

# California

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The Journal of the Osteopathic Physicians & Surgeons of California

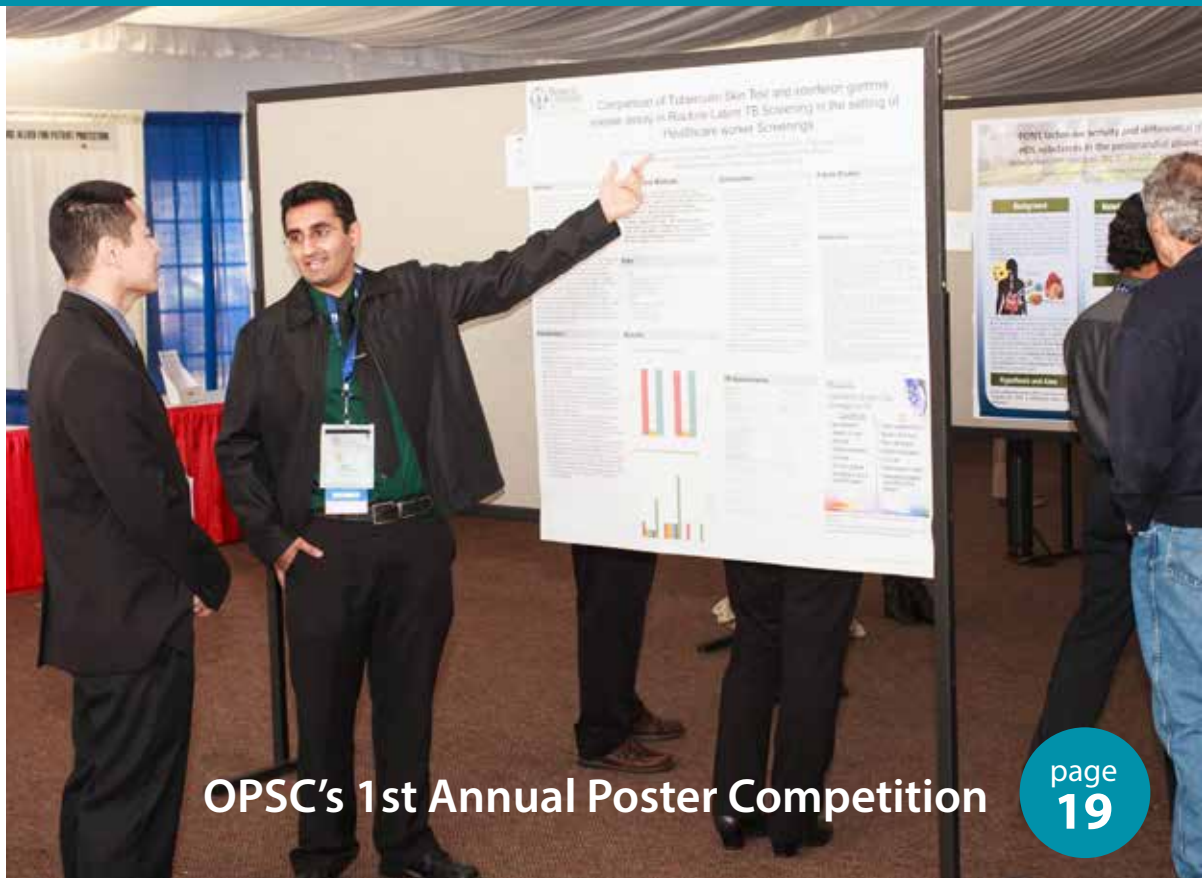
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OPSC's 1st Annual Poster Competition

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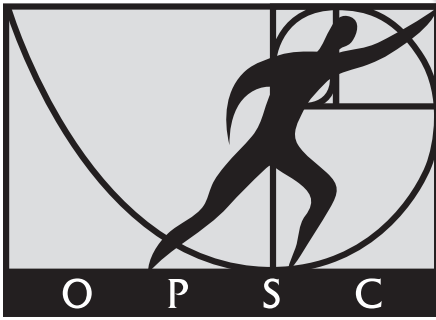
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# Issues We'll Confront This Year

► David Connett, DO, President OPSC

It is an honor to serve as your president of the Osteopathic Physicians and Surgeons of California. I plan to provide leadership on those issues that affect our seasoned osteopathic physicians and address concerns of our osteopathic medical students. A recurring theme will be identifying our strategic partners to work collaboratively when possible on common issues, assuring that our osteopathic identity and heritage is maintained for future generations of DOs.

We have had some early success in addressing discriminatory practices at multiple University of California medical schools that have excluded osteopathic medical students from doing student rotations at their institutions. These "audition" rotations are the primary mechanism for medical students to achieve employment as newly licensed osteopathic physicians as residents or fellows. These universities are state-supported academic medical centers which have allowed out-of-state and, in some instances, out-of-country allopathic students to rotate at their institutions but have precluded participation by osteopathic physicians. This is in contrast to non-state supported institutions such as Stanford, University of Southern California, and Loma Linda, all of which welcome osteopathic medical students.

