

THE BULLETIN

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

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Medicine Needs CPR

EMILY DALTON, M.D.



Some of the excellent discussion that took place at the executive committee in May focused around the sorry state of medicine in Humboldt County, and we thought it would be time to draw public attention to this problem. About a year ago we started a publicity project, but ended up dropping it for a variety of reasons. Now it is time to let people know that their health care system is falling apart. The press release we are planning will read something like what follows, but this is a draft, and any input or suggestions from membership would be appreciated.

Had Trouble Finding a Doctor Lately?

We, the physicians of Humboldt and Del Norte County, want you, our patients, to know that the state of medicine in this area has deteriorated over the past years, and is in danger of falling into dire straits. There are many reasons why that is so, and we cannot claim to understand them all, but the fact remains that local medical care is falling apart.

This is what we know:

1. People are having trouble finding a doctor. The local medical society had to drop its physician referral program because the number of calls from people wanting help finding a doctor became unmanageable, and the medical society didn't have anyone to send them to anyway.

2. Hospitals are providing more services for ever-decreasing reimbursements. The region's largest hospital, St Joseph's, managed to pull itself back from the brink of financial insolvency, but not by much. Recently St. Joseph's rehabilitation program came very close to having to be shut down

for lack of funding. To avoid bankruptcy, all hospitals have been forced to run at maximum efficiency which results in fewer open hospital beds with less staffing when hospitalization is needed.

3. The availability of subspecialists is at an all time low. The area has gone from having three or four Ear, Nose and Throat specialists to just one. We previously had 3 neurosurgeons—now there is one. All the local hospitals used to cover orthopedics. Now only St. Joseph's has 24/7 orthopedic coverage, which is maintained at great cost to the hospital (thank you St Joe's!). According to a survey done by SJH, there is a four month wait to see a neurosurgeon, a three month wait to see an Ear, Nose and Throat specialist, a two month wait to see a neurologist, and a one month wait to see an orthopedist—IF you can get an appointment. 43% of primary care offices do not accept MediCal, and 26% of non primary care practices do not accept MediCal. 18% of offices do not accept MediCare. Many offices are closed to any new patients regardless of coverage.

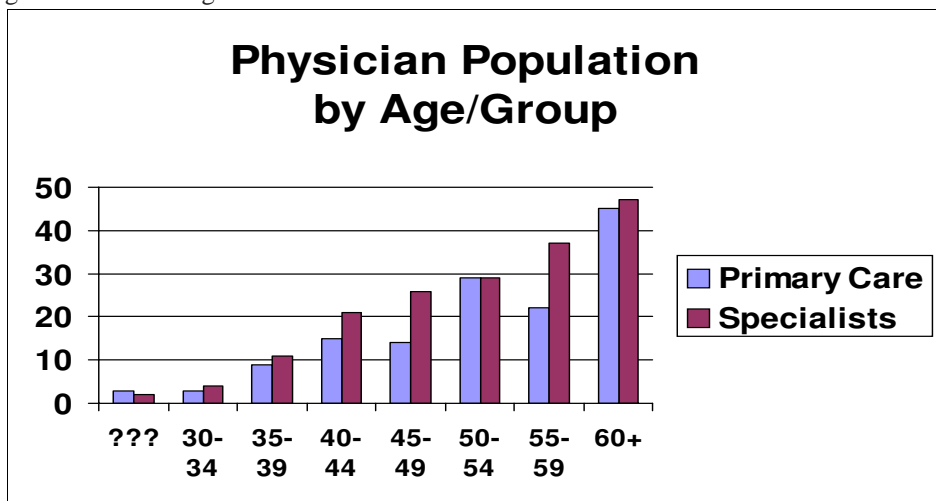
4. We, your doctors, are getting older; recruiting new doctors is increasingly difficult. **(See Graph Below)**

When we age and retire, no one is coming to take our place. Selling a private practice to a younger physician is not only impossible, it's a joke. The income to be made here is not enough to attract young physicians, even with a salary guarantee. Most new graduates are going to work at HMO's like Kaiser where they have regular hours, limited on-call time, and a guaranteed income.

