

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.

EDITORIAL & PUBLICATIONS COMMITTEE

Stephen Kamelgarn, M.D. "Guru"
Emily Dalton, M.D.
George Ingraham, M.D.
Leo Leer, M.D.
Scott Sattler, M.D.

EXECUTIVE DIRECTOR

Penny E. Figas

ADMINISTRATIVE ASSISTANT

Rebekah Harmon

CONSORTIUM COORDINATOR

Terri Taylor

EXECUTIVE BOARD

Hal Grotke, M.D. PRESIDENT
Mark Ellis, PRESIDENT-ELECT
John Mastroni, M.D. SECRETARY TREASURER
Emily Dalton, M.D. PAST PRESIDENT
Willard Hunter, M.D. DIRECTOR
Kelly Kinsley, M.D. DIRECTOR
John Nelson, M.D., DIRECTOR
Tim Nicely, M.D. DIRECTOR
Sandra Wilcox, M.D., DIRECTOR
Clayton Overton, III, M.D. DIRECTOR
Ann Lindsay, M.D. PUBLIC HEALTH OFFICER
Norman Bensky, M.D. EASTERN DISTRICT
Mark H. Davis, M.D. NORTHERN DISTRICT
Emily Dalton, M.D. CMA DELEGATE
Joan Hoffman, M.D. CMA DELEGATE
Kate McCaffrey, D.O. CMA DELEGATE
Mark Ellis, M.D. ALTERNATE DELEGATE
Hal Grotke, M.D. ALTERNATE DELEGATE
Clayton Overton, III, M.D. ALT. DELEGATE

George Jutila, M.D. SOLO & SMALL GRP FORUM
James Bronk, M.D. CMA DIST. X TRUSTEE
Mark Davis, M.D. CMA DIST. X TRUSTEE

In This Issue:

President's Page	2
<u>Full Disclosure: I have Multiple Conflicts of Interest,</u> <i>Hal Grotke, M.D.</i>	
In My Opinion	3
<u>The Caterpillar Syndrome,</u> <i>Scott Sattler, M.D.</i>	
Member Submission	4
<u>Questions for Prostate Cancer Screening,</u> <i>Drs. John Albertini, Michael Harmon, Join Luh,</i> <i>Kusum Stokes & Robin Zagone</i>	
From the Executive Desk	6
<u>Local Physician Data,</u> <i>Penny E. Figas</i>	
Meet Our New Members	6
H-DN "Tattler"	7
Public Health News	8
Mental Health Update	9
<u>An Unprincipled Approach to Balancing the Budget,</u> <i>Phillip R. Crandall</i>	
CMA Advocacy	10
<u>CMA Steps up Where AMA Can't,</u> <i>Elizabeth McNeil</i>	
CMA News	12
<u>The Bar to the Corporate Practice of Medicine</u>	
CMA Foundation News	14
<u>Focusing on Prevention is Money Well Spent,</u> <i>B. Hamilton, MD</i>	
NORCAL News	16
<u>Making Changes to a Medical Record:</u> <u>Corrections vs. Alterations</u>	
Board Briefs	20
Grand Rounds Calendar	22
Classified Advertising	24

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

The Bulletin is published monthly by the Humboldt-Del Norte County Medical Society, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367; FAX: (707) 442-8134; E-Mail: hdn/cms@sbcglobal.net Web page: www.hdn/cms.org

The Bulletin does not assume responsibility for author's statements or opinions; opinions expressed are not necessarily those of The Bulletin or the Humboldt-Del Norte County Medical Society.

Full Disclosure: I Have Multiple Conflicts of Interest

HAL GROTKE, M.D.



It is a sunny, breezy Sunday morning and I am sitting in my office, writing this three days after it was due, while procrastinating on the pile of paperwork on my desk with Enya blaring on my iPhone. I came straight here from the airport. Friday I ran out of here at 5:00 to catch the 6:10 flight to LA for a baby shower yesterday. Thankfully the flight was delayed a few minutes; I made it. Now I am staring back at a note on a chart that reads “please call pt; angry.” The name doesn’t look familiar. I don’t know what it’s about. This is really not what I want to be doing today. Conflict #1: I have way too much to do at home to be jetting away for a weekend. Conflict #2: I have way too much to do at home to be spending a weekend day in the office. Conflict #3: I would really rather be out enjoying the beautiful weather instead of being in the office or attending things at home that need attention. Well, I called the patient. I had gotten a lab report and had asked my MA to call the patient to tell them that the result was normal. It turns out that the tests had been ordered by a “physician extender” (midlevel, advanced practice clinician; what is the current acceptable terminology?) at another office. It is one of those tests that gets flagged results if the reported value is outside the 95% confidence interval but is often not abnormal even when it is reported as such. Furthermore, it turns out that the patient had already been told that the result was abnormal and that a consult was needed to investigate this further. The patient apparently has already been refused consultation by the subspecialist requested. The American Academy of Family Physicians says that a family doctor who follows 2000

