

# SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY

## PUBLIC HEALTH AND SAFETY

Assessing Potential for  
Violence in a Medical  
Setting

*Compounding  
Pharmacies*

Where's the  
Oversight?

Is Our Food  
Safe?

Earthquake  
Safety in the  
Workplace

Elderly Patients  
and Driving

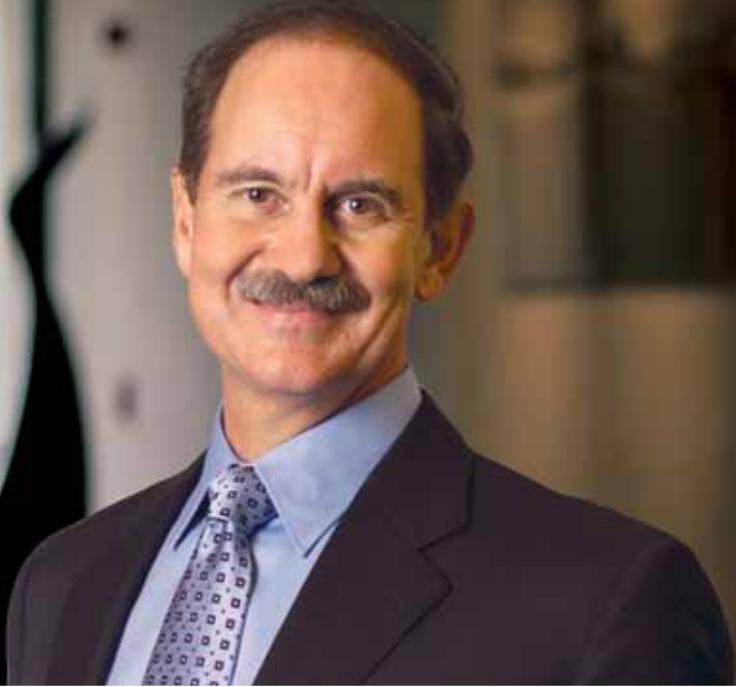
What Is a Physician's Role  
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VOL. 85 NO. 9 November 2012

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# MEMBERSHIP MATTERS

## Activities and Actions of Interest to SFMS Members

### CMA Delegates Set Policy at Annual Meeting



The SFMS delegation, along with more than 500 California physicians, convened in Sacramento for the 2012 CMA House of Delegates in mid-October. The CMA HOD is an annual conference at which all fifty-three California counties, representing all modes of practice, meet to discuss issues related to health care policy, medicine, and patient care, and to elect CMA officers.

The delegation submitted a dozen policy proposals for consideration and all were adopted, albeit some in watered-down form. CMA will now: advocate for a revitalized opioid tracking system, submit the landmark cannabis policy adopted last year to the AMA for national approval, urge more use of POLST forms statewide and of all advance directives for Medicare patients, oppose Big Pharma's delays on medications going to generic form, educate the public regarding risks of cell phone use while driving, and more. For more information please see SFMS President Dr. Peter Curran's reflections on page 9. A full report will be included in next month's issue of *San Francisco Medicine*.

### SFMS Member Receives Silver SPUR Award



Longtime SFMS member and leader Edward Chow, MD, was the recipient of a Silver SPUR Award at an awards luncheon on October 24. The Silver SPUR Awards honor individuals whose goals and achievements exemplify the highest aspirations of San Francisco and the Bay Area.

In selecting Dr. Chow for this prestigious honor, SPUR cited Dr.

Chow's history of service: "Edward A. Chow, MD, is a native San Franciscan who, as an internist for over four decades, has been addressing health needs, access, and disparities, including working with the Chinese Hospital and its physicians to create the Chinese Community Health Plan, the nation's first culturally competent health plan dedicated to the needs of an Asian community. He has served under five mayors on the San Francisco Health Commission, where he advocated for the rebuilding of its two public hospitals and established neighborhood primary care clinics."

SPUR is a preeminent urban planning and public policy organization that promotes good planning and good government in the San Francisco Bay Area. Please join SFMS in congratulating Dr. Chow on this well-deserved award.

### Sacramento Pediatrician Elected as CMA President

Paul R. Phinney, MD, was elected as the 2012–2013 president of the CMA at the House of Delegates in October.

Dr. Phinney, a Sacramento pediatrician at Kaiser Permanente, has been a member of CMA since 1988 and has served in a number of leadership roles. Prior to his post as president-elect, a position he held for the past year, Dr. Phinney was the chair of the CMA Board of Trustees and previously served on the CMA Council on Legislation and on the CMA Political Action Committee (CALPAC) board of directors.

Addressing the group of nearly 1,000 participants, Dr. Phinney challenged his colleagues to lead change rather than succumb to the default future.

"We owe it to the public and to our profession to be leaders in health care reform—to create a better future that we help invent," Dr. Phinney said to the crowd. "We should be aiming to create a future that is patient-centric, physician-driven, high in value and quality, and universally accessible."

### Pledge Your Commitment to Medicine and Renew Your Membership Today

SFMS would like to thank our 1,500-plus members for their support of the local medical society this year. Because of your support and participation in organized medicine, SFMS continues to be the preeminent physician organization championing the case of physicians and their patients as we face the many challenges of these changing times.

Please take a moment to renew your support of SFMS by remitting payment for your 2013 dues today. There are three easy ways to renew your dues again this year:

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Automatic Dues Renewal Plan by contacting SFMS at (415) 561-0850 or membership@sfms.org.

## CMA, AMA, and Others Developing Alternative Medicare Payment System to Replace SGR

CMA and AMA, along with more than 100 state and specialty medical societies, sent a letter to Congress on October 15 outlining the principles and core elements needed to successfully transition from the critically flawed sustainable growth rate (SGR) to a higher-performing Medicare program.

The principles outlined in the letter include the notion that successful delivery reform is essential, that the Medicare program must invest and support physician infrastructure, and that Medicare payment updates should not only reflect the costs of providing services but should also take into consideration efforts to improve quality and manage those costs.

In June of this year, an AMA SGR Task Force began work on a payment system for physicians that would be tied to payment points. While the working draft is confidential, the plan would include payment for things like quality, e-prescribing, adoption of EHR, best practices, chronic disease management, patient-centered medical homes, and outcomes.

## Connect and Communicate with Local Physicians on Your Smartphone

SFMS members with an iPad, iPod Touch, iPhone, and any Android-based phone or tablet receive a free subscription to DocBookMD. DocBookMD is a smartphone platform designed by physicians for physicians, providing a HIPAA-compliant way for physicians to connect, communicate, and collaborate within their local medical community and across the nation. This tool—selected as one of the top fifty iPad apps for physicians—has been embraced by primary care physicians and others seeking quick consults and pharmacy contacts. To enjoy complimentary access to DocBookMD, all you need is your six-digit SFMS/CMA member ID after downloading the app at iTunes or Google Play.

## Network with Colleagues at St. Mary's Medical Center Progressive Dinner

St. Mary's annual Progressive Dinner will take place on November 15, from 5:00 p.m. to 7:30 p.m. The event will highlight the new Women's Health Center imaging services, cardiovascular services, arrhythmia clinic, advanced wound healing and amputation prevention clinic, and the Comprehensive Lung Center. For more information or to RSVP, please contact Lydia Lee at (415) 750-5868 or Lydia.Lee@dignityhealth.org.

## Complimentary Webinars for SFMS Members

CMA offers a number of excellent webinars that are free to SFMS members. Members can register at [www.cmanet.org/events](http://www.cmanet.org/events).

November 8: 2013 Updates to Meaningful Use • 12:15 p.m. to 1:15 p.m.

November 15: Successful Medi-Cal Provider Enrollment • 12:15 p.m. to 1:15 p.m.

November 28: Understanding the CBAS Transition for Dual Eligibles • 12:15 p.m. to 1:15 p.m.

November 29: Essentials for ICD-10-CM: Part 1 • 7:45 a.m. to 8:45 a.m. or 12:15 p.m. to 1:15 p.m.

## November 2012

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## SFMS EXPERTS ANSWER PRACTICE-RELATED QUESTIONS



Get answers to your important practice-related questions with the help of SFMS experts. SFMS's Ask the SFMS feature connects members with SFMS physicians and partners who can answer questions on a wide variety of topics dealing with the practice of medicine, ranging from practice management, patient education, EHR assistance, health policy, and legal/malpractice to financial management and many more!

Each issue of *San Francisco Medicine* features a few commonly asked questions from physicians. For the full archive of questions and answers or to access extensive information and additional resources relating to each topic, please visit our member-only Ask the SFMS section at <http://www.sfms.org/ForPhysicians/AskSFMS.aspx>.

If you would like to submit a question for our experts, please email [info@sfms.org](mailto:info@sfms.org).

### **My claim was denied for timely filing. Do I have any recourse?**

Yes, if the claim involves a fully insured HMO or PPO claim, there are two specific laws that may be helpful. First, check to see that the claims filing deadline imposed by the payor is consistent with the law. Payors can't impose a deadline for receipt of a claim that is less than 90 days for contracted physicians and 180 days for noncontracted physicians (28 C.C.R. section 1300.71(b) and Insurance Code 10133.66(a)). Providers are free to contract for claims filing deadlines outside of the 90-day minimum.

Additionally, if the payor is not the primary payor under coordination of benefits, payors can't impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payor that is less than 90 days from the date of payment or date of contest, denial, or notice from the primary payor (28 C.C.R. section

1300.71(b) & Insurance Code section 10133.66(a)).

If your claim was denied for timely filing, the regulations also require the payor to allow for a "good cause" exception. Thus, physicians may be granted exceptions to the claims filing deadline if they can demonstrate a "good cause" for the delay. Upon the physician's submission of a written provider dispute that demonstrates a good cause for the delay, the payor must accept and adjudicate the claim in accordance with state payment laws (28 C.C.R. section 1300.71(b)(4) & Insurance Code section 10133.66.).

While the regulations fail to define "good cause," the DMHC has stated that they "... shall be the determiner of 'good cause' within the meaning of these regulations."

Physicians should review their managed care contracts to ensure that—if they contain contractually agreed-to deadlines that are less than those set forth above—they are complying with those deadlines. In addition, even where a coordination of benefits (COB) provision is at issue, payors cannot impose shorter deadlines than the law allows. Any violations should be reported to the California Medical Association (CMA) and the regulator.

On the government side, Medicare requires that claims be submitted within 365 days of the date of service, and Medi-Cal requires that claims be submitted within six months following the month in which the services were rendered. Medi-Cal claims submitted in months seven to nine are subject to a 25 percent payment reduction, and those submitted in months ten to twelve are subject to a 50 percent reduction.

*CMA's Center for Economic Services is staffed by practice management experts with a combined experience of more than 125 years in medical practice operations. Its SFMS member reimbursement helpline can be reached at (888) 401-5911 or [economicservices@cmanet.org](mailto:economicservices@cmanet.org).*

## Can I provide treatment for my friends, family members, and colleagues?

Although California law does not specifically prohibit treating oneself or one's family members, American Medical Association policy and the California Medical Board strongly discourage the practice. California law *does* prohibit prescribing or administering controlled substances to oneself.

AMA policy points out that treating a family member may cause the physician to lose objectivity and allow personal feelings to unduly affect his or her professional medical judgment. Patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination if they have a familial or personal relationship with the physician. Physicians may also feel obligated to provide treatment even if they are not comfortable doing so.

Physicians should also be aware that some payors limit their obligation to reimburse physicians who treat themselves or their relatives. Medicare, for example, expressly excludes coverage for treatment of a physician's immediate relatives.

*Melanie Neumeyer is a health law information specialist at the CMA. Contact her at (916) 551-2872 or mneumeyer@cmanet.org.*

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# PRESIDENT'S MESSAGE

Peter J. Curran, MD

## CMA House of Delegates

Waiting for the train to take me back home, I reflect on another policy-packed weekend at the annual California Medical Association House of Delegates meeting in Sacramento. Thoughtful consideration was given to resolutions ranging in scope from addressing the health risks of sitting too much to the implications of expansive workers' compensation reform.

Few delegates go home completely satisfied with the decisions of the House, but—win, lose, or defer—it is an efficient democracy with opportunity to come back and try again next year (the House also decided that redundant resolutions are permissible).

