For more information, contact Cheri Singleton, RN (253) 798-6487.

Immunizations: You can check our website monthly for updates on clinic locations and schedules - http://www.tpchd.org/cdc/imnunsites/html - or contact Cindy Miron, RN (235) 798-6556.

Network Nurses: You have probably seen one of the department's Network Nurses in your office in 2001 and 2002. They bring updates on reporting requirements, testing procedures and prevention messages to physicians' offices. In 2001, they also delivered newly-created bioterrorism materials. If you haven't been visited or would like more information, contact Sandy O'Donnell, RN (253) 798-7687.

Tuberculosis Treatment: Our Direct Observed Therapy (DOT) program was named the Most Innovative Public Health Program in Washington in 2001 by the Washington Association of Local Public Health Officers. Using computer and telephone technology, TPCHD staff can observe patients taking TB medications without driving to the individual's home. About 17 people use DOT to ensure therapy compliance. For more information, contact Peggy Cooley, RN (253) 798-2861.

Youth STD Prevention: Staff hold education sessions for incarcerated youth at Remann Hall, discussing STD prevention, violence prevention, and tobacco cessation. In 2001, 216 at the site were tested for HIV, with appropriate counseling and education associated with the tests. For more information, contact Teresa Smith (253) 798-2841.

See "Resources" page 16

New Members

Emery J. Chang, MD
General Surgery
Tacoma South Medical Clinic
2111 South 90th Street, Tacoma
253-539-9700
Medical School: Boston University
Internship: Boston University
Res: Western Reserve Care System

Mark A. Crowe, MD
Dermatology
Puyallup Dermatology Clinic
1706 S Meridian #140, Puyallup
253-841-2453
Medical School: University of Texas
Internship: William Beaumont AMC
Residency: William Beaumont AMC
Residency: Walter Reed AMC

Frederick W. Ehret, MD
Plastic Surgery
Pratt, Woodman and Ehret
2202 S Cedar St #300, Tacoma
253-627-2900
Medical School: Boston University
Internship: Boston University
Residency: Boston University
Residency: Harvard University
Fellowship: University of Washington

Phoebe F. Ho, MD
Ob/Gyn
Tacoma South Medical Clinic
2111 South 90th Street, Tacoma
253-539-9700
Medical School: UCLA
Internship: USC
Residency: Northeastern Ohio Univ

Jay K. Iyengar, MD
Pain Management
Cascade Interventional Pain Center
1901 S Union #A301, Tacoma
253-627-2666
Medical School: Mysore Med College
Internship: Univ of Connecticut
Residency: Richland Memorial Hosp
Fellowship: Univ of Iowa Hospitals

Sambasivarao V. Karanam, MD
General Practice
General Medical Clinics
15005 Pacific Ave, Tacoma
253-537-3724
Medical School: Patliputra Med College
Internship: Patliputra Hospital

Andrew B. Kopstein, MD
Ophthalmology
Cedar Medical Specialties
2202 S Cedar #100, Tacoma
253-759-5555
Medical School: Univ of Minnesota
Internship: Illinois Masonic Med Ctr
Residency: Loyola Univ Med Ctr

Stephen A. Koshel, PA-C
Orthopedic and General Surgery
Surgical First Assist Northwest
5500 Olympic Dr NW, Gig Harbor
253-853-1596
Prof School: Kettering College

Alison M. Prium, PA-C
Dermatology
Tacoma Narrows Dermatology Clinic
1033 Regents Blvd #204, Fircrest
253-564-3367
Prof School: Wake Forest University

Navdeep S. Rai, MD
Internal Medicine
Pulmonary Consultants
316 ML King Jr Way #410, Tacoma
253-572-5140
Medical School: Ohio State University
Internship: Cleveland Clinic
Residency: Cleveland Clinic
Fellowship: Cleveland Clinic

Kevin J. Roscoe, MD
Family Practice
Summit View Clinic
11019 Canyon Rd E, Puyallup
253-537-0293
Medical School: Albany Medical College
Internship: UC Davis Medical Center
Residency: UC Davis Medical Center
Fellow: USAF School of Aerospace Med

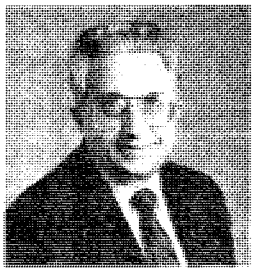
Peter B. Shelley, MD
Ophthalmology
32123 1st Ave S #A-3, Federal Way
253 927 7799
Medical School: Univ of Pennsylvania
Internship: Letterman Army Hospital
Residency: Letterman Army Hospital
Fellowship: Children's Hospital

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Management by Algorithm



Andrew Statson, MD

"It is a dainty thing to command, though it were but a flock of sheep."
Miguel de Cervantes (1651)

The state Department of Health sent us a flier on the importance of detecting microalbuminuria in diabetic patients. In case you missed it, the concern is about the high cost of treating renal failure and the belief that early diagnosis and proper treatment of kidney impairment in diabetics would reduce that cost. To help with the diagnosis, the flier had an algorithm on how to proceed with testing for the condition.

As an educational tool, that algorithm makes a valid point. Yet physicians who treat diabetes should be well aware of the problem and should know how to diagnose it and what to do about it. Apparently, such is not the case. At the end, the algorithm said that patients with microalbuminuria should be referred to endocrinologists or nephrologists for treatment. The flier, therefore, seems to be addressed to nurse practitioners, physician assistants and some family physicians who are not knowledgeable enough about the complexity of diabetes. It still did not admit that relegating the treatment of complex diseases to primary care was a costly mistake.

I thought that diabetes is an endocrine disease and is best treated by endocrinologists, but no, the flier did not say that. Since the flier clearly stated that the treatment of kidney failure is very expensive and the health department is concerned about that cost, I must conclude that it still considers the treatment of diabetes by endocrinologists not to be cost effective. They should be called in only in cases with complications. At the same time it admits that they have the skill to prevent serious complications that are expensive to treat. Interesting...

This trend to reduce medical practice to the execution of algorithms is very broad. Some carry the name of guidelines, but the basic premise is the same. The state medical association has guidelines, so do the AMA, the various specialty societies, the medical staffs at the hospitals and even some insurance companies. There is hardly a test, a procedure or a disease that is not the subject of several guidelines, sometimes contradictory, issued by different organizations.

We are buried under an avalanche of guidelines, recommendations and algorithms, all of them giving us the recipes on how to practice medicine. It is as if we never went to medical school. Is that a reflection on how well the medical schools teach us?

The algorithm is a mathematical construct. It has existed since antiquity. It consists in the execution of a procedure for a mathematical calculation, such as multiplication, division, finding the highest common divisor, etc. It was greatly expanded with the advent of computers and is a basic component of computer programs. As computers became ubiquitous, some people thought that since we could program computers, perhaps we could also program human beings. Hello to the Brave New World.

There are a few little problems with algorithms, though. Roger Penrose discussed them in detail in *The Emperor's New Mind*. Algorithms, by their nature, have to simplify the problems. "If...then...else." They require execution, not thought. They cannot deal with complexity.

That is fine for computers, but real life is anything but simple. The problems we face are complex and cannot easily be made to fit the boxes of an algorithm. We would have to squeeze or twist reality to make it meet the requirements of the algorithm. Sometimes that might work and the algorithm might help us avoid a mistake. At other times it would not and when it doesn't, the mistakes we make would be some whoppers.

We are frequently told to learn from the airlines, so let's do that. Here is an example. Last year, on September 11, four airplanes were commandeered by a few men armed with boxcutters - *boxcutters!* of all dumb things - and three of those planes were flown into buildings. I don't know what happened on board, I don't know how those

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Algorithm from page 9

people could get the pilots out of their seats and take over the controls.

I suspect the algorithm said, when hijackers threaten, give them what they want. Otherwise it would have been inconceivable that three or four men with boxcutters could overcome a crew of 12 and 200 passengers and take over the controls of a plane. Something interesting must have happened on the fourth plane. The passengers there must have learned the fate of the first three planes and must have decided, to their credit, to unravel the algorithm and take matters in their own hands.

The algorithm must have handed over the planes to the highjackers. Even more, they must have known the algorithm and exploited its weaknesses. Otherwise, how could they have thought it possible to succeed in such an undertaking? Without the algorithm, they would have been stopped by the crew, bound down by the passengers and that would have been the end of it. Once the algorithm got unraveled, the crew and passengers on several other planes were able to prevent additional catastrophes.

Algorithms stifle thinking. They are good for programming computers, but thinking is what humans do. IBM had a slogan, "machines should work, people should think." Yes, we can be wrong in our thoughts. Yes, we can make mistakes. Yet when we are stripped of individual initiative and admonished not to think, but to execute the algorithms, we see planes crashing into buildings on purpose.

So why do we persist in making algorithms. For instance, the algorithm on anthrax exposure is to turn over the suspected powder to the authorities, have them determine that there is a risk and only then start treatment of the exposed individuals. Yet two women died from pulmonary anthrax without any evidence of exposure. The algorithm failed them.

Does anyone out there believe that the next anthrax attack, if anthrax it is going to be, will come as a powder in a mail envelope? What a lack of imagination! This war is a battle of wits. We must use ours better if we want to win. The chiefs of the clans in the Middle East are masters at intrigue and assassination. The history of their endeavors goes back 4000 years. The current chiefs are the survivors in that game. Don't underestimate them.

The secret of management is not to follow formulas, but to alter them and to adapt them to changing circumstances. That requires healthy judgment and sound decisions, both based on solid thinking. Management requires the freedom to think and the freedom to act. Management by algorithm precludes thinking, therefore it is not management at all, it is execution of commands. Those are two different things.

The people who believe they can solve life's problems with algorithms make two serious mistakes. First, our problems cannot be compressed into a box, which can than be run by an algorithm and solved. Second, if people can be programmed to execute algorithms without thinking, they are no longer humans, they are robots. Algorithm makers may think that they command humans, but in fact they are programming automatons. While such an approach may work in some circumstances, overall it is not the proper use of human beings.

The clash between life's complexity and algorithms with their boxes is a clash between reality and wishful thinking. Reality has a way of winning this contest, to the detriment of the wishful thinkers. People need knowledge so they can make their own decisions. That's all it takes. Give people light and they will see their way. ■

Medical Malpractice: Separating Facts from Rumors

The current crisis in medical malpractice insurance is not unique to Washington State. We are in good company, with West Virginia, Pennsylvania, Nevada, Texas, and Florida having similar experiences. Ohio and our neighbor, Oregon, are on the verge of trouble due to loss of caps in recent years.

Gary Morse, VP and General Counsel, Physicians Insurance A Mutual Company, gave a factual, detailed presentation at the WSMA Interspecialty Council meeting on Saturday, March 16 at the SeaTac Hilton Hotel. His primary goal was to present accurate information in attempts to thwart the rumor mill.

In Pennsylvania, the state just passed insurance reform, but without caps. The Medical Society spent $4.5 million in lobbying and public relations. Nevada has had several hearings by the state insurance department. In Texas, they have a huge claim frequency problem, premiums have increased 60% or more. They do have a US Senate Candidate supporting reform. Florida obstetricians are paying over $100,000 for coverage, consequently many go without, and they are considering a push for a state constitutional amendment.

Medical Malpractice in Washington

Many companies are leaving the market in Washington State. In 1996 CNA left, and in 2001 Washington Casualty left the physician market. Also in 2001, St. Paul left the market nationwide. While this didn't impact physicians in our state directly, it dwarfs all other market changes and is an historic move in the business. Med Pro has recently had limited entry to the state market.

Washington has seen staggering jury awards in recent years. Overall (not just medical) personal injury verdicts and settlements have increased, not in frequency but in dollar amounts of awards. In 2000 there were 7 awards over $5 million and 4 over $10 million. In 2001 there were 8 over $5 million and 14 over $10 million. Of these cases, three were medical malpractice and were awards of $7.1, $10.6 and $16.2 million. Another four medical malpractice cases in 2001 resulted in awards of $4.5, $3.0, $2.1 and $1.2 million. All but the $3.0 million case were defended by Physicians Insurance.

Premium rates have risen steadily over the past five years. Physician's Insurance rates have increased an average of 6.25% each year for the last five years with most physicians seeing higher increases than noted here.

4.5% in 1998
7.7% in 1999
4.4% in 2000
6.0% in 2001
8.6% in 2002

A few extenuating factors contributing to increased premiums include companies eliminating what they term "unjustified" discounts for IPAs and other physician groups, some specialties that have been hit harder than others, and insureds that have increased their limits (over $1 million) because awards have become so high. Hospital premiums have increased about 30% for the past two years.

Why are we in this mess?

Economic inflation, social inflation, and legal inflation all contribute. Medical costs, compensations, and cost of living, particularly in urban areas have contributed to the rising costs of insurance. Social inflation speaks to our society that now believes $1 million dollars is no longer very much money. We have sports millionaires and Microsoft millionaires to thank for this. Ten years ago, 80% of physicians bought $1 million of coverage. Today, 85% buy $2 million and about 8% buy $5 million, the most available. Add a public that is angry about the health care system. They don't like managed care, they are upset because physicians spend less time with their patients, and they are angry about rising costs.

Legal inflation has taken hold because this state has been unsuccessful with tort reform. We have liberal courts and more emotional jurors – ones that respond primarily with sympathy and compassion. There is a well organized plantiffs' bar and a shortage of quality, defense attorneys. New mandates to disclose "medical errors" have also played a role, as has a public that thinks insurance is unlimited.

How do we manage this?

Of course the basics still apply. Tougher underwriting, proper pricing, new approaches to claims management and new risk management initiatives. There has been an increase in policy cancellations and an increase in rejection of applications. This was specifically reflected when approximately 200 applications that came from Washington Casualty Company to Physicians Insurance were rejected.

Claims have been managed by mediation, arbitration and private trials. Jury focus groups have been tried – which includes hiring people for mock trials, and high-low agreements are becoming more popular. This is an agreement where the parties agree before trial that if you lose, you still get something, but if you win, your award is capped. A plus with these agreements is that they are not reportable to the state or national practitioner data banks. And, risk management programs have included burnout prevention efforts as this is not an easy time to practice medicine.

There is no doubt that liability reform is in order. Ideas that need to be considered include:

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State launches program to assist Medicaid clients with chronic ills

Editor's Note: This program was presented at the WSMA Interspecialty Council Meeting on 3/16/02 There was concern expressed by physicians that the program will be disruptive and intrusive to existing physician/patient care giving relationships. In addition, it creates another expense item to the DSHS budget and particularly adds further administrative burdens for physicians who are already on the verge of economic collapse.

In an attempt to better manage care for patients with chronic diseases, the state is launching a "disease management" program to help coordinate care for Medicaid clients with kidney disease, diabetes, asthma or cardiac disease, including congestive heart failure.

The pilot project will begin with about 150 to 200 kidney-disease patients in Western Washington, and an unspecified number of patients with the other three conditions in all parts of the state.

The goals of the program, which starts April 1, are to improve patient care and contain costs, said Alice Lind, manager of the care coordination section for the Medical Assistance Administration of the Department of Social and Health Services (DSHS).

Medicaid is a state-federal health-insurance program for low-income residents.

Eventually, about 17,000 fee-for-service patients on Medicaid will participate in the program, Lind said.

Three companies, two headquartered in Denver and one in Chicago, will run the project under contract.

Local case managers will help ensure that proven, effective treatments are being provided, and help doctors and patients monitor complications or other problems that, left untreated, can lead to more expensive care such as hospitalization, Lind said.

Reminders of annual eye exams or assistance in controlling blood-sugar levels, for example, can help diabetics stay healthy, as well as help doctors manage such patients, Lind said.

The Disease Management contracts require the companies to guarantee overall savings for the state. Under their contracts, the companies will line up physicians and other health-care providers to serve as the patient's "medical home." These providers will treat the patients involved in the projects. The companies also will be responsible for establishing procedures and care-management reviews to be certain that care is being provided efficiently and appropriately.

Disease Management is based on the knowledge that intensive supervision of patients with chronic disease can result in improved health care as well as efficiencies that will save the state money.

"Our plan is to launch a system that will benefit state taxpayers as well as its clients over the long term," says DSHS Assistant Secretary Doug Porter, chief of the state's Medicaid program. Porter said the state has completed its negotiations with an initial group of experienced Disease Management vendors who have agreed to provide the oversight and intensive case management involved in the program.

The three companies contracted for Disease Management work so far are:

- **CorSolutions Medical, Inc.**, a Chicago-based health intelligence and solutions company, will provide population health-management care for clients with diabetes, congestive heart failure and coronary artery disease.
- **McKesson Health Solutions LLC**, of Denver, Colorado, a wholly-owned subsidiary of McKesson Corporation, which will manage care for asthma patients.
- **Renaissance Health Care Inc.**, also of Denver, which will provide management oversight for Western Washington clients with renal disease.

"Doctors are stressed already in Washington State - we don't need them to have any other excuses for leaving Medicaid," Lind said. ■

Excerpted from The Seattle Times 3/21/02

Applicants for Membership

Richard H. Bednarczyk, MD
Family Practice
Family Medicine of Fife
6040 20th St E #A, Fife
253-922-5262
Medical School: University of Michigan
Internship: Henry Ford Hospital
Residency: Wayne State University

Mazen Dahan, MD
Pediatrics
1802 S Yakima #300, Tacoma
Medical School: Aleppa University
Internship: U Hosp Ramon Ruiz Arnau
Residency: Mayaguez Medical Center

Ronald Schubert, MD
Family Practice
Westgate Family Practice
5702 N 26th Street, Tacoma
253-403-7100
Med School: Spartan Health Sci Univ
Residency: The Medical Center

Doug H. Smathers, MD
Family Practice/Ob
Sunrise Family Medicine
16515 Meridian E #104A, Puyallup
253-840-1859
Med School: Meharry Medical College
Internship: Valley Medical Center
Residency: Valley Medical Center

In My Opinion...

by Daisy Puracal, MD

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

More Thoughts on Health Care

(Another one of these!)

Daisy Puracal, MD

September 11th has blown everyone's mind! 5000 people dead in one sitting! The rally to this crisis was so powerful and heartwarming.

But behind all this, we are blind to the daily loss of lives because of poor access to health care, blind to the anguish and suffering of those who, for no fault of their own, are unable to afford basic health care. We have cried out to our leaders for years with no effect. They say the budget does not allow change. But yet with 9/11 the government has taken on all kinds of spending, including the salaries of airport security personnel!! The health care situation just keeps getting worse rather than better. The two groups (doctors and patients) who should have the most say have become the helpless stooges of insurers, private and otherwise.

Doctors are made to accept insulting levels of remuneration, expected to work long hours, neglect themselves and their families, live with the threat of punitive action being taken against them for paltry reasons and still have mud thrown in their faces. Dentists accept insurance payments, but balance bill their patients. The Medicare recipient pays the pharmacist full price for medications that doctors prescribe - while physicians get half their charges paid. What is wrong with this picture?

The cost of medications has soared to unbelievable heights. It seems like the pharmaceutical companies look to what the market will bear rather than actual cost of the medication to set their pricing. Elaborate charts are drawn up to show how much is being saved by reducing hospital stays to justify the outlandish price.

Patients are put through the hoop trying to negotiate their contracts. Premiums, deductibles and co-pays are increasing in leaps and bounds. A change of job throws them into another waiting period for medical treatment. They face having to meet the new set of deductibles all over again even if they just met it with the previous insurance. Medications have to be changed to the new formulary (and they had just found the right combination to control their chronic disease). Their doctor is no longer on the health plan and they need to find a new doctor. New patient charges are billed when they are seen which increases costs. Round and round it goes with ever-spiraling costs.

The security of affordable and available health from cradle to grave should be the unalienable right of every American citizen. It seems to me that a wealthy nation such as ours should be able to achieve a basic plan to allow this to happen.

Looking to Medicare as a model for delivery of health care, we see that Medicare is divided into two parts - Part A, which covers hospital care, and Part B, which is outpatient care. I propose that we do the same for all citizens. Insurance for hospital care will then be a lot cheaper as outpatient care is taken out of the equation.

There has been a proposal to use a portion of social security for individuals to invest and manage privately. What better investment is there than one's health? So why not use a percentage of social security for all outpatient care? A yearly cap is set for each individual who then orchestrates his/her own care as he/she thinks fit. So each individual can determine the nature of care they wish to seek - whether it is allopathic, naturopathic, chiropractic or whatever within certain guidelines to ensure that basic care is met. A governing board sets guidelines for charges. The patient is given a health card (much like a debit card) that is presented at the point of service. A printout tells the patient how much money remains in his/her account for the year and the provider is paid directly by social security. Excessive charges/utilization is tracked and patient and/or provider is "educated" accordingly.

With this system the patient becomes in charge of his/her own health care. The economic class system that currently exists is destroyed. Payment is for the cost of services rendered and not dependant of the type of insurance one has. Providers do not have to discriminate between Medicare/Medicaid/private insurance clients. Portability is ensured. The same system will be effective wherever one goes. Neither moving from state to state nor changing jobs will affect access to health care.

As an added incentive, if one's maximum for the year is not utilized, one can, after a certain number of years, use this accumulated money for education or housing expenses. The security of knowing your health care is

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always there for you, no matter what happens, will alleviate a great deal of the anxiety that is present in today's society. Providing for and improving education makes for higher caliber citizens. Home ownership can become a reality for a larger population. Allowing the circulation of social security money will expand the economy.

If the medical expenses exceed the cap set for the year, innovative programs to borrow the money from social security should be in place and a grace time given for the individual to pay it back at a later date.

Patients on Medicare continue to use the same percentage of social security for Part B expenses. This will be a tremendous financial relief for a good percentage of people living in fear, finding their shrunken incomes hardly enough to pay for daily living expenses let alone medications.

The remuneration for services has to be adequate to allow a provider to make a decent living, seeing a realistic number of patients a day. Teachers are fighting for smaller and smaller class sizes to do an effective job. So also the doctor/patient ratios needs to decrease to make for better care. It will defeat the purpose if the remunerations are so pitiful that physicians have to work the long hours that we currently seem to have to do to make ends meet. To guard against being forced into a situation where physicians are forced to accept below par remunerations, the contract with social security will allow balance billing at the physicians discretion. Charity care can become a reality again. As with all other free enterprise the market will stabilize itself.

Concluding remarks: The system is "broke." We have to provide for the citizens of this country. Charity has to begin here at home. America has to take care of its internal problems before it can be an effective and credible leader in the world. And yes, it is all about money (the lack of it). The piper (physician/provider) has to be paid. ■

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Malpractice from page 11

- A state constitutional amendment to allow caps (recently defeated in Oregon)
- Take medical malpractice out of the civil trial system (like workers compensation)
- Openly report and study medical errors in exchange for liability protections

The Health Care Liability Alliance is promoting nationwide reform in Congress. Physicians Insurance is represented on the board. It is obvious that physicians cannot continue with insurance premium increases. Something has to be done. ■

In My Opinion....

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Money Sense

Tax Law Increases College and Retirement Saving Opportunities

By Rosemary T. Berkery

The Economic Growth and Tax Relief Reconciliation Act of 2001 encompasses a wide range of changes that benefits taxpayers of all ages and income brackets - for example, a new 10 percent tax bracket, a drop in tax rates over the next five years and an increased child credit. But some of the greatest opportunities created by the law are in three major areas of personal finance - retirement saving, college funding and estate planning.

Retirement Saving

Both individual and employer-sponsored retirement saving plans got a boost with the new law. Beginning in 2002, the contribution limit for Individual Retirement Accounts, both traditional and Roth IRAs, increases to $3,000 a year, up from the current $2,000 annual limit. After that, the limit will move up in phases until it reaches $5,000 a year in 2008.

Individuals age 50 and over will be eligible to make additional "catch-up" IRA contributions of up to $500 in 2002 through 2005. The catch-up contribution limit will increase to $1,000 for 2006 and later years.

Participants in certain defined contribution retirement plans, such as 401(k) plans and 403(b) plans, will have increased salary deferral limits. Beginning in 2002, they may contribute up to $11,000 of their salary in 2002, an increase from $10,500 this year. The contribution limit is scheduled to rise annually in $1,000 increments to $15,000 in 2006.

The annual elective salary deferral limit for Savings Incentive Match Plan for Employees (SIMPLE) plans, available to companies of 100 or fewer workers, will rise to $7,000 next year, up from $6,500 this year. By 2005, that amount is slated to rise to $10,000.

Participants age 50 or over will have the opportunity to use a "catch-up" provision that may allow them to contribute an additional amount above the annual deferral limit. Eligible participants in 401(k) plans may be able to make catch-up contributions of $1,000 next year, an amount that increases in increments of $1,000 a year, to $5,000 in 2006.

College Saving

With a new law, two popular college-saving vehicles - state-sponsored 529 plans and Coverdell Education Savings Accounts (formerly known as Education IRAs) - become even more valuable funding avenues.

State-sponsored 529 college savings plans allow parents, grandparents and others to contribute to an account that can be used to pay a child's college tuition and room and board, as well as other expenses. The maximum lifetime contribution limit is often substantial: for example, Maine's plan allows a maximum lifetime contribution of $235,000.

Previously, the assets in the plan could grow tax-deferred, but were generally taxed at the child's rate when withdrawn for qualified higher education expenses. Starting in 2002, gains will be tax-free when withdrawn for qualified expenses. People saving through 529 plans can use the assets for private colleges and universities, as well as public institutions, and graduate and post-graduate schools, such as medical schools.

Also starting in 2002, for taxpayers who qualify, the annual non-deductible contribution limit to Coverdell Education Savings Accounts was increased to $2,000 a year per designated beneficiary, up from the current $500 annual limit. The assets can grow tax-deferred and be withdrawn tax free if used for qualified higher education expenses. The new law allows assets to be used for qualified elementary and secondary education expenses, including tuition for private and parochial schools.

Estate Planning

The new law repeals the estate tax in 2010. In the interim, it increases the credit that allows taxpayers to exempt a portion of their assets from estate taxes. In 2001, up to $675,000 of assets quality for the unified credit. Beginning in 2002, the estate tax exemption will be raised to $1 million and then gradually rise to $3.5 million in 2009. In 2002, the highest estate and gift tax rates will be reduced from 55 percent to 50 percent and will then gradually drop to 45 percent in 2007.

Unless the repeal is extended, in 2011 the estate tax exemption is scheduled to roll back to $1 million, the top estate and gift tax rate is slated to return to 55 percent. Because of these changes, you should thoroughly review your current estate plans.

Plan New Strategies

Meet with your tax and financial advisors to review the new tax law and its implications for your retirement saving, college funding and estate planning strategies. ■

For more information, please contact Erik Johnson, Financial Advisor, Merrill Lynch (206) 431-1667.

Retired Luncheon from page 5

common trend among gardeners young and old, of buying too many plants and not finding the time to get them in the ground or transplanted to other containers. "Container gardening does not include those black plastic pots they came in," she explained to a chuckling audience.

Stressing the importance of water-wise gardening, Ms. Sears went on to explain that "we should water less frequently but deep, and use soaker hoses whenever possible. This will provide adequate moisture, and help prevent mildew on plants.

She emphasized practicing environmentally safe gardening, including fewer pesticides and chemical-based fertilizers and weed-killers, noting that it has been proven that homeowners are the abusers of these pesticides and chemicals. Instead, she suggested using fertilizers that are organic-based, like compost and mulch and increasing your tolerance for bugs, remembering that a few bad bugs will bring many good ones, such as lady bugs that eat aphids.

She also encouraged proper pruning and transplanting of existing plants, shrubs and trees, and shared some very creative ways of maintaining a healthy garden. Gardens need pollenizers like butterflies and mason bees. Buy them if you have to. Keep the slugs away by having your neighbor kids pick them up from your yard.

In closing, Ms. Sears stated that, "sometimes through retirement, we get a chance to discover other things we enjoy. I hope that for you, it's gardening."

Ms. Sears and WSU Master Gardener Volunteers are able to problem-solve myriad questions about gardening, and are often found at local nurseries, hardware stores, farmers markets and fairs. They can also be reached Monday through Friday at the WSU Cooperative Extension Center, (253) 798-7170. Information, including materials provided at the luncheon, are also available online at www.gardening.wsu.edu.

The next Retired Physician Luncheon is scheduled for June 21st and will feature retired PCMS member **John Colen, MD**. Dr. Colen's presentation, "Along Russian Lines," will highlight his September 2001 trip to Moscow where he spoke at an international medical conference. He will also share his experiences as an overseas traveler during the New York WTC terrorist attacks. ■

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Environmental Health

Clean Air for Kids: Volunteers assess families' homes to identify what may be causing a child to cough and simple steps to reduce children's exposure to asthma-triggering events. For more information, including volunteering or scheduling a volunteer for an assessment, contact Amanda Odom (253) 798-2954.

Family-Based Services

Adolescent Health Programs: Staff provide "Functional Family Therapy," a twelve-week course of behavior modification, resource connection, and family support, to the youth and their families who are chronically truant or have had some involvement with the juvenile justice system. TPCHD's program is now the largest in the nation, at a case rate of 286 offenders and their families. Our success rates are very positive, including a decreased recidivism rate and increased school attendance and rising grade point averages. For more information on TPCHD help for adolescents, contact Ben Cables (253) 798-6485.

Home Visits: Public Health Nurses visited more than 5,000 families in 2001, providing intense education, health promotion and prevention interventions. Depending on the need, families were given information about medical care and social service resources, information about tobacco and substance abuse cessation programs, and parenting skills. Nurses based in hospitals screened the records of more than 7,000 newborns, referring those deemed at risk to the Family-based Service Program and community services. For more information, or to refer a family into this service, contact Allison Kemmer, RN (253) 798-4700.

Substance Abuse: The MOMS Program, which focuses on helping substance abusing pregnant and parenting women, served more methamphetamine abusers than any other Pierce County contracted program. In addition to cessation resources, staff provided domestic violence education, advocacy and support to approximately 3,600 women in 2001 and the program continues in 2002. For more information, or to refer a client, contact David Bischof (253) 798-6655.

Treatment Services: The department now treats 525 opiate addicts with methadone, and provides each client with counseling and resource information. At this point, treatment can be provided on demand, with no waiting list. For more information about methadone treatment, contact Marc Marquis (253) 798-4764. ■

COLLEGE OF MEDICAL EDUCATION

Allergy, Asthma and Pulmonology CME - May 3

Registration for this year's CME program focusing on subjects on allergy, asthma & pulmonology remains open for Friday, May 3 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

Subjects will cover:

- Update on Respiratory Tract Infections
- Asthma Treatment Option
- Latex Glove Allergies
- Endoscopic Nasal Surgery: When All Else Fails
- Emerging Trends in the Management of Asthma
- Do You Really Know How to Treat and Diagnose Allergies?
- Current Treatment of COPD

Call C.O.M.E. at 253-627-7137 to register. ■

2003 Whistler CME Set

The annual CME program at Whistler has been scheduled for January 22-26, 2003.

Details on lodging and the program will be available in a brochure available this summer. ■

Continuing Medical Education

Timely Topics Featured at Advances in Women's Medicine CME

The third annual CME program on Advances in Women's Medicine is scheduled for May 17, 2002. The conference will be held at St. Joseph Hospital.

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

Subjects scheduled to be covered include:

- A Learned Approach to Fibromyalgia, Arthritis and other Rheumatologic Disorders in Women
- Hormone Replacement Therapy and Alzheimer's Syndrome
- Withdrawal Bleeding Manipulation (No More Periods) with Hormonal Contraceptives
- Current Controversies in HRT and SERMS
- Lipids and HRT: A Lipidologist's Perspective
- New Approaches to Management of GYN Pain
- Update on Cosmetic Surgery and Non-surgical Cosmetic Treatments for Women

The course will be held at the Lagerquist Conference Center - Rooms 1A&B at St. Joseph Medical Center.

A program/registration brochure will be mailed in April. Those wishing to register can do so by calling the College at 627-7137. ■

Register by Web

You can now register for all the College's CME programs on the web. Just log on to the Pierce County Medical Society's home page at www.pcmswa.org and click on College of Medical Education. ■

Dates	Program	Director(s)
Friday, May 3	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 17	Advances in Women's Medicine	John Lenihan, Jr., MD

Classified Advertising

POSITIONS AVAILABLE

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

Family Practice physician
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United Cerebral Palsy of South
Puget Sound is actively recruiting members for its Board of Directors. If you have a background in or knowledge of the issues that surround cerebral palsy and have an interest in helping a young organization grow, please call our office for an application package (235) 565-1463.

Physicians' Review Network, an
accredited Independent Review Organization, needs your professional opinion about medical necessity. All specialties needed. 800-257-6888 x113. Visit www.prniro.com.

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412 Bowes Drive - 1540 sq ft consisting of examine rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

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BULLETIN

May, 2002

Photo by Sam Insalaco, MD

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
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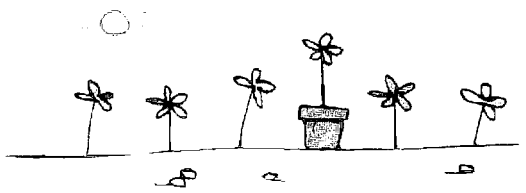
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

May, 2002



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President's Page

by Susan Salo, MD

Practice Viability

Susan Salo, MD

This year, the WSMA has one major priority in its focus: practice viability. Very large practices have failed in Olympia and Everett, and smaller practices are in trouble throughout the state; the situation has reached such crisis proportions that the WSMA legislative agenda is focused on the effects of various bills to the viability of medical practices.

Closely related is an attempt to push administrative simplification to minimize unproductive and unnecessary expenses of our current chaotic system.

Why have the WSMA officers come to the conclusion that this is necessary? In addition to the business failures mentioned above, many more offices have recorded losses in profitability or negative margins. With increasing financial pressure, some doctors are leaving Washington for other states (or more simply not choosing Washington to set up or join practices in the first place), some doctors are retiring early, and most doctors are giving consideration to limiting numbers or refusing Medicare - and Medicaid-insured patients.

Reimbursement from these two programs in particular has become so inadequate that the WSMA has noted direct correlation between large numbers of patients with these insurances and the likelihood that a practice will fail. An interesting comparison was published by the WSMA Health Care Economics Department (see chart) reporting that a dog's broken leg was four times as expensive in vet bills than the Washington State Medicaid payments for a fractured arm, and that a tanning salon visit is almost twice as expensive than the physician is paid for the resultant skin biopsy.

Fortunately, funding for interpreter services has been restored in the state budget, though lawmakers have looted future tobacco injury payments to solve this year's fiscal dilemma. (And who knows how they will solve the next one?)

I personally have another fear: that the medical care system and structure will be destroyed beyond repair before the general public becomes aware of its vulnerability.

Rather than a litany of despair, however, what we need is a coherent agenda for success. WSMA is prioritizing programs for viability in medical practices. Legislative efforts toward removing unfunded mandates, discussions with other states at the bottom of the Medicare payment scale, and educational courses directed at office management and at the most expeditious course to navigate HIPAA and other mandated changes are all taking place. The PCMS office is accumulating data for sharing with members to help improve office systems, is working with physicians' office managers to improve networking, and Membership Benefits, Inc. provides a temporary placement service to help bridge an absent employee's return or replacement. We are always seeking new ideas for other ways to help you, so keep in touch. ■

What's it worth? Washington State Medicaid payments compared to other commonly used services:[1]

Repair broken arm..... $114.74	*vs*	Repair dog's broken leg $500-800
Office visit $13.40		Take out pizza.....$19.00
Chest wound (knife).....$108.24		Clogged drain (RotoRooter)...$103/hr
Nail care/trimming.....$4.03		Pedicure/Manicure.....$50.00
Hernia repair.....$285.95		Car tune-up (60K service).....$495.00
Skin biopsy.....$26.89		Tanning salon.....$40.00

[1]Washington State Medical - Education and Research Foundation.

Referral coordinators working toward system improvements

Over 70 Pierce County primary care and specialty referral coordinators met at Tacoma's King Oscar Convention Center in April. The meeting, sponsored by Pierce County Medical Society (PCMS) and Tacoma Area Medical Managers (TAMM), focused on possible solutions to problems associated with the referral process, and featured a panel comprised of insurance representatives and referral coordinators. The group met for the first time in November and determined that quarterly meetings would be beneficial.

TAMM President Paulette Groves welcomed speakers and guests and introduced facilitator Isabelle Berka, Referral Coordinator at Summit View Clinic. Prior to introducing the afternoon's panel members, Isabelle encouraged active audience participation, reminding them that, "member input is what drives these meetings."

Representatives from Regence NDEX (Network Data Express) systems, Regence Blue Shield and Regence Care, Molina Health Care, PHN (Physician/Health System Network) and Mary Bridge Children's Health Alliance provided insight into the referral processes of each organization.

While acknowledging the disparities between each organization's referral processes, representatives became aligned in their support of streamlining the process. "We all have different referral systems, including computer systems. There is currently no standardized system to process referrals and claims. That is why we're meeting today, and working toward streamlining that process," affirmed Michelle Crisp, Regence Blue Shield Provider Customer Service Operations Supervisor. Michelle and other presenters are participants in the Washington Healthcare Forum, a group coordinated by the Washington State Medical Association to address administrative simplification, including improvements in the referral process.

The insurance organizations' representatives also found common ground in their support of electronic referrals, such as NDEX and PointShare. NDEX is a free extranet referral service, which should be available via the Internet sometime this summer, according to Ken Kurosawa, Regence NDEX Implementation Coordinator, who provides on site training and follow up for NDEX subscribers.

Other discussion items included front- and back-end referral processing, referrals for women's healthcare, patient responsibility for referrals and confirmation of coverage, and provider customer service issues. The insurance representatives encouraged feedback from referral coordinators in assisting them with educating their customer service representatives, in an effort to decrease mistakes made during initial referral inquiries.

Isabelle Berka of Summit View Clinic introduced the panel and facilitated the meeting

Suggestions for additional discussion topics and speakers were reviewed for the next meeting. Retroactive referrals and dealing with patients without referral authorizations were both recommended as issues that need to be discussed.

For a copy of handouts from the meeting, call PCMS, 572-3709. The next meeting is to be announced. ■

Streamlining the referral process was a major concern for the large crowd of referral coordinators in attendance

Michelle Crisp (left), Regence Blue Shield rep., and other panel members address customer service issues

Special Feature

by Jean Borst

A Prescription for Fraud

There is a growing problem in the medical community, and the results can be devastating. Physicians are robbed of their identity, pharmacists find themselves in the position of law enforcer, addicts are feeding a seemingly endless habit, and prescription drugs are finding a lucrative market on the streets.

While prescription fraud is often committed as a result of a person's addiction to prescription narcotics, many individuals are fraudulently obtaining the drugs to sell. The high likelihood of accurate dosage, purity, and lower price of prescription pills make them an attractive alternative to street drugs. For example, the prescription painkiller Oxycontin can bring $20 to $40 a tablet on the street, according to the DEA.

The DEA estimates that prescription drugs were sold for about $25 billion in 1993 in the illegal drug market, compared to an estimate of $31 billion spent that year on cocaine, including crack. About 2.6 million people in the U.S. use prescription drugs for "non-medical reasons" — more than the estimated number of users of heroin, crack and cocaine, according to surveys by the National Institute on Drug Abuse. According to the Drug Abuse Warning Network, prescription painkillers, sedatives, stimulants and tranquilizers are about 75 percent of the top 20 drugs mentioned in emergency room episodes each year.

In a nutshell...prescription fraud is a serious problem and probably more common than you think. Here are stories from two PCMS physicians, and comments from a local pharmacist.

'Unique' Experience with Pharmacy Fraud Makes Physician Proactive

"It all started last year," recalls **Dr. Sabrina Benjamin**, an internal medicine physician in Tacoma. "I was on vacation, and someone called in a prescription to a pharmacy for Ultram in my name. When the pharmacist at Kmart called my office for confirmation, a staff member said not to fill it, because she knew that I have a policy of never calling in that prescription."

"Two weeks later," she continued, "another pharmacy did fill the prescription — also for Ultram, but the checked bounced. They called my office and asked how to reach the patient, who, of course, wasn't a patient."

Dr. Benjamin called the police with each occurrence, and contacted the FBI and DEA the third time it happened. But to no avail. "I was told I couldn't do anything, because it was the pharmacy that was being defrauded. It was up to the pharmacy to file a complaint."

"I was very angry," she said. "This was a serious problem to me. Someone was using my identity, and I was told that I did not have a right to complain."

The multiple incidences were enough to prompt Dr. Benjamin to take action on her own. Following a series of phone calls, she composed a letter explaining the situation and listed all prescriptions that were not to be dispensed without her confirmation. She sent it to all local pharmacies.

On Thanksgiving morning 2001, Dr. Benjamin was working. Century Pharmacy, located at St. Joseph Hospital, received a call from someone with a prescription for Ultram in her name. The staff had posted Dr. Benjamin's letter near the phone, so when the call came in, they immediately called to confirm. They then notified the police. When a woman came into the phar-

See "Fraud" page 6

How to Protect Yourself from Prescription Fraud

Some tips from Purdue Pharma on how physicians can stop diversion and protect their practice:

- *Never sign an incomplete prescription.*
- *Use tamper-resistant pads that can't be photocopied.*
- *Write the quantity and strength of drugs in letters and numbers, like you would on a check. If just a number is on the prescription, it is easy to alter.*
- *Be wary of people who are not interested in having a physical examination, are unwilling to authorize release of prior medical records or have no interest in a diagnosis or a referral, saying they want the prescription now.*
- *Be cautious if a new patient has an unusual knowledge of controlled substances or when a new patient who requests a specific controlled drug is unwilling to try another medication.*
- *Stick to principles and take a complete history and perform a thorough physical examination.*
- *Look for drug abuse signs, such as inflamed nares, skin tracks and perforated nasal septum.*
- *Call police if you believe someone is trying to divert prescription medication.*

Source: Amednews.com, June 25, 2001

Fraud from page 5

macy to pick up her prescription of Ultram, she was arrested.

"I'm grateful that Century Plaza staff was adept enough to first pay attention to my letter, post it, and then respond accordingly," she said. "They were very helpful and very cooperative."

As for other pharmacies, "We were unable to convince them to call the police. And if the pharmacy doesn't file the complaint, nothing can happen."

In the meantime, Dr. Benjamin had to be aggressive. "I wrote letters, made phone calls to let all the pharmacies we deal with know that I don't call in for specific drugs. If a patient needs one of them, they are going to have to track me down because I won't call it in."

Dr. Benjamin also credited Tacoma's Lincoln Pharmacy. "The staff was very helpful in trying to apprehend the perpetrator when they called in the fraudulent prescription," she said. Unfortunately, the suspect never came in to pick up the medication.

"I felt personally violated as a professional. It was a hard lesson to learn how to be careful and protect my professional identity. I worked in the military system for years and was protected by the health system. I was astounded that someone could compromise my professional identity. What was also shocking was that when I talked to other physicians about this, I found out that it wasn't a unique experience."

Through Dr. Benjamin's assertiveness and the cooperation of area pharmacies, there were results, but not a complete resolution. One of the perpetrators was apprehended, "but we think there is still someone else out there doing this," she said.

Although not initially prompted by the incidents involving the fraudulent activity, Dr. Benjamin's office has put into place an electronic prescription system that eliminates interface with the patient and prevents illegal behavior associated with pharmacy fraud. "The system is tied directly from physician to pharmacy," Dr. Benjamin explained. "If a patient tries to alter a prescription, the pharmacist will recognize the discrepancy. It not only safeguards against fraud, but also prevents medication error. It protects the physicians, the pharmacy and the patient."

Everything between Dr. Benjamin and pharmacies is now handled electronically, with the exception of Madigan's pharmacy. Those prescriptions are hand written because the military has their own independent system. "I just need to trust that the patient will take it into the military system and not let anyone else get a hold of the prescription," she added.

When the Fraud Occurs Within the Office

While Dr. Benjamin's ordeal involved people she didn't know, **Dr. Mike Kelly's** story hit far too close to home for comfort.

Dr. Kelly, PCMS vice president and a family practice physician in Lakewood, came to realize prescription fraud was happening within his own office, which consists of two front office personnel and two back-office medical assistants. About a year ago, one of the MA's working in the back office overheard the other nurse calling in a prescription for Xanax for her sister.

"There were two things that the staff member knew," Dr. Kelly said. "The woman's sister was not a patient of mine, and that I hadn't authorized the prescription." After overhearing the conversation, the RN tracked down and called the pharmacy and asked the pharmacist to fax a copy of all the prescriptions on record for that person over the past five months. The list indicated that Dr. Kelly had OK'd several prescriptions for Vicodin, Valium and Xanax. "Of course," Dr. Kelly noted, "I hadn't authorized any of them."

Dr. Kelly confronted the employee and still bristles when he thinks

See "Fraud" page 8

Personal Problems of Physicians Committee

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

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

We Are Partners

As the Tacoma-Pierce County Health Department has moved forward with its bioterrorism planning, the relationship that exists between the department and the private practice physician becomes clearer and clearer. We are partners. It is very obvious to us in public health the central role that you play in our disease control efforts. I hope that it is apparent to you the role that public health plays in protecting the health of our community. Central to our efforts of working collaboratively with you is having clear lines of communication. Information needs to flow freely and accurately and in a timely manner in both directions from and to the private practitioner. One of the efforts that we have made is to try to visit each of the clinic sites in which you practice on a regular basis. The staff that make these visits are public health nurses. We call them Network Nurses as they work the network of close to 750 clinic sites spread across the county.

Each of their visits is an opportunity to strengthen the lines of communication between us. We need information on your infectious disease patients. We can work with your clinic staff to help make this process simple and not time consuming. We also hope that we can bring information to you and your clinic staff that will be useful to you in the management of your patients. The issues of family violence, alcohol and drug abuse, smoking cessation, and asthma prevention are just some of the services the department is involved in that might be useful in the care of your patients. Please encourage your staff to take the time to talk with our network nurses. I think it will be time well spent.

The following is information that may be useful to you. Please feel free to give patients these numbers, or refer them to these resources.

Asthma: 253-798-2954
Community-based partnership providing free services to assist families in implementing an asthma management plan; in-home visits, phone consultations, follow-up information shared with family's physician.

Domestic Violence 24-Hour Information and Referral Helpline: 800-798-4166
Safe, confidential place to talk about what is happening to the caller - for offenders, victims and friends of victims. Options discussed: assistance with filing reports, finding housing, transportation, moving to a safe location, support networks, meeting basic needs, formulate a safety plan.

Families Experiencing Trouble: 253-798-2842
Information, support groups and assistance for healthy pregnancy, newborn care, breastfeeding, parenting skills, SIDS prevention, early literacy, normal growth & development, injury prevention.

Teens in Trouble: 253-798-2949
Assessment, intervention, social work; Functional Family Therapy; referral to other professional service providers - substance abuse and mental health services, youth development, parent support, and community-based support. Public Health nurses, Social Workers and Therapists, Parent Partners and Community-based Coalitions provide coordinated services.

