Healthcare Journal
NEWS AND BUSINESS OF HEALTHCARE
OF NORTHERN CALIFORNIA

Vol. 3 No. 5 | www.hcjnc.com | September/October 2009 ❙ $6.00

The budget cut catastrophe

Local health care organizations take drastic measures to deliver services, survive amid $2.7B in cuts to health care

By Laura Scholes

You don't have to look very far to see the effects of our economic crisis. Foreclosure signs on the next block. A smaller-than-usual balance on your ATM receipt. Fewer dinners out. And in California, there's an even more ominous indicator: signs on health facilities and programs around the region reading, "Sorry, we're closed."

Though everyone knew budget cuts were coming, many facilities were thrown for a loop when all the wrangling in Sacramento came to an end. And while the largest of the cuts came from education ($9 billion), health care cuts came in second: $2.7 billion. To add insult to injury, a fair percentage of these cuts mean state health care programs are losing federal $2 to $1 matching dollars as well.

"It's devastating," said Barbara McCullough, Ph.D., executive director of Brighter Beginnings, a nonprofit that provides health care, education and job assistance to teenage parents and families in Alameda and Contra Costa counties. "We are struggling right now. We've had to cut case managers while at the same time dealing with more clients than ever coming to us for help. We're trying to serve twice as many as we're funded to serve."

And that's the catch-22 the state finds itself in: it is during bad economic times that health care services are needed the most.

"It's the most vulnerable getting hit by these cuts, and because of the economic problems at large, the wiggle room to tough it out is not there," says Stephen Shortell, Ph.D., dean of the School of Public Health and professor of health policy and management at University of California, Berkeley. "Also, these cuts create a multiplier effect. It's not just one leg of your chair being punched out; it's all four of the legs being punched out at once and you're sitting on the floor."

The line-item veto melee

What makes the state budget cuts to health care even more frustrating for some involved at the patient

*See **BUDGET** page 6*

Debunking the reform myths

Passions have run high and tempers flared in the health care reform debate. Unfortunately, misinformation rules the airwaves. We set the record straight.

See story on page 4.

Full investigation of Sutter Health

'Questionable business practices' cited in letter to state attorney general

By Rebekah Stone

The controversies surrounding Sutter Health have reached a boiling point, with 13 state legislators sending a letter to state Attorney General Jerry Brown, requesting an immediate investigation of all of Sutter's business practices.

Assemblyman Jared Huffman (D-San Rafael), Ellen Corbett (D-San Leandro and chairwoman of the California Senate Judiciary Committee) and Mark Leno (D-San Francisco) were among those to sign the letter, which alleged a litany of abuses across the region, including "…misrepresentation of hospital finances, economic and medical redlining, abuse of nonprofit status, anti-trust violations, questionable allocation of public assets, and execution of contracts that may be in conflict with existing law."

The letter goes on to state that, "In almost every community in which Sutter Health operates, a legal and public battle over their broken promises and questionable actions ensues … we ask that you take immediate steps to intervene to determine whether Sutter acted improperly."

The letter came in response to a growing laundry list of complaints against Sacramento-based Sutter, which operates 26 hospitals in the state.

First, there was St. Luke's in San Francisco, which brought an action for antitrust violations after Sutter brokered an exclusive contract with the Bay Area's largest network of doctors, allegedly in an effort to redirect wealthier patients away from St. Luke's.

Then came Santa Rosa, where Sutter attempted to close the county hospital, in violation of its 20-year contract with Sonoma County. While Sutter agreed to maintain acute care in Santa Rosa, it proposed limiting services and transferring the profitable ones to a for-profit subsidiary that will not be subject to a contract with the county.

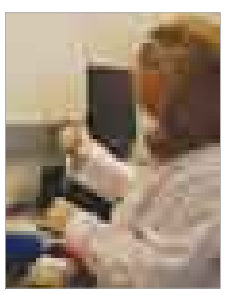
*See **SUTTER** page 23*

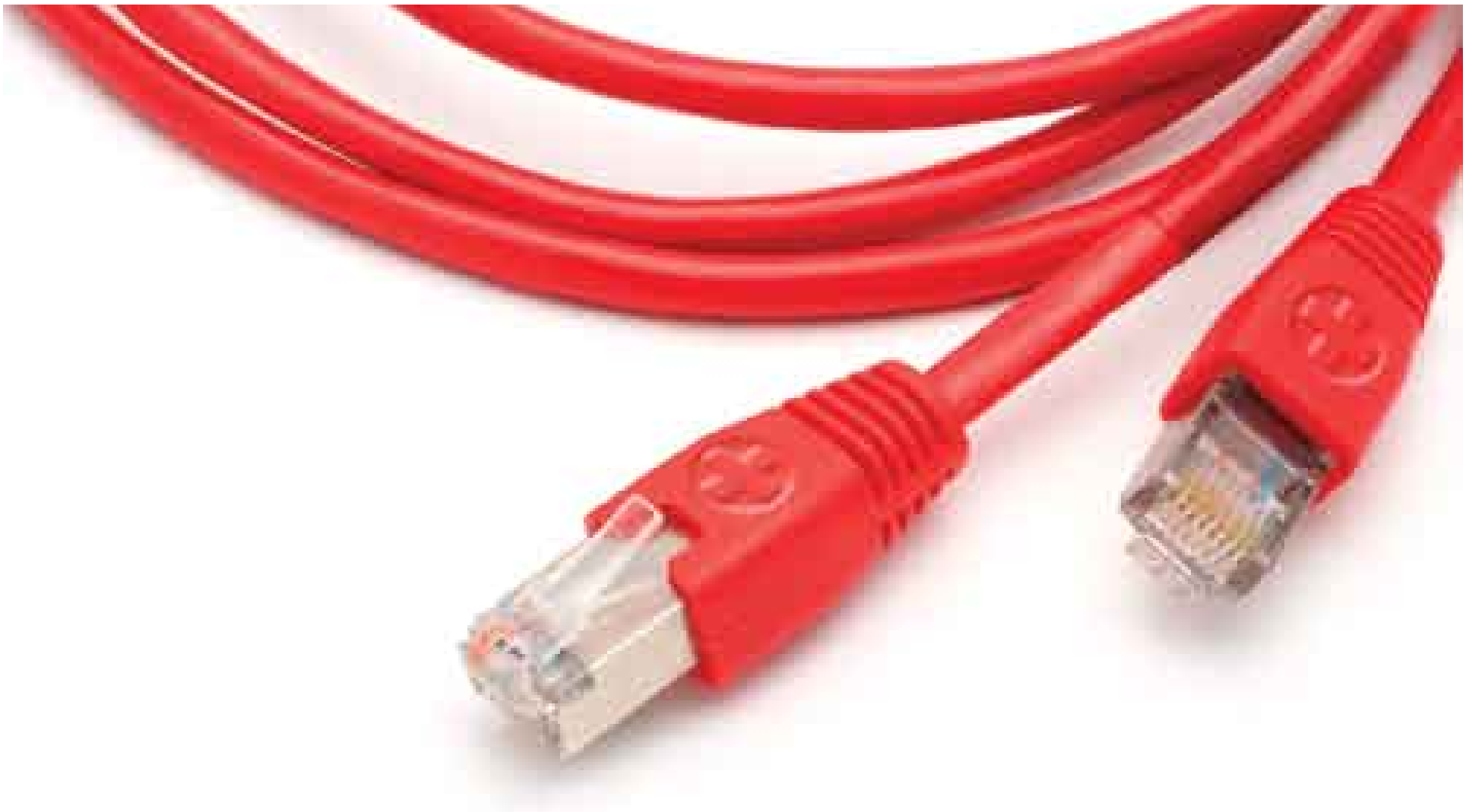
Santa Clara County Medical Association absorbs smaller Monterey society

By Troy May

In May Santa Clara County Medical Association absorbed the administrative functions of the Monterey County Medical Society to help sustain the waning and financially struggling society. But the move could cause a ripple effect stretching beyond Silicon Valley; it could act as a model organization for other small physician associations struggling to stay afloat.

*See **MONTEREY** page 24*





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INSIDE

Isotope shortages threaten diagnostics

Shutdown of two of the five nuclear production facilities worldwide shrinks supplies

By Rebekah Stone

Every day in America, nearly 55,000 patients undergo nuclear medicine tests, such as scans for heart disease or cancer, but those diagnostic tests are now in jeopardy.

Most nuclear medicine tests require the use of technetium-99m, a radioisotope that — until recently — was produced in only five nuclear facilities worldwide. Of those, all are at least 45 years old, and none are in the United States.

The abrupt closures of two of those facilities has left physicians scrambling to find access to the radioisotope and requiring them to postpone or cancel necessary scans for heart disease and cancer, or to turn to alternative tests that are not as accurate, take longer and expose patients to higher doses of radiation.

The National Research Universal reactor in Chalk River, Canada — which supplies about a third of U.S. technetium-99m — has been shut down no less than three times in the last 18 months on account of leaks of radioactive tritium-contaminated water. The most recent closure on May 14 brought an announcement that the facility would not reopen until the end of the year, though some experts suspect that it will never reopen if a containment vessel is badly corroded.

But even if it reopens as planned, it would be a short-term venture. Canadian Prime Minister Stephen Harper said that the facility would not continue to produce the radioisotope past 2016, due to the inability to bring a new reactor online.

Compounding the shortage caused by the closure of the Chalk River facility, the Petten nuclear reactor in the Netherlands — which provides half of the U.S. supply — shut down for one month for scheduled maintenance. The plant anticipates closing for at least three months next year for repairs.

The loss of America's two major sources of technetium-99m — m for "metastable" — has caused no less than a crisis. And intuitive practices like saving and storing the isotope are not options — the radioisotope is short-lived, with a half-life of only six hours that requires it be used within a day or two after production. The radioisotope allows physicians to examine bones and blood flow, among other things, and its short shelf life means it quickly disappears from the body, minimizing the dose of radiation a patient receives, but it also renders the isotope unable to be stockpiled.

About 91 percent of radiologists have reported suffering shortages, some that resulted in delays of several weeks due to the limited, sporadic supply, according to Michael Graham, M.D., president of SNM (which was formerly known as the Society of Nuclear Medicine). "It's possible that some deaths could occur (as a result of the shortage)," he told the *L.A. Times*.

And based on the simple economic principle of supply and demand, the cost of technetium-99m has climbed by 20 to 30 percent, while reimbursement for the procedures has remained fixed.

Both private companies and government agencies in the United States and Canada are actively searching for new sources of the isotope, including researching the feasibility of building new reactors or modifying existing research reactors, but any long-term solution is at least two to three years away.

The best hope seems to lie in the University of Missouri Research Reactor in Columbia, which could be modified to produce molybdenum-99 — the base from which the isotope is derived — at a cost of $50 million. The American Medical Isotopes Production Act, introduced by Reps. Edward Markey (D-Mass) and Fred Upton (R-Mich), would provide $163 million over five years for projects including the University of Missouri reactor upgrades. But even with funding, the reactor couldn't be viable until at least 2012.

In the meantime, some radiologists are using alternatives like fluorine-18, but Medicare and insurance companies typically do not cover these tests. Thallium-201 can be used in a pinch for heart perfusion scans, but both options are more invasive, less accurate and often result in large radiation doses to patients.

Rebekah Stone is the editor of the Healthcare Journal. You can reach her at rstone@hcjnc.com.

MICRA comes under fire

California Supreme Court upholds malpractice cap — for now

By Tony Edwards

The California Supreme Court announced in mid-August that it would not review the latest challenge to Medical Injury Compensation Reform Act (MICRA), reaffirming the landmark law's constitutionality.

First passed in 1975 and having seen off all challenges since, MICRA sets a cap on noneconomic damages a patient may receive. But it once again faced a challenge, as consumer attorneys attempted to overturn this cap.

The most recent challenge to MICRA came after a 47-year-old telephone company worker in Merced went in for outpatient surgery for an abscess. However, his anal sphincter muscle was inadvertently cut, leaving the man permanently incontinent.

A jury sided with the patient in July 2008 and awarded him nearly $2 million in damages, with approximately $700,000 of that judgment for "pain and suffering." The trial judge reduced that portion of the award to $250,000 per MICRA.

The judge's action led to an appeal, as lawyers for the patient said the judge's reduction of the award violated the state constitution's "inviolate right" to a jury trial.

A petition seeking review of a case was filed in Fresno in the 5th District Court of Appeals in May. In a unanimous and unpublished opinion, four judges on the Appellate Court ruled that only the California Supreme Court could decide the case differently. The Supreme Court announced that it would not review the case, leaving MICRA standing, for now.

Curtis Cole, JD, a partner with Cole Pedroza in Pasadena, argued the case in Fresno for the physician. Cole also successfully argued two of the landmark MICRA cases in the past (*Yates v. Pollock, 1987, and Fein v Permanente Medical Group, 1985*).

Cole said that the California courts have consistently upheld MICRA.

"The bottom line is that California courts have accepted that MICRA is constitutional," he said.

The Civil Justice Association of California, which filed an *amicus* brief in support of MICRA, said in a statement from President John Sullivan that MICRA helped make health care available in California.

"The Fifth Appellate District firmly rejected the plaintiffs' lawyers' rehashed arguments against MICRA, and the Supreme Court followed up in preserving this important tool that helps make health care available," Sullivan said. "For more than three decades, MICRA has stabilized medical malpractice insurance costs, secured access to physicians and hospitals and given people a fair way to settle their claims."

The attorneys beg to differ.

The Sacramento-based Consumer Attorneys of California (CAOC) countered that MICRA reform helps the insurance companies, not the physicians.

Nancy Peverini, senior legislative counsel at the CAOC, said one of the main reasons for seeking reform of MICRA was the changed financial landscape for the malpractice insurance companies.

"Malpractice insurance rates are declining," Peverini said. "Dozens of traditional and non-traditional malpractice insurers are writing coverage and new carriers are entering the industry."

Peverini said that as claims payments are decreasing, the insurance companies are making large profits.

"Malpractice insurance profits have been excessive for at least a decade," she said. "Doctors have an interest in viewing the global picture. Why should insurance companies profit at the expense of patients?"

To back up their case, the consumer attorneys cited data from the California Department of Insurance showing that malpractice insurers' profit rates were above what is defined as excessive.

According to the CDI's 1991-2008 California P&C Historical Premium and Loss report, there are 36 companies writing medical malpractice insurance in California, down from a high of 90 in 1994.

As the company count has dropped, so has the loss ratio (meaning an increase in profits) and the incurred losses.

Steven Heimberg, M.D., JD, of the Heimberg Law Group of Century City and a board member of the Consumer Attorneys Association of Los Angeles and Consumer Attorneys of California, cited fairness and accountability as keys to reform.

"The compensation cap is an unfair limit," he said. "The idea behind reform is to get the law in line with basic fairness."

In looking to reform MICRA, Peverini also cited physicians' commitment to quality patient care.

"Negligent care only occurs when a doctor falls below the standard of care of a similar physician practicing under the same circumstances," Peverini said. "Doctors have an interest in making sure that their colleagues follow that standard of care and do not cause harm to patients."

Peverini said that, unlike the situation in the past, medical malpractice insurers are now profitable and physicians have more choices from which to obtain malpractice insurance.

"Courts commenting on MICRA in the past have noted that when MICRA was enacted malpractice rates were increasing, very few firms were writing malpractice coverage, malpractice insurance claims payments were increasing and malpractice insurers were losing money," she said. Peverini cited *Fein v Permanente Medical Group* as an example.

"Today, in contrast, malpractice insurance rates are declining. New carriers are entering the industry and claims payments are decreasing," she said.

However Sullivan of the CJAC disagreed with the trial attorneys.

"This is the worst possible time to derail MICRA and send health care dollars to lawyers instead of to doctors, nurses, hospitals and clinics," he said.

Cole said that physicians and insurance companies need to be aware, as he sees this as the first of a renewed attack on tort reform.

"Will attorney groups continue to attack MICRA? Yes."

Tony Edwards is the digital media editor for the Healthcare Journal. He may be reached at tedwards@hcjnc.com.

Health Care REFORM

The truth about national health care

By Tony Edwards

Health care reform is the phrase on everyone's lips this fall, but what does it really mean?

Here, we address some of physicians' most pressing questions, like what options are really on the table and what changes would each require of a practicing physician? What exactly is a physician co-op? Is the general public even in support of health care reform? And what about our elected officials? Who are they taking money from?

As the story continues to develop, each Tuesday, we will decode the newest developments and tell you how Northern California's elected representatives are contributing to the national debate in our weekly health care reform e-mail newsletter. Sign up at hcjnc.com.

HR 3200 America's Affordable Health Choices Act

Sponsored by: John D. Dingell (D-Michigan's 15th District)

Local co-sponsors: George Miller (D-7th District-Martinez); Pete Stark (D-13th District-Hayward)

Where it stands: House Energy and Commerce (E+C) approved its version of the Bill 31-28. Energy and Commerce was the last of the five committees to which the bill was referred (E+C; Ways and Means; and Education and Labor). The bill, as a matter of course, was also referred to the Oversight and Government Reform and Budget Committees.

Ways and Means passed 23-18; Education and Labor passed 26-22.

There are three separate versions of the bill that have passed these committees. These versions will need to be reconciled by chairs of the committees before a vote is taken on the House floor. That vote will come in September, at earliest.

The vote was originally scheduled for before the House went on its August break. But the delay in a vote by the full House was a key component of the so-called 'Blue Dog compromise' between E+C chair Henry Waxman and conservative Democrats, to give the Representatives time to take the pulse of their constituents.

For physicians: In the original bill referred to committee(s), the federal government would negotiate physician rates directly under a public insurance plan option and linked public plan payments to Medicare rates. In the revised bill, negotiated physician rates cannot be lower than Medicare's rates, or greater than the average rates paid by those private plans who are participating in a national insurance exchange.

The new version of the bill also spells out the process that physicians could use to opt out of the public plan. The original legislation did not address medical liability reform. The bill that passed the E+C committee contains language that gives states financial incentives to put in liability reform.

The Senate Side

On July 2, the Senate Health, Education, Labor, and Pensions (HELP) committee approved its bill, known as the Kennedy-Dodd proposal. This proposal passed Committee by 13 to 10 (party line vote). Among its features, it would require employers with 25 or more workers to provide coverage or pay the government an annual fee of $750 for each full-time worker and $375 for each part-time employee.

The HELP committee's bill does not cover the costs involved in the expansion of Medicare, as Medicare is the jurisdiction of the Senate Finance Committee.

The Senate Finance Committee's (SFC) deliberations have been focused on the so-called 'Baucus Six,' a group of three Democrats and three Republications from the committee who meet in Montana Democratic Senator Max Baucus' office to grind out the details of a bill to present to the SFC. Baucus is chair of the Finance Committee.

