

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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Where Have All the Doctors Gone?

EMILY DALTON, M.D.



The Executive Board has been pondering two problems facing medicine in Humboldt and Del Norte counties: We have a shortage of physicians in Humboldt and Del Norte County, and those of us who are left are older than ever before.

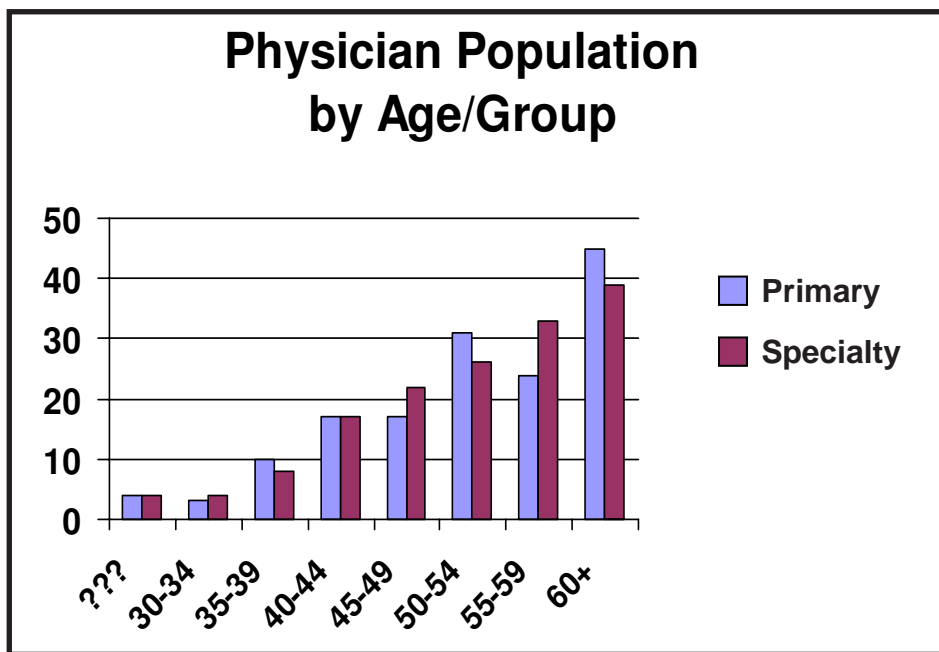
The following is a graph that depicts all the physicians in the area by age. If the trend toward increasing age continues, this area will soon be out of doctors.

Under the tireless leadership of Kay

will be posted to the Medical Society's website. Our goal is to raise \$30-40,000 to cover production costs, and so far we have received \$8,500 from hospitals and local businesses. Donations from the readership would be greatly appreciated.

Another encouragement that may bring new physicians to our area is the Steven M Thompson Loan Repayment Program. Our area qualifies as a shortage location, and physicians with educational

surgeons directly because of the potential for conflict of interest. In the State legislature there seems to be a strong will to change this established policy because there are 3 bills submitted (AB 646, AB 648, and SB 726) that would allow hospitals in rural areas to employ physicians directly. The motivation behind these bills is to get more doctors into rural areas because hospitals can offer benefits that private practice often does not, such as a guaranteed salary and more secure employment. CMA opposes all of these bills on the grounds that physician decision making should be independent and not biased by allegiances to a hospital-employer. §



Stokes, the Medical Society is working on a project aimed to address this issue. We want to produce a DVD showcasing the area's attributes that could aid in physician recruitment. It would be available to all entities recruiting physicians, and the format would be one that would allow the user to view the only the portions pertinent to his/her interests. Members of the recruitment DVD ad hoc committee have been designing formats, raising funds, and deciding which videographer should be contracted to create the production. A shorter version

loans can obtain funds for loan repayment if they work here. Unfortunately, the current language of the loan repayment program only includes MD's. CMA is supporting SB 606 introduced by Ducheny which would extend the benefit to osteopathic physicians as well. Our local clinics are designated as Federally Qualified Health Centers, therefore, we also have the benefit of loan repayment through the National Services Corps as well.

Historically, California has not allowed hospitals to employ physicians and

The annual Spring Social will be Friday May 1st from 6-9 pm at the Ingomar Club. Hope to see you all there!

Your membership in CALPAC will make a difference.

Please join your colleagues in supporting CALPAC -- CMA's political action committee-- and help strengthen our political voice.

By joining CALPAC, you help support candidates who share our philosophy and vision of the future of health care and medical practice.

CALPAC
1201 J Street, Suite 275
Sacramento, California 95814
1-800-CALPAC-9



Gross National Happiness and Medicine

SCOTT SATTLER, M.D.



Today, most countries define success in terms of economic growth measured as Gross Domestic Production, or GDP. Interestingly, there is a growing movement to define national success in more holistic terms via the concept of Gross National Happiness (GNH).

