

Pierce County Medical Society BULLETIN



December 2008/January 2009

The 2008 Annual Meeting Fun and Festive!



Dr. David Bales (left) was installed as the 120th President of PCMS. Dr. Ron Morris (right) presented him with his presidential gavel.

See story and more photos page 3



Paul Schneider, MD (rt) received the 2008 Community Service Award presented by Dr. Sumner Schoenike (See story page 7)



Past Presidents (1984-2009) unite! From left: Drs. David Law, Pat Hogan, Bill Marsh, Ron Morris, Bill Jackson, Joe Jasper, Charles Weatherby, Mike Kelly, John Rowlands, Pat Duffy, Richard Hawkins, Jim Wilson, George Tanbara, Sumner Schoenike and Dick Bowe. Excused: Drs. Gordon Klatt, Larry Larson and Patrice Stevenson. MIA: Guus Bischoff, Jim Fulcher, Stan Harris, Peter Marsh, Bill Ritchie, Jim Rooks, Susan Salo and Eileen Toth.

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of medicine and the betterment of the health and medical

welfare of the community. The opinions herein are those

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President's Page

by J. David Bales, MD

Cooperation, Communication, Collaboration



J. David Bales, MD

As I write this, it has been less than a month since **Dr. Ron Morris** passed the gavel – but I have already been quite busy with Society business. Perhaps the most exciting episode was welcoming the new Director of the Tacoma Pierce County Health Department, **Dr. Anthony Chen**. The event was co-sponsored by the Pierce County Medical Society and the Korean Women's Association. The reception and collaboration that sponsored the event was an appropriate reflection of our community. Attendance was as diverse as our community with political, health department, medical and community leaders present to welcome Dr. Chen.

Cooperation, communication and collaboration are hallmarks of our community. Even the recruiting process for our new Health Department Director was a massive collaboration with participation from all corners and walks of Tacoma and Pierce County. Our medical society was a major participant in the process with several of the Board attending numerous meetings and participating in an on-going electronic interchange with a wide variety of stakeholders.

After attending several Washington State Medical Association events, my perception is that the Pierce County Medical Society and our relationship with our community are the envy of many of our colleagues across the state. We have existed since 1888 and during that time have remained a proactive part of the community we serve. We can be justifiably proud of the leading role we have played in both the health and the health care of Tacoma and Pierce County. Our on-going cooperation and collaboration with the Health Department on such diverse projects as the Community Health Initiative, the Antibiotic Resistance Task Force, and the Medical Reserve Corps are examples of that role. The Community Health Clinics owe their origins to the Pierce County Medical Society leadership. Even competing health systems have sat around the same table to address such community wide issues as infection control in an effort that can best be described as "Coopetition!" The outcome of such collaboration has included local, national, and international recognition of the community's efforts and continued requests to utilize our products.

We face uncertain times with economic upheaval, political change, and military conflict to start the New Year. And yet, we have survived for over a century in equally disturbing times by keeping our focus on service to our patients and our community. How can we do otherwise? ■

FRANCISCAN HEALTH SYSTEM

++



ST. JOSEPH CARDIOTHORACIC SURGEONS:

Thomas Molloy, MD (*far left*)
 Gilbert Johnston, MD (*middle left*)
 Baiya Krishnadasan, MD (*middle right*)
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St. Joseph brings robotic heart surgery to Western Washington

Dr. Thomas Molloy (*far left*), medical director for cardiac surgery at St. Joseph Medical Center, performed the region's first endoscopic robotic heart surgery this spring, introducing a new technique that offers patients smaller incisions and faster recovery. Dr. Molloy, part of the St. Joseph Cardiothoracic Surgeons group, has performed more than 3,000 heart surgeries.

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Annual Meeting Recap

The 2008 Annual Meeting continues to please in new venue... good food, easy parking, etc.

The 2008 Annual Meeting was held for the second year in a row at the Fircrest Golf Club, where everyone agreed it has many benefits compared to the Tacoma Sheraton (Hotel Murano) where the meeting had been held for years. The parking lot provides great access to the building and is free and plentiful, the foyer provides a great place for visiting old friends and meeting new ones, the food is delicious and the hospitality first class. Not one complaint received in two years, only praise for the change. The evening had a full agenda of awards and raffles, welcoming of new officers and recognition and thanks for those completing their services and of course a featured speaker. The atmosphere was fun and very festive in the beautifully decorated club.

The evening was highlighted by surprising **Dr. Paul Schneider**, as he became the 17th recipient of the 2008 Community Service Award. Dr. Schneider received the award primarily for his passion for prevention and healthy lifestyles. (See article page 7) Due to the help of his wife and his colleagues, who told him a harmless white lie, he was in attendance to receive the award.

Dr. Ron Morris introduced **Dr. Charles Weatherby**, PCMS Foundation President who in turn introduced Letha Hollis, artist for the 2008 Holiday Sharing Card. Letha is a 7th grade student at Jason Lee Middle School in Tacoma. She drew three tickets for winners of the raffle. The lucky recipients were **Bill Jackson, MD** (PCMS President, 1988), **Rebecca Benko, MD** (TFM faculty) and Bob Perna (WSMA staff). All received a gift basket full of goodies and a \$100 gift certificate to a local restaurant.

Dr. Morris asked for a moment of silence in honor of each

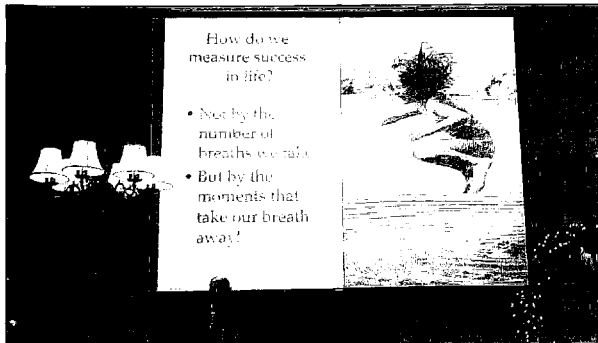
See "Annual Meeting" page 6



Outgoing President, Dr. Ron Morris after receiving his president's gift



New President, Dr. David Bales with wife Phyllis and speaker Mike Morrison



Michael Morrison, keynote speaker, showed many secrets about having a happy life



Dr. Sumner Schoenike says goodbye as Dr. Morris thanked him for seven years of board service

Annual Meeting from page 5

colleague that had died since last year's meeting. They included: **Drs. Leonard Allott, John Kanda, Sidney Kase, Edward Przasnyski, William Rohner, Arthur Smith and Marcus Stuen.** He also asked for remembrance of PCMS's great friend, Nikki Crowley who died two years ago, just after the annual meeting.

For appreciation he asked all past-presidents to stand and introduce themselves prior to gathering for a "past presidents" picture. They included, by year of service:

George Tanbara, MD (1981)
Pat Duffy, MD (1984)
Richard Hawkins, MD (1986)
Richard Bowe, MD (1987)
Bill Jackson, MD (1988)
Bill Marsh, MD (1991)
David Law, MD (1995)
John Rowlands, MD (1996)
Jim Wilson, MD (1998)
Charles Weatherby, MD (2000)
Mike Kelly, MD (2004)
Pat Hogan, DO (2005)
Joe Jasper, MD (2006)
Sumner Schoenike, MD (2007)
Ron Morris, MD (2008)

Dr. Morris then thanked the physicians who served on the board during his presidential year including **Drs. Sumner Schoenike, Steve Duncan, Jeff Smith, Jeff Nacht, David Bales, Lance Kirkegaard, Bill Hirota, Debra McAllister, Maureen Mooney, Ed Pullen and Don Trippel.** He also thanked the State Medical Association board members for their service. **Drs. Len Alenick, Richard Hawkins, Mike Kelly, Nick Rajacich and Don Russell.** Prior to his parting words, he asked for immediate past-president **Dr. Sumner Schoenike** to join him on stage for a special thank you. Presenting Dr. Schoenike with a parting gift he thanked him profusely for his seven years of board service.

Introducing the new president for 2009, Dr. Morris asked **Dr. David Bales** to join him on stage where he presented him with his presidential gavel. Dr. Bales thanked Dr. Morris for his service to PCMS and presented him with a thank you gift as well as a plaque noting his exemplary leadership and commitment to PCMS. Dr. Bales then asked the new trustees for 2009 to stand as he introduced them: **Drs. Steve Duncan, Ron Morris, Jeff Smith, Bill Hirota, Maureen Mooney, Raed Fahmy, Mark Grubb, Debra McAllister, Gary Nickel, Cecil Snodgrass and Champ Weeks.**

Before introducing the keynote speaker for the evening, Dr. Bales thanked his colleagues for their support and encouragement, noting that he looked forward to a productive year. ■



Rebecca Benko, MD, Tacoma family practitioner, winner of basket and gift certificate to the Lobster Shop



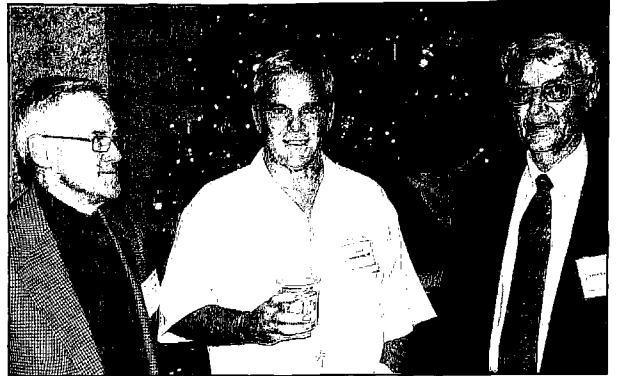
Bill Jackson, MD, PCMS Past President and retired radiologist, winner of basket and gift certificate to Stanley & Seafort's



Bob Perna, WSMA Director of Health Care Economics, winner of basket and gift certificate to Shenanigans



Drs. Joe Jasper (left), Bill Roes and Joan Halley enjoying a visit



From left, Past PCMS President Bill Marsh, Cecil Snodgrass and Vern Larson. Dr. Snodgrass is a newly elected trustee



Outgoing treasurer Dr. Jeff Nacht (right) and Dr. Jos Cove' and spouses during the social hour



From left - "talking shop" - Drs. John Rowlands, John Samms, Jim Patterson and John Hautala



PCMS Past President Pat Hogan has fun with the "wives" - from left - Donna Jasper (Joe), Ginny Craddock (Mark) and Joan Hogan - his own!



Past President Dr. Sumner Schoenike (right) talks with Dr. Bill Hirota, newly elected secretary, and his wife

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THE NEUROBIOLOGY OF MINDFULNESS-BASED PRACTICE

Presented by John S. Wendt, MD

January 20, 2009

About the presenter: Dr. Wendt earned his medical degree from the University of Michigan and completed his neurological residency at the University of Colorado. Board certified in neurology with a sub-specialty certification in headache medicine, he served on the faculty of the University of Texas Health Sciences Center Dallas for eight years before entering private practice in Federal Way in 1988. Dr. Wendt has special interest in, and has taught, mindfulness-based stress reduction (MBSR).



CAROTID STENTS

Presented by Brian Kott, MD

February 17, 2009

About the presenter: Dr. Kott earned his medical degree from the Medical College of Pennsylvania, and completed residencies in General Surgery and Diagnostic Radiology at the University of Washington, where he also completed a fellowship in Diagnostic and Interventional Neuroradiology. He serves on the faculty of Interventional Neuroradiology at the University of Washington.



NEURORADIOLOGY—UNUSUAL AND INTERESTING CASES

Presented by Frank Wessbecher, MD

March 17, 2009

About the presenter: Dr. Wessbecher earned his medical degree from Johns Hopkins University, served his residency in diagnostic radiology at Yale New Haven Hospital and completed a fellowship in neuroradiology at the University of Washington, where he is a clinic assistant professor in the department of radiology. Dr. Wessbecher is medical director at TRA Tacoma.



CHIARI MALFORMATION: MYTH & REALITY

Presented by Rich Ellenbogen, MD, FACS

April 21, 2009

About the presenter: Dr. Ellenbogen is Professor and Chairman of Neurological Surgery at the University of Washington School of Medicine, the Theodore S. Roberts Endowed Chair in Pediatric Neurosurgery, the Chief of Neurological Surgery at Harborview Medical Center, and Professor of Radiology. He received his medical degree from Brown University in 1983. After completing a residency in 1989 at Children's Hospital, Brigham & Women's Hospital in Boston/ Harvard Medical School, Dr. Ellenbogen then became Chief of Pediatric Neurosurgery and Director of the Surgical Epilepsy Program at Walter Reed Army Medical Center in Washington, D.C. In addition, he was the Neurosurgical Director of the DOD/VA Head Injury Project. He became the Chief of Neurosurgery and Residency Program Director at Walter Reed Army Medical Center, and Chairman of the National Capital Area Neurosurgery Residency Consortium prior to being recruited to University of Washington.

FRANCISCAN HEALTH
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2008 Community Service Award

Paul Schneider, MD recognized as the 2008 PCMS Community Service Award recipient

Dr. Paul Schneider was honored December 3rd at the Pierce County Medical Society Annual Meeting as the 17th recipient of the Community Service Award. The award is given annually and recognizes a physician that has contributed volunteer service to the community. This is important work that gets no remuneration and more often than not, no public recognition.

Dr. Schneider is widely recognized as a person eager to make a difference. His longstanding contributions to the welfare of the medical community and the general community at large are well known as indicated by the immediate and overwhelming audience response when his name was revealed as the honoree. There was no doubt that Dr. Schneider was the right choice!

PCMS extends gratitude to his wife Cathy for her assistance with getting him to the meeting. Unable to attend herself, she encouraged him to participate, knowing that he was to be honored by his colleagues. Fooled into thinking another group was to receive an award that he wanted to witness, it is believed by those closest to him that the honor was truly a surprise.

Colleague and friend, **Dr. Sumner Schoenike**, PCMS past president, had the pleasure of presenting the award. His script is below in its entirety.

Tonight, I have the distinct pleasure of being the messenger in honoring a colleague that I know has earned the respect of our entire medical community. Not only because he is an excellent physician and cares about his patients, as all of us do, but because he takes action beyond the day to day expected excellence, with an understanding and a belief that there is much more to helping people be healthy than advising and encouraging them during exam room visits. He believes it takes a "community" to foster healthy people. He has a vision for the big picture and he brings the small pieces together.

Thank you Paul Schneider!

Our honoree is an incredible "connector" of people and of organizations. He understands the importance of "collaboration" and the significance of "communication." He excels at both. His work is primarily in the background, not visible for most to realize, yet strong and steady, meaningful and significant, day after day, year after year. Connecting, communicating, collaborating.

Thank you Paul Schneider!



Paul Schneider, MD recipient of the 2008 PCMS Community Service Award

The PCMS Healthy Communities Pierce County project is solely due to the leadership of Dr. Schneider. With a vision of a healthier community, he has brought together community leaders and organizations all working toward the same goal. The project will soon be an independent 501 C3 organization and after success in the Gig Harbor/Key Peninsula area, the project is now starting in Puyallup/South Hill. Schools, municipalities, health care leaders, hospitals, parks department, community leaders, non profit organizations, fire departments and many others are collaborating on how best to plan, develop and support better health for everyone.

Thank you Paul Schneider!

The YMCA of Pierce County counts Dr. Schneider as one of their biggest blessings. He serves on their advisory council for the Gig Harbor/Key Peninsula area and worked tirelessly on their capital campaign. He is co-chair of their ACHIEVE project, a blue ribbon panel to stem the tide of childhood obesity. He has given countless hours including attendance at national meetings because he is so dedicated to helping children make good health choices saving them poor health as adults.

Thank you Paul Schneider!

I bet there isn't anyone in this room that would need

Sec "Award" page 26

Governor Gregoire to address WSMA Legislative Summit

Governor Gregoire is confirmed to speak at the WSMA Legislative Summit on Monday, January 26 at the Red Lion Hotel in Olympia. The cost is free for all WSMA members.

The Summit will begin at 8:30 am. with comments from the governor. Hear what's in store for health care this legislative session as she outlines the state's severe budget situation and budget cuts that could impact health care.



After the governor, national communications consultant, Pat Clark, will work with the highly regarded former house speaker, Denny Heck, to demonstrate the best way to communicate our messages with legislators. It will be an informative, engaging session.

Following the morning speakers, WSMA staff will review our briefing materials and will prep you for your afternoon appointments with legislators. (When you register, staff will take care of making your appointments with legislators from your district.)

The Summit will be held on Monday, January 26 at the Red Lion Hotel, 2300 Evergreen Park Drive SW Olympia. (Phone: 360.943.4000).

The Governor is scheduled to speak at 8:45 a.m. with an issue briefing to follow at 9:15. At 10:00 Pat Clark's session will begin until lunch is served at 11:30. At 12:30, everyone will board busses to go to the Capitol. Attendees will meet in groups with their legislators, based on their legislative district. All meetings will be scheduled by WSMA staff. Busses will return to the hotel every 15 minutes.

This year's conference is being planned with the Washington State Medical Group Management Association (WSMGMA), the Washington Ambulatory Surgery Center, and Physicians Insurance a Mutual Company. ■



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New Board of Trustees will lead PCMS in 2009



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



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



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



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



Ronald Morris, MD practices administrative medicine in Puyallup. He graduated from the University of Washington School of Medicine and completed his internship and residency at Wilson Memorial Hospital in New York.



Maureen Mooney, MD practices dermatology. She received her medical education from the University of Minnesota. She completed her internship at Hennepin County Medical Center followed by residency and fellowship training at New Jersey Medical School.



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



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



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



Cecil Snodgrass, MD is a family practice physician in Puyallup. He graduated from the University of Washington and completed his internship at California Pacific Medical Center.



Debra McAllister, MD practices obstetrics and gynecology in Puyallup. She attended St. Louis University School of Medicine and completed her internship and residency at Southwestern Medical School Parkland Memorial Hospital.



Champ Weeks, MD practices urology in Tacoma. He received his medical degree from the Medical University of South Carolina and fulfilled his residency training at Georgetown University Medical Center.

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.

Thanks to very generous PCMS Foundation contributors

PCMS extends a very grateful and heartfelt THANK YOU to all members who contributed to the 2008 holiday sharing card. The project allowed \$18,000 to be distributed to local non-profit organizations just when many of them were experiencing their greatest need.

Recipients included:

- Trinity Neighborhood Clinic
- Tacoma Rescue Mission
- St. Leo Food Connection
- Pierce County AIDS Foundation
- New Phoebe House Neighborhood Clinic
- Family Renewal Shelter
- Crystal Judson Family Justice Center
- Hospitality Kitchen
- American Lung Assoc. of the NW

Each year, the Holiday Sharing Card Project is administered to raise

funds for local non-profit agencies. The primary requirement is that funds be used in Pierce County to provide direct care or services to Pierce County's most needy citizens. This year, funds will help feed the hungry, provide safety and shelter, health care and medications and other essential needs.

Donations made after printing of the card to date include:

- John Dimant, MD**
- Chuck & Sherry Jacobson**
- Susanne Matthys-Ollodart, MD**
- Karen Nelson, MD**
- John A. Read, MD**
- Don & Barbara Russell**

The 2008 Holiday Sharing Card featured the artwork of 7th grade student Letha Hollis of Tacoma. Letha's artwork was selected from a group of over 50 entries to the art contest sponsored by

Jason Lee Junior High each year. Letha won recognition at the PCMS annual meeting as well as a set of blank cards featuring her artwork and a gift card from the Tacoma Mall.

Again, thank you. Your participation in this project makes a real difference in many lives in our community and demonstrates the charitable nature of the profession. ■

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Thanks to Toshiba for their generous support.

**Thursday, January 29, 2009
6:30-8:30pm**

Tacoma General Hospital
Jackson Hall
314 Martin Luther King Jr. Way

PRESENTERS:

Brian R. Kott, MD
Endovascular Interventional
Neuroradiologist

Alison Nohara, MD
Endovascular Interventional
Neuroradiologist

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The Health Status of Pierce County

by Anthony L-T Chen, MD

Colds, Cows and Contagion: Addressing Antibiotic Resistance



Anthony Chen, MD

Methicillin-resistant *Staphylococcus aureus* (MRSA) has been the subject of many recent startling headlines. "How our hospitals unleashed a MRSA epidemic," trumpeted the first in a recent three-day span in the *Seattle Times*. Will *Acinetobacter baumannii* be the next "superbug" headliner? Or perhaps *Streptococcus pneumoniae*?

Antibiotic resistance, especially manifested in multi-drug resistant organisms (MDRO), threatens to undermine some of our major medical advances yet it is neither as simple nor apocalyptic as portrayed in the media. It is a symptom of multiple interconnected factors which have no simple solution. Stemming the tide of antibiotic resistant organisms will require multiple partners and levels of intervention, prevention and control of transmission and sensible use of antibiotics.

Consider patients with flu symptoms that we have all seen: whether they leave our offices with an antibiotic prescription depends on their expectations and tenacity and our conviction and time pressure. Each antibiotic prescription begins to select resistant bacteria as it passes through that patient into the entire ecosystem. Sharing that ecosystem are millions of cows and farm animals fed antibiotics to boost growth and curb infections in the name of food production. Resistance breeds resistance: as we resort

to more potent and newer antibiotics to treat MRSA, we are seeing the emergence of vancomycin and linezolid resistance.

At the health department, we have been working with partners to monitor, plan and develop resources for the prevention and control of MRSA and other resistant organisms. For the last eight years, we have been monitoring MRSA and Vancomycin-resistant Enterococcus (VRE) through a voluntary reporting system involving all seven hospitals, fourteen long-term care facilities and approximately ten clinics in the county.

I do want to point out that we oppose mandatory reporting of invasive MRSA. Investigation of every invasive MRSA case would consume large amounts of resources without providing any useful data to inform our public health practice.

This is in contrast to our current surveillance system, which allows us to have a targeted focus on identifying and educating those with the highest level of risk.

In 2000, Tacoma-Pierce County Health Department convened physicians, hospital and long-term-care providers, microbiologists, pharmacists, educators, dairy farmers, veterinarians, and policy makers to form the Pierce County Antibiotic Resistance Task Force. Chaired by **Dr. David Bales**, the Task Force strives to reduce the emergence and spread of antibiotic resis-

tance in Pierce County through community-based activities aimed at promoting the appropriate use of antibiotics and enhancing infection control. Tacoma-Pierce County Health Department continues to act as the coordinating agency for the Task Force.

In collaboration with Washington Department of Health, Washington State Dairy Federation and local health care partners, the Task Force's accomplishments over the last four years include:

- Developing and distributing *Interim Guidelines for Management of Suspected Staphylococcus aureus Skin and Soft Tissue Infections* for health care providers and *Antibiotic Commonsense*, a quarterly newsletter for and by medical providers and pharmacists.
- Producing and distributing *What to do about MRSA* education toolkits for outpatient clinics/medical offices, childcare programs, schools, and shelter site services which have been adopted by state and regional programs and incorporated into national publications.
- Developing and distributing *Living with MRSA*. Again, widely adopted by state and local health departments and hospital systems across the USA and Canada as an educational tool for the public.
- Developing a set of assessment tools and best practice guidelines for

See "Resistance" page 24

Applicants for Membership

Sanjay Agrawal, MD

Gastroenterology
 Digestive Health Specialists
 2202 South Cedar #330, Tacoma
 253-272-5127
 Med School: SMS Med College, India
 Internship: SUNY
 Residency: SUNY
 Fellowship: UMASS Medical Center

Julian W. Ayer, MD

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 Internship: Madigan AMC
 Residency: University of North Texas
 Fellowship: Plano Orth & Sports Med

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 MultiCare Orthopedic & Sports Med
 3124 South 19th St #304, Tacoma
 253-459-7000
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 Internship: University of S Alabama
 Residency: University of S Alabama
 Fellowship: Orthopedic Sports Medicine
 Clinic of Alabama

Matthew A. Eisenberg, MD

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 MultiCare Health System
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 Internship: Boston Children's Hospital
 Residency: Boston Children's Hospital
 Fellowship: Univ of Washington

Lin Huang, MD

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In My Opinion

by Jeffrey L. Nacht, MD

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

Cherry Picking



Jeffrey Nacht, MD

There was an article in the last week of April 2008 in the local Vancouver newspaper about a young woman who was complaining to the B.C. College of Physicians and Surgeons regarding her mother. In the story, she related that her mother had been living in a city in Saskatchewan where the young woman had grown up. Her mother and father stayed in Saskatchewan when the daughter had married and moved to her husband's place of origin, British Columbia. Later, her sister, the only other sibling, had moved away as well. Some years back, her dad, the woman's long time husband had passed away. Now her mom was in her early 60's and tragically, developed pancreatic cancer. The daughter made arrangements to move her mom to Vancouver so that she could help with her care. The lady qualified for hospice care, which she desperately needed at the time of this complaint. But there was a catch. In order to be eligible for hospice care, she needed to have a primary care physician to refer her to the hospice program and to be the physician of record for care decisions.

Over the past two years, the daughter has tried everything to get her mom a doctor who would assume her care. Since she was no longer eligible for treatment, the oncologists would

not see her, and would require a referral from a primary care doctor in any case. The problem was that all of the doctors she called told her that her mom's case was too complicated and time consuming, and they couldn't afford to take her on as a new patient. Since the government reimburses all follow-up patient visits to a family doctor at \$30, they felt they couldn't afford to assume her care. So she complained to the College of Physicians and Surgeons, the governing body for the doctors, who admonished them for any behavior that amounted to "cherry-picking" good cases, reminding them of their Hippocratic Oath obligations.

The newspaper roundly criticized the doctors who refused to provide her care and take her on as a patient. It made me wonder about who was right. Were the physicians to blame for avoiding an economically unsound decision to take this patient on, knowing they would lose money and risk the viability of their practice, which was perennially at risk of financial failure? Or was the government and the system at fault, for setting reimbursement for primary care office work so low, that a practice that takes on the usual wide variety of simple and complex, young and old, quick and lengthy diagnostic and treatment problems typical of a G.P.'s practice, economically risky. I certainly sym-

pathized with the patient and her daughter. They deserve access to the care they need. But I can't help take note of the fact that this was not an isolated decision by one or two greedy docs out to make a fortune at the expense of their poor suffering patients.

The article related how this concerned daughter had called "every doctor's office in the region" before she finally did get someone to take on the care of her mom, who subsequently did receive a brief course of hospice care toward the end, and then finally passed away from her disease.

To me, the almost universal consensus among these primary care physicians to refuse to assume this family's burden of care is the most revealing. One must assume these doctors went into the practice of medicine for the same reasons most of us do. They felt a "calling," a need to care for the sick and the injured, regardless of cost and difficulty, of time and stress. For all of these doctors to make the same decision independently says something about the state of medicine in British Columbia, in Canada, and in a system where a single government payor sets the rules, and individual citizen/patient's rights and needs be damned. It makes you wonder what that system would function like in our community. ■

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In My Opinion

by Vernon O. Larson, 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.

Tennis Anyone?



Vernon Larson, MD

Do you like to visit foreign exotic places?

Do you need or want continuing medical education credits?

Do you play tennis?

If so, then think about joining the American Medical Tennis Association and the World Medical Tennis Society and participating in their meetings. The cost is nominal, the advantage great, and it is a lot of fun. You do not have to be a super expert at the game.

The American Medical Tennis Association has two to four tournaments each year somewhere in the U.S., usually in California or Florida but sometimes in the Carolinas or Northeast.

The World Medical Tennis Society has one meeting per year somewhere in the world. Next year the meeting is in Helsinki, Finland. Last year it was in Umag, Croatia. Recent sites have been Malta, Northern Italy near Venice, Sweden, Austria, Japan, Bali, Germany and the Czech Republic. World events have also been held in the U.S. at Lakeway, Texas, Fort Worth and San Diego, California.

There are CME lectures associated with the tennis and usually with six to twenty plus hours of Category 1 CME credit. Some of the lectures are by members and some by local medical school professors. Subjects are varied and cut across all specialties in a broad spectrum. From my attendance at many of the lectures, I can attest to their excellence. Should you wish to lecture on your zone of expertise, you would be quite welcome.

At the World Medical Tennis events there are usually two to twenty-six countries represented and 20-50 physicians from the United States plus spouses. The matches are age-bracketed and consolation rounds are played so you can be guaranteed several matches generally.

Singles, doubles and mixed are played. Last year in Croatia, there were 650 matches all played on very fine red clay courts also used by the world class circuit professional players.

Note that there are some very good players who attend the meetings. Several ex-Davis cup players from various countries play as well as nationally top ranked U.S. players so there is very good tennis to watch when you are not playing.

Of the local physicians you have been involved in recent years are **George Tanbara**, the late **Max Thomas** and myself.

To get more information go to www.mdtennis.org and from there go to the world medical tennis site. The current executive director is Betty Olsen of Salt Lake City, Utah. Her husband, Lon, who is a physician, arranged the teaching sessions.

All of the trips with the World Medical Tennis Association include a three or four day pre-trip guided tour of the general area. Last year's pre-trip included Trieste, Italy and Venice, Italy as well as tours in Croatia. We also visited the Island of Brijuni, the summer home of Tito the late dictator of Yugoslavia.

Should you want or need more information, call me or check out the above website. This is an excellent chance to make good friends in the medical community around the world. ■

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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.

Signing Out

"Americans can be counted on to do the right thing after they have exhausted all the options."

Winston Churchill



Andrew Statson, MD

Editor's Note: How does an organization properly thank a member who has contributed so much to the "Bulletin" for the last ten years, other than to simply say, thank you, Dr. Statson? Perhaps our readers can help us find a way. Please email your ideas to sue@pcmswa.org.

About ten years ago, when I started writing for the *Bulletin*, I thought that two or three years later I would run out of topics and ideas, and I would be done. Yet the topics and the ideas kept coming, and I kept writing.

I still have a number of topics I could write about, but the underlying philosophy, based on the superiority of the free market, remains. In that respect, I'm repeating myself. I know it is important to keep the discussion going, and to offer for consideration a wide variety of options, but repetition is boring, and boring the reader is something a writer cannot afford.

The Medical Society has been gracious to publish my articles, and I am thankful for the opportunity to submit them to you. I don't want to overstay my welcome, and I am afraid I may already have. I think it is time for me to get up, and let others sit at the keyboard.

I have tried to show that only prosperity can bring about good medical care to all, and that prosperity is based on freedom. Mandates only raise the cost and impoverish the people.

I also have found that life is the best teacher. I have been involved in medicine on both sides of the Iron Curtain and on both sides of the Atlantic, but no matter what I tell you about my experience, it will not resonate with you until you have lived through it yourselves.

Before WWII many people in my native country believed in the deception of socialism, namely that the state can bring about universal felicity through the use of force. A number of refugees from Russia filtered through the country and told the truth about the situation in the Soviet Union, but the people didn't believe it, not until they felt the whip on their own backs.

We are in for a long, cold winter. How long it will last I don't know, but eventually the snows will melt. Spring will come, and it will be time to sow. Then, I hope, we will be more careful about what we plant, because that will determine what we will reap the following autumn. Yes, I know, the lesson of history is that people don't learn from history. Yet I still hope that the good times will come back, even if only for a while, until we mess things up again.

All in all, I put my trust in the good American people, the ones who work hard, the producers. Our survival depends on them.

I have special thanks for the editor of the *Bulletin*, Sue Asher, and for Tanya, the lady at the receiving modem. They are doing a great job for the *Bulletin*.

Fare well, my friends. May the Force be with you. ■

IN MEMORIAM
SIDNEY KASE, MD
 1922 - 2008

Dr. Sidney Kase was born in New York City on July 8, 1922 and died on Monday, November 10. He was 86.

Dr. Kase graduated from the Chicago Medical School in 1949 and served an internship at the County Hospital of San Bernardino California. He completed residencies at Memorial Hospital of Long Beach, County Hospital of San Bernardino and City of Hope Medical Center in Duarte, California. He was a board certified surgeon and practiced in Puyallup from 1960 to 1991.

Dr. Kase is survived by his wife of 59 years Lori, four children Sheryl, Charles, Barbara and Ken as well as five grandsons.

PCMS extends sympathies to Dr. Kase's family.



Sidney Kase, MD

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IN MEMORIAM
JOHN COLEN, MD
1923 - 2008

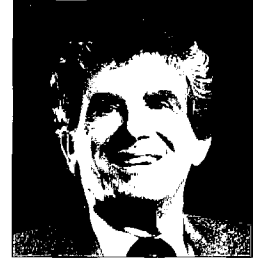
Dr. John Colen was born November 29, 1923 and died at the age of 85 on Friday, December 5.

Dr. Colen graduated from the State University of Leiden, Netherlands in 1950 and served an internship there as well. He completed his residency in Allergy and Internal Medicine at the University of Pittsburgh Medical Center Hospitals and in Internal Medicine at Kaiser Foundation Hospital in Vancouver, Washington. He was a Diplomat of the American Board of Allergy and Immunology and was a Clinical Professor of Medicine and attending staff physician at the University of Washington and Harbor View Medical Center hospitals.

He came to Tacoma in 1958 and started an allergy practice, presently known as Puget Sound Allergy, Asthma and Immunology Associates, from which he retired in 1989, serving as a consultant until 1995.

Dr. Colen was a member the of Pierce County Medical Society since 1958.

PCMS extends sympathies to Dr. Colon's family.



John Colen, MD

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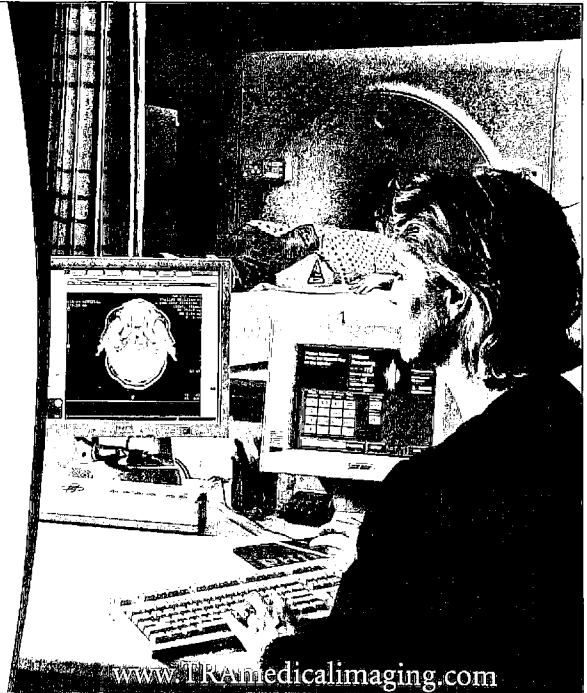
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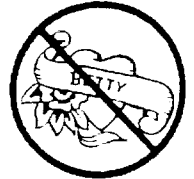
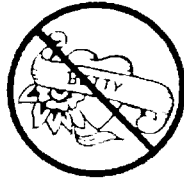
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It's Not Too Late! Whistler CME Jan 28 - Feb 1

The annual Whistler and CME course will be held Wednesday through Sunday, January 28th - February 1st, 2009. Make your reservations now as this course will NOT be held in 2010 due to the Winter Olympics.

As usual, the course will have a dynamite line up of speakers discussing a variety of topics of interest to all specialties. **Rick Tobin, MD and John Jiganti, MD** course directors, have done an outstanding job of scheduling speakers and topics in the past years.

The Whistler CME is a "resort" program, combining family vacationing, skiing, a resort atmosphere, with continuing medical education. 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. Reservations for the program's condos can be made by calling **Aspens on Blackcomb**, toll free, at 1-800-663-7711, booking code #470576. You must identify yourself as part of the College of Medical Education group. CME at Whistler participants are urged to make their condo reservations early as conference dates are during the busy ski season.

Call the College of Medical Education at 253-627-7137 to register.

Hope to see you there! ■

Continuing Medical Education

Mental Health 2009 CME - Register Now!

This year's *Mental Health 2009* CME will be held on Friday, February 6, 2009 at St. Joseph Medical Center under the medical direction of **David Law, MD**.

Topics and speakers include:

- *Physical Exercise as the Universal Brain and Mental Health Medicine*
- Patrick Hogan, DO
- *Geriatric Psychiatry: Depression, Delirium and Dementia*
- Douglas Wornell, MD
- *Fact or Fantasy: Straight Talk on New Treatments for Anxiety and Depression*
- Fletcher Taylor, MD
- *Mindfulness-Based Relapse Prevention in the Treatment of Addictive Behaviors*
- G. Alan Marlatt, PhD
- *Update on Opiate Replacement Therapy* - L. Paul Gianutsos, MD, MPH
- *New Approaches to Treatment of Bipolar Disorder* - Wayne Katon, MD

A one-day review and update focusing on the diagnosis, treatment and management of mental health complaints faced in the primary care and internal medicine practice. The course will cover a broad spectrum of problems ranging from pediatrics to the geriatric population. At the end of the conference, participants should be able to:

Understand the dose, mode of administration and mechanism of neurophysiologic action of physical exercise as medicine in the treatment of most mental health disorders and the prevention of cognitive and mood disturbances; Review and discuss psychiatric management of the elderly in the primary care setting; Understand and review new treatments for anxiety and depression. Discuss existing classes of antidepressants and their relative merits to guide a rational approach to treatment; Provide an overview of MBRP as an intervention designed to prevent relapse in the treatment of addictive behavior problems. The MBRP program consists of eight weekly outpatient group sessions. Preliminary results from a recent clinical trial will be presented; Understand that prescription opiate abuse and dependence is much more prevalent than heroin dependence. Opiate replacement therapy (ORT) is safe and effective treatment for opiate dependence. Understand that primary care physicians are well positioned to include ORT in their practice; Describe the newest data on mood stabilizers and atypical antidepressant treatment and side effects. Especially emphasize the association of these medications with obesity and metabolic syndrome and safest ways to approach this problem.

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is \$35 for PCMS members (active and retired) and \$50 for non-PCMS members. ■

<u>Date</u>	<u>Program</u>	<u>Director(s)</u>
Wednesday - Sunday January 28 - February 1	CME at Whistler	Rick Tobin, MD John Jiganti, MD
Friday, February 6	Mental Health	David Law, MD
Friday, March 13	Radiology for the Non-Radiologist	Mark Yuhasz, MD Andy Levine, MD
Thursday, April 16 Evening, 4-8 pm	New Developments in Primary Care	Michael Bateman, MD
Friday, May 8	Internal Medicine Review	Garrick Brown, MD
Friday, June 5	Primary Care 2009	Kevin Braun, MD

Resistance from page 7

dairy farmers to assess and improve antibiotic stewardship. Eight dairy farms were trained as role models.

If you are not already on board, how can you help? Begin by promoting the judicious use of antibiotics in our community. Diagnose effectively, stay current on treatment recommendations, and prescribe antibiotics appropriately. Educate your patients, the media, our politicians, and each other. Wash your hands and be a role model for preventing infection and transmission in your office and the hospital. Consider joining the Pierce County

Antibiotic Resistance Task Force. Advocate for adequate public health funding that supports effective community and population-based solutions. If you are interested in making a social statement, consider eschewing antibiotic-fed meat or becoming vegetarian.

As I mentioned, antibiotic resistance is a symptom of multiple interconnected factors, which will need multiple levels of intervention. I hope that we can count on you to be part of the solution on as many levels as possible. ■

Resources

Tacoma-Pierce County educational material on MRSA: www.tpchd.org/mrsa

CDC CD-MRSA information for Clinicians: www.cdc.gov/ncidod/dhqp/ar_mrsa_ca-clinicians.html

CDC Campaign to reduce antimicrobial resistance in healthcare settings - 12 step program: www.cdc.gov/drugresistance/healthcare/default.htm

WA State Department of Health, MRSA-general information: www.doh.wa.gov/Topics/Antibiotics/MRSA.htm



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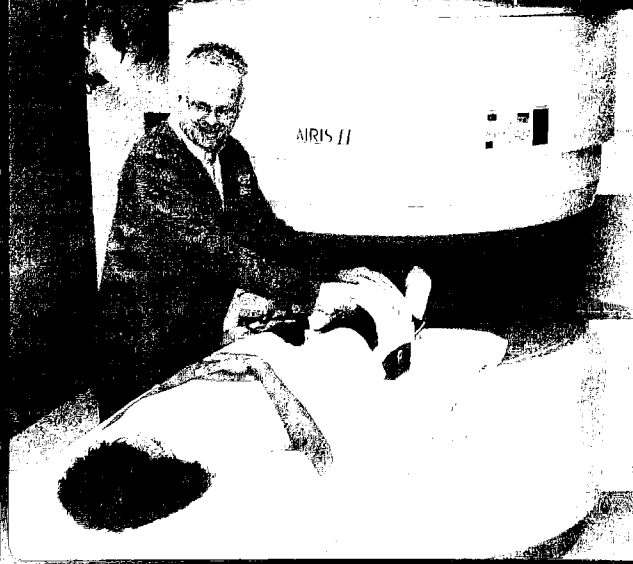
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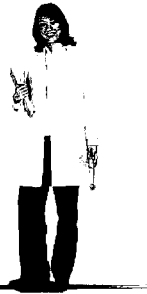
QuitSmart quit smoking classes being offered

MultiCare Center for Healthy Living and Franciscan Health System have teamed to offer **QuitSmart**. This quit smoking program is a medically-based program that prepares mentally and physically to break old habits and start healthy new ones. The trained facilitator will help identify and conquer challenges in quitting tobacco, and prepare a solid foundation for lifelong success.

Three 2-hour classes will be held March 10, 17 and 24 from 4:30 - 6:30pm or one day sessions will be held January 17, April 11 or September 19 at Allenmore Hospital and February 21, May 9 or October 17 at Good Samaritan Hospital, 9:30 am to 3:30 pm.

Topics include: Tobacco addiction, medications, withdrawal symptoms, tools & tips, coping skills, relapse, personal quit plans, stress management, nutrition, nicotine replacement, therapies, exercise & activities, recovery.

QuitSmart works in conjunction with free weekly support groups and attendance is recommended while preparing for and one year following final quit date. Healthy snacks and workbook included. Program fee \$25. For more information call 1-800-485-0205. ■



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Award from page 9


convincing of this man's contributions. I could go on listing his volunteer work at the free clinics, his teachings to medical students and primary care physicians, etc. But, his forte is collaborating, connecting and communicating. And he has combined these: his very best skills, with his passion for prevention and his passion for helping people prevent the very diseases that he treats later in life and put them to work in our community.

Thank you, Dr. Schneider!

Paul...your significant community contributions, including your ability to listen to every voice and hear what they say, your passion for and dedication to prevention and your very best skills are exactly why we honor you tonight.

One more time, thank you Dr. Schneider – we are grateful and appreciative of all that you do. ■


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BULLETIN

Pierce County Medical Society



February 2009

PCMS members visit Olympia, lobby for medicine



PCMS members (L to R) Drs. Len Alenick, Bill Hirota, Vita Pliskow, Don Russell and Terry Torgenrud prior to meeting with their 28th District Representative Troy Kelley during WSMA Legislative Day

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Pierce County Medical Society BULLETIN

February 2009

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President's Page

by J. David Bales, MD

I love it when a plan comes together...



J. David Bales, MD

Some of you may recall the 1970's TV series "The A Team" whose leader was a cigar chewing Colonel fond of saying "I love it when a plan comes together . . ." I couldn't help but think of that remark at January's Medical Reserve Corps (MRC) meeting that included an after action report of the December 2008 flooding that hit the Puyallup river and came close to breaching the levy – a situation that would've inundated the Puyallup city center and caused evacuation of large segments of the population in the area. As it was, a nursing home was evacuated and a call for evacuation support was passed to the MRC in the Emergency Operations Center. The MRC was able to respond to the request and deploy volunteers in just over an hour to assist in the displacement of elderly and disabled inhabitants of the nursing home.

Contrast this with the situation in 2005 when the call came to the Pierce County Medical Society for volunteers to screen up to 2000 evacuees from New Orleans – the first group of which was to land at McChord Air Force Base within 72 hours. A mass fax was sent out and within 24 hours over 24 physicians responded that they would be ready to participate. It was fortunate that those evacuees never arrived because the "devil in the details" revealed that none of those volunteers would have been allowed to participate!! None of us were registered emergency workers and none had completed any emergency worker training – even as limited as the training requirement was. That situation prompted Sue Asher, Executive Director of the PCMS, and several of the PCMS Board to say "Never again – we will be prepared next time." I used my response to Hurricane Katrina/Rita to observe and sort out the myriad faces of volunteerism in disaster. I became aware of the existence of the Medical Reserve Corps from several communities and returned convinced that this organization could become the conduit for preparedness with the least amount of time and resource expenditure. The Tacoma/Pierce County Health Department invested in the development of a local MRC and over the last three years has attracted volunteers of various disciplines and provided training and opportunities for community participation in such activities as the Homeless Connect program and support of the Tall Ships visit. They also train in community wide practice and planning for mass dispensing of vaccines and medications and development of alternate care facilities as part of a pandemic response.

The last three years of practice and planning paid off last month in response to the adverse weather conditions and its associated flooding. Continued strategic planning will soon occur and any interested member of this Society or the community at large is encouraged to join and be prepared for volunteer opportunities.

If you are interested, visit the TPCHD web site (under the "Health" tab) at www.tpchd.org or contact Justin Schumacher (jschumacher@tpchd.org or 253-798-7675) or Cait Campbell (CCampbell@tpchd.org). "I love it when a plan comes together." ■

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PCMS members visit Olympia and visit with their legislators during WSMA Legislative Day

It was a sunny day in Olympia, weather wise, which was in sharp contrast to the somber mood of legislators grappling with grim budget issues at WSMA's Legislative Day in late January.

Over 150 physicians visited the Capitol to stress the importance of medicine's issues to their elected representatives. PCMS members attending the day's activities included representatives from the 28th Legislative District, **Drs. Len Alenick, Bill Hirota, Vita Pliskow, Terry Torgenrud and Guthrie Turner.** From the 27th District, **Drs. Richard Hawkins, Kevin Murray, Nick Rajacich, Don Russell, Wendel Smith, George Tanbara and Ali Thomas.** From the 26th District, **Drs. Dan Ginsberg, Les Reed, Sumner Schoenike and Mark Yuhasz** and from the 25th District, **Drs. Ron Morris and Pam Cowell.**

The session began with a briefing for meetings with legislators and a review of issues and talking points. The targeted issues for this session included:

1) Medial Assistance, Basic Health Plan and Other Budget Items. The WSMA has grave concerns about the recommended cuts to the Basic Health Plan (BHP) the Medicare Program and GAU Medical funding. Legislators were urged, in their budget deliberations, to make sure that Medicaid and BHP and other vital health care services are appropriately funded and not subject to any cuts so that patients can have access to care when it is needed. It was explained that the neediest patients will go without health care, and the ED visits will increase further. Vaccines for kids is money very well spent and must be continued as our state already struggles with adequate vaccinations.

