

# THE BULLETIN

## *Our Mission:*

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

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

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# President's Message

**EMILY DALTON, M.D.**



In case you have not noticed, the Medical Society has proposed changing our financial year from a fiscal year to the calendar year, in order to be in sync with our parent organization, the CMA, and to promote better coordination between other organizations. The implications of this change, as spelled out in the bylaw revisions (that I'm sure all of you reviewed carefully in the last bulletin) would mean that the current cadre of officers would serve for 18 months instead of 12, and that the billing cycle will start 6 months earlier and be pro-rated. The other implication is that our annual meeting and election of officers will now take place in December. This may not be ideal, as December seems packed with parties and activities, but November is probably no better, and the organization must go on. We can have as many or as few organizational meetings as we want, but my sense is that member physicians have a limited amount of time and energy for these meetings, and if the annual meeting is a good one, attendance will be good also, whether in December or June.

I think the functions that the Medical Society sponsors are well-balanced and varied: A family oriented picnic in the fall, the annual organizational meeting now to

be held in December, and a spring social gathering. If anyone wants to offer ideas to change this pattern, let me know. The Women in Medicine group has not met for several years. Personally, I think we now have sufficient numbers of female physicians that such a group no longer fills any particular purpose, and is unfairly exclusionary to our male members. (Not that any of you men were knocking down the door to get in.....kind of like the Ingomar club—when they finally opened their doors to women, not very many were interested in joining.)

We are looking for people to participate on the Executive Committee. Please call Penny if you have an interest in getting more involved with your Medical Society, and even if you don't, do it anyway. The meetings are 1 hour once a month, which is a very reasonable time commitment. Representation should include a variety of specialties and geographic locations, so we need folks from Southern Humboldt and Del Norte right now. In addition, we have enough pediatricians and family doctors, but we could use more internists and sub-specialists.

This month the Editorial and Publications Committee is doing an overhaul of the

HDNCMS website. As I went over the site I was impressed with the number of helpful links present, and the wealth of information available. If you haven't checked it out, I highly recommend going to the site.

<http://www.humboldt1.com/~medsoc/>

Member websites are especially interesting, and they range from very basic to very high-tech. Links to the CMA, Medical Board and various specialty societies are very helpful. The history section is fascinating. If you are not familiar with the history of medicine in the area I recommend checking it out. You will encounter stories of Dr. Sam Burre trekking through the snow on horseback to retrieve a rancher with a shattered femur, tales of Jerold Phelps who did both anesthesia and surgery (on the same patients at the same time) in the hospital he founded in Garberville, and you may learn which local urologist was known as the "vasectomy king". You'll discover that surgeon Jack Walsh and his family ran a ski area on Berry's summit, and that Joe Antony was Santa every year for the children at Glenn Paul school. These and many more facts about the physicians of Humboldt-Del Norte county abound.

Again, check it out! §

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# The World Turned Upside Down

**GEORGE INGRAHAM, M.D.**



That is, we're told, the title of the march played by the British troops when they surrendered to General Washington at Yorktown in 1782, effectively ending the Revolutionary war and with it the longstanding custom ("The British always win.") of British dominance at sea and inevitable victory in land warfare. Another tradition shot to hell. Upside Down indeed.

See, I have always had a great fear of being upside down. Terrifies me. Not sure it rises to the rank of phobia, but close enough. Not long ago Patricia the yoga coach announced to our group that we were going to go inverted that morning. Cold sweat down the spine: I absolutely knew I couldn't do it: licked before I started. I mumbled something to the effect that I, um, wasn't sure I wanted to do this; but Patricia, who always knows what we're doing better than we do ourselves, poked here and prodded there, led me to the wall, and the next thing I knew my feet were pointed at the ceiling and the floor was above me. Terror was coming under control. I was still terrified, but...happy terrified. My eloquent

comment, to the amusement of the group, was a shakey "holy smoke". No idea where that came from; I never say "holy smoke". But then I'm seldom happily terrified.

In my long ago medical education, we learned of another phobia: government (or, as the assembly of grey haired white males wearing rimless glasses who constituted the AMA Board of Directors called it: "socialized" medicine. Hearing no dissenting voices (the term "activist" had not entered general use) we of course agreed: for did they not know what; aye, and where, a cruciate ligament was? And could they not spell "Desoxyribonucleic acid"?

Half a century later we stand at a threshold in medicine. For while the nation accepts that some walk to work, some ride the bus, and some relax in the limo; it is becoming less and less acceptable that some get all the health care they want and

some get little or none. And certainly we have managed to elect a government which will, because it must, make a start at dealing with that inequality and with it the economic problems and human misery which it engenders.

I think that most docs in active practice today have actually been ready for at least some change in this direction for years. We've been ready to follow, with the exception of a few holdouts, but the leaders haven't led. Among all of the other changes we're expecting during Mr. Obama's presidency, this ranks high. And the few of us who still have a knee jerk antipathy to "socialized" medicine will discover that it is much better than what we have now.

And America will be an even finer country to live in.

Holy smoke. §

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• **LETTERS** .....  
• Please congratulate the writers in the December  
• Bulletin for some really fine writing.  
• Thanks, Jay Davis .....  
.....

