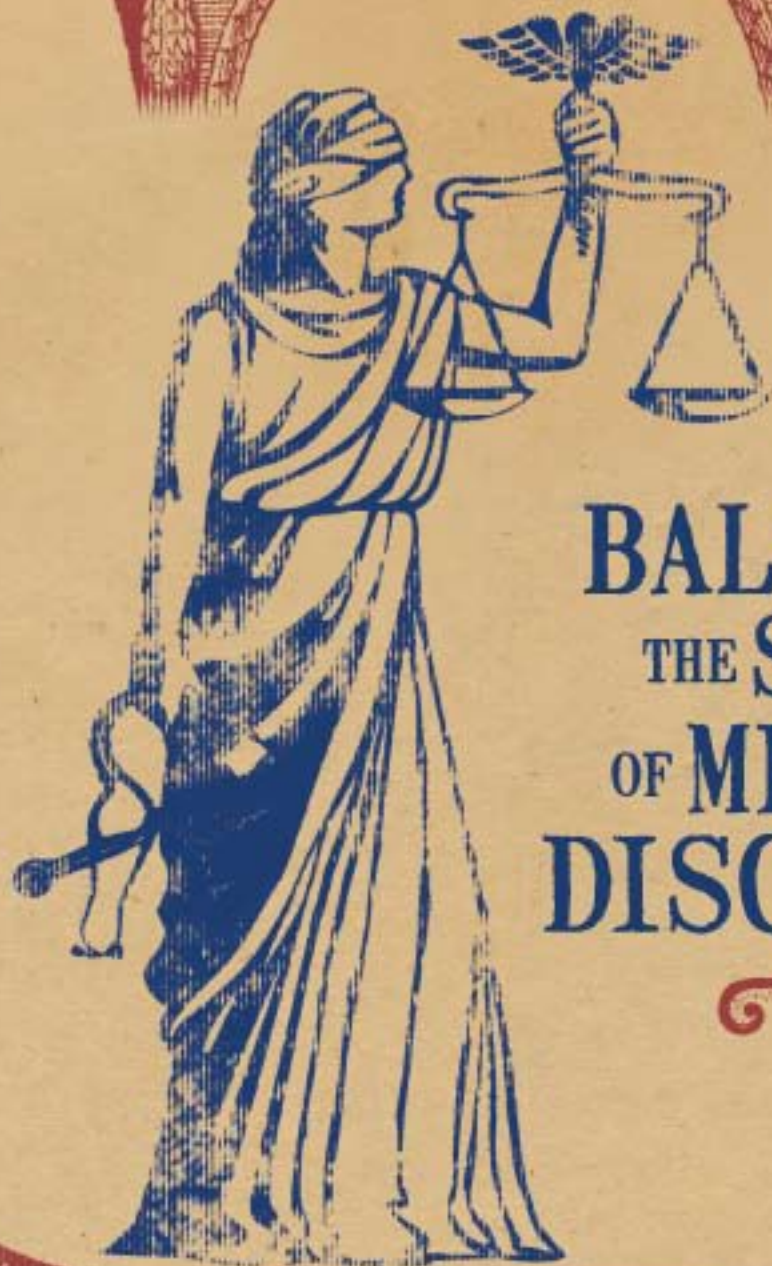


VOL. 79 NO. 4 JULY 2006 \$5.00

SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY



BALANCING
THE SCALES
OF MEDICAL
DISCIPLINE



CAN A MALPRACTICE INSURANCE COMPANY BE THIS VIGILANT?



Today, fast evolving procedures, unprecedented access by consumers to medical information, and new litigation strategies can quickly affect your exposure to malpractice claims. The Doctors Company aggressively monitors national trends to keep our clients informed on best practices to minimize their exposure to unnecessary risk. Vigilance that never wavers—what else would you expect from a medical malpractice insurance company called The Doctors Company? More than 10,000 of your California colleagues already know—we're a national company with local presence, standing ready to serve you.

To learn more, contact your local agent or call The Doctors Company at (800) 862-0375. You can also visit us online at www.thedoctors.com.

SAN FRANCISCO MEDICINE July 2006 Volume 79, Number 4
Balancing the Scales of Medical Discipline

FEATURE ARTICLES

- 10** Caught in the Process: One Physician's Experience with the Medical Board
Amanda Denz
- 12** A Change of Heart: One Drug Addict's Story
Raymond B. Kropp, MD
- 14** Preparing Medical Students for a Life of Reproachless Practice
Manisha Bahl and Katie Kelly
- 16** Serving on the Medical Board of California: One Physician's Story
Bernard Alpert, MD
- 17** Serving on the Medical Board of California: Another Point of View
Arthur E. Lyons, MD
- 19** Toward a More Accountable Profession: The Case of the Aging Physician
William A. Norcross, MD, Heather A. Ching, MFT, and William Seiber, PhD

OF INTEREST

- 21** Help for the Physician in Trouble
- 22** A Conversation About Renewing: Q&A with Linda Clever, MD
Amanda Denz
- 24** In My Opinion
Steve Heilig, MPH, Philip R. Lee, MD, and Marcus Conant, MD
- 25** Public Health Update: Preparing for Pandemic Influenza
Olivia Bruch, MSC, and Karen Holbrook, MD, MPH

MONTHLY COLUMNS

- 4** On Your Behalf
- 6** President's Message
Gordon Fung, MD, MPH
- 7** Editorial
Mike Denney, MD, PhD
- 26** Hospital News
- 29** In Memoriam
Nancy Thomson, MD

Editorial and Advertising Offices
1003 A O'Reilly
San Francisco, CA 94129
Phone: 415.561.0850 ext.261
Fax: 415.561.0833
Email: adenz@sfms.org
Web: www.sfms.org

Subscriptions:
\$45 per year; \$5 per issue
Advertising information is available on our
website, www.sfms.org, or can be sent upon
request

Printing:
Sundance Press
P.O. Box 26605
Tucson, AZ 85726-6605

How Does this Issue of SFM Look?

We are trying a few new things at *San Francisco Medicine* Magazine and would appreciate your feedback. If you have any comments on the look, style, or printing quality of this issue please let us know! All comments should be directed to Amanda Denz, our managing editor, by calling (415) 561-0850 extension 261 or sending an email to adenz@sfms.org

Editor Mike Denney, MD, PhD
Managing Editor Amanda Denz
Copy Editor Cynthia Rubin
Cover Artist Nico Johnston

EDITORIAL BOARD

Chairman Mike Denney
Obituarist Nancy Thomson

Stephen Askin	Gretchen Gooding	Judith Mates
Wade Aubry	Samuel Kao	Ricki Pollycove
Toni Brayer	Thomas Lee	Jordan Shlain
Corey Maas	Arthur Lyons	Leonard Shlain
Jerome Fishgold	Rita Melkonian	David Smith
Alan Greenwald	Kathleen Unger	Leo van der Reis
Erica Goode	Kenneth Maybury	Stephen Walsh

SFMS OFFICERS

President Gordon L. Fung
President-Elect Stephen E. Follansbee
Secretary Charles J. Wibbelsman
Treasurer Stephen H. Fugaro
Editor Mike Denney
Immediate Past President Alan G. Greenwald

SFMS Executive Staff

Executive Director Mary Lou Licwinko, JD, MHA
Director of Public Health & Education
 Steve L. Heilig, MPH
Director of Administration Posi Lyon
Director of Membership Therese Porter

Board of Directors

Mei-Ling E. Fong, MD	John W. Pierce, MD
Thomas H. Lee, MD	Daniel M. Raybin, MD
Carolyn D. Mar, MD	Michael H. Siu, MD
Rodman S. Rogers, MD	Richard L. Caplin, MD
John B. Sikorski, MD	Lucy S. Crain, MD
Peter W. Sullivan, MD	Jane M. Hightower, MD
John I. Umekubo, MD	Brian J. Lewis, MD
Gary L. Chan, MD	Michael Rokeach, MD
George A. Fouras, MD	Jordan Shlain, MD
Jeffrey Newman, MD	Alan M. Teitelbaum, MD
Thomas J. Peitz, MD	

CMA Trustee Robert J. Margolin

AMA Representatives

H. Hugh Vincent, Delegate
 Judith L. Mates, Alternate Delegate
 Judith L. Mates, AMA's Women
 Physicians Congress Governing Committee

ON YOUR BEHALF

A sampling of activities and actions of interest to SFMS members.

Notes from the Membership Department

The 2006-2007 Membership Directory is coming! It is due to be shipped from the printer to the SFMS membership in mid-July.

The San Francisco Medical Society is updating its Physician Referral Service information. Within the next few weeks, active SFMS members will be receiving letters requesting information regarding their participation in the SFMS Physician Referral Service.

Have you taken the survey yet? The San Francisco Medical Society is dedicated to making membership more valuable and enjoyable for all of its physician members, wherever they are in their careers. We recently circulated an online needs assessment survey to those members for whom we had email addresses. We also asked members to pass the survey on to nonmember physicians to get their input as well.

We will shortly be sending the survey out to members in hard copy form. However, you can still participate in the survey online—and direct nonmember physicians to respond as well—by going to www.sfms.org and clicking on the survey link, which will be on the home page. Your input is important—we encourage all members to respond and to circulate this important needs assessment tool to their physician colleagues.

Department of Public Health Launches Chronic Viral Hepatitis Registry

Approximately 25 percent of people chronically infected with hepatitis B virus (HBV) will suffer premature death from cirrhosis of the liver or hepatocellular cancer. The burden of chronic HBV infection may be particularly high in San Francisco, since many San Franciscans come from areas in Asia where HBV is highly endemic or have

other known risks for HBV acquisition such as men having sex with men.

The San Francisco Department of Public Health, Communicable Disease Control and Prevention Section, has initiated the Chronic Viral Hepatitis Registry in order to characterize HBV prevalence and risk factors and to identify missed opportunities for HBV screening and prevention among city residents. People with chronic HBV infection will be identified from laboratory results reported to the Department of Public Health.

For a sample of chronic HBV patients identified, a brief data form will be sent to the health care provider in order to obtain basic information on patient demographics, risk factors for disease, and reasons for testing. If you receive a data form on one of your patients, please take a few moments to complete and return it by fax to the Department of Public Health. To obtain more information or contact the project manager, please visit the Communicable Disease Control and Prevention website at www.sfdph.org/cdcp and navigate to the Chronic Viral Hepatitis Registry page.

CMS Says Hospitals Can Pay for On-Site CME Programs for Physicians

The Centers for Medicare & Medicaid Services (CMS) recently announced that it will allow hospitals to pay for on-site CME for its medical staff physicians. This is an important and long-awaited interpretation of CMS's physician self-referral anti-kick-back rules, which until now appeared to prohibit hospitals from paying for any CME on behalf of physicians, because such payments might be considered compensation for patient referrals.

"Traditional on-site hospital grand rounds and other similar in-house education programs provided by hospitals are important and convenient ways for physicians to earn CME credit and for hospitals to ensure high-quality patient care," wrote

CMS administrator Mark McClellan, MD, in a letter to AMA. "We do not believe that such programs...necessarily constitute remuneration to the physicians who attend them."

CMS will, however, continue to prohibit hospital payment for physicians' off-site CME programs.

Contact CMA's legal information line at (415) 882-5144 or legalinfo@cmanet.org.

Physicians Urged to Defer Meningitis Vaccine for Some Patients Until Supply Improves

Last year, the Centers for Disease Control and Prevention's Advisory Committee on Immunization urged that 11- and 12-year-olds, high school freshmen, and dorm-dwelling college students be vaccinated against meningitis. CDC's three-year goal is to have a new meningitis vaccine routinely administered at the same time as the measles-mumps-rubella shot for 12-year-olds.

However, an exceptionally high demand for the vaccine has prompted CDC to recommend that physicians defer vaccination of 11- and 12-year-olds until the supply improves, but to continue to vaccinate high school freshmen and dorm-dwelling college students. Other persons at high risk for meningococcal disease, including military recruits and travelers to areas in which meningococcal disease is prevalent, should also be vaccinated.

Physicians should keep track of the 11- and 12-year-olds whose vaccinations are deferred so they can be vaccinated as soon as the supply improves.

Contact Robin Flagg at (415) 882-5110 or rflagg@cmanet.org.

Get 40 Percent Off Palm Z22 PDA with Epocrates; Offer Good While Supplies Last!

CMA and the California HealthCare Foundation (CHCF) have collaborated to put easy-to-use technology and valuable

information about drug formularies—including Medicare Part D—literally in the palm of physicians' hands.

For a bundled price of \$99, physicians can purchase a Palm Z22 handheld computer and the Epocrates Rx Pro premium software. That's nearly 40 percent off the regular price. This offer, available to physicians and other clinicians, is only good while supplies last.

With the launch of Medicare Part D in January, Medicare recipients in California now can choose from 48 health plans. The multiple formularies complicate the prescribing challenges facing physicians. These tools will help physicians manage the volume of information needed to pick the correct medicines and provide high-quality care for their patients, especially those with chronic conditions who require multiple medications. Epocrates-enabled handheld computers allow a physician in an exam room to identify which medicines are in which formularies, check for drug interactions, and find drug alternatives.

