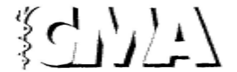
North Coast Physician



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In This Issue:

In My Opinion, Emily Dalton, M.D. 4
"Adoption"
Report from CMA Trustees, Drs. Bretan and Davis 5
OPEN FORUM
"What I Have Decided, What I Have Learned...."; Hal Grotke, M.D. 6
"Update Future of Sutter Coast Hospital"; Greg Duncan, M.D. .. 7
"Power of Belief, Part II"; Robert Moore, M.D. 8
MICRA: Protecting Community Clinics & Health Centers 9
CMA Awarded Health Insurance Exchange Outreach Grant 9
New President/CEO - St. Joseph/Redwood Memorial 10
PUBLIC HEALTH UPDATE; Donald I. Baird, M.D. 12
"Report on Tuberculosis in CA Available"
"Protect Vulnerable Infants From Pertussis"
HDN Tattler / Coming, Going & Moving Around 14
NORCAL Risk Management Seminars 15
Welcome Medical Students 16
Blood Bank News: AABB Audioconference Series 19
Blue Shield Automatically Opts Some Practices into Exchange...... 20
CMA Webinar Calendar 24
NORCAL CME Opportunities 25
IMQ LAUNCHES ONE-STOP ONLINE CME PLATFORM 25
CME Educational Calendar 26
Classified Ads 27

Cover Photo
"Elk Tribe (2) 2013"
Robert Soper, M.D.

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

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ADOPTION

Emily Dalton, M.D.

During an office visit a mother showed me a photo of a dark skinned girl with pearly white teeth uncovered by an impish smile. This was the 4 year old they would soon be adopting. The room was full of eager anticipation and I was lucky enough to be caught up in the joy of the the expansion of their family.

I was nine when my parents adopted four-year-old David into our family, and I doubt they thought much about how that decision would impact us now, 44 years later. They probably considered issues like whether they could afford his tuition at the alternative school we attended, or whether the three of us kids would all get along.

In 1968 it was a radical decision for a white family to adopt a black child. My father, whose family were from the South, was disinherited over it. Courageously, he stood firm for the values of unity and race equality in this public and personal way, loving David much more than whatever had been allocated to him in his father's will.

We were soft kids, my brother and I, gentle and sheltered from the types of storms David must have gone through. He arrived with his playful nature, boasting about how tough he could be. We used to laugh his bravado--how he, a small child, thought he could physically overpower any intruder. He would, he said, kick them and punch them and tie them up! We giggled.

When , inevitably, he and my brother fought, David used his uncut nails to scratch. As my father intervened his heart shrank from big to small and standing over the pale, bleeding boy he shouted at David "How dare you hurt MY son!" I stood back, knowing how wrong those words were, and how hurtful. I knew in my bones that David was just as much my brother as the brother I grew up with, and that one fight would never change that. He was family now, and that was that.

As a sibling trio we never lost the opportunity to gang up on each other. Sis and David against Bobby, or Sis and Bobby against David, and worst of all... both brothers against big sister. They taunted me mercilessly, yet somehow managed to stay just out of reach of my wildly swinging fists until all I could do was squeeze out tears of pure anger. Brothers!

When the boys were 10 and 11 they spent an entire year doing nothing but swearing and spitting. I was there, I saw it; I lived it. If they weren't cussing, they were spitting. If they weren't spitting, they were cussing. Occasionally a fire would be set in between the two activities, but soon it was back to hocking loogies and foul language. They seemed to have become alien creatures, and I worried they would never rejoin the human race. But eventually that phase passed, and we all became better friends. And as the years passed, our friendships blossomed even more.

Today my brother David and I are close. I feel so blessed to have him in my life. We vacation together, talk on the phone and exchange emails regularly. Because of adoption, I have a great friend. Because of adoption, I have 2 beautiful nieces and a nephew. Because of adoption, I have an ally when it comes to dealing with ageing parents. Because of adoption, I have the greatest brother anyone could ever ask for. Thank you, adoption!

