OPSC March on the Capitol

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CME by the Bay

21st Annual Fall Conference
September 10-12, 2010
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The Osteopathic Family

Over the last few weeks, I have considered what it means to be President of OPSC. Part of this reflection included contemplation on what I could bring to this position and an analysis of my own personal values. I realized one of my highest values was family, and in many ways, what I cherish in my own family can easily be applied to our extended osteopathic family. With that said, let me briefly review four aspects of “family life” that I hope will be reflected through OPSC over the next year.

1. Families plan

As you think of your own family, think of all the planning you have done with and for your family. We plan for vacations, we plan to buy homes, we plan to send our children to college, we plan for emergencies, and we plan for retirement.

With regard to our profession, we know we have many challenges ahead, not the least of which is the naturopathic issue, and it is crucial that we plan. Your Board of Directors has proactively started that process by updating and revisiting our strategic plan. We have identified three major areas that we believe are crucial: advocacy, continuing medical education, and membership. Planning for each of those areas will be an ongoing and transparent process. Additionally, we will value your suggestions and participation, as we recognize that collectively, we are a creative and inspired force.

2. Families divide and conquer

They rely on the talents and expertise of each member to accomplish what is best for the family. Think of your own family as you consider the day-to-day running of your household. Who cooks, who cleans, who does the yard work, who does the financial planning? How as a family do you divide the responsibilities of running a family? Also, think of the talents of the individual members of your family. I am certain that among you, we have gifted athletes, musicians, artists, and culinary experts. Now, think of how the combination of those talents and the division of labor not only allows your family to function, but also enriches every aspect of your life. We also know the importance of generations in our family. Our elderly provide wisdom and continuity with the past, and our youth provide energy and innovation.

As we apply those concepts to our profession, I know among us are not only brilliant physicians, but also those who are gifted teachers, writers, and public speakers. We have those who have expertise and knowledge of legislative affairs, knowledge of the legal climate, and knowledge of public relations. We also know how important it is that we take advantage of our professional generations. Our pioneers will provide us with that crucial link to the past including an awareness of important lessons learned and wisdom that only comes with their combined experience. Our new generation of osteopathic physicians will likewise bring energy, creativity and innovation to our profession.

As I consider the collective gifts of our osteopathic family, permit me to also share with you what a remarkable group of individuals you have representing you in your Board of Directors. They are talented, passionate, and gifted individuals who will represent your professional interests well. I include in this discussion a chance to thank our immediate past President, Dr. Bloom, whose leadership and wisdom were exemplary.

As we take stock of our talents and interests, our experience, and our wisdom and energy, it is crucial that with our upcoming challenges, we divide and conquer and rely on the engagement of our members, which is a perfect segue to point three.

3. Families come together in times of crisis

All of us have most likely experienced...
What a Difference a Season Makes!

The last issue of the California DO reflected the shock and anger experienced by the osteopathic profession as a result of the joining of naturopathic licensure into the Osteopathic Medical Board of California (OMBC). This issue has a distinctly more upbeat flavor, focusing on the positive strides made toward regaining osteopathic autonomy.

Of special note is SB 1050, OPSC’s legislation authored by Senator Leland Yee, which seeks to regain osteopathic autonomy by removing the two naturopathic doctor positions from the OMBC. The bill is making its way through the legislative process, and OPSC is optimistic about its chances of success.

The last few months have featured a whirlwind of events, meetings and negotiations, leading up to the introduction of this legislation. A wildly successful “March on the Capitol” was held February 4, with more than 150 osteopathic physicians and osteopathic medical students from throughout the state and across the nation converging on the California State Capitol. See the article later in this issue for photos and more details.

OPSC has been actively lobbying other influential decision makers as well. Some of the individuals with whom OPSC leaders, staff and lobbyist have met include:

- Governor Schwarzenegger’s staff members
- Senator Leland Yee
- Senator Gloria Negrete McLeod (represents WesternU/COMP and chairs key legislative committee)
- Senate Pro Tem Darrell Steinberg
- Other legislators
- Cabinet secretary Fred Aguiar
- Department of Consumer Affairs Director Brian Stiger
- Senate committee consultants
- California Medical Association leaders
- California Naturopathic Doctors Association

Looking to the future, OPSC leaders are addressing the question of how we keep something like this from happening again. The OPSC Board of Directors held a Strategic Planning Session in February to establish goals that will lead OPSC to better protect and promote the osteopathic profession. One of the conclusions that

Planning Strategically

OPSC President Susan Mackintosh, DO began her presidential year with a mission — to develop a strategic plan for the organization. She moved quickly to accomplish this goal, coordinating a full-day strategic planning session to take place two days before she was officially inducted in office. The OPSC Board held a scintillating planning session, during which they identified overarching goals and strategic objectives. Not surprisingly, based on activities of the recent year, advocacy efforts were deemed high priority. A summary of the goals is listed below.

But Board members wanted more. They wanted to identify specific measurable, achievable activities for OPSC to accomplish. On May 15-16, the Board will meet to follow up and identify appropriate activities. To ensure widespread involvement by OPSC members, the goals and strategic objectives have already been submitted to newly appointed committees with a request to suggest relevant activities for consideration. The full version of the strategic plan, once completed, will be presented to OPSC members.

Advocacy Goals

- OPSC is the nexus of autonomy for the practice of osteopathic medicine in the state of California.
- OPSC is the leader in achieving awareness of the osteopathic profession.

Membership Goals

- OPSC has a strong vibrant membership.
- OPSC supports and strengthens regional affiliates.
- Osteopathic physicians recognize the value of membership in the OPSC.
- OPSC’s programs, products, and services are essential, innovative and valuable to osteopathic physicians.
- OPSC supports the osteopathic education continuum by offering targeted programs, products and services.

Continuing Medical Education Goals

- OPSC is the preferred source of quality relevant CME for osteopathic physicians.

Continued on page 22

Steve Kamajian, DO and Teresa Swida, DO met with Senator Liu
Greetings! It is a distinct pleasure and privilege to become the new editor of the California DO journal. I’d like to thank President Susan Mackintosh for her consideration and leadership, and Kate McCaffery for her valued help during this transition. As you know, Kate is in the midst of re-starting her OMMM practice in beautiful Humboldt County where I’m sure she’ll be successful. Kate won’t be far away from OPSC as she’ll continue on the Publications Committee along with many new members. Kate and other past editors have set high standards which I fully intend to meet or exceed. I also want to thank Marsha Gladmon and Karen Caskey of OPSC for all their help in bringing this issue to fruition. It is confidence inspiring to know you’ve got a great team working with you! Now on to this issue!

It’s been a whirlwind 1st Quarter, 2010 for California DOs, OPSC, and healthcare on a national and state level. Dr. Mackintosh provides details on OPSC’s efforts at reversing the merger of Naturopathic Board and the Osteopathic Medical Board. Through OPSC’s legislative efforts, Senate Bill SB 1050 (Yee, no relation) was created to the Appropriations Committee along with many new members. Kate and other past editors have set high standards which I fully intend to meet or exceed. I also want to thank Marsha Gladmon and Karen Caskey of OPSC for all their help in bringing this issue to fruition. It is confidence inspiring to know you’ve got a great team working with you! Now on to this issue!

A Whirlwind 1st Quarter

Beginning with this issue, OPSC welcomes Bartley Yee, DO as the new Editor of the California DO. Dr. Yee joined the faculty at Western University College of Osteopathic Medicine of the Pacific in Pomona, California in 1999 and is currently an Assistant Professor of Family Practice Medicine. He teaches clinical skills and critical thinking development for OMS I and II students, was a systems course coordinator, and previous admissions committee chair. Dr. Yee was also Director of Medical Education (DME) and Traditional Internship Program Director at Arrowhead Regional Medical Center (ARMC) from 1999-2006, and is currently assisting COMP in graduate medical education development. Prior to Western, Dr. Yee was Medical Director for Pacific Hospital of Long Beach’s (PHLB) Family Medicine Clinic, as well as Assistant DME and Assistant Program Director for the Family Medicine Residency.

Dr. Yee is a 1984 graduate of Michigan State University College of Osteopathic Medicine in East Lansing, Michigan. He interned at Muskegon General Hospital in Michigan before returning home to California to complete his Family Medicine Residency at PHLB in 1987.

Dr. Yee has been an active member of OPSC since 1986. OPSC gratefully acknowledges the previous Editor, Kate McCaffrey, DO, who served in this position for one year.
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Fasten your seat belt, the world of healthcare policy has just shifted gears. Major healthcare policy changes from Washington, D.C. signal a shift in the rules by which 32 million Americans may engage the services of osteopathic physicians. More than four million Californians will now have access to some form of payment for your services that they previously had gone without, had acquired only episodically or had access to only through emergency rooms.

In the midst of this positive upheaval, or perhaps because of it, OPSC has redoubled its state healthcare policy efforts to ensure patient access and safety, fairness to providers and ever-improving quality with minimum government intervention in your practice.

In addition to OPSC’s continued fight to stave off deep State Budget cuts to Medi-Cal, Healthy Families, Access to Infants and Mothers (AIM), Prop. 63 mental health programs, Prop. 10 programs for children and many more, we are working with Senator Yee and his staff to restore the autonomy of the Osteopathic Medical Board and the Naturopathic Medicine Committee. As of this writing, we believe amendments to SB 1050 (see below) will be supported by both groups as it helps to protect patients and returns each group to its respective autonomy.

