

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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In This Issue:

President's Message	2
<i>It's a Wonderful, Medical Life, Emily Dalton, M.D.</i>	
In My Opinion	3
<i>Statistical Illiteracy, Lee Leer, M.D.</i>	
From the Executive Desk	4
<i>By-Laws AdHoc Committee Proposals</i>	
Open Forum	5
<i>Disclaiming the Standard Disclaimer, Matthew Fluke, M.D.</i>	
H-DN "Tattler"	6
2008-2009 Directory Updates	7
Public Health News	8
Public Service & Medical Ethics Committee	9
<i>Stefan Schunk, M.D.</i>	
Disaster Preparedness	10
<i>Disaster Preparedness Committee Update, Ann Lindsay, M.D.</i>	
CMA H.O.D.	11
<i>Highlights of the 2008 CMA H.O.D</i>	
NORCAL Risk Management News	14
<i>Terminating the Physician-Patient Relationship</i>	
AMA Update	15
<i>2009 Medicare Physician Payment Rule Published</i>	
Board Briefs	20
Grand Rounds Calendar	21
Classified Advertising	24

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

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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.

It's a Wonderful, Medical, Life

EMILY DALTON, M.D.



Dr. Sanders awoke to the sound of drilling outside his southwestern window. Not again, he thought. He peered through the blinds to see a huge crane, lifting large cement blocks onto an unfinished wall. Another night of incomplete sleep! What next? He roused himself, took a quick shower and wolfed down a few pieces of toast. What could he expect at the office today?

Yesterday had not gone well. The day had started out like this: When he arrived, the phone was ringing. He had been unable to afford to keep his receptionist, so he was now answering the phone himself. On the other end of the line was Altima, his lender, wanting to know how soon he would come up with a payment on the loan he had taken to keep his practice afloat. He informed them he would send something as soon as Medicare sent him his check, (which was already over a month late but should arrive soon). He sighed, shifted gears, and called back his first patient.

What a relief that at least he was no longer in court and could be back in the office practicing medicine. The malpractice case last month had been very stressful. He had referred a patient to a local surgeon for a hernia repair, and the patient had had a reaction to the anesthetic. He ended up being named in the lawsuit, and as a result, his malpractice premiums had gone up from \$35,000 annually to \$38,000. The lawyer for the plaintiff kept suggesting that he missed key findings on his preoperative history and physical, as though there was some obvious clue for the tendency to develop malignant hyperthermia. He heaved a sigh of relief that at least he didn't have to deal with \$60-80,000 annual premiums like his colleagues in OB and neurosurgery. The mounting number of 2 million dollar awards for pain and suffering had lead to

the bankruptcy of his preferred malpractice carrier, and the one he now had was shaky at best. He wondered how he could come up with the money for tail coverage for his impending retirement.

The first patient came in with a complaint of drinking a lot and urinating a lot. A review of systems revealed a medication list including risperidone. His blood sugar was 600, and the patient had also gained 30 pounds in the past 2 months.

"Who prescribed this for you?" asked Dr. Sanders.

"My therapist" replied the patient.

"Hasn't he been weighing you and checking blood sugars?"

Patient: "Why they don't even have a scale in their office, much less a glucometer." After recommending a switch from risperidone to lamotrigine for mood stabilization, and prescribing metformin and a glucometer to control the diabetes, Dr. Sanders broke the news to his patient that he would no longer be accepting Medicare,

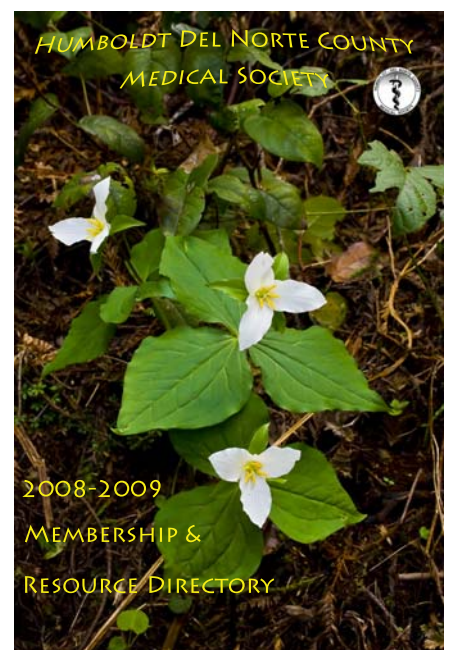
so that he would have to find a new doctor. The last round of 15% governmental cuts resulted in a reimbursement so low that he couldn't even cover his overhead, much less make any sort of an income. He was now planning to sell his practice to an independent nurse practitioner. Now that practitioners no longer had to work under physician supervision, they were in a better position to afford to run an office. With low malpractice premiums and less educational debt, they were buying up many of the now defunct physician-run businesses.