As part of a multi-pronged effort to correct this injustice, I met with multiple state senators and assemblymembers who provided unwavering support of the osteopathic students and our profession. I have also reached out to the president of the California Medical Association, Dr. Richard Thorp, who has also supported our efforts to end these discriminatory practices. Our legislative advocates, with the firm of Capital Advocacy, were invaluable in reaching out the UC System and arranging the multiple meetings regarding this issue.

Due to our efforts, all offending University of California medical schools have changed their websites accordingly to remove the offensive language regarding osteopathic medical students. We will now enter a phase to ensure the University of California is compliant and that their policies and culture reflect the change in their publications, so that osteopathic medical students have opportunities equal to any allopathic medical student.

MICRA (Medical Injury Compensation Reform Act), California's medical malpractice law, has provided significant relief for physicians and surgeons in the state since its 1975 implementation. This year MICRA is under a new level of direct assault by trial lawyers, who have introduced a ballot initiative to significantly increase the established cap for noneconomic damages in malpractice awards. If successful, an exponential increase in the cost and number of malpractice suits is anticipated, without improving patient care and quality. This will likely lead to an exodus of providers out of the state or motivate providers into early retirement. This assault against MICRA must be defeated. OPSC will continue working with Californians Allied for Patient Protection (CAPP), the strong, well-organized coalition established to defeat this initiative.

As part of my collaboration with the California Medical Association, I have asked Dr. Richard Thorp to work with OPSC in providing national leadership when it comes to healthcare reform. Currently, physicians have an uncertain future as we face the changes brought forth with the Affordable Care Act (ACA). This legislation, passed in Washington, requires implementation on a state level and does not address the basic fundamental issues facing medicine in the

Continued on page 33 ►



## Keep It Pure

► Brian Loveless, DO, Managing Editor

As we wrap up another wonderful Annual Convention in San Diego last month, we are again reminded of how powerful the DO spirit is. We had fantastic poster presentations from our students and residents, a strong slate of presenters, and great attendance (especially for the second year of our 3-year CME cycle!) Thanks go out once again to David Connett, DO for a solid conference.

Congratulations are also in order for Dr. Connett as he is handed the reins and becomes our President. Our deep gratitude goes out to Dr. Alesia Wagner for the wonderful job she did as President; she has set a high bar for Dr. Connett to achieve. We are sure he will rise to the challenge. In his inaugural address, Dr. Connett placed a specific emphasis on interacting with our local political representatives, something he has done and is asking the Board of Directors to do in earnest.

In this issue you will find a synopsis of the posters that were presented at our Annual Convention. The winning poster was presented by Fadi Arodaki, OMS. Congratulations to all the students and doctors for their efforts.

The buzz in the Osteopathic education community right now seems to be the news of a Memorandum of Understanding between the AOA, AACOM, and ACGME to unify graduate medical training under

one system. While this news has brought the predictable “doom and gloom” from some in the profession, the students and residents are excited by the outlook for increased exposure and availability of fellowship programs. As we were reminded recently by AOA President Norm Vinn, DO, the Osteopathic profession has faced many challenges in its young life, and has emerged each time stronger for the future. We would expect nothing less today.

Another highlight (lowlight?) of the new year has been the continued march of the Affordable Care Act. We reached another milestone with the arrival and subsequent delay in the hard deadline to enroll of March 31st. The administration, in a controversial move, announced that there would be a softening of the deadline for those who had begun the enrollment process but hadn't been able to complete it. Later announcements stated that as many as 7 million had enrolled in the program since the beginning of the year, with a note coming from the Rand Corporation that less than 1 million of those were previously un-insured. So the confusion continues, and it seems that it is the working DOs that are most confused: about the program, about patient's eligibility, about whether or not they are

Continued on page 33

### LETTER TO THE EDITOR

#### Clinical Office Tai Chi – and Me

Probably the healthiest thing we have done for our office is to create a Tai Chi exercise time. Fifteen minutes, mid-day which is paid but not mandatory has 100 % participation and is reaping unexpected and wonderful rewards. ([http://en.wikipedia.org/wiki/Tai\\_chi](http://en.wikipedia.org/wiki/Tai_chi))

Inside or outside—the space requirements are no more than the distance of a shoulder width stance and arm span. The dress is not special—solely the removal of shoes. Music is optional and soothing. A floor mat is a good idea especially outside. There are no equipment costs or requirements.

Our leader is an existing member of our staff—knowledgeable individuals are available in most communities of the country. Patients, adjacent business employees, family members all have

interest and attend because of the benefits. Once learned it is easy to practice at home, work, or on the road.