OPSC Bills:
Here are a few of the more than thirty other bills on which OPSC is working, on your behalf this year (Note: bill positions are interim):

Osteopathic Medical Board of California
SB 1050 (Yee)
Would remove naturopathic doctor positions from the Osteopathic Medical Board and add two public members in their stead, indemnify the OMBC of all actions of the Naturopathic Medicine Committee and allow the Committee to appoint its own staff. **Position: Sponsor**

**Physician Reimbursement for Immunizations of Children**
AB 2093 (V. Manuel Perez)
Would require health plans and health insurance companies that provide coverage for childhood and adolescent immunizations to reimburse physicians or physician groups in an amount not less than the actual cost of acquiring the vaccine plus the cost of administration of the vaccine. **Position: Support**

**Physician Charitable Contribution**
AB 2148 (Tran)
Would allow a deduction for the value of medical services contributed free of charge by a physician to a local community clinic. **Position: Support**

**Mandated Child Abuse Reporting**
AB 2229 (Brownley)
Would require a health practitioner or medical social worker who is making a mandated report pursuant to disclose “all known health needs of a child” where substance abuse is involved, including, but not limited to, a potential exposure to HIV infection. **Position: Oppose**

**Individual Health Care Coverage**
AB 2470 (De La Torre)
Would require healthcare plans and insurers to use standardized information, health history questions and medical underwriting procedures prior to insuring a patient (in order to help eliminate the practice of rescinding coverage for pre-existing but medically irrelevant conditions). **Position: Support**

**Cosmetic Surgery: Employment of Physicians and Surgeons**
AB 2566 (Carter)
Would help to protect patients in illegally staffed “medi-spas” by making businesses that provide outpatient elective cosmetic medical procedures or treatments, that are owned and operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists, guilty of a violation of fraud. **Position: Support**

**Health Plan Contracting Providers**
AB 2586 (Chesbro)
Would require health plans and insurers that contract with providers to demonstrate that a proposed network modification would meet access requirements prior to approval. Would require up-to-date lists of providers be submitted to insureds upon request. **Position: Support**

**Medical Malpractice Insurance for Volunteer Physicians and Surgeons**
SB 1031 (Corbett)
Would declare it the intent of the Legislature to implement the findings of a 2008 Health Professions Education Foundation study to provide medical malpractice insurance to volunteer physicians. **Position: Support**

**Prior Authorization for Mental Health Services**
SB 1169 (Lowenthal)
Would require plans and insurers to assign unique tracking numbers to claims and provider requests for authorization and to provide acknowledgment of receipt. When claims are contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the bill would require
the plan or insurer to acknowledge receipt of that information within three working days. **Position: Support**

**California Children and Families Program**  
**SBX8 41** (Cox)  
Would abolish the California Children and Families Commission and programs and transfer First 5, Prop. 10 dollars to the State General Fund. **Position: Oppose**

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**March on the Capitol**

More than 150 osteopathic physicians, students and faculty, all clad in white coats, descended on the State Capitol on February 4, 2010 to fight for osteopathic autonomy. The “Patients Before Politics” March on the Capitol was held to educate lawmakers on the need to remove naturopathic doctors from the Osteopathic Medical Board of California (OMBC).

Buses caravanned from Touro University California and Western University of Health Sciences to Sacramento, bringing osteopathic medical students to join physicians for the March on the Capitol. The day began with a morning of strategy sessions and advocacy training. After lunch, the group donned white coats and caused a dramatic stir by walking en masse to the Capitol, even drawing the attention of the state mounted police.

Osteopathic physicians and students met with nearly 30 different legislators and staff members throughout the afternoon, emphasizing the need for patient safety as the impetus to regain the autonomy of the OMBC. The reception from legislators and staff members was overwhelmingly positive, pledging support and asking questions.

Attendees found the day to be valuable. “I felt like I made a difference for my profession today,” stated one. Another said “I learned a lot about this issue and the legislative process.”

The March on the Capitol helped pave the way for the potential success of SB 1050, legislation that OPSC has introduced to remove the naturopathic doctor positions from the OMBC. As SB 1050 makes its way through the legislative process, OPSC will be calling on members to communicate with legislators, requesting support.

The joining of naturopathic licensure into the OMBC has energized the osteopathic profession like no other issue in decades. OPSC thanks the physicians and students who took time to participate in this enormously successful March on the Capitol.
Waking Up: A Lone Opinion from a California DO

We have a great opportunity to set the agenda for our future. The dissolution of the Naturopathic Bureau into the Osteopathic Medical Board of California by ABX4 20 has revived us as members of the Osteopathic Physicians and Surgeons of California. After reading The Merger by Sibylle Reinsch, PhD, Michael Seffinger, DO and Jerome Tobis, MD, I have found interesting parallels between the growth of osteopathic and naturopathic medicines in California. It also indicates how far we have come in the recognition of Osteopathic Medicine.

Given what has happened in the past with the trade of the DO degree for the MD degree and the merging of the osteopathic and allopathic state associations in an attempt to annihilate osteopathic medicine altogether, we should strive to be autonomous. We need to address how we are licensed. Should all healthcare professionals be governed by independent licensing boards or under a comprehensive board with a fair review among our peers? These decisions are often out of our control, but we should create or partner with other groups to lobby for legislation to study licensing and to preserve independent licensing boards.

How many times have you been asked if you are an OD or a medical doctor? Although insurance and other healthcare agencies now seem to understand what a DO is, the public may not. We could hire public relation firms for marketing; however, that may not be an effective use of our resources. We could attempt to define ourselves publicly using the internet more widely. We could utilize social networking to promote our profession, to market our organization, to celebrate our achievements, and to define who we are to a larger and wider audience. Why? This could encourage the public, legislators, and legislative staffers to learn about us, what we do, and what we have endured.

Another attainable goal is to have more DOs in leadership roles outside of our Osteopathic world. The future of medicine is in politics and policy. We could provide mid-career guidance and assistance to OPSC members to pursue leadership training in public policy and government. Some examples would be the California HealthCare Foundation (CHCF) Health Care Leadership Program, the Coro fellowship, California Senate and Assembly fellowship, and the White House fellowship. We would strengthen and preserve our organization by having OPSC members in these positions.

We must advocate for our patients and our profession in Sacramento. Elected officials want to hear from physicians. They like statistics and stories from the trenches. We should be active in networking with various political, civic, and business associations. Some examples would be the Lions, Rotary, Elks, Chamber of Commerce, the Lincoln Club, the New Majority in addition to the California Democratic and Republican Parties.

As physicians, we have endured medical school and residency. We have developed our abilities in treating patients in both inpatient and outpatient settings. Although we are confident with our abilities in problem solving, we are faced with legislative issues that are complex and new to many of us. We should maximize the use of consultants who have a strong background in the legislative process to educate and to train us. Through the stewardship of our executive director, we have access to top notch resources.

We have a great legacy in California. We have a greater opportunity ahead of us. We need to be involved to determine our future. I am proud to be a DO, but more so to be a DO in California and a member of OPSC.

We have a great legacy in California. We have a greater opportunity ahead of us. We need to be involved to determine our future.

Editorial assistance from Michael Seffinger, DO is greatly appreciated.
Abstract:
Subarachnoid hemorrhage is a common clinical entity that accounts for nearly fifty percent of hemorrhagic strokes. It is therefore important for clinicians to recognize both common and atypical presentations of this condition. This paper discusses the epidemiology, presentation, and diagnosis of subarachnoid hemorrhage. The discussion is followed by a case report describing an atypical presentation of subarachnoid hemorrhage in which the resolution of meningismus was accompanied by the development of lower back pain one week after the primary headache.

Introduction and epidemiology: Aneurysmal subarachnoid hemorrhage
The rupture of an intracranial aneurysm is the most common cause of subarachnoid hemorrhage. This results in the discharge of blood directly into the cerebrospinal fluid. Although the bleeding generally remits spontaneously after a few seconds, this is enough time to cause a significant increase in the intracranial pressure. Re-bleeding also commonly occurs within the first day, further exacerbating the early rise in intracranial pressure. The presence of blood in the cerebrospinal fluid acts as an irritant. This, in addition to the precipitous rise in intracranial pressure, is responsible for the headache and meningeal signs experienced by the patient.

The most common presentation (97 percent of cases) of subarachnoid hemorrhage is a severe headache of acute onset that is classically described as the “worst headache of my life.” This initial presenting headache occurs at night in 30 percent of cases. The headache may be lateralized in 30 percent of patients, shedding light on the approximate location of the ruptured aneurysm. Patients with subarachnoid hemorrhage may experience a brief loss of consciousness acutely. Seizures, nausea, vomiting or meningismus may also occur.

If blood products persistently irritate the dural linings of the central nervous system, meningismus may persist for several hours and be followed by lower back pain. This is because the presence of blood products in the cerebrospinal fluid, i.e. the same particles that result in a xanthochromic lumbar puncture, are highly abrasive to the dura and elicit an aseptic meningitis. Rarely, lower back pain may be preceded by a complete resolution of the meningeal signs over five to seven days. This atypical presentation of subarachnoid hemorrhage, observed on the order of only one or two times per annum at major tertiary care centers in the United States, is important to recognize in order to optimize patient care and avoid a costly diagnostic workup.

