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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AMA Support for HR3200

EMILY DALTON, M.D.

Colleagues: In place of my President's Message this month, please review the following communication from AMA regarding their support of HR3200. We invite your comments:

AMA SUPPORT FOR H.R. 3200

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Why is the AMA supporting H.R. 3200?

H.R. 3200 contains many elements that reflect AMA priorities for health system reform. This includes: expanding the availability of affordable health care coverage to the uninsured, increased support for prevention and wellness services, investments in the physician workforce, increased Medicare payments for primary care services without cutting payments for other services and, importantly, it represents medicine's best hope for eliminating the current sustainable growth rate (SGR) formula for updating Medicare physician payments. The AMA will be working with members of the House of Representatives to improve the bill by seeking changes (e.g., adding medical liability reforms). Favorable action on a House bill is necessary to move the process to the end game negotiations that will determine the specifics of a final bill.

Why did AMA react so quickly?

The AMA has been reviewing and submitting detailed comments on draft proposals for several months, as well as engaging in substantive discussions with Congressional leaders and staff. There were a limited number of changes made in a draft of the bill that was released on June 19. So, we were able to complete an analysis of the 1,000+ page bill relatively quickly. Two of the three House committees completed their mark-up of the legislation last week so it was important to voice our views prior to votes in committee.

Does the AMA support all provisions of H.R. 3200?

As is typical with very large bills, it contains many provisions that we wholeheartedly support, others that concern us, and still other provisions that we want to see changed. We plan to continue our efforts to refine those elements that are inconsistent with our policy as the legislative process progresses. For example, during the process of committee consideration we have been supporting amendments to provide federal support to states that implement liability reforms and to preserve patient access to physician-owned hospitals. This is the beginning of a very lengthy process and we believe our support helps put us in a very favorable position to advocate for important changes when a House and Senate conference committee is appointed to craft a single bill for final passage.

Does the AMA support the public plan provisions included in H.R. 3200?

The public plan provisions in H.R. 3200 represent an improvement over previous draft proposals. The Senate is developing different approaches to a public plan. H.R. 3200 would require a public plan to be self-sustaining and not dependent on the federal treasury, and it would not require physicians to participate. It also does not affect the ability of physicians to engage in private contracting arrangements with patients. We believe that, as the legislative process continues, the details surrounding the public plan option will change considerably.

By supporting health reform legislation that includes a public plan, isn't the AMA really endorsing socialized medicine? It truly is regrettable that so many of the important goals we hope to achieve through health system reform have been overshadowed by a headline-grabbing debate over the prospects of creating a coverage option bearing the label "public plan," without regard to the variety of forms such an option could take. The AMA continues to oppose nationalized medicine health insurance, and we continue to express opposition to elements of public plan proposals that we believe could lead us down the road to a single payer system or "socialized medicine." However, we remain open to proposals that are consistent with our principles of pluralism, freedom of choice, freedom of physician practice, and universal access.

I have heard that as many at 120 million people will be enrolled in the new public option health plan. Is that true?

No. The nonpartisan Congressional Budget Office has estimated that the bill will ensure that 97% of the legal, non-elderly population will have health insurance. At most, 12 million people would be enrolled in the public plan, representing only about 4% of the entire population. Overall, 37 million uninsured Americans will have health insurance coverage who do not have it now.

Won't employers simply drop coverage?

Again, the non-partisan Congressional Budget Office estimates that from 2010 until 2019, the number of Americans with employer provided coverage will increase from 150 million to 162 million people. Additionally, for those Americans who purchase coverage through the Health Insurance Exchange, two-thirds (or 20 million people) will choose private plans. This means a sig-

"HR3200" Continued on page 16

In My Opinion

Rebutting the Redux

Stephen Kamelgarn, M.D.

In the June issue of *The Bulletin,* my colleague and fellow editor Lee Leer wrote a provocative and well researched article on Health Care reform. It was designed as a counter-argument to us Single Payer Monomaniacs (myself among them), to show that the rest of the industrialized world doesn't have single payer. This is true.

However, what Dr Leer neglected to emphasize is that **all** of the different payer schemes used in the Industrialized World have one thing in common. They all have a public (read: government sponsored) health insurance alternative. France, Germany, Great Britain, The Netherlands, etc, may have a variety of private insurance alternatives, but *they must remain competitive* with the government-sponsored health care insurance that is offered. If they don't, they go out of business.