The Republicans in the group are Michael Enzi of Wyoming, Charles Grassley of Iowa and Olympia Snow of Maine. Senators Kent Conrad of North Dakota and Jeff Bingaman of New Mexico fill out the Democratic side.

The Congressional Budget Office weighed in on the subject in mid-July, saying that none of the plans being discussed would curb the rise in health care spending. Proposals to cover these costs include a surtax on high-income families and taxing employer-provided health benefits.

The Senate first announced there would not be a vote on health care reform before the August break. House leaders quickly followed suit, not wanting to vote on a tax increase that would be rejected by the Senate.

What's a health care co-op and how would it affect physicians?

As the Obama administration received criticism from its own party for appearing to back away from a government-run insurance program, the administration's latest idea does not state how it would affect physicians or other health care providers.

Statements made by various Obama administration officials, including the President himself, suggested the administration was backing away from one of the cornerstones of its health care reform plan, a government-run insurance program. The administration, facing a firestorm from supporters of the public insurance option within the Democratic Party, has moved to state that President Obama has reached no decision on whether to drop his support for a public insurance plan.

One of the alternatives put forward by the administration is a health insurance co-operative or an exchange. Reduced to its simplest terms, groups of consumers would band together and create a health insurance company.

Some co-ops, as they are called, do exist. The Group Health Cooperative of Puget Sound is one of them. However, as Timothy Stoltzfus Jost, a law professor at Washington and Lee University, said in the *New York Times*, it's not that easy to start an insurance company.

"The biggest problem is coming up with a network. You have to find doctors and hospitals and negotiate contracts. Most are already locked up by the dominant insurers," Jost said.

Even proponents of health care insurance co-operatives admit that a plan needs about half a million members before they can negotiate with providers.

Other than a vague plan to provide $6 billion in start up money to the co-operative/exchange, the administration has not put forward a specific proposal. Democratic leaders in the House and Senate, such as Jay Rockefeller (D-West Virginia), Nancy Pelosi (D-San Francisco), and George Miller (D-Martinez) have opposed the co-op idea and support the public insurance plan.

At this point, no one is really certain how this proposal would affect physicians. That question was put to the Menlo Park-based Kaiser Family Foundation, a leading source of health care reform information, by the HCJNC, and they were unable to come up with an answer.

Following the money

Do you contribute to a PAC or a lobbying organization? How much have your representatives in Congress received from health care lobbyists? How does this money affect their position on health care reform? Are physicians receiving value from the money donated to lobbying organizations?

The Center for Responsive Politics, which runs the Web site Opensecrets.org has released a chart, updated through mid-August of this year, of how much money representatives in Congress have taken from various health care lobbying categories.

As this chart adds all the money received since 1989, those who have been in Washington longer will have a higher total.

Nevertheless, health professionals (physicians, nurses, etc) have donated more than $1.7 million to Pete Stark over the years while George Miller has taken less than $200,000, reflecting the committees each has worked on. Senators Feinstein and Boxer have received in the neighborhood of $800,000 from health professionals.

Representative Anna Eshoo leads the Bay Area table of those receiving money from the pharmaceutical lobby, with almost $700,000 received, contrasted with the $162,000 Stark has received from the pharmaceutical lobbyists. It's worth noting that Rep. Eshoo has received more money from the pharmaceutical lobby than either Senator Boxer or Senator Feinstein.

Tony Edwards is the digital media editor for the Healthcare Journal. He may be reached at tedwards@hcjnc.com.

What do the people think?

Americans narrowly reject the idea of limiting future payment increases to Medicare providers in a just released poll by the Kaiser Family Foundation. In the survey, more than 1,200 people were asked about health care reform.

KEY FINDINGS:

Is now the time to handle health care reform?

53% Yes
42% No

(Note: June survey results – 61% yes, 35% no)

Will your family be better off if health care reform passes?

36% Yes
31% No

(Note: Those who believe their family will be worse off has jumped 10% since July)

Do you support individual components designed to expand coverage?

80% Support expansion of state programs, such as Medicaid
68% Support individual mandate
68% Support employer mandate
59% Support public plan option

Which specific elements of health reform are the most important to you?

32% Expanding and subsidizing health coverage to Americans who have been unable to afford it
24% Insurance reform
19% Strengthening prevention programs
9% Cost containment

Do you support or oppose the idea of limiting future increases in payment to Medicare providers as a way to pay for health care reform?

Respondents over age 65

55% Oppose
34% Support

(Note: In June, they opposed the plan 48% to 40%)

Respondents under age 65

49% Support
46% Oppose

(Note: In June, they supported the plan 56% to 35%)

How should physicians be paid?

44% physicians should continue to receive a fee-for-service payment
27% physicians should be paid 'per illness'
22% physicians should be paid a salary

The survey was designed and analyzed by public opinion researchers at the Kaiser Family Foundation and was conducted Aug. 4 - 11, 2009, among a nationally representative random sample of 1,203 adults ages 18 and older. Telephone interviews were carried out in English and Spanish. The margin of sampling error for the total sample is plus or minus 3 percentage points.

Congress should be sued for malpractice over alleged 'death panels'

The truth about end-of-life care in HR 3200

By Robert L. Weinmann, M.D.

By now, most people who can read know that assertions about "death panels" in HR 3200 are baloney. How, then, did the rumors gain a stranglehold on the outpouring of opposition? Could it have been because of the incredible incompetence of the proponents, especially numerous grand-standing Congressional representatives who spoke out about the 1,017 pages of legislation without knowing what they were talking about?

Did President Obama and Health and Human Services Secretary Kathleen Sebelius contribute to the debacle? Sebelius seemed to toss in the towel when she said that the end-of-life proposal was likely to be dropped from the bill. She could have said that this wrenching decision would be left in the hands of families and their personal doctors where it has always been — without a fee.

Got that? Without a fee.

Pages 424 and 425 of HR 3200 state that "advance care planning consultation means a consultation between the individual and a practitioner." Reference is made that this option applies "if … the individual involved has not had such a consultation within the last five years."

It then mentions that this option refers to "an explanation by the practitioner of advance directives, including living wills and durable powers of attorney…"

The option includes "an explanation of the practitioner of the role and responsibilities of a health care proxy," and "an explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title."

Nothing in the bill hints even vaguely to death panels or being shipped off on melting ice packs. Nothing in HR 3200 justifies Ex-Governor Sarah Palin's outbursts.

Opponents of HR 3200 repeatedly waved the Grandma Card and got away with it at town meetings and anywhere else they could shout loud enough. Why? The answer is that the proponents of the plan — including our Congressional representatives — knew so little about the bill that they couldn't refute even the most absurd assertions, not even the Death-To-Grandma claim.

Because the bill's alleged proponents, mostly Democrats, were so ignorant about the contents of HR 3200, they were unable to persuade anyone that they knew what they were talking about. They didn't, and it didn't matter to them, because the approach all along was partisan and political. This approach is attributable to the usual and customary ignorance about legislation that bears legislators' names but that is actually written by a committee of staff people. HR 3200 owes what little scholarship it has to Congressional staff, not to elected representatives.

On the other hand, Betsy McCaughey, formerly Lieutenant Governor of New York, known for her criticism of Hillary Clinton's health care program in 1994, actually appears to have read HR 3200. She has asserted that the bill "would make it mandatory — absolutely require — that every five years people in Medicare have a required counseling session that will tell them how to end life sooner, how to decline nutrition, how to decline being hydrated, how … to go into hospice care."

McCaughey didn't actually say that Grandma would get shipped off on a melting ice flow if she didn't comply. She used the language in the bill cleverly — cleverly enough to worry anyone who didn't read the actual language.

By contrast, the expressed concern of Senator Chuck Grassley (R-Iowa) that the end-of-life provisions could be "implemented incorrectly" shows sophisticated understanding about how the legislative process actually works.

Though significantly less sensational than death panels, his is a valid concern. The wording on pages 424 and 425 opens the door to oversight by Congressional staff to write Rules and Regulations to "implement" HR 3200. In these R and Rs, staff scholars may define who is or could be "a practitioner," e.g. an M.D, an RN, or the guy next door.

Can you see it now? A new bureaucracy could determine who'll be qualified as "practitioners" enabled to do end-of-life counseling. The next step could be formal qualifications, which will require payment for course work provided on a fee-for-service basis and more bureaucracy.

While some might argue that these clumsy consequences need not take place, the fact is that the sloppy bill-writing on pages 424 and 425 did not describe the word "practitioner." No specification was made that the intent was for the patient's own physicians to provide or authorize end-of-life counseling. Was this an intentional oversight? Was it Congressional malpractice?

In one speech by President Obama, it was stated that HR 3200 would give doctors a chance not only to advise patients about advance directives, but also to charge a fee for so doing. Never mind that physicians have willingly advised about end-of-life care without a fee for centuries.

The president missed the boat on the first count and fell off the boat on the second count. Pages 424 and 425 do not refer to doctors doing anything — the actual word used is "practitioner" or "practitioners." In this way, the bill opens up a "death-door" counseling to non-physicians, bureaucrats, anybody who could be designated a "practitioner."

Some of us may know doctors we'd rather not have doing this counseling. Some of us know non-doctors, especially hospice personnel, who would do it well. All the same, when President Obama specifically referred to doctors doing this counseling without acknowledging that it would not be exclusively doctors, he missed the boat. Where he and others fell off the boat (prior to boarding, let's say on the gangplank) was in not disclosing the implications of the word "practitioner."

The Obama administration is unlikely to give up on this issue. We're not obliged to wait and see if the administration weasels, as in limiting damages by turning to other options while denying that it's doing so.

In the meantime, who do we sue?

Robert Weinmann, M.D., maintains a private neurology practice in San Jose. Though he is a past president of the Union of American Physicians and Dentists (UAPD), and is affiliated with AFSCME, AFL-CIO, the views stated in this Op-Ed are the author's own and do not reflect the views of any organization or political party. Weinmann states he is happily bipartisan on health care issues.

UCSF Medical Group affiliates with Hill Physicians, ends relationship with Brown & Toland

By Tony Edwards

Ending a long relationship with Brown & Toland Medical Group, the UCSF Medical Group has affiliated with San Ramon-based Hill Physicians Medical Group for San Francisco patients. The new agreement is effective January 1, 2010. The agreement also applies to physicians at UCSF Children's Hospital.

According to the agreement, all physicians who are members of the UCSF Medical Group (i.e., faculty members of the clinical departments of the School of Medicine who also practice at UCSF) will become participating physicians of Hill Physicians.

On the patient side, those who belong to an HMO through Aetna, Anthem Blue Cross, Blue Shield, CIGNA, HealthNet or United/PacifiCare will be affected.

Sam Hawgood, MB, BS, the president of the UCSF Medical Group, and interim dean of the UCSF School of Medicine said that UCSF physicians played a key role in the decision to affiliate with Hill Physicians.

"A cross-functional team that included UCSF physicians from multiple specialties were highly involved in the decision to affiliate with Hill Physicians," Hawgood said. "This task force met for many months and thoughtfully evaluated UCSF's long-term managed care strategy."

Hawgood said the agreement gives UCSF more flexibility to meet patient and physician needs in the changing landscape of health care.

UCSF and Hill have launched Web sites and devoted sections of presently existing Web sites to what changes patients will face and what questions they may have. Hawgood said that outreach efforts have also been developed for physicians.

"Communications have been developed for UCSF faculty and community physicians to explain the new relationships with Hill Physicians and Brown & Toland," he said. "We also are inviting all community physicians in San Francisco to join UCSF physicians in this new network."

UCSF and Brown & Toland are discussing a new contractual arrangement to enable HMO patients with a Brown & Toland primary care doctors to still use UCSF services. There is no guarantee the discussion will lead to an agreement.

In a statement, Hill Physicians CEO Steve McDermott said the affiliation would help patients.

"This is an ideal combination for San Franciscans," said McDermott, "one of the nation's largest physician associations is combining with one of the nation's best medical centers."

For more, visit www.accessUCSF.org or www.HillPhysicians.com/UCSF.

CDPH issues new H1N1 recommendations to physicians

By Tony Edwards

With the fall flu season approaching, the California Department of Public Health has issued new recommendations to physicians for treating patients who may have the H1N1 flu.

In May, the CDPH recommended that physicians use "enhanced precautions" for those patients with a fever higher than 37.8°C or 100°F plus one or more of rhinorrhea, sore throat or cough.

For infection control purposes, the CDPH has revised these recommendations. The department has dropped the symptoms of rhinorrhea, nasal congestion, and sore throat, and added an age criterion for patients less than 60 years old.

According to the CDPH, epidemiologic data for hospitalized patients for June and July 2009 show a "significant relationship" between rates of H1N1 2009 influenza and age. In reports, 92 percent of patients who have been admitted to a hospital with H1N1 are younger than 60.

To reassure physicians and other health care providers, the department noted that any cases of H1N1 flu among providers have been "limited and not significant."

The department's definition of a confirmed case of H1N1 flu is a person with an acute febrile respiratory illness with laboratory confirmed pandemic (H1N1) influenza by one or more of the following tests: real-time RT-PCR Swine Influenza rRT-PCR Detection Panel (rRT-PCR Swine Flu Panel); or viral culture.

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Brighter Beginnings Executive Director Barbara McCullough (center) meets with staffers Candy Anderson and Natalie Berbick.

Gov's line item vetoes cut additional $489M from health care budgets

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care level is that they got dinged once by the legislature and then again by Schwarzenegger's line-item vetoes after the fact; the vetoes took away another $489 million.

Charlene Clemens of the Family Service Agency of San Francisco was one who was especially taken by surprise. She had presented data to the legislature to prove the effectiveness of their programs — a 5 percent repeat birth rate for their teenage mothers compared to a national average of 20 percent — and the legislature funded their program at 90 percent of their previous budget.

"Everyone in our organization was beside themselves with delight because we see these kids every day and see what our programs accomplish for both the teen mothers and their babies," Clemens said. "Then with one stroke of the pen, the governor took it all away. I've been here over 20 years and this is the absolute worst I've ever seen."

With the loss of matching federal funds, their organization lost approximately 60 percent of their budget, and now 2.5 case managers are doing the work of five.

Other facilities that don't have particularly large overall budget cuts are feeling the effects in targeted ways due to Schwarzenegger's elimination of adult services that are optional under Medi-Cal: dental, podiatry and optometry.

Open Door Community Health Centers, which operates 10 clinics in rural northern California, is one of those facilities. It's the largest primary care provider north of Santa Rosa; 40 percent of the area's population looks to Open Door for their health needs. Their budget was cut $5 million (about $1 million of that from the line-item veto), which has meant they've had to cut staff (mostly through attrition), reduced salaries (20 percent at the top, but no pay cuts to hourly employees) and have eliminated all overtime. They've been trying to deal with the cuts by staying as true to their mission as possible.

"Our philosophical roots are giving access to people who have difficulty getting access to good care, so we decided to quit accepting insured patients," said Open Door's Executive Director Hermann Spetzler. "If someone has to drive six or seven hours round trip to get health care, we don't want that to be the person who can't afford to take time off from their job."

Open Door's dental clinics have been hit particularly hard. They've had to close their first and oldest dental site in Arcata after 30 years and are looking at closing another dental program in October.

"This is all because of the elimination of what the governor called 'optional benefits,' which I think most reasonable people would not consider optional," said Spetzler. "We have never been a dental provider that does fancy bridgework; we do basic restorative dentistry to provide our older patients with dentures so they can keep eating. Now we are not able to provide dentures to anyone at this point.

"I know we all have to live within our means, but the wholesale elimination of programs like dental services is extremely difficult to understand. Health care is a continuum, and what's happening with these cuts is that the state is making bad economic decisions as well as bad medical decisions."

Aside from the optional benefits cuts, services for the elderly and disabled are another area where the cuts were deep. California Caregiver Resource Centers (CCRC), which operates 11 centers throughout the state, helps families who are caring for adults with chronic, disabling health conditions. Their budget last year was $10.9 million; after the budget wrangling, the legislature funded them at $7 million, but the governor's line-item veto slashed their budget again to $2.9 million, or a 72 percent cut.

"We've cut half our staff," said Donna Schempp, program director. "And those who are left come in everyday and say, 'What do you know? What does it look like today?' We haven't been told what we can do with the money they have authorized for us, so it makes it very hard to plan. Luckily, we still have our federal dollars so the remaining members of our staff are working very hard to give people the best service that we can while we're in limbo."

Photos: Rebekah Stone

Due to the state budget cuts, Barbara McCullough and her staff at Brighter Beginnings had to find ways to shave more than $1 million from their operating budget, even as more families seek their services.

One of CCRC's social workers, Lois Escobar, put a face on the problem. She has a client who is in her 40s, working full time, and trying to care for her father with dementia and an adult brother with developmental disabilities. After the budget cuts, her father's day care center was cut from five days to three, and her brother's care was cut to 10 hours a week. "She's overwhelmed," said Escobar. "She can't give up work, and she can't afford to private pay for the care that was lost due to the cuts."

Hope on the horizon

If there's any glimmer of hope, it comes in the form of a couple of lawsuits that have been filed to fight the line-item veto cuts. Senate President Pro Tempore Darrell Steinberg (D-Sacramento) filed a suit on July 29 alleging that Gov. Arnold Schwarzenegger overstepped his authority when he used line-item vetoes; a second suit was filed by health clinics and other advocates for the disabled to restore funds eliminated

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by the vetoes.

"I think the governor is showing us his true colors in attacking the most vulnerable populations, the elderly and disabled, while he keeps his buddies from paying a dime more in taxes," said Marty Lynch, Ph.D., executive director of Berkeley's LifeLong Medical Care, which has lost $1.5 million due to the cuts. "Everything that the state has done is 180 degrees opposite to what Obama and the Congress is trying to do to stimulate the economy and take care of the community."

UC Berkeley's Stephen Shortell, who is advising the Obama administration on health care delivery system reform, agrees. And though restoration of cuts through lawsuits or other means could help, it's not going to solve the problem.

"I've seen the state deteriorate over the last 35 years, specifically around education, health and other related things," he said. "I'm a big proponent of a constitutional convention, where we can reevaluate Proposition 13 and the two-thirds majority requirement to pass budgets and raise taxes. We've got a deep structural problem, and we're going to pay for this down the road unless we do something pretty fundamental to reorient the political system in our state."

Laura Scholes is a freelance writer in Berkeley. She may be reached at laura@laurascholes.com.

Healthy Families program slashed, then rescued (maybe)

When the legislature and Schwarzenegger got through with the budget, one of the most glaring cuts was to the popular Healthy Families Program, the state's children's health insurance program that provides coverage for nearly 1 million low-income children.

The program was slashed by $194 million, and the cuts would be further deepened by a loss of federal matching funds, which provide two dollars for every state dollar spent.