We, your doctors, care about the health of Humboldt and Del Norte Counties, and we want to see excellent medical care provided to all its denizens. However, we know what gets in the way of us taking care of you:

1. We get stuck in reams of paperwork with numerous different insurance companies who require us to study and debate numerous different con-

"CPR" Continued on page 5

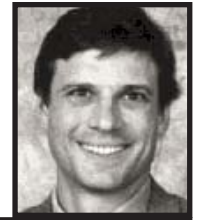


Primary Care = FP/GP, IM, Peds Specialists = all others
 Median Age: 54 Avg Age: 53

Status Selection: ACTIVE - GOV EMP - NONMEMB

Healthcare Reform Redux

LEE LEER, M.D.



Please don't read any further if:

- 1) you believe that healthcare is a privilege rather than a basic human right
- 2) you think that the American healthcare system is more or less OK the way it is
- 3) you think there *is* an American healthcare system
- 4) you believe it's economically possible to provide healthcare for all without rationing care

In what follows, I will critique specific arguments physicians make for health care reform and suggest a more appropriate and effective role for us as the nation once again enters a discussion about reform.

First, we physicians are no more experts at creating health policy than celebrities are at choosing presidents. Yet, like celebrities, we are earnest in our beliefs, and more than willing to share our opinions with the general public.

From what I read in the pages of *The Bulletin* and what I hear in informal discussion with colleagues, it's fair to say that a sizable and vocal percentage of local physicians are of the opinion that we should have a single payer, federally managed health plan that covers all citizens. Many physicians (and laypeople) holding this view base their opinions upon misconceptions about other countries' health care. For example, while many think Germany has a single payer, government funded healthcare system, it does not. Individuals are responsible for paying for their own insurance, and there is a mix of public (the majority, to be sure) and private insurance available. Similarly, many are surprised to learn that the

citizenry most satisfied with its healthcare (according to WHO data from 2008) resides in the Netherlands, which has a system of managed competition between a mix of private and public insurers – similar in many ways to what the Clintons failed so miserably to enact here in the early 1990's.

Perhaps more to the point, many people are unaware that the French healthcare system, which is single payer (but upwards of 70% of French citizens elect to purchase secondary private insurance) and is often pointed to as an example we should emulate, has run at a deficit since 1985 (the most recent figures peg the deficit at about 13.5 billion dollars). Said deficit, it turns out, doesn't have much to do with physician over-payment: French physicians earn on average 2/3 less than their American counterparts. Meanwhile, French per capita prescription drug usage is the highest in the world. Policy analysts argue this is because the French government subsidizes essentially all pharmaceutical costs and does not impose a restrictive formulary.

Some of our colleagues support health care reform by arguing they'd be able to "do what is best" for their patient without so many insurance company restrictions, limited formularies, and the like. Indeed. The only way ANY health care reform is going to actually control costs is if there is something approaching a national medical practice and procedures board that reviews all pharmaceuticals, procedures, and devices and that sets general protocols and policies. No, in the future you will not be able to prescribe brand name Crestor just because that nice drug rep showed you the JUPITER study and your patient's already on it anyway, so why change to something that costs

\$100/month less? And no, in the future we won't be able to do that nuclear stress test on our asymptomatic patients just because they had CABG 2 years ago. We will instead be choosing appropriate drugs from a limited formulary and following many more protocols and algorithms in providing care. At least, that's the future I hope for.

Profiteers in the medical-industrial complex are trying to ensure that the current dystopia of Crestor and nuclear-scans-for-all persists. I was thrilled to see that the Obama administration proposed to devote significant funding to Comparative-Effectiveness Research (CER). I was subsequently dismayed to learn that a host of physicians and essentially the entire conservative blogosphere and talk radio world have come out firmly *against* CER as being a step closer to government control of our lives. Yes, heaven forbid we have data showing simvastatin to be as effective as Crestor!

I am not an expert in health policy. Neither are you. We are each only an expert in our own tiny piece of a massively complex industry. For us to say that we know which specific funding system will be the best for our patients and for the country as a whole seems the ultimate of hubris.

I do know that I'm less concerned about the overarching structure – e.g. single payer, multiple non-profit companies, for-profit companies with managed competition – than I am about the devilish details of whatever system elected officials settle on. If we look at other countries as models, frankly none evinces clear superiority. What all the successful national models share, however, is centralized control over costs

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tracts. We fill out volumes of forms to try and get you the medication and the treatments you need because insurance companies have denied the treatments we recommend or the drugs we prescribe. These companies also, at times, delay payment of claims or refuse to pay claims at all. We have to hire full time staff to help us overcome the obstacles put forth by insurance companies just so we can get paid. It's not fun, and it is very expensive.

