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EDITORIAL DEADLINES
September 10, 2001: ABFP Recertification
December 10, 2001: Health Policy & Legislation
March 10, 2002: To Be Announced
June 10, 2001: To Be Announced

ON THE COVER
Summertime and the livin’ is easy

WFP POLICY & PURPOSE
The Washington Family Physician (WFP) Journal is the official quarterly publication of the Washington Academy of Family Physicians (WAFP). It serves as the primary communication vehicle to WAFP members. Its purpose is to provide timely and relevant information regarding the practice of family medicine, and report results of the policies determined by the Board of Directors and activities of members and committees.

The views and opinions expressed by all authors in this publication are their own and do not necessarily reflect those of the Academy. Publication should not be considered an endorsement, expressed or implied, by WAFP.

WFP also welcomes articles written in a respectful and collegial manner that reflect opinion and editorial, if in our opinion, publishing such articles is timely, relevant, and will be of interest to the general membership of the Academy. Such articles will be cleaantly identified as an individual writer’s opinion or point of view.

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The WFP Journal is distributed to 2,500 WAFP members in Washington state, plus the other constituent chapter offices of the AAFP throughout the United States.

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Message from the New WAFP President

Robert A. Crittenden, MD, MPH
WAFP President

It is an honor to be your President this year. The job carries a lot of responsibilities. My predecessor, Dan Austin, did much good work for the academy and has made my load lighter. Ruby Fusaro, our new Executive Director, and Nancy Caldwell and Janice McCarthy, our other Olympia staff, are real assets. We have an agenda begun by Dan that includes the Think Tank process as a good lead up to our Board Strategic Planning process this summer. We have leadership-training workshop being developed by Jan Vleck, our very able Washington Family Physician editor (mark your calendars for August 24 in Yakima — all are invited). These are great beginnings. But, as I have been listening to you, it is clear that we need to ramp up our work.

The issue that we have heard loud and clear at the Think Tank, the Annual Meeting, and in conversations with many of you is the shared concern for the economic viability of our practices. Rates paid have gone up, but not nearly enough to pay for the increased paperwork and hassle burden that practices are bearing. It seems to be a grave concern in urban, suburban and rural practices. We have taken on new insurance functions, but we have not seen the revenue to pay for these new roles. Family doctors are working longer hours, they appear to spending the same amount of time with their patients, but they are seeing more patients and are doing more ‘extra’ paperwork.

I truly believe that there are ways to make our practices more enjoyable and less of a burden. There are activities that we all do that are more complex than they need to be and there are activities that we should not be doing. One of the messages that we get from medical students who have experiences in your practices is that they love the work, but are concerned about burning out. We are not going to have students entering family medicine and we are not going to have happy family physicians unless we can make substantial changes in this hassle factor. This is not an easy task, but I think the stars are aligned.

I have appointed Drs. Steve Albrecht and John Anderson to take a lead on this issue for our Academy. As this is a cross-cutting issue, I have asked a number of the Chairs of certain Commissions and Committees to join this work group. I will work closely with them to improve the payments we receive and to decrease — significantly — the paper and complexity now on our backs. This will not be a short-term issue, but we need to start now.

Also, many of you have asked that we provide support and information about the new and changing world of information technology. I see this as a very important member service we can provide. For the past few years, Dr. Ed Kay has provided great leadership on this issue. He has stepped down and Dr. Carl Olden has agreed to take up the reins of the Information Services Committee. I have asked him to focus on practical information and
We contribute to sustained and measurable improvement in the health of the state’s entire population through leadership in public health programs and delivery of high-quality, evidence-based clinical care.

As a result of our political activism, both within our organization and in the legislative arena, all people gain access to health care for medical, dental and mental health needs through universal coverage.

Family practice as a discipline and the WAFP as an organization grow in strength. Our Academy effectively represents the diversity of the family physicians and the people of Washington in geography, demographics and practice settings.

The University of Washington Department of Family Medicine and its regional education program maintain their preeminent status as leaders in the profession, accomplished with the strong support of community-based physician preceptors who embrace an integrated model of care.

Family physicians are at the forefront of efforts to improve clinical care while serving as guides and advocates for our patients. We participate in the development and translation of information technology, value cost-containment, work towards advancing improvements in clinical decision making, and maintain a broad scope of clinical practice.

Dr. Crittenden is the President of the WAFP. He is an Associate Professor at University of Washington School of Medicine and Chief of the Family Medicine Service, Harborview Medical Center Director, Seattle. He is also in the Office of Education Policy, Office of the Dean.

Register Now!

The WAFP Leadership Training Workshop is scheduled for Friday, August 24 in Yakima. Call the WAFP Office at 1-800-621-8424 to register today! Space is very limited.

Washington Family Physician • Summer 2001 • 3
Meet the New Board

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Editor Shocked – Learns Family Practice
NOT Center of Universe!

Dr. Vleck does more than just talk about problems like “physician work-
force” and “energy crisis.” Not only does he work as a physician, but late-
ly he’s been riding his bicycle to that very work.

Several articles in this issue of Washington Family Physician discuss
physician workforce troubles. In my community, Olympia and vicinity, this
topic has been front-page news several times lately due to the proportionately
large numbers of primary care physi-
cians leaving practice or leaving the
area. Patients have been scrambling to
try to find new physicians.

Although that’s unpleasant for every-
one, and makes it harder to provide the
personalized continuous care that
Family Physicians take pride in, at least
the local crisis is drawing notice. It
probably is a good thing in some ways
that this is happening in the State capi-
tal, where the Legislature is meeting
(and meeting, and meeting...) because
they likely read our local newspaper.

In fact, a newspaper-sponsored com-
munity forum on health care access a
few weeks ago was standing room
only. Senators Patty Murray and Maria
Cantwell, State Insurance Commissioner
Mike Kreidler, and many other politi-
cians attended. That tells me people are
starting to notice there’s a problem.

It’s way too early to know whether
this will have any effect on Family
Physician supply in Washington. My
guess is that we still have more influ-
ence over this than the policy makers
do, as we host medical students in our
offices, help fund the R/UOP program
at the University of Washington, and
serve as role models to the youth of our
communities.

However, I am fully aware that
money talks. Reimbursement levels and
federal funding for graduate medical
education are two of the loudest voices
in the chorus. If these continue to fall,
no matter how much PR work we do on
behalf of Family Practice there will be
fewer of us with each passing decade.
[Unless Cuba picks up still more of the
load for training American doctors!]

The last big surge of interest in physi-
cian workforce analysis was in the mid-
1990s, when there were Congressional
hearings, articles in JAMA, and several
national policy analyses were pub-
lished. If another round of federal-level
discussion is due, it is still beyond the
horizon. For some inexplicable reason,
the language of the government debate
has shifted from discussing the needs of
the people to the more pragmatic level
of budgetary funding for health care
delivery and graduate medical educa-
tion. In the current fiscal climate, both of
these appear endangered.

Family Physicians should not have an
inflated view of our value in this debate.
Be aware that in health policy discus-
sions, family practice is not the leading
subject. Primary care is, which also
includes internal medicine, pediatrics,
and ob-gyn. Further, family physicians
are not the only players. Physicians,
nurse practitioners, and physician assis-
tants together constitute the supply, and
policy makers are generally concerned
more with the total than the relative

Continued on next page
numbers in each category.

Federal policy statements are pretty clear on a couple of things, though. Primary care clinicians (notice I didn’t say FPs, or even physicians) must improve their competency (this includes clinical skills and communication skills), improve access to care, and alleviate geographic maldistribution.

I believe that as a specialty we are still well positioned in these areas. We led all specialties in requiring periodic recertification – if you believe that is linked to competency – and Family Practice residencies are increasingly emphasizing ambulatory as well as impatient competencies that are defined and measured. We do provide access to many underserved and uninsured people, although many practices are reaching the breaking point as reimbursements decline. And we do provide the backbone of medical care in many rural and inner-city areas.

It’s sobering to realize, however, that organisms without backbones far outnumber those with backbones.

MEET THE BOARD
Continued from page 5

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CONFERENCE ON PATIENT CARE AD
(SLICK ENCLOSED)
I HAVE BEEN BLESSED

A long life and a wonderful wife have blessed me. I am a happy man. I would like to share what it is, upon reflection, over these many years of medical practice that has had a lasting impact. My long life seems something of a miracle. For much of my life I have given military or mission care of casualties, dying or very severely disabled. Why them and not me? I was a responder to urgent medical, emotional needs as a young medic in World War II, then as a doctor in the Korean War and subsequent conflicts, and then in Third World missions. As a medic in combat, I often faced death. I resolved that if I lived I would get my medical degree and give my life to peacemaking locally, nationally and worldy. My MD from the University of Pennsylvania gave me the opportunity and skills to respond to the physical, mental and spiritual pain and struggles of others for the rest of my life. It is a joy being a responder and teacher.

Congratulations to each of you on your MD achievement—never stop learning. Be a responder, and teach others wellness by prevention and healing. Teach mainly by examples and experiences. Remember, as healers we are vigilant to “Do No Harm.”

My private practice was interwoven with teaching medical and non-medical people, caring for those who are defenseless, and supporting those who defend our country—even unto death. My wife, Virginia and I had only one child, but seeing the needs, we adopted children and cared for foster children and youth. Our 55 mission years goes on throughout the world, but on a gentler scale.

I remember my father teaching me with parables in my early youth, and urging me to join the Boy Scouts whose motto is “Be Prepared.” I did, and after 69 years of scouting, I still learn and live by the Scout Oath and Law. My parents and scout leaders encouraged my career in medicine. They disciplined me and helped mature me. My achievements in youth and adulthood have kept me joyfuly excited, always prepared for whatever challenges I meet.

You face a chaotic world now with the greatest medical skills in history. No matter what specialty you go into, break down walls between patients and doctors. Take an active role in your community as a family, a healer, a teacher, a friend and a model to all—especially children. Life is a privilege, go for it! My combat, illnesses, injuries and death experiences confirm my positive conviction that life is to be lived in faith and love with opportunities to use your medical skills and knowledge. Do No Harm. Keep learning. Be prepared. Love your family and all people. Learn from your wise elders. Teach by example.

I read Proverbs, Psalms and Parables in the Bible. The writers are older and wiser than I am. My father gave me an old Crow Indian philosophy from buffalo hunting 150 years ago: “The past is a dead horse, don’t try to ride it.” I bequeath to you the leadership of loving care for healing our world.