If you are thinking about adopting, go for it! This is not only a gift that you give to a precious child, but also gift to all of your family, past, present and future. §

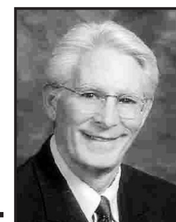
Mark Your Calendars:

SEPTEMBER 6, 2013	6:00 - 8:00 P.M.	Friday Beer Rounds - Madaket Cruise
SEPTEMBER 11, 2013	12:00 - 2:00 P.M.	Spouse Coffee
SEPTEMBER 26, 2013	1 - 3 P.M.	NORCAL RISK MANAGEMENT "Office Manager Roundtable"
	6-8 P.M.	"Behaviors That Undermine A Culture of Safety" (Physicians)
SEPTEMBER 28, 2013	11- 1 P.M.	Women In Medicine Social
NOVEMBER 2, 2013	6 - 8 P.M.	Physician Social/ Talent Show, Ingomar

Report from the CMA board of trustees

Dr. Peter Bretan

Dr. Mark Davis



The July 26 meeting of the CMA board of trustees focused on MICRA, governance issues and the CMA strategic plan.

MICRA. California's trial attorneys made good on their May threat to ask voters to repeal California's landmark Medical Injury Compensation Reform Act (MICRA) by submitting language to the California Attorney General, the first step in placing an initiative on the ballot. The initiative's main provision would increase the cap on speculative, "non-economic" damages from the current $250,000 to more than $1.2 million, with automatic increases every year. The initiative would also require drug and alcohol testing for all physicians on hospital medical staffs.

The measure is nothing more than a self-serving attempt by trial lawyers to generate more in legal fees. CMA and a coalition of doctors, hospitals, insurance companies, nurses, community clinics, local governments, labor unions, police, emergency responders, employer groups and others will wage a significant campaign to expose the lawyers' self-serving agenda and defeat the measure.

If the initiative is successful, it will cause malpractice rates to skyrocket, force the closure of safety net clinics and recreate the same conditions that threatened to throw California's healthcare system into crisis during the early 1970s. Imagine receiving notice that your medical malpractice premiums will increase 250% or even 400%. That's what occurred in 1974 and 1975, leading to a crisis of unprecedented proportions that forced providers to close their doors, leave California or choose to go without coverage. Failure to defend MICRA will destroy medical practices, resulting in irreparable damage and impeding access to care in California.

CMA estimates that it will need $40-60 million to defend MICRA. During the meeting, trustees were asked to contribute $2,000 each; by the end, more than $60,000 had been contributed. [Editor's note: CMA has raised more than $28 million to date.] The board also authorized CMA to loan the MICRA Education Fund $5 million to defend the measure.

Governance. Your district X trustees expressed our concern that the relevance of the CMA House of Delegates not be undermined, and that the HOD should remain the policymaking body of CMA. We also noted that it would be a reasonable idea to replace reference committees with increased activity in CMA councils and committees; that the business of the HOD should not be predetermined by a few; that previous debate of resolutions is paramount. After much discussion, the board passed a series of governance recommendations. The main points are summarized below.

• Beginning in 2016, the HOD would annually establish broad policy on three to five issues determined by the speakers, subject to the advice and consent of the board of trustees to be the most important issues affecting members, the Association and the practice of medicine. The board of trustees would detail and implement House-adopted policy on these issues and would assume responsibility for policy-making on all other matters. The board would be delegated authority currently vested in the House for internal administrative matters, such as component society charters and confirmation of elections and appointments.

• To enable more extensive and focused expertise to be brought to bear in less rushed deliberations and to promote continuity and coherence in CMA policy making, the issues determined as most important and designated for House of Delegates action would be referred to standing CMA councils and committees, which would replace and serve as reference committees of the House for purposes of studying the assigned issues, receiving testimony, and preparing reports with recommendations for House action.