2. Reimbursement from most government programs is inadequate, and at times the reimbursement from insurance companies is too, if we get gulled into signing a disadvantageous insurance contract (we went to medical school, not business school). The standard reimbursement for a MediCal visit does not cover our overhead costs, much less leave any payment for the

physician. No business can maintain itself that way.

3. Inane regulations pull us away from patient care and require us to spend time doing less important work in order to meet legal requirements.

4. Insufficient numbers of doctors work here, and there is no good way to recruit them

We all need to work together to solve this health care crisis. We wanted to let you know that we, your doctors, are worried, and are dealing with an unprecedented scarcity of resources and working under poorer conditions than we ever anticipated. We are watching as the structure we work in disintegrates around us. We don't have all the answers, but we want to be part of the solution, and the first step is voicing the problem. We did not want you to find out about the problems by not being able to get medical care when you need it. We want you know of our concern. §

**OFFICE MANAGER
NETWORKING MEETINGS**

EUREKA: Professional Healthcare Managers Group
(an independent networking Group)

3rd Wednesday each month @ 8:30 A.M.

Foundation Conference Room

Contact: Justin Takata, 443-8066

Meetings: 6/17 * 7/15 * 8/19

**HDN Foundation for Medical Care is hosting the following
Office Manager networking meetings:**

Contact: Rose, 443-4563 X 47 rgale@hdnfmc.com

ARCATA: 1st Thursday of each month 12:15 - 1:15 pm
Mad River Hospital, Minckler Education Room

FORTUNA: 3rd Thursday of each month 12:15 - 1:15 pm
Redwood Memorial Hosp., Marion Room



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



H1N1

INFLUENZA VIRUS UPDATE

The end of April through mid-May was a busy time for public health staff involved in the local response to the Swine Origin H1N1 influenza virus (S-OIV). S-OIV is concerning because it was a flu strain never seen before **and** it can be passed from person to person, unlike the strains of swine flu that a few people have caught directly from swine over the past decade. Flu strains change slightly from year to year, and can people build up immunity to common circulating flu strains over time. No one has built up immunity to a completely new strain like S-OIV. So far S-OIV has not caused a high percentage of serious illness and seems to be petering out with the onset of warm weather and the end of the flu season. The Humboldt County Public Health Branch operated a branch emergency operations center for 16 days, ending May 12. Although we did not have a case confirmed in the county, we monitored illness at schools, hospitals and emergency room. There were no significant increases. We also communicated with hospitals and other medical providers to get appropriate laboratory specimens submitted to the public health lab. We passed on information about protecting health workers and making sure patients received appropriate care. The Medical Society put together a Public Health Advisory Committee that met once to advise the Health Officer. (Thanks, Penny!). Public health nurses staffed the phones to answer questions from the public. We reported to the Board of Supervisors, the Arcata City Council and the Trinidad Rancheria as well as to radio, TV and newspapers. The message: **WASH YOUR HANDS; COVER YOUR COUGH; STAY HOME IF YOU ARE SICK!**

The California Department of Public Health held conference calls with local pub-

lic health officials 7 days a week and posted guidance on www.cdph.ca.gov. We had practiced emergency communication for just this type of situation, and the practice paid off. However, the S-OIV outbreak, although mild, pushed the surge capacity of the public health system to the maximum. Public health infrastructure has lost funding in recent years and has less surge capacity, particularly the laboratory system. The S-OIV also showed weaknesses in our surveillance, particularly our inability to get real-time information about ER visits and hospital admissions.

What now? All eyes are on the Southern Hemisphere, where the flu season is just starting and S-OIV may continue to evolve. We may have an S-OIV vaccine to distribute in the fall in addition to our usual flu shots, and we hope to get all high risk people immunized. Other immunizations can prevent death from bacterial complications of the influenza virus. People over 65 or those with chronic disease should have a pneumovax shot to prevent pneumonia. Parents should immunize their children, particularly against pneumococcal and haemophilus influenzae bacterial infections. We will encourage businesses and medical providers to prepare for flu season to limit illness in employees and customers. For more information on how to prepare visit www.cdph.ca.gov or humboldtthealthalert.org.

Kudos to the public health staff for a job well done!