Leeon F. Aller, MD, COL MC, USA (Ret.)
Founder-Hands for Peacemaking Foundation.

Title: Homeopathy, Allergy and Toxic Molds

WFP Spring 2001 Issue

Dear Dr. Vleck:

I would like to respond to the recent article entitled, “Homeopathy, Allergy and Toxic Molds.” That article is pregnant with multiple issues, which require far more than a simple letter to the editor to explain.

To get to the point, the dose does not always make the poison. Dr. Robertson is viewing the problem of environmental health from the perspective of toxicology alone: real-life situations are more complex and include not only poisoning effects but also sensitizations in addition to traditional immediate allergy. Additionally, not everyone is the same: several studies have indicated that at least 15 percent of our population is far more susceptible to developing sensitivities to perfumes, diesel exhaust, cleaning solutions and other common chemicals. And further, the contaminated buildings which create our environmentally triggered illnesses do not have single agents in them but may have a mix of allergy inducing molds, mycotoxins, dust, chemicals, bacterial toxins, viruses and other types of toxic agents such as may be found in industry. Environmental health cannot be simply analyzed from the point of view of toxicity but must include multiple other factors.

Along with most physicians, I am deeply concerned for children in our classrooms and workers at their job sites and family members in the homes who are experiencing real physical ill-

WFP welcomes letters written in a respectful and collegial manner that reflect opinion and editorials, if in our opinion, publishing such letters is timely, relevant, and will be of interest to the general membership of the Academy. All letters are an individual writer’s opinion or point of view and not that of the WAFP or WFP. WFP asks that you keep your letters brief and to the point (500 words or less; we reserve the right to edit for length) and provide contact information that will be published with your letter. Letters can be e-mailed to Jan P. Vleck, MD, Editor: editor@wafp.net or mailed to the WAFP offices.
ness and who may be heading for a worsening of their health unless the situation is properly understood and remediated. Disease arising out of exposure to contaminated environments, while not necessarily life-threatening, can cause serious acute and chronic illnesses to the point of inducing total incapacity to perform productive work, at times on a permanent basis. It is a major mistake, yes, a major mistake, to write off these complex patients as psychiatric oddities. If I might be so bold, let me say that I find myself professionally offended by those who, perhaps unwittingly, imply that all or even most of our environmental illness is a psychophysiological phenomenon growing out of a distorted belief system or targeted fears of pollution’s ill effects, or prior psychological trauma. If we take that point of you, and it is easy and less expensive over the short run to do so, I am afraid we do a great disservice to our patients over the long run. That is particularly true when there are tools available to sort out the physical from the psychological dimensions to illnesses triggered by molds, chemicals, pollen, foods, pesticides and other contaminants both indoors and out of doors. Of course, let us deal psychotherapeutically with overly anxious patients or those who hide deep hurts and conflicts under the label of mistaken “environmental illness.” But let us deal physically with those patients who physically suffer the effects of environmental exposures.

Chronic low-dose exposures can cause serious illness: it is not necessary for an individual to be exposed to a high level of toxic agent. Let it plainly be said that careful attention to maintaining clean environments is a good idea for all of us: it leads to decreased absenteeism, increased worker productivity, lower health care costs, improved classroom learning, less confusion among patients regarding environmentally triggered illnesses and a stronger society able to proactively live and work in the 21st century. Family Physicians have a major role to play in adequately managing the complexities of health care as we find ourselves inhabiting increasingly contaminated environments.

While at times it is very true that “The dose makes the poison”, it is far from being always the case in our complex world. I would invite any physician who is interested in learning more about the complexities of environmental illness to write me or visit the Web site suggested at the end of this article.

Yours kindly,
Philip Ranheim, M.D., FAAFP
Everett Washington
Honoring WAFP's Best in Family Medicine

Family Physician of the Year Amos “Pres” Bratrude, MD of Omak was honored by his friends and family at the annual banquet May 4 as the 2001 WAFP Family Physician of the Year. Dr. Bratrude has been a family physician for more than 41 years and practiced in Omak. Dr. Bratrude attended the University of Illinois School of Medicine. He then entered the United States Navy and attended the U.S. Naval School of Aviation Medicine; became a flight surgeon at the U. S. Naval Air Station on Whidbey Island, which introduced him to Washington State. Since then he has practiced family medicine in Omak.

Pres is well known for his involvement in the development of family practice. He has been very active with a variety of educational programs, speaking on radio programs, giving educational lectures to colleagues and was an initiator of a coalition, which is now called WWAMI. Pres was not only active in the educational arena, but also in the political arena, having been a Washington delegate to the AMA and holding many offices within that organization. He has been actively involved with the Academy as well, serving on the Board and chairing the Commission on Education.

The WAFP is proud to add to Pres’ list of honors this year’s Family Physician of the Year award.

Making a Difference

Daniel E. Austin, MD, outgoing president, presented Dr. Chris Covert-Bowlds with the 2001 Making a Difference Presidential Award at the annual banquet in Spokane. Dan has had the privilege and sometimes challenge of sharing a practice with Chris Covert-Bowlds, along with his other partners, Jim Moren, Tim Pearson, Janine Shaw, Susan Willis, and Chao Ying Wu. Chris advocates for noble causes with a zest matched by few. His accomplishments in the area of tobacco abuse have been astounding! His bone marrow transplant successes represent a close second. We, his partners, have to reel him in once in a while to keep him on task being a super family physician to those challenging patients he loves and cares for. Chris is being awarded the “Making a Difference” Presidential Award to acknowledge the dedication, zeal, and energy he has given to the community and his patients as a “make the world a better place” family physician.

Roy Virak, MD Memorial Scholarship Winner

Each year the WAFP Foundation presents this scholarship to a deserving family practice resident, in order to encourage his or her continued quest to become a fine example of what a family physician should be. This award is named for Dr. Roy H. Virak, and with the award comes a responsibility to follow Dr. Virak’s example of caring for others. Dr. Virak’s professional and personal life was dedicated to the service of others. He demonstrated the old fashioned values of the family doctor, while he worked to develop and gain a modern public and professional recognition of family medicine as a medical specialty.

Dr. Gwathney was nominated by Sam Cullison, MD, Director for the Swedish at Providence Family Practice Residency Program. Dr. Cullison stated in his nomination letter that “Dr.
Gwathney is one of the most dedicated and talented trainees to come through this program." Dr. Gwathney is very involved in community service through such organizations as the Ronald McDonald House and Big Brothers Big Sisters of King County. Dr. Cullison goes on to say that Dr. Gwathney has “demonstrated excellent leadership and professional achievement in his career. He has received numerous honors including Golden Key National Honor Society membership, the Benjamin Banneker Scholarship, the Helda Grant award, among others. Dr. Gwathney has superb interpersonal relationships with patients, resident peers, office staff and faculty. He is an effective public speaker and wonderful person.”

KCAFP Community Service Award for 2001

Dr. Anthony L. T. Chen, a Family Physician, who works at International Community Health Services (ICHS). Dr. Chen has been active in hepatitis B prevention among persons of Asian and Pacific Island (API) descent nationally and locally for years. Dr. Chen has been President of the National Asian and Pacific Islander Task Force: Focus on Hepatitis B Prevention in the past and is still very active with this organization. However, since at least 1996, Dr. Chen has been active in making hepatitis B prevention among APIs in King County and Washington State a local priority. Dr. Chen helped to develop the Asian and Pacific Islander Advisory Group that is still active today and is now a Task Force under the auspices of the Immunization Action Coalition of Washington (IACW). Dr. Chen has donated his free time to preventing hepatitis B among APIs in Washington State, as part of the API Task Force activities and independently.

Activities of the Task Force that were in large part due to Dr. Chen’s work include: (1) development of culturally appropriate brochure on hepatitis B for the API community available in English and 6 Asian languages, (2) development of beautiful and uniquely designed posters on hepatitis B prevention for APIs, translated into 7 languages, (3) development and implementation of hepatitis B immunization and blood testing clinics at 2 area Chinese language schools, and (4) development and implementation of a media outreach project focused on hepatitis B awareness and prevention targeting Asian ethnic media in King County. Dr. Chen is tirelessly com-
NEWS AND INFORMATION
Continued from page

mitted to preventing chronic hepatitis B among API children. He is the person who envisions what might be done and then helps find a way to make the project a reality. Additionally, he is consistently working to develop collaborations with health care professionals, health care organizations, and community members to further the goal of eliminating hepatitis B among API children locally and nationally.

Student Research Paper Recipients
Amy H. Olsen, 1st Place, Bellevue
Richard Rutherford, Honorable Mention, Spokane
Doug Wilson, Honorable Mention, Seattle

Minority Health Affairs Scholarship Winners
Justin Gatewood
Juan Alverque
Julian Perez

RRP Recipients for 2001
Derek A. Gedlaman, MD
Marie Matty, MD
David Della Lana, MD

This half-day seminar will be offered in Seattle on July 31; Spokane on August 2; SeaTac on Saturday, August 4; Tacoma on August 7; Everett on August 9; Wenatchee on August 14 and Vancouver on August 16. Seminars run from 12:30 - 4:30 p.m., except for the Saturday, August 4 program, which runs from 9:00 a.m. - 1:00 p.m. The sessions are presented by the WSMA.

AAFP This Week
Are you getting this wonderfully informative and brief weekly publication? It is sent via e-mail (or fax) to all AAFP members whose e-mail addresses are on file with AAFP and gives you a synopsis of all the important issues facing family medicine on a national level. To subscribe, use your member number to log in at www.aafp.org and look in “publications”.

Are you a Writer at Heart?
You are welcome to submit articles for consideration for a future issue of the Washington Family Physician. Upcoming themes are ABFP Recertification and Health Policy & Legislation. Please contact WFP at editor@wafp.net for more information and guidelines for articles.

Spotlight A WAFP Member
Would you like the opportunity to spotlight one of your colleagues? Do you know a family physician who is doing an excellent job representing the specialty of Family Practice. If so, this would be a great way to share information about our family docs with fellow WAFP members. Please e-mail your submissions to editor@wafp.net. We hope to hear from you!