The GNH movement started in the Kingdom of Bhutan, which borders on India and Tibet and is one of the globe's most isolated countries. By 1970, travel and technology had opened its doors to the modern world. King Jigme Singye Wangchuk felt a strong commitment to preserve his country's culture during this influx of modernization. In 1972, he crystallized this concern around the Buddhist notion that the ultimate purpose of life was inner happiness. He felt the need to define development in these terms, rather than solely in terms of abstract economic measurements such as GDP. Pursuit of this intention led to his establishment of Gross National Happiness as a primary national objective. In essence, individual happiness was to take precedence over economic prosperity as the nation developed. Quality of life, rather than sheer quantity of material production, was to be the ultimate social goal. With this guiding principle, the government took measures to preserve the nation's traditional culture and environment, successfully balancing modernization with conservation of Bhutan's identity and ancient traditions. Destruction of the country's environment was avoided. By 2002, their government was spending almost 18 percent of its national budget on education and health care, as compared with 2 to 3 percent for China. In 2006, *Business Week* rated Bhutan the happiest country in Asia and the eighth happiest country in the world, citing a global survey conducted that year by England's University of Leicester[1].

The U.S. ranked 23rd, due to "nagging poverty and spotty health care."

Not surprisingly, the Bhutanese concept has spread, moving rapidly from the Indian subcontinent into much of Southeast Asia. The Fourth International Conference on GNH was held in the Netherlands this past November and 25 countries were represented.

What, you might ask, does all this have to do with the current state of healthcare in the USA? As you may have guessed by now, I have a few thoughts on that subject.

Let's look for a moment at our health care system and how we define its success. As a profession, we tend to measure our accomplishments in terms of quantity of life as reflected by the vital statistics of life expectancy, infant mortality and maternal mortality. We pride ourselves, as well we should, that life expectancy at birth hit a national high of 78.1 years in 2006. We also cringe at the thought that, although we spend more money per capita on health care than any other country in the world, our life expectancy ranks #34, tied with Cuba, Costa Rica and Chile. But that's a topic best saved for another time.

It seems to me that within our profession's value structure, length of life is our primary success marker. It has become our "GDP." And we need to modify this goal, much as the king of Bhutan has done, by focusing more of our attention on gross medical happiness, or quality of life.

Even as the goals of GDP and GNH are not necessarily mutually exclusive, neither are those of longevity and quality of life. But we all know that sometimes they are. Slavery may improve GDP but would not improve Gross National Happiness. Placing NG tubes in chronic hemiplegic

dysphagic aphasic stroke patients may indeed improve longevity, but few would argue that it improves quality of life. There are states of health worse than death. Even as Bhutan has given higher priority to Gross National Happiness over GDP, there is an ever-increasing public demand of our profession that we manifest the capacity to give quality of life precedence over longevity.

In some areas of medicine we have done well with this. We quit doing yearly screening chest x-rays in smokers when we realized that finding early lung cancer did not improve survival. In fact, our well-intentioned efforts to cure this cancer were shown to significantly decrease quality adjusted longevity. In short, when evaluated in terms of quality-adjusted life years, treatment of this form of lung cancer was worse than the disease. Unfortunately, we have yet to apply the same wisdom to the use of PSA screening for prostate cancer. Like lung cancer in smokers, we haven't found a treatment for prostate cancer that is better than the disease in terms of quality-adjusted life years. Many other countries have stopped doing PSA testing in light of this reality. Ours, sadly, has not. (Hopefully, last month's JAMA article and Cancer Institute article on this subject [2] will help bring about this much needed change.)

As a profession we face similar conflict of intention (longevity vs. quality of life) when we attend patients near the end of their lives. There comes a time when disease-directed therapy, aimed primarily at prolonging length of life, has need to give way to comfort-directed therapy, whose ultimate goal is maximizing the quality, not the quantity, of one's remaining days. Clearly the public wants this, and just as

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Results of the Health Care Reform Survey

STEPHEN KAMELGARN, M.D.

Editor



Approximately one month ago we sent a survey to the membership soliciting their views on health care reform. The mainstream media have been reporting on the views of health care “experts,” the public and the AMA. What I haven’t seen are any articles about how the non-academic, docs-in-the-front-lines feel about what’s going on. After all, we are the foot soldiers in the healthcare wars; risking our careers and sanity while “the powers-that-be” debate policy and the insurance industry mount a blitzkrieg upon our autonomy, advocacy and humanity. We felt that it was time the local docs let our CMA reps know what *we* wanted. As a first step we needed to poll the membership to solicit their opinions and ideas. Toward that end we wrote a questionnaire to poll those ideas.

We (the designers of the survey) hoped to accomplish three separate, but related goals: 1) Is our membership happy with the way health care is currently delivered? ; 2) What ideas (if any) do we have for change; and 3) should we involve our local medical society into the debate, and officially attempt to change CMA’s policies on health care reform.