Dr. Sanders groaned, rolled over, and sat bolt upright to the sound of cinder blocks crunching outside his southwestern window. What an awful dream! He shook off the vestiges of that nightmare, and oriented himself to the world as he knew it: reasonable malpractice premiums, respect for physician scope of practice, and a challenging but (as of yet) still solvent medical practice.

Ever wonder what life would be like without CMA? §

The 2008-2009 Physician Membership Resource Directory is now available!

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Statistical Illiteracy

LEE LEER, M.D.



Example 1. In his 2007 campaign for the presidency, Rudy Giuliani said:

“I had prostate cancer. My chance of surviving prostate cancer – and thank God, I was cured of it – in the United States? Eight-two percent. My chance of surviving prostate cancer in Britain? Only 44 percent under socialized medicine.”

Example 2. Early detection with mammography reduces the risk of dying from breast cancer by 25%. Assume that 1,000 women aged 40 and older participate regularly in screening. How many fewer would die of breast cancer?

- a. 1
- b. 25
- c. 100
- d. 250

Example 3. The JUPITER (Justification for the Use of Statins in Prevention: an Intervention Trial Evaluating Rosuvastatin) Study has been all over the news in the past couple of weeks. A typical example of media coverage is the following excerpt from the *San Francisco Chronicle*:

The study found that those taking the medication Crestor for over a year and a half were 54 percent less likely to have a heart attack, 48 percent less likely to have a stroke, and 46 percent less likely to require angioplasty or bypass surgery.

“This was a well-organized international study,” said Dr. John Kane, a professor of medicine at UCSF who specializes in disorders of lipoprotein metabolism. He treats high-risk patients. (San Francisco Chronicle, No-

vember 11, 2008)

We will come back to the above examples in a moment. First, let’s consider how well we as a profession use statistics. Sir Muir Gray, Chief Knowledge Officer of the British National Health Service, said, “all screening programmes do harm; some do good as well, and, of these, some do more good than harm at reasonable cost.” Unfortunately, physicians are not generally likely to be able to sort out the wheat from the chaff when it comes to screening. Before reading further, consider the three screening examples presented above (PSA, mammography, CRP), and think about which would pass Sir Gray’s test for a worthwhile screening program. What are some of the pros and cons of each?

While population health screening recommendations are perhaps the easiest places to look for examples of statistical illiteracy, we ignore statistics to the detriment of our patients in many other areas as well. Consider, for example, the striking variability in the use of surgical treatments across the U.S. The proportion of women in Maine who have undergone hysterectomy varies by region from a high of 70% to a low of 20%. In Vermont, the rate of childhood tonsillectomy varies between 8% - 70%, prostate surgery in men in Iowa varies between 15% - 60%. Inarguably, surgical treatment is often not based on evidence. Rather, the tendency to follow local custom is the single most important explanation for regional differences in medical practice.

Collective statistical illiteracy may be one major reason why regional customs outweigh evidence. If we – as a profession specifically and as a society generally - don’t understand and don’t communicate statis-

tics appropriately, we have little chance of seeing the U.S. develop a cost-effective, high-quality healthcare system. While being able to understand and communicate basic statistics is critical lest we risk professional incompetency, it is even more critical when we consider the stakes at this time in our history as a nation. The American people will hopefully soon be embarking on a long-needed reformation of our healthcare delivery system. We physicians need to actively advocate for doing the right thing at the right time in the most cost effective way. If, however, we don’t even know or care how to evaluate “right things” and “right times” and “right costs,” then how can we possibly expect the public, the media, and our legislators to do so?