HIV, Sexually Transmitted Diseases, Testing, Reporting: 253-798-6410
Surveillance, technical consultation, outbreak investigation and control, contact tracing and partner notification, patient referral, comprehensive tuberculosis management for communicable disease control, unusual incidents, vaccine preventable, enterics, tuberculosis.

Smoking Cessation: 253-798-4707
Classes, support groups, 12-step programs, toll-free Quit Line, websites for tobacco information, phone counseling, free nicotine patch program for low income or underinsured smokers, training for health care providers and concerned community leaders on youth cessation facilitation, systems incorporation of tobacco services, workplace cessation activities and policies.

Substance Abuse (MOMS and Women's Recovery): 253-798-6655
Substance abusing low-income women (18+); alcohol treatment - pregnant, parenting, domestic violence, methamphetamine. Four locations: Tacoma Avenue, Puyallup, Lakewood, and Parkland. Medical coupons or sliding fee ($0 and up). Childcare at Tacoma Avenue site to age 13.

For additional information, visit our website: www.tpchd.org. ■

Fraud from page 6

of the conversation. "She looked me straight in the eye and completely denied everything," he recalls. "This was an employee who had joined the staff a few months earlier and had become absolutely essential to us," Dr. Kelly said. "She was a wonderful employee who did some fantastic things to benefit the office. She immediately came in and made herself indispensable. She was totally an above-board person. I didn't want to believe she had done something like this." He followed up the conversation by talking with the pharmacist who had videotape of the sister picking up her many prescriptions. "It was documented and confirmed," Dr. Kelly said. "I called the employee and told her she was fired and that I would be contacting the authorities. Even at that point, she still denied the charges."

The Medical Assistants Association conducted an investigation. After many denials, the woman finally admitted to fraud and lost her medical assistant's license. Dr. Kelly noted, however, that she's currently working as a receptionist at a local clinic.

And despite the video documentation and a positive identification by the pharmacist, the sister denied ever picking up the prescriptions. Dr. Kelly believes she was probably selling the drugs.

"It just goes to show how vulnerable offices are," Dr. Kelly said. "Staff members call in prescriptions for controlled substances to pharmacies all the time. If my other employee had not been so alert and aware, it could have gone on indefinitely."

One solution to prevent this from happening, Dr. Kelly notes, is to discontinue phoning in prescriptions. "If I call in a prescription for Xanax, how does the pharmacists really know it's me? It's easy enough for someone to get a hold of my DEA number."

Today, Dr. Kelly's office communicates with pharmacies almost exclusively by fax.

In addition, the office has in place an electronic medical records system through which he can write and print prescription orders. But his office isn't typical and the percentage of offices utilizing such a system is very small. The primary reason – cost. Dr. Kelly notes that there are several electronic prescription programs available on the market that don't require purchase of an entire medical records system. He highly recommends that offices go this route.

Dr. Kelly credits pharmacies for being alert to potential prescription fraud. "I've been very impressed by the pharmacies," he said. "They are very sharp and know what to look for." But being overly cautious has its down side, too. He recalled an incident where a pharmacist called him when a man came in with a prescription written by Dr. Kelly for a large quantity of Percocet. "The pharmacist thought the situation was suspicious and called me," Dr. Kelly said. "I didn't know the patient, so I was alarmed. I always sign my prescriptions in a certain color ink, and the pharmacist confirmed that it was not the ink color I use. But he felt it was an original signature, as opposed to a photocopy. But I knew I had not signed that prescription. The pharmacist said, 'That's all I need to know. I'm calling the police.'" A short time later, Dr. Kelly received a call from a police officer who told him they had the man in handcuffs and they were taking him to jail. "At that time, I asked where the prescription had been written. The patient said it had been written at St. Joe's upon his discharge from the hospital. That's when I realized that it might have been a real prescription written by another Dr. Michael J. Kelly who is a physician associated with St. Joe's." It turns out the prescription was legitimate.

"But, I certainly can't fault the pharmacist for that," Dr. Kelly noted. "He was being alert and did the right thing. However, pharmacies can sometimes be a bit overzealous." He recalled a physician who used to work in Tacoma who was turned in to the Medical Quality Assurance Commission by a pharmacist who felt he was over-prescribing narcotics for patients. The issue took years to resolve, and in the end, the physician was exonerated. "But those things don't happen too often," Dr. Kelly said. "I would prefer the pharmacist be alert and cautious. We all need to be."

Commonly Abused Prescription Drugs in the United States

Opiates ("Narcotics")

- **Oxycodone** (OxyContin, Percodan, Percocet, Tylox)
- **Hydrocodone** (Lortab, Lorcet, Vicodin aka Vicodan)
- **Meperidine** (Demerol, Mepergan)

Stimulants ("Uppers")

- **Methylphenidate** (Ritalin)
- **Amphetamine** (Dexedrine, Adderall)

Sedative-hypnotics ("Downers")

- **Diazepam** (Valium)
- **Alprazolam** (Xanax aka Zanax)
- **Lorazepam** (Activan)

A Pharmacist's Perspective

"We don't see a lot of fraud here on a regular basis, but we certainly have seen our share over the years," according to Allenmore pharmacist Dick Driskell. "This is an established pharmacy and staff. We have the same people behind the counter day in and day out. I think people know that this isn't the best place to come with a

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In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Evidence and Reality

Andrew Statson, MD

"It took the genius of Newton to show that the moon is falling,
when everybody could see that it isn't,
and the genius of Enstein to show that the moon travels in a straight path,
when everybody could see that it doesn't."

Author Unknown

I could not find the author of the above quote to give him credit. I may add a third name to the list. It took the genius of Galilei to show that the Earth moves, when everybody could see that it doesn't. There is sadness associated with his story. The authorities of the time were so blinded by the evidence that they could not see the reality he showed them. He was asked to repudiate his scientific conclusions, which he did, lest he burn at the stake.

Evidence-based medicine became a buzz phrase during the past five years. There is a good reason for it. Most people who have lived their entire lives in a free country, such as the U.S. and Britain, have a very high regard for the printed word. Those with a personal experience of life under the Nazis and the communists have a different view. This is best expressed in the form of a joke, which made the rounds of the Soviet block years ago. "Russia has two newspapers, *Truth* and *News*. In *Truth*, there is no news, in *News* there is no truth." The basic thrust of evidence-based medicine was to point out that the articles in the medical journals must be assessed critically and the value of their conclusions determined according to the strength of the study.

Healers appeared in human communities in prehistoric times. They learned from experience and from one another. Their view of healing was colored by the general view of nature during their time and at their place. The Greeks thought everything was made of the four basic elements, air, fire, earth and water, and diseases were due to disturbances in the four respective humors, which determined the four temperaments, sanguinic, choleric, melancholic and phlegmatic.

The Chinese saw disease as an imbalance between yang and yin and as a blockage in the flow of the vital forces along the six meridians of the body. The purpose of acupuncture is to release that blockage at the points where it occurs.

Western medicine is based on scientific trials. Even though observation and personal experience are a valuable foundation of medical practice, they are greatly enriched by sharing with others the personal knowledge each of us has acquired. In this process of sharing we have to explain how we did our observations and to justify our conclusions. Because medical practice goes back to before antiquity, there are things that were handed down from generation to generation, the truth of which was based on the experience of one teacher. That practical approach worked most of the time, so it was seldom questioned.

Shortly after WWII, Doctor Cochrane made the first concerted effort to study the medical literature and collect the articles that presented solid scientific data. He started his work at about the same time when Britain established the National Health Service. I don't know whether there was any connection between them at the beginning, but the NHS is a strong supporter of the Cochrane Library. The NHS also urged the British Medical Journal to develop a publication on clinical evidence, which now appears under that title and is updated twice a year. United Healthcare is a financial backer and has distributed the book to physicians in this country.

The efforts of those two insurance systems to educate us are laudable. They probably hope that we will treat their patients better and as the patients benefit, the industry will benefit from lower costs. The danger is twofold, that the studies are selected to meet the desires of the insurers for lower cost treatments, and that the selections represent a personal bias of the editors.

The goal of that publication is stated in the introduction: "It specifically aims not to make recommendations. This is because we feel that simply summarizing evidence will make it more widely useful. The experience of the clinical practice guideline movement has shown that it is nearly impossible to make recommendations that are appropriate in every situation. Differ-

See "Evidence" page 14

Alzheimer's Association will hold Pierce County Memory Walk

The Alzheimer's Association of Western and Central Washington will hold the Pierce County Memory Walk on Saturday, August 24th at Annie Wright School in Tacoma.

The walk is open to all families and professionals and will benefit services offered by the Association in support of the organization's mission of education, support and advocacy. Services and resources in Pierce County include the helpline, support groups, case management and education services.

To participate in the Memory Walk, or for more information about the Alzheimer's Association, call the Helpline at (800) 848-7097 or visit www.alzwa.org. ■

TEPR Conference and Exhibition

The 18th Annual TEPR 2002 - *Emerging Health Information Solutions* Conference and Exhibition will be held May 11-16, 2002 at the Washington State Convention Center in Seattle. New technologies and their promised solutions will be tested, compared and measured by health professionals from around the world during six days of accredited sessions, demonstrations and exhibits.

TEPR 2002 brings together healthcare providers, information specialists, vendors and leaders responsible for implementing and maintaining a successful information infrastructure. Medical Records Institute sponsors the conference with support from CAP Gemini Ernst & Young, ECG Management Consultants, Eclipsys, GE Medical Systems, IDX , Mobilocity, and Next Gen.

For exhibiting and sponsorship inquires call Ellen Boland at 617-964-3923 #226 or Kara Sanborn at 617-964-3923 #231 or visit www.tepr.com for more information. ■

A call to.....family physicians, pediatricians, and all who care for children

Child health advocates have concluded that the "Back to Sleep" message has not been effectively delivered to the African American community. It appears that while the message has been disseminated it has not reached the African American community with the same effectiveness as the majority community.[1]

In September 2000, Secretary Braddock released the DSHS Public Accountability Scorecard. Three important measures are included in this Scorecard: infant mortality, minority (i.e., African American and American Indian) infant mortality, and child deaths among DSHS clients.

While Washington's minority infant mortality has decreased by 50% in recent years - from a rate of 15.2 deaths per 1000 in 1990 to a rate of 7.6 per 1000 in 2000 - the minority infant mortality rate (7.6 per 1000) remains substantially higher than that for all infants (rate of 5.2 per 1000 in 2000).

At least three factors have contributed to recent improvements in infant mortality: the First Steps program has increased access to prenatal care and has provided enhanced prenatal care; surfactant therapy for respiratory disease has reduced mortality among very low birth weight infants; and the "Back to Sleep" media campaign reduced deaths from SIDS (Sudden Infant Death Syndrome).

Overall, since "Back to Sleep" has become a standard message for parents of newborn babies, Washington death rates from SIDS have decreased by more than 50% from 1.9 per 1000 in 1990-92 to 0.8 per 1000 in 1999.

In 1996, the proportion of healthy babies who were put down to sleep on their backs was just 17% for African American infants, less than half that for white infants (37%) according to data presented in the "National Infant Sleep Position Study."

Many of us have probably assumed that all is well. We have assumed that all parents and childcare providers have gotten the message about "Back to Sleep." The data stated previously dictate otherwise. Just as we strongly encourage those newborns to leave the hospitals in car seats, we as physicians must see to it that these same newborn mothers must be educated on the "Back to Sleep" campaign, especially the African American mothers.

The data indicates that somehow the message is not getting to them. While more culturally appropriate parent education materials about sleep positions is being developed and targeted to the African American community, it still remains up to us who see these children for their newborn and well-child exams to constantly inform the parents and childcare providers about the need for "Back to Sleep." Please don't assume that someone else is doing the education for us. Let us see to it that the SIDS death rate decreases for all children. ■

[1]California has developed more culturally appropriate parent education materials about sleep position, targeted to African Americans, and has agreed to print copies of these materials for the Medical Assistance Administration.

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forged prescription." He noted that larger chain stores are easier targets, and people will often bring fraudulent prescriptions in late in the day or evening when the regular staff isn't there.

Driskell notes that in his store fraud most often occurs with prescriptions for Oxycontin, a pain medication commonly prescribed for cancer or surgery patients. "It has a high value on the street, and it is also an abusive drug," he said.

"Patients are very convincing when they see their doctors," Driskell said. "They exaggerate their pain and convince physicians to write prescriptions in strengths and quantities that the patients don't necessarily need. When we see those kinds of prescriptions, we question them."

Over the years, Driskell and his staff have come to recognize the signs of fraud. "You can tell that the prescription isn't written quite right," he said. "Or you see the signature has been forged. After a while, you come to recognize how physicians write out prescriptions. You can see things that might set off alarms. Then you call the physician, and often our hunch is correct."

Driskell recalled one incident that occurred several months ago. A patient convinced a local oncologist that they needed a prescription for Oxycontin. "Then they managed to con us with a story that they were on welfare and needed the prescription but didn't have the money right then," Driskell said. "This was a situation where the doctor thought he was doing the right thing in helping the patient manage pain. We thought we were doing the right thing by trying to help a family having financial difficulties. It turns out it was all a con, and we were out $900 for trying to help."

Driskell offers the following advice to physicians.

1. Know your patients before writing a prescription.

2. Write out the quantity in a way that it cannot be altered. If a prescription is written for 10 tablets, that amount can easily be changed to 100. Driskell suggests writing the quantity and strength in numerals and words.

3. On refills, always write out the number in words ("zero" or "one"). Again, writing "1 refill" can easily be changed to "10 refills."

Most important, Driskell stresses, doctors should be on the cautious side, "especially if you are dealing with prescriptions for typically abusive drugs."

"I can't blame physicians when these things happen," he said. "They are extremely busy, and it's sometimes very hard to know when a patient isn't being honest."

Advances in technology pose challenges, he added. Copiers can now make duplicates of prescriptions that look like originals. Suddenly, a patient might have two, three or four copies of a single prescription.

Driskell noted that his pharmacy has been receiving more and more letters from physicians (such as Dr. Benjamin) asking pharmacists to be on the alert for prescriptions for certain drugs written in their names. "They are not writing prescriptions for these drugs," he says, "and they want us to notify them immediately if someone presents a prescription for them. And we are more than willing to cooperate." ■

Applicants for Membership

Roger C. Grayson, PA-C
General Surgery
Mt. Rainier Surgical Associates
419 South L Street #101, Tacoma
253-383-5949
Prof School: University of Washington

Uhng-Kyu Robert Shim, MD
Radiology
Diagnostic Imaging Northwest
222 15th Avenue SE, Puyallup
253-841-4353
Med School: Med College of Wisconsin
Internship: LA County UCS Med Ctr
Residency: Rochester Gen Hosp
Fellowship: University of Washington

Tien Ahn Wee, MD
Radiology
Diagnostic Imaging Northwest
222 - 15th Ave SE, Puyallup
253-841-84353
Medical School: Columbia University
Internship: University of Hawaii
Residency: Univ of California Davis
Fellowship: Memorial MRI Center

Justin K. Yoon, MD
Diagnostic Radiology
Tacoma Radiology
3402 S 18th St, Tacoma
253-383-1099
Med School: Virginia Commonwealth Univ
Internship: Georgetown Univ Med Ctr
Residency: University of Washington
Fellowship: University of Washington

In My Opinion...

by Stephen F. Duncan, MD

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

The Cell Phone

Stephen Duncan, MD

Much has been said about the rudeness of cell phone users. My wife's experience at a grocery checkout, where a woman talking on a cell phone nearly poked her eye out without even an excuse me, is just one example of the inappropriate behavior that cell phone users exhibit. Probably, we each have a favorite story of cell phones being misused in church, the public restroom, the theater, etc.

What some may not realize is that the doctor's exam room is not immune from the intrusiveness of the cell phone. In our office a woman carried on a complete conversation while the doctor, with the aid of the nurse, performed a pap smear and pelvic exam. I, personally, have entered the exam room to find the patient on the phone. In addition, I have had patients answer their phone in the middle of the visit or talk on the phone while I interviewed or examined their child or spouse. I even had a patient's friend try to carry on a phone conversation while I gave the patient instructions. The patient was deaf and required the instructions to be written. What is going on? The prize should be given to the contractor, who tried to carry on a walkie-talkie conversation with his employee, while he discussed his prostrate problem with me.

To many, these interruptions may seem ridiculous or petty; but let's face it, it is just plain RUDE to expect a physician or nurse to attend to medical problems while the patient is on the phone. With the exception of the President, who must keep the red phone with him at all times, there is no one on earth that is required to talk on the phone during a visit to the doctor. Don't patients realize that with the invention of voice messaging they will not miss the important call from their teenager to ask for permission to go to a friend's house anyway? What are they trying to do - share the exhilaration of the pelvic exam with their friend? I say stop it!

"In our office a woman carried on a complete conversation while the doctor, with the aid of the nurse, performed a pap smear and pelvic exam."

We actually have had discussion in our clinic on how to stop patients and others from using the cell phone in the exam room. The staff in our office, who find security in rules, have had signs erected as you go back to the exam rooms asking patients to not use their cell phones while present in the back office. This has not stopped it. If signs were effective, we would not have people in the express lane at the grocery store with a week's groceries. I suggested that the signs at least warn patients of potential equipment explosions if the phones are used in the exam rooms. That was vetoed.

We have had medical staff simply walk out of the room when a cell phone is in use. This has been met with varying levels of success. I have simply told patients very bluntly that they need to terminate the call immediately. I get strange looks but yet have not had a patient challenge my authority. I imagine that day will come. I am prepared to give that patient my unabashed opinion.

I suppose that we need a help book on the deterrence of this offensive behavior but I have not found one yet. Maybe there will be a continuing medical education meeting in Maui next winter on the cell phone problem. Until then, I will have to fantasize what it would be like to retrieve a cell phone with a sigmoidoscope. ■

Evidence from page 9

ences in individual patients' baseline risks and preferences, and in the local availability of interventions, will always mean that the evidence must be individually interpreted rather than applied across the board. *Clinical Evidence* provides the raw material for developing locally applicable clinical practice guidelines, and for physicians and patients to make up their own minds on the best course of action. We supply the evidence, you make the decisions."

The point that the evidence must be interpreted according to the individual situation is well made. We consider study results as evidence if they are true 95% of the time. Galilei did not say that the Earth rotates from West to East 95% of the time. Newton did not say that the moon falls 95% of the time. Our evidence is not reality and our reality remains unknown until after the treatment is completed and the results become known. Even then, we cannot be absolutely sure.

There is another problem, with this book and with medical literature in general. Because the data frequently are soft, the writers can insert in their conclusions their biases and their wishful thinking. I consider notorious in that respect a study made about twenty years ago, which reported that patients with previous cesarean section who delivered vaginally had fewer dehiscences of the uterine scar than those delivered by elective cesarean section prior to labor. The authors of the study did not have the nerve to claim that labor closes uterine dehiscences, but said that at least it does not increase the risk. However, the way they looked at the uterus in the two groups was so different, that no comparison could be made. Nevertheless, their conclusion was politically desirable and was quoted widely.

To see whether such bias could be present in *Clinical Evidence*, I opened the book to an area with which I should be familiar, perineal trauma in childbirth. There is a key message in the book: "One systematic review of RCT found no direct evidence about the effect of epidural anesthesia on rates of perineal trauma. However, epidural anesthesia was associated with an increased risk of instrumental delivery, which in turn is associated with increased risk of perineal trauma."

How do you interpret the above statement? It seems to say that people looked at perineal trauma in patients with epidural anesthesia, did not find an increased risk, but did not quite believe their results because of the increased rate of instrumental delivery, which should have caused more trauma.

The explanation came three pages later. There was a review of 11 RCT comparing epidural anesthesia with other forms of analgesia. Six of these trials provided data on the rate of instrumental delivery, which was increased in patients with epidurals. None of the studies looked at the rate of perineal trauma. The key message quoted above was based on no data. It was based on speculation and guilt by association. That is in a book titled *Clinical Evidence*.

My personal experience is that epidural anesthesia reduces the risk of perineal trauma (personal observations, level 3 evidence). The reason is that epidurals relax the perineal muscles and allow them to stretch more readily, and blunt the expulsive efforts, so that the delivery proceeds more slowly and the perineal muscles and skin have more time to stretch and are less likely to tear. I admit that I am biased.

I don't know for sure what the reality is. It probably varies from patient to patient. The evidence from the medical studies can light our way, but neither we, nor the authorities who dictate to us how to practice medicine, must allow it to blind us so much that we do not see the reality it can hide. ■

In My Opinion....

by Nichol Iverson, MD

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

Doctor, You've Been Faxed

Nichol Iverson, MD

Sergeant Joe Friday to a lady on Dragnet:
"Just give me the fax, ma'am."

Today I received a fax from a pharmacy company that delivers medicines to nursing homes. According to RCW2-4-6-8-whodoowee asphyxiate, I am now required to send a prescription to the pharmacy as well as writing an order for the nursing home for Schedule 2 drugs. Federal law #666, implemented under the paper production act of 2002.001, requires the signature to be written by the prescribing physician on the first Friday the 13th, following the first Blue Moon in February. Of course, the signature must be signed in cloned cow's blood, and then covered with the dung of the extinct Dodo bird. With each additional irritating speed bump in my practice, the revolution in medicine nears the point of no return. I just turned 57. "So what," you say! In a recent article, the *PCMS Bulletin* asserted that the average physician retires at age 57. I just might do that! Imagine the collective power we have to change the medical delivery system. We take our pens, pencils, Palm Pilots and iPAQ's, and quit playing the stupid game. How high does our overhead need to get, and how irritating do the regulations need to become, before the quality of life in the practice of medicine becomes too painful to endure? As a bonus we got a pay cut from Medicare! Imagine any other occupation where the widget has become the least important part of the industry. With each additional minute of paperwork, each Oxygen form, each disabled parking form, and each new set of orders that needs to be rewritten, we are spending less time with our patients.

The last weekend that I was on call, one of my colleague's patients asked, "Are you taking new patients? My mother just moved from Arizona, and has complicated medical problems, and was seen in the emergency room. We were told to try to find an internist to help manage her many problems, and I know that finding a doctor for a Medicare patient is difficult." I gave him some suggestions that work to get an occasional patient into my closed practice. Beg sincerely. What a tragic microcosm! But you ain't seen nutten yet. As the baby boomers enter the age of high medical utilization, suffering, among other things, the slow painful consequences of the tobacco terrorists, (those staunch Americans who kill 500,000 of our friends and neighbors annually), then will gum up the system long before they reach Medicare age. As physicians choose between Chapter 11 or selecting patients whose reimbursement exceeds Medicare's, who is going to be able to afford to see the elderly? Or me?

"How high does our overhead need to get, and how irritating do the regulations need to become, before the quality of life in the practice of medicine becomes too painful to endure?"

I have begun to develop a new set of ICBM codes to replace the CPT codes. First a brief lesson in math for all the history majors. The square root of negative one is the letter i. Thus began the notion of imaginary numbers. Suppose you have a typical internal medicine patient who has insulin dependent diabetes mellitus, with retinopathy, nephropathy, neuropathy, hyperlipidemia and its consequences. These might include, but are not limited to, a previous CVA, a couple MI's, congestive cardiomyopathy and a little fatty liver just for kicks. Add a few whacks to the pretibial area, and voila an amputation for a non-healing ulcer from the peripheral vascular disease. With some mild dementia, and a short leg, this poor chap tends to fall a fair amount, and to suffer a fracture or two or seventeen. With only mild hypertension, the medi-

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cations don't cause too much orthostatic hypotension until the caretaker tries to get him from his wheel chair to your exam table. He slithers onto the floor at which point you and the nurse are both incontinent trying to get him onto the exam table. As you try to stand up from the searing pain in your back, you notice that the seventeen family members who accompanied Mr. Disaster point out that his socks are different colors! "Oh, my God," you shout, "He's color blind, too!" Since the whole fam damily is planning a trip to Bermuda, there is no way Mr. D can go home. He needs to go to the hospital. After writing out his orders for 117 medications, insulin, radiographs to check to see if he broke something when he fell on his a**, you spend the next hour and 51 minutes trying to find a bed for him. Eventually you get an ambulance to pick him up, dictate his hospital summary, and then try to deal with the 17 incensed patients who have waited to spend their usual 11 nanoseconds with you for their appointments. Your best paying customers left. The appropriate ICBM code is i99115. The reimbursement is only imaginary, as your cost for the delays, psychiatrist bills, and trips to the chiropractor for your back, amount to 13 times your receipts from Medicare. You now know the Codes for **I**maginary **C**ash **B**enefiting **M**edicare. The combination of increased hassles and decreased reimbursement now describes CPT codes a.k.a. **C**haritable **P**hysician **T**asks. Now you know the official Federal acronym for Medicare's current payment plan, recently decoded by a genius about whom a movie is being filmed....The Lame Brane. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Allergy, Asthma and Pulmonology CME - May 3

Registration for this year's CME program focusing on subjects on allergy, asthma & pulmonology remains open for Friday, May 3 at St. Joseph Medical Center. The course is under the medical direction of **Alex Mihali, MD**.

Subjects will cover:

- Update on Respiratory Tract Infections
- Asthma Treatment Option
- Latex Glove Allergies
- Endoscopic Nasal Surgery: When All Else Fails
- Emerging Trends in the Management of Asthma
- Do You Really Know How to Treat and Diagnose Allergies?
- Current Treatment of COPD

Call C.O.M.E. at 253-627-7137 to register. ■

Register by Web

You can now register for all the College's CME programs on the web. Just log on to the Pierce County Medical Society's home page at www.pcmswa.org and click on College of Medical Education. ■

Advances in Women's Medicine CME Scheduled for May 17

The third annual CME program on Advances in Women's Medicine is scheduled for May 17, 2002. The conference will be held at St. Joseph Hospital.

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

Subjects scheduled to be covered include:

- A Learned Approach to Fibromyalgia, Arthritis and other Rheumatologic Disorders in Women
- Hormone Replacement Therapy and Alzheimer's Syndrome
- Withdrawal Bleeding Manipulation (No More Periods) with Hormonal Contraceptives
- Current Controversies in HRT and SERMS
- Lipids and HRT: A Lipidologist's Perspective
- New Approaches to Management of GYN Pain
- Update on Cosmetic Surgery and Non-surgical Cosmetic Treatments for Women

The course will be held at the Lagerquist Conference Center - Rooms 1A&B at St. Joseph Medical Center.

A program/registration brochure will be mailed in April. Those wishing to register can do so by calling the College at 627-7137. ■

A Pacific sunset as recorded by photographer and CME participant Sam Insalaco, MD from the Hapuna Prince Hotel waterfront. Over 50 local physicians accompanied by 100 family members enjoyed another College sponsored "resort" CME program held this year on the Big Island. A more detailed representation of program activities and fun will be displayed in the June PCMS Bulletin.

Operation Stroke to be launched in Pierce County May 17

The American Stroke Association, a division of the American Heart Association, will kick off its Operation Stroke program in Pierce County May 17.

Operation Stroke, a grassroots initiative to raise awareness of stroke warning signs and the critical need for immediate emergency treatment, will be launched during a breakfast from 7:00 a.m. to 8:30 a.m. at The Tacoma Club, 1201 Pacific Avenue, 16th Floor of the Wells Fargo Plaza.

Featured speakers will discuss the Operation Stroke program in detail, including plans for its implementation throughout Pierce County. They include **Dr. Pat Hogan**, a neurologist at Puget Sound Neurology in Tacoma; Dr. Michael Weinstein, a physiatrist at Virginia Mason Medical Center in Seattle; and **Dr. Federico Cruz-Uribe**, Director of the Tacoma-Pierce County Health Department.

The goal of Operation Stroke is to reduce the number of people who die or become permanently disabled by stroke, the nation's third leading killer behind heart disease and cancer. To do this, the American Stroke Association wants to increase public awareness of stroke warning signs and the Emergency Medical Services' ability to transport stroke patients, and boost the number of stroke patients who arrive at the hospital in time to receive acute treatment.

"We want to reduce the time it takes for stroke patients to get treatment, and to do that we need to improve early recognition of this deadly disease by helping both the general public and the medical community better understand risk factors and warning signs," Dr. Hogan said.

Operation Stroke mobilizes communities to improve the stroke chain of survival. Developed by the American Stroke Association, this four-step process includes:

- Rapid recognition and reaction to stroke warning signs. Recognize the warning signs and note the time when they first occur. Call 911 immediately. Tell the operator if you or the person you are with is having stroke warning signs.
- Rapid start of pre-hospital care. Receive early assessments and pre-hospital care by emergency medical personnel.
- Rapid Emergency Medical Services transport and hospital pre-notification. Get to an appropriate hospital quickly via EMS - ambulance personnel will notify the emergency room.
- Rapid diagnosis and treatment at the hospital. Receive prompt evaluation of medical data and treatment to restore blood flow to the brain or other treatments as appropriate by a properly staffed and equipped hospital.

Operation Stroke, organized by a coalition of civic leaders and volunteer health care professionals, is designed to reduce the amount of time it takes stroke patients to get to the hospital and be assessed for possible treatment with tPA. Studies have shown tPA, a clot-busting drug approved by the Food and Drug Administration in 1996, can significantly reduce the debilitating effects of stroke and minimize permanent disability if administered within three hours after the onset of symptoms.

An estimated 5 percent of stroke patients arrive at the hospital in time to receive potentially life-saving treatment because most people don't know the warning signs or don't realize they should seek medical help immediately.

They symptoms of stroke are: 1) sudden weakness or numbness of the face, arm or leg, especially on one side of the body; 2) sudden confusion, trouble speaking or understanding; 3) sudden trouble seeing in one or both eyes; 4) sudden trouble walking, dizziness, loss of balance or coordination; and 5) sudden severe headache with no known cause.

To RSVP for the Operation Stroke kick-off event or for more information, contact Colleen Wilks at 253-272-7854, extension 15, or colleen.wilks@heart.org. ■

Awards

Daisy S. Puracal, MD, family practitioner in Tacoma, has been awarded the honor of Founding Diplomate of the American Board of Holistic Medicine. ■

Classified Advertising

POSITIONS AVAILABLE

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

Family Practice physician needed. Exciting opportunity for energetic family practice physician in Tacoma, WA. Female Ob/Gyn wishes to office-share or partner with F.P. Great office location and beautifully remodeled office. Great patient base to quickly build a practice. Call and ask for Penny (253) 460-7777 or send CV to (253) 460-0959.

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Retired RN owns licensed tran-scription business. Four years experience. 24-hr turnaround. 460-1520.

POSITIONS AVAILABLE

United Cerebral Palsy of South Puget Sound is actively recruiting members for its Board of Directors. If you have a background in or knowledge of the issues that surround cerebral palsy and have an interest in helping a young organization grow, please call our office for an application package (235) 565-1463.

Seattle, Wash - Occupational Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examination rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

Medical Space For Sale. Premier location in newer building, with partial ownership in two commercial buildings in rapidly expanding South King County. Call 360-825-1389.

2400 sq ft space - $3,500/mo. Corner MLK & 8th - ample parking and storage. 360-458-5766.

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

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Pierce County Medical Society

BULLETIN

June, 2002

The Holderman family (left), Dr. William Holderman and wife Lisa with children Gracie and Lauren and the Katsman family (right), Dr. Ralph Katsman and wife Lisa with children Marisa and Danielle pose during the opening reception of the College of Medical Education's CME at Hawaii conference April 7-12, 2002 at Hapuna Beach

More photos pages 12-14

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
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223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

June, 2002

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President's Page

by Susan Salo, MD

"System Improvements"

Susan Salo, MD

For the past several years, I've been on the credentials committee, as a member, then as chair, a position **George Noble, MD** assumed when I assumed the presidency. Along with several other members, I noticed that very few of the new member applications provoked any question, most questions were trivial and were problems with the application completion. In those several years no problem arose that prevented an offer of membership.

When more medical schools began charging fees for verification of graduation, some rather hefty, especially when the number of applicants was considered, the credentialing process exceeded the value. This became even more obvious when staff time for credentialing work was factored in to the expense equation.

The Board of Trustees formed a membership committee to simplify and improve the process of application and acceptance. The Board expanded that commission to produce a membership policies manual and new brochures and application form. The result was a recommendation that since the State Department of Licensing and the hospitals all have a mandate and a serious legal obligation to credential in depth, license in the state should be considered adequate for membership. The Society will also track nonmember physicians in Pierce County, offer membership to any who are interested, and keep information on reasons for leaving the Society, in a continuing effort to remain relevant and to offer the best service that we can to new members.

I personally will ask the committee to continue to meet, to evaluate what we can improve, not just for new members, but to improve benefit to established members as well.

Please feel free to review these materials at the Society office and you can look forward to a notice regarding the required Bylaw change.

I'm anticipating the June membership meeting with Rick Creatura discussing lawsuits against plans, including lawsuits filed against Premera and Regence by Franciscan Medical Group and Tacoma Orthopedic Surgeons. In addition to my interest in this very timely topic, I've been informed that he is a very insightful speaker. Please join us on the 11th.

Thank you. ■

Physicians can request HIPAA delay until October 16th, 2002

Physicians can submit their request electronically to stave off Health Insurance Portability and Accountability Act (HIPAA) compliance for one year. Health plans, health clearinghouses and health care providers can use the Department of Health and Human Services model compliance plan to apply for a one-year extension to comply with HIPAA's Transactions and Code Sets (TCS) regulation. Under last December's Administrative Simplification Compliance Act, Congress authorized covered entities to ask to extend their compliance with the rule until October 16, 2003.

To obtain the extension, a covered entity must submit the compliance plan on or before October 15, 2002. The model compliance plan, instructions on how to file it electronically, is available at www.cms.gov/hipaa/hipaa2/ASCAForm.asp. You will be asked a few questions and asked to tell CMS what you have done to date. Once your compliance plan is submitted, you will receive an online confirmation number, which will serve as acknowledgment of your extension. You will not receive specific approval of your submitted compliance plan.

If you would prefer to file a manual (paper) submission through the mail, you may download a PDF file. CMS will not acknowledge receipt of paper submissions. For proof of delivery, use a delivery confirmation option, such as those offered by the U.S. Postal Service. Send paper submissions of your compliance plan, postmarked no later than October 15, 2002, to: ATTENTION: Model Compliance Plans, Centers for Medicare & Medicaid Services, P.O. Box 8040, Baltimore, MD 21244-8040. ■

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Niki R. Becker, MD
Delete 316 ML King address and phone

Mark A. Crowe, MD
Add the following to current listing:
Puyallup Dermatology
Physicians only: 445-6556
Res: 12613 133rd Ave E, Puyallup 98374
Res phone: 770-8785
E-mail: mcrowe@thedermdoc.com
Website: www.thedermdoc.com

Cynthia W. Edwards, MD
Change office phone to 403-7555 and physicians only phone to 403-7554

Stanton A. Erwin, MD
Delete 1410 S Meridian address and change fax number to 272-4765

Richard Hawkins, MD
Change office phone to 403-7555 and physicians only phone to 403-7554

Robert Z. McLees, MD
Change home zip to 98332

Medical Imaging Northwest
(Advertisement - Page 42)
Change website address to www.medimagingnw.com

Christopher R. Miller, MD
Change office phone to 403-7555 and physicians only phone to 403-7554

Craig A. Rone, MD
Delete 1410 S Meridian address and change fax number to 272-4765

Donald C. Weber, MD
Change fax number to 826-4792

ARE LAWSUITS THE ANSWER?

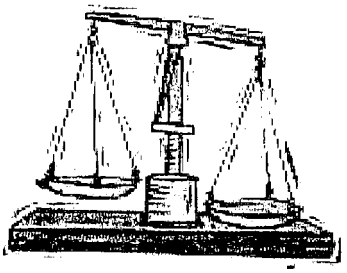
featuring

Rick Creatura

Attorney-at-Law

J. Richard Creatura, JD, practices with Gordon, Thomas, Honeywell, Malanca, Peterson and Daheim in Tacoma. He represents Tacoma Orthopaedic Surgeons and Franciscan Medical Group in class action lawsuits recently filed against Regence and Premera in Pierce County Superior Court. He just returned from Chicago where he met with AMA counsel and staff regarding national concerns and efforts to prevent unwarranted downcoding, bundling and other practices to delay and/or deny legitimate claims.

- Class Action? How/when to join
- Local and national lawsuit review
- Successes in other states?
- "Death by a Thousand Cuts"
- Identifying the scams
- Your questions?



June General Membership Meeting

⇨ Sponsored by Pharmacia ⇦

Tuesday, June 11, 2002 - *Social Hour*~6:00 pm, *Dinner*~6:30 pm, *Program*~7:30 pm
Landmark Convention Center - Temple Theatre Roof Garden, 47 Saint Helens Avenue, Tacoma

Complimentary for all PCMS members and their guest
$20.00 for non-members and additional guests

Return this portion of form to: PCMS, 223 Tacoma Ave S, Tacoma, WA 98402; Fax to 572-2470 or call 572-3667

Name: (please print or stamp) _____

I will be bringing my spouse or a guest. Name for name tag: _____

Please reserve _____ dinner(s) at *NO CHARGE for PCMS members and their guest*
$20.00 for non-members and additional guests

REGISTRATION REQUIRED by Friday, June 7th

If you register and later find you are unable to attend PLEASE call and cancel
The parking lot across the street now costs $3, but there is usually ample street parking

PCMS thanks 2002 Food Drive organizers and participants

The Pierce County Medical Society in conjunction with Food Lifeline recently concluded the first annual PCMS Food Drive. Medical Society members, their staff, family, friends and neighbors were challenged by Food Lifeline to help hungry people in Pierce County by collecting food to benefit local food banks and meal sites.

In April the Medical Society began delivering food donation boxes and barrels. By May 5, the total amount of food donations collected equaled 1,565 pounds with an additional $100 in cash donations.

Twenty three physicians and/or their offices were contributors to the first of what PCMS plans to be an annual event.

Pierce County has seen a dramatic increase in people needing emergency food assistance due to the economic downturn and events of September 11. Many businesses have stepped to the plate in recent months to help our local food banks, and Pierce County residents have shown overwhelming support.

The Medical Society extends a great big thank you to everyone who organized collection sites as well as to those who contributed. ■

Food Drive Contributors

Cascade Eye & Skin
Cedar Surgical Associates
Electrodiagnosis & Rehab
Family Medicine of Fife
Franciscan Medical Group (Gig Harbor)
Franciscan Specialty Care
Patrick Hogan, DO
Internal Medicine NW
Anthony Kim, MD
Lakewood Pediatrics
Mary Ann McDonald, MD
John Merrick, MD
Jane Moore, MD
Charles Prewitt, MD
Donald Shrewsbury, MD
Surinderjit Singh, MD
South Hill Family Medicine
Richard Waltman, MD
Denise Wells, MD
Robert Wright, MD
Carl Wulfestieg, MD
Amy Yu, MD

Physicians win legal victory in Georgia

In a major victory for U.S. physicians, a Georgia state court has ordered Georgia Blue Cross/Blue Shield to disclose its fee schedules and payment methodologies to members of its physician panel. It is believed to be the only case in the United States to force insurance companies to disclose to physicians, in advance, how much they will be paid for their services.

The April 29 decision came after the Medical Association of Georgia (MAG) and four of its members sued Georgia Blue for breach of contract. Nearly two years ago, a Georgia appellate court held in favor of the physicians, but it is only now that the trial court implemented the higher court order.

The AMA, through the Litigation Center and the Private Sector Advocacy group, helped MAG develop its legal strategy and finance the lawsuit. The AMA attempted to intervene as an additional plaintiff, but since MAG already represented the Federation interests, the court denied that request. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

TACOMA-PIERCE COUNTY
HEALTH
DEPARTMENT

Operation Stroke

The American Heart Association has launched Operation Stroke, an initiative intended to increase the chances of surviving a stroke. They focus on educating the public and medical providers to do the following:

1. **Rapid recognition and reaction to stroke warning signs**. Recognize the warning signs and note the time when they first occur. Call 911 immediately. Tell the operator you or the person you are with is having stroke warning signs.

2. **Rapid start of pre-hospital care**. Receive early assessments and pre-hospital care by Emergency Medical Personnel.

3. **Rapid Emergency Medical Services (EMS) system transport and hospital pre-notification**. Get to an appropriate hospital quickly via EMS; ambulance personnel will notify the emergency room.

4. **Rapid diagnosis and treatment at the hospital**. Receive prompt evaluation of medical data and treatment to restore blood flow to the brain or other treatments as appropriate by a properly staffed and equipped hospital.

In addition to the above, the Tacoma-Pierce County Health Department contributes to reducing the impact of strokes with a few key ***stroke prevention*** activities.

Many of you know of our well-publicized campaigns to prevent tobacco use, alcohol and drug abuse, and violence. The first two should have an impact on the number of people who have to deal with strokes in Pierce County. If we can lower the rate of smoking and alcohol or drug abuse, we should prevent a significant number of strokes each year.

We use a population-based approach, putting ads in movie theaters, on buses and billboards, and notify people about easy ways to get into cessation programs. We encourage restaurants to go smoke-free (we're up to 66% smoke-free in Pierce County right now) and work with physicians to have them inquire about tobacco use among their patients. It's working. The tobacco use rate in Pierce County is dropping.

We also administer a program that not many people know about. This one focuses more on the individual. The Ethnic Health Program involves a public health nurse educating people who attend the various ethnic meal programs throughout the county. She screens blood pressure and diabetes levels, refers people to physicians and other providers, and also teaches them how to lower those levels, through diet, exercise and, when necessary, taking medication.

We know that both high blood pressure and high blood sugar levels can leave the individual with a much higher probability of suffering a stroke or other cardiovascular event. We want to prevent that.

Here are some statistics to show the impact of this program.

At a mealsite for Japanese seniors, our PHN screened 62 individuals for blood pressure. Seventy-nine percent of them had significantly elevated levels. During the next twelve months, the 49 people with high levels were screened at least three times. They also participated in individual and group training about the role of diet, exercise and smoking in blood pressure levels. Twenty-three of the 49 were referred to physicians and encouraged to schedule a visit; eighty-seven percent of the referred clients saw their medical providers. Those who were put on medication for the high blood pressure were encouraged to take their meds regularly. Within a few months, 67% of the people who started out with high blood pressure reduced their levels, most of them to normal.

That statistic is repeated throughout the county. At a Cambodian mealsite, 73% of participants had elevated blood pressures and 65% of them reduced their levels to normal after education and ongoing screening; nearly 80% of those with high blood pressure were referred to physicians and 100% followed through. At a Samoan mealsite, 55% had high sugar levels. Eighty percent were referred and 93% of them complied. Eighty-two percent of the people with elevated levels dropped their sugar counts, half of them to normal levels with counseling, education and encouragement.

I could continue with statistics about people at Filipino, Vietnamese, Russian, and Hispanic mealsite programs. What's important is the ability to prevent strokes, through education and reinforcement of physician's treatment protocols.

Like you, I want to get rapid recognition and response to stroke, to give the best possible chance to people suffering from a stroke. I also want to see us do whatever we can to prevent strokes. Let's work on both aspects and lower the impact in Pierce County. ■

Board of Health receives grant to promote water fluoridation

The Washington Dental Service Foundation has awarded $420,000 to the Tacoma-Pierce County Board of Health to promote community water fluoridation. This grant has been matched with funds by the Tacoma-Pierce County Health Department for a total pool of $840,000 to offset the expected $1.4 million start-up costs to fluoridate.

The grant is in response to an April 4 vote by the Tacoma-Pierce County Board of Health to require communities with more than 5,000 people to implement water fluoridation measures by January 1, 2004. Affected water districts have until May 22 of this year to decide if they want to participate in the department's fluoridation by the 2004 deadline. The 300,000 residents of Fircrest, Tacoma, University Place, and the local military bases already have community water fluoridation.

Washington Dental Service Foundation Chair James N. Sledge, DDS, Spokane, said, "We applaud the efforts by the Board of Health to have this safe and effective disease prevention tool benefit more people in Pierce County." "The Foundation has worked with a number of oral health groups in Pierce County over the years, and this project is another step forward to improving oral health in the county."

The U.S. Center for Disease Control has recognized community water fluoridation as one of the ten great public health measures of the 20th century. According to the U.S. Surgeon General, community water fluoridation is the most cost-effective, practical and safest means for reducing and controlling oral health disease in a community.

The Washington Dental Service Foundation has a long history of support for community water fluoridation, including grants to the City of Yakima in 1998 and the City of Pasco in 1999 to assist their efforts to adjust the natural level of fluoride in their community water supplies.

The Washington Dental Service Foundation, funded by Washington Dental Service, is charged with helping improve oral health of all Washington citizens through proven and effective oral health measures. Created in 1985, the foundation is the state's largest foundation dedicated to oral health. ■

Applicants for Membership

Matthew B. Quick, MD
Family Practice
Lake Tapps Family Medicine
3920 West Tapps Dr E, Sumner
253-862-8001
Med School: Jefferson Medical College
Internship: Naval Hospital
Residency: West Pennsylvania Hospital

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

The Cost of Prevention

Andrew Statson, MD

"A stitch in time saves nine."
English proverb

A frequently repeated truism claims that an ounce of prevention is worth a pound of cure. The problem is that it is not always true. The saying really should be, "an ounce of prevention should save a pound of cure." Unfortunately, sometimes we may spend a pound on prevention to save an ounce of cure, especially if the money spent on prevention does not come out of our pockets, but the money spent on cure does.

Doctor Harry Goldblatt was our chief of pathology when I was a resident. Some of you may recognize his name. He did the pioneering work on the role of the kidney in hypertension. On the rare occasions when he led our pathology conferences, he dropped a pearl or two in our minds. He tried to temper our youthful eagerness to stamp out disease by reminding us of the human cost of every treatment. One day he told us, "We can prevent 99% of breast cancer by doing a bilateral mastectomy on every girl as she turns eighteen." Whoa! That gave us something to think about. Sure, we all were in favor of prevention, but at that cost?

When we become aware of a new risk, we tend to go overboard in our efforts to prevent it, before we have even assessed the magnitude of the problem. For instance, when Doctor Sculley and his associates reported the first several cases of clear cell adenocarcinoma of the vagina in young women who were exposed to stilbestrol in utero, our panic matched our consternation. The situation turned out not to be nearly as bad as it seemed at the time, but before we could decide that vaginal adenosis was not really clear cell carcinoma, a number of young women underwent radical hysterectomy and vaginectomy in the mistaken belief that they had or were about to develop vaginal cancer.

More recently, we went through weekly herpes cultures in pregnant women near term and multiple cesarean sections, in an effort to prevent neonatal herpes. We probably prevented a few cases, but at a tremendous cost. Some researchers speculated that we must have spent over a million dollars for each case we prevented. Yet, the law being what it is, we had to do it. Of course, the question came up, could we have spent that million dollars on other things that would have done more good. If so, who would make the decisions and allocate the funds?