WAFP Supports Breastfeeding
With the help of the endorsement of the WAFP, the WA 2001 legislature passed a bill which will help make it easier for Washington women to breastfeed. HR 1590 accomplishes the following 1) clarifies that indecent exposure law can no longer be used to harass women for breastfeeding, and 2) encourages businesses to adopt basic practices which facilitate continued lactation after return to work (e.g. a place to pump, a refrigerator, flexible use of break time, etc.). Families, employers, and physicians can find information about why and how to integrate breastfeeding and work via Healthy Mothers Healthy Babies www.hmhbwa.org, the Seattle King County Public Health Department, www.metrokc.gov, and the Surgeon General’s recent HHS Blueprint for Action on breastfeeding, www.4woman.gov/Breastfeeding/. For more information on national bills to reduce societal barriers to women’s ability to breastfeed as long as desired and/or recommended consult www.house.gov/maloney/issues/breastfeeding/index.htm. MaryAnn O’Hara, MD, MPH, MSt

Flu Vaccine Update
Below is an internet link to an article in today’s American Medical News entitled, “CDC: Order flu vaccine now for 2001-2002: A repeat of last year’s experience is not anticipated, but public health experts are calling for contingency plans just in case.

http://www.ama-assn.org/sci-pubs/amnews/pick_01/hll20618.htm

This article provides a summary account of the way the upcoming flu season is shaping up and reviews CDC recommendations.

AAFP/GAFP Foundation Golf Tournament
Attention Golfers! Register now for the AAFP/GAFP Foundation Golf Tournament on the beautiful “Woodlands” Golf Course in Braselton, Georgia. Beautiful championship course with contoured fairways, thick Bermuda roughs and strategically placed lakes and ponds. For more information please call the GAFP office at 1-404-321-7445.
The Tar Wars program was very successful in 2001. This year the program was presented in over 100 elementary schools in more than 500 4th and 5th grade classes, reaching over 13,000 students.

Thank you to all of the WAFP members for taking the time to help spread the Tar Wars message. We currently have 216 WAFP members who volunteer their time to present the program at elementary schools in their area. The success of the program depends on these Tar Wars volunteers to make sure the message is heard throughout the state.

We are in constant need of Tar Wars volunteers, as the demand for the program continues to grow. This year we invited teachers, nurses, physical education teachers and school counselors to present the program so more classes could become involved.

As a result we had over 150 creative posters submitted to the Washington State Tar Wars poster contest. Four finalists were selected and traveled to Spokane to be voted on by our WAFP members. Our first place winner is Karlie Kennedy of Snohomish, WA. Her poster has been forwarded on to the Washington, D.C., July 15-17.

This year the WAFP is very excited to announce that we will be able to send Karlie and her family to Washington, D.C. to participate in this very exciting event. This is the first time we have had funding to send our state winner to the National Tar Wars Poster Contest. I am very excited to go there. Thank you for making this program. It teaches kids that smoking is gross and what it does to your body. I was reading 50 Things You Should Know About Smoking and I found out that for every cigarette you smoke, you lose seven minutes of your life. I think I am very lucky because no one in my family smokes. Winning the poster contest was very exciting. The poster was a blast to make because we had to think of good ways to teach kids about how gross of a habit it is and that smoking doesn’t make you cool. I hope my poster reminds other kids how great it is to breathe fresh air.

—Sincerely, Karlie Kennedy
Many thanks to the friends of the Foundation, who donated, and purchased items at the recent auction held at our annual meeting in Spokane. Your generosity helped raise more than $8,500 for the Future of Family Medicine Fund, which will be used to support programs that enhance the specialty of family medicine and encourage medical students and residents in their choice of this specialty. Programs included are the AAFP Foundation Residency Repayment Program, the Summer Research Externship Program for UW medical students, scholarships for residents to attend the annual AAFP/STFM Patient Education Conference, support of the WAFP Think Tank on the “Future of Family Medicine” and other similar programs, projects and grants. Our goal for next year’s auction that will take place in Seattle, May 2002, is $20,000! Call the WAFP office with any donation ideas.

Gourmet Yakima Wine
Donated by: Michael Maples, MD
Purchased by: Jean Marshall, MD

Dinner for 4 at the home of Al Berg, MD
Donated by: Al Berg, MD
Purchased by: Stephen King, MD

2 Sets of Mariner tickets
Donated by: J. Luke Olson, MD
Purchased by: Daniel Austin, MD & Vicki Black, MD

Franklin Covey Planner package
Donated by: Franklin Covey, Inc.
Purchased by: Sandy Norris

Box of gourmet wine
Donated by: Ruby Fusaro
Purchased by: Jan Vleck, MD

Dinner for 2 at the home of Chris Gaynor, MD
Donated by: Chris Gaynor, MD
Purchased by: Daniel Austin, MD

Semiahmoo gift certificate for two
Donated by: Semiahmoo
Purchased by: Tom Osten, MD

Summit Inn gift certificate
Donated by: Summit Inn
Purchased by: Robert Crittenden, MD

WAFP Money Jar
Purchased by: Tom Osten, MD

Bellevue Gift Certificate
Donated by: Bellevue Best Western Inn
Purchased by: Don Solberg, MD

Handmade cardigan sweater
Donated by: Anne Montgomery, MD
Purchased by: John Anderson, MD

Framed farm scene print
Donated by: Mike Sullivan
Purchased by: Robert Riggs, MD

Trip for two to Anacortes
Donated by: Harold Clure, MD
Purchased by: Larry Johnson, MD

Gift certificate for 2 for a one day rafting trip
Donated by: Rivers Incorporated
Purchased by: Chris Bagarosh, MD

4 Admission tickets to the Northwest Trek
Donated by: Northwest Trek
Purchased by: Tom Norris, MD

Overnight accommodations for two at the Crowne Plaza Hotel-Seattle
Donated by: Crowne Plaza-Seattle
Purchased by: Mike Neff

Two person kayak rental for 4 hours on Lake Union
Donated by: Northwest Outdoor Center
Purchased by: Tom Norris, MD

4 Admission tickets to the Museum of History and Industry
Donated by: Museum of History and Industry
Purchased by: Jan Vleck, MD

One-night accommodations in a waterfront view room at the Port Angeles Red Lion Hotel
Donated by: Red Lion Hotel
Purchased by: Robert Van Citters, MD

6 Admission tickets to the IMAX Dome Theater in Seattle
Donated by: IMAX Dome Theater
Purchased by: Jan Vleck, MD

4 Admission tickets to the Seattle Art Museum or the Asian Art Museum in Seattle
Donated by: Seattle Art Museum
Purchased by: Robert Crittenden, MD

WAFP Denim Shirt and hat
Donated by: WAFP
Purchased by: Greg Ledgerwood, MD

Truckload of Tamarack Wood
Donated by: William Doyle, MD
Purchased by: Mike Luce, MD

Dinner for two at the Primo Grill
Donated by: Vicki Black, MD
Purchased by: Jan Vleck, MD

Crystal Wine Decanter, glasses and wine
Donated by: Tom Norris, MD
Purchased by: Harold Clure, MD

Gift certificate for dinner at Windows of the Seasons
Donated by: WestCoast Hotels
Purchased by: Tom Osten, MD

Margarita Party Tray
Donated by: WAFP
Purchased by: J. Luke Olson, MD

Pasta and wine basket
Donated by: WAFP
Purchased by: John Anderson, MD

Picnic Basket
Donated by: Ruby Fusaro
Purchased by: Tom Osten, MD

Tea Party Tray
Donated by: Daniel Austin, MD
Purchased by: Luanne Chen, MD

18 Holes of golf at Skamania Lodge
Donated by: Skamania Lodge
Purchased by: Tom Osten, MD

Baby basket
Donated by: WAFP
Purchased by: Stephen King, MD

11 inch bust of Charlie Pride
Donated by: Tom Osten, MD
Purchased by: Tom Osten, MD

Bath Basket
Donated by: WAFP
Purchased by: Stephen King, MD

African Masks
Donated by: Jean Marshall, MD
Purchased by: Carole Glasgow

DI DI Dolls
Donated by: John Plastino, MD
Purchased by: Daniel Austin, MD

Raven Print
Donated by: Al Berg, MD
Purchased by: Ed Kay, MD

Gift Certificate for two at La Conner Channel Lodge
Donated by: La Conner Channel Lodge
Purchased by: L. Sinclair
Cultural-Competence: Guidelines in Caring for Gay, Lesbian, and Bisexual Patients

Christopher H. Gaynor, MD, MA

The following is adapted from “A Provider’s Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population,” copyright 2000 Kaiser Permanente. It is essentially an outline of recommendations designed to engender dialogues on LGBT health care issues, increase clinical awareness, improve the levels of satisfaction and quality of health care that we deliver to our LGBT patients. This segment will address only the LGB population. Providing culturally competent care for transgender patients will be addressed in a separate article.

We, as Family Physicians, need to be cognizant of the enormous obstacles in the health care environment. Five major barriers to the provision of culturally competent care for the LGBT person are:

1. Invisibility of many of these individuals or a lack of willingness to self-identify due to fear of discrimination through historically negative interactions with health care institutions and providers
2. Homophobia
3. Heterosexism
4. Limited epidemiological research
5. Lack of provider knowledge of unique LGBT health care issues

General Information and Guidelines

• The specific health care needs of the gay, lesbian and bisexual (GLB) populations differ in important ways from those of exclusively heterosexual patients.
• About 5 to 10% of your patients are lesbian, gay or bisexual.
• Sexual behavior is fluid: A Patient may initially self-identify as hetero- or bisexual, and later in life consider herself exclusively lesbian.
• Sexual Orientation is no longer considered a “lifestyle choice.”
• Sexual Orientation may not be synonymous with sexual behavior: A woman who says she is a lesbian may occasionally engage in sex with men, and therefore be at risk of pregnancy, STDs, HPV. The same could be true for a heterosexual man, who would then potentially be at increased risk for morbidity associated with men having sex with men (MSM).
• Strong cultural or societal pressures may make it difficult for an individual to disclose same sex relationships, yet this information is vital for effective treatment. Making the patient feel as comfortable as possible in the patient-provider relationship increases the chances of complete disclosure.
• Be sensitive to the patient’s cultural milieu when suggesting resources or referrals for support services.
• LGBT people of color may be less likely than White LGBT persons to access mental health services and other social support services. Consider ways to communicate utilization of these services.