The majority of subarachnoid hemorrhages are caused by ruptured saccular aneurysms. Less common causes include traumatic ruptures, arteriovenous malformations or fistulae, vasculitides, intracranial arterial dissections, amyloid angiopathy, bleeding diatheses, and cocaine or amphetamine use. Most intracranial aneurysms in the anterior circulation are located on the circle of Willis. Common sites of aneurysms are the junction of the anterior communicating artery with the anterior cerebral artery, the junction of the posterior communicating artery with the internal carotid artery, and the bifurcation of the middle cerebral artery. Common sites for intracranial aneurysms in the posterior circulation include the superior part of the basilar artery, the junction of the basilar artery and the superior or anterior inferior cerebellar arteries, and the junction of the vertebral artery and the posterior inferior cerebellar artery.

The prevalence of intracranial saccular aneurysms is about 5 percent, or 10-15 million people in the United States by radiographic and autopsy series. Among these patients, 20-30 percent will have multiple aneurysms. Aneurysmal subarachnoid hemorrhages occur at an estimated rate of 6-16 per 100,000 people with a mean age of onset of fifty-five years. This correlates with an incidence of 30,000 cases in the United States per year. These statistics imply that the vast majority of intracranial aneurysms do not rupture. Nevertheless, the rupture of a saccular aneurysm is a cause of significant morbidity and mortality.

Magnetic resonance imaging of an evolving subarachnoid hemorrhage: An atypical presentation of lower back pain following an asymptomatic interval

Image 1: Non-contrast CT scan of the head reveals hyperdense fluid layering along the sulci extending into the left sylvian fissure consistent with blood hemorrhage in this location.
a serious matter that must be emergently addressed: approximately 10 percent of patients die before even reaching the hospital, and only 30 percent of patients return to their baseline status of functioning after treatment.9

The risk that a saccular aneurysm will rupture depends upon its size, location, and the patient’s prior history of subarachnoid hemorrhage. The natural history of subarachnoid hemorrhages and their likelihood of rupture were addressed by the International Study of Unruptured Intracranial Aneurysms (ISUIA). The study prospectively assessed 4060 patients in Europe, Canada and the United States. The results showed that, for aneurysms less than 7 mm at the time of diagnosis, the likelihood of rupture depends upon the patient’s prior history of subarachnoid hemorrhage. Intracranial aneurysms in patients with a history of prior subarachnoid hemorrhage rupture at a rate of 0.5 percent per year. Aneurysms in patients without a history of prior hemorrhage rupture at a rate of 0.1 percent per year. Aneurysms up to 10 mm in diameter were found to have similarly low rates of rupture irrespective of the patient’s past medical history. Nevertheless, an aneurysmal diameter of at least 10 mm at the time of diagnosis correlated with an increased risk of future growth.8,9

Based on these statistics, it would seem counter-intuitive that the majority of subarachnoid hemorrhages are secondary to intracranial aneurysms less than 7 mm in diameter. Several hypotheses have been put forward to account for this phenomenon. These include the hypothesis that intracranial aneurysms develop over days to weeks, not over years as previously thought.8,9 This timeline for aneurysm formation implies that there is a rapid increase in size followed by either rupture or stabilization of the aneurysm. Aneurysms stabilize because fibroblasts lay down excess collagen in a circumferential distribution along the blood vessel walls. This causes hardening of the aneurysmal walls, diminishing the likelihood of rupture.9 The chance of rupture is therefore minimal unless the aneurysm achieves a relatively large size before it is stabilized by collagen. Specifically, aneurysms generally remain stable unless they become larger than 10 mm prior to initial stabilization. This is because wall stress increases with the square of the diameter (Laplace’s law) to an extent that, at a certain minimum size, the protective layering of collagen will no longer be prohibitive to future growth and rupture of the aneurysm.2,3,8,10

The location of the aneurysm also correlates with its chances of rupture. The lowest rates of rupture are seen with cavernous carotid aneurysms. Anterior circulation aneurysms involving the anterior communicating, anterior cerebral or internal carotid arteries have intermediate rates of rupture. Posterior circulation aneurysms involving the vertebrobasilar, posterior cerebral, or posterior communicating arteries are most likely to rupture. Additionally, there are differences between populations that influence the rates of aneurysm rupture, with higher rates of hemorrhage seen in Japanese people.8,9 This may be due to environmental and genetic factors that affect the rate at which fibroblasts proliferate and lay down collagen in the central nervous system.

Diagnosis:
The sudden onset of a severe headache, irrespective of the prior history of the patient, is an indication for diagnostic evaluation to exclude a subarachnoid hemorrhage. In addition to the headache, associated signs and symptoms of subarachnoid hemorrhage include altered consciousness, collapse, vomiting, meningismus and retinal subhyaloid hemorrhages. The absence of lateralizing neurologic signs also supports the clinical diagnosis of subarachnoid hemorrhage.8,10

The first step in the diagnosis of subarachnoid hemorrhage is to confirm its presence; the second step is to determine its location and etiology. Non-contrast head computer tomography (CT) is the mainstay
gestive of subarachnoid hemorrhage. When performed within two to three days of the event, head CT scan and lumbar puncture will identify a subarachnoid hemorrhage with sensitivities of 92 percent and 93 percent, respectively.²⁻⁷ If performed after three days, the sensitivities of both diagnostic modalities diminish. If doubt remains as to the presence of a subarachnoid hemorrhage due to inconclusive head CT scan and lumbar puncture results, cerebral angiography remains the gold standard diagnostic modality to exclude a ruptured intracranial hemorrhage.⁸⁻⁹

**Case Report:**

An 80-year-old ambulatory Caucasian male without significant prior medical history presented to the emergency department with an excruciatingly-painful headache of acute onset. The pain was present diffusely but was most severe in the occipital region. The patient denied any history of head trauma or medical anticoagulation. He underwent non-contrast computed tomography scanning of the head which revealed hyperdense fluid layering along the sulci extending into the left sylvian fissure consistent with subarachnoid hemorrhage. He was subsequently transferred to the intensive care unit where conservative treatment was administered. The patient was observed in the intensive care unit for four days. The headache improved, and no neurologic deficits were observed in the interregnum. On the fifth day of hospitalization, the patient reported severe, non-tender, “achy” lower back pain. The pain localized to the lower back at the midline and did not radiate. The patient stated that the severity of the pain was not affected by changes in position or palpation by the clinician. There were no associated symptoms. No neurologic deficits were noted on physical examination.

The patient subsequently underwent magnetic resonance imaging (MRI) of the lumbosacral spine which revealed a 4 cm tubular intradural defect posterior to the L5 and S1 vertebral bodies. This defect suggested the pooling of hemorrhagic residual or blood products at the base of the patient’s spine. The defect demonstrated layering in the dependent portion of the thecal sac and had a maximum anterior-posterior diameter of 7 mm. There was a cephalad extension of the defect and a meniscus sign in the posterior and left lateral aspect of the thecal sac to the level of the L2 vertebral body. The fluid-fluid level within the thecal sac was also observed on the sagittal view. There was no impingement upon the right or left L5 or S1 nerve roots to account for the patient’s lower back pain.

**Discussion:**

The development of lower back pain on the fifth day of hospitalization, four days after the resolution of meningismus, surely is an atypical complication of subarachnoid hemorrhage. As previously mentioned, this is seen on the order of one or two times per annum at major tertiary care centers in the United States. Because of the extremely low incidence of this complication, it is impossible to determine the percentage of subarachnoid hemorrhages that are complicated by lower back pain following an asymptomatic interregnum. The mechanism of this phenomenon is likely related to the pooling of hemorrhagic residual, i.e. hemoglobin degradation products, within the dura at the base of the spine. These hemoglobin degradation products, the same components of the hemorrhagic residual that are responsible for the appearance of xanthochromia on lumbar puncture, also account for the patient’s lower back pain by causing meningeal irritation. The appearance of an intradural fluid-fluid level or defect on MRI may give the false impression of an inflammatory, infectious, or neoplastic infiltrate. However, in the context of subarachnoid hemorrhage, such a collection almost certainly represents the pooling of hemorrhagic residual in the intradural space at the base of the spine. This knowledge should aid clinicians in the avoidance of elaborate and expensive diagnostic strategies to elucidate the cause of unusual lower back pain five to seven days after the apparent resolution of symptoms associated with a subarachnoid hemorrhage.

References available upon request.
California’s Department of Managed Health Care (DMHC) recently issued regulations intended to ensure that health plan enrollees have access to timely health care services. These regulations could have a profound effect on California osteopathic physicians and surgeons and their patients. Similar, although less extensive regulations were issued by the Department of Insurance (DOI) in 2008. These already apply to some insurers, and some contracted PPOs and IPAs doing business in California on a fee-for-service basis. The new regulations stem from legislation (AB 2179) enacted in 2002 that allows the DMHC director to impose various legal remedies which may include a combination of civil, criminal and other administrative proceedings.

The FAQs developed here will help you better understand compliance and enforcement provisions of these new regulations. OPSC would like to hear how these regulations affect your practice. Specifically, these regulations could significantly affect the duration of patient visits and office costs. OPSC has warned the Department of Managed Health Care of this likely outcome and has been assured by the Department that it will not tolerate contract negotiations in which physicians are given this added responsibility without commensurate material changes to their (or their medical group’s) contract.

For more information, please contact OPSC or go to: http://wpso.dmhc.ca.gov/regulations/docs/regs/20/1261420231445.pdf

How, specifically, will this affect my practice?