The hot topics this year moved away from physicians' roles regarding cannabis to end-of-life issues related to scope of practice, reimbursement for telemedicine, and the always-interesting public health issues. Your San Francisco delegation was well represented with authored resolutions in many of these areas. Physicians made it clear that, although we support the concept of increased adoption of Physician Orders for Life-Sustaining Treatment (POLST), we want it to continue as a physician-to-patient communication, not an issue to be relegated to physician extenders. Additionally, the resident and young physician section were especially vocal at this year's House; one anxious resident reminded us that unless reimbursement keeps pace with the growth of electronic management of patients (i.e., telemedicine), his generation is in danger of becoming a volunteer health care delivery system. Meanwhile, I was reminded not to drive too fast or while distracted, keep the kids away from open windows, and beware of nanoparticles in my food and Medicare auditors in my office.

This year has largely been a boon year for advocacy at the CMA, with a couple of bumps in the road. The million-plus-dollar PAC at CMA set another record for member donations, with more than \$150,000 given at the House. The CMA continues to strongly support state legislators friendly to medicine. Pediatrician and Assemblyman Dr. Richard Pan (D-Sacramento) is well on his way to winning a second term and is the chair of the Assembly Health Committee. With a trend toward more physicians and fewer attorneys in the State Legislature, and the tireless advocacy of the CMA, the protections afforded by the Medical Injury Compensation Reform Act (MICRA) will continue to be in good standing during the next session. The legislative victories were somewhat dampened by concessions concerning workers' compensation reform in Senate Bill 863, recently signed by the governor. In the future, organized medicine needs advance warning to contest or adequately

amend these bills before they are signed into law. Several scope-of-practice issues are on the legislative horizon next year, and they will require the full attention of the CMA.

There are notable changes in CMA governance and administration. Dr. Paul Phinney, pediatrician from Kaiser Permanente in Sacramento, becomes president, and Jodie Hicks was replaced by Juan Torres as senior lobbyist and vice president of government relations. Early leadership development will be a focus of the San Francisco delegation to the CMA, so that SFMS will continue to be well represented at the state and national levels. Although membership is up at the CMA, only one in five physicians in California is a member of CMA (compared with nearly 90 percent in Texas), nearly sixty percent of members are over the age of sixty, and the practice mode of physicians continues to rapidly move to the "employed very large group" model.

It's fascinating to see how health care policy evolves over the years. Dr. Dexter Louie reminds me how attitudes of organized medicine changed toward patients with HIV/AIDS in the 1980s, much of the progress originating from advocacy efforts of District 8 (SFMS). This year the House recognized that health is negatively impacted without equal access to health care in civil unions regardless of sexual orientation. CMA membership's support for health care reform and the Affordable Care Act moved from 50 to 70 percent in one year. Clearly the House is not ready for the CMA to oppose the death penalty, however. The resolution written by the writer of this column got executed in the Rules Committee.



If you have an idea for a resolution to be addressed at the next CMA House of Delegates in Anaheim, please let your medical society representative know. Or better yet, consider running for a delegate seat yourself. More details of the new policy and other actions from this year's CMA meeting will appear in the December issue of *San Francisco Medicine*.

# SFMS Advocacy Activities

## A PROFESSIONAL VOICE FOR COMMUNITY HEALTH SINCE 1868

The San Francisco Medical Society (SFMS) has been involved in community health issues since 1868. As the only medical association in San Francisco representing the full range of medical specialties and interests, SFMS health advocacy has been broad. Via policy-making efforts with state and national medical and political leaders and an award-winning journal, SFMS has often been influential far beyond the city. The SFMS agenda and activities continue to focus on the community and the following areas of involvement:

- Forming HealthShare Bay Area (see below) to improve patient care and reduce costs
- Working with the physician community to promote the adoption of electronic health records to better serve patients
- Advocating against cuts to Medi-Cal and Medicare reimbursement to provide continued access to care for all San Franciscans
- Preserving the health care safety net and public health programs in times of severe budget cuts
- Supporting antitobacco legislation and San Francisco's law banning the sale of tobacco in pharmacies, and smoking in restaurants and other businesses, and eliminating tax credits for films showing smoking
- Supporting the Healthy San Francisco program and participating in legal defenses to preserve the program, while helping to monitor the program's progress
- Providing physicians for medical consultation for San Francisco schools and for volunteer care at community clinics
- Working on legislation to allow minors, without parental consent, to receive vaccines to prevent STIs; to prevent bans on medical procedures such as circumcision; and more
- Cosponsorship of the Hep B Free program in San Francisco
- Advocacy for improving end-of-life care in the Bay Area via new policies, use of new advance directives (such as POLST), and educational outreach to physicians and patients

## HOW SFMS SERVES THE COMMUNITY

**HEALTHSHARE BAY AREA** Working under the auspices of the SFMS Community Service Foundation and guided by a diverse board of San Francisco and Bay Area health care industry professionals, the SFMS worked to develop HealthShare Bay Area to provide the infrastructure for a unified electronic health record system. The project originally targeted San Francisco but now includes partners from the East Bay. This service allows providers to have access to secure community-wide patient data. It also permits patients to gain a complete view of their medical records, irrespective of where individual records may reside. HSBA will launch in 2012.

**UNIVERSAL ACCESS TO CARE** SFMS leaders have long advocated that every San Franciscan should have access to quality medical care. Recent SFMS participation in this effort has included the Mayor's Health Care Reform Task Force, the San Francisco Health Care Services Master Plan Task Force, and the Mayoral Task Force, which designed the Healthy San Francisco program. SFMS also joined in the lawsuits to preserve that program. SFMS has advo-

cated for community clinics since the founding of the original Haight-Ashbury Free Clinics in the 1960s.

**MEDICAL LIABILITY PROTECTION** The CMA and SFMS were instrumental in passing MICRA, which saves virtually every doctor many thousands of dollars in liability premiums annually and saves hospitals and health systems much more. We have successfully defeated repeated attacks on MICRA by trial lawyers through the years.

**REBUILDING/PRESERVING SAN FRANCISCO GENERAL HOSPITAL** SFMS spokespersons took a lead in advocating for full funding of the seismic rebuild and in advising, as members of the Mayoral committee, where and how that would occur.

**HIV PREVENTION AND TREATMENT** The SFMS was at the center of medical advocacy for solid responses to the AIDS epidemic, being among the first to push for legalized syringe exchange programs, adequate funding, and more.

**SCHOOL AND TEEN HEALTH** SFMS helped establish and staff a citywide school health education and condom program, removed questionable drug education efforts from high schools, worked on improving school nutritional standards, and provides medical consultation to the SFUSD school health service.

**ENVIRONMENTAL HEALTH** SFMS established a nationwide educational network on scientific approaches to environmental factors in human health; has advocated on reducing mercury, lead, and air pollution exposures; and much more.

**REPRODUCTIVE HEALTH AND RIGHTS** SFMS has been a state and national advocate for reproductive health and choice.

**BLOOD SUPPLY** SFMS has long been a partner of the Blood Centers of the Pacific and seeks to help increase donations.

**ORGAN DONATION** SFMS has been a leader in seeking improved donation of organs to decrease waiting lists, via education and new policies regarding consent and incentives for organ donation.

**OPERATION ACCESS** SFMS is a founding sponsor of this local organization providing free surgical services to the uninsured and has provided office space, volunteers, and funds.

**DRUG POLICY** SFMS has been a leader in exploring and advocating new and sound approaches to treating drug abuse, including some of the first policies regarding syringe exchange, medical cannabis, and treatment instead of incarceration.

**MEDICAL ETHICS** SFMS has developed and promulgated forward-looking policies and approaches regarding end-of-life care, patient directives, physician-assisted dying, and other topics of interest to patients, physicians, policy makers, and the general public.

# EDITORIAL

Gordon Fung, MD, PhD

## Public Health and Safety

Public health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. Public health professionals analyze the effect on health of genetics, personal choice, and the environment in order to develop programs that protect the health of your family and community.

Public health professionals try to prevent problems from happening or reoccurring through implementing educational programs, developing policies, administering services, regulating health systems and some health professions, and conducting research, in contrast to clinical professionals, such as doctors and nurses, who focus primarily on treating individuals after they become sick or injured. It is also a field that is concerned with limiting health disparities, and a large part of public health is the fight for health care equity, quality, and accessibility.

The dramatic achievements of public health in the twentieth century have improved our quality of life: an increase in life expectancy, worldwide reduction in infant and child mortality, and the elimination or reduction of many communicable diseases.

The above definition of public health and its impact was taken from the website [www.whatispublichealth.org](http://www.whatispublichealth.org). This was the definition that we used when we were trying to put together this month's theme. Obviously the breadth of topics covered by public health does not allow us to cover all issues, so we decided to focus on important ones with regard to safety, which some of our local leaders have been involved in.

Living in the Bay Area, we have all heard the warnings about upcoming earthquakes. The San Francisco Department of Public Health has expanded its website to include several pages of helpful tips on preparing for the next "Big One." How many of us have actually followed those tips? You would think that residents of San Francisco who lived through the last earthquake, which was pretty frightening and very disruptive, even at that size, would be prepared for the next one, which is projected to be major. But surveys have shown that not many people have prepared themselves adequately. Matt Springer has been on a crusade to get people prepared for the next big quake and has given several presentations in the community, created blogs, and kindly agreed to pass on his advice on securing your workplace and home for the next shaker. He also advises us to remind our patients about earthquake safety when doing a lifestyle check or review of systems.

One of the hottest current issues in public health safety is the safe use of cell phones. Is there a safe use? This is discussed by Devra Davis. Given the rapid growth of cell phones

and the movement away from landlines and pagers to exclusively wireless communications, being an informed consumer is the best way to reduce the risk of harm. Keeping current in the field and knowing what the gaps are will allow us to make better decisions on how we use these convenient and ubiquitous devices.

Another issue facing San Franciscans, with our large and growing elder community, is that of older drivers and public safety. This was recently discussed on NPR. Here, Linda Hill has submitted an article on the topic. Although there are many suggestions about what to do to work with older drivers, there are no mandatory laws that automatically withdraw a driver's license at a certain age. There are encouragements to bring the topic up with the elderly, but how does one do that, and are there resources to help a family member or your patient population? Most important, do you have a plan of action when you suspect one of your patients may be a danger to self and others as a driver? This is an important article to review if you take care of the elderly.

Paul Linde's article helps physicians and other providers assess potential for violence in a medical setting. He begins his article with, "The only predictable thing about human behavior is that it's unpredictable." He takes you through a few cases to illustrate the issue and then gives you the best guidelines for such situations.

One issue that all physicians are involved with is advising patients to eat right, exercise, and comply with the recommended medical regimen. But what happens when "healthy food" or medications are tainted? We usually depend on the FDA to monitor everything we eat or use diagnostically or therapeutically. Is this enough? In this issue, two articles discuss major problems that have recently been in the news: one, the case of the cantaloupe; the other, the rare fungal meningitis being distributed from compounding pharmacies.

Our final article was written by our own Steve Heilig, SFMS director of Public Health, who worked with our delegation to bring a resolution to the California Medical Association on the issue of gun safety. It's definitely worth reading.

As always, we hope you will enjoy this issue. We welcome any comments or suggestions about topics you would like us to cover in more depth.

# EARTHQUAKE SAFETY AT WORK

## An Important Topic to Review with Patients

Matthew L. Springer, PhD



**During routine appointments with patients, you probably ask basic health questions:** “Are you eating right, getting enough exercise, and avoiding cigarette smoke?” Some doctors also ask lifestyle questions that are not exactly medical but still are relevant to public health, such as: “Are you wearing your seat belt? Do you wear a helmet when riding your bike?”

However, I suspect that it is rare or never that questions get asked like, “Is the file cabinet in your office seismically braced?” And sure enough, if you trained in Florida, it may never even cross your mind. But in a seismic hotbed like the San Francisco Bay Area, earthquake safety is a mainstream public health issue, not just at home but at the workplace as well.

Thanks to many public safety campaigns, people are getting used to the idea that they need to take earthquake precautions at home, but translating these concepts to work spaces is harder, because the individual is not as in control of his or her surroundings.

Therefore, it becomes a partnership between the employee and the employer to provide a safe workplace that incorporates earthquake safety principles.