day, five days a week providing recommended preventive services. They also say that we should spend 8 hours a day, five days a week managing chronic disease. I don’t know how they come up with these numbers. They acknowledge/decry the nationwide shortage of family doctors and say that the solution is to use NPs/PAs/CNMs more. In general I am pleased with the care provided by these professionals. I cannot claim that I always get it right. This particular situation appears to me to be an important example of shortfall of at least this one of our colleagues with less training. Conflict #4: I am a control freak and some things are beyond my control. Conflict #5: I want all of my patients to get optimal care at all times but I and others sometimes err. I recently had another angry patient. Maybe angry patients are not as rare as any of us would like. Anyway, this other patient has all the usual chronic conditions: obesity, hypertension, dyslipidemia, and diabetes mellitus. She has not suffered any apparent complications of any of these conditions except the obesity. This patient’s insurance covers preventive services and hospitalization. She pays out of pocket for out-of-hospital acute care and for chronic disease management; they also have a pay-for-performance contract with my employer. She simply (honestly) cannot afford to pay for appropriate monitoring of her conditions. In my mind the care that I provide for her is preventive; again, she doesn’t have complications yet. When I bill appropriate monitoring as preventive the insurance refuses to pay because the tests are not indicated for screening. They are disease-specific. The P4P amount is not enough to cover the expense of the tests. I thought about paying


for her care out of the bonus I would get if she got appropriate care. It just isn’t enough. Conflict # next: ~~It can’t be done.~~ There are times when it seems impossible to give optimal care even for the patients who show up and seem to want to get optimal care. A couple months ago I was feeling a bit burned out. At the end of one particularly demanding day I went onto St Joe’s Physician Connect and found that three of my patients had been in ER that day for complaints that seemed that I probably could have taken care of them if they had been able to get an appointment with me. Thanks to an understanding employer I have since made some adjustments to my schedule. My days are now more tolerable and my patients now have more difficulty getting appointments with me. See conflict #4 above. Conflict # next (yes, I lost count): I don’t want to work so hard. I want more free time while always providing optimal care for all my patients. That’s enough for this article. Thanks for letting me vent. I don’t have any suggestions or solutions to offer this month. §

**Your membership
in CALPAC will
make a difference.**

Join with your colleagues and demonstrate your dedication to strengthening medicine's political voice in Sacramento .

CALPAC
1201 J Street, Suite 275
Sacramento, California 95814

1-800-CALPAC-9

CALPAC 

The Caterpillar Syndrome

SCOTT SATTLER, M.D.



As a family practice doc for the past thirty-odd years, I've had the opportunity to follow the births, lives and deaths of many Humboldt County residents. One of the most humbling and rewarding aspects of my practice has been its involvement with the intricacies of the dying process and the medical and family dynamics involved. As a profession, we don't talk about this very much; not that it's secret per se, but perhaps it's that we hold it as sacred. Most of us are shy when it comes to sharing these things. Yet we can gain a great deal from looking in this direction, as it is such an integral part of our practices and of our personal lives.

There is an aspect of the dying process that I have observed on many occasions that begs for discussion and contemplation. I wonder whether others who are working with the dying have observed this phenomenon, and I wonder whether, as you read this article, you might nod your head in recognition. Then again you might consider these musings merely the dodderings of a chronologically gifted, eccentric airhead. I look forward to your impressions and invite you to share them with me.

There is a Sufi saying that there is but one major sacred book -- the sacred manuscript of nature. The perception in this editorial comes from observing one of nature's wonders -- caterpillars. After hatching from its egg and devouring its eggshell, the caterpillar spends its life exploring its favorite vegetation, eating, and growing. Then, at a given point, it is as if it knows that it is time for its caterpillar life to end, and there emerges an irresistible desire to prepare for

its caterpillar demise. "Been there. Done that. Got the fuzzy t-shirt. Time to move on..." might be its driving motive. An internal switch is thrown; the desire to eat wanes and then disappears, supplanted by a desire to find a secluded protected environment where it will conclude its caterpillar life in relative safety. It finds the underside of a twig on its favorite bush, wraps itself in its security-blanket cocoon and surrenders to the overwhelming urge to release all aspects of its caterpillar life, simply trusting that all is well and as it should be. And then it dies to being a caterpillar.

I can almost imagine younger, more energetic caterpillar friends urging it to eat, eat just a little, and perhaps wanting it to stay involved with caterpillar community life. And in completion of this fantasy, I hear the cocoon-spinner's final plea to its more active companions: "If you really want to help me, just keep the birds away."