People quickly rallied to the defense of the program. The state's First Five Commission committed up to $81.4 million from tobacco tax funds to support the program, which helped, but still left a $112 million shortfall.

"I appreciate that First Five is willing to make the investment our state should be making, but passing the buck to them is not the answer," says Richard Pan, M.D., a pediatrician at UC Davis and chair of the state's first regional Children's Health Initiative. "It's just astonishing that a state like California would have a public official like the governor propose something so draconian."

One particular area of concern for Pan is the upcoming flu season, especially because of the H1N1 virus lurking. With the cuts to Healthy Families, rates of immunization will likely drop.

"The lower the percentage of people who get vaccinated, the more likely it is to spread around the community," said Pan. "And it's a geometric progression in an infection like flu; the risk of transmission magnifies tremendously and when you get down to a 70 percent immunization rate, it just goes everywhere."

Like the other cuts to health care, the cuts to Healthy Families can affect the health of children not just now, but for years to come. "People think what's the big deal if a kid doesn't get a wellness checkup this year," said Pan. "But it's not just a general checkup we do in those visits, we also screen for different developmental problems, and if they're not detected, you may miss a critical period of treatment, which would make a huge difference in the child's health and well-being."

Stephen Shortell, Ph.D., of UC Berkeley says the effects can be even more dramatic. "There's research now that shows that when children are lacking in nutrition or suffer abuse or otherwise have problem sustaining early in life, it can have an impact 15 or 25 years later and at great cost to the state," he said. "It's broader than their health; it can affect their learning ability in school, their cognitive capabilities and their emotional intelligence."

Perhaps because of research like this, the Senate Appropriations Committee just approved a measure (AB 1422) to restore the cuts and prevent more than 500,000 children from losing coverage. To offset those cuts, AB 1422 would require all participating families to pay higher copays; some families also would pay higher premiums. In addition, the measure would impose a 2 percent gross premiums tax on health plans that administer benefits for Medi-Cal. Because this in part depends on a tax increase, it will require a two-thirds majority vote in both houses.

Blows to nonprofit budgets

Bay Area California Caregiver Resource Centers
11 centers in Northern California
- $8 million cut or 72% of budget

Brighter Beginnings
Oakland, Richmond & Antioch
- Black Infant Health Program funds cut: $400,000 (+ federal match: $300,000)
- Adolescent Family Life Program cut: $345,000
- Total loss: 1.1 million or 25% of budget

Family Service Agency of San Francisco
- State funds cut $265,000 or 38% of budget
- Lost federal match of $152,000 or 22% of budget
- Total loss: $417,000 or $60% of budget

LifeLong Medical Center
Berkeley
- $1.5 million or 10% of budget (40% of dental budget)

Livingston Medical Center
Merced
- $480,000 or 7% of budget

Open Door Community Health Centers
10 clinics in rural northern California
- $5 million cut or 25% of budget

San Francisco's funds from state Office on AIDS
- $3.68 million cut
- $1.3 million for laboratory testing, primary medical care and housing for people living with HIV
- $2.4 million for HIV education, prevention, counseling and testing (82% cut)

Note: all figures are approximate. Source: California Department of Health and Human Services.

Photo courtesy of Takeda Pharmaceutical Co.

Takeda San Francisco carries the hopes of its Japanese parent company.

Takeda sets new global strategy

Japanese pharmaceutical company opens South S.F. oncology research facility

By Lynn Graebner

Japan's largest pharmaceutical company, a 228-year-old health care veteran, is carving a foothold in the Bay Area with its sights on becoming a leading global oncology company.

Acknowledging it has a lot of ground to make up, Takeda Pharmaceutical Co. Limited of Osaka has made some bold moves in the past 18 months. One of the most significant is the formation of a new company in South San Francisco for therapeutic antibody research, one of the most prolific sectors for new oncology therapies.

Building this new facility in the birthplace of biotech, down the street from the headquarters of biotechnology founder Genentech and local offices of Amgen Inc., a grandfather in the industry, represents a commitment by Takeda to found a biologics center of excellence, said Mary Haak-Frendscho, president and chief scientific officer of Takeda San Francisco.

"It's meant to send an important message that although we're late to the game, we're very serious and committed," she said.

Takeda San Francisco Inc., a wholly owned subsidiary of Takeda America Holdings Inc., will research therapeutics for oncology, inflammatory disease and metabolic disease. The company has been hiring experienced researchers from established biotech companies including Genentech; Abgenix Inc., which was based in Fremont before Amgen bought it in 2006; and Gaithersburg, Md.-based Medimmune LLC, which Swiss company AstraZeneca bought in 2007, Haak-Frendscho said. She herself came from XOMA (US) LLC, where she was the chief science officer and vice president of preclinical research.

Takeda is working on the final phase of the 64,000-sqaure-foot research and development facility in South San Francisco and has hired 60 of the 130 scientists it plans to house there by late 2010, Haak-Frendscho said.

More proof of Takeda's commitment to biologics came in May of 2008 when Takeda made its biggest step into the oncology field by acquiring oncology biopharmaceutical company Millennium Pharmaceuticals Inc. of Cambridge, Mass. for $8.8 billion, the largest U.S. biotech acquisition of the year.

"Millennium really propelled them into the limelight. Millennium's got a good product on the market and a late-stage pipeline," said Michael Latwis, a corporate analyst who covers Takeda for Waltham, Mass.-based Decision Resources, a pharmaceutical and health care research and advisory company.

Millennium has a robust pipeline of 13 drug candidates, several of which are in final clinical trials. It also has cancer drug

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Velcade on the market. Millennium will handle clinical trials for Takeda's oncology drug candidates.

Takeda has been actively partnering and buying assets in the United States as well. In February 2008 it signed a deal with Amgen Inc. of Thousand Oaks to develop and commercialize for the Japanese market as many as 13 therapies in Amgen's pipeline.

And in the last five years, Takeda has set up facilities in many of the biotech hubs around the world including Cambridge, Mass.; Cambridge, UK; San Diego; Singapore and now South San Francisco. But as Haak-Frendscho admits, there is a lot of catching up to do.

"The company is doing a lot of the right things but obviously their internal research in the past has not been able to compensate for an aging pharma portfolio," Latwis said.

Three of Takeda's major drugs will see their patents expire by 2012. And Takeda suffered a blow from the United States Food and Drug Administration in June when the agency informed Takeda that its type 2 diabetes drug, alogliptin, would need an additional cardiovascular safety trial due to new 2008 FDA guidelines.

Decision Resources forecasts Takeda's overall drug sales will see a 4 percent decline, compounded annually through 2015.

On the positive side, the company has a big net cash position and very little debt, Latwis said.

Tracy Lefteroff, global managing partner of the venture capital practice at PricewaterhouseCoopers LLP, one of the Big Four auditors, agreed that Takeda is financially strong. He said coming to the Bay Area was a very positive step for the company and that it has a good shot at realizing its goals in oncology.

But it will take a lot to become an oncology leader in the United States.

Decision Resources lists Takeda as the 12th largest oncology company globally with $1.5 billion in oncology sales. Roche is the top company with $19 billion in oncology sales. While Latwis' numbers show a 6 percent compounded annual growth for Takeda's oncology sales from the end of 2008 to the end of 2015, the rest of the oncology companies are slated to grow at the same rate, so catching up will be difficult.

Japanese pharma companies going Global

Takeda isn't the only Japanese pharmaceutical company seeking a more global presence.

"Just five years ago people looked at Japanese pharmaceutical companies as slow trotting," said Tracy Lefteroff, global managing partner of the venture capital practice at PricewaterhouseCoopers LLP, one of the Big Four auditors. "(Now) they're transforming into multinational competitors."

In January of 2008, Japanese pharma company Eisai Co. LTD bought MGI Pharma Inc., a biopharmaceutical oncology company from Bloomington, Minn. for $3.9 billion.

And on Sept. 3, 2009 Dainippon Sumitomo Pharma Co. LTD. made a $2.6 billion tender offer for Marlboro, Mass. biotech company Sepracor. That deal is expected to close by the end of the year.

Photos courtesy of Takeda Pharmaceutical Co.

Left: Mary Haak-Frendscho, president and CSO of Takeda San Francisco; Right: researchers have already begun work in the new South SF facility.

And big companies are getting bigger. This year Roche of Basel, Switzerland bought the rest of Genentech for more than $40 billion. Roche already owned 56 percent of Genentech. And Bristol-Myers Squibb Co. paid $2.4 billion for antibody therapeutic company Medarex Inc. of Princeton, N.J. on Sept. 1, 2009.

"With Medarex we're doubling our number of biologics," said Brian Henry, director of corporate communications for Bristol-Myers Squibb.

Takeda is in a good sector with antibodies, as that's the fastest growing segment in oncology with a 13.5 percent compounded annual growth rate projected through 2015, Latwis reported.

"Antibodies have gone from great expectations to 'they're never going to work' to great expectations again," said Steven Burrill, CEO of Burrill & Co., a San Francisco-based life sciences company in the areas of private equity, venture capital, merchant banking and media.

Antibody therapeutics is a fairly new drug platform, with the underlying technology developed in 1975, Haak-Frendscho said. Only 22 products have been approved to date, yet they have had a huge impact."Many of those drugs have been highly successful in transforming disease treatment," Haak-Frendscho said, naming Herceptin, Avastin and Rituxin. Half of the top 10 oncology drugs are antibodies, she added.

Burrill agrees that antibody therapeutics is a great opportunity for companies.

"The winners of that race have not been crowned yet, but they will be in the next decade … Takeda is late to the game, but is not out of it," he said.

Lynn Graebner is a freelance writer in Santa Cruz.

Manning the front lines of community health care

Led by pediatrician Sue Chan, Oakland's Asian Health Services celebrates 35 years

By Alice Chen

What would you do if the mother of a sick baby came to you overwhelmed, obviously on the brink of depression? Would you quickly write a prescription and send her on her way? Or would you do the unthinkable: take the child in for the weekend to give the mother a break? Sue Chan, M.D., a pediatrician at Asian Health Services, did both.

"That's who she is — very dedicated, principled," said Karen Mori, an RN who hired Chan decades ago as the first paid doctor at the AHS, a community health center that serves low-income immigrants and refugees in the heart of Oakland's Chinatown.

Now celebrating its 35th anniversary, the AHS started as an all-volunteer group that offered two days of clinic a week, but has grown into an organization that provides primary, dental and mental health services in 10 languages to 20,000 patients a year. Nearly 90 percent of the patients are non-English speakers, one-third are uninsured and 98 percent are below the poverty level.

Photo2: Rebekah Stone

Top: Sue Chan, M.D., makes the rounds at the bustling Oakland practice, still finding time to share a laugh with colleagues. Bottom: Chan has dedicated her medical career to providing care to the under-served Asian population in the heart of Oakland's Chinatown.

Chan, who's served as the medical director of AHS, is an extremely dedicated physician who helped set the tone of the organization.

One reason Chan is so passionate about AHS is that her background is quite similar to many of the immigrants served by the clinic. She was born in Shanghai during World War II, a time so bitter that her family had difficulty getting adequate nutrition. When the war ended, they moved to the United States, where her father had great difficulty finding adequate work, despite his Ph.D. in chemistry from the University of Michigan.

"He was given almost nothing [in terms of pay]," she recalled.

Meanwhile her mother, who had studied chemistry at Shanghai University, was hugely embarrassed to hold a job where she stood for up to 10 hours a day stuffing vegetables into cans.

Chan had several uncles, cousins and grandparents who were doctors, but she never considered the field because she didn't think she was smart enough. But when she entered college, she participated in a work-study program that spurred her to perform research at Memorial Sloan-Kettering Cancer Center and Jefferson Medical College. At Jefferson, she met an Indian surgeon who encouraged her. "You can do [medicine] if you have dedication and an interest in helping people," she recalled him saying.

The surgeon took Chan to an operating theater to observe a caesarean section. Blood gushed up, almost hitting the glass ceiling. "This looks pretty interesting," she thought.

After college, Chan went to Hong Kong and Taiwan for 18 months to study Chinese and figure out her life's direction. When she returned, Chan decided to attend medical school at Ohio State University, then completed her internship at the University of Chicago and embarked on a pediatrics residency back at Ohio State.

She then relocated to the Bay Area to earn a Masters of Public Health at UC Berkeley. The Bay Area was the first place (aside from Asia) where she wasn't one of just a handful of Asians. And she loved it.

Chan graduated in the early 1970s, on the heels of the Civil Rights movement. It was a time when many minority communities were agitating for equal access to schools, housing, health care and jobs. A large influx of Asians were arriving in Oakland, prompting a group of community leaders, health professionals and students to survey the 40-block area surrounding Chinatown. They discovered that those residents were getting health care services at half the rate of the mainstream population, probably because there was only one doctor in Chinatown.

The Chinatown community was predominantly uninsured and extremely low-income. They faced language, transportation, economic and cultural barriers to quality medical care. For example, immigrants from rural China even today can be uncomfortable with answering questions about sexual health or undressing completely for pelvic exams.

And so, as the pressing need for health services for the Chinatown population was established, AHS was born. Very soon thereafter, Chan joined the staff part-time, volunteering more than double her paid time. "That was tenor of the time," Chan laughed.

Today, Chan is beyond pleased that AHS has expanded so greatly — it now offers acupuncture, minor surgery and some specialty services including cardiology, neurology and dermatology. There are interpreters for nine languages including Mongolian, Khmer (Cambodian) and Mien. As of 2005, the organization employed 161 staff including 41 doctors, nurses and physician assistants and had an operating budget of $16 million.

And the AHS does more than just provide medical care – they organize the community, doing everything from encouraging patients to vote to bringing patients to Sacramento to speak out against proposed Medi-Cal cuts.

They also teach patients to advocate for themselves. "We explain their condition, why we're thinking about this treatment option, and they ask questions so they're empowered," Chan said. "It's not like that for a lot of patients who come from other countries or down the street from another doctor and have no idea of their diagnosis or why they're taking medicine."

Not only has Chan contributed to AHS, but she's also learned a lot from her experiences, especially as an activist. As an immigrant whose native tongue was not English, she was often reluctant to speak out for the community. "I've been growing up with the organization," Chan explained.

"I'm 68 years old and still happy to be here," she said. "I look forward to coming back to see patients. People who come to work for the organization are just exceptional. I'm in awe of them, their commitment to community and wanting to make difference."

In many ways her story is similar to those immigrants she serves, who may have been doctors or professionals in their own country but end up working in a supermarket or restaurant in America.

It was those meager beginnings that inspired Chan not only to become one of the first doctors at AHS, but also to dedicate herself to helping immigrants make a successful transition to a long, healthy life in their new home – even if it requires the occasional babysitting of newborns.

Alice Chen is a freelance writer in the Bay Area.

Asian Health Services

Main clinic: 818 Webster St., Oakland

Phone: (510) 986-6800

Web: www.asianhealthservices.org

Facility: 36 exam rooms and a dental clinic with seven chairs

Patients: 20,000 patients and more than 90,000 patient visits annually

Languages: English and nine Asian languages including Cantonese, Vietnamese, Mandarin, Korean, Khmer (Cambodian), Mien, Mongolian, Tagalog and Lao

focus: **LABORATORY MEDICINE AND PATHOLOGY**

Staying ahead of the viral curve

UCSF's Chiu Lab working to develop technology to identify viruses before they attack humans

Photos: Rebekah Stone

Top left: Charles Chiu, M.D. prepares to analyze viral samples. Top right: Chiu works with viral samples under a hood to minimize exposure. Center: Chiu hopes to develop technology that could identify known and unknown viruses in a matter of minutes, which could be invaluable to diagnostics and pandemic prevention and control.

By Lynn Graebner

Swine flu may have been circulating among pigs for many years prior to its transmission to humans, said Charles Chiu, M.D., director of the University of California, San Francisco's (UCSF) Viral Diagnostic and Discovery Center and its Chiu Lab.

Chiu is working on technology to identify viruses including H1N1 (swine flu) more quickly and accurately to avoid or lessen the impact of pandemics like the one we're now facing. He is working on virus surveillance technology that may eventually sequence the entire genomes of viruses within a matter of hours, providing detailed information about how these viruses are passing through a population and how they are changing in real time.

Chiu envisions a time, maybe in the next five to 10 years, when this type of virus surveillance technology could be cost effective and fast enough to be used by the Centers for Disease Control and Prevention, the United States Department of Food and Agriculture and other public health agencies to identify outbreaks in animals and humans as they happen, even if a virus has never been seen before, Chiu said.

In the meantime Chiu's lab is collaborating with other researchers and public health agencies to provide information on the H1N1 virus that could help them formulate better vaccines and therapies.

While doing a fellowship on infectious disease at UCSF, Chiu worked with UCSF researchers Joseph DeRisi and Don Ganem, who led the development of the Virochip microarray and deep sequencing technology that Chiu is now using in his lab.

The Virochip microarray has been credited with identifying SARS (Severe Acute Respiratory Syndrome) as a novel virus in 2003. SARS spread to 37 countries in just a few weeks.

The latest version of the Virochip consists of a glass slide with approximately 36,000 DNA fragments representing all viruses known to man, about 2,500 viruses in total. It can detect the presence of a virus in as little as 12 to 24 hours.

Sharon Hietala, a professor of diagnostic immunology at the California Animal Health and Food Safety Lab at UC Davis, said that many labs are now working with microarrays and gene chip analysis but that, in her opinion, DeRisi is the one who kick started the technology currently used.

"The work done in that lab set the stage," she said. Although the technology is still a bit too pricy for widespread use in animals, she said that chips are on their way and being tested in animals.

Additionally, Chiu is using research by DeRisi and Ganem on high throughput deep sequencing. By sequencing the whole genome of viruses from different individuals, over time researchers can better understand what changes are happening at a genetic level in the viruses. They can determine if a virus is becoming more resistant, more virulent and how it is spreading. This can be determined as these things are happening, in real time.

"This technology may help prevent something like this in the future," Chiu said. He hopes it will eventually be used as a routine surveillance tool in both animals and humans. He's discussing that with various groups, including the California Department of Public Health (CDPH).

"In an ideal world we would look at every animal reservoir that has flu," said Janice Louie, M.D., section chief for the Viral and Rickettsial Disease Laboratory at CDPH. But even if resources weren't an issue, Louie said she's not sure researchers would know what action to take if they did find a new virus. She wonders if it would mean culling a lot of pig herds?

Louie questions whether the technology Chiu is working on can help us avoid pandemics because flu is so unpredictable, she said. But if it helps us identify viruses that are resistant to drugs like Tamiflu, then clinical trials of other drugs could be accelerated by the U.S. Food and Drug Administration. So, in that sense, while the technology might not help us avoid pandemics, it could certainly lessen the impact and reach of a pandemic.