In a way, this is akin to the partnership that enables people to eat healthy food at a work cafeteria. The employee is in

ultimate control of what he/she eats, but the employer makes this easier by offering salads along with hamburgers and fries. Similarly, an employee will find it much easier to not store heavy items on top of a lipless shelf right above their desks if the employer gives them a shelf lip or an alternate location to store the items.

Thus, general wellness discussions with patients can include suggestions to take control of their surroundings at work: Request salads, shady outdoor seating, no-smoking policies, and working space arrangements that are as seismically safe as is reasonable to achieve.

Earthquake safety in the workplace has much in common with earthquake safety in the home. The basic concepts are the same. For example, in the home, you brace tall bookshelves, dressers, water heaters, and perhaps refrigerators to the wall. In an office setting, workers should be bracing file cabinets and other tall or heavy furniture, and in more clinical or industrial/R&D settings, any freezers, incubators, or other heavy or tall equipment should be similarly braced. Tell your patients to look up (and while you’re at it, you look up, too); if everything were to move a foot in some random direction, what would fall on you? The hazards are easy to spot if you already know what to look for at home; the laws of physics are no different at work.

Here’s another example. One staff employee at a UCSF site where I was giving an earthquake-safety talk asked me to look at an office suite and give her my opinion about whether their setup was sufficiently safe. It was a whole suite that

bottlenecked into a small office area through which everyone had to pass to get to the door that led out of the suite. In that small office area, the path to the exit door had large file cabinets against the wall that were not attached to anything, and I noted that if this furniture slid in a quake, it could block or at least impede access to people trying to get out, during or after the quake. If an employer is going to put staff behind a bottleneck, it's wise to ensure that the bottle doesn't get corked in the event of a quake.

Clearly, though, diverse work situations can involve hazards that one would not normally find at home. For instance, the one-week's worth of emergency supplies in your closet at home doesn't help you if you're trapped in your office (highly unlikely) or simply stuck at work with no way to get home and with nonworking credit cards and ATMs (more likely for some people). Having at least a day or two of personal supplies at work is a good idea, and the employer can stock up on supplies in a more official capacity. As an extension, if you wear "impractical footwear" at work, you might want to keep an old, ratty pair of sneakers in the office, just in case getting home involves a lot of walking. Then there is one of my favorite lines from the talks that I give about earthquake safety: You can decide ahead of time what table or other object you will get under during a large quake; but at work, you'd better figure out how many of your coworkers you will have to fight off to be the winner who gets under that one small table in the room!

Earthquake safety in the workplace requires common

sense on the part of both the employee and employer. Clinicians, at least general practitioners, wear an extra hat in this regard. In addition to being employees who should ensure that their own workplace is safe, and frequently being employers who should provide their medical and administrative staff with safe work conditions, they are also the health conscience of their patients and can potentially increase preventive health by urging their patients to take proper earthquake precautions at home *and* at work before having their lunch-time salad.

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# CELL PHONE SAFETY

## The Right to Know about Gray Matters

Devra Lee Davis, PhD, MPH

**Drugs, bike helmets, credit card agreements, cigarettes, air bags, and guns all come with notices regarding safe uses and risks.** Without laws to enforce them, such warnings are basically a form of product defense that allow manufacturers to say, “I told you so” should any problems develop later. But, where warnings are accompanied by enforceable laws, they can fundamentally change behavior. In fact, fewer kids try smoking nowadays as a consequence of what’s been a highly effective shock and awe campaign, including escalating cigarette taxes, massive public educational programs (now slated for cuts), laws that make it illegal to sell tobacco products to those under age eighteen, and warnings slapped directly on packaging.

But what are we to make of the fine-print advisories that come with new cell phones, which are seldom seen and even less frequently heeded? Blackberry’s Torch phone cautions teenagers and pregnant women not to hold the phone next to the lower abdomen. Apple’s iPhone 5 features a Houdini-like warning—now you see it, now you don’t. Printed warnings on thin paper package inserts that advised safe distances for using phones have disappeared.

If you want information about radiation safety and the iPhone, you can read the online product safety notice, which says:

*Radio signals: iPhone uses radio signals to connect to wireless networks. For information about the amount of power used to transmit these signals, and about steps you can take to minimize exposure, see Settings > General > About > Legal > RF Exposure.*

Then, after going through the above five clicks on your phone, the text below pops up:

*iPhone has been tested and meets applicable limits for Radio Frequency (RF) exposure.*

*Specific Absorption Rate (SAR) refers to the rate at which the body absorbs RF energy. SAR limits are 1.6 Watts per Kilogram (over a volume containing a mass of 1 gram of tissue) in countries that follow the United States FCC limit and 2.0 W/Kg (averaged over 10 grams of tissue) in countries that follow the Council of the European Union limit. During testing, iPhone radios are set to their highest transmission levels and placed in positions that simulate use against the head, with no separation, and near the body, with 10 mm separation.*

*To reduce exposure to RF energy, use a hands-free option, such as the built-in speakerphone, the supplied headphones, or other similar accessories. Carry iPhone at least 10 mm away from your body to ensure exposure levels remain at or below the as-tested levels. Cases with metal parts may change the RF performance of the device, including its compliance with RF ex-*



*posure guidelines, in a manner that has not been testified or certified.*

*SAR values for this device are available at: [www.apple.com/legal/rfexposure/iPhone4,1/en/](http://www.apple.com/legal/rfexposure/iPhone4,1/en/)*

Thus ends the advice. But wait, there’s a trick. If, at this point, you have not given up and you click on the above link purporting to be information on SAR values, you get right back to the text two paragraphs above.

What’s missing altogether is this previous statement on the phone that explained that phones carried in the pocket can exceed the FCC exposure guidelines: “Warning: iPhone’s SAR measurement may exceed the FCC exposure guidelines for body-worn operation if positioned less than 15 mm (5/8 inch) from the body (e.g., when carrying iPhone in your pocket).” In fact, commercials for cell phones that fill our airwaves, newspapers, and magazines routinely feature young children happily chatting with their phones held smack up against their developing bodies and brains, and iPads plopped directly over young gonads.

**It may well be legal for companies to sell devices that cannot be used safely in the ways they are advertised, but it is certainly not ethical to do so.**

When it comes to defining the right to know about this public health risk, San Francisco has been at the leading edge. Outgunned and outspent, the city’s legal department has stood its ground on the fundamental right to require phone sellers to tell the truth and inform people about ways to reduce their risks from cell phone radiation. After two years of prolix litigation, the court has agreed with industry: The right to free

speech does not apply to city officials concerned with public health, because this violates industry's free speech by compelling them to disclose the need to use precautions with cell phones before people buy them, rather than allowing this information to be freed from the bowels of the Internet.

In America today, about 20 million children under the age of fourteen have cell phones, and the CDC reported two years ago that one-fifth of all two-year-olds reportedly spend two hours a day in front of a screen. Increasingly, scientists and policy makers in tech-savvy nations like Israel and Finland are concerned that the ways these devices are used imperil the brain. The iPhone plastic baby rattle case protects the phone's glass screen from cracking when dropped or chomped on by babies, but it does not protect the infant's young brain or body from the phone's pulsed digital microwave radiation.

Cell phones have revolutionized the ability to carry out research and promote public health interventions. But there's growing recognition in tech-savvy nations that we need to get smarter about how we use these and other wireless devices. Growing numbers of national authorities, from Israel to France, India, Switzerland, and Russia are making concerted efforts to promote awareness of the need to practice "safe phone."

The proliferation of wireless gadgets overlooks a critical health issue—nonionizing microwave radiation from cell phones at levels that do not induce measurable changes in temperature can change and damage the brain and sperm of experimental animals. A cell phone is a two-way microwave radio with intermittent and destabilizing pulses, unlike microwave ovens that steadily operate at the same frequencies at much greater power. The weak and erratic microwave radiation from cell phones and tablets cannot directly break the bonds that hold molecules together, but it does disrupt DNA, weaken the brain's protective barrier, and release highly reactive and damaging free radicals. A five-year-old's brain, healthy or otherwise, is encased in a thinner skull and contains more fluid than an adult brain. According to studies carried out by industry modelers in Switzerland and France, the bone marrow of a child's head absorbs ten times more radiation than that of an adult, while that of infants and toddlers will absorb even more.

Few parents realize that infant apps such as *One Fish Two Fish*, *Peekaboo Farm*, and *Twinkle Twinkle Little Star* may do much more than amuse and distract babies. The American Academy of Pediatrics cautions that children need more real face-time than screen time; more laps than apps, and the group has written to the FCC supporting the need to revamp standards to recognize the growing use of these devices by infants and toddlers.

Most disconcerting are findings from Nesrin Seyhan, the NATO-supported founding chairman of the Biophysics Department at Gazi University in Ankara, Turkey, whose controlled studies show that prenatally exposed rats and rabbits have fewer brain cells—and those that survive sustain more damage to their brains, livers, reproductive systems, and eyes. Recent reports from Yale University's chief of obstetrics and gynecology, Hugh Taylor, found that prenatal exposure significantly increased hyperactive behavior in offspring and altered brain chemistry. Other research carried out by renowned National Institute of Drug Abuse Director Nora Volkow, MD, PhD,

finds that just fifty minutes of exposure to cell phone radiation in adult males directly alters the production of glucose—the brain's main fuel.

Experimental work completed by American, Australian, Greek, and Turkish teams working with experts in male reproductive health has reported that cell phone-radiation-exposed human sperm die three times faster, swim significantly more poorly, become more deformed, and develop significantly more damage to sperm DNA.

How is this possible? After all, headlines have repeatedly assured us that there's little to worry about, because we do not face an epidemic of brain cancer. Yet. In fact, the brain cancer story remains complex, because the disease has a long latency—up to four decades—and because past uses and users differ radically from current ones. But evidence on dangers to pregnancy and reproduction from cell phone use are mounting. Of course, not all studies find results, but those that do—especially recent efforts at Yale and the Cleveland Clinic—cannot simply be ignored because others do not find similar results.

What can you do to protect yourself from radiation emitted from high-tech gadgets? In fact, industry denial of the hazards is crumbling. Samsung is the number-one producer of cell phones in the world today. Their new Convoy 2 phone comes with this advice: "Your mobile device is not a toy. Do not allow children to play with it because they could hurt themselves and others, damage the device, or make calls that increase your mobile device bill."

"Keep the mobile device and all its parts and accessories out of the reach of small children."

Samsung and the City of San Francisco have the right idea. People have the right to know how to use these remarkable devices as safely as possible. When the court next reviews the case for the right to know in San Francisco, let's hope that the City will be able to prevail in sharing what it has determined with its citizens, whose health remains of direct relevance to public authorities.

### **When it comes to using electronic devices, remember: Distance is your friend.**

- Don't hold a cell phone directly up to your head. Use a headset or speakerphone to talk on the phone, or a nonmetal case that has been independently tested to reduce radiation up to 90 percent.
- Pregnant women should keep cell phones away from their abdomens, and men who wish to become fathers should never keep activated phones in their pockets.
- Don't allow children to play with or use your cell phone. Older children should use a headset or speakerphone when talking on a cell phone.
- Do not text and drive, and use specially adapted antennas for cars to avoid absorbing maximum power as the phone moves from one cell system to another.
- Turn off your wireless router at night to minimize exposure to radiation.
- Eat green vegetables and get a good night's sleep in a dark room to enhance natural repair of DNA that may have been damaged by radiation.

*Continued on page 17...*

# KEEPING OLDER DRIVERS SAFE

## . . . And out of the News

Linda L. Hill, MD, MPH

*Driver, eighty-six, loses license after mistaking the gas pedal for the brake and runs over man in Costco parking lot.*

\*\*\*\*\*

*Seventy-four-year-old driver with health problems plows into an El Cajon Carl's, Jr., killing a man inside.*

\*\*\*\*\*

*CHP Officers spend forty minutes pursuing elderly motorist from Encinitas to University City. Driver did not notice the six squad cars and police helicopter following him the entire way.*

\*\*\*\*\*

*Seventy-five-year-old driver with a bad hip mistook the gas for the brake and drove off a cliff at Cabrillo National Monument, resulting in his death.*

### **On average, men outlive their ability to drive safely by six years, and women by ten years.**

With individuals sixty-five years old and older the fastest-growing demographic in the United States today, the problem of elder driving safety is exploding. By 2020, there will be more than 40 million licensed drivers over the age of sixty-five in the United States. Our challenge is to identify—before tragedies occur—when alternative transportation options should be employed.