A government-sponsored health insurance (along the lines of Medicare) forces, by its very nature, all competing plans to keep their premiums and services in line if they wish to stay in business. This means that the private insurers in those countries can't jack up their premiums so their stockholders can earn a larger quarterly dividend, or the CEO can buy a new airplane. If they maintain all of the exclusions, denials and non-payments that our current insurance plans are so guilty of, their clients will go to other plans that will offer better service, even if it is the government sponsored health plan.

Just having President Obama mention a government-sponsored health plan alternative throws the medical insurance industry into a frenzy of reactionary action. Blue Cross of North Carolina is already amassing a "war chest" to start producing its version of the "Harry & Louise" ads that sunk the Clinton healthcare initiative 16 years ago. Why is the insurance industry so dead set against a government-sponsored health plan? That's easy. If people had a public alternative, the industry would have to seriously clean up its act to remain competitive and maintain its subscriber base.

The governments of the European and industrialized Asian countries also treat their private health insurers much like we treat our public utilities: there are strict price controls and operating guidelines as to how the insurance companies do business. The function of private enterprise is to attempt to maximize its profits, and, conversely, keep costs as low as possible. However, when a company supposedly acts as a public trust, then the profits must take a back seat to meeting the needs of the public. We saw what happened to electricity costs in California a number of years ago when those controls were lifted–we found ourselves in debt to Enron to the tune of over $9 billion. And right now, the private insurance industry is treating us in the same high-handed manner that Enron treated the people of California.

When we speak of healthcare reform we speak of two separate, but integrally related agendas: 1) Extending healthcare to all citizens without forcing them into bankruptcy; and 2) reining in costs to whoever is footing the healthcare bill. Obviously, at some level there is going to be a serious conflict in the two agendas–extending healthcare to everyone costs money, and we're trying to spend less money. This is where Dr Leer is correct in his statement: "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." The economics involved in healthcare reform are complex, byzantine and beyond the ken of just about everybody, let alone a bunch of doctors who *might* have taken an introductory Econ class in college many years ago.

That being said, we do know our little sector of the healthcare industry intimately. We know what works for our patients, and what doesn't. We see, and feel, the anguish they go through when they have to make the decision to either have their screening mammogram or pay that month's rent, because they can't afford to do both. I can't count how many times patients have told me that they can't afford to buy their medications this month, and I'm not talking expensive brand names, but "cheaper" generics.

I've heard the number that "73% of us are satisfied with our current health insurance coverage," and I just don't believe it. *Everyone* I've talked to: patients, other physicians, friends and anybody else I've spoken to about their personal health insurance is extremely dissatisfied with their coverage. My personal coverage is abysmal and my premiums high, and just about everyone I know feels the same way. Granted, I may be talking to a small sub-set of the chronic malcontents, but I don't think so. And that's just the view from the public. I won't even begin to go into the nightmare the private insurance industry has created for physicians with their interminable denials, appeals, shape-shifting formularies, and the like. That's grist for another mill.

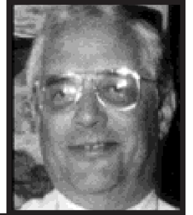
As long as private insurance can run unfettered like it has for the past 60 years,

"Opinion" Continued on page 4

Member Submission

My Word

Universal Health Care vs. Universal Health Insurance



Denver Nelson, M.D.

I am a retired neurosurgeon. Beginning in 1968, I practiced medicine and received medical care in academics, government service and private practice. During my medical career, I have seen medicine transition from a profession to a business. This transition has been a disaster for sick people and care givers and a windfall for insurance companies, pharmaceutical companies, medical equipment manufacturers and hospitals.

Medicine is not a business. The goal of medicine is to make sick people well. The goal of business is to make a profit. Business success is achieved by selling a product for as much as the market will tolerate and producing the product for as little as possible. The market price of the product will be set by competition. The costs can be lowered to the point where the product becomes so inadequate and cheap that the buying public will no longer buy it unless forced by government regulations as is currently proposed for health insurance.

Health insurance is not like most insurance. Compare fire and health insurance. Fire insurance is inexpensive. The chance of your house burning down is close to 0; but if it does, you will get a new house. Health insurance is very expensive, but there is a 100% chance that you will get sick and use your health insurance; and when you do become sick, you will discover that your medical insurance company either wants to cancel your coverage or wants you to have the least and the cheapest care possible and wants to pay your providers as little as possible.