I freely admit that this was, in no way, a scientific survey, (as was so forcefully pointed out by one of our non-respondents) and that any sort of “data analysis” would be problematic at best. Therefore, I could only get a “gestalt” of the survey, and only perform a “qualitative” analysis of the results. Despite these shortcomings, I think that the survey did show some interesting trends.

First of all, we had a tremendous response rate of 39 responses. This represents approximately 21% of our total membership. (To get doctors to respond to anything is extremely difficult, so a 20% response rate is little short of miraculous.) The respon-

dents were fairly evenly divided between primary care physicians and specialists: 22 PCP’s vs. 17 specialists.

Every single one of the respondents was unhappy with the way health care is financed in the US. To me, this signifies a tremendous level of dissatisfaction that will ultimately permeate all levels of discussion. The consensus was that about 15-20% of office overhead was directly related to billing issues, including insurance appeals. PCP’s felt, by a significant margin, that they were spending 10-20% of their overhead on billing, and the specialists were evenly divided from <10% to >20%—no clear trend. Yet, all physicians also felt that they were sacrificing only about 5-10% of their income due to denial of services. However, both the specialist and PCP respondents overwhelmingly felt (95% of PCP’s and 88% of specialists) that they were unable to provide necessary services to their patients due to insurance issues. To me, this indicates that the debate also contains a moral dimension—docs are distraught because they can’t provide needed services to their patients, and the financial dimensions are somewhat secondary.

The level of dissatisfaction was truly expressed in the questions that queried how much organized medicine should get involved in the debate. The overwhelming responses were that health care financing needed a major overhaul (100% of PCP’s and 88% of specialists) and that organized medicine, both the CMA and our little local HDNCMS need to be extremely active and vocal (77% of PCP’s/82% of specialists for “major” CMA involvement; 68% PCP’s/65% specialists for “major” HDNCMS involvement).

However when we come to how we feel what shape health care reform was to take, the responses were far more variable

and less clear cut. We gave the respondents nine choices as to a variety of proposed changes to the health care system. I broadly categorized the choices as either advocating major changes, or just “tinkering” with our current system; the two were not mutually exclusive and the respondents could respond to as many of the choices as they felt appropriate. There was also a tenth choice for the respondent to write in his/her own plan.

Although there was tremendous cross-over due to the study’s design, there did seem to be a trend that the physicians were advocating for more major changes in the system, rather than just “tinkering” with the current system. One surprising finding was how closely aligned on almost all the questions (and choices) the PCP’s and specialists were. We’ve been hearing for years that there have been different agendas for the primary care and specialist docs in our society. Looking at the results of the poll, I tend to question that assumption.

This is especially true when looking at the overwhelming response to the “single payer” choice. 82% of the primary care docs wanted to see a Single Payer program in place. But what was truly (and pleasantly) surprising was that 71% of the specialists also wanted to see a Single Payer system in place! It’s surprising because most studies project that specialists would lose income in a single payer system. This tells me that the “turf” wars may be more imaginary than real. It seems that we, both PCP’s and specialists, can come together for our common good and voice similar dissatisfactions with the current healthcare climate.

Despite its unscientific construction and probable selection bias (i.e. people who were satisfied with the way things are prob-

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ably didn't answer), I think the survey shows (or at least, hints at) that there is tremendous dissatisfaction with the current system, and the overwhelming majority of local physicians do favor a single payer system. To me, this indicates a mandate for our local society to start pushing the CMA to take a more active role in advocating for a single-payer healthcare system. I understand that, after discussing the results of the poll at the most recent Executive Board Meeting, the Board voted 3-2 to send a letter to CMA urging them to withdraw their opposition to SB 810 (Single Payer for California), and, more important, urging CMA to poll the entire membership on their feelings toward single payer.

If anyone wants a copy of the "tabulated" results of the survey, please get in touch with Penny at the Medical Society Office, and we'll get you a copy, so you can draw your own conclusions. §

"Opinion" Continued from page 3

clearly many in medicine have a hard time making this transition despite patients' wishes.

It is time for the medical profession to overtly clarify its value system and give assurance to our patients that we are absolutely committed to maximizing quality of life even as we strive to enhance overall longevity. And we must reassure them that they, not we physicians, are ultimately their own healthcare decision makers. In short, we must embrace the goal of Gross National Medical Happiness as our paradigm and place it above the concept of Gross National Absolute Longevity.

[1] Business Week, Europe section, October 11, 2006 URL: http://images.businessweek.com/ss/06/10/happiest_countries/index_01.htm

This British survey compiled data from

UNESCO, the CIA, the New Economics Foundation, and the World Health Organization, among others, and concluded that wealth, access to health care, and basic education were the most critical factors in determining happiness.