The age at which driving becomes unsafe is variable, with many individuals continuing to drive safely into their ninth decade. Older adults have positive driving attributes such as experience, being more likely to follow the laws and less likely to take risks; however, as a group, they have rates of death per distance driven and per population as high as that for teenage boys, due mainly to declining vision, impaired cognitive function, general frailty, and chronic diseases with their associated medications. In addition, in crashes of the same intensity, older adults have three to four times the risk of death as twenty-year-olds due to decreased muscle mass and osteoporosis.

AMA has recognized the role of physicians in identifying which older adults should no longer be driving and has developed guidelines that provide tools and practice management aids, including sample letters, screening tests, management guidelines, and charting aids. The screening tests suggested by AMA are blunt but identify three areas of concern: vision (acuity and fields), frailty (gait speed, range of motion, and strength), and cognition (Trail-Making B and Clock Drawing). The bluntness of these tools stems from the paucity of data linking failure (as a group) on these tests directly to the outcomes of interest: citations, crashes, injuries, and deaths. There is, however, more than sufficient evidence on each of these tests with the relevant outcomes to support their inclusion.

In addition to the seven tests, the screening process should also cover targeted history to include a history of loss of con-



sciousness, seizures, dementia (all reportable to the California Department of Motor Vehicles), medication history to include drugs that interfere with cognition, and especially patient or family concerns about the ability to drive safely. Since driving involves rapid decision making, especially under stressful conditions that cannot be duplicated in the doctor's office, family concerns remain the most effective screen.

For patients who pass all seven screens, management should focus on restricting medications to their lowest necessary doses; on strict avoidance of alcohol while driving; and on counseling on safe driving. Seniors should be retested periodically or with health changes. These screening tests may identify problems associated with temporary or correctable changes in function. In those cases, referral and evaluation, with treatment, may result in enough improvement in function to resume driving.

If the vision or frailty tests are failed, assess whether the diagnosis has been made and whether there is a reversible component. If the deficit is permanent and the patient wishes to continue driving, consultation with an occupational therapist with advanced training in driver assessment may help in deciding whether this is a safe option. Known as certified driving rehabilitation specialists (CDRS), these health professionals can take drivers on the road and provide both safety assessments and rehabilitation of driving skills. Currently, CDRS programs exist at Sharp Memorial and Tri-City hospitals.

The failure of the dementia testing requires further evaluation to confirm the diagnosis and determine the level of dementia. The DMV feels that some individuals with early dementia are able to continue driving safely; however, they want to be aware of these individuals and conduct testing and monitoring. As with patients exhibiting frailty and impaired vision, a CDRS can be helpful in providing guidance for patients with mild dementia.

The DMV mandates reporting of drivers with dementia, a loss of consciousness, or seizures. Reporting can be done through the Confidentiality and Morbidity Report (CMR) form or through the DMV's DS 699: Request for Driver Reexamination. Physicians can also report drivers with other health issues—such as substance abuse, vision deficits, frailty, and medication side-effects—that may potentially impair their driving. Physicians who report are protected from liability by Health and Safety Code 103900. Especially once families have expressed concern, physicians who choose not to report could face potential liability in the event of an accident. Lawsuits by third parties injured in an accident are often not covered by malpractice policies.

Once the DMV has been notified, whether by an emergency department, the treating physician, or law enforcement, a detailed medical questionnaire (Driving Medical Evaluation, or DME) is sent to the patient. Physicians traditionally dread filling out these forms, but irrelevant sections may simply be lined out rather than completed in detail. The legal consensus is that no liability attaches to filling out the DME, unless deliberately and provably false statements are made.

The most helpful questions for the DMV hearing officer are, "In your opinion, does your patient's medical condition affect safe driving?" and, "Do you currently advise against driving?" Physicians may hesitate to answer these questions, but no liability attaches to answering them. Our medical opinion carries great weight, but the ultimate decision and liability rests with the DMV.

Patients may be reluctant to bring driving concerns to their physician's attention. Driving is a sensitive issue for many older adults who depend on driving for independence. Driving cessation in this population has been associated with a three-fold decrease in out-of-home activity and a two-and-a-half-fold increase in depressive symptoms. Thus, ARDDS (age-related driving disorders screening) should be conducted in a supportive environment where options for continued mobility can be given to patients who should no longer be driving.

U.C. San Diego has been training professionals on ARDDS since 2004 through funding from the California Office of Traffic Safety. Our team is a unique partnership of preventive-medicine physicians in the Department of Family and Preventive Medicine, led by Dr. Linda Hill, and trauma surgeons in the Division of Trauma, led by Dr. Raul Coimbra. More than 1,000 patients have been screened for ARDDS in both in- and outpatient settings. We have found both settings to be valuable: Outpatient settings capture the majority of older adults, and primary care physicians are ideally suited to screen and counsel on this issue. Inpatient settings provide access to persons whose health may have suddenly changed and where driving is either temporarily or permanently unsafe. Screening is well accepted, and satisfaction levels are high in both settings.

Addressing driving retirement requires effort on many levels. The availability of alternative transportation methods for older adults is a problem that must be addressed by society through increasing public transportation options. The government has a role through the DMV in helping to identify unsafe drivers during relicensing; however, the health care system must also play a crucial role as physicians screen and identify

patients. Society, older adults, and their families depend on physicians to help them through this transition.

*Linda L. Hill, MD, MPH, and SDCMS-CMA member since 2010, is a professor in the Department of Family and Preventive Medicine at UCSD, director of the UCSD/SDSU General Preventive Medicine Residency, and the director of TREDs (Training, Research, and Education for Driving Safety). Visit [SDCMS.org/publications](http://SDCMS.org/publications) to access this article with references, graphics, and a list of alternative mobility resources.*

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### Cell Phone Safety

*Continued from page 15...*

It's time somebody working for the telecommunications industry told the truth. The way most people use cell phones next to their brains and bodies violates the FCC standards. Manufacturers have an obligation to identify and reduce risks and to design phones that can be safely held next to the body. If they do so, our children and grandchildren will not look back on us in shock at the disconnect between what science tells us about microwave radiation from cell phones and how we use them today, but with gratitude that we took simple steps to protect us all. Stop hiding behind fine print legalese buried on websites and tell people what they have the right to know.

For more information, please view YouTube videos from Dutch National Public Television with English subtitles by Google, <http://www.youtube.com/watch?v=CC-Cpa3TTz4&feature=youtu.be&a>, or my all-hands talk to the National Institute of Environmental Health Sciences at <http://www.youtube.com/watch?v=wNNSztN7wJc&list=UUGOSWG5fR2X9TU3wN5aUgzW&index=1&feature=plcp>. Information about creating school contests and programs to promote cell phone safety awareness can be found along with advice about the need to Practice Safe Phone, written by medical experts: <http://www.environmentalhealthtrust.org/content/downloads>.

*Devra Davis, BS, MA, PhD, MPH, is the president and founder of Environmental Health Trust, a nonprofit research, education, and policy group. Davis is an award-winning scientist who has authored more than 200 publications, edited eleven monographs, and written three popular books, including Disconnect—The Truth about Cell Phone Radiation, What Industry Has Done to Hide It, and How to Protect Your Family (Dutton/Plume, 2011). A former presidential appointee and the founding director of the Board on Environmental Studies and Toxicology of the U.S. National Academy of Sciences, Davis currently works with officials in Italy, Switzerland, Finland, and Israel to advance training and research programs on cell phones and health. She recently received the Lifetime Achievement Award from Green America for her "groundbreaking work" on the link between cell phone radiation and health. A major review of cell phone testing methods by the U.S. Government Accountability Office is calling on the Federal Communications Commission to revamp its fifteen-year-old methods. [http://magazine.jhsph.edu/2012/technology/online\\_extras/alumni\\_dispatches/devra\\_davis/](http://magazine.jhsph.edu/2012/technology/online_extras/alumni_dispatches/devra_davis/)*

# A DANGER TO OTHERS

## Assessing Potential for Violence in a Medical Setting

Paul R. Linde, MD

**The only predictable thing about human behavior is that it's unpredictable.** According to the noted forensic psychiatrist Dr. Robert Simon, in his book *Bad Men Do What Good Men Dream*, "Assessing the risk of violence is a lot like weather forecasting: pretty good for the very immediate future and not so good for the longer term."<sup>1</sup>

But it can also be said that every human being has the capacity to sense danger on the spot, within a framework of seconds.

Take the case of this typical patient brought to San Francisco General Hospital's Psychiatric Emergency Service:

A middle-aged man, handcuffed, is half-dragged, half-walked through the double doors of PES with two police officers. His face and mouth are covered by a spit mask. He screams expletives, directly threatens to dismember a cop, wears layers of shabby clothes, emits an odor of dirty/greasy sweat, and alternately lunges and kicks, first at the officers and then at the psychiatric nurses.

The police officers eventually contain him with indelicate submission holds before staff members set out to restrain and medicate him. One of the officers writes out the 5150, a one-page legal document, checking the box for "danger to others" after summarizing on paper the circumstances of the man's detention.

A person can be involuntarily detained for up to seventy-two hours in a medical or psychiatric facility, according to the State of California's Welfare and Institutions code 5150, if a police officer or mental health professional believes that person to be at high risk of attempting suicide or becoming violent, or if that person is gravely disabled due to a psychiatric disorder.

It takes no special medical or psychiatric training to surmise that the man described above is, in the moment, dangerous and unhinged, if not out-and-out psychotic. Whether he got that way from the injection of methamphetamines or from forgetting to take his antipsychotic medications is an academic point at that juncture.

This article seeks to clarify the kinds of typical violent patients evaluated in PES and to educate community-based physicians with practical measures to both assess and manage the risk of violence.

I've worked as an attending psychiatrist at SFGH for more than twenty years. PES is San Francisco's primary receiving facility for 5150 patients. Officers of the San Francisco Police Department are the most common originators of 5150 holds, though we also accept transfers of patients from other counties or hospitals and from community clinics.

The law governing psychiatric holds is forty-five years

old, written in an era when California's state hospitals held more than 30,000 patients and deinstitutionalization was just beginning. This law, penned in an unlikely alliance of liberal and conservative legislators, was called the Lanterman-Petris-Short (LPS) Act and provided due-process standards for the involuntary commitment of patients.

In a hospital or clinic setting, there are four basic types of potentially violent individuals: intoxicated, paranoid, delirious/demented, and antisocial.

The most common type of violent patient is the intoxicated one. Alcohol, a cheap and legal drug, is also one of the most dangerous in this way. The disinhibition caused by alcohol's adverse effects on a person's ability to control his or her impulses leads to anger and threats of violence. Furthermore, one's executive functions, including personal judgment, are affected. Habitual drinkers, or those mixing alcohol with benzodiazepines and/or opioids, are also at greater risk of being amnesic for events while intoxicated.

The paranoid patient may be the most dangerous in the moment but is also the most acutely treatable with a reduction in stimulation and/or the offering of psychiatric medications. Paranoid patients, whose suspicions often arise in the context of acute episodes of serious psychiatric disorders such as schizophrenia, schizoaffective disorder, severe bipolar disorder, and, certainly, intoxicated states, strike out because they perceive a risk, believe that they are the ones under attack, and feel they must strike out to defend themselves.

The other major problem drugs are stimulants. Methamphetamine, especially if injected, causes psychomotor agitation, often irritability mixed with the euphoria, and, most important, persecutory ideation and hallucinations, both visual and auditory. This paranoia can cause a person to become violent against those perceived as posing a risk. And in states of paranoia, a wide net can be cast.

Once these patients are detoxified, fortunately, the vast majority no longer threaten to commit violence and are often no longer even angry.

Delirious and demented patients are also potentially dangerous, but their violent behavior is often impulsive, poorly organized, and rapidly resolving. The best management of delirious patients involves diagnosing and treating the medical cause of the mental status alteration. The ideal management of demented patients involves keeping their medical conditions well treated; pruning their med list; and reorienting them with respect to person, place, time, and situation. Sometimes low doses of sedatives or antipsychotics may need to be used in this population for short-term management.

The antisocial patients are the most frightening from my

perspective, because they can plan their attack. Their ability to think in an organized fashion is not impacted by a formal thought disorder of schizophrenia or clouded by dementia. They calculate their attack for its greatest effect. And, long term, these may be the most dangerous because they do have the ability to track you down in the community and involve others if their plans demand it.