I think many humans do this, too. Over the years I've noticed a similar pattern, especially in elders who have recently survived the death of their lifelong mate. Quite often the surviving spouse would unexpectedly die within six to eighteen months after their loved one passed. When I talked with their families, I often heard a similar story, namely that the surviving spouse had proceeded to wrap up the family business after the funeral of their mate, had often mended any personal issues that needed tending, and then simply withdrawn from societal obligations, reduced their food and fluid intake, gotten the dwindles and simply died. It was as if a switch in the core of their being had been triggered, and they knew that their life

as a human was drawing to its natural end. They were fully ready to move on, and all family entreaties to "eat just a little more" were kindly ignored. They did not meet the formal medical criteria for depression. They were not, on the whole, nearly as unhappy as their families. I have seen this pattern of end-of-life behavior time and time again.

Sometimes the triggering scenario is different. I often saw a similar pattern of behavior in those diagnosed with end stage malignancies. When confronted with the reality that long-term quality survival was no longer a realistic option, this pattern often emerged. The gift of cancer, it seems, is that of Time. Unlike sudden cardiovascular death, the incurable cancer patient is given a window of time within which to do the necessary homework on the physical, mental and spiritual planes if they so desire and if they are given the freedom and the opportunity to do so. Read: "Keep the birds away." Frequently this end-of-life-pattern mimics the pattern described above, namely, that of the Caterpillar Syndrome.

I do not feel that this condition is pathologic. There is little, if any dis-ease on the part of the patient, unless those caring for them induce this condition out of their own frustration, anger, fear or greed. I have felt no sense at all of suicidal ideation in these patients. Is the caterpillar being suicidal when it attaches its silk purchase to the twig and starts to spin its cocoon? To the contrary, my sense is that this syndrome is a part of the 'Death with dignity' that we espouse so repeatedly at the

Continued on page 13

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

of nonphysicians who are under enormous pressures to cut costs or increase revenues will threaten the independent medical judgment necessary to ensure patients are protected. A study was recently released that shows that a motivation for hospitals to acquire physician practices is financially based, that is, to increase referrals from the physicians that they employ and to share in their revenue — not just for increased access for patients. In addition, hospitals are already interfering with medical staffs' ability to ensure quality care through independent self-governance. For example, some hospitals have adopted medical management protocols that have resulted in inappropriate hospital tests, procedures, and stays, jeopardizing patients and increasing costs.

5. Hospital districts already have numerous financial incentives they can use to recruit physicians. Proponents of eliminating the corporate bar, including hospitals districts, have failed to show why allowing corporate entities to directly hire physicians would work where these incentives have failed. A list of incentives currently available to hospitals and hospitals districts includes:

a. guaranteeing to a physician and surgeon a minimum income for a period of no more than three years from the opening of the physician and surgeon's practice,

b. guaranteeing purchases of necessary equipment by the physician and surgeon,

c. providing reduced rental rates of office space in any building owned by the district or any of its affiliated entities, and

d. providing other incentives to a physician and surgeon in exchange for consideration and upon terms and conditions the hospital district's board of directors deems reasonable and appropriate.

None of these incentives grants hospitals or hospital districts the control over the actions of physicians that they seek through the ability to hire physicians — the real goal of eliminating the patient protections of the corporate bar.

Of concern to CMA, there is significant misrepresentation by opponents of the bar to the corporate practice of medicine. They have created a website that claims that eliminating the corporate bar would solve California's physician shortage (despite not creating a single new additional physician or residency slot in the state!), that incorrectly states that "support for SB 726 is broad, diverse, and expert" ["From doctors and healthcare experts, to civil-rights groups and faith-based organizations, Californians with conscience are calling for an exemption to the 'physician hiring ban.'"], that falsely states that AMA supports eliminating the corporate bar, and that inappropri-

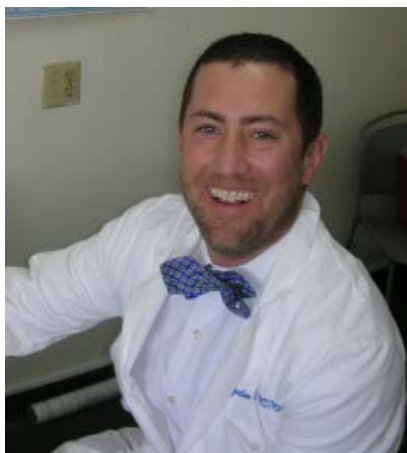
ately uses CMA data in an effort to make it appear as though CMA supports SB 726 as a way to solve the doctor shortage in California.

* California's Legislature responded to a hospital shortage after World War II by enacting the Local Hospital District Act, which later became the Health Care District Act, a body of law that authorizes communities to form special districts to construct and operate hospitals and other healthcare facilities to meet local needs.§

Reprinted from the San Diego Physician magazine, April 2010

Continued from page 3

theoretic and institutional levels. As physicians we have a hard time dealing with this. We have a hard time remembering that our obligation of caring for patients begins and ends with actual caring for our patients. This includes inquiring as to their most heartfelt desires at this stage of life, and honoring them, supporting them, and indeed protecting them from 'the birds,' namely those who would impose a different scenario upon them for their own personal needs and desires. We owe this to our patients, for who can provide this service to them if not we?
§



Jonathan Rutchik, MD, MPH

is a physician board certified in both neurology and occupational and environmental medicine from the SF Bay area.