Medical insurance companies are businesses and exist to make a profit. From a business perspective, the only profitable way to run a medical insurance company is to sell medical coverage to well customers for a low price and then limit their care when the customers become sick patients. Unfortunately the current discussion about health insurance versus health care is being debated by well customers instead of sick patients. I never had a sick patient tell me to provide the cheapest care available.

So where does that leave us? We have greedy businesses whose objective is to make a profit by providing poor or no health care and who want to make even more money by requiring everyone to have health insurance. I think universal health insurance is a very poor choice. The other alternative is to have the government "socialize" medicine; certainly one of the alleged great evils of conservative and main stream Americans.

Medical care is not a right. An American citizen's unalienable rights from the Declaration of Independence are life, liberty and the pursuit of happiness. Constitutionally guaranteed rights are free speech, bear arms, no troops in your house, no unreasonable search and seizure, no double jeopardy or self incrimination, trial by jury, civil trial if the dispute is greater than $20, no cruel and unusual punishment, any sex or race can vote, no poll tax and voting if you are 18. Nowhere does it say there is a right to health care.

I am not a fan of government providing continually increasing services in an inefficient and expensive manner. In most cases private enterprise is better and more cost efficient, but there are some things that government does better than private enterprise. Government maintains an army and fights wars far better than for-hire companies. Police and fire protection is much better accomplished by government. One may object to aspects of our legal system, but you surely would not want to turn the system entirely over to lawyers with judges responding to the highest bidder. Our gigantic and excellent road system was built and is maintained by the government. Very basic levels of nutrition, housing and education for the less fortunate members of society are only provided by the government.

There are, of course, areas that government does less well and should not be involved in, but government does some things better than private enterprise. Military and VA medicine is not only better done by government but also less expensive. I have come to believe that the government can and would do a better job of providing health care to Americans. And remember, we are the government.

Looking back on my medical career, the best and most satisfying time was the year I spent in Vietnam. I hope that our legislators can overcome the intense lobbying efforts of the medical industrial complex and enact government health care. We will all be better off. *§*

"Opinion" Continued from page 3

we will see chronic dissatisfaction, by both patient and physician. Unless, we can regulate Health insurance as a public utility and/ or offer a government sponsored health care alternative, we will never see any meaningful health care reform. As Paul Krugman (Nobel prize winner for economics 2009) has written: ". . .So let me offer Congress two pieces of advice: 1) Don't trust the insurance industry and 2) Don't trust the insurance industry." (*New York Times* June 5, 2009) *§*

ANN LINDSAY, M.D.

Humboldt County Public Health Officer

Since January 2009, more animals have tested positive for rabies in Humboldt than in any other California county, and the majority of those animals are foxes. In the last 7 months 18 individuals ranging in age from 7 – 94 years have begun rabies prophylaxis after fox encounters in Humboldt. Public Health case interviews would indicate that rabies turns a fox into an attack machine. In the reported encounters the fox appears out of nowhere to attack people as they sit in chairs, exit cars, or water lawns. Rabid fox attacks on household pets have been reported, and providers must assume that unwitnessed attacks on wildlife, feral cats, and livestock could have taken place. Given this epidemic, unprecedented in recent years, all physicians need to closely evaluate patients presenting with animal bites and/or scratches, *even if the animal was a family pet*. Can the dog or cat be observed for 10 days? Physicians must complete a "Bite Report" available from the Animal Shelter (840-9132). For stray dog and cat bites it is also recommended that the physician prompt the bite victim to call their local law enforcement for assistance in locating the animal.

Information on rabies can be obtained from the site www.cdph.ca.gov

Local information on rabies for patients and providers alike is available at:
Environmental Health (animals) 445-6215
Public Health (humans) 268-2182
County Animal Shelter 840-9132 (for Bite Report forms) §

BLOOD BANK AUDIO CONFERENCE

The Northern California Community Blood Bank is again pleased to announce its participation the education programs offered through the AABB Audio-Conference program. The programs are available free to the medical community and offer continuing education credit for physicians (1.5 CME contact hours), nurses (1.8 CE contact hours), and medical technologists (1.5 CE contact hours). Certificates of attendance are also available for others in attendance. Audio-conferences that would be of interest to the medical community are listed below.