So what can a community-based physician do if confronted with a potentially violent patient in either a hospital or an office setting? It's important to be aware if a patient has a history of perpetrating violence, as past behavior in this matter does, to some extent, predict future behavior.

But if you remember nothing else from this article, remember this: Trust your gut.

The gut check is an evolutionary holdover from caveman days, arising from your time-trusted limbic system and primitive cortex.

If you have a sick feeling in the pit of your stomach with a patient, it's time to take action: Leave the room if necessary. Call security. Call 911. Call for a stat psychiatric consult. If appropriate, somehow get the person to an ER, PES, or a psychiatric unit for a 5150 evaluation.

But if the threat is directed primarily at you, not exactly imminent, and you're not worried about the person's risk of hurting others in the community, it may be safest to just let the person walk away, given the great chance that they will never return and never contact you again.

Debrief these clinical events with colleagues, both medical and psychiatric. It may not hurt to discuss the situation with your medicolegal risk manager.

And, at least, know about the ability to make a Tarasoff warning.

There are few situations in which a clinician, either medical or psychiatric, can break a patient's confidentiality without consent. However, one is when a clinician learns of a patient's intention to kill another person. The provider is legally allowed to contact the intended victim and the local police department.

This legality was generated by case law, specifically *Tarasoff v. Regents of the University of California*, decided by the California Supreme Court in 1976 after the U.C. Berkeley student counseling service was held liable when it did not

break confidentiality to warn a potential murder victim of a patient's stated threat to kill her. This has been interpreted as a "duty to warn" an intended victim; a later case, adjudicated in 1982, added an additional "duty to protect" an intended victim as well.

If, as a medical provider, you think a situation might warrant a Tarasoff warning, then, of course, you need the involvement of a psychiatrist or other mental health professional.

The bottom line is this: Protect yourself from harm and do your best to protect others. And, when in doubt, get help. But know that no crystal ball exists when it comes to predicting human behavior.

*Paul R. Linde, MD, is an attending psychiatrist at SFGH and clinical professor of psychiatry at UCSF. His latest book is *Danger to Self: On the Front Line with an ER Psychiatrist*, published by the University of California Press in 2010.*

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# THE CASE OF THE CANTALOUPE

## Millions Sickened by Food Certified as Safe

Stephanie Armour, John Lippert, and Michael Smith

**William Beach loved cantaloupe**—so much so that, starting in June last year, he ate it almost every day. By August, the eighty-seven-year-old retired tractor mechanic from Mustang, Oklahoma, was complaining to his family that he was fatigued and feeling pain throughout his body.

On September 1, 2011, Beach got out of bed in the middle of the night, dressed, and walked into the living room. His wife, Monette, found him collapsed on the floor in the morning. At the hospital, blood poured from his mouth and nose.

He died that night, a victim of *Listeria monocytogenes*, a bacterium that can lead to a blood infection and damage to the brain and spinal cord, *Bloomberg Markets* magazine reports in its November issue.

Beach was one of thirty-three people killed by *Listeria* that was later traced by the U.S. Food and Drug Administration and state officials to contaminated cantaloupes from one Colorado farm. It was the deadliest outbreak of food-borne disease in the country in almost 100 years.

“He died in terror and pain,” said his daughter Debbie Frederick.

### For-Profit Inspections

About seven weeks after Beach started eating cantaloupes, a private, for-profit inspection company awarded a top safety rating to Jensen Farms, the Granada, Colorado, grower of his toxic fruit. The approval meant retailers such as Walmart and Wegmans Food Markets, Inc., could sell Jensen melons.

The FDA, a federal agency nominally responsible for overseeing most food safety, had never inspected Jensen.

During the past two decades, the food industry has taken over much of the FDA’s role in ensuring that what Americans eat is safe. The agency can’t come close to vetting its jurisdiction of \$1.2 trillion in annual food sales.

In 2011, the FDA inspected 6 percent of domestic food producers and just 0.4 percent of importers. The FDA has had no rules for how often food producers must be inspected.

The food industry hires for-profit inspection companies—known as third-party auditors—who aren’t required by law to meet any federal standards and have no government supervision. Some of these monitors choose to follow guidelines from trade groups that include ConAgra Foods, Inc.; Kraft Foods, Inc.; and Wal-Mart.

The private inspectors that companies select often check only those areas their clients ask them to review. That means they can miss deadly pathogens lurking in places they never examined.

Food sickens 48 million Americans a year, with 128,000

hospitalized and 3,000 killed, the Centers for Disease Control and Prevention estimates. The rate of infections linked to food-borne *Salmonella*, which causes the most illnesses and deaths, rose 10 percent from 2006 to 2010.

The United States had thirty-seven recalls of fruits and vegetables in 2011, up from two in 2005. Many of the victims of contaminated food are those with underdeveloped or weakened immune systems, such as children and the elderly.

### Cloaked in Secrecy

What for-hire auditors do is cloaked in secrecy; they don’t have to make their findings public. *Bloomberg Markets* obtained four audit reports and three audit certificates through court cases, congressional investigations, and company websites.

Six audits gave sterling marks to the cantaloupe farm, an egg producer, a peanut processor, and a ground-turkey plant—either before or right after they supplied toxic food.

Collectively, these growers and processors were responsible for tainted food that sickened 2,936 people and killed 43 in fifty states.

“The outbreaks we’re seeing are endless,” said Doug Powell, lead author of an August 30, 2012, study on third-party monitors called “Audits and Inspections Are Never Enough.” Powell, a professor of food safety at Kansas State University, said Americans are at risk whenever they go to a supermarket.

“You need to be in a culture that takes food safety seriously,” Powell said. “Right now, what we have is hidden. The third-party auditor stickers and certificates are meaningless.”

*This article originally appeared in the San Francisco Chronicle.*



# COMPOUNDING PHARMACIES

## Where's the Oversight?

David Pittman

**The current fungal meningitis outbreak** has put a spotlight on compounding pharmacies, and regulators and stakeholders say Congress needs to clarify exactly who should regulate these entities.

The practice of compounding, which has been around for decades, was intended to give pharmacies the ability to produce a product under a doctor's orders when a particular drug wasn't available. It can also allow pharmacists to concoct alternative delivery methods, add flavors, or sidestep any inactive ingredients a patient may be allergic to.

The original intent was for the pharmacy to produce one drug for one patient at the request of one physician.

But compounding pharmacies have slowly grown over recent years—even industry trade groups are unsure exactly when that began—and in some cases have started to act like small manufacturers. Companies like the New England Compounding Center (NECC) in Framingham, Massachusetts, ship thousands of vials of product all across the country.

Now industry attorneys, government regulators, and other stakeholders say Congress needs to act to clarify who has authority to regulate such practices. The FDA—despite clamoring for such power before—has had most, if not all, of that authority taken away and it now lies with states, where regulations and oversight vary widely.

In a nutshell, pharmacies, including compounders, are regulated by states; drug manufacturers are overseen by the FDA.

The possible problems that can ensue because of the fuzzy line that separates one group from the other came into sharp focus in the past week when fungus-tainted batches of the steroid methylprednisolone acetate made by NECC sparked the meningitis outbreak that sickened and killed people in numerous states.

"It's a gray area because there's no clear standard as to when the pharmacy crosses the line and looks more like a manufacturer than a compounding pharmacy," said Linda Bentley, a Boston attorney with Mintz Levin who advises manufacturers on FDA regulatory law. "I mean, that's a big hole. The problem is that it's hard to know where the edges are."

### Compounding Oversight

The FDA's role in overseeing compounding pharmacies has been muddled by legislation and court cases over the years, so now it's difficult for even the agency to understand what—if any—authority it has, Joe Cabaleiro, executive director of the standards group the Pharmacy Compounding Accreditation Board, said.

The landmark 1938 Food, Drug, and Cosmetic Act, which

outlines the FDA's authority, doesn't mention compounding.

In 1997's FDA Modernization Act, Congress specifically mentioned compounding, but it exempted compounded drugs from some of the oversight required for licensing of new drugs provided certain conditions were met.

Charles Raubichek, partner at Frommer Lawrence & Haug in New York City and head of the firm's FDA law group, explained that the 1997 changes provided a safe harbor for compounding oversight—as long as a drug's production quantity was limited, it was based on a valid prescription, and was produced with FDA-approved materials.

The part of the law that gave the FDA authority to regulate marketing practices of compounding pharmacies was declared unconstitutional by the Supreme Court in 2002, after one such pharmacy challenged it.

Different circuit courts ruled the entire compounding section of the law unconstitutional, but the Supreme Court kept all but the promotional portion intact. Legal experts point to the case as an example of the complexities courts have introduced, making it difficult for the FDA to apply the law.

In 2009, the FDA was rebuffed by a Colorado district court when the agency tried to exert its authority over a compounder it believed was acting like a manufacturer. The court ruled the FDA never had a definition of compounding.

Until a clearer definition is put in place, experts believe, the line between compounding pharmacy and small manufacturer is unclear.

"FDA evaluates compliance with the exemption on a case-by-case basis," Raubichek said. "Compounding pharmacies try to stay within the safe harbor for the drugs."

In at least the steroid/meningitis case, NECC appears to have been acting like a small manufacturer—operating without FDA oversight—and producing 17,000 vials of the steroid injection. "This appears to be one of those loophole situations because of the back-and-forth that needs to be addressed," Cabaleiro said.

### Growth of Compounding

Compounding pharmacies saw a lot of growth around 2000 when grocery stores and big-box retailers started to build pharmacies in their outlets, said Frances Richmond, PhD, director of the regulatory science program at the University of Southern California in Los Angeles. Smaller neighborhood pharmacies had trouble competing with their \$4 prescriptions.

Those pharmacies needed a way to better compete and saw compounding as an avenue where big retailers couldn't

*Continued on the following page...*

go, she said. Rather than producing one prescription at a time, they could mass-produce certain products and have them ready for orders from hospitals and clinics.

But as compounding grew, state oversight of pharmacies was limited, particularly as the recession shrank states' revenues, Richmond said. The muddled state-federal oversight dynamic and fact that state regulators don't have a grasp of manufacturing regulations also put the states in a bind.

"It really is difficult for them to do the job," Richmond said. "I wouldn't say they've been dropping the ball, but the ball is really slippery."

Raubichek believes the FDA suspected compounding was on the rise in the 1990s when the agency started pushing for more authority, but the attorney doesn't have data to back up his suspicions. "I know the FDA's interest in the area has grown since the late 1990s," he said.

Experts estimate there are nearly 3,000 compounding pharmacies operating today. "The FDA may not even know how many or where they are," Bentley said. "If it's a drug-manufacturing facility, they have to register with the FDA. There's no such requirement for compounding pharmacies."

### **FDA Wants Clarification**

In a conference call with reporters in October, Deb Autor, an FDA deputy commissioner and global regulatory czar, said it's time for regulations to catch up with the modern practice of pharmacies.

"The world has changed a lot since the days of mortar and pestle, and this is the time for pharmacists, for lawmakers, for regulators, and for doctors to sit down to grapple with this new model of pharmacy compounding and come up with a regulatory scheme that appropriately controls the risk," Autor said.

One area that needs clarification, she said, is determining when a pharmacy moves beyond compounding one prescription at a time into small-scale manufacturing. Autor said there is "some legal dispute" about the FDA's authority to look at a pharmacy's records to determine if it's acting like a manufacturer or not.

"In some cases, we are blocked from the threshold determination of the regulatory ability with respect to the compounders," Autor said. "It becomes a bit of a catch-22 in respect to the agency's ability to effectively regulate the pharmacies."

This week isn't the first time the FDA has noted needed action to clarify the federal-state dynamic over compounding oversight. In an October 2003 hearing before the Senate Health, Education, Labor, and Pensions Committee on regulation of compounding pharmacies, then-deputy director of the FDA's drug center, Steven Galston, MD, noted the lack of oversight in some cases.

"Limited state resources and varying standards and regulatory requirements are factors that affect the adequacy of state regulation," Galston said at the time. "In addition, there is variability in commitment to regulate pharmacy com-

pounding among the states."

### **Congress Poised to Step In**

Democrats and Republicans have tried to weigh in on both the FDA's authority and the meningitis outbreak.