So now, let’s consider our examples.

In **Example 1**, Mr. Giuliani was really referring to “5-year survival rate,” which is obviously influenced by *lead time bias* as well as *over diagnosis bias*. The former refers to making a diagnosis at an earlier stage in disease – say with PSA screening. The latter to diagnosing a “disease” that might never had manifested itself had it not been screened for – say again, with PSA screening. In Britain, PSA screening is, if not discouraged, at least not encouraged, and in fact is seldom done. Prostate cancer in Britain is generally diagnosed when symptoms develop. Thus, in Britain, all prostate cancer diagnoses do indeed represent what we all think of when we say prostate cancer (i.e. a relentless disease that, untreated, has a high likelihood of being fatal), and many more diagnoses are made at later stages in the disease than here in the U.S.

“Opinion” Continued on page 16

Disclaiming the Standard Disclaimer

MATTHEW FLUKE, M.D.



Some institutions choose to put a “standard disclaimer” at the end of all of their mammogram reports. I don’t, and I’ll explain why.

By standard disclaimer, I mean a statement which is pasted to the end of each mammogram report, not dictated by the radiologist. The disclaimer usually says something like this “X% of breast cancers are not visible mammographically. Adenosis and dense breasts can obscure lesions. Negative mammogram results should not deter biopsy of clinically suspicious lesions.” These statements are true, so why not include them on all the reports?

In my earlier article “Getting The Most Out Of Breast Imaging”, my first recommendation was to differentiate screening from diagnosis. Screening mammogram patients *by definition* do not have a clinically suspicious lesion. Therefore, in an ideal world at least, the disclaimer is unnecessary on a screening mammogram report, because, a screening mammogram patient *by definition* does not have a clinically significant lesion.

As we do live in the real world, not the ideal one, I understand that sometimes women get their annual screening mammograms first, and then come to the office later for the clinical breast examina-

tion. To me, this is not entirely optimal, however, I would much, much rather have this happen, than to not have the women screened at all.

If a woman has a negative screening mammogram, and 20 minutes later is found to have a clinically suspicious lesion in the breast, the next step (usually) is not biopsy (although some might do an FNA or needle biopsy in the office). Next step- the patient needs *another* mammogram, a diagnostic mammogram and ultrasound.

Therefore, if I were going to write a standard disclaimer for a screening mammogram report, it would read “This report assumes there are no symptoms or signs requiring diagnostic evaluation for possible breast cancer. If you or your patient believe that there may be a clinically significant breast lesion, please send the patient back for diagnostic mammography and ultrasound.”

So, what if a woman does have something of concern by palpation or otherwise? These patients appropriately get diagnostic mammography and ultrasound. In the majority of cases, the mammography and ultrasound does not demonstrate any lesions. Why not put the standard disclaimer on all the diagnostic mammograms?

In that situation, I dictate the disclaimer into my impression, as opposed to having the transcriptionist cut and paste standard jargon onto the end of the report. My gut feeling about standard disclaimers in general is that their purpose more often seems designed to “cover your ass” for the writer of the disclaimer, rather than to inform the reader of the disclaimer. Perhaps many of you feel the same. A standard disclaimer may not strong enough in this situation.

By dictating the disclaimer into my impression, my hope is that the reader will take it seriously. My dictated disclaimer usually says something like “In the absence of any imaging correlate to the history of [palpable mass, palpable thickening, breast pain, etc.], it is recommended that the further management of this finding be based on the clinical breast examination.”

Research shows that women referred for diagnostic breast imaging for “palpable thickening” without discrete mass have breast cancer as a cause of the thickening in about 5-8% of cases. Not very high, but certainly high enough to merit workup. If there is a focal hard lump, obviously the breast cancer rate will be much higher, and for most other symptoms, such as focal

“Disclaimer” Continued on page 9

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ANN LINDSAY, M.D.