He visits the Eureka/Arcata area every 3-4 months to perform worker's compensation Neurology consultations, EMG and NCV testing and Qualified Medical Examinations including AMEs.

Please call his office to schedule an appointment.

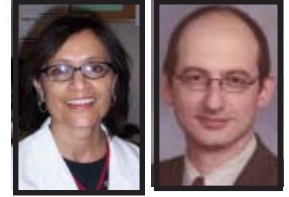
TEL: 415-381-3133
FAX: 415-381-3131

EMAIL: office@neoma.com
WEBSITE: www.neoma.com

Questions for Prostate Cancer Screening, Part II



John Albertini, M.D., Michael Harmon, M.D.,
Join Luh, M.D., Kusum Stokes, M.D.
and Robin Zagone, M.D.



Ed Note: In light of the American Cancer Society guidelines for the Screening for Prostate Cancer (see last month's issue of The Bulletin), The American Cancer Society, Dr. Kusum Stokes (KS), Dr. John Albertini (JA), Dr. Robin Zagone (RZ), Dr. Michael Harmon (MH), and Dr. Join Luh (JL) recently got together to discuss the pros and cons of prostate cancer screening, especially in light of the recent NEJM studies and the revised ACS guidelines on prostate cancer screening. The editors felt that this was an important enough topic, that it should be printed in its entirety. Part I, (published last month) focused on the value of the PSA test and on whom it should be performed. The focus in Part 2 is on what to do for an abnormal screening, the controversy surrounding screening, and is there anything better in the future.

KS: So the PSA or digital rectal exam is abnormal. What's next?

JA: I think if somebody has failed the screening, and that's defined by either having an abnormal PSA level if they're new to the PSA screening, or have an elevated PSA velocity (greater than 0.75 ng/ml increase per year for 2 consecutive years), or has a suspicious or abnormal digital-rectal exam, then the discussion of whether or not he should go on with further testing needs to be done with the patient. If that patient has a good 10 year life expectancy, understands the risks and benefits of being treated for prostate cancer, and wishes to know if he has prostate cancer, then the next step is a transrectal ultrasound combined with an

ultrasound guided biopsy of the prostate. This is a procedure that is done with no IV or oral sedation; it can be done with some local anesthetic and usually takes about 15 minutes. Historically, this was associated with some discomfort, although with new techniques, it's usually associated with very minimal discomfort. Like any other test, it does carry some risks although they're very small; the risks being some discomfort during the procedure, an approximately 2% risk of infection, and a small risk of bleeding, most of which is clinically insignificant.

MH: When I first started practicing in Eureka 18 years ago, the majority of our patients with prostate cancer had large palpable masses in the prostate. They were often diagnosed when they had symptoms such as blood in their urine, difficulty urinating, or pain. Now, the vast majority of our patients with prostate cancer are diagnosed by PSA level alone with normal prostate exams. As a result, we're treating people with much earlier stage disease because of PSA detection. One of the biggest benefits of catching prostate cancer early is avoiding anti-androgens. Anti-androgen therapy (hormone therapy) has more side effects, and changes a patient's life more than surgery or radiation. A man on hormone therapy is like a man going through menopause. Anti-androgens block the male hormone testosterone and, as a result, a patient has hot flashes, night sweats, gynecomastia, fatigue, loss of libido, loss of sexual function, loss of muscle mass, weight gain, difficulty sleeping at night and, sometimes, depression. These symptoms can last

months, if not years, even after the anti-androgen therapy has been discontinued.

JL: There are additional metabolic consequences of anti-androgen therapy, such as unmasking underlying coronary artery disease. It's also the first time you have to worry about osteoporosis in men in addition to the "menopausal" symptoms that they may go through, so this has led to many concerns about the systemic side effects of long-term use of hormone therapy.

RZ: In my opinion, the goal of PSA screening is not to detect prostate cancer, but rather to detect prostate cancer *early* in order to avoid a lot of the morbidity that has been outlined. The average time of progression for all comers for prostate cancer that is detected, based solely on elevated PSA and absence of symptoms or abnormal rectal exams, is close to 6 years.

KS: So, should a PSA screening and a rectal exam in men over 50 be mandatory?

RZ: If the question is, should it be mandatory practice, I would say no. I think screening should be offered to all men and some form of discussion of the pros and cons of screening should be exercised, but I think withholding screening would be a disservice to our patients. PSA screening should be optional.

JA: I think it's going to be important for the primary care physician to understand the potential medical legal implications of not addressing the issue of prostate cancer with

someone who does have a good life expectancy, and, potentially, could have a significant impact by learning that they have a prostate cancer early. I think it's important, at the very least, to document that they've had that discussion with the patient. For, if they do follow somebody for a period of time and the patient does, in fact, have an undetected malignancy that then progresses and is no longer amenable to local treatment, there is a potential associated medical legal liability.