The GOP-led House Energy and Commerce Committee has sought a bipartisan briefing from FDA and CDC officials to gather information about the multistate outbreak.

Representatives Rosa DeLauro (D-Conn.), who sits on the subcommittee that oversees the FDA's budget, and Ed Markey (D-Mass.) each said separately this week that they intend to introduce legislation to give the FDA greater authority over compounding pharmacies.

"I believe this outbreak and corresponding recall make clear that strong federal authority is needed over these large-scale compounding pharmacies to ensure that patients receive safe and effective drugs, that we better monitor adverse events associated with these drugs, and that there is a single entity responsible for verifying appropriate marketing and safe drug production," DeLauro wrote in a letter to Health and Human Services Secretary Kathleen Sebelius requesting information about the gaps in regulation of compounding pharmacies.

### **What Needs to Happen**

Industry experts provided their summation of what action is needed to prevent this fall's debacle from repeating itself: Congress needs to act to clarify the FDA's authority of compounding pharmacies, states and the FDA should work more closely together, and industry groups should set and enforce voluntary standards.

Cabaleiro said pharmacies need to return to traditional compounding: one prescription, one patient.

People could argue that the FDA doesn't do a good enough job policing its safe harbor, but that's also a resource issue for the agency, Raubichek said. "Just because there's one safety issue doesn't mean the FDA is not doing its job."

*David Pittman is the Washington correspondent and Michael Smith the North American correspondent for MedPage Today. This article originally appeared on <http://www.medpagetoday.com> and has been reprinted with permission. Copyright MedPage Today, LLC. All Rights Reserved.*

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# CEASE-FIRE

## What to Tell Patients While Waiting for Political Sanity

Steve Heilig, MPH

*A lone gunman opened fire today in (San Francisco, Aurora, Columbine, Virginia Tech, Tucson, Oak Creek . . . ) and shot \_\_\_ innocent people, killing \_\_\_ people and wounding \_\_\_ more." Politicians offered sympathy but no solutions. Survivors were left to grieve without hope of change.*

**So go the news stories each time a mass shooting occurs.** But beyond the headlines lies an ongoing national epidemic: Thirty people are murdered via guns on the average day, adding up to almost 12,000 gun homicides in the each year. In addition, accidental shootings claim many more. Inevitable, or preventable?

That depends on whom you ask. Some people think we should ask physicians. Years ago, the California Academy of Pediatrics asked me (perhaps because I was once a certified "junior marksman"?) to help develop policy and educational materials regarding having guns in the home, so that doctors could best advise parents on the safest practices. About one-third of American homes have guns, and half of those are not locked away, even with kids present. Two-thirds of accidental shooting deaths occur in homes.

Working with pediatricians, we developed some evidence-based advice and published it. We didn't say "Ban guns" but offered seemingly obvious advice, such as, "Keep your guns locked away, unloaded, warn your kids about them," and so on.

The guidelines were widely praised as sensible. But soon I began hearing from gun owners who thought we were anti-American, and worse. One physician told me he needed to draw his gun every time he came to San Francisco! This is a dominant paranoid mentality in the National Rifle Association, judging from its members' public comments and positions—even though violent crime has been declining in most American communities for a long time. Thus, in perhaps the most ironic, or even craziest, development in this realm, politicians in Florida actually passed a law that would have made doctors who followed the guidelines criminals: It would have been illegal to talk about guns with patients. This law was overturned, but it indicates both the power and the extremism of the gun lobby.

In a more perfect world, perhaps we could usefully ban guns. The United Kingdom does, and its homicide rate is about one quarter that of the United States. But that's impossible here, and nobody reasonably proposes it. Still, that's the specter raised by the National Rifle Association, which calls virtually any change in the status quo "gun grabbing." The NRA's motto is "no compromise." Its solution? More guns; members say this will deter crime. But the Harvard Injury Control Research Center's evidence is that the more guns, the higher the homicide rate. The NRA doesn't care for such facts, and to them any form of gun control is a step toward a total ban.

For an illuminating, balanced examination of the protracted gun debate, see *Gunfight: The Battle over the Right to Bear Arms in America* by Adam Winkler, professor of constitutional law at UCLA (my *San Francisco Chronicle* review of this book can be found at [sfgate.com](http://sfgate.com)). Winkler retells key legal battles and examines scandals regarding gun research. Gun control was first proposed to disarm freed slaves and a century later, ironically, flaunted by the Black Panthers, who held that "the gun is the only thing that will free us." He also shows how the NRA evolved from a sporting organization to a powerhouse lobby whose CEO calls federal authorities "a jackbooted group of fascists." Thus in elections, gun issues are rendered another form of "don't ask, don't tell"—even politicians known to favor more gun control are afraid to advocate their beliefs.

Yet Winkler notes that "strong majorities of gun owners favor compromise when it comes to gun control," and he would welcome mandated gun safety courses, background checks, and waiting periods for gun purchases, as well as bans at places such as campuses. He reaches for an optimistic stance, that we can have both a right to weapons and better controls. On such policy issues the American Academy of Pediatrics says this: "We make it too easy for dangerous people to obtain dangerous weapons. There are only a few gun control laws on the books, and even those have loopholes. We should make it harder for convicted felons, the dangerously mentally ill, and youth to get the guns in the first place. We can do this by passing effective laws that make sense"

But such sanity is not coming soon. Thus, until it does, here is what the AAP offers as practical advice:

### **American Academy of Pediatrics: Gun Safety—Keeping Children Safe**

**Research shows guns in homes are a serious risk to families:** A gun kept in the home is forty-three times more likely to kill someone known to the family than to kill someone in self-defense. A gun kept in the home triples the risk of homicide. The risk of suicide is five times more likely if a gun is kept in the home.

**Advice to parents:** The best way to keep your children safe from injury or death from guns is to *never* have a gun in the home. Do not purchase a gun, especially a handgun. Remove all guns present in the home.

Talk to your children about the dangers of guns, and tell them to stay away from guns. Find out if there are guns in the homes where your children play. If so, talk to the adults in the house about the dangers of guns to their families.

**For those who know of the dangers of guns but still keep a gun in the home:** Always keep the gun unloaded and locked up. Lock and store the bullets in a separate place. Make sure to hide the keys to the locked boxes.

# HOSPITAL NEWS



**KAISER**  
Robert Mithun, MD



**SFVAMC**  
Diana Nicoll,  
MD, PhD, MPA



**Saint Francis**  
Patricia Galamba, MD

Although millions of Americans are living with viral hepatitis, many are unaware of their status and are not receiving treatment for their condition. The Institute of Medicine 2010 report, "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C" provides recommendations to help improve disease surveillance, knowledge, and awareness of viral hepatitis among the public and providers; access to vaccination; and delivery of viral hepatitis prevention and care services.

Chronic hepatitis B is of particular importance in the San Francisco Bay Area, where its prevalence is the largest health disparity between Asian-Pacific Islanders (API) and the general United States population. One in ten Asian-Americans is infected with chronic hepatitis B. Asian-Americans make up about one-third of the San Francisco population. In 2007, the Hep B Free model was established, with stakeholders including the API community, health care systems, policy makers, businesses, and the general public in San Francisco.

Since its inception, Kaiser Permanente has played a significant role, providing resources, financial support, and clinical expertise in coming up with clinical guidelines. Our champion, Dr. Lisa Tang, was instrumental in raising clinicians' awareness through a clinician honor roll and a mass media campaign. As chairperson of the National Task Force on Hepatitis B, she also brings a national perspective to this growing public health concern. Leveraging its electronic medical record system, Kaiser Permanente has launched the first-ever comprehensive liver care program that incorporates disease surveillance and chronic disease management.

Additionally, Kaiser Permanente implemented the CDC's recommendations of patient safety and disease prevention. Hepatitis B is a blood-borne virus. We test and vaccinate susceptible health care personnel for hepatitis B. We practice standard (universal) infection control precautions and use safe devices to prevent injuries that confer risk for hepatitis B transmission to patients and providers.

A study titled, "Time to Treatment among Veterans of Conflicts in Iraq and Afghanistan with Psychiatric Diagnoses," published in the October 2012 *Journal of Psychiatric Services*, found that many veterans returning from deployment in Iraq and Afghanistan with mental health problems were not engaged in adequate mental health services in a timely manner.

The authors conducted a retrospective cohort analysis of more than 314,000 medical records of veterans of the conflicts in Iraq and Afghanistan who enrolled in Veterans Affairs (V.A.) health care, had a psychiatric diagnosis, and had used primary or mental health outpatient care between October 2001 and September 2011.

The median time between end of last deployment and initiation of care was about one-and-a-half years for primary care and two years for mental health outpatient care. The median time for engagement in minimally adequate mental health care (eight treatments sessions in a twelve-month period) was four years.

Male veterans delayed longer than female veterans, especially those less than twenty-five years old. Delay was also associated with living far away from V.A. medical facilities and with being in a racial minority group.

Since previous studies have shown that barriers to seeking care include stigma, negative career impact, and military culture, various efforts have been made to reduce these barriers to treatment as early mental health treatment may reduce chronicity. Efforts are being made in the military to destigmatize posttraumatic stress. Care models have been set up in V.A. clinics to integrate primary care and mental health care, and telemental health can be useful for veterans living at a distance from V.A. clinics.

The authors of the paper were Shira Manguen, PhD; Erin Madden; Beth Cohen, MD; Daniel Bertenthal; and Karen Hope Seal, MD, MPH; all of San Francisco V.A. Medical Center.

In honoring the theme of this issue, I consulted with Dr. Mel Blaustein, medical director of Psychiatry Services, and Karen Wells, RN, clinical director of Behavioral Health Services, to fully understand the vital work we do in our inpatient (closed) psychiatric unit. Saint Francis has one of several psychiatry units in the city, with twenty-four beds and a capacity to grow up to thirty-six beds. Because of our location and the fact that our emergency room is the second highest in activity to San Francisco General Hospital, we treat a large number of 5150s. Many of our patients present with depression, multiple substance abuse issues, psychotic and suicidal behavior; a high recidivism rate, as well as a history of multiple incarcerations. This process of admission requires an application for a seventy-two-hour detention for evaluation and treatment of a mental disorder based on danger to self and/or danger to others and/or grave disability. Absent of a mental illness, danger to others does not include isolated criminal behavior and/or threats. A 5150 may only be written by those approved by the County Board of Supervisors, emergency room physicians, psychiatrists, or the police department.

Some patients are held for longer than seventy-two hours if the psychiatrist states that the patient requires continued treatment and the patient is unwilling or unable to sign in voluntarily through a 5250 (fourteen-day certification). A patient has two opportunities to contest the fourteen-day certification. The first is a Certification Review Hearing (CRH) held on the Behavioral Health Unit. If the patient is not released at the CRH, they may file a writ of habeas corpus and appear before a Superior Court judge at Superior Court.

Our Behavioral Health Unit sees many homeless, indigent, and underserved patients. Dignity Health's vision to work with the underserved is truly fulfilled on a daily basis in our Behavioral Health Unit. Saint Francis and the physicians and caregivers in the Behavioral Health Unit are proud of their commitment to and role in providing these services for the San Francisco community.



St. Mary's  
Francis Charlton,  
MD

Prevention has become a major focus in health care. Most of what we do in primary care is aimed at preventing expected complications related to our patients' genetics or behavior and lifestyle. Blood pressure regulation; lipid management; diabetes control; weight reduction; dietary restrictions for gout, celiac disease, and lactose intolerance are concerns that we deal with many times every day.

Of course, the best treatment for all infectious diseases is to prevent them in the first place. Hand washing, vaccinations, and barrier precautions of myriad types all represent the first lines of defense against the spread of infections.

Cancer screening has grown increasingly sophisticated. Pap smears, colonoscopies, low-dose chest CT scans, mammograms, and the ever-controversial PSA testing are among the more common cancer-prevention/early-detection modalities that have gained widespread recognition and use to save lives.

Cardiovascular risk assessment is perhaps the most sophisticated of all of the areas in which we try to minimize patient risk. LDL cholesterol, BP, and glucose targets have been set for various at-risk groups. Noninvasive vascular studies such as ultrasound, stress echocardiogram, and ultrafast CT identify patients likely to benefit from surgical, radiologic, or cardiac intervention.