Prevention has had a number of great success stories in medicine. The practical eradication of smallpox is one. I only hope we did not drop our guard too early on that one. The role of the Pap smear in the prevention of cervical cancer is undeniable. The lifetime risk for cancer of the cervix has dropped from 3% to less than one in a thousand. Here, also, some researchers claim that we don't need to do Pap smears every year, that it is too expensive and the risk is not that high. Perhaps, but should we drop our guard because we have been successful? How much prevention is too much? Who should decide?

About twenty years ago, a few complaints by women in the South were made public. The patients claimed that they were sterilized without their consent. They stated that either they did not understand the nature of the proposed operation or they were led to believe they could not get prenatal care unless they also agreed to have a tubal ligation.

Some civil rights groups got hold of the story, there was a hint of eugenics and ethnic cleansing, so Congress had to act. The result was the current requirement that women receiving public assistance must sign a permit for sterilization containing a federally mandated language, then they have to wait thirty days before they can be sterilized. In case of labor and delivery more than thirty days before term, they must have signed the permit at least three days ahead of time.

I don't know how many unwanted sterilizations were prevented by this law, but I know that many women were denied a desired sterilization at the time most appropriate for them. Pa-

See "Prevention" page 18

New PhRMA code on Interactions with Healthcare Professionals adopted

Editor's Note: Fortunately, the new PhRMA code will not interrupt sponsorships of our annual CME conferences sponsored by the College of Medical Education or sponsorship of PCMS General Membership Meetings

On April 18, 2002, the PhRMA Executive Committee voted to adopt a new PhRMA Code on Interactions with Healthcare Professionals.

The voluntary code outlines **guidelines for how sales representatives and others involved in marketing pharmaceuticals should interact with healthcare professionals**. The main points of the new code are as follows:

General Interaction: Interaction should focus on informing the healthcare professional about scientific and educational information and supporting scientific medical research and education to maximize patient benefits.

Entertainment: Interaction should not include entertainment. Interaction should occur at a venue conducive to providing scientific or educational information. Specifically, this means no "dine and dash," no entertainment, and no recreational events (for example, sporting events or spa visits).

Continuing Education: Companies can provide support to the conference sponsor but should not fund individual participants. That means, a company should not pay an individual's tuition, but could provide support to the event sponsor. That sponsor may in turn provide grants to individuals to participate, or to reduce the overall registration fees for all attendees.

Consultants: Legitimate consulting or advisory arrangements are appropriate but token consulting arrangements should not be used to justify payments to healthcare professionals. Characteristics of legitimate consulting arrangements include the retention of professionals based on their expertise, not as a reward or inducement for prescribing, and retaining no more consultants than needed for the specific program. For example, it would be inappropriate to retain 10,000 physicians for a program that requires no more than 1,000, or to select them as a reward for high prescribing.

Educational and Healthcare Practice-related Items: Educational and practice-related items may be provided to healthcare professionals, but should be for the healthcare benefit of patients and of less than substantial value (100 dollars or less). Items for the personal benefit of the healthcare professional should not be offered or distributed. In short, nothing should be offered or provided that would interfere with the independence of the healthcare professional's prescribing practices.

The effective date of the code is July 1, 2002.

For a complete copy of the code, please call the Society office at 572-3667.■

House bill recognizes crises, revitalizes tort reform

For at least the seventh time in a decade, the U.S. House of Representatives is set to consider legislation that would change how the legal system handles medical malpractices cases.

In April, a bipartisan coalition of representatives introduced a tort reform bill that includes everything from capping noneconomic damages at $250,000 to allowing future economic damages to be paid over time. And patients - except when the injured party is a child younger than 6 - would have three years to file a lawsuit. That statute of limitations is shorter than what exists in most states now.

Although the House has taken up tort reform before, only to see the legislation go nowhere in the Senate, physicians say the atmosphere is different this time.

There is more pressure for change, they say. Doctors are seeing cuts in payments they receive from Medicare and HMOs, while at the same time liability insurance rates are rising sharply in many states. The combination is forcing some doctors to retire early or to stop offering high-risk services, such as obstetrics. Some emergency departments can't find physicians to take call.

"We have a small time bomb ticking here," said Ann C. Cea, MD, a radiologist from Rye Brook, NY and president of the Medical Society of the State of New York. "We're losing physicians. There has to be something that gives."

Tort reform is the first step to helping physicians stay in practice, she and others say.

Physicians believe that the legislation would help curb rising liability insurance rates that are driving many doctors from practice and, in turn, hurting patients' access to care.

"The health of the nation depends on it," said Donald J. Palmisano, MD, AMA secretary-treasurer.

In addition to the noneconomic damages cap, the bill would make physicians responsible only for the portion of damages for which they are responsible. The courts could limit attorneys' share of awards. And to be awarded punitive damages, patients would have to show clear and convincing evidence of malicious intent to injure or deliberate failure to act to avoid injury.

The bill also would leave some power with the states. Those with damage caps - whether larger or smaller than the HEALTH Act provisions - could use their own guidelines.

But trial lawyers don't see the bill in the positive light physicians do.

"It is extreme in every detail," said Carlton Carl, Assn. of Trial Lawyers of America spokesman. "It will punish victims of medical malpractice. If this is a response to medical malpractice premiums, then it's absolutely the wrong approach."

Carl said every type of insurance is seeing increases, and tort reform won't reduce liability premiums. "I would be surprised if this passed."

And finding senators who are willing to support a bill will likely be difficult. Previous legislation passed by the House has died in the Senate.

But as more physicians retire early and others stop offering certain services, patients will likely help put pressure on their senators to take action, supporters of the HEALTH Act say.

"We believe now with this crises and with the American public's support, that we will be successful," Dr. Palmisano said. ■

Excerpted from AMNews, 5/13/02

CME at Hawaii includes education, family, and sun

COLLEGE OF MEDICAL EDUCATION

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

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

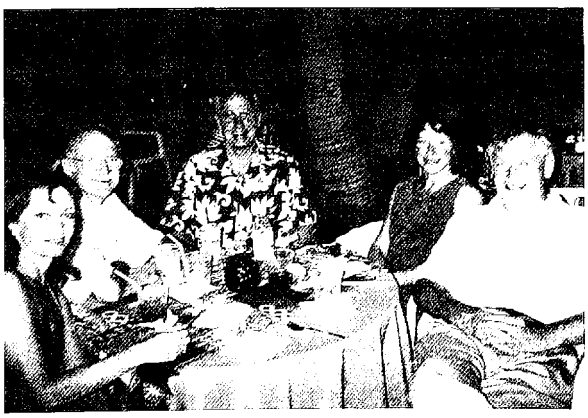
Out of the classroom, conference participants and their families enjoyed exploring Hawaii, water sports and, of course, great weather.

The College continues to offer resort CME conferences both in ski locations and in sunny resort areas. The next ski program will be held again in Whistler, British Columbia in January of 2003. The next CME at Hawaii program will likely be scheduled for spring vacation of 2004.

The College would like to thank conference participant Sam Insalaco, MD for contributing to these photos. ■

Dr. Ron Graf, Tacoma endocrinologist, enjoys the Hapuna pool and Hawaii sun with daughters Hailey and Hannah

Dr. Pat Hogan, PCMS Secretary/Treasurer, and his wife Carolyn enjoyed the R and R of being away from home



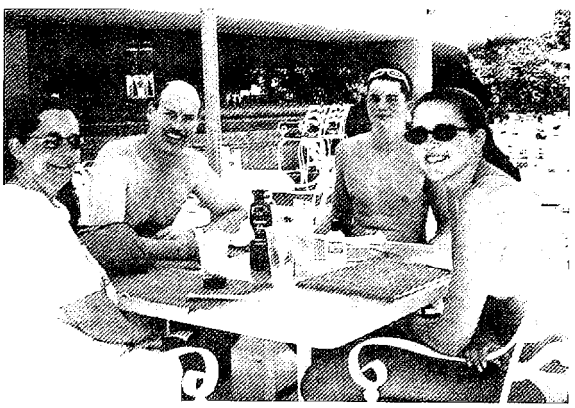
Ann and Ron Taylor (left), Alex and Debbie Mihali (center) and PCMS Past-President Jim Wilson (right) enjoy the conference opening reception

Dr. John Van Buskirk and family enjoy the Hapuna pool. Dr. Van Buskirk is a faculty member of Tacoma Family Medicine

Dr. John Rowlands updates conference participants on Thromboembolic disease and severe septis syndrome. Dr. Rowlands served as PCMS President in 1996

Dr. William Holderman makes a point in his CME presentation on Inflammatory Bowel Disease. Dr. Holderman serves on the College Board of Directors

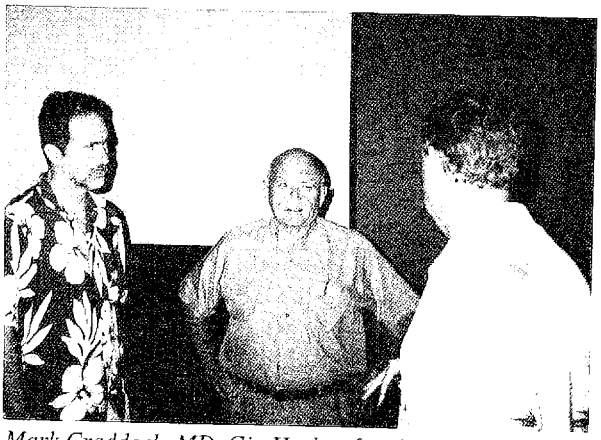
Left to right - Dr. Mark Craddock, Dr. Pat Hogan, Carolyn Hogan, Jinny Craddock, and Dr. Needham Ward are all smiles after snorkeling



Waiting for lunch around the pool, the Kennedy family (l-r) Jane, Kevin, Colin and Caitlen enjoy Hawaii. Dr. Kennedy practices otolaryngology

Conference speaker Dr. John Rowlands (right) further clarifies his point to CME participants Drs. Ron Graf (left) and Antonio Garcia

Dr. David Magelssen and his wife, Penny, enjoyed the break away from the busy life at home. Dr. Magelssen is a Lakewood ob/gyn

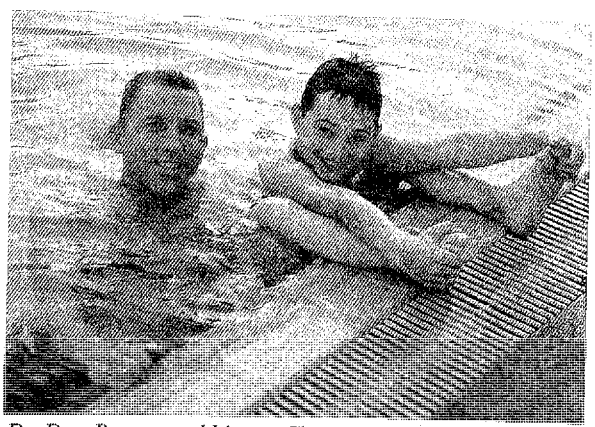


Mark Craddock, MD, Gig Harbor family practitioner, and speaker David Dunner, MD (center) discuss points with Puyallup neurologist Dale Overfield, MD (right)

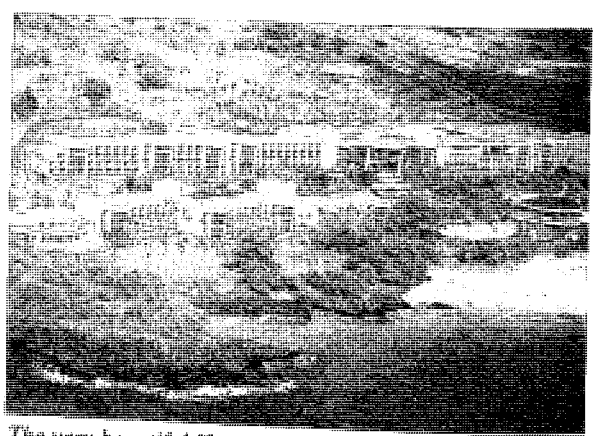
Matt Goodin, son of John Goodin, MD proudly stands behind his "board" before enjoying the beach. Matt's dad is a Tacoma ophthalmologist

Dr. David Law and his wife Beverly in front of the pool during Sunday's reception. Dr. Law was PCMS President in 1995 and now serves as a WSMA trustee

Dr. Jay Winemiller and friend visit with Dr. Teresa Clabots. Dr. Winemiller is a urologist and Dr. Clabots a pediatrician, both practice in Lakewood



Dr. Don Boutry and his son Kevin enjoy the Hapuna pool after the morning's CME session. Dr. Boutry practices ob/gyn in Tacoma



The very beautiful Hapuna Beach Prince located on the "Big Island" on the Kona Coast received rave reviews from conference participants

In My Opinion...

by Daisy Puracal, MD,ABHM

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

A Butterfly Flapped

Referrals/Preauthorizations

Daisy Puracal, MD

It is said that when a butterfly flaps its wings, it is felt on the other side of the continent. A small change can have far-reaching and untoward consequences.

The referral process as it stands today is one such flap. How did this whole situation start up? The way I recall it, it had to do with turf and control issues. Primary care doctors did not want to see patients going to specialist care without going through them. Although this made perfect sense theoretically, the bottleneck at the primary care office and the hassles with the paperwork have created a virtual nightmare for all - doctors, specialists, staff and insurers. It has not saved any money in the system for anyone and everyone complains about it. So why are we still persisting with this farce? Is it to "save face" or is there some hidden value to this?

From my point of view, there is some advantage to having some form of a referral process:

1) Patients are evaluated in a more comprehensive fashion.

2) The initial work-up is done at the primary care facility.

3) A more appropriate referral is set in place.

4) Specialists can hone in on the problem at hand with a good part of the initial work-up done.

5) Resources are used much more efficiently.

The current system however is not working! The way I see the situation:

1) The final decision is not with the primary care doctors. It is with some clerk, fresh out of school, that is at the other end of the line at the insurance agency, who does not know right from left and has no clue about medical decision-making.

2) The person at the other end is almost always in training because the last one had left because the stress was too much to handle.

3) There is not enough staff/lines at the other end to deal with the volume and we are kept on eternal hold (or the staff is on a prolonged coffee break!).

4) Patients have been "educated" that primary care doctors will not refer because of financial "disincentives" to do so (fallout from the capitation system) and so they demand referrals.

5) The volume of patients needing/wanting referrals has necessitated additional staffing just to keep up with this function.

6) Specialists are dumping all preauthorizations for subsequent testing and/or surgeries for the primary care office to second-guess the rationale for the tests or the procedure planned.

7) Specialists send the patients to other specialties without the knowledge of the primary care physician. Five months later, a desperate plea from the patient/specialist comes to the primary care physician for a retrograde referral because the claim was denied.

8) There is no consistency amongst different insurers as to the format or procedures that need pre-authorizations/referrals.

9) From my perspective I find it is helpful to communicate with the patient about their needs and preferences. I assess the situation to confirm the appropriateness of the referral and try to glean enough data to allow the referral to be set in place. Patients often don't realize the time and effort it takes behind the scenes for the process. Getting data, looking up appropriate codes, getting through to the insurance company and sending data to the specialist. I generally cannot do all of this without a patient appointment to the office. The patient sometimes sees this as an unnecessary visit and they storm in to the office madder than hell, and resent having to pay the co-pay for the visit. We are viewed as having dollar signs for eyes. In no other profession is a service asked for with the expectation that it will be free.

10) There are times, however, that I think that the process is redundant - a waste of time and resources (e.g., when a patient has a diagnosed cancer, has been under specialist care, and needs ongoing care but the referral has "expired").

11) Then there is the question of referral to alternative care providers! This is something I truly wrestle with. There is no way I can tell a patient, "Yes, a chiropractor will take care of your problem," especially when the al-

See "Referrals" page 16

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lopathic methods that I am familiar with are not given a chance to prove themselves. How can I take on the responsibility of referrals to a field (e.g. naturopathy, acupuncture) that I am ignorant about or am not confidant will help the patient. I have no problems with patients seeking alternative care, but that responsibility and the outcomes/consequences of that action should be with the patient.

12) Another area of contention for me is referrals for massage therapy. Undeniably a massage almost always feels wonderful whether one is in pain or tired or just because. The difficulty is where to draw the line as to what should be covered by the already strained medical system. I do not want this responsibility. Massage therapy has not been proven to affect the outcomes of disease. It can be administered by oneself, or a family member and is available at beauty salons. How far do we stretch "medical therapy." Will hair and nail care be the next covered benefit?

13) One slip up and the whole claim is denied even if the referral is undeniably appropriate. Who is setting up these rules at our expense? The service was already provided, in good faith.

It seems to me that we need to re-evaluate the whole concept of referrals and the process, by asking what it is we want to achieve. If the answer is patient care and cost containment, then we need to do away with the current process. Without a doubt there does need to be checks and balances, especially for the large ticket items.

The patient is paying the insurer for administration of services. It goes without saying that they should have some input to the nature of care they wish to seek.

Administration on the other hand needs to look at the finances, what the premium is supposed to cover and balance needs with cost containment.

I propose that insurance companies hire a nurse, preferably an RN that has sufficient expertise to manage a "referral center." Patients are encouraged to see the primary care physician through the media/flyers and educational material sent out by the insurance companies. Primary care doctors are in a unique position to know the span of medical care and are a good resource for appropriate care. If the primary care doctor determines that specialist care or tests are needed, the physician's office sets up the appointments, but the patient calls the RN at the "referral center" to authorize payment. This will be an opportune time for the nurse to explain the patient's portion of the bill, before the service is done. The nurse can explain limits of a benefit (e.g. number or visits to a physical therapist before being reevaluated by a physician). In the same way, a specialist orders test/procedures and the RN deals directly with the patient regarding payment issues.

When appropriate, the RN can bypass the primary care doctor and do a direct recommendation to a specialist. She would have a better handle on the patient's history from the codes and all the different doctors the patient has been seeing and be able to be sure that the basics are done for his/her care and that there is no duplication of services and cut down on doctor shopping. Just this alone - reducing redundant visits, I intuit, will save the insurers money.

Alternative care can be offered as a separate package and handled like vision and dental health care for additional premiums for those who are so inclined. Patients can directly see a CAM provider depending on the benefit package subscribed to and this solves the issue of referrals to CAM providers by primary care physicians.

Two different functions (i.e., delivery of care and authorization for payment) are conglomerated into one function with fuzzy boundaries, at the primary care doctors office and the insurance agency. With the change I propose, the responsibility of finances goes back to the insurance companies, which is why we have insurance companies in the first place. Delivery of care will be back in the domain of the physician, and we will be able to reclaim our function as healers again, rather than "referral station" or "watchdogs/medical police" for the insurance agency. ■

IN MEMORIAM
VINCENT M. MURPHY, MD
1923-2002

Vincent M. Murphy, MD was born October 19, 1923 in Seattle and died May 6, 2002 at his home in Edgewood. After receiving his medical degree from Creighton University in Omaha Nebraska in 1953, he completed his internship at Providence Hospital in Seattle and residency and Tacoma General Hospital. He decided to speacialize in anesthesiology after meeting Dr. John Bonica. In 1957, Dr. Murphy started as the first anesthesiologist at Good Samaritan Hospital and practiced his entire career there until his retirement in 1985.

Dr. Murphy was a member of the Pierce County Medical Society since 1956.

PCMS extends sympathy to his wife Elizabeth and their family.

IN MEMORIAM
DENNIS A. WIGHT, MD
1942-2002

Dennis A. Wight, MD was born May 27, 1942 in Los Angeles, California and died tragically May 4, 2002 in a skiing accident. Dr. Wight received his medical degree from George Washington University School of Medicine in Washington, DC in 1967. He attended El Camino Jr. College and the University of Utah before beginning his medical studies. He served in the Army Medical Corps in Colorado, Kentucky, Germany, Virginia and Washington (at Madigan), resigning his commisison in 1976 to enter private practice.

Dennis Wight, MD

Dr. Wight was a Pierce County Medical Society member since 1976 and practiced obstetrics and gynecology in Tacoma. He enjoyed his professional life, especially when bringing new lives into this world.

Dr. Wight was very involved in with his church and was a Scout Master, leading his sons and other boys on 'high adventures', but instilling high values at the same time.

PCMS extends sympathy to Dr. Wight's wife Elizabeth and their children.

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tients, even when properly counselled, take time to make their decisions, miss appointments, move to another area or present late for care. When they finally ask to have their tubes tied, it is already too late.

How often does that happen? I would guess it involves about two percent of all pregnant patients. With four million births a year, that makes 80,000 patients. If they don't get sterilized at the time of their delivery or section, they have to use birth control and come back for another operation.

Many of them come back a month or two later and have the procedure. Many others stay on birth control for months, or even years, and eventually have it done. Much too often, however, patients come back pregnant and either have an abortion followed by a tubal ligation, or end up delivering a child they didn't want and could ill afford.

The economic cost of the additional care and disability of these patients probably averages $1,000, for a total of $80 million per year. If this prevents eighty unwanted sterilizations per year, it is achieved at a cost of $1 million dollars per case. If it prevents 8,000, the cost would be $10,000, just enough to pay for the tubal reanastomosis of those who did not want to be sterilized. Apart from the cost, this exercise essentially protects some people at the expense of others, who are made to suffer.

I know we are a rich country and can afford to spend a few million dollars here and there, but there must be a better way to prevent unwanted sterilization and at a much lower cost. In this situation we are spending a pound of prevention to save an ounce of cure.

Granted, $80 million is minuscule compared to the health care budget, but this is only one instance of widespread efforts at prevention, no matter what the cost. These efforts are a large contributing factor to the high cost of drugs and to the recurrent shortage of vaccines and injectables. They raise our costs of providing care and are a source of expense and inconvenience to us and to our patients by wasting time and effort. They lead to frequent delays and occasional denials of appropriate treatments. The overall result is skimpier care at a higher cost.

The basic issue here is money, or rather, the lack of it. Someone mentioned that we are experiencing a scarcity of dollars. That is true, money is a scarce commodity. Does anyone know of a time in history when money had not been scarce? Someone has to work to make it, before it can be spent. Who? There was a time in the past when masters had slaves, who worked and made the money for them. That system proved economically inefficient and the industrial revolution swept it away. Now we consider slavery to be immoral. It is also illegal, at least, overt slavery is. So who is going to work to make the money? Any volunteers? Please don't all speak at the same time. ■

Classified Advertising

POSITIONS AVAILABLE

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

Family Practice physician needed. Exciting opportunity for energetic family practice physician in Tacoma, WA. Female Ob/Gyn wishes to office-share or partner with F.P. Great office location and beautifully remodeled office. Great patient base to quickly build a practice. Call and ask for Penny (253) 460-7777 or send CV to (253) 460-0959.

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Retired RN owns licensed tran-scription business. Four years experience. 24-hr turnaround. 460-1520.

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Milton/Edgewood. Practice in a growing community. Feel wanted, needed and welcome. Just right for Family Medicine. Built-out primary care medical office complete with reception, patient records, 12 exam rooms, procedure room, x-ray, lab, and nurses station. Ready to lease. Call Tom Perkins, 206-465-0300.

Family Practice physician is searching for a FT/PT physician (internal or general practice) to assist in a very busy practice. Salary plus incentive. Please submit your resume and CV to: **Jay G. Sacks, MD,** 3611 S D St #12, Tacoma WA 98418 or call (253) 475-2601.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

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

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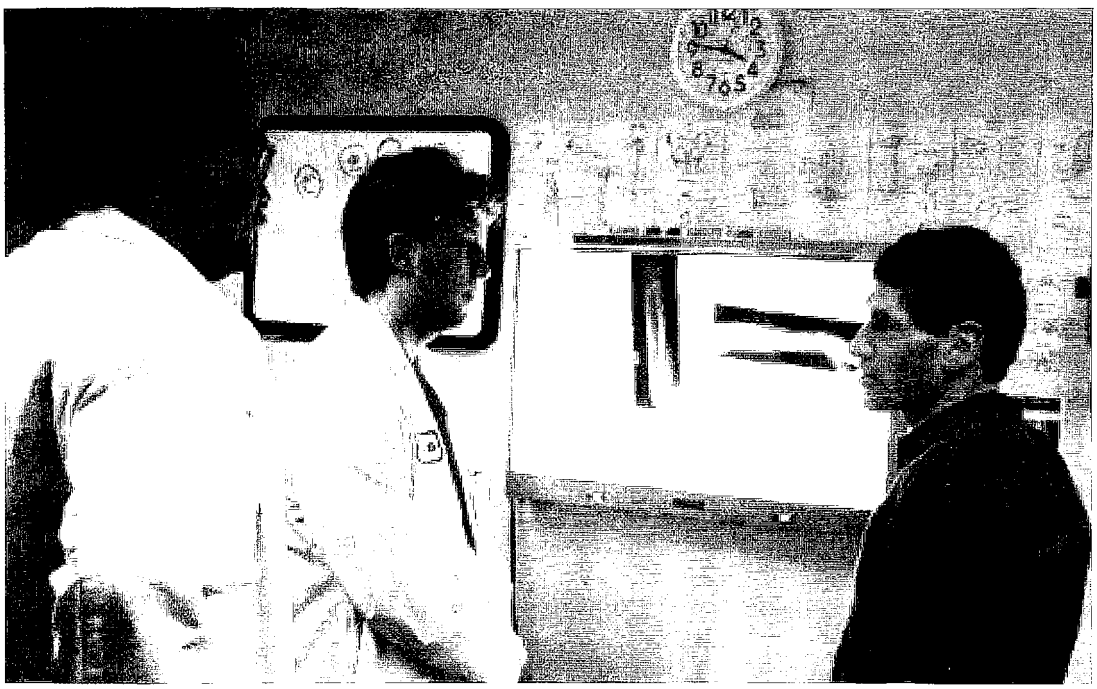
Pierce County Medical Society
BULLETIN

July, 2002



David Acosta, MD, (left) Tacoma Family Medicine faculty member, and 3rd-year resident Matt Davis, MD (right) with John Jiganti, MD of Tacoma Orthopaedic Surgeons review film at Tacoma Family Medicine's Orthopedic Referral Clinic

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INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
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Pierce County Medical Society
BULLETIN

July, 2002

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President's Page

by Susan Salo, MD

The Good News

Susan Salo, MD

Is there any? Earlier this month, incoming WSMA president, Maureen Callaghan, MD, and chief executive officer Tom Curry, came to the Pierce County Medical Society Board of Trustees meeting to share the good news with us. They shared some interesting perspectives.

One of the first perspectives is that as things get worse, they get better. Economic threats to medical practices and to individual physicians have made us recipients of increased sympathy from our patients, the legislature, and the public at large. This public support, combined with an increasing concern regarding options if the present system melts down completely, may allow us more leverage in negotiations and in relationships. (Unfortunately, the first metaphor to come to mind is as an endangered species, hardly a good news comparison!)

Doctors, usually looking for a way to "fix" a problem, are reconsidering strategy, focusing on what we can control, talking to patients about problems and focusing on position in and value to society.

Many doctors and practices are retooling themselves, changing their mission, focusing on successful techniques and areas of expertise, marketing themselves successfully and making some gains. Some are thriving. Patient selection is becoming more acceptable and understood as a business decision; i.e. it's becoming OK to say "no" to patients and to contracts.

Another point of leverage is that health care systems comprise 11% of the state's economy. As a unit, this is a big piece; unfortunately we seldom act in a unified manner and the industry includes factions with very disparate and even conflicting interests.

Finally, increasing interest is being generated in physicians for entering public discussions and interviewing candidates for office. PCMS will continue to set up dinner meetings for members to informally chat with their legislators and will be organizing candidate interviews later this summer.

So in this topsy-turvy world the cloud may have some silver lining after all! ■

Coming in August

"Leaving Corporate Medicine" will be featured in the August Bulletin, telling the story of Primary Care NW as ***Drs. Demirjian, Weatherby, Bateman, Hillis and Dilworth*** *left their "employed" positions and returned to the world of private practice.*

Welcome - New Members

Richard H. Bednarczyk, MD
Family Practice
Family Medicine of Fife
6040 20th Street E #A, Fife
253-922-5262
Medical School: Univ of Michigan
Internship: Henry Ford Hospital
Residency: Wayne State University

Mazen Dahan, MD
Pediatrics
1802 S Yakima #300, Tacoma
Medical School: Aleppa University
Internship: U Hosp Ramon Ruiz Arnau
Residency: Mayaguez Medical Center

Roger Grayson, PA-C
General Surgery
Mt. Rainier Surgical Associates
419 South L Street #101, Tacoma
253-383-5949
Prof School: University of Washington

Roman L. Kutsy, MD
Neurology
Neurology and Neurosurgery Assoc.
915 6th Ave #2, Tacoma
253-282-5056
Medical School: Perm State
Internship: Albany Medical Center
Residency: Albany Medical Center
Residency: University of Washington

Matthew Quick, MD
Family Practice
Lake Tapps Family Medicine
3920 West Tapps Dr E, Sumner
253-862-8001
Med School: Jefferson Medical College
Internship: Naval Hosp, Camp Pendleton
Residency: West Pennsylvania Hospital

Ronald Schubert, MD
Family Practice
Westgate Family Practice
5702 N 26th Street, Tacoma
253-403-7100
Med School: Spartan Health Sciences
Residency: The Medical Center

Robert Shim, MD
Radiology
Diagnostic Imaging Northwest
222 15th Avenue SE, Puyallup
253-841-4353
Med School: Med College of Wisconsin
Internship: LA County UCS Med Ctr
Residency: Rochester Gen Hosp
Fellowship: University of Washington

Victoria M. Silas, MD
Orthopedics
316 ML King Jr Way #312, Tacoma
253-627-7143
Medical School: Univ of Massachusetts
Internship: Univ of New Mexico Hosp
Residency: Univ of New Mexico Hosp
Fellowship: LSUMC - Children's Hosp

Doug H. Smathers, MD
Family Practice/Ob
Sunrise Family Medicine
16515 Meridian E #104A, Puyallup
253-840-1859
Med School: Meharry Medical College
Internship: Valley Medical Center
Residency: Valley Medical Center

Justin Yoon, MD
Diagnostic Radiology
Tacoma Radiology
3402 S 18th St, Tacoma
253-383-1099
Med School: Virginia Commonwealth
Internship: Georgetown Univ Med Ctr
Residency: University of Washington
Fellowship: University of Washington

Applicants for Membership

Dali Chen, MD
Internal Medicine/Endocrinology
Endocrine Consultants NW
1628 S Mildred #104, Tacoma
253-565-6777
Medical School: Beijing Medical Univ
Internship: Univ of Texas Health Science Center at San Antonio
Residency: Univ of Texas Health Science Center at San Antonio
Fellowship: Univ of Texas Southwestern Medical Center

Alan D. Pearson, MD
Radiology
Diagnostic Imaging Northwest
222 15th Ave SE, Puyallup
253-841-4353
Medical School: Uniformed Services University of the Health Sciences
Internship: Madigan Army Med Ctr
Residency: Madigan Army Med Ctr

Korina Tanner, MD
Family Practice
South Hill Family Medicine
3908 10th St SE, Puyallup
235-848-5951
Medical School: Creighton University
Internship: Valley Medical Center
Residency: Valley Medical Center

Alexander D. Serra, MD
Radiology
33801 1st Way S, #101, Federal Way
253-942-7226
Medical School: Cornell University
Internship: Greenwich Hospital
Residency: University of Colorado
Fellowship: UCSF

Special Feature

by Jean Borst

The Tacoma Family Medicine Orthopedic Referral Clinic: Education, Experience, and a Helping Hand Extended to the Community

Dr. Matt Davis, a third-year resident, has just seen a victim of a roller-blading accident. The young man was seen at the Tacoma General ER and was visiting the Tacoma Family Medicine Orthopedic Referral Clinic for follow up and because he was experiencing some unusual pain. To further immobilize the injury, Dr. Davis located a splint and asked the patient to return in three weeks.

Moments later, a different type of case presents itself. There is an injury, but also evidence of continuing domestic abuse. "Here is yet another educational opportunity," says Dr. Kevin Murray, program director for the Tacoma Family Medicine Residency Program and faculty representative for the day. "In this setting, residents have opportunities of learning that go way beyond the injury." Issues such as violence, domestic abuse, mental illness and other extraneous factors can often present themselves.

Matt Davis, MD (right) 3rd-year TFM resident and Nicki Novak, MA (left) treat 12 year-old patient Thomas Ball at the Tacoma Family Medicine Orthopedic Referral Clinic

A few years ago, **Dr. David Kilgore** of Tacoma Family Medicine was contemplating two troubling issues. Residents were getting little educational exposure to orthopedics. While part of their training involved a year-long rotation at Madigan or local orthopedic clinics, practical exposure — in a family practice setting — was minimal.

Also of concern was a growing access-to-care problem within the community for individuals needing orthopedic care. "People had difficulty getting into orthopedic offices for various reasons," according to Dr. Kilgore. "And our residents were not getting enough exposure to acute injuries." From this melding of issues came the Tacoma Family Medicine Orthopedic Referral Clinic. "Everyone wins," said Dr. Kilgore, Clinic Coordinator. "The ERs and urgent care centers have a follow-up location to refer patients, the community has greater access to orthopedic care, and residents have more exposure to ortho injuries."

"The ERs and urgent care centers have a follow-up location to refer patients, the community has greater access to orthopedic are, and residents have more exposure to ortho injuries."

Established in 1998 and located on the fourth floor of the Tacoma Family Medicine building, the Orthopedic Referral Clinic provides high-quality follow-up care for a wide variety of musculoskeletal and sports injuries — regardless of the patient's ability to pay — in an academic teaching environment. Senior family practice residents staff the clinic, with supervision provided by residency faculty and a rotating pool of community orthopedists. The clinic is open every Wednesday morning and is set up to accommodate up to eight patients. At present, however, the clinic is seeing on average only about four patients each week.

There is a pharmacy on site, and the clinic can arrange for physical therapy services at Tacoma General Hospital and the University of Puget Sound therapy program. More extensive procedures are referred out to orthopedists in the community. Due to the nature of the clinic, they **cannot** provide care for the followiug conditions:

• Labor and Industries injuries. With the rotation of faculty, orthope-

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dists, and residents, continuity of care cannot be provided as specified by L&I.

• Chronic low back pain or neck pain

• Complicated multi-trauma, multi-system injuries, complex unstable fractures

• Chronic pain syndrome

Residents are encouraged to take a "first stab" at diagnosis and treatment plans and perform any necessary procedures, Dr. Kilgore explained, which enables them to develop independent clinical assessment skills. "Learning proceeds more quickly if the residents are encouraged to apply what they know first instead of being told," Dr. Kilgore added. The faculty staff fills knowledge gaps and teaches general principles appropriate for a primary care physician's knowledge in orthopedics. For example, a faculty member indicates where the resident is on track and corrects any misinformation and supplies needed clinical knowledge as necessary. In addition, faculty members also point out complications to watch for and help outline referral indications for each case.

Mid-morning on clinic days, an orthopedist arrives at the office, and the resident and faculty member then have the opportunity to present their cases and discuss X-rays, follow-up, and complications. Before finishing with each patient, the faculty member and/or resident clearly summarize the treatment and follow-up plan. "Increasingly," Dr. Kilgore explained, "we are trying to model evidence-based medicine using references to respected studies as a basis for decision making in primary care."

"The clinic offers residents an opportunity to see orthopedic problems in a family practice setting," explained Dr. Kevin Murray, the clinic's program director. "Orthopedics is an area that is difficult to teach if you don't have hands-on experience. The residents need to have the opportunity to expand their level of comfort and confidence, and the clinic experience offers residents a good sense of personal limits. So many orthopedic issues come up in family practice, and not everything has to be referred to a specialist."

"In addition," Dr. Murray continued, "residents have the opportunity to work with a specific population of people — the underserved, under-insured and the uninsured." And because early detection of orthopedic injuries is vital, the clinic further benefits individuals who need to be seen on relatively short notice.

Currently, the majority of patients seen at the clinic are referred internally by TFM physicians or local ER or urgent care facilities. Patients may be no-doc, self-pay patients from Tacoma General or Allenmore ERs or MultiCare urgent care centers; or referrals from community clinics with a variety of insurance coverage or no insurance at all. Tacoma Family Medicine takes care of all billing arrangements, including arranging for sliding fee or payment plans for self-pay patients. In addition, the staff arranges for physical therapy services for patients without adequate insurance or funds.

"The clinic provides urgent care centers and ERs an outlet for referrals," Dr. Murray explained. "Otherwise, it's challenging for people with substandard or no insurance to find specialists. And quite honestly, it's difficult for specialists to see patients who cannot pay or who have insurance that pays very little. Access to care is a continuing problem. But here is a program that's working. We would like the public to be aware that it exists."

At present, 15 orthopedists volunteer at the clinic on a rotation basis. These physicians also accept patients in their offices who are referred by the clinic for additional treatment. They are crucial to the high quality of care and teaching we can provide at the clinic, Dr. Kilgore remarked. Dr. Kilgore extends his gratitude to the following orthopedists for their participation: **Drs. Fred Thompson, Ian Lawson and Greg Popich**, Pacific Sports Medicine; **Drs. Jack Stewart, John**

See "Orthopedic" page 16

How to Refer a Patient to the Tacoma Family Medicine Orthopedic Referral Clinic

1. Make sure the patient's injury falls within the eligibility requirements and that the follow-up can wait until the next available appointment time.

*2. To make an appointment with the orthopedic scheduler, please call the clinic at **253-403-2956**, Monday-Friday, 9 a.m. – 5 p.m. or **253-403-2995** on evenings and weekends. Please, do not have the patient make the appointment themselves.*

3. Please remind the patient to bring x-rays, records and current meds with them.

4. The clinic is located two blocks from Tacoma General Hospital at 521 Martin Luther King Jr. Way, at the corner of 6th Ave. and MLK Way, on the fourth floor.

If you have additional questions, please feel free to leave a message at the aforementioned telephone numbers for the Dr. David Kilgore, clinic coordinator.

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Use of Federal Funding for Bioterrorism Preparedness and Response

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT

We continually hear a lot about potential threats of biological, chemical or nuclear attacks by terrorists. Tacoma-Pierce County Health Department has been working to coordinate our efforts with the Pierce County Department of Emergency Management, hospitals throughout the county, and, of course, the Pierce County Medical Society.

Federico Cruz-Uribe, MD

Federal money has been provided to states who successfully complete a grant application. Fortunately, Washington is one of only 24 states whose application was received without change. Funding will be sent to Pierce County soon to plan in more detail what our response will be. Here's the work we'll be doing with those funds (and corresponding to the requirements of the grant).

We will get information out to you as our plans develop. If you would like additional information, contact Joby Winans (253-798-2853).

Background: In response to the events of September 11, 2001, Congress provided significant funding to strengthen public health infrastructure and to prepare specifically for effective responses to bioterrorism. The threat of bioterrorism requires unique capacities. Unlike an overt attack with a bomb, which is immediately known and casualties clearly identified, infectious disease outbreaks reveal themselves over time. Infected individuals will request medical help from physicians, clinics and hospitals, first singly and then at a rate that indicates a health response is needed. Those who are ill may be scattered geographically and show symptoms at different rates of times, depending on the biological agent and the mechanism of dispersal.

Building a Surveillance and Response System: Key to an effective response in Pierce County is having in place a system, capable of connecting essential agencies rapidly to one another, to the state and to federal agencies. Such a system requires the building of new, strong partnerships between the Tacoma-Pierce County Health Department, Pierce County medical providers, hospitals, fire and police first responders, laboratories, and emergency management services, and state and federal agencies.

Funds to Pierce County: Pierce County will receive $823,000 to support the work needed to fortify the department's surveillance and response capabilities related to bioterrorism, to build bridges to other departments in the county, and to provide the ongoing communication and training that will keep the system operational.

Areas of Focus: From May 15, 2002 through August, 2003, the department will fulfill the requirements, primarily assessing needs and creating plans, attached to the federal grant, in the following areas. The funds in parentheses are those allocated to Pierce County.

- Area A: Preparedness Planning and Readiness Assessment ($325,000) - Assessing how ready we are to respond effectively to a bioterrorist event.
- Area B: Surveillance and Epidemiology Capacity ($355,000) - Planning how to detect and respond to disease outbreaks.
- Area C: Laboratory Capacity - No funding directly to Pierce County, but increasing the state's clinical lab capacity will help us do our work.
- Area D: Health Alert Network/ Communications and Information Technology ($8,000) - Addressing the need to move information and data quickly and securely to respond to a public health event.
- Area E: Communicating Health Risk and Health Information Dissemination - Funding for this area has been allocated to Seattle and Spokane, to prepare methods for communicating effectively with the public.
- Area F: Education and Training ($135,000) - Developing a delivery system for education of public health staff, emergency responders, and health care providers in Pierce County.

Ongoing Funding: We anticipate funding will continue beyond August, 2003 (legislation is currently before Congress), allowing the Tacoma-Pierce County Health Department and other local and state health departments to implement the plans built with this first allocation. ■

June General Membership Meeting Recap

"Are Lawsuits the Answer?"

Editor's Note: This coverage of the class-action lawsuit that was filed by Tacoma Orthopedic Surgeons and Franciscan Medical Group against Regence and Premera in Pierce County Superior Court in March, 2002 is from the June General Membership Meeting. The featured speaker was attorney Rick Creatura from Gordon, Thomas Honeywell, Malanca, Peterson and Daheim in Tacoma.

Breach of contract is the primary basis of the lawsuit against Regence and Premera according to Rick Creatura, attorney and speaker at the June General Membership Meeting which was held at the Landmark Convention Center in Tacoma. It's simple, he said, in that physicians contract with Premera and Regence and expect to get paid for the services they render. The contracts with these insurers that physicians are expected to sign without negotiation, do not say that they have a right not to pay physicians for their services or that they have a right to bundle or downcode. Consequently, physicians are not being paid in accordance with their contracts. Creatura also contends that the contracts are particularly troublesome because they are not subject to negotiations, and should you attempt to negotiate or change the terms you are met with opposition. While the insurance

> *"The result of a contract that is not subject to negotiation, combined with a software product that is designed to not pay you for the services you provide, results in 'death by a thousand cuts'."*

commissioner's office does approve the contract, they do not take steps to look out for downcoding or bundling practices adding that the edits have become more significant over the years from hundreds, to thousands to now over tens of thousands that have made their way into the software. The result of a contract that is not subject to negotiation, combined with a software product that is designed not to pay you for the services you provide, results in "death by a thousand cuts," coined by Creatura. Each billing may be $100 or $50 less than what you should be paid if coding practices were done correctly.

So how did death by a thousand cuts begin? According to Creatura it all started in 1997 when a software company developed a product named ClaimCheck that they sold to insur-

See "Lawsuits" page 13

Dr. Mike Kelly, (left) Lakewood family physician, his wife Sam and Dr. Jim Rooks, Lakewood otolaryngologist, visit after the dinner meeting

Dr. Dick Bowe, (right) Tacoma ophthalmologist, shares his thoughts with speaker Rick Creatura, JD

Drs. George Noble, (right) pediatric surgeon, and retired pediatrician Joe Wearn enjoyed "catching up"

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Crying Wolf

Andrew Statson, MD

"The end of the world has been postponed due to the lack of trained trumpeteers."
Army graffiti (1969)

The ACOG has marshalled its resources for a war against another form of terrorism, a legal one, expressed by awards and punitive damages in the millions and juries acting as liability bomb squads. Pennsylvania was one of the hardest hit, so when their legislature rose to the challenge and enacted a liability reform bill, I was encouraged. Then I read the provisions of the law and didn't know whether to laugh or cry. It is enlightening to see what they call reform.

Writing in *ACOG Today*, Albert L. Strunk, JD, MD, vice-president for fellowship activities of the College, made what I think are some of the most cogent remarks to come from any leader of our profession. "What concerned me most was that many of the legislators perceive that their constituents - our patients - are not raising alarms about professional liability, tort reform, and the availability and affordability of liability insurance. Physicians are screaming, but patients are largely silent. From a legislator's perspective, physicians' claims that dire events are about to occur sound like cries of 'Wolf!' They have heard such cries before - in the fifties, sixties, mid-seventies, and mid-to-late eighties - all without the arrival of the feared and fabled canine. It seems that neither legislators nor patients understand the magnitude of the current stresses on the health care system well enough to appreciate that this time the wolf is the real canis lupus."

I don't know whether the wolf is for real this time, the future will tell, but I agree with his assessment that neither our patients, nor the legislators, are concerned about the current situation. The chances that we will get any significant relief are about the same as those for our colleagues in Pennsylvania.

Those of you who have read *Atlas Shrugged* will recognize in the words of Doctor Strunk one of the three statements Hank Rearden heard on the night of his disappearance. They gave him the insight he needed to understand the nature of the men he faced. For those who have not read that book, here are the three statements:

1. "You won't go bankrupt. You'll always produce...You can't help it. It's in your blood. Or to be more scientific: you're conditioned that way."

That is true. We will continue to work, no matter what they do to us. We love our work. We are physicians because that is what we want to do more than anything else in the world. We care about our patients. We are proud of the job we do. We have taken care of patients without considering whether we would get paid or not. We thoroughly enjoyed being of service. We have done it in the past and will continue to do it in the future.

The only things we asked for our work were the acknowledgment of a job well done and the ability to earn a good living. We thought those things would be a small payment for the value of the services we gave. We were wrong. That payment has not been forthcoming. We will be there, at our posts, because we can't help it. It's in our blood. So why should they pay us more? Why should they care?

2. "Well, after all, you businessmen have kept predicting disasters for years, you've cried catastrophe at every progressive measure and told us that we'll perish - be we haven't."

That also is true. In the early 1960s, the AMA was in the forefront of the battle against Medicare. We showed that it would not help, but may make matters worse; that it was not needed, because anyone who required care already could get it, if not in the county hospitals, then in the charity wards and clinics of the private hospitals and in many other free clinics, supported by charitable organizations. We were right. The availability of care for people today is not better, and in some respects is much worse.

The AMA also pointed out that the

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Wolf from page 9

costs of the proposed programs were going to be much higher than projected. Their estimate was 40 billion dollars, instead of the official projection of 10 billion. The current budget of the CMS is over $420 billion. In constant dollars that is twice the most pessimistic AMA projections and eight times the official estimate. That does not include what the states spend on welfare. In addition to the direct costs of the program, the welfare system destroyed the county hospitals and the charity wards and clinics. It has resulted in reduced availability of care for those without coverage and in a much higher cost to those who can still buy insurance and pay their own way.

We screamed again when the Professional Standards Review Organizations, followed by managed care, limited our ability to make sound decisions for the treatment of our patients. We objected to the escalating cost of liability insurance and to the contracts which did not allow us to raise our fees to meet our rising expenses. We objected to the increasing regulatory burden imposed upon us.

The conditions under which we work have made it more and more difficult for us to do our job. In a sense, we feel like Gulliver, bound down by a multitude of strings, made of alphabet soup regulations. We are barley able to move, but are still working, because we care about what we do, because we shudder to think what would happen to our fellow countrymen when they need our help and we are not there to give it.

3. "Oh, you'll do something!"