KS: Perhaps we could even comment about any new or better prostate detection tests that might be on the rise that you guys may have heard of.

JA: Many other tests have been suggested to replace, or at least enhance, PSA screening. There is the percent free PSA that Dr Harmon talked about last month. However, there's a number of other blood checks that look promising, as well. Most recently, there are urinary markers that have shown some usefulness in detecting early prostate cancer. The problem arises, as always, with the sensitivity and specificity of the tests, as well as the long-term studies that are needed to validate the efficacy of these tests. Currently, nothing has supplanted PSA as an early diagnostic screening test.

MH: Prior to the routine use of PSA, there was a blood test called prostatic acid phosphatase and that had some correlation with the presence of prostate cancer.

KS: What do you feel about the use of that test?

RZ: It has largely been supplanted by PSA, but there are occasions where we use it as an adjunct, particularly in cases where there is a "undifferentiated" prostate cancer that may not be able to synthesize the Prostate Specific Antigen; sometimes that may be an adjunct that could be used but it would not

be a routine screening tool.

KS: What are your thoughts about the 2 landmark studies published in last year's *NEJM*^{1,2} on prostate cancer screening?

JA: I think it is important when anybody looks at a study and looks at the conclusion that they critically analyze exactly how the study was done. It's important to understand what the questions were that the study was trying to address, and exactly what the end points of the study were. Again, many studies use death as an end point. It's important to look at quality of life issues such as morbidity, and it's extremely important to look at who's screened, the dropout rate, etc. before you come to a conclusion from these studies.

MH: When the articles came out in *New England Journal of Medicine* and the conclusion was to not do prostate screening because PSA screening did not save lives, based on the American study. Most of the doctors who stated they were going to change their practice based upon this study had never actually read the study themselves and I think it's very important when you read this study you realize that there's some major flaws.

1. In the very beginning, the study was flawed. The Control Group, one would assume, would be people who were not getting any PSA tests at all. However, the Control Group, in this study, was actually comprised of patients where the doctor was *not to suggest* to them that they should have a PSA. If they were already getting PSA's, they would continue, but the doctor would not *suggest* to them that they should. For the experimental group, the group where you assume everyone is getting PSA's done, the reality was that the doctor was *merely supposed to suggest* to the patient that they should do it and *it was up to the*

patient to decide whether or not they would. So the number of people who were getting PSA screening between the control and the study group were actually very similar, which does not stratify or predict anything. The control and experimental arms were essentially the same.

2. The other major flaw in the study was that in the study group, for those patients who actually had an elevated PSA, underwent prostate biopsy, and found to have prostate cancer, the study then required the doctor to give the patient the *choice* of whether to treat it or to observe it. Screening *cannot* result in an increased cure rate if you detect a cancer and choose not to treat it.

3. Probably the biggest flaw was using death as the end point. For this study, I believe follow up was 5 years. If every single patient in that study had cancer of the prostate, in 5 years, the majority wouldn't be dead anyway. You need a much longer timeframe. The more appropriate end point would not be death, but rather, whether or not they had a cancer of the prostate which had become clinically significant. If someone had a prostate cancer that was asymptomatic, and he died from something else, then that would not be of importance. But if somebody ended up having a prostate cancer that caused painful bone metastases, possibly suffering pathological fractures, and had to undergo years of anti-androgen therapy, and its attendant side-effects, along with multiple courses of radiation, even though he may live the same amount of time, there's a huge decrement in his quality of life.

RZ: Making mortality the end point in the study is tricky because if the patients that were diagnosed with cancer did receive treatment, I would say this speaks to a vic-

Continued from page 5

tory in early intervention to prevent mortality.

JL: Both the European trial (which showed a 20% reduction in death with prostate cancer screening) and the PLCO trial conducted in the United States (discussed above and showed no survival benefit with screening) actually led to more confusion among the lay public, even though committees for both studies decided it was time to publish these findings on interim analysis. Both studies drew criticism for being published too early before the 13 year data would actually be available, where assessments of mortality would be more meaningful. Another criticism is the composition of members of the US Preventative Services Task Force that came up with the prostate screening recommendations. Not one member was a urologist, medical oncologist, or radiation oncologist. A few were nurses, one was an obstetrician, and the rest were primary care physicians or epidemiologists with primary care training. This same criticism was echoed in the guidelines for breast cancer screening when no radiologists were on the panel.

KS: Thanks so much for your informative comments. Is there anything you all would like to add?

RZ: For me, the best way to summarize the

issue is this: the PSA assay is not specific to prostate cancer. However, it is, at the moment, the best screening tool for early detection and intervention of prostate cancer. Prostate cancer is the most common solid tumor in men, and is still the second most common cause of cancer specific mortality in men. Prostate cancer specific mortality has decreased since PSA was introduced, and I think those are the facts that still speak for themselves. Eventually, perhaps a more specific screening test will evolve, but for the time being, it is still a great benefit and utility to have the PSA as a screening tool.