Bone density testing enables us to treat many prior to fracture occurrence. As our population ages and these screening tests achieve greater use, this last-named risk, that of fractures, takes on added significance. We are staying healthier longer, to the point that falls and injuries are ever more likely to affect our lifespans. We must direct more of our attention to falls prevention by identifying those at risk and prophylactically addressing their pathology. National Falls Prevention Awareness Day is observed annually on the first day of fall (9/22/12). Google *Falls Prevention Awareness Day* to learn more about what you can do to make this a safer world.



CPMC  
Michael Rokeach,  
MD

Two scientists at California Pacific Medical Center Research Institute (CPMCRI) are receiving media attention for the progress they're making in finding a nontoxic means of reducing metastasis in certain breast and other cancers. A nonpsychotropic compound in cannabis has been found to inhibit the activity of a gene responsible for metastasis in aggressive types of breast cancer—in particular those whose only possible treatment involves chemotherapy. The story is many years in the making and involves two discoveries, the first by Pierre Desprez, PhD, and the second by Sean McAllister, PhD. Id-1, a gene first identified in 1991 and known to be a key player in embryonic development, was determined by Dr. Desprez to also be a culprit in the metastasis of certain types of breast and other cancers. Our researchers also discovered that Id-2, a gene related to Id-1, had a completely inverse role in breast cancer, i.e., it had an antimetastatic function. Cannabidiol (CBD), a compound found in cannabis, was shown by Dr. McAllister to inhibit ("down-regulate") Id-1 in human breast cancer cells both in culture and in animal studies—meaning that CBD has stopped Id-1 from causing metastasis. Moreover, CBD has been found to increase the activity of Id-2 (the "good gene") in the same human breast cancer cells.

The researchers' current work shows that CBD appears to have the same effect in other types of cancer as well; publication of a new study on this work is forthcoming. Pre-clinical (animal) studies are continuing, with the goal of beginning clinical (human) trials as soon as possible. This research promises to offer a safe alternative to chemotherapy that would have fewer side effects with possibly equal, if not better, results. Importantly, the research thus far has shown the most promise for those aggressive breast cancers that do not have receptors for hormones and thus do not respond to therapies such as Tamoxifen or Herceptin.



UCSF  
Michael Gropper,  
MD

When Rochelle Dicker, MD, was a UCSF intern, she cared for a sixteen-year-old who had been shot as a result of gang violence. He was eventually discharged, but he returned to the emergency room a few weeks later after he was shot again. Now a trauma surgeon at San Francisco General Hospital, Dicker founded the Wraparound Project in 2006. One of the nation's first hospital-based violence-prevention programs, it seeks to close the revolving door of violent injury by seizing the "teachable moment" that many patients experience in the hospital. The Wraparound Project has a team of three culturally competent case managers who grew up in the same communities as their clients. They establish trusting relationships with patients at the bedside, where they conduct an initial needs assessment. They often start to break the cycle of violence in the SFGH parking lot, by talking with friends and relatives of the victim who might otherwise plan retaliation. After a patient is discharged, the case managers may make home visits; assist with court advocacy; and help participants find employment, transfer to safer schools, and connect with mental health services. Case managers can even arrange for youth to remove gang-related tattoos. Recently, SFGH launched the Empowerment Center, a leadership academy designed to help selected Wraparound Project graduates build skills and become agents of positive change in their communities. By helping clients access community risk-reduction resources, the project has cut reinjury rates from 16 percent to 4 percent. The program also saves money, since the average cost of caring for one youth victim of interpersonal violence is nearly \$50,000, and more than 80 percent of victims are either uninsured or on public insurance programs such as Medi-Cal. Dicker receives frequent inquiries from other hospitals across North America and has helped many trauma centers start similar programs. She and colleagues at other hospitals are advocating for national policy changes that would make such programs the standard of care at all Level I trauma centers with high rates of violent injury. For more information, visit [violenceprevention.surgery.ucsf.edu](http://violenceprevention.surgery.ucsf.edu).

**The Black Plague was a major pestilence in the 14th century.**



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\* Institute of Medicine. "To err is human: building a safer health system." Washington, DC: National Academy Press; 2000

# SFMS ANNUAL CAREER FAIR

The third annual SFMS Career Fair enjoyed a great turnout. Residents and fellows from the four San Francisco-based residency programs connected with recruiters from twenty exhibiting organizations representing a variety of practice types and settings based in San Francisco Bay Area. Many residents felt this was a wonderful opportunity to become acquainted with local practice position opportunities and choices available in their specialty, and connect with small clinics and groups that may have been overshadowed by regional or national job search events. One event attendee commented, "Thank you for organizing an event that showcases the Bay Area's local community clinics. This event is unlike any other because of the emphasis on San Francisco Bay Area job opportunities."

For those that missed the career fair, SFMS will be publishing a list of available positions and recruiter contact information in a special November job search eNewsletter to SFMS members. SFMS is already planning for next year's event, tentatively scheduled for October 2012.

SFMS would like to thank St. Mary's Medical Center and Dignity Health Foundation for providing the venue for this event. We would also like to recognize our participating exhibitors, Lydia Lee of St. Mary's Medical Center, Dr. Toni Brayer of Sutter Health, and the staff at the graduate medical departments of CPMC, UCSF, St. Mary's, and Kaiser Permanente for their generosity and support.

## 2012 Exhibitors

**Alta Bates Summit Medical Center & Sutter East Bay Medical Foundation**  
**Asian Health Services**  
**California Pacific Medical Center**  
**Chinese Hospital**  
**Dignity Health Medical Foundation**  
**Golden Gate Endocrine Specialists**  
**HealthRight 360: Haight Ashbury Free Clinics**  
**Walden House**  
**Kaiser Permanente**  
**John Muir Health**  
**La Clinica de La Raza**  
**Marin General Hospital**  
**Mission Neighborhood Health Clinic**  
**My Doctor Medical Group**  
**NorthEast Medical Services**  
**One Medical Group**  
**Pacific Family Practice - After Hours Care**  
**Palo Alto Medical Foundation**  
**Saint Francis Memorial Hospital**  
**SF Women's Healthcare Inc.**  
**Sutter Health Sacramento Sierra Region**



# NATIONAL COPD AWARENESS MONTH

## A Note from the CMA Foundation about November

Known by many names, COPD (chronic obstructive pulmonary disease) is a serious lung disease that is now the third leading cause of death in the United States. It is one of the nation's largest health care concerns and is severely underdiagnosed and undertreated, according to the COPD Foundation. More than 12 million people are currently diagnosed with COPD, and it's estimated that another 12 million may have COPD but don't realize it. According to the Centers for Disease Control (CDC), in 2005, COPD caused an estimated 126,005 U.S. deaths in people older than twenty-five years of age.

Prevention of COPD begins with reducing or eliminating smoking initiation among teens and young adults and encouraging cessation among current smokers. Approximately 75 percent of COPD cases are attributed to cigarette smoking. You can take an active role in talking to your patients about smoking cessation and provide them with resources to help them. Refer them to the California Smokers' Helpline website at <http://www.nobutts.org/Information/p.shtml>, or they can call (800) NO-BUTTS, where a live person will counsel them on cessation options.

Although tobacco use is a key factor in the development and progression of COPD, other factors also play a role, including asthma, exposure to air pollutants in the home and workplace, genetic factors, and respiratory infections. Occupational exposures include chemical fumes, gases, vapors, and dust. If your patient works around these types of lung irritants, suggest that he or she talk to the supervisor about the best means of protection, such as wearing a mask.

A simple spirometry test can be used to measure pulmonary function and detect COPD in current and former smokers aged forty-five years and older and in anyone with breathing problems due to environmental exposure to smoke or occupational pollutants.

By taking steps now and talking with your patients about smoking cessation, treatment options, and symptoms such as coughing or wheezing, you can help them reduce the effects of COPD, and many symptoms can be treated with medications. If your patients have respiratory infections, they should be treated with antibiotics, but only in appropriate cases. Antibiotics are not recommended except for use in the treatment of bacterial infections.

### Resources

For more information, go to the CMA Foundation website at <http://www.aware.md/PatientsAndConsumers/EdMaterials.aspx>.

The COPD Foundation has a handy pocket guide for diagnosing and managing COPD, available at <http://www.copdfoundation.org/Resources/EducationalMaterials/COPDPocketConsultantGuide.aspx>.

The CDC website lists estimated COPD prevalence by industry at <http://www2a.cdc.gov/drds/WorldReportData/FigureTableDetails.asp?FigureTableID=950&GroupRefNumber=T10-03>.

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# SAVE THE DATE: SAN FRANCISCO MEDICAL SOCIETY ANNUAL DINNER JANUARY 31, 2013

Reception 6:30 PM | Dinner and program 7:30 PM | Concordia-Argonaut | 1142 Van Ness Avenue

Shannon Udovic-Constant, MD, will be installed as 2013 President. Special Guest Speaker: Catherine R. Lucey, MD, Professor of Medicine/Vice Dean for Education - UCSF School of Medicine

**Black Tie Optional**

Invitations will be mailed at the end of December

**RSVP Required**

# SAN FRANCISCO POLST COALITION

## Mainstreaming Palliative and End-of-Life Care

Jeffrey Newman, MD, MPH, and Steve Heilig, MPH

*“When it came time for my family to discuss end-of-life care issues for my father, the POLST framework was invaluable. It greatly facilitated early and useful dialogue and allowed us to come to a very comfortable consensus despite a longstanding history of disagreement over his earlier long-term care issues.”*—Keith Loring, MD, FACEP, emergency physician and SFMS board member

**There is an ever-increasing focus on health care provided toward of the end of life, for multiple reasons.** For one thing, there is growing awareness that end-of-life care has often fallen short of what is desirable and possible, and thus the growth of palliative care, new models of long-term care, and so on. A generation of baby boomers are bringing their high expectations for self-determination into their later years. New policies will force attention to cost issues as reimbursement becomes more tied to quality and use standards.

The modern medical ethics movement can be seen at least in part as a “patient empowerment” trend, and one way this has been codified into practice is through the use of various advance directives used to document patient preferences for care. The documents have been available for decades, but still only a minority of patients completes them. And it must be admitted that more forms are not a panacea—but they can help immensely when patients might no longer be able to tell clinicians what they desire.

The SFMS and some key partners have been working with grants from the Metta Fund and the California HealthCare Foundation to support a number of activities increasing conversations among patients with advanced illness, their physicians, and other health care professionals. Advanced directives and POLST documents are more widely used in nursing homes, hospitals, and ambulatory care. Again, however, most patients in the “last chapter” (operationally defined as life expectancy of less than a year) still do not take advantage of these opportunities. A recent survey of EOL attitudes and practices among California adults reveals that while 82 percent believe that it is important to have wishes in writing, only 23 percent have done this; 47 percent would like to have “the conversation” with their physician (61 percent of those over 65); and 70 percent would like to die at home, but this occurred in only 32 percent of deaths in 2009.<sup>1</sup>

Another recent study of POLST implementation among nursing homes in California indicates that POLST use has become common, especially in areas served by a POLST Coalition, as in San Francisco. We and other coalitions have assessed the POLST process in nursing homes and offered suggestions for quality improvement.<sup>2</sup>

Steven Pantilat, MD, a leading figure in palliative medicine at UCSF, has offered the following practical suggestions to in-

crease availability and access to palliative care: Establish organized programs at all hospitals, open access to hospice without giving up advanced illness management, expand the supply of physician and nurse specialists, educate all clinicians in basic palliative care, and educate the public through a marketing campaign.<sup>3</sup> Widespread programs to reduce hospital readmissions should also focus on advanced illness and EOL issues that underlie many of these cases. The San Francisco Department of Aging and Adult Services (DAAS) has been awarded a Medicare Community-Based Care Transitions Program (CCTP) contract to provide services through a hospital-to-home transitional care model focused on lowering hospital readmissions. This collaborative model includes DAAS, nine additional community-based organizations, and eight hospitals in San Francisco County. Services include coaching, care coordination, and a support services package of meals, homecare, and transportation. We are exploring opportunities to incorporate assessment of needs for palliative and EOL services and referral.

Among the many ways San Francisco physicians can support this and other hospital readmission efforts is to provide early follow-up appointments for patients after hospitalization—and, when appropriate, initiate referrals to palliative care, advanced illness management, and hospice. And whenever appropriate, consider using a POLST form with your patients—for the third time in this journal, the actual form is included here for your convenience. Your patients, their families, and some of your colleagues will be grateful.