These regulations will require each plan to “ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes”:

- 24/7: Triage or screening availability by telephone
- 30 minutes: Waiting time limit for telephone triage
- 10 minutes: Waiting time limit to speak to plan rep during normal business hours
- 48 hours: Limit for urgent care appointments not requiring prior authorization
- 96 hours: Limit for urgent care appts requiring prior auth. (including specialists)
- 10 business days: Limit for non-urgent primary care appointments
- 15 business days: Limit for non-urgent appointments with specialists
- 10 business days: Limit for non-urgent appts with a mental health care provider
- 15 business days: Limit for non-urgent appointments for ancillary services

Do the regulations affect all PPO and HMO contracted physicians, or HMO contracted physicians only?

It affects PPO and HMO contracted physicians.

What will trigger enforcement?

Enforcement by DMHC and/or DOI will be triggered by a pattern of violations or a particularly bad one. In the case of a patient making a complaint to an insurer, it will be the insurer’s responsibility to have internal processes, sanctions, etc. Patients may also complain directly to the DMHC or DOI which may also trigger enforcement activity.

How will enforcement be carried out?

Enforcement by DMHC would be against the health plans and insurers (rather than providers directly) and, in the case of DMHC can be as tough or lenient as the Director believes is warranted. Penalties against the physician will likely be contractual and be part of a plan’s (or other insurance company’s) policies agreed to by providers.

Will the timeliness of the services that I provide create a new professional standard of care or create a new cause of action against me?

No. These regulations do not establish new professional standards of practice for physicians or other providers, nor do they create a new cause of action or a defense to liability.

What would the penalties be against physicians?

DMHC would not penalize physicians. Because it is “delegated,” the plan would be penalized, the plan would pass the pain along to the physician or group. The role of the DOI, and its enforcement teeth, are a bit less defined. DOI must report to the legislature on progress and PPO/IPA adherence. But, the enabling legislation gives less enforcement power to the DOI Commissioner than it does the DMHC Director.

What do telephone triage and triage waiting time mean?

Telephone triage means the “assessment of an enrollee’s health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee for purposes of determining the enrollee’s need for care.” Telephone waiting time is the interval in which the patient waits to speak by telephone with that physician, nurse or other qualified professional.
When Garima Loharuka, OMS IV, began her journey at Touro in 2006, she set out to create more clinical opportunities for herself and her peers. Under the supervision of Babak Mokari, DO, Student Doctor Loharuka reserved a regular space at the Suitcase Clinic in Berkeley, California for Touro students to practice their diagnostic and treatment skills in a clinical setting. Founded in 1989 by medical students and doctors from the UC Berkeley and UCSF joint medical program, the Suitcase Clinic defines its mission, “to promote the health and overall wellbeing of underserved individuals through service provision, cooperative learning, and collective action among community and professional volunteers, students, and participants.”

Every Tuesday, the clinic fulfills their mission by providing a two-hour clinic and safe space for the Bay Area community. Clients can sign up for foot washing, shaving, clothes and food, medical care, eye care, legal counsel, and many other services. Today, the six coordinators in charge of maintaining Touro’s involvement in suitcase clinic are Paul Elizondo, OMS II, Aysun Azimi, OMS II, Robyn Young, OMS II, Nathan Widboom, OMS II, Pierce Stewart, OMS II, and Jesse Reinking, OMS II. Touro students also volunteer at the Women’s Suitcase Clinic on Mondays. Janet Burns, DO, is the supervisor for Touro volunteers at Women’s Suitcase Clinic, and the coordinators are Catherine Lacy, OMS II and Kathleen Starr, OMS II. Pharmacy students from Touro can also be found at the clinic, performing screening vitals, glucose testing, and helping patients manage their medications.

At Suitcase Clinic, Touro students work in pairs to do H&Ps and treat a total of ten clients within two hours. Many clients return to the clinic for further treatment, which gives students experience with continuity of care. “It is a gift to see the improvements clients make in their lives after seeing you just once,” says Pierce Stewart, OMS II.

Touro students love to volunteer at Suitcase Clinic to learn from clients who have a long history of trauma and somatic dysfunction. Volunteers improve their OMM skills, increase their palpatory ability, and get a better sense of what to expect with patients during clinical rotations. Touro students also gain unique exposure to the homeless community, listening to their stories and examining their physical and mental status. There are many homeless communities in California, and one of the largest is in the Bay Area. Suitcase clinic is a great way for Touro students to experience treating this important group of individuals.

For more information about volunteering or donations, please visit http://www.suitcaseclinic.org/ or contact Robyn Young at robyn.young@tu.edu.
The 2010 49th Annual Convention and Exposition was well worth all the hype. If you missed OPSC’s More Fun in the Sun 2010 you truly missed some extraordinary speakers and events. This event was held at the Renaissance Palm Springs Hotel, formerly the Wyndham Hotel, located in the heart of Palm Springs, February 10-14, 2010.

OPSC President and Convention Chair Susan Mackintosh, DO opened the 49th Annual Convention by offering thanks and warm wishes to all in attendance. The opening ceremony speakers included AOA President Larry A. Wickless, DO and AOA Executive Director John Crosby, JD, followed by keynote speaker Stanley Fleming, DO, MA, Family Medicine Physician with sub-specialties in Adolescent medicine, HIV & AIDS related diseases and Aviation Medicine.

Outstanding speakers delivered top notch CME lectures with topics ranging from public health and lung cancer, adolescent medicine and an osteoporosis update to One Health One Medicine zoonotic diseases to a naturopathic licensure update. The exhibit show featured 27 companies representing pharmaceutical, medical technology, financial, equipment and wellness.

Oh, we can’t forget to mention the hospitality events at the 49th Annual Convention. Starting Wednesday afternoon, OSTEOPAC sponsored their third annual Silent Action with unique and fun items that extended the duration of the convention. Wednesday night the Welcome Reception, which was held in the Exhibit hall, featured wine, hors d’oeuvres and camaraderie. The President’s Ball and Reception, sponsored by Western University of Health Sciences, celebrated the leadership of the osteopathic profession in California. The 2010-2011 OPSC officers and directors were installed by AOA President Larry A. Wickless, DO. Jeff Bloom, DO was presented with a clock in appreciation of his successful year as OPSC President and Susan Mackintosh, DO gave her inaugural speech as the incoming OPSC President for 2010-2011.

Thanks to the Education Committee members, OPSC staff, volunteers, and especially the Chairs of the Day: Sanjeev Batra, DO; Galen Church, DO; Patricia Rehfield, DO; Blake Wylie, DO; and Richard Pitts, DO. Without their dedication to the osteopathic profession and OPSC, the convention would not have been a success!

Start now to prepare for the 50th Annual Convention and Exposition! We will be in a new and fabulous location - sunny San Diego. Be sure to mark your calendars now for February 9-13, 2011 at the luxurious Hyatt Regency Mission Bay Spa and Marina, San Diego, California. Please watch for information on our website: www.opsc.org

OPSC would like to acknowledge and thank the following sponsors for their support:

- Western University / COMP
- Veritas Health Services
- Genentech
- PriCara
- Boehringer Ingelheim
- Eli Lilly and Company
- Amgen
- The California Endowment
Awards Presented at the 49th Annual Convention

- Physician of the Year: Lionel B. Katchem, DO
- OPSC Award: Greg Pecchia, DO
- MVP Award: William Henning, DO
- Special Recognition: Michael Clearfield, DO
- Special Recognition: Gary Gramm, DO
- Rookie of the Year: Blake Wylie, DO
- Richard Eby Humanitarian: Cynthia Mackey, DO
- Lifetime Achievement: William Ryan, DO
- Legislator of the Year: Senator Leland Yee, PhD
- Supporter of the Year: Clinton Adams, WesternU/COMP
- Outgoing President: Jeff Bloom, DO
- Convention Chair Appreciation: Susan Mackintosh, DO

Convention Program Committee Members

Susan Mackintosh, DO
Convention Chair

Rolf Knapp, DO
Chair, Education Committee

Brian Loveless, DO
Vice-Chair, Education Committee

Linda Agresti, DO
Chair, Committee on Exhibits & Grants

Ernest H. Agresti, Jr., DO
Brook Alexander, DO
Jeff Bloom, DO
Lionel B. Katchem, DO
Geraldine O’Shea, DO
Greg Pecchia, DO
Mark D. Schneider, DO
Education Committee

*New Location Next Year*
2011 Annual Convention
Hyatt Regency Mission Bay Marina & Spa
February 9-13, 2011
SAN DIEGO, CA

Senator Leland Yee, Ph.D. receives OPSC's 2010 Legislator of the Year award from President Jeff Bloom, DO

OPSC Incoming President Susan Mackintosh, DO presents the Lifetime Achievement Award to her father, William Ryan, DO

OMT demonstration
New President Takes Office

Susan Mackintosh, DO, MPH was inducted as the new President of the Osteopathic Physicians and Surgeons of California (OPSC) on Saturday, February 13, 2010. The induction was performed by American Osteopathic Association President Larry Wickless, DO, during the President’s Banquet that took place at the Renaissance Hotel in Palm Springs.

Dr. Mackintosh is Director of Interprofessional Education at Western University of Health Sciences. An active OPSC member since 2003, she served on the Board of Directors from 2005-2008 and was the Chairperson of the OPSC 2010 Annual Convention. Dr. Mackintosh holds active memberships in the American Osteopathic Association and the Golden Key Honor Society.

Dr. Mackintosh is a 1992 graduate of Western University College of Osteopathic Medicine of the Pacific. In addition, she earned her Masters of Public Health from American Military University in 2008.