2) Expanded Scope for Medical Assistants. (House Bill 1414) Support was urged for this bill which would expand the scope of practice for medical assistants to allow them to provide oral medications to patients via a physician's office. Current state law allows medical assistants to provide medications only via injections. They are prohibited from dispensing medications orally, meaning they can give a shot but not a Tylenol tablet. Easing this restriction for the health care team makes sense.

3) Public Health Funding. (HB 1307) Stable, dedicated funding for essential public health services designated to assure that all local health jurisdictions have sufficient resources is a priority of WSMA and PCMS. Public health is the first line of defense in responding to disease outbreaks, bioterrorism and in disaster preparedness. It is also the center of a quality health care system and is the most cost effective system for disease prevention and health improvement. Participants briefed legislators that Public Health cannot afford any more budget cuts.

4) Wrongful Death. The WSMA opposes efforts to expand the state's wrongful death statute by broadening the scope of people who are allowed to file a wrongful death claim. It is expected that the trial bar will make a strong push for passage of this legislation this year. They seek to expand who is eligible to receive compensation by removing certain dependency and residency requirements and by increasing the age that a parent of a deceased child can bring an action from 18 to 26. The bills would also expand the types of damages recoverable under the statute and would require compensation for loss of enjoyment of life by the decedent. This proposal, supported by the Washington State Trial Lawyers Association, runs counter to the agreement reached with them in 2006, and codified HB2292 on health care liability reform. If passed, they will add to physician premiums for medical liability coverage.

5) Office-based Imaging. The WSMA has serious concerns about efforts to ban self-referral for electronic imaging services, computed axial tomography services, positron emission tomography services, or single photon emission computed tomography services. The WSMA urged physicians to ask legislators to craft common sense laws regarding self-referral that address inappropriate utilization of these services and not ban referrals to physician owned services.

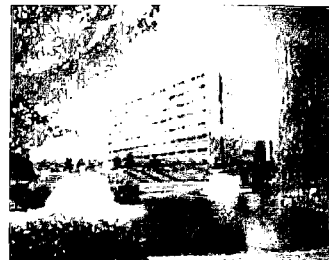
After legislative briefings and sessions on how to communicate with your legislator – participants boarded buses to the Capitol. Briefings were held with Mary Selecky, Secretary of the Department of Health, and Doug Porter, Assistant Secretary DSHS, Medicaid Director.

The featured speaker of the day was Governor Christine Gregoire. In her address, she noted the difficult decisions they were facing as the legislature must cut \$6 billion from a \$30 billion budget. She explained that 60% of the Budget is mandated and not touchable, so the \$6 billion has to come from the other 40%. She reported with confidence that the SCHIP bill will be passed out of the Senate and will provide an additional \$94 million for the current fiscal year and over \$500 million over next five years to increase coverage for children up to 300% of the federal poverty level. She said she is also expecting an additional \$2 million from the federal budget which will help defray state cuts.

The governor asked the WSMA to continue their excellent working relationship with her as budget and reform issues continue. She added that the health care reform working group passed two years ago to work on health care reform issues including meetings around the state might be funded, but if so, it would be on a very limited basis.

PCMS extends a hearty "thank you" to all participants. ■

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The Health Status of Pierce County

by Anthony L-T Chen, MD



Anthony Chen, MD

Our public health work plan - 2009

At the Tacoma-Pierce County Health Department, our Mission is: To safeguard and enhance the health of the communities of Pierce County. We provide a broad scope of critical services that go beyond ensuring safe food in our restaurants, clean drinking water, protection from infectious outbreaks, and clean air free from tobacco smoke. Our services also include ensuring access to medical, dental, and social services; long term investments in our children and families resulting in more learning, less violence, and productive citizens of our county; and the development of healthy communities for healthy people.

In many ways, what we do overlaps with what you – the members of the Pierce County Medical Society – do, but we tend to focus on populations and systems rather than individuals, and on prevention rather than treatment. Our work so often intertwines: we distribute vaccines for all children in our county, but you are the ones who engage the parents and give the shots. You fill out the school physicals and shot records while we work with the school nurses to make sure all the children in the class get their shots and reduce the chance we'll have to investigate an outbreak of chickenpox or other contagious disease. If a child falls from the jungle gym and breaks an arm, you are the ones in the office or emergency room who cast it. Yet we help make sure the

child has health insurance and a medical home so s/he can get the care. In fact, going back in time, we may have helped make sure that child's mother got into your office so you could provide prenatal care. We may have home visited Mom, resulting in better pregnancies, a better start in life, and many fewer referrals to our overburdened social service system. Indeed, we are all members of the village that is raising the child.

When it comes to financing, however, our systems are very different. Challenging as they may be, you do have a system of medical insurance, Medicaid, Medicare, and other reimbursement programs that pay for your services. In contrast, there are few things we can bill a third party. Some services are supported by licensing fees but most are funded by federal, state, and private grants and by city and county appropriations.

Now, we are facing critical funding threats. Federal and state categorical funding as well as state, city, and county discretionary funding have been flat for some time. Adjusted for population growth and inflation, our purchasing power is plummeting.

You may remember that prior to 2000, public health was supported by the Motor Vehicle Excise Tax. How someone decided that the value of one's car was related to his or her share of public health protection is beyond me, and Tim Eyman took advan-

tage of that disconnect. When his Initiative 695 slashed the price of car tabs, it took a chainsaw to public health funding. The State Legislature provided some backfill funds in 2001, which we have been spending down since.

In 2007, the Legislature through E2SSB 5930 invested \$10 million a year on statewide public health priorities, although it was estimated that \$40 million was needed just to meet current shortages. Now, as you all know, the State is facing a \$5.7 billion, and ever growing, shortfall. Already, we have been receiving letters from DOH and DSHS notifying us of cuts to and elimination of programs. At the same time, the economic downturn has reduced our licensing revenues as the construction and restaurant businesses have suffered.

In this context, what are our priorities for the coming year? As the new Director, I am working with managers and staff to: 1) build a public health strategic plan for our communities, 2) preserve and where possible improve our ability to provide essential services, 3) advance policy interventions that advance public health, and 4) seek stable and dedicated funding to continue our work.

Much of the work is currently internal, starting with establishing goals and purposes within the scope of our Mission. Especially in a time of tight

See "TPCHD" page 10

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Doctor liable for not providing sign language interpreter

A punitive damages verdict is enough to catch anyone's attention. But a verdict for punitive damages in a disability discrimination case can be a double whammy for physicians.

Since such claims are not covered under traditional medical liability insurance, any judgments would come out of doctors' own pockets.

That is exactly what befell New Jersey rheumatologist Robert A. Fogari, MD, when a Hudson County jury in October 2008 unanimously handed down a \$400,000 award against him for allegedly refusing to pay for a sign language interpreter for a patient who is deaf. Half of the award was for punitive damages.

The verdict is believed by some legal experts to be among the largest of its kind, and has many physicians fearing it will set a dangerous precedent and prompt similar litigation.

Dr. Fogari had treated Irma Gerena for lupus for about a year and a half, beginning in May 2004. Over the course of about 20 office visits, Gerena claimed in court documents that she repeatedly asked Dr. Fogari to provide a sign language interpreter, but was rebuffed.

The Jersey City rheumatologist argued that, as a solo physician, he could not afford the cost, which was estimated at \$150 to \$200 per visit. The expense was overly burdensome given that Medicare reimbursed only \$49 per visit, according to Dr. Fogari's attorney. Instead of hiring an interpreter, Dr. Fogari exchanged written notes with Gerena, with the help of family members. After her diagnosis, Gerena's treatment largely involved monthly check-ups to monitor her medication, with no major complications, the doctor's attorney said.

Gerena made no allegations of medical negligence. But because Dr. Fogari denied her an interpreter, she claimed she never had "any real understanding" of her diagnosis, treatment or prognosis, and was deprived of an equal opportunity to fully participate in her medical care, according to the complaint. Dr. Fogari treated Gerena's condition with steroids, but she alleged the

doctor never fully explained the risks and benefits.

Gerena transferred to another doctor. She then sued Dr. Fogari, alleging he violated the federal Americans with Disabilities Act and the Rehabilitation Act, as well as New Jersey's anti-discrimination law. The jury agreed, finding Dr. Fogari discriminated against Gerena when he failed to provide a sign language interpreter to make sure he was effectively communicating with his patient. Dr. Fogari is appealing the verdict.

Effective communication

State and federal law generally prohibit discrimination on the basis of disability and require physicians and other private, covered entities to provide reasonable public accommodations to ensure "effective communication" with patients who have disabilities such as blindness or hearing impairment, and with their family members.

But those accommodations include a range of so-called auxiliary aids that doctors can use, including note-takers or video or computer-based transcription devices, which can be less expensive than an interpreter service, said Lawrence Downs, general counsel to the Medical Society of New Jersey. The physician organization is considering getting involved in the case on appeal.

"We need to make sure those remain viable options for physicians. And the courts have been careful in saying, if [doctors] can communicate effectively and patients can participate in their treatment, physicians have pretty wide latitude in how to effectuate that communication," Downs said.

A qualified interpreter may be required for complex diagnoses or treatment decisions, such as a high-risk surgery, but not necessarily for routine or maintenance care, he said.

"No one disagrees there should be effective communication. ... The question is, how does public policy justify physicians bearing the cost [of a more expensive interpreter service] when reimbursement doesn't come close to covering it?" Downs asked.

Gerena had argued to the jury that the annual cost of a sign language interpreter amounted to less than a quarter of a percent of Dr. Fogari's yearly income.

The expense may seem negligible for a single patient, said Antranig Aslanian Jr., the rheumatologist's attorney. "But what if you had 40 or 50 patients?"

State and federal disability and anti-discrimination laws contemplated the impact that such accommodations would have on a smaller versus a larger practice, he said.

The courts also should consider whether medical negligence was a factor, Aslanian said. Gerena was not required to show that anything went wrong with her care in order to bring her disability discrimination claim. At the same time, Dr. Fogari was prevented from raising that defense.

Meanwhile, because disability discrimination claims typically are not covered by medical liability insurance, physicians are left personally liable for any judgments. That, on top of the interpreter costs, puts additional strain on doctors and ultimately strains access to care, Aslanian said. He added that in this case, the punitive damages - typically rendered for intentional conduct - were unwarranted.

"There was no question in this case regarding any malpractice or misdiagnosis. So if a patient is properly treated, there had to be some reasonable, effective communication," he said, noting that Dr. Fogari and Gerena mutually agreed to communicate using written notes.

"The patient wasn't treated differently than anyone else, so how is that discriminating?"

American Medical Association policy opposes any discrimination based on an individual's disability. The AMA also supports legislative efforts to clarify requirements in the Americans with Disabilities Act regarding the provision of qualified interpreters for patients with hearing impairment. Orga-

TPCHD

from page 7

resources, we have to be sure where we are going so we can prioritize and plan the best strategy. We are committed to establishing clear measures and logical processes that will help us integrate and innovate. We look to break down silos and develop different and better ways to do our internal processes and external programs. As we proceed, we are committed to being transparent, innovative, and collaborative.


Our policy portfolio is not fully established, but we anticipate topics will include:

- Sustainable Public Health funding
- Tobacco: smoking in cars with children; smoking in multi-unit rental housing
- Immunizations: exemptions from school requirements*; efforts that result in decreasing immunization rates*
- Early childhood interventions: home-visiting learning and prevention programs
- Vital records: electronic approval of birth and death certificates
- Health care access: children's health coverage; universal health coverage
- Chronic disease prevention: active living and healthy eating; menu labeling, built environment, health disparities
- Environmental health: reduction of local authority*

- Communicable diseases: HIV testing, screening and treatment of latent TB infections

(* - these are topics that we oppose because they erode our ability to protect the public's health)

Regardless of the plan, processes, or policies we implement, we will be successful only if we can rely on the medical community and our other partners to work with us. I look forward to building our relationships so, together, we can safeguard and enhance the health of the communities of Pierce County. ■



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Washington Ranks #10 in America's Health Rankings

The United Health Foundation has ranked Washington State #10 this year compared to #12 in 2007 in its annual health care and outcomes report for 2008. Determinants include:

- 1) Personal Behaviors such as smoking, drinking and obesity
- 2) Community and Environment such as graduation, crime, occupational fatalities, infectious diseases, poverty and air pollution
- 3) Public & Health Policies which measure insurance coverage, public health funding and immunization coverage
- 4) Clinical Care including adequacy of prenatal care, primary care physicians and preventable hospitalizations
- 5) Health Outcomes for poor mental health days, poor physical health days, geographic disparity, infant mortality, cardiovascular deaths, cancer deaths and premature deaths

Washington's strengths included:

- 1) Low prevalence of smoking at 16.8% of the population
- 2) Low percentage of children in poverty at 11.6% of those under 18
- 3) Low infant mortality rate at 4.8% deaths per 1,000 live births
- 4) Low rate of preventable hospitalizations with 51.9% discharges per 1,000 Medicare enrollees

Washington's challenges remain:

- 1) Low immunization coverage with 73.9% of children ages 19 to 35 months receiving complete immunization
- 2) Low high school graduation rate with 75% of incoming ninth graders who graduate within four years
- 3) Many poor physical health days per month at 3.6 days in the previous 30 days
- 4) High geographic disparity within the state at 12.3%

Significant changes from 2007 to 2008:

- 1) In the past year the percentage of children in poverty increased from 10.5% to 11.6% of persons under age 18
- 2) In the past year, the rate of uninsured population decreased from 12.5% to 11.6%
- 3) Since 1990, the infant mortality rate decreased from 9.7% to 4.8% deaths per 1,000 live births
- 4) Since 1990, the prevalence of obesity increased from 9.4% to 25.9% of the population

Health Disparities: In Washington, low birth weight babies are more common among non-Hispanic blacks at 10.6% than Hispanics at 5.9%. Cardiovascular death rates vary by race in the state, with all races experiencing 263.7 deaths per 100,000 population in contrast to blacks who experience 329.7 deaths per 100,000 population.

For more info about the UHF's health rankings visit the State Health Department website at www.doh.wa.gov. ■

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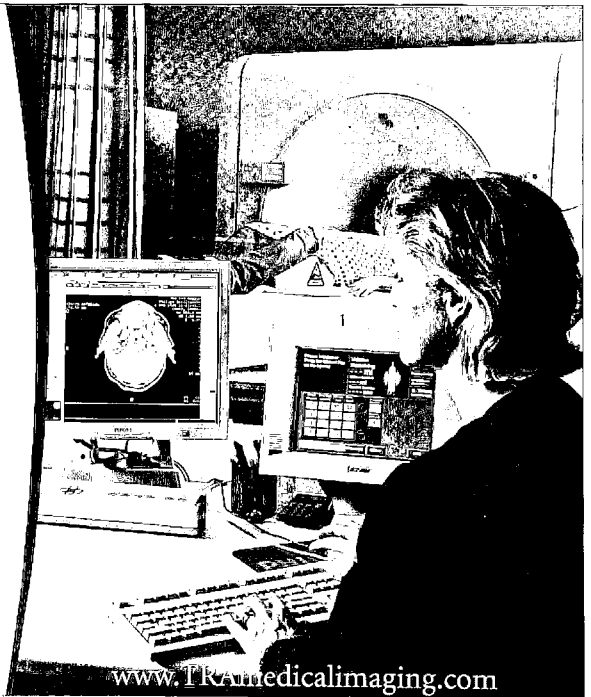
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from page 9

nized medicine continues to monitor enforcement of the ADA provisions to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with patients who are hearing impaired.

A patient's perspective

Whether effective communication exists, however, rests in the view of the patient, not the doctor, said Clara R. Smit, Gerena's attorney.

She pointed to a 2001 New Jersey appeals court decision in *Borgesser v. Jersey Shore Medical Center* that has served as a state and national precedent, and was among the first to define effective communication.

Judges ruled that effective communication was essential during "critical" points of the patient's treatment - aspects that involve significant procedures, consent, diagnoses or treatment options - and that the efficacy of the communication method chosen had to be viewed from the patient's perspective.

In that case, the patient was hospitalized after complications arose from an abnormally rapid heartbeat, during which time the hospital declined her requests for a sign language interpreter. There were no allegations of inadequate care. The hospital was found liable for disability discrimination.

"We as a society have determined we want to have equal access for all patients with disabilities," said Smit, of East Brunswick, N.J. "But even if a doctor thinks he can communicate, that doesn't mean patients can ask questions when they want to and understand enough to really make the decisions they need to make about their medical treatment."

Smit said the punitive damages award in Gerena's case sends a strong message to doctors that they cannot ignore legal obligations to accommodate patients with disabilities. In addition to her requests, Gerena had a sign language interpreter service call Dr. Fogari to offer its services and inform him of the law and Gerena's need, according to

court documents.

The U.S. Department of Justice also can enforce the Americans with Disabilities Act. A West Virginia primary care practice in December 2008 settled a complaint that a patient filed with the government, saying the group failed to provide a sign language interpreter or other auxiliary aids to its patients. The group agreed to pay \$5,000 in damages and civil penalties, establish nondiscriminatory policies for providing effective communication, and train staff and post notices on the policies.

Physicians can argue that providing such services may pose a hardship on their practices, but rarely are such defenses successful, according to legal experts.

Courts generally will consider a doctor's overall resources, financial or otherwise, said Paula Pearlman, executive director of the Disability Rights Legal Center in Los Angeles. For example, courts will look at a doctor's income tax returns. "And in every community there are services available," through advocacy or other organizations to accommodate patients with disabilities, Pearlman said. Doctors also can receive tax credits for providing such services.

"It is an added requirement," Pearlman said. "But you want to give your patient the best possible care, and it's just the cost of doing business." ■

Reprinted from *AMNews*, Jan 5 2009

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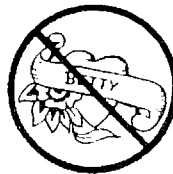
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Trial Lawyer's Association (WSTLA) is now the Washington State Association for Justice!

The Washington State Trial Lawyers Association (WSTLA) has announced its new moniker, the Washington State Association for Justice (WSAJ). "We shall march forward under this banner in service and defense of liberty, truth, justice, equality and the common good," said John Budlong, WSJ president in announcing the change.

The name was chosen to better

align with the Mission of the organization which is "To protect and promote a fair justice system and the right to trial by jury and to ensure that any person who is harmed by the misconduct or negligence of others can obtain justice in America's courtrooms, even in actions against the most powerful interests."

When using the new WSJ name they will continue to note they were

"formerly the Washington State Trial Lawyers Association" for a limited time. They are not abandoning "trial lawyer," just moving toward the future with a focus on justice according to the information on their website.

WSAJ's mission is helped considerably with enormous contributions to their PACs (currently at 10). Keep this in mind when you receive solicitations for membership in WAMPAC. ■

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Dr. Mooney earned her medical degree at the University of Minnesota Medical School. Her residency was completed at the University of Medicine and Dentistry of New Jersey, followed by fellowships in dermatopathology and Mohs micrographic surgery. Her main areas of practice are skin cancer and Mohs surgery.

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Physician Lifelong Learner Program – please provide your feedback!

The PCMS Physician Life-long Learner Program (PLL) has met with great success since its inception in February 2007. The program couples Pierce County Medical Society with the University of Puget Sound's (UPS) community outreach program. The program offers seminar-based discussions on academic topics of interest. Professors give a 20-30 minute talk on a subject in their research or specialty area, and then open the class for questions and discussions. Attendees are welcome to bring their spouse and/or interested guests. A \$10 fee is charged to cover the cost of a "box lunch," and the class, normally scheduled on the 3rd Tuesday of the month on the UPS campus, begins at 6:30 until 7:30 pm.

The PLL was the idea of Past-President **Sumner Schoenike, MD** who

recently handed the oversight to **Joe Jasper, MD** who has sought assistance from **Dan Ginsberg, MD**.

This program provides an opportunity for physicians to expand their intellect beyond the borders of medicine. Many of the topics offered the last two years have served to broaden understanding of the wider community and the world in general. Topics have ranged from "Fair Trade Under Attack" to "Memory Illusions in the Laboratory and in the Real World." Seven programs were held in 2007 and eight in 2008 with attendance ranging from 15 to 47.

The February 17 program will be "The Rise and Fall of Antibiotics" by John Hanson, Ph.D., Professor of Chemistry and the March 17 program will be about tracking the impacts and

measurement of auto emissions. Topics have been selected based on solicitation from UPS faculty. They appreciate and enjoy the opportunity to interact with physicians in the classroom – making for stimulating and interesting discussions.

Drs. Jasper and Ginsberg are seeking ideas for topics of interest from PCMS members and encouraging even more participation in the program. If you have not attended the program, is there something that could be changed that would encourage your attendance?

Change of date, time, child care provisions, other? Please let PCMS know your thoughts about the PLLP program by emailing Sue Asher at sue@pcmswa.org.

Hope to see you Tuesday, February 17, 6:30 pm at UPS!! ■



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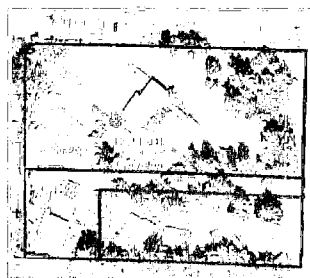
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Radiology for the Non-Radiologist March 13, 2009 - Register Now!

This year's *Radiology for the Non-Radiologist* CME will be held on Friday, March 13, 2009 at Fircrest Golf Club under the medical direction of **Andy Levine, MD** and **John Peixotto, MD**.

Topics and speakers include:

- *Pathogenesis and Imaging Evaluation of Back Pain*
- Jonathan Kell, MD and Scott Walker, MD
- *Diagnostic Imaging: Getting the Most for You and Your Patient*
- Andrew Levine, MD
- *Breast MRI Screening of the High Risk Patient*
- Robert Gutierrez, MD
- *New Treatments in Acute Stroke*
- Alison Nohara, MD
- *Radiation Safety for the Referring Physicians: What You Need to Know*
- Mark Yuhasz, MD
- *Musculoskeletal Radiology: Pathways of Imaging Diagnosis and Evaluation*
- David Shook, MD

Start thinking about CME at Hawaii in 2010

The College of Medical Education has selected the beautiful Island of Kauai for our 2010 *CME at Hawaii* program. Kauai is famous for its spectacular beaches, majestic canyons and lush valleys. Kauai is an Eden for relaxation and adventure.

The conference will be held sometime in late March or early April of 2010, the same week that Tacoma, Gig Harbor and Puyallup school districts have their spring break. When these dates are released we will let you know so you can secure your vacation and start the planning. The resort location should be selected by the end of February.

We hope you will plan to join your colleagues and their families next spring for our *CME at Hawaii* program. ■

This highly focused program is a one day continuing education course designed to update primary care and specialty physicians on advances in radiology. At the conclusion of the course, participants should be able to:

Understand the pathology and progression of degenerative disk disease within the spine. Identify the imaging findings that correspond to different stages in degenerative disk disease. Understand the epidemiology and natural course of uncomplicated low back pain. Identify the appropriate clinical indications, based on history and physical examination that call for imaging studies, including radiographs of the spine as well as CT or MRI exams; Review the basic imaging modalities available today along with their advantages/disadvantages. Discuss issues relating to radiation safety and contrast administration. Discuss the ACR (American College of Radiology) appropriateness criteria and other sources for information about diagnostic imaging procedures; Discuss and give a brief introduction to breast MRI and to outline its indications, strengths, and limitations; Identify and review new treatments in acute stroke; Recognize and outline radiation safety for the referring patient; Understand the strengths and weaknesses of different imaging modalities in regards to MSK imaging. Define and introduce the concept of ACR appropriateness.

You should receive a program brochure in the mail shortly with registration information or call the College at 253-627-7137 to register over the phone. The fee is \$35 for PCMS members (active and retired) and \$50 for non-PCMS members. ■

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<u>Date</u>	<u>Program</u>	<u>Director(s)</u>
Friday, March 13	Radiology for the Non-Radiologist	Mark Yuhasz, MD Andy Levine, MD
Thursday, April 16 Evening, 4-8 pm	New Developments in Primary Care	Michael Bateman, MD
Friday, May 8	Internal Medicine Review	Garrick Brown, MD
Friday, June 5	Primary Care 2009	Kevin Braun, MD

Doctors In the House sponsors The Canadian Brass

"Doctors in the House" – that's an intriguing name, the name of a group of physicians who share a passion for great music and join together to support the arts in our community. Many of us chose to practice in Tacoma not only because it was a good place to practice and close to mountains and sea, but also because it had an increasingly vibrant history and inspiring cultural offerings.

The Tacoma Philharmonic, now celebrating its 72nd Anniversary Season, is one of Pierce County's most storied arts organizations. Each year the Philharmonic presents world-class music experiences, including world renowned solo artists, chamber ensembles and orchestras. Presentations have included Yo-Yo Ma, Midori, Itzhak Perlman, Joshua Bell and James Galway, just to name a few. The current season's concerts have included stellar performances by the Academy of St. Martin in the Fields and YouTube sensation Straight No Chaser.

Doctors in the House was orga-

nized five years ago by a group of physicians who have been long-time supporters of the Philharmonic's programs. This season Doctors in the House will sponsor a concert by the world's most famous brass ensemble. The Canadian Brass, on Thursday, March 19 at the Pantages Theater in downtown Tacoma.

Founded in 1970, the Canadian Brass was named the "world's leading brass ensemble" by The Washington Post and credited as "the men who put brass music on the map." They are best known for their ability to seamlessly cross between classical and jazz styles.

As usual, however, ticket sales will cover only half of the concert's cost. Doctors in the House helps with the other half! Our sponsorship of this concert helps to pay the costs of bringing these brilliant artists to Tacoma, helps to assure the continued growth of the musical arts in our community, and assists in funding the Philharmonic's other programs which seek to develop new and informed future audiences for

great classical and contemporary music.

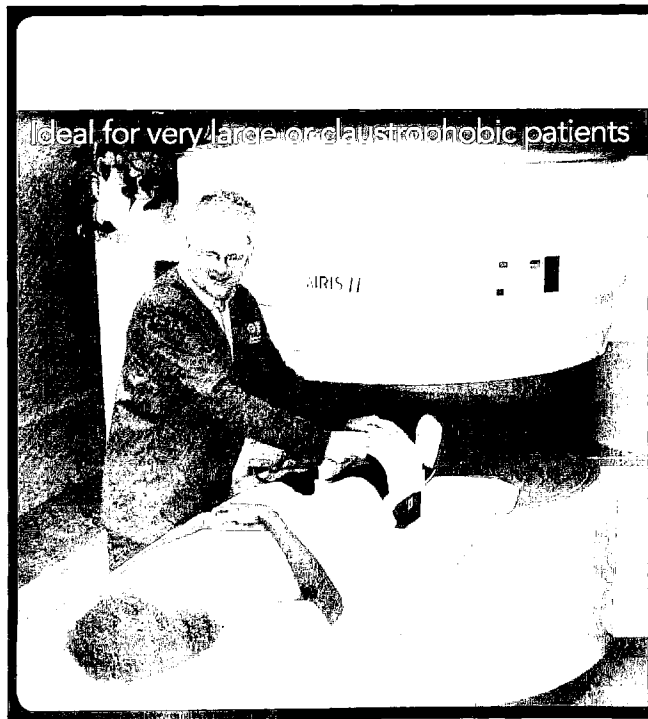
Doctors in the House sponsorship advantages to physicians include:

- Two complimentary tickets to the Canadian Brass concert for a contribution of \$250, four tickets for \$500, eight tickets for \$1,000.

- Invitation to a Members Only reception with The Canadian Brass immediately following the performance.

- Recognition from the stage, in a lobby poster, in the program brochure and in the Philharmonic's newsletter, and recognition of your support for classical music presentation among your peers and throughout the community.

We invite you to join us as a member of Doctors in the House. We look forward to celebrating with you on March 19 as we sponsor the Canadian Brass at the Pantages Theater! For information please call (253) 272-0809, email exec@tacomaphilharmonic.org or Dr. Richard Hoffmeister at 584-6935 or by email at richardhoffmeister@mac.com. ■



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BULLETIN



March 2009



The University of Texas - Medical Branch

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BULLETIN

Pierce County Medical Society



March 2009

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President's Page

by J. David Bales, MD

Oh Brother - Where Art Thou??



J. David Bales, MD

The annual Pierce County Board of Trustee's retreat kicked off on January 17, 2009, with presentations by the Washington State Medical Association President, Executive Director, and Lobbyist with a review of both the WSMA agenda and the current climate concerning health care in both Washingtons. Our local Hospital/Health Systems gave updates on individual and collaborative efforts in our community and this was followed by the Tacoma/Pierce County Health Department Director reviewing the 2009 priorities and goals of the Health Department. The PCMS Executive Director then gave a PCMS Organizational review and update.

All of these presentations carried a couple of themes that are well known to you by virtue of living in this area. The first is that "the times they are achanging" and health care is pretty near the top of local and national agendas. Second was the obvious downturn in the economy that affects us individually and "corporately" regardless of the business environment we work in. Third was the emphasis by its absence of any solutions.

As a Board we attempted to address "Staying Relevant in an Unstable Environment." The discussion was wide ranging and reminded me of the outcome of **Ron Morris, MD**, "SWOT" (Strengths, Weaknesses, Opportunities and Threats) analysis that the Board participated in last year. Addressed in every one of those categories was membership. Being a membership organization is one of our strengths, one of our weaknesses, and is both an opportunity and a threat.

The WSMA's Leadership retreat last year began with a keynote speaker who addressed all of the above with a recommendation that medicine speak with one voice if it hoped to have any influence on the outcome of the political and economic pressures on our society. That was an echo of the comments by presenters of last year's Legislative Summit in Olympia – namely, that "divide and conquer" had always been an effective strategy to overcome the medical communities concerns and, oh by the way, physicians had the reputation of having deep pockets but short arms!!

Physician membership in the American Medical Association is about 18% and getting participation in state and local "house of medicine" activities is traditionally difficult. Thus my title – "Oh (82% of my) brothers, where art thou?? I've heard all of the reasons for not being a member – "I'm already a member of a specialty society, the AMA is a bunch of dinosaurs and they don't represent me, I only want to practice medicine and am not interested in business or politics."

Unfortunately, all of those positions contribute to the "divide and conquer" approach and will certainly promulgate a self fulfilling prophecy as others go about the business of defining the business, politics and economics of medicine of the future. Your individual positions may not make it to the top of the "Voice of Medicine" list if you are a member, but it certainly won't be heard if you are not. The "Health Care Reform" (or more likely "Re-engineering") train is leaving the station. Don't get left standing on the platform. ■

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Responding to I-1000 Physician Participation and End-of-Life Care

by Kristin Petersen, Coopersmith Health Law Group

Initiative 1000, the "Washington Death with Dignity Act," authorizes an attending physician to prescribe lethal medication to certain terminally ill patients.

A physician has the right to decide whether to participate in the new law. The law only applies to willing health care providers. Many hospitals and physicians are grappling with what their policy or approach should be.

The decision whether to participate in the law is complex and driven by a host of personal and professional considerations, including a concern among some physicians that participation in a law that helps end a patient's life may create a stigma for the profession.

END-OF-LIFE CARE

The law appears to be sparking discussions among medical communities and professional associations about improving end-of-life care.

One study found that the passage of the Death with Dignity Act in Oregon brought agreement by both proponents and opponents of the law regarding the need to improve care of the dying. Many Oregon physicians reported that they had made efforts to improve their care for terminally ill patients, were more likely to refer these patients to hospice, and believed that hospice is more accessible since passage of Oregon's Death with Dignity Act.¹

A patient's request for information about the law presents an opportunity for physicians to help patients make informed decisions about their care and discuss concerns they may have about end-of-life care. The law does not provide guidance for physicians on how to respond to patients.

A physician may want to determine what is behind the patient's inquiry:

- Is the patient in pain?
- Does the patient fear she or he will have pain?
- Is the patient concerned about being a burden to loved ones?
- Is there a fear of loss of control? A fear of the unknown?
- Has the patient had an unpleasant experience watching a loved one die?

ADVANCE DIRECTIVES

Washington law requires hospitals to ask patients if they have made an advance directive when the patient is admitted to the hospital. Washington also has a newly instituted Living Will Registry. The Department of Health manages the confidential database that patients and providers may utilize to

store and access advance directives.

A patient's advance directive may potentially conflict with either the hospital's policy or the physician's decision not to participate in the new law. If a conflict exists, the patient should be informed of the conflict and attempts should be made to honor the portions of the advance directives that are not in conflict.

HOSPITAL AND PROVIDER POLICIES

A physician should carefully review the contracts, policies, and bylaws of the hospitals he or she is affiliated with, as well as agreements with other providers and with health plans that may address the treatment of the terminally ill.

Like physicians, hospitals have the right to decide whether to participate in the new law. A hospital choosing not to participate may prohibit a physician it employs or contracts with from participating in the law, within certain limitations. The hospital can only prohibit a physician from participating:

- On the hospital premises;
- In facilities or on property owned or controlled by the hospital; or
- As part of the physician's services as an employee or independent contractor of the hospital.

A hospital must document its decision to prohibit participation in the law in its policies, procedures, and medical staff bylaws. The hospital must also provide notice of its decision to physicians with privileges to practice at the hospital and to the general public.

A hospital's policy, however, cannot prohibit a physician from:

- Making an initial determination that a patient is terminally ill and informing the patient;
- Providing information about the new law to a patient who requests the information; or
- Providing the patient, upon the patient's request, a referral to another physician who may be able to respond to the patient concerning the new law.

Conversely, a hospital choosing to participate in the law cannot require a physician to participate.

CONFIDENTIALITY AND PRIVACY

There are no special provisions in the new law pertaining to communications between the physician and patient.

See "I-1000" page 19

¹ See Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act. JAMA. 2001;285:2363-2369.



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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH
and Acacia Larson, MPH, RD, CD

Promoting Healthy Eating and Active Living in Pierce County



Anthony Chen, MD

March is National Nutrition Month, the perfect time to discuss the elephant in the room: obesity. It is well known that obesity rates have been rising nationally and locally for the past two decades, and that obesity confers an increased risk of a whole host of chronic diseases. Two-thirds of adults (1) and a quarter of high school students in Pierce County are overweight or obese (2). When we consider that carrying just 10-20 pounds of excess weight increases risk of coronary heart disease by up to 60% (3) and that being born to obese parents increases the risk of a child becoming overweight (2), it becomes clear that obesity places a huge burden on our current and future health care system.

There is no quick fix to this problem, and while asking patients to make healthy lifestyle choices is part of the solution, it must be part of a larger coordinated effort to create environments that promote healthy lifestyle choices. This is another situation where the medical community and public health must continue to work together.

As physicians, your patients will look to you for guidance on how to make healthy and nutritious choices. Here are a few simple strategies:

- When discussing nutrition as a weight maintenance strategy, keep it simple and focus on the positive. The only way to prevent weight gain is to balance calories eaten with calories burned through physical activity. I per-

sonally like to use the bank account analogy: what you have in the bank comes down to the difference between what you put in and what you take out. In other words, patients should be "spending" everything they can in their calorie bank. It's one account that's better kept empty.

- Encourage your patients to eat five or more cups of low-calorie fruits and vegetables every day and to get 30 to 60 minutes of physical activity at least 5 days a week. For children and parents, I find that the "5-2-1" message is easy for them to remember: 5 servings of fruits and vegetables, no more than 2 hours of television and video games, and at least 1 hour of exercise each day. Holding up your fingers with each number gives the child a visual cue that you can revisit at each office visit.

- Encourage low-calorie beverages. Soda and juices are calorically dense and are linked with weight gain. For adults, just switching from two sodas a day to one soda a day can result in a 10-15 pound weight loss over one year. For children, present parents with the opposite message: remind them that children do not need to drink juice or soda and that kids can gain ten pounds in a year from sugary drinks alone. Besides, the cheapest, healthiest drink still comes out of the faucet.

- Encourage breastfeeding. Children who are breastfed have a reduced risk of obesity (4).

- Be a role model.

- Join CHAMP, the Pierce County Medical Society's Coalition for Healthy Active Medical Professionals. It raises awareness and increases the fitness and health of the medical community. For more information go to health and fitness initiatives at: www.pcmswa.org.

- Institute healthy workplace practices at your office that encourage healthy foods by taking the Healthy Food in Healthcare Pledge, or creating a healthy food policy for work meetings and vending machines. Of course, if you belong to a larger health care system, ask them whether they have implemented similar policies systemwide.

- Find active ways to get to work. Walk, ride a bike, or take the bus. Not only does it keep you healthy and save money, but you will find it refreshing and an opportunity to see your community as your patients see it.

Our environment has a substantial influence on our personal behavior. For a person who lives in South Tacoma and relies on public transportation, the nearest source of food may be a convenience store loaded with processed foods and devoid of fresh fruits and vegetables. The choices available to us depend largely on our environment. If we work together to create environments that encourage physical activity and access to healthy foods, then making healthy lifestyle changes becomes much easier.

See "TPCHD" page 10

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


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From the history file...

Tacoma's medical community rallies in the 1907 streetcar accident that killed 43

Four young nuns from the Order of Saint Francis arrived in Tacoma the summer of 1888 to establish a school, an orphanage and a dispensary to care for the needy. Father Hylebos had directed construction of a house on the corner of south 18th and I streets for this purpose. The Sisters arrived a day ahead of schedule and spent their first night at the opulent Tacoma Hotel, probably the one night in their lives they enjoyed such luxury.

The Academy of Saint Francis flourished, but it wasn't long before the ten bed dispensary on the second floor was filled with accident cases from the mills, the ships in port and the logging camps surrounding town. The summer of 1890 four more nuns were called to Tacoma to assist in the dispensary and to raise funds to build a charity hospital here. In 1891 the new hospital was opened and the Academy was closed down. Eight years later the hospital was expanded to twice its original size, including a modern steam-belt passenger elevator guaranteed to attain a speed of 175 feet per minute in the three-story building. In 1902 the name of the Hospital had changed from the Saint Francis Hospital to Saint Joseph's, and the speedy elevator was replaced by a more reliable one by Otis.

It had been a continuing struggle, but the little Sisters of Saint Francis had at last, in the year 1900, one of the most modern hospitals in the State, the most modern surgery and the best-equipped emergency facilities for industrial accidents in the area.

J.J. McKone, chief surgeon at Saint Joseph's, was described as a fearless and able surgeon with a biting Irish wit. The counterpart of Fannie Paddock's Charles McCutcheon, Doctor McCone enlivened the P.C.M.S meetings with his jokes. He was intensely religious and often operated with C.E. Case, who was an atheist. Doctor McCreery recalled later... "Many a bitter religious war was waged over the open abdomen there."

The morning of the Fourth of July, 1900, Doctor McCone was making hospital rounds at Saint Joseph's, as were Drs. Case, Libby, Parks and Rummel. The Sisters on the night watch had just retired for their day's rest. The morning was sunny and quiet. Downtown, the streets were decorated with flags and bunting for the festivities planned to celebrate the



Tacoma Railway and Power Company streetcar, ca. 1907

day. A battalion of veterans of the Philippine War assembled at 25th street to march in the parade down Pacific Avenue later that morning.

Shortly after eight o'clock, across Old Woman's Gulch, a streetcar especially scheduled as an excursion car from south Tacoma to the festivities downtown approached the downhill grade on Delinn Avenue. The car's capacity was sixty persons but over twice that number packed the car, with mostly the women and children crammed inside and with the boys and men packed tightly on the vestibules, hanging onto the outside of the car.

Delinn Avenue ran downhill eight blocks, then turned onto C Street and crossed on a wooden bridge about one hundred and fifteen feet over Old Woman's Gulch.

As the streetcar began its downhill descent toward the bridge, the speed of the car was suddenly accelerated and a man jumped off. This gentleman later recounted... "I wasn't certain I had done the correct thing in taking a tumble off the car... but being from San Francisco, I had experienced runaway cars, and it was almost a reflex to roll off onto the grass."

The car careened away from him downhill. The passengers were screaming and some were jumping off. Some threw their babies out of the car windows. The man from San Francisco ran downhill after the car. He said... "I looked down at my feet and there was a child of about three years who had been thrown out the window of the car. I didn't go any farther."

Another man who had jumped from the runaway car told later... "For several blocks we heard the cries of jump, jump off now! from some people on board. The crowd inside the streetcar was crushed together so that no one could have moved out. We stood outside on the vestibule, seeing the car was out of control, but never imagining the chance to leap away. One man did jump. It was several blocks later that another man attempted to jump and was restrained by some

See "Accident" page 12

TPCHD

from page 7

Pierce County has several innovative partnerships that help create healthy environments. A few examples are:

- **Healthy Communities of Pierce County** started as a collaborative effort of the Medical Society and the Health Department. It seeks to improve the health and wellness of Pierce County residents through healthy eating and physical activity. It promotes environmental solutions and institutional and government policies and practices. For more information see: www.healthypierce.org.

- **The Pierce County Gets Fit Initiative** encourages healthy menu options at over 60 local restaurants through the Get Fit Passport to Healthy Dining Out program. More information can be found at the Center for Healthy Living at: www.multicare.org.

- **The Tacoma-Pierce County Walking Guide** is a guide to 25 walking routes throughout the county. It highlights the efforts of many cities and towns and can help increase awareness about local opportunities for walking to improve health. For more information, or to request a copy contact: Acacia Larson at alarson@tpchd.org

- **SmartMenu** is a voluntary pilot menu labeling program that encourages locally owned and operated restaurants in Pierce County to provide nutrition information on their menus. Customers can place stickers on their bill receipts to let restaurants know that they would like to see nutrition information on menus. For more information and to order stickers visit the

Smart Menu page at: www.tpchd.org or call 253-405-8024

- **The 2009 Pierce County Community Action Plan for Active Living and Healthy Eating** is a guide to specific actions that communities can take to create healthier environments in Pierce County by making healthy food available and affordable in all communities, and creating built environments that support physical activity as part of everyday life. An example is supporting farm to institution practices as a strategy to provide healthy food in hospital settings. For more information, or to request a copy contact: Kirsten Frandsen at kfrandsen@tpchd.org

There are so many other ways that we can make a difference. Thank you for your efforts in the exam room to promote healthy eating and active living. Thank you, also, to all of you like **Dr. Patrick Hogan** (founder of CHAMPS) and **Dr. Jane Moore** (Director of Healthy Communities of Pierce County) who are working at community levels. ■

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Dr. Mooney is board-certified in dermatology and dermatopathology, and is a fellow of the American College of Mohs Surgery, American Society of Dermatologic Surgery and the American Academy of Dermatology.

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Dr. Mooney earned her medical degree at the University of Minnesota Medical School. Her residency was completed at the University of Medicine and Dentistry of New Jersey, followed by fellowships in dermatopathology and Mohs micrographic surgery. Her main areas of practice are skin cancer and Mohs surgery.

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The Washington Death with Dignity Act

Physicians Insurance has prepared this summary of the Washington State Death with Dignity Act, which comes into effect in March, 2009. The summary defines the criteria for patient participation and physicians' guidelines for either carrying out patients' requests, or for opting out of doing so. Physicians Insurance members may log onto www.phyins.com, to find the proposed Department of Health forms that must be completed as required by current regulations. Non-PI members can access these proposed forms on the DOH Web site.

SUMMARY:

The Washington Death with Dignity Act (Act), Initiative 1000, was passed on November 4, 2008, and allows terminally ill, competent, adult Washington residents, medically confirmed to die within six months, to request and self-administer life-ending medication prescribed by their attending physician. The new law goes into effect 120 days after the election (March 5, 2009).

Currently, the Department of Health (DOH) is proposing rules to implement Initiative 1000. The proposed rules clarify definitions, reporting requirements for health care providers, and confidentiality of the collected information.

CRITERIA FOR PATIENT PARTICIPATION:

The patient must meet certain qualifications to receive a prescription for life-ending medications. The attending physician with primary responsibility for the care of the patient and treatment of the patient's terminal disease must document terminal diagnosis and prognosis, competency, volition, and informed consent.

- **Age:** The patient must be at least 18 years of age.
- **Residency:** Washington residency is required and is confirmed by obtaining copies of the patient's driver's license, voter registration, or evidence of property ownership or lease in Washington.
- **Competency:** The patient must have the ability to make and communicate an informed decision to health care providers based on a court opinion, patient's attending or consulting physician, psychiatrist, or psychologist. Psychiatric or psychological counseling is required if either the attending or consulting physician opines that the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment. Life-ending medication may not be prescribed if a person is suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- **Volition:** A terminal patient's request for life-ending medication must be voluntary and without coercion, duress, fraud, undue influence, or reservations. The attending physician de-

termines whether the patient's request is voluntary. The patient signs the Request for Medication to End My Life in a Humane and Dignified Manner form, confirming the voluntary nature of their request. Two witnesses sign the form and attest to the patient's identity, signature, and volition.

- **Terminal disease:** The attending physician who has primary responsibility for the care of the patient makes the initial determination of whether a patient has a terminal disease, defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. At the request of the attending physician, the consulting physician who is qualified by specialty or experience to make a professional diagnosis and prognosis confirms the terminal diagnosis, competency, and voluntary nature of the request by examining the patient and their relevant medical records.

- **Referral to a consulting physician is mandatory:** The consulting physician, qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease, examines the patient and their relevant medical records; confirms, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease; and verifies that the patient is competent and acting voluntarily, and has made an informed decision.

- **A qualified patient must make an informed decision:** The attending physician discusses the following relevant facts with a qualified patient and documents the information provided in the medical record:

1. Medical diagnosis;
2. Prognosis;
3. Potential risk associated with taking the medication to be prescribed;
4. Probable result of taking the medication to be prescribed; and
5. Feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

Additionally, the attending physician is responsible for:

1. Recommending that the patient notify next of kin (however, a patient who declines or is unable to notify next of kin shall not have their request denied);
2. Counseling the patient about having another person present when the patient takes the medication prescribed and of not taking the medication in a public place; and
3. Informing the patient of their opportunity to rescind their request at any time and in any manner, and offering the patient an opportunity to rescind at the end of the 15-day waiting period.

Accident from page 9

men on board. There was a scuffle. Some threw their young children off the car as it rushed down the hill. We saw that one was crushed on the logs alongside the track. It seemed a long time that we sped down the hill towards the bridge. I was pushed off above the bluff at the last moment, against my own design."

The crash of the car against the hillside was heard all over the town. The sound of the crash reverberated in the gulch and then there was silence. The streetcar had jumped the track at the turn onto the bridge, had flipped over in midair and smashed upside down over a hundred feet below on the bank of the gulch. Only four of the passengers escaped uninjured. Thirty seven died in the wreck, eighty five were horribly injured and six of those injured died later.

The battalion of veterans of the Philippine War rushed to the scene of the disaster. They found a small woman there directing rescue operations with a dozen men and ropes and chains. They had already rigged a crude hoist and had lifted the over-

turned streetcar. Underneath it, in a pile of smashed wood, in their Fourth of July finery, were the dead and dying.

The Veterans set up a first aid station at the pump house about a hundred yards back in the gulch. From there the injured were loaded onto every kind of dray which could be pressed into service and carried up the winding road to Saint Joseph's Hospital above the hill.

