THE BULLETIN

Our Mission:
To promote the science and art of medicine, the care and well being of patients, the protection of the public health, and the interests of the medical profession.

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Original tree art by Samuel P. Burre, M.D. (1957) and adorned by George Ingraham, M.D. (2002)

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President's Message

EMILY DALTON, M.D.

This month David Ford, the CMA's Associate Director of Medical and Regulatory Policy, came to Humboldt County to talk about health reform. He gave a presentation that included an update on what is going on in politics, both nationally and state-wide, and he spoke about CMA's stance on various topics including single payer. The CMA is neither pro nor con with regard to single payer, because physician members do not agree on supporting this. However, if single payer system comes into being, there are stipulations that CMA would want to see included as stated in resolution 212a-07:

CMA on Single Payer (212a-07): In order for CMA to consider support of a single payer health reform proposal, the following criteria must exist within the proposal:

1. Physicians must be provided a means to ensure payment of their usual and customary charges as defined by the Gould criteria*.
2. A scientific (apolitical) body to make benefit/coverage decisions.
3. Pluralistic delivery system options must be retained (e.g., pre-paid group practices, FFS).
4. A mechanism for addressing fraud.
5. Patients allowed to buy up --to purchase additional coverage outside the single plan.
6. Benefits must be structured (not open ended).
7. A mechanism to address capital investment and infrastructure building.
8. Except for low-income families, medically appropriate co-insurance be incorporated to discourage excessive utilization.

Locally, there is a lot of interest in single payer as the only realistic solution to our current health care woes. Please respond to the survey we are sending out, because if we garner support for a position supporting a single payer solution we will communicate this to the CMA. §

*** "The Gould Criteria"**
(1) the provider's training, qualifications, and length of time in practice,
(2) the nature of the services provided,
(3) the fees usually charged by the provider,
(4) prevailing provider rates charged in the general geographic area in which the services were rendered,
(5) other aspect of the economics of the medical provider's practice that are relevant, and
(6) any unusual circumstances in the case.

(Gould v. WCAB, 1992)

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Medical Autopsy: The Forgotten Teacher

Scott Sattler, MD

Remember when we used to do autopsies on other than just coroner's cases? When I trained at Valley Medical Center in San Jose in the 1960s and 70s, essentially every hospital death went to autopsy unless the family requested otherwise and the resident couldn't persuade them differently. The involved medical staff would usually attend the procedure. Weekly morbidity and mortality conferences (M & M's) would discuss the case and correlate the pathologic findings with the premortem diagnoses. It was often a humbling experience.

In the mid-1980's, data showed that such autopsies revealed a major misdiagnosis of the primary cause of death in 20 to 40% of cases. In 10 to 15% of all cases, the missed diagnoses would likely have affected patient outcome. Did I mention that autopsies are a humbling experience?

When I first came to Humboldt County (to the Hoopa Indian Reservation to be exact) in 1974, the tradition of medical (as opposed to forensic) autopsy was still going strong. I well remember the woman with advanced diabetes whose chemistries and comfort just couldn't be controlled and, despite intensive care and multiple specialty consultations, whose deterioration was unstoppable. I remember her, in great part, because of her autopsy. The vision of her large undiagnosed pituitary tumor and the dent it had made on her optic chiasm is burned onto my permanent intracranial hard drive. Before that day pituitary tumors were a theoretical construct I'd learned about in med school. That day they became real.

When I moved my practice to Eureka in 1982 we were still doing medical autopsies, but over the years they became fewer and fewer. Out of curiosity I went over to the Coastal Pathology office the other day and talked with them about it. They showed me the book where they record all the autopsies done by their group (and by the Humboldt Central Pathology group which preceded them). It contains records going back to 1983, when 40 medical autopsies were performed. By 1986 it had dropped to 30, and by 1989 to 16. There were only 9 done in 1991. By 1999, only 4. In 2005 there were just 2 and there have been none done in the area served by Coastal Path (Humboldt and Del Norte counties) since June of 2007, almost two years ago.

We have lost a helpful friend and an inspiring teacher. On this part of the North Coast, medical autopsy is no more.