History and Physical

• Exclude assumptions about gender from patient intake forms (e.g. husband/wife, mother/father). Instead use gender-neutral terms such as “life-partner/spouse,” “parent.”
• Questions about families should allow for alternative families including two parents of the same sex and more than two parents.
• For questions where there are other possible answers, an ‘other’ category should be included with space to explain (e.g., single, married, widowed, other.)
• The form needs to include an explanation about how confidentiality will be protected and who has access to the information. Offer the patient the right to refuse to answer a question.

Patient Interview

• Make no assumptions. Any person who walks into a provider’s office could self-identify as LGBT and/or have a history of relationships with members of the same sex. Similarly they may have been born the opposite sex.
• Sexual behavior can change over time. Questions on sexual orientation and behavior need to be asked of everyone and asked repeatedly over time.
• Health care providers can apologize if a patient seems offended and should explain that they are in a learning process. A brief explanation about why information is necessary to
CULTURAL COMPETENCE

Continued from previous page

provide the best care possible can be offered. Ask what terminology the
treatment the patient prefers (e.g., if you call a part-
er a lover and the patient seems offended, ask what s/he usually calls

• Try to be completely comfortable talking about sex (slang and technical).

• Condemning is never helpful. Providers have the right to their own morals and beliefs in their personal lives, but not when they interfere with the delivery of necessary care. LGBT patients are usually sensitive during the interview about what they perceive as the provider’s attitude toward them.

• A provider who is not comfortable or knowledgeable of particular behaviors, lifestyles, or orientations should seek out a colleague who has expertise in LGBT health care. After the medical interview is complete, refer the patient, pointing out that the colleague has special expertise in this area, not that s/he is uncomfortable treating the patient.

• Explain how the patient’s confidentiality will be protected, and who will have access to the information. Give the patient the option of refusing to answer a question. If the patient’s confidentiality cannot be protected, it may be to the patient’s disadvantage to provide specific information if it is recorded in the medical chart.

• Advocate for all patients to enact medical powers of attorney, and respect those choices once implemented.

Risk Factors

• Homophobia and heterosexism exist at the individual, group and institutional level. Being sensitive to personal and institutional biases toward heterosexuality can help a provider to see and then address these biases.

• A provider’s personal religious or moral beliefs can be separate from the dynamics of their relationship with LGBT patients. Assess how your biases impact the way you communicate with the patient and the way you interpret symptoms.

• Communicate a safe environment to facilitate discussion during interviews. Use non-judgemental and gender-neutral terminology.

• Make no assumptions about a patient’s behavior or health needs. Ask the patient and use his or her language to describe relationships, sexual behaviors and health concerns.

• Focus on behavior rather than sexual orientation. Do not assume that all patients are heterosexual, or if legally married, are either heterosexual and/or monogamous.

• Respect a patient’s wishes or needs to disclose or not disclose his or her sexual or gender identity.

• LGBT individuals may be at an increased risk for substance abuse. Be knowledgeable about alcohol and drug use patterns and counsel patients accordingly.

• Ask about sexual behavior and sexual orientation.

• Be knowledgeable about sexual practices so that preventable risks can be discussed during an office visit.

• When questioning a person who has been hurt during sexual play, explore the consensual nature of the activity before counseling about abusive relationships.

HIV/AIDS and Other Sexually Transmitted Diseases

• Developing comfort and confidence in taking a sexual history is critical to a comprehensive risk assessment.

• Identification and aggressive treatment of STDs can have a positive effect on the long-term survival and transmission rates.

• Primary care visits are an important opportunity for education on safer sex practices.

• Screening for STDs is as important as screening for HIV. A primary care visit is an important opportunity to encourage testing.

• If a patient tests positive for an STD, he/she should be counseled about notifying current and previous partners.

• Gay and bisexual men should be screened for hepatitis A, B, and C. If results indicate no exposure and no immunity to hepatitis A or B, vaccination should be offered and provided. Prevention for hepatitis C should be encouraged, including not sharing needles if intravenous drug use is noted. The proper use of latex condoms during sexual activity among MSMs should be advised.

• If patients are found to have acute or chronic hepatitis B or C, risks of transmission to others should be discussed. Liver function and chronicity should be assessed and therapy should be advised, if appropriate.

• Whenever possible and appropriate, discuss sexual risk behavior and risk reduction strategies for all STDs.

• Know that MSMs can present with STDs in less common locations such as the pharynx or anus. Anal warts and dysplasia are much more common in MSMs than in their heterosexual counterparts.

• Sexually active gay or bisexual males should be screened for syphilis, gonorrhea, HPV, and Chlamydia from the appropriate sources (genital, oral cavity, rectum) based on the patient’s sexual behaviors (note: not all gay men
CULTURAL COMPETENCE
Continued from previous page

engage in ano-receptive or any other specific sexual activity).
• Incidence of STD in women having sex with women (WSW) is less clear, but appropriate screening should be done.

Obstetrical and Gynecological Concerns
• Understand the reasons for the reluctance of many lesbians and bisexual women to seek care, and be aware of the potential negative impact of homophobia upon their care.
• Avoid making heterosexual assumptions when gathering social and medical information. For example, asking your female patients about birth control methods, before asking with whom she has sex, assumes heterosexuality. Asking instead “Is there any need for birth control? Why or Why not?” would be a more productive approach.
• Lesbian sex can transmit most STDs. Therefore, it is important to screen lesbian and bisexual women on the same basis as heterosexual women.
• Breast cancer may be more prevalent among lesbian and bisexual women. Encourage breast self-examination and conduct regular breast exams and mammograms when indicated.
• Offer to involve a patient’s partner in discussions about care.
• Provide appropriate resources to aid them in assuring their medical and legal needs are met.

Adolescent Health
• Be comfortable with issues of sexual orientation and gender identity as well as non-threatening and non-judgmental interview techniques.
• Often a health care provider may be the only person with whom an adolescent will share his/her sexual orientation.
• Be familiar with and have resources available for LGBT teenagers such as counseling services, peer groups, and groups for parents, such as Parents, Families and Friends of Lesbians and Gays (PFLAG).
• Be aware of the risk factors for the LGBT adolescent: suicidal ideation, STDs and substance abuse, such as tobacco and alcohol.

Parenting
• The provider should not assume that a single parent is heterosexual.
• Discern and acknowledge the family structure, using questions such as “Who cares for this child?” and “What does the child call his/her parents?”
• Use health history forms that use neutral terms such as parent/guardian, rather than the father and mother, facilitate the disclosure of alternative family structures and send a message of inclusion to parents.
• Even if no arrangements exist to give both parents legal rights of consent, couples who are committed to raising a child together respond positively when the child’s provider acknowledges both parents’ roles, maintains eye contact with both, and includes both in discussions about the child’s health care. Parents take offense when the provider refers to the child as only belonging to the biological or legal parent, or excludes the non-biological parent from discussions about the child’s care. Parents have reported this type of negative experience most frequently in emergency and urgent care settings.
• Younger children and mid- to late adolescents tend to be more accepting of alternative family structures than older elementary or middle school children. Middle school, a difficult time for many children, can be especially difficult for children of lesbian and gay parents. These children may confront a surge of homophobic insults and a developmentally appropriate desire to conform to their peers. Ask the child if he or she encounters any teasing or harassment because of the parents’ sexual orientation.

Mental Health Concerns
• Homosexuality does not require treatment. So-called “Reparative therapies” are potentially harmful.
• Providers need to be aware of the stress of living in a community with AIDS so that care can be delivered in a compassionate and non-judgmental manner. This information can be obtained by assessing the patient’s scope of presenting medical concerns, sexual history, high risk behaviors, recent stressors (including significant losses), and other relevant information in addition to the standard history and physical. The providers can consider making a recommendation for a psychosocial evaluation.
• Ask questions in a non-threatening, non-judgmental manner.
• Welcome the inclusion of same-sex partners in health-care decisions.
• LGBT adolescents may be at increased risk of domestic violence. Assess and make appropriate referrals.
• Continue to assess for alcohol/drug use and sexual behaviors in older adult patients.
• Screen for domestic violence in all patient populations.
• Ask patients about a personal history of hate crimes/violence. Victims of violence are at increased risk of post-traumatic stress disorder.
• Differentiate between depression and sadness, shock or bereavement. Seek consultation if appropriate.


Dr. Gaynor is a family physician who practices in Lynnwood. He is also the Chair for the Committee on Special Constituencies.
Nancy J. Auer, MD,  
WSMA President

Doctors looking for Greener Pastures

Scanning the newspaper clippings for the past couple of months, I found the following headlines:

“Endless bureaucracy is forcing many doctors to leave practice” – The Olympian

“Doctor shortage becoming critical” – The Olympian

“Frustrations lead to exodus from state” – The Olympian

“MDs leaving area as reimbursements drop” – Bellingham Business Journal

“Survey of doctor groups finds most struggling” – Puget Sound Business Journal

It seems like the media is finally getting the point that there’s a problem in our communities, thanks in large part to our CURE Campaign (1). It is regrettable that the same can’t be said of the legislature.

Since January, our message to the legislature has been clear – Washington state is on the brink of a health care crisis. Doctors are closing their practices; patients are unable to find new physicians; sick and injured individuals are clogging hospital emergency departments.

The crisis is not just a problem for the poor and elderly, who rely on government-funded health care programs. Many middle-class working families struggle to get the coverage and the care they need. Most medical practices now operate at a loss. In 1999, as previously reported, the average medical practice in Washington state lost $95,000, according to a study conducted by researchers at Washington State University.

Each time a physician leaves, retires or closes his/her doors, about 2,000 patients must find a new caregiver – regardless of their insurance coverage. And many of the remaining doctors are overloaded and can’t accept new patients.

Reimbursement rates are so low that physicians lose money when they treat patients on subsidized state and federal insurance plans. Some have stopped treating these patients in order to salvage their practices for all their patients. According to the Whatcom County Medical Society, there are not any family practice physicians in private practice in Whatcom County who are seeing new Medicare or Medicaid patients.

While some physicians have limited or simply stopped treating these patients, others are leaving the area. With the closure of the Memorial Clinic in Thurston-Mason County, many report that these physicians are not simply setting out a new shingle. Instead many are moving or retiring early. According to the Thurston-Mason County Medical Society, during the past 18-24 months 25 physicians have retired early, and 22 have moved out of the area. Most are primary care specialists. In addition, 17 have reduced their schedules to part-time.