Humboldt County Public Health Officer

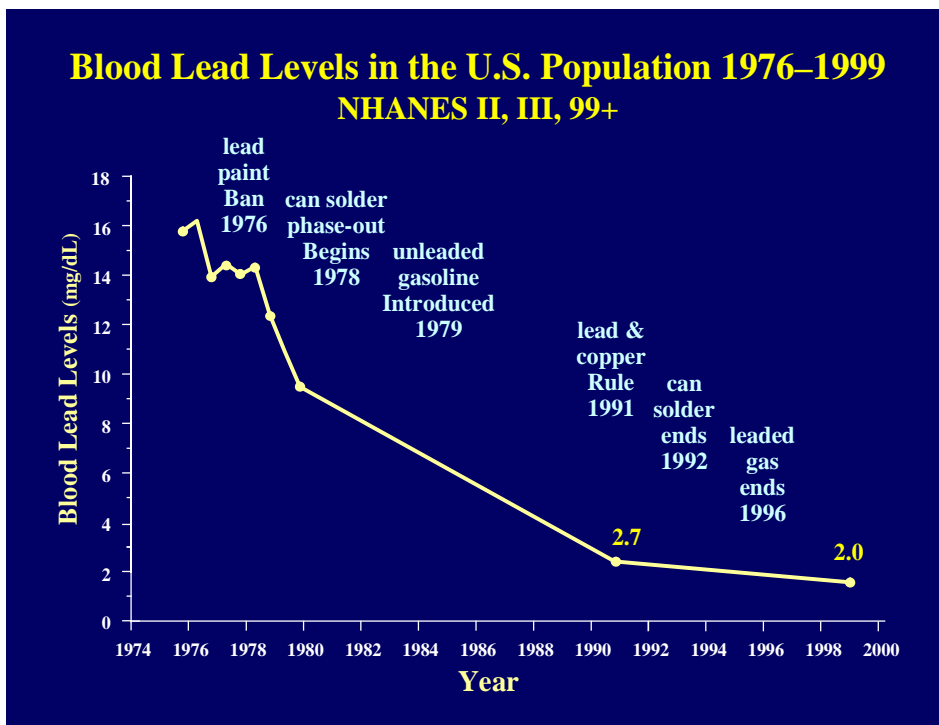


In 1965 only blood lead levels over 60 were thought to be toxic. The average blood lead level in the US was about 22 microgram/dl. Most cities reported an average of 10 lead deaths per year and many children were hospitalized for treatment. Many more lost IQ points as a result of lead exposure, and suffered life-long consequences. Lead was in paint, gasoline, food cans and in solder on water pipes. In the subsequent 30 years, public health advocates worked successfully in the realm of politics to limit human exposure to lead.

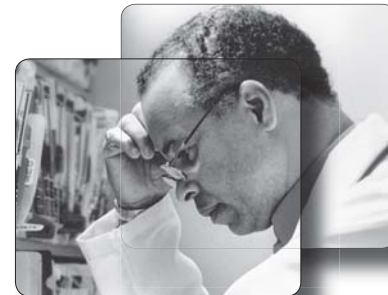
As a result, the population is much healthier, and hundreds of billions of dollars of lost productivity and health care costs have been avoided for each year children are not exposed to toxic levels. Now a level of 10 or even lower is considered alarming.

The history of blood lead levels in the United States shows clearly how protecting the public's health frequently leads public health practitioners beyond supplying individual services into the political arena. The major public health issues of today are obesity and global warming. Hopefully, we can be successful like we were with lead. §

As a result, the population is much



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Substance abuse, depression, and career burnout can impact anyone. Including doctors. The Physicians' and Dentists' Confidential Line is here to help.

About the hotline: We are a confidential hotline for impaired physicians and dentists. Our sole mission is to help impaired doctors and dentists help themselves before their lives and livelihood are put into jeopardy.

How it works: Callers are quickly put in touch with hotline staff, all of whom are physicians or dentists with expertise in the field of addiction. We are supportive and nonjudgmental, and all calls are treated with the utmost confidentiality.

Who should call: If you are a physician or dentist looking for help with substance abuse or a psychological or emotional problem, we are here to help you. Also, if you are a colleague or family member of an impaired physician, please call.