Louie's lab shares virus specimens with the Chiu Lab and they meet regularly to explore the discovery of new viruses, she said.

Ian Lipkin, M.D., director of the Center for Infection and Immunity (CII), consisting of 65 investigators at Columbia University, said it's reasonable to do sentinel testing of animals, but it should be done using the least expensive technology that is sufficiently sensitive to detect microbes in animal specimens. Most investigators use polymerase chain reaction (PCR), which indicates a positive test if pieces of a pathogen's genome are detected. The CII uses a multiplex PCR method (MassTag PCR) that detects up to 30 different viruses and bacteria for the same cost as a single agent PCR.

Lipkin's lab houses a World Health Organization center working on diagnostics and discovery and Lipkin is working with colleagues globally as well as the Department of Defense to analyze cases of respiratory disease and to follow influenza virus evolution.

Lipkin's Lab is also developing what he calls "fieldable versions" for both the PCR technology they are using and for GreeneChips. GreeneChips contain up to one million pieces of genetic material from viruses, bacteria, fungi and parasites that can identify pathogens in human fluid and tissue samples. Access to that type of technology on site where outbreaks of viruses are happening would help with triage and containment, Lipkin said.

The President's Council of Advisors on Science and Technology issued a report on Aug. 7 stating that H1N1 could cause between 30,000 and 90,000 deaths this year in the United States, potentially triple the deaths from the seasonal flu and will likely be concentrated more in children and young adults.

Given that possibility and the fact that since 1973, more than 30 diseases linked to viruses and bacteria that were previously unknown have surfaced, such as avian flu, West Nile virus, Ebola virus, AIDS/HIV and Hepatitis C, according to the Ontario Agency for Health Protection and Promotion, there is certainly a need for new tools that can alert us to the presence of new viruses. That would afford us more precious time for reigning in the spread and developing effective treatments for those afflicted.

Already, Chiu's technology has successfully been used to identify viruses in diagnostics, and he hopes that the technology developed at UCSF could one day identify and help combat the even the toughest of future viruses.

Lynn Graebner is a freelance writer in Santa Cruz.

focus: **LABORATORY MEDICINE AND PATHOLOGY**

A preemptive strike on diabetes

Emeryville's Tethys Biosciences rolls out pre-diabetes test

By Alice Chen

A slim, fit, 50-year-old Korean sushi chef with high blood pressure visits his cardiologist, who notices his blood sugar is also a bit high at 120. Just months ago, his doctor Edward Kersh might've said "Don't worry about it, let's watch this."

But this time Kersh has access to a new fasting blood test — the PreDx Diabetes Risk Score — created by Tethys Bioscience in Emeryville. The DRS predicts the patient's possibility of getting diabetes within five years.

When the results return, the patient scores an 8 on a scale of 1 to 10, meaning that without making lifestyle changes now, he has a 12.2 percent chance of converting to diabetes by the time he reaches , nearly four times the risk of the general population.

"With this guy, no one would have had a clue about it. You look at him and think he's not a candidate for diabetes until the day he goes into a diabetic coma or has one of the complications of diabetes," said Kersh, chief of cardiology at St. Luke's Hospital in San Francisco.. Kersh is so enthusiastic about the results he's seen with the DRS that he may work with Tethys Bioscience in the future.

In this case, it turned out that the patient ate lots of rice, didn't realize soy sauce had excessive sodium, and, Kersh thinks, probably drank a lot of beer (It's in the culture of sushi chefs, he explained).

Now the patient is altering his diet by cutting carbohydrates and hoping to head off the disease before he truly becomes a diabetic.

The DRS is already available in Northern California and is gaining both momentum and attention. Unlike existing methods of determining risk for Type 2 diabetes, which look at single markers including BMI, fasting glucose or HbA1c, the DRS measures multiple biomarkers, including ferritin, glucose, adiponectin, insulin, HbA1c, interleukin-2 receptor-alpha and C-reactive protein. These biomarkers are linked to biological pathways like cardiovascular disease and inflammation, cell death, obesity, glucose metabolism and other metabolic disorders that lead to Type 2 diabetes.

The DRS was developed using blood samples from 8,700 participants in two long-range European studies. Hersh noted the subjects were primarily Caucasian and that there's no evidence that the biomarkers are the same for minorities, like blacks and Hispanics, who have higher conversion rates to diabetes. But, he added, "I don't see any reason why [biomarkers] wouldn't be the same."

Tethys Bioscience analyzes blood samples using an algorithm that translates marker measurements into a score that correlates with the patient's chance of developing diabetes within five years. Patients with the highest category of scores — from 8 to 10 — have anywhere from a 12 to a 60 percent chance of conversion, depending on their risk factors.

The DRS is recommended for people over the age of 30 who have at least one risk factor for diabetes, including obesity, family history, high glucose, inactivity, high cholesterol, metabolic syndrome, high blood pressure or a previous history of gestational diabetes.

Though the test and analysis costs $465, Tethys is not billing patients right now, but rather working to get insurance companies to cover the cost.

And Tethys contended that the DRS provides better risk discrimination than existing tests because it's personalized and specific. Some doctors say high PreDX scores have a greater impact on patient's behavior than previous tests. "The patient doesn't live in a world of statistics, but seeing something graphic, color-coded helps them to feel the fear of developing diabetes," one doctor responded to Tethys Biosciences' anonymous survey.

And the PreDx even changes doctor behavior. "When I see a high or even a moderate score, it changes my tone and I'm going to be more aggressive with [patients]," said another doctor surveyed.

Patients are considered at risk for diabetes if they have impaired glucose tolerance, impaired fasting glucose (IFG), or both conditions.

More than 57 million Americans over age 20 had IFG in 2007 and were considered at risk, but according to Tethys Biosciences , the Inter99 study showed that conversion rates of IFG patients ages 39 and up with a BMI greater than 25is nine percent. (The CDC follows studies that show 1.5 to 23 percent of patients with IFG will develop diabetes within a year and the majority will become diabetic within 10 years.)

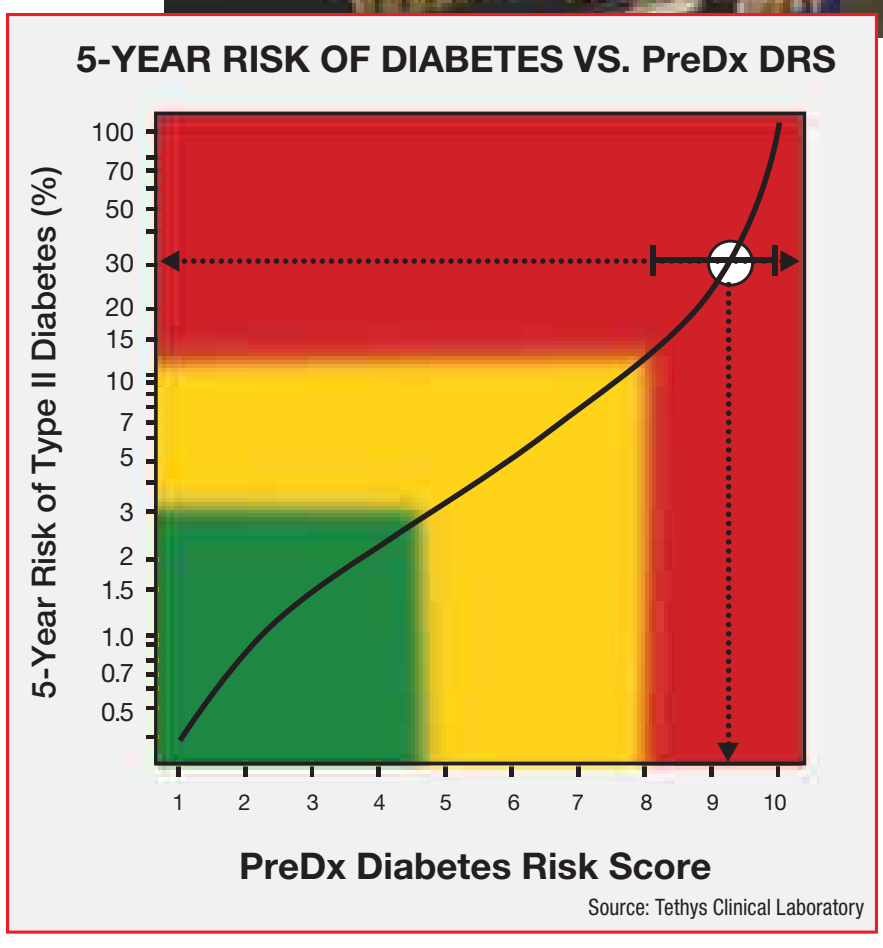
Some may ask, why is it necessary to know one's exact risk for diabetes — why not put all 57 million pre-diabetics on a plan to change their lifestyle? According to Kersh it is unrealistic to expect the majority of people to make life changes. Additionally, Kersh has found that the DRS is a more effective motivator than other tests.

"I'll sit here with a patient and [tell them

See ***TETHYS****, page 13*

Photo: Rebekah Stone

Tethys employees analyze patients' blood samples in for the PreDx DRS, which evaluates the risk of developing Type 2 diabetes within a five year period.

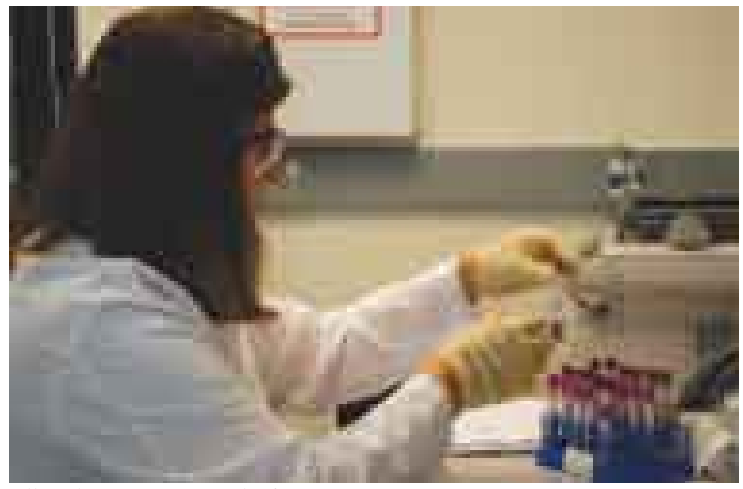


focus: LABORATORY MEDICINE AND PATHOLOGY

TETHYS, from page 12

they have] slightly elevated blood pressure and blood sugar. They walk out feeling the same as when they walked in," Kersh explained. "When you show them this paper, 'You're going to get diabetes. Here's the evidence,' they walk out with a different psychological headset. Now they're told to really do something. There are consequences."

But Christian Vaisse, M.D., a UCSF associate professor of medicine, told the San Francisco Chronicle that it's unclear whether people would change their ways because of the DRS. It could be wiser to regularly give more people an inexpensive blood sugar test to determine whether they already have diabetes, he added, citing the fact that about a quarter of the 24 million people who have diabetes don't realize it.



Photos: Rebekah Stone

Left to right: A lab specialist works to program a robot to read samples; Marianne Weinell works to prepare samples for PreDx DRS assessment.

At a glance

Tethys Bioscience
5858 Horton St., Ste. 550
Emeryville, CA
(510) 420-6700
www.tethysbio.com
Founded in 2005
In addition to its PreDX test, Tethys is in the process of developing risk tests for osteoporotic fractures and cardiovascular events.

Vaisse said pre-diabetes can be detected by an inexpensive oral glucose tolerance test, which typically costs in the ballpark of $40. After the patient swallows a sugar cube, clinicians measure how fast the sugar levels in the blood subside. "It's clear it's not 100 percent predictive, but it is very sensitive," he said.

Tethys president Michael Richey, however, doesn't see the DRS as being at odds with Vaisse's position. "If you use a fasting glucose test and you find undiagnosed diabetics, it's good news. Wouldn't you like to prevent this disease?" he asked, adding that some models say the health care system can save up to $30,000 per case of diabetes avoided.

Diabetes affects 8 percent of Americans and was the seventh leading cause of death in the United States in 2006. It can lead to serious complications including kidney disease, stroke, heart disease, blindness and amputations. Diabetes cost $174 billion in 2007, according to the Centers for Disease Control and Prevention.

One key way to reduce the devastation is through early detection, so potential patients can make lifestyle changes — and to a lesser extent use medications — to prevent or delay the onset of disease.

And as a result, medical experts across the board are calling for better ways to assess diabetes risk.

"Diagnostic tests should be developed to better distinguish patients who will progress to diabetes from those who will not," recommended the American College of Endocrinology and the American Association of Clinical Endocrinologists in their 2008 consensus statement on the diagnosis and management of pre-diabetes. They added, "It is clear that the risks and adverse consequences of high blood glucose occur at much lower glucose levels than those at which we currently define as diabetes."

The DRS may be just the tool to make those early diagnoses.

Alice Chen is a freelance writer based in the Bay Area.

focus: **LABORATORY MEDICINE AND PATHOLOGY**

From the lab to the lawmakers

Pathologist George Lundberg launches The Lundberg Institute

By Rebekah Stone

Photo: Rebekah Stone

George Lundberg, M.D. — if the name rings a bell, that's no surprise.

Perhaps you recognize it from his time as professor and chair of pathology at UC Davis. Or maybe you saw it in print during his 17 years as editor-in-chief of JAMA and the American Medical Association's other 38 medical journals. Or perhaps you even took a class from him during the 10 years he spent as professor of pathology and associate director of laboratories at the Los Angeles County/USC Medical Center.

But no matter where you might have seen it, George Lundberg is a name you should know.

Raised in rural Alabama, Lundberg's story began unremarkably, but certainly didn't stay that way long, as he skipped grades and struck out for college at the tender age of 15. He completed his undergraduate work, his medical degree, and an 11-year stint in the U.S. Army during the Vietnam War Era. A pathologist first, Lundberg worked in tropical medicine in Central America, forensic medicine in New York, Sweden and England, and worked his way up to the post of president of the American Society of Clinical Pathologists.

In 1982, after contributing articles to several publications, and "being in the right place at the right time," he said, he was named editor-in-chief at the American Medical Association and took full editorial responsibility for the association's medical journals. He oversaw the publication of such groundbreaking articles as the autopsy of JFK and the identification of AIDS.

In 1999, he was publicly and dramatically fired for choosing to publish an article on sex habits among college students, after his publisher prohibited its publication.

"The support I received from fellow journalists and fellow doctors during that time was both unexpected and affirming," he said. "Publishing that article was the right thing to do, and I was willing to stake my career on it."

Job offers from all over the country poured in, but it was Medscape — the leading source of online health information and education for physicians and health care professionals — that caught his eye. He became editor-in-chief of both *Medscape General Medicine* and CBS HealthWatch.com. He served as special health care advisor to the chairman and CEO of WebMD, and as editor-in-chief of eMedicine, the original open access comprehensive medical textbook.

He charted so much of the online territory for medicine that the Industry Standard named him "Online Health Care's Medicine Man" in 2000.

But with his success and years of covering medicine came a larger perspective of the industry, and a sense of responsibility.

"You reach a point in life where you can no longer just stand by and watch decisions being made," he said.

Instead, he founded The Lundberg Institute, a nonprofit whose purpose is "to forge a patient-physician alliance based on trust, providing leadership, strategies, and communications that promote evidence-informed, efficient, and effective health care delivery to benefit the health and well-being of patients, physicians, and the public."

In a nutshell, he hopes to change the landscape of medicine in America.

"All health care should be local and personal," he said. "One patient, one physician; one moment, one decision. Doctors and patients together have enormous power. All we have to do is help turn our focus back there, and we can turn this ship around."

Rebekah Stone is the editor of the Healthcare Journal. She may be reached at rstone@hcjnc.com.

The Lundberg Institute

HQ: 104 Altura Vista,
Los Gatos, CA 95032

Founded: 2009

Web: www.lundberginstitute.org

Mission: To "provide a platform for aligning physician and patient interests and values and to seek improved outcomes. These values are Trust, Truth-telling, Teaching, and Transparency. TLI aspires to inform and mobilize physicians through leadership education and training, technology, best practices, and other action-oriented strategies. Patients benefit most when they have access to competent physicians practicing evidence-informed medicine and reliable information about their health concerns. They need access to productive, competent physicians in multiple specialties close at hand, physicians who participate in smoothly functioning, effective, and efficient practices, whether in solo practice or in small or large groups. The worst situation for patients is if physicians become so discouraged fighting a dysfunctional 'Health Care System' that they close their practices and leave the public underserved."

Lundberg's seven ways to cut medical costs now

"I believe that there are still many ethical and professional American physicians and many intelligent American patients who are capable of, in an alliance of patients and physicians, doing 'the right things,'" George Lundberg wrote in *The Health Care Blog.*

One of those 'right things' is cutting medical costs.

He pits fee-for-service incentives as a key reason that at least 30 percent of the $2.5 trillion expended annually for American health care is unnecessary. Eliminating that waste could save $750 billion annually with no harm to patient outcomes, he estimates.

And paramount to trimming that fat are these seven tenets:

1. Intensive medical therapy should be substituted for coronary artery bypass grafting (around 500,000 procedures annually) for many patients with established coronary artery disease, saving many billions of dollars annually.

2. The same for invasive angioplasty and stenting (around 1 million procedures per year) saving tens of billions of dollars annually.

3. Most non-indicated PSA screening for prostate cancer should be stopped. Radical surgery as the usual treatment for most prostate cancers should cease since it causes more harm than good. Billions saved here.

4. Screening mammography in women under 50 who have no clinical indication should be stopped and for those over 50 sharply curtailed, since it now seems to lead to at least as much harm as good. More billions saved.

5. CAT scans and MRIs are impressive art forms and can be useful clinically. However, their use is unnecessary much of the time to guide correct therapeutic decisions. Such expensive diagnostic tests should not be paid for on a case by case basis but grouped along with other diagnostic tests, by some capitated or packaged method that is use-neutral. More billions saved.

6. We must stop paying huge sums to clinical oncologists and their institutions for administering chemotherapeutic false hope, along with real suffering from adverse effects, to patients with widespread metastatic cancer. More billions saved.

7. Death, which comes to us all, should be as dignified and free from pain and suffering as possible. We should stop paying physicians and institutions to prolong dying with false hope, bravado and intensive therapy, which only adds to their profit margin. Such behavior is almost unthinkable and yet is commonplace. More billions saved.

OFF CALL

TRAVEL AND LEISURE SECTION

Off Call— that special time when physicians can relax and get away from the pressures of the profession.

A novel pursuit

Stanford's Abraham Verghese proves the pen is as mighty as the scalpel

By Lorri Ungaretti

Photo: Lorri Ungaretti

Verghese is given "protected time to write" at Stanford University, where he is program director of Stanford's Internal Residency Program and senior associate chair for the theory and practice of medicine.