Already have a handheld computer? Access the Part D formularies free through Epocrates' online and handheld drug reference guides. And don't forget that CMA members receive 30 percent off one-year subscriptions and 35 percent off two-year subscriptions to any Epocrates product. Students and residents receive 50 percent off all Epocrates products.

Contact CMA's member help line, (888) 233-2937.


CMA Defends Women's Reproductive Rights

CMA recently submitted an amicus brief in support of a lawsuit brought by the State of California challenging a federal abortion-related spending restriction that could deny California agencies more than \$49 billion in federal funds. The restriction, known as the Weldon Amendment, essentially allows "health care entities" to refuse to perform, pay or provide coverage for, or refer for abortions regardless of federal, state, or local laws to the contrary.

Although California law protects the right of religious facilities and individual health providers to refuse to participate in abortion services, California law requires that such services be provided in medical emergencies. Under the Weldon Amendment, California could be denied tens of billions of dollars of federal funds if it enforces state laws, which require that physicians treat all patients whose health or life is endangered, including from dangers that arise from pregnancy and can be prevented only by emergency abortion.

"The amendment could deprive women who need emergency abortions—and only women who need emergency abortions—from the protections afforded to all other patients by California's regulation of the medical profession," wrote CMA in its brief. "Congress would not think to prohibit California from disciplining a doctor who refused to perform CPR for patients suffering from cardiac arrest, refused to operate on patients suffering from severe cranial bleeding...or refused to give fluids to patients who were dehydrated."

CMA's brief explained that there are a variety of reasons that women develop medical complications during pregnancy that jeopardize their lives and require immediate abortions. CMA's brief argues that the Weldon Amendment violates women's constitutional right to seek lifesaving emergency abortion care.

For more information contact CMA through the legal information line (415) 882-5144 or legalinfo@cmanet.org. 

For Local Events of Interest Visit the SFMS Website

Our events page is now updated on a regular basis to include SFMS events and other local events of interest. Just go to our home page and click on "Calendar of Events" on the left-hand side.

Visit us at: www.sfms.org

Gordon Fung, MD, MPH



Who Is Responsible for Our Physicians?

If we are to take an objective look at medical care delivery and the physician's role there is at least one significant flaw in our current system when it comes to supporting and managing our main providers of health care.

For a point of comparison, let's take a conventional business model. The front-line entry level worker is hired to do the work. That person has a supervisor to train, monitor, and support him or her. There are reviews of performance, and if a problem develops the supervisor is the first line of support and discipline. The supervisor is on another level, not only having knowledge of the work involved, but also possessing the training or skills to supervise and manage other workers. Up one more level are the managers and directors, who have the task of overseeing larger groups of people, but with the added responsibility of creatively managing the workforce to create maximum productivity.

These individuals have specific training in management, including motivation and discipline. When an individual becomes less productive or has behavioral issues there is a built-in system, albeit hierarchical, to address the problem and determine whether suspension or termination is appropriate.

In the medical care delivery system, the physician is the entry-level worker who provides direct care to the patient. But this system lacks the hierarchy that most businesses possess. There isn't supervision in private or community practice settings, where most medical care is delivered once a physician completes his or her training. And in community hospitals physicians are granted privileges based on their training and competencies and are then allowed to practice those privileges in a self-governed system that looks mainly at complications or complaints. In the academic setting, which I am more familiar with lately, a business model system does exist to an extent. The entry-level workers are the intern house staff. The supervisors and managers are the residents, fellows, and attending staff, but no clear levels exist above that. The attendings are encouraged to be good mentors, teachers, and physicians, but, in reality, their training does not specifically include management or disciplinary skills to use while overseeing the entry-level workers.


During practice we've come to appreciate what is good work and what is not, and most of us have developed our own criteria or guidelines to decide what appropriate behavior is for

physicians. Most of our training remains "see one, do one, and teach one." And fortunately, or unfortunately, we don't witness a lot of deviance—which would allow us to learn from others.

With the changing practice of medicine from the hospital setting to the outpatient setting, problems come to light through different channels. Some patients now complain to the medical board, the medical society, their health plans, their lawyers, or the courts. Insurance agencies have also gotten involved by monitoring physicians. Some use "quality initiatives" to detect the physician who is an outlier in terms of excess activity and, recently, not achieving a standard of practice for certain quality measures. In hospitals the nurses, support staff, and house staff monitor attending physician quality and behavior, even though none of these people are trained to be the monitors of physicians' performance.

If a problem is detected there is no universal system to deal with it. Physicians in community practice who do not associate themselves with a hospital do not have supervisors. They only have their own sense of ethics, values, and payors' or patients' complaints to reflect on. For those physicians in groups there is the additional dynamic of partner relationships, but the responsibility of supporting and managing the problem physician is usually not a task designated to any one group member, unless the group is very large.

In management courses for business, there are a whole host of options on how to deal with disruptive employees and how to set up your organization to address these issues directly and rapidly. Certainly with large group practices and in the hospital settings problem physicians who have been identified are dealt with in varying ways, usually by committees. But one problem with this system is that physicians who are given charge of the committees also have limited training in employee management. And where does that leave solo or small group practices?

Perhaps this should be an activity of the local medical societies, or maybe the medical board—but is that what we really want? I don't have the answers, but this edition of *San Francisco Medicine* certainly addresses some of the situations that have arisen in our current system. Taking the changing practice of medicine into account, we need to look at how our system is set up and design a better way to help the physicians who are doing the main work of delivering care to the community. 

Mike Denney, MD, PhD



Double, Double, Doctor in Trouble

In Greek mythology, Hecate, who serves as a guide at both graveyards and crossroads, is the most enigmatic of all the goddesses. A personification of paradox, she is described as both a hag and a lovely one, she presides over both the dark and the bright phases of the moon, she acknowledges both evil and goodness, and she can bestow both punishment and blessings. Hecate is a goddess of life, death, and rebirth.

This mythical deity of both shadow and light has been portrayed throughout history as a redoubtable figure, appearing in such diverse venues as the Persephone myth, Shakespeare's *Macbeth*, William Blake's poems, Hellboy Comics, the television series *Buffy the Vampire Slayer*, the movie *Charmed*, a video game about the Age of Mythology, and a popular Internet game called Rising Force Online—to name a few.

In *Macbeth*, the witches cast a spell of doom as they chant, "Fair is foul, and foul is fair; Hover through the fog and filthy air." As though under their curse, Macbeth goes on a murderous rampage. That's when Hecate enters this troubled story and harshly rebukes the witches for expressing only their dark and evil side. She complains that she "was never called to bear my part/Or show the glory of our art." Undaunted, the witches continue to stir their wicked brew, chanting, "Double, double, toil and trouble/Fire burn and cauldron bubble."

As in this issue of *San Francisco Medicine* we try to balance the scales of medical discipline, is it possible that the many-faceted Hecate can be our guide? To be sure, all of us who have been called to the healing professions must maintain impeccable moral and ethical standards—both to act in the best interests of patients and to do no harm. Yet when we are forced to "hover through the fog and filthy air" of medical wrongdoing, both the accused and those who stand in judgment are wont to become psychologically immersed in a cauldron of doom. Perhaps that is why most of us, upon receiving our current edition of the Medical Board of California's *Action Report*, are inexorably drawn to the back pages to see who among us has been punished.


Doctors who commit crimes or unethical deeds or who for whatever reason are not competent to practice safely must have their behavior corrected, be punished when appropriate, and hopefully be rehabilitated. To do less would be a disservice to humanity. Still,

doctors who are competent and have the highest intentions yet find themselves under scrutiny—those who make honest errors, who under stress suffer temporary lapses in judgment, or who might be falsely accused—might begin to wonder if "fair is foul, and foul is fair" in our system of peer review and medical discipline.

Within a profession with the high ideal of healing others, even being accused of wrongdoing can seem to be a fall from grace. When collegial peer review and corrective action progresses to accusations of possible grave transgressions, most physicians might feel to be under the spell of Hecate's dark side of the moon. And when the system of judgment moves from cooperative quality assurance review to the seemingly hostile legal arena of medical board and courtroom, we may, indeed, hear the witches chanting, "Double, double, doctor in trouble/Fire burn and cauldron bubble."

To make matters worse, medical discipline is determined by administrative law, for which the rules of evidence and the criteria for judgment are less about one's constitutional rights as a citizen and more about the privilege to maintain a license as a physician. We might wonder: Who are the "expert" physicians for the state who will sit in judgment of our worthiness? Bewildered by these shifts from a collegial medical system to an adversarial legal model, we may want to complain as did Hecate that she "was never called to bear my part/Or show the glory of our art."

In view of all this, perhaps it would be helpful if, whether being accused or sitting in judgment, we physicians collectively remember that Hecate acts as guide not only in graveyards but at crossroads, and she bestows not only punishment but blessings. She is often depicted as having three heads, representing the three paths on which one may proceed when arriving at a crossroads. In the troubled chambers of medical discipline those three heads might be named prevention, correction, and rehabilitation.

As in these pages our colleagues report on the paradoxical nature of medical discipline, we can acknowledge that one of Hecate's heads is that of a snake, that earthly creature that sheds its skin and regenerates a new one every year. We can strive to remember that Hecate is a goddess not only of life and death, but of rebirth. 

For your professional liability insurance needs...

Have you
received a Notice of
Non-Renewal or
Cancellation?
Are you facing a
significant rate increase?
Call Us,
We Can Help!
1-866-815-5776



Aon Physician Alliance is the solution.

As an independent insurance broker, Aon Physician Alliance is dedicated to serving the medical malpractice insurance needs of physicians and surgeons. We represent your interests.

Aon Physician Alliance is a part of Aon Corporation, one of the world's largest insurance brokers, and a Fortune 200 company. We have established professional relationships with most of the nation's top medical malpractice insurers to provide you with the choices you need. We also have the experience and knowledge of the medical professional liability market to ensure that you are getting the most value for your insurance dollar.

Our expertise is in placing not only preferred and standard risks but also physicians that are considered high risk because of specialty, claims history, situation, or the practice involves new procedures.

Whether you are facing a rate increase, cancellation, non renewal or would just like to compare your current insurance, Aon Physician Alliance is there for you.

We Insure: Physicians, Surgery Centers, Medical Spas, and Clinics

**Call Aon Physician Alliance at 1-866-815-5776
to get us working for you.**

AON *Physician Alliance*
www.aonphysicianalliance.com

Aon Physician Alliance is a division of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License # 0795465.

Throughout the years the Hippocratic Oath has undergone many changes that reflect the changing face of medical practice. Today, most medical schools use modern versions of the oath originally crafted in ancient Greece. The oath below, written by Louis Lasagna, is one of the more widely used of the modern versions. It is also the version used by the University of San Francisco to swear new graduates into the profession.

THE OATH OF LASAGNA

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply for the benefit of the sick all measures which are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say, "I know not," nor will I fail to call in my colleague when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart or a cancerous growth, but a sick human being, whose illness may affect both family and economic stability. My responsibility includes those related problems if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all, those sound of mind and body, as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Caught in the Process: One Physician's Experience with the Medical Board

Amanda Denz

For most physicians the thought of being investigated by the medical board is a terrifying one. Whether they think about it often or not, for many the fear remains somewhere in the back of their minds. This is what drives physicians to start reading the California Medical Board's *Action Report* by turning to the last section first. And while many read the "Administrative Actions" to monitor which colleagues are listed, most have probably considered how it would feel to see their own name appear.

According to the California Medical Board's 2004-2005 Annual Report, the Division of Medical Quality received 7,503 complaints during that fiscal year. From these complaints it opened 1,443 cases, 521 of which were eventually referred to the attorney general. Of these referrals 34 cases were referred further for criminal action.

From fraud to negligence, the medical board's investigations cover the gamut of possible wrongdoings. The process each case goes through is lengthy, with many steps designed to weed out instances where physicians are not in fact at fault—but how long does it take to relieve the system of these cases? For Brent Cox, MD, the answer was almost a year.

Dr. Cox is a psychiatrist who sees a number of cases of treatment-resistant depression. He is an expert in psychopharmacology and often his patients are those who fail to respond to typical antidepressant agents. In 1998 and 1999 he was treating an older woman, a lawyer, who was suffering from severely treatment-resistant major depressive disorder. She had seen a number of primary care doctors and psychiatrists and was not responding to conventional intervention methods. She felt disengaged from her family, was having difficulty using

her legal skills creatively, and was just pining to get back to her old self.

"We went through a series of relatively conventional treatments using individual broad-spectrum and combined antidepressant agents, using augmentation strategies, utilizing thyroid hormones and metabolic interventions, and some other standard protocols," says Dr. Cox. "Over the course of a year's time she didn't respond, so we eventually decided to use MAO inhibitors."

A Quick Course in Antidepressant Agents

Agents that are widely used for depression today, like Zoloft, Prozac, and the other selective serotonin reuptake inhibitors (SSRIs), are considered quite safe and user friendly. Adverse effects are minimal and there is no real risk of accidental overdose. There are also newer-generation, broad-spectrum agents that affect not just serotonin, but also norepinephrine. These can help a subset of people who don't respond to SSRIs.