Recruiting physicians to this state has also become difficult. In a recent survey of the Washington State Medical Group Managers Association (WSMG-MA) members, 47 out of 62 respondents said they had trouble recruiting physicians. The top four specialties...
were orthopedics, family physicians, internists and cardiologists. When asked how the market compares to five years ago, 44 respondents said it has become more difficult to recruit physicians. One of the major reasons why recruiting has become more difficult – non-competitive salaries.

In the midst of all this, the state has embarked on an expensive, intrusive and offensive payment recovery effort dubbed the Payment Integrity Program (PIP). Launched last year, the program seeks out alleged “overpayments” made by Medicaid to physicians. The PIP relies on a proprietary computer program operated by a company in Maine. If the state finds an alleged error, it can demand a refund up to three years after the payment was made to the physician. A physician may then be forced to go through a laborious, expensive process to justify further services that were provided in good faith.

The state says this program will help it better provide vital social and health care services to Washington’s most vulnerable citizens. It doesn’t tell you that the money collected goes back into the general fund. PIP won’t help the poor get better access to health care and social services. And state-funded medical programs already under-pay doctors for their services, leaving many practices struggling financially. PIP only drives physicians away from helping patients in these programs.

It isn’t a hyperbole to state that our delivery system appears ready to collapse. Even people with the best, most comprehensive health insurance won’t escape. As you and I both know, if a medical practice in a community can no longer afford to keep its doors open, no one will get care.

While the WSMA looks for long-term solutions, legislative decisions can be made to help ease some of the burdens on our state’s health care system. They include:

- Provide medical practices with the same B&O tax exemption already given to hospitals for revenue from publicly funded health care programs.
- Stop the Payment Integrity Program (PIP).
- Stop legislative mandates and expanded scopes of practice, which drive up costs.
- Provide relief from unfounded regulations that only add to the administrative burdens of medical practices, including such things as the Clinical Laboratory Improvement Act (CLIA) and interpreter services.

Sadly, at the time this edition of the Journal went to press our legislators had taken no steps to ease the burdens, albeit there was some discussion underway during the special session to restore the eligibility cuts in the Basic Health Plan that the House version of the budget proposed. Overall, political leadership – with some exceptions – to deal with these problems has been lacking.

The WSMA supports an adult public discussion of the hard choices that must be made in order for the state to effectively allocate its health care resources.

The conversation needs to start now and needs to begin with these two questions: Is the doctor in? For how long?

1 The CURE Campaign is a joint project undertaken by the WSMA and Physicians Insurance to communicate to the public what is happening to medical practice in the State of Washington and what physicians are doing to make the health care system more responsive to patient needs.

Dr. Auer is president of the Washington State Medical Association. An emergency physician by training, she is currently the Vice President of Medical Affairs at Swedish Medical Center.

GREENER PASTURES
Continued from previous page

FUNDAMENTALS OF MANAGEMENT AD
USE KEYLINE
(SLICK ENCLOSED)
The 2001 Annual Meeting is now behind us, but many wonderful and challenging opportunities are before us. This being my first Annual Meeting-House of Delegates Conference, I was once again duly impressed with the motivation and inspiration of those attending to make a difference in the communities we serve. The Resolutions that the House of Delegates dealt with cover a good variety of concerns. (See related article on those resolutions that were adopted.)

Although I am new to the medical field, I consider myself an informed reader with an awareness of our state’s health care issues primarily from the consumer’s point of view. Now, with more understanding of the providers’ point of view, it is clear that we have a serious crisis threatening the health care of Washington State’s citizens.

You all have known the crisis for a long time and have been living it on a daily basis. Recently two of our national senators attended a forum in Olympia on the health care crisis, stating they understanding the issues, and want to do something, but… With the lack of any real progress with our state legislature regarding health care concerns, there is some doubt the legislators truly understand the crisis, as they are willing to close the session without facing the issues.

Family practice, unlike any other specialty is truly the safety net of our health care systems. It is the family physician who is more likely to reside and practice in the underserved areas of our communities. But, the safety net is in trouble. In the past few months, I have learned from your meetings and activities that there are many roots to the problem: managed care, inadequate access to care, inattention to the health needs of our communities, increasing cost of practice management coupled with reduction in reimbursements, and the rapid spread of expensive technologies that do not improve the health of our state’s overall population.

There are no simple answers. However, family physicians must not continue to practice in quiet desperation. The time is at hand to work on comprehensive solutions. All must come together in a collaborative effort and address health care concerns for the public good. The call is for LEADERSHIP! The Washington Academy of Family Physicians stands up to this challenge and needs your active participation. The Leadership Workshop on August 24th at WestCoast Hotel in Yakima offers a great opportunity to strengthen the impact our organization can have. Please, be part of this; your ideas are very important and so is your willingness to put them into action. If the safety net fails, who will be there to care for our communities? Family physicians cannot continue as a “voice in the wilderness.” That voice must become stronger, louder, and focused for effectiveness. This can only happen with YOU.

Ruby is the Executive Director for the WAEP. She has four wonderful daughters and eight perfect grandchildren.

“When faced with challenges, the trick is not to think about what to do, but to marshal the energy and the courage to act.”
Tobacco Quit Line Serves Thousands
Health Care Providers Can Refer
Patients to 1-877-270-STOP

Maxine Hayes, MD, MPH

Washington state’s new toll-free Tobacco Quit Line has helped more than 8,000 people during its first six months in operation. This volume of calls (over 300 inquiries a week, on average, since November) exceeds many initial expectations, and clearly shows the public interest in access to telephone-based tobacco cessation services.

Also encouraging is the fact that nine in ten of all callers are themselves addicted to tobacco; and say they’re “ready to quit.” They are calling the Quit Line because they need and want a helping hand.

And they’re receiving just that.

Professional cessation specialists help callers understand the many different ways they can kick the tobacco habit and quit for good. They offer free one-on-one counseling and customized quit plans over the phone – all proven techniques to help patients succeed in quitting:

• Individual counseling, motivation and problem-solving advice;
• Up-to-date information about pharmacological support, including cessation benefits offered by patients’ health plans;
• Information and referrals to available community-based tobacco cessation-support resources; and
• A Tobacco Quit Kit containing custom-selected materials mailed promptly as a follow-up to their initial telephone counseling session.

Quit Line operators are skilled in all forms of nicotine addiction – cigarettes, chewing tobacco, cigars and pipes – and in all stages of a patient’s readiness to quit.

Health care providers can refer patients with confidence to the Washington Tobacco Quit Line.

Clinical studies show that combined methods of assistance with tobacco cessation, such as behavioral counseling and telephone quit lines, can significantly increase quitting and abstinence rates. The U.S. Public Health Service guideline, Treating Tobacco Use and Dependence, now recommends brief counseling as part of effective clinical intervention.

Using the “best practices” of other states, our Quit Line is designed to assist health care providers in helping their tobacco-addicted patients. Telephone counseling is a promising strategy to advance provider approaches to tobacco intervention, commonly known as the “5 A’s:”

1) Ask about tobacco use;
2) Advise to quit;
3) Assess willingness to make a quit attempt;
4) Assist in quit attempt; and,
5) Arrange follow-up.

While most health care providers have opportunities during routine office visits to pursue steps one, two, three (ask, advise and assess), time constraints often prevent in-depth counseling and follow-up support.

Now, with Washington’s Tobacco Quit Line, health care providers can refer patients to an effective referral resource for tobacco cessation assistance. Every patient can access one-on-one telephone counseling and referral to follow-up support.

Call the Quit Line yourself, before referring a patient. I think you’ll come away impressed, as many of our colleagues have, and adopt the Quit Line as a referral resource in your everyday practice.

You Make the Call

Health care providers have been leading advocates for tobacco prevention and control efforts in our state. The Quit Line, a prudent investment of proceeds from the Master Tobacco Settlement Agreement, is an effective cessation-referral resource for patients who smoke or chew tobacco.

We cannot overemphasize how important provider referrals are to the Quit Line. Patients advised to quit by their providers are much more likely to make a serious attempt. Patients who call the Quit Line – because they need and want a helping hand – are much more likely to succeed.

Working together, we’re all making progress.

Free patient education materials promoting the Quit Line are available by contacting Carla Huyck, Department of Health/Tobacco Prevention and Control Program at 360-236-3678.

Maxine Hayes, MD, MPH, is State Health Officer for the Washington State at the Department of Health. Previously, Dr. Hayes was a primary care physician practicing in King County.
Dan Austin, MD and the new WAFP President Bob Crittenden, MD enjoying the annual banquet.

WAFP member Bill Phillips, MD enjoyed his ride on the Spokane River.

Outgoing resident Trustee Margo Budman, MD with incoming resident Trustee Carla Ainsworth, MD.

WAFP members, students and residents wait to take a ride down the Spokane River.

Don Solberg, MD, the WAFP Treasurer performing rounds with the famous money jar to raise money for the WAFP Foundation Auction.
Incoming president Dr. Crittenden means business!
Al Berg, MD and Jean Marshall, MD, Vice President keep smiling.

Jeff Maple, MD and his wife enjoy food and fun at the WAFP hospitality suite.

John McCarthy, MD of Tonasket with his two sons at the WAFP Family Function on the beautiful Spokane River.

Dan and Sandy Austin enjoying the barbecue at the WAFP Family Function.

Student Research Paper Award Winner
Amy H. Olsen

Luanne Chen, MD and Sally Gasparich keep smiling at the WAFP Annual Meeting.
House of Delegates Actions
May 3, 2001
The following resolutions were adopted.

Anti-trust Information
RESOLVED that the WAFP develop and disseminate to its members a clarification of which economic issues can and cannot be discussed among unaffiliated physicians under current anti-trust laws.

Prescription Drug Formularies
RESOLVED that the WAFP encourage the Association of Washington Health Care Plans to urge its members to establish a more universal, less restrictive drug formulary for the benefit of both the patients and the health care providers.

Role of Physician Extenders
RESOLVED that the Washington Academy of Family Physicians take measures to create public awareness of the role of the family physician.

Abolish the Payment Integrity Program of DSHS
RESOLVED that the WAFP effectively inform each representative of the Washington State Legislature protesting this program and encouraging improved funding for health care in Washington State.

Affirmative Action
RESOLVED that the WAFP work with the WSMA and with the University of Washington School of Medicine to prioritize developing medical students committed to serving underserved populations in both rural and urban communities.