I did some homework attempting to find out just how our profession had let this happen. Medical autopsy provides the cornerstone of physical diagnosis; how could we have let it disappear? Was this an isolated Northern California phenomenon or is it more widespread? Has the need for autopsy diminished in light of current medical technology? Are there not enough pathologists these days? Perhaps there's just no money to pay for them? Or have clinicians simply lost interest? Are we as clinicians drowning in the current dysfunctional medical system so badly that we just can't bother with it anymore? What's happened?

Not surprisingly, there is a significant body of literature on the subject. Two local pathologists in the Coastal Pathology group were also happy to provide their input. Here's the picture as I've come to see it.

The demise of the medical autopsy started in 1971 when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) removed the requirement that hospitals must have a minimum autopsy rate of 20% to keep their accreditation. I can't find any explanation as to why they did this. Nationwide the autopsy rate started dropping shortly thereafter and is currently hovering at around 10%.

There is a definite problem with reimbursement. Medicare says its DRG payments include autopsy-related activities, but they do not include reimbursement for the physician and for other professional components of the autopsy services. As a result, there is little incentive for hospitals to increase autopsy rates. Despite this, St. Joseph Hospital's policy is to fund any autopsy requested by an attending physicians if the patient's family can't afford it. They consider it an aspect of supporting their staff physicians' continuing education.

A third reason for the demise of autopsy relates to physicians' fear of litigation and medical staff disciplinary action. Interestingly, there are research findings showing that autopsy does not increase the risk of litigation, even when findings don't support the premortem diagnosis.

Another misconception is that autopsies aren't needed given today's technology. Unfortunately research shows that this is a myth. Diagnostic discrepancies between pre-and postmortem diagnoses persist at a relatively unchanged rate.

Finally, the pathologists with whom I

"Opinion" Continued on page 9

Editor's Thoughts

The 7 Percent (non)Solution

Stephen Kamelgarn, M.D.

At least twice in the last several months I've gone to meetings about health care where the statement (or variations, thereof) was made: "Only 7 percent of medical school grads go into Family Medicine as a specialty." Although that number seemed somewhat low, I felt that it could conceivably be real. We all know that primary care receives abysmal reimbursement from the insurers, and that there is more money to be made in specialties. We all have first and second hand experience on how hard it is for someone to find a primary care physician--and it's becoming harder all the time. However, I now have good reason to believe that those numbers are *very* wrong.

In my capacity as Medical Director for the thirteen third year medical students that are up here from Touro University I had to do a little research regarding the potential feasibility of starting a Family Medicine Residency program up here. I came up with some interesting numbers:

In 2007, there were 16,139 allopathic medical school graduates, of whom, approximately 1200 chose Family Medicine as their primary field of specialization[1]. This represents about 7.4% of the graduating class. So far, the numbers concur. But with a little further digging I came up with some more numbers:

In 2008, there were 2,654 available Family Practice residency slots available, and 2,404 were filled (90.6%)[2]. Now, if only 1200 MD's elected to go into Family Medicine and 2400 slots were filled, who made up the other 1200? Well, it turns out that the remaining 1200 slots were filled by graduate DO's. (This isn't exactly rocket science math, since only MD's and DO's are considered doctors and can go into *any* residency program.) According to AOA [3]statistics, approximately 40% of DO grads choose Family Practice as their primary specialty. There has been an approximately 50% increase in the number of DO grads between 1995 and 2007 with 3,024 graduating last year. This represents about 15.8% of the total number of newly graduated physicians. But it does represent another 1200 (or about 50%) of the number of new graduate physicians electing to go into Family Practice.

Osteopathic physicians represent one of the fastest growing segments of health care professional in the US. AOA estimates that by the year 2020, there will be at least 100,000 practicing DO's, and they will represent an ever increasing proportion of the physician pool[3]. The other noticeable trend is that osteopaths tend to be somewhat younger than their allopathic colleagues. In 2008, almost 50% of DO's were younger than 45 while only 39% of MD's were. Conversely, only 10% of DO's were older than 65 while 19% of MD's were[3]. This implies that as we age, our likelihood of having a DO as a physician (especially as a primary care physician) will be fairly high.