* * * * *

ALERT:

Blue Green Algae (BGA) Toxins May Affect Fresh Water Recreational Users

The local medical community should be aware that there is the potential for human illness from exposure to BGA toxins during summer/fall water recreation. Between 2001 and 2004, several dog deaths

have been reported following the dogs' exposure to BGA in Humboldt and Mendocino County water bodies. The presence of BGA toxins has been documented for at least two local rivers, the Klamath and the South Fork Eel, but these toxins could occur in any fresh water body or lagoon. Children, the elderly and those with pre-existing medical conditions are most susceptible to illnesses from BGA toxins. Local tribal officials in particular are concerned about exposure of tribal members to BGA toxins in the Klamath. The Humboldt Department of Health and Human Services (DHHS) recommends that clinicians be on the alert for BGA-related illnesses, and asks that any incidents be reported promptly, as outlined below.

a. Clinicians should routinely ask patients if they have had any fresh water recreational contact prior to the onset of a sudden illness or rash.

b. For detailed information on symptoms associated with BGA exposure, see these websites:

*Centers for Disease Control: <http://www.cdc.gov/hab/cyanobacteria/default.htm>

*California Department of Public Health: <http://www.cdph.ca.gov/healthinfo/vironhealth/water/Pages/bluegreenalgae.aspx>

c. For a recent Humboldt County DHHS press release on local BGA issues, see:

<http://www.humboldt.ca.us/HHS/PHB/EnvironmentalHealth> (7/11/08 BGA press release)

d. Please report any illnesses that may be associated with blue green algae exposure to:

Harriet Hill, Registered Environmental Health Specialist, Humboldt County Division of Environmental Health, 7 0 7 - 2 6 8 - 2 2 2 8 , harriet.hill@co.humboldt.ca.us §

Local Immunization Coverage Gap Putting our Community at Risk

JOHN SULLIVAN, M.D.

Deputy Health Officer



The current pandemic influenza, as well as last year's outbreaks of measles in San Diego and invasive *H. flu B* disease in Minnesota, can remind us as parents and practitioners that vaccine-preventable disease can still happen. These days most parents and many providers lack enough first hand experience with these diseases to appreciate them concretely, and promoting immunization is repetitious, and not always the most immediately rewarding part of our day, especially with increasing numbers of parents worried by media anti-vaccine misinformation. Some factors to motivate us and for parents to consider:

- Latest data for each Humboldt County school on immunization status at Kindergarten entry varied from 12% to 100% being fully up to date. California and US average is 68%, with 82% of students up to date on 6 highest priority diseases.
- Only about half of schools had enough measles, pertussis, or varicella coverage to provide herd protection against an outbreak, which could also be brought home or to health care settings to affect elders, young infants, or medically fragile contacts. Probably this reflects similar lack of H.flu coverage for same pupils as infants.
- In about half of schools low rates were due mainly to personal exemptions, and half to "conditional" admission (behind but planning to catch up), with five of the worst including both. This included both public, private, affluent, and poor schools.
- It is unclear how vigorous each

school was on following California Education Code in requiring progress at catching up for conditionally admitted pupils.

- Last year's San Diego measles outbreak (imported case from Switzerland to a school with many unimmunized pupils) spread rapidly before recognized, and 70 children's parents spent 21 days without daycare while their kids were under quarantine.
- Being behind at 5 reflects having been behind as an infant (most vulnerable to severe illness) It takes multiple boosters to provide full protection to infants. Infants are the most vulnerable to severe illness or complications from pathogens they are highly likely to encounter locally such as pertussis, *H. flu*, pneumococcus, influenza, and rotavirus.
- Children under 2 years old are at as high risk for severe or complicated influenza as the elderly, and if unimmunized have the immune memory of zero to 2 flu seasons for protection.
- Much severe illness from pandemic or even seasonal influenza is due

to secondary infection with vaccine amelioratable pneumococcus or Hemophilus "influenzae."

- Before H flu vaccine was available, invasive H flu B disease was a staple of pediatric training and locally we would have several cases a year of meningitis, sepsis, bone or joint infection or pneumonia in young children. Now the illness is rare in children.
- Many families consider their children's primary medical provider as a very influential source of information on vaccine risks and benefits. Strategies exist for promoting partnership for informed decisionmaking (please see next month's article).
- At least half the problem locally is with "catching up" for partially immunized children.

In summary: Students in many of our schools (and their families) cannot count on "herd" protection from diseases to which they are likely to be exposed locally, and may spread to more vulnerable populations, especially un- or incompletely- immunized infants. §



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“OPINION” Continued from page 3

(e.g., Canada, Great Britain, the Netherlands, Japan).