All audio-conferences are scheduled from 11:00 a.m. - 12:30 p.m. in NCCBB conference room. Please call at least a day ahead to reserve a space for any audio-conference you wish to attend. *Hope to see you there!*

- **Wed. September 9, 2009 Transfusing the Chronic Patient Population**
- **Wed. September 23, 2009 Legal Issues in Blood Banking: Real Case Studies**
- **Wed. October 7, 2009 Lessons Learned from the Battlefield: Use of Whole Blood and Blood Components**

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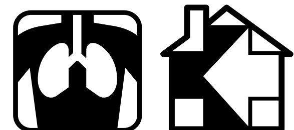

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Fictitious Name Permits

In order to practice medicine in California one mst have a valid license from the Medical Board. However, the business of practicing medicine may also require additional registrations and permits.

The first step is to decide upon a business structure. For information about how to set up a business or to decide which structure may be the best for you, please contact your attorney, certified public accountant, or your local medical association.

The medical practice has to be given a name. Business and Professions Code section 2285 requires a physician who practices under a name other than his or her own to obtain a fictitious name permit (FNP) from the Medical Board. In other words, if the name of a practice is different than the licensee's name or if it includes a qualifier other than the one which denotes corporate existence, an FNP is required. If a licensee's name is Jane Doe, M.D. the following practice names would not require a permit: Jane Doe, M.D.; Jane Doe, M.D., inc.; or Jane Doe M.D., a Professional Medical Corporation. However, the following names would require and FNP: Sunshine Medical Clinic, Sunshine Medical Corporation, or Jane Doe Sunshine Medical Clinic.

An FNP is not the same as a fictitious business name statement or a local business permit or registration. These are overseen by city or county governments. Having a city/county-level permit or registration does not exempt a physician from the requirement for an FNP. For information about what business requirements your city or county has and how to apply, please contact the appropriate city or county officials.

It should be noted that practicing medicine under a fictitious name without an FNP may subject a licensee to citation and fine or other administrative action, and may cause significant headaches. A recent ruling (Richard Garcia vs. Kenneson Farms, Inc. and State Compensation Insurance Fund, case number FRE0196745; ADJ2268134, April 16, 2009) by a workers' compensation administrative law judge found that the State Compensation Insurance Fund did not have to pay for over $2 million in services rendered by a physician who had not been practicing under his name and did not have an FNP at the time such services were performed. The physician was in violation of Business and Professions Code sections 2285 and 2415, and Title 13, California Code of Regulations section 1350.2(c).

Misdemeanor Convictions - Must be Reported

Physicians are required per California Business and Professions Code section 802.1 to report to the Board if they have been charged or convicted of a felony. Legislation was passed in 2005 to amend this statute to include the requirement that physicians also must report any misdemeanor conviction. As is required for reporting felony convictions, the law specifies that the report be made to the Board in writing within 30 days. Failure to file a report may result in a fine not to exceed $5,000.

Since July 1, 2008, the Board has issued 52 citations and fines to physicians for not reporting misdemeanor convictions. The inclusion of this article, for a second time, is to alert and rmind physicians of this mandate, and the importance of reporting to the Board in a timely manner.

A form has been created to facilitate reporting convictions to the Medical Board. The form is on the Board's web site at www.mbc.ca.gov, under forms, Mandatory Reporting Forms, and is entitled, "Physician Reporting-Criminal Actions."

Are health plans or medical groups denying treatments for your patients?

Get an Independent Medical Review through the Department of Managed Care.

1-888-466-2291 or www.dmhc.ca.gov

July 21, 2009

The meeting was called to order by President, Emily Dalton, M.D. at 12:20 P.M.

M/S/C to approve the items from the "Consent Calendar":
-Minutes of the July 15, 2009 Executive Bd Meeting, as presented.
-Society Budget Report / Balance Sheet, as presented.
-CME Budget Report/ Balance Sheet, as presented.
-AMA Highlights of Annual HOD Meeting, report to file.
-CMA Membership Report, to file.
-CMA Membership Analysis Report, to file.
-Del Norte Access to Care Report, to file.
-NORCAP Grant Letter, to file.

Discussion followed regarding setting up a meeting with our Delegates/Alternates to the CMA House to discuss Health Care Reform issues. The list of members responding that they were interested in attending a meeting will be forwarded to Dr. Hoffman for her use in communicating with them directly. Suggested scheduling the meeting sometime in September just prior to the CMA House of Delegates meeting.

Membership Committee Reports were presented. Encouraged review of the CMA Minute Recruiter, which are to be prepared monthly by CMA Membership staff. Review of the Coming, Going and Moving Around report. Communication regarding physician movement was strongly encouraged.