OPSC welcomes Dr. Mackintosh as the new 2010-2011 President.

New Officers and Board Members

Please meet the Osteopathic Physicians & Surgeons of California’s (OPSC) newest officers and Board members:

**President-elect Gregory Pecchia, DO**

- Specialty: Family Practice/Geriatric Medicine
- Title: Clinician, consulting Medical Director for Ambulatory Informatics
- Practice Location: Eisenhower Medical Center, Rancho Mirage
- OPSC Regional Affiliate: Orange County
- Medical School: MSU-COM 1983

**Vice President William Henning, DO**

- Specialty: Family Practice
- Title: Chief Medical Officer
- Practice Location: Inland Empire Health Plan, San Bernardino
- OPSC Regional Affiliate: San Bernardino County
- Medical School: WesternU/COMP 1986

Osteopathic Physicians & Surgeons of California is proud to celebrate 50 years of serving the osteopathic profession in California and looks forward to another successful 50 years!
Board Members (2010-2013)

**David Connett, DO**

- Specialty: Family Practice
- Title: Assistant Dean of Postdoctoral Education and Development, Associate Professor
- Practice Location: Pomona
- OPSC Regional Affiliate: Los Angeles County
- Medical School: WesternU/COMP 1984

**John Krpan, DO**

- Specialty: Family Practice
- Practice Location: Sierra Conservation Center, Jamestown
- OPSC Regional Affiliate: Sacramento
- Medical School: WesternU/COMP 1995

**John Kowalczyk, DO**

- Specialty: Urology
- Practice Location: Urology Group of Southern California, Lim-Keith Multispecialty Clinics and Pacific Oaks Medical Group, Los Angeles
- OPSC Regional Affiliate: Los Angeles County
- Medical School: CCOM 1989

Board Members (2010-2011)

**James Huang, DO**

- Specialty: Family Practice
- Practice Location: Private Practice, Brea
- OPSC Regional Affiliate: Orange County
- Medical School: DMU/COMS 1999

**Alesia Wagner, DO**

- Specialty: Family Practice
- Title: Regional Medical Director
- Practice Location: US Healthworks, Valencia
- OPSC Regional Affiliate: Los Angeles County
- Medical School: DMU/COMS 1983

Board of Directors Report

The OPSC Board of Directors met twice in conjunction with the OPSC 2010 Annual Convention at the Palm Springs Renaissance Hotel, on Wednesday, February 10 and on Sunday, February 14. During these meetings, the Board:

- Selected the Hyatt Regency Mission Bay Spa and Marina as the site of OPSC’s 2011-2013 Annual Conventions.
- Authorized expenditure of funds for calendar year 2010 activities associated with efforts to regain osteopathic autonomy.
- Received a report from Secretary/Treasurer Alesia Wagner, DO that OPSC is in a very stable financial position.
- Considered the feasibility of purchasing a property for the OPSC headquarters building.
- Selected Alesia Wagner, DO as OPSC’s 2010-2011 Secretary/Treasurer.
- Approved appointment of the 2010-2011 Committee Chairs and Vice-Chairs.
- Established a 50th Anniversary Task Force to plan a celebration for OPSC’s 50th year in existence.
- Approved Geraldine O’Shea, DO as Chair of the California delegation to the 2010 AOA House of Delegates.
- Authorized expenditure of funds to lease appropriate membership management software.
- Established principles regarding OPSC’s legislation on naturopathic licensure.
- Received a membership report indicating that OPSC membership numbers continue to grow.
A New Frontier in Workers’ Compensation

Look around and you see signs of a troubled economy everywhere – businesses closing, high unemployment numbers, and fewer crowds around shopping malls. No doubt businesses are struggling, and keeping costs down is a priority for businesses. One of the areas where businesses are looking to contain costs is in workers’ compensation claims. As occupational medicine physicians, we play a significant role in helping employers effectively manage the care of their injured workers. Today’s environment provides us with an opportunity to reduce cost for businesses in the area of workers’ compensation without compromising the quality of patient care by incorporating a stewardship model of care.

Occupational medicine physicians serve as the steward of care for the injured worker. We are in the best position to facilitate communication, education, and participation of all stakeholders through this process. Being a steward of care requires identifying causation, secondary issues, and contributing co-morbidities while recognizing the behavioral and circumstantial realities as well as social and workplace issues. At the initial visit, the treating physician establishes expectations including participation and compliance with the treatment plan. The treatment plan is re-emphasized and reviewed at every subsequent visit. Effective communication with the injured worker and the employer regarding expectations, responsibilities, and treatment plan is essential to getting the person back to his/her usual and customary job quickly.

The injured workers also need to be aware of the basic functioning and process of the workers’ compensation system. Understanding that the system’s ultimate goal is returning them to their pre-injured state, as well as knowing their rights and the limitations and strengths of the system, will help to reduce medical legal costs which represent a significant portion of the cost in workers’ compensation. Over the past several years, the rise in California’s workers’ compensation costs has been attributed mostly to non-medical costs and administrative costs. According to the Workers’ Compensation Insurance Rating Bureau, from 2005 to 2007, medical containment costs such as utilization review and nurse case management are up 51 percent, and medical legal expenses are up 59 percent during the same period. Developing trust between the occupational physician and the injured worker by communicating all aspects of the care with the patient and involving the patient in the decision making process will help to foster a positive relationship that can help reduce unnecessary medical legal costs. Many studies have shown that legal costs are reduced when patients feel that their physician is empathetic towards them and has their best interests in mind.

Evaluating employers is also an essential role of the treating physician. Evidence has shown that early intervention and treatment of the workplace injuries and illnesses can positively impact outcomes. The treating physician has an obligation as the steward of care to educate the employer about this positive impact. Understanding the importance of having a return to work program is crucial. An injured worker is much more motivated to get healthy when they stay in the work environment through return to work programs. However, it is imperative that the occupational medicine physician communicates effectively regarding specific work restrictions. Restrictions should clearly define the functional capabilities of the injured worker. This will ensure that the injured worker will not be endangered while enabling them to still meaningfully contribute to their work place.

The occupational medicine physician is in a favorable position to exert positive influence on all stakeholders in the process. The measure of success is heavily dependent on good outcomes, and therefore delivering high quality of care is of the utmost importance. Evidence based medicine should be the standard of care, with recognition that each patient is an individual and that variance from common treatment guidelines may be needed in some cases. Practicing occupational medicine consistent with the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines as well as other established occupational standard of care provides the foundation for an effective treatment plan in accordance with best practices. Adjusting treatment plans as needed based on progression or regression of the condition through frequent communication and re-evaluation of patients is important.

The stewardship model for treating the injured workers seems simple, yet sometimes the simplest things can be the hardest things to accomplish. According to the Work Loss Data Institute’s 2010 State Report Cards for Workers’ Comp that was released March 15, 2010, California Workers’ Comp scored a grade “D” based on the state’s performance from 2000 to 2007. The report card provides five different outcome measures in the areas of incidence rates, cases missing work, median disability durations, delayed recovery rate, and on key conditions and compares the results among the states for each year. There is room for improvement. The occupational medicine physician serves as the bridge between the health care sector and the business sector. This unique role of the occupational medicine physician can help reduce costs for businesses while maintaining the highest quality of care in this time of economic challenges.
Jimma University Hospital, in Jimma, Ethiopia was the site of my summer internship as a medical student in 2008, just finishing my first year at Touro University, College of Osteopathic Medicine in California. Jimma Hospital serves a quarter of the nation of Ethiopia, and patients will travel hundreds of miles by foot, mule-pulled cart, or bus to seek care.

During my rotation in the labor and delivery ward, an 18-year-old primagravida woman arrived. When I met her, she had been in labor for more than 24 hours and the hospital hadn’t had water for a few days. She was exhausted, dehydrated and her labor was failing to progress. She was falling asleep between contractions and her contractions were happening further and further apart. She was laboring on a vinyl bed without family nearby in a room with several other laboring women. An intern assigned to her was talking about starting pitocin. In Ethiopia, pitocin is used only if completely necessary because supplies are limited.

As I sat watching, I was overcome by the desire to help this woman in her struggle. As a first year student, the tools available to me to help this woman were fairly limited. During my first year of medical school, I had been empowered by many OMT labs. After the lessons of my first year quickly flashed through my head, I decided OMT was the tool most readily available to meet the needs of the situation. I asked the intern if I could try some “massage” first, before they gave her pitocin. I loosely explained OMM. First, I must “do no harm,” and so chose to use only gentle, fairly benign techniques. During an OMT lab, I remembered hearing the term “lumbosacral decompression,” although I had never seen that technique performed. The woman was arching her back uncomfortably, so I thought she could benefit from having some space in her lumbosacral junction. In Ethiopia there are several dialects and this woman spoke a different one than the intern, but we were able to convey the request to lay lateral recumbent. I put my hand over her sacrum and put gentle caudal traction on the sacrum, being extremely careful not to pull laterally in either direction. She moaned with pleasure and I was shocked at how easily the sacrum moved under my hands.