If we truly care about reform, we should be exercising our lungs and our pens advocating for the things we know first hand, and leave the macro reform choices to the real experts. We physicians should literally be screaming with one harmonizing, deafening voice that the system needs: a standardized billing form across all insurances; standardized and rational formularies; evidence-based treatment protocols; pervasive Comparative-Efficacy Research; elimination of the current huge regional variation in quantity of care (without any difference in quality); affordable and equivalent insurance for all. HOW these things come to pass is frankly less important than THAT they come to pass. Unfortunately, we physicians have been spending so much of our energy enjoying the game of “create a new system” that we’ve failed to mobilize for what should be the real battle: advocating for those things we understand, those things that make a difference in patients’ health outcomes.

Finally, we physicians have been so busy telling everyone who will listen that we know all the answers that we seldom stop to ask the public what it thinks. To that end, the following polling data may be of interest. While 49% of people surveyed think that our healthcare system needs “fundamental change” and 38% think it needs a

“complete rebuild” (CBS News/New York Times Poll. April 22-26, 2009), the story is different when we hone in on the individual. Specifically, when asked if they are satisfied or dissatisfied with their current health insurance coverage, 73% report being satisfied, against only 26% who are dissatisfied. When asked if they are satisfied or dissatisfied with the total cost of their healthcare, 52% report being satisfied, vs. 48% who are dissatisfied. (CNN/Opinion Research Corporation Poll. March 12-15, 2009).

Given that nearly three-quarters of us are satisfied with our insurance coverage, it is naïve in the extreme to expect politicians to choose to worry the satisfied majority by totally revamping their health coverage! It would seem reasonable, however, that the political will could be found to make those 48% who are dissatisfied with costs somewhat more satisfied. Which, I argue, gets us back to my suggestion that rather than getting our underwear in a bind about single payer vs. other options, we use what influence we really do have to make sure that costs are controlled, access is assured, and quality is measured and rewarded. For example, if I tell my congressperson that, because I’m an office based family physician, I know that single payer/managed competition/unfettered private insurance is best, he or she might rightly wonder what makes me such an authority, given my limited view of the whole.

However, my congressperson is apt to listen if I speak about my direct experiences and what my daily life teaches: that there are too many patients who can’t afford to see me; that my practice is drowning in paperwork that is not only excessive but that varies from insurance company to insurance company; that the silly dichotomy between “workers comp” and “private” insurance only serves to frustrate physicians and harm patients; that prescription drug costs prohibit many patients from getting a consistent supply of important medications; that we need a system that doesn’t financially discourage patients from seeking care when they become ill, a system that rewards physicians for providing appropriate preventive care; that as a primary care physician I’m an endangered species, and if my species becomes extinct, congressional leaders and their constituents will then see what a true healthcare crisis really is. §

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Enthoven, AC, Wynand, P.M.M. van de Ven, (2007) Going Dutch – Managed-Competition Health Insurance in the Netherlands. *NEJM*, 357:24, pp 2421-2423.

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*Member of the California Society for Healthcare Attorneys

May 19, 2009

The meeting was called to order by President Emily Dalton, M.D. at 12:25 P.M.,

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

- Approve the minutes of the April 20, 2009 Executive Board Meeting, as presented.
- Approve the Society and CME Budget Reports, as presented
- Review of the 2009 MICRA Savings Chart.
- Shared Federal Update from CMA VP Federal Relations, Elizabeth McNeil.
- CMA response to the California Healthcare Reporting Initiative regarding California Physician Performance Initiative.
- CMA Physician Web Survey Results.

UPDATE presented of the Legislative Hot Sheet. Mentioned that there are currently three bills in the legislature currently to allow hospitals to employ physicians.

MEMBERSHIP UPDATE:

- Presented the Coming, Going and Moving Around Report.
- Information was available regarding the new member benefit with Staples.
- Shared Current CMA Minute Recruiter.

SHARED letter from CMA President's Forum regarding suggestions for reorganization of CMA.

UPDATE was presented regarding the Physician Recruitment DVD. Reported that the Practice Opportunity Section of the Medical Society website has been changing frequently.

DISCUSSION was held regarding the AmeriMed Physician Supply Study done by St. Jos./Redwood. Suggested checking to see if any media releases were planned. Suggested checking to see how we compare to other rural areas.