Yes. Every time in the past, when a new rule bound us down more, we somehow found a way to keep going. We have had to run faster and faster just to stay in the same place. So what if they pile even more regulations on us? So what if they pay us less and less for more and more work? We'll do something. We'll deliver the care. We can't help ourselves. It's in our blood. Besides, so far, nothing bad has happened in spite of our dire warnings. We are just crying wolf, but the wolf is not there. Even if it were, we'd do something.

On another occasion, Hank Rearden was asked the question, "Every one of those girders has a limit to the load it can carry. What's yours?" That is a question our fellow countrymen, by serving on juries, our insurance companies, by cutting down their payments to us, and our legislators, by passing laws, are asking of us now. It is a question each one of us will have to answer for himself, sooner or later.

- **What is our breaking point?**
- **How heavy a burden can we carry?**
- **With how much more can they encumber us and get away with it?**

Even if we don't answer that question now, we must prepare for the day when we'll be forced to answer it. Unfortunately for us, we have few alternatives to practicing medicine, none of them satisfactory. We are physicians. Medicine is in our blood. We'll continue to work. We can't help it.

Perhaps one day, when we finally are fully stripped of our ability to take care of our patients, we will turn to the regulators and ask, "We have a patient here. What tests would you want us to do? What treatments would you want us to give? What prescriptions would you want us to write?" When they tell us, "We don't know, you are the doctors," we would reply, "We don't know, either. You haven't left us any option." Is it conceivable that the end of the world might come, even in the absence of trumpeteers? ■

Members complete Sound to Narrows 2002

More than 5,000 runners participated in the Sound to Narrows on Saturday, June 8. Among them was **Dr. Ron Taylor**, Tacoma general surgeon, who finished third in his division with an excellent time of 52:30, beating his last year's time by 24 seconds!

Dr. William Jackson, diagnostic radiologist, finished seventh in his division with a time of 1:03:02.

One of the remaining few who has run in every Sound to Narrows for 30 years, was **Cordell Bahn, MD** retired cardiovascular surgeon, who finished with a time of 1:15:51.

Congratulations to all PCMS members and their family members for a great accomplishment:

Majeed Al-Mateen, MD, Tacoma pediatric neurologist, just over an hour at 1:00:31

Marc Aversa, MD, Puyallup family practitioner, did an even 58:00

Nancy Becker, DO, Otolaryngologist, completed the 5k in 49:24

Corinne Bell, DO, Associate Medical Director for Premera Blue Cross, 1:45:51

Loren Betteridge, MD, Tacoma family practitioner, 59:03

Thomas Charbonnel, MD, Tacoma pediatrician, 1:10:58

Lauren Colman, MD, Tacoma oncologist/hematologist, 1:02:16

Mark Craddock, MD, Gig Harbor family practitioner, 1:11:55

Stephen Elder, MD, Tacoma anesthesiologist, a competitive 52:29

Jim Furstoss, MD, retired otolaryngologist, 1:03:25

Martin Goldsmith, MD, pediatrician, improved his time by about four minutes at 56:36

Patrick Hogan, DO, Tacoma neurologist, 58:09

Jim Rooks, MD, Lakewood otolaryngologist, 1:11:55

James Schopp, MD, Tacoma general surgeon, 55:44

William Shields, MD, ophthalmologist, 1:02:18

Darryl Tan, MD, Lakewood pediatrician, 1:00:54

Congratulations to all Pierce County Medical Society members and their families on completing such a challenging run.

Please forgive us if we failed to list your name and contact the PCMS office (572-3667) so we can include your name in the next issue of the *Bulletin*. ■

Patrick Hogan, DO

William Jackson, MD

Additional finishers - 10k

Tom Bell, 1:09:17
Donna Jackson, 1:00:19
Mary Ann Retailliau, 2:12:23
Allison Rone, 55:10
Caitlin Stevenson, 1:23:00
Collin Stevenson, 52:59

Ron Taylor, MD

Cordell Bahn, MD

Additional finishers - 5k

Sylvia Al-Mateen, 46:36
Merlene Betteridge, 35:30
Judy Chan, 51:53
Christopher Stevenson, 30:36

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Bruce Baker, MD
Change information to the following:
5814 Graham Ave #100
Sumner, WA 98390
Office phone: 863-4474
Physicians only: 863-7212
FAX: 863-4062
DSHS Billing #: 1115179

David Ricker, MD
Change home address to:
7847 N Woodworth Ave
Tacoma, WA 98406
Home phone: 752-2835

Eileen Toth, MD
Change home number to: 383-4185

In the Health Agencies section (pg. 301)
Puget Sound Home Care
Change Clinical Director's name to:
Mirjam Jackson, RN

Lawsuits from page 8

ance companies across the nation. Claim-Check is a computerized program designed to automatically bundle or downcode certain professional services billings. Other software products came on board. The companies started marketing their products as "programs that could save millions of dollars because codes should be bundled together." Now prevalent, a major problem is that there is no standard for what constitutes an appropriate bundle compared to an inappropriate bundle. The companies claim they have a panel of specialists for appropriate coding, and there is the Correct Coding Initiative (CCI), set up by the federal government that has attempted to set a standard for appropriateness. The CCI standards are at least open to the public while the many private insurance companies keep their guidelines private. Many of these products, even today, are sold to insurance companies with a proprietary, confidential information stamp on them which means you cannot share the information with physicians. Physicians cannot find out exactly how their billing is being edited, downcoded or bundled by these products. So, the physician submits the bill without a clue as to what he/she is going to get back in payment. It may be full payment or it may be substantially reduced.

These are the biggest problems that have prompted litigation across the country, according to Creatura. There are lawsuits in Florida against Aetna and several BlueCross/Blue Shield carriers and one in Illinois against Cigna. One of the reasons why litigation was initiated here is that Blue Cross/Blue Shield affiliates are not part of a national association (not owned nationally) and so Regence and Premera, even though they are very large in the northwest have not been named in any of the other suits filed throughout the country. Creatura's firm was contacted by a national firm handling national suits and asked if physicians in our area were having the same problems with bundling and downcoding. Both Tacoma Orthopedic Surgeons (TOS) and

Further Information on Lawsuits...

- *Covenants of good faith and fair dealing: when you enter into a contract, you recognize that arbitration may be appropriate for disputes, but when arbitration and alternative dispute resolution procedures are being used as a weapon and there are not legitimate disputes but, in fact, disputes not based on good faith misunderstanding, then these provisions should not be enforceable. Creatura intends to argue this in court and there is law across the country that he thinks will support this.*
- *A gold standard needs to be established that is very specific for payment, so it is very clear when insurance companies are violating it. Until and unless everybody knows the rules, there are no secrets, and everybody knows how much they will get paid for what, it's an un-level playing field and doctors are at a great disadvantage.*
- *TOS and FMG acknowledged that someone needed to stand up and make a difference while other groups were fearful of going up against the behemoth insurance companies. Even though there are laws that protect against retribution and the attorneys understand the laws and watch for it, they continue to seek offices that have cases of bundling and downcoding difficulties with these companies.*
- *Awards?? This is a class where it could be 2% of gross billings annually and claims could go back for six years. The second part is increased cost of claims handling – if you can come up an with economic model to show the kind of damages you have had from increased claims cost that would be another added damage. We are certainly talking thousands of dollars per physician in the state.*
- *Software company liability?? There are no contracts with these folks. You can sue a third party under the Initial Interference with Business practice, IF they are aware of the contractual relationship and interfere with it. The problem is it's difficult to prove what software product is involved, and also difficult to prove that they were aware of what was going on specifically.*
- *Estimated Time Line?? Two years. A trial date has been set for fall, 2003. But, lots of things can happen between now and then and you never can guess when it might go to settlement. Some business transaction may spark movement at any time.*
- *How to Help? Write, email or call Rick Creatura with examples of inappropriately, bundled, or downcoded billings and if possible, provide the EOB with deleted patient names. Because of black box edits, he does need help. Tell him who you are and the problems you are experiencing. All information is confidential. Call PCMS for his contact number.*

Lawsuits from page 13

Franciscan Medical Group (FMG) were contacted by Creatura's firm to see if they were experiencing the same difficulties. Together they make for great class representatives, including both specialty and primary care representation, according to Creatura.

The dichotomy of fighting death by a thousand cuts is this – you may either go through an elaborate, expensive appeals procedure (three tiers for Premera, two for Regence) and then a complicated and expensive arbitration proceeding which can cost far more than the amount in dispute or you can resubmit the bill for processing, then have it sent back with a notation that it has already been submitted and on and on until the time and trouble far exceed any payment that would have been received. More logically, however, you can simply write it off and go on to the next bill and see if you get paid correctly for that one. In 1999, efforts in Olympia tried to curb delays in payment and the OIC made findings that insurance companies were "unfairly delaying payment to providers" and criticized insurance carriers for instituting unfair dispute resolution processes. Certain regulations were implemented including that carriers may not require alternative dispute resolution to the exclusion of judicial remedies. This is good for physicians because of the power of Premera and Regence, the largest insurance carriers, they contract with 23,000 health care providers in Washington state and the chance of any one small provider taking them on in their elaborate appeals process or arbitration over a $100 dispute is just inconsequential. Even for the group the size of FMG, it's not cost effective. The only way to have bargaining power or clout is through a class-action type litigation. In a class action, all the doctors in the state can be represented which levels the playing field against Regence and Premera. In response, and not wanting this to happen, both carriers filed motions to block the class-action and to enforce certain arbitration and alternative dispute provisions in the contracts. Their goal is to split this up to 23,000 cases of individual claims.

Regence and Premera were first served with a subpoena requiring them to appear and produce the person most knowledgeable about their claims software products, their contracts and their billing procedures. Instead of producing a person, they sent back a motion asking that the case be dismissed because the arbitration/dispute resolution process was not followed. This battle has been won against Premera - as the judge ruled that the alternative dispute resolution and arbitration provisions are no longer effective because of the Washington regulations that were adopted in 1999 and that new contracts that do not provide for arbitration are enforceable and there is no requirement to go into separate arbitrations. Creatura said he had received word from the opposing counsel that they are planning on appealing, which may delay actions again, but they are hopeful that the court of appeals will quickly re-

See "Lawsuits" page 16

PCMS members educate politicians about practicing medicine

Many PCMS members have been telling legislators about the frustration of practicing medicine in Washington State. At Legislative Day in January, several physicians met with Senator Jim Kastama (D-25) in his Olympia office. Without enough time to thoroughly discuss issues of concern, Senator Kastama agreed to meet with physicians again because he was interested in hearing more specifically about the issues troubling to physicians. The meeting was scheduled for late February at Good Samaritan Hospital in Puyallup and all physicians that live or practice in the 25th district were invited to attend. Sixteen physicians attended and discussed many frustrations but a major issue of concern was medical malpractice insurance. At the suggestion of Senator Kastama, another meeting was scheduled to meet with Insurance Commissioner Mike Kreidler to specifically discuss the medical malpractice issue.

The meeting with Commissioner Kreidler and Senator Kastama was held at Good Samaritan Hospital in May. Fifty-five physicians attended to tell Commissioner Kreidler about the severe increases in malpractice insurance premiums as well as other frustrations with insurance companies. Although leaving without hope of imminent solutions, at least there were good discussions and attendees had the opportunity to voice their concerns.

In late June, just over twenty physicians met with Representative Mike Carrell (R-28). Once again, one by one, they voiced their frustrations about numerous issues that are impacting their medical practices and ultimately their economic and/or practice viability. Mr. Carrell heard about recruitment difficulties, malpractice insurance premiums, tort reform, mandated benefits, ED crowding, declining reimbursements, increased government regulations and paperwork requirements, white coat flight, mental health parity, the Medicaid waiver, and other concerns for well over an hour.

> *"Your vocation is medicine, but your job has to be politics."*
>
> - Mike Carrell (R-28)
> speaking to physicians in the 28th legislative district

He did receive kudos for continuation of funding for vaccines for children. University Place pediatrician **Terry Torgenrud, MD**, thanked him for the legislature's continued funding for vaccines noting that this state would be in dire trouble if they ever opted to cease coverage.

Mr. Carrell told the doctors attending that even though their vocation is medicine, their job has to be politics. He noted that he believes that government should not be intruding in health care and that government should not interfere in the doctor/patient relationship. He said he will work with physicians and he wants to become better educated and aware of problems of the medical profession. He reminded everyone, however, that he is only one of 49 votes in Olympia.

PCMS will continue to schedule informal dinner meetings with legislators in Pierce County districts. If you are interested in participating, please call the office for more information, 572-3667. ■

Lawsuits from page 14

ject their request. Regence is planning on filing their motions to dismiss and Creatura expects to be fighting this battle over the next few weeks.

We are a long way from class certification, however, noted Creatura. The court will review whether a class will be made to present a case against the defendant. Representatives will be evaluated to determine if they are appropriate for the class and attorneys will also be evaluated for appropriateness. Then the court oversees representation of the class. Once the court certifies the class then notices are sent to all potential class members and they will have the option of staying in the lawsuit – if they do nothing they will stay in – or opting out. It is called an opt-out class certification.

The court evaluates comments from class members, evaluates attorney's fees and costs. Creatura noted that he is not being paid for his work until and unless the lawsuit is won. Because his firm is assuming risk, they are certain they have an excellent case and he intends to get paid by winning. He noted that he is very fortunate that he works for a large firm that can underwrite his costs, and that they are willing to take the risk.

Class action suits are grueling, noted Creatura. You have the burdens of many people on your back, but because you can make such a difference for so many people, they are also the most rewarding. ■

Orthopedic from page 6

Jiganti, Peter Krumins, Douglas Hassan and James Wyman, Tacoma Orthopedic Surgeons; **Drs. Bob Yancey, Robert Kunkle and Denise Wells**, Harbor Orthopedics; **Dr. Neville Lewis**, NW Ortho; **Dr. John Bargren**, Tacoma Orthopedic Center; and **Drs. Nick Rajacich and Victoria Silas**, pediatric orthopedics.

"There are so many benefits to this type of clinic," according to **Dr. John Bargren**, who volunteers at the clinic two to three times a year. "The clinic serves a wonderful purpose, giving residents the exposure to orthopedics, while serving a population in need."

The faculty, residents and orthopedists would like to see increased activity at the weekly clinic and hope more and more physicians will take advantage of this valuable educational and community resource.

"We have a resident, faculty member and orthopedist dedicated to this office one-half day a week," Dr. Murray said. "We're here to see patients, so we encourage offices, ERs and urgent care centers to take advantage of this." ■

COLLEGE OF MEDICAL EDUCATION

Common Office Problems CME will be held October 4

Topics are set for the College's Common Office Problems CME scheduled for Friday, October 4, 2002. The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD.**

This year's course will cover:

- Rheumatology
- Chronic Renal Care
- Advances in Contraceptives
- Stages of Type II Diabetes
- Migraines
- Substance Abuse and Depression
- Dermatology
- BPH

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137 between 7:45 a.m. and 5:00 p.m.■

Continuing Medical Education

C.O.M.E. Board Announces 2002-2003 CME Program Schedule

The College of Medical Education's Board of Directors announced its CME schedule for 2002-2003 at the June meeting. Courses are offered in response to local physician interest and are designed and directed by local physicians. All courses offer AMA and AAFP Category I credit.

A course calendar identifying the course title, dates, brief description and course directors will be mailed in early September. For additional information on next year's offerings, please call the College at 627-7137. ■

2003 Whistler CME Program set January 22-26

The annual Whistler CME program has been set for January 22-26, 2003 at the Aspens Condos, with rates the same as last year. A program brochure with course details will be available in September. Watch your mail!■

Dates	Program	Director(s)
Friday, October 4	Common Office Problems	Mark Craddock, MD
Friday, Novmber 8	Infectious Diseases Update	James DeMaio, MD
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Wednesday; Tuesday January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Gregg Ostergren, DO
Friday, February 7	Primary Care	TBA
Wednesday-Sunday March 5-9	CME and the Mariners	TBA
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Classified Advertising

POSITIONS AVAILABLE

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

Family Practice physician
needed. Exciting opportunity for energetic family practice physician in Tacoma, WA. Female Ob/Gyn wishes to office-share or partner with F.P. Great office location and beautifully remodeled office. Great patient base to quickly build a practice. Call and ask for Penny (253) 460-7777 or send CV to (253) 460-0959.

Family Physicians wanted to work
at Sea Mar Community Health Centers. Sea Mar is dedicated to serving the underserved with emphasis in the Latino population throughout Western Washington. OB is required and Spanish language proficiency is preferred. We offer a competitive salary, benefits and a sabbatical plan. Choose from the following locations with openings: Tacoma: 3 FP positions available. The practice is expanding to 5 family physicians. Hospital care is at Tacoma General Hospital. Call is 1 in 4. Contact **Phillip Reilly, MD** if interested. (253) 593-2144.

POSITIONS AVAILABLE

Seattle, Wash - Occupational
Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

Milton/Edgewood. "Calling Dr.
Welby." Ideal environment for establishing a new practice: No competition; a large, underserved patient base; an economically stable community; a "turn-key" facility with 12 exam rooms, reception, procedure room, x-ray/lab; local hospital and community support. Call Tom Perkins for more information, 206-465-0300.

POSITIONS WANTED

Experienced licensed medical
transcriptionist interested in transcribing P/T from home or at your facility. Please call Michelle Sutczak at 253-761-8196 or 253-376-0167.

OFFICE SPACE

1,800 sq ft remaining on first
floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Fircrest Medical Office Space
412 Bowes Drive - 1540 sq ft consisting of examination rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Lakewood property for sale or
lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

2900 sq ft medical space - $10-12
psf NNN, 7 exams, x-ray, procedure room. Lakewood. 253-584-2000.

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

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Pierce County Medical Society
BULLETIN

August, 2002

"Leaving Corporate Medicine"

The physicians of Primary*Care* Northwest
(From left) Drs. Keith Demirjian, Raymond Dilworth, Steven Hillis, Michael Bateman, and Charles Weatherby with nurse practitioners Sydni Wright (left) and Karen Weil

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INSIDE:

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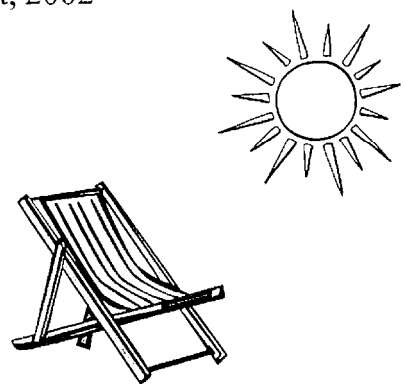
Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

August, 2002



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President's Page

by Susan Salo, MD

Life is Interesting

(Certainly more so than the alternative)

Susan Salo, MD

As I was retaking my Family Practice Board exam in July, for the fifth time, I couldn't help thinking about the tremendous strides the science of medicine has taken, just within my lifetime, and the mismatch between the science and the scientific illiteracy of the population and the majority of our patients.

My training and the expectations of my field are of scientific integrity, testing hypotheses and treatments, determining what works (and what doesn't!) to advise and to treat my patients.

The success of combining individual scientific patient care with dramatic advances in public health modalities for prevention has been phenomenal.

Unfortunately, the populace at large—our patients—accept these advances with near-magic expectations. Without understanding the scientific method by which they have been developed, and without the understanding of the method by which these were accomplished, patients have difficulty—or inability—in comparing different medical approaches or comparing medical to naturopathic and other "alternative" therapies. They thus depend on the practitioner to advise them fairly but are unable to independently evaluate the advice or to compare and contrast alternative therapies. I would be frustrated and frightened to be dependent on advice and unable to independently evaluate and compare alternatives, and must assume our patients feel similarly.

How do we tackle an unscientific, or even antiscientific, environment and culture? Our attempts with individual patients, one at a time, are imperative but slow and very inefficient. School programs are certainly attempting to teach students to analyze conflicting information but are overwhelmed by class size and subject complexity.

I wish I had an answer to some of the above; I don't, nor do I expect anyone else has (—PLEASE let me know if you do—) but when we analyze and communicate with our legislators we need to remember that they must deal with the same scientific naiveté as the population at large. We need to teach, not only the information we want to impart, but also the scientific and analytic method for interpretation.

We have a lot of work ahead. ■

Sound to Narrows Update

In the July issue of the *Bulletin* the Medical Society congratulated members who completed the Sound to Narrows run in Tacoma on June 8. We inadvertently failed to include:

Maureen Mooney, MD, dermatologist, who completed the race with an excellent time of 58:55, which placed her in the top 200 women, 99th to be exact!

Lawrence White, MD, ophthalmologist, finished at 1:03:14, another fantastic time!

Our apologies to Drs. Mooney and White and congratulations on a great run! ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Van Pickup

Federico Cruz-Uribe, MD

The central part of Tacoma, including the Hilltop area, has long struggled with public drunkenness. Local neighborhoods and public places, and even local homes, have had to deal with lewd and unsanitary behavior. This has contributed not just to having to deal with bad behaviors, but a junking up of the neighborhood with bottles and cans and garbage strewn everywhere. Recently, neighborhood coalitions banded together and demanded that cheap fortified alcohol products be taken off the shelves of local stores. This was an attempt to lessen the bouts of public drinking. Cheap fortified wine and malt liquor products are a common source of alcohol for our local addicts. But other alcohol products stay on the shelves. Removing cheap high-content products doesn't solve the problem of chronic public inebriation.

Communities in their frustration have looked at any means to address the problem. The literature is very clear around what works for chronic alcoholics. Six months of intensive inpatient treatment that includes re-socialization, extensive job training, and health and nutrition services. But few communities in the United States will make this kind of investment to address chronic alcoholism among local citizens. Instead we arrest or pick up public drunks and they end up in jail or in social detox centers where they sleep off the latest binge and hit the streets the next morning. If communities are unwilling or unable to commit to a six-month treatment approach, what can a local area do to address the problem of chronic public inebriation?

"Tacoma does not have a comprehensive community plan. It needs one and will not get on top of public drunkenness until it does."

Several areas including Sacramento, California have instituted approaches that are a blending of different models. In Sacramento, their system starts with a van that cruises the high-risk areas of the city and picks up public drunks. The individuals are taken to a sobering unit where over a 72-hour period they are basically kept in a warm, safe environment (with very few amenities). They are offered long-term treatment (21 day treatment slots). If this is refused then after 72 hours they are released into the community. Not the best scenario, but it gets them off the streets for a longer period of time and still offers treatment that could help a significant percentage of these more seriously addicted people.

Tacoma does not have a comprehensive community plan. It needs one and will not get on top of public drunkenness until it does. Restricting sales of cheap booze will just shift some of the public drinking from one neighborhood to another. Pick up vans, sobering units, access to clinical detox and long term treatment are key parts to any solution. It is long overdue that we move on this problem. Our central community deserves better.

Let me know if you have ideas or want to help out in developing a plan. We can use your help. ■

Special Feature

by Jean Borst

Breaking Away:
How one Group of Physicians Walked Away from Corporate Medicine

The days are long. All the issues associated with running a business are ever present. The demand for compliance to rules and regulations never goes away. There are unexpected expenses. There are more unexpected expenses. There is the fear of the unknown.

Most of all, however, there is the tremendous sense of satisfaction that each and every day is about providing the best medical care possible in an environment that is ideal for physicians, staff and patients alike.

Welcome to Primary Care Northwest.

"When we made the decision to go into private practice, I assumed there would be more resources available out there," said **Dr. Steven Hillis**. "Having never been in private practice, it was entirely new territory for me." Dr. Hillis, along with the other three physician owners of Primary Care Northwest, quickly found out just how few resources there were. And that's why the group is so willing to share their story and provide guidance and assistance for other physicians contemplating a change from corporate to private medicine.

Primary Care Northwest is not quite three years old, but it is now the largest independent family practice in Tacoma. The four owner physicians — **Dr. Hillis, Dr. Keith Demirjian, Dr. Charles Weatherby** and **Dr. Michael Bateman** — are comfortably practicing medicine in a newly remodeled facility that is efficiently designed for physicians and patients alike. But getting to this point was no simple task. It required the hard work, motivation and stamina of a determined group of physicians and a dedicated staff, not to mention the courage to walk away from a guaranteed salary, pension plan, benefits, and someone else dealing with payroll taxes, personnel issues and office supplies.

In February 1999, the four were employed by MultiCare Health System, practicing family medicine as a group in the Baker Building. When MultiCare was renegotiating physician contracts and reconfiguring pay schedules, "we realized we were in jeopardy of taking a substantial financial hit," Dr. Hillis said.

"Now I can control my own destiny. If I don't like something, I can change it. You can lose that sense of control in corporate medicine."

- Steve Hillis, MD -

"At the time, we really didn't know what would transpire," Dr. Demirjian added. "But we knew that we needed to find out exactly how each member of the group was feeling and what each one of us wanted to do." Dr. Demirjian, who had been in private practice before, added, "I don't think that I, alone, would have made the decision to go back into private practice. But when I could sense that it was a group movement, it was a lot easier for me to consider."

Dr. Weatherby, who had also previously been in private practice, concurred. "It would have been much harder as an individual to make this decision. It made a big difference being part of a group."

"I think the greatest frustration in the whole process was fear of the unknown," said Dr. Bateman. "I had worked for MultiCare for 11 years and had never been in private practice before."

Two physicians from the group opted to go it alone — Dr. Bob Stuart went to Gig Harbor, and Dr. Randy Buckner went to Olympia. By August 1999, the remaining four physicians had made a decision and began their independent practice, remaining in the same space at the Baker Building. Primary Care Northwest is completely independent and is not affiliated with any system. Everything done in the office is fee for service.

According to Rhonda Wilson, office manager of Primary Care Northwest, once the decision was made to create the practice, the four partners formed a limited liability corporation (LLC). They then went to a bank, and each took out a line of credit to draw on for the first few months. "It was a couple of months before we saw a good cash flow," Wilson noted.

"When we left the system, we didn't have any reserves to carry forward," explained Dr. Hillis. "All accounts receivable remained in the MultiCare system. So we had no operational monies for the first couple of months. We were seeing patients, but the turnover time from billing patients to receiving the money is anywhere

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from one to three months. Making sure we had the necessary revenue to keep operations going was probably the biggest thing, operationally, that we had to deal with."

"It was hard," Dr. Demirjian recalled. "There were a lot of things that made the transition easier — we kept our own patients, the scheduling process remained the same, we were able to keep our charts, we stayed in the same setting. The operations inside the office looked the same, but behind the scenes, the paper changes we had to make were horrendous."

"You don't realize how much has to be in place and operational on day one," Wilson noted." In a limited amount of time, the office had to create policy and procedure manuals, payroll systems, electronic billing systems, employee handbooks, and insurance policies. They had to obtain new tax ID numbers and Medicare numbers, physicians had to reapply for accreditation, there were insurance issues. Once all of that is in place, you start contracting with other carriers." The practice is large enough that insurance carriers will deal with the group directly. "Many will not do that if you are a small independent practice," Wilson noted.

With no model to follow, no "guidebook" to making such a transition, Dr. Hillis turned to his friend **Dr. William Holderman**, a gastroenterologist at Digestive Health Specialists. The invaluable help of Dr. Holderman and Bob Murphy, Administrator, Digestive Health Specialists, helped Primary Care Northwest put its systems into place. "If we hadn't had their support," Dr. Hillis said, "we couldn't have done it."

One of the greatest challenges the group faced in getting up and running was creating a clean billing system. When Wilson joined the team in June 2000, also coming from MultiCare, that was one of her first tasks. "We had information that had been downloaded from the old system and wasn't fresh," she recalled. "If I can offer one piece of advice, it's don't depend on someone else for information in regards to your billing. Never take a download. Always start out with fresh information, fresh cards, fresh copies."

Another thing that eased the transition was the fact that a majority of their staff opted to join them in their new venture. "We sat down and tried to negotiate a transition plan that would benefit us and our employees," according to Dr. Bateman. "Everyone who worked for us was guaranteed a job within the MultiCare System if they decided not to follow us. That was very important to us." Most employees did follow, however, and most have remained. Recognizing the value of their dedicated staff, Primary Care Northwest offers an employee profit sharing program, "so our employees can benefit from us doing well," Dr. Weatherby noted. "That wasn't an option at MultiCare."

Defining the practice

In addition to systems, paperwork and staffing issues, the group needed to come to some serious decisions about the nature of their practice. One issue that was tossed about for several months was the decision to forego hospital work. "You want to be the total family doctor and do everything," Dr. Weatherby said. "But you look at the efficiencies in running your practice, and going to the hospital takes away from the office. The trend in medicine today is to turn that care over to hospitalists, but you still can't help wanting to be like the old-time doc."

"It does make it easier to make that decision knowing there are well-qualified hospitalists to manage your patients when they are in the hospital," Dr. Demirjian added. "Family practice is becoming so office intensive. To finish a day in the office and then go to the hospital — well, it just makes for a very long, difficult day."

Transition No. 2

Not long after establishing their practice, the group realized that the 4,800 square feet office space in the Baker Building would not be sufficient. "MultiCare didn't have any additional space to accommodate the growing practice," Dr. Weatherby explained, so Dr. Bateman took on the task of locating space. "I think he looked at every corner of the city," said Dr. Demirjian. "He explored every option."

Eventually, the group settled on leasing a building at 1812 S. J Street, directly across the street from the entrance to St. Joseph Medical Center. Now called Northwest Medical Plaza, the space was completely gutted and redesigned for the practice. "It was important to stay close to the three hospitals," said Sydni Wright, ARNP, who has been with the practice since the beginning. "It needed to be a space with easy access for patients, and access to nearby services and specialists." Patients have appreciated the parking and security guard on duty.

The new office opened its doors at the J Street location on August 24, 2001. The main floor is 7,000 square feet with an additional 2,000 square feet upstairs and additional space on the lower level. Approximately 150-200 patients a day receive care in the building. In addition to the five physicians, there are two nurse practitioners, three check in staff, two check out staff (who handle managed care and specialist referrals); one transcriptionist; one lab tech; one radiology tech; one nurse for each provider; three and a half medical records staff; an office manager; and three billers.

"There was so much work involved in this move," Wilson noted. "We had to build an office, design it to be efficient, and once again go through moving all the contracts and numbers to a new location. Timing was critical, but the transition came off as planned. The doctors invested a huge amount of time in the design and process." Since they had all been a part of the MultiCare system and very familiar with JACHO

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In My Opinion....

by John P. Lenihan, Jr., MD

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

"Call Your Provider for Advice!"

John Lenihan, MD

The words, "call your provider for advice" at the end of a news article always get my attention, especially when the article is sensational. Case in point: I awoke on the morning of Wednesday July 10th and picked up my morning paper off of the front porch. There on the front page of the Tacoma News Tribune, the headline stated: "Hormones More Harmful Than Helpful." The Seattle PI headline read "Hormone Replacement Study Halted!" I anxiously scanned both articles and discovered that part of the large NIH sponsored Women's Health Initiative Study had been halted early. The interim safety board had determined that the data was conclusive enough in one arm of the large prospective study of hormone replacement therapy (HRT) in healthy women to halt that part of the study after only five years instead of the eight years that were originally planned. The newspaper article cited significant increases in the risks of cardiovascular diseases and breast cancer. The articles finished by recommending that women get in touch with their providers before making any decisions about HRT. Great. The article wasn't even scheduled to be published in JAMA until July 17th and all I had to go on was the newspaper article. This is my worst nightmare!

By the time I arrived at the office, there were already dozens of calls from our anxious patients wanting to know what to do. I jumped on the JAMA web site and found that the article wasn't posted yet. My specialty organizations (ACOG, NAMS, etc.) were also unaware and so there was no help there either. I developed some bullet points from the information I had and gave this to my staff as an outline on how to reply to all of the anxious phone calls (see page 13 for outline). Two days later, JAMA, in an unusual move, did post the article earlier than usual on the web. Within the next twenty four hours, I had reviews available from national experts on how to interpret the data and what the implications were for women who were confused about HRT. It turns out the results of the study were not a total surprise to those of us who follow this area closely. The increased risks of breast cancer and cardiovascular disease were consistent with other recent studies that showed that HRT is not a panacea for all women. But the magnitude of the increased risk translated into only a few additional cases of disease. And the risks were only associated with the combination estrogen/progestin arm (Prem-Pro), while the estrogen only arm (Premarin) did not show any increase in risk of either problem at the five year level.

The talking heads on the evening news ranted about "how could American physicians prescribe dangerous drugs to our patients without having any scientific studies to support those recommendations?" In fact, HRT has been one of the most studied pharmacologic therapies in the history of drug research. And all of the very large case controlled retrospective cohort studies as well as the biological plausibility studies supported HRT as beneficial to most women. However, HRT has never been touted as beneficial for ALL women. For at least a decade now, specialists in this area have been trying to identify which women would be at higher risk for problems from HRT so that their providers could suggest alternative therapies for them.

So now, as is the case with most of the therapies that we advocate, there are pros and there are cons. Those of us who deal with patients every day realize that the decision to utilize any therapy requires a dialogue as well as an allowance for a particular individual's risk vs. benefit ratio. And yes, there are certainly still significant benefits from HRT. But I, for one, certainly feel more comfortable having this discussion with my patients after I have had an opportunity to review the published data and see how the recognized experts in this field respond to it. Given the recurring nature of the medias' proclivity to publish sensational medical articles before we, the providers, have access to the information, I am starting to tell all of my patients at every visit to not panic every time a headline blares at them regarding some new health risk. Give me time and I will get them the information that best applies this news to their unique situation. In other words, I am asking my patients to be patient. ■

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guidelines, the entire staff was very in tune with making the new office totally compliant with rules and regulations.

As a result, the office is designed for maximum efficiency. Each physician has his own pod, as do the two nurse practitioners. There are separate check in and check out areas. A registered dietician also has space. The two-sided waiting room has 56 chairs and additional bench seating. One huge positive of the new space is 130 parking stalls — all at ground level.

"We wanted to create a model that would enable us to do as much for our patients here as we possibly could," said Dr. Weatherby. "It was important to create conveniences for our patients."

"The bottom line is that we want the patient to have a good experience when they come here," Dr. Hillis said. "Most lab tests are done in the office, and the results are available right away. If someone is coughing and needs a chest x-ray, the patient only has to go downstairs. If someone has a billing question, they can sit down with someone right away right here in the office. We have tried to get the process for the patient as simple as possible."

Because the space is designed so efficiently, productivity is enhanced. Of course, the physicians are also more productive because they are putting in a great deal of time. "Each doctor spends a lot of time with each patient," Wilson said. "They all have long days. They work very hard.

In addition to seeing patients, each of the owner physicians has a specific role in the office. Dr. Hillis deals with most of the financial issues associated with the clinic; Dr. Bateman oversees the lab; Dr. Weatherby supervises the nurse practitioners and is assisting Wilson with HIPPA guidelines; Dr. Demirjian is involved with budgeting and the call schedule. They come together at 7 a.m. every Thursday to "hammer out" various issues such as capital expense purchases, personnel

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Thinking of quitting? Read this first

If you're thinking of leaving corporate medicine to establish your own practice, experts offer this advice:

· Give it time. It takes up to four months to get a Medicare provider number, and three to six months to get on health-plan provider lists. Telephone directory listings take even longer. A noncompete clause may also mean you have to relocate. Figure on a minimum of six months lead time.

· Seek out advice. Turn to medical associations, practice consultants and other such groups.

· Figure out the financing. To fund your new venture, consider banks, the Small Business Administration, a second mortgage on your home, pension and retirement funds, personal savings, and equity in an existing practice. Arrange a line of credit that gives you 90 days of operating capital, or a minimum of $30,000.

· Calculate your costs. If you cut every corner possible, you may be able to get through the first year with $100,000. When you factor in leasing and outfitting an office; equipment, malpractice, general liability, personal and employee insurance; computers and software; staffing and overhead, you're probably looking at more than twice that amount.

· Get the equipment. Decide whether to lease or buy. Leasing requires less initial capital; buying means it's yours in the long run. Consider used equipment, which, thanks to medical consolidation, is widely available.

· Consider outsourcing. If you're striking out on your own, a medical assistant may be all the staff you need. In most states, they're trained to handle limited medical tasks such as injections, plus administration. Consider outsourcing your billing and ancillary services like lab work or X-rays.

· Don't burn bridges. You'll need former colleagues, health plans and hospital contacts for referrals. Polish your networking skills and consider trading call with other independent doctors so you can avoid the high cost (up to $3,000 a week) of bringing in locum tenens help.

· Get your name out. Volunteer in community activities and advertise the opening of your practice. If you're willing to accept preferred provider contracts, get on their lists. Figure on one to two years to fill the practice, and a year to break even financially.

· Consider compromise. Join an IPA for managed-care clout. Rather than starting from scratch, think about joining an established private practice.

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

The Impossible Dream

Andrew Statson, MD

"The inherent vice of capitalism is the unequal sharing of blessings; the inherent virtue of socialism is the equal sharing of miseries."
Sir Winston Churchill

I am indebted to Dr. Jordan for the above quote. Since he sent it to me, I felt I had to write an article about it, so here it is.

As children, we play, go to school, help with the occasional chores and do whatever we can. When we go home, we have a roof over our head, clothes in our closet and food on the table. Childhood is socialism at its best. We do according to our abilities and someone else takes care of our needs. Of course, we may vaguely remember the many times when the fulfillment of our wishes, which we thought to be needs, was denied. Somehow we survived.

The transition to adulthood forced us to assume responsibility for ourselves. In some ways, it is a frightening experience. We face the world at large, where transactions are based on trade, not on need. When we want something, we have to pay for it. That means we have to earn it. During our twenties, the responsibility of adulthood can be distressing. Adjusting to such a change can be difficult, even though we may still get help from our parents. The wish for the simpler life of childhood tends to linger.

The almost irresistible appeal of socialism is based on that simplicity. From everyone according to his abilities, to everyone according to his needs. Sounds wonderful, doesn't it? Ah, if men were angels!

The first experiment with socialism on this side of the Atlantic was the Plymouth Colony, established by the Mayflower Compact. It is also the best known. Many others followed, in this country and in Canada, right through the twentieth century, including the hippie communes, the Moonies and others.

All these communes were formed as voluntary associations based on brother-love and evolved along the same line. They started with the resources their members brought into them when joining. They all went through three stages, stagnation, impoverishment and disintegration.

The heavy-handed socialism of the old continent had an advantage. It was established by the state and was backed by a pervasive police force, complete with prisons and concentration camps, and by a huge army. In spite of all that, state socialism went through the same three stages, stagnation, impoverishment and disintegration.

The Western European brand of socialism is mixed, in the respect that most of the economy is capitalistic, so that the stagnation and impoverishment are blunted. Even so, the burden of the socialistic programs on the economy got to be too heavy and all countries, including Sweden, had to scale down their social services.

No, socialism does not work. Its simplicity cannot match the complexities of life. The simple solutions, attractive and easily expressed in slogans, don't cut it. The system breaks down because of the details. Needs are elastic, and so are abilities.

In the semi-socialistic system of health care in this country, we already faced the issue of medical necessity. We all observed the elasticity of needs, depending on who is paying for the treatment and how much it is going to cost. We saw the divergence between the opinions of the insurance companies and of the patients as to what constitutes need. The experiment with managed care was about the control of needs. Its goal was to shrink them as much as possible.

When economists discuss elasticity, they refer to the changes in demand as a result of changes in price. I cannot resist quoting from the textbook *University Economics*, by Alchian and Allen: "The law of demand is a denial of the idea of 'needs'...It is said that we need more highways. Does this mean we should have them regardless of the cost -- that is despite the forsaken alternatives?... When someone says there is a need for something, he should always be asked, in order to achieve what, at what cost of other goods or needs, and at whose cost?... When my

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and staffing, remodeling issues, paperwork, and when to bring in new providers. "We meet, we make decisions, we do it. The process is a lot easier," said Dr. Demirjian. It was around the table at one of their weekly meetings that the decision was made to hire Dr. Ray Dilworth, also a former corporate physician. The group is currently considering adding an additional physician.

But it takes a village to raise a practice, and it's not just the physicians working long days. "We have a very committed staff," Wilson said. "And personally, I've never worked harder in my life than I have the last two years. It's been a real challenge, but it's also had its great successes. In a practice like this, when everything is new territory, you immediately see when something is working and when something is not working. We've made some good choices as far as purchasing equipment and adding staff. Bringing in Dr. Dilworth in November has been very good for the practice," Wilson said. "He brings a great deal of stability, maturity and character to the group."

Dealing with the Pitfalls

All the physicians agree that this was the right decision. No question. But as with any new endeavor, there have been pitfalls. That's why they want to share their experience with others. "It can be done, and it can be done well," Wilson said. "We've learned a lot about how to do it and what not to do. There are many mistakes you make when going into private practice. Knowing the pitfalls can save people a lot of grief."

Among the pitfalls...audits. "The minute you change your tax ID numbers or your location, you trigger every audit by every insurance company imaginable," Wilson said. "We were here a week, and we were already audited," Dr. Demirjian said. "Fortunately, we had everything in place. But if we hadn't, we could have lost our insurance contracts."

Support from the Community

In addition to the invaluable time and advice from Bob Murphy at Digestive Health Specialists, the group has also received a great deal of positive support and feedback from the medical community. Additionally, several physicians have contacted the group for advice on their own practice. "Some of the people we hear from are going through the same process we went through a few years ago," said Dr. Demirjian.

"Physician satisfaction is so important," Dr. Hillis said. "Physicians are frustrated over and over again by the things that change without any control. That was one of the biggest issues for me working in corporate medicine. Now, I can control my own destiny. If I don't like something, I can change it. There is also a greater sense of calmness in the group. Sure, we have all the other headaches — bills, income statements, other issues involved with running a business — but we have control. You can lose that sense of control in corporate medicine.

"It can be done," he said, "but it has to be well planned. And you have to surround yourself with people who know how to do it. We tried to do it the best we could."

Obviously, these four physicians share the same philosophies regarding their practice and the practice of medicine. (And not surprisingly, the similarities don't end there. They are all community-oriented individuals and devoted family men.) And while a group private practice was a good choice for these four individuals, they are all quick to note that what they did wasn't just about getting out of MultiCare. "I don't want to give the impression that our choice was a slight against MultiCare," Dr. Hillis said.

"MultiCare has some excellent systems in place and do some wonderful things," Wilson added. "It just wasn't right for these four guys. These are four strong, dynamic individuals, and I personally can't imagine them in *any* system."

There will be much to celebrate when the group marks its one-year anniversary in their new building this August. "This is the first year to turn the corner," Wilson said. "We're doing everything correctly. Costs are down, the move is behind us, and the hard stuff is in the past. Now, the doctors can really enjoy what they've worked very hard for." ■

Primary Care Northwest is accepting new patients. If you would like to contact the physicians at Primary Care Northwest to learn more about their experience, contact Rhonda Wilson at 552-5301.

In My Opinion....

by Rebecca A. Sullivan, MD and Allison M. Bailey

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

Making Sense of RVU's and Reimbursement

Payment to Physician = [((RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU malpractice x GPCI malpractice)) x CF]

Rebecca Sullivan, MD

Not familiar with this formula? Perhaps you should be (and your biller certainly should be), because this is the formula under which most physicians are paid. Reimbursement is probably number one, two and three on the list of topics of discussion among physicians these days. This article will review the various parameters that impact reimbursement.

Occasionally a physician will comment that "Washington physicians receive the lowest (or second lowest) Medicare reimbursement in the country." This statement reflects confusion with something called the AAPCC, or Adjusted Average Per Capita Cost. The AAPCC is the historical average per capita cost for Medicare patients. This cost base includes all costs for the Medicare recipient, including costs for care by hospitals, physicians and other providers. This amount is the basis for the amount paid to organizations that take risk for Medicare HMO patients. In a sense the AAPCC is the basis for the 'premium' that the federal government pays to HMO's for each Medicare HMO patient, which is 95% of the AAPCC. Historically, Washington has had one of the lowest AAPCC rates in the country. The reason that Washington's AAPCC is so low is that Washington has generally spent significantly less than other states in taking care of Medicare patients, primarily because its rate of hospitalization is so much lower than states on the east coast, for example. The relative level of the AAPCC, however, does not determine how much is paid to the physician. A Medicare HMO in turn contracts with providers at certain rates. The rates are typically set at a percent of Medicare fee-for-service rates.

For Medicare and most other insured patients, physicians receive reimbursement that is from a formula based on the RBRVS, or Resource Based Relative Value Scale. The RBRVS is a national system of reimbursement that is based on the resources that went into providing the service.

"Reimbursement is probably number one, two and three on the list of topics of discussion among physicians these days."

History

Up until 1992 reimbursement for Medicare, and other payors, was based upon 'usual and customary charges'; thus, there were marked differences geographically in what physicians were paid for the same services. The Social Security Act of 1992 changed that. The Act required a number of things, including: (1) a fee schedule for the payment of physicians' services; (2) a sustainable growth rate for the rates of increase in Medicare expenditures for physicians' services; and (3) payments under the fee schedule be based on national uniform relative value units (RVUs) using the resources used by a physician in furnishing a service. Another section of the Act required that adjustments in RVUs must not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If this tolerance is exceeded, then adjustments to the conversion factors (CFs) must be made to preserve budget neutrality. Under the formula established by the Social Security Act, the payment to a physician is the product of three factors: (1) a nationally uniform relative value for the service (RVU); (2) a geographic adjustment factor (GAF) for each area of the country; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

Relative Value Units (RVU's)

Medicare defined three types of resources that go into establishing the RVU for services provided by a physician: physician work, practice expense, and malpractice expense. The 1992 law required that the physician work component be resource-based. The physician work component accounts, on av-

See "RVU's" page 12

RVU's from page 11

erage, for 55% of the total relative value for each service.

The work components of the RVUs for most codes were developed originally by a research team at the Harvard School of Public Health. In constructing the vignettes for the work RVUs, Harvard worked with panels of expert physicians and obtained input from physicians from numerous specialties. The factors used to determine physician work include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient.

A 1994 amendment to the Social Security Act required practice expense RVUs be resource-based as well. As amended by the Balanced Budget Act (BBA), this required the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource-based practice expense RVUs becoming fully effective in 2002. The practice expense component of the RBRVS accounts for an average of 42% of the total relative value for each service.

The BBA also required the implementation of resource-based malpractice RVUs for services furnished beginning in 2000. With this transition of the resource-based practice expense relative units ending on January 1, 2002, all three components of the RBRVS are now resource-based.

Some services do not have Medicare RVU's, since Medicare does not pay for those services; however, St. Anthony's, a healthcare publishing company, has calculated weights for unweighted codes. They publish several RVU resources, which may be purchased through www.st-anthony.com; however, these resources may cost several hundred dollars. Payors using the Medicare RBRVS for payment may note on their reimbursement schedule that they are using St. Anthony's RVU's for Medicare unweighted CPT codes. Medicare RVU's can be downloaded without charge from www.hcfa.gov/stats/cpt/rvudown.htm. This is updated quarterly. There are over 7,500 weighted Medicare CPT codes, each with its own RVU.