Imagine working at a prestigious university where you practice medicine and teach medical students but are also given "protected time to write."

Abraham Verghese, M.D., MACP, happily finds himself in this position. He is program director of Stanford's Internal Residency Program and senior associate chair for the theory and practice of medicine. He has published several articles, two nonfiction books, and most recently, his first novel *Cutting for Stone*, which received rave reviews from both *The Washington Post* and *The New York Times Book Review*.

Verghese was born in Ethiopia of Indian parents. He attended medical school at Madras Medical College and completed his residency in Johnson City, Tenn. After completing a fellowship at Boston University School of Medicine, he stayed on for another two years.

But then he returned to Johnson City, where he specialized in infectious diseases during the early years of the AIDS crisis in the 1980s.

The "AIDS cocktail" has helped people forget the period when doctors could do little for AIDS patients except watch them die and try to make their remaining days comfortable. In Tennessee, Verghese treated patients who were often shunned by family, doctors, nurses and the community. He learned that although he could not be the all-curing doctor, he could help patients come to terms with their fatal illness and heal in other ways.

Verghese said that when he was working in those early days of AIDS, "it was important for me to write in order to understand what was going on. Just thinking or talking about something doesn't do that. Writing helps me understand what I'm thinking."

In 1990, Verghese took a hiatus from medicine to join the Iowa Writers Workshop at the University of Iowa, where he earned a Master of Fine Arts in 1991. He then accepted a position as professor of medicine and chief of the division of infectious diseases at Texas Tech Health Services Center in El Paso, Texas.

And it was here, in El Paso, that Verghese began writing seriously.

Verghese's compassionate approach to working with terminally ill patients in rural Tennessee became the basis for his first book, *My Own Country: A Doctor's Story*, published in 1995. This moving memoir of his work with AIDS patients, their families and the surrounding community became a National Book Critics Circle Award finalist and a Time magazine Book of the Year.

In his second book, *The Tennis Partner*, Verghese recalls a close friendship with a colleague who had problems with drug addiction.

Cutting for Stone, published this year, is an epic novel that spans 50 years, starting in Addis Ababa, Ethiopia. The book begins with a difficult birth — difficult not only because the mother is in distress but also because she is a nun and the father, Thomas Stone, is the surgeon charged with saving the mother and her twin babies. The twins survive, the mother does not and the father disappears.

Over the next 50 years, we come to know the doctors who marry each other for love and raise the twins, Marion and Shiva Stone. We also come to know the fears, loves, and motivations of Marion, the narrator, and his brother, Shiva.

Verghese has a talent for weaving many events and emotions into a story — love, loss, confusion, responsibility, sexual experiences, life choices (and their consequences), genital mutilation, political upheaval, and more. The book is emotionally riveting, and the reader gets to know and care for all the characters.

Verghese is an extraordinary writer, writing clearly and passionately about medical and life issues in a way that draws in the reader.

He acknowledged that while the book's geographic descriptions are based on his early experiences in Addis Ababa, he stressed that the story is not autobiographical.

"When you write, it's your imagination that comes through," he explained. "When you give people emotions and have them speak, you are revealing your own great loves and pet peeves."

Verghese believes that "there is something mysterious about the act of writing." He found that many of his tomes are not what he thought they would be when he started.

When asked why he wrote a novel after two books of nonfiction, Verghese said, "Fiction is a way we interpret ourselves. When good fiction works, there's truth at work."

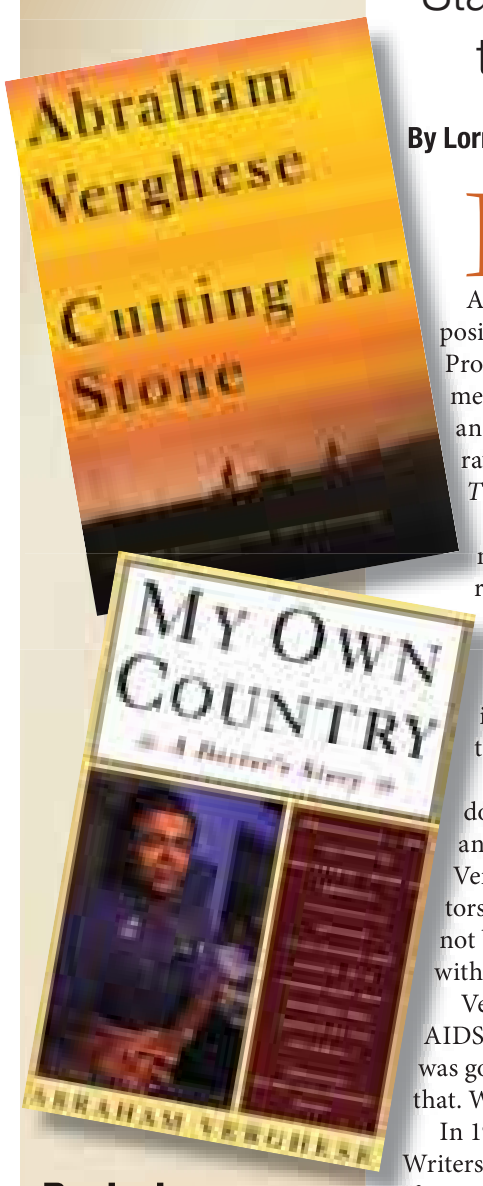
Furthermore, Verghese enjoys reading novels. "You can get into a spaceship and spend five hours in another place, then come back — all in the same afternoon. A good novel doesn't just distract you from your life; it transports you to another world."

But when the time comes for him to put a good novel back on the shelf and return to work, he is happy to, as he thinks highly of the doctors he works with here in northern California.

"These doctors seem to be throwbacks to the classical physicians — not narrowly focusing on only their own thing," he said. "They don't fit the stereotype of the crass physician searching for lots of money."

"Stanford is an incredible place," Verghese added. "All the doctors here have a 'specialness'— research, medicine. Mine is writing. Stanford is willing to try new things. When I worked at other medical schools, I did some writing, but they largely wanted me to be a clinician. Here, I am given time to pursue my writing."

Lorri Ungaretti is a contributing editor of the Healthcare Journal. She can be reached at info@lorriungaretti.com.



Books by Abraham Verghese, M.D.

Cutting for Stone (2009)

The Tennis Partner: A Doctor's Story of Friendship and Loss (1998)

My Own Country: A Doctor's Story (1995)

Web site
www.abrahamverghese.com

Palace of Fine Arts Photo: Phillip H. Coblentz

No parking, no problem

See San Francisco by foot

By Lorri Ungaretti

San Francisco was recently dubbed America's most walkable city by walkscore.com, a service designed to help those seeking a less automobile-dependant lifestyle.

Next time you're looking for something fun, inexpensive and informative to do in San Francisco, check it out on foot for yourself. Leave your car behind and consider going on one of the many free walking tours offered by San Francisco City Guides.

Do you want to know more about Chinatown? The Golden Gate Bridge? North Beach? Coit Tower? Nob Hill? SF City Guides has walking tours for all of those famous places.

But there are also tours that show you areas you might not know about, such as the art of murals, downtown skyscrapers and rooftop gardens. There's "Bawdy and Naughty," a tour of downtown's Maiden Lane, focusing on the history of "professional ladies" in San Francisco.

Or perhaps you would like to learn about one of the city's many neighborhoods. City Guides offers behind-the-scenes looks at the Mission, Noe Valley, Castro, Inner Sunset, Marina and much more. You can learn about the city's unusual architecture by taking the Art Deco Marina, Victorian San Francisco or Gold Coast Architecture tour. Occasionally, owners of the historic houses will even invite a passing tour group inside to really see the home.

"You never know what will happen on a City Guides tour," said guide Mark Hall. "The most unusual thing that happened during one of my tours was when our group arrived at Mission Street just as news of a big Mexican soccer victory had hit. People were going crazy, driving down the street waving big Mexican flags, cheering and blasting salsa music. The walkers loved it, and you really knew you were in the Mission District."

In October and May, when the weather tends to be better, special tours explore Glen Park, Tenderloin, West Portal, Visitacion Valley, Inner Richmond, neighborhood stairways and more. One tour explains the details and history of Diego Rivera's mural at City College (originally part of the Treasure Island World's Fair). You can also walk to learn about cemeteries, local churches and the Panama Pacific Exposition. To celebrate Halloween, two popular October tours talk about "ghosts" at City Hall and at the Palace Hotel.

"City Guides is the best deal in San Francisco — and the most fun," said walker Tony Holiday. "No matter how many times I go on one of the walks, I always learn something new."

SF City Guides is a nonprofit, primarily volunteer operation sponsored by the San Francisco Public Library. It was founded in 1978 and now boasts more than 200 guides leading hundreds of tours a year to more than 20,000 walkers.

SF City Guides walking tours are free (donations accepted). You do not need to make a reservation — just show up at the

*See **CITY GUIDES**, page 17*

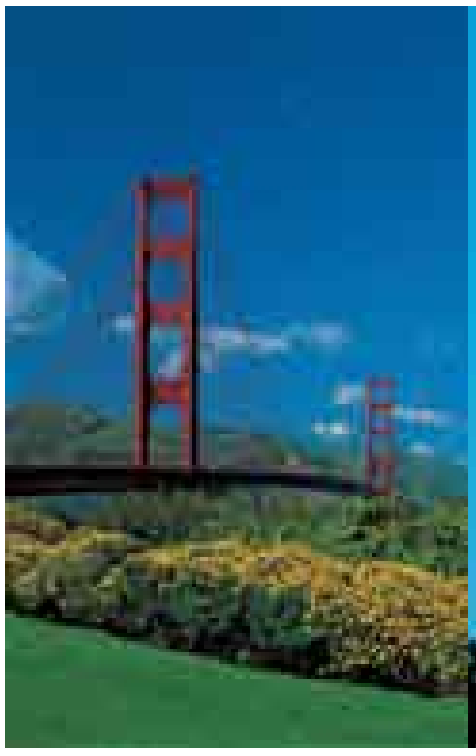
Two SF City Guides showing pictures during their tour of the Dogpatch neighborhood.

Photo courtesy of SF City Guides

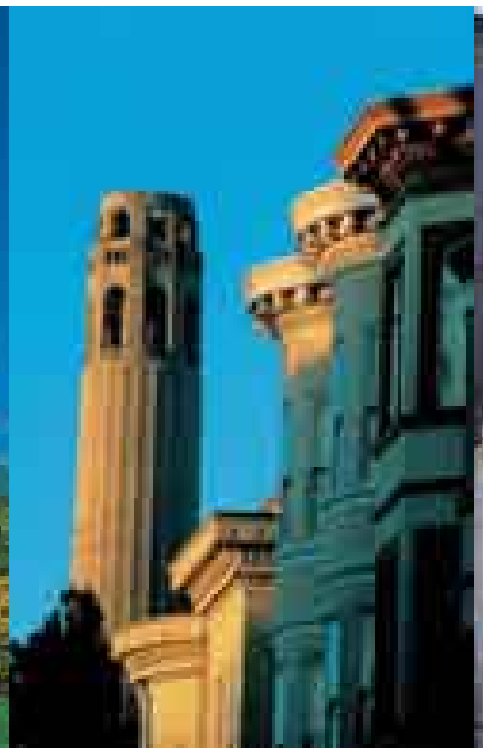
SF City Guide Jacquie Proctor leading one of the downtown tours.

Photo courtesy of SF City Guides

OFF CALL TRAVEL AND LEISURE SECTION



Golden Gate Bridge Photo: Phillip Coblentz



Coit Tower Photo courtesy of SF City Guides

Victorian Homes Photo: Garrett Culhane

One of the special May and October tours explores Golden Gate Heights stairways. Photos: Brian Smith

***CITY GUIDES**, from page 16*

place and time indicated on the schedule. Most tours last 1-1/2 to 2 hours, and are held rain or shine. (Any long-time City Guide can tell you about a walk given in the driving rain.) Tours are offered every day, except Thanksgiving, Christmas Eve, Christmas, New Year's Eve and New Year's Day.

Take a walk with SF City Guides! You'll learn a lot and have fun learning.

Lorri Ungaretti is a contributing editor to the Healthcare Journal. A San Francisco City Guide since 2002, she leads the Inner Sunset and Sigmund Stern Grove tours. You can reach her at info@lorriungaretti.com.

SAN FRANCISCO CITY GUIDES

Pick up an SF City Guides tour schedule at any branch of the San Francisco Library or visit the organization's Web site at sfcityguides.org.

Phone: (415) 557-4266
Email: tours@sfcityguides.org
Private group tours (8 or more people) must be scheduled in advance.

Model Boat of Amenhotep III. Dynasty 18, reign of Amenhotep II (1426-1400 BC). Painted wood. Egyptian Museum, Cairo. Photo: McMillan Group.

San Francisco's de Young Museum hosts the Boy King's treasures

By Sheila Riley

The record-breaking exhibit of artifacts from King Tut's tomb that first came to San Francisco 30 years ago has returned — and it's only gotten better with age.

"Tutankhamun and The Golden Age of the Pharaohs," at the de Young Museum in San Francisco's Golden Gate Park, is on view until March 28, 2010. Sponsored by National Geographic, the exhibit features 50 objects, all more than 3,000 years old, from the tomb of the "Boy King."

And this time around, it includes 80 objects from tombs of his royal predecessors, family and court officials.

"The significance of this exhibition is that it does put Tut into a context," said Renée Dreyfus, curator of ancient art and interpretation at the Fine Arts Museums, which include the de Young. "In the previous exhibit, we only learned that he was a boy king, and he was surrounded with some of the most beautiful objects that Egypt has ever created."

Tut died at 18 or 19 in the ninth year of his reign — 1323 B.C. British archaeologist Howard Carter discovered his treasure-filled tomb in Egypt's Valley of the Kings in 1922.

And now Northern California's Egyptophiles can see that very expedition through the photographs of Harry Burton — who documented the Carter expedition — as the de Young exhibit boasts no less than 38 of Burton's photographs.

But photos of the tomb's original excavation are only the beginning of the exhibit's offerings.

Among the exhibit's spectacular objects are the gilded funerary mask and coffin of Tjuya, a non-royal in-law of Amenhotep III. The wooden coffin is elaborately decorated with spells and divine imagery.

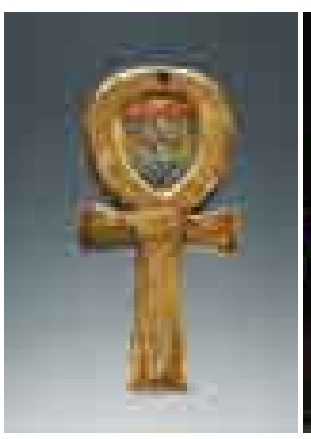
An ornate piece of jewelry, described as a "coronation pectoral," with a scarab at its center, is also part of the exhibit. Meant to protect its wearer from evil, the jewelry is made of precious metals, semiprecious stone, and glass, and decorated with solar and lunar designs.

A cylindrical cosmetic jar, made of calcite, ivory and gold, with a reclining lion on its lid, was designed for more everyday use.

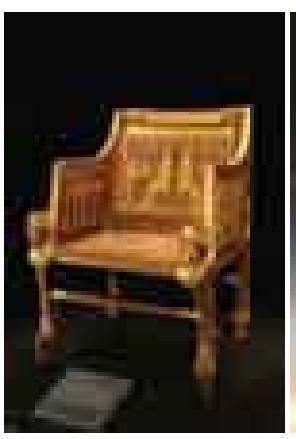
Other not-to-be-missed artifacts include the face from a statue of famously beautiful Queen Nefertiti, a painted wood torso of Tut, a gold and precious stone inlaid "coffinette" that contained Tut's mummified internal organs, and an inlaid board game that accompanied the young king on his journey to the afterlife.

Sheila Riley is a freelance writer in San Francisco.

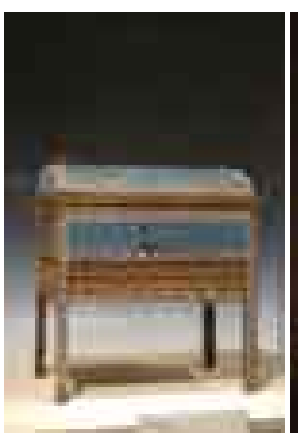
Tutankhamun as King of Upper Egypt (left); Tutankhamun as King of Lower Egypt (right). Dynasty 18; reign of Tutankhamun (1332-1322 BC). Gilded wood. Egyptian Museum; Cairo. Photo: Kenneth Garrett © 2008; National Geographic.



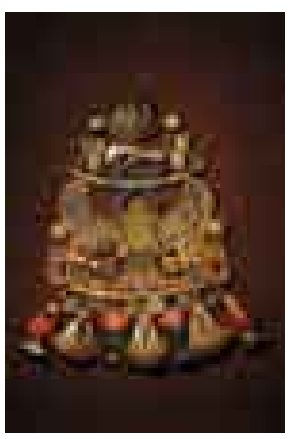
Mirror Case in the Shape of an Ankh. Dynasty 18, reign of Tutankhamun (1332-1322 BC). Wood, gold, silver leaf. Egyptian Museum, Cairo. Photo: Andreas F. Voegelin, Antikenmuseum Basel and Sammlung Ludwig.



Chair of Princess Sitamun. Dynasty 18, reign of Amenhotep III. Wood, partially gilded and silver-plated. Thebes, Valley of the Kings, tomb of Yuya and Tjuya. Photo credit: McMillan Group.



Elaborately decorated chest. Dynasty 18, reign of Amenhotep III. Wood, Ivory, ebony, faience. Thebes, Valley of the Kings, tomb of Yuya and Tjuya. Photo credit: McMillan Group.



Pectoral with Solar/Lunar Emblem and Scarab. Dynasty 18; reign of Tutankhamun (1332-1322 BC). Gold; silver; electrum; semiprecious stones. Egyptian Museum; Cairo. Photo: Kenneth Garrett © 2008/National Geographic.

Tutankhamun and the Golden Age of the Pharaohs

De Young Museum, Golden Gate Park
www.deyoungmuseum.org
(415) 750-3600

Hours
Through Sept. 30
Monday-Sunday 9 a.m. to 9 p.m.
Last ticket 7:30 p.m.