DISCUSSION was held regarding the proposed letter regarding Single Payer and support of SB810 to the Media and our local legislators. Suggested sending out the text of SB810 and CMA's list of what needs to be included in order for CMA to support a single payer concept and take a vote at the next meeting. Asked whether "single payer" was defined in the previous survey. Suggested that any proposed letter should be sent through CMA.

SHARED "draft" HIT Campaign Plan submitted by David Ford (CMA).

EXECUTIVE DIRECTOR UPDATE was presented as follows:

- reported working with a couple past members regarding renewal of membership.
- reported that the delinquent members have now been dropped from membership, however, we are still working to get them reinstated.
- Reported that the Spring Social was held May 1st and went well. There were 67 in attendance, including 3 non-members.
- reported that the MICRA Savings Chart will be published in the next Bulletin.

COMMITTEE UPDATES:

CONSORTIUM FOR C.M.E.: Pain Management Seminar was held April 25th @ Red Lion and went very well. 77 people were in attendance (including 35 physicians!). Thank you to the subcommittee: Drs. Marshall, Connor, Pennington, Varav and Mahoney; and to our CME Coordinator Terri Taylor;

CME Coordinator Terri Taylor attended recent Annual IMQ Meeting in Sacramento - report will follow.

EDITORIAL AND PUBLICATIONS COMMITTEE:

Minutes of the March 11, 2009 meeting included in Consent Calendar.

MEDICAL QUALITY REVIEW COMMITTEE:

Next meeting re-scheduled for May 20, 2009 @ 7:00 P.M. Two cases scheduled for review.

PHYSICIAN WELL BEING COMMITTEE

Working with Sutter Coast Hospital for representative to committee. Next meeting will be scheduled around availability of Sutter Coast representative to teleconference in.

Proposed updates to the Physician Well Being Committee brochure - draft to follow.

PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE

1 Reviews in process. 4 complaint forms sent.

HEALTH OFFICER UPDATE was presented, as follows:

Update regarding the Swine Flu was presented. Currently 1 case has been diagnosed in Humboldt County. There is currently no risk to the community. 5460 cases have been confirmed nationally with 6 deaths. 33 people hospitalized. 90% of the specimens sent to the state were NOT Swine Flu. Thank you to the Medical Society for helping to circulate updates.

Reported that we have 24% or less students that are fully

immunized. Physicians need to help with education of patients as we have the lowest immunization rates in the state, second is San Luis Obispo. Mentioned that St. Jos. Hospital are now immunizing women/adults to help protect infants. Agreed that we need a good Ad campaign.

Reported that no local job cuts are anticipated.

DISCUSSION followed regarding proposal to increase public awareness regarding the local health care crisis, shortages of physicians, etc. Reminded the board of the previous attempt that was tabled as there was no “solution” to offer to the problem. Suggested checking with St. Jos. to see if they planned to do a media piece on the AmeriMed survey results. Agreed to revise and re-circulate the letter that was developed several months ago for comment and discuss this again at next month’s meeting.

REPORTED sending a letter in support of a grant to the Bertha

Lytel Russ Foundation for Emergency Medical Services to help support their Medical Director position.

M/S/C to send letter to Humboldt and Del Norte County Schools regarding sports physicals and encouraging patients to go through their primary care physicians.

M/S/C to sign on to the community letter writing campaign to encourage President Obama to visit the North Coast to shed light on the economic and health care challenges facing Humboldt County.

M/S/C to reinstate membership for Jerryl Rubin, M.D., dues are now paid.

There being no further business, the meeting was adjourned at 1:30 p.m. Next meeting is scheduled for June 15, 2009 at 6:30 p.m. §



AWARE Physician Survey

The California Medical Association Foundation’s Alliance Working for Antibiotic Resistance Education (AWARE) Project supports physician efforts to promote appropriate antibiotic use and decrease the incidence of antibiotic resistance. The Project has taken the lead in bringing together physicians, pharmacists, health plans, and key healthcare stakeholders to develop the AWARE Provider Toolkit for the 2009 cold and flu season.

We invite you to respond to our brief physician survey which will be instrumental in our efforts to ensure that the AWARE Provider Toolkit continues to be a useful source of information for California’s health care professionals. To respond to our survey, please see the “In the News” section of the AWARE web site home page, www.aware.md.

For more information about the AWARE Project and Provider Toolkit, please contact Sandra Navarro, PhD, MPH, Director of Clinical and Quality Improvement, (916) 779-6637 or snavarro@thecmafoundation.org.

