North Coast Physician

In This Issue:

Cover Photo
"Horses In The Fog"
Stephen Kamelgarn, 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.

North Coast Physician 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: hdncms@sbcglobal.net Web page: *www.hdncms.org*

Jules

Lee Leer, MD

The first time I saw a patient who probably had AIDS was in 1982. I was a 3rd year medical student on my Internal Medicine rotation. He was suffering from an unidentified viral encephalopathy. At that time, of course, there was no HIV test, as the causative agent had not yet been identified. Rotations came and went, I never made an effort to track him down, but I assume the worst.

There was another during my 3rd year of residency. He came to me as an unassigned patient through the ER. By this time, HIV had been identified, and he was positive. Initially, his opportunistic infections responded to treatment, but he never totally bounced back, and suffered a steady decline until he died 6 months or so later. He was divorced, the closeted gay father of two teen-age sons, who lived with him not far from the clinic. As he became more ill, I took to making home visits. His sons were scared, but supportive. His extended family was scared and NOT supportive. They wanted to burn the house down after he died. They were quite serious about this. I talked with some of them once or twice. I'm sure nothing I said changed their minds, but--to my knowledge--the house is still standing.

My first job after residency was working in a satellite clinic for a large medical group (NOT Kaiser, just to be clear) in Southern California. Work was sort of slow, and I wanted to do something more meaningful than I seemed to be doing. I called the Inland AIDS Project to let them know I was available for referrals if they had any patients in need. The first person they sent to meet me was their nurse and clinical case manager, sent to make sure I wasn't some sort of a nut case. It was 1987, and it turns out that I was the first physician to ever call and ask to receive referrals.

A few weeks later, they referred Jules (not his real name) to me. He looked very healthy, except for the fact that he was having some trouble breathing and couldn't keep his fevers under control. His pneumocystis pneumonia responded very well that first time to treatment. Shortly thereafter, I started him on the state of the art treatment: two AZT capsules every 4 hours around the clock (those were the days when at any given HIV conference, beepers would go off continuously, reminding the patients attending that it was time to take their meds). He was full of life, Jules. He edited a style/fashion magazine, he traveled, and he was a loving devoted father. He was interested in everyone and everything around him, and became a friend. When Jules met our infant daughter he christened her "Miss Jane." A small thing, to be sure, but it stuck. To this day I call her "Miss." Not politically correct perhaps, but she hasn't yet taken me to task.

Several more patients followed. They were, for the most part, wonderful men and women. Interesting, compelling life stories, in many cases brilliant in their fields. There were police officers, rabbis, priests, and physicians. There was the 17-year-old boy who was infected after he and his girlfriend had intercourse once. She'd become infected a few years earlier after receiving multiple transfusions during treatment following a nearly fatal auto accident. Those transfusions occurred, of course, before HIV had been identified and before the blood supply was made relatively safe. One minute she was a happy healthy teenager, the next she was intubated and dying in the local ICU... only then was she discovered to be HIV positive. There was the actor back from a successful career on Broadway, now staying with his parents so they could nurse and nurture him as he died. There were housewives with small children. There was the young man who had his food trays at Loma Linda University Hospital slid on the floor across the threshold into his room, because the nurses and nurses aids feared infection. He was shocked when my medical assistant and I touched him with our bare hands. Truly, there was a lot of silly and harmful paranoia back then. The more I think about it, the more memories flood back. I've received letters from some of these old patients, heard updates about others. Some are alive and thriving, some have died. But still, Jules stays with me more intensely than any patient I've ever had the privilege of treating.

After I had been working for about 9 months or so with the multi-specialty group, its owner expressed his dissatisfaction with me - during a group meeting - for attracting an HIV practice. In the first place, he didn't like that many of these patients lost their health insurance after a few months and were subsequently only covered by Medi-Cal. In addition, a few with private insurance were covered by one of the capitated plans that made up the majority of our business. He feared that word would get out and soon we'd go broke caring for all the Managed Care HIV patients in San Bernardino County. Finally, he believed that if "normal" patients found out why some of the other patients were sitting in the waiting room, they would be likely to choose another group for their care.