The Sisters wrote in their journal... "Those who witnessed the effects of that accident will never forget

it." Most of the injured were brought to the Sisters, as it was the nearest hospital. The injured were lying on tables in the Surgery, in the Etherizing Room and on the floor, waiting for attendance.

The Mayor refused to open the Fourth of July ceremonies, and himself remained at the pump house until the last of the injured had been cared for. The city was aghast at the horrible scene of death in their midst. All was confusion in the frantic search for parents by children, children by parents.

See "Accident" page 13

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Accident from page 12

The people of the city responded promptly to the catastrophe as the Sisters wrote in their journal... "No sooner had the first cases come, they (the people of the city) offered assistance, bringing with them wines, brandy, old linen and flowers for the comfort of the poor sufferers."

News of the disaster reached Doctor Yokum by telegraph in Seattle, and he lost no time in obtaining a fast horse for the frantic ride back to Tacoma. Every Doctor in the county was pressed into service that day and for the weeks following.


Doctor McCutcheon was at Conney Island, and heard the news by telegraph. He wired back his concern for the families of the victims and his distress at being unable to assist all those in this distressful situation. At Fannie Paddock Hospital his capable wife took charge in directing the care

of the injured sent there.

At Saint Joseph's Hospital the Sisters of the night watch retired at last to rest part of this day, July 5th 1900. The avowed atheist, Doctor C.E. Case, left the Operating Room after almost twenty four hours of continuous surgery, shaking out the long black

beard he had tucked into his vest while he worked there.

The Sisters wrote in their journal a decade later... "Thanks to the mercy of God, and to the skill of the doctors and nurses, many recovered (the streetcar disaster) and are strong and healthy today with no signs of the accident." ■



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IN MEMORIAM
ANTHONY J. O'KEEFE, MD
 1931 - 2009

Dr. Anthony O'Keefe was born on August 5, 1931 and passed away peacefully at his home in Gig Harbor on January 19, 2009. He was 78.

Dr. O'Keefe received his medical degree from the University College of Cork, National University of Ireland in 1955. He completed his internship at South Infirmary Hospital in Ireland and residency at the University of Manitoba, Canada. Fellowship training was done at Tacoma General Hospital.

Dr. O'Keefe was an original partner of Tacoma Anesthesia Associates and practiced at Tacoma General Hospital throughout his career. He made many lifetime friendships with the doctors and nurses he worked with every day and loved their monthly breakfast get togethers - always sharing a recent joke, good story, and cherished memories of their times together.

PCMS extends sympathies to Dr. O'Keefe's family.



Anthony O'Keefe, MD

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IN MEMORIAM
JOHN B. COOMBS, MD
1946 - 2009

Dr. John Coombs passed away at his Seattle home on January 18, 2009 at the age of 63 after being diagnosed with malignant melanoma.

Dr. Coombs received his M.D. degree in 1972 from Cornell University School of Medicine, where he also earned a master's degree in nutrition. He did his residency training in family medicine and in pediatrics at the University of Washington.

Dr. Coombs' rural health career began in 1974 when he worked as a physician in Tonasket, WA for the National Health Service Corp. He then practiced pediatrics and family medicine in Omak, WA from 1979 to 1984.

He went on to direct the Tacoma Family Medicine Residency, and in 1987 was named vice president for medical affairs at MultiCare. In 1993 he was named UW associate dean for regional affairs and rural health, and later associate vice president for medical affairs and vice dean for regional affairs.

He held national leadership roles in the American Hospital Association, the National Rural Health Association, the Task Force on Perinatal Care in Rural Areas and other health services advocacy groups. He is a past president of the Washington State Academy of Family Physicians.

PCMS extends sympathies to Dr. Coombs' family.



John Coombs, MD

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253-502-5965
Med School: George Washington Univ
Internship: Madigan AMC
Residency: Madigan AMC
Fellowship: Duke Univ Eye Center

Thomas L. Cross, DO

Orthopedic Surgery
Federal Way Orthopedic Assoc (FMG)
34612 - 6th Ave #300, Federal Way
253-838-8552
Med School: Kirksville College
Internship: Flint Osteopathic Hospital
Residency: Flint Osteopathic Hospital

Eve S. Cunningham, MD

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St. Joseph Women's Clinic (FMG)
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Residency: Kaiser Permanente

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Northwest Vascular Surgery (FMG)
202 N Division St #402, Auburn
253-833-8032
Med School: University of Jordan
Internship: Union Memorial Hospital
Residency: Union Memorial Hospital
Residency: Illinois Masonic Med Ctr
Fellowship: Loyola University Med Ctr

Michael J. Franceschina, DO

Orthopedic Surgery
Federal Way Orthopedic Assoc (FMG)
34612 - 6th Ave #300, Federal Way
253-838-8552
Med School: College of Osteopathic
Medicine of the Pacific
Internship: Botsford General Hospital
Residency: Botsford General Hospital
Fellowship: Inst for Bone & Joint Disorders

Mark A. Friedman, MD

Orthopedic Surgery
Harbor Orthopedic Clinic (FMG)
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253-851-6075
Med School: Univ of Chicago Hospitals
Internship: University of Michigan
Residency: University of Michigan

Maria L.C. Guina, MD

Neurology
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11311 Bridgeport Way SW #205, Lakewood
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Internship: Maryland General Hospital
Residency: Thomas Jefferson Univ Hosp
Fellowship: Thomas Jefferson Univ Hosp

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Family Medicine
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4700 Pt. Fosdick Dr NW #202, Gig Harbor
253-857-1450
Med School: University of the East
Internship: JFK Medical Center
Residency: JFK Medical Center

Joshua A. Johnston, MD

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34612 - 6th Ave #300, Federal Way
253-838-8552
Med School: University of Washington
Internship: Michigan State University
Residency: Michigan State University
Fellowship: Santa Monica Orthopedic
and Sports Medicine Group

Wajahat A. Khan, MD

Family Practice
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6401 Kimball Dr NW, Gig Harbor
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Med School: Taipei Medical College
Internship: Washington Hospital Center
Residency: Washington Hospital Center

Amelito Benedicto R. Malapira, MD

Neurology
Northwest Neurology (FMG)
11311 Bridgeport Way SW #205, Lakewood
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Family Medicine
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253-964-5260
Med School: Western University of
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Internship: Pacific Hosp of Long Beach
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Ob/Gyn
Gig Harbor Medical Clinic
6401 Kimball Dr NW, Gig Harbor
253-858-9192
Med School: Northwestern University
Internship: Naval Hospital Oakland
Residency: Naval Hospital Oakland

Hong Nhung T. Nguyen, MD

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30809 - 1st Ave S, Federal Way
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Med School: SABA University
Residency: Research Family Medicine

Melanie S. Orencia, MD

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Med School: St. Louis University
Internship: Wyoming Valley Fam Med
Residency: Wyoming Valley Fam Med

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Internship: University of Michigan
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Residency: Dalhousie University
Fellowship: Good Samaritan Hosp, OH

Dina C. Titova, MD

Int Med/Rheumatology
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Internship: St. Vincent Hospital
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Felix G. Vladimirov, MD

Vascular Surgery
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Internship: Mt. Sinai School of Medicine
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Linh N. Vu, MD

Family Practice
The Lakewood Clinic (FMG)
11307 Bridgeport Way SW #220, Lakewood
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Med School: Spartan Health Sci Univ
Residency: Niagara Falls Mem Med Ctr

J. Denise Wells, MD

Orthopedic Surgery
Federal Way Orthopedic Assoc (FMG)
34612 - 6th Ave #300, Federal Way
253-838-8552
Med School: University of Arkansas
Internship: University of Maryland
Residency: University of Maryland

Benny Y.H. Wang, MD

Anesthesiology
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Death with Dignity

from page 11

Immediately before writing the prescription for life-ending medication, the attending physician verifies and documents that the qualified patient is making an informed decision.

- A qualified patient makes two oral requests and one written request for medication: A qualified patient makes an oral request and a written request and reiterates the oral request to their attending physician at least fifteen days after making the initial oral request. At the time of the patient's second oral request, the attending physician offers the patient an opportunity to rescind the request. The written request must be submitted to the attending physician at least 48-hours before the prescription is written. The attending physician documents all oral and written requests for life-ending medication, recording the date and time of the requests and witnesses.

- Patient's written request is properly witnessed by two persons, neither of whom may be the attending physician: A Request for Medication to End My Life in a Humane and Dignified Manner is signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that the patient is competent, acting voluntarily, and is not being coerced to sign the request. One of the witnesses must not be a relative of the patient by blood, marriage, or adoption, an heir, or an owner, operator, or employee of the health care facility where the person is a patient or resident. If the person is an inpatient in a health care facility, one of the witnesses must be designated by the facility.

- The patient may rescind their request for life-ending medication in any manner and at any time, regardless of their mental state: The attending physician must offer the patient an opportunity to rescind at the time of the patient's second oral request.

- The attending physician assumes responsibility for the patient's care and certifying compliance with the Act: The attending physician's certification is documented in the medical records. If more than one physician is involved in the patient's care, an attending physician is designated and documented in the medical records.

- Life-ending medication is dispensed by the attending physician or pharmacist: The attending physician dispenses the medication, including ancillary medications intended to minimize the patient's discomfort, directly if authorized by statute, rule, or DEA certification. With patient's written request, the attending physician contacts a pharmacist, informing them of the prescription and delivering the prescription personally, by mail, or facsimile. The pharmacist dispenses the medications directly to either the patient, the attending physician, or a patient's expressly identified agent. Dispensing by mail or other form of courier is prohibited. Any prescribed

medication not self-administered is disposed by lawful means.

- The patient self-administers the prescribed life-ending medication. The Act does not authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia.

- The attending physician is responsible for documenting the date and time of the following actions in the medical record:

1. All oral requests by a patient for medication to end their life in a humane and dignified manner;
2. All written requests by a patient for medication to end their life in a humane and dignified manner;
3. Attending physician's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;
4. Consulting physician's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;
5. Report of the outcome and determinations made during counseling, if performed;
6. Attending physician's offer to the patient to rescind their request at the time of the patient's second oral request; and
7. Attending physician's note indicating that all requirements of the Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

- The attending physician is responsible for records with the Department of Health: The attending physician may sign the patient's death certificate which lists the underlying terminal disease as the cause of death. The attending physician mails dispensing records and other administratively required documentation to the Department of Health no later than 30 calendar days after writing the prescription and dispensing medication. However, all documents required to be filed with the DOH are mailed no later than 30 calendar days after the date of death of the patient. Information collected by DOH is not a public record available for public inspection.

- Physicians may choose whether to participate in patient's decision to request life-ending medication: If a health care provider is unable or unwilling to carry out a patient's request and the patient transfers his care to a new health care provider, the prior health care provider transfers, upon request, a copy of the patient's relevant medical records to the new provider. A professional organization or association, or health care provider may not subject a person to censure, discipline, suspension, loss of license, privileges, or membership, or other penalty for participating or refusing to participate in

See "Death with Dignity" page 22

I-1000 from page 5

The standard legal protections for health care information continue to apply. While the law generally permits the communication of patient information between providers for treatment purposes, it would be prudent for the physician to seek a patient's written consent prior to disclosing a patient's request for lethal medication to anyone. Physicians should document efforts to seek the patient's consent and the patient's response.

The new law does state that a physician should receive written consent from a patient prior to contacting a pharmacist about a prescription for lethal medication.

LEGAL PROTECTIONS

The law provides physicians immunity from civil or criminal liability and professional disciplinary action for participating in good-faith compliance with the law. This includes being present when a qualified patient takes the prescribed medication to end her or his life. (The law does not authorize a physician to end a patient's life by lethal injection, mercy killing, or active euthanasia.) The "good faith" immunity provided for does not lower the standard of care for health care providers.

The law specifically states that participation in the law does not constitute unprofessional conduct. A hospital should not make a report to the Department of Health if it

suspends or terminates a physician's staff membership or privileges solely on the basis of the physician participating in the law or violating the hospital's policy on life-ending medication. The law does not address whether a report to the National Practitioner Databank would be required.

A physician should become well-acquainted with the law and carefully review the specific safeguards, waiting periods, and documentation requirements that the law prescribes. Doing so will maximize protection for both the patient and physician. ■

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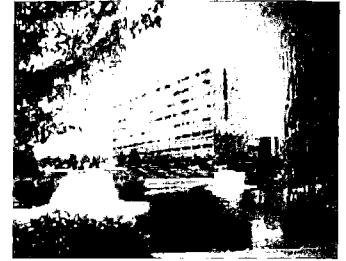
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- *Electronic Records for the Rest of Us*
- Panel Discussion moderated by Joseph Regimbal, MD
- *Concussion in the J: High and High School Age Athlete*
- Gregory Cain, MD
- *Combination Lipid Therapy to Maximize Cardiovascular Benefits*
- B. Greg Brown, MD, PhD

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- Identify and discuss significant benefits for both practice efficiencies as well as clinical safety and improve compliance with clinical guideline recommendations.
- Understand the proper diagnosis and management of the adolescent and young adult athlete suffering a concussion in youth sports. Explain and emphasize how important it is to recognize concussion in these athletes and to remove them from practice and play until fully recovered
- Summarize published data on the benefits of drugs that are primarily LDL-C lowering agents, and of those that primarily raise HDL-C.
- Discuss and review published data on the benefits of drug combinations that substantially affect both LDL-C and HDL-C simultaneously. Conclude that the LDL-C and HDL-C effects of the combination is the sum of the lipid and clinical effects of each component drug. Therefore, 60-75% CV risk reduction can be expected from currently available lipid drug combinations.

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<u>Date</u>	<u>Program</u>	<u>Director(s)</u>
Thursday, April 16 Evening, 4-8 pm	New Developments in Primary Care	Michael Bateman, MD
Friday, May 8	Internal Medicine Review	Garrick Brown, MD
Friday, June 5	Primary Care 2009	Kevin Braun, MD

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We hope you will plan to join your colleagues and their families next spring for our *CME at Hawaii* program. ■

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Death with Dignity from page 18

good faith compliance with the Act. A person is not subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with the Act.

- Hospitals and other health care facilities may prohibit physicians from providing services authorized by the Act on their premises: Health care providers, including hospitals, may prohibit another health care provider from participating in the Act on the premises, if the prohibiting provider has given written notice to all health care providers with privileges and to the general public of the provider's policy. Physicians who perform services authorized by the Act on the hospital's premises in violation of hospital policy may be disciplined, including loss of privileges or membership, or other sanctions provided under the medical staff bylaws. Due process requirements are applicable. Additional sanctions include termination of a lease or employee con-

tract. Provider actions under the Act may not be the sole basis for a report of unprofessional conduct.

- Forms [DOH has drafted the following forms as part of its proposed rules]:

1. Request for Medication to End My Life in a Humane and Dignified Manner;
2. Attending Physician's Compliance Form;
3. Consulting Physician's Compliance Form;
4. Psychiatric/Psychological Consultant's Form;
5. Pharmacy Dispensing Record; and
6. Attending Physician's After Death Reporting Form

The information in this article is obtained from sources generally considered to be reliable; however, accuracy and completeness are not guaranteed. This document does not establish

a standard of care. It is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to your attorney. ■

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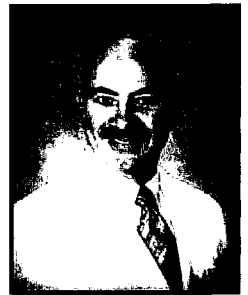
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BULLETIN

Pierce County Medical Society



April 2009



The Ohio State University College of Medicine

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BULLETIN

Pierce County Medical Society



April 2009

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President's Page

by J. David Bales, MD

The Elephant in the Room



J. David Bales, MD

Most are familiar with the story of five blind men describing an elephant – each gave a detailed report of what an elephant was from their own experience and each was right from that perspective. We are being inundated with information about health care and its re-engineering or reform. All of the bits of information are truthful and correct from a perspective, but most do not cover the length and breadth of the “elephant.”

My own contribution to the elephant description is necessarily unique to my perspective but I hope will provoke some reading and thinking about what is going on in Health Care today. Access, quality and cost are the framework of most discussions in Health Care but the elephant in the room that includes access, quality, and cost is money. There isn't enough and the current direction of our society and economy means there will be even less in the immediate and perhaps even long term future. If the only answer being proposed to access, quality, and cost is “More Money” then we've blinded ourselves to the elephant.

So what is the answer? I don't have an answer but I always have a response and that is we have to figure out what we will not pay for or where we can do for less. When I take a personal hit in income, I may search for “more money” but I am more likely to look at what I am spending and where I can do for less. The enormity of the money problem demands that we start having the discussion of where we will be more efficient or what we will not do.

How do we do that?

Of the editorials I've recently seen I was most impressed by one from the UK in the 4 March 2009 *Journal of the American Medical Association* by Dr. Sir John Oldham “Achieving Large System Change in Health Care” (*JAMA* 301:965-6). With historical large system change, tweaking the status quo was not an option. Dr. Oldham suggests that knowledge and utilization of evidence, improvement methods and human factors can result in step change in the outcome of a large system. His proposition that the key health team member is the patient is reminiscent of the Dartmouth Clinical Microsystems work and the Swedish “What would Esther want?” approach to improving health care systems. (See: *Quality by Design* by Nelson, Batalden, and Godfrey – Jossey-Bass Publisher or www.clinicalmicrosystem.org). The book contains the entire Dartmouth improvement curriculum.

So how does that translate into deciding where we will spend what we have? We are being asked to do more with less and do it better – and that is a standard starting point for most improvement work. It can be done, but it will take training, work, and the “cooperation, collaboration, and communication” already a hallmark of this community. ■

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Jeff Nacht, MD assumes Presidency of PCMS Subsidiary, Membership Benefits, Inc. as Dr. Tim Schubert retires and moves to Mexico

Jeffrey Nacht, MD, orthopedic surgeon, was recently elected to serve as President of the PCMS wholly owned, for-profit subsidiary corporation, PCMS Membership Benefits Inc. (MBI). MBI oversees the for-profit business affairs of the organization in-



Jeff Nacht, MD

cluding owning and operating the building at 223 Tacoma Avenue South, publication services such as advertising sales and Editors for the PCMS monthly *Bulletin*, the placement service, including the temporary placement agency, and all other business that is either income producing or related to benefits for members. MBI revenues reached just a few hundred dollars shy of the million dollar mark in 2008.

Dr. Nacht recently completed two years of service on the PCMS Board of Trustees as Treasurer, a position that also requires serving as Secretary/Treasurer for MBI. The Treasurer is responsible for overseeing the funds of the organizations, presenting the finance report to the Board of Trustees and working with staff and leadership in determining the best financial decisions for the organization's financial health. MBI has worked to increase reserve levels for the last few years and has been successful in doing so, now having 51% of their annual budgeted expenses set aside.

Timothy Schubert, MD, gastroenterologist with Digestive Health Specialists, served as President from 2003 through December 2008 when he retired and moved to Mexico. Current board members include **Drs. Drew Deutsch, Keith Demirjian, Steve Duncan, Mark Gildenhar, Maureen Mooney, Steve Settle and Joe Wearn.**

PCMS extends heartfelt thanks to Dr. Schubert for his many years of service and wishes him and his wife Arlene well in their new adventures. ■

Attention PCMS Active & Retired Physicians!

Health care volunteers, Janet Runbeck, RN, and **Mary Hoagland-Scher, MD**, have made great progress toward opening a RotaCare Free Chronic Care Clinic in Pierce County, and they are currently recruiting physicians and other health care providers to help staff the clinic and provide volunteer patient care.

Funding has been granted from the local Rotary 8 Club, and the clinic has partnered with local labs for free services. Liability insurance for each provider will be provided by the Washington State Department of Health.

Particulars about the clinic include:

Where: 1704 E. 85th St., Tacoma, 98408 (the clinic will take place at Lutheran Church of Christ the King).

When: The clinic will be open on Wednesday evenings from 5-8 p.m. The clinic is scheduled to open in May.

Who: Two physicians or other providers, two nurses, and a few support staff will be needed to operate the clinic per shift.

What: Clinic volunteers (YOU!) will be charged with the medical treatment of chronic diseases, namely hypertension, hypercholesterolemia, and diabetes.

Why: Access to care in Pierce County is dwindling - especially care for chronic illness - and efforts will be made to reach out to neighbors who have been dangerously living without care!

Your time commitment: The amount of time donated to this free clinic will be determined by each individual volunteer, however, we expect that most physicians or others will volunteer just once every other month. That's just six evenings a year!

Your contribution of valued time and expertise would be greatly appreciated. If you are willing to volunteer or need more information, please contact Janet Runbeck at 253-752-5565 or janetrunbeck@harbornet.com.

Thank you for your consideration. ■

A Must-Attend for Practice Managers

The Washington State Medical Group Management Association (WSMGMA) Annual Meeting is one of the best practice management events in the country. This year 400 practice managers from Washington and Oregon will convene at the Portland, Oregon Convention Center for this national-caliber conference.

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To request a brochure contact Jan Larsen at 206-956-3643 or email jal@wsma.org. A meeting brochure and online registration can also be found at www.wsmgma.org. ■

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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH,
David Harrowe, MD, MPH, JD
and Claudia Catastini, MA

Chlamydia, Gonorrhea, and Expedited Partner Therapy



Anthony Chen, MD

Pierce County has a sexually transmitted disease problem. With April bearing the title of STD Awareness Month, now is a very good time to expound upon the two most common STDs - chlamydia and gonorrhea, both of which have reached disturbing rates in Pierce County.

Our county's rates of chlamydia and gonorrhea are the second highest in the state. Of course we recognize that these numbers very likely under represent the actual amount of disease, as well as the true extent of the health problems caused by these diseases in our community. We find ourselves at the tip of a very dangerous iceberg.

Improving the sexual health of our community will require innovative partnerships between healthcare providers and public health. We will need new options for the treatment of partners, and new resources for disease investigation. Clearly there are multitudes of pressing issues to be addressed, but let's consider this problem an opportunity. We have an opportunity to jointly tackle the rising rate of sexually transmitted diseases in our county, as well as an opportunity to develop solutions that will prevent us from reaching these rates again.

Epidemiology:

In 2007, the incidence of chlamydia (CT) infection in Pierce County was 425 per 100,000 population compared to 295 per 100,000 for Washington State. The incidence of gonorrhea (GC) was 105

per 100,000 for Pierce County, versus 56 for Washington State. Preliminary 2008 estimates are that Pierce County had 3,828 cases of CT and 674 cases of GC, a 17% increase in CT and a 19% decrease in GC.

While the majority of GC and CT cases occur in Caucasians, infection rates are highest in African-Americans. Pierce County has a higher proportion (about 7.0%) of African-Americans than any Washington county, which accounts for some of the difference in rates.

People 15 to 24 years of age have higher rates of GC and CT than other age groups. Pierce County has a somewhat younger population than the State, which also contributes to the difference in rates. The impact of the large military installations within Pierce County on our STD rates is under investigation, but a preliminary study failed to show an adverse effect.

Implications for Public Health:

Because infections with GC and CT are often asymptomatic, these STDs can easily spread through populations. While half of men infected with GC have symptoms, only a quarter of women do.

Regardless of whether the initial infection was symptomatic, complications can ensue and may be severe. In women, both GC and CT can cause pelvic inflammatory disease (PID), which can lead to chronic pelvic pain, infertility, and/or ectopic pregnancy. If un-

treated, 20-40% of women infected with CT and 10-20% of women with GC will develop PID (1). In pregnant women, untreated STDs are associated with premature delivery, abortions, stillbirths, and congenital infection.

Complications in men are less common. Both CT and GC can lead to epididymitis.

With either GC or CT infections, both men and women are more susceptible to infection by the human immunodeficiency virus (HIV).

Non-urogenital manifestations of GC include pharyngitis, proctitis, conjunctivitis, perihepatitis, and disseminated infection (skin lesions, tenosynovitis, and/or arthritis). More rarely, endocarditis or meningitis can occur. Similarly, CT can cause proctitis, conjunctivitis, pneumonia, and Reiter's syndrome (arthritis, urethritis, and conjunctivitis).

What Pierce County Physicians Can Do:

In general, take a detailed sexual history, be non-judgmental, and ask open-ended questions. Do not make assumptions about sexual orientation or that married individuals or those in long-term relationships are monogamous. Ask about and encourage the use of latex condoms as an effective barrier to transmission of STDs. For young patients, it may be helpful to demonstrate correct condom use by applying it over two fingers or a penis

See "TPCHD" page 18

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National Health IT Chief Named

David Blumenthal, MD, is President Obama's choice to be national coordinator for health information technology, the Dept. of Health and Human Services announced March 20.

As national coordinator, Dr. Blumenthal will be charged with leading the implementation of a nationwide interoperable health information technology infrastructure. Significant funding for the initiative was included in the recently enacted \$787 billion federal stimulus package.

"As a primary care physician who has used an electronic record to care for patients every day for 10 years, I understand the enormous potential of this technology," he said in a statement.


Dr. Blumenthal most recently served as director of the Institute for Health Policy at the Massachusetts General Hospital/Partners Healthcare System in Boston and was a senior health adviser to the Obama campaign. He also was a professor of medicine and health policy at Harvard Medical School, where he served as director of the Harvard University Interfaculty Program for Health Systems Improvement.

"We look forward to working with him to ensure physicians receive the support they need to meaningfully adopt [electronic medical records] that lead to greater efficiency and quality," said AMA Board of Trustees Chair Joseph M. Heyman, MD. "Dr. Blumenthal will play an important leadership role in the coming years as we work to realize the promise of HIT to optimize quality and coordination by establishing interoperability standards, addressing privacy and security, and properly aligning incentives." ■

Reprinted from AMNews, March 30, 2009

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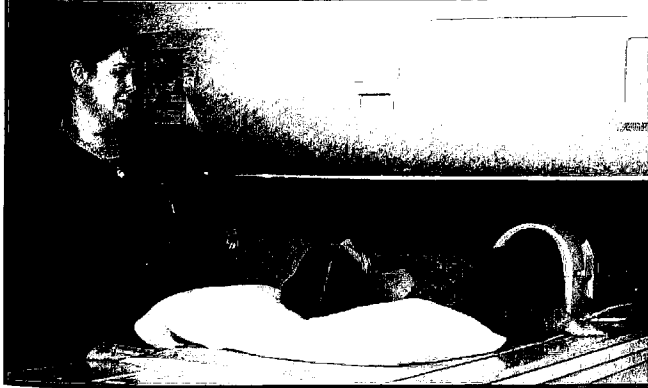
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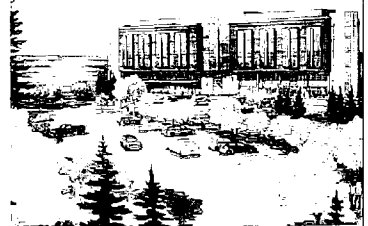
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At the same table: Alternative liability resolution

More doctors are considering mediation and other voluntary methods to avoid a costly, adversarial court system. But some say it's no panacea for doctors' liability woes

In their quest to keep medical liability disputes out of the courtroom, some Pennsylvania physicians have found some strange bedfellows. The Montgomery County Medical Society teamed up with the Montgomery Bar Assn. to launch a mediation pilot program in March 2008 at Abington Memorial Hospital. The project, four years in the making, aims to turn the tables on the traditional litigation system by bringing doctors, patients and lawyers to the table to voluntarily resolve issues without the tensions and costs of court.

"The key word is nonadversarial," said rheumatologist Mark A. Lopatin, MD, a county medical society board member who practices at Abington. "The goal is to bring both sides together to discuss the issue. We can talk about money and all those things [in court], but you lose sight of the human element in a lawsuit."

The Abington project, supported by the Pennsylvania Medical Society, evolved with a nudge from the state Supreme Court in 2004. To fend off rising medical liability claims and insurance rates and keep doctors in the state, the high court, at the urging of Gov. Ed G. Rendell, encouraged hospitals to explore mediation to settle cases more efficiently.

Unlike arbitration, mediators do not make final decisions, and both parties still have the option of going to court, important for lawyers. But often the courtroom is as trying an experience for patients as it is for doctors, said Robert F. Morris Jr., immediate past president of the Montgomery Bar Assn.

"The courts work well in just compensation for most patients," he said. "But it's a difficult thing to relive an injury through the court system, and if we can avoid all that and still reach a fair result, the public is well-served."

While the partnership may be unique, Pennsylvania doctors are not alone in their efforts. Legal experts say mediation and other voluntary, early intervention programs are attracting inter-

est — among plaintiffs and defendants — as an alternative to the court system, particularly as tort reform efforts face ongoing challenges and the patient safety movement gains ground.

Open Communication

Proponents tout mediation not only because it saves time and money, but primarily because it encourages open dialogue between both sides.

"Litigation is win or lose, and there's no in-between," said Jane Ruddell, founder and president of Health Care Resolutions LLC, a Pennsylvania firm specializing in alternative dispute resolution. "We saw mediation as a way of addressing patients' financial medical injury needs, but also as a way to talk about what can we learn from this experience," said Ruddell, who has assisted

with mediation projects in the state.

A Chicago hospital solves 95% of its liability claims through mediation.

While a typical lawsuit takes weeks or years, including trial and appeals, mediation can resolve a dispute in days or hours. Little discovery is involved, which means lower legal fees for both sides and a higher percentage of an award for patients. Confidentiality also encourages candid conversations because shared information cannot be used in court.

Abington's two-step process begins with an informal meeting between the patient and members of a cadre of hospital administrators, doctors or nurses trained in conflict resolution. Patients can seek counsel at any time. If the patient is not satisfied with the out-

See "Liability" page 13

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come of the discussion, the issue can proceed to formal mediation, where a trained physician-lawyer team helps both sides reach a mutual agreement. The physician typically will be in the appropriate specialty and can provide insight to the parties involved, as can the lawyer, Dr. Lopatin said.

Though in early stages, the Abington project is banking on success based on results elsewhere.

Chicago's Rush University Medical Center started a mediation program in 1995; since 2004, 95% of claims have been resolved through the process. Rush also uses a co-mediation model, with a team including a defense lawyer selected by the patient. Both sides in the case split the cost.

The process helps both sides evaluate the strengths and weaknesses of a case through a neutral party, said Max D. Brown, Rush's general counsel. "We are able to settle those cases that need to be settled and defend those that need to be defended at trial."

Rush won all but one of the remaining 5% of cases that went to court. Meanwhile, defense costs for the self-insured hospital dropped more than 60%, and the number of claims filed against Rush has remained relatively stable. Cooperation typically results in more reasonable settlements, versus often unpredictable or excessive jury ver-

dicts, Brown said.

Mediation typically occurs after a claim has been made and lawyers have locked horns. But some programs are aiming to intervene earlier.

What started as an effort to cut costs at the University of Michigan Health System has evolved into an integral part of quality improvement, said Richard C. Boothman, the hospital system's chief risk officer. "We want to be more proactive at learning about unexpected outcomes long before lawyers are involved. So it's not just an alternative to court, it's upstream of court," he said.

Mediation is just one tool to resolve potential medical liability disputes through a voluntary resolution program set up in 2001. In 1994, Michigan passed a law requiring a six-months notice before a lawsuit is filed formally. The university decided to take advantage of that time to investigate claims early, share information with both parties (with or without lawyers) and decide how best to handle a case, if it should be dropped, settled or defended.

"We said to ourselves, we're not going to abdicate our responsibility to

the patient relationship just because something went wrong and we're not going to give deference to the legal system and assume court is the only place we have to fix these problems," Boothman said. The university has seen claims plummet more than 60%, while legal expenses and average claims processing time dropped by more than half.

No silver bullet

But critics warn that mediation and other voluntary methods are no silver bullet for resolving physicians' medical liability woes.

Such models, while gaining popularity, have yet to be tested widely, said American Medical Association Board of Trustees member Robert M. Wah, MD. The AMA is exploring alternatives to the current system, including mediation. But unlike caps on noneconomic damages, mediation has yet to prove it can markedly cut insurance premiums or lawsuits.

"Doctors are interested in anything that improves the current court-based system," he said. But despite anecdotal evidence of the benefits of mediation and other approaches, "it is not conclu-

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Laborists become the newest hospital specialists

Ob-gyns are being hired to deliver babies during set schedules, with the hospital paying their liability insurance and salaries

A growing number of hospitals, following the growth of primary care doctors as facility-only hospitalists, are implementing laborist programs.

Laborists, or OB hospitalists, were conceived to fill a void created by ob-gyns leaving the field because of long hours and high liability insurance premiums. Like hospitalists, laborists are employed by the hospital, which determines their role and pays their salary and liability insurance. Some only deliver babies. Others do triage, make patient rounds and deliver babies whose mothers do not have doctors.

In most cases, a patient's private physician decides who will do the delivery. If it is the laborist, the hospital is paid for the delivery portion of the bill.

"Our OB hospitalists are not there to cut in on a physician's patients. They are there to help if they are

needed," said Christopher Swain, MD, an ob-gyn and founder of OB Hospitalist Group Inc. of Greenville, South Carolina, which sets up programs in hospitals.

Hundreds of hospitals across the country have created laborist programs, say physicians who have searched for these positions. The American College of Obstetricians and Gynecologists called use of OB hospitalists widespread but does not have a formal opinion on the practice, according to a spokeswoman.

"Almost all the disruption and chaos of an ob-gyn practice are gone," said Luisa Kontoules, MD, who works as a laborist at Cape Cod Hospital in Hyannis, Massachusetts, every other weekend, from Friday night to Monday morning while maintaining her own gynecology practice.

Dr. Kontoules said her 62-hour schedule is manageable, and she gets plenty of sleep between deliveries.

OB Hospitalist Group has a network of 450 physicians and has placed 60 of them, Dr. Swain said. Laborists' shifts range from 12 hours to 62 hours. Most work nights or weekends only.

Experts say advantages for laborists include set schedules, fewer hours, no on-call work and no office to manage. For private-practice ob-gyns, laborists provide the flexibility of having another obstetrician on hand to do a delivery.

A spokeswoman for ProMutual Group in Boston, the state's largest insurer, said it is keeping an eye on laborists, "but it is too new a trend to determine if it will result in lower medical liability premiums." ■

Reprinted from AMNews, April 1, 2009

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Doctors increasingly close doors to drug reps, while pharma cuts ranks

Many physicians see detailers only with scheduled appointments. Drugmakers are responding to hard times with layoffs and a shift toward online marketing

The relationship between doctors and drug reps may never be the same again.

Pharmaceutical companies — battered by a sluggish drug pipeline, the looming loss of blockbuster patented drugs, an economy in recession and scrutiny of their relationships with physicians — are re-examining the value of sending drug reps into doctors' offices. Detailers are struggling to grab a shrinking slice of physicians' valuable time and attention while adjusting to new drug industry rules banning freebies such as pens and notepads.

At its peak in 2007, the American pharmaceutical industry fielded 102,000 sales reps, said Chris Wright, managing principal for the consulting firm ZS Associates' U.S. Pharmaceuticals Practice. Drugmakers have slashed the number to 92,000 since then, and ZS projects the number will fall to 75,000 by 2012 at the latest, saving the industry \$3.6 billion.

Pharma's return on investment in its sales force has plummeted. For every 100 reps who visit a practice, 37 place their products in the office's sample cabinet, and only 20 speak to a physician in person, said the New York-based consulting group TNS Healthcare. Profit per drug rep visit fell 23% from 2004 to 2005, said a February PricewaterhouseCoopers report on pharma's future.

"The old sales model is broken now, and who knows how it will look in the future," said Peter H. Nalen, president of Compass Healthcare Communications, an online drug marketer in Princeton, N.J. "What's happening is that pharmaceutical companies are realizing there are other ways to reach the doctor instead of banging on the door of the doctor who just doesn't want to talk to you."

The time squeeze and the new drug industry rules are "changing the landscape quite dramatically," Nalen said. Another troubling sign for drugmakers: More than a third of medical schools require drug reps to have appointments before seeing physicians or residents, according to the American Medical Student Assn.'s 2008 PharmFree Scorecard. The Assn. of American Medical Colleges recommended the by-appointment-only policy in May 2008.

While most physicians still have positive views of detailers and drugmakers, those sentiments are cooling.

About one in four physicians works in a practice that refuses to see drug reps. Of doctors who do see reps, about 40% will meet with detailers only with scheduled appointments. The by-appointment-only figure jumped 23% during the last six months of 2008, according to a survey of more than 227,000 medical practices representing 640,000 physicians that was released in February.

The survey, conducted by the doctor-profiling firm SK&A Information Services Inc., did not seek to determine why some physicians are giving drug reps the cold shoulder. But physicians and pharmaceutical industry consultants say doctors have felt besieged by the number of reps visiting their offices and taking up precious time in an era of declining payment.

Last year saw a slight drop in a measure of the quality of detailers' relationships with doctors, based on a TNS survey of more than 1,500 doctors. And negative word-of-mouth about pharma rose sharply among physicians — this so-called market-resistance index jumped 62% in the last year, TNS said.

Controversies over the drugs marketed as Vioxx (rofecoxib), Avandia

(rosiglitazone) and Vytorin (ezetimibe and simvastatin) appear to be making doctors more skeptical of drugmakers as an information source, said Jerome L. Avorn, MD, professor of medicine at Harvard Medical School in Massachusetts.

"Doctors are increasingly concerned that the sales pitches from drug reps are not giving them the full story," said Dr. Avorn, author of the 2004 book, *Powerful Medicines: The Benefits, Risks, and Costs of Prescription Drugs*.

Ken Johnson, senior vice president at the Pharmaceutical Research and Manufacturers of America, said in a statement that detailing visits are good for doctors and patients. "Interactions between physicians and pharmaceutical company representatives benefit patient care through the exchange of information about new medicines, new uses of medicines, the latest clinical data, appropriate dosing and emerging safety issues."

Interacting with detailers

For every physician, it seems, there is a different way to handle drug reps.

Charles E. Crutchfield III, MD, is a dermatologist with a high-volume practice in Eagan, Minn., a suburb of Minneapolis. Though five to 10 reps visit his office daily, he strictly limits detailers to one five-minute session a week and requires that the rep provide lunch for his staff.

"The reps know they are not allowed to disturb me when I am seeing patients," Dr. Crutchfield said. "If they do bring samples, I have a nurse who will bring the pad back to me so I can sign it. I will not see or talk to reps when I'm in clinic."

Ari Silver-Isenstadt, MD, persuaded the four other doctors and of-

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office staff in his Baltimore pediatrics practice to adopt, in January 2008, a "no soliciting" policy for drug reps. Dr. Silver-Istenstadt is a member of the National Physicians Alliance, whose Un-branded Doctor Campaign urges physicians to refuse industry gifts and stop seeing drug reps.

Despite the new survey figures showing that doctors are cooling to drug reps, he said physicians should be more aggressively addressing the conflict of interest detailers pose.

"More than half of us doctors still just have a feeding frenzy of reps in our offices," he said. "We should be ashamed of ourselves for allowing such an intertwining of our patients' best interests with the convenience and niceties of drug reps."

Not all doctors share Dr. Silver-Istenstadt's hard-line view.

Most are simply pressed for time. Drug companies are trying to reach out to doctors via the Web, experts said.

About 45,000 doctors meet with detailers using online video, and 300,000 physicians say they are open to doing so, said a September 2008 study from Manhattan Research, a drug marketing research firm.

Visits by drug reps will not disappear entirely, experts said. Rather, the sales force that survives the layoffs will be better trained and have a greater depth of clinical and scientific knowledge.

Detailers "reach the customer in a way that other promotional techniques do not," said Wright, of the ZS Associates consulting firm. "And for many of these doctors, the choices they make about what to prescribe are worth a considerable amount of money.

"When that's on the table, it makes sense to send a highly trained person to make sure the doctor knows about the medicine before making those choices." ■

Reprinted from AMNews, March 23, 2009

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Doctors Push for Clean Slate on Medicare Reimbursement Rates

Every year or so, we hear that some big Medicare pay cuts for doctors are on the way. Almost every time, Congress swoops in at the last minute to block the cuts. Leaders of the AMA and other big doctor groups have been in Congress lately asking for a change to the underlying system that keeps creating these near misses.

At issue is the "Sustainable Growth Rate," a formula Congress created in 1997 to try to keep payments from spiraling out of control.

Congress's trick in recent years has been to temporarily block cuts that are due according to the SGR formula, without ever formally adopting a new formula. SGR says docs are due for a 21% Medicare pay cut on Jan. 1, 2010, notes the AMA newsletter American Medical News. It's unlikely Congress would let that happen, and the Obama Administration's budget assumes that the pay cuts will not take effect.

Testifying at a recent Congressional hearing, leaders from the AMA, the American College of Physicians and the American College of Surgeons praised the budget. The AMA official called for setting a new, higher baseline for SGR.

More broadly, lots of policy types are questioning the whole idea of paying doctors for every procedure they do, without regard to quality of care or long-term outcomes. Medicare is piloting a program in which hospitals and doctors split bundled payments. So if health reform really gets rolling this year, docs may see Medicare payment reform move way beyond a new baseline for SGR. ■

Reprinted from *WSJ Blog*, March 30, 2009

U.S. Acts to Ease Costs of Private Medicare Plans

The Obama administration set new terms for private Medicare plans that are aimed at protecting sick patients from paying high charges and giving consumers a clearer idea of what the plans cover.

The changes, announced Monday by the Centers for Medicare and Medicaid Services, the federal agency that manages Medicare, are part of conditions that insurance companies must meet if they want to bid on Medicare insurance business this year.

Administration officials said the changes are intended to weed out certain out-of-pocket costs charged by Medicare Advantage, the private version of the federal health-insurance program for the elderly. Medicare Advantage plans, they said, will face more government scrutiny if they don't cap a patient's annual out-of-pocket costs at \$3,400 or less, or if they charge patients more than traditional Medicare does for dialysis, home health care and other services. If the government deems the charges too high, insurers will be asked to scale them back.

In addition, insurers won't be allowed to charge sick, low-income patients more than what they would pay under traditional Medicare.

The changes represent the first steps by President Barack Obama's administration to rein in Medicare Advantage. Mr. Obama has criticized the private plans for spending too much while doing too little to care for the nation's elderly and disabled. He has proposed cutting payments to those plans to help pay for a health-care overhaul.

Medicare Advantage, which has about 10 million enrollees, wraps physician and hospital services in one. Unlike traditional Medicare, the government doesn't pay providers directly but instead pays insurance plans to manage care.

Additionally, the administration will eliminate about 1,400, or 27%, of Medicare Advantage plans in an effort to make it easier for beneficiaries to compare options. It is targeting those plans with fewer than 10 enrollees that are similar to other plans.

For drug plans, insurers will have to describe their coverage of the "doughnut hole" — the gap where consumers generally must begin paying the full cost of their medicines — in simple terms.

"By strengthening our oversight efforts, we are protecting beneficiaries and taxpayers by ensuring that the data provided by plan sponsors is reliable and correct," said Jonathan Blum, CMS's acting director of the Center for Drug and Health Plan Choice. ■

Reprinted from *WSJ*, March 31, 2009



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TPCHD

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model. Consider making condoms available in exam rooms, restrooms, and/or the reception desk to encourage use and signal that your practice is open to discussing sexual issues.

In 2006, the CDC (Centers for Disease Control and Prevention in Atlanta, Georgia) issued revised guidelines for treating STDs (2). The guidelines are available online (<http://www.cdc.gov/std/treatment/>) and can be downloaded to a PDA or as a PDF file. Key clinical interventions to prevent spread of GC and CT outlined below are drawn from that document.

The CDC recommends routine annual testing for CT of all sexually active women 25 years or younger. Women older than 25 should be tested if they have risk factors for CT infection, such as a new sex partner or multiple sex partners. All pregnant women should be tested for CT.

Currently, the CDC does not recommend heterosexual men be screened, unless they are contacts. Homosexual men, if sexually active within the preceding year, should be screened. Screening recommendations for men who have sex with men and women who have sex with women are indicated on pages 9 and 10, respectively, of the CDC guidelines (2).

Reinfection rates for both GC and CT are high (11-13% for CT patients within 4 months of treatment) (1). The CDC recommends testing for reinfection 3 months after completion of treatment for the initial infection. If the patient is not seen at this time, tests for reinfection can be done within 12 months. For non-pregnant patients treated with recommended or accepted alternative regimens, tests-of-cure (repeat testing 3-4 weeks after treatment) are not recommended, unless symptoms persist or compliance is in question.

Because CT often accompanies GC infection, if a patient is diagnosed with GC and concomitant CT infection not ruled out with a negative nucleic acid amplification test, the patient is treated for both GC and CT.

Appropriate and timely management of sex partners aid in limiting the spread of both GC and CT. All partners who had sexual contact with GC or CT index cases in the 60 days prior to diagnosis or onset of symptoms of the index case should be evaluated, tested and treated. If the last sexual contact was more than 60 days, then the most recent contact to the index case should be evaluated.

Strategies to reduce obstacles to treatment of STDs are described below.

Consent Issues:

In Washington State, persons as young as 14 years of age may legally consent to diagnosis and treatment for STDs. This includes HIV testing and treatment. Medical providers may not inform parents of such testing or treatment without the minor's express consent.

Expedited Partner Therapy:

Ideally, physicians should arrange to directly examine,

test and treat partners. However, sexual contacts may not seek evaluation, or communicating with them may be difficult. For these situations, the CDC and the Washington Medical Quality Assurance Commission have endorsed expedited partner therapy (EPT) (3,4). With EPT, the original patient (OP) is given either a prescription or medication to take to his/her sexual contact. Along with medication, the OP is given written information with instructions for taking the medication (including a check for allergies), general health counseling and advice to seek medical evaluation. Alternatively, a prescription can be called into a pharmacy for the contact to pick up. Male index cases should inform female contacts to seek evaluation for PID.

Expedited partner therapy is not recommended for sexually transmitted infections other than GC or CT. It is also not recommended for men who have sex with men because sexually active male homosexuals often have coexisting infections, including undiagnosed HIV.

Antibiotics employed in EPT are azithromycin for CT and oral third generation cephalosporins for GC. Randomized controlled trials have found fewer re-infections among index cases, as has been found in randomized controlled trials (1). No serious adverse reactions to EPT medication were documented in these trials, and none have been reported from states that allow EPT.

The CDC has collaborated with the Center for Law and the Public's Health to evaluate laws in the 50 states, and the District of Columbia as to the legality of EPT. As of February 2009, it noted Washington as 1 of the 15 states in which EPT was permitted.

Free Medication for Partner Treatment

To help you ensure that your patients' sex partners are treated, Washington State Department of Health and the Tacoma-Pierce County Health Department are providing free medication for all partners who need treatment. Free partner medications are available at selected local pharmacies.

A list of pharmacies providing free medication for treatment of GC and CT in sex partners is available at the Washington State Department of Health's website (www.doh.wa.gov/cfh/STD/EPT.htm).

Call or fax the prescription to the pharmacy. When phoning in prescriptions, please let the pharmacy know that you want to prescribe the "free Public Health Partner Management Medications."

EPT prescription forms are available at the Tacoma-Pierce County Health Department. For prescription forms, call Crystal James at 253-798-3818.