Discussion followed regarding the Editor's response to the proposed changes in Editorial Policies. M/S/C to approve the following revision:

"The policy of the Editorial and Publications Committee is that we shall publish any submission by any Society member so long as it relates to medical practice, either in our community or the nation at large, and 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 any submission if he/she deems it inappropriate."*

Executive Director Update was presented as follows:
-June Telephone Log*: (176 calls logged)*
Physician "Lists" sent out to people looking for a new physician (31)
Complaint calls (Complaint forms sent) (4)
Requests for information on "Red Flag Rules"
Requests for Medical Record Location (4)
requests for location of physician / or APC
requests for list of Physician/APC NPI numbers
requests for Notary services
requests for CME Reports for re-licensure
assisted with expediting CA Medical Licenses for two new physicians.
-Update regarding Condolences and Get Well Wishes sent to members.
-Report on Welcome Packets sent to:
-Jennifer Dawson, D.O.., FM, Arcata
-Judd Dawson, D.O.., FM, Arcata
-Ali Gamini, M.D., Medical Oncology, E.I.M.
-Martin Majer, M.D., Medical Oncology, E.I.M.
-Antoinette Martinez, M.D., OBGYN, UIHS
- Sent invitation to Multiple Membership Status to all the Specialty Clinic Physicians.

- Forwarded communication to Exec Board from CMA regarding the Department of Managed Health Care's (DMHC) latest draft of the timely access regulation. Comment period ends June 25th.

-NORCAL Risk Management Seminar scheduled for October 1, 2009, 7-9 pm. "Anatomy of a Lawsuit" will be the topic.

- Forwarded to Exec Board communication and link from CMA regarding the Office of the National Coordinator for Health IT's (ONCHIT) draft guidelines for the "meaningful use" of Electronic Health Records by physicians and the various aspects of the implementation of the provider incentives in the Federal Stimulus Bill.

-Notified local offices regarding FAX SCAM ALERT by The Centers for Medicare & Medicaid Services (CMS).

-Scheduled MEDICAL SOCIETY FAMILY PICNIC for Saturday, September 26, 2009 at Sequoia Park - 1:00 - 4:00 P.M. MARK YOUR CALENDARS!

COMMITTEE UPDATES:

CONSORTIUM FOR C.M.E.

CME Coordinator attended recent Annual IMQ Meeting in Sacramento - report will follow. Next Meeting scheduled: August 12, 2009

EDITORIAL AND PUBLICATIONS COMMITTEE:

Web subcommittee met June 17th to discuss home page layout with video clips.

Next meeting is scheduled for September 9, 2009.

MEDICAL QUALITY REVIEW COMMITTEE:

Next meeting re-scheduled for Sept. 30, 2009 @ 7:00 P.M.

NORCAL Risk Management Seminar "Anatomy of a Lawsuit" scheduled October 1st.

PHYSICIAN WELL BEING COMMITTEE

New Representative Sutter Coast: Warren Rehwaldt, M.D.

Next meeting scheduled for October 13, 2009.

Proposed updates to the Physician Well Being Committee brochure

- draft to follow.

PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE

1 Review(s) in process. 4 complaint forms sent.

Reported by Dr. Lindsay that she and Martin Love are continuing the work of the IT Committee in helping to establish electronic referrals. There are a couple of practices that are testing the program currently. Criterias are being established for appropriate referrals, i.e. California Children's Services referrals must come only from a Pediatrician, etc.

Public Health Update was presented as follows:

-15 rabid animals have been tested since June 15. 45 reports of animals and others that weren't tested, is a huge issue. Reports need to be brought to the attention of public health and fish and game. Posters are being developed to help notify the public and encourage them to report strange animal behaviors.

-H1N1 cases have not quieted down. Not very lethal (less than 5% mortality) Government vaccination campaign - probably will be directed at children and health care workers (not necessarily the well elderly). Vaccine will come out early this year. Campaign Sept/Oct. By Oct hope to get H1N1 - distributed through Public Health. Who and how many doses don't know yet. The Medical Society Public Health Advisory Committee *(chiefs, pediatrics, SNFs, Infectious Disease, etc)* will be called together to discuss the immunization campaign.

Shared a copy of a "My Word" article that was written by Denver Nelson, M.D. and published in the local Times Standard titled "Universal Health Care in America Versus Universal Health Insurance". Suggested reprinting the article in *The Bulletin*.