• Standing councils and committees would be expanded and/or restructured as appropriate and as needed to equip them for their greater role as drivers of CMA policy-making. In addition to consideration of individual qualifications, efforts would continue to achieve reasonable balance in the geographic, specialty and mode-of-practice representation of CMA membership in council and committee appointments.

• Reports and recommendations of the council and committees serving as reference committees would be made available at a date early enough to allow delegation caucus meetings to occur prior to the annual session, enabling floor action on recommendations to commence immediately upon the convening of the HOD and saving CMA

"Trustees", Continued on Pg. 23

“Trustees”, Cont. from Pg. 5

and component medical societies substantial costs they would otherwise incur.

• The annual session would become a two-day meeting consisting of: (1) action on council and committee reports addressing the three to five issues specified by the speakers; (2) action on any matters the board of trustees may refer to the House; (3) elections of officers; (4) educational sessions on key issues; and (5) ceremonial functions that would be scheduled during an evening dinner open to all CMA members.

• The ability of individual members to introduce business of the Association would be preserved by enhancing the existing year-round resolution process, whereby resolutions received would be referred to standing councils and committees for purposes of study, receipt of testimony and preparation of reports with recommendations for action by the board of trustees.

• As transitional steps toward a two-day annual session, HOD reference committees would begin functioning as entirely “virtual” reference committees, beginning with one committee in 2013, two or more at the 2014 annual session, and all committees by 2015. Testimony would be received online, and reports with recommended actions would be distributed no later than the opening session of the HOD.

• That the board of trustees direct that a study be undertaken in consultation with component medical societies to explore a possible redrawing of the CMA geographic district boundaries, in order to reflect the growth and redistribution of California’s physician population and provide greater representational equity among component societies and districts.

The implications of these recommendations are significant for District X. Please let your trustees know your views so they can share them with the board of trustees prior to the next HOD, scheduled for Oct. 11-13.

Strategic Plan. The CMA Executive Committee has identified five distinct goals on which CMA should concentrate its efforts: (1) grow membership by 5%; (2) commitment to public health; (3) prosperity for all physicians; (4) defend MICRA; (5) lead change in health reform. §

“Sutter”, Cont. from Pg. 7

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(Regulation 485.620(a), 6/7/13)

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If you have ideas or comments you would like to share, please send them to me at the email address below, or stop by my office on 1200 Marshall St. to learn more or add your name to the more than 3,000 local residents who have signed a petition opposing Regionalization and Critical Access designation for Sutter Coast Hospital. To join our email newsletter, just send me an email to drgjduncan@yahoo.com .

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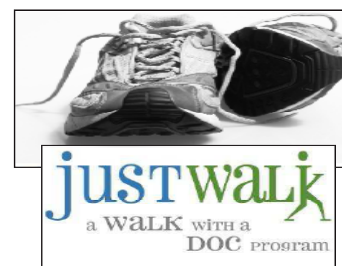

What I have decided, what I have learned and what I have left to learn

HAL GROTKE, M.D.

Last month I wrote about a few crazy ideas I have to increase physician recruitment to our area. I am very serious about us having a medical school locally but I have decided that a family medicine residency will be faster and easier (in a purely relative sense) and get us a finished product, ie. doctors ready to practice, much more quickly. The medical school idea will have to wait at least if I'm going to be involved in its development.

There are a few different kinds of family medicine residencies in a few different senses. First, there is the "sponsoring organization." Second, there are full and rural track programs. Third, there are allopathic and osteopathic programs. There are probably other broad distinctions of which I will learn as I continue the process.