## 58<sup>th</sup> Annual Yosemite Postgraduate Institute for Primary Care Physicians

- Location:** Yosemite Lodge, Yosemite National Park
- Date:** April 3-5, 2009
- Tuition:** \$325 Physicians  
\$275 Allied Health Professionals (RN, NP, PA)  
\$100 Medical Students, interns, or residents
- Credit:** Up to 16 hours, Category 1 and Prescribe Credit

**For more information:**  
*Fresno-Madera Medical Society,*  
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**ANN LINDSAY, M.D.**  
*Humboldt County Public Health Officer*

**CDC EXPANDS TESTING  
RECOMMENDATIONS FOR  
CHRONIC HEPATITIS B VIRUS  
INFECTION**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm>

<http://www.cdc.gov/hepatitis/HBV/TestingChronic.htm>

In the United States, chronic hepatitis B is the underlying cause of an estimated 2,000 – 4,000 deaths each year from cirrhosis and liver cancer. New CDC recommendations are key to increasing the early diagnosis of chronic hepatitis B virus (HBV) infection, since many of the estimated 800,000 – 1.4 million Americans with chronic HBV infection have no symptoms and are unaware of their disease.

The new testing recommendations build upon and reinforce past recommendations to test all pregnant women, infants born to infected mothers, household contacts and sex partners of infected individuals, and people with HIV.

Routine testing is now recommended for additional populations, including:

- Individuals born in Asia, Africa, and other geographic regions with 2 percent or higher prevalence of chronic HBV infections: Previous CDC recommendations called for testing of people born in areas with 8 percent prevalence. Expanded testing is essential since the rate of liver cancer deaths and chronic HBV in the United States remains high among foreign-born U.S. populations from these areas. For example, nearly one in 12 Asian Americans and Pacific Islanders living in the United States is HBV-infected, and one-third or more are unaware.
- Men who have sex with men and injection drug users: Routine testing is needed for these persons since both have a higher prevalence of chronic HBV infection than the overall U.S. population. Up to 3 percent of MSM and up to 6 percent of IDUs are estimated to be chronically infected with HBV, compared to three tenths of one percent of the general population.

- Persons with abnormal liver function tests (not explained by other conditions) and persons who require immunosuppressive therapy (e.g., chemotherapy for malignant diseases).

The new CDC report also gives recommendations for referral of HBV-infected persons to specialists for ongoing monitoring and medical care. Most of the effective medications for chronic HBV treatment have become available only in the last five years. In addition, the recommendations advise healthcare providers to provide culturally-sensitive ongoing patient education, begin lifelong monitoring for progression of liver disease, and ensure protection of household members and other close contacts of infected persons.

The medical community can promote comprehensive prevention and treatment efforts for HBV, including vaccination for all infants and at-risk adults; catch-up vaccination of previously unvaccinated children; routine screening for all pregnant women; treatment of newborns of infected or untested mothers; and testing household

***Continued on next page***

**SUBJECTS NEEDED**

**Intraductal Therapy of DCIS: A PreSurgery Trial**

We are seeking 30 women newly diagnosed with DCIS on core biopsy (sterotactic, 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

contacts and sex partners of HBV-infected persons.

**FOOD, INCOMES AND HEALTH:  
A NEW LOOK  
AT THE OBESITY EPIDEMIC**

If you are poor, your chances of being obese are much higher than if you are well off. Adam Drewnowski, PhD, of the Center for Obesity Research at the University of Washington, mapped out obesity rates across King County, Washington. Obesity rates range from a low of 5% to a high of 30% depending on zip code. The price of real estate, i.e. economic status of a neighborhood, proved to be a reliable predictor both of obesity and of diabetes-related deaths.

Some would say that people make poor choices regarding fitness or diet, but

many people have little freedom of choice. Reducing money for food below a certain level almost guarantees that the diet will be energy-rich and nutrient poor. Computer optimization programs, when given cost constraints, come up with food purchases similar to those eaten by people with limited food budgets. Evidently, low income people make the best choice available to them.

People who are not sure they will have food money throughout the month tend to overeat when food is available. Furthermore, periods of inadequate calorie intake make a person's metabolism more efficient at storing calories as fat.

The social and economic policies of recent times have created an obese and increasingly diabetic underclass. Wiping out poverty is easier said than done. Yet, as

Humboldt County decides on the General Plan Update to guide the next 20 years, we can plan to make life choices more equitable for low income residents. For example, we can aim to reverse the trend of the last six years of producing more than enough medium and high income housing and less than half the needed low-income housing. More expensive housing means less food money for people with low incomes. Or we can make public transit a more realistic choice or focus new development in neighborhoods where residents can walk or bike to work, school or other activities. Currently, a median-income family spends 27% of their income on transportation. Lower transportation costs could both improve food choices and increase physical activity. §

**PHYSICIAN DISASTER PREPAREDNESS  
IN THE EVENT OF A MAJOR DISASTER:**

**<BE PREPARED**

- *Personal / Neighborhood Disaster Plan & Preparation*
- *Battery Operated Radio*
- *Carry Personal Disaster Supplies in Vehicle*

**<TUNE IN**

HUMBOLDT CO.: TUNE IN TO KINS 980 AM.  
DEL NORTE CO.: TUNE IN TO KPOD 97.9 FM / 1240 AM

**(DO NOT RELY ON TELEPHONES FOR NOTIFICATION)**

**<\*LISTEN FOR INSTRUCTIONS.**

*If requested, report to your primary hospital or assigned hospital (If unable to physically get there - go to the closest hospital)*

***\*Carry your drivers license and wallet ID issued by the Medical Board of California  
AT ALL TIMES.***

***\*Wear comfortable, rugged shoes and clothing!***