Typically, psychiatrists prescribing antidepressants follow a sequence that starts with simpler agents and moves on to the more complex, broader-spectrum ones. If patients don't respond to a dual-action agent, two complimentary dual-action agents may be prescribed simultaneously. If that still does not work, psychiatrists will often try augmentation strategies, adding substances

like thyroid hormones or lithium to the mix—which has a 30 to 60 percent chance of making a difference. Monoamine oxidase

"The process each case goes through is lengthy, with many steps designed to weed out instances where physicians are not in fact at fault—but how long does it take to relieve the system of these cases?"

(MAO) inhibitors are often the next step. They are essentially the broadest spectrum of all currently available antidepressants—they address every neurotransmitter that is likely to be involved in depression.

"But MAO inhibitors have fallen into disuse, because of the risk of what is known as the 'wine and cheese' reaction," Dr. Cox

notes. "It is very easy to ingest something that will create a serious, and even fatal, reaction, and in the late '70s a number of people taking these medications died after going to wine and cheese parties, because both aged cheeses and wines contain these elements."

"As a result MAO inhibitors became regarded as complicated agents to use," he adds, "so when the newer, safer agents came out, physicians were just delighted to not have to prescribe MAO inhibitors anymore. But the bottom line is that even though these newer agents are 'cleaner,' safer, and better tolerated, none of them has replaced the MAO inhibitors as the ultimate treatment before you start thinking about heavy-duty interventions like electroshock therapy."

Dr. Cox is one of less than half a dozen people in Northern California who prescribes these medications, which he uses primarily for treatment-resistant de-

pression.

"I often see people who have failed with everything else, and you do really have to bring in the big guns—and these are amazingly effective agents," he notes. "The dietary restrictions are not as complicated as we once thought, and a few of the medications available are surprisingly well tolerated. They are not really noxious drugs to take—you won't see weight gain, dry mouth, or constipation, which you will see with many newer-generation drugs."

One Bad Reaction

Dr. Cox's patient went through a sequence of conventional treatment options over the course of a year and nothing seemed to work. "With this patient, we agreed that MAO inhibitors were the last thing we were going to try before moving on to some really experimental or intensive interventions," he recalls. "So I started her on Parnate and we made step-wise adjustments on the dosage. But she did not respond to more conventional lower-end dosages."

Raising the dosage was the next option. "There is a whole literature on the use of higher-end doses of MAO inhibitors that comes out of Jay Amsterdam's group at the University of Pennsylvania," Dr. Cox explains. "He wrote and published articles 10 to 15 years ago indicating that a subset of patients didn't respond to conventional doses, but when pushed into a higher dosing window, experienced phenomenal responses. In his studies he explored what the optimal dosing window was from the standpoint of safety and effectiveness and concluded that the 20- to 60-milligram dosing range listed on the package insert was way off the mark. For truly treatment-resistant depression the ideal dosing range was more accurately between 40 to 180 milligrams daily. He also pointed out that the use of higher dosages did not increase the risk of dietary or over-the-counter drug interactions and was remarkably well tolerated."

Dr. Cox decided to follow Jay Amsterdam's protocol and increase the dose of Parnate. As a result, the patient did respond.

"And she responded remarkably well," he adds. "She had few side effects and she became virtually symptom free. She became a glowing exponent of how remarkable this

antidepressant agent was, by virtue of how it changed her life."

After being on the Parnate for 6 months, the patient went on a trip to Boston. While traveling she had an episode of delirium; She didn't know what day of the week it was, and was markedly disoriented, so her family brought her to the ER. At the hospital, the doctors discovered that, for no apparent reason, platelet count was down. They concluded that she must have ingested something that interacted with the Parnate. They were not able to confirm that—she had not taken any cold medications or lapsed in the dietary requirements as far as they knew—but it seemed the most likely explanation, so they stopped all of her medications. Apart from the Parnate, she'd been on a few antihypertensive agents. Within five days she came out of the delirium.

"The conclusion of the medical service there was that she developed a reaction to the Parnate," says Dr. Cox. "But after she came out of her delirium they did not restart any of her medications—including those for hypertension."

At the hospital in Boston somebody rounding on the unit had a conversation with the patient and her family, informing them that the dose of Parnate she'd been on was beyond a range that anybody had ever used before, and that it was what had caused her delirium.

When the patient returned to California, she filed a malpractice suit. Not wanting to deal with a lengthy lawsuit, Dr. Cox settled out of court for a sum that covered the patient's hospitalization charges. After the settlement he thought the problem was over. Even though all malpractice suits are reviewed by the medical board, he figured that since he'd been following established protocol and had not mismanaged the case, nothing would come of it. He thought the medical board review would be more of a formality—until the letter came.

First the board requested more information about the case; the initial reviewer was not a psychiatrist and thought that someone who was should look it over, so he

had flagged Dr. Cox's case for follow-up. Next the case went onto a psychiatrist for review, but this physician did not specialize in psychopharmacology and was not aware of the protocol Dr. Cox had been operating under.

Dr. Cox was then called in for an interview. The person interviewing him, as a representative of the board, was a pediatrician.

"You can't have those kinds of papers filed against you and not see your life pass before your eyes. You envision your license being revoked, articles about you in the paper, and your name in the back of the *Action Report*"

After the interview his case was sent on to another reviewer, a forensic psychiatrist, who wrote that Dr. Cox had mismanaged the case. Not only did she disagree with his use of MAO inhibitors, but she also attacked his use of two dual-action agents simultaneously earlier on in the case. As a result, his case was ultimately sent to the state attorney general.

"You can't have those kinds of papers filed against you and not see your life pass before your eyes," says Dr. Cox. "You envision your license being revoked, articles about you in the paper, and your name in the back of the *Action Report* alongside docs who are embezzling money, sexually assaulting patients, and prescribing high-dose Oxycontin to patients they haven't seen in five years."

At this point he needed to hire an attorney. Dr. Cox also decided to call on many of his colleagues who were considered experts in psychopharmacology to write about his management of the case—including Dr. Jay Amsterdam, who had established the protocols.

"Amsterdam wrote back to me and said not only did he think the Parnate was not the culprit in this case, but he felt the two antihypertensive agents probably caused the delirium," notes Dr. Cox. "They were

Continued on page 18...

A Change of Heart: One Drug Addict's Story

Raymond B. Kropp, MD

Editor's note: This month we decided to reprint the following story from a 1998 issue of San Francisco Medicine. Addiction is a special risk for physicians and other health care workers and can often lead to disciplinary action. All too often this topic is taboo in medical circles. The following article is a personal account by a doctor who experienced addiction's devastating effects and who describes his road to recovery. San Francisco Medicine is grateful that Dr. Kropp was willing to share his story.

It is hard to believe how many years have passed since my battle with addiction. How great life has become in the interim! Back in 1985 things were very different. I had just lost my anesthesia job at a prestigious hospital, following a near-fatal illness from which I had barely escaped the grim reaper. This was all due to the fact that two-and-one-half months prior, I had made the decision to try a little sufentanyl, intravenously, which quite rapidly led to the near-death experience.

Obviously this "trial" using an intravenous narcotic did not come out of thin air. As with many health care providers, my quest in life was to help others—without a lot of concern for my own well-being—a noble cause in and of itself. This works for many doctors and nurses for a while, but some of us run out of the self-control that keeps us within the bounds of societal expectations. When it happened to me, I began looking everywhere for distractions from my inner unrest. The ultimate distraction was

narcotics.

I was raised in the Midwest in an upper middle-class household with two older sisters and both of my parents. Although things appeared to be good within our family from the outside, in fact, they really were not. I felt a terrible loneliness and anger toward my father. Even my closest friends could not imagine why I was so angry with my dad, but I was, and it quietly gnawed at my insides. No matter how well I did in school or sports, I could not seem to get my father's overt love or support.

I drank heavily during my high school years when I was not studying or involved in sports. My peers saw me as just one of those guys who drank too much, but otherwise a good student and sportsman. During college, my drinking became heavier on the weekends, but I was so focused on becoming a physician that I refused to let the alcohol interfere with my goals.

I experimented with marijuana and diet pills—to help me stay awake to study—but wasn't really interested in how those drugs made me feel. By the time I finished college and made it into medical school, my drive to become a physician seemed to fill

the emptiness that I had felt earlier in my life. For a while life seemed to be moving along quite nicely. By the end of medical school and my training in both surgery and anesthesia, I had a pretty wife, a handsome son, a large house in the suburbs, and a fabulous job as an anesthesiologist at a busy hospital. What more could one ask for?

As life became easier and less focused

for me, very slowly and subtly the old feelings of emptiness that I'd experienced during my formative years returned. I cannot say that I recognized it at the time, only in retrospect. But as time went on, the feelings became more intense and persistent, and I remember noting that I felt like I had a huge hole right through my core—an emptiness that could only be "numbed" away.

Now, with money and time on my hands, I found a lot of ways to erase (temporarily) this empty feeling. Working hard was a great solution for a while. I found that if I worked to exhaustion I received two payoffs: first, I did not have time to pay attention to my feelings, and second, I received a lot of adoration and praise for my "selfless" way of life—the life of a doctor. One thing that working hard did not do was to build a strong marital relationship. The waning of my marriage probably led to more drinking. This occurred mostly on weekends because I was on call much of the week.

When workaholism began to fail in numbing my inner unrest and my marriage was on the rocks, I began to chase women to distract myself. This, too, ran its course and left me with that ever-growing hole in my core.

I knew that I was depressed about my plight in life and recalled from medical school that Dexedrine was prescribed as an antidepressant for some patients. So, I started self-prescribing Dexedrine as a remedy for my ills. This actually worked for a while, like all the other "remedies"—with one caveat. The Dexedrine gave me a headache. I self-prescribed an oral narcotic to combat the headache. This was the state of my logic and my first introduction to narcotics. I knew from the very first time I tried them that narcotics were "my friend." The drug actu-

ally took away my inner unrest and made me forget about my failing marriage.

This kind of usage lasted several years until, once again, the drugs stopped producing the desired effect. It was a time in my life, as in many men's lives, that *everything* seemed to stop working for me. I was about 40 years old, in a blaring midlife crisis. One day I found myself noticing how comfortable my patients were after receiving intravenous narcotics following surgery. I wondered what it would feel like to receive such drugs. This is when I crossed the line. As an anesthesiologist, I knew how to handle narcotics, and I certainly knew all there was to know about addiction, so I was not worried about trying a "little" intravenous narcotic.

Today, as I reflect back on my mental processes and logic that led me to use IV narcotics for the first time, I find it incredulous. But then, I was depressed and in pain. I was so willful and full of my own self-importance that my thought processes were not clear, nor were they in keeping with that of a "reasonable" man. I do not think I could have ever climbed out of this morass by my own power. I needed intervention—and I got it.

It came in the form of a near-death experience which started with a viral respiratory infection, but ended in staphylococcus septicemia, lung abscesses, a one-and-a-half-gallon gastric hemorrhage and a failure of both my kidneys and liver. Within five days of being admitted to the hospital, I was given last rites. For reasons I cannot fully explain other than by crediting divine intervention, I survived. But by the time I left the hospital, the entire community knew about my addiction, including the Board of Medical Quality Assurance. Needless to say, I got my intervention—and it literally saved my life.

Normally I am a quick learner, but not in the case of recovering from substance

abuse. It took a relapse after finishing a rehabilitation program before I could kick the habit. When I did finally kick it, my life changed completely. I began to listen to the advice of others who were in recovery, and no matter how much I believed that

my ideas were better, I followed their advice. I began to believe in a power greater than myself. At first it was the fellowship of recovering addicts; but eventually it took the form of God in a much different way than what I had learned as a child. This was a personal, kind God, who expected that I

should do what I could and then let go of the outcome. This was a much more reasonable way of living for me—and it worked!

I began living and dealing with life's problems quite differently than I had before. I began paying attention to the present, understanding that what matters is right in front of me all the time—not in the future or in the past.

I began to believe that my purpose in life was truly to show up, pay attention, and not tell lies; everything else would work itself out—with one caveat. I still had some skeletons in my closet, which I needed to deal with. I needed to make amends with my father. I understood that only I could change my way of thinking and sincerely alter my feelings toward him. With the help of others, including a therapist, I was able to make those amends. He was also very willing to make amends with me, and we embarked on a truly loving relationship through the rest of his waning years. By the time he died some four years later, we had become as close as I had ever wished for—and his passing was an extremely loving event for me.

Life is still sometimes difficult; I don't expect that will ever change. I still, at times, slip back into some old, bad habits like working too hard and not taking care of myself. But today, I am remarried, to a wonderful

woman, and have close, loving relationships with my two grown sons. Between the love and support of my family and the new way of dealing with life that I learned as a result of my recovery from addiction, I have returned to the path that I hope I can follow until I complete my mission while alive on this planet. **sfm**

Since the original publishing of this article in 1998, Dr. Kropp has passed away. When he wrote this piece he was working as the medical director and anesthesiologist at HealthSouth Surgery Center of San Francisco. He was also a member of the CMA and the San Francisco Medical Society and served on both organizations' Committees for Well-Being of Physicians. After his recovery he also occasionally lectured on physician substance abuse throughout the state.

The Well-Being of Physicians Committee offers confidential guidance to physicians with chemical dependency or other problems and is chaired by David Smith, MD, of the Haight Ashbury Free Clinic, Inc. For more information contact Dr. Smith or Steve Heilig at (415) 561-0850, extension 270. There are other members of the committee from the staffs at most San Francisco hospitals. Steve or David will put you in touch with the appropriate contact. Rest assured that the strictest confidence will be kept and that physicians need not leave their names when calling. If you would rather contact the non-local California Medical Association, its physician hotline is (650) 756-7787.