JA: The only thing I would add to that is that with the significant percentage of our population now being healthier and living longer, I think it would be a mistake to deny healthy individuals, with a very long life expectancy and few other co-morbid diseases, the benefits from having this information. Prostate cancer is definitely not a benign entity. The key, in the future, is to further tailor who would most benefit from this test, and perhaps find other tests that may either supplant PSA, or be an adjunct to PSA, to detect those clinically significant cancers earlier and therefore allow them to be treated successfully.

RZ: This may have already been said, but I think 2 of the misconceptions can be derived from some of the recent articles in the

public press would be that PSA failed to detect prostate cancer and that prostate cancer is not a morbid or mortal disease. Neither are, in fact, true.

JA: Earlier detection of cancer in individuals that will need treatment definitely has an impact on the morbidity of most treatments as well. With newer surgical techniques, including:

laparoscopic robotic techniques; the ability to use cryotherapy; potentially do selective cryotherapy in very early stage cancers; and the ability to use brachytherapy or intensity modulated radiation therapy in patients that have very early disease, the morbidity and some of the feared complications of treatment are much less in individuals that have an early stage of the disease than more advanced disease. I think primary care doctors are in a unique position to truly identify those men who would benefit from this screening, and it certainly would be important for them to, at least, have a discussion with those men who are at highest risk. §

References

- 1.Schroder FH, Hugosson J, Roobol MJ, et al. "Screening and Prostate-Cancer Mortality in a Randomized European Study." *N Engl J Med.*, 360:1320-8. March 26, 2009
- 2.Andriole GL, Grubb RL 3rd, Buys SS, et al. "Mortality Results from a Randomized Prostate-Cancer Screening Trial." *N Engl J Med.*, 360:1310-9. March 26, 2009

**Janssen, Malloy, Needham,
Morrison, Reinholtsen, Crowley & Griego LLP**
Attorneys at Law

730 Fifth Street, Eureka, California 95501
(707) 445-2071 Facsimile: (707) 445-8305

W. Timothy Needham - Michael Morrison* - Dennis Reinholtsen - Michael J. Crowley
Patrik Griego - Frances K. Greenleaf - Amelia K. Burroughs - Shanti Michaels

☛MEDICAL MALPRACTICE DEFENSE

☛BUYING/SELLING OF MEDICAL PRACTICES

☛PHYSICIAN EMPLOYMENT CONTRACTS

☛MEDICAL RECORD ISSUES

☛ESTATE PLANNING

☛HOSPITAL-BASED PHYSICIAN CONTRACTS

☛INFORMED CONSENT ISSUES

☛PEER REVIEW

☛MEDICAL BOARD INVESTIGATION

☛PHYSICIAN RECRUITMENT CONTRACT

☛UNPROFESSIONAL CONDUCT CLAIMS

☛GENERAL BUSINESS LAW

www.janssenlaw.com

*Member of the California Society for Healthcare Attorneys

Local Physician Data

PENNY E. FIGAS

Executive Director



One of many important roles of a county medical society is to keep accurate records of all physicians within our jurisdiction, which sometimes isn't as easy as one would think. There have been many times that I have threatened to put "Detective" in my title.

Many people have heard me say for several years that I wish we could put a sign up at the county lines that states: "If you are a physician coming to, or going from, Humboldt or Del Norte County, PLEASE let the Medical Society know." I still think we should.

There are several ways of identifying new physicians. The easiest, of course, are those physicians joining current member practices. We work with your offices to keep us updated on any changes. We frequently get calls from your offices, your transcription or billing services, or the public asking if we know of Dr "X." If we haven't, that's when the "detective" work begins. We have a great working relationship with the hospital medical staff coordinators, and are on the distribution list to help keep track of *locum tenens* physicians in the area. The Medical Board, AMA Movement Reports, local newspapers, etc. are some of the "tools" we use to stay on top of who is coming or going, and where they went.

I am very proud that we have built an outstanding database for tracking all of our local physicians. The information contained in the database is invaluable in generating both our Physician Membership Resource Directory and Physician Residence Directory, among other things. The many lists that are published to help make yours' and your office staffs' jobs a little easier are generated from the database: *Member lists, specialty index, office practices, advanced*

practice clinicians and the non-member index, to name a few of the functions of the database. With the database program we can generate a number of different reports that can be used in a variety of ways: Numbers of physicians by specialty, by specialty and city, physician population by age/group. Currently, we are working to break down FTE (full-time equivalent) options to generate an even clearer picture for use in manpower shortage designations, etc.

We continue to work towards automating as many functions as possible to avoid having to duplicate and constantly cross check information;- i.e. working on consolidating the broadcast fax and broadcast e-mail lists, which are currently run in separate programs.