See a more recent related article: Business Week, Global Section, August 20, 2008

URL: http://www.businessweek.com/globalbiz/content/aug2008/gb20080820_874593.htm

[2] New York Times, Health Section, March 18, 2009

URL: http://www.nytimes.com/2009/03/19/health/19cancer.html?_r=1&emc=eta1

The PSA blood test, used to screen for prostate cancer, saves few lives and leads to risky and unnecessary treatments for large numbers of men, two large studies have found. §

Physicians • Clinicians • Healthcare Administrators

Humboldt Physician Communication Initiative and Hospice of Humboldt present

PREMIER PALLIATIVE CARE EXPERT

DR. IRA BYOCK

Ira Byock, M.D. is Director of Palliative Medicine at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire and a Professor at Dartmouth Medical School. Dr. Byock's book, "Dying Well" has become a standard in the field of palliative care. His most recent book, "The Four Things that Matter Most," is used as a counseling tool by palliative care and hospice programs, as well as within pastoral care.

PRESENTATION

The Nature of Suffering and the Nature of Opportunity Through the End of Life

Illness and dying cannot be fully encompassed by the problem based model of medicine. Beyond symptoms and suffering, dying is a profound personal experience for the individual as well as for his or her family. A therapeutic approach to fostering human development through end of life can empower clinicians with tools to alleviate suffering and improve quality of life and guide the people we serve to a satisfying sense of life completion and life closure.

Presented with support from the California HealthCare Foundation, the Humboldt-Del Norte Independent Practice Association, the McLean Foundation and the Union Labor Health Foundation.

**May 29, 2009, 6pm
at Baywood Golf &
Country Club, Arcata.**

Tickets: \$25 for presentation and dinner. Spouses are welcome.

Reservations required. Tickets are available from Hospice of Humboldt.

**— Call 441-0105, ext 305 —
for tickets.**

**CME pending through
Humboldt-Del Norte Consortium.
Stipend available for IPA members.**





ANN LINDSAY, M.D.
Humboldt County Public Health Officer

WRITTEN CONSENT FOR HIV TESTING NO LONGER REQUIRED

HIV infection and AIDS remain among the leading causes of illness and death in the United States. There are an estimated 56,000 new infections annually in the United States and over one-fifth (21 percent) of individuals living with HIV infection are estimated to be unaware of their HIV status. Perinatal HIV transmission also continues, primarily among women who lack prenatal care or who were not provided the opportunity for an HIV test during pregnancy. Perinatal transmission rates can be reduced from approximately 25 percent without treatment to below 2 percent with universal screening of pregnant women in combination with prophylactic administration of antiretroviral drugs, scheduled cesarean delivery when indicated, and avoidance of breast feeding.

The objectives of these recommendations are: to increase HIV screening of patients, including pregnant women, in health care settings, increase access to care and treatment, and to reduce perinatal, sexual, and injection drug use-associated transmission of HIV in the United States. California Department of Public Health supports these recommendations to the extent that resources are available to implement them.

California Law

In California, two recent changes to HIV testing law have supported the effort to bring “opt-out” (routine offering with the option to decline to take an HIV test) HIV testing to the state’s health care facilities.

1. As of January 1, 2008, Medical care providers ordering HIV tests are no longer

required to obtain written consent for an HIV test,

2. Nor are laboratories processing HIV tests ordered by medical care providers required to obtain either written or oral consent to process the ordered test.

Resources

The DHHS, Public Health Branch’s North Coast AIDS Project may be contacted for local assistance with HIV testing and referrals for prevention as well as care, treatment, and support services. A comprehensive array of services, including life-saving medications, are available for people with and at risk for HIV infection in California (information about many of these is also available at the OA Web site: www.cdph.ca.gov/programs/AIDS. §

2006 Centers for Disease Control and Prevention (CDC) Guidelines

In 2006, CDC issued “Revised Recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health Care Settings,” recommending routine HIV screening for people 13 to 64 years old who access care in a variety of medical settings.

PHYSICIANS WELL-BEING COMMITTEE

CONFIDENTIAL ASSISTANCE

Physician-to-Physician

- Dr. Soper: 445-4705 * Dr. Gardner: 445-0373
Dr. Hunter: 441-1624 * Dr. T. Dennis: 725-6101
Dr. Frugoni: 825-5000 * Dr. Fratkin: 496-6846
Or contact a physician through CMA at 650/756-7787

SUBJECTS NEEDED

Intraductal Therapy of DCIS: A PreSurgery Trial

We are seeking 30 women newly diagnosed with DCIS on core biopsy (stereotactic, Mammotome, or ultrasound-guided vacuum-assisted techniques).

For details, please call 707-476-0690.

Sponsored by: Dr. Susan Love Research Foundation and
the CA Breast Cancer Research Program