The RVUs for radiology services are based on the American College of Radiology relative value scale, which was integrated into the overall physician fee schedule. The RVUs for anesthesia services are based on RVUs from a uniform relative value guide. A separate conversion factor was developed for anesthesia services because time is recognized as a factor in determining payment for these services. As a result, there is a separate payment system for anesthesia.

Geographic Adjustment Factor
(Geographic Practice Cost Indices)

The Geographic Adjustment Factor (GAF) used in the formula for payment is designed to account for geographic variations in the costs of providing services. The GAF is actually the weighted sum of three indices. Separate geographic practice cost indices (GPCIs) have been developed for each of the three components of the RVU, namely a work GPCI, a practice expense GPCI, and a malpractice GPCI. Thus, a separate geographic adjustment is made for each component. The GPCIs (pronounced 'gypsies') reflect the differences in costs of practice expenses, malpractice insurance, and physician work among different geographic areas of the country.

The GPCIs for each component of the RVU varies yearly and geographically; they are available in books or on-line, and are reviewed annually. Sometimes an entire state will have the same GPCIs; sometimes there will be sub-areas within a state. Below are some representative GPCIs from throughout the United States. Please note that Pierce County (which is part of 'Washington, Rest of') has neither the highest nor lowest GPCIs in the country in any of the three categories. Obviously, the lower the GPCI, the lower the overall payment.

See "RVU's" page 14

Locality Name	Work	Practice Expense	Malpractice
Alabama	0.978	0.871	0.841
Alaska	1.063	1.172	1.378
California*, Rest Of	1.007	1.039	0.723
California, Los Angeles	1.055	1.169	0.901
California, Oakland/Berkeley	1.04	1.216	0.677
California, San Francisco	1.067	1.378	0.677
Dc + Maryland/Virginia Suburbs	1.05	1.164	0.97
Florida, Miami	1.015	1.064	2.439
Florida, Rest Of	0.975	0.947	1.296
Hawaii/Guam	0.997	1.154	0.894
Illinois, Chicago,	1.027	1.09	1.745
Illinois, East St. Louis	0.988	0.927	1.589
Illinois, Rest Of	0.964	0.888	1.074
New Mexico	0.973	0.905	0.809
New York, Manhattan	1.093	1.352	1.661
New York, Rest Of	0.998	0.951	0.778
North Dakota	0.95	0.879	0.657
Oregon, Rest Of	0.961	0.935	0.511
Utah	0.977	0.925	0.619
Washington, Rest Of	**0.982**	**0.974**	**0.765**
Washington, Seattle (King County)	1.005	1.09	0.765
West Virginia	0.963	0.852	1.242
Wyoming	0.967	0.895	0.855

Response to News Media Articles on Hormone Therapy

What Happened: News stories: "Hormones More Harmful Than Helpful" (TNT, 7-10-02)

Data: WHI ongoing study stopped early because of adverse outcomes in combination HRT group.

- 16,000 healthy women age 50-79 on PremPro (with a uterus), Premarin (without a uterus) or Placebo
- 29% increased risk of heart attacks over five years (PremPro only, not Premarin)
- 41% increased risk of stroke
- Doubling of the incidence of blood clots (DVT)
- 26% increase risk of breast cancer (only after five years)

BUT

- 37% fewer hip fractures
- 34% fewer colon cancers
- NO difference in mortality in either group

ABSOLUTE RISK is still small:

If 10,000 women took **PremPro**, over five years, there would be:

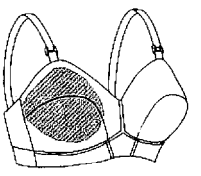
- 7 more heart attacks (37 vs 30)
- 8 more strokes (29 vs 21)
- 8 more lung clots
- Twice as many DVT's (34 vs 16)
- 8 more breast cancers (38 vs 30)
- 6 fewer colon cancers (10 vs 16)
- 5 fewer hip fractures (10 vs 15)
- The same number of deaths from all causes

Who is at most risk?

- Heart Disease: Smokers, hypertensive, diabetics, strong family history, elevated triglycerides
- Blood Clots: Previous blood clot, those with inherited tendency to clot more (Thrombophilias), smokers
- Breast Cancer: Positive family history of first degree relative, those with dense breasts, previous biopsies with atypical cells or hyperplasia, obese women, Nulliparous or delayed childbearing
- Colon Cancer: Positive family history
- Hip Fracture: Thin white women, smokers, positive family history, thyroid or steroid use

What should we do?

- If on Prem-Pro, consider switching products to utilize a different progestin. Alternatively, hysterectomy would negate the need for a progestin
- If on Premarin, continue, but consider lowering the dose over time
- If on other HRT (Activella, FemHrt, etc.) continue for now. Consider lowering dose over time
- All women on hormones should utilize low dose aspirin: a baby ASA or one regular ASA daily
- Stop hormones temporarily if you have a leg injury or become immobilized for a prolonged period
- Check Triglycerides and Lipoprotein-a. If abnormal, consider other therapies (higher risk of heart disease in these women)
- If you choose to stop HRT, discuss with your physician or other health care provider other strategies to lower your risk of heart disease, colon CA, osteoporosis, etc.
- Come in and review this issue with your physician or other health care provider annually!



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Conversion Factors (CF's)

Conversion Factors (CF's) vary yearly, because of the laws requiring budget neutrality. Below is a table with the conversions factors used since 1992.

Summary

There are several components to the reimbursement formula:

1. **RVU** (nationally uniform for each CPT code)
   a. work
   b. practice expense
   c. malpractice
2. **GPCI** (geographic variation)
   a. work GPCI
   b. practice expense GPCI
   c. malpractice GPCI
3. **Conversion Factor** (one national amount)

These components are then used in the formula below for calculating the Medicare fee for a given service in a given geographic area:

Payment to Physician = [((RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU malpractice x GPCI malpractice)) x CF]

Most major payors have quickly adopted Medicare's system of reimbursement, although the conversion factor, and whether they use the GPCI adjustment, is different depending on the payor. In addition, all plans administered through the Washington State Health Care Authority, including Medicaid, L&I, and the Uniform Medical Plan, use the same basic Medicare RVU system, but use state-specific GPCI's, which are available through the Health Care Authority, and can be found in the provider manuals. For CPT codes not weighted by Medicare, the State has established specific reimbursements, rather than weights.

Although a physician will not personally be using this information, it is important that they ensure that their billing department understands it, and is using it to verify that they are being paid correctly. In addition, this information can be used to set charges above expected reimbursement, so that money is not inadvertently being left on the table. ■

The National Conversion Factors used in the computation of every fee schedule amount.

Year	Conversion Factor	Surgical	Non-Surgical	Primary Care
2002	$36.1992			
2001	$38.2581			
2000	$36.6137			
1999	$34.7135			
1998	$36.6873			
1997		$40.9603	$33.8454	$35.7671
1996		$40.7986	$34.6293	$35.4173
1995		$39.447	$34.616	$36.382
1994		$35.158	$32.905	$33.718
1993		$31.962	$31.249	
1992	$31.001			

Welcome - New Members

Dali Chen, MD
Internal Medicine/Endocrinology
Endocrine Consultants NW
1628 S Mildred #104, Tacoma
253-565-6777
Medical School: Beijing Medical Univ
Internship: Univ of Texas HSC
Residency: Univ of Texas HSC
Fellowship: Univ of Texas SW Med Ctr

Alan D. Pearson, MD
Radiology
Diagnostic Imaging Northwest
222 15th Ave SE, Puyallup
253-841-4353
Medical School: Uniformed Services University of the Health Sciences
Internship: Madigan Army Med Ctr
Residency: Madigan Army Med Ctr

Korina Tanner, MD
Family Practice
South Hill Family Medicine
3908 10th St SE, Puyallup
235-848-5951
Medical School: Creighton University
Internship: Valley Medical Center
Residency: Valley Medical Center

Alexander D. Serra, MD
Radiology
33801 1st Way S, #101, Federal Way
253-942-7226
Medical School: Cornell University
Internship: Greenwich Hospital
Residency: University of Colorado
Fellowship: UCSF

Tien Ahn Wee, MD
Radiology
Diagnostic Imaging Northwest
222 - 15th Ave SE, Puyallup
253-841-4353
Medical School: Columbia University
Internship: University of Hawaii
Residency: Univ of California Davis
Fellowship: Memorial MRI Center

Applicants for Membership

Brenda A. Myers-Powell, MD
Ophthalmology
Retina & Macula Specialists
2914 S Alder, Tacoma
253-272-9245
Medical School: Washington University
Internship: St. John' Mercy Med Ctr
Residency: University of Texas
Fellowship: National Eye Institute

Corrie A. Naasz, MD
Internal Medicine/Pediatrics
Gig Harbor Medical Clinic
6401 Kimball Dr, Gig Harbor
253-858-9191
Med School: University of Louisville
Internship: University of Louisville
Residency: University of Louisville
Residency: Michigan State University

Thanh V. Pham, MD
Internal Medicine
4620 Bridgeport Way W, Tacoma
253-564-0170
Medical School: St. Louis University
Internship: St. Louis University
Residency: St. Louis University

Dream from page 9

wife says, 'we need a new car' or 'we need a larger house'...I disagree by saying, 'Of course we need it. What shall we give up to get it? What do we need less?'... We know of no more common denial of the law of demand than the repeated talk about 'vital needs.' At best, such talk is the result of ignorance that goods are scarce. At worst, it is a calculated attempt to confuse the reader or listener into paying the costs of what the speaker wants."

The resources of the community in which we live are limited by the productive capacity of its members. We can always spend more, but before we do, someone has to produce it. Because of that limitation, whenever we buy something, it is always instead of something else that we have to forgo. There is no way around it.

The elasticity of abilities is another aspect of the failure of socialism. In order to produce to the best of our abilities, we need incentives. If our needs are going to be satisfied no matter what we do, what is the incentive to push ourselves to do better?

For instance, we went through ten, twelve or more years of training after high school in order to become physicians. Why did we do it? If we wanted to be of service to our fellow men, there are many other ways we could have done it. Why did we choose one of the most difficult? Why did we go through the hardship of training? Why do we work as many hours a day as we do, day and night, weekday and weekend? True, we get satisfaction and pride. Great!

How do we live on satisfaction and pride? Do we bake them before we eat them? Will they pay the mortgage? Will they send the children to college?

In spite of the complexity of the health care system, there is a persistent belief, even after the failure of Hillary Clinton to resolve that issue, that somehow, if the government took over the financing of health care, all our problems would disappear. That is too simplistic to be workable.

We cannot expect that Uncle Sam will open his wallet and let us keep ours closed. He does not make money, not even by printing it. We have to make it first. He gets it from us. After he runs it through his accounts, he may return some of it. Unfortunately, he gets bogged down in paperwork and that costs a lot of money. Do you know of any government program that is run at a lower overhead than a similar one by private enterprise? The post office? The VA hospitals? Amtrak? Public transit? Yes. Sure.

If the government took over the health care system in this country, it would have to run the hospitals and our offices. Actually, it won't be too bad for us. We'll work in clinics, on a salary. Our hours will be limited by work rules to forty per week or even fewer, we'll have two coffee breaks and one lunch break a day. We won't need to think. We'll do as we are told. We'll execute the algorithms. The government will pay our malpractice insurance. Best of all, when we are off, we are off.

Of course, when we work fewer hours and at a more leisurely pace, our productivity will drop. It will take three times as many physicians to do the work we do now. For instance, in the mid-fifties, Russia boasted it had 750,000 practicing physicians, versus 250,000 in the US for the same number of people. We can fully expect that the annual cost of health care will triple, to about three trillion dollars, I know, I may be exaggerating, but so what. We are a rich country, we can afford it, even if it gets to be that much.

The alternative is capitalism, transactions based on trade, people assuming the responsibility for themselves, for their own care, for their own welfare. No waste of public resources, because capitalism is thrifty. Perhaps we can hope that our people will grow up to become adults. The French have a saying, "If you're not liberal at twenty, you don't have a heart; if you're not conservative at forty, you don't have a head." Perhaps one day we'll turn forty. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Common Office Problems CME scheduled for October 4, 2002

Topics are set for the College's Common Office Problems CME schedule for Friday, October 4, 2002. The conference will be held at St. Joseph Medical Center, Rooms 1 A&B.

The program will offer 6 Category I CME credits and is again directed by **Mark Craddock, MD**.

This year's course will cover:

- Rheumatology
- Chronic Renal Care
- Advances in Contraceptives
- Stages of Type II Diabetes
- Migraines
- Substance Abuse and Depression
- Dermatology
- BPH

The course is designed for the primary care clinician and focuses on practical approaches to the most common dilemmas faced in the daily routine of medical practice. Look for the registration brochure in the mail just after Labor Day.

For more information, please call the College of Medical Education, 627-7137 between 7:45 a.m. and 5:00 p.m. ■

January 2003 Whistler CME Registration Open

Registration is open for the College's CME at Whistler/Blackcomb program. The conference is scheduled for January 22-26, 2003. The program brochure will be mailed in August.

Reservations for the Aspen condos can be made by calling the Aspens on Blackcomb, toll free at 1-877-408-8899. You must identify yourself as part of the COME group. Likewise, you are encouraged to make your reservations soon to ensure space - at least by December 1, 2002, when any remaining condos in the block will be released.■

ID Update CME set November 8

The annual Infectious Diseases Update is set for Friday, November 8, 2002. The very popular course will return this year to the Sheraton Hotel. The program is directed by **Jim DeMaio, MD** and will feature University of Washington-based speakers, Drs. David Spach and Anna Wald. They will join Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections.

The registration brochure will be mailed in September. ■

Dates	Program	Director(s)
Friday, October 4	Common Office Problems	Mark Craddock, MD
Friday, Novmber 8	Infectious Diseases Update	James DeMaio, MD
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Wednesday; Tuesday January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Gregg Ostergren, DO
Friday, February 7	Primary Care - 2003	TBA
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD, FACE
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Gurjit Kaeley, MD
Change office address and phone to:
R.O.A.D. Clinic, 4905 108th St SW, Lakewood WA 98498
253-983-8385

Johnette Maehren, DO
Change office address to:
314 Martin L King Jr Way #208, Tacoma, WA 98405

Robert Marsh, MD
Change home address and phone to:
1120 23rd Ave Ct SW, Puyallup 98371
253-446-0102
Change physician only phone to: 253-864-1715
Change e-mail address to: remarshmd@remarshmd.com

Sandra Reilley, MD
Change office address to:
1901 S Union #B-2005, Tacoma WA 98405

Gail Venuto, MD
Change office address and phone to:
St. Joseph Medical Clinic, 1708 S Yakima Ave, Tacoma 98405
253-627-9151

Classified Advertising

POSITIONS AVAILABLE

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

Seattle, Wash - Occupational Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

POSITIONS AVAILABLE

Family Physicians wanted to work at Sea Mar Community Health Centers. Sea Mar is dedicated to serving the underserved with emphasis in the Latino population throughout Western Washington. OB is required and Spanish language proficiency is preferred. We offer a competitive salary, benefits and a sabbatical plan. Choose from the following locations with openings: Tacoma: 3 FP positions available. The practice is expanding to 5 family physicians. Hospital care is at Tacoma General Hospital. Call is 1 in 4. Contact **Phillip Reilly, MD** if interested. (253) 593-2144.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examination rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Price Reduced. Lakewood prop-erty for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

Medical space for sale and/or lease in rapidly growing South King County with 85,000 population service area. Need for pulmonary, pediatric, orthopedic and gynecologic specialties. Call 360-825-1389.

2900 sq ft medical space - $10-12 psf NNN, 7 exams, x-ray, procedure room. Lakewood. 253-584-2000.

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Pierce County Medical Society
BULLETIN
September, 2002

Summer Biking Events

Courage Classic

Don Shrewsbury, MD (left) and Bill Martin, MD on their ascent up Stevens Pass on day three of the Courage Classic

Seattle-to-Portland

Dr. Pat Hogan (front) and his son Patrick (back) completed the 200 mile Seattle-to-Portland bicycle ride in one day

See stories and more photos - pages 6 & 7

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

September, 2002

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President's Page

by Susan Salo, MD

WSMA Annual Meeting

Susan Salo, MD

In a few days the 2002 WSMA annual meeting will convene, right here in Tacoma. I hope Pierce County physicians will take advantage of the convenience to attend and participate.

The program starts Friday afternoon with the former governor of Colorado, Richard Lamm, giving a talk titled "A New Moral Vision For Health Care." Oregon's Governor John Kitzhaber, the originator of the Oregon Health Plan, has also been invited, and will be an exciting speaker if he can attend. This should be a stimulating discussion!

The WSMA business sessions include discussions in Reference Committees of last year's work and of new resolutions proposed by members; some of this is routine, but some of the resolutions can be provocative and the discussions lively. This process culminates in the House of Delegates session Sunday. Although I don't yet know what subjects will be addressed in this year's resolutions, one of our Trustees, **Dr. Ken Feucht**, has proposed several related to practice and insurance concerns.

Lectures and presentations Friday and Saturday (when they are concurrent with the Reference Committees) include options for FREE CME (!) in both medical disciplines and in new practice management information and skills. Subjects range from primary care ENT and Psychiatry to Specialty Ophthalmologic presentations. A Health Care Economics Program by Andy Dolan, whom I know to be an excellent speaker, intrigues me.

The opportunity to meet friends from throughout the state, to attend the President's dinner and entertainment, the WAMPAC and Senior Physicians' Lunch, and Saturday's Spouses' Continental breakfast, provide time to round out the agenda.

The annual meeting's location in Tacoma this year provides a unique opportunity to attend, to participate, to learn something, and to have fun...please join us. ■

Editor's Note: See page 8 for more information on the WSMA Annual Meeting.

In My Opinion.....

by Tom Bageant, MD

My concerns about medical care in Washington state

I am a retired anesthesiologist, having practiced at Allenmore Hospital for over 23 years. I have very real concerns about the state of medical care in our county and state. These are my questions...

• Why are malpractice insurance rates allowed to increase when insurance companies' investments do poorly? Why aren't these rates forced to decrease when their investments do well?

• Why does the state legislature not embrace meaningful tort reform that benefits recipients, caps unreasonable judgments, and stops huge windfalls for lawyers?

• Why did our legislators bow to lobbyists and pass the "any willing provider" law knowing that insurance providers would have to pay huge sums for unproven modalities?

• How can the State of Nevada pay more than twice the unit value for Anesthesiologist's professional services than Washington State?

• How can our Medicare System pay over $10,000 per Medicare patient per year in Washington, D.C. and only +/-$3,900 per patient per year in Washington State?

• How can our state politicians, state hospital administrators, and state HMOs continue to watch physicians leave the state, watch the availability of care for DSHS and Medicare patients dwindle, and witness the lack of insurance availability and soaring cost for insurance that can be found?

• How can doctors and/or hospitals recruit, and keep, new physicians when these physicians can go to other states and work less, make more, and have less stress?

• Why are we, the citizens of Washington State, allowing our medical care system to fall apart?

And, I offer my thoughts on reform:

• Tort reform that limits awards for "pain and suffering" and caps legal fees.

• Repeal the "any willing provider" law and stop mandated payments for unproven modalities of care.

• Demand parity with respect to Medicare payments throughout the country.

• Prioritize medical services and pay reasonable amounts for professional services and hospital services.

• Physicians and hospitals must stop their adversarial relationships and insist that state and national leaders help with the repairs that are needed.

Tom Bageant, MD

• With the help of State and National Medical Societies, create a State Formulary for medications and medical appliances and limit their cost.

• Work with insurance companies and encourage them to provide both major medical coverage and malpractice coverage within this state, at competitive rates; based on their expenses not on the health of their investments.

• Envision large regional medical centers, with both highway and air access, residency and nurses training facilities, full acute care facilities (from trauma to obstetrics, from acute psychiatric care to pediatric care, pain therapy to oncology, etc.), interim care facilities, nursing care and assisted living facilities, and research facilities.

The providers of conventional medical care in this state deserve better pay, more respect, better understanding, and much more support from their administrators and legislators. Our medical care system needs revitalization and people, from multiple disciplines, with energy, knowledge, vision and power to work toward this goal. ■

Tacoma News Tribune covers local doctors' concerns

Tacoma News Tribune addresses malpractice crisis and ill effects

Editor's Note: This article is excerpted from the Tacoma News Tribune, 8/18/02. For a complete copy of the article, "Rising malpractice rates, shrinking doctor pool" call PCMS 527-3667.

In her feature article of Sunday, August 18, Sandi Doughton, News Tribune reporter interviewed PCMS members **Drs. Terry Utt, Patty Kulpa,** and **John Lenihan**, all victims of skyrocketing malpractice premiums. Her lengthy article unravels different causes for increases, depending upon who you talk to, as well as differing opinions about the severity of the situation.

"When the economy weakens... insurance companies always respond the same way – by raising premiums," said Joanne Doroshow, executive director of the Washington D.C. based Center for Justice and Democracy, an offshoot of Ralph Nader's consumer rights network. Many other groups contend that the situation is overblown and the blame lies with the sagging economy and questionable business practices of the insurance companies. Dr. Kulpa, Gig Harbor ob/gyn, will stop delivering babies at the end of September, while Dr. Utt, Puyallup family practictioner, is unsure of how long he will be able to continue the most gratifying part of his practice. Dr. Lenihan, Tacoma ob/gyn, noted that he knows of six local obstetricians who will not be delivering babies next year for one reason or another, unless something is done.

Washington state physicians are suffering from insurance sticker shock this year particularly. The severity of the problem is open to debate although the AMA has identified Washington as one of 12 states that are in crisis mode. While claiming that one of the state's largest insurers left the state, it was actually the second largest, Washington Casualty Company, leaving about 17% of the state's physicians to find new coverage. A recent PCMS survey revealed (see survey results, page 16) an average increase of 50% this year from the 193 physicians responding.

While the extent of the problem is not agreed upon, neither are the causes. For most in the health care profession, the problem is clearly multimillion-dollar lawsuit awards and a legal system that promotes them. While the number of medical malpractice suits in the state has remained constant, the amount paid out has risen from $80.7 million in 1999 to $103 million in 2001. While the Bush administration supports limiting damage awards, a House bill that would have capped damage amounts failed in the Senate in August.

Mike Kreidler, Washington Insurance Commissioner gives little hope for a damage cap in Washington state, as it has been declared unconstitutional by the State Supreme Court. WSMA is working on alternative proposals such as limits on attorney fees, and a workman's compensation-like system

See "Crisis" page 16

Washington doctors feel the squeeze from all directions

Practices hurt by malpractice premiums, low payments

Editor's Note: This editorial is reprinted from the 8/20/02 Tacoma News Tribune in its entirety. It followed front page coverage on Sunday, August 20, "Rising malpractice rates, shrinking doctor pool," written by reporter Sandi Doughton.

While doctors are rarely poor, they can be driven out of a practice - or out of the state - by high expenses or low payments. This has begun to happen to Washington doctors - and the public has begun to feel the impact.

On Sunday, *The News Tribune's* Sandi Doughton documented the rapid escalation of malpractice premiums in Washington. It doesn't compare with the crisis reported earlier this year in Nevada, where staggering premium increases had many obstetricians refusing to take on new pregnancies. But average OB premiums have ballooned by nearly 80 percent in this state since 1997, and some Washington obstetricians say they are now paying $100,000 a year.

The overall cost of malpractice coverage in Washington rose 10 to 12 percent this year, according to the state insurance commissioner's office, and many Pierce County physicians are reporting much higher increases.

"The reported premium increases may be driven less by what is happening in courtrooms than on Wall Street"

While doctors' advocates tend to talk about out-of-control jury verdicts and the necessity of tort reform, Doughton's report tells a more complex story. At least in Washington state, the number of malpractice lawsuits has not increased substantially in recent years, and total damages have been relatively stable.

The reported premium increases may be driven less by what is happening in courtrooms than on Wall Street: Insurance companies have been earning far less money on their investments

See "Squeeze" page 16

Seattle-to-Portland, 200 miles, 1 or 2 days...

Several PCMS members took part in the 23rd Annual 200 mile Seattle-to-Portland (STP) Bicycle Classic Ride July 13-14. Most of the 9000 riders stay the first night in Centralia or Chehalis, which is 94 miles from the University of Washington starting point. About 1500 of them do the ride in one day including Tacoma neurologist **Pat Hogan** and his son Patrick.

Other PCMS members participating in the ride included: Gig Harbor family physician **Mark Craddock**, Puyallup internist **Nichol Iverson**, Tacoma general surgeon **William Martin** and his wife Karyl, anesthesiologist **Brad Pattison**, Tacoma internist **Henry Retailliau** and his son Daniel, and gastroenterologist **Gary Taubman**.

Congratulations to all riders!■

Nic Iverson, MD ,Puyallup internist, in Longview, WA, the 150 mile mark

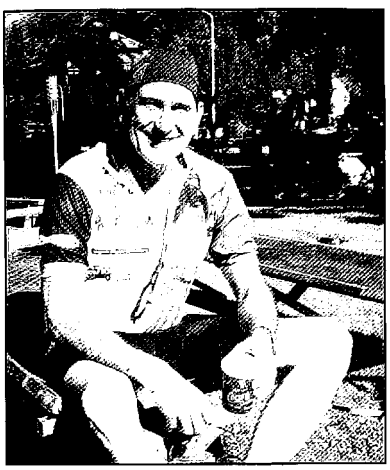
Dr. Bill Martin, general surgeon, and his wife Karyl, smiling at the finish line

Courage Classic, 172 miles, 3 days...

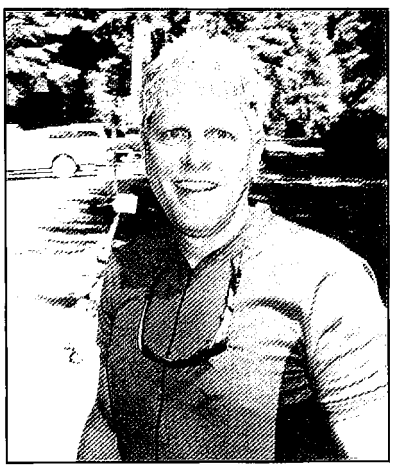
Congratulations are in order to PCMS members who rode this year's Courage Classic. They are Drs. **George Brown**, Administrative Medicine; **William Martin**, General Surgeon, and his wife Karyl; **Henry Retailliau**, Internal Medicine, and his son Daniel; **Steve Settle**, Physical Medicine and Rehab; **Don Shrewsbury**, Otolaryngologist; and **Gary Taubman**, Gastroenterologist.

The weekend started in Snoqualimie with the first day ending 57 miles later in Cle Elum. The second day leads riders to Leavenworth after a 55 mile ride. The third day riders end up in Skykomish after completing the final 60 miles of the ride. Total elevation gain for this ride is 10,036 feet!

This year's 11th Annual Courage Classic bicycle tour took place on August 10-12. Proceeds from the Courage Classic benefit the Rotary Endowment for the Intervention and Prevention of Child Abuse and Neglect at Mary Bridge Children's Hosptial as well as the Children's Trust Foundation. ■

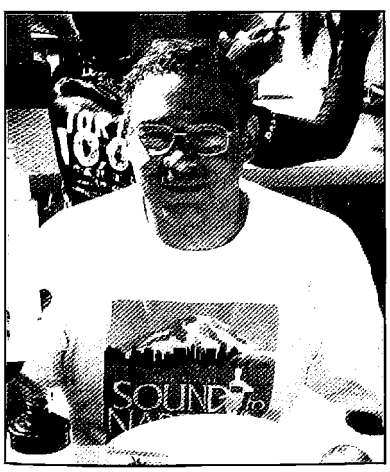


Bill Martin, MD relaxing on the way up Stevens Pass



Gary Taubman, MD looking fresh and ready on Day 1

George Brown, MD ascending Stevens Pass, Day 3



Dr. George Brown at the Summit of Blewitt Pass, Day 2

Dr. Gary Taubman (second from left) with friends along the way

Dr. Steve Settle (right) with a PT buddy after the first day of riding

Stu Farber, MD accepts position at UW, thanks colleagues for support

Dear Colleagues:

Thanks for your note inquiring about my continued membership in the Pierce County Medical Society. I am sorry to inform you that I will not be renewing my membership. But I am pleased to share why. As of July 1, 2002 I have accepted a full time appointment as an Associate Professor in the Department of Family Medicine at the University of Washington School of Medicine. My focus at the medical school will be medical student education, particularly in Geriatrics and Palliative Care. My particular job responsibilities will include:

- Co-director of the required third year family medicine clerkship.
- Developing curriculum and teaching the Palliative Care/End-of-Life portion of the newly required fourth year Chronic Care Clerkship that starts September 2003.
- Family Medicine 546 a pre-clinical Hospice elective.
- Family Medicine 547 a pre-clinical Spirituality in Medicine elective.
- Conduct research and develop clinical experiences that promote improved education and practice in Palliative and End-of-Life Care for students, residents, and practicing physicians.

Since I will be working in Seattle, I have moved my local membership to the King County Medical Society. I continue to be deeply involved with the WSMA sponsored End-of-Life Consensus Coalition. I look forward to seeing many familiar faces at the educational conference Linda Seaman and I are planning, **Caring Conversations: Moving from Cure to Comfort**, during the September annual meeting.

I will continue to consult with the Oncology Program at MultiCare in implementing innovations that promote Palliative Care into their programs for the rest of the year. My wife and I continue to call Pierce County our home.

I want to thank my many friends and associates who as members of the PCMS have supported my efforts to improve care for patients and families at the end of life. I look forward to sharing the inspiration, creativity and knowledge that I have been privileged to gain in my association with all of you while at the Medical School.

Warmly,

Stu Farber

FOCUS – is theme of the 2002 WSMA Annual Meeting

Tacoma – City of Destiny and host of the 2002 WSMA Annual Meeting, September 20-22.

Focus, focus, focus has been the mantra all year of Sam Cullison, MD, president of the WSMA. The focus has been on practice viability, administrative simplification and strength of the association. While Dr. Cullison maintains that access to care for all patients is a leading value of the WSMA, unless something is done about practice viability, patient access will be unachievable.

Dr. Cullison invites any interested physician to participate in the WSMA Annual Meeting. And, there is something for everyone, no doubt. From keynote speakers, to excellent choices of CME programs, president's dinners, receptions, etc. A potpourri of activities and events, including the meeting of the House of Delegates, the governing body for the association.

CME activities include courses on addiction medicine, allergy, asthma & immunology, bioterrorism, otolaryngology for primary care, physician burn-out and time management, STDs, ophthalmology, electronic medical records, primary care psychiatry, end of life, antibiotic resistance, advances in women's health and health care economics, and a program about insurance "opt out" and revenue strategies for the medical practice, presented by Andy Dolan, WSMA attorney.

The meeting will be held at the Tacoma Sheraton, Friday-Sunday, September 20-22. For program information, please call the PCMS office 572-3667. ■

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Our Bandwagon Mentality

Andrew Statson, MD

"Far from the madding crowd's ignoble strife
Their sober wishes never learned to stray;
Along the cool sequestered vale of life
They kept the noiseless tenor of their way."
Thomas Gray (1751)

A new treatment is the most effective during the first six months after its introduction and loses a lot of its effectiveness after one year. That is an aphorism, well known among medical researchers and a good illustration of our bandwagon mentality.

Every treatment works well in certain situations, on a defined group of patients. When people find out that it helped their friends and neighbors, who had symptoms vaguely similar to their own, they want to try that new magic potion, hoping it will work on them as well. Most of the time, it doesn't.

The widespread use produces a number of side-effects and complications, so that the new treatment is condemned, or even abandoned, although it still works well in a select population, just as it always did. The key word here is "select." Every treatment can produce side-effects and complications, but in a certain type of patient with a ceratin problem, its benefits largely outweigh any possible risks. This was brought home to me by the following example:

Years ago, when giving estrogen to patients with history of endometrial cancer was unthinkable, a renowned gynecologic oncologist reported the situation with one of his patients. She was an educated, professional woman, whom he had treated for endometrial cancer. She developed severe climacteric symptoms afterwards, to the point where nobody could live with her, nor could she live with herself. She tried all the other available preparations, without any relief. Estrogen was the only thing left.

Of course, he advised her that she cannot take estrogen because it will increase the cancer recurrence risk. After several months of suffering, she went to see him and told him, "Doctor, there are things in life worse than death. Give me estrogen. I would rather die from cancer some time in the future, than live with myself as I feel now."

Most of us have enough sense to recognize a fake bandwagon and we try to move out of the way, but our patients seldom have that ability. They get angry when we, as representatives of "traditional medicine" refuse to prescribe for them the magic substance they think will at least relieve their suffering, and possibly cure them forever.

One of these miracle preparations was the high dose progesterone suppository for the treatment of premenstrual tension. It was recommended by Dr. Katarina D'Alton and publicized not in our medical journals, but in the lay magazines and paperback books. I learned about it from patients, who insisted that I prescribe it to them. When I told them I didn't think it would help, they swore that either they had already taken it and felt much better, or knew someone who had PMS in the worst way and was completely relieved by that treatment.

Most of them had literature obtained by calling the toll-free number of a PMS support group, which extolled the virtues of progesterone. They had lists of pharmacies, which would make the preparations for them. The recommended dosages at first were 100 mg of progesterone, then 200, then 400; once a day, then twice a day, then four times a day.

I cannot even guess the cost of this preparation to the patients. I don't think it was cheap. After three or four years, the dust settled and it became clear that progesterone was not better than placebo. The fad consumed itself in its own fire and died.

I won't list the various preparations for weight loss which have come and gone over the years. All of them were miserable long-term failures. Some of them resulted in serious complications.

The one fling that turned out to be quite expensive for us was the space age magic ray, the laser. The popular press carried the stories of this won-

See "Bandwagon" page 10

Bandwagon from page 9

derful new treatment, which could cure endometriosis, restore fertility, destroy cancer and eliminate pelvic pain. Patients called to ask whether we did laser treatments, and flocked to those who did. Each one of us took several training seminars, at the cost of two to three thousands dollars each. The hospitals bought the equipment, at the cost of fifty to one hundred thousand dollars per unit.

Considering the cost of the training, frequently out of town, and the time away from the practice, each one of us must have spent $10-15,000 or more to acquire the basic skill so we could get credentialed by our hospitals. Multiply that by 25,000 gynecologists. The total cost to us probably was of the order of $400 million. The hospitals probably spent an equal amount for the machines and their upkeep.

The manufacturers were faced with a rapid growth in demand for lasers. They were forced to rush to market their rather primitive equipment, which needed frequent adjustments and expensive maintenance. They did not have time to design sturdy, low maintenance systems. Perhaps they hoped that the demand for lasers would go on forever, the situation certainly gave us that feeling, and they would have the opportunity to improve their equipment over time. When disenchantment set in, the market dried out. The laser lost its chance, at least for the time being.

By the time we realized that lasers, except in rare situations, were not better than electrosurgical equipment, we had spent about a billion dollars on the technology. We had to. There was a strong patient pressure to provide that service.

At the time the laser rage was spreading, there were a few cool heads in our profession, who publicly denounced it. After a talk on the surgical treatment of infertility, Dr. Anne Colston Wentz, for instance, in answer to a question from the audience, said that the laser is nothing more than a very expensive knife. Others expressed the same opinion, but their voices were drowned by the clamor of patients for the magic rays.

We are subjected to pressures by the patients, to be sure, but our problem is that we are not immune to the bandwagon contagion. Instead of opposing it early, before it spreads, we tend to let it build up, and eventually we find ourselves forced to join it.

Charles Dickens describes this mob psychology in the following passage from *Pickwick Papers*:

"It's always best on those occasions to do what the mob do."

"But, suppose there are two mobs?" suggested Mr. Snodgrass.

"Shout with the largest," repled Mr. Pickwick.

The strange thing is that people in this country, with our individualism, with our pluralism, with the incomplete blend of so many cultures, can become so carried away by the mass effect of a mob, that they give up their individuality in the process. I suppose people are people, no matter where they are. ■

In My Opinion....

by Daisy S. Puracal, MD

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

On Medicare

Editor's Note: PCMS is not encouraging medical practices to cease caring for Medicare or Medicaid patients, or implying that physicians should take any action. These decisions must be made on an individual basis. A Medicare/Medicaid Opt-Out Guide is available on the WSMA Web site at www.wsma.org.

Daisy Puracal, MD

I recently made the painful choice of opting out of the Medicare program. It was heartbreaking to let my patients, who had become part of my life, go - to tell them that I can no longer care for them. I had wrestled with this for the last few years, but the recent cut in reimbursements tipped the scales and I knew that it had to be so. Although I had stopped taking on new Medicare recipients several years ago, I still found my Medicare percentages slowly rising as my patients aged with me. I could see this to be the trend and needed to find a way to allow my patients to continue with me without compromising my practice or marginalizing my care. Hence the opt out program - patients were given the choice to stay in the practice on a private contract or find a physician who was still accepting Medicare payments.

I had so enjoyed taking care of my older patients. Their maturity, wisdom and "life smarts" far surpassed mine. It was often a challenge to deal with the multiple medical problems that they presented, but I found this to be mentally stimulating and balanced out any negative factors.

A medical practice is quite different from most other businesses in that most of the revenues come from the "hands on" work of the physician and the practice is "dead" when the physician is sick or away. So there is a physical limitation as to how much revenue the physician can generate. The overhead expense in the medical office is considerably greater than similar small businesses and spirals upwards each year. It is a tricky feat to put in enough time at work to balance the budget and have enough time left over to enjoy any kind of normal life. So for financial considerations, and physical and mental sanity, I had to weed out the sector that was a potential back-breaker for my practice.

Another more important reason for the change was the realization that I would myself soon be on Medicare. I want the system changed before I get there! I sought help from my patients to see this happen for their sakes and mine. I sent out letters to all my patients informing them of the change I was making and urged them to contact their representative and agitate for change in the system. I was thrilled to hear that a number did in fact make the effort to do so!

Francis Bellamy who wrote the original Pledge of Allegiance (Aug. 1892) envisioned a planned economy with political, social and economic equality for all. The only reason "equality" did not make it in the pledge was the racial and gender discrimination that existed in his time. Dr. Mortimer Adler wrote "the three great ideas of American tradition are Equality, Liberty and Justice for all." With the current healthcare situation there is no equality, liberty or justice for the senior citizen. It is a social injustice to foster this inequality and push upright and honorable citizens who have worked hard all their lives into a less than desirable status and jeopardize their access to physician services. This social injustice and age discrimination is against the very nature of the constitution.

Medicare does provide for a large part of medical costs for the elderly and is a system that has worked in part but is increasingly not meeting the needs of provider/client as health costs have mushroomed. I can understand that funding is limited especially as growth in the Medicare population has outstripped predicted rates with improved health care. What I cannot understand is why it is not possible for the private sector to fill in the gap. Supposedly the Medigap and supplemental policies are supposed to do just that. What a farce! None of the supplemental plans allow for reimbursements even a penny more than what Medicare "allows" to the physician.

A physician contracted with Medicare cannot balance bill the patient and has to accept the allowable amounts as payment in full. This means that once on Medicare you are made to stay as second-class citizens. Even if one had the means to buy multiple policies the physician will never ever be paid more than the pittance that Medicare allows. And this amount will be shrinking as

See "Medicare" page 12

Medicare from page 11

Medicare and Medicaid team up to form a single entity and become increasingly a single payor. (Incidentally, CMS is a fine example of how a single payor system will turn out in this country.) How ridiculous to accept this state of affairs and allow this situation to continue as is. I am sure that this was not the intent that policy makers had when they set out the rules. Laws, rules and regulations were made for mankind and not the other way. If something is not working, men/women can change things with due diligence.

A private insurance agency contracts with the physician to pay roughly 80-90% of charges. If insurance A paid 80% and the patients secondary insurance B was contracted to pay 90% then insurance B would pay the extra 10% according to their contract. But if this insurance B was the secondary payor for a Medicare patient this changes and reimbursements are capped at Medicare rates. Is this not a contractual violation for insurance B to not pay physicians the contracted rate of 90%? I do remember that when I first started my practice, secondary insurances would pick up the differential and my reimbursement for a Medicare patient would be the same as for any other patient as long as he/she had a supplemental insurance. Somewhere down the line this changed. I am not sure how or why.

This simple move to have secondary insurances pick up the tab would allow for solvency in a good percentage of medical practices without costing the government an extra dime. The secondary insurance would cover prescriptions just as they would for a non-Medicare patient. This again would resolve part of the prescription dilemma we are faced with. A component of the House Republican proposal to "fix" prescription drug benefit programs is to allow beneficiaries to purchase drug coverage from private insurers. How about changing this proposal to allow beneficiaries to purchase drug and medical coverage from private insurers which is what supplemental insurance should be. The "new" supplemental insurance will honor physician/insurer contracts without interference from Medicare and at rates comparable to private insurance for non-Medicare recipients. Senior citizens will be treated on par with everyone else. The supplemental insurance can also be a means for the Medicaid population to transition to full coverage.

I miss my patients. I want to be able to see them again. ■

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Video Directly Observed Therapy

Federico Cruz-Uribe, MD

Much like TB control, care of the HIV positive patient is complicated by difficulties with compliance. So much depends on the meds being taken following a consistent schedule. Treatment failures and resistant organisms are common by-products when meds are not taken according to protocol. Having learned much from the successful efforts with directly observed therapy in TB treatment and control, we are looking to apply this to our HIV positive patients. We think it has great potential.

The following, by David Selvage, MHS, HIV/AIDS Case Manager, gives you more information about this new program at TPCHD.

- Federico Cruz-Uribe, MD, MPH

Maria had difficulty with her HIV medications, so she stopped taking them after two weeks.

But recently Maria was enrolled in the Video Directly Observed Therapy (VDOT) pilot project being conducted by Infections Limited and the Tacoma Pierce County Health Department, and she has only missed one dose in the last month.

Last summer, Maria's doctor started her on three different HIV medications, also known as Highly Active AnitRetroviral Therapy (HAART), that she had to take twice a day.

During this time, Maria also began to experience extreme fatigue. She would frequently come home in the evening from work, collapse on her bed, and fall asleep before she could remember to eat anything or take her evening dose. When she did remember to take the medications, she experienced multiple side effects.

So she just stopped.

In January, however, Maria's HIV doctor recommended she enroll in the VDOT pilot project. VDOT is designed to assist patients during the transition to HAART.

The VDOT program works like this:

Maria has a videophone in her apartment. Twice a day, at times that work around her schedule, a HIV/AIDS Case Manager from the Tacoma Pierce County Health Department calls to remind her to take her medications. The Case Manager also has videophone. This allows the client and the Case Manager to carry on a conversation in real time and make face-to-face contact.

The Case Manager encourages and supports Maria, helps her manage HAART side effects, and acts as a sentinel for her health care provider if other medication or HIV related problems arise.

The videophone only transmits video images to another videophone, and only if the client has the videophone camera lens open. Otherwise, it's just a phone.

Since January 2002, nine patients have enrolled in the project through Infections Limited in Tacoma. Preliminary results are encouraging.

"So far, we've attained undetectable viral loads on three patients, nearly undetectable viral loads on another, and CD4 counts above 200 on four of these patients. Three patients withdrew after about two weeks for various reasons. Keep in mind that all of the patients have had tremendous difficulty remembering to take medications in the past," states Catherine Sanders, LPN, Adherence Nurse with Infections Limited.

The goal of the project is to evaluate whether or not the use of VDOT during the first few months of therapy will help patients to develop the habit of taking medications on a regular and routine basis. This is particularly important with HAART since studies have shown HAART must be taken correctly 95% of the time to prevent the development of viral resistance.

Enrollment into the project is completely voluntary.

For more information about VDOT enrollment, call David Selvage at (253) 798-7681. ■

Note: Maria is not an actual patient. She is a fictitious composite of several patients, some of whom have participated in VDOT so far. Any resemblance to an actual patient is coincidental.

Injury Charts On-Line

The Children's Safety Network National Injury Data Technical Assistance Center provides updated adolescent injury trend charts on-line at: http://www.injuryprevention.org/info/data.htm.

Click on any state and get statewide trends among 10-14 and 15-19 year olds for motor vehicle, suicide and homicide related injury deaths. Injury incidence and costs are also detailed. Trends span from 1980-1998 and rates are calculated as 3-year running averages. With these charts you may compare the motor vehicle, suicide and homicide rates in any given state with those in its HRSA region and in the USA.

There are several states with very interesting trends. For example, South Dakota's motor vehicle and suicide trends, North Dakota's suicide trend, Wyoming, West Virginia, Mississippi and Nevada's motor vehicle trend among 10-14 year olds, Idaho's suicide trend among 10-14 year olds, and the decline in MV deaths in Montana. ■

Applicants for Membership

David A. Davidson, MD
Diagnostic Radiology
Diagnostic Imaging Northwest
222 15th Ave SE, Puyallup
253-841-4353
Medical School: Univ of Washington
Residency: Univ of Oklahoma
Fellowship: Univ of Massachusetts

Marco C. Louisse, MD
Family Practice
Community Health Care
101 E 26th St #100, Tacoma
253-597-4550
Medical School: Univ of Chicago
Internship: UCLA
Residency: UCLA

Mohamed B. Osman, MD
Family Practice
Community Health Care
1110 Fryar Road, Sumner 98390
253-863-0413
Medical School: Kalinin State, USSR
Internship: Toleo-Mercy Hospital
Residency: Mercy Hospital

Raju Patel, DO
Cardiology
Cardiac Health Specialists
1802 S Yakima #307, Tacoma
Medical School: School of Osteopathic Medicine, Kansas City
Internship: Detroit Osteopathic Hospital
Residency: Tulane University

John A. Read, MD
Ob/Gyn
Pacific NW Maternal-Fetal Medicine
1717 S J St 12th Flr, Tacoma 98405
253-591-6878
Medical School: UCLA
Internship: Walter Reed AMC
Residency: Walter Reed AMC
Fellowship: LAC-USC

Do not send any cards to Craig Shergold!

Editor's Note: PCMS has been informed that many physicians have recently participated in sending letters out in support of this appeal.

Craig Shergold is alive and well. He does not want any more cards.

If you contact the "Children's Make a Wish" foundation, you will find that they are not soliciting any form of card for Craig Shergold or anyone else. Better yet, if you call the publisher of the Guinness Book of World Records (US publisher is "Facts on File" @ 212-683-2244 ext. 336), you can get this same story confirmed. You will also find that they will no longer endorse or support any effort to break this record.

Many years ago, Craig Shergold developed a brain tumor, believed inoperable. He sought to set the Guinness record for get-well cards. The effort was well-publicized around the world, and he did, indeed set the record (consult a recent edition of the book {p.207 of the 1992 US edition, for instance} - he has received in excess of 33 million cards to date; he officially set the record as of November 17, 1989.)

As part of this whole story, his plight caught the attention of John Kluge, the US billionaire, who paid for Craig to come to the US and receive specialized treatment. As a result, Craig has recovered completely from his non-malignant tumor. He is also no longer seven, but twelve (as of January 1992).