Now, how to take advantage of the somato-visceral and visero-somatic reflexes? While remembering the anatomy I had learned during my first year of medical school the thought occurred: there are a lot of nerves coming out of the sacrum and some go to the uterus. Maybe stimulation would help? There had been an OMT lab in which we stimulated the branches of the trigeminal nerve to help alleviate sinus pressure, with gentle small circles over the nerve roots. I applied the same technique to the nerve roots exiting the sacrum, bilaterally, moving cephalad to caudal (soft tissue technique). She immediately had a contraction. The intern, still looking skeptical, couldn’t believe it and asked me to try again in 10 minutes. I tried to hide my excitement to add credibility to my technique. In 10 minutes, I did it again and she had another contraction. This time the intern called over the other interns to hear my explanation of what I had done. I explained it, as though it was a well-established technique, discussing the anatomy and the paths of the nerves, of which I had been taking advantage. I performed the technique one more time and now her contractions had gained momentum. The intern said we should go to lunch because she still had a while to go, at least a few more hours. My colleague and I went to lunch for half an hour and when we came back she had already delivered.

Through simple integration of my formal teaching, I was able to deliver a treatment appropriate for the situation. This experience imparted faith in my education, faith in our field of Osteopathy and most importantly, inspired further innovation in my own practice of OMT.
2009-2010 OPSC Report Card
What We’ve Done for Our Members!

Discounted Continuing Medical Education:
- 48th Annual Convention - February 11-16, 2009
  Wyndham Hotel, Palm Springs, CA
  - 40 Hours of 1A CME
- 20th Annual Fall Conference - Sept. 11-13, 2009
  Monterey Plaza Hotel & Spa, Monterey, CA
  - 22 Hours of 1A CME
- 49th Annual Convention - February 10-14, 2010
  Renaissance Palm Springs, Palm Springs, CA
  - 39 Hours of 1A CME

Professional Aids:
- Networking opportunities
  - Regional Affiliate Meetings
  - Annual Convention
  - Fall Conference
- On-Line membership directory
- Website
- OPSC’s California DO magazine
  - Spring
  - Summer
  - Fall
- E-Mail updates
  - Monthly

Government Affairs:
- Legislative advocacy and updates
- Introduction of SB 1050 (Bill to remove naturopathic doctors from OMBC)
- OPSC’s Day at the Capitol
- Representation before governmental and professional agencies

Membership Representation:
- Osteopathic Medical Board of California
- AOA House of Delegates
- Division of Workers’ Compensation
- Centers for Medicare and Medicaid Services

Student Activities:
- Participation in student-related activities
  - Club Day
  - Student Orientation
  - Honors Day
  - Graduation
- Student Mentorship Program
- Student/Intern/Resident Program
  - Lecture Series

State and Socioeconomic Affairs:
- Confidential assistance on Medicare/Medicaid, managed care and physicians reimbursement.
- Assistance with reimbursement from third parties.
- Answers to questions about medical licensing and legislative/regulatory activities that may affect your practice.

Other Accomplishments:
- Helped members get paid by Medicare during difficult transition period
- Added DOs to state’s physician loan repayment program
- Added DOs to physician workforce data
- Protected OPSC funds via secure and stable investments

A+
The Los Angeles County Osteopathic Medical Association has found a way to promote local osteopathic unity, despite busy freeways and urban sprawl: “Smorgasbord Saturdays.” Thanks to the generosity of Western University, College of Osteopathic Medicine, DOs in L. A. have been getting together for Saturday morning CME lectures and a chance to mix with colleagues in the area.

Thirty-one physicians and students gathered together on March 6th for bagels, coffee, and lectures in Endocrinology. The featured speakers were Airani Sathananan, MD, Clinical Faculty at Western University; Sam Sheldon, PharmD of the Compounding Pharmacy of Beverly Hills; and Stefan Hagopian, DO, FAAO, of Santa Monica.

Virginia M. Johnson, DO, President, conducted a business meeting with an update on legislative activities. An election was held for an open officer seat, and LACOMA is delighted to announce that J. Martin Porcelli, DO is now Vice President. Dr. Porcelli is a Past-President of LACOMA, and brings much appreciated insight and leadership to the group.

Following classroom lectures, LACOMA convened in the OMM lab for an inspiring and informative workshop in osteopathic manipulative medicine presented by Dr. Hagopian.

Ethan Allen, DO, Past-President of both the OPSC and LACOMA, met with the COMP students in attendance, sharing his dedication to osteopathic medicine with the future generation of DOs.

Many thanks to Byron Holloway, OMS I, OPSC Student Club President, and to Doug Sato, OMS I, for their help in organizing this meeting.

LACOMA’s next “Smorgasbord Saturday” will be held on October 2nd, at Western U. A dinner meeting is also scheduled for May 19th. Information on these meetings will be posted in advance on OPSC’s website, www.opsc.org.

Virginia M. Johnson, DO
President, LACOMA

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Welcome New Members!

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Pamela Boswell, DO, San Diego
Joe Bui, DO, Merced
Elise Lenore Bukont, DO, Thousand Oaks
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Michael Cerni, DO, Laguna Niguel
Kan Chen, DO, Le Mesa
Laurie Clark, DO, Granite Bay
William Coburn, III, DO, Pasadena
Joseph Cook, DO, Lancaster
Kevan Craig, DO, Los Angeles
Thai Dang, DO, Downey
Laurie Diem, DO, Rancho Cucamonga
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Wendy Flapan, DO, San Jose
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Sharon Gerardi, DO, Clovis
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Joseph John Ginejko, DO, Hanford
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Michael M. Green, DO, Fullerton
Jason Groomer, DO, West Hills
Vadim Gurvits, DO, Menifee
Willie Harris, DO, Patton
John B. Hawkins, DO, Sherman Oaks
Richard Holden, DO, Fresno
David C. Horowitz, DO, Long Beach
Jonathan Horowitz, DO, Santa Monica
Mohammad Jamshidi-Nezhad, DO, Oceanside
Raymond Jones, DO, Rosemead
Christos Karanikiss, DO, Fontana
Kamelia Kashani, DO, Chino Hills
Ashraf Kasto, DO, Carlsbad
Nithya Kona, DO, Upland
Rita Susan Koshinski, DO, Monterey
Sara R. Kossuth, DO, West Hills
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James Moynihan, DO, Loma Linda
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Daniel Nargizian, DO, Burbank
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Sonja Santana, DO, Pleasanton
Paula Schwarz, DO, Burlingame
Tigaliat Shalita, DO, West Hills
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Natasha Siddiqui, DO, San Diego
Mehrzad Soleimani, DO, Northridge
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Leslie Aaron Tsang, DO, Vallejo
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John Vanderford, DO, Birmingham, MI
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Ron Zuiderweg, DO, Goodyear, AZ

Military
Joshua Meador, DO, Fresno

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Heather Kranitz, DO, Santa Ana
Nee Sheet A. Parikh, DO, Orange
Kamran Parsa, DO, Pomona
Jessie E Rollins, DO, Redlands
Bahnam Thomas, DO, Los Angeles
Elijah Wogu, DO, Colton

Retired
Paul Anile, DO, Long Beach
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Thomas Brown, DO, Vacaville
James J. Hill, DO, Fallbrook
John Landsberger, DO, Los Angeles
Eugene Pudbury, DO, San Francisco

EXECUTIVE DIRECTOR’S REPORT
Continued from page 3

that came out of the session was that OPSC needs to focus even greater resources on advocacy efforts. We need to make sure legislators and other decision makers recognize and understand the osteopathic profession. In previous years, we have held an annual Legislative Day and taken positions on legislation impacting osteopathic physicians. But we can do more. Here are some of the short-term action items planned:

- Train osteopathic “Ambassadors,” preparing OPSC leaders and members to speak on behalf of the profession before legislators, media, and in other public forums
- Identify 10 legislators/staff members to serve as “DO Champions”
- OPSC members hold meetings with legislators in their districts

To facilitate these enhanced advocacy efforts, OPSC has secured a grass-roots advocacy computer program called VoterVOICE. This program allows members to easily identify and communicate with legislators on issues important to the osteopathic profession. Keep an eye out for e-mails calling members to action, particularly on SB 1050 this year.

The events of the past year have challenged OPSC to reassess our focus. I’m proud of the OPSC Board of Directors for taking action to improve our processes, establishing tangible goals to measure the success of our efforts. We will keep you updated throughout the year as our new plan of action is implemented. In the meantime, I welcome any feedback you may wish to offer.

NEW ANNUAL CONVENTION LOCATION
SAN DIEGO, CA
Hyatt Regency Mission Bay Spa & Marina
February 9-13, 2011
Touro University and College

Touro University and College recently lost its founder and President, Dr. Bernard Lander on February 8, 2010. Dr. Lander was a social scientist and educator, an ordained rabbi and preeminent leader in the Jewish and educational communities. Dr. Lander founded Touro College in 1971 and Touro University-California in 1997. Today Touro is a multi-campus international institution that educates more than 17,500 students at 29 locations in California, New York, Nevada, Florida, Israel, Russia, Germany and France. A multi-campus memorial ceremony was conducted at Touro-California on March 15, 2010 to honor Dr. Lander, not only for his contributions for Touro but for his endless pursuit for the betterment of humankind through education and health care.

On March 18, Touro appointed Alan Kadish MD as the new President and CEO of Touro College and University system. Dr. Kadish received his MD degree from Albert Einstein College of Medicine at Yeshiva University and his postdoctoral training at the Brigham and Women’s Hospital of Harvard Medical School and the University of Pennsylvania, where he trained in cardiology and cardiac electrophysiology. On March 16, Dr. Kadish visited the campus of Touro California where he met with AOA President Larry Wickless DO and then subsequently met again with Dr. Wickless to tour the AOA building in Chicago on March 23.