Additional Measures taken by the Health Department:

The Tacoma-Pierce County Health Department has enhanced efforts to address GC and CT in our County:

TPCHD from page 18

* In 2007, the communicable disease program initiated its EPT program. Disease control staff now provide partners with free medication through the local pharmacy EPT participants.

* In 2008, the program added two disease control staff in order to increase program capacity for CT & GC case interviewing and EPT. During 2008, the program has been able to significantly increase both case interviews and EPT partner treatment.

* In 2008, the CD program Health Educator starting conducting STD educational presentations in local high schools, at college health fairs, and community events. These presentations include, when appropriate, GC & CT testing for participants.

* During 2009, the Tacoma-Pierce County Health Department staff will be asking local medical providers to partner with EPT efforts. TPCHD will be contacting providers who report GC & CT cases and indicate on the case report no partners were treated with EPT. TPCHD will be asking those providers to consider implementing EPT for their patients' partners. TPCHD needs medical providers to help treat partners. With Public Health and medical providers working together to treat partners, more partners will receive treatment, and trans-

mission (and re-infection) of these diseases could be significantly reduced.

With increased vigilance and intervention from both medical and public health communities, we hope to curb chlamydia and gonorrhea infections and relinquish Pierce County's ignominious position in the STD rankings.

References:

1) Trigg BG, et al. Sexually transmitted infections and pelvic inflammatory disease in women. *Med Clin N Am* 92: 1083-1113, 2008.

2) Centers for Disease Control and Prevention. Sexually transmitted disease treatment guidelines, 2006. *MMWR* 55 (No. RR-11): 1-94, 2006. Available online at: <http://www.cdc.gov/std/treatment/>

3) Centers for Disease Control and Prevention. Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and Chlamydia infection. *MMWR* 57 (No. RR-9): 1-83, 2008.

4) Medical Quality Assurance Commission. Treating partners of patients with sexually transmitted Chlamydia and gonorrhea. Policy Statement No. MD2008-03, 23 May 2008. ■



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2010 CME in Kauai

by Lori Carr, Program Administrator
College of Medical Education

Save the Dates: March 28 - April 3, 2010 at the Sheraton Kauai Resort



Lori Carr

Aloha!

Much planning has already gone into the 2010 CME conference to be held in Kauai next Spring. The dates of the conference are planned around the Spring breaks of most of the area schools again to make it the best family and/or couples vacation. The prices we have negotiated are what I would consider the "2010 Stimulus CME" vacation trip that will be affordable for the entire family to come along.

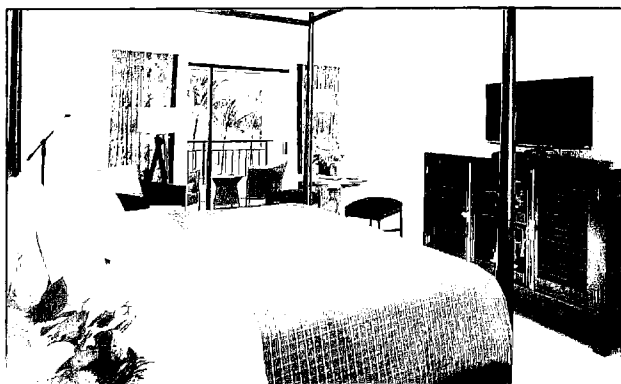
The Sheraton Kauai Resort has recently completed a \$15 million guestroom renovation. Each guestroom has a modern, tropical feel. The new rooms feature flat screen televisions, refrigerators, Kauai coffee, and large lanais with ocean views. The Resort fees have been waived and we are able to offer discounted breakfasts everyday for families staying at the Resort. The Sheraton Kauai Resort also offers a wonderful beach perfect for surfing and snorkeling, two amazing golf courses in the surrounding area, as well as close proximity to Waimea Canyon and boat tours of the beautiful Napali Coast. Ocean front rooms start in the low to middle \$200's per night price range.

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Dr. Mark Craddock, program director, and I look forward to seeing you in Kauai! Please call me, Lori Carr at 253-672-7137, or Jeanette if you have any questions or need more information.

Mahalo!



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Primary Care CME - June 5

Mark your calendar for the *Primary Care 2009* CME, scheduled for Friday, June 5, 2009 at the Fircrest Golf Club, 1500 Regents Blvd, Fircrest, WA. The course is under the medical direction of **Kevin Braun, MD**.

This one-day program focuses on the latest updates and clinical challenges common to the primary care and internal medicine practice. It is similar to the New Approaches to Common Office Problems CME course and will provide updates of selected topics. Physician assistants will also be interested in attending.

Registration fee is \$35 for PCMS members (active and retired) and \$50 for non-PCMS members. Six Category 1 CME credits are being offered.

A program brochure will be mailed shortly. For more information contact the College of Medical Education at 253-627-7137. ■

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Internal Medicine Review May 8, Register Now!

The *Internal Medicine Review* CME is scheduled for May 8, 2009 and is being held at St. Joseph Medical Center, Lagerquist Conference Center, 1717 South J Street, Tacoma WA.

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

The course is under the medical direction of **Garrick Brown, MD** and offers seven Category 1 CME credits.

Topics and speakers include:

"Aldosterone, the Unturned Rock of Renal and Cardiovascular Disease"
- Paul Schneider, MD

"Demystifying and Demythifying Fibromyalgia" - Robert Ettlinger, MD

"Capsule Endoscopy; Why & When" - Sanjay Agrawal, MD

"Celiac's Sprue: Meeting the Gluten Challenge" - Darren Schwartz, MD

"Physiologic Changes in Brain with Exercise in Alzheimers and Parkinsons"
- Patrick Hogan, DO

"Noninvasive Evaluation of Chest Pain: What You Need To Know!"
- Thomas Sawyer, MD

"Chronic Acalculous Biliary Colic" - C. Stevens Hammer, MD

"A Toe in the Water of Mind-Body Medicine" - Benjamin Haslund, MD

At the conclusion of this program, participants should be able to: Acknowledge and appreciate new information regarding the physiologic effect of aldosterone in promoting cardiovascular and renal injury and be comfortable with initiating and monitoring aldosterone receptor blockage therapy; Understand the ACR criteria for diagnosis of Fibromyalgia. Discuss and make aware of three FDA approved treatments for Fibromyalgia; Discuss and understand better options for small bowel evaluation; Understand the mechanism of action and implementation of exercise as medicine for patients with neurological disorders; Discuss and better understand outpatient workup and evaluation of chest pain; Understand the pathophysiology, diagnosis and management of biliary type in absence of gallstones; Discuss and understand the holistic perspective on some of the organizing principles of medicine and how we might be more effective in the relief of suffering.

Program brochures have been mailed. Seating is limited, so it is recommended you register early. To register or for more information, please call the College of Medical Education at 253-627-7137.

If you are a member of the Tacoma Academy of Internal Medicine, there is no charge to attend this program. The cost for PCMS members (active and retired) is \$35 and non-PCMS members is \$50. ■

Liability

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sive, and what we need to have is clear evidence.”

Making the process mandatory also may carry problems, said Michael L. McCall of the physician-run liability carrier, Medical Mutual Insurance Co. of Maine. Vermont and Maine, among other states, require parties to go through court-ordered mediation before a case can proceed to trial. In such states, the process often turns out to be an extra cost in cases clearly defensible in court, said McCall, Medical Mutual’s senior vice-president of insurance operations.

“When it takes place under statutory mandate, it’s not nearly as effective as when it occurs voluntarily,” McCall said. Even then, voluntary mediation programs could have the unintended consequence of increasing claims if every adverse outcome is mediated, he warned.

Rush University’s Brown said the hospital’s stable claims experience dispels the notion that mediation makes it

“an easy target” for settlements. Caps can help keep settlements and claims frequency in check. But if limits disappear, such as through a pending constitutional challenge to Illinois’ law limiting noneconomic awards, “it’s even more reason to have mediation,” he said.

Aside from money, however, if overall patient safety is a goal of mediation or other voluntary resolution efforts, confidentiality rules make it difficult for anyone outside of a closed forum to learn from the process, said A. Jenny Foreit, senior counsel of health care for Common Good, a bipartisan coalition that developed the health court concept.

Getting on board

There are other impediments to doctors’ widespread acceptance of mediation. Settlements are reportable to the National Practitioner Data Bank. Some doctors mistake mediation for arbitration, which means a final decision. Others see it as an extra step on the

path to litigation, rather than prevention. That’s why the Pennsylvania Medical Society launched a program to educate and train doctors on mediation not long after the Supreme Court directive, said Ruddell, who helped develop the project.

Experts at Rush University and the University of Michigan said doctors have embraced the chance to talk about adverse issues before rushing to court, and cooperation from local lawyers also has been key.

Despite possible pitfalls, physicians and lawyers at Abington Memorial Hospital say mediation is worthwhile to help break down litigation barriers. Dr. Lopatin, the rheumatologist, said he would have welcomed the chance to discuss one patient’s case openly, rather than endure lengthy depositions and what he saw as a frivolous settlement. “I would have loved to avoid that emotional ordeal and deal with it in a more humane way.” ■

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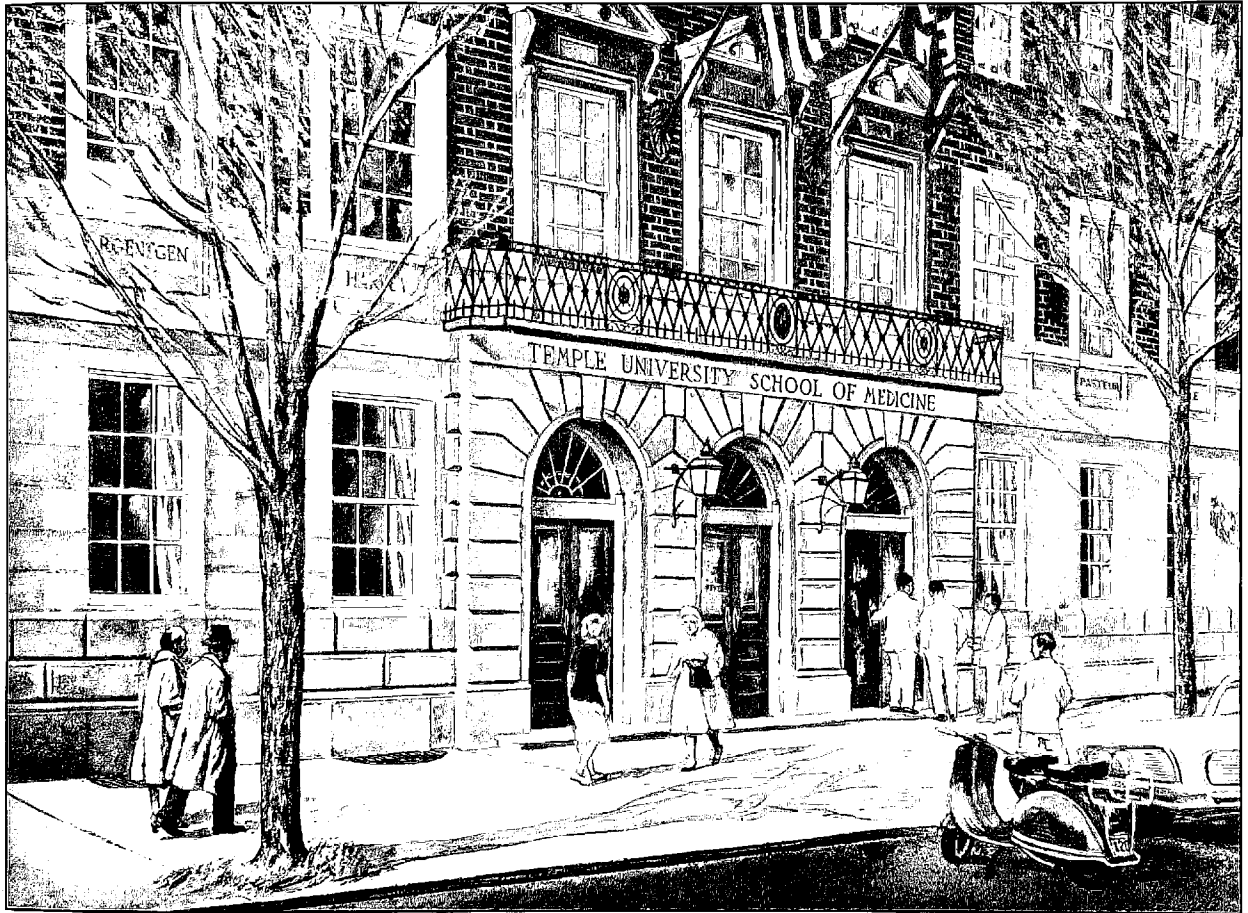
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BULLETIN



May 2009



Temple University School of Medicine

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Pierce County Medical Society

BULLETIN



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President's Page

by J. David Bales, MD

I Have a Dream...

*J. David Bales, MD*

I grew up in the South during the tumult of equal rights demonstrations and the violence that culminated in multiple assassinations including the author of the now famous line "I have a dream . . ." Some have suggested that the dream has come true with the current national administration but I think we still have a long way to go before character content equals race or religion in mankind's judgment of each other and the ultimate termination of man's inhumanity to man.

However, one dream in Pierce County has been realized with less fanfare, violence, and notoriety over the past forty years. On March 25, 2009 members of the Pierce County Medical Society joined several hundred others (including the new Secretary of Commerce, Gary Locke) to celebrate 40 years of Community Health Clinics in Pierce County and honor Mr. Lyle Quasim. What started as a dream of PCMS member **George Tanbara, MD** and a handful of others has resulted in a system of primary care for the poor and underserved of this county. That system cares for nearly 40,000 of the 100,000 un – and under insured of our community and may well be a template that other communities can use to respond to the growing population of uninsured and the dwindling population of primary care providers.

Almost as important as the vision of providing care for the underserved was the transition from PCMS and other volunteers to a self sustaining network of clinics that could provide a medical home for their patients. The transition was the result of the collaboration and cooperation of volunteers, and a coalition of local and national government. The entire process was nicely summarized in a film clip of reminiscence by the original dreamers that was shown at the celebratory luncheon – it is recommended viewing and PCMS has a copy.

So, what of dreamers today? Are we out of dreams and visions? I don't think so. Recent President of PCMS, **Sumner Schoenike, MD**, continues to work with a grass roots coalition called "We Can Do Better" whose current vision is a continuation of the CHC's dream by developing access to specialty care in an organized and sustainable fashion. We are looking at the experience of other communities such as Whatcom County's Project Access (http://www.whatcomalliance.org/services/whatcom_project_access.htm) and the community-based, practice-controlled resources of Community Care of North Carolina (www.communitycarenc.com) for ideas and templates to respond to a small part of the national questions on health care. Call PCMS if you would like to participate. ■

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Dr. Andrew Statson: After 10 Years, 'The Invisible Hand' Signs Off

By Jean Fitch Borst

"The act of writing is an act of optimism. You would not take the trouble to do it if you felt it didn't matter."

Edward Albee

"I admire anybody who has the guts to write anything at all."

E.B. White

Dr. Andrew Statson finds himself in an unusual position this month – he is the subject of this column, not the author. For over 10 years, he wrote a monthly column for the PCMS *Bulletin* called "The Invisible Hand," sharing his ideas and opinions with PCMS members - ideas and opinions he acknowledges were not always politically correct. He filed his last article in January of this year.

This month, PCMS takes the opportunity to thank Dr. Statson for his contributions and for offering PCMS members a decade of thought-provoking and insightful commentary.

Providing the Ammo

It was 1998 when Dr. Statson contacted PCMS executive director Doug Jackman about being a monthly contributor to the *Bulletin*. "When I was practicing medicine in California, I wrote a column for the Orange County Medical Society that provoked a great deal of discussion among my colleagues. I wanted to resurrect the column to stir up debate and give ammunition to my Pierce County colleagues in the defense of the private practice of medicine," he says. His first submission was titled "The Fourteen Percent Fallacy" and ran in the March 1998 *Bulletin*. When he filed his story, he told Doug that meeting a monthly deadline wouldn't be easy, but he hoped to do it at least for a while. The rest, as they say, is history.

Over the years, Dr. Statson tackled a wide array of topics, touching on malpractice issues, commercialism in medicine, medical savings accounts, equitable compensation, profiling and more. Anyone who read his columns knows Dr. Statson is a fierce free market advocate. One of the primary reasons he stopped writing his column was because he felt he had exhausted the subject. "I felt like I was repeating myself," he says. "How many ways can I say a free market would be better than a controlled one?"

When he began writing his column, his focus was primarily on economic issues and later shifted to politics. "Eventually, I was writing primarily about moral issues," he says. In his November 2008 column called "Moral Hazard." He wrote, "Moral hazard arises when others intervene to modify, for good or for ill, the consequences of a person's actions.

About Dr. Statson

Dr. Statson began his medical studies in his native Bulgaria after graduating from high school. He finished his medical degree at Paris University and remained in France for a short time before moving to the United States in the early 1960s. He completed his internship and residency in Cleveland, and was drafted by the army 18 months later.

Dr. Statson was stationed in Los Angeles when he finished his stint in the military. He set up practice in Orange County – first as a partner and then as a solo OB/Gyn practitioner – where he remained for six years. California's medical malpractice crisis prompted his move to the Pacific Northwest. "Southern California has just one season, and I wanted to go someplace that had a different climate. I like this area, and I like the rain."

Dr. Statson retired in 2002.

Practicing medicine for 35 years, Dr. Statson has seen remarkable changes in medicine. "The practice of medicine is still rewarding, but the hassles you have to go through now are so discouraging," he says. "My son went into medicine. I can't say I would discourage him, but I believe you really have to want to do it. There should be nothing else you would rather do. It's also much harder now than when I started. But if I had to make the decision now to go into medicine, I would have to say I would probably do it."

Whether it consists in punishing those who work, through taxation, or in rewarding those who don't, through subsidies, moral hazard gives the wrong signals. The result is to discourage production and thrift, while stimulating consumption and waste."

"A few individuals may break the rules and get hurt as a result, but a healthy society can shrug them off and continue to prosper. When the rule-breaking becomes widespread, the social structure crumbles, and the good people suffer along with the bad."

Dr. Statson believes "Moral Hazard" is something physicians should read alone with their conscience. For anyone who missed the article, he is happy to provide a copy.

While exploring some admittedly touchy subjects in his

See "Statson" page 19

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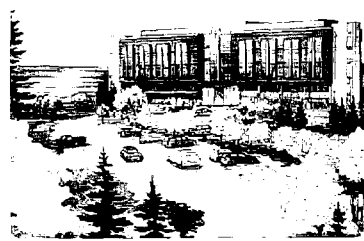
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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH,
and Frank Dibiase, MA

Clean Air for Kids - Making Integrated Asthma Management a Reality



Anthony Chen, MD

May is Allergy and Asthma Awareness month. For many Pierce County residents with asthma, there is still much room for improvement on awareness and disease management. As their physicians, you often face anxiety or frustration in taking care of them. Fortunately, there is a great, effective program to help called Clean Air for Kids. Despite the name, this community-based prevention partnership is not just for kids and not just about clean air. Best of all, it is comprehensive and free.

Before I share some of the program details, let us take a look at the asthma problem in Pierce County. Asthma prevalence is a challenge to measure and we use different surveys and surveillance methods (some of which are not done every year), so you may see different numbers in other sources or websites. Approximately 14,750 (7.3%, 2005 data) of the children in Pierce County and 7.7% (2003) in Washington State are currently diagnosed with asthma compared to 8.9% (2003-2005 average) for the country as a whole. Another perspective on the impact is provided by emergency department visits for asthma: the emergency department surveillance system (EEDS) reported 1,200 pediatric visits in Pierce County (non-federal facilities) in 2008 while the BRPSS survey reported 6,571

visits in 2005. In 2007, there were 200 pediatric and 460 adult hospital admissions for asthma in Pierce County (non-federal facilities).

These numbers alone do not paint a true picture of what uncontrolled asthma means to a person or a family's quality of life. Children with uncontrolled asthma often have interrupted sleep, whether just coughing or uncontrolled wheezing and shortness of breath. This has ripple effects: the child may not be able to play sports, may be too tired to concentrate at school the next day, or may not be able to attend

ous epinephrine, and intravenous aminophylline. We have shifted from the emergency room to outpatient and home; from rescue medications to controller medications; from asthma therapy to monitoring asthma control. With greater acceptance of the Chronic Care Model in our practices and emphasis on environmental control, we now have more strategies for intervention.

The 2007 National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma focuses on monitoring asthma control as the goal for asthma therapy and distinguish between asthma

therapy and monitoring asthma control. The guidelines place new emphasis on "multifaceted approaches to patient education and to the control of environmental factors or comorbid conditions that affects asthma." The four components of asthma care

"Luckily, we have come a long way from the days of oral theophylline, subcutaneous epinephrine, and intravenous aminophylline. We have shifted from the emergency room to outpatient and home; from rescue medications to controller medications; from asthma therapy to monitoring asthma control."

school at all. Parents also become sleep deprived and worried: they may miss work to care for an asthmatic child. The physical, emotional, and economic costs are huge.

As physicians, we will see these children and adults with asthma in the emergency room, hospital, and our offices. Regardless of the acuity, these patients present challenges to us. Luckily, we have come a long way from the days of oral theophylline, subcutane-

include: assessment and monitoring, patient education, control of environmental factors and other conditions that can affect asthma, and medications. It emphasizes self-management, stepwise approaches, and collaboration.

Clean Air for Kids, a local partnership of the Tacoma-Pierce County Health Department, American Lung Association Northwest, University of

See "TPCHD" page 8

TPCHD from page 7

Washington Tacoma and area medical providers have teamed up for over 10 years to provide services that make a difference. At the core of the Clean Air for Kids are trained asthma outreach workers who visit the homes of families with asthma. Research indicates that something as old-fashioned as a house call can be every bit as powerful as asthma medications including inhaled corticosteroids. The benefits will go even further when used as part of a comprehensive plan.

Part health care worker, part environmental scientist, and part social worker, Clean Air for Kids asthma outreach workers begin by listening to the needs of the family. Next they discuss the doctor's orders, assess the home environment for asthma triggers, and wrap-up with an asthma action plan tailored to the needs of the family. Free supplies are provided as appropriate and include spacers to be used with an inhaler, allergen-barrier pillow and mattress covers, or an opportunity to borrow a humidity gauge or a HEPA vacuum cleaner. Maintenance request letters for landlords are often part of a visit. All at no cost to the family.

Follow-up phone calls and additional home visits are provided as needed to ensure the family understands the action plan and has the support they need to be successful. With permission from the family, follow-up is also conducted with their primary care provider or referring provider to ensure everyone is in the loop. You can see how Clean Air for Kids works on all four components of asthma care.

Published, program evaluation information documents its effectiveness. Follow-up surveys to families served show:

- * Caregivers reported significantly higher quality of life at follow-up than at baseline.

- * At follow-up, 93% of the children had asthma management plans as compared with 31% at baseline.

- * Self-reported hospitalizations were significantly reduced.

- * All of the families made changes

to minimize household asthma triggers.

- * Caregivers reported high satisfaction with the AOW and 90% of them felt that the home environmental assessment conducted by the AOW helped improve their child's asthma.

Additional research further demonstrates the efficacy of home visits not only to improved health outcomes but also to decreased emergency care and significant reductions in medical care costs. The Inner City Asthma Study, a national study of home visits, demonstrated a 13.6% reduction in urgent clinic and emergency department use and 11% reduction in hospitalizations. The Seattle-King County Healthy Homes study showed an average reduction in urgent medical care costs of \$2,370 per client that received a mean of 7 visits and \$2,238 in the group that received a single visit.

Clean Air for Kids services are provided at no cost to families. A combination of grant dollars and funds provided by the Lung Association and the Tacoma-Pierce County Health Department cover expenses.

In summary, the Clean Air for Kids partnership helps families with asthma

and their providers address the four components of asthma care and implement an integrated approach to asthma management advocated by the 2007 Guidelines and the Chronic Care Model. We are lucky to have this resource available and hope that you and your patients will take advantage of it.

If you'd like to learn more about the program or have families in your care that you think could benefit, please call 253-798-2954, send a fax to 253-798-4700, or visit our website <http://www.tpchd.org/asthma>. You will find a lot of information including links to a Do-It-Yourself Home Environmental Assessment, Pierce County Asthma & Air Quality Data, and the American Lung Association of Washington.

You can learn more about the Chronic Care Model at <http://www.improvingchroniccare.org/>. You can order a CD and download presentations, references, and even a business model for integrating the Chronic Care Model into your practice.

You can order or download the 2007 Guidelines for the Diagnosis and Management of Asthma at <http://www.nhlbi.nih.gov/guidelines/asthma/>. ■



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AMA letter backs Obama's broad principles for health system reform

The Association outlines the next steps Congress and the White House should take to turn the tenets into policy changes

The American Medical Association earlier this month further fleshed out what it will push for in this year's landmark health system reform debate, aligning itself with several core principles from President Obama and offering more specifics about how to achieve them.

In an April 13 letter to the White House, the AMA announced its strong support for eight guiding principles against which Obama has said he will gauge the health reform effort as he works with Congress. The AMA made the statement in an effort to show it is backing this "historic opportunity to improve the system," while also highlighting more specific issues the organization wants Congress to address this year, said AMA President Nancy H. Nielsen, MD, PhD. She co-signed the letter with AMA President-elect J. James Rohack, MD.

"We are committed to reform, and we want to expand access to care for all Americans," Dr. Nielsen said. "This is an important year, because more people may lose their jobs and their health insurance, and we have grave concerns about that and the loss of preventive services."

The eight basic principles — including guaranteeing patient choice and aiming for universal health care coverage — lack details, although Obama further outlined his long-term vision in his budget proposal released Feb. 26. The AMA letter indicates that the standards dovetail with more expansive policy changes for which the Association already is pushing.

But embracing the eight principles does not mean the AMA necessarily backs every idea on health reform that Obama has revealed so far. For instance, the president has called for creating a public health plan option linked with a national health insurance exchange to serve as competition for private plans. In its letter to the White House, the AMA says it supports a health insurance exchange to ensure coverage

choice and portability, but it does not weigh in on the public plan option. To move toward universal coverage, Congress should build on the employer-based system and strengthen the safety net provided by publicly financed programs such as Medicare, Medicaid and the Children's Health Insurance Program, Dr. Nielsen and Dr. Rohack wrote.

Dr. Nielsen stressed that the organization is mindful of the need to watch the dollar signs as policymakers work toward the goal of universal coverage. "It's very important for us that all Americans have health care coverage that's affordable. But we do understand that we can't afford everything for everybody, so we need to have fiscally responsible conversations."

The letter proposes expanding on Obama's principles in a number of ways, including:

- Reforming and improving the insurance market through the use of modified community rating, guaranteed renewability and fewer benefit mandates.
- Assisting low-income individuals through premium subsidies and cost-sharing assistance.
- Promoting medical home models to reduce system fragmentation and improve care coordination.
- Establishing antitrust reforms that would allow groups of physicians to contract jointly with payers as long as the doctors certify they are collaborating on health information technology and quality improvement initiatives.
- Easing the effect of liability pressure on the practice of defensive medicine through innovative approaches, such as health courts, early disclosure and compensation programs, and expert witness qualification standards.

Some signs of progress

Dr. Nielsen said she is encouraged by the progress already made in talks about Medicare physician payment reform, a key part of the AMA's broader

health system reform agenda. Physicians soon may begin to see pilot programs testing various payment models in an attempt to find long-term alternatives to the current system, she said. "It's early, but there's no question that's on the table."

In his fiscal 2010 budget proposal, Obama said Medicare's physician pay cuts as mandated by law are not practical. He said Congress should plan on spending \$330 billion over the next decade to repeal the current pay system instead of simply patching it year after year.

The next steps on the issue are up to lawmakers. The AMA was one of more than 70 medical organizations that signed an April 13 letter to the House Budget Committee asking Congress to retain a section in the House budget proposal that could make it easier for lawmakers to approve a payment overhaul. By suspending "pay as you go" rules for a large initial portion of a physician pay proposal, the House budget would obviate the need to find hundreds of billions of dollars in offsets otherwise needed to prevent the overhaul from running up deficit spending. At this article's deadline, lawmakers were still negotiating over the differences between the House budget blueprint and the Senate version, which does not include the pay-go exemption.

At least two key Senate leaders think Congress can move quickly, even though it is contemplating the largest health system overhaul proposed in 15 years. "We have jointly laid out an aggressive schedule to accomplish our goal" of enacting comprehensive health system reform, said an April 20 letter to Obama from Senate Finance Committee Chair Max Baucus (D, Mont.) and Senate Health, Education, Labor and Pensions Committee Chair Edward Kennedy (D, Mass.). Both committees plan to mark up legislation in early June.

See "Obama" page 18

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Physician Self-Care: Physician, Please Don't Heal Thyself

In a book entitled *The Physician as Patient*, by Michael F. Myers, MD, and Glen O. Gabbard, MD, the psychology of physicians and the culture of medicine are aptly described.¹ Gabbard feels that the perfectionistic behaviors that patients seek and that the field of medicine rewards become "personally expensive." Although perfectionism may lead to comprehensive diagnostic efforts, precision in the ordering of lab tests, and thorough treatment planning - all of which serve the patient well - it is the same perfectionistic expectations that often become maladaptive when they are applied to oneself and to nonpatient relationships. Several investigators, including Gabbard, have concluded that perfectionism is a vulnerability factor for depression, burnout, anxiety and eventual suicide.^{1,2,3}

The roots of perfectionism

Clinical work with physicians by the Washington Physicians Health Program (WPHP) confirms that perfectionism in physicians is often associated with a childhood belief that they were not sufficiently valued or loved by their parents. Further, these physicians believed that if their childhood behavior and achievement became perfect, then the love would follow. Low self-esteem could often be overcome with accolades and attention. However, when awards were forthcoming (for the high school valedictorian, the summa cum laude graduate, etc.), the only response from perfect children was to demand even more of themselves. Gratification and contentment, if they occurred, were

short-lived and had little real value. Instead, they were replaced with the psychic torment of still trying to be good enough. Unfortunately, it is not uncommon that the perfect child tried to become the perfect physician.

When illness becomes unacceptable

What happens when the perfect physician develops a substance abuse problem, depression, or major disorder? Is the physician able to seek help for this disorder as if it were hypertension or diabetes? Unfortunately, more often than not, the answer is no. **At the WPHP we know that the ability of a physician to identify as someone who is "ill" instead of "bad" is rare. Additionally, it is compounded by the shame and guilt that arises from the cognitive distortion that "this should never have happened to me and people have finally found out what a fraud I really am."**

In fact, when the self-doubt and shame are combined with an exaggerated sense of self-responsibility and responsibility to others, we don't believe we have permission to be sick at all. We readily ask our patients not to return to work because they are "too sick" to do so, but how often do we come to work minimizing our own illness when we are just as ill ourselves? We compulsively search for depression in our patients while at the same time rationalizing our own depression as just being "a bad day." How capable are we of concluding that our alcohol consumption has become as problematic as that of our patients?

Because of the expectations of so-



Mick Oreskovich, MD, Medical Director and CEO, Washington Physicians Health Program

ciety and of ourselves that "we should be different," we are unable to accept any illness in ourselves that connotes a sense of loss of control. We may know that "something isn't right," but what it is and what to do about it isn't usually within our grasp. We search for less egregious explanations, minimize our symptoms, rationalize our response, and deny our own access to adequate care. It seems as if we are not good enough to be "that sick."

Why self-diagnosis and self-care don't work

The doubt, shame, and exaggerated responsibility also predispose us to self-diagnosis and self-care. How can we delegate our health to someone else when we should have been taking better care of ourselves? If we do seek care and are appropriately treated, how often do we take the medication as prescribed and complete the prescription? In fact, we physicians are notorious for stopping the medication because of side effects or adjusting the dosage without telling our physician because we know better and "don't want to bother them." So the Benadryl becomes Ambien, the ibuprofen becomes Vicodin, and recurrent suicidal ideation is dismissed because "I would never do that." The physician who self-treats is

See "Heal" page 12

Heal

 from page 11

said to have "a fool for a patient." And the physician who diverts a controlled substance also violates state and federal laws.

How can physicians get better?

We deserve the same quality of care that we provide to others. We have the same prevalence and incidence of disorders as our patients - and our suicide rate is much higher than that of the general population.⁴ What can we do to change this paradigm?

- Acknowledge that our health is as important as the health of our patients.
- Seek adequate medical care, especially preventive care, and be compliant with all treatment recommendations.
- Take all medications exactly as prescribed.
- Avoid all self-diagnosis and especially self-treatment: it is dangerous and we deserve better than that.
- Seek additional education and training that allow us to distinguish the differences among stress, burnout, poor

boundaries, maladaptive coping, depression, risk of suicide, substance abuse, and substance dependence.

- Become familiar with resources and services of organizations like the WPHP (www.wphp.org) as well as the American Foundation for Suicide Prevention (www.afsp.org and DoctorsWithDepression.org).

Simple as it may seem, it is true that the healthier we are, the healthier our patients will become!

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Reprinted from The Physicians' Report, Spring 2009

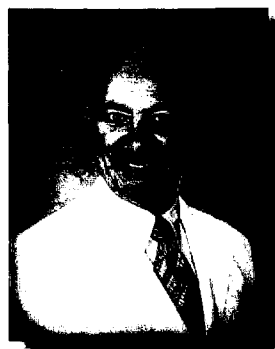
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Patient Identity Theft and the FTC's Red Flags Rule

In November 2007, the Federal Trade Commission (FTC), the federal bank regulatory agencies, and the National Credit Union Administration together issued a "Red Flags" Rule, regulations that require creditors to put into practice a program for detection, preventing, and mitigating identity theft. Health care providers and clinics that accept patients' payment on terms or from credit cards are considered creditors, and thereby subject to the new Red Flags Rule. As a result, every physician and their practice must comply with these regulations. The rule becomes enforceable on May 1, 2009 **but has now been delayed until August 1st** to allow practices more time for policies and training. Go to <http://www2.ftc.gov/redflagsrule> for full details on the regulations and compliance guidelines.

Protecting patients' identities

According to the FTC, medical identity theft accounted for 3% of identity theft crimes, or 249,000 of the estimated 8.3 million people whose identities were stolen in 2005. With a real patient's medical identification, a thief can access prescription drugs and treatment, tricking the health care delivery system into believing his or her assumed medical identity is genuine - and then walk away, leaving the real patient holding the bill. What's worse is that law enforcement officials have found it difficult to track, locate, and prosecute medical identity thieves.

A patient's medical information also includes a date of birth, a Social Security number, photographs, addresses, telephone numbers, e-mail addresses, and other personal identity information that thieves use to abuse the victim's financial resources. The new Red Flags Rule can help clinics formalize ways to watch out for potential patient-information security breaches.

HIPAA is not the only federal law that oversees the protection of sensitive patient information. The FTC's Red Flags Rule offers succinct guidelines for protecting patients against identity theft.

What is a red flag?

The FTC defines a red flag as a "pattern, practice, or specific activity that indicates the possible existence of identity theft." Under the Red Flags Rule, "identity theft" means "a fraud committed or attempted using the identifying information of another person without authority." The Red Flags Rule requires creditors to put policies and programs in place that:

- identify relevant red flags
- detect red flags in patient accounts
- respond appropriately to any red flags in patient records
- update the red flags program periodically to reflect changes in risks to patients, and the safety and soundness of patients from identity theft

What you need to do

Develop a red flags policy in your practice. It must be formalized in writing and known to all employees who access or manage patient-identity information. Establish reasonable procedures for identifying red flags that address these categories:

- Alerts, notifications, or other warnings from consumer reporting agencies, such as fraud-detection services
- Suspicious documents
- Suspicious personal identifying information, such as a suspicious address change
- Suspicious activity related to a patient's information
- Notices from patients, victims of identity theft, or law enforcement officials

The FTC lists 26 red flags within these five categories. To review these red flags, go to the FTC's Red Flags Rule web site: <http://www2.ftc.gov/redflagsrule>. The FTC offers businesses a how-to guide for establishing red flag policies.

You can scale your red flags policy to the size and complexity of your practice. It can be one page long, or several pages, depending on the nature of your patient recordkeeping system. It may be as simple as checking IDs, and verifying credit card numbers with financial institutions. Your red flags policy must also include a reporting system, in the event you suspect identity theft, to law enforcement or credit-reporting agencies. It must also be updated frequently, based on risk assessments that examine the vulnerability of your red flags program. A governing body, such as a board of directors or a senior employee, must approve your red flags policy as well as any changes to it.

Noncompliance

You may incur civil monetary penalties of up to \$2,500 per violation for noncompliance. It's good business practice to initiate a formalized red flags policy to fight against patients', and your own, identity theft.

Resources

Contact the FTC at redflags@ftc.gov with any questions you may have about launching an appropriate red flags policy in your practice. More detailed information can be found at <http://www.ftc.gov/bcp/edu/pubs/articles/artll.shtm>.

You can download the FTC's publication, *Fighting Fraud with the Red Flags Rule: A How-To Guide for Business*, at <http://www.ftc.gov/bcp/edu/pubs/business/idtheft/bus23.pdf>.

Contact your Physicians Insurance risk management representative for information about this and other risk management topics. Call the Seattle office at 206-343-7300 or 1-800-962-1399. E-mail an expert at risk@phyins.com. ■

Reprinted from Physicians Risk Management UPDATE, Volume XX, Number 3

IN MEMORIAM
DAVID E. WILHYDE, MD

1934 - 2009

Dr. David Wilhyde passed away at home on March 9, 2009 after a long illness with pulmonary fibrosis.

Dr. Wilhyde graduated from the University of Washington Medical School in 1960. He interned at the University of Chicago Hospital and returned to UW for his pathology residency. He then went to Cincinnati, Ohio to complete a two-year pediatric pathology fellowship prior to returning to the Northwest for good.



David Wilhyde, MD

Dr. Wilhyde spent 38 years of his medical career as a pathologist at St. Joseph Hospital. He was a fellow of the College of American Pathologists, a member of AMA, WSMA and PCMS. He served as Chief of Staff at Allenmore Hospital in 1988.

Dr. Wilhyde was a great proponent of amateur boxing and spent many years as fight doctor for Golden Gloves. He was a sports enthusiast, including skiing, squash, flying, scuba diving, cycling, tennis and golf, which he frequently did with his many medical community friends.

A devoted family man, he is survived by Alice, his wife of 48 years, a daughter, son, grandchildren, sister, cousins, nieces and nephews. His dogs, especially Samantha, were special companions to him.

Remembrances can be made to your favorite medical education scholarship fund or the Tacoma/Pierce County Humane Society.

PCMS extends sympathies to Dr. Wilhyde's widow Alice and their entire family.

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IN MEMORIAM
STANLEY W. TUELL, MD
 1918 - 2009

Dr. Tuell passed away on March 30, 2009 at the age of 90. He was born and raised in Tacoma and attended Stadium High School and the University of Washington. He received his medical degree in 1943 from Northwestern University Medical School where he also completed his graduate surgical training prior to returning to Seattle where he did his internship at Swedish Hospital. A dedicated surgeon, Dr. Tuell served Tacoma for over 30 years at Tacoma General, St. Joseph, Mary Bridge Children's, Mt. View, Doctors, Auburn General and Madigan Hospitals.



Stanley Tuell, MD

Dr. Tuell was a very active PCMS member and served as President in 1963. He was a strong supporter of PCMS and WSMA activities over the years serving as WSMA Speaker of the House for many, many years. He was a professional parliamentarian, and became an instructor of Parliamentary Law and Procedure at Tacoma Community College and belonged to the National Association of Parliamentarians.

He also belonged to the American College of Surgeons, Washington State Board of Medical Examiners, and served on the Washington State Medical Quality Assurance Commission.

Dr. Tuell's obituary in *The News Tribune* cited him as a man with high standards; never wavering in word or deed. He had a professional, proper, calm demeanor as a doctor that belied his goofy sense of humor. He was, they wrote, a constant, good, happy and lucky man.

Remembrances may be made to the Mary Bridge Children's Foundation.

PCMS extends sympathies to Dr. Tuell's family.



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IN MEMORIAM
ROBERT R. BURT, MD

1920 - 2009

Dr. Robert Burt passed away on his 89th birthday, March 25, 2009.

Dr. Burt obtained his medical degree from the University of Oregon Medical School in 1944 and served his residency at Harborview Hospital in Seattle. He was appointed to a fellowship in surgery at the Mayo Clinic in Rochester, Minnesota where he received his surgical training. He specialized in abdominal surgery and was certified by the American Board of Surgery.

Dr. Burt was a member of the Tacoma Surgical Club (of which he was a past president), a Diplomat of the American Board of Surgery, American Board of Abdominal Surgery, The Priestly Society of the Mayo Clinic and the American Society of Abdominal Surgeons. He served on the staff of Tacoma General Hospital, where he was Director of Interns. He also served on the staffs of St. Joseph Hospital, Doctors Hospital and Mary Bridge Hospital, and was past president of the Lakewood Hospital medical staff.

Remembrances may be made to Friends of American Lake Veterans Golf Course, Rehabilitation and Learning Center, 10101 Cedrona St SW, Lakewood WA 98498.

PCMS extends sympathies to Dr. Burt's family.



Robert Burt, MD

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Oregon developing comprehensive health system reform

Covering more uninsured in the state hinges on a proposed tax increase on certain hospitals and health plans

Oregon lawmakers are considering a package of bills that would cover tens of thousands more residents, draw an additional \$1 billion in federal Medicaid funding and turn over control of the state's health system to a citizen-led health care authority.

But the coverage expansion depends on a controversial proposed tax increase on hospitals and health plans that would raise more than \$300 million a year to draw the federal funding. The proposal allows the expansion of public health plans to cover 80,000 children and 100,000 adults.

The legislative package is based on recommendations from the Oregon Health Fund Board, a seven-member citizen's panel the Legislature created in 2007. The board in November 2008 called for a nonpartisan, citizen-led health care authority to refocus the state's health system on equitable, cost-effective, preventive care and craft a plan to cover all Oregonians by

2015. More than 600,000 residents are uninsured.

The health authority would take over the responsibilities of various state health agencies and would resemble the Kansas Health Policy Authority, said Carol Robinson, the Oregon Health Fund Board's interim executive director. The Kansas authority in 2005 took charge of the state's Medicaid program and Children's Health Insurance Program. But it also coordinates state health care purchasing and compiles and distributes health care data. "We think the authority is really the keystone to doing this right," Robinson said.

Lawmakers have introduced other legislation this spring — also based on the board's recommendations — that would:

- Charge the health authority with establishing a health insurance exchange to provide more affordable coverage options.

- Set standards for medical homes, including focusing on preventive and coordinated care.

- Create a database of claims to compare health care costs and assess care effectiveness.

- Further develop evidence-based care guidelines in cooperation with the private sector.

Political observers said they expect the Legislature to adopt some sort of major reform legislation by the summer. "Something will happen," said Oregon Medical Assn. President Peter Bernardo, MD. The Oregon House is considering most of the changes in two comprehensive reform bills. The Senate is looking at several similar measures independently. Committees were debating the bills at this article's deadline.

The Oregon Medical Association has supported the reform process, but Dr. Bernardo said the society is con-

See "Oregon" page 20

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Obama

from page 9

Obama's 8 principles

The AMA has aligned itself with President Obama's eight basic health system reform principles and provided ideas about how Congress and the administration can achieve them. Here are the original principles for a reform plan as the White House describes them:

Guarantee choice: The plan should provide Americans a choice of health plans and physicians. People will be allowed to keep their own doctor and their employer-based health plan.

Make health coverage affordable: The plan must reduce waste and fraud, high administrative costs, unnecessary tests and services, and other inefficiencies that drive up costs with no added health benefits.

Protect families' financial health: The plan must reduce the growing premiums and other costs American citizens and businesses pay for health care. People must be protected from bankruptcy due to catastrophic illness.

Invest in prevention and wellness: The plan must invest in public health measures proven to reduce cost drivers in our system — such as obesity, sed-

entary lifestyles and smoking — as well as guarantee access to proven preventive treatments.

Provide portability of coverage: People should not be locked into their jobs just to secure health coverage, and no American should be denied coverage because of preexisting conditions.

Aim for universality: The plan must put the United States on a clear path to cover all Americans.

Improve patient safety and quality care: The plan must ensure the implementation of proven patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology with rigorous privacy protections and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.

Maintain long-term fiscal sustainability: The plan must pay for itself by reducing the level of cost growth, improving productivity and dedicating additional sources of revenue.

Source: The White House, AMA letter (www.ama-assn.org/ama/pub/news-events/news-events/obama-principles-health-care.shtml) ■

Reprinted from *AMNews*, April 27, 2009

Applicants for Membership

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Statson from page 5

columns. Dr. Statson says he has received relatively little feedback over the years. "My colleagues say they are impressed with what I write. They think I made good points. Some said I tell it like it is," he says. "People are sometimes amazed by what I have to say. Let's say my columns are not always politically correct."

Dr. Statson said that he initially thought he would exhaust the topics he could write about much sooner, but they just kept coming, typically spurred by a news item, something on the Internet, or a tidbit passed along by a fellow PCMS member. "I think I wrote to try to shake people to think about these things," he says. "That was my intent. But people are busy. They are working hard, and they don't have time. Until things go wrong, people generally won't pay attention."

Dr. Statson hoped other PCMS members would want to respond to his columns and submit their own articles, expressing differing views. "There would be more conversation and more opportunity for debate," he says. "But that only happened a few times. I do hope that others will step forward and be willing to contribute to the newsletter and offer their thoughts and opinions about what is going on with the practice of medicine."

The Patient is Responsible

An avowed libertarian, Dr. Statson is firmly against increased government control of health care and cautions against a move toward national health care. Giving people more control over their health care and health insurance creates new incentives for people to be more engaged managing their health. "Patients should be responsible for their own health care," he says. "They need help, I don't argue that. But they should always have control."

In a June 2005 column, he wrote, "Health care is an economic good, and as such, it has a cost. It uses resources and those resources are limited. There

are just so much of them to go around. In the market, the decision to consume resources belongs to the buyer."

"This is a deep problem that is profoundly disturbing to me," Dr. Statson explains. "It's about getting something one doesn't deserve, getting something for nothing. People think the government will give medical care to everyone, but they won't. Many, in fact, will be denied care. I've seen it happen in other countries, and it will happen here, too. Writing in an April 2001 article titled "Too Good to Be True," Dr. Statson commented, "Medical care as a right, whenever and in any way we want it, without doing anything to earn or deserve it, given to us on the sole basis of our wishes, sounds too good to be true, and so it will turn out to be."

"We are moving to national health care and, I'm afraid, the only thing that will save us is if the money isn't there to pay for it," he notes. "We saw it in the 1970s when there was a push for national health care. With inflation and the economic slump, they ran out of money and couldn't finance it."