The Patient-Physician Referral program is tied to our database program and can generate a list of physicians within the specialty requested to mail, e-mail or fax to patients looking for a new physician. With the frequent changes in the ability of our local practices accepting new patients, we

are no longer tracking that, nor are we able to track the various insurance carriers that practices are contracted with. We advise the patients that they will need to contact the individual offices as to what insurances are accepted.

We are able to assist you, your offices and patients with location of patient records when physicians move or retire and/or need a forwarding address.

We are working very closely with C.M.A., as they upgrade their current system, so that CMA may work more closely with the county medical societies to regularly exchanging data electronically. Historically, this has been a duplicative effort, where either the local county society or CMA comes up short. Now, with the advent of the internet and our powerful database close integration and reliable information can become a reality. Ahh, what did we ever do before computers? (I think I still have a few sheets of carbon paper somewhere). §

MEET OUR NEW MEMBERS

Please join us in welcoming the following new members. Contact the Medical Society office if you wish further information about any of our member physicians.

(Cut out on dotted line to add to your 2010 Membership Directory)



KEVEN J. NEVIL, M.D.
Obstetrics/Gynecology

Board Certification: American Board of Obstetrics & Gynecology (2004)
Ross University School of Medicine (1998)

Eureka OB-GYN

2607 Harris Street, Suite B, Eureka, CA 95503

(707) 445-3443 FAX: (707) 445-1848

Office Manager: Kim Pfanenstiel

May 17, 2010

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

AGREED that “action” items that members wish to have pulled from the “Consent Calendar” for discussion need to be done prior to the meeting in order to have back-up documentation available.

Any member wishing to discuss an opposing viewpoint to a position CMA Board of Trustees has taken should be encouraged to bring it to the attention of the Executive Board for discussion and formal communication back to CMA.

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

-Minutes of the April 19, 2010 Executive Board Meeting, as presented.

-Physician Coming/Going Grid, to file.

-Society Budget Report/Balance Sheet, approve as presented.

-Consortium Budget Report/Balance Sheet, approve as presented.

-HOD Planning Calendar, to file.

-CMA Membership Report, to file.

-Membership Committee Meeting minutes April 15, 2010, approve as presented.

-Membership Committee Meeting minutes May 10, 2010, approve as presented.

-Communication San Mateo CMS re: AB2093, to file.

-Physician Well Being Committee Meeting minutes May 11, 2010, approve as presented.

DISCUSSION followed regarding feedback from the membership regarding the letter sent out to solicit feedback regarding increasing membership. Feedback from several members was that they were interested in belonging to the local but not the state (*or vice-versa in a couple cases*), however, as a component of the state membership in both is required.

Dr. Davis reminded that any member can submit a resolution for consideration of the CMA House of Delegates, which is the body that sets policy for the organization. Although any member can submit direct to CMA, it is best to utilize the process of generating support locally, then through the district to the annual HOD.

SUGGESTED working with the Editorial and Publications Committee to increase member communications on “What We Do”. Information needs to get to non-members as well. Suggested dedicating at least one issue of *The Bulletin* each year to membership benefits and distribute it to all physicians. Mentioned that a grant request could be submitted to the HDN FMC/IPA to help with funding the costs of additional printing and postage. Target should be around the same time we send dues statements to all physicians (November).

AGREED that the Executive Board and Membership Committee need to continue to enlist the support of our members in our recruitment and retention efforts. Every physician should be a member and support their local professional society.

PRESIDENT REPORT was presented, as follows:

-reported sending a letter in support of nomination of Ann Lindsay, M.D. for CAL eConnect.

-reported sending letter in opposition of SB 726 (Ashburn).

EXECUTIVE DIRECTOR UPDATE was presented as follows:

-reported that Denver Nelson, M.D. was appointed Humboldt County Planning Commissioner District 1. Mentioned will include note in the “Tattler” along with a Welcome Back to John Nelson, M.D. who was called to Active duty.

-reported that there was low attendance at the recent Spring Social. Mentioned that it appears that the Ingomar is the big “draw” for this event.

-reported on several Welcome Letters sent.

-reported that the CMA Best Practices Seminar will be rescheduled when our speaker is back to work.

-reported that the CMA-IMQ Accreditation for the Jail and Juvenile Hall was presented at the Humboldt County Board of Supervisors meeting.

-mentioned that this year’s NORCAL Risk Management Seminars are being scheduled as follows:

-September 8, 7-9 p.m. (Wed) Physicians

“*Disclosure of Unanticipated Outcomes*”

-September 9, 1-3 p.m. (Thurs) Staff/Office Managers

“*Office Practice Strategies and Resources for Reducing Risk*”

-September 10, 1-3 p.m. (Friday) Del Norte Members/Staff
“Office Practice Strategies and Resources for Reducing Risk”

COMMITTEE UPDATES followed.

-CONSORTIUM COMMITTEE: mentioned that the **Consortium for CME** Infectious Disease Subcommittee met recently to discuss coordination of an I.D. Conference this year.

-EDITORIAL AND PUBLICATIONS COMMITTEE - mentioned that the next meeting of the committee will be focusing on review/updates to the website. Exec Board was encouraged to review our website and give feedback.