Preparing Medical Students for a Life of Reproachless Practice

Manisha Bahl and Katie Kelly

Editor's note: This article, written by first-year UCSF medical students Bahl and Kelly, describes new ways that medical education can address such issues as stress, depression, grief, awe, wholeness, and service so as to prepare students for a life of practice. This prevention can help these physicians later in their careers to avoid subsequent burnout, breaches of standards, and possible medical discipline.

A 2002 study on the use of mental health services in medical school found that almost one-fourth of first- and second-year medical students at UCSF had moderate to severe depressive symptoms, according to the Beck Depression Inventory criteria. And yet, less than one-fourth of those students with depressive symptoms sought out mental health services, citing such reasons as lack of time, lack of confidentiality, the stigma of mental illness, and high costs.

It is well known that medical students are more prone to depression than their nonmedical peers. A longitudinal study at the University of Massachusetts found that the rate of depression among students entering medical school is similar to that among other people of similar ages, but the prevalence increases disproportionately over the course of medical school. Some believe that medical students' increased risk of depression can be attributed to the deterioration of students' coping strategies and personal health as they progress through school. Others cite the emotional, academic, and time challenges involved in becoming a physician, which can wear on students and unmask psychological vulnerabilities. Edie Deniro, UCSF first-year medical student, finds that the significant time

commitment required by medical school sometimes causes her stress and limits her nonmedical activities and interests, such as yoga. One of the challenges this year, she says, has been "re-prioritizing, making choices about which activities to pursue outside of medical school."

Diagnosing depression in medical students can be difficult, as symptoms

"Students fear that documentation of their treatment for depression will jeopardize their future careers, as candidates for medical licensure are expected to disclose any disorder that might impair their ability to practice."

of depression can be confounded by the effects of stress inherent in student life, and students often dismiss their feelings as normal emotional responses to medical school. Furthermore, medical students who are diagnosed with depression or recognize that they need help are often reluctant to seek out care. Susannah Graves, UCSF first-year medical student, points out that this reluctance stems from peer discomfort and social stigma.

"Since most specialists we are referred to belong to UCSF, this can be uncomfortable since they will be our future colleagues

... especially when seeking treatment for psychiatric problems, which have more social stigma than other medical conditions," says Graves.

Students also fear that documentation of their treatment for depression will jeopardize their future careers, as candidates for medical licensure are expected to disclose the diagnosis of or treatment for any disorder that might impair their ability to practice. Moreover, as they begin to treat sick patients, depressed medical students usually become even more reluctant to admit that they themselves need help.

UCSF, however, makes significant efforts to teach students to monitor their own health and to encourage them to seek out help when needed. The primary resource for student mental health at UCSF is the Medical Student Well-Being (MSWB) Program, which offers several services and programs to promote a healthier learning environment and to assist students with a broad range of difficulties. One of the MSWB's most important services is individual counseling for students experiencing depression, loss and grief, anxiety, relationship or family troubles, academic difficulties, and alcohol or substance use problems. A UCSF fourth-year medical student who wishes to remain anonymous sought out help from the MSWB Program when her depression required her to take time off from medical school during her first year. She found the staff to be approachable and supportive, and she was particularly grateful for their help in finding a long-term therapist whom she felt comfortable with and whom she continues to work with today.

The MSWB Program also offers several group programs for medical students. The

Partners in Medicine Program addresses the stress medical education creates in medical students' relationships. Medical students and their significant others are invited to quarterly social and educational events, such as a welcoming dinner and discussions and panels on couples' communication, dual-career marriages, children, and board exams. Other programs include On Doctoring discussion groups, which meet weekly in the first and second years and monthly in the third and fourth years and provide a forum for students to discuss their reactions to the process of becoming a physician. Stress Rounds, which are one-hour meetings held with third-year students once during their Medicine clerkships and once during their ob-gyn clerkships, provide a forum for students to discuss stressful situations that arise during clinical work, such as difficult patient/house staff interactions, the sense of constantly being evaluated, and the frustration of being at the bottom of the hospital hierarchy. The MSWB Program also offers seminars and presentations in response to student feedback on topics such as coping with death and dying, talking about diversity issues, and dealing with board exams.

Dr. Daryn Reicherter, assistant director of the MSWB Program, feels that these programs have successfully promoted the mental well-being of UCSF students for years and feels that the flexibility of the programs contributes significantly to their overall effectiveness.

"We do our best to meet the changing needs of the classes as they arise," said Reicherter. "Within the broad spectrum of 'well-being' for medical students, we try to create a solution for each need."

Staff psychologist Dr. Sally Hand finds working with medical students very satisfying.

"Medical students deal with tremendous stress and, as in all areas of their lives, they approach understanding themselves with amazing intelligence and vitality" she says.

Catherine Campbell, UCSF first-year medical student, found an elective course she took at UCSF useful in learning how to cope with the challenges of medical school.

"The Healer's Art," a course designed by Dr. Rachel Naomi Remen, director of the Institute for the Study of Health and Illness at Commonweal and professor of Family and Community Medicine at UCSF School of Medicine, takes a highly innovative, interactive, and contemplative approach to helping students perceive the personal and universal meaning in their daily experience of medicine. Offered to first- and second-year medical students, "The Healer's Art" combines large group talks with smaller group experiential exercises that examine topics including wholeness, loss, grief, awe, and service.


The class "allowed me to get in touch with myself as a human being and to why I'm actually here in medical school," says Campbell.

Other popular electives include "Massage and Meditation" and "Spirituality in Medicine."

Surprisingly, when polled about the emotional and mental strain of medical

school, many current students say they have found their first year of medical school to be less stressful than they had anticipated. Thayer Heath, UCSF first-year medical student, attributes his well-being to the "pass-fail system [that] really helps generate a team atmosphere" and the supportive professors and staff.

"I am taken aback sometimes by the sincere interest that our professors take in our lives," said Heath.

Feng-Yen Li, UCSF first-year medical student, believes that the pass-fail system and the structure of the curriculum with its combination of lecture, small groups, and online modules have made medical school "more fun and stress-free than I thought it would be." Many other students, however, acknowledge the significant academic and emotional challenges of medical school and recognize that, ultimately, medical students must learn how to take care of themselves, as they learn how to take care of others. 

Tracy Zweig Associates

A Physician Registry and Placement Firm

Physicians

Physician Assistants

Nurse Practitioners

LOCUM TENENS PERMANENT PLACEMENT

Voice: (800) 919-9141 or (805) 641-9141

Fax: (805) 641-9143

email: tzweig@tracyzweig.com

Website: www.tracyzweig.com

Serving on the Medical Board of California: One Physician's Story



Bernard Alpert, MD

When I was president of the Medical Board of California from 2001 to 2002, I was aware of my dual role as both the “regulator” as an officer of the board and the “regulated” as a practicing physician. Since there are relatively few of us with both monikers, we have a tacit responsibility, indeed an obligation, to communicate with the hundreds of board employees and to articulate the necessity and value of regulation to the community of licensed physicians.

My initial task was to address and engage in dialogue with California's core of board investigators at a statewide conference in Sacramento. A few days before the conference, Dave Thornton, chief of enforcement for the Medical Board, was seated in my office waiting room. He was there on board business. A patient of mine with some family members was also in the waiting room. I greeted Mr. Thornton and introduced him, including his job title, to my patient, who happened also to be a good friend of mine. My patient's brow furrowed with concern, and he blurted out, “Oh dear, Dr. Alpert, I hope everything is all right.”

At the conference, I told this story to the gathered staff members to emphasize the powerful impact that a formal visit of an investigator from the Medical Board has upon the psychological and professional well-being of a physician. I spoke of my intention to enhance two-way communication with the various staff from the point of view of one who is both regulator and regulated, a vantage point they could not have. The investigators openly welcomed this exchange and seemed to go about their work seriously and professionally, and hopefully with an enhanced sense of humanity.

As my work on the board progressed,

I also tried to make the investigators aware that as regulators we could not ignore the environments in which the “regulated” worked. The vast changes in medical practice patterns were taking a toll on practicing physicians. The inversion of incentives and resultant paradoxes created by various prospective payment systems, along with the layered structures of the managed care environment, were creating a palpable trend of anxiousness in the lives of practicing physicians.

Nowadays, an estimated 80 percent of physicians will experience the occupational stress syndrome known as burnout, a measure of institutional dysfunction. Surveys routinely indicate that large numbers of practicing MDs discourage their children from entering medicine as a profession. Ours is the first generation of American physicians where this has been observed. This saddens me. I specifically maintain that our licensee pool is one of society's most valuable human resource groups, and that the energy-depleting forces currently affecting the profession are counterproductive to our collective goal of actually raising the standards of care. It also seems to me that the public has not yet connected these dots to the extent that it is in their power to effect meaningful change.

When I was on the Medical Board, I reviewed our disciplinary goals. As a framework, I invoked the consumer advocacy group Public Citizen's rating scale for state medical boards, which is published annually. This group ranks boards from 1 to 50 based on the number of disciplinary cases handled during the year, thereby assuring that a board gets a high standing if it exhibits an abundance of disciplinary actions. I postulated that on this basis a board

that ranks consistently at the top of the rankings must therefore exhibit behavior by one of two mechanisms, both of which, paradoxically, reflect poorly on the state. Either the state has an inordinate number of problematic licensed physicians, or it exercises inappropriate overutilization of disciplinary actions. Moreover, a state that regularly ranks 50th either has extremely few physicians with difficulties, or has inappropriate underutilization of disciplinary actions. The desirable goals are, of course, that a state board would exercise appropriate and fair, and hopefully few, disciplinary actions, with high standards of professional conduct maintained as a result.

The Medical Board of California has no disciplinary quotas—it responds to complaints. It remains vigilant as to license impropriety. There is no evidence that complaints go unaddressed, and the concurrent trends in malpractice claims do not lead to a conclusion that disciplinary cases are being ignored. A low number of disciplinary actions seems to actually reflect an appropriate posture in a high-quality environment. Conversely, a high number of license actions would definitely indicate a problem, of either low medical quality or an overdisciplinary environment.

Overall, I feel that the membership of the Medical Board of California is exquisitely sensitive to the necessity of timeliness in the processing of both discipline and licensing. Still, the realities of recent budget cuts and reductions in staff have placed an exceptional burden on the system. However, the goal remains that of maintaining the highest standards of medical care for the citizens of California. **Sfm**

Serving on the Medical Board of California: Another Point of View



Arthur E. Lyons, MD

My appointment to the Medical Board of California a few years ago came as a surprise since I was not a particular partisan for the governor at the time. I accepted because I felt it was important. It is not often that one can be in a position that may make a difference in the way medicine is practiced and this appeared to be an opportunity to do just that. I was not disappointed.

The positions on the Medical Board are all voluntary. Made up of 12 physicians and 9 laypeople, it is part of the Department of Consumer Affairs, which incidentally also includes boards for beauticians, dry cleaners, and contractors. Appointments are the prerogative of the governor, subject to a rubber-stamp approval by the state senate. The board consists of two divisions, that of Licensure and that of Medical Quality. I was appointed a member of the latter. After my initial appointment, what came as an even bigger surprise was discovering the dedication and quality of the other appointees.

The board meets as a whole only four times a year for two days to transact business at various places in California. Its meetings are mostly, but not entirely, open to the public. After I was given a quick orientation by the Administrative Director, my desk quickly became a daily receptacle of forwarded files. File review, I learned, was where the real work of the board is carried out.

There are 100,000 or so physicians licensed to practice in California. The Medical Board has been given the responsibility by the legislature to protect the public from bad medicine. It is not concerned with chiropractic care, which has its own board, legalized separately by public referendum. Furthermore, it cannot guarantee

good medical care, nor can it adjudicate fee disputes.

The staff of the board is required to respond to complaints about doctors brought to it from any source. It cannot itself initiate a complaint. After initial evaluation, many complaints are deemed frivolous and are disregarded. In addition to disciplining doctors, protection of the public includes helping physicians maintain their practices—if at all possible. The board takes this responsibility seriously and has a system of professional rehabilitation and retraining for deficient doctors. Licenses are revoked only when that seems to be the most responsible course, when rehabilitation is not an option or has failed.

Board members review cases and confirm that the investigations by board staff, consultants, and attorneys are appropriate and that the penalty, if any, is reasonable considering the offense. Only if there is a major dispute will the division as a whole hold a formal hearing. The Action Report is the board's newsletter and is distributed regularly to report its activities, including disciplinary actions.

After serving four years, I came away with certain impressions. The most significant, I believe, is that the Medical Board does an exemplary job in policing California physicians. However, we know we only address the tip of the iceberg. When one understands that the board is perpetually starved for money to pay for investigators or consultants who pursue and review allegations, it is remarkable that it does as well as it does in protecting the public from the medically incompetent.

While I was on the board there was a budget and hiring freeze that affected all of the activities. This happened in spite of the

fact that the board is self-supporting, since its budget is covered entirely by physicians' licensure fees. During the freeze not only was the board prevented from spending its own money, but the governor was able to use that money for other purposes. As a non-civil servant I could never understand that, though the paid staff seemed resigned to it—to them it seemed to make sense.