Writing is More Than a Casual Interest

Dr. Statson has been writing nearly all his life. "I've liked to write since I was a kid," he says, turning his focus in the last several years to fiction. Since his retirement in 2002, he devotes two to three hours a day to his writing projects, which include three completed

manuscripts (science fiction books he calls them "marginally medical"). He is currently working on a "more mainstream" novel. His hope is to eventually publish. "I've written more as a physician and scientist than fiction. Writing fiction is very different."

Retirement has also given Dr. Statson more time for his other passion – reading. He enjoys an array of subjects from history and politics to economics and physics.

To his colleagues who might be considering retirement, Dr. Statson says, "There is a life after medicine. Personally, I'm enjoying it. The most important thing, I believe, is that you should be willing to accept a significant drop in your standard of living. You might think you will live with a lot of ease, travel the world, and have expensive hobbies. You won't be able to. We are all now in a different climate. If you can accept that, you will enjoy retirement."

While no longer writing for the PCMS *Bulletin*, Dr. Statson continues his support of free market medicine, and is willing and available to express his views. "I'm not one to stand on the street and hand out pamphlets, wave a sign or march in a demonstration," he says. "But if someone asked me to speak or write about the free market, I would do that."

Dr. Statson can be reached via email at anstatson@att.net. ■



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Oregon

from page 17

cerned about the scope, power and expertise of the proposed health care authority. "All of us are worried that it will be a huge government organization that will have the ability to mandate care."

The OMA, however, supports the coverage expansion to an additional 80,000 children and the approximately 100,000 adults in Oregon with incomes at or below the federal poverty level. The association is wary of provider taxes, Dr. Bernardo said, but it supports finding a way to leverage the \$1 billion in available federal Medicaid funding.

The proposed tax would swallow hospitals' profit margins, said Kevin Earls, vice president of policy and advocacy for the Oregon Assn. of Hospitals and Health Systems, which represents the 78 hospitals in the state. Bills under consideration would increase the existing tax on hospital revenues for the state's 26 more urban hospitals, raising it

to 4% from less than 1%. But Oregon hospitals had an average profit margin of only 3.8% in 2008, Earls said. "It taxes hospitals to the point of having financial losses." The measure also would levy a 1.5% tax on health plans' gross premiums.

The hospital association joined with health plans in March to offer an alternate proposal to maintain the existing hospital tax, set to expire Oct. 1, and institute a 1% tax on medical and dental claims, Earls said. This tax would affect all health plans, including the 40% of plans that are self-funded and do not charge premiums. It would raise \$215 million a year, enough to cover 60,000 children and 45,000 low-income adults, he said.

Democrats have the two-thirds majorities in both chambers needed to adopt new taxes, plus the support of the governor's office, said Republican Rep. Ron Maurer, the vice chair on the House Health Care Committee. Maurer's high-

est priority is an amendment subjecting the tax increases to a statewide referendum. "I'm not convinced that voters are willing to change our health care system if it includes a bunch of new taxes." He added that health system reform needs to ensure that health care consumers better understand the cost of the services they use. ■

Reprinted from *AMNews*, April 27, 2009

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"Crimes by Drug Seeking Patients: How to Spot Them and Report Them"
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"The Physician's Role in Patient Safety"
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"Survivorship - A Challenge for the Future"
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"Vitamin D: New Understanding of the Role of Vitamin D in Health and Disease"
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You should have received a program brochure/registration from in the mail. To register or for more information, please call the College of Medical Education at 253-627-7137.

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Pierce County Medical Society



June 2009

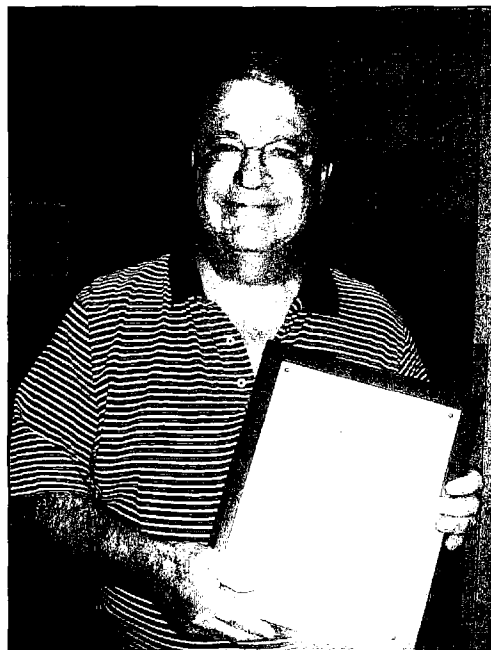


Above - Dr. Patrick Hogan, in his CHAMP (Coalition for Healthy Active Medical Professionals) shirt, works with Gig Harbor city officials to install course mile markers to promote exercise as part of the PCMS Healthy Communities Pierce County (HCPC) initiative

See story page 5

Below - Dr. Peter Marsh displays his award presented at the WSMA Leadership Conference in Chelan in appreciation of his contributions to WSMA and the medical profession

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BULLETIN

Pierce County Medical Society



June 2009

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President's Page

by J. David Bales, MD

Lot's Happening...



J. David Bales, MD

The last couple of months has been crammed full of activities that involve the PCMS. In April 2009 we had a unique CME activity in Nicaragua that was both stimulating and entertaining. The subjects ranged from Tropical Diseases to the Epidemiology of Happiness. Activities ranged from the sublime (sun and pool) to the ridiculous (Zip Line)! We will try to get a more detailed article for the *Bulletin* because the trip was definitely worthwhile, educational, and fun!

May has been crammed full, too. The annual WSMA Leadership Conference in Chelan was as inspiring as always with the theme "Get Inspired." Topics again covered the spectrum of health care issues including economics, patient safety, physician/hospital relationships, and effective leadership strategies and practices. Physician leadership seems to be the cry from health care reform and the WSMA Leadership Conference certainly rises to the occasion of pointing a direction to the future.

At the county level, the PCMS partnered with the Business Examiner for the second year in recognizing our local Healthcare Champions. The event recognized outstanding individuals like **Gordon Klatt, MD**, founder of Relay for Life, which has become an annual 24 hour relay in all 50 states and 22 countries to benefit cancer research. **Dr. Khai Tran**, Medical Director of the Carol Milgard Breast Center and TRA physician for championing this community collaboration in efforts to speed the diagnosis of breast findings in our community. Cooperative efforts by all of the health systems with community groups such as the Korean Women's Association also received well deserved recognition. Healthcare Champions are those that do not ask "What's in it for me?" but rather "What's in me for it."

Within the PCMS the "We Can Do Better" committee continues to make progress on a Project Access type of specialty referral model to serve the under and uninsured of our community. Work on the Web Page has progressed as has the Physician Life Long Learner program and we look forward to a summer that will include some baseball with the Rainiers Team here in Tacoma.

There is "Lot's Happening" and most of it is good! ■

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Healthy Communities Pierce County at work on the Key Peninsula and Gig Harbor

The Healthy Communities Pierce County (HCPC) initiative was started by PCMS in late 2006 to improve the health status of Pierce County residents by organizing community programs and activities that encourage increased physical exercise and good nutrition. The brainchild of **Dr. Paul Schneider**, he joined forces with **Drs. Pat Hogan** and **Summer Schoenike** to write a proposal to seek PCMS funding to hire a part time director for the project. **Dr. Jane Moore** was hired in early 2007 and has expanded the program to east Pierce County from the peninsula. The Tacoma Pierce County Health Department has been a major partner in the project and contributed funding for Dr. Moore's salary the first year of operation.

Community projects abound due to the work of Dr. Moore and her many committee members and volunteers working to improve the health of their communities. Two particularly newsworthy projects include:



Dr. Hogan unwrapping the "green" mile markers just installed on the Gig Harbor waterfront route



Dr. Hogan and crew at work installing the first marker on Gig Harbor's waterfront

Exercise Route Mile Markers: Dr. Pat Hogan and his Active Aging Committee, in efforts to encourage walking and running in the downtown Gig Harbor area thought that mile markers would be a great addition to the scenic walkability of the Gig Harbor area. He researched companies that could produce the markers and worked with the City of Gig Harbor for installation of the three, four-mile route markers. On Tuesday, May 26, the mile markers were installed.

Each route has different color markers. One route has blue markers, one green and the third is marked in red numbers. All three routes include markers at each half mile mark and are two miles with a return loop back to the original start.

As the markers were being installed, many walkers and runners along the Gig Harbor waterfront expressed their enthusiasm and excitement for the wonderful addition to their city. This will help Gig Harbor residents and visitors of the city chart their progress as they work to become healthier by increasing their exercise and keeping track of how many miles they cover.

Community Gardens: Another very exciting project of HCPC is the Gig Harbor/Key Peninsula Community Gardens Project (CGP). Also started by the Active Aging Committee,



Jan Schoenike plants potatoes



Community Garden Project volunteers recently planted a garden that will benefit the FISH food bank

See "Healthy" page 6

No Down Time as Rule Writers and Agencies Pick Up Where Legislators Left Off (From WSMA "Monday Memo" 6/8/09)

The legislative session may have adjourned several weeks ago but many successful bills signed into law need rules to be implemented or direct agencies to take actions that push the issues forward.

Here are some of the policy issues that the WSMA is working on during this "interim" period between adjournment of the 2009 session and the gaveling to order of the 2010 session next January. (Actually, as state revenues continue to decline, rumblings about a special session are being heard. There could be another very tough budget/tax special session later this fall.)

Administrative simplification – The Executive Oversight Group (EOG) of the Washington Office of the Insurance Commissioner (OIC) is guiding the progress of the WorkSMART Institute, the private sector organization implementing the administrative simplification and common credentialing data collection of SB 5346. Bob Perna, WSMA director of health care economics, serves on the EOG. WSMA responsible staff: Len Eddinger, senior director of legislative and regulatory affairs, and Bob Perna, director of health care economics (rjp@wsma.org).

Major Issues: Ensure the smooth implementation of electronic "best practices" for claims operations, implementing centralized electronic credentialing, and appropriate education of practice staff. The EOG must finish its work by December 31, 2010 (if not, the OIC can step in via regulatory action).

Imaging – The Advanced Imaging Work Group, under the Health Care Authority, is reviewing decision aids and authorization guidelines for certain advanced imaging studies, as specified in the imaging bill (ESHB 2105). The deadline for its recommendations is July 1, 2009. WSMA Past President Dr. Brian Wicks is the WSMA's representative to this body. WSMA responsible staff: Bob Perna (rjp@wsma.org).

Major Issues: Ensure that recommended systems meet the needs of physicians and practice staff and do not impose administrative burdens or associated costs.

ASF licensure – The Department of Health is finalizing the rules for Ambulatory Surgery Facility (ASF) licensure, to go into effect July 1, 2009. WSMA responsible staff: Tim Layton, director of legal affairs (tim@wsma.org).

Major Issues: Ensure all ASFs are licensed by July 1 and that non-certified ASFs are aware of these new licensure requirements and are treated fairly by DoH.

Medical Assistants Practice Scope – The DoH will conduct a "sunrise" review on the Medical Assistants bill (HB 1414) in the near future. It also will promulgate rules to implement the statute. WSMA responsible staff: Carl Nelson, associate director of legislative and regulatory affairs (can@wsma.org).

Major Issues: None apparent at this time, but the potential for problems remains.

Increased State Purchasing of Generics – Rulemaking by DSHS to implement the governor's prescription drug bill is to begin soon, as its savings are incorporated into the 2009-11 budget. WSMA responsible staff: Len Eddinger (len@wsma.org) and Tim Layton (tim@wsma.org).

Major Issues: Ensure that department rules remains true to the intent of the legislation.

Retired Volunteer Physician Study – The Medical Quality Assurance Commission must begin work on the retired volunteer physician study bill that passed during the session. The bill tasks the MQAC with determining whether retired volunteer physicians can provide non-primary care services. WSMA responsible staff: Len Eddinger (len@wsma.org).

Major Issues: None apparent at this time.

Medical Home – Medical Home reimbursement pilot projects were authorized by SSB5891. The HCA and DSHS must design, oversee implementation and evaluate one or more pilot projects. WSMA responsible staff: Bob Perna (rjp@wsma.org).

Major Issues: Ensure the fair implementation and objective assessment of the forthcoming pilots.

Vaccines, or Lack Thereof – Thanks to the budget, the state's childhood vaccine program is transitioning from a universal system to a much more limited system. As of July 1, 2009, children with private health insurance will no longer be eligible for state-supplied HPV vaccine, and by May 1, 2010, those children will no longer be eligible for any state supplied vaccine.

See "Down Time" page 15

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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH,
and MerrieLynn Rice, RN, BSN, IBCLC

Helping Parents and Children Succeed Through the Nurse-Family Partnership



Anthony Chen, MD

Teen pregnancy has significant health and social implications for our community. From the medical perspective, these young mothers are at a significantly higher risk for adverse pregnancy outcomes and their children are at an increased risk for low birth weight and its associated complications.

There are many social consequences as well: teen mothers are more likely to drop out of school, end up on welfare, and in general have poorer socio-economic outcomes. Their children are at risk for compromised development, poor school performance and delinquency. Obviously, these are concerns for many mothers besides teenagers, thus creating circumstances by which a large number of children can become pre-destined for a precarious and vulnerable future.

All of us have seen patients with these medical and social outcomes, and it often leaves us frustrated. Until we find the magic cure, physicians need to intervene on whatever level, and in whatever way we can: providing preconceptional care, teaching parenting and providing anticipatory guidance, providing family planning services, mentoring youth, building patients' self-esteem and social capital, collaborating with and making referrals to social services, and so on. Tacoma-Pierce County Health Department has several interventions including Family Support Centers and Maternity Support Services (MSS, or First Steps), but this article will focus on a particularly inten-

sive program. Nurse-Family Partnership® (NFP).

The Health Department is using Nurse-Family Partnership® to improve pregnancy outcomes, child health and development, and economic self-sufficiency to subsequently break the cycle of poverty. NFP is an evidence-based, structured, home visiting program that partners a nurse with an expectant mother early in the pregnancy. The nurse provides ongoing home visits through the child's second birthday. The program helps women to engage in good preventive health practices, including participating in prenatal care, improving diet, and reducing use of cigarettes, alcohol and illegal substances. Child health and development is improved by increasing parental engagement, and through the development of good parenting skills. Economic self-sufficiency is improved by helping parents create a vision for their own future that includes: planning future pregnancies, continuing their education, and finding employment.

Nurse-Family Partnership focuses on low-income, first-time mothers who may be socially isolated or experiencing severe adversity. Women voluntarily enroll—ideally as early as possible, with preferred program entry by the 16th week of pregnancy. Both the nurse and the mother make a two-and-a-half year commitment to meeting these goals together. Over the duration of the program, the nurse will average 64 visits with the mother and develop a strong

and trusting relationship. Typically, home visits are scheduled:

- Weekly during the first month following enrollment;
- Bimonthly for the remainder of the pregnancy;
- Weekly during the first six weeks after delivery;
- Bimonthly thereafter through the 21st month of childhood; and
- Monthly until the child reaches age two

During these visits, the nurse follows visit-by-visit guidelines which provide a comprehensive structure for working with families that focus on several areas: personal health, environmental health, quality of care giving for the child, maternal life course development, family and friend support, and health and human services utilization.

This intensive level of support helps women prepare for the emotional, social, and physical challenges of a healthy birth. Prenatal support is the starting point, but the nurse continues to serve her client after she delivers her child, teaching parenting and life skills that foster positive growth for both mother and child.

Nurse-Family Partnership has an extraordinary 30-year track record: randomized, controlled trials demonstrate sizable and sustained improvements in the health and economic prospects of low-income, first-time mothers and their

See "TPCHD" page 8

TPCHD from page 7

children. Every dollar invested in NFP can yield more than five dollars in return. Across the country, NFP has consistently shown:

- Improved prenatal health
- Fewer subsequent pregnancies
- Increased intervals between births
- Increased maternal employment
- Fewer childhood injuries, neglect and abuse
- Improvement in the child's school readiness

Currently the Health Department has five nurses providing NFP services and each nurse can carry a maximum of 25 families. The program has one nurse that serves Spanish-speaking families. The program is relatively new for the Department, but here are a few of the statistics to date:

- 121 active clients enrolled in program

- Client median age at intake was 19 years
- 118 babies born into program
- 92% of the babies were full-term
- 90% of children immunized by 6 months of age
- 90% of the mothers initiated breastfeeding

Statewide data is similar and additionally shows:

- 86% of children ages 0-12 months had no ER visits or hospitalization due to injury or ingestions
- 28% of NFP mothers who did not have a diploma/GED at intake and completed the program subsequently earned their diploma/GED

Tacoma-Pierce County Health Department is committed to producing enduring improvements in the health and well being of low-income, first-time par-

ents and their children. We need your help to make this initiative a success by identifying and referring women who qualify for services. Eligible participants are women who:

- 1) Are currently less than 26 weeks pregnant. (ideally enrolled by the 16th week of pregnancy but no later than 28 weeks),
- 2) Will be first-time mothers, and
- 3) Are Medicaid eligible

Although the program targets young mothers, there are no age, medical, or immigration restrictions. In the fall of 2009 as the first clients graduate from our program, we will be open for additional referrals.

To make a referral please call central intake at 253 798-6403 and specify NFP or fax referrals to 253 798-3522. For additional program information, please contact MerrieLynn Rice, Supervisor of NFP at 253-798-3539 or mrice@tpchd.org. ■

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Congratulations to 2009 Pierce County Health Care Champions

The 2009 Health Care Champions for Pierce County were recently recognized at the second annual leadership recognition event sponsored by the Business Examiner. The annual event recognizes honorees from the following categories:

Community Impact Award: An individual or practice group whose involvement or innovation in health care issues has affected a broad section of the community.

Distinguished Service Award: An individual or practice group whose demonstrated service within the health care field has been extraordinary over an extended period of time.

Emergency Services Award: A medical response unit with an outstanding "save" or innovators in providing emergency care and services to the community.

Military Services Award: An individual or practice group whose involvement or innovation in health care issues has benefited the military community.

Support Services Award: The extraordinary impacts affected by a support person or group within the health care field.

PCMS partnered with the Business Examiner and served on the judging panel to select the following professionals from a host of nominations that were submitted for consideration:

Community Impact Award – DR. KHAI TRAN, Medical Director, Carol Milgard Breast Center. Dr. Khai Tran is the medical director of the new cancer facility in Tacoma, Carol Milgard Breast Center, and a TRA physician. It was an effort that he helped form and champion for several years. The center opened just months ago, thanks in part to a \$5 million donation from the Gary E. Milgard Family Foundation.

"This was born out of the need to create a breast imaging program that would provide state-of-the-art technology to all women regardless of socio-

economic status, improve access to services, have mammograms interpreted by highly skilled and dedicated mammographers, and significantly decrease the time from screening to diagnosis," Tran said, noting that test results that once took weeks are now available in days. "I have spent thousands of hours on this project because at the end of the day, I am committed to doing what is right for our patients; to make a real difference in someone's life by finding that early cancer, and to know that this program will be here to provide this level of service for all women for generations to come."

Not only is this business model unique to health care, but so is the center's formation since it includes a partnership between MultiCare Health System, Franciscan Health System and TRA Medical Imaging.

"The program is much more complicated and interesting, but in a nutshell, the above is made possible to convincing all three organizations to collaborate, realize the economies of scale, and stop duplicating services," he said, noting that he was a medical director at all three health organizations at one point. "Our program is easily one of the busiest in the United States. It is quite remarkable. I am most proud of the remarkable dedication of our staff and everyone who has been involved with this project from the very beginning, because we all believed that this was the right thing to do. In the end, we must remember that our efforts must result in better care for our patients."

Dr. Tran hopes that the nationally recognized center becomes a model for future efforts that will lead to better access to health care of all sorts, not just cancer treatments.

"Moving into a new era of health care in which we must be good stewards of limited health care resources and are asked to do more with less, this breast program that I have envisioned is a perfect recipe towards those goals,

and I believe that we will and must see more collaborations like this in the future," he said. "This breast imaging program here in Tacoma is already receiving important recognition nationally."

Distinguished Service Award – DR. GORDON KLATT, Colon/Rectal Surgeon and Founder of Relay for Life. Dr. Gordon Klatt is a giver. As a doctor he has given countless hours of service to patients and as a community booster, he gives his time and talent for a variety of causes.

His legacy is forever tied to the American Cancer Society, an agency he first started trying to aid by gathering donations from friends who pledged dollars to support a 24-hour run. That single effort has bloomed into what is now Relay For Life, the agency's top fundraiser after being expanded and duplicated around the nation.

The seed of that growing effort was planted in 1984, when Dr. Klatt was serving as the president of the Tacoma unit of the American Cancer Society. The group was raising about \$200,000 a year at the time. It needed more. He was asked to help the Pierce County unit of the American Cancer Society raise money. With no experience in gathering dollars for nonprofits, he turned his passion for exercise into a fund-raising event.

He trained and gathered pledges for the better part of a year before he tightened up his running shoes at University of Puget Sound's Baker Stadium in what would become a 24-hour run and walk. He tallied more than 83 miles of leg-jarring strides that day and night as patients, friends and coworkers stopped by to cheer him on lap after lap. Several of them paid \$25 to join the effort for a few laps.

Dr. Klatt even continued his trial of endurance after collapsing from hypothermia less than halfway through the

See "Champions" page 10

Champions from page 9

run. His effort raised \$27,000 and grew into the idea of team fund-raising events in the years to come.

The first community-wide Relay For Life was held with 19 walking teams taking to the track at Stadium High School in 1986. It raised \$33,000 and proved the concept would work.

Other 24-hour events have since been held in all 50 states and in 22 countries, all to benefit cancer treatment and prevention efforts. The tally of support generated from Relay For Life events has since topped \$3.5 billion. There are 5,000 relay events held every year.

"Relay For Life proves that with determination, one person can truly make a difference," Dr. Theodore Bridge stated in his nomination.

Not to be mistaken as being too serious about his work, Dr. Klatt practices at K-Y Surgical Associates. Its web site

is buttsareus.com, announcing his specialty in rectal procedures.

Emergency Services Award – Good Samaritan and EMS Partnership

Military Award – MultiCare Neuroscience Vestibular & Balance Program and MAMC Partnership

Support Services Award – Franciscan Breast Cancer Navigator Program and Korean Women's Association's Community Health Care Outreach Programs

PCMS members receiving honorable mention in the Community Impact Award category and the Emergency Services Award category included **Dr. Thomas Molloy** and **Dr. Alison Nohara** and **Brian Kott**, respectively. Dr. Molloy, Medical Director for

Cardiac Surgery at St. Joseph Hospital pioneered robot assisted minimally-invasive heart surgery in Western Washington when he performed the very first procedure of its type at St. Joseph Medical Center. He has since performed dozens of these advanced surgeries and earned the respect of heart surgeons around the U.S., many of whom have traveled to Tacoma to observe him using the DaVinci Surgical System robot in the operating room.

Drs. Alison Nohara and Brian Kott of TRA Medical Imaging and Neuro Interventional Surgeons at Tacoma General Hospital and St. Joseph Medical Center work tirelessly to provide stroke and aneurysm care to patients at Tacoma General and St. Joseph's Medical Centers. They are national standouts in their specialty field.

PCMS congratulates all recipients of the 2009 awards. ■



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Peter Marsh MD honored and thanked by WSMA at Lake Chelan Leadership Conference

Dr. Peter Marsh, asked to come to the WSMA Leadership Conference at Lake Chelan in May to play golf, learned at the meeting that he was being honored for his many and varied contributions to the state medical association and the medical profession in the state of Washington. Receiving a standing ovation from the crowd of about 200, Dr. Marsh noted it was an honor and privilege to contribute to a profession that serves the community and to be able to consider so many fine people his colleagues and friends.

Dr. Marsh's plaque highlighted the basis for this well deserved award:

WHEREAS, Throughout his time as a voluntary leader in the Washington State Medical Association Dr. Peter K.

Marsh has demonstrated the hallmarks of an effective leader – vision, commitment, collaboration, enthusiasm, and “team spirit” AND

WHEREAS, Dr. Marsh, as President of the WSMA in 1997-1998 achieved the singular distinction of having his name used as a verb (e.g., he “Marsh-ed” the governor, among others) due to his willingness to be frank and succinct in his communications; AND

WHEREAS, Dr. Marsh was instrumental in negotiating a smooth and successful transition for Physicians Insurance from a reciprocal exchange to a mutual form of organization, AND

WHEREAS, Dr. Marsh is conclud-

ing an extremely beneficial and productive – typically – tenure on the Board of Directors of Physicians Insurance A Mutual Company, THEREFORE BE IT

RESOLVED, that the WSMA recognize Dr. Peter K. Marsh for setting a very high standard of physician leadership, AND BE IT FURTHER

RESOLVED, that the WSMA extend to Dr. Marsh its appreciation for his myriad and varied most beneficial contributions to the Association and to the medical profession of the State of Washington.

PCMS extends congratulations to Dr. Marsh for a well deserved award. ■

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Americans Postpone Healthcare: Study

Twenty percent of Americans say they have delayed or postponed medical care, mostly doctor visits, and many said cost was the main reason, according to a survey released on Monday.

The Thomson Reuters survey found 21% of U.S. adults expected to have difficulty paying for health insurance or healthcare services in the next three months.

"The results of this survey have serious implications for public health officials, hospital administrators, and healthcare consumers," Gary Pickens of the Healthcare division of Thomson Reuters, who led the study, said in a statement.

"We are seeing a positive correlation between Americans losing their access to employer-sponsored health insurance and deferral of healthcare."

Pickens added that "if this trend continues, it will ultimately have an impact on our collective well-being."

Thomson Reuters Healthcare is part

of the same company as the Reuters news agency.

Pickens and colleagues surveyed 12,000 Americans in February and March and said their findings were representative of the United States in general.

They found that 24% of people who canceled or postponed care said cost was the primary reason.

In 2006, the last time the question was asked on the survey, 15.9% of people said they had postponed or canceled medical care in the past year.

More than 54% who skipped care said they missed a doctor visit. Eight percent said they delayed or skipped medical imaging of some sort.

Pickens and colleagues found the percentage of households with employer-sponsored insurance declined to 54.6% in 2009 from 59% in early 2008. The percentage of adults covered by Medicaid, the state-federal health insurance plan for the poor, rose to 14.5% in 2009 from 11.9% in 2008. ■

Reprinted from Medscape, April 20, 2009

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Unpaid care hikes private insurance premiums by billions

But estimates differ on the total effect, in dollars, of uncompensated care for the uninsured

Privately insured Americans pay at least hundreds of dollars more in premiums each year to help cover the cost of caring for the nearly 46 million uninsured people in the U.S. according to a new report commissioned by the health advocacy group Families USA.

Some hospitals, physician group practices and other health professionals are able to recoup some costs of caring for the uninsured by negotiating higher payment rates from private insurers, a phenomenon known as cost-shifting. Hospitals and others provided \$116 billion worth of care to the nation's uninsured in 2008, including \$42.7 billion that wasn't paid for by the government or the uninsured patients, according to the report. "Hidden Health Tax: Americans Pay A Premium," re-

leased May 28, was based on an analysis by actuarial consultants Milliman Inc. (www.familiesusa.org/resources/publications/reports/hidden-health-tax.html).

Shifting this \$42.7 billion in costs to private insurers added an average of \$1,017 to families' annual premiums, which totaled about \$13,275 in 2008, the report concluded. Individuals paid \$368 more in premiums because of cost-shifting, for an average yearly cost of \$4,803 in 2008. "Unless and until health coverage is expanded, businesses and insured families will continue to be hit hard in the pocketbook by a large hidden health tax," said Families USA Executive Director Ron Pollack.

Public hospitals shifted 3% to 4% of their uncompensated care costs to

private insurers in 2006, said Larry Gage, president of the National Association of Public Hospitals and Health Systems, which represents about 130 hospitals. "We do cost-shift wherever we can," Gage said.

Senate Finance Committee Chair Max Baucus (D. Mont.) and other lawmakers have cited cost-shifting as one key reason to adopt health system reform that would cover as many of the 45.7 million uninsured as possible. Pollack said offering health insurance to all of the nation's uninsured would not immediately end cost-shifting and lower insurance premiums, but it would start that process.

Another cost-shifting report reached a more conservative estimate.

See "Premiums" page 14

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Dr. Park received his medical degree from Jefferson Medical College in Philadelphia and completed his ophthalmology residency at the University of Washington. He completed his clinical and surgical fellowship in glaucoma at the New York Eye and Ear Infirmary. Dr. Park is a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. He has published original research on glaucoma in some of the most respected ophthalmology journals.

Premiums from page 13

A study commissioned by the Kaiser Family Foundation projected that there was \$57.4 billion of uncompensated care in 2008, including \$35 billion by hospitals, \$14.6 billion by community facilities and \$7.8 billion by private, office-based physicians. The Families USA report did not offer similar detail. The Kaiser report was published Aug. 25, 2008, in an online edition of *Health Affairs* (content.healthaffairs.org/cgi/content/abstract/27/15/w399f).

The Kaiser report concluded that hospitals and physicians would only be able to shift \$14.1 billion of those costs to private insurance in 2008. That report accounted for certain government payments to help care for the uninsured, such as Medicare payments to hospitals that serve large low-income populations. The Families USA analysis did not take those payments into account because the group said they are designed to support the cost of caring for Medicare patients.

The Kaiser report also assumed that hospitals and physicians would absorb some of the uncompensated care costs by lowering their profit margins.

A co-author of the Families USA report agreed that not all physician practices can negotiate higher private insurance fees. "Our impression ... is that nonspecialist physician practices are less able to shift costs," said Kathleen Stoll, the organization's director of health policy. She added that

hospitals appear to be able to cost-shift more than physicians can.

No matter the figure, cost-shifting occurs, according to Robert Moffit, PhD, director of the Center for Health Policy Studies at the Heritage Foundation, a conservative think tank based in Washington, D.C. "Substantively, what they're saying is correct," Moffit said. However, the size of the shift varies widely from state to state, he said. ■

Reprinted from AMNews, June 8, 2009



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Down Time from page 6

The WSMA has formed a Vaccination Work Group to evaluate private sector options. Another group of affected organizations' lobbyists has been formed to evaluate potential legislative action to help with this problem. WSMA President Elect Dr. Deb Harper chairs the WSMA's work group. WSMA responsible staff: Len Eddinger (len@wsma.org), Bob Perna (rjp@wsma.org), and Tim Layton (tim@wsma.org).

Major Issues: Educate practices on this transition and collaborate with the interest groups to ensure that practices are not adversely affected, while seeking to improve the rate of immunizations.

Rx Scripts – The Board of Pharmacy must define implementation rules for the legislation (HB 2014) that requires all prescriptions to be produced on tamper-resistant forms. WSMA responsible staff: Len Eddinger (len@wsma.org).

Major Issues: Provide adequate time for the physician community to change over to the new scripts.

Human Trafficking – The MQAC has been directed by legislation to produce information for physicians to use in identifying victims of human trafficking. WSMA responsible staff: Len Eddinger (len@wsma.org).

Major Issues: None apparent at this time.

A Bill on MRSA is Out There – A bill requiring pre-admission testing has been drafted by Rep. Campbell. WSMA responsible staff: Tim Layton (tim@wsma.org) and Len Eddinger (len@wsma.org).

Major Issues: No science to support the need for such a bill. The WSMA is setting up meetings to educate Rep. Campbell and other legislators. ■

Healthy from page 5

this offshoot group of volunteers, including Drs. Hogan and Sumner Schoenike and their wives helped break ground to get the CGP underway at Gig Harbor's 16 acre Wilkinson Farm City Park. With goals of encouraging healthy eating and improved nutrition, community participation, exercise and giving to the community, the 70 ft. x 30 ft. pilot garden has been planted with beans, corn, potatoes, onions, squash and other such vegetables. The City of Gig Harbor gave permission to plant and there is lots of community support so far with assistance from the city, PenMet Parks and the Master Gardeners organization and many volunteers.

At harvest time the food will go directly to the area food banks to supplement their canned goods and basic food items. To get involved in the community garden project you can email ghcommunitygardens@gmail.com or call 253.228-0538.

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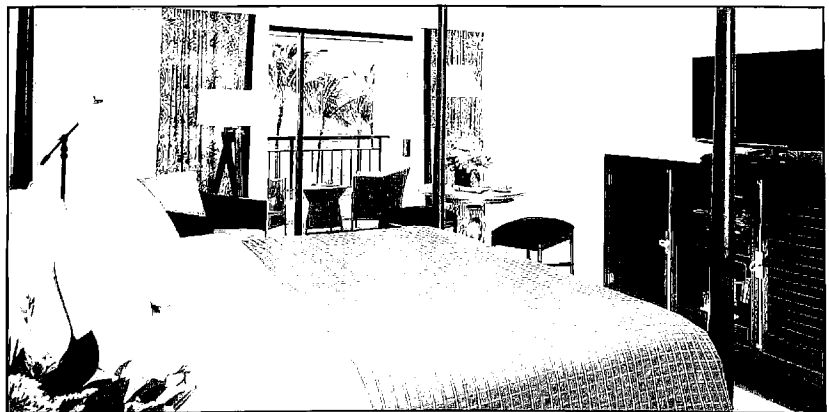
CME Hour/Credit Requirements for Medical License Renewal

A total of 66 medical licensing boards in 45 states, the District of Columbia and three territories (Guam, Puerto Rico and the Virgin Islands) will require physicians to obtain CME hours/credits for license renewal in 2009. The number of required credits varies from state to state, but most states also require that a portion of the CME be *AMA PRA Category 1 Credit™* or equivalent.

Of the licensing jurisdictions that require CME, 43 will accept the AMA PRA certificate or approved application as equivalent for the purpose of licensure re-registration.

For an updated breakdown of requirements by state, see the AMA's recently released *State Medical Licensure Requirements and Statistics*, 2009 edition, and refer to Table 16. "Continuing Medical Education for Licensure Reregistration."

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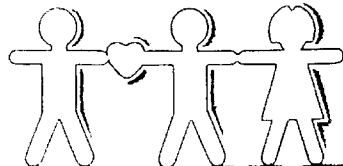
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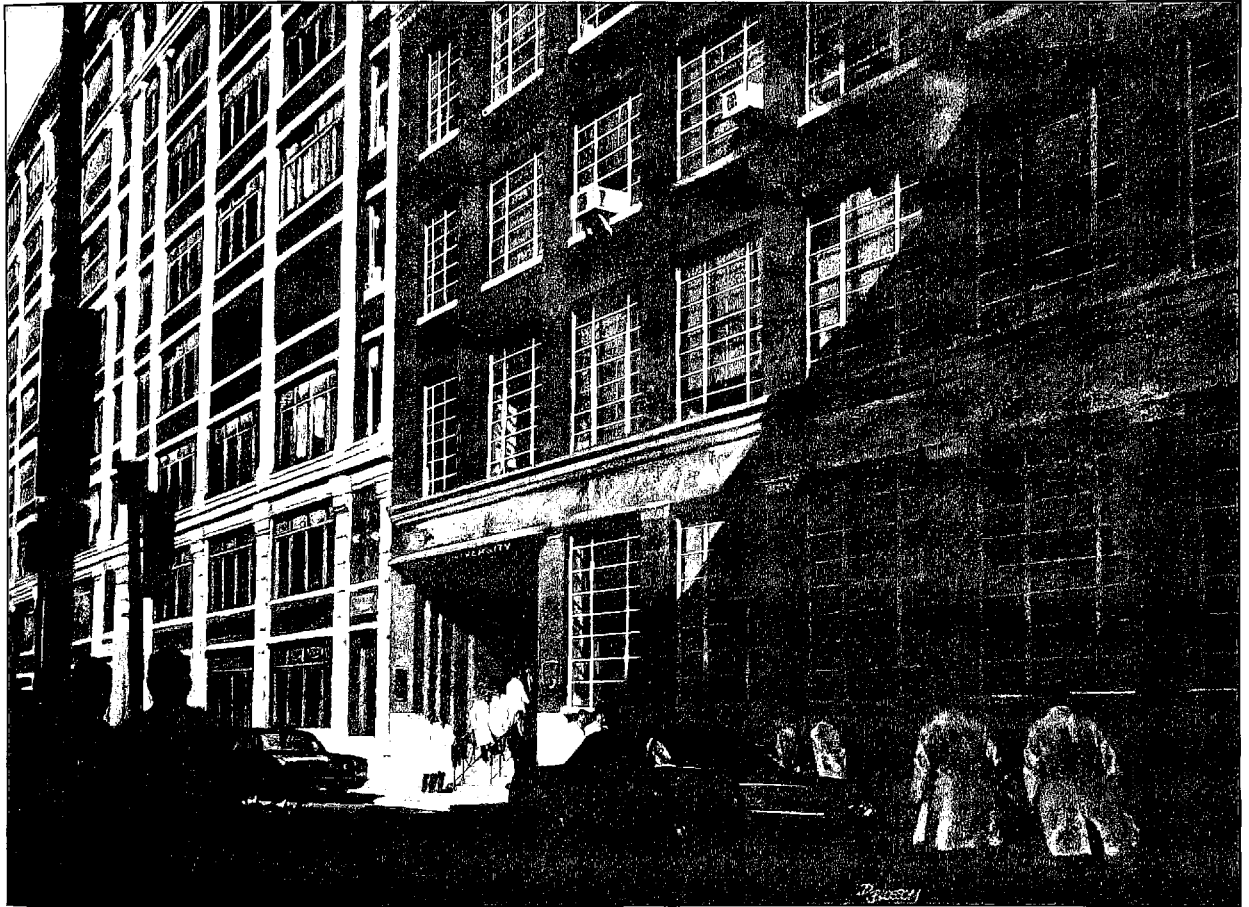
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Pierce County Medical Society



July 2009



Tufts University School of Medicine

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Pierce County Medical Society

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July 2009

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President's Page

by J. David Bales, MD

Visibility



J. David Bales, MD

There are times when I get discouraged with the feeling that a lot of what we do either goes unnoticed or at least unappreciated. Some of that came to a screeching halt when four leaders of health care in Pierce County were asked to have lunch with the Governor on 12 June 2009. While the occasion of her visit to Tacoma was the graduation of the University of Washington – Tacoma, she took the opportunity to sit with some health care professionals to ask about our opinion of the impact of the currently proposed budget cuts on health care.

That was when my thoughts of anonymity of the Pierce County Medical Society and the Washington State Medical Association came to an end. The Governor was well prepared and familiar with all of those present and even knew of proposals to the WSMA House of Delegates the previous year. Wow – if the Governor was aware of what's happening at the WSMA House of Delegates, maybe those activities are not quite as futile as I sometimes feel.

Which brings me to the other activities of June 2009. Several meetings have and will continue to take place between the WSMA and county medical societies that are discussing the relationship between county societies and the state society. At the center of the discussion is how unified we are – especially when we speak with “one voice.” Speaking with one voice requires a certain degree of discipline as well as cooperation, collaboration, and communication. There have been infractions of these three C's at both the state and county level and these have served to divide rather than unify. I am hopeful that the current discussions and their outcome will serve as more dialogue than discussion and the resulting proposal to the House of Delegates this fall will result in a “one voice” that even the Governor will continue to pay attention.

At the national level, health care legislation is moving rapidly and I think we will see something come from it by this fall. What it is and what it will mean may take years to sort out, but it will be significant whatever the outcome. I was disappointed that the AMA was one of over 35 organizations invited to the White House for discussions of where we should go – hardly “one voice.” I was pleased that the President attended and spoke to the AMA House of Delegates and asked for help to get something meaningful into law. I could only wish that more than the AMA's “one voice” represented more than 17% of physicians in this country. ■

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5 people die under new Washington physician-assisted suicide law

Fourteen patients in the state requested doctors' aid in dying. Meanwhile, more patients than ever made use of Oregon's death-with-dignity law in 2008

Five Washington patients with terminal illnesses ingested lethal doses of medication prescribed for them by physicians under their state's new death-with-dignity law, approved by 58% of voters in a November 2008 ballot initiative.

At this article's deadline, 14 patients had made written requests for life-ending prescriptions, according to a Web site updated weekly by the Washington State Department of Health. Thirteen lethal prescriptions had been dispensed by pharmacies. In two of these cases, a mental health professional was consulted and filed a compliance form. The psychiatric referral is required if the attending or consulting physician has doubts about the patient's mental competence.

The Washington law, which took effect March 5 and is virtually identical to Oregon's first-in-the-nation law, makes physician-assisted suicide available to patients who have been judged terminally ill by two doctors. Patients must make an oral request and a witnessed written request. Another oral request must be made 15 days later.

Physicians must tell patients about options such as hospice and palliative care. Doctors may refuse to participate and are not obligated to refer patients elsewhere.

At least two of the five patients who died worked with the nonprofit Compassion & Choices of Washington to make use of the state law. The second patient did not want any information released publicly, but 66-year-old Linda Fleming — diagnosed with stage IV pancreatic cancer — allowed the organization to release details of her case after she died in May.

"It was very important to me to be conscious, clear-minded and alert at the time of my death," Fleming said in the Compassion & Choices statement.

"The powerful pain medications were making it difficult to maintain the state of mind I wanted to have at my death. And I knew I would have to increase them. I am grateful that the Death with Dignity law provides me the choice of a death that fits my own personal beliefs."

More deaths in Oregon

The Washington deaths join more than 400 patients who have died since 1998 under the Oregon Death With Dignity Act. Last year marked a high for both the number of patients who received lethal prescriptions, 88, and the

Compassion & Choices of Oregon, patients may not receive truly informed consent from a physician who "tells them their life has value."

George Eighmey, executive director of Compassion & Choices of Oregon, called the comment "offensive" and said his organization works to "encourage people to be enrolled in hospice care and palliative care because we don't want them to make the decision to use death with dignity based upon pain or some suffering that can be addressed.

"We always give [patients] the full range of options," Eighmey said.

Montana is the third state where doctor-assisted suicide is legal, after a lower-court state judge ruled in December 2008 that patients with terminal

illnesses have a constitutional right to physicians' aid in dying. No patients have completed physician-assisted suicide yet under the ruling, which took effect immediately. The state is appealing the decision in the case, *Baxter v. Montana*, to the state's Supreme Court. Oral arguments are expected to be scheduled for some time in the fall.

In June, a variety of groups filed friend-of-the-court briefs in favor of upholding the decision, among them the American Medical Student Association and the American Medical Women's Association. Neither the Montana Medical Association nor the AMA has plans to participate in the case.

AMA policy "strongly opposes any bill to legalize physician-assisted suicide" because the practice is "fundamentally inconsistent with the physician's role as healer." ■

From *AMNews*, July 6, 2009

Doctor-assisted suicide is legal in Washington, Oregon and Montana.

number of patients - 60 - who died after ingesting the medications, according to a report from the Oregon Department of Human Services. In 2007, 85 prescriptions were ordered, and 49 patients took the lethal medications.

Kenneth R. Stevens, MD, is vice president of Physicians for Compassionate Care Education Foundation, which opposes doctor-aided dying. He said he was troubled that patients in only two of the 60 cases were referred for a mental-health evaluation. He also alleged that because so many of the cases, 88% in 2008, are facilitated by

What editorial writers are saying about Obama's idea for a public health plan

All agree that health care costs are spiraling, but a sampling of editorials in newspapers across the country shows a wide ideological divide about the public plan option.

A public health plan

There is no serious consideration in Congress of a single-payer governmental program that would enroll virtually everyone. Nor is there any talk of extending the veterans health care system, a stellar example of "socialized medicine," to the general public. The debate is really over whether to open the door a crack for a new public plan to compete with the private plans. Most Democrats see this as an important element in any health care reform, and so do we. *New York Times*, June 20

What health reform must do

A public option may be the only means of ensuring there is a viable coverage plan for everyone, and it already has brought private insurers to the negotiating table. So a public option should remain in the mix until there is another way of guaranteeing universal coverage. *St. Petersburg (Fla.) Times*, June 21

President's "option" will kill private system

President Obama was shrewd enough to repackage socialized medicine as merely a new and improved version of the current public/private system. This "public option," as the president describes it, would undercut private health insurance plans and put a quick end to the current employer-sponsored system. Millions of Americans would then depend on Washington — liberal Democrats' fondest dream — to provide their health care. *Press-Register* (Mobile, Ala.) June 16

President Obama rolls out health care "Trojan horse"

The real Trojan horse is Obama's representation that including a government health insurance option alongside private plans isn't the first step toward a complete federal takeover. "The public option is not your enemy," Obama said, "it is your friend." Obama should get a real fight on that one. *Daily Oklahoman* (Oklahoma City), June 17

What doesn't work

Obama, Sen. Edward Kennedy — chairman of the Senate

See "Editorial" page 10

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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH,
and Linda Gillis, RDH, BSDH

Oral Health in the Practice of Medicine



Anthony Chen, MD

Somewhere in the evolution of health care, the head got cut off from the body: the practice and financing of medicine has diverged from mental health and oral health. Since Dental Awareness Day is July 10, 2009, we are reminded that oral health is an integral part of physical health.

In 2000, the Surgeon General's report *Oral Health in America* brought to our attention that dental caries is the single-most common chronic childhood disease and that the social impact of oral disease is substantial. In 2005, 45% of low-income preschoolers in Washington suffered from dental decay, an increase from 38% in 1994. Among 3rd Grade students, 60% had past or current tooth decay and 19% had untreated tooth decay. There are striking disparities: poor children suffer twice as much dental caries as their more affluent peers and are less likely to be treated. Uninsured children are 2.5 times less likely than insured children to receive dental care.

More than 51 million school hours are lost each year to dental-related illness. Pain and suffering due to untreated dental disease can lead to problems in eating, speaking, sleeping, and paying attention in the classroom.

Adults are also affected. Despite recommendations for twice yearly check-ups, in 2004 only 70% of Washington adults aged 18 and older had visited a dentist in the past year. Most adults show signs of gum disease, and severe periodontal disease is found in 14% of adults 45-54 years old and 23% of those 65-74 years old. Thirty percent of those 65 years and older have lost all their teeth.

While caries and gum disease are the first things that come to mind, let us not forget that oral health also encompasses oral and pharyngeal malignancies, oro-facial injuries (eg, automobile or sports injuries), and congenital malformations.

Access to dental care is problematic. We frequently hear about the number of people without health insurance, yet among adults (19 years or older), three times as many do not have dental insurance. Even though Medicaid provides dental coverage, recipients often have difficulty finding a dentist who accepts Medicaid.

Despite the current recommendation for "1st dental visit by age 1 year," many parents are not complying. Perhaps this is due to economics, old fears, or availability of dentists. Part of the problem may be physicians and dentists who still remember old recommendations for children to see the dentist at age three or four years. In contrast, children are seen by a physician when they are born and have frequent well-child visits in their first two years of life. Because many patients will see physicians for medical issues, and we know that access to medical care is better than for dental care, we have a great opportunity for the medical community to contribute to oral health in Pierce County.