Hanford Nuclear Waste
RESOLVED that the WAFP opposes additional off-site waste being added to the overburdened Hanford Site until the current nuclear waste storage problems and environmental threat to the surrounding area are solved, and a publicly vested national plan for nuclear waste be created; and be it further RESOLVED that the WAFP support working towards a solution to the Hanford Site nuclear waste problem and encourages the creations of a national plan for nuclear waste disposal to ensure optimum public health; and be it further RESOLVED that the WAFP delegate to the AAFP Congress of Delegates submit these resolutions to the AAFP so that the AAFP puts forth a national solution to facilitate a national program for the disposal of waste for the optimal public health; and be it further RESOLVED that the WAFP Delegate to the WSMA submit a similar resolution to the WSMA.

Chronic Illness Care
RESOLVED that the WAFP submit a resolution to AAFA to encourage the implementation of primary care based systems of effective care of patients with chronic illness, and develop models of equitable and appropriate reimbursements for these systems of care.

I-601 Exemption
RESOLVED that the WAFP continue to work with the WSMA to support legislation aimed at exempting health care exemptions from the I-601 spending limits or otherwise modifying the state budget to assure adequate reimbursement for health care services; and be it further RESOLVED that the WAFP develop or adapt a patient education handout about the legislative issues concerning health care access and reimbursement, including specific bills before the state legislature, that members can customize with local legislators; contact information and distribute to patients to encourage them to contact their legislators.

Political Action Committee
RESOLVED that the WAFP direct its Board of Directors to explore the feasibility of creating their own Political Action Committee; and be it further RESOLVED that the WAFP direct its Board of Directors to explore the feasibility of employing a part-time or ad hoc lobbyist to the Washington State Legislature.

Evaluation of Relationship with AMA
RESOLVED that the AAFP board of Directors will conduct a cost-benefit analysis on the AAFP’s involvement with the AMA; and be it further RESOLVED that the AAFP Board of Directors will report the results of this analysis to the 2002 AAFP Congress of Delegates.

Completion of Rural Health Initiative Fund and Building of Family Medicine Research Fund and Future of Family Medicine Fund
RESOLVED that the expiring Rural Health dues assessment be replaced by an annual $50.00 assessment that will be approved on a four-year cycle. This assessment will be levied on the WAFP Active Membership through the WAFP Foundation. The assessment will assist in completing Rural Health endowment, to allow development of endowments to support the Future of Family Medicine activities and Family Medicine Research.

Continued on page 26
Earlier this year, Luberoff – long time editor of “Chemical Innovations” – decided to try to quantify today’s image of the word “chemical.” Taking advantage of the Google search engine, he scanned an enormous number of technical articles (English language only) for their use of the term “chemical” and uncovered more than 1.07 million such articles. He then examined the modifiers – the adjectives that were used along with “chemical.” Not surprisingly to me, more that 90% of the modifiers had clear, negative connotations – e.g. bad, toxic, hazardous, catastrophic, etc. His findings gave credence to the fact that our society holds chemicals in particularly low esteem. It confirms why a popular CEO turned down offers as either president of a pesticide company on the one hand or a pharmaceutical company on the other – the resultant image seemed to him to be incompatible with his ‘personal life.’

As noted in the 24 May issue of Nature, it and a number of other science publications – Science, New Scientists, Scientific American and others – have all spoken out that chemists have to change their individual and collective images to begin to capture any of the best and brightest minds of the younger generation to enter their field. A group at Harvard has actually sought to uncover why the field is proving so unattractive; their answers are addressed in the above referenced Nature – but no where do they mention that the chemist deals with chemicals – and, since chemicals are all bad, so too, must be all chemists.

Think for a moment. If such an image were to involve medicine, what would happen? What could be done if 90% of physicians – 90%! – were viewed in a bad light by the general public? Even though the medical profession – actually all professions! – is not held in as high esteem as it was 40 or so years ago, people’s personal physicians are viewed quite differently.

My own doctor maintains a particularly high level of esteem – especially compared to consultants, academics and medical executives. Obviously my doctor’s human component augmented by his or her care, consideration and communication seems to overcome many, many individual short comings.

Today’s family practitioners might think back to the 60’s and 70’s and reflect on the then-current image of ‘general practitioners.’ For a number of reasons – the emergence of the specialties, the experiences of WWII, and the flooding of the Eastern portion of the country with non-English speaking immigrant physicians who failed to get appointments on hospital medical staffs and were forced to pursue ghetto-based general practice – these and other reasons resulted in medical students and residents shunning the role of general practitioner as a career choice – despite our nation’s health policy gurus’ pleas to the contrary. Up stepped the American Academy of Family Physicians helping to change the image – as ably assisted by some governmental dollars to promote primary care. Today, one scarcely hears of the bedraggled ‘general practitioner’; instead its ‘my family physician.’

Here in the West, this transition took little effort to succeed – but in those cities of the

Continued on next page
PRESERVE YOUR IMAGE
Continued from previous page

East – those monuments to urban blight – many have yet to see the light. Moreover, a number of their medical schools are still in a phase of total denial; they don’t even have family medicine departments. A few in that hub of the medical universe – Boston – fail to note that the world of medicine has changed and that family medicine has helped lead the way. But, today, there is emerging concern that – like the field of chemistry – the field of family medicine is not attracting the best and the brightest. Personally, I’m skeptical that any solid data – except this year’s matching program – tend to even hint that there is a problem. Nonetheless, the leaders of any wise discipline would do well to maintain an effective marketing program to appeal to the apparent wants and needs of difference sections of the country. From my vantage point, just look at the Pacific Northwest; it’s particularly well off with an enormous strength of its training programs, their follow through and alumni activities. Only Boeing fails to recognize it is clearly the best in the country.

My message is, however, a simple one. In addition to flattering each reader, could I plead that all of you also market the fields of chemistry and chemicals. After all, you and I are nothing but a glob of chemicals that somehow inter-relate with each other in a usually constructive manner. Certainly, some chemicals have had some negative effects on society but, on balance, the field of chemistry has burgeoned food production, has abolished nutritional and many infectious diseases and has created plastics, nanotechnology, MRI’s and still better chocolate, all to the benefit of mankind. Talk to your kids and your colleagues about this issue; those with good images could do much to correct the images of some components of our society that are less fortunate – and so misinformed. Which will you back – using pesticides or genetically modified foods? Grousing about either is totally incompatible with our future. For me – I plan to use both.

A transplanted Easterner, Dr. Robertson did med school and residency at the University of Rochester. He moved to the University of Washington in 1963 as an Associate Dean and has served as Medical Director of a Poison Center since 1956 – with beeper availability when they appeared in 1964. His now-retired-physician spouse and he have five great kids – 4 greater grandchildren and hordes of happy memories.

HIGHLIGHTS OF ANNUAL MEETING
Continued from page 24

activities, and development of endowments for other projects deemed important to its membership and leadership.

New Physician Mentor Program
RESOLVED that the WAFP House of Delegates support the formation of a mentor program for new family physicians in practice; and be it further RESOLVED that the WAFP Board of Directors creates a task force to develop this concept.

Task Force on Presidential Compensation
RESOLVED that the WAFP Board of Directors creates a task force to study the potential of compensation for the WAFP President in the future.

Recognition and Best Wishes for Dr. Gary Snyder
RESOLVED that the WAFP House of Delegates recognizes and expresses our sincere thanks to Dr. Snyder for his great service and for his many contributions; and be it further RESOLVED that we wish him all success for a complete recovery.

MOM CARE AD
(SLICK ENCLOSED)
Summer Medical Institute Northwest 2000: A Community-focused Training Opportunity

Melanie Payne, MPH
Robert Grotz, MD
Steve Baker, MD

The Summer Medical Institute Northwest (SMI NW) was a church-sponsored summer training program for medical students to experience one-on-one clinical experience while serving communities that had limited or even no access to medical care. The Vancouver-area program provided a unique experience for students by allowing them to offer both medical and spiritual assistance to a diverse population who had limited access to medical care and social support systems. This allowed medical students an opportunity to develop critical linkages between medical care and religious growth, to serve the underserved, and to integrate their religious faith along with their medical practice skills.

Project Funding and Oversight
The SMI NW program was sponsored by the New Heights Clinic in Vancouver, Washington, which also provided logistical and volunteer support. Since 1996, the New Heights Clinic has been an outreach of New Heights Church to the medically underserved of the greater Vancouver, Washington and Portland, Oregon metropolitan area.

Participants’ housing, weekday meals, and daily transportation were provided. The students brought spending money for weekend meals, recreational activities, and personal incidentals. In addition, students and other volunteers provided for their own transportation to and from Vancouver, Washington.

Dr. Steve Baker, who directed the SMI NW program, serves as the Medical Director of the New Heights Clinic. All patient services at the New Heights Clinic are free. The medical students worked with licensed physicians in general or specialty practice, licensed nurses, qualified nurse assistants, and other professionals in the fields of physical therapy, psychology, social service, and administration.

A research team consisting of several physicians, an epidemiologist and four of the medical students helped direct and document the activities of the SMI NW program.

Medical Student Participants
Sixteen first and third year medical students from the Western United States and Canada participated in SMI NW. They were selected for their leadership qualities, character, and experience or interest in serving the underserved. Every student expressed a wish to serve God through the practice of medicine as an expression of faith.

Communities Served by SMI NW 2000
The Vancouver areas served were selected on the basis of recommendations of public assistance agency workers, law enforcement personnel, and the City Planner’s office. The population included people of Caucasian, Hispanic, and Russian descent. Interpreters were available for non-English speaking residents. The targeted communities within Vancouver were at risk for being medically underserved and comprised mostly apartment complexes. At the invitation of Yakima tribal leaders, some Native American fishing settlements along the Columbia River were also served. These included people living in isolation, and there were some single-parent families with many children.

Project Activities
The 3-1/2 week program ran from mid-June to mid-July. During a three-day orientation, the students were trained in the areas of health care delivery, research protocol, and cultural issues. Then, teams comprised of two to three students conducted door-to-door surveys of the status of individuals’ health and provided medical care, information, and other services as needed (e.g., smoking cessation information). By visiting these homes, students addressed documented barriers to care such as cost, transportation, language, etc. During the visits, students provided education, established relationships with the patients, and encouraged follow-up with local health care providers.