*Dr. Jeff Newman is director of the Sutter Health Institute for Research and Education, adjunct professor at UCSF, and a former SFMS board member. Steve Heilig is on the staff of the San Francisco Medical Society and is coeditor of the Cambridge Quarterly of Healthcare Ethics. References are available online at <http://bit.ly/TVzsKd>. For more information and the POLST forms, see <http://www.capolst.org>*

### Postscript

At last month’s annual CMA meeting, the following new statewide policy was adopted:

### INCREASING UTILIZATION OF POLST ORDERS

Authors: Jeffrey Newman, MD; Leslie Lopato MD; Adam Schickelanz, MD. *That to increase and improve use of Physicians Orders for Life-Sustaining Treatment (POLST), CMA encourage physicians to become educated about all aspects of the POLST form and to integrate discussions about, and utilize, POLST in all appropriate instances where medical services are provided to patients at the end of life.*

# IN MEMORIAM

## Damian Augustyn, MD

Dr. Damian Augustyn died peacefully on October 3, 2012, at the age of 60. The beloved son of Joseph Augustyn and Laura Urban Augustyn, Damian is survived by his children Catherine Elizabeth (27) and Damian Alexander (24), his sister Francene Augustyn Newbury (Michael), brother Stephen Augustyn, nephews Joseph and Michael Augustyn, and his mother. Damian was married for thirty-five years to his beloved wife and best friend Dr. Caroline Craig Augustyn, who died in May. Dr. Augustyn specialized in internal medicine and gastroenterology in San Francisco. A graduate of Stanford University and Harvard Medical School, he completed his training at the University of Colorado and UCSF Medical Centers. Dr. Augustyn distinguished himself as a leader in his field for thirty years at California Pacific Medical Center (CPMC), both in the medical community and as a clinician in private practice. He was respected for the compassion, sensitivity, and dedication he showed to his patients and was heralded by his peers for his knowledge, clinical skills, and consulting expertise. He was chief of Gastroenterology and Hepatology at CPMC for ten years be-

fore becoming chief of the medical staff and a member of the medical executive committee and board of directors. He served as managing partner of Pacific Internal Medicine Associates, as a member of the boards of directors of the San Francisco Endoscopy Center, Sutter West Bay Hospitals, and Anthem-Wellpoint-Blue Cross Insurance Company, and as chief financial officer and treasurer of a medical malpractice insurance company. In addition, he was recognized as a leading clinician by the American Gastroenterological Association (AGA) and proudly served as the organization's chief financial officer, treasurer-secretary, and member of the board of governors and executive committee. Dr. Augustyn was a role model for practitioners throughout his career and was committed to education, serving as associate clinical professor of medicine at UCSF School of Medicine. He was well respected and admired by his colleagues for his wisdom, judgment, and fairness. He was committed to providing love, support, and guidance to his family, friends, and patients and will be remembered for the concern and care he gave to all.

# WELCOME NEW SFMS MEMBERS

SFMS is pleased to welcome the following physicians to membership in the Medical Society. With your membership, you will join more than 1,500 members championing the cause of San Francisco physicians and their patients.

**Russell Eugene Ching, MD** | Cardiovascular Disease  
**Edward Miranda, MD** | Plastic Surgery  
**Poornima Kaul, MD** | Obstetrics and Gynecology  
**Ahmed S H Alkoraishi, MD** | Colon and Rectal Surgery  
**Maria Niloofer Ansari, MD** | Cardiovascular Disease  
**Michelle Sharon Barry, MD** | Diagnostic Radiology  
**Wayne Harris Bellows, MD** | Anesthesiology  
**Susan Nicole Brim, MD** | Emergency Medicine  
**Brian Scott Cain, MD** | General Surgery  
**Gregory Stewart Chang, MD** | Anesthesiology  
**Sarah Catherine Cherny, MD** | Pathology  
**Elizabeth Ruth Dawes, MD** | Psychiatry  
**Lewis Stanley Deen, MD** | Psychiatry  
**Elysia Marie Engelage, MD** | Internal Medicine  
**Junming Fang, MD** | Pathology  
**Allan Eugene Fisch, MD** | Diagnostic Radiology  
**Ginny Fong, MD** | Obstetrics and Gynecology  
**Tara Lynn Greenhow, MD** | Pediatrics  
**Scott Anthony Guyon, MD** | Emergency Medicine  
**Anas Hana, MD** | Internal Medicine  
**Yao Ying Heng, MD** | Gastroenterology  
**Ian Patrick Hoffman, MD** | Family Medicine  
**Ivan Huang, MD** | Obstetrics and Gynecology  
**Mylinh Dang Huynh, MD** | Diagnostic Radiology  
**Molly Bowen James-Myers, MD** | Psychiatry  
**Laura Allyson Jernigan, MD** | Pediatrics  
**John Luther Jones, MD** | Thoracic Surgery

**Rakesh P Jotwani, MD** | Hospitalist  
**Monica Elise Kendrick, MD** | Obstetrics and Gynecology  
**Gordon Kahang Lai, MD** | Diagnostic Radiology  
**Linh My Lam, MD** | Anesthesiology  
**Thoby James Lawrence, MD** | Internal Medicine  
**Alan Huy Le, MD** | Internal Medicine  
**Melody Yeming Ng Lee, MD** | Family Medicine  
**Gordon Kent Leung, MD** | Cardiovascular Disease  
**Yulan Liao, MD** | Psychiatry  
**Christina Khine Lim, MD** | Anesthesiology  
**Amy Ying-Ju Lin, MD** | Medical Oncology  
**Edmond L Liu, MD** | Family Medicine  
**Raymond Liu, MD** | Hematology  
**Joseph Everett Long, MD** | Internal Medicine  
**Lissette Lopez, MD** | Family Medicine  
**Kenneth Neal Mahrer, MD** | Cardiovascular Disease  
**Sarah Maria Mandel, MD** | Obstetrics and Gynecology  
**Jacqueline Felice Marcus, MD** | Neurology  
**Scott Allen Mayfield, MD** | Anesthesiology  
**Sharon Suzanne McDaniel, MD** | Neurology  
**Edward John McNulty, MD** | Cardiovascular Disease  
**Roberto Duran Mendez, MD** | Orthopaedic Surgery  
**Jonathan L Miller, MD** | Orthopaedic Surgery  
**Kenny Yeukhon Mok, MD** | Internal Medicine  
**Irene Moy, MD** | Obstetrics and Gynecology  
**Craig Anthony Munroe, MD** | Gastroenterology  
**Wayne Lamont Pack, Jr., MD** | Ophthalmology

**Catherine Bethan Powell, MD** | Obstetrics and Gynecology  
**John Kenneth Quatannens, MD** | Internal Medicine  
**William Jay Raskoff, MD** | Cardiovascular Disease  
**Lissa K Rechten, MD** | Child and Adolescent Psychiatry  
**Edward Jay Rich, MD** | Pediatric Gastroenterology  
**Mark Francis Robb, MD** | Internal Medicine  
**Monique Danielle Schaulis, MD** | Emergency Medicine  
**Christopher Ludwig Schiessl, MD** | Internal Medicine  
**Michael W Sdao, MD** | General Practice  
**Kamaljit Sran, MD** | Internal Medicine  
**Eric J Suba, MD** | Pathology  
**John C Sun, MD** | Gastroenterology  
**Stephanie Marie Terry, MD** | Obstetrics and Gynecology  
**Amy Susan Tezza, MD** | Internal Medicine  
**Michelle Mai-Trang Trinh, MD** | Diagnostic Radiology  
**Michael Robert Tyndall, MD** | Pediatric Cardiology  
**Yinn Shin Tzeng, MD** | Obstetrics and Gynecology  
**Graham A. Walker, MD** | Emergency Medicine  
**Justin Yixiong Wang, MD** | Internal Medicine  
**Erica Fran Weiss, MD** | Obstetrics and Gynecology  
**Irene Pui Lai Wong, MD** | Pediatrics  
**Osvaldo Junito Yano, MD** | Vascular Surgery  
**Irene Yeh, MD** | Psychiatry  
**Jonathan Gordon Zaroff, MD** | Internal Medicine  
**Xiaoyan Zhang, MD** | Ophthalmology



# Take a closer look at your dental plan

**It's Open Enrollment** time for the San Francisco Medical Society sponsored Group Dental program. This plan is designed to help you, your family and your employees minimize the out-of-pocket expense of regular dental care.

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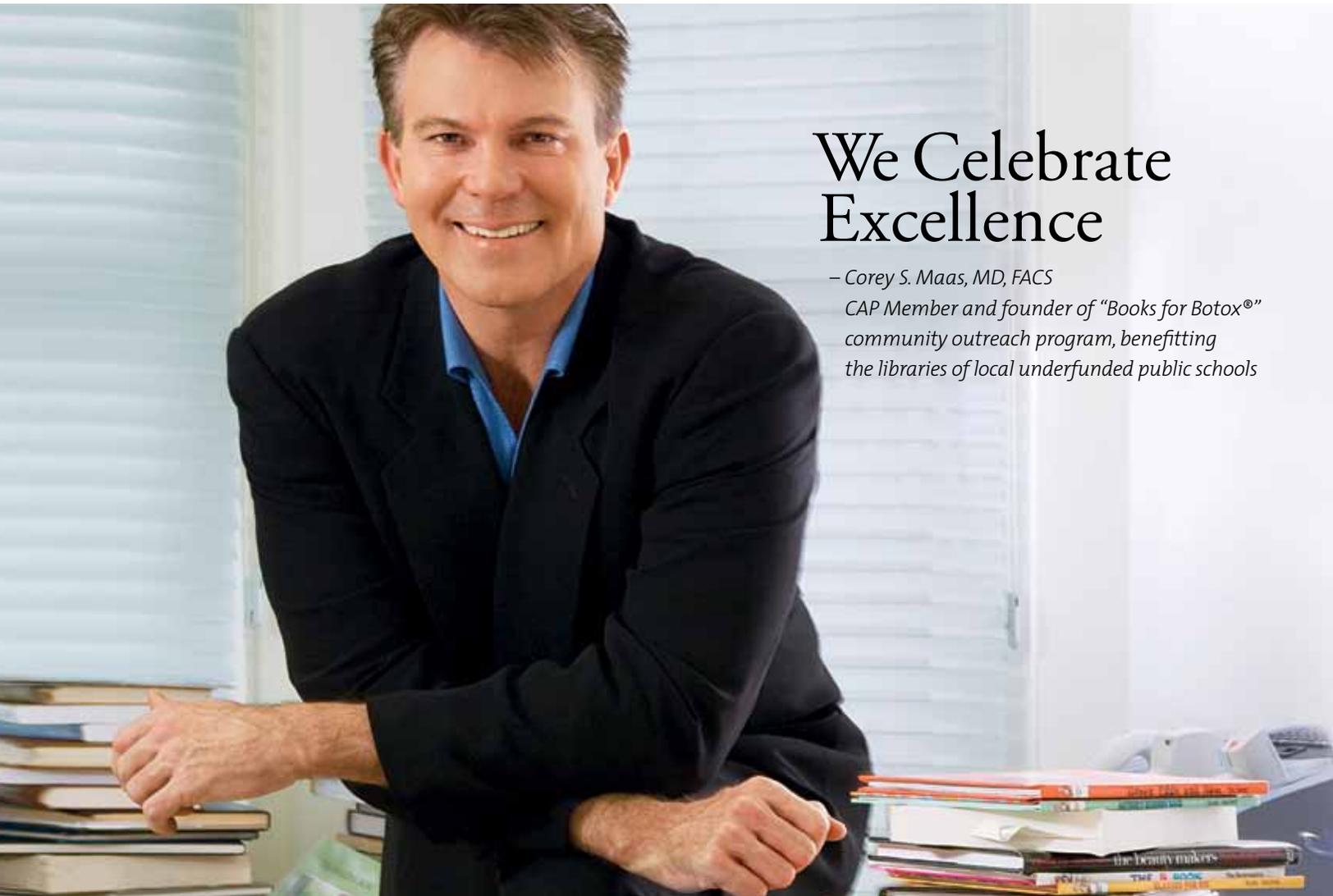


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