As for the board itself, I found the members extremely conscientious, taking their responsibilities very seriously. Members are from all parts of the state and the physicians represent virtually every specialty. The lay members were similarly bright and unusually well informed. There is virtually 100 percent attendance at all meetings and I believe every case was thoughtfully considered.

The attorneys assigned to the board from the attorney general's office, however, are another story. They are frequently very inexperienced. Most cases are settled without the necessity of a hearing, but the settlements worked out between the physician's attorney and the board too often seemed inappropriate. I was impressed with how often the attorneys missed the point. Often, there appeared to be no appreciation of how dangerous certain physicians' activities were. I am not referring to the crossing of sexual or personal boundaries, nor am I referring to substance abuse problems, both of which are usually penalized appropriately. However, I was aware that defective judgment and dangerous and useless treatments were, often, not fully appreciated when working out penalties and remedial actions. Examples come to mind of poor practice such as elective procedures with serious potential complications, such

Continued on page 18...

Continued from page 11...

ingested right before the episode began, but no one had paid attention to them because they were standard medications. So I did a Medline search and pulled up about 16 references citing delirium in connection with the combination of antihypertensive agents she was taking."

After about four months of back-and-forth with the attorney general's office, the case was dropped. But the entire experience, Dr. Cox says, left a resoundingly daunting impression. Not only did he spend thousands of dollars of his own money, but he lost weight, on many nights couldn't sleep, and began to question whether or not he could continue with his practice.

"I do things in my clinical practice that are really cutting edge and risk taking and I had never been medical-legally phobic up to that point," he says. "I've always done what I had to do to get patients well and I'd never looked over my shoulder and wondered if someone was going to sue me or dropped a case and referred it to someone else because I didn't want to take the difficult steps. I am one of the people they refer those cases to—so if I didn't see them, who would?"

"I realized that I was in danger in just doing what it is that I do," he adds. "It wasn't just MAO inhibitors; it was the nature of my practice, since I do things that others won't. I push doses of drugs beyond where other people will take them, I use combinations that are not widely used, and I do these kinds of things because many of my patients have really run out of options. After this experience I was really examining whether I wanted to continue in the field because I felt like what I was trying to do

was compromised."

Part of his disillusionment stemmed from the medical board's process, he says. As one of a handful of area psychopharmacologists with experience using MAO inhibitors, he felt the board had not turned to someone with equal or greater expertise when reviewing his case. Instead, he watched as physicians—colleagues who, under normal circumstances, might consult with him on their cases of treatment-resistant depression—reviewed his work and passed judgment on his treatment choices.

"My experience was like being ground up slowly by a big machine where there were no individual bad guys; in fact, many of the people I encountered were good people doing what it was they were supposed to be doing," he reflects. "But the medical board sees cases involving every specialty, and they don't seem to know where to turn to find specialists to use as reviewers. They have people from various disciplines who consult with them, but many of them are generalists. And that is what I saw in my case." **sfm**

Attention San Francisco Physicians SF Medicine Magazine Seeks Your Creativity!

We want to publish poetry, short anecdotal stories, photography, drawings, collages, and photographs of paintings or sculptures created by SF Physicians. Please don't be shy, submit your artwork! Send all material to Amanda Denz, 1003A O'Reilly Ave. San Francisco, CA 94129, or by e-mail, adenz@sfms.org.

Annual General Meeting of the San Francisco Medical Society

Hold the Date! The SFMS General Meeting will take place on Monday September 11th, 2006, from 6 to 7:30 pm. Tentative guest speakers include Mayor Gavin Newsom and CMA President Michael J. Sexton, MD.

The nominations committee will be presented. Members are also invited to attend the regular board meeting which will immediately follow the general meeting. This presents a good opportunity to meet with SFMS leadership and learn firsthand what SFMS and the CMA are involved in on behalf of San Francisco's physicians.

Continued from page 17...

as surgery for weight loss or back pain. Accusations and resulting settlements in such cases often seemed irrelevant, blamed on defective paperwork or the like, instead of being recognized as indicative of gross incompetence. On the other hand, physicians were occasionally pursued for trivial reasons simply because of inadequacy of our consultants or inexperience on the part of our attorneys.

In addition to matters of discipline, the board's Division of Licensure reviews and approves medical school training with the intent of increasing the number of competent practicing physicians in the state. While I was on the board, we also set up a program to help underserved populations in California with a loan payback program for young doctors. This program was the result of the imagination and foresight of the board president at the time, SFMS member Bud Alpert.

The only down moments I can recall were when, periodically, a member of the legislature would appear before the board. This would invariably be disagreeable to me. Some sort of politically inspired grandstanding and an expressed or implied threat usually seemed to accompany the visit. The implied threat was that the board was "not doing its job." Frequently I had to resist the urge to respond. Even though the job paid nothing and took time from my practice, I wanted to continue. To paraphrase the English satirist W. S. Gilbert, spare us from the "statesmen with an itch from interfering in matters which they do not understand."

My experience on the Medical Board was a reassuring and a truly rewarding one; hopefully I did some good, and I had an opportunity to meet wonderful and dedicated individuals. To serve our profession and our state is a rare privilege, and I encourage others in our San Francisco Medical Society to do the same. **sfm**

Toward a More Accountable Profession: The Case of the Aging Physician

William A. Norcross, MD, Heather A. Ching, MFT, and William Seiber, PhD

The Medical Board of California asks the UCSD Physician Assessment and Clinical Education (PACE) Program, an independent program of the UCSD School of Medicine, to assess physicians for clinical competency. Typically, this assessment follows after administrative charges are filed against the physician's license and disciplinary action is imposed. PACE faculty and staff conduct a number of tests to determine if a physician has deficiencies in any area of clinical competency or if there could be other factors that contributed to the disciplinary action. Over the years, several MBC referrals have led to the discovery of physicians having neurocognitive deficits sufficient to interfere with their ability to practice medicine safely.

A typical instance was one of an 80-year-old vascular surgeon who was disciplined because of problems with the postoperative management of a patient that resulted in a fatal outcome. He was found to have significant deficits in memory, a diminished ability to learn new information, abnormal visuospatial perceptions, and a deficit in fine motor function of the dominant hand.

Another example is that of a 74-year-old primary care physician who demonstrated confusion, disorientation, and inappropriate responses while participating in a PACE educational program. He was referred for a medical evaluation and formal neuropsychological testing, which revealed findings consistent with a chronic organic brain syndrome.

In all cases where health concerns are discovered, the information is shared with the physician and he/she is strongly encouraged to be evaluated by his or her personal physician(s).

We believe it is likely that in many of these cases, as in the examples above, the neurocognitive deficits that PACE uncovered were directly related to the event(s) that led to their discipline by the board. In the majority of these cases there was no evidence that the physician's hospital or medical group questioned his competency, put restrictions on his practice, or made an effort to refer him for further evaluation. This was true even in cases in which the doctor had suffered a stroke and there was gross evidence of paralysis, abnormal speech, and/or obvious decline in mental function. As a profession, physicians are very reluctant to approach a colleague about a perceived health problem. Moreover, physicians with cognitive problems are often unwilling or unable to seek help or retire from clinical practice. It is sad to witness a physician end a career of dedication and service in such a tragic manner.

Although the majority of physicians who choose to continue to practice medicine beyond age 65 are likely to be competent and sufficiently healthy to practice medicine safely, the incidence of many serious diseases increases with age. Unfortunately, many of these diseases occur insidiously and many may not be apparent to the person afflicted. In population-based studies of community-dwelling persons age 65 and older, mild Parkinsonism was found in about 25 percent in people over 65, and symptoms and signs of pre-dementia in 1 to 2 percent, with a significant rate of annual conversion to dementia. While higher education appears to confer a mild protective effect from dementia, there is no reason to suspect that physicians would not suffer the risk of increasing likelihood of neurodegenerative processes with age. Other studies show a

significant incidence of hearing impairment and vision loss with aging.

Commercial airline pilots, a profession to which the medical profession is often, arguably, compared, deal with the increasing incidence of disease with age through a program of mandatory, intensive testing and assessment and compulsory retirement from flying at age 60. (I am told that the requirement is neither evidence-based nor purely related to health or fitness concerns. I offer this only as an interesting point of comparison with another highly regarded profession whose members are responsible for the welfare and safety of the public.)

There is no consensus regarding routine health or competency screening of physicians. To our knowledge, the only mandatory assessment program for aging physicians is conducted by Canada's College of Physicians and Surgeons of the Province of Ontario, which requires physicians age 70 and older who wish to continue active medical practice to undergo a compulsory peer review every five years. But world opinion is divided on this issue. In considering the same general issue, the New Zealand Human Rights Commission states that any form of compulsory assessment of physicians solely based on age represented age discrimination.

While we agree that discrimination based solely on age is abhorrent, we feel compelled to recognize that a host of diseases causing decrements in physical, sensory, and neurocognitive functions increases sharply with advanced age. Whether the finding is related or not to physical and mental decline, a growing body of evidence demonstrates that physicians who have been in practice longer are at significant

Continued on page 30...

“A former employee is suing me for wrongful termination. Does my insurance cover that?”

It does if you have
Employment Practices Liability Insurance.

Why is Employment Practices Liability Insurance needed?*

- Statistics show an employer is more likely to have an employment claim than a property or general liability claim.
- The average amount paid for out-of-court settlement is \$40,000.
- Defense of the average EPLI case, through trial, costs over \$45,000.
- The median compensatory award in EPLI cases is \$218,000.
- 67% of all employment cases that litigate result in a judgment for the plaintiff.
- 10% of awards in cases involving discrimination and wrongful termination are in excess of \$1,000,000.
- Six out of ten employers have faced employee lawsuits within the last five years.

Employment related suits usually involve one or more of the following: discrimination, sexual harassment, wrongful termination or workplace torts. The purpose of the SFMS program is to provide members with the needed tools and protection generally missing from other insurance policies.

SFMS's claims made program provides members with significant benefits:

- Web based training for members, office managers and employees to help minimize exposure to employment practices lawsuits.
- Access to a legal information hotline staffed by employment practices attorneys.
- Review of employee handbooks and employment applications.
- Economically priced Employment Practices Liability Insurance** that provides for defense costs and losses an insured becomes legally obligated to pay as a result of a covered claim.
- Choice of policy limits of \$250,000, \$500,000 or \$1,000,000.
- Low minimum premiums.
- Low per claim deductibles.
- 60 day extended reporting endorsement included.

For more information on the **Special First Time Buyers Program** or to receive a brochure and application, call a Marsh Client Service Representative at **800-842-3761** or e-mail CMACounty.Insurance@marsh.com.

Sponsored by:



Administered by:



* Society for Human Resource Management – 2002 ** Coverage provided by a carrier rated A by AM Best

Help for the Physician in Trouble

Occasionally every physician needs help—whether it be with legal problems, stress, mental health, or substance abuse. The following is a list of online resources assembled by CMA and SFMS to guide physicians through their troubled times.

Referral Resources:

- Medical Board of California www.medbd.ca.gov
- MBC Diversion Program www.medbd.ca.gov/Diversion.htm
- County Medical Societies www.cmanet.org/publicdoc.cfm/63/0/countyall
- California Specialty Medical Societies www.cmanet.org/publicdoc.cfm/60/0/linklist/55
- American Medical Society www.ama-assn.org

Legal Information:

- CMA Medical-Legal Online Library www.cmanet.org/bookstore/cmaoncall.cfm
- AMA Legal Resources www.ama-assn.org/ama/pub/category/4541.html

Physician Stress and Burnout:

- Finding Meaning in Medicine www.meaninginmedicine.org/home.html
- Center for Professional and Personal Renewal www.cppr.com/

Mental Health:

- National Institute of Mental Health (NIMH) www.nimh.nih.gov

Substance Abuse:

- California Department of Alcohol and Drug Programs-Resource Center (California Only) <http://www.adp.ca.gov/>
- Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov/
- International Doctors in Alcoholics Anonymous www.idaa.org
- National Institute on Drug Abuse (NIDA) www.drugabuse.gov

Treatment Facilities:

- SAMHSA's Searchable Directory of Treatment Programs <http://dasis3.samhsa.gov/>
- State of California Narcotic Treatment Program Directory www.adp.ca.gov/pdf/clinicdr.pdf

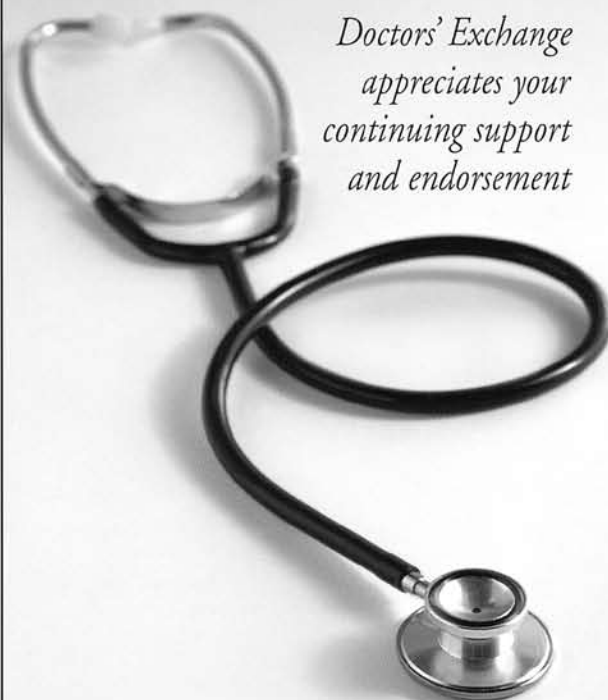
Recovery Meetings:

- Northern California AA www.aanorcal.org/service.htm
- Northern California NA meetings www.norcalna.org/meeting.html
- Dual Recovery Meetings www.draonline.org/meetings.html

Outside California:

- State Medical Societies www.ama-assn.org/ama/pub/category/7630.html

T H A N K Y O U
San Francisco Medical Society



*Doctors' Exchange
appreciates your
continuing support
and endorsement*

**doctors'
exchange**

Discounted Prices for Society Members

- Specialized 24 hour answering service
- Voice mail with operator reversion, press "0"
- Paging in alpha numeric (text) and digital
- Management of on-call information

Doctors' Exchange is owned and operated by:

 **Connections**
COMMUNICATION SERVICES

For information 415-431-4803

A Conversation About Renewing: Q & A with Linda Clever, MD

Amanda Denz

This month *San Francisco Medicine* had the opportunity to speak with Linda Clever, MD, about how physicians can remain buoyant and enthusiastic despite stress and other pressures brought on by medical practice. Dr. Clever's program RENEW was developed with this aim in mind. In the upcoming months, Dr. Clever will be working with the San Francisco Medical Society to create a RENEW program for members.