In December of 2009 after an extensive national search, Touro University-California selected Dr. Marilyn Hopkins as the new Provost and Chief Operating Officer. Dr. Hopkins formerly served as Dean of California State University Sacramento’s College of Health and Human Services where she had been faculty for 23 years and since 1997 served as Dean of the College of Health and Human Services.

On March 11, Touro University California purchased the 44 acres on which the campus has resided since 1999. Although the University was on a long term lease, the purchase of the campus facilitates efforts to upgrade our facilities and grounds for the over 1400 students located on our campus.

Touro University-California and the

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SI 14833 (8/09)
Solano County Department of Health and Social Services collaborated on a Community Outreach Program providing local H1N1 Vaccination Clinics. The TUC professional colleges and their students staffed eleven clinics from November through February and vaccinated over 3300 men, women and children in Solano County.

In October of 2009, students from the COM and Pharmacy programs received a grant from Target to conduct health education clinics to help low income local residents find free or low-cost medical services. In March, our students led the fourth annual Teen Life conference where over 300 local teenagers were educated on diet, exercise, stress management, drugs, alcohol, teen pregnancy and health and nutrition. In April, the Vallejo City Unified School District will open its second school based health center supervised by Touro faculty and staffed by Touro students.

Touro University College of Osteopathic Medicine-CA

Touro University College of Osteopathic Medicine-CA, in conjunction with OPSC and Western U/COMP, sent over 150 students and faculty to our state capitol and met with legislators to address the joining of naturopathic licensure into the Osteopathic Medical Board of California. Following the legislative meetings Senator Leland Lee submitted Senate Bill 1050 to address this issue on behalf of our profession to clarify concerns relative to this issue.

The COM Research laboratories on campus have been active for faculty and students alike. Our students received seed grants from AMA foundation and the American Heart Association. In addition, 27 student research presentations were completed at numerous conferences including the ACP, AOA, SOMA, AAO as well as our Intramural Research Day. At the recent 9th Annual LBORC Student Research Poster Competition our students placed 1st in Public Health/Education category and 3rd in Clinical Research.

TUCOM welcomed a new faculty Jasmin Nibbe, MD in Primary Care and announced the appointment of Jennifer Ferrell, DO as Vice Chair of the Department of Primary Care.

Accreditation Activities

The University (both California and Nevada campuses) is in the third of a three-stage regional accreditation review by the Western Association of Schools and Colleges. The focus of this review is Educational Effectiveness which was held on March 24-26, 2010. The key component of this visit is the provision of evidence that our students are achieving learning outcomes that are common to all of our programs. The University has eight such outcomes that have been agreed upon by leadership of all programs. The University also was a part of a site visit for Regional accreditation by the Western Association of Schools and Colleges.

In March, our students led the fourth annual Teen Life conference where over 300 local teenagers were educated on diet, exercise, stress management, drugs, alcohol, teen pregnancy and health and nutrition. In April, the Vallejo City Unified School District will open its second school based health center supervised by Touro faculty and staffed by Touro students.

California DOs Well Represented at the National Board of Osteopathic Medical Examiners (NBOME) 2010 Standards Setting Committees Meeting

The meeting was held at the National Center for Clinical Skills Testing in Conshohocken, PA. Dat Trinh, DO of WesternU and Jennifer Ferrell, DO of Touro attended the February 2010 meeting for SOAP Notes and OMM evaluation, while James Foy, DO, Touro, and Bartley Yee, DO, WesternU, attended the March 2010 meeting on Humanistic Domain and Data Gathering. The NBOME reviews standards for the COMLEX and COMLEX II-PE exams every three years. Passage of these national board exams are required for Osteopathic medical school graduation. For more information, see www.nbome.org.

Touro Students’ Report

The Touro University OPSC Student Club started out the semester by participating in OPSC DO Day at the State Capitol on February 4, 2010. Over a hundred students wore their white coats and met with various state legislators and their staffs to inform them about “Patients before Politics” and osteopathic autonomy.

There was a great turn out because Touro COM students were interested and expressed concern with the merger of naturopaths and OPSC. The day started out with an orientation with information and points to present to the legislators and media. Afterwards, students walked over to the Capitol to have their pictures taken in front of the Capitol building. Students were split into groups to address state legislators and their staff. A few students even met with one of the governor’s chief policy advisor! OPSC DO Day was a success thanks to the students, faculty, speakers and OPSC staff who put this together.

OPSC Board member Joseph Zammuto, DO spoke to the student club members on February 25, 2010 about the benefits of private practice versus contracted employment. He gave a great informative talk and addressed many students’ questions and concerns about their future and career.

Also during the meeting with Dr. Zammuto, new officers were elected for the next school year (Fall 2010 to Spring 2011). Congratulations to Sarah Zitsman (President), Lauren Wenger (Vice President) and Brittney Dautremont (Treasurer). I hope the new officers will have a rewarding experience serving OPSC as I have.

Anjuli Sinha, OMS II
Student Club President
Health Education Center Opens
A tangible sense of excitement filled the new Health Education Center (HEC) as students returned from winter break to begin classes on Jan. 4.

The 180,000-square-foot center, part of WesternU’s $100 million campus expansion project, features two 356-seat lecture halls, small group learning rooms for the Interprofessional Education curriculum, teaching laboratories in dental medicine and optometry, research laboratories, commons areas, conference rooms and faculty offices.

HEC houses the College of Osteopathic Medicine of the Pacific, the College of Dental Medicine, the College of Optometry and the College of Podiatric Medicine. WesternU also has completed construction of a 600-space parking garage and is close to finishing the Patient Care Center, which will house a pharmacy, optometry clinic, outpatient clinics in osteopathic and podiatric medicine, and an outpatient dental clinic. All clinical areas will be open to the public.

First-year students will begin the Interprofessional Education curriculum this semester, bringing together all the disciplines on campus so students will understand other health professions and provide and promote a team approach to patient care and health care management, leading to improved patient care.

WesternU named to President’s Honor Roll for community service
Western University of Health Sciences students remembered one of their own by raising more than $1,200 during their lunchtime in March 2010.

Daniel Kloos, who had been accepted to join the College of Osteopathic Medicine of the Pacific (COMP) this August as a member of the class of 2014, was killed in the Jan. 23 earthquake that has claimed more than 200,000 lives. He was visiting his sister, a volunteer at a Haitian orphanage, when the quake struck.

Students from seven colleges helped organize the soccer (futsal) tournament and lunch sales to donate to a Haitian orphanage in honor of Daniel Kloos’ family.

“I was very proud to see the class support and efforts made to rally the cause honoring the memory of a student of another college,” said Sue Lee, MSN-E 2013 class president. “There is a real sense of family and support here at this University interprofessionally.”

Clinton Adams, DO
Dean
The student chapter of OPSC at the Western University of Health Sciences had a great start to 2010. In early February new officers for 2010-2011 were elected and successfully transitioned roles with past executive officers. Past President Catherine Bellus (OMS II) handed over the reins to current president Byron Holloway (OMS I). Supporting Byron and OPSC is an excited and enthusiastic executive board consisting of Vice-President Andrew Boulos, Treasurer Milind Parikh, Secretary Jason Lam, Osteopathic Education Coordinator Noah Settgren, and Northwest Track Representative Jillian Hansen.

OPSC at WesternU has already had a very active and exciting year. On February 4th a number of OPSC members traveled to Vallejo, where they joined forces with fellow osteopathic medical students from Touro University, and participated in OPSC’s March on the Capitol. Osteopathic physicians and medical students spent the day in Sacramento meeting with legislators to discuss the recent merger of the Osteopathic and Naturopathic licensing boards. OPSC also hosted Senator Gloria McLeod at the WesternU campus where she held an open forum regarding medical issues with an audience of more than 50 medical students, faculty, and physicians. Most recently, club members participated in OPSC’s Annual Convention held in Palm Springs and proudly watched WesternU’s very own Dr. Susan Mackintosh as she was installed as the new OPSC President for the coming year.

To fulfill one of their major goals, the current club executive board is working closely with Dr. Mackintosh, Executive Director Kathleen Creason, and the past club executive board members on ideas and programs to increase OPSC’s campus impact and presence. Efforts to do so will include a continuing OPSC-sponsored lunch lecture series that will cover topics such as cuts in physician reimbursement, the business of medicine, and the challenges facing DOs operating in an MD dominated environment. In the spirit of professionalism, OPSC will also look to increase community involvement and collaboration with other on-campus clubs. And finally, plans are currently in the works to maintain involvement by 3rd and 4th year students as they move into their rotation by introducing a “COMPanion” program where they are paired with 1st and 2nd years, along with a board study program.

Anyone interested in becoming active with WesternU’s OPSC chapter is encouraged to contact us at OPSCclub@westernu.edu. We are always looking for new speakers and new lecture topics. We would also be very appreciative of any time or resources you would be willing to donate.