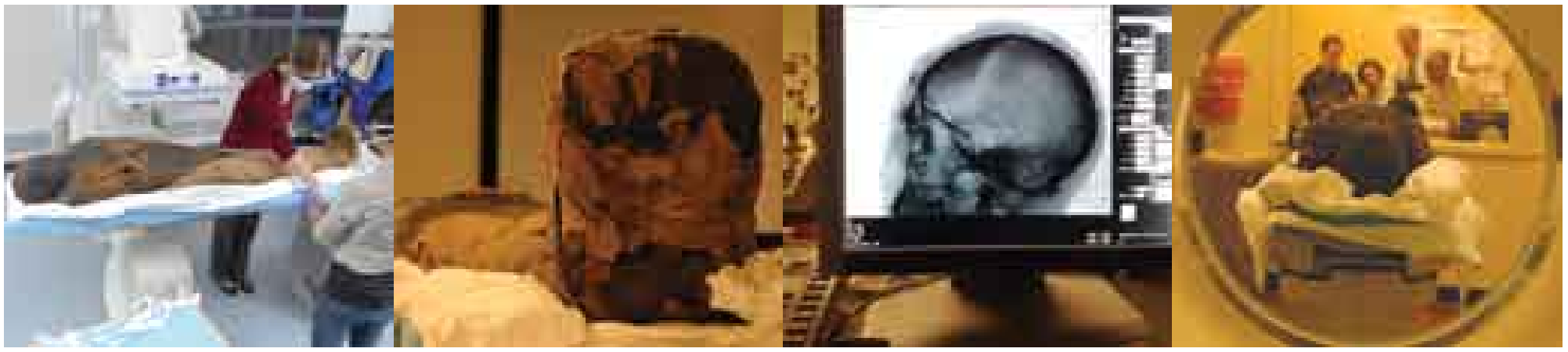
Oct. 1 to March 28, 2010
Tuesday-Sunday 9 a.m. to 6:30 p.m.
Last ticket 5 p.m.

8:45 p.m. on Fridays
Last ticket 7 p.m.

Ticket Prices
From $16.50 for ages 6-17 to $32.50 for adults (member price $22.50). Children 5 and under free.

Capacity is limited, and advance purchase is strongly encouraged.

OFF CALL TRAVEL AND LEISURE SECTION



Decoding mummies through medicine

Radiologists at the Stanford University School of Medicine tended to an unlikely patient in August: A more than 2,000-year-old mummy believed to be an ancient Egyptian priest.

The mummy, who belongs to the Fine Arts Museums of San Francisco, arrived at Stanford in a climate-controlled truck, where radiologists were ready and waiting.

Using cutting-edge computed tomography, or CT, scans to peer through its dressings at the preserved body inside, the scans enabled scientists to create three-dimensional images of the body from the inside out. Researchers also plan to use images of the man's skull to build a clay reconstruction of his face, providing a peek at what he might have looked like. In addition to those uses, the scans may help to determine what materials the ancient Egyptian is wrapped in.

Following a thorough examination by Stanford radiologist Rebecca Fahrig, Ph.D., as well as Renee Dreyfus, FAMSF antiquities curator, and Jonathan Elias of the Ahkmin Mummy Studies Consortium, the mummy returned to San Francisco, where it will be the centerpiece of the Legion of Honor's "Very Postmortem: Mummies and Medicine" exhibition, which opens on Oct. 31, 2009.

The mummy is thought to be that of Iret-net Hor-irw, who was a minor priest in the city of Ahkmim on the east bank of the Nile in Egypt. X-rays done in 1970 suggest that he was in his mid-20s when he died of unknown causes. The mummy had been on loan to the Haggin Museum in Stockton, but was returned this month to the San Francisco museums in preparation for the new exhibition. He will remain on display at the Legion of Honor through the summer of 2010.

Left to right: PHOTO 1: Conservators unwrap the mummy from his protective packaging materials, revealing his linen bandages. His right elbow is visible through the worn wrappings. Photo by Mark Riesenberger. PHOTO 2: The resin-encrusted feet of the mummy are visible beneath his wrappings. Conservators plan to stabilize the linens to prevent them from unraveling further. Photo by Stephanie Pappas. PHOTO 3: The CT scanner reveals three amulets in the bandages around Iret-net Hor-irw's head. On his forehead rests a scarab beetle, a symbol of eternal being. At the base of his skull, a pillow amulet represents an Egyptian headrest. Above his right eye, a two-plumes amulet represents fertility and the good life. Photo by Alex Braddock. PHOTO 4: Egyptologist Jonathan Elias (left, standing), radiologist Volney van Dalsem (second from right), dentist and veteran mummy-scanner Paul Wood (far right) and other researchers peer at CT images of Iret-net Hor-irw at the Palo Alto Imaging Center. Photo by Stephanie Pappas.

Photos: Courtesy of the Stanford Office of Communication & Public Affairs

HEALTH CARE AT A GLANCE

SACRAMENTO/ NORCAL

Sacramento's Mercy General receives accreditation as chest pain center

Mercy General Hospital received full Cycle II accreditation with PCI (percutaneous coronary intervention) from the Accreditation Review Committee of the Society of Chest Pain Centers. Mercy is the first and only hospital in Sacramento to receive the chest pain accreditation.

Heart attacks are the leading cause of death in the United States, with 600,000 people dying annually of heart disease. The goal of the Society of Chest Pain Centers is to significantly reduce the mortality rate of these patients by teaching the public to recognize and react to the early symptoms of a possible heart attack, reduce the time it takes to receive treatment, and increase the accuracy and effectiveness of treatment.

"This distinction signifies our consistent systematic approach for chest pain patients, which ensures better outcomes," said **Doris Frazier**, vice president of cardiovascular services at Mercy.

Kaiser's Vacaville hospital to open this fall

After delaying the opening of its $500 million Vacaville hospital due to the economic downturn, Kaiser Permanente now expects to open its new facility this fall.

Though staffing levels and the exact opening date are yet to be determined, the official opening is expected in October or November. The Vacaville hospital's neighboring 217,000 square foot medical office building opened last November.

The 340,000 square foot facility will boast up to 150 beds, and will include emergency services, a critical care unit, medical-surgical suites, and full diagnostic and support services. Initially, labor and delivery services will not be offered in Vacaville, but rather at Kaiser's existing Vallejo medical center.

BAY AREA

Feds commit $800M to H1N1 vaccine, much to flow to Novartis

The federal government has committed more than $800 million to buy more of the two key ingredients for brewing the H1N1 swine flu vaccine, according to the Department of Health and Human Services. The money will be used to place additional orders on existing contracts with vaccine manufacturers, including the former Chiron Corp. facility in Emeryville, which is now owned by Novartis.

Stanford's Sandra Horning joins Genentech

Genentech Inc. announced the appointment of **Sandra Horning, M.D.,** to senior vice president, global head, clinical development hematology/oncology. In her new role, Horning will be responsible for leading the medical and scientific strategies for the global clinical development portfolio in oncology.

"I'm eager to be joining Genentech," Horning said. "They have an unparalleled pipeline of innovative cancer medicine in addition to multiple commercial products that have improved the lives of cancer patients."

Hayward's St. Rose nets $42M in bonds

St. Rose Hospital had a lot to celebrate as it received a $50 million bond issue, which netted $42 million after fees and expenses. The bond funding will be used to update the Hayward facility to comply with state seismic retrofitting requirements and make other improvements, pay off debts and add 30 single-patient rooms to the 160-bed, 47-year-old hospital.

Portola Pharmaceuticals signs $470M deal

South San Francisco-based Portola Pharmaceuticals signed an exclusive global licensing deal with Merck & Co. Inc. for stroke drug betrixaban. Merck will pay Portola an upfront fee of $50 million, while the value of the deal could climb to as much as $470 million upon hitting milestones.

Presidio Pharmaceuticals lands $27M in funding

San Francisco's Presidio Pharmaceuticals raised $27 million in venture funding to advance its hepatitis C drug candidate through clinical studies and to develop other programs. New Leaf Venture Partners joined the current investor syndicate comprised of Panorama Capital, Baker Brothers Investments, Ventures West Capital, Bay City Capital, Nexus Medical Partners and Sagamore BioVentures in the recent financing.

SILICON VALLEY

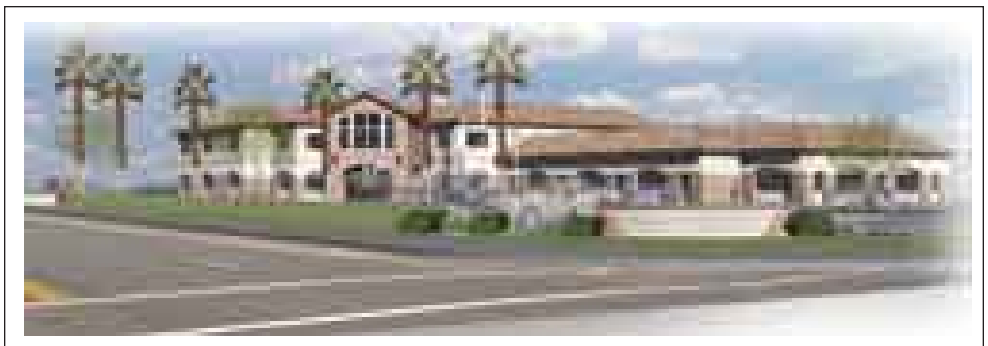
Stanford study spotlights new breast pump approach for mothers of preemies

Mothers of premature infants should not rely solely on breast pumps to establish and maintain their breast milk supply, researchers at Lucile Packard Children's Hospital and Stanford University of Medicine have found. Instead, using their own hands to stimulate milk production was found to be a simple, safe and free tool.

The findings contradict widely held assumptions that premature delivery lessens the hormone signals needed to establish breast-feeding.

In the study, 67 new mothers of premature infants learned how to combine an electric breast pump with hand-expression techniques to extract milk. By the end of the eight-week study, their average milk production exceeded the amount needed to feed a healthy 3-month-old, even though none of the women studied could nurse when their babies were born. The findings could have implications for women who have full-term infants as well.

The study was led by **Jane Morton, M.D.,** director of the breast-feeding medicine program at Packard Children's, and **William Rhine, M.D.,** a neonatologist at Packard, and was funded by grants from the National Institutes of Health and by Medela Inc. Medical Research in Switzerland, a manufacturer of breast pumps.



Salinas Valley system breaks ground on new medical complex

Salinas Valley Memorial Healthcare System broke ground on a new medical complex on Abbott Street in Salinas. The new, 40,000 square foot facility will house future hospital services on the second floor, while the first floor will be leased by Salinas Valley PrimeCare Medical Group.

The building is slated for completion in September 2010.

Brain signaling differs in children, adults, Stanford study finds

Vinod Menon

Kaustubh Supekar

Mark Musen

The first-ever comparison of synchronization of brain signals in children and young adults helps explain why children are less adept at multitasking, emotion regulation and other behaviors that come with maturity, according to researchers at the Stanford University School of Medicine.

The study, which appeared in PLoS-Biology, offers unexpected insights into how the brain matures. It also lays the groundwork for understanding neurodevelopmental problems such as autism and attention deficit-hyperactivity disorder.

Stanford's **Vinod Menon, Ph.D.**, associate professor of psychiatry and behavioral sciences and of neuroscience, **Kaustubh Supekar**, a graduate student in biomedical informatics who is the paper's first author, and **Mark Musen, M.D., Ph.D.**, professor of medicine at the Center for Biomedical Informatics Research collaborated on the study. The research was funded by grants from the National Institutes of Health and the National Science Foundation.

The next step in the research, Menon said, will be to compare the brain signaling and synchronization in children with neurodevelopmental disorders to that of typically developing children. Such comparisons could eventually illuminate the origins of autism, ADHD and schizophrenia.

Ovarian cancer tests flawed, according to Stanford study

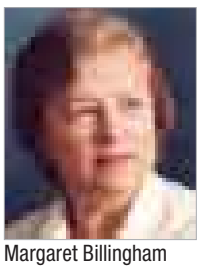
Diagnostic tests for ovarian cancer are ineffective for early detection of the disease, according to researchers at Stanford University School of Medicine. A new study finds that in order to make a significant dent in the mortality rate for the deadly cancer, the tests would need to detect tumors of less than 1 cm in diameter, or about 200-times smaller in mass than those currently used to assess potential new tests. Still, if that hurdle can be overcome, there is good reason to believe that testing could make a big difference. The window of opportunity for treating these clinically undetectable cancers before they become life threatening is surprisingly long: about four years.

"We are miles away from detecting the most deadly ovarian tumors at this early stage," said Stanford biochemistry professor **Patrick Brown, M.D., PhD.** "But now we have a chance of actually designing an effective test that will allow us to treat them before they become deadly."

If a blood test is to be effective, said Brown, it will likely require identifying new markers that are never produced by normal cells — rather than testing for abnormally high levels of proteins detectable in normal blood, as current tests do. Other possible strategies might rely on new molecular imaging methods or fluid samples from the uterus or vagina — in which tumor markers are likely to be more concentrated.

The Canary Foundation and Howard Hughes Medical Institute funded the study, authored by Brown and **Chana Palmer, Ph.D.**, of the Canary Foundation.

Heart transplant pathology pioneer Margaret Billingham dies



Margaret Billingham

Margaret Billingham, M.D., a founder of the field of cardiac transplantation pathology who developed the "Billingham's criteria" that doctors still use to grade heart transplant rejection, died of kidney cancer on July 14. She was 78.

Billingham, director of cardiac pathology emeritus and a professor of pathology at the Stanford University Medical Center, left behind a curriculum vitae spanning 50 years and more than 50 pages. In addition to her work in cardiac transplant rejection, she also made major contributions to research into the toxicity of the chemotherapy drug adriamycin and the development of heart biopsy techniques.

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HEALTH CARE AT A GLANCE

Continued from page 20

Press named psychologist of the year


Robin Press

The Santa Clara County Psychological Association named **Robin Press, Ph.D.**, as its Psychologist of the Year. The Los Altos-based psychologist is a specialist in the area of psychological assessment, and her work in developing and directing the Assessment Center at the Gronowski Clinic at the Pacific Graduate School of Psychology was cited in the award's presentation.

Iron-binding drug could help diabetics heal stubborn wounds, Stanford study finds


Geoffrey Gurtner

A drug used to remove iron from the body could help doctors fight one of diabetes' cruelest complications: poor wound healing, which can lead to amputation of patients' toes, feet and even legs.

The drug, deferoxamine, helps diabetic mice heal small cuts 10 days faster than those who did not receive treatment, according to researchers from Stanford University School of Medicine and the Albert Einstein College of Medicine.

The team is now working to arrange human trials for deferoxamine. If the results translate, it could help doctors combat such diabetic complications as foot ulcers, an "unmet medical need of gigantic proportions," said **Geoffrey Gurtner, M.D.,** professor of surgery and senior author on the paper.

The first author on the paper is **Hariharan Thangarajah, M.D.**, of the department of surgery at Stanford. Other researchers at Stanford and Einstein participated in the study, which was funded by the National Institute of Diabetes and Digestive and Kidney Diseases.

Bay Area Parent Magazine top health care picks

Readers of Bay Area Parent magazine cast their votes online for the "best" family friendly businesses, including doctors, dentists and hospitals. Top pediatricians included **David Trager, M.D.** (gold) and **Peter Contini, M.D.** (silver).

Award-winning dentists included **Adolfo Barrera, DDS** (gold) and **Agape Dental Group** (silver).

Sequoia Hospital in Redwood City has taken the title of best hospital for the second consecutive year.

"Receiving the Best Hospital honor two years in a row demonstrates that not only do we deliver great care to our moms and babies, but we take excellent care of the rest of the family too," said Jennifer Doran, RN, BSN, director of perinatal services. San Jose's Good Samaritan Hospital and Palo Alto Medial Foundation each were silver medal winners.

Addario family gives $500,000 for new Sequoia Hospital

Bonnie and Tony Addario pledged $500,000 to help build and equip Redwood City's new Sequoia Hospital. The gift was made in support of Sequoia's Imaging Center, in honor of oncologist **Fred Marcus, M.D.,** who cared for Bonnie during her battle with lung cancer.

The gift was made to The New Sequoia Hospital Campaign, which has raised $7.6 million of its $20 million goal. The new hospital will be a full-service, 148,000 square foot building adjacent to the existing hospital facility.

Stanford researchers win pediatric cancer grant

Pediatric cancer researchers **Norman Lacayo, M.D.**, and **Gary Dahl, M.D.**, of Stanford University's Comprehensive Cancer Center were one of eight teams nationwide to win V Foundation for Cancer Research grants this year. The Cary, N.C., foundation awarded grants to eight research teams totaling $1.75 million.

Salinas Valley Memorial honored with major AHA award and in survey of best U.S. hospitals

Salinas Valley Memorial Healthcare System recently received recognition from two major organizations — the American Heart Association and U.S. News and World Report's survey of America's Best Hospitals.

The public health care system received the American Heart Association's Get With The Guidelines — Coronary Artery Disease Gold Performance Achievement Award.

Under the Get With The Guidelines — CAD program, patients are started on

*See **AT A GLANCE**, page 22*

HEALTH CARE AT A GLANCE

Continued from page 21

aggressive risk reduction therapies in the hospital, receive smoking cessation and weight management counseling and receive referrals for cardiac rehabilitation before they are discharged. Hospitals receiving the award must demonstrate for 24 consecutive months that at least 85 percent of its eligible coronary patients are discharged following the AHA's recommended treatment guidelines.

And in this year's survey of America's Best Hospitals, which ranks hospitals in 16 specialties, using criteria such as patient safety, nurse staffing and technology, the hospital system received high marks.

"We appreciate being recognized as a leader in health care," said **Sam Downing,** MBA, MPH, president and CEO of Salinas Valley Memorial. "Our staff is focused on providing quality patient care every day, and our commitment to bringing the latest technology to our region is something that benefits the residents of this district and beyond."

Yahoo! Employee Foundation awards grant to Pathways Hospice Foundation

Pathways Hospice Foundation received a grant of $34,345 from the Yahoo Employee Foundation, a corporate advised fund of the Silicon Valley Community Foundation.

The grant will support the home health and hospice agency's 24-hour nursing team known as the "Dream Team," which provides telephone consultations and home visits within five Bay Area counties. In 2008, the Dream Team logged approximately 7,724 calls and made 2,378 home visits.

Stanford Medical School wins $10M NIMH grant

Stanford's School of Medicine was awarded a $10 million, five-year National Institute of Mental Health grant to help establish and run the Silvio O. Conte Center for Neuroscience Research.

The new center will focus on neuroplasticity, or how the brain changes during development or when exposed to changing conditions. The research could potentially have implications for understanding schizophrenia, autism, bipolar disorder, pain syndromes and other conditions that induce brain adaptations.

The center will be led by director **Robert Malenka, M.D.**, Stanford professors **Thomas Sudjof, M.D.**, and **Karl Deisseroth, M.D.,** and UC Berkeley associate professor of neurobiology **Lu Chen**.

Hospice of the Valley adds new members to board of directors


Sutton Roley


Terry Rutledge


Euan Thomson

Sutton Roley of CPS CORFAC International, **Terry Rutledge** of Samaritan Medical Center and **Euan Thomson** of Accuray have joined the board of directors of Hospice of the Valley.