The Washington State Medical Association, Washington Academy of Family Physicians and the Washington Chapter of the American Academy of Pediatrics have all passed resolutions to encourage physicians to identify and promote treatment of oral health problems and to support education and ad-

vocacy efforts aimed at reducing the burden of disease. There are many resources to support physicians in this effort.

For example, the American Academy of Pediatrics has an online curriculum called *Protecting All Children's Teeth (PACT)* focused on the important role that oral health plays in the overall health of patients. Physicians are eligible to receive a maximum of 11.0 AMA PRA Category 1 Credits upon completion of the training, which will help them become more knowledgeable about child oral health, more competent in providing oral health guidance and preventive care, and more comfortable sharing the responsibility of oral health. To learn more and access the training, go to <http://aap.org/oralhealth/pact.cfm>.

Similarly, the Society of Teachers of Family Medicine has developed a curriculum called "Smiles for Life" that is used by many residency programs. Physicians can access the slide shows and materials (including pocket cards and applications for Palm or PocketPC handhelds) at <http://www.smilesforlife2.org/home.html>. Physicians are eligible to receive 12.5 prescribed credits from the American Academy of Family Physicians upon completion of the training.

The Washington Dental Service Foundation trains primary care providers to deliver oral health preventive care—including recognizing early childhood caries, making appropriate referrals, and applying fluoride varnish

See "TPCHD" page 8

TPCHD from page 7

treatment—as part of well-child checks. This practical, and potentially revenue generating, CME training is free, includes lunch, takes about 90 minutes, and can be arranged at your office. Training materials, parent educational tools and samples of fluoride varnish are provided, along with ongoing technical support. Reimbursement is available for providers that receive the training. Nearly 2,000 primary care providers across the state have already been trained. To learn more, go to <http://www.kidsoralhealth.org/provider-index.html>. To arrange training, contact: Dianne Riter at driter@deltadentalwa.com. The Tacoma-Pierce County Health Department's Oral Health Program (253-798-6579) can also help arrange the training.

Of course, physicians can help with oral health care at all stages of the life cycle. With the right skills and commitment to perform oral examinations, physicians can recognize early changes due to baby bottle tooth decay, tooth enamel corrosion from bulimia, "meth mouth" from chronic methamphetamine abuse, oral manifestations of HIV, gingivitis and periodontal disease, and oral malignancies. Preventive oral health care starts with infants and children, but also has to be integrated with adolescent athletes (mouth guards and sports drinks) and those with chronic diseases (diabetes, HIV, cancer).

As you can see, there is a great need for physicians and other health care providers to do their part in providing oral health care. This is another area that we want to thank you for your role in protecting and enhancing the health of the citizens of Pierce County.

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2. <http://www.wdsfoundation.org/pcp.pdf>.
3. <http://www.cdc.gov/nohss/index.htm>.
4. Protecting All Children's Teeth (PACT) <http://aap.org/oralhealth/pact.cfm>
5. Smiles for Life <http://www.smilesforlife2.org/home.html>.
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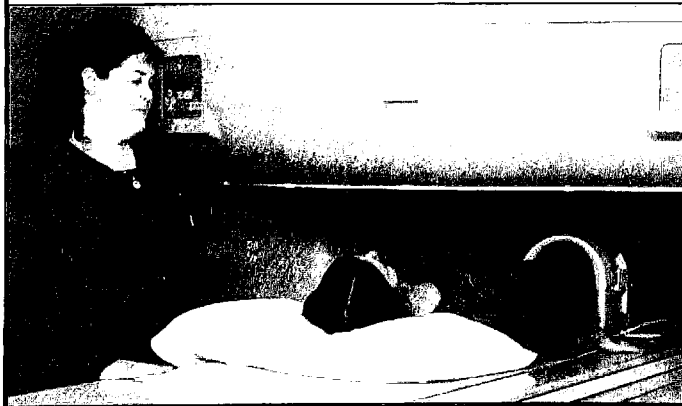
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BY FAX: 253.572.2470

BY EMAIL: tanya@pcmswa.org

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Editorial from page 6

health committee and a longtime proponent of national health care — and many other Democrats insist on the public option. Obama, in a letter to Senate leaders, said that option would make the health care system more competitive “and keep the insurance companies honest.” We don’t purport to know what shape that plan should take. What we know for certain is that the system that exists does not work for many, if not most, Americans. *Gainesville (Fla.) Sun*, June 14

Fix U.S. health care to improve California’s financial well-being

Providing universal coverage will deal with the health care crisis on a personal level, but from the standpoint of the national economy, cutting costs is even more important. ... If we can accomplish that goal, Americans won’t care whether the system is public, private or, most likely, a combination. But it’s hard to see how to get the cost savings without some competitive pressure. *San Jose (Calif.) Mercury News*, June 14 ■

Reprinted from AMNews, July 6, 2009



The Home Doctor

Physicians

Ready for a change?

The Home Doctor provides primary care medicine in residential care homes throughout the greater Puget Sound region. The Home Doctor started in 1998 and has provided more than 200,000 home visits. The experienced staff and electronic infrastructure makes the practice efficient and profitable.

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Oregon moves forward with health care reform legislation

Oregon has long been touted as a leader in the health care reform arena, mostly due to the efforts of former Governor and physician John Kitzhaber. Governor Kitzhaber started The Archimedes project and has worked tirelessly on reform of the health care system for many years. This year, 2009, there was significant progress made in terms of health care reform and Oregon's public health.

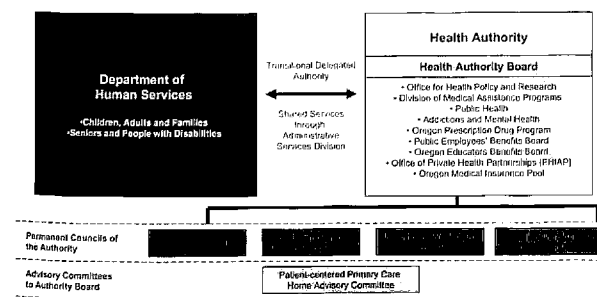
On June 26 of this year, Oregon Governor Ted Kulongoski signed HB 2009 into law. The bill, at its core will:

- Create the opportunity for a more rational and efficient way to control health care costs in Oregon through creation of the Oregon Health Authority
- Pave the way for components such as the Oregon Health Insurance Exchange and development of a publicly owned, publicly administered and accountable health plan within the exchange
- Incorporate several bills that started the session as separate bills, such as developing a POLST registry, developing an all-payer, all-claims database and efforts to shift more support to primary care.

Both the house and senate health committees worked tirelessly to create companion bills that would generate revenue to support HB 2009, which in these challenging economic times was no easy task. They also found ways to fund HB 2116 which will cover about 80,000 additional children and 35,000 adults via the Oregon Health Plan. The funding plan continues and expands a tax on hospitals that can be matched with federal dollars and imposes a tax on insurers based on premiums that are collected. Although this is not seen as a sustainable long term option, it offers improvement for the time being.

As the Oregon Legislature adjourns more work begins - implementing the structure that was recently passed. An important aspect is the creation of an Oregon Health Policy Board - a nine-member board that will oversee the work of the Oregon Health Authority, and crafting of the administrative rules that will dictate the work of the state agencies. Public engagement in both of these areas will be critical and Washington State will be watching. ■

HB 2009-B



Health Care Access & Affordability

KEY LEGISLATION

- *HB 2009 establishes the Oregon Health Policy Board, which will streamline certain health and health insurance functions that now belong to Dept. of Human Services and Dept. of Consumer and Business Services.*
- *HB 2116 will allow Oregon to capitalize on \$2 billion in federal matching funds over the next 4 years and will cover 80,000 additional kids and 35,000 adults under the Oregon Health Plan.*
- *HB 2535 creates the Oregon Charitable Prescription Drug Program which allows Oregonians to donate their unused medication for use by those who could otherwise not afford it.*
- *HB 2376 requires pharmaceutical and medical device companies to annually disclose to the Oregon Department of Justice the value, nature and purpose of any gift or payment over \$500 given to health care professionals. Disclosure information will be compiled into an easily accessible online searchable database.*
- *HB 2755 instructs DCBS to conduct a study of reinsurance alternatives. Reinsurance is essentially insurance for insurers.*
- *HB 2433 helps Oregonians who lose their jobs keep their health coverage by providing up to 65 percent of the costs of staying on their former employer's work plan to all workers under the federal stimulus package.*
- *HB 2672 includes all smokeless tobacco companies in the restrictions on youth marketing in the smokeless tobacco master settlement agreement, and increases the tax on a new wave of smokeless tobacco products. The bill will tax smokeless tobacco by can and weight.*
- *HB 2420 establishes cancer as presumed to be job related if manifested during a firefighter's career and provides coverage for firefighters from 12 types of cancer.*

SESSION HIGHLIGHTS

- *In 2009, Oregon House Democrats passed landmark reforms aimed at covering kids and the uninsured, and containing the rampant escalation in the cost of health care.*
- *Legislation passed to cover 95% of Oregon kids and tens of thousands additional adults and created jobs in the thriving health care sector by making sure taxpayer dollars remained.*
- *Government is more streamlined to make it leaner and more efficient, reducing costs and improving health outcomes.*
- *Access to prescription medication increased by al-*

See "Oregon" page 14

MGMA report on physician relocations

In 2008, before the recession had fully hit, doctors just out of residencies were more likely to move to North Carolina and Illinois, and those with more experience preferred Florida and Texas, according to a new report by the Medical Group Management Association in collaboration with the National Association of Physician Recruiters.

Michigan, Ohio and Pennsylvania lost physicians, but the number of doctor jobs increased in Virginia and Florida, according to the report issued June 17.

The authors suspect that experienced physicians may be moving to Florida and Texas because these states do not have income tax.

"[This] could add a significant amount to a physician's income — especially now, when physicians experience consistent financial burdens from managed care and reduced Medicare/Medicaid payments," said Martin Osinski, immediate past president of the National Association of Physician Recruiters.

The "Physician Placement Starting Salary Survey: 2009 Report Based on 2008 Data" also found that newly trained doctors landing jobs in emergency medicine, infectious disease and hematology/oncology were receiving higher salaries than in the past. Starting salaries were highest for those entering hospital-based practices. ■

From AMNews, July 6, 2009

Allowable Records Copy Fee Increases

The Washington State Department of Health has announced an increase in the allowable fees for searching and duplicating medical records. Effective July 1, 2009, the maximum charge for copying medical records can be no more than \$1.02 per page for the first 30 pages and no more than \$.78 per page for all additional pages. A \$23 clerical fee may be charged for searching and handling records, but federal law prohibits charging this fee to the patient or the patient's representative. ■

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Congratulations Sound to Narrows finishers

Special recognition goes to **Dr. Cordell Bahn**, retired cardiovascular surgeon who has run in EVERY Sound to Narrows event for 36 years. He almost missed one year due to a family wedding, but fortunately was able to make arrangements at the last minute. Dr. Bahn completed his 36th running in 2:02:07.

Several physicians completed the 12k (7.46 mile) challenging run in **ONE HOUR OR LESS!**

Tammara Stefanelli, MD.
Tacoma Family Physician: **55:46**

Chad Krilich, MD.
MultiCare Medical Group Associate Medical Director: **57:10**

Jos Cové, MD. Tacoma Orthopaedic Surgeon: **59:19**

Other finishers include:

Loren Betteridge, MD. Tacoma Family Physician

Mark Craddock, MD, Gig Harbor, Family Physician

Debora Overstreet, MD, Tacoma Pediatrician

Jim Rooks, MD, Lakewood Otolaryngologist

James Schopp, MD, Tacoma General Surgeon

Darryl Tan, MD, Lakewood Pediatrician

Carl Wulfesteig, MD, Federal Way Otolaryngologist

PCMS congratulates all members and their families on accomplishing such a physically challenging event. Congratulations are also in order to the many participants of the 12K and 5K walking categories as well.

IF YOU WERE A PARTICIPANT IN THE SOUND TO NARROWS, BUT ARE NOT LISTED IN THIS REPORT, PLEASE CALL THE MEDICAL SOCIETY OFFICE AND WE WILL RUN ADDITIONAL NAMES NEXT MONTH.

We may have missed you in reviewing the categories. Apologies are extended to those members we missed, and again, congratulations to all finishers. ■



Cordell Bahn, MD

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Oregon from page 11

lowing Oregonians to donate their unused medication for use by those who could otherwise not afford it.

- Transparency improved by shining a light on the financial relationships health care professionals enter into with pharmaceutical companies and medical device manufacturers.

- We studied the factors that are driving the escalation in insurance rates to create solutions that will slow it down.

- The long-term health of today's adolescents is improved by making it harder for them to acquire products like chewing tobacco.

- Oregonians who are out of work due to the national recession now find it easier to hold on to their health coverage, adding a bit of stability for families facing tough times. ■

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loren.finleymd@wmmossjr.com

Note: This announcement is not an offer to sell nor a solicitation of an offer to buy securities. Such an offer is contained only in the official company prospectus

Starting last February, a group of Pierce County physicians teamed up with local bio-scientists to create a new business culturing algae. The goal was to make a commercially viable algae farm/production plant. Algae's benefits include:

- High Yield: algae produces nearly 1000 times the oil per acre as soy beans or canola.
- Greenhouse gases: algae can scrub CO and CO2 from industrial smokestacks.
- Nutraceuticals: algae oil contains high quality omega-3 fatty acids.
- Animal Feed: dried algae is a high-protein feed for animals and fish.

WM Moss Jr Corporation, based in Tacoma, plans to break ground on an industrial-scale algae farm in Oregon, where state-level "green programs" offset the risk and expense of bio-fuel energy projects. An investment opportunity is open to a limited number of qualified investors.

Scope of Practice Revised for Health Care Assistants

As of July 26, Health Care Assistants (HCAs) are authorized to administer certain over-the-counter and legend drugs pursuant to a written order of a supervising health care practitioner. Competency must be demonstrated by the HCA to administer drugs as determined by the supervisor or employer of the HCA who must be physically present and immediately available in the health care facility.

Health Care assistants are unlicensed persons who assist licensed providers in the delivery of certain health care treatment to patients. A medical assistant who earned a certificate through an education program or received a credential as a CMA or RMA through a national examination is not a certified health care assistant unless he or she is certified through the Washington State Department of Health. Health Care Assistants are allowed to perform those duties that are within the HCAs supervising practitioner's scope of practice.

Only HCAs who are certified as category C or E by the Department of Health will be able to administer these medications via oral, topical, rectal, otic, ophthalmic, or inhaled routes:

- Over the counter medications such as Benadryl, acetaminophen, ibuprofen, aspirin, Neosporin, Polysporin, normal saline, Colace, Kenalog and hydrocortisone cream
- Non over the counter unit-dose legend drugs such as Kenalog, hydrocortisone cream, Reglan, Compazine, Zofran, Bactroban, albuterol, Xopenex, Silvadene, a gastrointestinal cocktail, fluoride, LMX cream, EMLA cream, LAT, optic dyes,

oral contrast, and oxygen

- Vaccines that are administered by injection, orally or topically including nasal administration

HCAs are prohibited from administering any controlled substances, any experimental drugs, or any cancer chemotherapy agent unless a licensed health care provider is physically present in the immediate vicinity where the drug is administered. A licensed health care provider must administer a medication if a patient is unable to physically ingest or safely apply a medication independently or with assistance. A licensed provider must also administer medication to a patient if the patient is incapable of being aware that he or she is taking it.

Each licensed provider's facility must maintain a list of specific drugs, diagnostic agents, and vaccines, and the method of administration of those drugs, diagnostic agents, and vaccines that HCAs are authorized to administer. The list must be signed and dated by both the delegator and the individual HCA certified by the Department of Health. The signed list must be forwarded to the Department of Health and also be available for review at the facility.

Within the scope of their licensure, physicians, osteopathic physicians, podiatrists, nurses, advanced registered nurse practitioners, naturopaths, physician assistants or osteopathic physician assistants may perform as HCA supervising practitioners. ■



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Fellowship: University of Wisconsin
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2009 Annual CME Survey Results

2010 CME in Kauai - Start Planning!

Much planning has already gone into the 2010 CME conference to be held in Kauai next Spring. The dates of the conference, March 28 - April 3, 2010, are planned around the Spring breaks of most of the area schools to make it the best family and/or couples vacation.

The Sheraton Kauai Resort has recently completed a \$15 million guest room renovation. Each guest room has a modern, tropical feel and feature flat screen televisions, refrigerators, Kauai coffee, and large lanais with ocean views. The Resort fees have been waived and we are able to offer discounted breakfasts everyday for families staying at the Resort. The Sheraton Kauai Resort also offers a wonderful beach perfect for surfing and snorkeling, two amazing golf courses in the surrounding area, as well as close proximity to Waimea Canyon and boat tours of the beautiful Napali Coast. Ocean front rooms start in the low to middle \$200 per night price range.

Jeanette Paul with Thomson Travel and Cruise will be taking care of our special room rates and securing the best airfare available for the group. You can contact her at 253-627-8221 or email her at jeanette@thomsontravelandcruise.com to start your planning now.

Please call the College at 253-672-7137 or Jeanette if you have any questions or need more information. ■

The College recently conducted their annual physician survey for setting the annual course schedule for the 2009-2010 program year. The survey included questions about clinical program preferences, quality and performance improvement, preferences for days, times, and teaching styles for courses and many other areas that helps set and plan a program that is most in line with what Pierce County physicians are seeking for their CME needs.

There were 84 responses to the survey and of these, 64% indicated that they do attend College of Medical Education courses. The vast majority selected Friday as their best day to attend a full day course, and lecture was the overall preferred learning style. Topic was the highest rated factor in determining whether to attend a CME program.

When asked to rate general clinical programs they would attend, respondents selected the following in order of preference:

1. Infectious Disease
2. Cardiology
3. Dermatology and Endocrinology
4. Neurology
5. Orthopedics
6. Mental Health
7. Nephrology
8. Pediatrics
9. Ob/Gyn and Oncology
10. Pathology
11. Gastroenterology and Geriatrics

And, specific clinical programs in order of interest to responders included:

1. New Drug Therapies
2. Headache and Pain Management
3. Cerebrovascular Disease/Stroke
4. Sleep Disorders
5. Diabetes
6. Cardiac Risk Factor Management
7. Obesity Management
8. Osteoporosis
9. Diagnostic Radiology
10. Moderate Sedation & Analgesia

The college conducts eight to nine programs each year between September and June, as the "program year" correlates with the school year. Most courses are local, but each year one is held at Whistler for the winter ski CME and every other year a course is held in Hawaii scheduled around local school districts spring breaks. This year, a course was held in Nicaragua with 37 attendees at the very successful, inaugural course.

The College Board of Directors, led by President **John Jiganti, MD**, is working on setting the course calendar for 2009-2010. Watch the *Bulletin* as well as your mail for the soon to be released annual calendar.

If you would like a copy of the survey results, call the College at 253.627-7137 and one will be emailed or mailed to you. ■

Save the Dates...

Friday, October 2, 2009

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Friday, November 6, 2009

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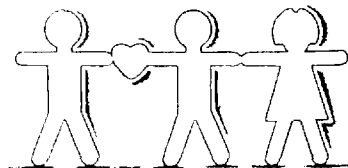
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BULLETIN

Pierce County Medical Society



August 2009

A Look to the **2009 Annual Meeting**

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Pierce County Medical Society

BULLETIN



August 2009

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President's Page

by J. David Bales, MD

Dr. Gawande



J. David Bales, MD

By the time this goes to press, much of the debate on Healthcare Reform and even legislation may be over. Support and dissent for multiple positions are being widely broadcast and diverse “voice of medicine” has become even more diverse. The outcome of the debate and legislation are unknown but it is likely that things will not remain the same. Unintended consequences may also rule the day!

As with many hotly contested issues, some jewels seem to float to the top. One that has appealed to me as well as to the President of the United States has been the writings of Dr. Atul Gawande. He does some writing for *The New Yorker* and his piece on the variation in Medicare costs by geographic region caught everyone’s eye. He has published a couple of books that are essentially compilations of his articles – I am currently reading “Better” and continue to be impressed by his even handed approach to issues that involve us all.

Dr. Gawande has pointed out that we providers don’t make all of the money spent in medicine, but we certainly are responsible for spending most of it. The physician’s pen bears the biggest cost and a visit that pays the provider \$100 might easily order \$100,000 worth of goods and services. In my opinion he correctly points out that most of the proposals for cost control don’t come close to answering this dilemma.

He also points out that health care teams are responsible for outcomes and no individual can take all of the credit or the blame for those outcomes.

So, one of the questions in today’s debate is how to pull the health care team into answering the questions of quality and cost. The President has asked physicians for leadership in the health care debate and our first response has been to split the AMA over support of a “Public Plan” – probably not a response he was looking for!

I’m reminded of the bumper sticker that proclaims to “Think Globally – Act Locally” and think it is an appropriate approach. We can all play a part in “Health Care Reform” by participating in improving conditions locally using a patient focused, continuous process of health care improvement. There are ample opportunities in our hospitals, our medical groups, and our community to participate and I challenge you to do so. ■

Editor’s Note: If you would like a copy of Dr. Gawande’s article “The Cost Conundrum” from The New Yorker, please email your request to sue@pcmswa.org.

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Partnership provides free cataract surgery for uninsured

Editor's Note: Kudos and thanks to Dr. Jerry Shields and Cascade Eye & Skin for their significant contributions to the community as outlined in this The News Tribune reprint, written by Kathleen Merryman. We recognize this is but one example of the significant amount of uncompensated care that physicians provide for patients who need assistance.

Dr. Jerry Shields had been waiting 10 months to look deep into Paulina Molina's eyes.

Shortly after 9:30 a.m. Tuesday, his patience paid off.

He inaugurated a partnership between public health agencies and Cascade Eye & Skin Centers, P.C., in Puyallup by removing the cataract that had impeded Molina's sight.

"They make a little incision into the eye, go down, over and down," said clinic administrator Wanda Davis. "When they are finished, the pressure of the eyeball closes, so there is no stitch."

It's like operating in an M&M, she said, with the lens as the chocolate filling.

"You go in there and break up the chocolate and remove the matter. You put a new lens in there, and it expands," she said.

Shields did all that in under 10 minutes, after those 10 months of waiting for a patient.

Just before the Puyallup Fair last year, Shields and his colleagues at Cascade contacted United Way of Pierce County, Tacoma-Pierce County Health Department and Community Health

Care. Would it be possible, they asked, to give free cataract removal surgeries to two needy people a month?

People in the agencies serving low-income people were elated.

"Once people come into Community Health Care, they have a medical home," said Linda Cameron of United Way. "But one of the barriers is not having enough specialists. For a specialist to say, 'I want to do this,' is extraordinary."

They spread the word. And they waited.

A client at Project Homeless Connect seemed like a candidate, but got to only one appointment and did not, or could not, follow through.

The doctors saved the sight of several people referred through churches and Good Samaritan Hospital, but that was outside of the new collaboration.

Over the months, Angel Ortiz Hernandez, managed care coordinator at Community Health Care, tracked seven or eight patients who needed cataract surgery, but had insurance to cover it.

Finally, Molina, an uninsured grandmother, told a clinician she wanted to be able to sew and do household chores again.

tients, will take home a flowering kalanchoe. It's a gift, said Miller, that "they can clearly see the day after surgery."

None of these people asked for this story because they wanted personal publicity. Cascade docs have been doing mission work abroad and charity work at home for years with nary a peep of press. They enjoy it, believe they are blessed, and that's enough.

They asked because they need help getting the word out to people who want to see clearly again.

Hernandez, Cameron and Myrick know there are people who need cataract surgery, but don't ask about it because they don't have insurance, or the \$2,500 to \$3,000 per eye to buy the procedure.

Hernandez guesses patients coming to Community Health Care clinics for, say, heart ailments, are not mentioning their poor vision. He suspects some clinicians have forgotten, or not heard, about the offer of free cataract surgery.

Last year, Hernandez managed 30,000 referrals for patients who needed a specialist's care.

"When they are uninsured, it is a big dilemma, of course," he said.

Given that, Cascade's commitment to two free cataract surgeries a month for uninsured patients is a valuable asset, and Hernandez is eager to use it. He's so eager, he'd like people who need the surgery to call him directly at 253-722-1541.

If you know someone who's uninsured and can't read this because of cataracts, call Hernandez. Make Shields, Davis, Miller and all their colleagues happy. ■

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"Hernandez guesses patients coming to Community Health Care clinics for, say, heart ailments, are not mentioning their poor vision. He suspects some clinicians have forgotten, or not heard, about the offer of free cataract surgery.

Last year, Hernandez managed 30,000 referrals for patients who needed a specialist's care.

"When they are uninsured, it is a big dilemma, of course," he said.

Hernandez referred her, and, on Tuesday, Cameron and Helen Myrick, also of United Way, welcomed her to the clinic.

Shields, Davis and administrative assistant AnnaMarie Miller, had lined up Rainier Anesthesia Associates, P.C., Abbot Medical Optics and Alcon Pharmaceuticals to provide anesthesia, drugs and the lens for the operation.

Clinic staff will care for Molina through her follow-up appointments.

Today, after her first follow-up, Molina, like all Cascade's cataract pa-

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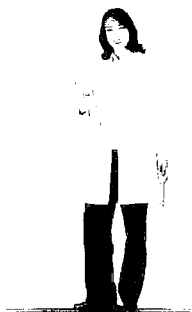
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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH, David Harrowe, MD, MPH,
Cindy Smith, BSN, RN and Nigel Turner, RS, MPH

Old and New Challenges for Immunizations, Part 1



Anthony Chen, MD

A few years ago, I was talking to a bright young pediatrician colleague (he had been Chief Resident at Boston Children's Hospital) when I learned that he had not done many lumbar punctures in his training and had never seen a case of meningitis. Flash back to my family medicine residency days in Cincinnati Children's Emergency Room: I became so proficient at doing LPs on children and infants that I could still do them 15 years later in practice. Unfortunately, I also remember the times my heart would sink when the spinal fluid dripped out cloudy rather than "crystal clear" because it meant a life, death, or permanent disability situation.

What caused the difference? During my residency, we started giving the Hemophilus influenzae type b (Hib) vaccine to kids and what had been the leading cause of bacterial meningitis in children under 5 years old started to vanish. This was later followed by Pneumococcal conjugate (PCV7) vaccine, which further reduced cases of meningitis, pneumonia, bacteremia, and ear infections.

My son would call me an old fogey for reminiscing like this, but August is, after all, National Immunization Awareness Month so bear with me.

Immunizations have been so successful—some would hail them as one of the greatest achievements of modern medicine—that we take them for granted. I remember my brothers and me all coming down with measles in elementary school; now we teach stu-

dents and residents with photos and the C's mnemonic (cough, coryza, conjunctivitis, and Koplik spots) because there are no teaching cases. While I never saw iron lungs, I remember the withered legs and leg braces of polio survivors; our older colleagues will likely remember the swimming pool closures when epidemics struck in the summer. I also remember getting pricked in the arm with a bifurcated needle for my smallpox vaccination; nowadays, few would recognize the circular scars that were the badge of protection. In Washington, our last case of smallpox was in 1946, polio in 1977, and diphtheria in 1979.

Who could have imagined that, in addition to preventing infectious diseases, a vaccine could prevent cancer and chronic disease? When Taiwan and other Asian countries began universal vaccination against hepatitis B over 20 years ago, both the pediatric chronic hepatitis B and liver cancer rates plummeted within a few years. Worldwide, countless cases of cirrhosis and liver cancer have been averted. The human papilloma virus (HPV) vaccine now promises to do the same for the most common sexually transmitted disease and cervical cancer.

These achievements are a great example of partnership between public health, schools, and medical providers working towards a common goal. In 2008, 413,537 doses of vaccine were distributed by public health and administered by Pierce County medical pro-

viders. Most pediatricians and family physicians in the county and 14 out of 16 school districts can access Child Profile, the statewide electronic immunization registry, to view and input immunizations.

Unfortunately, these achievements are not static. Each child born is another child that needs to be protected from the infectious diseases that still lurk out there. If s/he is not properly immunized, not only can that child become sick, but s/he may infect others in the community. As science advances, we will find vaccines to prevent other diseases but will have to decide whether to give them and how to pay for them. Invariably, we will also be challenged by novel diseases.

In a future issue, I will discuss challenges to immunization coverage from societal attitudes and parental hesitancy, but in this article I will address the changes to the vaccine funding system. It will take continued partnership to maintain our achievements and I will outline some strategies to address the challenges.

Until recently, Washington State was one of the few states providing all childhood vaccines free to medical providers. Nationwide, the Vaccines for Children (VFC) program covers Medicaid eligible, uninsured, underinsured, American Indian, and Alaska Native children; in Washington, the State pays to cover all others. The cost of publicly funding vaccinations has skyrocketed

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TPCHD from page 7

as the population grew, the number of recommended vaccinations dramatically increased, and costly new vaccines (eg, about \$400 for the HPV series) were added. The cost of recommended vaccines for a child through adolescence climbed from \$45 in 1985 to \$155 in 1995 and \$1183 in 2006. It is easy to understand why our State's budget woes have led to cuts and significant changes in vaccine funding.

Effective July 1, 2009, free HPV vaccine will only be available to VFC-eligible and State insured (ie, Apple Health for Kids and Basic Health Plan) children. On May 1, 2010, funding for all other vaccines will similarly be cut. What this means is that providers will need to screen for eligibility and order and maintain separate supplies of vaccine for publicly-covered and privately-insured patients.

For providers, this is a potential logistic and financial nightmare. For us in public health, we are worried that immunization rates will drop as barriers increase for patients and providers. We are also concerned that some providers may choose to stop providing immunizations altogether.

There are two strategies you can do now to help: 1) plan for the anticipated changes, and 2) advocate for a better solution.

If there is a silver lining to this dark cloud, it is that only HPV vaccine was cut first. This will give practices the opportunity to plan and test changes with a vaccine that is lower

volume and not mandated before the full changes take effect in ten months. The State DOH and our Health Department nurses have already been working with practices to educate them of changes, help with screening for eligibility, and otherwise provide support. As practices look to purchase private supplies of vaccines, they will need to compare sources (eg, vaccine manufacturer, distributor/reseller) and explore options for group purchasing. The Washington Chapter of the American Academy of Pediatrics (WCAAP) is leading efforts to develop a purchasing cooperative. Some practices may be able to purchase through their hospital.

There will be many practical aspects to consider. Do you have mechanisms to store the private vaccine at the same standards as public vaccine and have a system to account for the doses separately? Can your providers easily identify the patient's vaccine eligibility and know how to properly bill? Is your billing department ready to bill private insurers for the vaccine? Do you need to renegotiate administration costs with your insurers? If you use an electronic health record, is it set up to order and bill private and public vaccines differently; can you work with your IT department or the vendor to put in pop-up reminders, templates, or automate some processes?

Local communities may be developing their own solutions. Some counties have reported that pharmacies in some

See "TPCHD" page 10

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Dear Colleagues: An Invitation

I'd like to personally invite you to join me at the 2009 Annual Meeting of the WSMA House of Delegates, October 2-4 at the Davenport Hotel in Spokane.

The theme of this year's meeting is *A Look to the Future*. This year's opening session keynote address will feature futurist Joe Flower. Joe will address what the next 20 years in healthcare may hold for both patients and physicians.

The keynote address will be followed by the annual Don Keith Lecture. This year's speaker is Dr. Glen O. Gabbard who will address *The Physician as Patient*.

The WSMA Annual House of Delegates meeting is an opportunity for physicians around the state and across all specialties to come together to set the policies and goals for the Association.

The policy "heart" of the meeting will be reference committee meetings on Saturday morning, followed by the House of Delegates session on Sunday. It is the House that sets the broad policy course for the WSMA.

There are two opportunities for debate on every item of business brought before the House. The first comes during the reference committee hearings that are open to every WSMA member. Following these hearings, each of the three reference committees prepares a report recommending specific action and takes these recommendations to the entire House of Delegates on Sunday morning for its final action.

The annual meeting is not just about setting WSMA policies, although this is a large part of the meeting. It also provides educational and networking opportunities for all physicians.

On Friday and Saturday a variety of scientific sessions will be available, all providing additional CME Category I credit.

The WSMA's Annual Meeting brings Washington state physicians together in a forum like no other. If you haven't joined us in the past, I urge you to do so this year. Come and witness all that the WSMA does on your behalf.

Sincerely,

Cynthia A. Markus, MD; President, WSMA

Editor's Note: If you would like to attend the WSMA Annual Meeting and serve as a delegate, please contact Sue Asher at PCMS, sue@pcmswa.org, for more information.



Cynthia A. Markus, MD

AMA to Wall Street Journal: Rationale for Supporting House Health Care Bill

Wall Street Journal Letter to the Editor

I'd like to share the American Medical Association's rationale for supporting the House health-care bill. Without a bill that can pass the House, there will be no health reform this year. The House bill is an important starting point. The AMA will stay engaged to improve the final bill for patients and physicians.

Reform of the broken Medicare physician payment formula is necessary to assure long-term access to care for seniors, and its inclusion in the House bill is a huge victory for Medicare patients and their physicians. Its inclusion is one of many reasons the AMA supports the bill. It also establishes a health insurance exchange that would provide a choice of plans to the uninsured, self-insured and small business employees, with voluntary physician participation.

The AMA is committed to achieving health reform this year that will provide all Americans with affordable, high-quality health care. The House bill helps achieve this by extending health-insurance coverage to nearly all Americans and eliminates coverage denials based on pre-existing conditions.

Our position at the center of the health-reform debate is an honor and a serious responsibility. Maintaining the status quo is not an option. The AMA will stay engaged to get meaningful health reform that benefits patients and physicians signed into law this year.

J. James Rohack, MD

American Medical Association President, Chicago

TPCHD

from page 8

communities have made arrangements to order, bill, and even administer HPV vaccine for privately-insured patients. We are all learning as we go along. Make sure you talk to your colleagues in other practices and in states who have different vaccine supplies. Our Health Department nurses are available to help as well.

We are lucky that we live in a democratic society, so we have the option to advocate for a better solution. From my many years of practice, I realized that, regardless of how good a doctor I was, there were going to be decisions made by politicians, insurers, and others that would adversely impact my patients. We have no choice but to become involved.

Currently, the WSMA, WCAAP, WAFP, ACP Washington Chapter, and local public health are working on strategies for practicing physicians to deal with the changes in vaccine funding. Simultaneously, the WCAAP is spear-

heading efforts with legislators, insurers, and all stakeholders to restore a seamless vaccine supply system that will support a goal of immunizing all our children. So, we plan for the worst and hope for the best.

What can you do help this advocacy effort?

1. If you currently provide vaccinations, please keep on doing so! Your commitment to immunizing our citizens will send a strong message. Be patient and know that your colleagues are working to develop solutions that will help your practice.

2. Voice your concerns, suggestions, and support to your medical and specialty society leadership. We need to speak with one voice and work for a unified solution. Until a policy solution is developed, it is best to let the leadership coordinate their messages with key players.

3. Encourage all your colleagues who are not currently members to join

their local medical and specialty society. Regardless of their past experience with organized medicine, it is a much better choice than disorganized medicine. I am focusing on the vaccine supply system in this article, but remember that health care reform is on the agenda and that discussion will affect every provider and practice.

4. Once a policy solution is developed, follow your medical and specialty society's lead in reaching out to your elected officials and legislators to seek their support.

On behalf of public health and our citizens, I want to thank you for all the work that you do in promoting immunizations in your practice. Let me end with some resources that you may find useful. Please look for Part 2 in a future issue.

• <http://www.doh.wa.gov/cfh/Immunize/default.htm>. The Washington DOH's website with information for

See "TPCHD" page 18

MAUREEN A. MOONEY, M.D.

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Dr. Mooney earned her medical degree at the University of Minnesota Medical School. Her residency was completed at the University of Medicine and Dentistry of New Jersey, followed by fellowships in dermatopathology and Mohs micrographic surgery. Her main areas of practice are skin cancer and Mohs surgery.

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Maureen A. Mooney, M.D.

Dr. Mooney is board-certified in dermatology and dermatopathology, and is a fellow of the American College of Mohs Surgery, American Society of Dermatologic Surgery and the American Academy of Dermatology.

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Some states still prohibit hospitals from hiring doctors; physicians want to keep it that way

California and Texas are among states with bans. Hospitals want the right to hire doctors to address rural shortages, but physicians fear loss of autonomy

Medical associations in California and Texas have been battling legislation that would allow rural hospitals to directly hire doctors — a move some physicians say threatens to undermine their independent medical judgment and hinder patient care.

Most states allow for direct hospital employment of physicians — a growing trend in recent years as doctors increasingly seek more financial stability. California and Texas, however, are among only a handful of states that generally prohibit hospitals from employing doctors, under long-standing laws aimed at preventing corporate interference with the practice of medicine.

Hospitals have sought the right to hire doctors in the Golden and Lone Star states, saying the changes are necessary to recruit doctors to underserved areas.

The California and Texas medical associations don't dispute the need to address shortages. But they say there are other ways to recruit doctors without thwarting medical independence, such as reducing medical student debt and increasing residency slots.

The employment legislation proposed in California would do nothing to alleviate physician shortages, said Brett Michelin, California Medical Assn. associate director of government affairs. "It just changes the economics."

Instead, doctors on a hospital's payroll would be subject to administrators' rules on admissions, tests and referrals, rather than being free to make decisions based on patients' needs, he said.

"Physicians' sole interest is ethically to their patients. They don't have a legal duty to make the hospital money, and that's what we want to avoid," Michelin said.

If hired doctors are required to perform certain procedures at their respec-

tive hospitals, outside competition and patient choice may suffer, he added. And without adequate protections, hospitals may unfairly terminate non-employed physicians' privileges to push a hired arrangement.

The CMA successfully lobbied for provisions that would prevent privileged doctors from being supplanted under a bill to create a pilot project allowing certain rural hospitals to hire up to five physicians for 10 years. But the CMA remains opposed to the overall measure, which cleared a state Assembly committee in July after passing the Senate a month earlier. Two other bills would have annulled the ban and allowed various rural hospitals to hire physicians and surgeons, but those measures failed.

In Texas, a hospital employment measure was defeated because it would have undermined the state's 2003 liability reforms, according to Gov. Rick Perry's veto of the bill in June.

The legislation would have permitted publicly run hospitals in counties with fewer than 50,000 residents to hire physicians. An undebated, last-minute amendment, however, threatened to increase those doctors' liability risks beyond the state's damage caps.

While generally opposed to the bill, the Texas Medical Assn. successfully lobbied for protections of employed doctors' clinical independence, as well as for due process safeguards for hired and nonhired physicians.

Concerns lingered that broad language in the bill would allow hospitals to justify employment beyond underserved areas. The CMA expressed similar apprehension to the proposal in its state.

Roughly 80% of Texas counties have fewer than 50,000 residents, said Dan K. McCoy, MD, chair of the TMA's legislation council.

"We recognize that rural Texas is really hurting. But putting corporations in control of the doctor-patient relationship is not the right answer," he said. "The local community's medical staff should be involved in determining whether there's actually a need for this."

But hospitals in Texas continue to lose physicians, particularly younger ones, to surrounding states that allow employment relationships, said Jennifer Banda, Texas Hospital Assn. senior director of government affairs. Because rural areas have fewer physicians, it's often difficult for them to meet the requirements to contract as a group.

Exceptions to the California and Texas bans allow teaching hospitals and federally qualified health centers to hire doctors. Physician groups also may contract with hospitals for services in quasi-employment arrangements.

The difference, said Dr. McCoy, is "doctors are still in control and there's a separation of that corporate power."

Issues include patient access to care

Hospitals and some physicians say allowing direct hospital employment not only would ease strains on access to care, it also would help relieve doctors of some of the financial and administrative burdens that keep them from focusing on patient care.

California Hospital Assn. spokeswoman Jan Emerson called California's prohibition outdated. The proposed changes don't "force doctors to do anything. This just gives them an option if they want to have a sustainable income, pay their debt, have their medical malpractice insurance covered and not deal with insurance company billings."

Emerson added that competition in rural areas is virtually nonexistent.

See "Hospitals" page 12

Hospitals from page 11

"This is about access to care."

California hematologist and oncologist John Rochat, MD, runs his clinic out of Mendocino Coast District Hospital, where he was hired under a smaller pilot project launched in 2003. Working for the hospital is the only way he can afford to stock the chemotherapy drugs his clinic patients need, as well as pay for his own family's health insurance coverage. He dismissed the notion his administrators dictate how he practices.

If the proposed legislation fails, he will be out of a job next year, and the small rural hospital in northern California will lose its only cancer specialist.

"I would have to send patients hours away, they would have to stay in a hotel overnight, and [their] drivers not going to work that day. So the cost of that health care is phenomenal," Dr. Rochat said.

Financial pressures continue to drive more doctors to opt for hospital employment, said Medical Group Management Assn. President and CEO William F. Jessee, MD. But many still choose urban or suburban areas over rural regions.


Elizabeth A. Snelson, a Minnesota-based lawyer who represents medical staffs around the country, said hospital employment continues to affect the role and dynamic of the medical staff.

"There is a legitimate concern over the amount of influence the hospital can have over physicians, not just in the direct practice of medicine, but in the decision-making of the

medical staff organization," she said. Staff bylaws should ensure that such authority is not limited to hospital employees and that hired doctors can exercise their votes without fear of getting fired, she said.

James Bentley, a senior vice president at the American Hospital Assn., said employment contracts help clearly define both the hospital's and physician's goals and expectations. He acknowledged that "no matter what the arrangement, getting physicians and hospitals to work together can create tension. But clearly, we are all being pushed to be more efficient and more effective, and that collaboration, sometimes to the point of employment, is changing relationships." ■

Reprinted from AMNews, Aug. 3, 2009



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More Great News in Gig Harbor...

Please join us in welcoming cardiologist Dr. Scott Werden & his family to our community!
 Find out more about Dr. Werden at www.cardiachealthspecialists.com

A Journey to Nicaragua

2007 was a momentous year for my wife and I as we left our comfortable jobs in Tacoma and moved ourselves to a small organic farm on the Pacific coast of Nicaragua.

To many of our friends, this seemed like an abrupt event. But, we had been complaining for some time about the stress of our jobs and the need to do something different. We had talked for many years about living and working abroad. Often we can blame our children for any big change events in family life. My son can share some of the responsibility. His closest friend from high school had joined the Peace Corps after college and got assigned to Nicaragua. After leaving the Peace Corps he stayed in country. My son started to visit him on a regular basis. After about the 5th visit I asked my son why all the interest in Nicaragua? His answer was typical father-son stuff. "Dad, you wouldn't understand. It's a real frontier down there, with so many opportunities to do things." Our children are often so subtle. He was suggesting that I was ready for a retirement center and a walker and not an adventure. I tagged along on his next trip and quickly found myself hooked on the area.

What excited my son was the entrepreneurial atmosphere down here. Truth be told, the flexibility, uncertainty and the often chaotic nature of life in this country also drew me like a magnet. And things started to come together as they often do in life changing events. On my next trip my wife and daughter accompanied me for a month long visit. Despite a nasty bout of traveller's illness, my wife was quickly intrigued with the area. We stayed in the small town of San Juan del Sur on the Pacific coast for two weeks and then headed inland to a plateau outside the town where we stayed at Finca Las Nubes, an organic farm and bio-reserve that is committed to a self sustaining approach to agriculture. We fell in love with the place and when you are in love you often make decisions quickly and decisively. The owner and founder

of the farm (Chris Robertson) is a builder from northern California with a Johnny Appleseed-like enthusiasm for re-foresting southern Nicaragua and for attracting like-minded people to live on the finca and create a sustainable community. We always wanted to live in a more balanced way with our environment and make a difference in the health of our community. This led to an afternoon on Chris' patio describing the kind of house we would like to live in if we lived at Finca Las Nubes. On the back of a napkin he sketched out our dream house and a day later had a more formally drawn out design for a home that fit perfectly into the landscape of this organic farm. Seven months later the house was finished, built by hand by workers on the farm.

Having this new home (both the house and the finca) made the decision to move much easier. It meant distancing ourselves from our many friends, selling our house in Tacoma, and divesting ourselves of much of the stuff that we had accumulated living in the same place for 15 years. We ended up giving away most of our furniture and household items, donating endless bags of clothes to the Goodwill and St Vinnie's. Most painful for me was giving up many of the 100's of books we had collected over the years. I wanted to keep each and every one. But when the dust settled, we arrived with just four suitcases and set up our house. It has been pretty uneventful despite regular encounters with poisonous snakes, monkeys, scorpions, ant invasions, and power outages. And even a visit from the president of Nicaragua...Daniel Ortega. We have settled right in to a slower paced and healthier lifestyle. I lost 25 lbs the first 2 months and have kept the weight off.

I find myself in the middle of the food production part of the finca. I spend many hours a day out in the gardens. We grow about 60 different fruits and vegetables on a 250 acre farm. Everyday feels like an adventure as we try to figure out how to grow and



Federico Cruz-Uribe, MD

sustain crops without the use of chemical fertilizers, pesticides and herbicides.

Alden has been very invested in designing and establishing a clinic to serve the local community including the finca workers and their families. After many discussions with local providers we have decided to also focus on diabetic patients as there is a desperate need for care among these individuals. We were surprised at the prevalence of the disease and the lack of services available. Our decision to focus on diabetics is very exciting as we know that we can provide services that will make a big difference in the health of this group.

We held a continuing medical education course this April. We believe it was a huge success. We hosted 37 people who stayed in one of the 7 beautiful homes here on the finca. The participants enjoyed outstanding presentations, food and lodging. The participants and their families had a chance to see a country at a different stage of development. In our global economy and our increasingly borderless world, we very much need to better understand the challenges faced by people in other countries who lack the resources we have in the U.S. I hope that the participants who came got a glimpse of this in their short stay.

We look forward to hosting future sessions and hope that more colleagues from the Medical Society and friends will come visit us.

I can be reached directly at 253-564-8218 (toll free) or via e-mail feruzu@gmail.com.

Dr. Federico Cruz-Uribe was the director of the Tacoma/Pierce County Health Department from 1992-2007.

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Internship: UC Davis
Residency: UC Davis
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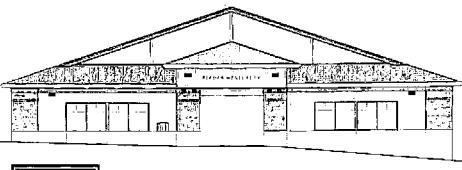
Elizabeth T. McKinney, MD

Ob/Gyn
MultiCare Regional Mater/Fetal Med
314 ML King Jr Way #402, Tacoma
253-403-9200
Med School: Washington University
Internship: Naval Medical Center
Residency: Naval Medical Center
Fellowship: University of Tennessee

Zhiqian (Roger) Wang, MD

Rheumatology
ROAD Clinic (FMG)
11311 Bridgeport Way SW #214, Lakewood
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Internship: Cleveland Clinic
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Medical homes: Who gets paid?

Many physician organizations and policy experts agree that the federal government should pay more to practices that serve as patient-centered medical homes. But heated debate continues over what types of practices should qualify.