-MEMBERSHIP COMMITTEE: welcome Dr. Wilcox to the Membership Committee. Executive Board will be invited to participate in all Membership Committee meetings as well.

CMA TRUSTEE UPDATE was presented, as follows:

-reported on the 5 year “fix” to stop the Medicare cuts and CMA and AMA’s continuing fight for the SGR Fix.

-reported that CMA has prepared a summary of the Governor’s Proposed State Budget and the impact on physicians. CMA will keep members updated.

-reported that Legislative Alerts have been sent out encouraging members to contact their Assemblymember’s and encourage Protection of the Ban on Corporate Practice of Medicine and opposition to AB 726 (*Ashburn*)

-mentioned that the Board of Trustees will be meeting again in a month. Also hope to have an update from the CMA Finance Committee at the next meeting.

DEL NORTE UPDATE was presented, as follows:

-reported on on-going recruitment and retention efforts of our Del Norte physicians.

TREASURER REPORT was presented, as follows:

-reported that in addition to focusing on member retention and recruitment, it was suggested that local dues be increased \$20., noting that the last increase was done in 1994. **M/S/C** to increase the Medical Society dues to \$390.00 for 2011.

MEMBERSHIP COMMITTEE REPORT was briefly presented. Mentioned suggestion to develop a Membership Benefit Card with discounts to local businesses, restaurants, memberships in clubs, etc. Agreed that this would take a lot of staff time to pull this

together. Questioned whether we should survey the membership regarding interest. Suggested crafting a letter to go out to a few local businesses to see what interest there would be from them.

REPORTED receiving a request from our local Organized Medical Staff Section (OMSS) representative, Bill Carlson, M.D. for review of the CMA Model Medical Staff Bylaws and solicit feedback. Agreed to send the bylaws and summary out for review.

SHARED communication received from HSU President Richmond in response to the Medical Society’s letter in support of the HSU Nursing Program.

SHARED results of the Medicare Survey sent to the membership. 24 responses were received, most of which plan to reduce the number of new and existing patients with Medicare Coverage if they proposed cuts aren’t stopped. The information was forwarded to our CMA Federal Relations staff.

REPORTED that the Editorial and Publications Committee will focus on the redesign of the Medical Society website at their next meeting. Encouraged the Exec Board to review the website and provide some feedback.

DISCUSSION followed regarding the formation of the California Physician Health, Inc (CPH) that is being formed as a joint effort of the California Medical Association, California Society of Addiction Medicine, the California Psychiatric Association, and the California Hospital Association, to replace the Medical Board Diversion Program. The CPH intends to be funded by a contract with the State of California though an increase in medical license fees, subject to the passage of enacting legislation (AB 526). Since funding is not yet available, CPH is asking for contributions to fund the first to years of the program. A pledge of \$500 per year for two years is requested. **M/S/C** to request a contribution of \$200 each from our local hospitals.

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

-Keven Nevil, M.D. OB-GYN Eureka OB-GYN/HCMA

There being no further business, the meeting was adjourned at 8:50 P.M. Next meeting is scheduled for June 21, 2010 at 7:00 p.m. §

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

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 Terri Clark at (707) 443-4666x22 or tclark@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)

FOR SALE

FOR SALE. 2 HON 800 series file cabinets; 42" W, legal size 5 drawer dlide out with locking covers. "Putty"; new cond.; Pd. \$1200 ea.; sell @ \$800 ea. 444-8390.

PROPERTY FOR SALE / RENT /LEASE

MEDICAL/DENTAL SPACE FOR LEASE, 1059 S.F.– efficient, 3 exam rooms, lab, ADA accessible throughout, new flooring/paint, excellent location very close to St. Joseph Hospital with ample parking, call 442-1020 to view.

2 MEDICAL OFFICES FOR LEASE: 2504 Harrison Avenue, Eureka, CA. 1688 sq. ft. & 1326 sq. ft. Can be seen by appointment. Phone 530-755-1354 / 916-261-8088.

FOR LEASE: Join our new professional medical facilities near Mad River Hospital. Build to suit in new Planned Unit Development. 1200 - 4000 sq. ft. spaces. Contact Mark , 707-616-4416 or e-mail: Jones202@suddenlink.net.

Looking for host housing and low cost housing for visiting medical students in Humboldt and Del Norte Counties. In an effort to recruit physicians to our area, we are having medical students rotate through our hospitals and offices. The medical students basically need a desk, a bed, a quiet room and wireless access if possible. Some of them need host housing and some can pay up to \$100 per week. They usually stay 4 to 8 weeks. If you have an extra guest room and would like to host a medical student, please call: Kate McCaffrey D.O. at 707-599-2829.

Display
Advertising
Rate
Schedule

<u>SIZE</u>	<u>MONTHLY</u>	<u>SIZE</u>
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"

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

Classified Ads
 4.75 per line