Psychosocial and spiritual assistance and referrals were made as requested. Four health conditions were the focus of the project: asthma, diabetes, hypertension, and tetanus immunization. SMI NW medical advisory teams comprised of physicians and nurse clinicians wrote protocols for each of the health screenings. The students were trained during...
Continued from previous page

SUMMER MEDICAL INSTITUTE

SMI NW by the advisory teams to measure peak expiratory flows, to measure blood sugar and blood pressure, and to obtain an immunization history and give tetanus vaccination when indicated.

Each team carried medical equipment standardized for the screenings they would perform. They worked methodically through the selected areas and neighborhoods, knocking on doors, explaining the purpose of their visit, and offering their services. Therefore, the patients were seen at their own place of residence instead of having to go to a health care provider's office.

When a medical problem surfaced during the health screenings, the students provided recommendations for follow-up care either with the patient's physician or through the New Heights Clinic (for those without medical insurance). Each patient was given a "prescription card" that detailed the medical findings and risk factors for the particular health condition(s). The patient was encouraged to take the prescription card to their medical provider and discuss it as indicated.

**Project Results**

Overall, SMI NW students participated in 1,999 attempts at service (or doors knocked on to offer medical service) over a 14-day period. Overall, 14% of the service attempts resulted in at least one health screening (n=286). Other people were not at home (62%) while the remainder were not interested and refused participation (24%). Of the patients screened, the majority agreed to the screening for high blood pressure, and about one half were screened for diabetes (Table 1). Fewer patients were screened for asthma or given the tetanus vaccination.

**Selected Health Conditions**

Each of the four targeted health conditions represented a fairly common medical problem so there was a strong likelihood that the students would encounter patients with each of them during the program. Each medical condition had a screening test that could be performed with easily portable equipment. Also, the tests were relatively easy to teach to the medical students during the orientation period. Early diagnosis of each of the conditions could result in treatment benefits for individual patients.

In conducting the home visits, the students hoped to eliminate some of the barriers that individuals may face in seeking medical care and treatment. The project sought to identify patients who 1) were unaware that they had a certain health condition (newly diagnosed patients) and 2) were aware of their health condition(s) but unaware that the condition may not be controlled adequately (previously diagnosed patients).

**Table 1. Participation in Health Screenings**

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<thead>
<tr>
<th>Health Condition</th>
<th>Count</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>N=192</td>
<td>67%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>N=148</td>
<td>52%</td>
</tr>
<tr>
<td>Asthma</td>
<td>N=87</td>
<td>30%</td>
</tr>
<tr>
<td>Tetanus Vaccination</td>
<td>N=60</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Project Conclusions and Recommendations**

The SMI NW program targeted four common health conditions in some medically underserved areas of southwest Washington. While allowing medical students to supplement their school curriculum with hands-on experience, the program provided free medical care to patients in their own homes, which helped minimize certain barriers to care such as cost and transportation. At the same time, the project allowed patients to have a positive interaction with the medical community. There were good experiences on numerous fronts (including medical, community, and spiritual) for the medical students and the patients they served.

Overall, patients seemed more inclined to participate in less invasive or less difficult screenings. The screening for hypertension included a simple blood pressure measurement with a standard arm cuff and had the highest uptake. On the other extreme, the tetanus vaccination required an injection intramuscularly, and had the lowest uptake.

We hope that identification and increased awareness of the selected health conditions will help minimize the short- and long-term complications associated with the selected medical conditions. Students encouraged follow-up, and taught primary prevention methods such as diet, exercise, and lifestyle changes. Secondary prevention methods were also encouraged to help control the conditions and minimize risks through diet, exercise, medication, medical monitoring, and modifying environments and lifestyles as needed.

SMI NW was an enormous undertaking that provided an extraordinary experience and opportunity for the medical students, faculty and staff of the program. As well, the program served an important role in the community by offering free medical services to communities in need. There is a continued need in the Vancouver area for medical care focusing on the medically underserved. Therefore, New Heights Clinic will further develop and expand the SMI NW program as needed for future years.

Continued on page 31
Miriam Marcus-Smith, RN, MHA
Gail Neuenschwander
Jan Norman, RD, CDE

An article in the Summer 2000 issue of Washington Family Physician described the importance of using standardized methods for determining glycated hemoglobin in diabetes management. At the time of that article, staff of the Standardized Laboratory Practices Project (SLPP), sponsored by the Department of Health, had determined that approximately 80% of the glycated hemoglobin tests conducted in licensed laboratories in Washington were performed using a method certified by the National Glycohemoglobin Standardization Program (NGSP). Decreasing the variation in technique, test results, and reference ranges allows comparison among tests and contributes to improved control and outcomes.

The SLPP carried out a variety of educational efforts to increase understanding of the importance of using standardized methods. A recent resurvey by the Department of Health’s Office of Laboratory Quality Assurance found that approximately 95% of the glycated hemoglobin tests are now being performed using such methods. This increase is the result of important choices: laboratories are choosing to use these methods, and more manufacturers are seeking certification by the NGSP. Providers should continue to be aware of methods’ certification status, as movement on and off the list can occur for a variety of reasons. The list of certified methods, updated quarterly, can be viewed at the NGSP’s web site: www.missouri.edu/~diabetes/ngsp.html

The implications of this change over the last year are significant: decreasing variation allows providers and people with diabetes to evaluate the effectiveness of management strategies and to determine if adequate glucose control is being achieved and maintained by people with diabetes. This is key to improving and preventing microvascular and macrovascular complications. Using a standardized methodology allows comparison of results in several ways:

- for the patient across time, especially if he or she changes primary care providers
- across patients within a provider’s panel of patients;
- across providers for profiling;
- across health plans for profiling, e.g., National Committee for Quality Improvement HEDIS measures.

The value of glycated hemoglobin is THE primary determinant of diabetes outcomes. It is essential that this test methodology be standardized nationally. Our achievements in Washington put us a step ahead of the nation for improved monitoring on a population basis.

Miriam Marcus-Smith is the Quality Improvement Program Director at the Foundation for Health Care Quality, a private, not-for-profit organization based in Seattle.
G’day! In January, my family and I moved to Melbourne, Australia due to a job opportunity for my husband at The Boeing Company. We are here for about three years, then we will return to Seattle. Last November, I ran into Bob Crittenden at the Husky football game. He suggested that I write once we were settled, and offer my thoughts about health care in a social democracy.

The most striking example of Australian public health is the sharps container in every stall of every public bathroom. With two small children, we spend a lot of time at parks, and a lot of time in the bathroom. At first, I thought the sharps containers might only be a city thing – they’re not. I have subsequently learned that they were placed in a rather blitzkrieg fashion early on in the epidemic, before people had a chance to introduce judgment on people with HIV. There is, however, lots of controversy and debate about the recent opening of an injection room in Sydney.

Another difference in a social democracy is the funding for infrastructure. The sharps containers are actually emptied, and the bathrooms cleaned on a regular basis.

I have recently started working as a Research Fellow with the Australasian Cochrane Center. The Cochrane Collaboration is an international, multidisciplinary organization dedicated to creating quality systematic reviews of the medical literature for clinically relevant topics. I love that our reviews cover everything from dust-mite eradication to pharmaceutical treatments. It is nothing if not practical. If you don’t have access to the Cochrane Library at your office, you can access it through the UW Health Sciences Library Web site.

On one of my projects at the Australasian Cochrane Center is a course on how to critically review the literature via distance education. Issues of professional isolation, lack of access to the Internet, and difficulty in attending continuing medical education courses are just as prevalent here as in WWAMI region.

As the Australians love to debate, I will offer the opportunity for one. The other day, I met an OB/GYN from Sydney who offered a very thought-provoking idea when he learned of my expatriate status, and my husband’s guarantee of employment upon return: Why not offer a similar guarantee to experienced clinicians to work in rural areas? Yes, there are loan repayment schemes, both in the US and Australia. His point was that after 10 years of practice, he would consider moving to the bush if he knew, like me, that he was going back. Both he and his family could then consider it an adventure and an opportunity. The key would be the repatriation process: helping clinicians find a new position, paying for the return move, and offering refresher courses.

Best wishes to you all. We have plenty of room for visitors.

Janet Piehl served as the WAFP Resident Trustee and recently moved to Australia with her husband and two wonderful children.
Students Experience Family Medicine During Summer R/UOP Program

Key to the Mission of the Washington Academy of Family Physicians is the R/UOP program. This successful program continues this year with the following Preceptors and Students. While the students are paid a small stipend, the participating family physicians are involved on a volunteer basis because of their passion for the program specifically and family practice in general. WAFP expresses appreciation to all the Preceptors and also to the WAFP Foundation for funding this program. We also thank the UW Department of Family Medicine (Dr. Roger Rosenblatt and his great staff) for coordinating the program.

**PRECEPTORS:**
- Peter Viavant, MD, Walla Walla
- Cheryl Workman, MD, Omak
- James Keene, MD, Sunnyside
- Richard Kozakiewics, MD, Omak
- Karen Easton, MD, Grandview
- Mark Larson, MD, Ellensburg
- Linda Powell, MD, Odessa
- Randel Bunch, ME, Orthello
- Malcom Butler, MD, Wenatchee
- John Kremer, MD, Chelan
- Carl Morris, MD, Tonasket
- Andre Nye, MD, Moses Lake
- Michael Luce, MD, Dayton
- Bertha Stafford, MD, Ferndale
- Michael Buben, MD, South Bend
- David Harvey, MD, Seattle
- Burk Gossom, MD, Friday Harbor
- Christopher Hartlestad, MD, Seattle
- Steven Kriebel, MD, Forks
- Kevin McCurry, MD, Mossyrock
- Roger Oakes, MD, Port Angeles
- Judith Featherstone, MD, Auburn
- Alan Chun, MD, Seattle
- Richard Avalon, DO, Cathlamet
- Ellen Rak, MD, Mt. Vernon
- Gary Schillhammer, MD, Arlington

**STUDENTS:**
- Christina Derleth
- Chester Gail
- Justin Gatewood
- Ari Gilmore
- Carolyn Halley
- Idiko Hegavyar
- Lindsey Johnson
- Zahir Karmali
- Erika Lease
- Carolyn McHugh
- Alyssa Stephenson-Famy
- Munir-zakary Tanas
- Bob Thong
- Alison DeSano
- Kevin Dooms
- Nancy Dunbar
- Hamilton Gillespie
- Hollie Matthews
- Wendy McGoodwin
- Stephanie Owens
- Robert Perry
- Richard Smith
- Bradford Stephens
- Emily Williams
- Julie Willner
- Lonnie Yeung

Best wishes to all of you for an enjoyable summer.