Asking for help is one of the most difficult and heroic things you can do. Be a hero.

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The Physicians' and Dentists' Confidential Line is a project of the California Medical Association, with additional support from the California Dental Association. Membership in these organizations is encouraged, but is not required to use the hotline.

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Dr. Hunter: 441-1624 * Dr. T. Dennis: 725-6101 * Dr. Frugoni: 825-5000
Dr. Fratkin: 496-6846 * Dr. Zedelis: 415-265-2842
Or contact a physician through CMA at **650/756-7787**

Public Service & Medical Ethics Committee

STEFAN SCHUNK, M.D.

Chair



Admit it: it's happened to you before. You have an irate patient who is dissatisfied with life in general but with you and your staff specifically. It's been a long day. You're tired and cranky. You just don't have it in you to lend an empathetic ear to this person. Let us help you. Through our Public Service and Medical Ethics Committee the Medical Society is able to serve as a mediator between patients and physicians by reviewing patient grievances and attempting to resolve them before they've had time to escalate into reports made to the Medical Board of California and potential lawsuits.

According to most professional liability insurance carriers, a great number of lawsuits are due to poor communication of miscommunicating between patients and their physicians. The HDNCMS Public Service and Medical Ethics Committee is often very successful in putting out these small fires before they become uncontrollable. In many cases, patients just want to be heard.

Many times, just a phone call is enough to calm them down and the incident goes no further. So what should you do the next time a patient approaches your desk waving an angry finger in your face and wants to register a complaint against you? Send them to the Medical Society for a Patient Complaint Form. If you wish to have copies of the Patient Complaint Forms- to hand to these patients, please contact the Society Office for a generic form or refer your patients to the Medical Society's website to download a copy of the form: www.humboldt1.com/~medsoc.

Since the first of the year, the Medical Society has fielded approximately 15 complaint calls relating to issues such as: patient-physician communication; termination of patient-physician relationship; treatment by physician and/or staff; billing issues; complaints regarding access to medical records, etc. Of those complaint calls, 12 were sent complaint forms and 4 were referred to the Medical Board. 4 complaint

forms were returned and went through the formal review process. The "system" works.

This is a members-only service, so patients contacting the Society office with a complaint will be asked which physician they are referring to. If the physician is not currently a member- the patient will be referred to the Medical Board's toll free complaint line.

I have been asked to continue as the Chairperson for the Public Service and Medical Ethics Committee. Along with other committee members; Drs. Lesch, Mahan, Jutila and Mahoney, we serve as "correspondents" on a rotating basis.

For further information regarding the committee, or how complaint calls are handled, please contact the Medical Society office, 442-2367. If you're interested in serving on the committee, or making a nomination, please let us know. §

"Disclaimer" Continued from page 5

breast pain, the cancer rate is much lower.

Differentiate screening from diagnosis, for many reasons, including efficiency. Screening programs apply to populations, and must be efficient to be cost-effective and widely applicable.

Screening mammogram patients are given a 10 minute appointment time slot. When a patient comes in for a screening mammogram, as when an asymptomatic patient comes in for a pre-op screening chest x-ray, the images are obtained by the radiologic technologist, and are dictated later by the radiologist.

Diagnostic mammography patients

are given a 20 minute time slot, as well as an ultrasound appointment to follow, although the ultrasound is sometimes canceled. The radiologist reviews the diagnostic mammograms before the patient leaves, makes a decision as to whether or not the patient needs additional views and an ultrasound, reviews the ultrasound, and sometimes has a discussion with the woman about the results. The goal of the diagnostic breast imaging visit is to resolve as many imaging issues as possible before the woman leaves, so the patient doesn't have to come back for a second diagnostic or recall visit.