Byron Holloway, OMS I
Student Club President

### 2010 - 2011 Chairs and Vice-Chairs

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<th>Committee</th>
<th>Chair</th>
<th>Vice-Chair</th>
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<td>Lionel B. Katchem, DO &amp; David Connett, DO</td>
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<td>Education</td>
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<td>James B. Roth, DO</td>
<td>John Krpan, DO</td>
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<td>David Connett, DO</td>
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<td>Gregory Pecchia, DO</td>
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<td>OSTEO PAC</td>
<td>James M. Lally, DO</td>
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<td>Public Relations</td>
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<td>Blake Wylie, DO</td>
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<td>50th Celebration Task Force</td>
<td>Rick M. Hirsch, DO</td>
<td>Alesia J. Wagner, DO</td>
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<tr>
<td>Autonomy Task Force</td>
<td>William W. Henning, DO</td>
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Members in the News

David A. Berman, DO

was recently named a “Top Doc” in the Sacramento Region by Sacramento Magazine. Dr. Berman was selected as the top emergency room physician based on results of a Sacramento Magazine survey conducted of area physicians. He is an emergency room physician at Kaiser Permanente Roseville Medical Center in Roseville, CA. Dr. Berman graduated from Des Moines University College of Osteopathic Medicine in 1979 and has been a member of Osteopathic Physicians and Surgeons of California since 1991. Congratulations Dr. Berman.

Dr. Charles J. Sophy, DO

recently co-authored a book with Brown Kogen call Side by Side: The Revolutionary Mother-Daughter Program for Conflict Free Communication. The book, released this past February, is designed to help mothers effectively navigate their relationships with their daughters.

Dr. Sophy is a private practice psychiatrist in Beverly Hills, CA. He also serves as Medical Director for the Los Angeles County Department of Children and Family Services. He is a 1986 graduate of Philadelphia College of Osteopathic Medicine in Philadelphia, PA and has been a member of Osteopathic Physicians and Surgeons of California since 1993. Congratulations Dr. Sophy.

Upcoming Meetings and Events

May 15-16, 2010
Advocacy Training
OPSC Board of Directors Meeting/Strategic Planning
Wes. Univ. of Health Sciences Pomona, CA
Contact: Kathleen Creason @ kathleen@opsc.org or (800) 638-6772

May 19, 2010
Greater Sacramento Osteopathic Medical Assn
MDD - Janak Mahtani, MD Suede Blue, 1400 Eureka Road, Roseville, CA 95661
6:30 pm - 9:00 pm
2 hrs 1A CME credit anticipated
RSVP: Marsha Gladmon @ meetings@opsc.org, (800) 638-6772 or register on-line @ http://www.opsc.org/calendar.cfm

May 19, 2010
Los Angeles County Osteopathic Medical Assn
Patina Restaurant
141 South Grand Ave, Los Angeles, CA 90012
6:30 pm
1 hr 1A CME credit anticipated
Contact: Virginia Johnson, DO at vmjohnsondo@yahoo.com

May 23-26, 2010
Biodynamics Phase VIII –
Stefan Hagopian, DO
Topanga, CA
Contact: Stefan Hagopian, DO at (310) 576-2505

May 25, 2010
San Bernardino Osteopathic Medical Association
Honolulu Harry’s, Chino, CA
2 hrs 1A CME credit anticipated
Contact: Nannette Nevaes at (909) 464-8604 or NNevaes@cvmc.com

June 12-16, 2010
The Cranial Academy
Introductory Course in Osteopathy in the Cranial Field
La Quinta Resort & Club, Palm Springs, CA
For more information visit www.cranialacademy.org

June 17-20, 2010
The Cranial Academy
Annual Conference
La Quinta Resort & Club, Palm Springs, CA

For more information visit www.cranialacademy.org

June 16, 2010
Greater Sacramento Osteopathic Medical Assn
Migraines
6:30 pm - 9:00 pm
2 hrs 1A CME credit anticipated
RSVP: Marsha Gladmon @ meetings@opsc.org, (800) 638-6772 or register on-line @ http://www.opsc.org/calendar.cfm

July 13-18, 2010
AOA Board of Trustees and House of Delegates Meeting
Fairmont Hotel, Chicago, IL
Contact: Carol-Lynn Zurek, Director of BOT/HOD Relations @ czurek@osteopathic.org

July 21, 2010
Greater Sacramento Osteopathic Medical Assn
COPD
6:30 pm – 9:00 pm
2 hrs 1A CME credit anticipated
RSVP: Marsha Gladmon @ meetings@opsc.org, (800) 638-6772 or register on-line @ http://www.opsc.org/calendar.cfm

June 22, 2010
San Bernardino Osteopathic Medical Association
Honolulu Harry’s, Chino, CA
2 hrs of 1A CME credit anticipated
Contact: Nannette Nevaes at (909) 464-8604 or NNevaes@cvmc.com

August 5-8, 2010
ACOFP CA 34th Annual Scientific Medical Seminar
35 hrs of 1A CME credits anticipated
Disneyland Hotel, Anaheim, CA
For more information, visit www.acofpca.org

August 18, 2010
Greater Sacramento Osteopathic Medical Assn
6:30 pm - 9:00 pm
2 hrs 1A CME credit anticipated
RSVP: Marsha Gladmon @ meetings@opsc.org, (800) 638-6772 or register on-line @ http://www.opsc.org/calendar.cfm

August 24, 2010
San Bernardino Osteopathic Medical Association
Honolulu Harry’s, Chino, CA
2 hrs 1A CME credit anticipated
Contact: Nannette Nevaes at (909) 464-8604 or NNevaes@cvmc.com

September 8-10, 2011
OPSC 22nd Annual Fall Conference CME by the Bay
InterContinental The Clement Monterey, Monterey, CA
22 hrs 1A CME credit anticipated
Contact: OPSC at (800) 638-6772 or meetings@opsc.org

September 9, 2011
OPSC Board of Directors Meeting
InterContinental The Clement Monterey, Monterey, CA
9:00 am - 12:00 pm

September 10, 2011
OPSC 50th Annual Convention & Exposition
Hyatt Regency Mission Bay Marina and Spa
San Diego, CA
40 hrs 1A CME credit anticipated
Contact: OPSC at (800) 638-6772 or meetings@opsc.org

February 13, 2011
OPSC Board of Directors Meeting
InterContinental The Clement Monterey, Monterey, CA
9:00 am - 12:00 pm
REGISTRATION FORM

21st Annual Fall Conference         September 10-12, 2010
InterContinental, the Clement Monterey
750 Cannery Row, Monterey, CA 93940
888-424-6835

Name       AOA Number

☐ Home ☐ Work       Street

City       State       Zip

Phone       Fax

Email address

College       Year of Graduation       Specialty

Early Registration Fees
The deadline for pre-registration is August 16, 2010. Registration received after the deadline and on-site registrations will be subject to a $50 fee and are accepted on a space available basis. Fees include: registration, CME Lectures, exhibits, and scheduled meals for the individual physician. Guests (including children over 5 years of age) must purchase tickets to participate in meals. Please make sure to check the registration category:

REGISTRATION FEES:
☐ Member Physician $295
☐ Member Retired Physician $225
☐ Non Member Physician $545
☐ Non Member Retired Physician $475
☐ Intern/Resident – Full Registration $75
☐ Intern/Resident – Program Only $0
☐ Allied Professional $245

MEMBERSHIP FEES:
☐ Active 3 or more years in practice $475
☐ Active in 2nd year of practice $350
☐ Active in 1st year of practice $250
☐ Retired $100
☐ Military $100
☐ Associate (out of State DO) $75

1. Out of state registrants must provide membership verification of your home state osteopathic association. California physicians must be a member in good standing with OPSC. 2. Must be in an accredited internship/residency program, verification is required. 3. Meals not included

☐ Guest/Spouse $95     Guest/Spouse Name
☐ Children (per child) $45     No. of children

Special Needs or Dietary Requests

PAYMENT INFORMATION

☐ Check enclosed    ☐ Visa ☐ Mastercard

$ _______ Registration Fee Total

$ _______ Guest/Spouse/Child Fee Total

$ _______ Membership Renewal Fee Total

$ _______ Total Enclosed/Due

Card Number

Exp. Date

Name on Card

Signature

Billing address if different than above

RSVP FOR SATURDAY EVENING DINNER LECTURE:
☐ Yes, _______ adults will be attending    ☐ No, I will not be attending

OPSC is trying to go green! If you bring your laptop, you will be provided the syllabus on a Jump/Flash drive at no charge. If you are unable to bring your laptop, a printed copy will be provided at a fee of $25. Would you like a printed copy? ☐ Yes ☐ No

To submit your registration please mail to:
OPSC, 1900 Point West Way, Suite 188,
Sacramento, CA 95815 or
Fax: (916) 561-0728
You can also register on-line at
www.opsc.org

Cancellations: All cancellation requests must be made in writing and received by OPSC no later than August 23, 2010. A $50 processing fee will be assessed for all cancellations. Registration fees are not refundable after August 23, 2010.
You are invited to be a part of OPSC’s Fall Conference and spend the weekend in Monterey’s newest, most luxurious and romantic location. The InterContinental the Clement Monterey is next to the world-renowned Monterey Bay Aquarium in the heart of John Steinbeck’s historic Cannery Row. Many guest rooms and suites feature fireplaces, balconies and ocean views and all sparkle with stylish décor.

OPSC has obtained a special rate for conference attendees at the InterContinental the Clement Monterey, located at 750 Cannery Row, Monterey, CA 93940 (inland view rooms at $230, single or double occupancy, plus applicable taxes). Contact the InterContinental at 1-888-424-6835. The room rate is available until August 10, 2010 and don’t forget to mention OPSC to receive this special rate.

William Henning, DO
Conference Chair

Topics Will Include:
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- Obesity
- Chronic Pain
- Substance Abuse
- State Healthcare & Budget Issues
- OMM
- ICD Coding & HCCs
- EMR

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