SFM: What led you to develop RENEW?

Dr. Clever: I'm an internist and I was trained in internal medicine, infectious diseases, occupational medicine, and community medicine. Throughout my career I've always been interested in how lives and work/career interact because we are more than just one dimension. Our bodies, our souls, our families, our friends, our work, and our neighborhoods—we have all of these things.

Then, several years ago, all of the wheels came off my life in a series of terrible ways. Within a period of 18 months my mother died, my house was broken into, I lost two jobs, my father died, and then my husband, who is also an internist, was diagnosed with carcinoma of the prostate. He is fine now, but after all of that, it was necessary for me to rethink all of my basics, to really define what was important to me.

When I had served on the Stanford Board of Trustees, one of the other members was John W. Gardner, who started Common Cause after he was Secretary of Health, Education, and Welfare under President Johnson. He had written a great deal about excellence, leadership, and about renewing. And here I was in the time of my life when I needed to renew and I thought this was a

great time to put theory into practice.

Sometimes you get worn out doing good, and sometimes terrible things happened to you. How do people become buoyant, engaged, and excited despite all of this?

If, at the point where you are in life, you either know everything or you have lost that compelling need to explore, how do you get the courage to keep exploring? And when things are going well, how do you still keep

immediately started working with nurses, then schoolteachers, attorneys, and other professions.

SFM: What are the Conversation Groups like?

Dr. Clever: "Con" means with and "versus" means turn, so when you are having a conversation with someone it means you are willing to turn with them and get a new idea—this is not just about reshuffling the deck, it's about getting new cards.

At the Conversation Groups, the topic is renewing. We discuss renewing and refreshing, and we figure out how to regain effectiveness, enthusiasm, and our sense of purpose, fun, and joy. We also have a good time together!

One of our first conversation groups started at CPMC and is still going after seven years. We talk about topics such as: What is success? How do you get through a tough day? How do we deal with aging? How do we live our values? These topics are always on our minds, but we don't talk about them that much. When you are in a conversation with people you might not know very well, but whom you trust, you can come to grips with some of these things, and move ahead.

SFM: Who do you think will enjoy or benefit from these Conversation Groups?

Dr. Clever: RENEW isn't for people who are profoundly in trouble. It is for people who want to become buoyant again. It's for explorers, discoverers, people who want more of an adventure in life. It's for wonderers. Since we are more fragmented these days, this provides an opportunity to come together with people who either are



looking forward? How do you keep from being a barnacle of a person and make yourself a leaping dolphin of a person?

SFM: So how did you eventually put theory into practice?

Dr. Clever: That was the challenge. A group of colleagues and friends got together and started RENEW. They became the board and the advisers, and I started doing grand rounds at various places. Then we started seminars and workshops, and finally Conversation Groups®—which we will be doing with the Medical Society. RENEW started with physicians and then

like-minded or have at least had some of the same experiences. This way you don't have to figure everything out yourself; you can get ideas from others—others who are in the same boat. And the same boat can be age 28 to 88, because part of that boat involves trying to figure out "what is the purpose of life?"

SFM: *What do you hope to accomplish with the conversation groups at SFMS?*

Dr. Clever: First of all, it would be great to get a regular group of attendees and to keep the group going for a long time. And second would be that every time, people leave with new ideas, or they find new paths, or new self-confidence, and/or new approaches to life. People who come should feel that they are not alone. This really is a way to build community.

SFM: *What other things can doctors do in their lives to stay energized or keep from getting stagnant?*

Dr. Clever: I know this will be a shocking statement...but I think that physicians have the same DNA as everyone else. I do

think we have one of the hardest jobs in the world. Our jobs are extraordinarily sad, sometimes, and challenging, and wonderful. Many physicians would do it over again, and then there are some—and these numbers are increasing—who wouldn't, and who wouldn't advise their children to. That is tragic.

But I do think that, just like everybody else, physicians need to keep learning—whether they take a class in something that interests them, anything from Sanskrit to watercolor, or they join a group that does something interesting. In addition to the learning that we have to do in our careers, exploring personal interests is so important.

We physicians need to stay involved with the world, keep on reading the newspapers and staying informed about public events. Many physicians become divorced from the rest of the world, but we do have an obligation to live in it.

We have such a different responsibility than most other professions. We hold responsibility for people's lives and their futures. The way we differ from firefighters and other people who save lives is that we have a relationship with our patients and

the quality of that relationship affects them. To know what we are doing and to do no harm—those are also huge responsibilities. And how do we deal with that?

These are all things that we discuss together during conversation groups. Many people want to know, "How can I do it all?" And the answer is that we can't do it all, all at once, but we can decide how to pick and choose wisely.

It's so important that our spirits are high. Not just for our patients but for our families and colleagues and ourselves. **Sfm**

RENEW is coming to the San Francisco Medical Society!

The San Francisco Medical Society is introducing a RENEW program for SFMS members starting July 19 at 5:30 p.m. with a second meeting on August 16 at 5:30 p.m. at the SFMS Presidio offices. The preliminary meetings will be complimentary and will feature the delicious catering of the SFMS chef! RSVP to Carol Nolan, cnolan@sfms.org (415) 561-0850 extension 0. For more information about RENEW visit www.renewnow.org.

Thinking about electronic medical records? What about your paper records?

If you are planning to implement an electronic medical record system, what are you going to do with all those *paper* patient charts and billing files? Consider scanning them to a digital database with **deliverExchange™**. Let us scan your records to CD or DVD, and realize the benefits of this cost-effective alternative:

- Save time spent filing and retrieving records
- Data encrypted for confidentiality
- Records accessible 24/7
- Files can be printed out, electronically transmitted, or uploaded to your EMR
- Eliminate lost or misfiled records
- Keep extra copy for disaster recovery
- Save space and storage costs

We pick up your records, scan them at our imaging unit in San Jose, produce quality images on CDs or DVDs, and handle the destruction of the paper records.



2054 Zanker Road
San Jose, CA 95131
Contact: Liz Allan
phone 408.436.1701 ext.131
fax 408.436.1626

You may not know our name, but if you practice in San Francisco city or county you know our service. For over 30 years, SOURCECORP Deliverex has been the vendor of choice for record management in the Bay Area.

The Band Plays On—Again: Getting Away with Torture?

Steve Heilig, MPH, Philip R. Lee, MD, and Marcus Conant, MD

The ethical standards of the medical profession have consistently and universally condemned any participation by physicians in direct or indirect abuse of prisoners or any other person for any reason, as embodied in the dictum “First, do no harm.”

Additionally, the dominant “evidence-based” opinion regarding the utility of torture is that it elicits faulty information and increases the risk of retribution—of the torturing nation’s own soldiers and citizens being abused. The navy’s own general counsel has said that mistreating prisoners is “almost incalculably harmful to US foreign, military and legal policies.” It has also been called “a wonderful recruitment trigger” for potential terrorists.

By mid-2005, there was disturbing but solid evidence that since 9/11, codes of treatment were violated in US-run facilities in Cuba, Iraq, and possibly Afghanistan. Some American physicians, possibly including some California medical licensees, were implicated as having been directly or indirectly involved in such abuses.

A leading medical ethicist, Steven Miles, MD, has written in *The Lancet* and in his new book *Oath Betrayed* that “not only were doctors, nurses, and medics silent while prisoners were abused; physicians and psychologists provided information that helped determine how much and what kind of mistreatment could be delivered to detainees during interrogation. Additionally, these harsh examinations were monitored by health professionals operating under the purview of the U.S. military.”

Concerned that not enough was being done to uphold hal- lowed ethical standards, we wrote a letter to the *New England Journal of Medicine*—which had published some of the disturbing information. In our letter we pointed out that all physicians, including those serving in the military, are licensed by a state medical board and beholden to the same ethical standards as any member of our profession. We asked that the military disclose the names of physicians involved in abuse of prisoners to medical boards and the AMA for investigation and possible discipline.

The *NEJM* published our letter in October 2005. The response? Virtually none. The Associated Press did disseminate a news release but even our own local newspapers and media did not cover this call for accountability. Eventually the chairman of the board of the AMA sent a letter to the *NEJM* in response to ours,

explaining AMA actions to date, and reiterating that “physician involvement in such mistreatment comprises the integrity of the medical profession”—but the *NEJM* chose not to print it. The editor of the AMA’s own fine newspaper, *American Medical News*, did not respond to half a dozen attempts to discuss an article or opinion piece on this topic.

Were we naive in expecting others to share our—and the AMA’s—concern? We expected that having a call for action in the nation’s leading general medical journal merited some response. Apparently we were wrong. But why?

It’s likely there are multiple reasons. Perhaps some military physicians, within the rigid hierarchy of the military and under the duress of wartime, are more prone to slip in their standards due to various pressures. Perhaps few really believe that the kind of documented maltreatment we and others have cited, which has even resulted in at least one death among prisoners, is truly “torture” and is thus permitted – which is just what some leaders in Washington are

now arguing to be the case as they seek to weaken the Geneva Conventions.

To be clear, we fully believe that the vast majority of military physicians are ethical people, and that those who have transgressed are a tiny minority. But this episode has provoked in us a disturbing flashback to the early days of the HIV epidemic, starting a quarter century ago. Scientific and media reports were telling us something bad was occurring. Some among the “powers that be” ignored the warnings—“and the band played on”, as *San Francisco Chronicle* journalist Randy Shilts titled his landmark book on those early days. Those delays cost many people very dearly, and are now recalled by many with shame.

Will many of us also look back in shame at our silent complicity with abuse perpetuated by our own fellow citizens? **sfm**

“Our lives begin to end the day we become silent about things that matter.”

—Martin Luther King Jr.

Steve Heilig, MPH, is on the SFMS staff and is coeditor of the Cambridge Quarterly of Healthcare Ethics. Philip Lee, MD, is professor at both Stanford and UCSF medical schools, UCSF Chancellor Emeritus, and former United States Assistant Secretary of Health. Marcus Conant, MD, is clinical professor of medicine at UCSF and a leading figure in responding to the HIV epidemic. Their views here are their own.

Preparing for Pandemic Influenza in San Francisco

Olivia Bruch, MSC, and Karen Holbrook, MD, MPH

Since 1997, avian influenza H5N1, commonly known as bird flu, has killed millions of birds globally, infected fewer than 250 people, and killed approximately 50 percent of those known to be infected. The RNA of influenza A viruses, including the H5N1 strains, frequently undergoes point mutations and occasionally shifts dramatically. Thus, there is concern that this virus could mutate to a highly transmissible strain and widely infect a vulnerable world population. This possibility has prompted public health leaders to prepare for an influenza pandemic.

Preparing for pandemic flu is different than preparing for other disasters in that the pandemic flu has the potential to last up to 24 months. In an extreme scenario the pandemic virus could cause widespread waves of illness, overwhelm our health care system, cause high levels of absenteeism in every type of workforce, and result in shortages of essential goods. Vaccines may not be available for at least six months and antiviral drugs may not be effective or widely available.

The San Francisco Department of Public Health (SFPDH) is closely monitoring the status of avian influenza and is preparing for the possible introduction of the current H5N1 strain (not easily transmissible) or a pandemic influenza strain. Key preparedness goals include identifying disease, reducing transmission, coordinating care of the ill, maintaining essential services, communicating accurate real-time information, and minimizing social disruptions and the economic impact of a pandemic. To achieve these SFPDH is working on many fronts:

To enhance clinicians' ability to recognize and appropriately respond to cases of H5N1 and/or pandemic influenza, SFPDH provides guidance via Health Alerts, a 24/7 disease reporting number, (415) 554-2830, web postings, and presentations. San Francisco clinicians received a health advisory that addressed suspected avian influenza cases in November 2005 (see www.sfdph.org/healthalert for a copy) and numerous clinicians have attended SFPDH-led avian/pandemic flu lectures. Currently, target audiences include emergency, primary care, pulmonary, and infectious disease clinical staff. To find out about lecture schedules, contact olivia.bruch@sfdph.org.