I left, and was fortunate enough to be hired by a 3-doctor family medicine group. Those physicians didn't share my passion for

Cont Next Page

CONT FROM PAGE 4

HIV care, but they were supportive. Very supportive. My new group generally did not accept Medi-Cal, but we made exceptions. Jules knew about the Medi-Cal part, but was unaware we made exceptions. One day, as he and I were sitting in the hospital's outpatient clinic, getting him checked in for a transfusion, he asked me if I could recommend a good doctor, since with his upcoming transition to Medi-Cal he assumed he wouldn't be able to continue seeing me. I wanted to cry. This is what he had been worried about for the past week: that towards the end of his life, the insurance "issue" would force him to train a new doctor!

The last time I saw Jules was on morning rounds at the hospital before going to my office. I had admitted him the night before, and he was barely conscious, clearly in the last stages of whatever multitude of opportunistic infections were consuming him. That morning I quickly looked in on him, made sure he wasn't in pain, and left him alone in his room to die. Mind you, that wasn't my conscious thought - that I was leaving him to die - but it's in fact what I did. What, at some level, I probably knew I was doing. I have no recollection of the patients I saw that morning. None of them stick in my mind so much as the one I failed to see and be with. His lover got there after he died. His children hadn't seen him in a few days, and in any event their mother wouldn't have allowed them into his hospital room at that time. I was the only one who could have been there. I was the only one who could have sat witness with him. But I left.

Over the years, I've made several medical "mistakes." Diagnostic misses, medication errors... the usual. Each of these troubled me, in its time. But nothing sticks like that day, when really what was needed of me was nothing medical at all. I'd like to say that this event was transformational for me. But that would be melodramatic and untrue. At best, the experience, and many others since then, have nudged me towards being a better human, a better doctor. Although I can't put my finger on exactly when or how or how much, I know I have changed. My memories are my yardstick. Memories that keep people alive in some metaphysical way.

And I know that even though I failed Jules at the very end, I also made a huge positive difference in his life.

I wonder if that still happens for my patients in this post-plague age in which we now find ourselves. For sure, my current patients are getting the best electronic medical record system experience they've ever had, and they're plugged into more health maintenance databases than they've ever been. I'm a more seasoned clinician, and that must be a good thing. Yet, I wonder more and more of late whether it's enough. Whether my patients today get as much of me as did Jules and all of the other ghosts who haunt my memory. §

SAVE THE DATE

CMA
LEADERSHIP ACADEMY
April 27-29, 2012
Disneyland Hotel, Anaheim, CA

Did You Know....
The Medical Society offers NOTARY PUBLIC services for our members at no charge.

Our First Steps Toward Integrating Mental Health with Primary Care

HARPREET S. DUGGAL, M.D.
Medical Director, Mental Health Branch

When talking about integrating mental health with primary care, the first model that it conjures up in one's mind is the oft-repeated four-quadrant clinical integration model for treating clients with both medical and mental health diagnoses. This model, while being a good guide to what services should be assigned to mental health versus primary care, can only succeed if there is some level of existing collaboration and communication between the two systems of care. Our Primary Care Integration Project, launched on January 3rd as part of our performance improvement project, aims to lay the ground work for integration of mental health and primary care. This project involves clients who are provided treatment at the Adult Outpatient Clinic located at the Clark Complex in Eureka.

This endeavor involves several key changes in how clients will be evaluated at the Adult Outpatient Clinic. Some of these changes are highlighted below:

1. The access team, when evaluating a client for the first time, will ascertain if the client has a primary care provider (PCP).

2. If the client has a PCP, a release of information for the PCP will be requested of the client so as to open a channel of communication between the clinic and the PCP.

3. If referred by PCP, the access team will ensure that the PCP has sent the referral using our new referral form. This will help the access team triage the client for the type of help they are seeking, as sometimes clients may seek therapy alone and not medications. This formal referral process also streamlines evaluations done by the medical staff as they can home in on the reason for referral, previous psychiatric diagnosis, treatments and what the client/PCP expect from the referral. This not only drives our treatment to be more client-centric, but also makes providers aware of the each other's expectations.