For his part, Roley has more than 25 years of experience in the commercial real estate brokerage industry.

Rutledge, on the other hand, has more than 25 years of experience in the health care industry, with an emphasis in leadership and operations management, strategic business planning and project development, and performance in community hospitals and medical center settings.

Lastly, Thomson's years of experience encompass research, teaching undergraduates and post graduates, clinical science, hospital management, medical device management and consultancy. He is the president and CEO of Accuray Inc., a public medical device company in Sunnyvale.

Celebrating 30 years of community service, Hospice of the Valley — the first community-based hospice in Santa Clara County — has provided end-of-life care and grief support to 30,000 people since 1979.

What you missed!

Our e-newsletter readers receive breaking news and analysis on stories crucial to your practice. On Tuesdays we deliver an update and preview of what's happening in health care reform and on Thursdays it's the issues that affect the practice of medicine in Northern California. Sign up at our Web site, www.hcjnc.com

The five biggest stories you missed.

1. MICRA Upheld by California Supreme Court
2. Anna Eshoo receives more money from pharmaceutical companies than Senators Boxer or Feinstein
3. New H1N1 guidelines in place
4. UCSF partners with Hill Physicians
5. Top practice challenges in 2009

UPCOMING EVENTS

Sept. 9-13
8th Annual Physician's Art & Music Show
- Santa Cruz
- www.cruzmed.org

Sept. 10
4th Annual Psychotic Disorders Conference
- Sacramento
- www.ucdmc.ucdavis.edu

Sept. 10-13
Women's and Pediatric Dermatology Seminar 2009
- San Francisco
- www.sdefderm.com

Sept. 11-13
The Changing Practice of Anesthesia
- San Francisco
- www.cme.ucsf.edu

Sept. 18-19
Hospice and Palliative Care in Developing Countries
- Fresno
- www.hindshospice.org

Sept. 23
Best Practices in Managing a Hospital Medicine Program
- San Francisco
- www.cme.ucsf.edu

Sept. 24-26
Fifth Annual Oncology Congress
- Hilton San Francisco
- www.oncologycongress.com/B1

Oct. 7
Cancer Advances: Public Forum on Breast Cancer
- San Francisco
- www.ascocancerfoundation.org

Oct. 8-10
2009 Breast Cancer Symposium
- San Francisco
- www.breastcasymposium.org

Oct. 16-17
Eating Disorders in Children, Adolescents and Young Adults
- Stanford
- www.stanford.edu

Oct. 21-23
Primary Care Medicine: Practices and Principles
- San Francisco
- www.cme.ucsf.edu

Oct. 26-29
Advanced Imaging Course in California Wine Country
- Sonoma
- www.ucdmc.ucdavis.edu

Nov. 1-2
Treating the Whole Patient: The Body-Mind Connection
- Mandalay Bay Convention Center, Las Vegas
- www.cmellc.com/twp/

Nov. 4
Thyroid and Parathyroid Ultrasound Course
- San Francisco
- www.cme.ucsf.edu

Nov. 5-7
UCSF Otolarynology Update 2009
- San Francisco
- www.cme.ucsf.edu

Nov. 6-7
4th Annual NorCal Bone and Mineral Symposium
- Monterey
- www.cme.ucsf.edu

Nov. 13-14
UCSF 4th Annual Primary Care Sports Medicine
- San Francisco
- www.cme.ucsf.edu

Nov. 14
Emerging Strategies in Women's Cancers
- Omni San Francisco Hotel
- www.cancerlearning.com

Dec. 3-4
Controversies in Women's Health
- San Francisco
- www.cme.ucsf.edu

Dec. 3-5
The Medical Management of HIV / AIDS
- San Francisco
- www.cme.ucsf.edu

Dec. 11-13
26th Annual Advances in Heart Disease
- San Francisco
- www.cme.ucsf.edu

Feb. 12-13, 2010
16th Annual Advances in Diagnosis and Treatment of Sleep Apnea and Snoring
- San Francisco
- www.cme.ucsf.edu

Feb. 13-16
Pacific Rim Otolarnology Head and Neck Surgery Update
- Honolulu
- www.cme.ucsf.edu

Feb. 13-20
Emergency Medicine Reviewe
- Norwegian Cruise Line to Hawaiian Islands
- www.continuingeducation.net

Does your organization have an upcoming event?

To have your event included in our "Upcoming Events" calendar send your information to:
news@hcjnc.com

Multiple battles over Sutter's broken promises, questionable actions led to letter

SUTTER, from page 1

Next on the list of grievances was San Leandro Hospital. After losing money on the facility, Sutter has opted to leave its lease early and plans to transfer the facility to Alameda County for non acute-care uses. Critics allege that Sutter and its new Eden Medical Center in Castro Valley are limiting access to care. According to the letter, the Eden Township Healthcare District requested an independent audit of the district's books after questions were raised "as to conflict of interest in the execution of a memorandum of understanding" that could allow Sutter to assume ownership of the public hospital "at a price below value" and "without a vote of the people, and without restriction on the future role of the hospital in meeting local health needs." It remains to be seen whether the hospital will ultimately remain open, and in what capacity.

But when Sutter disclosed in July that it had pulled more than $88 million from Marin General Hospital over the last two years — $48 million in Marin General's profits in 2008 and $38.7 million in 2007 — that disclosure proved to be the last straw for legislators.

"Troubled" by reports of the cash transfer, Huffman wrote a letter to the Marin General Hospital Board on July 17, demanding justification for the approval of the cash-grab and relevant documentation in support of their decision. Instead, he said in a statement, the board offered a generic explanation of how affiliates within the Sutter "family" benefit from one another.

Huffman's follow-up letter to the board went unanswered.

"Since the board has chosen to ignore my repeated inquiries, it is time to seek the assistance of the Attorney General to determine if any improprieties occurred in these transactions," he said in a Sept. 1 statement. "Frankly, I am not surprised to learn that similar suspicious transactions have cropped up in other areas."

For its part, Sutter has maintained that its actions in all of the questioned locations are in accordance with its system-wide financial policies, and that its actions do in fact serve the interests of those communities.

Bill Gleeson, a senior Sutter Health spokesman, issued a written statement that the legislators' letter "misrepresents Sutter Health's impressive track record of preserving and expanding access to care, and misrepresents our service to low-income patients and communities."

According to Gleeson, Sutter has invested more than $5 billion since 2000 to build and improve hospitals and clinics all over Northern California.

But Huffman vowed that he would not let the controversy be swept under the rug without a thorough investigation.

"I will utilize the full authority of my office, if necessary, to get this information," he wrote to the Marin board. "If it appears these [cash] transfers were improper, I will fight to secure the return of these funds to Marin General Hospital."

Rebekah Stone is the editor of the Healthcare Journal. She may be reached at rstone@hcjnc.com.

Marin General Hospital Board: Community-minded citizens or Sutter minions?

As Assemblyman Jared Huffman and his fellow legislators pursue hopes of an investigation into Sutter's business practices, Huffman is not overlooking the culpability of the not-for-profit corporation that oversees Marin General Hospital for Sutter — particularly the board's role in the transfer of more than $120 million in profits since 1995.

The Marin General Hospital board of directors is comprised of 13 community members. Two were directly appointed by Sutter, the rest are appointed by previous board members but are subject to Sutter's approval. One member, David Bradley, is the Sutter executive in charge of Marin General.

The board voted to approve the transfers of $88 million from Marin General's profits to Sutter's Sacramento headquarters in the last two years. Previous transfers bring the total to $120 million that has been transferred out since 1995, compared to only $5.3 million that has been transferred in.

But the question remains: whose interests should the board members serve — Sutter's or the Marin community's?

According to Huffman, they should be serving the best interests of Marin.

His July 17 letter to the board requested that its members "explain the basis for allowing these large transfers of money out of Marin General Hospital to other Sutter hospitals." Furthermore, he requested all documents relating to the board's role in "reviewing, commenting upon, advising or approving these transfers."

The response by board chairman Robert Heller explained the familial cash policy of Sutter, whereby excess cash from profitable hospitals is funneled to Sutter's less-profitable facilities.

But this explanation wasn't enough for Huffman. He responded with the speculation that the board "simply rubber-stamped the looting of Marin General Hospital."

"My questions are about your role, as fiduciaries of Marin General Hospital and the patients it serves, in allowing these massive transfers to happen," he wrote.

And he's not the only one who doesn't seem to buy the "aw, shucks, we're a family" sensibility. Now, the Marin Board of Supervisors is getting involved in the fight. On Sept. 1, the board unanimously adopted a resolution calling on the board of directors to "fully fulfill its fiduciary duties to the hospital and the Marin County community."

Further questions have been raised about the interests of the board in light of the realization that it would be within the bounds of Sutter's lease for the board to move funds to a depreciation account, which couldn't be transferred by Sutter.

According to Marin Healthcare District Chief Financial Officer David Cox, the board is authorized to put about $100 million into a depreciation account. To date, the board has failed to put any money off limits.

Marin General board members have declined to comment, directing all questions to Sutter spokesman Bill Gleeson.

POINT OF VIEW

Physicians have surprising stake in medical policy research


Philip Alper

How often do we doctors think about our stake in medical research?

I do, every time another "evaluation" judging my "clinical performance" crosses my desk. These documents are so consequential to reputation and future earnings and are so prone to error that the California Medical Association advises physicians to demand the raw data upon which "performance ratings" are based.

Frankly, you and I know that the quality of the medical research behind the performance evaluations of physicians and the interest in paying for performance by private and government payers — as well as employers — is deeply flawed and essentially unreliable. Why we have remained so passive in the face of a lack of truly evidence-based policy decisions is a mystery that probably relates to our being busy with our practices and not fully understanding the issues and what to do about them.

The result, however, is a physician workforce (especially in primary care) that is subject to minute analysis based on the quick and dirty application of one after another research article purporting to show a cost or care benefit by manipulating practice patterns and mandating new investments by physicians. These are amplified by propaganda, for example, the simultaneous contention by George Bush, Hillary Clinton and Bill Gates, late in the last administration, that electronic medical records will be the salvation of American medicine. This received wisdom has now been perpetuated across the political divide by President Obama.

The strain between easy generalizations and the tendency to turn them into burdensome policy is taking its toll. Three decades ago, an article in The Wall Street Journal discussed how the "study industry" in America, at the time worth $8 billion, left much to be desired because researchers tended to write for the edification of one another and not to produce useful answers for the funders of their studies — or for that matter, for the citizenry at large.

Since then, the number of billions has increased enormously, especially in health research. The National Institutes of Health budget, to give one example, rose from $11.9 billion in 1996 to $27.1 billion by 2003. According to the federal Office of the Budget, the NIH enacted appropriation for 2009 is $30.3 billion, an increase of nearly $1 billion since 2008, despite an austerity program that slowed the rate of increase.

It is becoming clear that health policy and clinical research overlap and cannot be entirely separated. Clinical medical journals, including JAMA and the NEJM, now publish many policy articles, while traditional policy journals often delve into clinical issues. One study often seems to contradict another, whether it relates to the value of health information technology or whether to tightly control glucose levels in the ICU. Yesterday's received wisdom about the value of tight control was so emphatic that it has become a performance measure for ICU care. Today, however, we learn that tight control increases mortality rates. This is frustrating! Who is watching the researchers to see that they are doing their job properly?

Apparently nobody. A rare pair of articles in the August 11 issue of Health Affairs belatedly highlights this as a problem.

One article, titled "Connecting the Ivory Tower to Main Street: Setting Research Priorities for Real-World Impact" complains of the gap between the priorities of those who fund and conduct research and the needs of the private "decision-making community" (which, notably, does not include physicians). Significantly, for that "community," clinical effectiveness and quality rank fourth in importance — after the following business considerations: consumer behavior relating to health plan design, return on investment and understanding how to identify the most and least efficient providers. The goals and needs of patients are as prominently absent in the discussion as those of physicians. One can only wonder about the quality of research that will emerge from such a biased (yet well-funded) approach.

The other article, "The Unhealthy State of Health Policy Research," by SR Majumdar and SB Soumerai, is far more useful for everyone. Its sub-title maintains that "Poor-quality research can jeopardize the quality of policies that rely on that research."

Two common errors are largely responsible. First is the notion that only randomized control trials are reliable, even though they are difficult to impossible to do in policy research. Consequently, designs providing other kinds of good evidence tend to be mixed with bad evidence. The authors note that, "…the methods of many published studies are sufficiently flawed that it might not be possible for health care professionals, article peer reviewers, editors, journalists, the public, or policymakers to know what studies to believe or disbelieve. Even the highest-impact journals are not immune to this malady…"

With little or no awareness of the difference, the media tend to give "equal-time" to good and bad research, further confounding the issues.

Therefore, a touted study using community pharmacists to provide diabetes education showed unbelievably good results in diabetic control and lowering costs until it was realized that there were no controls and half the patients were lost to follow-up. Likewise, "many pay for performance policies have little supporting valid evidence."

Health information technology research is a particular problem. Billions of federal dollars are earmarked in support, but, "almost no evidence exists on the impact of commercially available proprietary systems that are likely to be adopted by most typical U.S. office practices."

Nor has the impact on patients been adequately assessed. Even worse, careful studies in both the United States and the United Kingdom in the care of heart disease and asthma by computerized decision support — despite considerable cost — seem to have had little impact.

The authors conclude that considerable additional research should be done before rolling out a scheduled $100 billion investment in IT and penalizing physicians who do not comply.

Majumdar and Soumerai offer a number of suggestions how to make health policy research more credible. Years of observation and participation have given me a few suggestions of my own.

Current research often excludes the obvious. A prominent researcher I know was attempting to uncover the motivation of surgeons in setting up their own facilities to operate. He was examining large insurance databases, hoping to show that more money was the reason. "But just to be sure," I asked, "have you spoken with any surgeons?"

He had not, nor did he plan to. But had he done so, there's a lot he could have learned about the inefficiency of operating in general hospitals that can be improved upon with more direct control. Such additional information could have helped him avoid policy advice based on incomplete understanding.

There is a recognized way to get such information. It is called the Critical Incident Technique (see Wikipedia). It has been in use in research for more than 75 years and involves collecting the direct observations of involved parties — doctors, for example.

There may well be an inherent bias against including practicing physicians in health policy and even in some clinical research that we may not be able to overcome. But better-designed research will protect both our patients and us from flawed policy advice and its often quick and dirty implementation.

Reliable evidence-based behavior works both ways.

Philip Alper, M.D., is a clinical professor of medicine at UC San Francisco and practices internal medicine in Burlingame.

Financial hardship drives many smaller associations to join forces with larger, stable 'parents'

MONTEREY, from page 1

In fact, the Sonoma County Medical Association manages the Marin Medical Society in a similar arrangement to the one brokered by Santa Clara and Monterey, and the benefits of such a model are many, according to Santa Clara County Medical Association executive director Bill Parrish.

Many small county medical associations are facing a serious problem during the next several years, Parrish said. The executive directors have likely been with the organizations for years and are up for retirement and it's more difficult to find replacements, especially for the salary many of them can afford.

As was the case at Monterey County, as membership numbers drop, benefits are cut. Then more members leave the organization rather than pay the same amount of dues, or even higher, for fewer benefits. Monterey's society has about 250 members this year, down from nearly 265 in 2007.

Instead of closing their doors due to trailing membership numbers and sinking profits, some small medical societies are opting to join with 'parent' associations, like the agreement between Monterey and Santa Clara.

"This arrangement is good for both organizations," said Parrish, who brokered the deal between Monterey and Santa Clara.

In this case, the medical society will continue to have a board in Monterey County to represent its physicians, but all other functions will be operated out of the San Jose office for the SCCMA.

Monterey County physicians will be offered more services, benefits and even lower annual dues under the new arrangement. Now, the dues are $350, down from $360 last year.

Under SCCMA, Monterey County physicians will be offered assistance in solving problems with insurance companies, more continuing education workshops and a 22 percent discount on Verizon and other equipment for a physician's office.

"Just last week a physician from Monterey called us upset. He had hired a consulting firm, but felt he got ripped off," Parrish said. "We helped him negotiate a better deal."

This will become a model organization and partnership for more medical associations across the state, Parrish said.

The decision to partner with Santa Clara came after Monterey County Medical Society, a nonprofit organization, suffered financial losses of $124,329 in 2007. During the same period in 2006, the association made a profit of $7,010, according to the latest 990s filed with the Internal Revenue Service.

The medical society had a $161,691 in revenue for 2007, while its Executive Director, Ivey Zinaida, was paid $99,266 a year in salary, according to federal documents. Zinaida retired in 2007.

The Healthcare Journal was unable to reach Monterey's board members for comments on this story.

Santa Clara County Medical Association, on the other hand, is one of the largest medical associations in California. In 2007, the association had a profit of $53,920 on $1.2 million in revenue, according to 990 filing with the IRS. Bill Parrish, the executive director, earns a salary of $364,000 a year.

Now that the merger is complete, one primary objective for the SCCMA is to grow membership. Given that there are 600 physicians in the county, Parrish said, there is plenty of room for more among the medical society's ranks.

Troy May is a contributing editor of the Healthcare Journal. He may be reached at tmay@hcjnc.com.

POINT OF VIEW

Schwarzenegger using Board of Registered Nursing as scapegoat

Deborah Burger

The much-hyped controversy over the California Board of Registered Nursing (BRN) has opened up a can of worms reminding many of years of failure by Gov. Arnold Schwarzenegger's administration in adequately protecting the health and safety of Californians.

Media reports on delays in the process for disciplinary action against registered nurses unwittingly exposed a number of systemic deficiencies plaguing the enforcement process of nearly all of the healing arts boards within the Department of Consumer Affairs.

Since then, it has become widely recognized that the enforcement process — not just for the BRN, but for the consumer boards as a whole — is broken.

The reality is that the BRN, which has over 350,000 licensees — a number greater than most of the other boards, has actually fared better in complaint investigations than other boards who experienced long delays but have disproportionately fewer licensees. Moreover, the total number of complaints against RNs generally makes up only about 1 percent of the total number of active licensed registered nurses in California, and an average of only 0.1 percent of active licensed RNs have disciplinary action taken against them.

What the governor failed to note in his showboating move to fire BRN members (which he had appointed) and force the resignation of the BRN's longtime executive officer was that the BRN has little control over the enforcement system, including the well-publicized prolonged complaint investigations, which are actually performed by investigators in the Department of Consumer Affairs, not the BRN.

Nor does the BRN control its own budget, or have any authority to fill vacant enforcement-related positions, or take significant measures to address RN enforcement without approval from the administration.