Disease control teams are trained, ready to respond to reports and facilitate testing. To rapidly diagnose cases the San Francisco Public Health Laboratory has acquired the equipment, reagents, and skills to provide PCR testing of respiratory specimens for influenza A and B and the subtypes H1 and H3. Soon the lab will also be able to test for the subtype H5.

To reduce transmission and ensure care for the ill SFPDH is taking the following steps: developing infection control guidelines

for health care workers, first responders, and others (see document on www.sfdph.org/cdcp); heightening awareness of public hygiene practices (e.g., hand washing, cough etiquette); strengthening hospital surge capacity plans; acquiring a small cache of antiviral agents and preparing to stage state or federal stockpiles of medicines to treat confirmed or suspected cases; developing protocols for isolating confirmed or suspected cases in the health care and/or home setting; developing protocols for home- or facility-based quarantine of people exposed to a confirmed or suspected case; outlining social distancing strategies (e.g., limiting large public gatherings).

To minimize social disruptions and the economic impact of a pandemic, the health department has been collaborating with a city agencywide Avian/Pandemic Flu Task Force. Since fall of 2005 the task force has been working to ensure a coordinated response and to see that essential city services remain functional. SFPDH has provided a pandemic flu continuity of operations plan (COOP) template (see www.sfdph.org/cdcp for a copy) and ongoing guidance to leaders and planners.

The health department is also assisting other community groups with planning. Various meetings and presentations on pandemic flu preparedness are being held through the Hospital Council Emergency Preparedness Task Force, Infection Control Working Group, business associations, and organizations that meet the needs of special populations. A COOP template tailored for businesses and organizations will be made available in June.

To communicate accurate real time information to the San Francisco community the health department will use a variety of media outlets, including website postings (www.sfdph.org/cdcp), health alerts faxed to clinicians, public information lines, press releases, and press conferences. Presently the website has avian/pandemic flu news, fact sheets, flyers for upcoming presentations, and more. Many of these tools can be handed out to patients who have questions or concerns.

Because clinicians play a key role in the city's response we ask that you also prepare for a pandemic flu. Have the 24/7 disease reporting telephone number handy, (415) 554-2830, know your office's or facility's plan, and develop your own personal disaster plan to ensure that family members are cared for while you are at work. For details on how to prepare see www.sfdph.org/cdcp.

While we hope that San Francisco will be spared a severe pandemic, planning for the worst by developing comprehensive response plans and strong relationships with community partners helps us to meet both everyday challenges and those of any disaster. **sfm**

Veterans
Diana Nicoll, MD,
PhD, MPA



Saint Francis
Guido Gores, MD



St. Luke's
Jerome Franz, MD



U.S. Congresswoman Nancy Pelosi (D-Calif.) cut the ceremonial ribbon at the grand opening of the Center for the Imaging of Neurodegenerative Diseases (CIND) at the San Francisco VA Medical Center on Friday, May 12. The opening ceremony took place on the SFVAMC campus in historic Building 13, which has been renovated and now houses the CIND research program.

Rep. Pelosi was part of a group of distinguished guests that included Dr. Joel Kupersmith, Chief Research and Development Officer of the Veterans Health Administration, and Col. Karl Friedl, Commander of the US Army Research Institute of Environmental Medicine and administrator of a Department of Defense-funded research program at CIND.

The mission of CIND is the early detection and subsequent monitoring of chronic and neurodegenerative brain diseases and conditions such as Alzheimer's disease, post-traumatic stress disorder (PTSD), Gulf War illness, Parkinson's disease, epilepsy, and HIV dementia. Brain images are obtained with magnetic resonance imaging (MRI), a noninvasive, nonradioactive technology. At the heart of the CIND equipment array is a state-of-the-art 4.0 Tesla MRI instrument, the only one of its kind in the VA system, which is several times more powerful than conventional MRI devices.

CIND is the result of collaboration between the Department of Veterans Affairs, the Department of the Army, the National Institutes of Health, the Northern California Institute for Research and Education, and the University of California, San Francisco.

On Thursday, June 29, we held our Richard J. Bartlett Memorial Lecture with distinguished speaker William P. Schechter, MD, FACS. Our Distinguished Lecture Series aims to provide a venue to listen to and learn from some of the nation's most respected clinicians and researchers. Dr. Schechter is a Professor of Clinical Surgery and the Vice Chair of Surgery at UCSF and the Chief of Surgery at San Francisco General. The topic of the lecture was "Terrorist mass casualty events in Israel: Historical context and clinical management." Along with his excellent lecturing talent, Dr. Schechter is especially experienced in this area due to time he spent at the Shaare Zedek Medical Center in Jerusalem, Israel. Between January 1 and June 30, 2004, he studied civilian hospital response to mass casualty events. In his lecture Dr. Schechter explained the principles of mass casualty triage in the field, the principles of civilian hospital response to a mass casualty event, and the clinical manifestations and management of blast injury due to explosions.

Saint Francis Memorial Hospital was also honored as one of 39 national recipients of the American College of Surgeons' Commission on Cancer Outstanding Achievement Award. The award is given only to cancer care facilities that achieve commendation in more than eight areas of the 45 areas surveyed during the comprehensive on-site evaluation. Our very own Cancer Care Committee, established in 1975, sees that Saint Francis meets these high standards in prevention, early detection, treatment, rehabilitation, emotional and spiritual support, and long-term follow-up services for patients diagnosed with cancer.

Integration of management goes forward as we await the attorney general's approval for St. Luke's to become a fourth campus of CPMC. After a period when we were saying goodbye to someone on staff every month, we are now seeing more new faces, some of them longtime employees of CPMC who are bringing expertise but also learning from our culture of service to the community. They are also finding areas of excellence here, such as obstetrics, which has once again been given Sutter's highest award for performance in first pregnancy and delivery, thanks to our outstanding team of doctors, midwives, and nurses.

The childhood asthma program also won Sutter's award for best overall performance. This status will be enhanced in the near future by a grant of \$170,000 over three years from the California Asthma Public Health Initiative. The money will allow St. Luke's Pediatric Center to participate in the Best Practices in Childhood Asthma program. The project leader is Kevin Chu, MD, who advocates early detection, prevention, monitoring, and treatment. He has hired a full-time asthma coordinator, Diana Williams, PAC, to test, educate, and follow up on the patients in this pilot program.

For many years St. Luke's had a School of Nursing. It trained excellent RNs, some of whom still work with us. We now have the happy news that St. Luke's will once again be a center for training. The Samuel Merritt School of Nursing will locate some of its programs here in the Hartzell Building, which housed our old school. We expect the educational activities will keep our nursing staff at top performance, enhance patient care, and provide a source of nurses for the future.

UCSF
Linda Reilly, MD

UCSF Medical Center recently opened the first center in the country to serve the specific cardiovascular care needs of Asians in the Bay Area and beyond. The UCSF Asian Heart & Vascular Center will focus on advanced heart care treatment that is respectful of the cultural, genetic, and physiological differences that distinguish the Asian population.

The facility, located at UCSF Medical Center at Mount Zion, features a stress echocardiogram lab, patient screening rooms, and an education and research center equipped with staff, computers, and reading materials. Patients and community members can use the center to learn about heart disease, and prevention and treatment options. Patients will also receive information and language-appropriate educational materials, and interpreters are on staff and available to speak to patients in their native languages.

The UCSF Asian Heart and Vascular Center will also serve as an identified leadership institution to coordinate and plan basic and clinical research efforts.

While Asian Americans share the same risk factors as the general population, including high rates of hypertension, obesity, diabetes, and smoking, studies have shown important differences in cardiovascular function and outcome in Asian Americans. "There is a scarcity of programs that cater to Asians culturally, linguistically, and medically," says Gordon Fung, MD, director of the new center. "Adding to the problem is a lack of clinical data on this population, making it difficult to master-plan research and tailor treatment."

For more information or to refer a patient, contact the Asian Heart and Vascular Center at (415) 885-3678.

St. Mary's
Kenneth Mills, MD



Expectations for professionalism from our physicians run high at St. Mary's, and the medical staff introduced its own code of conduct some three years ago. All physicians attest to this standard at the time of initial application to the medical staff and at each reappointment. We feel that our reputation in the broader community is based on involvement in quality improvement, peer review, utilization management, and patient safety. We expect our physicians to promote a safe, cooperative, and professional health care environment where all individuals are treated courteously, respectfully, and with dignity. Disruptive or disrespectful conduct affects the ability of others to do their jobs competently and creates a potentially hostile work environment for hospital employees, parishioners, patients, and others.

We also recognize that physicians are only human and at times operate under considerable stress. We are prepared to help the troubled or disruptive physician deal with these issues and maintain their contribution to their profession and the medical center. We have an active Well-Being Committee that respects confidentiality but allows review and monitoring of behavior. We work with the Diversion Program of the Medical Board of California to keep physicians working in a safe environment. As a physician family at St. Mary's, we stand ready to support our fellow doctors in time of need. I would also like to make a pitch for the RENEW Program, the brainchild of Dr. Linda Clever (see interview on page 22), which, among other activities, has developed facilitated conversation groups encouraging health care professionals to explore ways to enhance satisfaction in their journey as a doctor.

Finally, we encourage all our medical staff to marvel at the wonder and grace of their profession. This is best done with balance in our lives. Attention to self and family is the best equalizer.

Seton
Stephen Conrad, MD



I was pleased to hear that the focus of the current issue is on "wayward physicians." I would like to say that there are none, but I cannot. However, I can say with confidence that, thankfully, their numbers at Seton are few.

As physicians, we have been placed in a unique position. Despite recent changes in health care, we remain trusted. The doctor-patient relationship, as codified in the Hippocratic Oath thousands of years ago, remains sacred. Implicit in this bond is the understanding that the doctor will work on behalf of the patient—not on behalf of the HMO, insurance company, or other third party.

This unique and sacred trust does not come without obligations. As physicians, we are held to professional standards that are high and sometimes difficult to maintain. I can say with pride that breaching these standards is rare. Nevertheless, when these violations occur, the entire profession is weakened and it is our responsibility to respond.

At Seton, as with other medical staffs, we are endowed with an excellent Physicians' Well-Being Committee. This group is chaired by Tim Isaacs, MD, psychiatrist par excellence. He researches relevant articles on physician wellness and impairment and distributes them to the medical staff in the monthly mailing. Dr. Isaacs is always available to the medical staff for personal as well as patient problems. For violations that are considered more serious, an ad hoc committee is appointed and a judicial review can result. An appeals process is also available.

Again, fortunately, egregious problems of this nature are rare at Seton. Dr. Isaacs and his committee are like the Maytag repairmen, waiting by the telephone for calls that don't often come. It is through the hard work of this committee and the general integrity of my colleagues in medicine that "wayward physicians" are an anomaly at Seton.

CPMC

Damian Augustyn, MD



Chinese

Fred Hom, MD



Congratulations to Dr. John Moretto, who was recently reappointed chair of the Department of Pathology for a second five-year term. Dr. Moretto is a graduate of Stanford University School of Medicine and has been a member of the CPMC Medical Staff since 1995.

The CPMC Medical Laboratories at both the California and Davies campuses were recently awarded accreditation by the College of American Pathologists. The CAP program is the most respected and recognized laboratory accreditation program in the world.

Dr. Donald Fletcher, CPMC Department of Ophthalmology, received the "Meritorious Award for Outstanding Lifetime Contributions in Low Vision" from the Association for Education and Rehabilitation of the Blind and Visually Impaired.

The CPMC Facilities Development team is now building a new Philips-Stereotaxis cath lab in the Kanbar Center. Targeted for completion early next year, it will become Kanbar's fourth cath lab, helping CPMC serve more patients in an improved environment. This effort has been enabled by the CPMC Foundation, which has raised nearly \$2 million to support the work of our cardiologists.

CEO Brenda Yee was pleased to announce the outstanding final results of the JCAHO/CAL Survey for Chinese Hospital: only four "Requirements for Improvement." Given that Chinese is the first hospital in the Bay Area to experience an unannounced survey, its JCAHO Task Force should be commended for "mobilizing the troops" with literally only two hours' notice. In addition to our leader, Ms. Yee, task force members

include Dr. James Yan, cochair and Medical Director of Performance Improvement; Dr. Joseph Woo, Chief of Staff; Stuart Fong of Risk Management and Infection Control; Dolores Ong, Director of Nursing; Rebecca Sulpacio, Performance Improvement; Elena Tinloy, Director of Clinical Services; Dr. Wai-Lam Chan, Director of Sunset Health Services; Jian Zhang, NP and manager of Sunset Health Services; myself, Dr. Fred Hom, Vice-Chief of Staff; and most of all, Patricia Chung, JCAHO Survey Coordinator. Also to be acknowledged are all the medical staff and hospital staff who took time off to participate in the survey. Thank you to all involved.

SFMS Symphony Night Returning this fall!

More information—including the date—for this SFMS Membership favorite will be available soon.