The problem is that the mimeographed sheets and letters seeking cards for Craig have continued to be circulated. As a result, get-well cards continue to pour in to the post office for Royal Marsden Hospital in England. Worse, the appeal has mutated into various other versions, such as an appeal for business cards, one for postcards, and another version that appeals for holiday cards.

The Shergold family has publicly appealed many times for people to cease to mail cards and letters, and that no more appeals be made on their behalf. One easily accessible way to verify this is with the article on page 24 of the July 19, 1990 *NY Times. People* magazine wrote an article about it on June 1, 1991, page 63. Many other publications have also carried stories on this; even Ann Landers wrote about it on June 23, 1991, but people still keep sending cards. Both Guinness and Royal Marsden have repeatedly issued press releases asking people to stop circulating requests for cards, as they are creating an undue burden on both the hospital and the postal service.

The Guinness people have discontinued the category to prevent this kind of thing from ever happening again, and are doing their utmost to kill any further mailings. The Royal Marsden Hospital is at a loss what to do with the cards that continue to arrive - most are being sold to stamp collectors and paper recyclers, and none go on to Craig.

This appeal for Craig, as well as many urban legends, regularly appear on electronic bulletin boards around the world, and in many organizational newsletters and bulletins. It is both heartening and unfortunate that there are so many well-meaning people who continue to propagate these stories.

Please save this announcement and post it anywhere you've seen the original plea. If you see it in the future, as you probably will, you can attach a copy of this announcement.■

Medical Malpractice survey results available

Thank you to the many members who responded to our July survey regarding medical malpractice costs and availability in Pierce County. There were 193 physicians represented in responses to the survey which asked, by specialty, about the increases in premiums in the last two years, the name of the carrier and if there was difficulty obtaining coverage.

The survey was completed for Sandi Doughton of the *Tacoma News Tribune* who was was gathering information for a future feature article on the medical malpractice liability issue. (See article summary, page 5)

Highlights of the survey include a 300% premium increase reported by a small family practice group, while the lowest increase was 3% from a radiologist. No surprise that ob/gyn physicians had the highest average premium at $44,238, followed by plastic surgeons at $41,806. While other surgery specialties were in the $32-36,000 range. The lowest averages were seen by physical medicine and rehab physicians at $7,822 followed by general internists at $7,891. The average increase by all groups was 50% compared to the average increase for the last two years combined of 34%.

If you would like a copy of the survey which breaks down increases by specialty, please call the office, 572-3667 and a copy will be faxed or mailed to you. ■

Squeeze from page 5

lately, and appear to be compensating by charging their customers more.

This doesn't mean there is no room for tort reform - only that tort reform is unlikely to prove a panacea for malpractice costs.

Malpractice itself is only part of a much larger picture. Many Washington medical practices are distressed, not only by insurance premiums but by a deluge of required insurance paperwork, escalating administrative costs and grossly inadequate payments from Medicare, Medicaid and private insurers.

Medicare is the key to the payment problem, because other insurers tend to base their own reimbursement rates on the federal program. For complicated reasons, Medicare pays Washington doctors less than it pays the doctors of 41 other states. In 2000, for example, Medicare paid more than $6,900 per patient in Florida and New York - compared to about $3,900 in Washington state.

This inequity - combined with malpractice costs and other pressures - is causing Washington doctors to limit their Medicare and Medicaid patients, retire early or even move to states where they are paid substantially more for doing the same job. Tom Curry, chief executive officer of the Washington State Medical Association, summed up the situation: "It's a terrible confluence of negative trends right now and, for some, the medical malpractice increases are the final straw."

The Washington Supreme Court has in the past overturned legislative attempts at tort reform, making it difficult to control malpractice costs in the legal arena. But the Medicare reimbursement rates are the greater problem: if Washington doctors were reimbursed at the national average, their practices could handle higher overhead costs.

The state's congressional delegation has been working on this problem, so far without success. Unless a remedy is found, too many Washingtonians will wind up without that first and utter necessity of medical care: a doctor. ■

Crisis from page 5

to standardize damages and allow for doctors to pay over several years.

Half of the obstetricians in the state that responded to a WSMA survey reported that they would stop delivering babies if their premiums reached $40,000-70,000. The current state average is now about $42,000 while Pierce County's average is $44,238. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Whistler/Blackcomb CME condo reservations deadline December 1

Registration is open for the College's CME at Whistler/Blackcomb program; brochures were recently mailed. The conference is scheduled for January 22-26, 2003.

Reservations for the block of condos, THIS YEAR AGAIN ALL IN THE ASPENS, are available. Reservations can be made by calling the Aspens on Blackcomb, toll free at 1-800-777-0185. You must identify yourself as part of the College of Medical Education to receive the negotiated reduced rates. THE COLLEGE'S BLOCK OF ROOMS WILL BE RELEASED AFTER DECEMBER 1, 2002.

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

Common Office Problems CME Registration Open

Registration is underway for the very popular Common Office Problems CME program. This year's conference is scheduled for Friday, **October 4, 2002**. The conference will be held at St. Joseph Medical Center, Rooms, 1A & B.

The program will offer 6 Category I CME credits and will be directed by **Mark Craddock, MD.** ■

Spring Training CME Likely March 5-9, 2003

The College of Medical Education is waiting for the actual spring training schedule to be announced by the Mariners before finalizing the Phoenix CME dates next March. Tentative plans are set for March 5-9, 2003.

The College has selected the Embassy Suites Phoenix-North for conference headquarters. The large and beautiful hotel is conveniently located close to the Mariners Peoria stadium and offers reduced and competitive rates for complete two-room suites that include a private bedroom and separate living area with sofabed.

Plan now no matter how the team finishes this season. Start fresh with the Mariners in March, 2003. ■

Dates	Program	Director(s)
Friday, October 4	Common Office Problems	Mark Craddock, MD
Friday, Novmber 8	Infectious Diseases Update	James DeMaio, MD
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Wednesday; Tuesday January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Emery Chang, MD
Change office address and phone to:
6210 75th St W #B-100, Lakewood 98499
253-984-6200 and add second office:
1811 ML King Jr Wy #230, Tacoma 98405

Clark Deem, MD
Change office address to:
4717 S 19th St #101, Tacoma 98405

Ian Lawson, MD
Change office address and phone to:
Mountain Orthopaedic Specialists
1550 S Union Ave #210, Tacoma 98405
253-752-0714
253-761-2451 fax
253-752-5408 physicians only
www.orthodoc.aaos.org/mountainmd

Henry Retailliau, MD
Change office address to:
2420 S Union #100, Tacoma 98405
253-403-4444

Raheela Sadiq, MD
Change office address and phone to:
Sumner Family Medicine
1518 Main Street, Sumner 98390
253-863-6338
253-863-8518 fax
253-863-9635 physicians only

W. Frederick Thompson, MD
Change office address and phone to:
Mountain Orthopaedic Specialists
1550 S Union Ave #210, Tacoma 98405
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253-761-2451 fax
253-752-5408 physicians only
www.orthodoc.aaos.org/mountainmd

Classified Advertising

POSITIONS AVAILABLE

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

Seattle, Wash - Occupational Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

POSITIONS AVAILABLE

Family Physicians wanted to work at Sea Mar Community Health Centers. Sea Mar is dedicated to serving the underserved with emphasis in the Latino population throughout Western Washington. OB is required and Spanish language proficiency is preferred. We offer a competitive salary, benefits and a sabbatical plan. Choose from the following locations with openings: Tacoma: 3 FP positions available. The practice is expanding to 5 family physicians. Hospital care is at Tacoma General Hospital. Call is 1 in 4. Contact **Phillip Reilly, MD** if interested. (253) 593-2144.

GENERAL

University Place 2 BR/2 BA condo in small park-like setting. New carpet, paint, bathrooms. Attached one-car garage/auto opener. Available October. $1050/month. 565-8634.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examination rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Price Reduced. Lakewood prop-erty for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

Medical space for sale and/or lease in rapidly growing South King County with 85,000 population service area. Need for pulmonary, pediatric, dermatology, orthopedic and gynecologic specialties. Call 360-825-1389.

2900 sq ft medical space - $10-12 psf NNN, 7 exams, x-ray, procedure room. Lakewood. 253-584-2000.

Bayview Medical. North End Tacoma. 3,500 sq ft. Nine exam rooms, x-ray and lab, reception area, ample storage and parking. Call 253-752-6150.

1,118 sq. ft. available across the street from Good Samaritan Hospital. Great access, newer building, ample parking, terms negotiable. Kim Thomas 425-454-1405.

For Lease: New office space located in Fircrest. 4,000 sq ft or less, no B&O tax. Call 564-8784.

Pierce County Medical Society
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Tacoma, WA 98402

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Pierce County Medical Society
BULLETIN

October, 2002

Delegates Represent Pierce County at WSMA Annual Meeting

Front row (l to r): Drs. David Law, Ken Feucht, Leonard Alenick, Patrice Stevenson and Federico Cruz-Uribe
Center row: Physician assistant Cynthia Weissinger. Back row: Drs. Joe Regimbal, Ron Morris, Don Russell, Allison Odenthal, Susan Salo, Steve Duncan, Nick Rajacich, Sumner Schoenike, Mike Kelly, Jim Rooks and Richard Hawkins. Not pictured: Dr. Asuquo Esuabana

Richard Hawkins, MD serves his last year as WSMA Speaker of the House

See highlights, page 5

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
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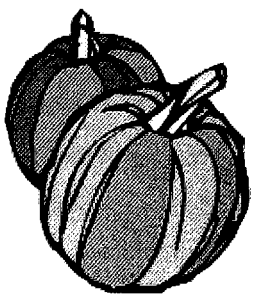
Pierce County Medical Society

BULLETIN

October, 2002



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Special Feature

by Jean Borst

The Medical Malpractice Mess

"Our society will have to make the choice between access to unlimited damages for medical injuries and access to health care," according to Tom Myers, president and CEO of Physicians Insurance a Mutual Company. "In the end, I believe they will opt for access to health care. However, the process of getting there will be extremely unpleasant."

Myers, speaking at the September 10 PCMS General Membership Meeting, offered an informative, albeit bleak, picture of the "Medical Malpractice Mess." While the malpractice insurance issue may not yet be at crisis level in the state of Washington, it may soon be if significant changes don't occur. "In a couple of years," Myers said, "capacity issues will become more pronounced, and physicians are going to be hard hit by dramatically increased rates driven by loss severity."

The Issue of Capacity

"We have a capacity of how much insurance we can sell," Myers explained, "and we're beginning to see the test of that capacity."

Capacity is being consumed by various factors, Myers explained. In just the past few months, major players have left the medical malpractice insurance market — some voluntarily and some due to insolvency. The impact of that departure is significant, and the outlook doesn't look good. "When Washington Casualty Company departed the market last October, our company picked up a great deal of business as a result," Myers said. "At the end of 2001, we insured 6,200 physicians. By the end of 2002, we estimate our numbers will be up to 7,100 physicians. Normally, in a dynamic insurance market, there are others out there that are ready to step in and fill the void and take care of the problem," Myers explained. "That just is not happening. No one is bringing new capital into the medical malpractice insurance business."

In addition to the exodus of insurance companies from the market, rate increases and net operating losses are significant contributors to the capacity crunch. Those combined factors make Myers nervous about the future. "The long-term concern is will there be enough capacity to make medical malpractice insurance available to all who need it," Myers said. He added that his own company anticipates reaching capacity by 2003.

"While the malpractice insurance issue may not yet be at crisis level in the state of Washington, it may soon be if significant changes don't occur."

Tom Myers

"Ongoing escalators in loss severity will continue to drive rate increases," Myers noted. "And we see nothing on the horizon to slow the growth of loss severity."

What's driving this increase? Myers noted the following factors:

• **The general population is desensitized to the value of money.** These are the psychological reasons — the lottery mentality, influx of "Microsoft millionaires," $200 million salaries for the A-Rods of the world. In addition, the judicial system is yielding extreme outcomes due to a changing jury pool and unrealistic expectations.

• **Poor medicine.** "We're asking ourselves, 'Is this a function of managed care?' There are more claims with more serious injuries and increased claims that are totally indefensible, and therefore not readily negotiable.

• **Economic and inflationary issues** such as:

- Escalation in personal incomes
- Large liens from health insurers
- Increased expert witness costs
- Increased defense attorney fees
- Increased pain and suffering awards

Additional factors put pressure on insurance companies. With a reduction in investment income, equity values have been hit hard and fixed income is in decline. Reinsurance is a big factor, as well — the industry is still reeling from 9/11, has experienced a decade of disappointing financial performance and capital is leaving the industry.

So, What's to Come?

There are three issues at heart regarding the current status of the medical malpractice insurance market, Myers noted:

• Supply and demand is becoming unbalanced.

• Rates are rising to take into account escalating loss severity, increased reinsurance cost and diminish-

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Malpractice from page 3

ing investment income.

• The expectation is that medical malpractice rates will continue to increase in double-digit annual bites. This is occurring at a time when health care providers are least able to pay ever-increasing premiums.

"We are not in crisis now," Myers said, "but we probably will be in a couple of years." To remedy the problem, Myers offered three possible solutions:

• **Higher interest rates over time.** "This is not likely to happen, soon," Myers noted.

• **Healthier reinsurance industry.** "I'm guessing three to five years before we're there," he said.

• **Tort Reform.** "This is the big one," Myers noted, "but it's currently a long shot at best."

The Importance of Tort Reform

Myers dedicated a good deal of his presentation on tort reform, pointing to a successful model in California — MICRA, the Medical Injury Compensation Reform Act of 1975. The following is an excerpt from an article on the NORCAL Medical Insurance Company website: "Since 1975, MICRA has played a key role in protecting physicians from becoming the proverbial 'deep pockets' that trial lawyers aim to target, and is critical to the future stability of the healthcare industry in California." See the full text of this article, as well as a detailed explanation of MICRA, in the accompanying articles in this newsletter.

At the federal level, Myers noted that MICRA-like legislation is currently going through the US House. Similar bills have passed the House in the past, but it is highly unlikely, he said, that the US Senate would agree to strong legislation.

At the Washington State level, strong tort reform legislation was passed by the Washington State legislature in 1986. All the meaningful provisions, however, were found to be un-

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MICRA Background

The Medical Injury Compensation Reform Act (MICRA) was born out of the medical malpractice crisis of 1975. Prior to the 1960s, physicians were rarely subject to medical malpractice claims and the cost of medical malpractice insurance represented a negligible part of a physician's overhead expense.

The 1960s saw an explosion of litigation, particularly in high-risk specialties such as anesthesia, obstetrics and surgical practices. Trial lawyers specializing in medical malpractice cases developed trial techniques that inflamed the passions of juries, which resulted in hundreds of million-dollar verdicts. To make matters worse, there was no legislative mechanism in place for keeping the system in check and protecting physicians from catastrophic losses.

By the mid-1970s, this emergent culture of rampant litigation and astronomical jury awards had so materially altered the face of healthcare that many professional liability carriers implemented steep rate increases in an effort to bolster reserves and maintain profitability. In California alone, liability premiums as a whole increased by 400 percent to 600 percent between 1965 and 1971; the increase for surgery was 950 percent between 1966 and 1970. Further increases followed in the early 1970s. Many other carriers opted to exit the medical malpractice arena altogether. The cumulative effect was that thousands of physicians were left with either devastatingly high premiums or no coverage at all, causing a massive withdrawal of medical services throughout California that the media dubbed a "doctors' malpractice strike."

In 1975, as groups of physicians were banding together at the local level to share risk and advocate legislative reform through their local, state and national trade associations, the political system was galvanized to enact MICRA. MICRA, which became effective on December 17, 1975, balanced medical tort reform with insurance regulatory reform and increased supervision of physicians. After an intense fight in the courts, MICRA was upheld by the California Supreme Court in 1986. By the late 1980s, attorneys and trial judges were actively applying MICRA's medical tort reforms, resulting in a moderation of previous loss trends.

As losses declined, physician-owned medical malpractice insurers - including NORCAL - began a financial program to return redundant reserves in the form of policyholder dividends. Based on the savings generated by MICRA, NORCAL has returned over $250 million in dividends and has held rates constant for almost 12 years.

Working to Uphold MICRA

For years, trial lawyers and patients' advocates have been calling for the repeal of the medical tort reform provisions contained in MICRA. However, the broad-sweeping benefits of MICRA are indisputable. Studies conducted by prominent researchers have demonstrated that the direct and indirect savings in the United States resulting from medical tort reforms could be up to $60 billion annually. If MICRA-style medical tort reforms were adopted nationwide, direct savings in medical malpractice premiums are estimated at $10 billion, and indirect savings due to a reduction in defensive medicine are estimated in the range of $50 billion.

Since 1975, MICRA has played a key role in protecting physicians from becoming the proverbial "deep pockets" that trial lawyers aim to target, and is critical to the future stability of the healthcare industry in California. On a continuous basis, NORCAL partners with local medical societies and other organizations to uphold MICRA and other tort reforms in local, state and national political venues.

For more information on MICRA visit www.micra.org.

WSMA Annual Meeting has record attendance

Delegates retain organizational focus on practice viability

Tacoma brought out record attendance for the WSMA Annual Meeting held September 20-22 at the Sheraton Hotel in Tacoma. Over 500 people registered for the meeting which included numerous CME opportunities for physicians.

The primary business of the meeting, however, was the House of Delegates meeting, where association policy is set. After debating numerous resolutions at reference committee meetings on Saturday, the House convened on Sunday morning at 8:00 a.m. to further discuss and vote on issues.

Highlights of the actions taken by the House include:

•continue to lobby for tort reform at the state and/or federal levels. WSMA will continue to work with the Liability Reform Coalition on this issue.

•oppose the Premera Conversion. Premera Blue Cross is undergoing conversion to a for-profit, stock company. WSMA will publicly oppose this conversion unless Premera agrees to extend the process for a year to allow time to study the actual impact on subscribers, patients, hospitals and physicians.

•continue the organizational focus on economic viability of medical practices and administrative simplification with an eye toward tort reform and Medicare. The House also elected to keep studying and watching issues affiliated with financing and delivery of health care.

•discuss with county and specialty society leaders the possibility of a single, unified medical association and report back at the 2003 meeting and also charged the Executive Committee to study the composition of the Board of Trustees, including the elimination of large county society seats to also be reported back to the board next year.

New officers and trustees were installed at the meeting, including PCMS representatives **Patrice Stevenson, MD** (Trustee) and **Nick Rajacich, MD** (Trustee). Holdover positions include **David Law, MD** (Western District) **Leonard Alenick, MD** (AMA Delegate) and **Don Russell, DO** (WAMPAC Chair).

PCMS members serving as Delegates to WSMA included: **Drs. Susan Salo, Jim Rooks, Mike Kelly, Steve Duncan, Patrice Stevenson, Ken Feucht, Allison Odenthal, Joe Regimbal, Sumner Schoenike, Ron Morris, Federico Cruz-Uribe, Don Russell,** and **Asuquo Esuabana.** WSMA/AMA representatives attending included **Drs. Nick Rajacich, David Law, Leonard Alenick,** and for his last meeting **Richard Hawkins,** Speaker of the House.

The WSMA Board of Trustees meets in October, February, May and September in four locations around the state and welcomes input and comments from members regarding issues of any concern to physicians.■

WSMA House of Delegates said goodbye to Speaker and friend, Dr. Richard Hawkins

Since 1986, **Dr. Richard Hawkins** has kept the WSMA House of Delegates in line with Roberts Rules of Order. He assumed the Speaker position in 1993 after serving as Vice-Speaker from 1986-1993.

Pierce County has a reputation for producing parliamentarians. Dr. Hawkin's predecessor was **Stan Tuell, MD,** retired Tacoma surgeon and longtime parliamentarian. Dr. Tuell served as WSMA Speaker of the House for 17 years and also taught many classes at Tacoma Community College on parliamentary procedures.

The WSMA Board of Trustees recognized and thanked Dr. Hawkins for his longtime tenure, as did the House of Delegates at their second session on Sunday, September 22. Awarded his gavel and a special book on baseball, he received a standing ovation from the House as well as a special cake at the morning break.

"The House of Delegates will not be the same without Dr. Hawkins," noted Tom Curry, CEO of WSMA. "He has contributed his knowledge, leadership and particularly his good humor for many years and he will be sorely missed," he added.

Richard Hawkins, MD

Dr. Hawkins provided his final "gift" to WSMA colleagues at the President's reception on Saturday night when he partnered with new president Maureen Callaghan, MD from Olympia at the piano. The pair entertained attendees by playing two duets, which were both received with hearty applause.

PCMS congratulates and thanks Dr. Hawkins for his longtime service.■

TACOMA-PIERCE COUNTY
HEALTH DEPARTMENT

Public Health Advisory

Reporting and Testing for Suspected West Nile Virus

The Tacoma-Pierce County Health Department encourages health care providers to report cases of human encephalitis of unknown etiology. With the recent revision of the notifiable conditions list in Washington, unexplained critical illness or death of potential infectious etiology is now immediately reportable. A case of encephalitis of unknown etiology falls into this category. Your reporting will help us identify new and emerging infectious diseases, such as West Nile virus or to detect possible incidents of bioterrorism.

What to report?

Hospitalized adult or pediatric patients with any of the following clinical syndromes:

1. Viral encephalitis, a clinical diagnosis characterized by:
   a. Fever > 38°C or 100°F, **and**
   b. CNS involvement, including altered mental status (altered level of consciousness, confusion, agitation, or lethargy) or other cortical signs (cranial nerve palsies; paresis or paralysis, or seizures), **and**
   c. Abnormal CSF profile suggestive of viral etiology: a negative bacterial stain and culture, CSF pleocytosis, predominantly lymphocytes, and/or moderately elevated protein.
2. Aseptic meningitis occurring June through September in any patient > 17 years of age, characterized by:
   a. Fever > 38°C or 100°F, **and**
   b. Signs of meningeal inflammation (stiff neck, headache, photophobia), **and**
   c. Abnormal CSF profile suggestive of viral etiology: a negative bacterial stain and culture, CSF pleocytosis, predominantly lymphocytes, and/or moderately elevated protein.
3. Presumed Guillain-Barre syndrome, especially with atypical features, such as fever, altered mental status and/or CSF pleocytosis.

Testing

Cases that meet the above criteria can be screened by testing serum for St. Louis encephalitis (SLE) IgM antibody through your clinical lab. SLE and WNV are closely-related viruses and infection with WNV may cross-react with SLE IgM antibody. The Health Department should be notified of any cases of encephalitis that test positive for SLE IgM antibody, so that follow-up testing for WNV can be performed. In addition to the SLE screening, for cases meeting criteria, the state public health lab will facilitate testing for WNV IgM antibody by ELISA on serum and CSF. When you call to report a suspected case, we will help to determine if testing for the West Nile Virus needs to be sent to the CDC Laboratory, and will assist in arranging testing. More extensive testing (viral culture, polymerase chain reaction assay, or plaque-neutralizing antibody titers) may be performed for confirmation. For cases with a low probability for WNV (having only one or two of the clinical criteria), screening for SLE can be considered if the clinician wishes to rule out WNV.

What specimens to obtain and when?

CSF - 2 tubes (if possible), without preservative, containing at least 1 cc each.

Serum - 2 tubes (separated serum, not whole blood) containing at least 3 cc each.

- Both CSF and serum should be obtained ≥ 8 days after onset of symptoms; convalescent serum may be requested for additional testing and should be obtained 2-4 weeks after onset.
- CSF and sera should be refrigerated and transported cold. Frozen CSF is acceptable, but should be transported on dry ice.
- **Specimens should be submitted** with a completed Washington State Department of Health, Public Health Laboratory *Virus and Rickettsial Examinations form* to: Washington State Department of Health Public Health Laboratory, 1610 NE 150th Street, Shoreline, WA 98155

How tests will be interpreted?

IgM antibody develops by day 8, and IgG antibody usually by 3 weeks after onset. In general, convalescent specimens should be drawn about 2-3 weeks after acute specimens. A negative result on a specimen obtain < 8 days after onset of illness will be reported as "inconclusive." A convalescent specimen, obtained at least 2 weeks after the first specimen, will be needed to make a final determination. A positive test result on an acute specimen will be reported as "suspect positive" and sent to CDC for confirmation by serum plaque-neutralizing antibody assay. Cross-reaction may occur following yellow fever or Japanese encephalitis vaccination, or with a previous history of viral encephalitis or dengue.

How to report?

Contact the Tacoma-Pierce County Health Department Communicable Disease Control at (253) 798-6410, press "0", or call the 24 hour reporting line at (253) 798-6534. Suspected cases of West Nile viral (WNV) disease are immediately reportable in Washington State.

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Address _____

_____

Telephone _____

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Total Enclosed $ _____

Payment ☐ Check ☐ Visa ☐ Mastercard

Credit Card Number _____ Expiration Date _____

Signature _____

Photocopy registration form for additional attendees

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Pierce County Medical Society

Pharmacy Directory - 2003

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Albertson s 3905 Bridgeport Way West		**565-7997**	FX: 460-0440
Albertson s 2401 North Pearl St		**752-7919**	FX: 761-7730
Albertson s 104 Military Rd South		**538-2611**	FX: 538-4918
Albertson s 8611 Steilacoom Blvd		**582-4149**	FX: 582-8664
Allenmore MultiCare Pharmacy South 19th & Union		**403-5150**	FX: 403-7573
Allenmore Pharmacy 1901 South Union #A252		**383-5519**	FX: 272-9324
Bartell Drugs 3601 Sixth Ave		**761-2520**	FX: 761-7462
Bartell Drugs 2700 Bridgeport Way W #D		**564-0088**	FX: 564-1412
Bridgeport Professional (retail) 7424 Bridgeport Wy West		**582-1662**	FX: 589-9698
Bridgeport Services (institutional) 7424 Bridgeport Wy West		**582-2282**	FX: 589-8784
Century Plaza 1708 South Yakima	(#1)	**591-6920**	FX: 305-6420
Chung Pharmacy 9122 South Tacoma Way #104		**584-2484**	FX: 584-6094
Cost Less Prescriptions 5431 Pacific Ave		**474-9493**	FX: 474-2369
Cost Less Prescriptions 1109 Regents Blvd (Firerest)		**564-5200**	FX: 564-6698
Cost Plus Family Care Center & Pharmacy 204 North I St		**627-1188**	FX: 627-0158
Costco Pharmacy 2219 South 37th St		**671-6002**	FX: 671-6009
Franciscan Pharmacy - Tacoma South. 2111 South 90th		**535-5615**	FX: 535-5717
Fred Meyer 4505 South 19th Street		**752-9110**	FX: 756-9320
Fred Meyer 6901 South 19th Street		**534-3033**	FX: 534-3027
Hospice Care Center Pharmacy 34503 9th Ave #110		**942-4018**	FX: 942-4078
Kmart 1414 East 72nd		**537-6668**	FX: 539-8461
Lincoln Pharmacy 821 South 38th		**473-1155**	FX: 473-1158
Longs Drugs 5401 6th Ave #600	(#2)	**752-1484**	FX: 761-9430
Longs Drugs 7901 South Hosmer	(#2)	**472-0924**	FX: 472-3789
Mary Bridge Clinics Pharmacy 311 South L St		**403-1411**	FX: 403-1745
Mega Pharmacy 7911 South Hosmer		**473-1919**	FX: 473-6528
MultiCare Clinic Pharmacy 521 MLK Jr. Way		**403-4920**	FX: 403-4856
Parkland Marketplace 13322 Pacific Ave		**531-3711**	FX: 537-0993
Puget Sound Pharmacy 1112 6th Ave #101		**272-1107**	FX: 272-7327
Rainier Pharmacy 1901 South Cedar #104		**272-2293**	FX: 272-2294
Rankos Pharmacy 101 North Tacoma Ave		**383-2411**	FX: 572-4329
RiteAid 3840 Bridgeport Way West	(#8)	**564-2255**	FX: 564-0189
RiteAid 1105 MLK Jr Wy	(#8)	**779-0604**	FX: 779-0608
RiteAid 5700 100th St SW #100 (Lakewood)	(#8)	**588-3666**	FX: 588-1922
RiteAid 7041 Pacific Ave	(#8)	**474-8500**	FX: 474-0253
RiteAid 1850 South Mildred	(#8)	**460-9599**	FX: 460-5998
RiteAid 15801 Pacific Ave	(#8)	**531-7427**	FX: 535-9279
RiteAid 1912 North Pearl	(#8)	**756-6707**	FX: 879-0273
RiteAid 4502 South Steele St (Tacoma Mall)	(#8)	**474-8355**	FX: 473-3949
RiteAid 22311 Mountain Hwy East (Spanaway)	(#8)	**846-0542**	FX: 846-8716
Safeway 707 South 56th St	(#2)	**471-1730**	FX: 471-3529
Safeway 2411 North Proctor	(#2)	**759-9889**	FX: 756-6902
Safeway 10223 Gravelly Lk Dr SW	(#2)	**581-7181**	FX: 588-3658
Safeway 1302 South 38th St	(#2)	**471-5511**	FX: 471-9673
Safeway 1624 72nd St East	(#2)	**537-2435**	FX: 537-3019
Safeway 1112 South M St	(#2)	**572-7753**	FX: 272-9315
Tacoma Medical Center Pharmacy 1206 South 11th St #1		**383-5359**	FX: 383-4732
Tacoma Pharmacy 9115 South Tacoma Way #109		**984-9580**	FX: 984-1294
Top Food & Drug 3130 South 23rd		**591-3110**	FX: 591-6278
Union Ave Pharmacy 2302 South Union		**752-1705**	FX: 761-9315
Walgreens 9505 Bridgeport Way SW	(#1)	**582-2230**	FX: 582-0654
Walgreens 8405 Pacific Ave	(#1)	**536-3705**	FX: 536-4659
Walgreens 4315 6th Ave	(#1)	**756-5159**	FX: 756-5086
Walgreens 7451 Cirque Dr West	(#1)	**564-7569**	FX: 564-8208
Walgreens 8224 Steilacoom Blvd SW (Lakewood)	(#1)	**581-0398**	FX: 581-0997

Bonney Lake (all area codes are 253)

Albertson s 20025 Hwy 410		**826-5757**	FX: 826-5759
Fred Meyer 20901 Hwy 410		**891-7333**	FX: 891-7327
RiteAid 21302 Hwy 410	(#8)	**862-2822**	FX: 862-8430
Safeway 21301 Hwy 410	(#2)	**862-2533**	FX: 862-2173

Eatonville/Enumclaw/Orting (all area codes are 360)

Bridgeport Professional Pharmacy 3021 Griffin Ave		**802-2441**	FX: 802-5472
Cope s Orting Pharmacy 134 Washington Ave		**893-2117**	FX: 893-8888
Kirk s Pharmacy (Eatonville) 104 Mashell Ave North		**832-4700**	FX: 832-4520
Safeway (Orting) 301 Whitesell St NW	(#2)	**893-0843**	FX: 893-0856

Federal Way - King County (all area codes are 253)

Albertson s 33620 21st Ave SW		**952-3323**	FX: 874-4853
Costco 35100 Enchanted Pkwy		**874-4431**	FX: 874-5773
Family Pharmacy 30809 1st Ave South #K		**839-3100**	FX: 941-4310
Franciscan Pharmacy at St. Francis 34515 9th Ave South	(#1)	**942-4040**	FX: 942-4075
Fred Meyer 33702 21st Ave SW		**952-0133**	FX: 952-0142
Longs Drugs 1209 South 320th St	(#2)	**946-1222**	FX: 945-7138
QFC Pharmacy 31217 Pacific Hwy South		**941-0841**	FX: 946-7988
RiteAid 2131 SW 336th St	(#8)	**952-2803**	FX: 952-0387
RiteAid 32015 Pacific Hwy South	(#8)	**945-6011**	FX: 946-0258
Top Food & Drug 31515 20th Ave South		**839-9322**	FX: 839-9397
Virginia Mason South 33501 1st Way South		**874-1650**	FX: 874-1665

Gig Harbor (all area codes are 253)

Bartell Drugs 5500 Olympic Drive		**858-7455**	FX: 858-7460
Gig Harbor Rexall 3114 Judson St		**858-9908**	FX: 858-7213
Olympic Pharmacy 4700 Pt. Fosdick Dr NW #120		**858-9941**	FX: 851-9942
Purdy Costless Prescriptions 14218 92nd Ave NW		**857-7797**	FX: 857-7679
RiteAid 4818 Pt. Fosdick Dr NW	(#8)	**851-6939**	FX: 858-3203
Safeway 4831 Pt. Fosdick Dr NW	(#2)	**851-6870**	FX: 858-4973
Target Pharmacy 11400 51st Ave NW		**858-7799**	FX: 858-7799

Milton/Fife (all area codes are 253)

Albertson s 2800 Milton Way #10		**952-8436**	FX: 952-8478
Fife United Drug 5303 Pacific Hwy East		**922-0222**	FX: 926-2541
RiteAid (Milton) 900 East Meridian	(#8)	**952-2680**	FX: 925-0685
Safeway (Milton) 900 East Meridian	(#2)	**952-0390**	FX: 952-4354

Puyallup (all area codes are 253)

Albertson s 16120 Meridian East		**845-9617**	FX: 770-3578
Albertson s 11012 Canyon Rd East		**537-3808**	FX: 539-3654
Beall s Pharm & Compounding Ctr 618 S Meridian Ste A		**845-8444**	FX: 845-7114
Costco 1201 39th Ave SW		**445-7542**	FX: 445-7549
Fred Meyer 1100 Meridian North	(#3)	**840-8183**	FX: 840-8177
Fred Meyer 17404 Meridian East	(#3)	**445-7873**	FX: 445-7867
Medicine Shoppe 1210 East Main		**848-1597**	FX: 848-6268
RiteAid 1323 East Main	(#8)	**848-3564**	FX: 770-9187
RiteAid 12811 Meridian St East	(#8)	**770-4700**	FX: 435-9268
RiteAid 3717 South Meridian	(#8)	**848-1544**	FX: 841-4119
RiteAid 11220 East Canyon Rd	(#8)	**537-3071**	FX: 537-1825
Safeway 4301 South Meridian	(#2)	**841-6495**	FX: 841-6496
Safeway 10105 224th St East (Graham)	(#2)	**847-7634**	FX: 847-7635
Safeway 5512 161st East (at Canyon Road)	(#2)	**531-5831**	FX: 536-5235
Summit Trading Pharmacy 10409 Canyon Rd East		**840-2098**	FX: 840-0308
Top Food & Drug 201 37th Ave SE	(#1)	**770-7720**	FX: 770-7738
Walmart Pharmacy 310 31st Ave SE		**770-9889**	FX: 770-9983

Sumner (all area codes are 253)

Mark s Pharmacy & Mainstreet Mercantile 1119 Main		**863-6223**	FX: 863-6273
Nicholson s Pharmacy 910 Alder Ave		**863-8141**	FX: 863-3707

Hospital Outpatient Pharmacies (all area codes are 253)

Allenmore Hospital		**403-5150**	FX: 403-5092
Good Samaritan Hospital		**841-5899**	FX: 770-5655
Mary Bridge Children s Hospital		**403-1076**	FX: 403-1558
Puget Sound Behavioral Health		**798-4472**	FX: 798-4361
St. Clare Hospital Pharmacy		**581-6410**	FX: 589-8294
St. Francis Hospital Pharmacy		**927-9700**	FX: 952-7924
St. Joseph Medical Center	(#1)	**591-6920**	FX: 305-6420
Tacoma General Hospital		**403-1076**	FX: 403-1558

Numbers in parentheses are to be pressed at voice mail prompt for calls from physician offices only

KARLA

BUTTORFF

For Pierce County District Court

Judge Position 7 NP

Dear Physician:

Karla Buttorff is running for **Pierce County District Court Judge Position 7.** Karla is a graduate of both St. Louis University, (B.A. History) and St. Luke's Hospital School of Nursing (RN). Karla first served as a cardiac surgical nurse before going to London, England where she directed the laboratory and clinical trials of a U.S.-developed artificial heart. Moving later to the Pacific Northwest, she earned a law degree from the University of Puget Sound (1990). Following law school, Karla planned and developed the cardiac program at St. Peter's Hospital in Olympia.

Karla has practiced family and business law for the past ten years in Gig Harbor and Tacoma. Karla has acted as a guardian ad litem for minor children. She is also trained and experienced in mediation, and has mediated claims for the District Court.

Karla has strong family ties to the Pierce County community. She has successfully ascended Mt. Rainier, and is an avid fly fisherman and birdwatcher. Karla has the experience and skills necessary to effectively serve our community as a District Court Judge. Karla believes that our safety, including our children and our elderly is a critical issue, and that the District Court plays an integral part in ensuring that safety.

We share the opinion of Vernon R. Pearson, *Washington Supreme Court Justice Retired,* that

> "Karla's **integrity, objectivity,** and **decisiveness,** together with her experience as a **surgical nurse** and **family attorney** will make her an excellent judge."

The Committee to Elect Karla Buttorff thanks you for your support and your vote!

ENDORSED BY:

Firefighters #31, *State Auditor*, Brian Sonntag, *Justice* Vernon R. Pearson, *Ret.*, Dr. Douglas Buttorff, Dr. Wayne Zimmerman, Dr. John Huddlestone, Dr. Sandra Reilley, Dr. Peter K. Marsh, Dr. Robert Klein, Dr. James Buttorff, *Senator* Rosa Franklin, Albert Malanca, Lucille Hurst, Robert E. Cooper, *U.S. Magistrate Judge Ret.*, Carol Baarsma, *Tacoma City Councilman*, Bill Evans, Vincent Gadbow, Nick Markovich, Ralph & Eleanor Dickman, John Barline, John Bechtholt, Mory Manning, Patricia Tebb, among others.

Presented by the Committee to Elect Karla Buttorff
2522 No. Proctor, PMB #136, Tacoma, WA 98406
Telephone: 253.761.8570

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

West Nile Virus on its Way

The mosquito season may have passed for 2002, without the appearance of West Nile Virus in the state of Washington, but we can't dodge this disease much longer. Birds in Mexico are testing positive for the virus, so once the northern migration starts, we'll have another disease to deal with. And, despite the fact that many more people are more seriously sickened by the flu than by West Nile Fever, the media has marked the progress of the virus across the country, daily posting disease and death rates, so public anxiety is high.

Federico Cruz-Uribe, MD

Perhaps this fact sheet can be useful for working with patients nervous about West Nile Virus.

The chance of getting the disease is low

Serologic studies of New York residents during the 1999 outbreak of West Nile Virus (published in *Lancet* in July 2002) indicated that thousands of people probably had symptomless West Nile viral infections, with fewer than 1% resulting in severe neurological disease. Current data by the CDC indicates that about one in five people who are infected with the West Nile Virus will show symptoms. Of this number, about 0.6% will progress to encephalitis or meningitis, with death resulting in approximately 14% of those cases. By mid-September, 2002, about 1,400 people in 30 states had symptoms of West Nile Fever and 66 died.

By comparison, the CDC reports that about 10% to 20% of U.S. residents will get the flu each year. Approximately 114,000 people will have to be hospitalized because of the disease and an average of 20,000 people will die from the flu.

The Tacoma-Pierce County Health Department (TPCHD) and the state Department of Health (DOH) are actively monitoring for the disease

Starting in the fall of 2001, the DOH initiated active surveillance of mosquitoes, dead birds, and enhanced passive surveillance of humans and horses (reports through physicians and veterinarians), specific to recognizing the start of West Nile Virus. Monitoring of adult and larval mosquitoes identifies species, and density and location of vectors. Several testing sites exist throughout the state, including Pierce County's Northwest Trek.

TPCHD is the focal point for dead bird collection. Because of the susceptibility of crows to the disease, they are good sentinels for indicating the presence of West Nile Virus in an area. Crows that have died without a recognizable cause, within 48 hours of testing and that are in good shape, are sent from TPCHD to the National Wildlife Health Center laboratory in Madison, Wisconsin. Residents who find a dead crow, which has not died from an obvious cause, can contact the TPCHD at (253) 798-7694. TPCHD has sent more than 20 carcasses for testing, with non positive to date.

This month, DOH will post their annual report on the surveillance activities on their website: www.doh.wa.gov.

Surveillance will continue next spring, providing information as soon as the virus arrives.

Individuals can take steps to lower their changes of getting infected

Knowing where mosquitoes are and avoiding them is an easy way to prevent the disease. Since there is no indication of a human to human or bird or animal to human infection, the only route seems to be through mosquito bites (although evidence indicates transference of the virus during organ transplants).

You can share with anxious patients a few simple steps to take to eliminate mosquito breeding grounds and exposure:

- Avoid being outdoors in early morning and early evening, times when mosquitoes are most likely feeding.
- If you're going to be outside, wear long-sleeve shirts and long pants and apply insect repellant that contains DEET to repel mosquitoes.
- At least once a week, empty containers with standing water on your property, such as water troughs or plant stands. If you own a pond, stock it with fish that eat mosquito larvae.
- Clean clogged roof gutters and make sure they drain properly to prevent water from backing up.
- Repair or replace screened doors and windows that have holes large enough for a mosquito to get through.

For more clinical information about the West Nile Virus, log on to the TPCHD website at www.tpchd.org for links to the Centers for Disease Control and other information on West Nile Virus. ■

Applicants for Membership

Linda E. Day, MD
Ophthalmology
4717 S 19th St #103, Tacoma
253-248-2020
Medical School: Albert Einstein
Internship: St. Vincents Hosp/Med Ctr
Residency: St. Vincents Hosp/Med Ctr
Fellowship: Univ of Washington

Tammy C. D'Souza, DO
Family Practice
Tacoma South Medical Clinic
2111 S 90th St, Tacoma 98444
253-539-9700
Medical School: Chicago College of Osteopathic Medicine
Internship: Southern Illinois University
Residency: Southern Illinois University

Robert D. Jensen, MD, MPH
Anatomic & Clinic Pathology
Tacoma-Pierce County Health Dept.
3629 South D Street, Tacoma
253-798-7665
Medical School: University of Nebraska
Residency: University of Iowa Hospitals
Addl: Medical College of Wisconsin

Francis T. Geissler, MD
Ophthalmology
4707 S 19th St #103, Tacoma
253-248-2020
Medical School: Univ of Washington
Internship: Med U of South Carolina
Residency: Med U of South Carolina

Michael W. Johnson, MD
Family Practice
University Place Medical Clinic
4620 Bridgeport Way W, UP
253-564-0170
Medical School: Uniformed Serv Univ
Internship: Eisenhower AMC
Residency: Eisenhower AMC
Fellowship: Uniformed Serv Univ

John P. Knutson, MD
Orthopaedics
Harbor Orthopaedics
4700 Pt. Fosdick Dr NW #206
253-851-6075
Medical School: Uniformed Serv Univ
Internship: Oakland Naval Hospital
Residency: Bethesda Naval Hospital

Clifford A. Porter, MD
General Surgery
Mt. Rainier Surgical Associates
419 S L St #101, Tacoma
253-383-5949
Medical School: Uniformed Serv Univ
Internship: Letterman AMC
Residency: Letterman AMC

Gari S. Reddy, MD
Internal Medicine
Community Health Care
1102 S I St, Tacoma
253-597-3813
Medical School: S.V. Medical College
Residency: St. Michael's Med Ctr

Roberto A. Secaira, MD
Cardiology
Cardiac Health Specialists
1802 S Yakima #307, Tacoma
Medical School: Francisco Marroquin
Internship: Fitzgerald Mercy
Residency: MCP/Hahneman Univ
Fellowship: MCP/Hahneman Univ

Amy M. Tsuchida, MD
Gastroenterology
Tacoma Digestive Disease Center
4700 Pt Fosdick Dr #308, Gig Harbor
253-272-8664
Medical School: Uniformed Serv Univ
Internship: Tripler AMC
Residency: Madigan AMC
Fellowship: Walter Reed AMC

Yu Zhu, MD
Neurology
Neurology & Neurosurgery of Tacoma
915 6th Ave #2, Tacoma
253-383-5056
Medical School: Suzhou Med College
Internship: Shadyside Hospital
Residency: UNC Hospitals
Fellowship: UNC Hospitals

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Unintended Consequences

Andrew Statson, MD

"You can never do merely one thing"
Ecologists' slogan

The road medicine has traveled during its history, like the one leading to hell, is paved with good intentions. For instance, heroin was synthesized in the hope that it would not be habit forming and would reduce the incidence of morphine addiction. Perhaps it did so to a certain degree, but not in the sense we had anticipated. Oops!

Over the centuries, the medical profession has been on the receiving end of many jokes. Moliere delighted his audiences with the comedy *The Imaginary Sick Man*, where he portrayed the physicians as using bombastic snobbery to hide their ignorance. Today we know much more about diseases and treatments, yet we are not immune to the bombastic snobbery which characterized our medieval predecessors.

"I don't know" seems to be one of the hardest things for us to say. There are physicians ready to appeal to the public in general and recommend this or that treatment as the only way to health. This is especially true for dietary approaches and food supplements, but it applies to many other areas of medicine. Unfortunately, there are physicians in academic positions who promote to the public the results of their research, hoping perhaps that it would lead to increased subsidies for further studies.

Over time, our claims and counterclaims have changed enough to make people wonder whether we really know what we are talking about. There was a time when alcohol was considered so bad that it was demonized and its use in any amount was prohibited by law. I will not discuss the unintended consequences of the prohibition experiment. Thomas M. Coffee documented its history well in *The Long Thirst*.

Today we are told that one glass of wine a day reduces the risk of heart attacks. That may or may not be true, but it did not stop some from making the claim. There was a time when fat was considered almost poisonous. Now there are rumors that it is not so bad after all. There was a time when people were told to drink large amounts of water, whether they were thirsty or not.

"The nature of medical practice is such that we will forever have to make decisions based on incomplete information. There will always be risks, side effects, unintended consequences."

Now we are told that it really doesn't make much difference how much fluid we drink. If we are thirsty, we may drink, if we are not, we don't have to. Fancy that!

Of course, there will always be people who will pay exorbitant amounts of money to obtain the magic potion that will give them eternal youth, eternal health, or eternal life. What they look for is not medicine, and certainly not science. They want sorcery.

The latest bandwagon our profession has jumped on is evidence-based medicine. Don't misunderstand me. Evidence derived from medical studies is the best way to develop our science. It is the foundation on which to base our treatments. Unfortunately, the current approach to evidence-based medicine blinds us to the reality that every patient is different.

What is good for some, or even most, is not necessarily good for all. What is bad for some, or even for most, is not necessarily bad for all. What is good in some doses is not necessarily good in different doses. What is bad in some amounts is not necessarily bad in different amounts. Thalidomide is bad for the fetus of a pregnant woman, but it is good for someone with leprosy and also in some other situations.

The success of every treatment is based on the individual characteristics of the patient and on his condition. That is where the art of medical practice comes into play. We all have favorite drugs, dosages and regimens. When we prescribe them, we still adjust our treatment to the seriousness of the condition and to the response of the patient.