Sponsoring organizations can be either hospitals, ie. hospital based programs, or community organizations. Among sponsoring community organizations those can be FQHCs, Rural Health Clinics or consortia. As I have read through the academic requirements set forth by ACGME I think none of our local hospitals or even any two of our local hospitals have the patient volume adequate to have a hospital based program. I think we will need to train our residents at St. Joe's, Redwood Memorial AND Mad River hospitals. I think that if we are going to get true cooperation from all of them the program cannot be operated by any of them. I know that there is not a Rural Health Clinic in our area that is big enough to be a sponsoring organization. I plan to talk with Hermann Spetzler about whether the Open Door system might want to be the sponsoring organization. I personally prefer the idea of the consortium based program so as to be inclusive in the community. Another reason that I think that a community based program is preferable to a hospital based program is that there are federal grants for community based and not hospital based primary care residencies. That is part of PPACA. Unfortunately the latest grant cycle, the third annually, closed two days after I learned of it and I am nowhere near ready to apply for a grant. I have learned that Blue Shield of California Foundation has given grants for starting community based programs. AAFP-foundation does not provide such grants and did not have any concrete suggestions for other grant opportunities.

A few years ago our community hosted 14 medical students for a whole academic year and that supersaturated the potential learning environment. If we were to start a full, three year, allopathic program there would be a minimum of 12 residents, four for each year. I am concerned that may be too much to take on all at once. A rural track program in which residents spend their intern year at an academic center would require minimum of two residents in each the second and third year classes. They would match to our program and then move here after finishing internship such as at UC Davis Medical Center in Sacramento. Another option might be to have a full, three year, osteopathic program with a minimum of two residents for each of the three years. I am very confident that our community could support four to six physicians in training. I think that planning to build up to a full program with 12 residents may be a realistic goal as we attract more faculty to the area and as more people have access to care through coverage as a result of PPACA.

I have introduced the idea to the Medicine Department meeting attended by Dr. O'Brien as well as the Physician Recruitment and Retention Committee for the St. Joe's system. Judging by body language and facial expression Dr. O'Brien appeared interested and asked some useful questions. The the Physician Recruitment and Retention Committee meeting Joe Carroll expressed strong interest but that was just a few days before he became ill. I don't know any administrators at Mad River hospital. When I have opportunity to discuss it with someone there I will need help with how to sell them on the idea. I would greatly appreciate any help with approaching them.

I will keep you all informed of any progress. I am grateful for all the offers to help in the process and the overwhelming positive feedback on the idea. I'm not good at asking for or even accepting help but at some point I will not be able to do it myself. I still have patients to see and a business to run. Right now in the purely informational phase I will handle it for now. §

Did You Know.....
Legal Help Available

CMA's online health law library contains over 4,500 pages of On-Call documents and valuable information for physicians and their staff. Access to the library is free to members.

Open Forum

SUPERVISORS REQUEST INFORMATION, SUTTER HEALTH SAYS NO

Gregory Duncan, M.D.

Chief-of-Staff

Sutter Coast Hospital

First, I write to thank the Board of Supervisors for sending another excellent letter to Sutter Health, reiterating the Supervisors' ongoing opposition to Sutter Health's plans to dissolve our local hospital Board of Directors, and transfer ownership and governance of Sutter Coast Hospital to a San Francisco based Board appointed by Sutter Health. The latest letter, addressed to Sutter Health CEO Patrick Fry and Sutter Coast CEO Linda Horn, repeated the Supervisors' concerns with Critical Access, including the facts that "the program would eliminate 50% of our hospital beds, necessitating hundreds of emergency patient transfers every year to distant hospitals, at the patients' risk and expense, and without their family or local doctor at the receiving hospital." The Supervisors also noted that Critical Access would precipitate significant layoffs at Sutter Coast.

Sutter Health's response to the Supervisors' latest request for records was blunt. During last week's hospital Board meeting, Sutter Health Regional President Mike Cohill stated, "we will not be releasing our meeting minutes to the Board of Supervisors or anybody else."

I understand Sutter Health is not legally obligated to release our hospital meeting minutes, but I certainly agree with several Supervisors who requested Sutter Health release the data and meeting minutes. I fully agree with Supervisor Finigan, who advised in open session, "If you really want an open discussion, then release the data."