For years, the two streams of medical training have been on a parallel, seldom intersecting, course. One exception that stands out is the third year training that we're providing to the third year Touro students. Most of their clinical experience is provided by MD's, and no one seems to be the worse off. In fact, the students are receiving an excellent clinical experience. But, can we, as a medical community, do anything else? Well, for one, we could enroll a larger number of our local physicians, as preceptors, for the training of these young doctors. The physicians who have participated this past year in the Touro program have done an heroic job in taking their responsibilities seriously, and the students who have rotated up here with us have gotten a good experience–different from what we all went through as third year students, but good, nonetheless. But we need more physicians to participate if we wish the program to survive and thrive up here. But, beyond increasing our participation with the medical students, is there anything else we can do?

Intermittently, over the years, we've talked about getting a Family Medicine Residency program up here. As I have pointed out in earlier articles, approximately 1/3 of Family Practice residents will settle to within 100 miles of where they do their residency. This would provide us with a built-in pool of new physicians. UC Davis is usually mentioned as the sponsoring institution of such a residency. Perhaps it's time that we cast our nets wider. Here are some salient points we need to think about:

Fact: There's a huge primary care physician shortage in both our little corner of paradise and the country at large.

Fact: If there is to be any meaningful health care reform in this country *and* cost containment, the reform must be primary care driven.

Fact: With a >90% fill rate of available Family Medicine residency slots, there is room for more programs, as well as expansion of existing programs

Fact: Demographics are favoring Osteopaths as providing an increasing share of care in our country in the future

Fact: More osteopaths are willing to go into primary care than their allopathic colleagues.

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spoke don’t really wish to do more autopsies than they are doing at the present time. They have indeed contracted with the hospitals to provide the autopsy service when requested, and they will do so, but would much rather not. Surgical pathology is keeping them very busy and they have little time for autopsies. Reimbursement is felt to be poor-to-middling for the time spent, and they must do the autopsies at the funeral homes where the facilities are marginal and where there is little manpower help.

So the bottom line is that physicians on staff at SJH may indeed order autopsies when there is an educational need to do so and the next of kin has agreed. Just speak to the Nurse Director/Administrative Supervisor on duty to start the process.

A larger question, however, remains. It is clear that as a profession we must not abandon the autopsy. We must maintain our gold standard for clinical diagnosis. Currently our national health statistics are significantly skewed by the current rate of unchallenged inaccurate premortem diagnoses. This data is used to establish funding for research and preventative medicine programs. It needs to reflect accurate diagnoses.

Given the realities of today’s medicine, the current healthcare delivery system is simply not able to provide the number of autopsies needed. As our profession works to develop a newer, more functional health care system in this period of political renewal, let us not forget this critical need. We need more pathologists, perhaps circuit pathologists, who have the time and the training to provide this service. We need to reimburse them appropriately. We need to have local autopsy suites (like the one in the coroner’s office in Eureka), which are well equipped and staffed to facilitate physician involvement for both forensic and non-forensic autopsies. But most of all we need to regroup around this issue and require our healthcare system to return to us one of our most valuable tools. Professionally and ethically, we can’t let it just fade away. §

“Thoughts” Continued from page 4

Conclusion: We need to think about getting a Family Medicine program up here that could easily be a DO program, (or better still a joint MD/DO program).

For us to succeed up here in providing health care to our citizens we need to incorporate the contribution made by our DO colleagues in any plans. This means that we MD’s need to get over our “MD-centrism” and include our osteopathic colleagues when looking at health care delivery in the US.

And the next time I go to a meeting where I hear the 7 percent number bandied about I will stand and say, “You’re missing the future.”

[1]. American Council of Graduate Medical Education; 2008 Report

[2]. HTTP://www.aafp.org/online/en/home/residents/match/table1

[3]. AOA *Osteopathic Medical Profession Report*; 2008

Responsible Opioid Prescribing: A Physician’s Guide Available for Online Purchase

Responsible Opioid Prescribing: A Physician’s Guide offers physicians effective strategies for reducing the risk of addiction, abuse and diversion of opioids that they prescribe for their patients in pain. This concise, 150-page book offers pragmatic steps for risk reduction and improved patient care, including:

- Patient evaluation, including risk assessment
- Treatment plans that incorporate functional goals
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- Periodic review and monitoring of patients
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Written by pain medicine specialist Scott M. Fishman, M.D., chief of the Division of Pain Medicine at the University of California, Davis, the book translates the Federation of State Medical Boards’ (FSMB) consensus-model policy on pain management into practical, office-based pain management guidelines. *Responsible Opioid Prescribing: A Physician’s Guide* is available at **www.fsmb.org** for $12.95.