Discussion continued regarding the proposed submission to the local newspapers in attempt to educate regarding local healthcare issues. Letter was sent out for additional feedback, however, not everyone received the communication. Suggested including some of the positive things that are happening locally. Subcommittee was appointed to work on the revisions to the letter and review again at the next meeting.

Legislative Update was presented. Discussed CMA's position regarding the Health Care Reform Proposals and the status of several important legislative activities. Strongly encouraged every member to assist in recruitment efforts - we must have an effective organization to help deal with the legal, economic and political challenges facing physicians. Mentioned that Congressman Mike Thompson continues to be a very effective advocate on the Medicare GPCI reform and rural health. Encouraged our representatives that work closely with our local legislators to help educate the membership through *The Bulletin*.

Reported that CMA CEO Joe Dunn will be stepping down from his position. CMA is forming a search committee to look for a replacement.

M/S/C to approve Elliott Gagnon, M.D., Plastic Surgery, Eureka for membership.

The meeting was adjourned at 1:30 P.M. Next meeting is scheduled for August 17, 2009 at 7:00 P.M. §

"CMA" Continued from page 12

reason, physicians have been unable to adequately invest in HIT and other innovations that improve care coordination and chronic disease management.

More than 60% of California physicians said they would stop taking new Medicare patients or leave the program altogether if the rates are not updated. Moreover, 48% of California physicians are over age 50, nearing retirement and curbing patient care services. California will face a severe shortage of physicians if the program is not reformed. Seniors in California already report difficulties finding a doctor.

CMA Medicare Reform Principles

CMA is proposing a series of payment options depending on a physician's mode of practice that appropriately realigns incentives. Patient care coordination and management require investments in physician services, including HIT. Physicians are eager to end the "Hamster Wheel of Volume" that has plagued the program and interfered with quality physician- patient relationships.

The CMA plan calls for

- The immediate elimination of the Sustainable Growth Rate (SGR)
- A 10% catch-up rate increase for all services in 2010
- Annual payment updates based on medical practice cost inflation with appropriate utilization management
- At least 3% cumulative/annual increases for E&M primary care services
- A payment system that rewards coordination of care through both medical home management of patients, and Physician Accountable Care Organizations (ACOs) that incent physicians to collaborate and share in the hospital Part A savings achieved through their efforts to prevent unnecessary and costly hospitalizations.
- Allowing groups to directly contract with Medicare on a capitated basis.
- Private contracting with Medicare patients. §

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

Also refer to Practice Opportunities on our website
www.hdncms.org

FAMILY PHYSICIAN NEEDED to replace departing Medical Director at Southern Trinity Health Services, serving beautiful southern Trinity and southeastern Humboldt county communities. We offer a competitive salary and benefits package including liability insurance. Interested physicians should call Cathy Larsen, Executive Director at 707-574-6616. Also see our website at www.sthsclinic.org.

PHYSICIAN NEEDED for busy occpational 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.

FOR SALE / LEASE

FOR SALE Prime Central Ave. McKinleyville Location Currently Lima's Pharmacy. Real estate only for sale (Lima's Is expanding to new site) 2 separate legal parcels under 1 roof. Lots of parking, ideal medical or professional office use. Only $345,000 Northbay Realty 707-599-7962

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.

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

ANNOUNCEMENTS

NEW PRACTICE COMING THIS FALL: Redwood Osteopathy! Dr. McCaffrey will be opening a new practice offering osteopathic and homeopathic care, functional medicine, chronic pain evaluations, physical therapy and non-surgical neuromusculoskeletal evaluation and management. Outpatient referrals and consultations welcome. Medicare accepted. Low cost medical student osteopathic clinic to open as well. Please have patients and your staff email me on my website for more information: ***redwoodosteopathy.com*** Thank you and stay tuned for more updates! *(KM0709)*

Display Advertising Rate Schedule

SIZE	MONTHLY	SIZE
1/4 Page	$120.00	7.45" x 2.61"
1/2 Page	$140.00	7.45" x 5.23"
1/3 Page Vertical	$130.00	2.37" x 9.95"
Full Page	$170.00	7.45" x 9.95"
Inside Cover/Full Page	$240.00	7.90" x 10.40"
Business Card Ad	$60.00	Copy Ready 2" x 3.5"

Classified Ads
4.75 per line

DEADLINE: 15th day of the preceding month to be published