Together with the Board of Supervisors and the Healthcare District, I will continue to work to preserve a full service, locally owned hospital, and prevent downsizing to a Critical Access facility.

Second, we have identified another problem with Critical Access--it will increase costs to patients, and not just costs of transports to distant hospitals. In order to reduce the number of emergency patient transfers imposed by the Critical Access bed limit, Sutter's consultant wrote the following: "the Hospital [Sutter Coast] can aggressively use observation bed services; however, this may not be sufficient to allow the Hospital to eliminate the transfer of patients outside the community."

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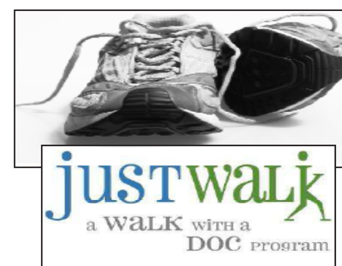

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

FAMILY PRACTICE MD/DO NEEDED. Open Door is seeking Family Practice MD/DO's for our McKinleyville, Crescent City and Eureka clinic sites. Requirements include CA license, DEA, Board Certification and EMR experience. Visit www.opendoorhealth.com to get to know us. Email CV and cover letter to: cwebb@opendoorhealth.com.

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)*

FNP WANTED. 3 days per week (Tuesday, Wednesday, Friday) 8 to 5:30 is 27 hours patient time, and 8 hours paid paperwork time in addition, that is full time 35 hours. With vaction, paid holidays, CME time, CME paid, malpractice and liscences paid. Hourly rate based on experience. Work in small solo family practice in Eureka with Dr Teresa Marshall and Carolyn Barnhart FNP with wonderful office staff, full EMR web based system that is easy to learn and training time paid. Please call 445-5900 or email to drmarshallsoffice@att.net and ask any more questions you have.

PRIMARY CARE NP/PA NEEDED. Outstanding Primary Care NP/PA sought by private multispecialty clinic. This full time position located in Eureka will be an integral part of our primary care delivery team and will work closely with an Internal Medicine Physician. An adult focused Physician Assistant or Nurse Practitioner would be the ideal complement to our existing staff. Experience with electronic health records is a plus.

We offer a friendly and professional environment with a focus on patient care and an excellent reputation for quality service dating back to the early 1970's. A competitive salary, health insurance and pension benefits along with a generous productivity bonus structure will be rewarded to the successful applicant.

Please respond with a cover letter and resume to andyj@eimdoc.com

JOB OPPORTUNITIES

BUSY MEDICAL PRACTICE LOOKING FOR PA OR FNP. Part time or time negotiable. Please call Dee @ 707 444-3885

FNP NEEDED. Full Time. Busy Family Practice. Contact: Lorraine (707) 443-8335

PROPERTY FOR SALE/ RENT/ LEASE

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.

HOUSE FOR RENT. 4 bedroom, 2.5 bath house for rent in Eureka, CA. With office and den, gas fireplace insert and new upgraded kitchen. Wall of windows gives view of secluded backyard , side yard has raised beds for gardening. Good neighborhood; walking distance to Eureka High, 4 minutes drive to St. Jo.
No smoking inside or out. Rent $1950./month. Call: 707 499-2405 or 707 849-5178.

MISCELLANEOUS

FIREWOOD FOR SALE. Call (707) 499-2805

E-Mail Address Updates? Allied Health Practitioner Updates? Find information published in the Directory that needs to be updated? Please let the Medical Society know so we can keep records as up-to-date as possible.

Display Advertising Rate Schedule

SIZE	MONTHLY	SIZE
1/4 Page	$140.00	7.45" x 2.61"
1/2 Page	$160.00	7.45" x 5.23"
1/3 Page Vertical	$150.00	2.37" x 9.95"
Full Page	$200.00	7.45" x 9.95"
Inside Cover/Full Page	$275.00	7.90" x 10.40"
Business Card Ad	$65.00	Copy Ready 2" x 3.5"
Classified Ads	$5.25 per line	

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