Pacific Professional Building 2100 Webster Street On the Pacific Campus of California Pacific Medical Center



Call (415) 923-3195 or email
Pan-Med@aol.com
for space availability

SFMS Day at the Ballgame coming soon!

This event will take place late Summer/early Fall. Please watch the magazine and check our website, www.sfms.org, for more information.

IN MEMORIAM

Nancy Thomson, MD, SFM Obituarist

Berdeen Frankel, MD

Dr. Berdeen Frankel (Paul) passed away on May 18, 2006, at the age of 86. She was born on December 5, 1919, to Mathilde and Joseph Frankel.

She received a BA in sociology from the University of California at Berkeley and received her MD from Stanford University School of Medicine in 1948, specializing in psychiatry. She was one of only three women in her graduating medical class.

Dr. Frankel practiced psychiatry in San Francisco for over 50 years, specializing in psychiatric diagnosis and treatment, psychopharmacology, and psychotherapy. She was an attending physician at Staint Francis Memorial Hospital, where she received the Distinguished Service Award. She was also an assistant clinical professor at UCSF. She was a life fellow of the American Psychiatric Association, a member of the American and Northern California Psychiatric Associations, and a member of the San Francisco Medical Society since 1953. She researched and published articles on thyroid function in mental disease and prediction of performance for medical students.

Dr. Frankel was also a member of the Commonwealth Club of San Francisco, the San Francisco World Affairs Council, and the Metropolitan Museum of Art. Her avocations included national politics, arts and antiques, world travel, and gourmet dining. She had an elegant sense of style and a wonderful sense of humor. She was an avid reader and it seemed to her daughters and those close to her that there was not a word in the dictionary for which she did not know the definition.

Dr. Frankel married Joseph Paul, a political public relations consultant, in 1956. They purchased a house on Jackson Street in San Francisco's Pacific Heights, where they lived with their two daughters, Mimi and Mary.

Her husband died suddenly in 1972 and

Dr. Frankel raised their daughters as a single, working mother with a steadfast determination. Her unwavering efforts and emphasis on the importance of education led to Mimi attending and graduating from Stanford University, and Mary from Harvard—both made her most proud. Unfortunately, Mimi died from anorexia/bulimia in December 2001. Dr. Frankel set up an endowment at Stanford University for medical research into the causes and treatment of these diseases; contributions in Dr. Frankel's memory may be made to the Berdeen Frankel Paul Endowment for Anorexia and Bulimia Nervosa, c/o Rich Yates, Stanford University, Director of Planned Giving, Frances C. Arrillaga Alumni Center, 326 Galvez St., Stanford, CA 94305-6105.

Dr. Frankel is survived by her daughter Mary Paul Brown (Martin), former sons-in-law Vincent Allio and Andrew Nash, four grandchildren, her brother and sister-in-law, and three nephews and nieces.

Benjamin Gross, MD

Dr. Benjamin Gross, longtime psychiatrist in San Francisco, passed away April 17, 2006, of prostate cancer at his home in Sebastopol. He was 84.

He was born March 1, 1922, in San Francisco's Fillmore district to Polish Jewish immigrant parents. He graduated from Lowell High School in 1938, received a BA in literature from UC Berkeley in 1942, and earned his MD from UCSF in 1946. He worked for the Public Health Service for two years in Europe serving in Hamburg, Germany, and Rotterdam, the Netherlands.

After completing his residency in psychiatry in 1954, he opened his practice in San Francisco. He also saw patients at clinics run by the city. He was psychiatric consultant for San Francisco Suicide Prevention in the late 1960s, training people who fielded emergency calls. He was also one of the first

psychiatric consultants advising the Golden Gate Bridge District on whether to put up a suicide barrier.

He liked to recount how, at the age of one, he became ill and the physician who came to the house quickly surmised the family could not afford to pay for the medicine he needed. Instead of making a fuss about it, the doctor slyly left the needed sum under the prescription form. Dr. Gross worked for 30 years on the faculty of the UCSF psychiatric institute and was responsible for naming it Langley Porter after the doctor who had helped him and his family so many years before.

He also pursued his interest in literature, teaching a class in literature and psychology at San Francisco State for a decade in the height of student unrest in the 1960s. He taught the same course at the Fromm Institute at USF until the late 1990s. He won the U.S. amateur senior chess championship in 1989, and naturally the psychology of chess was one of his favorite teaching topics. He may have been the only professor to link chess with the Russian novelist Fyodor Dostoevsky, according to friends and colleagues. After medical school, he drove to Washington, D.C., to train for his job with the Public Health Service, surviving on a large sack of dates. However, his interest in literature got the best of him in St. Louis when, browsing in a bookstore, he found a complete set of the works of William Shakespeare, and blew the rest of his trip money purchasing it. He had to take a job unloading sacks of Borax detergent for two weeks in order to finance the rest of the drive.

His wife of 61 years, Anita, said he was very brilliant and also very sensitive: "He was such an all-around man." He is also survived by his son, his sister, Ruth Hipshman of San Mateo, and two grandchildren.

Continued on page 30...

IN MEMORIAM

Malcolm S.M. Watts, MD

Dr. Malcolm S.M. Watts, Past President of the San Francisco Medical Society (1961), passed away on June 8, 2006 after a short illness. He was 91 years old and was surrounded by his loving family at the time of his death.

He was born in New York City on April 30, 1905. He attended Trinity School, Harvard College, and Harvard Medical School. While serving in the U.S. Army during World War II, he visited his lab partner from medical school, Dr. Herbert Moffitt, who introduced Dr. Watts to his cousin, Genevieve Moffitt, whom he married after the war.

He embarked on a triple career of private practice, teaching and administration at UCSF, and, community service. At UCSF he was a popular professor of internal medicine, constantly upholding the values of "old-time doctors" and stressing the importance of treating the whole person. He also acted as Assistant Dean and Assistant to the Chancellor. UCSF honored his contributions with the UCSF Medal in 1983.

Dr. Watts was active in the San Francisco Medical Society, the California Medical Association, and the American Medical Association. He was editor of *California Medicine*, eventually expanding it into *Western Regional Journal of Medicine*. He wrote hundreds of editorials. He was also editor of the *Journal of Continuing Education in the Health Professions*. He served on dozens of other committees and boards, both charitable and professional, at the civic, professional, state, and national levels. He also served as president of the American Societies of Internal Medicine.

Some of his proudest achievements in the public realm were assisting in the establishment of the UCSF Medical Center in Fresno, administering the California Area Health Education Centers program (AHEC) for medically underserved areas, helping to establish the San Francisco Consortium, and contributing to all aspects of continuing medical health education. He also advised the U.S. government on health policy. He was always proud that the pub-

licly financed programs he administered never incurred overruns, much to the astonishment of government auditors.

He also greatly enjoyed his memberships at the University Club, the Pacific Union Club, and the Medical Friends of Wine.


In spite of all his professional activities, Dr. Watts was completely devoted to his wife and family, supporting them in the ups and downs of life. He enjoyed relaxing in the Napa Valley with family and friends and traveling around the world. In his eighties, he put a lifetime's experience into an autobiography and philosophical writings for his family. Even at the end, at San Francisco Towers and Hospice by the Bay, he taught about facing death with dignity, openness and his characteristic dry sense of humor.

He was preceded in death by his wife, Genevieve, and his son Malcolm S.M. Watts II. He is survived by his son James Watts, his daughters Pauline Watts and Elizabeth Thompson-Watts, and five grandchildren. He was father-in-law to Mary-Michael Watts, Aldona Watts, Peter Thompson, and the late Charles Trinkaus.

Continued from page 19...

risk for providing lower-quality care. Because of this growing body of evidence, we believe that the real risks to the public safety outweigh any theoretical concerns for individual physicians.

The development of a uniform and validated assessment of health and general competency for all physicians licensed in California who wish to continue actively practicing medicine beyond age 65 or 70 seems to be a reasonable response to this problem. We propose that such a program be created and implemented by the profession and not mandated by legislation. The composition of such a program, as well as the age at which it should be required, should be evidence-based to the extent possible, and should include input of all the stakeholders.

Although the goal is universal competency screening, we acknowledge that such a program would be a "shock" to the culture of our profession in the United States, and there would be many significant and justified concerns about it. For those reasons, we suggest that, at least in its first few years, while it is being studied, the program be voluntary, confidential, and nonpunitive. Over time, such a program would do much to ensure the public safety and enhance the trust that our patients invest in us. 

Reprinted with permission from the California Medical Board's Action News. The content of this article represents the views of the author and should not necessarily be construed as representing the views of the Medical Board or the San Francisco Medical Society.

SFMS Membership Mixer

6:00 to 8:00 Thursday, August 24

Togonon Gallery (www.TogononGallery.com) located at 77 Geary Street, 2nd floor in San Francisco.

This will be a wonderful opportunity for SFMS members to meet and mingle with SFMS leadership and CMA amidst an exciting exhibit of art from Myanmar (formerly Burma) with beverages and hors d'oeuvres, art and collegiality, plus live jazz! New members are especially encouraged to attend. In order for us to get an accurate catering count, we would appreciate an RSVP to Therese Porter, Director of Membership at (415) 561-0850, extension 268 or tporter@sfms.org by August 4th

Good News from the Membership Services Committee

Recently the San Francisco Medical Society's Fellowship and Wellness Committee merged with its Physician Membership Services Committee. The member doctors and staff of this revitalized and newly expanded Membership Services Committee are committed to finding ways to make membership more meaningful and useful for member physicians at all stages of their careers, from medical school through retirement. At the most recent meeting of the committee, many ideas were discussed that address both professional and personal concerns in physicians' lives.

Recruitment of new members, and retention of existing members, require innovative thinking and passionate, directed action. The Committee is at an early stage of developing a program to welcome new members—students, residents and physicians at every career stage—by having existing members reach out and directly communicate to potential new members in a form of sponsorship. The idea is to make physicians feel both welcomed and inspired to participate in the activities of the medical society.

One of the most profound benefits of SFMS membership is collegiality, the opportunity to interact with peers across the spectrum of career stage, specialty, and practice milieu. As a way to foster and enhance this experience, many social events are in the planning stages, including a revival of the SFMS night at the San Francisco Symphony, an outing to a local baseball game, museum and gallery events, and other "mixer"-type events that get members meeting and talking.

The committee is currently facilitating a pilot program of Dr. Linda Clever's RENEW program this summer. RENEW was developed to help physicians regain and sustain their energy, motivation, and enthusiasm through all areas of their lives, and Dr. Clever is eager to develop a program that will speak to SFMS members' specific needs.

Over the next several months, the committee will be discussing and developing ideas with a professional focus, including the production of informational seminars on topics such as practice management, professional development, and the demands

of living and practicing in San Francisco. Items related to physician health and well-being that will be addressed in the months to come may include health club memberships, personal training programs, family-friendly activities, and ways to share the rich history of SFMS with its members and the city at large. —*Therese Porter*

Announcements

Jack Lewin, MD, vice president and chief executive officer for the California Medical Association, has been chosen to act as chief executive officer of the American College of Cardiology starting this fall. Dr. Lewin will remain with the CMA through October and then relocate to the Washington, D.C., area. His first day with the ACC will be Nov. 13, 2006. Congratulations, Dr. Lewin!

Classified Ads

Send **Electronic Claims Using Your Own Software!**

Save time and money! FREE trial offer!

Call Signature Claims toll free (877) 744-2561

Electrolysis—Permanent Hair Removal

Renee Yates, R.E., L.E.

2355 Ocean Avenue

San Francisco, CA 94127 (near Stonestown)

415-333-2444

CET Cancer Center-High Dose Rate Brachytherapy Specialists

25 years of brachytherapy experience, D. Jeffrey Demanes, M.D.

First High Dose Rate (HDR) Brachytherapy only Center Providing Treatment and Care for Prostate, Gynecological, Breast, Head & Neck and Other Localized Tumors. Offering High Quality Care Exceptional Survival and Tumor Control Results

Call (877) 238-1437 or E-mail info@cetmc.com

California Endocurietherapy Medical Corp

3012 Summit St. Suite 2675

Oakland, CA 94609

Phone: (510) 986-0690 Fax: (510) 986-0159

<http://www.cetmc.com/>

Mon-Fri, 8:30AM to 5:00PM

Does it feel like the world is closing in on you?



Let **MIEC** take care of the **malpractice pressures** so you can focus on your practice.

The doctors that formed this company established a business structure and philosophy that means you never have to ask yourself if you are insured with the right company.

- **We have a ZERO profit motive**
- **MIEC is 100% owned and governed by the doctors it insures**
- **31 years of continuous service** to California doctors
- **Claims Expertise.** We have now resolved over 24,000 malpractice claims and lawsuits reported by our policyholders over the past 31 years. Nearly 90% are closed without payment.
- **We carry one of the highest security ratings** of A- {excellent} issued by AM Best's

Next Steps:

For more information or download an application: Go to www.miec.com "Applications & Forms" to download an application or click on "Why MIEC" to better understand our philosophy and structure.

Call us: at 800-227-4527. Ask for Phanelia Hill (phaneliah@miec.com) our California underwriter or Diane Major (dianem@miec.com) / Lauren Kielian (laurenk@miec.com) our Underwriting Managers.