Many years ago, in a discussion of infections in gynecology, one of our professors said, "There is *contamination*, like a pussycat, and there is *CONTAMINATION*, like a tiger." You

See "Consequences" page 10

Consequences from page 9

wouldn't hunt a tiger with the same gun you would use for a cat. They require different approaches, and for each patient, the treatment will vary according to the response.

Well designed medical studies are important to build a database, but are dangerous because many of us are subtly or not so subtly pressured into following the resulting guidelines, without consideration of the individual patient. With such an approach, we may end up doing more harm than good to those who don't get sick according to the book.

I wanted to avoid discussing hormone replacement therapy, but it looks like I'll have to use it as an example, both of our endeavor to discover the evidence and in our failure to answer the questions which are really important to the patients. In the mid-sixties, I had the opportunity to hear Dr. Robert Wilson propound estrogen replacement therapy. His paperback book, *Feminine Forever*, made a splash. He had started with stilbestrol some 10-15 years earlier, but now recommended Premarin. Estinyl also became available then, with the development of birth control pills. Women were promised eternal youth.

By 1968, the reports of endometrial cancer appeared, but progestins came to the rescue. We knew that estrogen relieved the symptoms of menopause. We knew that it reduced the risk of osteoporosis. As we advanced from treatment to prevention of potential future problems, the risk-to-benefit equation changed. Is it good to give medication to patients with no symptoms to prevent a future condition that they may or may not acquire? The question of risk becomes more important and the answer, as always, depends on the individual patient. For some it is better, for others, it isn't.

How are we going to know which is which? That is a question the Women's Health Initiative was intended to answer, but didn't. Perhaps, the question they asked was statistical, not individual. Only, that doesn't help us. That does not tell me what will happen to the patient in my office.

Statistically, some women will develop breast cancer. Did the hormones cause it, or was it there already? Did the hormones make it grow faster? Were they the same patients who were protected from getting colon cancer? If so, the question would be to choose your cancer. If not, they obviously benefit from different treatments. How do we tell them apart?

Who are at risk for cardiovascular problems? We don't know. We know that not all are. Should we deny the treatment to all because some of them will have a stroke. That is a decision only the patients can make. What if we used a different progestin? We don't know. Natural progesterone? We don't know. A different estrogen? We don't know.

Yes, these questions will be studied over the next five or ten years. By the time we get the results, we will have new preparations and will be faced with the same questions. The steady progress of medicine, by its nature, doesn't allow us to wait for the answers which all the extensive, well-designed studies are expected to give us. The nature of medical practice is such that we will forever have to make decisions based on incomplete information. There will always be risks, side effects, unintended consequences.

We never know how the patients will react to a certain medication. We never know what the consequences will be. We can be sure there will be consequences, and some of them may not be what we intended. We, and even more so our patients, must understand that we cannot escape from that trap. There is a risk in everything we do. Nothing is absolutely safe. In this respect, it is our duty to face our patients and tell them so. They will respect us much more for being honest with them.■

In My Opinion....

by Carl Wulfestieg, MD

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

I'm Out

Carl Wulfestieg, MD

Editor's Note: PCMS is not encouraging medical practices to cease caring for Medicare, Medicaid, or any other specific type of patients, or implying that physicians should take any action. These decisions must be made on an individual basis. A Medicare/Medicaid Opt-Out Guide is available on the WSMA Web site at www.wsma.org.

I have been a member of the medical community of Tacoma for over 20 years, and during that time I have had ample opportunity to observe the political processes in this state and how they affect healthcare. I have had the experience of practicing in a fee-for-service environment before and during "managed care." Throughout that time, I have attempted to deliver care to all patients without consideration for their ability to pay. Unfortunately, the time is fast approaching when this will no longer be possible. Increasing expenses, the current malpractice problem, and decreasing reimbursements are forcing me to change my behavior.

I have learned from the voters of this state that we can sacrifice infrastructure for the sake of lower taxes. I have seen voters cripple schools by not showing up to vote in bond elections. I have learned from our "representatives" who often refuse to take a stand in Olympia, preferring to let the initiative process decide the will of the people. Teachers' unions, health care workers' unions, and numerous other trade unions strike for better pay, working conditions, and benefits.

WSMA and many of us have communicated with our representatives in Olympia to ask for legislative relief of B and O taxes on Medicaid and Medicare payments, such as that received by virtually all of the hospitals in this state, and we have been told no! The state doesn't have the money. The hospitals claim that they are nonprofit, but their tax and other subsidies, probably are as great, if not greater, than the cost of the free care they give. We physicians also provide free care and get no subsidies. In fact, we are told that we will lose clinical privileges in the hospitals if we don't see these "no pay" or "poor pay" patients.

In the past, I was paid "usual and customary" by most insurers, and DSHS used a 1974 California Relative Value Scale with a low multiplier. Over time, as we are all aware, Medicare and then all payers went to a RBRVS system with frequently modified relative values. Each payer had a different multiplier and interpretation of what RBRVS meant. DSHS chose to drastically modify the system by favoring OB and pediatrics over adult medicine and all other care. Primary care providers under some capitated plans fared better then specialists who remained on "fee-for-service."

I take care of many children in my practice, a number of whom are covered by Medicaid, but I am paid 64% of that paid to a pediatrician for the same work. In addition, with the notable exception of OB, DSHS fees for all providers have fallen since 1996 when this fee scale was established. While this was occurring, eligibility rules were changed to dramatically increase the number of patients covered by Medicaid and Basic Health Plans. I believe that DSHS counted on physicians' altruism and sense of duty to patients and expected that we would continue to provide care in this changing environment.

Several weeks ago, we all should have received a memorandum from Douglas Porter, Assistant Secretary, Medical Assistance Administration with the subject, "Mandatory Re-Enrollment for all MAA Providers." MAA is demanding that all providers sign a new Core Provider Agreement by November 30, 2002 in order to be paid after January 1, 2003. Each of us will need to carefully consider whether to execute the new contract. I recommend that everyone review the contract and consider whether it makes sense for their practice. Naturally, many practices have different needs and requirements, however, I hope we are all beyond mindlessly signing everything that crosses our desks. It is not immoral to consider your own financial viability.

Regardless of whether you sign or not, we need to lawfully work with organized medicine to impress upon government that its tendency to set fees depending on the political worth of practitioners instead of on the services they provide to patients needs to stop. However, I, for one, have come to the end of my rope. On November 30, 2002 I will not return the new Core Provider Agreement. Each of you will need to decide that for yourself, and I respect that this can be a difficult decision. But a state government as cynical as ours is in promising the world to its covered patients and paying peanuts unless you are on a political favorite list has crushed, by example, my idealism. I'm out. ■

Courage Classic Update

In the September issue of the *Bulletin*, the Medical Society congratulated members who completed the 11th Annual Courage Classic bicycle tour, which took place August 10-12 and took riders from Snoqualmie to Skykomish. We inadvertently failed to include **Patty Kulpa, MD,** who not only participated in the ride but has been a participant and a sponsor of the event for most of its eleven years.

Our apologies to Dr. Kulpa and congratulations!■

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Malpractice from page 4

constitutional by the Washington State Supreme Court. "What turned out to be a major victory in the mid-80s was by 1990 very shallow," Myers said.

Myers noted that MICRA has worked in California for over 25 years, and will likely be the model that Washington State will look to. The question is...when?

According to Myers, there is a long-held view that meaningful tort reform in Washington State will require a constitutional amendment to succeed, which would require a two-thirds favorable vote of the State legislature and a simple majority of favorable votes of Washington State voters. "Our company, along with other insurance companies, the WSMA, and others are spending time to determine if now is the rime to produce meaningful tort reform in the state of Washington. The consensus is, yes — it is time." He added, however, "with the legislature dominated by attorneys, I don't think that this is going to go very far up the state level at this time. But again, I'm convinced by watching the downward evolution of your business that a year or two from now the circumstances will be different. Legislators will begin to hear from their constituents and realize that something has to be done."

The most controversial element of the reform debate is limiting plaintiff attorney's contingency fees. "From what we see, attorney's are getting between 40-50 percent, and the plaintiff pays all expenses incurred if they are successful. It's amazing to me that if someone is injured, they get a $500,000 judgement or settlement, the attorney takes between $200,000-250,000 plus expenses and their health insurer, with a $300,000 lien, takes the rest. It's obviously not right. **Significant limitations on plaintiff attorney's fees is a major part of MICRA and a significant part of why it's worked so well, but it is definitely going to be the hottest issue.**"

What is MICRA?

MICRA, California's Medical Injury Compensation Reform Act.

For almost three decades, MICRA has protected access to health care for Californians.

"MICRA" is the Medical Injury Compensation Reform Act of 1975.

MICRA's Basic Provisions:

• Limits on Non-Economic Damages

Non-economic damages in a claim against a health care provider for medical negligence are limited to $250,000. Economic damages, such as lost earnings, medical care, and rehabilitation costs, are not limited by statute. *California Civil Code Section 3333.2.*

• Evidence of Collateral Source Payments

A defendant in a medical liability action may introduce evidence of collateral source payments (such as from personal health insurance) as they relate to damages sought by the claimant. If a defendant introduces such evidence, the claimant may also introduce evidence of the cost of the premiums for such personal insurance. *Civil Code Section 3333.1.*

• Limits on Attorney Contingency Fees

In an action against a health care provider for professional negligence, an attorney's contingency fee is limited to 40% of the first $50,000 recovered; 33% of the next $50,000; 25% of the next $500,000, and 15% of any amount exceeding $600,000. *California Business and Professions Code Section 6146.*

• Advance Notice of a Claim

To further the public policy of resolving meritorious claims outside of the court system, MICRA requires a claimant to give a 90-day notice of an intention to bring a suit for alleged professional negligence. If the notice is given within 90 days of the expiration of the statute of limitations, the statute is extended 90 days from the date of the notice. *California Code of Civil Procedure Sections 364 and 365.*

• Statute of Limitations

In California, a claim for alleged medical negligence must be brought within one year from the discovery of an injury and its negligent cause, or within three years from injury. *Code of Civil Procedure Section 340.5.*

• Periodic Payments of Future Damages

A health care professional may elect to pay a claimant's future economic damages, if over $50,000, in periodic amounts. This avoids a claimant's wasting of an award prior to actual need. *Code of Civil Procedure Section 667.7.*

• Binding Arbitration of Disputes

Patients and their health care providers may agree that any future dispute may be resolved through binding arbitration. California statute requires specific language for such contracts and also provides that all such contracts be revocable within 30 days. *Code of Civil Procedure Section 1295.*

Needless to say, the road toward solutions for the medical malpractice mess is long, winding, and riddled with detours. One thing appears certain, however. Without significant reconstruction — most notably through strong tort reform legislation based on a proven model in California — the road in Washington State will probably lead to a dead end.

In My Opinion....

by David Roskoph, CFP

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

Is There Any Place to Hide When the Malpractice Insurance is Exceeded?

The tug-of-war between the trial lawyers against the rest of the world may seem lopsided until you realize that they're winning! Trial lawyers have been asking juries for and receiving bigger and bigger malpractice settlements. There's only so much actual damage that can be assessed, however, the pain and suffering awards are on a ballistic course in states where no caps have been placed on them. The number of lawsuits filed each day now exceeds 50,000 with an estimated 10,000 of them aimed at the medical industry! As a result of this trend, the average malpractice coverage of one million may not provide enough protection in the event of a jury verdict. What the judgment can collect of your personal assets, if the malpractice limit has been exceeded, is the over-one-million dollar question.

Collection of judgments is a state matter with the Employment Retirement Security Act of 1974 (ERISA) as the only federal preemption. Although laws are constantly in flux, you can find a complete listing of the state laws by visiting www.mrsc.org/mc/toc/rcw.htm, the Revised Code of Washington (RCW) website. You're looking for Title 6 – Enforcement of Judgments. Below is an overview of four asset categories that probably contain the vast majority of your wealth: 1) qualified retirement plans (employee and sponsor-only), 2) insurance proceeds, 3) personal residences and 4) other personal property.

1) Qualified plans fall into two basic categories, those covered by ERISA and those not covered under the ERISA laws. ERISA plans offer the most solid barrier protecting your retirement assets from judgments. Those not covered by ERISA fall back under state jurisdiction. Generally, tax qualified retirement plans will be protected from the claims of the participants' creditors when it is a defined benefit or a defined contribution plan. Defined contribution plans include profit sharing plans, employee stock ownership plans, money purchase pension plans, target benefit plans and 401(k) plans. ERISA protects retirement assets from creditors, legal judgments and even bankruptcy claims, a protection upheld by the U.S. Supreme Court. The reason this will probably withstand future tests is that retirees whose assets have been stripped by creditors would become burdens to the government. Some pension plans that may benefit only the business owner, such as a Keogh's (including the owner's spouse) IRAs, whether traditional, Roth, SEP or SIMPLE are not protected under federal law. Their jurisdiction then falls through to the state. RCW 6.15.025 does include IRAs, Roth's & Keogh's into its definition of assets protected from collection.

2) RCW 6.15.035 protects "people" insurance proceeds. The lawful beneficiary, assignee, or payee of a disability income, life insurance (individual and group life) or annuity income payments are all included in this statute under the same concept as the protection afforded qualified plans. Insurance payments represent a stream of income that if stopped, may make the beneficiary a dependent. However, annuity payments over $250 per month are not excluded.

3) Your home and property are known collectively as your "homestead" and are covered in RCW 6.13.010 – 6.13.240. Pay particular attention to Section 6.13.030 ". . .but the homestead exemption amount shall not exceed the **lesser of** (1) the total net value of the lands, mobile home, improvements, and other personal property, as described in RCW 6.13.010, or (2) the sum of $40,000 in the case of lands, mobile home, and improvements." I excerpted from the body of the code but the amount seems unequivocal and therefore potentially represents the greatest threat to your asset base.

4) Here are excerpts from most of the exempted personal property covered in RCW 6.15.050.

(1) Clothing ". . but not to exceed one thousand dollars in value in furs, jewelry, and personal ornaments for any individual." (2) Libraries, pictures and keepsakes ". . but not to exceed $1,500 in value." (3) (a) The individual's or community's household goods, appliances, furniture, and home and yard equipment, not to exceed $2,700 in value for the individual or $5,400 for the community." (b) Other personal property, except personal earnings as provided under RCW 6.15.050 (1), not to exceed $2,000 in value, of which not more than two hundred dollars in value may consist of cash, and of which **not more than two hundred dollars in value may consist of bank accounts, savings and loan accounts, stocks, bonds, or other securities;** (c) A vehicle ". . not to exceed two thousand five hundred dollars or for a community two motor vehicles used for personal transportation, not to exceed five thousand dollars in aggregate value; (d) Past, present and future child support; (e) Health aids; (f) Collectable debts or judgments ". . . not to exceed $16,150 on account of personal bodily injury, not including pain and suffering." (b) **To a physician,**

See "Hide" page 18

COLLEGE OF MEDICAL EDUCATION

Whistler Condo Reservations Deadline December 1

CME at Whistler participants are urged to make their condo reservations early. Reservations for the block of condos, ALL IN THE ASPENS, are available. To take advantage of these savings, you must make your reservations soon, as conference dates are during the high ski season. The College's reserved block of rooms will be released after December 1, 2002.

Reservations can be made by calling toll free at 1-800-777-0185. You must identify yourself as a part of the C.O.M.E. group. For more information call the College at 627-7137. ■

Whistler CME set January 22-26, 2003 Condo Reservations/Course Registration Open

Registration is open for the College's CME at Whistler/Blackcomb program. The conference is scheduled for January 22-26, 2003.

The College of Medical Education has again selected the Aspens Condos for accommodations because of the very competitive rates (compared to hotels and other condos) and quality of the lodging.

These negotiated group rates have increased only $10 Canadian, and combined with the Canadian/U.S. exchange rate, result in major savings for the conference registrant.

A collection of one and two bedroom luxury condominiums just steps from the Blackcomb chair and gondola are available. Space is available on a first come first served basis in the Aspens.

The College is offering family vacationing, skiing and the usual quality continuing medical education to PCMS members and other physicians. With Category I credits, the CME program features a potpourri of subjects of interest to all specialties.

The program is under the direction of **Drs. John Jiganti and Richard Tobin**. This year's subjects include address on: A Dermatology Update; Discoveries in the Migraine Brain: The Slippery Slope to Relief of Agony; Management of Common Thyroid Problems; HRTs: The Real Story; Abnormal Liver Enzymes, NASH and HCV Update; What's New in Children's Orthopedics?; GI Hospital Medicine; Issues in Virtual Imaging and Radiologic Screening; Advances and Retreats in Infectious Diseases; Emerging Roles for Bone-Marrow and Stem-Cell Transplantation.■

The Aspens, the conference loding and meeting location, is situated on the slopes of Blackcomb Mountain with ski-in/ski-out steps to the chair

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

GI Update CME set for December 6

A new program dedicated to gastroenterology for the primary care physician is set for December 6, 2002.

Gastroenterology for Primary Care is a one day review and update focusing on the diagnosis, treatment and management of GI issues faced in the primary care and internal medicine practice. The course will be held above the Tacoma Sheraton Hotel in the Tacoma Convention Center.

The program is directed by **Ralph Katsman, MD**. He has assembled mostly local gastroenterologists to present on the timely and appropriate subjects. The program is complimentary and offers 6 Category I CME credits.

A program brochure will be mailed in early November. Subjects planned include:

- Abnormal Liver Enzymes, NASH & HCV Update
- Dyspepsia
- IBS: New Answers for the Challenging Patient
- GERD: Treatment Options
- Diagnosis and Medical Management of IBD
- Tales from the Other Side: GI Hospital Medicine
- Colon Cancer Screening : Who, When, Why ■

ID Update set for November 8, returning to Sheraton this year

The annual Infectious Diseases Update is set for Friday, November 8, 2002. The very popular course will return this year to the Sheraton Hotel - in the hotel ballrooms.

The program is directed by **Jim DeMaio, MD** and will feature nationally known expert Dr. David Spach joining Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections.

This year's program includes presentations on:

- Update on Viruses and Immunology
- BV: It Don't Never get no Respect
- 2002 Antimicrobial Update
- Creepy-Crawlies
- West Nile Virus: In Your Neighborhood Soon?
- Herpetic Infections: New Directions
- Endocarditis: New Developments and Old Truths
- Food-Borne Illnesses: How Safe is Our Food? ■

Dates	Program	Director(s)
Friday, Novmber 8	Infectious Diseases Update	James DeMaio, MD
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Monday, January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

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surgeon, attorney, clergy, or other professional person, the individual's library, office furniture, office equipment and supplies, not to exceed $5,000 in value.

ERISA plans that include employees are the most secure asset class. Other retirement plans that cover only sponsors are less secure federally but are presently protected under state laws. Personal residences in excess of $40,000 and most other private assets are exposed to collection and may need to be protected through some change in ownership or trust arrangement. There are many "asset protection" attorneys proposing off-shore limited liability corporations (LLC) as a solution to this exposure. Get legal council to determine whether your risk is worth the estimated cost of $20,000 to $30,000 to set up. This has been a layman's eye-view and should not be construed as a legal opinion. ■

David J. Roskoph, MBA is a fee-based Investment Advisor and Financial Planner in Gig Harbor.

Jury awards keep going up

The median jury award -- up 100% since 1995.

1995:	$500,000
1996:	$474,536
1997:	$503,000
1998:	$733,900
1999:	$700,000
2000:	$1,000,000
2001:	not yet available

Going to trial

Compensatory award medians for the most common judgments between 1994 and 2000.

Childbirth	$2,050,000
Cancer diagnosis	$1,000,000
Delayed treatment	$1,000,000
Diagnosis	$750,000
Medication	$668,000
Lack of informed consent	$500,000
Nonsurgical treatment	$400,000

Source: Jury Verdict Research report "Medical Malpractice: Verdicts, Settlements and Statistical Analysis"

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Add to 2002 Directory:
John Hilger, MD
Facial Plastic Surgery
1901 S Union #B7008, Tacoma 98405
ph: 253-383-2033
fax: 206-623-8883
phys only: 253-383-2034

David Law, MD
Change office address to:
314 ML King Jr Way #101
Tacoma WA 98405

Peninsula Family Medical Center
including the following physicians:
Mark Craddock, MD
James Patterson, MD
Gary Pingrey, DO
John Samms, MD
Jennifer Smith, MD
Change office suite number to: #220

Classified Advertising

POSITIONS AVAILABLE

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

Seattle, Wash - Occupational Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

POSITIONS AVAILABLE

Family Physicians wanted to work at Sea Mar Community Health Centers. Sea Mar is dedicated to serving the underserved with emphasis in the Latino population throughout Western Washington. OB is required and Spanish language proficiency is preferred. We offer a competitive salary, benefits and a sabbatical plan. Choose from the following locations with openings: Tacoma: 3 FP positions available. The practice is expanding to 5 family physicians. Hospital care is at Tacoma General Hospital. Call is 1 in 4. Contact **Phillip Reilly, MD** if interested. (253) 593-2144.

GENERAL

University Place 2 BR/2 BA condo in small park-like setting. New carpet, paint, bathrooms. Attached one-car garage/auto opener. Available October. $1050/month. 565-8634.

OFFICE SPACE

1,800 sq ft remaining on first floor at 1310-A South Union. All new tenant improvements included. Easy access, quiet, terms negotiable. Call Dr. Lovy at 756-2182 or 206-387-6633.

Fircrest Medical Office Space 412 Bowes Drive - 1540 sq ft consisting of examination rooms, offices, reception area, lab and x-ray rooms plus 300 sq ft storage. Will remodel to suit. Call (253) 863-3366 or (253) 272-4588.

Price Reduced. Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

Medical space for sale and/or lease in rapidly growing South King County with 85,000 population service area. Need for pulmonary, pediatric, dermatology, orthopedic and gynecologic specialties. Call 360-825-1389.

Bayview Medical. North End Tacoma. 3,500 sq ft. Nine exam rooms, x-ray and lab, reception area, ample storage and parking. Call 253-752-6150.

1,118 sq. ft. available across the street from Good Samaritan Hospital. Great access, newer building, ample parking, terms negotiable. Kim Thomas 425-454-1405.

For Lease: New office space located in Fircrest. 4,000 sq ft or less, no B&O tax. Call 564-8784.

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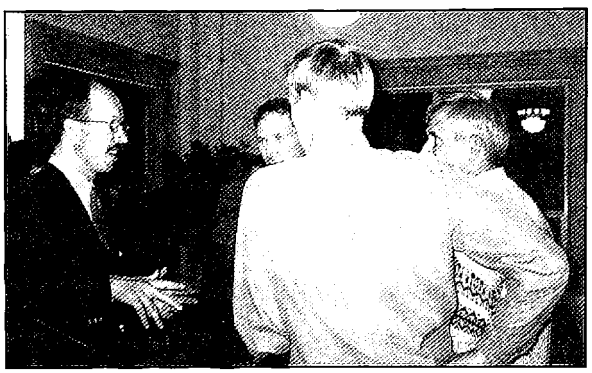
Pierce County Medical Society
BULLETIN

November, 2002

Pierce County Medical Society welcomes new members and informs and entertains active as well as retired members at various Society functions



GENERAL MEMBERSHIP MEETING
Jason Edwards' (left) exhilarating talk on climbing Mt. Everest wowed 150 PCMS members and guests in October

NEW MEMBER RECEPTION
Board of Trustee members Joe Regimbal, MD (left) and Pat Hogan, DO (right) visit with new Tacoma neurologist Yu Zhu, MD at the October reception

RETIRED MEMBER LUNCHEON
Dr. Stan Sollie (center) spoke to retired members on his travels to South America. He is flanked by MaryJo Hopkins and David Hopkins, MD, past PCMS President (1976)

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society
BULLETIN

November, 2002

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President's Page

by Susan Salo, MD

We Will Thrive

Susan Salo, MD

WOW! Wasn't Jason Edwards' talk entertaining? And his photos were brilliant! **Dr. Mike Kelly**, our Vice President, deserves recognition for a stellar job this year as program chair.

It's now November, and the year is dwindling. Next month the annual meeting and inauguration of new officers will complete the year.

The nominating committee met and is recommending members who will do an excellent service in helping navigate the increasingly turbulent waters ahead. If nominating committee recommendations are validated by the electorate, **Dr. Michael Kelly** will become President-elect, **Dr. Patrick Hogan** will move up to Vice President, **Dr. Steven Duncan** will become Secretary, and **Dr. Kenneth Feucht**, Treasurer. A trio of new trustees begins each year, and this year's candidates have all been very active in both the medical society and in the medical community at large: **Dr. Ron Morris**, family practitioner from Puyallup, **Dr. Joseph Jasper**, pain management specialist from Tacoma, and **Dr. Laurel Harris**, ophthalmologist from Tacoma/Puyallup. And, of course, **Dr. James Rooks**, our President-elect, will assume the Presidency, and I cannot imagine a better captain. (If you don't know all these folks, biography information will accompany your ballot.) I cannot imagine a better slate of candidates!

Our medical society and the officers we elect will face a challenging year and years into the future. Most of the major problems with practice viability-excessive expenses and inadequate recompense, diversion of resources by legislative mandate and bureaucratic fiat-are not resonant issues with the public at large or by candidates for public office, and may worsen until the community at large feels its medical care and safety threatened directly.

But I will not end pessimistically. Our community of physicians has a tremendous resilience and tenacity. Our members are exceedingly intelligent and talented, and the services we provide are crucial.

This will not change. And we will thrive. ■

Practice size trend: small to big, then small once again

Some physicians who got caught up in the 1990s merger mania are returning to the solo and small group practices from whence they came

After 15 years, Ruth Hoddinott, MD and Jeff Gee, MD got tired of following a trend toward ever-larger practices. But in deciding to go back to their roots as a two-physician group, it turns out they're following the latest movement: leaving a big group for a smaller practice.

Most doctors are still in groups of three or more, but recruiting firms and consultants around the country have noticed a shift toward one- and two-doctor practices, a movement led by primary-care physicians who have learned firsthand that a bigger practice is not always better.

The number of doctors placed in group or hospital settings has declined 14 percentage points during the last five years, while those taking jobs in solo, partnership or association settings -- in which doctors pool space and equipment but don't share revenue -- increased by the same level, according to Merritt, Hawkins & Associates, a staffing and recruiting firm based in Irving, Texas. The firm conducts an annual review of the placements it facilitates each year, with last year's sample numbering about 2,200 physicians.

The number of physicians placed in two-person partnerships increased from 9% in 1997-98 to 22% in 2001-02, while physicians placed in group settings dropped from 53% to 41%, according to the firm's statistics.

"They're shifting away from the economies-of-scale approach, which hasn't played out too well," said Merritt Hawkins spokesman Phil Miller.

Solo start-ups have "probably quintupled over the last three years," said Keith Borglum, vice president of Professional Management and Marketing, a consulting firm based in Santa Rosa, California. The trend seems to mirror the plateauing of capitation as a payment form and consumers' shift away from the most restrictive HMO plans.

"A lot have gone back to PPOs and discounted fee for service," Borglum said. "It's easier now for solo and small practices to flourish."

Getting Big

In 1987, Dr. Hoddinott and Dr. Gee purchased a fairly busy internal medicine practice. By 1989, the office, Bay Area Family Physicians, had grown to four physicians.

"It was still the trend," Dr. Hoddinott said. "You add physicians because they will work and pay for your overhead. They do the work and pay the bills, and you take home the money. Wrong."

By 1995, when Mullikin Medical Centers, a practice management company, came knocking, the idea of someone else handling the business side of the practice sounded good.

Mullikin acquired the practice assets, paying "enough to pay off our loans," Dr. Hoddinott said. Not long after the ink dried on that contract, however, Mullikin was acquired by MedPartners, which was on its way to becoming the nation's largest physician practice management company.

MedPartners figured it would build economies of scale to help reduce the cost of running a practice and perhaps use its weight to get better managed care contracts; neither of those things happened. MedPartners ended up in bankruptcy and shed its practices, changing its name to CaremarkRx, a pharmacy benefits management company it had acquired.

Growing pains return

In 1998 Drs. Hoddinott and Gee reacquired their practice assets from MedPartners. But as their own bosses again, they lost the income guarantees. So they decided to grow again; by 2001, Bay Area Family Physicians had six physicians, including five partners, and a nurse practitioner.

"Through four years of finances, if you look at a graph, it was like a roller coaster," Dr. Hoddinott said. "How much we were drawing from our line of credit was how we measured our success."

"Every time we were on the climb up, something happened," she said -- an IPA would go out of business or an HMO would abandon the market. The financial problems took their toll, and personality conflicts arose. The group broke up.

While attorneys continue to negotiate over how to split the revenues and costs of the old practice five ways, the two original partners have formed Bay Area Family Practice. They've set it up in a similar fashion to what they established 15 years ago, with one exception: their nurse practitioner at the old office, Norma Espinoza -- who is also certified as a physician assistant -- has been added as an equal partner.

They don't intend to get bigger. In fact, they recently moved into office space one-third the size of what they had last year. "We did it on purpose," Dr. Hoddinott said. "We didn't want to have that chance to grow again."

"My last gasp"

Not everybody is rushing to leave large practices. Specialists, for example, are showing no signs of reducing the size of their groups.

"A lot of specialists still prefer the large groups because they want to be affiliated with academics or funded research," said Leta Davenport, a recruiter with Bellwether Associates, a physician recruitment and placement firm in Charleston, S.C.

See "Trend" page 14

General Membership Meeting Recap

by Jean Borst

Peak Performance - An Evening with Jason Edwards

"Go as far as you can see. When you get there, you will be able to see further."
-Unknown

At the age of 13, Jason Edwards set his sights on the stars. But his desire was not to travel into space. It was to stand atop the world's highest mountains and experience the feeling of being close enough to the stars to reach up and touch them.

A packed house was on hand at the October 8 General Membership Meeting to hear Jason Edwards present a fascinating program on his Mt. Everest expeditions. With climbing suits adorning the stage, and a Power Point presentation offering dazzling images, Edwards presented an insightful personal account of his 2001 successful ascent of the highest peak in the world. Of the approximately 4,000 people who have attempted to summit Everest, only 660 have been successful.

Highlighting the evening was the appearance and introduction of Bronka Sundstrom, a 77-year old dynamo who was accompanied by Edwards on a recent climb to the summit of Mt. Rainier. Sundstrom set a record for the oldest woman to climb Rainier and one of only a few climbers of any age to make the ascent and descent on the same day.

Called to Climb

Edwards is an AMGA Certified Senior Alpine Mountain Guide and Director of Mountain Experience, an organization that conducts commercial expeditions and treks around the world. As a young teenage, Edwards was captivated by the book "Banner in the Sky" and the 1963 National Geographic on the First American Ascent of Mt. Everest. The mountains called to him, and he began his guiding career in the 1970s. Since that time, he has guided ascents of many mountains, including Mt. McKinley and Mt. Rainier, as well as multiple expeditions to peaks in many other countries. Edwards is also a schoolteacher at Stahl Junior High in Puyallup - his "day job," as he puts it. "My Everest experience was a perfect lesson for my kids," he said. "It gave them an opportunity to look beyond a person's daily life and see what can be accomplished." Throughout his journey up Everest, Edwards kept in touch with his students and colleagues through the Puyallup School District's Dream Quest(tm) web site. This gave his students and the students of the district a first-hand account of the expedition, as well as information and insight about Mt. Everest and the culture and religion of Nepal. Since returning from his adventure, Edwards speaks to students and community groups about the importance of having dreams, setting goals to achieve dreams, and the required discipline to accomplish those dreams.

"It was quite a stressful job to manage everyone on the mountain and worry about their safety for three months. That's why I needed to see my doctor as soon as I got back home!"

Getting Ready

Edwards gave a fascinating breakdown of the trek, from his arrival in Katmandu in March 2001 to completion of the climb nearly three months later. The trip from Katmandu to Base Camp was a fascinating leg of the journey. Edwards shared pictures of bridges covered with prayer flags, in addition to a sobering photo of a monument to American Scott Fisher, one of many climbers who died attempting to climb Everest. He also explained the various religious ceremonies and prayers conducted by the Sherpas, including the Puja, a blessing ceremony Sherpas hold before they will begin climbing.

The arrival at base camp commenced a huge process of preparing for the climb. "Base camp is where all the staging takes place," Edwards explained. Needless to say, preparing for a three-month trek to the world's highest peak is not an easy task. As expedition leader, Edwards was in charge of an entourage of about 25 people that included five climbers who hired Edwards as a guide, two assistants (one American and one Peruvian), 12 climbing Sherpas, five cooks and assistant cooks, and a military officer from the Nepali government. "It was quite a stressful job to manage everyone on the mountain and worry about their safety for three months," Edwards said. "That's why I needed to see my doctor as soon as I got back home!"

Along with Edwards's team, there

See "Peak" page 6

Peak from page 5

were 13 other teams at base camp preparing to climb. "We all tried to work together to make sure each team was successful," Edwards noted.

The Climb Begins

Edwards and his team took the South Col route of Everest which follows the Khumba Ice Fall, continues through to western "Cwm," climbs the Lhotse face, heads to the south summit, and ascends the "Hillary Step" at almost 29,000 feet, which leads to the summit at 29,028 feet.

Travelling from Base Camp to Camp 1, the team encountered the most dangerous area on the mountain - the Khumba Ice Fall. "Once you start, you can't stop," Edwards explained. "It's just too dangerous." There were more than a few gasps from the audience when Edwards showed pictures of the ladders the team had to use to cross over the treacherous crevasses. "The ladders are not very stable," he noted. "Definitely not OSHA approved."

At this point of the evening, Edwards pointed out two interesting, yet ominous, Everest stats: For every 10 individuals who reach the summit, one doesn't make it. And, those who don't use oxygen, for every two that make it, one will not come back.

The team reached Camp 1 at 19,500 feet, where they were able to spend a comfortable couple of nights before heading through the Western Cwm to reach Camp 2 at 21,500 feet. At this point, oxygen canisters were accumulated for the higher altitudes.

Next stop was Camp 3 at 23,500 feet. "This is where we start using oxygen," Edwards said. "Things start getting tough."

Camp 4 at 26,000 feet has been known as "the highest junk yard in the world." Not so, said Edwards. Efforts have been made in recent years to ensure the area is clear of debris. Sherpas are now hired to bring the garbage off the mountain. At this point of the climb, team members are on oxygen 24/7.

On the night before the ascent to the summit, the team slept three to five

See "Peak" page 16

EVEREST FACTS:

Check EverestHistory.com for much more than is listed here...

- Mt. Everest 8848 meters or 29,029 ft*
  *Note the National Geographic Society has determined the height as being 29,035 feet. However, this "new" height is not yet determined as official to our knowledge. As the norm with Everest, nothing is simple.
- Longitude: 86°55'40" E
- Latitude: 27°59'16" N
- Nepal Name: Sagarmatha
- Tibetan Name: Chomolungma

Time Line

1841: Sir George Everest, surveyor of India from records location of Everest labeling it Peak XV.

1856: Surveyor Andrew Waugh completes first height measurement, declaring Everest to be 8840 meters high. (29,002 feet)

1859: Peak XV re-named Mt. Everest to honor Sir George Everest.

1921: British expedition: None reach the summit.

1924: British team with Lt. Col. Norton reaches 8580 meters without oxygen. George Mallory and Andrew Irving are seen somewhere above Camp 1. They never return.

1934: Maurice Wilson attempts to solo Everest - his body is later found at 6400 meters.

1950: Tibet falls under Chinese rule , expeditions are closed. Nepal allows expeditions from the south.

1953: First Climb: Tenzing Norgay (Nepal) & Sir Edmund Percival Hillary (New Zealand) 5/29/53 via the South-East Ridge Route.

1955: Height of Everest is adjusted by 26 feet to 8,848 meters.

1960: Chinese team summits via the North Ridge.

1973: Shambu Tamang of Nepal, summits at 16 years old. Later said to be 18 or so. So is Everest!!!

1975: Junko Tabei of Japan became the first woman to reach the summit on 5/16/75 via the South-East Ridge.

1978: First Ascent without bottled oxygen: Peter Habeler (Austria) and Reinhold Messner (Italy) 5/8/78 via the South-East Ridge.

1979: China opens up the north side again.

1980: Solo: Reinhold Messner (Italy) 8/20/80 via the North Col to the North Face and the Great Couloir. He climbed for three days entirely alone from his base camp at 6,500 meters without the use of artificial oxygen via the North Col/North Face route.

1980: First Winter ascent Krzysztof Wielicki (Poland) 2/17/80.

1990: First Married Couple to summit together: Andrej & Marija Stremfelj (Slovenia), 10/7/90.

See "Facts" page 18

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

State should tailor health care to benefit the greatest number in need

TACOMA-PIERCE COUNTY
HEALTH
DEPARTMENT

Last week Gary Locke, our no-governor, came to Tacoma to talk about the present state budget crisis. We are $2 billion short of revenues to keep our state budget afloat.

Federico Cruz-Uribe, MD

How we got ourselves in this fix is a long, sad story, but there are parts of it that are worth going over.

There are several things at the heart of this mess. A troubled economy is certainly a contributor. Health care inflation also added to the cost of existing programs.

A series of citizen initiatives are a part of all this, placing limits on what government could spend and on how much it could raise in taxes each year. Initiatives also specified special areas where funds had to be spent (limiting classroom size and requiring salary increases for teachers). All in all, these measures meant less money was coming into government, and more resources needed to be put into existing parts of the system.

The bottom line is simple: There isn't enough money in the till to pay for existing services. The solutions that are coming forward are described as very complicated, but they come down to a simple notion of either raising revenues and/or changing the services that government provides.

Now you'll notice I didn't say cutting services. I said changing services, because that is one of the options.

Some elected officials have said we need to do more with less. We all know what this means for those of us who live on relatively fixed incomes. You have to look at stretching your dollars further. The not-steak-but-hamburger approach.

There is a powerful logic to this. But our state government struggles with this approach as it is all too often locked into doing business in the same old ways.

What do I really mean by the not-steak-but-hamburger approach? List the critical parts of government and then look at each one and ask how we can use a less-expensive approach, without eliminating groups of people from needed services. If it can be done less expensively in the private sector, why would we not do it that way? If it can be done in a different way, why not jump on this?

Health care is the most obvious place to look, since it is such a large part of state government. If we are short of money, what do we cut? On the table right now from the no-governor is cutting off large numbers of people from critically needed services. If we are short of money, then just push people away from services. If there is a shortage of money, then a smaller number of people can eat steak.

Sadly, we never consider having a larger number eating hamburger. Right now our rules say it is better that a small number of people receive a rich package of services and a large number receive none.

It is time we stepped out of the box and asked what will benefit the greatest number in need. The answer is clear: a basic package of health care services that can reach a broad mass of our neediest citizens.

Why the reluctance to go this way? Mostly old thinking. If it is not the same for everyone, then don't do it. We can't have two standards of care.

This is truly a luxury that we cannot afford, and it denotes a bit of hypocrisy as we already have two standards of care. We just don't admit it. Too many people who need care are going without it. We are truly in the midst of a budget crisis in government. But it really is more of a crisis brought on by a lack of new thought and new actions. We are caught in a cycle of doing the same things over and over again and expecting different results.

Please, Gov. Locke, step out of the box, throw away the rules and write better ones. Go in different directions.

Lead us out of this mess.

You can't succeed if you do what you've been doing all along. It doesn't work. Your state needs you to step out on this one. ■

Reprinted from the News Tribune, 10/20/02

Applicants for Membership

Darlene R. Coe, MD
Pediatrics
Lakewood Pediatric Associates
7424 Bridgeport Way W #203, Lakewood
253-581-2111
Med School: Med College of Wisconsin
Internship: Children's Hosp, Wisconsin
Residency: Children's Hosp, Wisconsin

Paul S. Darby, MD, PhD
Occupational/Environmental Medicine
Franciscan Port Clinic
1930 Port of Tacoma Rd, Tacoma
253-274-5521
Medical School: Georgetown University
Internship: Madigan AMC
Residency: University of Washington

George F. Gleva, MD
Internal Medicine
St. Joseph Medical Center
1717 South J Street, Tacoma
253-779-6341
Medical School: Marshall University
Internship: Brown Univ R.I. Hospital
Residency: Brown Univ R.I. Hospital

Corey Q. Hatfield, PA
Family Practice
Community Health Care
101 E 26th St #101, Tacoma
253-597-4550
Training: Medex Northwest University

Yajuan (June) He, MD
Nephrology
Pacific Nephrology Associates
1802 S Yakima #208, Tacoma
253-627-5755
Medical School: Shanghai Med Univ
Internship: UT Houston Med School
Residency: UT Houston Med School
Fellowship: UT Houston Med School

Andrei M. Ionescu, MD
Internal Medicine
Internal Medicine Northwest
316 Martin L King Jr Way #304, Tacoma
253-272-5076
Medical School: Univ of Carol Davila
Internship: N. Gh. Lupu Univ Hospital
Residency: Lincoln Med Ctr/Cornell
Addl: Danbury Hospital/Yale

Manuel G. Iregui, MD
Pulmonary Medicine/Critical Care
316 Martin L King Jr Way #401, Tacoma
253-572-5140
Med School: Colegio Mayor De Nuestra
Internship: Washington University
Residency: Washington University
Fellowship: Washington University

Daniel Kachelmyer, PA-C
Dermatology
Cascade Eye and Skin
1703 S Meridian #101, Puyallup
253-848-3000

Frank Y. Kim, MD
Urology
Urologic Northwest Surgeons
316 Martin L King Jr Way #201, Tacoma
253-383-4404
Medical School: Univ of Chicago
Internship: Cornell-Northshore
Residency: Cornell-Northshore
Residency: Cornell Medical Center

Ann M. Lee, MD
Pulmonary Disease/Critical Care
Pulmonary Consultants
316 Martin L King Jr Way #401, Tacoma
253-572-5140
Medical School: New York University
Internship: UCLA
Residency: UCLA
Fellowship: Johns Hopkins University

Elizabeth A. Lien, MD
Infectious Disease
Infections Limited
1624 S I Street #305, Tacoma
253-428-8700
Medical School: Creighton University
Internship: Creighton University
Residency: Creighton University
Fellowship: Creighton University

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Legislative Relief

Andrew Statson, MD

"Blessed are those who don't expect anything, for they shall not be disappointed."
Anonymous

Our professional associations, especially in the fields hardest hit, are trying to do something about the liability maelstrom churning our profession. Their approach is to appeal to the legislators, hoping that a new liability law would help bring premiums to a more reasonable level. I am afraid they will be disappointed, and so will all of us who expect a legislative solution to the problems created by our legal environment.

If the California experience means anything, the cost of liability insurance will not go down. It will continue to rise, even though perhaps at a slower pace. I don't know the details of the California law, but I heard a lot about the situation in Nevada. The legislature in that state recently passed a tort reform law full of loopholes. It will do little to alleviate the crisis there, even though there is a limit on the compensation for pain and suffering at $350,000. A judge, however, can set aside the limit in certain situations.

The compensatory damages are quite elastic. How can one determine loss of income for a child? How can one determine the medical costs to be incurred in the future? Of course, the lawyers claim all that is worth millions. Juries tend to be much too sympathetic, as when they award over $20 billion to a smoker who chose not to quite. Help was available, had she decided to do so. There must be something wrong with our legal system, something that will destroy us more surely than any foreign terrorism.

During the first century of our republic, physician practices were not regulated. The patients were the judges of a physician's fitness to practice. They decided whether a physician's professional knowledge, technical skill, judgment soundness and general competence were such that he could remain in practice. They did that by patronizing those physicians. Medical services were a function of the market and the customers, that is the patients, decided whether to avail themselves of those services.

"There must be something wrong with our legal system, something that will destroy us more surely than any foreign terrorism."

At a certain point, however, the practice of medicine became politicized. It did not matter any longer whether the physicians were knowledgeable, skillful and competent. They were not allowed to practice unless the state had granted them a license. Since then the practice of medicine has been based on a privilege, bestowed us by the government, rather than on rewards, given to us by the patients.

During the past thirty years, this politicization has lead to a progressively increasing regulatory burden and the liability situation is only a part of the whole picture. When the PSRO made their appearance, we had multiple private discussions about this encroachment on our practice. In a conversation while scrubbing with a senior colleague and friend, I made the point that our interests and the interests of the patients coincide. We want to take care of our patients, they want to get the care, so we should work together to oppose the requirements of the PSRO.

"No," he said, "our interests and the interests of the patients don't coincide, they are opposite."

At the time, I did not understand what he meant. I just said, "If so, there is no hope for us." He shrugged. It took me years to realize that he was right. We want to take care of the patients, but we also want to be paid appropriately for our services. The patients want the care, but they don't want to pay for it. "My insurance will pay for everything!" is a common statement.

See "Relief" page 10

Relief from page 9

When the insurance pays, the patients think that we should be satisfied. They don't care that quite often the payment we get barely covers our overhead. In all the years of practice, I had only one patient tell me that the insurance company should not have discounted my fee, but paid it in full. The work that I did was worth it. However, she did not offer to make up the difference, and I would not have had the liberty of accepting it even if she had.

So now we are forced to play ball with the politicians, hoping to win. We are not going to. Of course, they may throw us a few crumbs, just to keep us quiet, but we cannot win at that game. Only they can win it. It is their ball, their arena. They make the rules and change them as they go to suit themselves. Nobody can play that game against them and win.

Their current priorities are defense and police protection. In health care, prescription benefits for Medicare have much higher priority than increasing payments to physicians. They promised free health care to the people and they have to deliver or will be voted out of office. We are the tools they will use to make good on their promise.

Money is scarce and they are afraid to raise taxes, so they have cut down the payments to us. We don't count. Out of 90 million voters, we can command at most a million, not enough to matter. Only when our system breaks down completely, will they realize that they abused us. By then, it will be too late to save the system.

My hope is that a parallel system of free market health care will develop before things get that bad. There are alternatives. In Australia and in France, private physicians can bill the patients directly, who then submit their request for reimbursement to the health care system. The state pays them according to its fee schedule, which could be as low as 50% of the actual physician fees.

Another option for us is to refuse all insurance contracts and accept only patients willing to pay our fees. Some of our colleagues have done that and reportedly are satisfied with their decision, but most of us will have difficulty earning a living, especially in the surgical specialties. The charges for surgical procedures are high and very few patients are able to pay them.

The first step for us is to realize that our standing in the political arena is very low. Then we can start looking for alternatives and prepare to drop out of the political game. I apologize to being so pessimistic. I think things will have to get much worse before they get better, Yet I remember a saying, "When it gets darkest, the stars come out." Any volunteers for a trip to another planet? ■

Inaugural New Member Reception spells success

New PCMS members were invited to meet board members and staff and see the PCMS office at the new member reception held on Wednesday, October 16. New members that joined within the last year were invited to attend.

New surgeons and dermatologists; a family practitioner, radiologist, neurologist and others were in attendance, all looking to meet colleagues and find out more about PCMS.