February 23, 2009

The meeting was called to order by President, Emily Dalton, M.D. at 7:00 P.M.

M/S/C to approve the following items on the Consent Calendar:

-Minutes of the January 20, 2009 Executive Board Meeting, as presented.

-Society Budget Report / Balance Sheet

-CME Balance Sheet

-CMA Federal Issues Update

-AMA Advocacy Update

-CMA Praises HIT Funding for Pediatricians

-Recruitment DVD Cmt 11/7, 12/5 & 2/13/09

-Touro Medical Director Paper of Local Program

UPDATE of the Humboldt-Del Norte Clinical Rotations Program was presented and how the program has been running over the past year with the 14 medical students that have been placed locally. Dr. Kamelgarn has been working with Touro and the medical students as the local Director of Medical Education. Touro has made a significant contribution to the Medical Society for utilizing space, staffing and operational expenses for the local program. Although Touro is still committed to working with us, due to the difficulties in placing the students, housing issues and the expense of the program, they have decided to pull the program for next year and coordinate a few local rotations from their end. Dr. Pera reported that Touro is working on setting up a residency program in the Bay area, which would be a "draw" for us locally.

DISCUSSION followed regarding a proposed membership survey and cover letter that has been proposed by a couple of our members to assess the membership's opinions regarding a Single Payer Health System. Agreed that the membership feedback would be very useful and would be communicated to CMA. Revisions to the questions were suggested. **M/S/C** to send out the Health Care Reform Questionnaire, as revised

MEMBERSHIP REPORTS were presented as follows:

-Aging Physician Graph broken down by Specialty, Primary Care and county. The average age of physicians in Humboldt is 54 years, Del Norte is 52 years.

-Coming, Going and Moving Around was presented for review.

-report of members outstanding on 2009 Dues

EXECUTIVE DIRECTOR UPDATE was presented as follows:

-reported that the notices for the CMA Leadership Academy have been mailed out to the membership. Drs. Cobb and Jutila strongly encouraged attendance at this meeting. Suggested letting Ms. Figas know of plans to attend to take advantage of discounts for multiple registrations.

-reported that 23 physicians attended the January 27th Physician Forum on Health Care Reform.

-reported IRS acknowledgment of change from fiscal to calendar year.

-Working with both St. Jos. And Redwood to clarify data on physician FTE on report done by AmeriMed. Data should be finalized soon and FTE data will be imported into Medical Society database.

-Recruitment DVD Committee working on soliciting contributions to move forward with project. Minimum $25,000. To start. Working on grant application Union Labor Hospital Foundation.

-Scheduled MEDICARE SEMINAR (PALMETTO) for Thursday, April 9, 2009. 8:30 - 12:30 p.m. Use room at Humboldt Plaza (Umpqua Bank) - Offices will be notified.

-Scheduled MEDICAL SOCIETY FAMILY PICNIC for Saturday, September 26, 2009 at Sequoia Park - 1:00 - 4:00 P.M. Working on scheduling the Spring Social in early May @ Ingomar.

-Updates on committee activities was presented.

DISCUSSIONS followed regarding the proposed changes to the Editorial Policy on member submissions. M/S/C to approve the revision of the following paragraph:

The policy of the Editorial Committee is that we shall publish any submission by any Society member so long as it relates (no matter how tangentially) to medical practice, either in our community or the nation at large, and it is not deliberately libelous. This could also include personal anecdotes, travel stories, book or movie reviews, or any other topic that so moves a member to write and communicate with their colleagues. The Editor reserves the right to withhold submissions if he/she deems the subject is inappropriate.

REPORTED that it is time to discuss options for the NORCAL Community Involvement Fund Grant. Decision will need to be made at the next Executive Board meeting on who our candidate will be for 2009.

SUGGESTED inviting Dustin Cochrane to speak at the next Medical Society meeting regarding CMA's Division of Government Relations.

M/S/C to approve the following applicant for membership:

-Howard Fellows, MD - Med Oncology - Eureka

The meeting was adjourned at 8:30 P.M. Next meeting is scheduled for March 17,2 009 at 12:15p.m.