**SUMMER MEDICAL INSTITUTE**
Continued from page 28

For SMI NW program information, contact
Dr. Steve Baker, Director
Summer Medical Institute Northwest
7913 NE 58th Ave.
Vancouver, WA 98665

Melanie Payne earned a Master of Public Health from Emory University in Atlanta, GA. Since then she has worked as an epidemiologist at the federal, state, and local levels. She is currently an epidemiologist with a local health department in Washington State. She co-directed the research team for the Summer Medical Institute Northwest.

Robert Grotz, MD was the co-director of the research team for the Summer Medical Institute Northwest.

Steve Baker, MD, did his family medicine residency at Providence St Peter Hospital in Olympia, WA. Then was in a group family practice in Vancouver, WA, for 6 years. During this time he started New Heights Clinic, a church-based free medical clinic for people with no insurance. He now works as a medical consultant for a midwife and nurse practitioner clinic for low-income patients. He is Director of the Summer Medical Institute Northwest.
Continuing Medical Education


COURSE SPONSORS AND CONTACT INFORMATION

CME Harborview-Contact: Gayle Splater, Cytology Continuing Education, Dept. of Pathology, Harborview Medical Center, 325 Ninth Ave, Seattle, WA 98104; tel 206-223-5953.

PCMS CME Contact: Executive Director, College of Medical Education, 705 S Ninth, No. 203, Tacoma, WA 98405; tel 206-627-7137.

U/W (University of Washington) Contact: U/W School of Medicine, Div. of CME, SC-50, Seattle, WA 98195; tel 206-543-1050.

VMMC (Virginia Mason Medical Center) Contact: Linda Orgel, Division of Continuing Medical Education, Virginia Mason Medical Center, PO Box 900, Seattle, WA 98111; tel 206-340-2058.

WSMA (Washington State Medical Association) Continuing Medical Education, 2033 Sixth Ave, Ste 1100, Seattle, WA 98121; tel 206-441-9762.
Welcome New Members!

The WAFP is growing! The WAFP’s Active membership numbers have increased by 57 members since May of 2000. We recently received an award at the National Leadership Conference for having 100% of the Residents in Washington State as members of the WAFP. Thanks to the Residency Program Directors and Program Coordinators for helping us reach this goal. Also, we have 10 new Student members since our last publication.

Active
Heather G. H. Awad, MD, Olympia
David Baines, MD, Seattle
Sofia Bayfield, MD, Issaquah
Robert Berns, MD, Tacoma
Jack Choi, MD, Fort Lewis
Maricar De Guzman-Abajero, MD, Covington
Diane Dozois, MD, Seattle
Rose Marie Columbini, MD, Bonney Lake
Mark Fishman, MD, Bellevue
Anastasia Fyntirlakis, MD, Tacoma
Michelle Levy, MD, Everett
Kaviitha Vani Manjunath, MD, Sunnyside
Steven McCrorey, MD, Spokane
Mark Moscovitz, MD, Seattle
Wendy Neary, MD, Kent
Harry Pepe III, MD, Kenmore
Julie Phelps, MD, Tacoma
Catherine Ponzoo, MD, Bellevue
Susan Lisker Powell, MD, Okanogan
Chinda Roach, MD, Lynnwood
John R. Rogers, MD, Walla Walla
Christopher J. Sargent, MD, Evenson
Daniel Schmidt, MD, Spokane
Thomas A. Thorn, MD, Moses Lake
Panthenia F. Tobaison, MD, Bothell
Edward Wakatake, MD, Kent
David Zieve, MD, Seattle

Students
Stacy Dickhans
Matt Ashback
Deborah Love
Richard Rose
Brett Daniel
Jill Heynen
Leif Lunde
Mark Slabaugh
Eamon O’Reilly
Catherine Keay

Membership Status Totals as of 5/31/01

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<td>2,513</td>
</tr>
</tbody>
</table>

Thanks to the following doctors that have been with the Academy for 35 or more years.

- Mortimer Solon Aller, MD
- Bryan M Anderson, MD
- John P Archer, MD
- Thomas C Avalon, MD
- Benjamin A Baker, MD
- Burton A Barofsky, MD
- John A Barth, MD
- Frederick Becker, MD
- Duncan Bell, MD
- Harry D Betteridge, MD
- Martin Everett Blankenship, MD
- Frederick W Bolton, MD
- Richard V Bond, MD
- John Dalton Bond, MD
- David Myron Bratrude, MD
- Milton M Brooking, MD
- Lawrence Edgar Brooks, MD
- Bertram R Bunch, MD
- Maurice Burden, MD
- E C Burgoyne, MD
- Ralph H Butts, MD
- John R F Coffin, MD
- Joseph Bell Coppock, MD
- Jack H Cowan, MD
- Richard Howard Crabill, MD
- Jack B Dahlen, MD
- Alvin L Davis, MD
- David W Deisher, MD
- Ruby Ayako, MD
- Den Dulk, MD
- Ralph J Dona, MD
- Eugene F Doornink, MD
- James W Dugaw, MD
- Frederick W Eddings, MD
- James Howard Ehlers, MD
- Nola Mae Erickson, MD
- Donald Malcolm Erie, MD
- Alan L W Fairbanks, MD
- Richard E Ferguson, MD
- Melvin Hilding Fields, MD
- Samuel F Flint, MD
- Thomas Pidduck Foote, MD
- Norman W Fuesler, MD
- Arthur Belden Funkhouser, MD
- Branitley P Fusaro, MD
- Eugene Fox Galvin, MD

Clarence H Ganz, MD
Howard B Geyman, MD
Weldon C Gimlett, MD
John Payne Glein, MD
Ben Ross Goodnow, MD
Theodore Jay Graham, MD
Robert W Graisy, MD
Charles A Grant, MD
Harry Ernest Gross, MD
Norman A Gudgel, MD
Richard Dean Gunsul, MD
Leeon Floyd Hahn, MD
Jack Thurston Hammond, MD
Edward L Hann, MD
Donald J Hanson, MD
Gerald F Hazelrigg, MD
Spencer William Henriques, MD
H Cary Hevel, MD
William Field Hopfner, MD
Albert Frank Hopkins, MD
Edward A Howell, MD
Arnold W Inouye, MD
John F Johansson, MD
Edwin F Johnson, MD
John Masayoshi Jones, MD
Robert Kanda, MD
Thomas Henry Keith, MD
Chris C Kemman, MD
James M Klein, MD
Glenn George Klein, MD
Kenneth D Kogan, MD
Robert M Lance, MD
David Stephen Lawson, MD
James E Layton, MD
Robert Clayton Leibold, MD
Bryce Leeversee, MD
Robert P Liewer, MD
Robert Martin Lincoln, MD
Robert D Ludwick, MD
Ruby Malott, MD
Wilbur J Mangan, MD
Ross M Mariner, MD
Richard Elton McBride, MD
William A McClellan, MD
Robert W McCluskey, MD
Kenneth Hudson McConnell, MD
Emil W McGranahan, MD
Robert L McKibben, MD
Phillip Girard McRae, MD
F R Mead, MD
Stanley Ray Meyer, MD
Donald Arthur Nelson, MD
Laird Donald Moore, MD
G Dean Nebel, MD
Ronald Fordham Nelson, MD
James Frederick Nishimura, MD
Robert E Norquist, MD
Wayne Bowman Park, MD
Robert A Pass, MD
Arthur L Pass, MD

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THE WASHINGTON STATE Rural Locum Tenens Program is seeking family physicians who are interested in providing short-term, temporary coverage for practices throughout the state of Washington. All arrangements for employment are negotiated between the professionals and the facilities, and there is never a charge for our referrals to either party. To receive an application and additional information, please contact the Area Health Education Center at WSU Spokane, 509-358-7640. E-mail: Rundlett@wsu.edu

OPPORTUNITY, for a board certified, residency trained FP to start BUSY, while I introduce them to community and the practice and start working 1/2 time myself in preparation for retirement in a few years. OB and OMT optional but would be a plus. Privileges in a mixed staff hospital, the only one in the county, and membership in our “Group Practice without walls” for the right physician. Small northwest Washington city near Canadian border, with easy access to Vancouver, BC and Seattle. Mild climate, good schools, boating and fishing in the San Juan Islands, skiing in the nearby North Cascades Thanksgiving to Memorial Day. University in town. Contact Philip M. Andress, DO, Wendy Graignic, 904 East Chestnut Street, Bellingham, WA, 98225. Call 360-676-4400 or fax inquiries/CV to 360-676-5841. Email: pmandress@hinet.org

MEDICAL DIRECTOR – Seattle Puget Sound Neighborhood Health Centers (PSNCH) one of the mainstays of the Seattle Area’s health care safety net system. We have five medical clinics offering comprehensive primary care. As Medical Director, you will provide leadership for our medical program and participate as a member of the top management team. Please see the WAFP web site (www.wafp.net for a complete description) or contact Mark Secord, Executive Director, PSNCH, 903 Spruce Street #201, Seattle WA 98104, 206-461-6935, 206-461-8382 fax, or e-mail secorm@psnch.org for further information.

UNIQUE OPPORTUNITY for full time board certified/eligible family physician with Puget Sound island group practice. Full spectrum outpatient primary care with hospital OB optional. Community clinic with rich 28 year history of solid local support. Longstanding links to major Seattle hospitals. Contact: Dave Waguespack, Administrator, 206-463-3671 or send CV to P.O. Box 529, Vashon, WA 98070.

DYNAMIC PRIMARY CARE GROUP in Bellingham, WA seeks personable BC/BE FP. Stimulating and enjoyable spectrum of practice with congenial colleagues. Modern, superbly equipped facility with excellent support staff. Send resume to nchang@caremedicalgroup.com or by fax to 360-734-2128.

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The presentations last approximately one hour and the schedule is very flexible. If you would like further information regarding this great program please call Nancy Caldwell, Washington State Tar Wars Coordinator, toll free in Washington at 800-621-8424 or 360-352-8595.

To become a Tar Wars presenter, fill out this form and mail to: Tar Wars, 2404 Chandler Ct. SW, Ste. 260, Olympia, WA 98502-6034.

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