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

Also refer to Practice Opportunities on our website
www.humboldt1.com/~medsoc

FAMILY MEDICINE AND INTERNAL MEDICINE ROLES

AVAILABLE IN ARCATA, CA

HOSPITALIST SERVICES MEDICAL GROUP

FM and IM physician opportunities available at Mad River Community Hospital located in the beautiful redwood forest-filled city of Arcata, California! Mad River Community Hospital (MRCH) is a 78-bed acute care medical facility located in Arcata, CA. MRCH offers premier healthcare to the county of Humboldt. It is a locally owned and operated independent hospital that provides a complete range of acute care inpatient services.

Requirements: Board Certified/Board Eligible Family Practice or Internal Medicine licensed in the state of California. Must become Board Certified within two years of date of hire.

Have it All with HSMG/Valley Emergency Physicians:

- Flexible Schedules •Paid Malpractice with Tail
- Beautiful, Healthy Locations •Physician Owned and Managed •No Outside Owners or Investors
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- CME Opportunities

HOSPITALIST SERVICES MEDICAL GROUP offers you many opportunities across beautiful California from the San Joaquin Valley to the Oregon border and from the rugged northcoast to the isolated slopes of the Sierra Nevada mountains.

Owned and managed by our doctors, HSMG focuses on helping you advance your career and develop your skills while providing great medical care.

Full Time and Part Time

Salary: \$90000 plus 2 openings.

Additional Salary Information: Hourly plus productivity. Will consider sign on and relocation bonus'.

Contact Information:

Francie Louie, Sr. Recruiter, francioulouie@valleyemergency.com,
Direct line: 925-997-4767.

PHYSICIAN NEEDED for busy occupational Environmental Health Practice. Full or Part time. Contact Dee at: dmsalter@sbcglobal.net (ds0309)

FAMILY MEDICINE PHYSICIAN NEEDED to join established practice in Fortuna, CA. Would consider some locum work while considering relocation to our area. If interested please contact: Mary Moriarty, Office Manager, e-mail: Loletamary1@aol.com, (707) 725-3318. (PO)

OB-GYN NEEDED for very busy established practice. Total Women's Health including IVF. 4-D OB Ultrasound Machine, Dexa Scanner, Advanced GYN Surgery, High Risk OB, etc. Potential for expanding practice and services. Contact Kim Pfanensteil, Office Manager, (707) 445-3443. (www.stokesmd.com) (DS)

FULL OR PART TIME PHYSICIAN OR MIDLEVEL OPPORTUNITY.

Mobile Medical Office is looking for a full or part-time. physician or Nurse Practitioner to join our staff. We are a non-profit mobile clinic which brings healthcare to the underserved in Humboldt County. Contact Wendy Ring, M.D. at (707) 498-6183 or wring@mobilemed.org for details. (WR)

WANTED - FAMILY PRACTICE PHYSICIAN

Full or part time. Aviation Medical Examiner preferred. Contact George Jutila, M.D., 725-3334 or home.md@suddenlink.net GJ

TRANSCRIPTIONIST NEEDED

for full-time in-house medical transcription. If interested, contact Dee or Joan at 444-3885 (NK 1008)

URGENT CARE CLINIC:

North Coast Emergency Physicians Group is looking for Family Practice Physicians interested in part time work in the new St. Joseph Hospital Urgent Care Clinic. Malpractice insurance is paid through the Group. Please contact Ronald Cordova, MD, Managing Partner for North Coast Emergency Physicians at (707) 616-7435 if you are interested.

WANTED - PHYSICIAN or MID-LEVEL PRACTITIONER

Opportunity for physician or mid-level practitioner with interest in or knowledge of Functional Medicine. Thriving cash-based solo practice, ready to expand with a second provider. Can help train motivated person. Call Rick 707-407-5321. (bc0209)

FOR SALE / LEASE

FOR SALE: Wallach LL100 Cryosurgical System. Like new condition. Two trigger freeze-defrost, three cryotips, #20 cylinder mover. \$800. Scott 839-1286

FOR LEASE: Professional / medical office space near Mad River Hospital. Build to suit in new Planned Unit Development. 850 sq. ft. available now. Contact Mark Jones, 707-616-4416 or e-mail: Jones202@suddenlink.net .

MEDICAL OFFICE FOR LEASE. 2504 Harrison Avenue, Eureka, CA. 1688 sq. ft. Can be seen by appointment. Phone 530-755-1354 /916-261-8088.