In conclusion, if one is going to put a standard disclaimer on the mammogram report, why not paste one on all imaging reports? For those of you who feel that a

disclaimer is of value, here is a standard disclaimer that you can copy and paste onto any of my reports:

"This imaging report contains information that is potentially clinically significant. It is the responsibility of the ordering practitioner to correlate this report with all available pertinent patient information in order to maximize the diagnostic benefit of the data contained herein. If the results of this imaging study are discordant with your clinical impression, please bring this to the attention of the interpreting radiologist, as additional image analysis of this study, and/or additional imaging studies may be indicated. This study has been interpreted in correlation with a limited

"Disclaimer" Continued on page 18

"Opinion" Continued from page 3

What results from comparing actual mortality rates rather than rather meaningless 5-year survival rates? In the U.S, there are about 26 prostate cancer deaths/100,000 men; in Britain about 27/100,000: basically the same absolute outcome in both countries. The real difference is that here more men have been unnecessarily over-diagnosed and have undergone unnecessary surgery and/or radiation. The British spend less money than we do on prostate cancer, yet they have the same mortality (death rate) and considerably lower morbidity (psychological and physical damage resulting from both over-diagnosis and over-treatment). Sadly, the media totally missed the story, because they are no more statistically literate than our politicians... who are no less statistically literate than we physicians.

Example 2 is a question asked in 2006 of 150 physicians during a course in risk communication. Two-thirds of them gave the correct answer: 1. Sixteen percent thought that the answer was 25, 3% guessed 100, and fully 15% (23 physicians) guessed that 250 was the correct answer. Again, the correct answer is "1." Of the 4 women who will die from breast cancer, mammographic screening can be expected to reduce their risk of dying from breast cancer by 25%, or by 1/1000. Put another way, the absolute risk reduction afforded by mammography is 0.1% (from 0.4% to 0.3%), and the number needed to screen is 1000 women/life saved. Furthermore, when women participate in a 10-year program of annual mammography, fully 50% of the women without cancer can expect one or more false-positive test results. Mind you, I'm not committing the medical heresy of arguing against the overall value of mammography, I'm just proposing that most of us don't really understand the ramifications of what we ask our patients to do; far fewer of us indeed are actually able to fully inform our

patients.

Example 3. Briefly, a recent study in the NEJM looked at about 18,000 healthy adults with normal LDL (less than 130) but with elevated ultrasensitive C-Reactive Protein levels. Exactly ½ the study participants were treated with Crestor, and the other ½ with placebo. The study was intended to run for 4 years, but its independent data monitors interrupted it early after noting a "huge" treatment benefit. Before taking a closer look at the findings, it's important to also know that the maker of Crestor funded the study **and** that the study's lead author happens to own the patent on the ultrasensitive CRP test used.

So what did the study really show us? Active treatment (receiving Crestor daily for 1.9 years) did indeed lead to a heart attack risk reduction of 54%. That is the *relative* risk reduction, yes, but the *absolute* reduction in risk was from 0.76% down to 0.3% - thus one could equally accurately say that the study showed that treatment decreased the (already very low) risk of heart attack by 0.46%. Similarly, the absolute risk of stroke was decreased by a whopping 0.35%, and the risk of revascularization by 0.81% over the 1.9 years of the study. Hardly as impressive sounding, is it? Even less impressive when we consider that 120 people would have to be treated for 1.9 years, at a cost (considering only the cost of Crestor, and not doctor visits, labs, etc.) of \$287,109. Oh yeah, and *there was no statistically significant difference in all cause mortality.*

Additionally, suspicions regarding statistical accuracy are raised by the surprising lack of expected side effects in the treatment group (no myopathy!) coupled with the unexpected and thus far unexplained side effect of increased diabetes diagnoses in the treatment group. If, however, one reads the responses to the study on the NEJM web site, it's clear that some doctors are ready to *change their practices* based upon this

study: statistical irrelevancy, cost-benefit, industry ties and conflicts of interest be damned!

For the health of our patients and for the health of our economy, we physicians need to be able to understand and act on the statistical implications of clinical research. Imagine the harm done and the money wasted were we to implement PSA screening, mammography, and CRP testing across the board starting at age 40! Instead we must come to understand and to act upon what statistics are really telling us. We must look at regional variations in surgical rates and at the benefits of screening programs. Imagine if we were to eliminate routine PSA screening, if we were to advocate against routine mammography prior to age 50 (and maybe not annually?), if we relegated ultrasensitive CRP screening to the bin of "requires further research (as surely it does)." Imagine if we pre-screened elective surgery based upon outcomes-proven best practices so as to eliminate senseless regional variation. By simply understanding and using the statistics that stare us in the face every day, we'd save money and have a happier and healthier population. §

1. The studies and statistics referenced above (excepting the JUPITER data and discussion) are quoted from Gigermenzer, Gaissmaier, et al., November 2007, Helping Doctors and Patients Make Sense of Health Statistics, *Psychological Science in the Public Interest*, vol. 8 No. 2 (pp. 53 - 96).