To make matters worse, the governor's imposition of furloughs has impeded the ability of boards, like the BRN, to execute their enforcement roles. Since these boards are funded through license fees, the furloughs produce no general fund savings. While some of these boards, including the BRN, have generated fund reserves, they lack the authority to spend them to improve enforcement.

Instead, the reserves have been a treasure trove for the administration during tough budget years. The BRN alone has provided $14 million to the state's general fund in recent years.

But, rather than getting to the root of the enforcement problem for all of the consumer boards by addressing the bottleneck within the Department of Consumer Affairs, exempting the boards from furloughs, or giving the boards the spending authority they need to improve enforcement, the governor typically responded with actions designed to attract headlines rather than solve problems.

And, the problem goes further.

Lax enforcement, and indifference or opposition to such investigations of public or workplace safety concerns, is a hallmark of the Schwarzenegger years.

In June, for example, 47 field inspectors, seniors and district managers who interact with the state Occupational Safety and Health Appeals board wrote a scathing public letter about agency practices that "have significantly undermined our ability to do our job of protecting the lives, health and safety of California workers."

In their letter, the signers noted the practices, which include overbooking hearing days, refusing to prioritize cases, long backlog of petitions and other shortcomings over a period of the last four years.

Among the results, investigators for the department are routinely "outgunned" by employer corporate attorneys "even before we have been triple booked with hearings," the 47 signers wrote.

During efforts to pass stronger enforcement legislation last year, workplace activists cited a backlog of 4,000 cases that have resulted in delays of 24 months before appeals are decided by the occupational safety board.

The Schwarzenegger administration has yet to respond to those concerns. The BRN imbroglio will be another test.

While the governor has made promises to overhaul the enforcement system, there's a fundamental contradiction between what he says, and what his administration continues to do. He cannot simultaneously pledge to guard consumers while slashing programs and forcing state employees off the job. He cannot promise greater patient protections while opposing policies to improve enforcement of public safety agencies and advancing efforts to roll back workplace rights.

Finally, the governor's promises today have little in common with his public record since taking office. For all the efforts to portray Gov. Schwarzenegger as a more compassionate or liberal politician than others in his party, his policies on workplace and public safety bear a strong resemblance to the anti-government, anti-regulatory philosophy that have wreaked so much damage in Washington , D.C. and California.

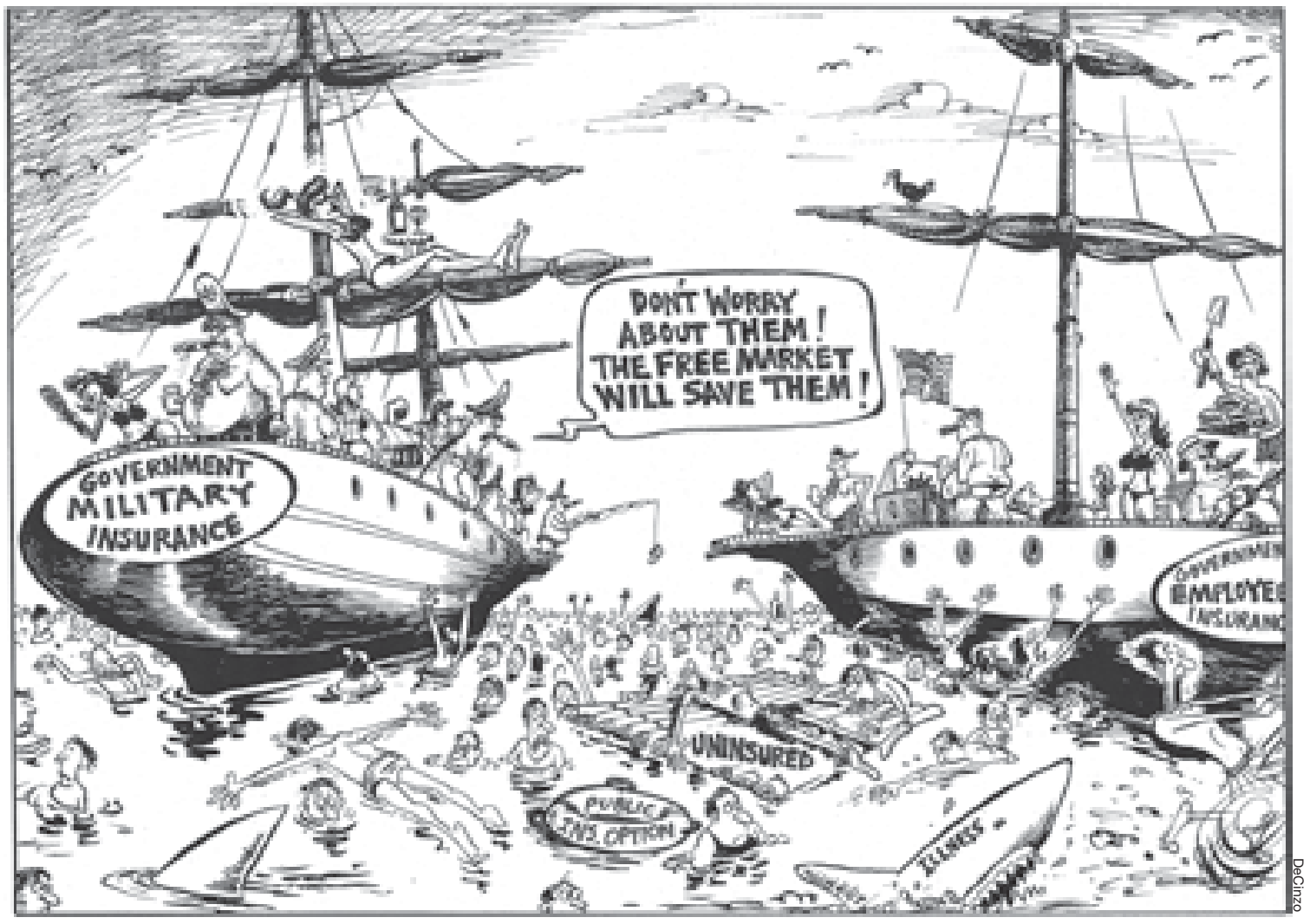
They stem from the outlook of conservative politicians and their corporate allies who oppose and seek to undermine regulatory oversight intended to protect public or employee health and safety as hostile to business.

Despite his sometimes misleading reputation, Gov. Schwarzenegger has a well-established five year record of opposing and vetoing legislation to improve enforcement of public safety agencies, and issuing emergency regulations to roll back workplace rights.

We can hope for a change to promote greater protection for California consumers and patients, but it may have to wait until we have another governor.

Deborah Burger is co-president of the California Nurses Association/National Nurses Organizing Committee. She may be reached at (510) 273-2200.

EDITORIAL



Buzzwords begone: Keep saying "death panels" and everyone loses

"Health care reform" is perhaps the most loaded three-word phrase in America right now.

And it's about time that someone other than physicians and the insurance industry started paying attention to our rapidly imploding system.

But contrary to the mantra "all press is good press," the wrong attention on this issue is much worse than none at all.

To put it bluntly, health care reform threatens to become the new celebrity "it" couple, where public knowledge on the matter consists of what they've been handfed by the media combined with rumors and resulting "gut reactions," rather than on facts, data or even reality. These gut reactions are largely the result of a rumor mill built on a pile of sand that is accepted as truth by the public at large, but then dismissed from the cultural psyche entirely as the population becomes bored.

This reform is now taking the exact same route. Mention health care reform, and people will likely be able to spout a few key phrases — "Obamacare," "death panels," and "rationing" are the most common — but beyond those catch phrases, very little is known or understood, even by doctors, who stand to gain or lose the most.

Media reports on the reform package have been embarrassing at best. The American public doesn't understand what's really in the bill, doctors don't understand, even the elected officials who will be voting on the package don't seem to have a firm grasp on what it is that they'll be voting on (take Missouri Senator Claire McCaskill for example, who said on August 11, "There is no bill right now to be for or against.").

And yet a vote is approaching, ready or not. While we can hope that Sen. McCaskill has taken some time during the August recess to educate herself on the matter, the responsibility for our health care system does not lie on the shoulders of the elected officials in office. It is the responsibility of the medical community to educate ourselves and tell our officials how they should vote on these matters.

Whether we agree or disagree with the package, it is our responsibility to make an informed decision and then pass along fair, unbiased information to our families, friends and patients, so they can decide whether or not they agree with the actual proposals, not with the concept of an invented "death panel."

It's fairly safe to say that no one wants government-rationed health care where Uncle Sam has the power to pull the plug on your actual uncle.

Who benefits, after all, from the misinformation swirling around us and the "I want my America back!" town hall fanatics? Certainly not the patients — or physicians, for that matter.

There are only two groups that benefit from this cacophony: the media, who gain ratings the more sensational their reporting becomes, and, even more dangerously, those who would rather see reform efforts spectacularly crash than have an honest discussion about improvements to the current system.

As President Obama said in his address to both Houses on Sept. 9, "Confusion has reigned. It's the same partisan spectacle that hardens the disdain that many Americans have for their own government … I will not waste time with those who have made the calculation that it's better politics to kill this plan than improve it."

These "death panel" obstructionists perpetuate the hysteria surrounding what could be an open debate, often because the current system suits them just fine, and they fear that an honest discussion would lead to having their own business practices scrutinized, or that the results of said discussion would yield fewer almighty dollars for their over-stuffed pockets.

But with 46 million Americans uninsured, health care lobbyists more powerful than ever and access to care lacking at best, our system is broken. Whether HR 3200 is the best option is debatable, but the status quo is most definitely not the best we can do. And these obstructionists serve merely to drown out the legitimate concerns about this most recent proposal.

We need to start educating our communities on what this reform really is, and we've dedicated a portion of this very issue to decoding the proposals (yep, we've actually read 'em) and providing well-informed commentary on the debate and the legitimately troubling sections of HR 3200.

No matter which side of the fence you find yourself on, we owe it to ourselves to have the most accurate and fair debate on health care reform as possible. Put pressure on your representatives to leave political games and scare tactics at the door. Tell them what you've seen in your practice. Tell them your ideas for improving the system. Tell them what you see in the proposal that won't work.

It's time for an honest discussion, and we physicians are the experts in the medical industry. Now, let's step up to the plate and start a real dialogue.

Healthcare Journal OF NORTHERN CALIFORNIA

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P.O. Box 320733
Los Gatos, CA 95032
408-355-0042
www.hcjnc.com

Published by
PALO ALTO MEDICAL PUBLISHING INCORPORATED

POINT OF VIEW

Elastic and fantastic: The joys of an economy-driven health care system

Daniel Shin

Enough about quality, let's talk about quantity. The concrete colossus that is U.S. medicine is such a significant part of the nation's economy, at nearly 17 percent in 2008, that spending less on medical care could hurt the economy. In other words, is it too big to fail?

In medical school, I thought that demand for medical care was inelastic. It seemed like if you had an acute myocardial infarction or myelogenous leukemia, you needed treatment. But that isn't completely true.

According to research by Richard Cooper, professor at the Medical College of Wisconsin, demand for medical care has no correlation to age of the population, co-morbidities or disease. It is statistically correlated to only one thing: the economy.

In the last 40 years, economic growth and health care spending have been systematically linked in the United States and developed nations. The problem is that health care spending outpaces economic growth overall. But Cooper highlights that this also occurs with spending on leisure and electronics. For each 1 percent increase in GDP, health care spending increases 1.5 percent (mostly in non-physician labor costs like nursing and technicians), while the physician supply increases only 0.75 percent.

He doesn't subscribe to the "supplier-induced demand" argument: the reverse notion that the supply of doctors increases the demand for care, from an observed correlation between the number of surgeons and the amount of surgery in demand. But a similar correlation exists between obstetricians and babies, so he asks: where does the demand originate? Surely families aren't planning their pregnancies based on the number of obstetricians at their local birthing center.

In its current form, health care's command of the U.S. GDP is projected to be 20 percent in seven years. We spent $7,000 on health care per person, equating to $2.1 trillion a year. The amount we spend on health care is more than the entire GDP of Italy. I wonder, what does that mean? That means we expend more on Flexi-Seals, Posey vests, sitters, haloperidol and Beano than Italians spend on aesthetically pleasing Ferrari F430s, Illy cappuccinos and Gordon Rush shoes. That seems obscene.

According to Robert Kuttner, co-editor of the American Prospect and senior fellow at the public policy research organization, Demos, in a Perspective piece in the New England Journal of Medicine, the current system is a blend of overtreatment and undertreatment, with research showing one fifth to one third of medical costs do nothing to improve health.

And standard clinical practice is still not the norm, after three decades of studying variation of practice in managed care; it is obvious there are still wide variations in clinical practice today.

For cutting costs, there is certainly low-hanging fruit that gets ignored. As an internist by training first and specialist second, I like low-hanging fruit. I like what Harold Luft describes in *Total Cure: The Antidote to the Health Care Crisis* as the 'old technologies,' which include routine hand washing and careful listening to the patient's problem. These are much underused.

David, the neurosurgeon, recounted a story about the MediEvac helicopter as it approached Lexington, Ky. after picking up a patient. He took the phone call from the flight paramedics while on trauma:

"Go ahead," David said.

"Yea, David, we got this guy," the paramedic said. "We got this guy, he was drivin' a '72 Chevy Nova and hit a birch tree. We intubated him in the field and he was movin' around, so we paralyzed him."

"Yes."

"Yea. '72 Nova into a birch tree."

"Vital signs?"

"What?"

"Vital signs."

"Hold on." It was not lost on him that they always knew the make and model of the car and the species of tree, but the vitals were the last piece of information that they scurried about to get.

There are other examples of low-hanging fruit. A June 2007 paper in the New England Journal of Medicine attributes most of the decline in coronary deaths from 1980 to 2000 to the use of inexpensive drugs and the management of cholesterol and blood pressure. More expensive procedures, such as bypass and angioplasty, accounted for less than 7 percent of the decline.

But even with all of the low-hanging fruit, the projections of massive costs are still what's grabbing most people's attention — and for good reason.

Compared to the top income tax bracket in 1980, today people are enjoying lower taxes and lower capital gains taxes (28 percent in 1980 to 15 percent now). Tax cuts led Ronald Reagan to victory in the 1980s and to economic growth. This growth was also supposed to increase tax receipts faster than federal spending, which it did not. The share of federal income to fund Social Security and Medicare is 8.6 percent for 2010. If today's tax rates remain, these two entitlement programs will take up 76 percent of federal income tax revenue in 2050. In other words, taxes will have to be raised or entitlement programs will have to be lowered.

The Centers for Medicare and Medicaid Services published projections in the February 2008 issue of Health Affairs that health care spending would be $4.3 trillion in 2017, with Medicare picking up 20.7 percent of the bill. A single payer medical system, but not necessarily a single provider, would reap the benefits of lower overhead and administrative costs (3 percent in Medicare compared to 10 to 20 percent in private insurance).

But this is the United States of America; we don't have an army, we have the Army, Navy, Air Force and Marines. We also have the Coast Guard, National Guard, FBI, CIA and NSA. By the same token, there is not a medical system, per se. We have an alphabet soup consisting of the VA Administration, Medicare Parts A, B, D, Medicaid, HMOs and PPOs, credit card users, personal bankruptcy and frequent fliers to the emergency room.

In some perverse way, the more diverse the portfolio, the less likely one part will bring down the whole enterprise.

Just look at Medicare Part D: In November 2006, local government agencies offered 48 competing plans, some had more than 70. A "donut hole" gap in coverage begins after the insurer and beneficiary have spent $2,700 in 2009, then the beneficiary pays another $4,350 alone, until catastrophic coverage begins. Anything that is this unnecessarily complex is usually hiding something (it's mediocre, or in less delicate terms, it's shite).

Whether you're John Henry or Jon Bon Jovi, an oracle or auricle, bucolic or embolic, you will need medical care at some point. Hopefully it will be when you are 90 years old, and despite all the technology at hand, you will still be assessed as a possible surgery case by your doctor by the fact that you "still mow the lawn" and "drive your own car." Ultimately these are the clinical aphorisms of medicine.

If you want to fix the uncomprehending U.S. medical system, put a wad of cocoa leaves in one cheek and a pinch of Copenhagen between the other cheek and gum. You brew a large pot of coffee and turn on the computer. Then you put arse in chair and start racking your brain to fix it. You can get all aggro but it will not relent easily. I do not envy the President or Congress for trying to fix the American health care system because, truth be told, it is not a system at all.

Daniel D. Shin, M.D., is an infectious diseases specialist. He is a clinical assistant professor of medicine at UC San Francisco and is in private practice in Mountain View.

LETTERS TO THE EDITOR

Marin's problems far from over

The last issue with your authoritative and accurate piece on the ongoing struggle between Marin General Hospital and Sutter Health came yesterday ("$49M drained from Marin General," July/August 2009).

Early in 1996, shortly after Sutter acquired the 30-year lease, Henry Buhrmann asked the elected board to approve MGH joining Sutter's "obligated group." What are the obligations? Marin would become a guarantor of Sutter's mega-buck debt and Sutter would be permitted to sweep away money anytime there was more than a 14-day operating cash supply.

We're still suffering the fallout of this bad deal – the $88 million snatched in the last two years wasn't the beginning, and unless we hold Sutter's feet to the fire, it won't be the last.

Norman Carrigg, M.D.
San Rafael

Docs must look out for eating disorders

Hooray! A special thanks to editor Rebekah Stone and writer Alice Chen for the excellent feature article on eating disorders in adult women ("Eating disorders skyrocket among adult women," July/August 2009). Thank you for helping get the word out about these devastating and frequently overlooked disorders.

Janice Bremis
Executive Director,
Eating Disorder Resource Center
San Jose

RAISING THE BAR. AND THE ROOF.

SOON WE'LL OPEN THE DOOR TO AN EVEN HIGHER LEVEL OF HEALTH CARE.

From left: Diana Russell, chief of clinical operations/chief nursing officer; Michael Podlone, MD, chief of medical staff; Ken King, vice president, facilities and support services; Linda Heider, president, El Camino Hospital Auxiliary; and Ken Graham, chief executive officer.

The new El Camino Hospital will open soon, on time, under budget and on the cusp of a new era in health care. Thanks to our community — for financial support through the passage of Measure D — and to the hard work of thousands of employees, contractors and volunteers, we will soon step into the hospital of the future. It was designed from the ground up, with patient needs as top priority. Here, form truly follows function, as every innovation improves efficiency, adds technology and enhances the patient and visitor experience. What's more, this new hospital is going to make a seismic change in the delivery of high-quality care — literally — because it's one of the first to comply with new earthquake safety regulations. Built for today and tomorrow, this is much more than a hospital: It is a visionary health care destination where we can serve you and your patients well for many years to come.

For more information about El Camino Hospital, call us or visit our Web site.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

www.elcaminohospital.org
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