In developing a pending Medicare medical home demonstration project, the Centers for Medicare & Medicaid Services indicated that it largely based its definition of a patient-centered medical home upon literature from the American College of Physicians. The ACP represents internists, who, along with family doctors and geriatricians, are considered to be the more traditional examples of primary care physicians.

CMS also excluded certain specialties and subspecialties, including radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, psychiatry and surgery. Specialists are concerned that the deck is stacked too heavily in favor of primary care.

"If medical home or other innovative delivery systems are to succeed, there must be collaboration between primary care and specialty medicine." Steven Schlossberg, MD, said at a May hearing before the Senate Health, Education, Labor and Pensions Committee. He is chair of health policy at the American Urological Assn., which is a member of the Alliance of Specialty Medicine. "Primary care will not always be the most cost-efficient and effective provider for every condition and disease."

Dr. Schlossberg said policymakers should think in terms of identifying a "principal" physician -- and not always as-

sume it will be a primary care doctor. Specialists note that a woman might consider a gynecologist to be her primary physician, while a patient with prostate cancer might want a urologist in that position.

The AMA says patients should be able to choose physicians from a range of practices and specialties to serve as their key coordinators in a medical home.

"It's not so important to think about whether the physician is in a specialty practice or primary care setting, but more about what the services and benefits are that a patient gets through a patient-centered medical home," said Robert M. Wah, MD, an AMA Board of Trustees member. ■

Reprinted from AMNews, July 2009



Jon F. Geffen, D.O., board certified in Physical Medicine and Rehabilitation specializing in Interventional Pain, Electrodiagnostics and non-surgical orthopaedics.

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90-Minute Webinar: 2010 ICD-9 Changes & ICD-10 Implementation

On Thursday, September 17, 2009 WSMA will be presenting a 90-minute webinar "2010 ICD-9 Changes & ICD-10 Implementation." The course provides guidance and training on CPT and ICD-9-CM coding issues via the WSMA's Practice Management Seminars and our Coding Hotline. The Webinar is from 12:00-1:30 pm PT and is presented by Michelle Lott, CPC, Associate Director of Health Care Economics/Practice Resource Center for WSMA.

The 2010 changes to ICD-9 have been issued. **As no grace period exists for the transition to the annual coding changes, practices will need to be ready by October 1st to begin using the new codes and to discontinue using the invalid codes.** Also, pressure is growing for the conversion to the dramatically more detailed and complex system of ICD-10 codes.

You will learn:

- ICD-9 2010 Changes - Information on the 2010 changes to the ICD-9 codes, how the 141 new codes could affect your practice and review of the Updated ICD-9 Guidelines and the effects on code selection.
- Preparing for ICD-10 Implementation - Overview of ICD-10 versus ICD-9, "Mapping" ICD-9 to the new ICD-10 Codes and guidance on approaching ICD-10 implementation, minimizing impact on the practice.

This program has prior approval of the American Academy of Professional Coders for 1.5 Continuing Education Units.

WSMA and WSMGMA members can attend for a price of \$89. One registration fee per phone line lets your entire staff listen in. Non-members: Call for pricing.

To register or for more information, contact Jenelle Dalit at 1-800-552-0612 or via email jed@wsma.org. Register online at the WSMA Practice Resource Center. ■

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2009-2010 CME Program Schedule

New Approaches to Common Medical Problems in Primary Care - Friday, October 2, 2009

This one-day conference will provide comprehensive updates of selected topics in general internal medicine and primary care which are critical to the practicing physician.

Infectious Diseases Update - Friday, November 6, 2009

This clinically-oriented course is designed specifically for the primary care and internal medicine physician interested in an update on the diagnosis, treatment and prevention of common infectious diseases of adults.

Endocrinology for Primary Care - Thursday, February 4, 2010

This seminar will provide a working knowledge of common endocrinological problems and will reinforce clinical manifestations, diagnosis and management of most major endocrine disorders.

Pain Management Symposium - Friday, March 5, 2010

The goal of this symposium is to promote a better understanding of the pathophysiology of acute and chronic pain and to enhance the knowledge regarding various chronic neuropathic pain conditions as well as to critically review the novel state-of-the-art interventional and non-interventional techniques in diagnosis and management of chronic pain.

CME at Hawaii (Island of Kauai) - March 28 - April 3, 2010

This course offers a broad range of topics relevant to the primary care and internal medicine physician, qualifying for 16 Category 1 CME credits.

New Developments in Primary Care - Wednesday, April 28, 2010

This course is designed for practicing internists, family physicians, physician assistants and specialists interested in expansion of their primary care knowledge and skills.

Internal Medicine Review 2010 - Friday, May 21, 2010

The goal of this program is to provide a better understanding of several of the most common disease processes, in light of rapid scientific advances.

Primary Care Conference 2010 - Friday June 18, 2010

This is a one-day course focusing on the latest updates and clinical challenges common to the primary care and internal medicine practice.

Please call the College at 253-627-7137 with questions/registration information. ■

Program Registration Fee Increases

The College of Medical Education Board of directors approved a course tuition increase at their June, 2009 meeting.

The College will continue to offer the lowest fees in Washington for CME programs. The fees will increase to \$60 for PCMS active/retired members and \$85 for non-members for a one-day, six hour credit program. An early registration discount of \$25 if registered in advance by a certain specified time was also added.

The College remains committed to offering a menu of offerings based on local physicians' need. If you have suggestions or would like to be involved call Lori Carr or Sue Asher at 627-7137. ■

2010 CME in Kauai - Start Planning!

Much planning has already gone into the 2010 CME conference to be held in Kauai next Spring. The dates of the conference, March 28 - April 3, 2010, are planned around the Spring breaks of most of the area schools to make it the best family and/or couples vacation.

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

TPCHD

from page 10

schools, parents, and providers. There are details on the changes to universal vaccine purchasing.

• <http://www.cispimmunize.org>.

The AAP's website for families and clinicians to support childhood immunization.

• <http://www.cdc.gov/vaccines/default.htm>. The CDC website with lots of information including immunization schedules, information sheets, and news.

• <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm>. Part of the CDC website that covers common misconceptions about vaccination and how to respond to them, including numbers to quote on the Risk from Disease versus Risk from Vaccines

• <http://www.immunize.org/>. The Immunization Coalition website that has forms, schedules, information, and all kinds of resources. You can sign up for newsletters as well.

• <http://www.immunized.org/>. The Society of Teachers of Family Medicine Group on Immunization Education website. Reference articles and schedules. You can download Shots 2009, a quick reference guide to the 2009 Immunization Schedules, for Palm OS and PocketPC. A commercial version is also available for iPhone, Blackberry and other platforms.

• For a brief history of vaccinations: Riedel S. Edward Jenner and the history of smallpox and vaccination. Proc (Bayl Univ Med Cent) 2005; 18(1):21-25. Available online at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1200696> or <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1200696&blobtype=pdf>. ■

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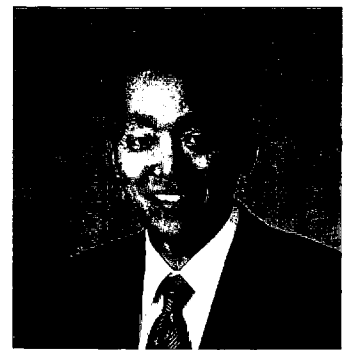
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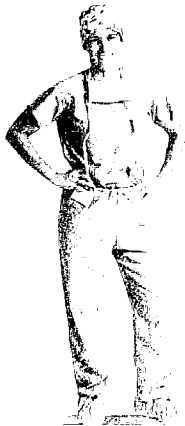
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BULLETIN



September 2009



The party deck provided a perfect venue for eating, socializing and watching baseball

1st Annual PCMS Doctors and Baseball

PCMS members, families and friends enjoyed barbecue, drinks, baseball and lots of social time at the 1st Annual event. Even Rhubarb the Reindeer was there!

(More pictures page 5)



Dr. Kyung Noh, Lakewood gastroenterologist, gets cozy with Rhubarb!

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 - 7 **TPCHD: "Summertime Fun and Surface Water Concerns"**
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Pierce County Medical Society **BULLETIN**

September 2009

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President's Page

by J. David Bales, MD

“How Do I Really Matter”



J. David Bales, MD

In last month's *Bulletin* I mentioned *The New Yorker* article by a Harvard surgeon, Dr. Atul Gawande, that had caught the eye of the President of the United States. The article brought to my attention further writings by Dr. Gawande. Articles that started as pieces for *The New Yorker* subsequently found their way into book form – *Complications and Better*. A colleague loaned me *Better* and reading it revealed a very even-handed, well written, discussion of topics from hand washing to tort reform.

The most impressive thoughts to me, however, were his suggestions to some medical students in an attempt to answer the question “How do I really matter” in a profession that relies on millions of team members. He had five suggestions for how one might make a worthy difference – to become a “positive deviant” (reference to thinking in his chapter on hand washing). I think the suggestions worthy of all of us – not just students.

First – **Ask an Unscripted Question** – ask something in the physician-patient encounter that makes the connection more human and less like a machine. For me, it's easy since I deal with a lot of retired military and am retired military myself – connecting through similar experiences or assignments does indeed make the moment more human – and less mechanical.

Second – **Don't Complain** – while we've much to complain about, “nothing in medicine is more dispiriting than hearing doctors complain” – I'm as guilty of this as anyone, but it is true. “Resist it. It's boring, it doesn't solve anything, and it will get you down.”

Third – **Count Something** – this suggestion has real appeal to me because I tend to count everything. When I started, it seemed that much of what I thought of as cause and effect didn't survive the numbers - so I kept doing it. Dr. Gawande's only requirement is that it should be interesting to you. “If you count something you find interesting, you will learn something interesting.”

Forth – **Write Something** – anything, for that matter – a blog, a paper, or a poem. Even a small observation about your world makes you part of a larger world and may become a fragment of collective thought that is greater than any individual. “The published word is a declaration of membership in . . . community and . . . a willingness to contribute something meaningful to it.”

Fifth – **Change** – “make yourself an early adopter. Look for the opportunity to change. . . be willing to recognize the inadequacies in what you do and to seek out solutions. As successful as medicine is, it remains replete with uncertainties and failure. . . it often seems safest to do what everyone else is doing . . . but a doctor must not let that happen . . .”

Better is definitely worth reading. It is well written and thought provoking. With all that we are facing – provoking thought should be a requirement!! ■

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Doctors and Baseball - a successful first year

The 1st Annual Doctors and Baseball event held August 19th at Cheney Stadium was successful with 85 members, family and friends attending the event. It was a hot evening, and fortunately, the party deck was shaded from the very warm afternoon sun.

Participants enjoyed a barbecue buffet with drinks at the party deck tables and were free to roam around the deck, visit with friends and colleagues, watch baseball, eat and drink and even get a hug from Rhubarb, the Rainier's mascot.

Comments from attendees indicated strong support for offering the event next year as well. It was the perfect venue for socializing, watching the game, enjoying the warm summer evening, being with family, and enjoying a "ballpark" meal. ■



PCMS President Dr. Dave Bales (left) takes the opportunity to visit with Dr. Kirk Harmon



Dr. Ron Morris (standing far left) visits with Dr. Mike Kelly, while their families enjoy the game



Puyallup pediatrician Mark Grubb and his wife Nancy Grubb (Puyallup family practitioner) brought their two daughters



Dr. Kiyooki Hori (left), Joe Jasper and David Lukens (front) enjoy the game



From right, Drs. David Law, Pat Hogan and Jane Moore (back to camera) enjoyed dinner together as well as the baseball game

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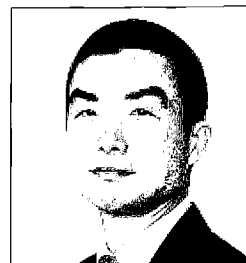
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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH;
Ray Hanowell, BS, RS; and Lindsay Tuttle, BS

Summertime Fun and Surface Water Concerns



Anthony Chen, MD

As residents of Pierce County, we are blessed with abundant and beautiful natural resources, stretching from the waters of Puget Sound to the summit of Mount Rainier. In these late months of summer, residents of Pierce County are still taking advantage of the outdoors and warm weather and we need to advise them and watch for problems with sun, insects, food, and water. This month, let me focus on hazards that our residents might encounter when enjoying our local lakes and salt water beaches, whether they are swimming, fishing, collecting shellfish, or boating.

Water Safety

Hot weather plus cool water is usually an invitation for fun, but it can be dangerous! An estimated ten people a day die from unintentional drowning in the United States (not including boating injuries) and perhaps four times as many are treated in the emergency room for submersion injuries. In children age 1-14 years, fatal drowning is the second-leading cause of unintentional injury-related death.

Any body of water is a potential risk, and the risk varies by age. Children under one year most often drown in things present in every home: bathtubs, buckets, or toilets; all it takes is an inch of water. Children age 1-4 years most often drown in home swimming pools. With increasing age, and especially over 15 years old, drownings occur more in natural water settings such as

lakes, rivers, or the ocean.

Supervision, barriers (e.g., swimming pool fences), and personal flotation devices are key in the prevention of drowning. In adolescents and adults, control of drinking behavior is important since alcohol is involved in up to half of water recreation deaths and about one in five boating fatalities. For children and adolescents, physicians should routinely inquire about swimming ability and encourage swimming lessons, especially among African Americans, American Indians, and other groups with historically low rates of swimming due to social and economic factors.

For more information, please see the websites of the Centers for Disease Control and Prevention <http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.htm>, Safe Kids USA <http://www.usa.safekids.org/water/>, the National Drowning Prevention Alliance <http://www.ndpa.org/home/index.htm>, and the U.S. Coast Guard <http://www.uscgboating.org/>.

Waterborne Illnesses

Surface waters can contain a number of disease-causing organisms and swimming in lakes may lead to gastrointestinal, upper respiratory, or skin infections. Pathogens include *Escherichia coli* O157:H7, *Shigella*, *Pseudomonas*, Norwalk-like viruses, and parasites including *Giardia* and *Cryptosporidium*. It is not feasible to test for all possible

water-borne pathogens so indicator organisms are used to assess the risk of illness. Per Environmental Protection Agency guidance, *E. coli* is used as an indication of the risk of bacterial illness.

Locally, Tacoma-Pierce County Health Department monitors *E. coli* counts at three lakes (American Lake, Spanaway Lake, and Lake Tapps) each summer. Samples are taken every other week and if high *E. coli* counts are found, another sample is taken. Once confirmed, a swimming advisory is issued, the Health Department website is updated, an email is sent to those registered to receive lake advisories, and caution signs are posted.

Water quality at swimming beaches varies from year to year but, in general, American Lake and Lake Tapps beaches have lower *E. coli* counts than Spanaway Lake. Some summers, including last summer and so far this summer (as of July 28, 2009), *E. coli* counts have been low at all beaches and no advisories have been needed.

The Health Department also monitors six saltwater swimming beaches. This monitoring is similar to that for freshwater beaches except Enterococci, rather than *E. coli*, are the indicator used, and sampling is conducted weekly rather than every other week. In general, saltwater beaches have better bacterial quality and fewer advisories than lakes.

Although the beach monitoring and public notification effort helps pro-

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tect public health, there are a number of limitations. One limitation is that many illness outbreaks associated with swimming have been caused by a sick swimmer infecting other swimmers, rather than by a failing septic system or other external source of pollution. Routine monitoring cannot detect this kind of problem. Another limitation is that illnesses caused by swimming in contaminated waters are likely greatly under reported because they can also be caused by contaminated food or contact with a sick individual. If you have a patient who may have one of the illnesses mentioned above, please ask about a recent swimming history. If you suspect an illness may be associated with swimming in a local lake or river, please call our Environmental Health Specialists Ray Hanowell (253)798-2845 or Lindsay Tuttle (253)798-3530.

Toxic Algae (Cyanobacteria)

Years ago in Biology class, I remember learning about primitive photosynthetic bacteria called "blue-green algae." They have been credited for creating much of the oxygen on Earth, helping fix nitrogen in rice fields, and other important roles. Today, the average person will more likely know Cyanobacteria as the "Toxic Algae" that sicken people and pets who swim in local lakes. Summer is when poisonings from toxic algae are most likely to occur, although pet poisonings have occurred in the winter and spring at American Lake and Clear Lake. Toxic algae blooms have been reported in Pierce County lakes since at least 1989, when several pets were poi-

soned at American Lake. Since then, fifteen other lakes, ponds, and streams in Pierce County have had advisories issued due to toxic blooms and the incidence seems to be increasing in Pierce County and across the state.

The Health Department's Toxic Algae Program monitors toxic algae blooms and notifies the public when a public health concern exists. Water samples are tested for microcystins (hepatotoxins) and in some cases up to three additional toxins (anatoxin-a and saxitoxins, which are neurotoxins; and cylindrospermopsin, a hepatotoxin). Toxin concentrations vary tremendously by lake and from week to week; but, in general, levels are high enough to indicate the potential for animal poisoning to occur. Washington State Department of Health (DOH) guidelines identify a public health concern whenever toxin levels exceed 6 ug/L (part per billion) for microcystin or 1 ug/L for anatoxin-a. Microcystin levels were above 6 ug/L in Waughop Lake in Fort Steilacoom Park for most of the summer and fall of 2008. The highest microcystin concentration in a Pierce County lake was from Ohop Lake on September 16, 2008, when an algae/water sample had a concentration of 4.620 ug/L.

These toxins are extremely potent and symptoms can begin within minutes of ingestion: muscle weakness, vomiting, diarrhea, and/or nausea; large amounts can be fatal. Skin contact may cause irritation. The risk to pets is much greater: when drinking from a lake or licking their coats, they may in-

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Dr. Park received his medical degree from Jefferson Medical College in Philadelphia and completed his ophthalmology residency at the University of Washington. He completed his clinical and surgical fellowship in glaucoma at the New York Eye and Ear Infirmary. Dr. Park is a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. He has published original research on glaucoma in some of the most respected ophthalmology journals.



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Spouse/Guest(s) name for name tag: _____

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The parking lot across the street charges \$5, but there is usually ample street parking at no charge

IN MEMORIAM
ROBERT W. KUNKLE, MD
1948 - 2009

Our Pierce County medical community was deeply saddened by the tragic news that Dr. Robert Kunkle drowned August 9, the result of a scuba diving accident. A diver for ten years, Dr. Kunkle got caught in a strong current at the end of a master dive group session. He was 61.

A respected orthopedic surgeon, Dr. Kunkle came to Tacoma from California to practice medicine in January 1991, joining an orthopedic practice on Tacoma's hilltop. He was owner of Gig Harbor Bone and Joint Clinic.

He received his medical degree from Johns Hopkins School of Medicine in 1981 and completed his internship and residency at the University of California Irvine Medical Center. He was board certified in orthopedic surgery and practiced at his clinic in Gig Harbor.

Dr. Kunkle was with his family on vacation in Canada at the time of his death. He is survived by his wife, Darla Smedley, ARNP, and three siblings. Remembrances may be made in Dr. Kunkle's name to a memorial fund at any Columbia Bank.

PCMS extends sincere sympathies to Dr. Kunkle's family, friends and patients.



Robert Kunkle, MD

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gest large quantities of algae which is compounded by their small body size. If a dog or cat shows signs of vomiting, lethargy, disorientation, or seizures, pet owners and their veterinarians should consider the possibility of exposure to toxic algae, especially if the pet lives nearby or was recently swimming in a lake with a bloom.

The Health Department is working in partnership with DOH, Ecology, and other agencies on a CDC grant to better identify human health risks of toxic algae. A list of possible toxic algae poisonings in Pierce County includes 29 possible human cases since 1989. Symptoms often included gastrointestinal illness and/or headaches and a burning sensation in the throat. The actual number of poisonings is likely much higher and we hope to develop a tracking system to more accurately assess the extent of human, pet, and wild-life poisonings.

Remember, the only way to know if a bloom is toxic is to test it for toxicity. To report an algae bloom or possible human or animal poisoning in Pierce County, contact Lindsay Tuttle at (253)798-3530. To report a bloom elsewhere in the state, contact Trisha Shoblom at the Department of Ecology at (425) 649-7288. You can also make a report to DOH at 1-877-485-7316.

To find out if a lake has a toxic algae advisory, go to the Health Department's website, at www.tpchd.org/toxicalgae. You can also sign up on the website to receive email notice of advisories as they are issued. For more information on Ecology's Freshwater Algae Control Program, go to <http://www.ecy.wa.gov/programs/wq/plants/algae/index.html>. For more information, see the websites of DOH <http://www.doh.wa.gov/ehp/algae/default.htm> and CDC <http://www.cdc.gov/hab/cyano bacteria/default.htm>.

Paralytic Shellfish Poisoning

Paralytic Shellfish Poisoning (PSP) is a serious concern in Puget Sound. In 2000, nine people in the Gig Harbor area became ill after eating contaminated shellfish and five required hospitalization. Fortunately, fatalities were avoided.

Common symptoms of PSP, which may begin within minutes of eating the shellfish, include tingling lips and tongue which spreads to the fingers and toes. In severe cases, victims have difficulty breathing and require immediate hospitalization. If any symptoms are noted, it is important to induce vomiting.

Paralytic Shellfish Poisoning is caused by eating shellfish containing a potent neurotoxin produced by a naturally occurring plankton. Under favorable conditions, the plankton reproduces rapidly to form large blooms that

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“Gently” managed care (America’s Health Insurance Plans annual meeting)

Health plans say they want to see healthier patients and more efficient physicians, and that offering education and guidelines is one way to do that. The skeptical audience, however, wonders if it’s all about money

Health plans are moving away from care and into “care management.”

Knowing that they don’t inspire trust, but that physicians do, insurers want to make physicians messengers for health plans, improving members’ health to save money. But they also want to prompt doctors to change their own behavior for even more savings to the plan.

“Health plans are realizing they have to work with the trusted brand of the physician,” said Dennis Schmuland, MD, a family physician who is the health plans industry solutions director for the U.S. Health and Life Sciences Group at Microsoft.

The difference between care and care management, proponents say, lies in enhancing the role of the physician — at worst in a superficial sense, and at best in a way that allows the physician to make good decisions without interference.

At the annual meeting of America’s Health Insurance Plans, held in San Diego in June, some of the flashiest, biggest booths — one offering martinis, another offering California wine — were hosted by firms vying to sell health plans the perfect care-management tool.

All promised a means to gently, effectively use physicians to change patient behavior in a way that doesn’t alienate either the patient or physician, and results in savings for the insurer.

Some vendors, such as Emeryville, Calif.-based MedeAnalytics, offer software packages for hospitals and health plans. Other firms have integrated care-management prompts into existing products. Boston-based American Well, for instance, has integrated prompts into its portal for online medical visits.

“What we see in the market is a proper evolution: You have to keep the doctor in the center,” said American

Well President and Chief Executive Officer Roy Schoenberg, MD. “Patients viscerally say, ‘I need to see a doctor.’”

In many cases, care-management systems can be integrated into a health plan’s Web page and are automated. So when staff at the front desk run an eligibility check, the system produces reminders and suggestions, such as, “This patient’s record shows some signs that she has a history of depression. Consider giving her a depression questionnaire as part of this visit,” or, “This patient is due for a mammogram. Please schedule an appointment soon.” Those messages could show up in an e-mail, a text message or a window on a doctor’s handheld computer.

“It’s kind of catching the patient at the moment of truth,” said Ted Ryan, vice president of sales for ZeOmega, a Frisco, Texas-based care-management system company. “You’ve got the data and got the patient in front of you. Before, it would have been a letter after the fact, or the ability to extract that data and push it back into clinic just wasn’t there — that was a daylong project.”

Doctor skepticism

But physicians may not be easily convinced that health plans are interested in “care management” for the right reasons, or that health plans can improve the system.

“I think it’s a waste of money and not helpful,” said Joseph W. Stubbs, MD, an internist from Albany, Ga., who is president of the American College of Physicians.

“So many times, their information is erroneous and irrelevant, because they don’t have access to the clinical record,” he said. “I can’t tell you how many pieces of paper I have that say have you considered this or that.”

It would make more sense, he said, to pay doctors directly to manage care rather than hiring a third company to deliver messages from the health plan to the patient.

Short of that, he said, for any health plan communication to be effective, it should be initiated by the physician, completed electronically and linked to a clinical record, not just claims data.

Health plans and vendors of care-management systems said they know the problems. Doctors are overwhelmed with information, most of which comes at the wrong time, the wrong way or both.

Rather than simply using a preapproval requirement, “when a physician does make a request for advanced imaging or prescription, why not deliver the evidence-based guidelines side by side with the approval?” Dr. Schmuland asked.

There is also the credibility problem. Doctors don’t always trust clinical information handed to them by health plans, so the health plans need a third party to provide objective clinical evidence that will sway doctors to do the right things. That’s where the care-management companies say they come in.

They try to stress to doctors that they’re not all about money. Instead, they pitch how their systems focus on quality measurement based on established standards. Some also use systems that integrate the practice record. For example, MEDdecision, a subsidiary of nonprofit Blues plan holder Health Care Service Corp., uses electronic health records as touch points for advising physicians, hospitals, health plans and patients. It identifies “gaps in care” and passes that information on to doctors in a nonintrusive way.

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Brothers Four to headline PCMS Annual Meeting

Wednesday, December 2 – mark your calendar for the 2009 PCMS Annual Meeting. As always, this event will offer a festive night of socializing with friends, great entertainment and of course a great dinner at the Fircrest Golf Club.

The Brothers Four will entertain as they have been doing for 40 years. Their repertoire includes tunes of old and new, including This Land is Your Land, Yellow Bird, etc. . . . And, for those who have not heard their music, you can check them out online at www.brothersfour.com and go to the sound clips section to hear a selection of their songs. Then come see them in person!

Other features of the night will include the very popular raffle that benefits the PCMS Foundation, presentation of the PCMS Community Service Award, as well as the change of officers for 2010.

Watch your mail for program details and we look forward to seeing you in early December. ■



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Scott Storrer, president and chief operating officer for MEDdecision, said many physicians in focus groups hosted by the company said they would pay for the system themselves because they found it so useful.

Care-management companies also say they could solve one of health insurers' big quandaries: how to use the vast amount of information they hold — claims data about members' hospital stays, visits to the doctor, prescription drugs — to cut costs and improve care.

Over the past five years, some health plans have tried sending the information and tools they own straight to members. The idea is that motivated patients spending their own money will search for value, educate themselves and act in their own best interests while driving quality and efficiency.

It's still in play, but it hasn't worked out as quickly or as well as some had hoped. Consumers have proven difficult to reach, they don't have the information they want, and, despite sometimes having good information, they still don't always make the best choices.

"I think there's less belief that it really is just a health-plan-to-consumer interaction that's going to make the difference," Dr. Schmuland said. "There's recognition across the industry that health care is a collaborative team process, and that to really have the long-term impact in reducing chronic disease and improve health, that requires more than just giving information to the consumer."

Not insignificantly, care-management companies say health plans are willing to pay doctors for their time and attention, either under a capitated payment system or a fee-for-service arrangement as part of pay-for-performance programs.

Proponents say that under a health plan's care-management system integrated into its existing portal, doctors would be prompted at the time of care to follow pay-for-performance guidelines. Tracking success would be simpler, and the clinical rationale for the pay-for-performance incentives would be delivered to the doctor at the time of care. "As annoying as pay-for-performance can be, physicians know it's coming, so the more opportunity they can have to get access to data [that supports payments], the better," said Terry Fouts, MD, chief medical officer for MedAnalytics.

Beyond paying for doctors to follow health plans' advice, those in the field said health plans also are figuring out that much of their success depends on the tone of their communications.

The key to getting doctor buy-in is in how the message is framed, said Matthew Zubiller, business leader for advanced diagnostics management for McKesson, which owns InterQual, one of the oldest care-management tools. "Physicians don't mind being asked questions, but not stupid questions," he said. "This is about engaging the health care provider in a different way." ■

Reprinted from AMNews, August 10, 2009

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Dr. Joseph Sam, PET/CT and Nuclear Medicine Radiologist

TPCHD from page 10

may be manifested as "red tide." Their toxin accumulates in filter-feeding shellfish such as clams, oysters, and mussels and is not destroyed by cooking or freezing. Shellfish containing high concentrations of the toxin do not look or taste any different than shellfish free of the toxin. Despite the "red tide" moniker, water color provides no indication of toxicity. The only way to detect toxins is by laboratory testing.

The DOH regularly tests shellfish samples throughout Puget Sound. In Pierce County, samples are collected locations such as Sunrise Beach County Park, Narrows Bridge Park, Penrose Point State Park, and the Vaughn Bay Sandspit. Sampling is conducted year-round but focuses on the summer months when PSP concentrations are likely to be higher. Signs may be, but are not always, posted at the larger public beaches when it is not safe to harvest shellfish. Since conditions can change rapidly, it is extremely important to find out shellfish closure areas before collecting by calling the DOH

Biotoxin Hotline at 1-800-562-5632 or checking online at <http://www.doh.wa.gov/ehp/sf/biotoxin.htm>. Current PSP information in Pierce County is also available from the Health Department Shellfish Message Line at (253)798-3767.

You can learn more at the DOH website above or at the CDC Marine Toxins page at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/marine_toxins_g.htm

In summary, our abundant natural resources provide a rich variety of opportunities for recreation and sustenance that make the Northwest a great place to live and raise a family. However, these resources are not without risk and care must be taken to stay safe and healthy. Residents may encounter problems with sun, insects, food, and water, and in this article I have focused on water safety, waterborne illnesses, toxic algae, and paralytic shellfish poisoning. The Health Department is available as a partner to keep our residents safe and healthy. ■

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Physicians Insurance A Mutual Company Announces a \$5 Million Dividend Distribution to Physician Owners

The Board of Directors of Physicians Insurance recently announced that the company will distribute \$5,000,000 in dividends to eligible members in September 2009. Those eligible will receive a pro rata share of the total dividend based on their individual premium written from January 1, 1982, through September 1, 2009. Physicians Insurance is a mutual company, where the physician insureds are owners who share in the company's success.

The company's success comes as a result of sound fiscal and risk management practices, including strong capitalization, conservative reserves, aggressive claims defense, and fair and reasonable claims costs. "The dividend is one way of saying 'thank you' to our dedicated physician owners who contribute to the strength of Physicians Insurance," said Mary-Lou A. Misrahy, ARM, president and CEO of the firm.

James P. Campbell, MD, chairman of the board at Physicians Insurance, attested that the dividend is also a reflection of physician-owner members' low loss experience that contributes to the impressive profile of the company's retained capital. "The dividend distribution is only one of many ways the company rewards its members. We practice patient-focused care that results in lower claims," he said.

In addition to the dividend as a means of rewarding members for the company's outstanding performance, premium credits are available to insureds through exclusive programs, including ACCOLADES™, the company's loss experience credit, now available in all service territories. Physicians Insurance also rewards members with premium credits based on their specific practice profiles.

In keeping with the company mission of providing insurance coverage at the lowest possible cost consistent with sound financial and insurance practices, Physicians Insurance is rewarding eligible members for participation in their mutual company. "We are owned by physicians and we operate for physicians," Ms. Misrahy said. "This dividend distribution shows our commitment to operating a medical liability insurance business that respects this fact. That's the value of buying from a mutual company."

Physicians Insurance A Mutual Company, a Washington-based provider of medical professional liability insurance coverage, is composed of more than 5,700 owner physicians in the states of Washington, Idaho and Oregon. Founded in 1981, the \$355 million firm has grown to be the largest insurer of physicians in Washington State. Physicians Insurance holds an A- (Excellent) rating by A.M. Best Company, the world's leading insurance-company rating agency. Physicians Insurance maintains corporate headquarters in Seattle, with regional offices in Spokane and Portland.

The following are commonly asked questions regarding the \$5 million dividend distribution.

Who is eligible for the dividend?

Those eligible include Physicians Insurance physicians or other persons with individual limits of liability policies in force on September 1, 2009. Exceptions are those insured under an extended reporting endorsement, a policy subject to a retrospective rating plan or a policy rated on per visit or full-time equivalent basis.

I am insured on a per visit rated policy. Will I receive a dividend?

No, only insureds for which premium is calculated on individual exposure will receive a portion of this distribution.

How is the dividend calculated?

Eligible recipients will receive a pro rata share of the \$5 million dividend, based on their medical professional liability premiums written from January 1, 1982 through September 1, 2009. Minimum dividend payments are \$100.

Is my dividend taxable?

No. The dividend is classified as a return of premium. Therefore, it is not a taxable event. We recommend that you discuss your dividend payment with your tax advisor as to any concerns you may have about IRS implications.

Can I apply my dividend to future premium?

Yes, you may return your dividend check to Physicians Insurance to apply to future premium, if you wish.

I am on a group policy. How will my dividend be paid?

Members covered on our Healthcare Facility Policy form (usually our larger clinic insureds) will receive their dividend as part of one check paid to the clinic. An itemized accounting of the dividend attributable to each insured will be included with the check.

I am part of a group but I have my own individual policy. Will my dividend check be paid to the group?

No, members insured on their own individual policy will receive a check payable to that insured individually.

My group has a deductible. Are we eligible for the dividend?

Yes, policies with a deductible are eligible to receive a dividend allocation.

If you have any further questions, please call Physicians Insurance in Seattle at (206) 343-7300 or 1-800-962-1399. ■



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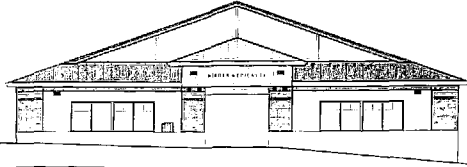
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Internship: USC Medical Center

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

Continuing Medical Education

New Approaches to Common Medical Problems in Primary Care

New Approaches to Common Medical Problems in Primary Care will be held on Friday, October 2, 2009 at Fircrest Golf Club under the medical direction of **Mark Craddock, MD**. Course hours are from 8:00 am to 3:15 pm and will offer 6 hours of Category 1 CME.

This one-day conference will provide comprehensive updates of selected topics in general internal medicine and primary care which are critical to the practicing physician. Teaching methods will include lectures, case presentations and question and answers with faculty. Practical and evidence-based approaches to treatment will be included. This course is appropriate for family practice, general practice and internal medicine physicians and will also be of great interest to physician assistants.

This year's topics and speakers include:

- Ovarian Cancer Update Michelle Benoit, MD
 - Red Eye: When to Treat and When to Refer Keith Dahlhauser, MD
 - Hypertension: An Update for the Office Practice Eugene Yang, MD
 - An Update on Advances in Cardiovascular Diseases Read Fahmy, MD
 - Spine Pain Intervention Techniques Jay Iyengar, MD
 - Prostate Cancer: Options & Management John Corman, MD
- (See "Common Office Problems" page 18 for program objectives)

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is \$60 for PCMS members (active and retired) and \$85 for non-PCMS members. ■

Infectious Diseases Update

This year's *Infectious Diseases Update* will be held on Friday, November 6, 2009 at Fircrest Golf Club under the medical direction of **Elizabeth Lien, MD**. The program begins at 8:00 am and adjourns at 3:15 pm. Six hours of Category 1 CME are offered.

This clinically-oriented course is designed specifically for the primary care and internal medicine physician interested in an update on the diagnosis, treatment and prevention of common infectious diseases of adults. It will provide a comprehensive overview of infections seen in the ambulatory practice with an emphasis on areas of controversy and new developments in this field.

This year's topics and speakers include:

- Prevention of Inf. Diseases in the Primary Care Setting Romona Popa, MD
 - Vaccine Update: Swine Flu and Beyond! Lawrence Schwartz, MD
 - Infections of the Central Nervous System Elizabeth Lien, MD
 - Lyme Disease Quackery David McEniry, MD
 - Infectious Disease Challenges in the 21st Century Laurel Preheim, MD
 - Prosthetic Joint Infections:
 - It's More Common Than You Would Think! Olympia Tachopoulou, MD
- (See "Infectious Diseases" page 18 for program objectives)

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is \$60 for PCMS members (active and retired) and \$85 for non-PCMS members. ■

Common Office Problems from page 17


Program Objectives: At the end of the conference participants should be able to:

- Understand and discuss ovarian cancer (non-screening, BRCA positive patients and breast cancer patients for risk reducing BSO).
- Identify common causes and treatments of red eye and recognize when to treat and when to refer for specialty care.
- To discuss recent clinical trials and how they may impact our treatment of hypertension in the office.
- Understand and discuss direct Renin Inhibitors: Learn about this new class of medication for hypertension; indication and contraindication. Percutaneous aortic valve replacement. Who qualifies? Where to do and new indications for biventricular devices for CHF.
- Understand methods for treating spinal pain secondary to osteoarthritis including radicular pain from the neck and back.
- Relate the differences in prostate cancer options and review the most important clinical aspects in the diagnosis, evaluation and management of patients with prostate cancer. ■

Infectious Diseases from page 17

Program Objectives: At the end of the conference participants should be able to:

- Understand and recognize many infectious diseases that can be avoided by preventative measures in the primary care setting.
- Understand and discuss current vaccine updates.
- Discuss and review the differences between viral and bacterial infections and understand how to treat and manage the infections. Understand the epidemiology of various central nervous system infections.
- Recognize legitimate diagnostic treatment modalities for Lyme disease.
- Be familiar with and outline new and re-emerging infectious diseases.
- Recognize and discuss joint infections and better understand the differences in management of early versus late prosthetic joint infection. ■



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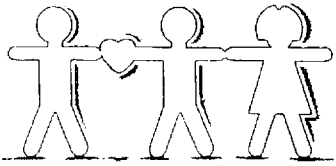
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BULLETIN

Pierce County Medical Society



October 2009

PCMS Delegates participate in WSMA Annual Meeting in Spokane



Pictured left to right: Speaker of the House Dr. Richard Hawkins; Drs. Dan Ginsberg, Steve Duncan, Mike Kelly, Steve Konicek, Len Alenick, Sumner Schoenike, Ron Morris, Mark Grubb, Patricia O'Halloran, Bill Hirota, Nick Rajacich and PCMS President Dave Bales. Participating but not pictured: Drs. Anthony Chen and Don Russell

See story page 11

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Pierce County Medical Society

BULLETIN



October 2009

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

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President's Page

by J. David Bales, MD

A Physician's Lament



J. David Bales, MD

Almost daily I hear some opinion on the current Health Care Reform debate. These range from leaving things the way they are ("the system is not broken") to completely revamp everything ("the system is completely broken"). Included in these opinions are suggested solutions to some part of the debate – Electronic Medical Records, Single Payer System, Tort Reform, etc. All have lengthy and detailed arguments for or against any particular aspect of the debate. The legislation is over 1000 pages long (the original Medicare legislation was two pages!) – extrapolation of all of the unintended consequences of the Medicare legislation to the current legislation boggles the mind.

At the risk of being accused of step 1 of the Shiva factor (for those who didn't attend the WSMA Leadership Conference this year – see Seminars in Anesthesia, Perioperative Medicine and Pain (2007)26, 158-166), namely "Posturing" – the Socratic appeal to authority – I will point out that I have worked two thirds of my nearly 40 year career in a "Socialized Medicine" system (Government owned, budget driven, on salary) and one third in a "Fee For Service" system (Private, productivity based, revenue driven, compensation formula). These two systems represent the opposite ends of the spectrum in terms of organizational structure and management – I term them "budget driven" and "revenue driven." I have also been a patient in the British National Health Service and on the receiving end of a frequently referenced "Socialized Medicine" system.

My current opinion of 99% of the current debate and my current opinion of the two ends of the spectrum of "systems" is that they don't address the underlying problem – one that I expressed in my early pages this year – namely, they don't even hint at how we can do more and better with less resources. Everyone is scrambling to finance a growing gap between what money exists and what money is likely to be spent under any given scenario – and none of the scenario's project decreasing expenditures or increased resources.

How can this be done? I have suggested that using quality improvement techniques in a systematic fashion is the solution but examples of successful implementation of this strategy are few and far between and I have personally only read about them. The closest personal participation in this methodology has been on fragmentary "projects" that faded more quickly than they took place. Results were never systematized or used as a stepping stone for "continuous improvement" and no one has pushed the methodology to the "culture" level where everyone making decisions does so based on data derived from a continuous process of improvement. It has been frustrating and disappointing to say the least.

I can hope that the outcome of the current efforts will follow a more productive path but I don't have the illusion that it will. The medical profession has to take a lead in doing it and it will have to start where each of us is now. To paraphrase Ghandi – we have to become the change we seek in the world. ■

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The Tacoma Trauma Center Celebrates its Ninth Year...and says goodbye to two individuals instrumental to its success

Dr. Mike Newcomb was instrumental in the creation of the Tacoma Trauma Center and Tacoma Trust and an active member of the Trust's board for several years. Just prior to leaving his position in July as senior vice president and chief medical



Mike Newcomb, MD

officer for Franciscan Health System (he'll be heading to a new professional adventure with Legacy Health, a hospital system based in Portland), he spoke to the Pierce County Medical Society. **Dr. Lori Morgan**, trauma director since 2001, also recently departed to join Legacy Health.

In June 2000, Tacoma General Hospital and St. Joseph Medical Center were jointly designated as adult Level II trauma centers serving Pierce County. Since that time, a team of dedicated trauma surgeons and physician assistants, along with a community of subspecialists, have provided Pierce County citizens with the quickest possible access to quality trauma care. Despite initial



Lori Morgan, MD

resistance and concerns about the Center's operating model (the two systems alternate as the trauma receiving hospital every other day, while Madigan Army Medical Center, also a state-designate adult Level II trauma facility, operates concurrently 24/7), the Tacoma Trauma Center has surprised naysayers and surpassed expectations. Volumes have been higher than expected, mortality data and complication rates hold up to any trauma system in the country, and the Center's referral rate to Harborview has gone down every year.

"The Trauma Center happened because physicians in the community saw a need for the system and understood that it couldn't be the same as it was before, resting on the backs of private-practice physicians," Dr. Newcomb explained. But getting it off the ground wasn't easy. "It took three full years of hard work to get it up and running," he said. The team looked at several models before choosing one shared between Tacoma's health systems. The Tacoma Trust was created to administer the program. "It took a lot of time and legal discussion, but it came to pass through hard work on numerous fronts. It was all about the willingness of community physicians – specialists and otherwise – to look at the new model and work with it. And indeed they did. The physicians have done a phenomenal job of stepping up, and I'm honored by

their efforts. And we have trusted their clinical judgment. When there are cases they can't manage, we make the clinical decision to send them out."

Two Systems Working Together

Dr. Lori Morgan said the collaborative effort between hospital systems is key to the center's success. "This has been and continues to be a huge medical community effort, and I'm confident in the Trauma Center's continued success and outstanding service to Pierce County," she noted.

Dr. Newcomb concurred. "Working collaboratively with an organization that's competitive, we were able to do a lot in 10 years. The two systems are working for the community, doing things we could not have accomplished independently. Trauma care and the Carol Milgard Breast Center are two wonderful examples of how we can be better when we collaborate. The organizations will continue to be competitive, and that's good. But we are collaborating when necessary to improve systems and quality of care."

Pigs are Flying!

Dr. Newcomb says there have been many heartwarming moments over the last nine years, "particularly in regard to patients we've seen who would not have made it to Seattle if they needed to be transferred. "Among the highlights of his tenure here occurred during a state certification process. "The physician heading the team initially made a comment that the system would be successful only when pigs fly. After the certification process, he said, 'All I can say is pigs are flying in Tacoma.' That was fabulous! What we had created was about working together toward a common goal, and at that moment it became clear that it really works. That was very gratifying for me."

Looking Ahead

"We have a very mature system today," Dr. Newcomb explained. "I don't see any major obstacles for continued services. We do need to be aware of continued growing volume and further pressure from outlying communities. It's going to be a challenge, and I'm concerned about meeting demand. But personally, I think the challenges will be met."

As he leaves Pierce County behind and looks toward a whole new set of challenges as senior vice president in charge of Legacy Health's medical group, Dr. Newcomb said he is honored to have been a part of this medical community. "I've worked with the most dedicated physicians and other health care providers anyone could imagine," he noted. "These individuals keep providing ever better quality care and services in an era of restrained resources. It amazes me, and my hat is off to the medical community. They understand why we went into health care." ■

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PITUITARY TUMORS

Presented by Daniel Silbergeld, MD

October 20, 2009

About the presenter: Dr. Silbergeld received his medical degree from the University of Cincinnati. He completed his residency in Neurological Surgery and fellowships in both Neuro-Oncology and Epilepsy Surgery at the University of Washington, where he serves on the faculty of the Department of Neurological Surgery. He is Chief of Neurosurgery at the University of Washington Medical Center.



MINDFULNESS BASED STRESS REDUCTION II — REVIEW OF NEUROBIOLOGY AND EVIDENCE-BASED MEDICINE

Presented by John Wendt, MD

November 17, 2009

About the presenter: Dr. Wendt earned his medical degree from the University of Michigan and completed his neurological residency at the University of Colorado. Board certified in Neurology with sub-specialty certification in headache medicine, he served on the faculty of the University of Texas Health Sciences Center in Dallas for eight years before entering private practice in Federal Way in 1988. Dr. Wendt has special interest in, and has taught, mindfulness-based stress reduction (MBSR).



CAFFEINE AND COFFEE: THEIR EFFECTS ON HUMANS AND INFLUENCE UPON HISTORY

Presented by David Brown, MD

December 15, 2009

About the presenter: Dr. Brown earned his medical degree from the University of Arkansas for Medical Sciences and completed his residency at Walter Reed Army Medical Center. Board certified in neurology and sleep medicine and certified by the United Council for Neurologic Subspecialties in neuroimaging, Dr. Brown serves as the Medical Director of the St. Francis Sleep Disorders Center and practices at the Federal Way Neurology and Headache Clinic.

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In My Opinion

by David Cameron, 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 \$30,000 Bottle of Insulin: Who Pays the Price for Our Failing Health Care System?



David Cameron, MD

It's easy to identify the inefficiencies and ineffectiveness in our health care system. Working in a community health clinic, I see daily the dramatic effects of having a health care system with over 35 million uninsured Americans (plus 9 million uninsured foreign nationals). But you don't have to work in the medical field to experience the scope of this problem. Many receive office emails asking for assistance from coworkers in times of need. Churches field prayer requests regarding financial hardship due to medical bills. Many Americans are flocking to free clinics and are opting for only catastrophic coverage health care plans because this is their only option. In an economic downturn such as the one we are now experiencing, even more Americans lose their insurance coverage. The uninsured masses, like an 800 pound gorilla in the room, simply cannot be ignored.

Let me tell you a true story that represents just a single hair from that gorilla. Out of work for over a year and unable to pay his COBRA premiums, John unavoidably joined the ranks of the uninsured. Unfortunately, because John is a diabetic, the cost of doctors' visits, lab tests, test strips, lancets, syringes and insulin were overwhelming, and he quickly burned through his meager savings. One day, he was denied the insulin he needed at the pharmacy because he didn't have the \$20 for the bottle. While he was attempting to scrape together the cash for his insulin

he became hyperglycemic, dehydrated and finally profoundly acidotic. Later, he was found by one of his friends lying on the floor of his apartment, non-responsive and nearly dead.