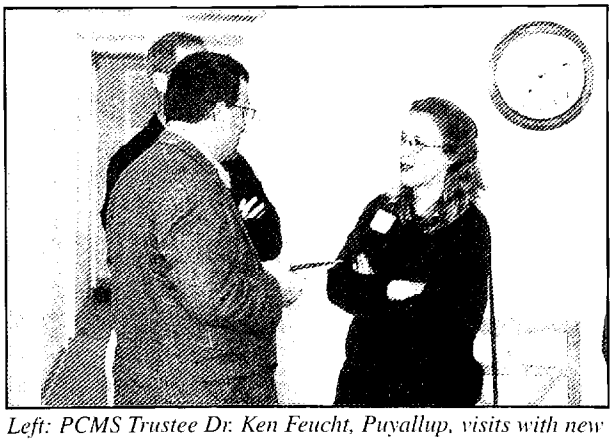
The new member reception is part of the new membership protocols adopted by the PCMS Board of Trustees in May of this year. Looking to simplify the application process and reach out to new members, the idea of the reception was readily accepted as part of the new process. Receptions will be held once or twice each year to meet and welcome new members to the community and/or the Society.

PCMS no longer credentials physicians that apply for membership but does require a copy of their state medical license. This has greatly reduced the length of time between application and approval for membership. What used to take six months or longer now takes only a couple of weeks to process. The change has saved time and money for PCMS, particularly given that most universities and medical schools had started to charge for copies of paperwork and references.

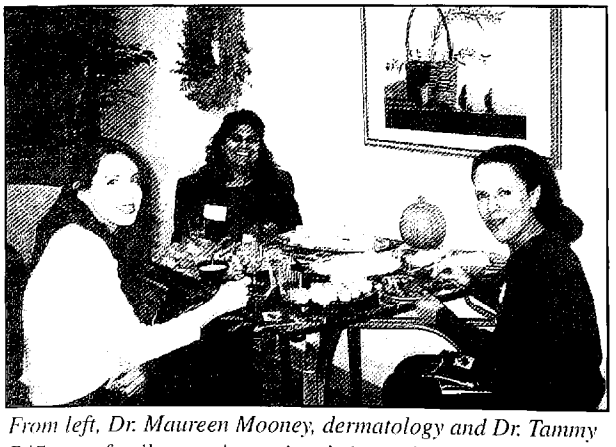
PCMS has processed 48 new member applications between January and September of this year.

PCMS welcomes all new members and invites them to be active in all Society activities. If you would like to be more involved, please call any Board of Trustee member or Sue Asher at the Society office, 572-3667. ■

Left: PCMS VP Mike Kelly, MD, visits with new Federal Way radiologist Dr. Alexander Serra and his wife Susan



Left: PCMS Trustee Dr. Ken Feucht, Puyallup, visits with new member Leaza Dierwechter, MD. Both are general surgeons.



From left, Dr. Maureen Mooney, dermatology and Dr. Tammy D'Souza, family practice, enjoy their meal with Physician Assistant Patricia Ferrer.

WSMA testifies against Premera conversion

Editor's Note: This testimony was given by the Washington State Medical Association to the Insurance Commissioner and Attorney General at a recent town hall meeting.

On behalf of WSMA, which represents over 8,800 physicians and surgeons, I am here to testify in opposition to the conversion of Premera from a not-for-profit insurance company and to ask you, as regulators, to substantially slow the process of investigation so that organizations have the opportunity to more carefully review this conversion.

At our recent Annual Meeting in Tacoma, the association's House of Delegates unanimously adopted a resolution to oppose the Premera Conversion.

Our House of Delegates is comprised of physicians from every county and every medical specialty society and practice in every type of setting, from academia, to large groups to individual practices.

If Premera converts to investor owned status, physicians across the state fear that the company's attention will turn from concern for its subscribers and network of physicians and hospitals to increasing financial returns to the company's shareholders.

It is a hard reality that management in such a company structure has the fundamental fiduciary obligation to its many investors, both individual and institutional -- to maximize the return on their investment.

Management asserts that the best way to do this is through offering a price competitive product that meets consumers' needs and which includes a satisfied, viable network of suppliers -- physicians and hospitals.

However, as management's interest turns to increasing profits, our members are certain that it will come at the expense of Premera's participating physicians and hospitals, which are all struggling right now.

Here are some of our concerns:

• In areas of Washington State where Premera is functionally a single payer -- such as Eastern Washington -- what impact will this conversion have on the market and the physician and hospital network? We feel it will be negative and will reduce fees for services, or, worse yet, the company will leave a market where it cannot realize a "sufficient" return on investment to satisfy new stockholders.

• What exactly is the thinking of management on why it needs to convert to for-profit status? Exactly how threatened is the plan? To what use will the newfound capital be put? The experience nationally seems to be that capital raised through such conversions has been used to acquire other plans.

• Is Premera positioning itself to be an acquisition target by such large multi-state insurers such as Wellpoint or Anthem? If shareholder value would be increased through such a sale, how could Premera not sell -- despite what corporate leaders say at this time?

• Will more attention be toward "growing the company" to make it a more attractive acquisition target than to attending to the needs of its subscribers and network in our state?

• As a for-profit company, will subsequent stock offerings be used to enrich senior management?

• What will happen to Premera's commitment to Healthy Options and the state's Basic Health Plan?

Finally, we ask both the Commissioner and Attorney General to insure -- should you be inclined to grant this conversion request -- that the assets of Premera be preserved in a not-for-profit organization or foundation supporting the health of the community. ■

Retired Member Luncheon

Retired members and their spouses/guests gathered at the Fircrest Golf Club on Friday, October 18 to hear **Dr. Stan Sollie** and his wife Dagny share tales from their recent trip to South America. After lunch, Dr. Sollie moderated a video presentation highlighting their tours of the Amazon River and Peru's Machu Picchu.

The video superbly demonstrated the day to day details of the trip. The steep, long, windy roads leading to Machu Picchu were real enough to convince many that this might not be the first place on their list to visit. And, the heat and wilds of the Amazon were truly apparent in watching the day to day events that unfolded on film.

Dr. Sollie's knowledge of the Amazon River and the history of Machu Picchu, that accompanied the video, made his presentation very interesting and worthwhile.

Retired members have repeatedly confirmed that they prefer to have travel or hobby related topics for speakers at their quarterly luncheon meetings. If you are willing to share your travel stories with the group, or have a hobby to share, please call the Society office, 572-3667. ■

Left: Dr. Dave Hopkins visits with Dr. Stan Sollie after his excellent presentation about the Amazon and Machu Picchu

Left, Dr. Harold Johnston and his wife, Mary, visit with Mrs. Dagny Sollie about their fascinating trip

Trend from page 4

Some large primary care groups also are thriving, although James Ferrara, MD, a pediatrician and CEO of Bay Area Pediatric Medical Group in northern California, said his 16-physician group thrives in part because it is divided into three business units.

The group has a side business -- handling collections for Bay Area Family Practice.

Meanwhile, Drs. Hoddinott and Gee are hoping that the small-practice model will give them the income and job satisfaction they thought they would find in a large practice.

"This is my last gasp, or it's off to New Zealand I go," Dr. Hoddinott said. "If you had told me a year ago that we would be setting up a whole new practice, I would have told you you're crazy."■

AMNews, 11/04/02

Bigger not necessarily better

Merritt, Hawkins & Associates, a physician recruitment and placement firm based in Irving, Texas, conducts an annual review each year of the placements it helped facilitate. The data -- the firm conducted about 2,200 searches nationwide last year -- show more positions are being filled in smaller settings than they were five years ago, while placements in group and hospital settings are down. Merritt Hawkins officials say this is evidence of a trend toward smaller practices.■

	1997-98	1998-99	1999-00	2000-01	2001-02
Group	53%	53%	43%	40%	41%
Hospital	16%	15%	20%	15%	14%
Solo	16%	16%	16%	22%	16%
Partnership	9%	10%	15%	17%	22%
Association	2%	2%	3%	4%	3%
HMO	1%	1%	2%	1%	1%
Other	3%	3%	1%	1%	3%

Source: Merrit, Hawkins & Associates

COLLEGE OF MEDICAL EDUCATION

Whistler Condo Reservations Deadline 12/1

CME at Whistler participants are urged to make their condo reservations early. Reservations for the block of condos, ALL IN THE ASPENS, are available. To take advantage of these savings, you must make your reservations soon, as conference dates are during the high ski season. The College's reserved block of rooms will be released after December 1, 2002.

Reservations can be made by calling toll free at 1-800-777-0185. You must identify yourself as a part of the C.O.M.E. group. For more information call the College at 627-7137. ■

ID Update set for November 8

The annual Infectious Diseases Update is set for Friday, November 8, 2002. The very popular course will return this year to the Sheraton Hotel - in the hotel ballrooms.

The program is directed by **Jim DeMaio, MD** and will feature nationally known expert Dr. David Spach joining Infections Limited physicians as they give presentations on specific disease areas. The course is designed as an update on common outpatient and inpatient infections. ■

Continuing Medical Education

Gastroenterology for Primary Care CME Registration Open

Registration is open for the Gastroenterology for Primary Care CME program set for December 6, 2002. The course will be held above the Tacoma Sheraton Hotel in the Tacoma Convention Center.

The program is directed by **Ralph Katsman, MD**. He has assembled mostly local gastroenterologists to present on the timely and appropriate subjects. The program is complimentary and offers 6 Category 1 CME credits.

The program brochure was mailed in early November. Subjects planned include:

- Abnormal Liver Enzymes, NASH & HCV Update
- Dyspepsia
- IBS: New Answers for the Challenging Patient
- GERD: Treatment Options
- Diagnosis and Medical Management of IBD
- Tales from the Other Side: GI Hospital Medicine
- Colon Cancer Screening : Who, When, Why ■

Dates	Program	Director(s)
Friday, Novmber 8	Infectious Diseases Update	James DeMaio, MD
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Monday, January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Peak from page 6

hours before making the 16-hour aggressive climb to the highest point. At 29,000 feet, they encountered the Hillary Step. "To climb the Hillary Step," Edwards said, "you have to remain focused, concentrate on breathing, and take one step at a time. It's tough going. Your crampons are scraping on the rock because there is only about a quarter inch of snow. You can't see your feet because of the oxygen mask, and it's 10,000 feet down on each side."

Finally, on his fourth attempt at climbing Mt. Everest, Edwards reached the summit on May 24, 2001. "You are on top of the world," Edwards said. "You feel like you can reach up and touch the stars."

Edwards explained that the climb to Everest doesn't end at the summit and is truly a round-trip experience. "It's a very emotional experience coming down," he said. Additionally, as guide director, Edwards was responsible for getting each member of his team off that mountain. "The adventure wasn't over until everyone was safely back to camp," he said. "And the route down is not an easy one. It is always changing. You never know what to expect. One thing is certain, though - the mountain does not loosen its grip on you until you're off it."

Since the first successful ascent of Mt. Everest by Edmund Hillary and Tenzing Norgay in 1953, 142 people have perished trying to climb the peak. "Why do people put themselves at such risk?," Edwards posed. "You all have taken challenges and risks to do things in your lives. These people are not much different."

"It's all about challenge and attempting things that are seemingly impossible," Edwards said. On the mountain at the same time Edwards and his team were making their climb were the first blind climber to reach the summit and the oldest individual (at age 64) to make a successful climb.

With the team safely off the mountain and back in Katmandu, it was time for celebration. Sherpas opened their doors and entertained in their homes. The group gathered at Rumdoodle, a local restaurant, where all those who successfully climb Mt. Everest are given the honor of signing a board and becoming members of that very limited and elite group to have conquered the peak. "I had always thought about signing my name on that board," Edwards said. "I finally got my chance in 2001."

Jason Edwards can be reached via email at Jason@mountainexperience.com. Highlights of his 2001 Everest climb, as well as other recent expeditions, can be accessed via the Puyallup School District's web site at http://everest.puyallup.k12.was.us. ■

MAMC Alumni Association

Madigan Army Medical Center is interested in starting an Alumni Association for past physicians and other health care providers. If you were ever stationed at Madigan for training or as staff and are interested, please contact Ms. Louise Hammond, Secretary to the Deputy Commander for Clinical Services, Madigan Army Medical Center at (253)968-1190. ■

In My Opinion....

by Teresa Clabots, MD

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

Redefining the Meaning of Success (Delayed Gratification)

Teresa Clabots, MD

When I was little growing up in St. Louis, one of my most cherished memories was whenever we were able to scrape up fifty cents and four of us children would get on a paddle boat for an hour at the small lake in Forest Park. Imagine the ungodly heat of a St. Louis summer, with your clothes sticking to you, and your hair soaked and sticking to your neck, yet on the paddle boat there was a nice cool breeze, no mosquitoes, and we managed to spray each other with cool refreshing lake water. The time just flew by as we took turns paddling. I wanted so much just to have two more quarters so we could extend those happy moments by another hour.

I worked in restaurants through high school, fully aware that food was a priority for survival, and the owner gave me all the left over food at the end of the night. I would then bicycle home loaded with whatever had been the special of the day, and a left over pie balanced on one hand carefully guiding the handlebars with my free hand. This was the only way I could consume enough calories to be on the swim team.

Then I went off to college, raising money by selling my blood, and working in the hospital chemistry lab to pay for my room and board expenses. Medical school was yet another stint at delayed gratification, taking extra call and moonlighting at the city hospital delivering babies to earn money. When we were married, I got a wedding band, but no diamond engagement ring, since we couldn't afford one.

I still remember when my husband got his first paycheck as a resident. We bought a down comforter to ward off the freezing winters and fixed the tiny ring my mother had given to me, which had needed repair for six years.

We worked as residents, moonlighted at the local hospitals, and together managed to scrape enough money to buy our first small home. Our biggest expense was childcare. But early on we opened the kids' college accounts, since our gift to them was going to be a completely paid-off education before they went into the real world.

I finished paying for my medical school at the age of 40. At 43 we stared paying for my eldest's college tuition.

Medicine has changed a lot in the last 20 years. I never thought it would be this frustrating. If someone had put in four years of medical school, then residency and then a fellowship, and then made as much money as a nurse, I would not have believed them. Yet that is exactly what happened to me. In particular, reimbursement to many physicians has fallen so much that there are fewer and fewer applicants to programs with long residencies. The answer by the government is to graduate more and more paraprofessionals.

I predict there will be unimaginable shortages as the doctors in my generation, fed up with managed care, quit and the babyboomers also enter retirement age. I can't tell you about how many have quit already.

There is a diaspora of female physicians who have abandoned medicine. The female family practitioner who became a realtor, the female surgeon who became an editor, the pediatrician who became a stay at home mom, the female cardiologist who became a politician. What a shame and what a terrible waste of all that knowledge.

And I have come to redefine success, not as to what I earn, but instead I look at my children as they grow, and I will be fulfilled in this lifetime if my kids are honest, kind people who find a soulmate to be the love of their life and find happiness in their work. That is a mother's wish.

And yet a part of me always wanted and yearned for that paddle boat. So we finally got one. Come over and take a free ride in my dream boat. The kids and their friends love it. ■

Facts from page 6

1990: First son of a summiter to Summit Everest: Peter Hillary (New Zealand) 5/10/90.

1990: First father and son to summit together: Jean Noel Roche and his son Zebulon. They flew together on a tandem paraglider from the south Col. They landed at base camp on the 7th of October 1990.

1992: First case of two brothers who reach the Summit together: Alberto and Felix Inurrategui September 25, 1992.

1996: Ang Rita Sherpa (born 1947), Summits Everest for the 10th time. All ascents were oxygen-less.

1996: North Side: Fastest Ascent via the standard North Col-north ridge-north face Route: Hans Kammerlander (Italian) 5/24/96, 16 hours 45 minutes from base camp. He left BC at 6400 meters at 5pm on May 23, 1996 and was on the Summit 16 hours 45 minutes later at 9:45am the next day. He descended most of the route on skis.

1999: Babu spent over 21 hours on the Summit of Everest.

2000: First true Ski descent: Davo Karnicar

2000: Speed Record Nepal Side: Babu Chiri Sherpa

2000: Apa Sherpa Summits for the 11th time.

2000: Oldest woman: Anna Czerwinska (born 7/10/49) climbed Everest from Nepal side on 5/22/2000.

2001: Roche Bertrand and his wife Claire Bernier Roche flew together on a tandem paraglider from the North side Summit of Everest. The paraglider arrived at ABC 8 minutes later...This first husband and wife to fly from the Summit together !

2001: Stefan Gatt the first to Snowboard from the Summit of Everest.

2001: Marco Siffredi on his Snowboard completed the first-ever descent of Everest on a snowboard from the Summit to ABC.

2001: American Erik Weihenmayer becomes the first ever blind person to Summit Everest. ■

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

Directory Changes

Please make note of the following changes to your 2002 PCMS Directory

Joan Halley, DO
Change office suite number to: #220

Thomas Irish, MD
Dr. Irish will be retiring December 31, 2002. He will continue doing surgical assists and IME exams.

Classified Advertising

POSITIONS AVAILABLE

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

Seattle, Wash - Occupational Medicine. Outstanding opportunity for B/C or B/Q US residency trained occupational medicine physician. Located just 30 minutes from Seattle, this growing, full service program provides excellent salary and full benefit package. Full or part time positions available. Please fax your CV to 866-264-2818 or email to providerservices@multicare.org. For more information, please call 800-621-0301. Website: www.multicare.org.

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Price Reduced. Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

OFFICE SPACE

Medical space for sale and/or lease in rapidly growing South King County with 85,000 population service area. Need for pulmonary, pediatric, dermatology, orthopedic and gynecologic specialties. Call 360-825-1389.

Bayview Medical. North End Tacoma. 3,500 sq ft. Nine exam rooms, x-ray and lab, reception area, ample storage and parking. Call 253-752-6150.

For Lease: New office space located in Fircrest. 4,000 sq ft or less, no B&O tax. Call 564-8784.

GENERAL

University Place 2 BR/2 BA condo in small park-like setting. New carpet, paint, bathrooms. Attached one-car garage/auto opener. Available October. $1050/month. 565-8634.

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Pierce County Medical Society

BULLETIN

December, 2002

INSIDE:

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

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

Managing Editor: Sue Asher
Editorial Committee: MBI Board of Directors
Advertising Information: 253-572-3666
223 Tacoma Avenue South, Tacoma WA 98402
253-572-3666; FAX: 253-572-2470
E-mail address: pcmswa@pcmswa.org
Home Page: http://www.pcmswa.org

Pierce County Medical Society

BULLETIN

December, 2002

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President's Page

by Susan Salo, MD

Year's End

Susan Salo, MD

After a glorious autumn, we are truly dwindling down to the year's end - annual meeting time with changing of the guard, a new president and officers.

In January, at our trustees' retreat, we decided on several priorities for attention over the year and into the future:

WSMA has concentrated on practice survival this year, with many excellent programs, and PCMS chose to remain aligned with their administrative simplification efforts for physician practices. PCMS organized meetings for referral coordinators in efforts to streamline the process and improve communications between offices. The monthly TAMM (Tacoma Area Medical Managers) group continues to meet.

We wanted to accelerate and smooth the membership application process and become more welcoming to new members. We developed a new membership policy manual, including recruitment and retention guidelines, produced a new membership brochure and application, eliminated the Credentials Committee and the credential requirement for membership, and incorporated "New Member Receptions" (planned semiannually) at the office.

We wanted to simplify the officers' meeting schedule and have started by combining the Executive Committee meetings with the trustees' meetings for most of the year.

The Society needed a policy and procedures manual, and the director has begun development, and has brought several policies to the trustees for approval and incorporation. This will be a continuing process.

We have attempted to introduce our members to the legislative process by sponsoring meetings with legislators in several districts. These have been well attended, and will, I hope, allow us to start communicating more effectively with our lawmakers.

And, of course we have maintained all of our ongoing activities and continued the work of our three subsidiary corporations. The College of Medical Education and their mission of providing accredited CME programs, Membership Benefits, Inc., and their excellent work in the employment and publication arenas, and our newest organization, the PCMS Foundation, which raises funds to distribute to local non-profit organizations that primarily provide low or no cost health care and social service needs. At the onset of the recession a substantial decrease in business required cost-cutting and downsizing of MBI, but volume has resumed and we are now again stable.

One area that I had pledged myself to address, but have neglected, is "The Fish-Head Guy." As pointed out by **Dr. Patrice Stevenson** last year, this logo is a rather dated and (should I be honest) a rather pathetic logo for our Society. This will, however, await a future administration.

This year, which I can now admit I approached with some trepidation, has passed very quickly. I would like to thank so many people for guidance and help, but this column cannot be extended to include them all.

There is much more to do, and next year's president, **Dr. Jim Rooks**, will do a superb job of leading us into the future. ■

HealthSouth due for rehabilitation

HealthSouth, which spent the 1990s aggressively building the nation's largest chain of rehabilitation facilities and outpatient surgery centers, is in need of some rehabilitation itself.

The Birmingham, Alabama based company, which owns 1,900 centers spread over all 50 states and a few locations elsewhere, has suffered compound fractures over the last year. The most severe was because CMS clarified how physical therapy services would be billed and the company's revenue declined by $175 million in 2002. Things only got worse from there.

Historically, companies that grew too fast suffered under some combination of an inability to integrate their acquisitions into a cohesive whole, a propensity to upset physicians by cutting corners in paying for care, or questions over whether they're over-billing Medicare or other insurers to keep earnings growing to Wall Street's satisfaction. The real key, however, is how the company is being managed. Whether it is big or small, you have to pay close attention to business policy and financial policy.

One disturbing sign for all of the for-profit health care companies is that many seem to be on an acquisition binge again. Tenet and HCA, in particular, have been expanding hospitals or buying more of them. This is something that there is concern about because too aggressive acquisitions have gotten companies in trouble in the past.

HealthSouth is not the only health care service company that has stumbled in recent years.

• HCA, formerly known as Columbia/HCA, was the subject of a Justice Department investigation during the 1990s, which charged the for-profit hospital company of defrauding Medicare by listing expenses in its cost reports that Medicare did not cover. In 1997 they pleaded guilty to committing Medicare fraud and paid $840 million in fines and penalties. They sold off many of their hospitals and ambulatory centers, brought in new management and hired an executive to focus on corporate ethics.

• MedPartners, the physician practice management company, declared bankruptcy in 1999, a year after rival PhyCor withdrew an $8 billion offer to buy the company because of MedPartners' shaky finances. In 2000, KPC Medical Management, declared bankruptcy and shut down many clinics, forcing 250,000 patients to find other places to receive medical care.

• PhyCor sold its last multispecialty clinic in 2001 and declared bankruptcy earlier this year. The company recently emerged from Chapter 11 bankruptcy proceedings with a new name, Aveta Health

• Behavioral health care giant Magellan Health Services, Inc., is struggling with $1 billion in debt.

• Tenet Healthcare Inc., a large hospital chain, is under HHS investigation for its unusually high outlier billing. The FBI is also investigating two Redding, CA cardiac surgeons for allegedly performing unnecessary heart surgeries. ■

Excerpted from AM News 12/2/02

Personal Problems of Physicians Committee

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

Your colleagues want to help

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

Confidentiality Assured

The Health Status of Pierce County

Federico Cruz-Uribe, MD
Director of Health

Bioterrorism Prevention for Pierce County

Federico Cruz-Uribe, MD

Since September 11, the threat of bioterrorism, long ignored or denied, has heightened. Two potential bioterrorist agents are of special concern - anthrax and smallpox. Anthrax, as we saw last fall, is aerosolizable and the threat is effective in terrorizing the public. The *variola* virus can also be created in an aerosol form and is both stable in that form and apparently requires a low dose to cause infection. And with a mortality rate as high as 30%, smallpox has been called the most dangerous of potential biological weapons. Under direction from the state Department of Health and the Centers for Disease Control, the Tacoma-Pierce County Health department is currently developing plans for both pre-event and post-event inoculation for smallpox.

The National Smallpox Prevention Plan calls for several actions to control the spread of smallpox if it is intentionally released. The first strategy is traditional public health: surveillance. Medical personnel observing a suspicious rash in a patient should contact the Health Department (253-798-6410). A suspicious rash is one that is most dense on the face and extremities, with lesions of equal stages of development on adjacent areas of the skin. In chickenpox (*varicella*), the disease most likely confused with smallpox (*variola*), the lesions appear in crops every few days, so lesions are at different stages of maturation, even in the same area. Chicken pox lesions are unlike smallpox in that *varicella* are much more superficial, centripetal, and rarely found on palms and soles. A good website for learning details about diagnosing smallpox is: http://www.cdc.gov/nip/ed/smallpox-trg/clinician-should-know/default.htm.

"Communities are expected to develop Smallpox Response Teams, to investigate and facilitate the diagnostic work-up of initial suspect cases and to commence control measures...TPCHD is developing the list of public health and hospital/medical staff for this group, which could be vaccinated as early as later this month"

The next strategy for smallpox control involves isolation of infected people and inoculation of household or other close contact. Details about where people with smallpox would be quarantined in Pierce County have not been finalized, but several sites are under consideration and will be shared with the medical community once decisions are made. In addition to where isolation occurs, who will be involved in providing medical evaluation and care is being planned. Under the plan, communities are expected to develop Smallpox Response Teams, to investigate and facilitate the diagnostic work-up of initial suspect cases and to commence control measures. These teams will include people who would administer smallpox vaccines to contacts as well as follow-up on treatment and investigate other possible cases. Since these individuals will have direct patient contact, they will need to be vaccinated prior to an outbreak. TPCHD is developing the list of public health and hospital/medical staff for this group, which could be vaccinated as early as late December, 2002.

To protect first responders (emergency room personnel, emergency medical staff, and others), the to create a larger team of public health responders, once the first group of people is vaccinated, this second, larger group will be inoculated.

In the event of an outbreak, a corps of public health and medical personnel could be called upon to vaccinate thousands of people, within the

See "Prevention" page 14

Applicants for Membership

Peter M. Benda, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle 98124
206-622-7747
Med School: University of Washington
Residency: University of Washington

Yuriy J. Bilan, PA-C
Family Practice
Community Health Care
253-404-0737
3611 S D Street, Tacoma 98418
Training: Medex NW, Seattle

David A. Cameron, MD
Family Practice
Community Health Care
9112 Lakewood Dr SW #203, Lakewood
253-589-7030
Med School: University of Washington
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Armando J. Garcia, PA-C
Family Practice
Community Health Care
101 E 26th St #100, Tacoma 98421
253-597-4550
Training: Seamar Clinic, Mt. Vernon

Neil R. Hannigan, MD
Internal Medicine/Nephrology
1624 S I St #200, Tacoma 98405
253-272-5881
Med School: McMaster University
Internship: University of Calgary
Residency: University of Calgary
Fellowship: University of Ottowa

George F. Jackson, III, MD
Psychiatry
Rainier Associates
5909 Orchard St W, Tacoma 98467
253-475-6021
Med School: Drew/UCLA
Internship: Duke University
Residency: Duke University

Michael H. Kalnoski, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle 98124
206-622-7747
Med School: St. Louis University
Residency: University of Washington
Fellowship: University of Washington

Dennis J. Kim, MD
Internal Medicine
Tacoma Medical Clinic
9312 S Tacoma Way #150, Lakewood
253-588-0370
Med School: Loma Linda University
Internship: Emory University
Residency: Emory University

Nurit Licht, MD
Family Practice
Community Health Care
101 E 26th St #100, Tacoma 98421
253-597-4550
Med School: Dartmouth
Internship: Lawrence Family Practice
Residency: Lawrence Family Practice

Michael A. McNutt, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle 98124
206-622-7747
Med School: University of Minnesota
Residency: University of Washington
Fellowship: University of Washington

Kenneth A. Meckler, MD
Pathology
Puget Sound Institute of Pathology
1717 S J St, Tacoma 98405
252-591-6713
Med School: University of Washington
Internship: University of Washington
Residency: University of Washington
Fellowship: University of Washington

Larry K. O'Bryant, MD
Pathology
Pathology Associates of Tacoma
315 ML King Jr Way, Tacoma 98405
253-403-1043
Med School: USUHS
Internship: Brooks AMC
Residency: Tripler AMC

Timothy Panzer, MD
Family Practice
Community Health Care
101 E 26th St #100, Tacoma 98421
253-597-4550
Med School: University of Washington
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Narinder Sandhu, MD
Family Practice
Community Health Care
1102 S I Street, Tacoma 98405
253-597-3813
Med School: MGIMS, India
Internship: Frances Newton Hospital
Residency: Polyclinic Medical Center
Fellowship: California Hospital Med Ctr

David A. Velling, MD
Anesthesiology
Rainier Anesthesia Associates
400 E Pioneer Ave #208, Puyallup 98372
253-445-5828
Med School: U of Southern California
Internship: LA County-USC Med Ctr
Residency: LA County-USC Med Ctr
Fellowship: Mayo Clinic

In My Opinion.... The Invisible Hand

by Andrew Statson, MD

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

Universal Coverage

Andrew Statson, MD

"Every time the government attempts to handle our affairs, it costs more and the results are worse than if we had handled them ourselves."
Benjamin Constant (1818)

Dr. Charles B. Hammond is the newly installed president of ACOG. In his address to the fellowship at the annual meeting in May, he called for basic health coverage for all, to include preventive and obstetric care and medications. He did not say who will arrange for such coverage and who will pay for it, but the usual implication in such statements is that the government will arrange for it and the taxpayers will pay the bill. "We are the only developed nation in the world," he said, "who does not provide at least basic health care for all its citizens." Of course, that may mean we are smarter than the others, but again, maybe not. To find out, we should look at their health care systems and see how they fare. Almost all of the following was reported by *Reuters Health News*.

The Japanese prime minister, Junichiro Koizumi, reported that the health insurance system has run short of money, but he has vowed to rein in the budget instead, to avoid further inflating the massive national debt.

The public health insurance system in Germany covers about 90% of the population. It had a deficit of 2.8 billion euros in 2001, which triggered a sharp increase in the monthly health insurance premiums in January to an average of 400 euros per person per month. In spite of that increase in premiums, the public health insurance groups reported another deficit for the first quarter of 2002, so that another large increase in premiums next year is very likely.

At the same time, the average premiums charged by private insurance companies is 200 euros a month. Germans who earn over 3400 euros a month can opt out of the public system and have done so in large numbers. Of course, the claim is that younger and healthier people opt for private insurance.

It is also stated that the public insurance system has legislative mandates to offer a certain coverage, nearly identical to all. For instance, medically required treatment at resort spas is covered for up to three weeks every three years. That includes "father-mother-child" spa treatments. Health insurance must cover the cost in full, including per diem. At the same time, the private companies can write policies to fit the needs of their customers.

A big expense is the cost of drugs, and public spending of drugs increased 11.5% in 2001. For this year, Health Minister Ulla Schmidt asked the physicians to cut down prescription drug costs by 5% compared to last year. According to current reports, they will not be able to do that and drug expenditures are expected to rise by another 5%.

The Austrian coalition government is divided over the health insurance crisis there. Medical costs are paid by *Krankenkassen* (illness funds), which are state-owned. People are covered according to where they live or work. Each fund charges differently, for instance with copays when a hospital visit is made, so that some funds get more money from subscribers and have a solid balance sheet. Others, primarily in the big cities, have had more generous benefits and are now facing bankruptcy. The Health Ministry proposal is to strip the wealthy funds to bail out the bankrupt ones, rather than to increase the budget.

I have talked with enough Canadian colleagues to know that their system is underfunded. They are paid set amounts and when their costs go up, for instance with rising liability premiums, they cannot meet their expenses.

The same situation is present in Australia. United Medical Protective went into receivership earlier this year. Dr. Kerryn Phelps, president of the Australian Medical Association, wants to see an end to the notion that patients have the basic right to sue their doctors. She said there is a crisis in every country that has medical litigation. That is only part of it. Physician costs in general have outstripped the Medicare payments. Many family physicians are forced to charge patients a fee exceeding the government rebate, so they

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Coverage from page 7

can meet their expenses. They are allowed to charge patients directly and let them seek reimbursement from the government program.

The Italian government plans to introduce private health insurance in the form of mutual aid associations based on compulsory individual contributions. The reimbursement for drugs will be limited and patients wanting a specific drug will have to pay for it.

French physicians also may charge patients directly. The government program reimburses at the official schedule, which is about 50% of actual fees. Even so, France expects a health system deficit of 3.3 billion euros in 2002 and 4.6 billion in 2003. To cut costs, reimbursement for drugs will be at the price level of generic drugs. So-called ineffective medications will not be covered.

Sir Anthony Grabham, president of the British Medical Association said that the publicly funded National Health Service is beyond repair. "Looking at the lowest third of NHS performance, we are, in terms of availability, verging on Third World medicine in what is one of the most affluent countries in the world."

After 50 years of underfunding, the patients face interminable hospital waiting lists, crowded emergency rooms and disillusioned staff. Patients go to private hospitals to have the operations they want and pay out of pocket or with the help of private insurance. Surgeon Julian Elkington said, "It's heart-breaking, but now the truth has escaped - the NHS is falling to bits."

The situation in all developed countries is the same. They all are chronically underfunded and many patients seek private care and pay the charges. Is there anything above worth emulating? Apart from the option of direct billing to patients and having them be reimbursed by Medicare or Medicaid, nothing. Perhaps we can do better. After all, we are Americans, the most prosperous nation on Earth.

Look at our record. Does anyone out there think that Medicare and Medicaid are not underfunded? Currently there are 45 million people covered by Medicare and 25 million by Medicaid. There is a significant overlap between the two, since many patients have both. The actual number of people covered by the government programs is of the order of 60 million. The combined health care expenditures of the federal and state governments are of the order of 600 billion, or ten thousand dollars per patient per year, over $800 per month.

According to Pointshare, the overall cost of administration is .33 cents of every health care dollar. J.D. Kleinke wrote an editorial in *Barron's*, published 6-17-02, titled *How to Revive Health Care*, in which he gave an estimate of the administrative costs at 40% out of total expenditures of $1.3 trillion. That makes them $520 billion. Considering that only 22% of the population is covered by the government, whose overhead is higher than for private plans, what would the administration's share of costs be if the government covered

See "Coverage" page 14

WSMA and AMA News Briefs

The WSMA's *Annual Legislative Summit* will be held Monday, February 3 in Olympia. The stakes have never been higher. Please urge your colleagues to attend. This year's program is being held on Monday to reduce your time out of office for those traveling from outside the Puget Sound basin. Please watch your mail or fax for further info or call the Pierce County Medical Society office.

The AMA Interim Meeting will focus on advocacy and legislation as the national association seeks to streamline the work of its House of Delegates. Reference Committees have been winnowed down to five. There will be a major report on the AMA's work to morph itself into an "Organization of Organizations" - which has been supported by the WSMA. The WSMA delegation will take three resolutions to the meeting, based on action taken by the WSMA House of Delegates last September:

• National Regulation of Health Insurance Markets - directs the AMA to study the benefits and risks of national health insurance regulation, and report back to the House by its December 2003 meeting, and to adopt the policy of supporting a repeal of the McCarran-Ferguson Act (the Act, passed in 1945, declares that federal antitrust laws shall not cover the business of insurance as long as it is regulated by the states).

• Nationalized Medicaid Study - directs the AMA to study the benefits and risks of a nationalized Medicaid program, and report back to the AMA House by its December 2003 meeting.

• Tax Exemption for Health Insurance Paid for by Employers - directs the AMA to pursue across the board equitable tax-exemption for health insurance premiums.

***"Healthcare at Risk in Turbulent Times"* is the theme of the May 9-10 WSMA Leadership Conference** which will be held in Lake Chelan. Program highlights - as of this printing - include:

Friday, May 9
Leadership Training Institute - Susan Reynolds, MD, PhD
Plenary Session: *"Over the Horizon: The Shape of Things to Come"*
Breakout Sessions on:
- Effective Media Techniques
- Oral Storytelling: The Art of Making Effective and Entertaining Presentations
- Personal Financial Planning
- Financial Decision Making

Saturday, May 10
Plenary Session (TBD)
Breakout Sessions on:
- Technology Forum: What's New in EMR's and Wireless
- Quality Forum: Aligning Incentives and Quality Improvement; Who's Doing What and What Kind of Deals Are They Making
- Safety Forum: The Latest from Leapfrog and Patient Safety Coalition; Communicating ■

Continuing Medical Education and Mariner's Spring Training - Join us in Phoenix on March 5-9, 2003

The College of Medical Education has confirmed the dates of March 5-9, 2003 for its CME program in Phoenix. The actual course is the mornings of March 6-8. **Richard Hawkins, MD** is the program director.

The Mariner Spring Training schedule was released just last week with the Mariners **playing games in the nearby home Peoria stadium for all the days of our planned meeting**.

As part of planning, the College has selected the Embassy Suites Phoenix/North for conference headquarters. The large and beautiful hotel is conveniently located close to the Mariners Peoria stadium and offers greatly reduced and competitive rates for complete two-room suites that include a private bedroom and separate living area with sofabed. You can make your reservations by calling the hotel directly at 602-375-1777 or 800-527-7715. Be sure to mention you are with the College of Medical Education.

Flights to Phoenix during March often sell out in advance. In order to assure that you will have seats, we urge you to make reservations soon.

All Wanderlands Travel (new home of Olympus Travel) is handling the flight arrangements. Specifically, MARILYN is prepared to assist you in securing these seats. Please call Marilyn at 572-6271.

The program brochures will be mailed soon. Start fresh with the Mariners in March 2003. ■

Tentative Mariners 2003 Spring Training Schedule:
March 6 v. Oakland @ Peoria
March 7 v. San Francisco @ Peoria
March 8 v. Kansas City @ Peoria

COLLEGE OF MEDICAL EDUCATION

Primary Care 2003 CME set for February 7

A new COME program designed for the primary care physician is set for February 7.

The one-day program will feature speakers who will focus on timely subjects faced in the daily routine of the primary care practice.

The course is directed by **William Knittel, MD.** ■

Whistler CME Lodging Still Open - Today!

At press time, both condos at the Aspens and rooms at the Chateau were still available for the CME program set for January 22-26, 2003 in Whistler - at the College's discounted rate.

To make reservations, you may call the Aspens at 1-800-777-0185 or the Chateau at 1-800-606-8244. In both cases, you must identify yourself with the College of Medical Education group. ■

Continuing Medical Education

Primary Care Cardiology CME set for evenings of January 6 & 13

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

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

The program will begin with three hours of CME on the 6th and end with three *additional* hours of CME on the 13th. The change is in response to expressed interest by physicians from the College's recent CME survey. Physicians are finding it difficult to take time away from their office hours.

Topics will include:

- HRTs: Cardiovascular Friend or Foe
- Renal and Cardio Protective Uses for ARBs: New Studies
- A *Practical* Approach to Treating Heart Failure
- Treating Lipids *Aggressively*
- Evidence-Based Medicine: How Cardiovascular Trials are Effecting Our Practice
- Diabetes: At the Heart of the Matter ■

Dates	Program	Director(s)
Friday, December 6	Gastroenterology for Primary Care	Ralph Katsman, MD
Monday, January 6; 13	Cardiology for Primary Care	Gregg Ostergren, DO
Wednesday-Sunday January 22-26	CME @ Whistler	John Jiganti, MD Rick Tobin, MD
Friday, February 7	Primary Care - 2003	William Knittel, MD
Wednesday-Sunday March 5-9	CME and the Mariners	Richard Hawkins, MD
Thursday-Friday March 13-14	Internal Medicine Review 2003	Maureen Nuccio, MD
Friday, April 4	Endocrinology for Primary Care	Ron Graf, MD
Friday, May 2	Allergy, Asthma & Pulmonology for Primary Care	Alex Mihali, MD
Friday, May 16	Advances in Women's Medicine	John Lenihan, Jr., MD

Institute of Medicine's New Report Now Available "The Future of the Public's Health in the 21st Century"

The Institute of Medicine recently released a new report - The Future of the Public's Health in the 21st Century.

The IOM's 2002 report notes that progress has been made in several areas of public health, including defining and gaining broad consensus regarding the ten essential public health services and development of a national plan to strengthen our Nation's public health infrastructure. However, the report also notes several areas that still need improvement; most notable among these are consistent standards for public health agencies and professionals, and the data and research to better understand what works best to improve the public's health.

The report, which is 400 pages, features an executive summary and the following chapters - including appendixes:

1. Assuring America's Health
2. Understanding Population Health and Its Determinants
3. The Governmental Public Health Infrastructure
4. The Community
5. The Health Care Delivery System
6. Employers and Business
7. Media
8. Academia

To access the report online, go to www.nap.edu/books/0309086221/html/. ■

In My Opinion....

by Teresa Clabots, MD

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

A Question of Balance

Teresa Clabots, MD

There are days when I walk a tight rope, concerned that being five minutes late to pick up my youngest daughter will emotionally scar here.

I shouldn't worry. She knows her mom is always available by beeper, has a cell phone, and although late at times due to patient responsibilities, she has only been forgotten and abandoned once in her short life of nine years.

Being a mom and a doctor has its own set of challenges. It is at times difficult to find a balance between two competing and all consuming careers, motherhood and doctorhood (let alone finding time for wifehood).

Do I round before or after carpool? Do I read to my young child before bedtime or do I read a journal? Do I run errands at lunch time or do I return patient phone calls instead of letting the nurse handle them?

Doctor's children have a particularly difficult time, in that injuries that would take the average child to the emergency room, receive just a passing glance from a doctor mom. I particularly remember one summer while volunteering at diabetes camp, my daughter jammed her finger playing volleyball. She complained and I ignored her, since she was still about to move it in all directions, and honestly I was very busy with my duties at camp, so I buddytaped it and gave her Tylenol. X-rayed a week later, she had a nice little chip fracture.

That taught her a lesson, that she should complain MORE than once to me if she was truly in pain. It also taught me a lesson. Now I check on each child nightly to be sure that they are okay and don't have any signs of the beginning of any diseases, triggering a whole set of telephone calls trying to provide alternate child care.

I have been known to dose that mild viral fever aggressively in the morning, in the hope that they will make it through the day at school without spiking a temp.

What happens in a household where there is a doctor mom, is that there are a lot of lists everywhere, back up plans for emergencies, stashes of frozen tv dinners, and a whole network of loyal friends who serve as a support network. Planning has to be done the night before, with clothes laid out, so there is no running around in the morning looking for lost articles of clothing.

I used to feel guilty while at work and also felt guilty at home. At work I would make grocery lists and at home I would worry about patients.

I have had to learn to compartmentalize better. Now I give myself 100% at work, and I try to give myself 100% at home, although the perpetual beeper is an annoying umbilical cord.

What recommendations would I give to the young career moms in medicine? Be organized. Be efficient at work. Try not to have charts hanging overnight. Learn to multitask; do dishes while you are on the phone, read journals while waiting for your daughter to get out of dance class or piano class. Learn to cook two meals at once so there are always leftovers.

But most importantly, hire help. Your time is too valuable, and you have to realize that you just can't do it all. Try to do the best in whichever situation you are in, but realize early that there will always be a little extra dust in your house, the laundry can wait, and will pile up for days, waiting while more important things take over, and those Christmas cards just might get sent out by Valentine's day. The most important thing is to love your child unconditionally.

Also, reach out to your friends, your friendly surgeon, obstetrician, neurologist, ENT, ER physician, orthopedist, for this network of colleagues is also in the same boat. We are all in this together.

And don't forget your partner in all this. He deserves some quality time with you too. Learn to laugh when you make a mistake. Be resilient. Learn to handle curve balls. For life is too short to have regrets.

I love going to work and making a difference in someone's life. I also love seeing my child grow into a confident, loving person.

What I tell my patients, family, and friends, is this...do the best that you can. That is all that counts. ■

Prevention from page 5

first four days of infection, to prevent its spread to the general public.

Vaccination for the entire public is still being debated, and vaccine has been located to cover all U.S. citizens. Before 1972, smallpox vaccination was recommended for all U.S. children at age 1 year. But routine vaccination in the United States stopped in 1972, and since then, few people younger than 29 years have received the vaccine. Today, approximately 42% of the U.S. population is under the age of 29. And the duration of immunity is unclear, but probably does not last more than ten years.

Barriers exist for vaccinating people. Those with depressed immune systems or with severe skin rashes are at higher risk for complications from the vaccine. If no smallpox threat existed, the complications would pose an unnecessary risk. However, if the disease appeared in Pierce County or another community, the risk of reaction would be far lower than that posed by the disease. A vaccination administered with four days of first exposure has been shown to offer some protection against acquiring infection and significant protection against a fatal outcome.

To some, this intense level of preparation is a needless exercise, citing the low probability of an intentional release of *variola* virus here. For others, the rate of fatality and post-infection complications requires serious planning to prevent and control the disease. Staff at TPCHD are preparing for smallpox as for other communicable diseases. We are organizing systems of surveillance, response, and prevention. As details are developed and policies set, staff will keep the medical community informed. Or, if you have questions, contact TPCHD's Bioterrorism Coordinator, Robert Jensen, MD, MPH, at (253) 798-7665. ■

Coverage from page 8

everybody? 60%? More? At $10,000 per person per year, that coverage would cost $2.8 trillion! That is 27% of the GDP. You thought 14% was bad. That does not include prescription benefits for Medicare. If the system is underfunded now, can you expect it will be well funded if it covered all citizens?

The administrative and regulatory burdens are the major reason for the above costs. If the above data were presented to an independent observer, he would have a good reason to doubt the sanity of our system. People don't become rich by spending large amounts of money on unproductive work, and don't stay rich when they do. The same is true of countries.

One way to solve this problem is to cut administration and regulation costs by 90%. All charges for less than a certain amount, in the range of $300, will have to be paid by the patients. Insurance has to be true to its name and cover only large losses. If so, it will cost much less. Eliminate the annual deductible, which still requires processing, even if no payment is made.

That way we can free over $400 billion a year, now spent on unproductive paper-pushing. Try to imagine what $400 billion, put to productive work, can do for our economy and for our standard of living. Among other things, in ten years, we all will drive electro-hydride cars, cut down air pollution in our cities and stop sending billions of dollars to OPEC, thereby subsidizing international terrorism. ■

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Family Practice Physician/Puyallup. Summit View Clinic is currently seeking a family practitioner to add to our five-physician-owned practice. We are a well-established FP group with 5 physicians, 1 ARNP, and 3 PA-Cs. This is an outstanding opportunity for an instant practice. We are a progressive practice equipped with Electronic Medical Record, treadmill, full service lab, dictation, bone density ultrasound, family counseling, and physical therapy. We offer competitive salary and benefit package. Visit our website www.summitviewclinic.com. For more information, call LaDonna Mohler (253) 537-0293 or fax (253) 536-1824.

Board certified family practice physician wanted for South King County Medical Clinic. Great opportunity for motivated doctor. Fax CV to 253-804-5797.

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Price Reduced. Lakewood property for sale or lease - Class A. Ample parking. Highly visible. Easy access. 4900 sq ft available now. Total sq ft of 8733. Close to 100th & Bridgeport Way SW. Call Bob York or Cody Miller at 253-531-9400. Crescent Realty, Inc.

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