4. For clients who don't have a PCP, the access team will help the client get established with a new PCP. This will serve our clients in a more holistic way, as many of them have chronic medical conditions, including but not limited to signs of metabolic syndrome.

5. Once evaluated by the access team and after having met the State-mandated medical necessity criteria, the client will be referred to appropriate services, including the therapy support or medication support.

6. Clients seen for medication support will be assessed periodically using an objective scale defining stability (Clinical Global Impressions – Improvement) and when they reach a certain threshold of improvement, they will be transferred back to the PCP, with some exceptions. These exceptions include clients with a psychotic illness, recent treatment with psychiatric emergency or inpatient services, clients on medications like Clozapine or long acting antipsychotics, and clients needing more comprehensive services.

7. The actual transfer process to PCP is a multidisciplinary approach and will entail the psychiatrist/NP initi ating the transfer by contacting the PCP and apprising them of the impending transfer, the RN completing the paperwork for the transfer and sending it to the PCP office and the Outpatient Scheduler making the actual appointment with the PCP office. The Outpatient Scheduler will also verify if the client kept the appointment with their PCP and provide support to accomplish this if needed.

8. The psychiatrist/NP will be available for consultation after a client has been transferred to the PCP.

While we would like the referrals from PCP to follow this protocol, we will continue to provide services to clients who do not have a PCP, or do not wish to see a PCP, or have not been formally referred by a PCP. Crisis services or any other services with the access team, Psychiatric Emergency Services and inpatient services (Sempervirens) will not be affected by this new procedure. We would like to improve and streamline this endeavor based on the feedback we get from our staff and from the PCPs. We hope that these first steps of enhancing communication and collaboration with primary care will usher this new paradigm of integration and improve the overall care for our mutual clients.

For questions or comments, Dr. Duggal can be reached at (707) 268-2942 or hduggal@co.humboldt.ca.us §

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

NURSE PRACTITIONER WANTED We are currently seeking a Nurse Practitioner with experience in women's healthcare. The position is approximately 1.5-2 days per week with the opportunity to gain more hours by filling in for our other providers, during their vacations. Please fax current CV or resume to (707) 443-3971, Attention: Stephanie.

WANTED ADVANCED PRACTICE CLINICIAN for multi-clinician Family Practice office with >20 years of experience, 2 locations; Fortuna and Ferndale, on the beautiful Northern Coast of California. Competitive salary and benefits package, Rural Health Clinic with federal loan payback options, equal opportunity employer. Minimum of 2 years experience required. For more information please call, 530-941-7612, or fax CV to 707-725-2978. *(db911)*

FNP/NP or PA-C NEEDED. Pt time with option of full-time. Inpatient experience preferred, but not required. Contact Nina, 725-4477. *(rg1011)*

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)*

PART TIME HOSPITALIST OPPORTUNITY - DAY SHIFT
Mad River Community Hospital is searching for an additional day time Hospitalist to work with the full time Hospitalist on duty. We are seeking candidates that take pride in providing quality patient care. This position includes care of ICU and Med/Surg patients. We offer a competitive salary and an opportunity to be part of a very cohesive medical team. Please contact Karen Thomas, Physician Recruiter at (707) 442-4848 or by e-mail at ktnap@sbcglobal.net.

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.

MEDICAL OFFICE SPACE AVAILABLE - LEASE.
2504 Harrison Avenue, Eureka. Call: (916) 261-8088.

ELEGANT HOUSE WITH SPLENDID OCEAN VIEW FOR SALE, CA 95503. 4 BR 4 BA. 3-car garage. 7000 sqf. 9 acre lot. Fully fenced in. Great for horse owners too. $1,260,000 OBO. For pictures: www.owners.com, listing ID JMD6087. MLS #234337. Regina Scholz. Regina_scholz@yahoo.com, (707) 845-4740 or RMK Realty 441-1765. *(rs1011)*

Did You Know....
Members may run classified ads in *North Coast Physician* at no charge for the first six months for business-related ads and ½ price for personal ads.

Did You Know.....
Members can request to post physician and APC recruitment notices on the website at no charge.

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