Thankfully, his friend called 911, and John was rushed to the hospital where he was admitted to the ICU because of his severe diabetic ketoacidosis. After more than a week in the hospital, John's condition stabilized, and he was released to go home with a bill for over \$30,000 that he would never be able to pay.

Subsequently, he became my patient at Community Health Care and was able to get his doctors' visits, labs, diabetic supplies and insulin more affordably on a sliding scale. Even though John was able to receive the care that he needed from our clinic, the number of uninsured patients in America vastly exceeds the capacity that can be served by community health clinics. This story is just another classic example of how we can have such an expensive health care system, yet so many Americans are unhealthy because they fall through the cracks.

John's story illustrates the following:

- Lack of insurance leads to poorer health. This is a fairly obvious fact, but it's often overlooked or under-appreciated since we have not yet made any meaningful strides in reducing the number of uninsured patients. Uninsured families are 9-10 times more likely to

forego health care. This lack of preventive care in uninsured patients results in diseases that are more advanced and difficult to treat when they finally do seek medical treatment.

- Treating uninsured Americans is expensive for all of us. It is not only expensive for uninsured families, but also for hospitals and taxpayers. Even if patients go to the Emergency Room for their care and cannot pay for it, someone has to absorb those costs. Let's think about my patient, John. Surely a man who cannot afford a \$20 bottle of insulin will not be paying off a \$30,000 hospital bill. Many of our uninsured patients generate hospital bills large enough so that they qualify for Medicaid, which will then pay their medical expenses. Although there is concern that health-care reform will be expensive for taxpayers, we must remember that the current system is already rapidly depleting taxpayer dollars.

Primary Care needs in a Health Care System

The best way to cut costs for taxpayers and individuals is to offer those who are currently uninsured access to a primary care physician. This is true for two reasons:

- 1) Coverage for preventive care and basic medical needs. How did the cost of a \$20 insulin bottle turn into a \$30,000 hospital bill? Because a patient was denied inexpensive primary care. Coverage

See "Price" page 8

Price from page 7

for preventive care and basic medical needs would radically improve the health of Americans. Health concerns would be addressed in a more timely and cost-effective manner. Providing coverage for preventive care and even the very basic medical needs such as a few clinic visits a year, coverage for x-rays, lab tests and a limited medication formulary would significantly reduce costly ER visits and hospitalizations. Patients could get access to care before the illness has progressed to the point of being more difficult and expensive to treat.

2) Patients need a patient-centered medical home. This is the place where one primary care provider coordinates the patient's overall health care. Patients have open access to their clinic and can see their regular medical provider instead of having to go to the Emergency Room to be seen for their cough or urinary tract infection. With a

patient-centered medical home, there is an emphasis on health information technology and best medical practices to promote quality while curbing costs. Medications prescribed from multiple doctors are reviewed by each patient's personal doctor in order to prevent drug interactions. Just like in a good kitchen, it is best to avoid having eight cooks trying to spice the chili at one time.

The 800 pound gorilla is looking us straight in the eye. The one thing we can't do is to ignore the problem. As a nation, each day we do nothing costs us dearly—in taxpayer dollars and, ultimately, in the needless suffering and shortened lives of our fellow citizens. ■

David Cameron is a Family Physician at Community Health Care in Lakewood, WA and co-author of The Rest of Health.

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The Health Status of Pierce County

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

Old and New Challenges for Immunizations, Part 2



Anthony Chen, MD

Two months ago, I wrote of how—in one of the great successes of modern medicine—immunizations have prevented countless illnesses and deaths from infectious diseases. Amazingly, all this started with a country doctor in England, Edward Jenner. Dr. Jenner built on folk knowledge of the protective effect of cowpox to develop a vaccine against smallpox in 1796, paving the way to the elimination of smallpox in 1977. In fact, the word “vaccination” derives from the Latin *vaccinia* for cowpox, which in turn is derived from *vacca* for cow. To give perspective to the magnitude of the problem, 400,000 people died annually of smallpox in 18th century Europe. The case-fatality rate was 20–60% and higher in infants—80% in London and 98% in Berlin in the late 1800s. A 1721 smallpox epidemic in Boston infected half of the population of 12,000 with a fatality rate of 14% (1,2).

History often repeats itself, although for different reasons. There were public fears of inoculations even then. Variolation—inoculation with the pus of smallpox lesions—was an ancient practice to protect against smallpox. While effective (in the 1721 Boston epidemic, the mortality rate of those variolated was only 2%), variolation was known to cause fatal smallpox 2–3% of the time, spark epidemics, and transmit bloodborne infections like syphilis. While Jenner’s vaccination technique had none of these consequences, it had to fight the fear of intro-

ducing foreign animal products into the body, and the additional fear that it might turn people into cows.

Today, concerns about vaccine safety are again an issue and are contributing to an erosion of our gains in immunization. Parents are always trying to do the best for their children; however, this intention is molded by their beliefs, information sources, assessment of risk, and practical issues. Beliefs and attitudes towards immunization may be religious, philosophical, political, social, personal, or any combination. The diversity of information sources—print and broadcast media, the internet, word-of-mouth—means the public is bombarded by a babel of information. Since the level of health literacy varies, the public can find it challenging to assess the accuracy of the information. Since immunizations have been so successful, parents erroneously perceive that infectious diseases are not serious and that the risk of infection is very low; they instead focus on the possible risks of adverse reactions. Lastly, many practical issues may create barriers: cost, insurance (or lack of it), availability of doctor’s appointments, misplacement of shot records, and so on.

One marker for “vaccine hesitancy” is the increase in requests for exemptions from school entry immunization requirements. From the 2002–03 to 2008–09 school years, the exemption rates rose from 4.1% to 7.6% in Washington State and from 2.9% to 6.2% in

Pierce County. County exemption rates vary from less than 2% to more than 10%. Among Pierce County’s 15 school districts, exemption rates during the 2007–2008 school year varied from 1.5% to 9.3%. Washington is one of the easiest states in the country for parents to obtain exemptions and over 90% of those granted are for personal belief rather than medical or religious reasons.

Why are we concerned about exemption rates? Using measles as an example, we usually consider that when 95% or more of a group is immunized, there will be “herd immunity” that protects susceptible individuals and prevents isolated infections from becoming outbreaks. You can see that exemption rates in some of our schools have caused the immunization level to drop below 95%. In other states, outbreaks of measles and pertussis have occurred in schools with exemption rates as low as 3%, with those claiming exemptions (ages 3–18) being 22 times more likely to acquire measles and 6 times more likely to acquire pertussis than vaccinated children. For the younger children (ages 3–10), the risks were 62 and 16 times respectively (2,3).

In the past two years, there have been two pertussis outbreaks in Washington. San Juan County (K–12 exemption rate of 12.0% in 2008–09) experienced an outbreak of nearly 100 pertussis cases from October 2007 to March 2008. Nearly half the exposures occurred in schools and pre-schools. Is-

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land County (K-12 exemption rate of 11.4% in 2007-08) experienced a pertussis outbreak of 91 cases last summer, mostly in children 5-13 years of age who were exposed during sporting events.

Again, this is a situation where physicians and the Health Department can work in partnership, both through policy and directly with patients.

At the Health Department, we are closely monitoring the immunization rates in Pierce County schools. Based on Clover Park School District's successful efforts to keep their non-medical exemption rates low, we have developed a model school vaccination policy and are working with other school districts on implementation.

Last year, the Pierce County Medical Society, with support from the Health Department, sponsored a Washington State Medical Association resolution calling on the Legislature to require documented discussion of the risks and benefits of vaccination with a licensed medical provider before an exemption

can be issued. The bill passed one house of the Legislature but bogged down in the other with amendments. We hope that the bill will be reintroduced next legislative session with the support of the medical and public health communities.

As physicians, you have unique opportunities to address parents' concerns and help them make good decisions for the health of their children and the community. Remember that parents generally want the best for their children and their decisions are molded by their beliefs, information sources, assessment of risk, and practical issues.

A recent Center for Disease Control and Prevention (CDC) training session recommends the following communication strategies (5):

- Use the 5 C's: chemistry, clarity, consistency, credibility, and caring.
- Establish rapport, communicate, and build trust.
- Ask about parents' experiences and listen with empathy to their concerns.

- Provide your own vaccine safety experiences.

- Tell actual adverse consequences of individuals who were not vaccinated.

- Relate efforts to assure vaccine safety.

- Advise about normal, local responses and what to do if a severe adverse reaction occurs.

That presentation and many other resources are available online (see references and Provider Resources at end of article).

Currently, vaccine safety concerns widely spread in the media and internet can be broken into two themes: worries over an increased risk of autism and of "overloading" the immune system.

Sometimes providing facts can be helpful. For example, to address concerns of overloading the immune system, it may help to point out that modern vaccines are much more specific and contain only a small fraction of the

See "TPCHD" page 12

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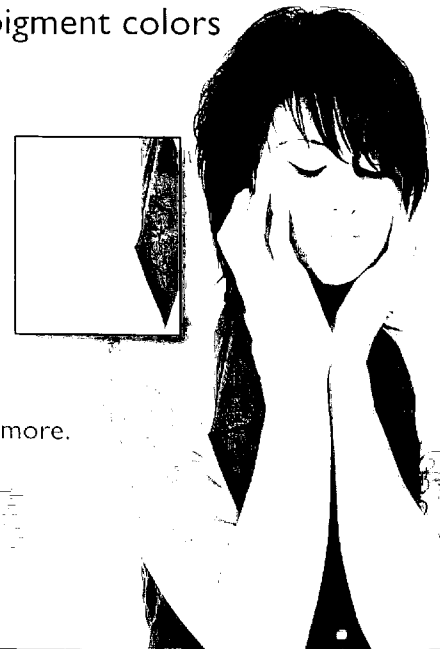
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PCMS members participate in WSMA Annual Meeting in Spokane

PCMS members **Drs. Anthony Chen, Dan Ginsberg, Steve Konicek, Patricia O'Halloran, Summer Schoenike** and Board of Trustee members **Drs. David Bales, Steve Duncan, Ron Morris, Mark Grubb** and **Bill Hirota** joined WSMA Representatives **Drs. Len Alenick, Richard Hawkins, Mike Kelly, Nick Rajacich, Don Russell** (and Ron Morris) in representing Pierce County at the WSMA Annual Meeting in Spokane October 2-4. All served as Delegates and had voting privileges on the House of Delegates floor.

There was lively debate and discussions on many resolutions ranging from support for a continued Universal Vaccine Purchase and Distribution system to support for taxation and regulation of marijuana – which were adopted and not adopted respectively by the House of Delegates.

The 2009 Business plan for the association was approved and includes the organizational priorities which are:

- To make Washington a better place to practice medicine and to receive care;
- To support a medical practice environment that serves the needs of the public and profession;
- To strengthen the ability of the WSMA to provide value to its members.

There was debate and discussions around health care reform as well as medicine's organizational relationships. There was strong support for county medical societies and the state medical association to work collaboratively and to include ALL physicians in the organization's leadership structure and not follow a path that would exclude any specific practice type from serving in a leadership capacity. The House also approved a resolution calling for a significant reduction in WAMPAC dues from \$250 to \$25, which included an option to direct that \$25 to WAMPAC or the tax exempt WSMA Foundation, and an additional \$25 increase in WSMA dues. WSMA dues were last increased five percent to \$485 in 2004.

PCMS extends a huge thank you to all delegates for their personal contribution of valuable time to participate in the WSMA Annual Meeting. ■

Spokane Pediatrician named WSMA President

Nicholas Rajacich, MD elected 1st VP

Dr. Deborah J. Harper was elected president of the Washington State Medical Association (WSMA) at their annual meeting in Spokane. Sunday, October 4. The WSMA represents over 9,600 physicians, residents, medical students, and physician-assistants throughout Washington state.

Dr. Harper is pediatrician at Group Health Cooperative in Spokane. She is also an assistant dean at the University of Washington School of Medicine and oversees UW medical student and residency programs in eastern Washington. Dr. Harper also serves as a consultant pediatrician with Partners with Families and Children in Spokane.

Dr. Harper received her medical degree from the University of Illinois. She completed her pediatric residency at Cook County Hospital in Chicago. She is board certified in pediatrics.

Dr. Harper has held numerous leadership positions at the WSMA and is also a fellow in the American Academy of Pediatrics.

The following physicians were also elected as officers at the association's annual meeting: Dr. Dean Martz, Spokane neurosurgeon, president-elect; **Dr. Nicholas Rajacich**, Tacoma orthopedic surgeon, 1st Vice President; Dr. Michael Weinstein, Seattle rehabilitation hospitalist, 2nd Vice President; Dr. Douglas R. Myers, Vancouver otolaryngologist, Secretary-Treasurer; Dr. Dale P. Reisner, Seattle maternal fetal medicine specialist, Assistant Secretary-Treasurer. The seventh officer of WSMA Executive Committee is past-president, Dr. Cynthia A. Markus, an emergency physician from Snohomish County, who will serve as committee chair. ■



Deborah Harper, MD



Nick Rajacich, MD

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TPCHD from page 10

number of different proteins that vaccines from even the 1980s contained. As a result, although a child now gets more vaccines, the total amount of immunogenic material received is much smaller (6).

However, a journalist analyzing the autism debate points out that facts have their limitations (7):

People relate much more to a dramatic story than they do to facts, risk analyses, and statistical studies. If you discount these stories, people think you have an ulterior motive or you're not taking them seriously...[consider] providing an alternative, science-based explanation or relating emotionally compelling tales about counter-risk in the same narrative format.

Personal stories resonate most with those who see trust in experts as a risk in itself—a possibility whenever people must grapple with science-based decisions that affect them... consider taking a page out of the hero's

handbook by embracing the power of stories—that is, adding a bit of drama—to show that even though scientists can't say just what causes autism or how to prevent it, the evidence tells us not to blame vaccines.

So, in discussing immune system overload, you may be more effective adapting the CDC's suggested response (8):

Children are exposed to many foreign antigens every day. Eating food introduces new bacteria into the body, and numerous bacteria live in the mouth and nose, exposing the immune system to still more antigens. An upper respiratory viral infection exposes a child to 4 - 10 antigens, and a case of "strep throat" to 25 - 50.

Similarly, you may more clearly communicate risk when you discuss recent outbreaks of vaccine preventable disease and mortality rates before vaccination. You can adapt CDC's summary of "Risk from Disease versus Risk from Vaccines" (9):

Even one serious adverse event in a

million doses of vaccine cannot be justified if there is no benefit from the vaccination. If there were no vaccines, there would be many more cases of disease, and along with more disease, there would be serious sequelae and more deaths. But looking at risk alone is not enough. You must always look at both risks and benefits. Comparing the risk from disease with the risk from the vaccines can give us an idea of the benefits we get from vaccinating our children.

Risk from Disease:

Measles Pneumonia: 6 in 100

Measles Encephalitis: 1 in 1,000

Measles Death: 2 in 1,000

Congenital Rubella Syndrome: 1 in 4 (if woman becomes infected early in pregnancy)

Risk from Vaccines:

MMR Encephalitis or severe allergic reaction: 1 in 1,000,000

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Lowering sodium intake could lower health costs

Reducing the nation's collective consumption of sodium could lower medical treatment costs by about \$18 billion a year and improve the quality of life for millions of Americans, says a new RAND Corp. study.

The study estimated that meeting national sodium guidelines could eliminate 11 million cases of hypertension and extend the lives of thousands each year. The findings are in the September/October *American Journal of Health Promotion* (www.rand.org/health/abstracts/2009/palar.html).

The Institute of Medicine recommends that healthy adults consume no more than 2,300 mg of sodium each day and that high-risk groups — including older adults, blacks and those with high blood pressure — consume less. However, using data from the National Health and Nutrition Examination Survey, RAND researchers estimate that U.S. adults consume about 3,400 mg of sodium per day.

"Our results were driven by the fact that 30% of the nation's population has hypertension," said lead researcher Kartika Palar, a doctoral fellow at the RAND Pardee Graduate School in Santa Monica, Calif. "One of the reasons that hypertension is so pervasive is that sodium consumption is so high."

The study is among the first to estimate the economic benefits of lowering sodium consumption among Americans, the researchers said. They added that their estimates are conservative because they were not able to calculate savings for illnesses such as cardiovascular diseases, where sodium consumption plays a less-defined role.

The American Medical Association and other groups have long advocated for food labels and restaurant menus to include sodium content to guide people toward healthier choices. In 2006, the AMA adopted policy calling for a minimum 50% reduction, within 10 years, in the amount of sodium in processed foods, fast-food products and restaurant meals. Studies have found that the largest boost in sodium intake can be traced to consumption of processed foods and restaurant meals, rather than from salt added in home-cooked meals. ■

From AMNews, Oct. 1, 2009

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TPCHD

from page 12

In keeping with the times, CDC has a YouTube video (complete with out-takes at the end), entitled "Get The Picture: Child Immunizations." Consider referring patients to see it, or watch it yourself for a demonstration on communicating and answering questions.

Hopefully, this article has provided you with concrete strategies and resources to help you address vaccine hesitancy and continue promoting immunizations in your practice.

Erratum and Addendum:

After Part I was published, an astute reader, **Dr. David Judish**, called to clarify my statement that there had been no polio cases since 1977 because he treated a case of polio from live vaccine during his residency in the early 1990s. In clarification, the last case of wild-virus polio in Washington was in 1977 as stated in our article; the last case of domestic wild-virus polio in the United States was in 1979. While the live oral polio vaccine (OPV) was used, vaccine-associated paralytic polio (VAPP) occurred sporadically at a rate of one case per 13 million doses of OPV distributed.

There were single cases in Washington in 1991 (Kitsap Co), 1992 (Pierce Co), and 1993 (Benton Co). From 1980-1998, 144 cases of VAPP were reported in the United States; no domestic wild-virus polio cases were reported but there were eight imported cases (10).

Because the risk of VAPP was eclipsing the risk of wild-virus infection, the United States began transitioning to inactivated poliovirus vaccine (IPV) - which cannot transmit polio infection - with a sequential IPV-OPV schedule in 1997 and then an all-IPV schedule in 2000. The last case of VAPP in the United States was reported in 1999. In 2005, a 22 yo college student who never had been vaccinated against polio because of religious exemption contracted VAPP while on an exchange program in Costa Rica.

References:

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<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1200696&blobtype=pdf>

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3) Feikin DR, et al. Individual and community risks of measles and pertussis associated with personal exemptions to immunization. *JAMA* 2000;284(24):3145-3151.

4) Omer SB, et al. Nonmedical exemptions to school immunization requirements: secular trends and association of state policies with pertussis incidence. *JAMA* 2006;296(14):1757-1763.

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See "TPCHD" page 18

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This year's *Infectious Diseases Update* will be held on Friday, November 6, 2009 at Fircrest Golf Club under the medical direction of **Elizabeth Lien, MD**. The program begins at 8:00 am and adjourns at 3:15 pm. Six hours of Category I CME are offered.

This clinically-oriented course is designed specifically for the primary care and internal medicine physician interested in an update on the diagnosis, treatment and prevention of common infectious diseases of adults.

This year's topics and speakers include:

- *Prevention of Infectious Diseases in the Primary Care Setting* - Romona Popa, MD
- *Vaccine Update: Swine Flu and Beyond!* - Lawrence Schwartz, MD
- *Infections of the Central Nervous System* - Elizabeth Lien, MD
- *Lyme Disease Quackery* - David McEniry, MD
- *Infectious Disease Challenges in the 21st Century* - Laurel Preheim, MD
- *Prosthetic Joint Infections: It's More Common Than You Would Think!* - Olympia Tachopoulou, MD

You should have received a program brochure in the mail with registration information or call the College at 253-627-7137 to register over the phone. The fee is \$60 for PCMS members (active and retired) and \$85 for non-PCMS members. ■

Continuing Medical Education

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

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

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

TPCHD

from page 16

7) Gross L. A broken trust: Lessons from the vaccine-autism wars. *PLoS Biol*, 2009;7(5): e1000114. doi:10.1371/journal.pbio.1000114. Available online at: <http://www.plosbiology.org/article/info%3Adoi%2F10.1371%2Fjournal.pbio.1000114> or <http://www.immunize.org/images/dontmiss/journal.pbio.1000114.pdf>

8) <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm#Givingachildmultiple>

9) <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm#risk>

10) <http://www.youtube.com/watch?v=3uVvq7dbf4s>

11) Landaverde M, Salas D, Humberto M, et al. Imported vaccine-associated paralytic poliomyelitis --- United States, 2005. *MMWR*, 2006; 55:97-99. Available for download at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5504a2.htm>

Provider Resources, Vaccine Hesitancy:

- Immunization Action Coalition of Washington (IACW). Addressing Parents' Concerns About Vaccines: <http://www.immunizewa.org/concerns>

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- Centers for Disease Control and Prevention (CDC):

- Some Common Misconceptions About Vaccination and How to Respond to Them <http://www.cdc.gov/vaccines/vac-gen/6mishome.htm>

- Provider's Guide: Helping Parents Who Question Vaccines <http://www.cdc.gov/vaccines/pubs/providers-guide-parents-questioning-vacc.htm>

- Immunization Action Coalition (IAC). Vaccine Concerns: Responding to Concerns About Vaccines: www.immunize.org/concerns/

- National Network of Immunization Information (NNii). Immunization Issues: Vaccine Misinformation: www.immunizationinfo.org/immunization_issues_detail.cfm?id=52

- Children's Hospital of Philadelphia (CHOP) Vaccine Education Center: <http://www.chop.edu/consumer/jsp/microsite/microsite.jsp?id=75918>

Provider Resources, General Immunization Information:

- American Academy of Pediatrics (AAP), Childhood Immunization Support Program (CISP) <http://www.cisp.immunize.org>

- Society of Teachers of Family Medicine (STFM) Group on Immunization Education <http://www.immunizationed.org/>

- Centers for Disease Control and Prevention (CDC), Vaccines and Immunizations: <http://www.cdc.gov/vaccines/default.htm>

- Washington State Dept. of Health (DOH): www.doh.wa.gov/cfh/immunize/

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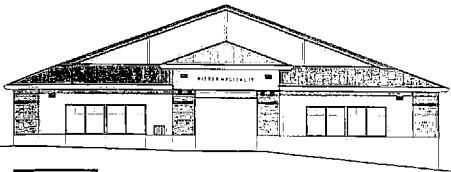
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November 2009



Columbia University College of Physicians and Surgeons

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- 11 TPCHD: "The Needs and the Power of Many" by Anthony L-T Chen, MD, MPH

Pierre County Medical Society

BULLETIN



November 2009

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President's Page

by J. David Bales, MD

Thanksgiving



J. David Bales, MD

It seems hardly possible that my year as President of PCMS is nearly over – and that this will be my last “President’s Page.” Review of the year through these pages reinforces how busy the year has been and how much the Society has been involved in and accomplished. I won’t try to catalog those activities here and only want to express how grateful I am to have been involved.

A tune from the 1940’s movie classic *Holiday Inn* keeps running through my head – no, it’s not “White Christmas” - although that was the most enduring of the dozen or so pieces in the movie. The one that I keep humming was performed by Tacoma native Bing Crosby sitting alone at a huge dining table with a fully roasted Thanksgiving turkey with all of the trimmings bemoaning his fate while listening to his most recent composition for the holiday “I’ve Got Plenty to be Thankful For.” The song lists a number of things he doesn’t have, but always ends with “I’ve got plenty to be thankful for . . . eyes to see with, ears to hear with . . .”

The tune has stuck with me since October 14, 2009 when I was finally able to participate in an activity I have been involved with over the past three years, Project Homeless Connect. You can google the name and find the history of its start up in San Francisco some years ago – an effort to connect the homeless with services available to them in a “one stop” format that could be repeated periodically. Various services including medical, social security, dental, animal services, licensing, hair cuts, etc., etc. are brought together under one roof and homeless from around the area brought in to receive those services. As was pointed out by the Federal coordinator, the real “Connect” was our own human connection with people whom we usually try not to see on the street.

My participation was through the Medical Reserve Corps giving immunizations with other volunteers such as the Pacific Lutheran University senior nursing students. It was pleasant to receive the thanks and kudos from participants for what we were doing, but it was poignant and sad to recognize some of the participants – acquaintances who had lost jobs and all they owned over the past year.

So, as we come to the Holiday season amidst economic and health care turmoil, and as I come to the end of my tenure as President of the Pierce County Medical Society, don’t be surprised to find me humming a little tune from a 60 year old movie – “I’ve got plenty to be thankful for . . .” ■

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Public's view of health care overhaul has familiar ring

Americans' opinion of the health care proposals now before Congress is eerily similar to public sentiment about the Clinton health reform initiatives in 1994, according to an analysis published online yesterday in *The New England Journal of Medicine* - and that may not bode well for Democrats.

Americans believe the health care system needs to be fixed and they like many of the ideas Democrats are proposing, the report found. But they believe the specific proposals taking shape would not benefit them personally, and they fear they could result in more expensive and lower-quality care.

The report, which examines more than 30 polls conducted this fall and during the spring of 1994, when the Clinton health reform effort was gasping its last breaths, was co-authored by Robert J. Blendon, a professor of health policy and political analysis at the Harvard School of Public Health. Both parties have regularly consulted Blendon, a leading specialist on health care and public opinion.

"When you go from 'health reform' to the bills, the bills have no majority support anywhere," Blendon said in an interview.

President Obama has won far more cooperation from Congress this year than Clinton did in the mid-1990s, partly because of a difference in strategy: Obama let Congress handle the details of the bill drafting, while Clinton provoked resentment among lawmakers by employing a secretive process within the executive branch.

At this time in 1993, the parallel point in the Clinton presidency, Clinton had not yet completed work on his initial proposal. This year five congressional committees have passed legislation, and the House and Senate are nearing initial votes on bills with similar approaches to the problem of how to cover nearly 50 million uninsured Americans.

Jim Dau, a spokesman for AARP, said that because insurance premiums

have skyrocketed in the last 15 years, interest groups from across the political spectrum now agree that doing nothing is not an option.

"The big difference is that right now, everybody's united on the fact that we need this, employers, labor, consumer advocates," he said.

But Blendon's analysis hones in on a key point that Democrats may focus on more intensely after elections this week underscored deep concerns about the economy and, in some places, dissatisfaction with Democratic leadership.

Blendon said the reason support for health care overhaul deteriorates when the questions focus on specific legislation is that people rarely consider that fixing problems requires trade-offs.

For example, he said, seniors may support the concept of a health care overhaul, but some are suspicious of proposals to cut a portion of future spending increases for some kinds of Medicare providers - such as nursing homes and home health aides - to subsidize coverage for the uninsured.

Blendon called affordability the "sleeper issue" of the health care debate.

All the proposals would require most Americans to obtain health insurance or pay a penalty, so as the legislation solidifies, people will pay close attention to how much insurance will cost those who don't have it now.

One way that Massachusetts avoided a collapse of support for its

2006 health care law, Blendon said, was by providing substantial premium subsidies for the low-income uninsured. The proposals Congress is considering would not be as generous.

He said the analysis, which he co-authored with John Benson, a research associate at Harvard's public health school, suggests that proponents of the health care overhaul should more clearly articulate how their legislation would benefit middle-class Americans - not just those who find themselves in dramatic or rare situations, but regular families facing large medical bills they cannot afford to pay.

The legislation would, for example, prohibit insurers from discriminating against people because of preexisting health conditions, and it would provide access to more affordable insurance than many people have now.

Senator Ron Wyden, an Oregon Democrat, agreed.

"Reformers still have a lot of work to do to show the typical middle-class person why reform will work for them," Wyden said.

But Wyden also said Democrats can do more to contain costs and provide choices to people who already have insurance but find it far too expensive.

He is pushing an amendment that would allow more Americans to buy coverage through the new "exchanges" using pretax dollars and whatever contributions their employers would make. ■

Reprinted from The Boston Globe, 11/5/09

Report on H1N1 cases in CA shows hospitalization can occur at all ages

In contrast to some common perceptions regarding 2009 H1N1 influenza infections, an examination of cases in California indicates that hospitalization and death can occur at all ages, and about 30 percent of hospitalized cases have been severe enough to require treatment in an intensive care unit, according to a study in the November 4 issue of the *Journal of the American Medical Association*.

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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.



Andrew Statson, MD

The Summer of our Discontent

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness. . . ."

From "The Tale of Two Cities"

Charles Dickens (1859)

What's wrong with you, guys? Aren't you willing to take a stand and speak up? Are you all down in the dumps? Cheer up! I have some good news for you. The end is near, and it's closer than you think. No, I don't mean the end of the world. I mean the end of the socialist century. But first, allow me to give you the bad news.

The executive vice-president of ACOG acknowledged receiving letters from fellows opposed to the ACOG support for the reform bill, and explained that in Washington one had to be at the table in order to escape being on the menu. If the leadership of the College truly represents the concerns of the membership, its main objective ought to be tort reform. For the AMA, the goal would be a permanent fix of the Medicare payment formula.

It seems to me that neither of these issues will be resolved to our satisfaction. Are the AMA and ACOG at the table or on the menu? Or are they at the table while we, the practicing physicians, are on the menu? I'll let you reach your own conclusion.

I think they sold their soul for a place at the bargaining table. So did several other players, such as AARP and the insurance companies, and not one of them realized what The Wall Street Journal so aptly said that a seat at the table this time meant being on the menu.

Fortunately for us, the people are taking things in their own hands. They

are stirring and speaking up. They are even more eager to make sure they get good medical care than we are to give it to them. The tea parties and the town hall meetings were wonderful.

As to the March in Washington on September 12, it really shook up the politicians. They downplayed it, to be sure. Our own Tribune gave it three column-inches on page 5, and didn't deign to show a picture. They couldn't find a "real" one, you understand. I doubt The Washington Post carried much of a story on it either, even though it happened on its own turf.

The interesting part is that The Telegraph, in London, had one of the best write-ups of the event, complete with a number of pictures. It says something about our news services when Britain's can be a better source of news about us than our own.

Of course, our rulers said that it was all Astroturf, the same rulers who saw green shoots in the economy. I think they got it backwards. The green in the economy is Astroturf, the result of the trillions of green shoveled into bankrupt companies by the Fed and the Treasury, while the tea parties and the town hall meetings were the real green shoots. Several months ago the California voters brilliantly demonstrated that truth when, by a two thirds majority, they rejected all five initiatives submitted to them with the aim to raise their taxes. Astroturf, indeed.

While the debate on the reform bill

has been going on, The Wall Street Journal has carried at least two good articles or opinion pieces per week looking at the economics and the politics of the issues. Most other news services have been disappointing.

One thing I learned living first under Nazi, and then under Communist rule, is to read between the lines and to listen for what is not said. For instance, one day in 1943, the evening radio news reported on a battle in the Pacific, in which the Japanese reportedly did well, but had not a word about the fronts in Italy and Russia. My dad smiled and said, "They didn't say anything about Europe. The Germans must not be doing too well."

We listened to Radio Free Europe, the Voice of America, BBC, but most of their programs in our language were jammed. So the way to learn what was going on was to listen to French or English short wave radio broadcasts. BBC had a good station in the 31 meter band, but I mostly listened to Radio Monte Carlo, in the 49 meter band. It had five minutes of news on the hour, every hour, and longer programs several times a day. And then, there was the grapevine, the underground information service. The Communists couldn't suppress that.

Our rulers today have the will and the power to ram a health care bill through Congress. They also are pushing the cap and trade bill, and they both

See "Discontent" page 10

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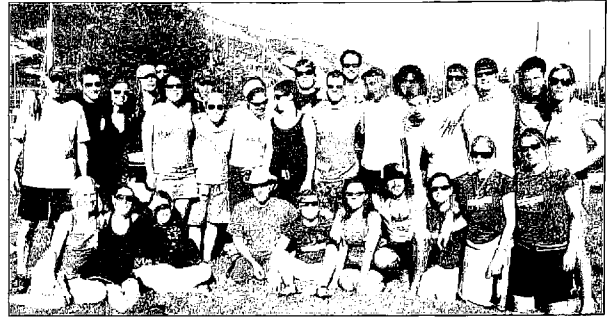
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In My Opinion

by Rick Schoen, 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.

First Descents: A Volunteer Experience with Young Adults with Cancer



Dr. Schoen, back row left, and Jen Lee, front row left

My wife, Jen Lee, and I were encouraged a few years back to volunteer for First Descents, a nonprofit out of Colorado that runs outdoor adventure camps for young adults ages 18-45 with cancer. Most of these are river kayak experience camps, which melds nicely with our appreciation and love of rivers. We finally applied and were asked to work at the first Northwest camp to be held in July 2009 in White Salmon, WA. I was to be one of the medical staff, and Jen the photographer. She also became yoga leader, driver, and back up Nurse Practitioner. And we got to be on the river with the "campers." Jen was a young adult with cancer a while back, and was looking forward to sharing and participating.

In mid July, we arrived for our week in White Salmon to meet other volunteers, get some orientation, and welcome the campers. As the campers arrived, their excitement and enthusiasm was infectious. It was wonderful to see friendships made quickly. I heard candid discussions of cancer, treatments, and medications. These folks seemed very knowledgeable and open.

The staff at the camps included volunteers from kitchen staff, to counselor-teachers, to river support, and medical support. It was great to see how many folks wanted to volunteer from all over. Families touched by cancer in some way came from Vancouver and Portland to cook meals for the campers daily. And all did so happily. Food, gear, and staff were donated by

the local boating community and businesses. One local raft and kayak business, Wet Planet, supplied all the equipment, provided lunch every day, and our support raft and rafter. A huge donation. I think there were a lot of volunteer river folks who wanted to share their passion with these campers.

The campers started their river time a bit timidly as might be expected. Some were still in treatment and most were pretty fresh out of treatment. Not all the campers had lots of outdoor experience or were previously active. Soon before our eyes the group developed a true zest for the adventure. Even the less athletic individuals surprised themselves and others with their "go for it" approach. In just a few days they were kayaking the river including some moderate rapids. Big smiles and great attitudes! Their desire for learning was very clear. Even when flipping and swimming in a rapid, all we saw were smiles and fun. During the week we saw many of these individuals open up and grow tremendously. Facing these new challenges on the rivers seemed to create bonds and rediscovery of their ability to control their own lives.

In the evenings we relaxed, played group games, and awards were given daily for on water achievement, best statement of the day, and the goofiest award. The staff awarded the first set, and the previous day winner campers had to choose each day thereafter. The winners got to wear special items for 24 hours such as a pink helmet, or an ugly

tie. They were worn with pride. The campers were amazingly supportive of each other and the staff.

The atmosphere encouraged all to push their limits. Jen got to lead spontaneous yoga classes for several days. This was a first for her. Also the photographer role was a growth experience for Jen - she did well including a slide show presentation on the last evening. One evening we had a "slack line" set. This is a one inch wide strap tied firmly between trees 20-30 feet apart. One puts a foot on the line, jumps up, crosses the line like a tight rope, turns and returns. The experienced individuals did this without aid, and even threw in some tricks. Most of the folks required a bit of support. Since some ankle surgery, my balance had never returned to its best (not great to begin). I thought to myself, I couldn't do that; I didn't volunteer. When Chucky, who was not real strong or athletic, finally gave it a go, and did better than expected; I had to try. And, yes, I surprised myself doing fairly well too. We live and learn.

All the campers, the regular staff, and the visiting day staff were fun and interesting folks - all very supportive. We felt honored and blessed to participate. The staff learned and grew as much as anyone. It was so inspiring to see so many give and donate time and money to others during this week. These campers had a lot to teach anyone. They truly enjoyed and lived this

See "Volunteer" page 16

Discontent

from page 7

are stamped "urgent." Ever wonder why? Why is it so important to pass the health bill this year, when the benefits would not begin until four years from now? The reason actually is very simple, when you think of it. Both bills are tax bills. They are an excuse to raise taxes on everybody. And the Treasury is empty.

Did I say taxes? I am sorry. They are not taxes, you see, because they are for our benefit. For the health bill, think of them as mandatory insurance premiums. The fact that taxes are mandatory, too, is only a superficial resemblance. For the cap and trade bill, the taxes are on the evil energy companies. The cost of energy will go up, but the energy companies will be blamed. Besides, you see, it's all for our own good.

Last year I reported that the unfunded liabilities of Social Security and Medicare were 99.2 trillion dollars. Recently I saw a figure of 104.4 trillion. The federal debt will be over 12 trillion by the time you read this, and that is only the on-budget items.

Off budget, they have the health and pension programs for all federal, state and local government employees,

the guarantees of Fannie and Freddie, of Ginnie and Sally, of the FHA and the SBA, and the total on all that is unfathomable. To pull a number out of my hat, that must amount to at least 30-40 trillion, and probably more.

The good part is that the more they spend, the sooner their system will crumble. The country will still be here, and so will the people, at least most of us, and when the system crumbles, we'll start rebuilding.

The picture is gloomy, but there are two bright lights, and those are the really good news. The first one was expressed by the main character in "1984," Winston Smith, who wrote in his diary, "If there is hope, it lies with the proles." (the proles were the proletarians, the ordinary people).

That is what I see happening now. Our people are waking up. They are taking a stand. They are speaking up. Even though our rulers have power, there is a limit to what they can do. Think of the German "Democratic" Republic. There came a time, on November 9, 1989, when even the Stasi, one of the most oppressive police forces in the history of the world, refused to shoot at

the people.

The other bright light was best expressed by Margaret Thatcher. She said, "The problem with socialism is that eventually you run out of other people's money." All socialist systems ran on borrowed money, and eventually repudiated their debts. To be sure, Mussolini, Hitler, Stalin, Mao, and all the others stole from their own people and wrecked their country's economy, but they also borrowed lavishly from Western bankers, mostly from the US. And when they didn't pay, the US taxpayers made the banks whole.

You probably remember when Peronist Argentina defaulted on its bonds in the 1970's, and how the Fed went to the rescue of Citi, Chase and a few others. Then, Congress enacted the Brady Bonds bill, and the U.S. taxpayers assumed the risk for the loans the banks made to the countries of South America.

Well, I have news for all of them. America is broke. There is no more other people's money. It has run out. For an entire century the amazing resilience and productivity of American

See "Discontent" page 12

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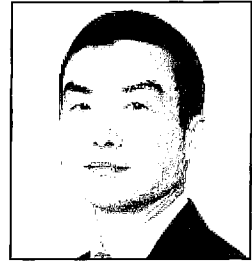
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The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

The Needs and the Power of Many

*Anthony Chen, MD*

As I write this article, the Health Department had just participated in the Third Annual Project Homeless Connect at the Tacoma Dome. In case you missed it, there was an article in the *Tacoma News Tribune*: <http://www.thenewstribune.com/topstory/story/916754.html>. Pierce County Medical Society **President David Bales, MD**, our perennial Medical Reserve Corps (MRC) booster, was there overseeing the nursing students and other MRC volunteers administering flu shots. **Chad Krilich, MD** and other volunteers from the Neighborhood Clinic were providing medical and pharmacy services. Our dental colleagues were providing dental services in mobile operatories while hygienists and students were providing screening and education. All kinds of other services were provided, from eye exams and glasses to haircuts. Representatives from support services such as Veterans Affairs, DSHS, and homeless outreach were on site to make sure attendees were connected to resources after the event. Even pets were provided services. It is an incredible affair and if you have never seen it, check out the website <http://pchomelessconnect.org> for photos, and be sure to visit next year.

In public health we always look beneath the surface and upstream. On the one hand, Project Homeless Connect was a success, serving 1,500 people (up from 900 last year) with so many stories of the impact services made to those who received them. On the other hand, I could not help but think about how the 50% increase in volume was a sobering indication of what is going on in our communities.

Just today, Dieringer School District Superintendent Neumeier-Martinson was telling me about a student whom they have to provide transportation for every day, because the family became homeless and moved to stay with relatives in Tacoma. In Spring, Tacoma School District Superintendent Jarvis had already seen homeless students jump from 400 to 1,000. Pierce County's annual homeless count was 1,743 in 2008; it jumped by 20% to 2,083 in 2009. The United Way of Pierce County's 211 line calls for basic food resources in the 4th Quarter jumped 35% from 621 in 2007 to 841 in 2008; you can see other Community Wellness Indicators at <http://www.indicators.uwpc.org/>. The Emergency Food Network has seen a 35% increase in clients served (from 591,000 to 797,000) and a 28% increase in food distributed (from 8.1 million to 10.4 million tons). I am sure that each of you has seen firsthand the economy's impact on your patients and communities.

So what are we to do in the face of such overwhelming needs? Any little bit that we do might be just a drop in the bucket, but every little bit helps. Any donation to Emergency Food Network (www.efoodnet.org), United Way (www.uwpc.org), South Sound Outreach Services (www.southsoundoutreach.com), Metropolitan Development Council (www.mdc-tacoma.org), or other agencies gets leveraged with other resources for greater impact. Any hours donated in community service or at a free clinic (eg, Neighborhood Clinic [www.neighborhoodclinetacoma.org] or the new Rotacare Chronic Health Care Clinic [www.rotacaretacoma.org]) similarly gets leveraged. Project Homeless Connect is an example of how many organizations and individuals come together to make a big impact. We know that many of you are also providing free or discounted services to the poor and uninsured, whether individually or as a group (eg, the initiative by Cascade Eye and Skin Centers that was highlighted in a past PCMS *Bulletin* issue <http://www.uwpc.org/TNT072209.html>). When PCMS rolls out Pierce County Project Access, there will be more opportunities to leverage resources.

At the Health Department, we will continue to work with community partners to make sure that there are systems in place to address this unprecedented rise in need. Wherever we can, we will try to address upstream factors that can help reduce the need. Together, we can draw on the power of many to meet the needs of many. ■

Discontent from page 10

capitalism supported the socialist countries of Latin America and Europe, of Africa and Asia, financed two world wars and the reconstruction of the countries destroyed by them. We were seldom thanked for our help, and the loans we made went mostly unpaid.

No more. Now American capitalism, like Gulliver in the land of the Lilliputians, is bound down by thousands of strings, consisting of rules and regulations, controls and mandates, and a variety of taxes. It is flat on its back. Unless it is released from those ties, it cannot continue to produce, and releasing it is not in the plan. Increasing its burdens is. This is the end of the line.


We'll go through a rough patch for a while, but we'll pull through. You may remember the scene in "Atlas Shrugged" when Dagny heard of the accident in the tunnel and ran back to work. Francisco d'Anconia yelled after her, "Don't give them your mind." He was right, but her return didn't change anything. They didn't listen. They can't listen. They firmly believe that they know what is best for us better than we do, and they are going to use their power to give it to us whether we want it or not.

The basic problem of the socialist system is not economic, and it is not political. It is moral. It violates the most es-

sential rights any civilization must respect if it is to survive -- the rights of the individual to his person and to his property. Without them, all other rights are meaningless.

We can't prevent the breakdown of the socialist system. When that happens, we'll rebuild our country on our terms. In the meantime, take a stand and speak up. Remember Patrick Henry: "Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it, Almighty God. I know not what course others may take, but as for me, give me liberty or give me death!" What is your choice?

Cheer up, my friends. The end is near. ■



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JAMES E. HAZELRIGG, MD

1928 - 2009

Dr. Hazelrigg passed away on October 18, 2009 at the age of 81.

He received his medical degree from the University of Nebraska in 1954 and completed his internship at Pierce County Hospital in Tacoma. He began private practice in Browns Point in 1955 where he served the community as a family physician for forty years, retiring in February 1995. He was the only physician in the Browns Point area for thirty-eight years.



James Hazelrigg, MD

Dr. Hazelrigg served as a Trustee and Vice President of the Pierce County Medical Society. Other positions held include Medical Staff President, Doctors Hospital; Medical Staff Secretary, Mary Bridge Hospital; Trustee, Pierce County Medical Bureau; Chair, Mental Health Committee; Member, Washington Association of Family Practice; Chair, WSMA Mental Health Committee; and Member, Doctors Hospital Board of Trustees. Dr. Hazelrigg was honored as Physician of the Year by the Washington State Medical Association in 1974.

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



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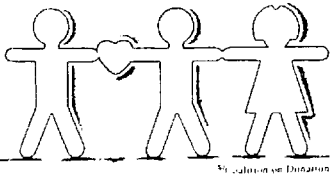
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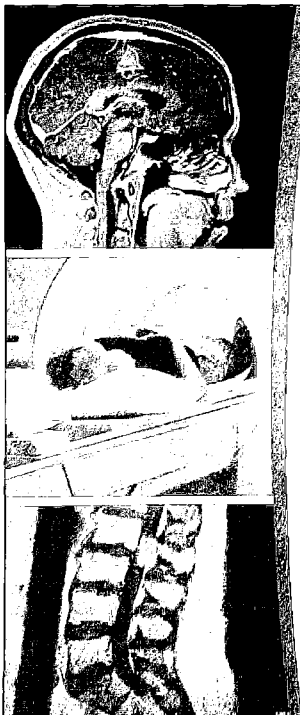
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Volunteer from page 9

time. Jen and I hope to volunteer many more times. This was the response of all the staff and visitors. We could see these folks, whose lives had been severely shaken early on, begin to take back control. It seemed to us these camps served a great purpose, and did a good job of it. Campers and staff came away with life time friends and support.

There are 70,000 new cancer cases yearly in the U.S. in 20-30 yr olds. Minimal experience with the medical system, less stable financials, and all at a time they should be setting their identity. Lymphomas, leukemia, sarcoma, testicular and ovarian cancers are common. Half the people at our camp were dealing with breast cancer. This age group has less support than other ages. We were impressed at how the camp seemed to help these folks get a start back to living life.

First Descents has operated since 2001 in many sites throughout the western U.S. In 2009, FD ran nine camps, all full with waiting lists. Camp-

ers are carefully screened by the medical review committee and approval from their physicians is required. Their hopes and plans are to add more camps and stabilize and improve their current camps. They do run on a bit of a shoestring, but seem to do a good job even

so. They are always looking for volunteers, equipment, etc. Check out their website at www.firstdescents.org. Jen and I are always willing to talk and share our experience with First Descents. Feel free to call 253-549-4147, or email yakrik@yahoo.com. Enjoy your rivers! ■



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

This year's topics include:

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- *Cushing's Syndrome*
- *Endocrine Mechanisms of Weight Loss and Diabetes Resolution after Bariatric Surgery*

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

Continuing Medical Education

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

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

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

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

This year's topics and speakers include:

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

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

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

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Dr. Park received his medical degree from Jefferson Medical College in Philadelphia and completed his ophthalmology residency at the University of Washington. He completed his clinical and surgical fellowship in glaucoma at the New York Eye and Ear Infirmary. Dr. Park is a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. He has published original research on glaucoma in some of the most respected ophthalmology journals.

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

Pediatric Opportunity-Puyallup, WA

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

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Dr. Mooney is board-certified in dermatology and dermatopathology, and is a fellow of the American College of Mohs Surgery, American Society of Dermatologic Surgery and the American Academy of Dermatology.

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