2. Ridker PM, Danielson E, Fonseca FAH, et al. Rosuvastatin to prevent vascular events in men and women with elevated C-reactive protein. *N Engl J Med* 2008;359:2195-2207.

"Bylaws" Continued from page 17

Service and Medical Ethics Committee.

SECTION 1.J: NOMINATING COMMITTEE

3. METHOD OF ELECTION:

Nominations will be made on the previous year's ballot and members nominated will be polled regarding their interest in serving. A ballot will be ~~faxed~~ *e-mailed* out, *unless faxed copy requested*, to the membership to elect the members who will serve as the Nominating Committee for that year. The names of this committee shall be published in the Society Bulletin ~~not later than March-April~~ *two months before the annual meeting*.

8. DUTIES:

The Nominating Committee shall *develop and* publish the proposed slate of Officers, *Directors and Committees* in ~~the April-May and June~~ *three consecutive issues of "The Bulletin" preceding the annual meeting*. ~~issues of the Medical Society "The Bulletin"~~. Members will be polled for *additional* nominations. ~~in the January and February~~ *May and June* issue of "The Bulletin". *This slate shall also be read at the June annual meeting and nominations shall be accepted from the floor.* The election will be held ~~in June~~ *at the annual meeting, with newly elected representatives to assume office as of July 1st January 1st.*

SECTION 1.M PUBLIC SERVICE AND MEDICAL ETHICS COMMIT-

TEE

8. DUTIES: It shall be the duty of this committee to mediate, ~~and upon request, arbitrate~~ all matters of dispute, controversy, contention or grievance arising between members or between members and others, involving relations with the public and the Principles of Medical Ethics. The proceedings of this committee shall be confidential unless mediation be unsuccessful, in which event the interested person or persons may request a decision of the Executive Committee, in which case the committee shall present its recommendations to the Executive Committee. The Executive Committee may choose to decide the issue or, at its discretion, refer the issue to the Medical Quality Review Committee and after reasonable notice to all parties and full opportunity for all parties to be heard, the decision shall be final.

ARTICLE 16
AMENDMENTS

SECTION 1: PROCEDURE

Any amendment or amendments to any part of the By-Laws may be proposed in writing for discussion by the Executive Committee. *The Bylaws adhoc committee should include the Medical Society officers (President, President-Elect, Secretary/Treasurer and Past President) whenever possible.*

SECTION 3: MAINTENANCE AND INSPECTION OF ARTICLES AND

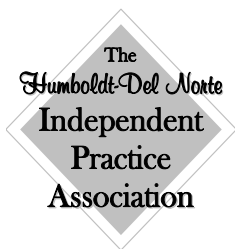
BYLAWS.

The Society shall keep at its principal office the original or a copy of the Bylaws as amended to date, which shall be open to inspection by the Active Membership at all reasonable times during office hours. Upon request, any Member may obtain a copy of the Bylaws as amended to date. *Bylaws are posted on the Medical Society website.* §

"Disclaimer" Continued from page 9

amount of available information, including the provided history. Absent and/or inaccurate provided information may reduce the accuracy of this report. It is often helpful for imaging studies to be compared to previous pertinent imaging studies which may have been performed at other outside institutions; it is the responsibility of the ordering practitioner to make these studies available to the interpreting radiologist, or to at least alert the radiologist to the existence of such studies. A negative imaging result is not a guarantee of the absence of disease. Disease processes may be present which have not sufficiently progressed to be detectable on the requested imaging study, as imaging studies vary widely in their sensitivity to pathologies of varying types."

The opinions expressed in this article are mine alone, and have not been reviewed or approved by any of my colleagues. §



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