Each individual progresses at their own pace. The benefit is obviously in physical fitness but probably the greatest benefit is psychologically with the improvement of mental fitness. ([http://www.health.harvard.edu/newsletters/Harvard\\_Womens\\_Health\\_Watch/2009/May/The-health-benefits-of-tai-chi](http://www.health.harvard.edu/newsletters/Harvard_Womens_Health_Watch/2009/May/The-health-benefits-of-tai-chi))

We have no data, and do not intend to create a study—we are a small family practice in Orange, California yet the rewards are worthy of a trial. The stress reduction, improved staff camaraderie and improved productivity make this a great investment.

Bryn J. Henderson, DO, JD, FACPE, CIME  
April 17, 2014



## “A Week in the Life . . .”

► Kathleen S. Creason, MBA, Executive Director

*Following is a sample of activities undertaken during a representative week in the life of OPSC's Executive Director.*

### Monday

I don't usually drink caffeine, but Monday mornings sometimes make me question that choice. As I sit down at my desk this morning and take a look at my calendar for the week, though, I find myself becoming energized. There are a number of upcoming events that excite me. The first is today's scheduled lunch meeting with Dustin Corcoran, CEO of the California Medical Association. OPSC shares many common issues with CMA and it's nice for us to have a chance to chat about several that are specific to the osteopathic profession and the physician community. I'm fortunate to have a strong collegial relationship with Dustin and his key staff, all of whom are bright, professional, and articulate. During today's meeting, Dustin and I talk about the proposed Southern California medical school which would negatively impact osteopathic rotations and residency programs, efforts to protect Medicare and Medicaid physician payments, upcoming legislative issues, and organizational changes.

Having caught up on e-mail in the morning, I take time in the afternoon to follow up on some projects in process. I put out a request to members for sample health plan contracts as follow-up to a meeting we held with the Department of Managed Health Care in an effort to eliminate misclassification of OMT. We have implemented two new physician-in-training contests - a video production contest for students and a research poster contest for residents - which require action. I wrap up the day trying to stay on top of e-mails that have come in throughout the day. It's a never-ending cycle, though so much easier and faster than the primitive methods of communication available when I started in association management two decades ago. Uh, when I was 7.

### Tuesday

This morning starts off with an off-site legislative fundraiser. Our highly respected legislative advocacy firm holds multiple events each week, giving OPSC the opportunity to meet and educate a wide range of state legislators. I'm thrilled to find out that this legislator has a brother-in-law who is a DO, so I don't have to do the whole "what is a DO?" talk and instead can focus in greater depth on issues impacting the profession. On my way back into the office, I run by the State Capitol to pick up a matted, framed legislative resolution

that Senator Mimi Walters has written to congratulate David Connett, DO on his induction as OPSC President. Once in the office, I take time to focus on some administrative details, such as signing checks - including the substantial check we're giving to fight the potential anti-MICRA ballot proposition. I'm thankful for OPSC staff members Karl, Cassandra, and Annette. They are invaluable. They work hard on a daily basis to keep projects moving along and handle complex administrative processes, which allows me to spend the bulk of my time on advocacy and broader policy issues.

Tuesday afternoon, I have a long discussion and follow-up e-mails with Dr. Connett about an astonishing discrimination issue that was brought to our attention by Harjoyt Toor, OMS, OPSC's Student Club President at Touro. Three of the University of California facilities publicly state that they will not accept osteopathic medical students for rotations/clerkships. We did not receive satisfactory resolution from a telephone conversation we held with UC administration on the topic, so we're now implementing a 5 point action plan to resolve the issue. This one has us fired up!

### Wednesday

After spending a short time in the office, I head off to a press event urging elimination of the planned 10% cut to Medi-Cal rates. As part of a coalition led by the California Medical Association, OPSC has been active in fighting reduction of the already dismal Medi-Cal payment rates for physicians. The legislature has been supportive - as evidenced by the two legislators speaking at the press event - but the challenge is finding the money in a strapped budget. We'll continue to press on.

This afternoon, I review a book called "Race for Relevance" recommended by AOA President Norm Vinn, DO, which pinpoints changes that associations must consider in their effort to thrive long term. The OPSC Board of Directors has selected this topic as the "Mega Issue" for its next meeting. To facilitate the discussion, I excerpt portions of the book that are strategically thought provoking. It's difficult to find time in the everyday whirlwind to read industry literature and think big picture, so I relish this opportunity.

5:00 but the work day is not yet over. I attend a reception featuring California's Lieutenant Governor Gavin Newsom. He and I chat personally for about 15 minutes, during which time he proves himself

Continued on page 34 ►

# Spring Legislative Update

▶ **Dave Helmsin and Jennifer Snyder, Capitol Advocacy**

## 2014 Legislative Session

The Legislature convened its 2014 session in January with high hopes that it would be a productive, successful year. Democrats held “supermajorities” in both legislative houses, the state’s budget was in balance with additional surplus funds that could finance plans for new spending on services to children, the poor, and the disabled. Unfortunately, in the last few months, the atmosphere has deteriorated considerably with three Democratic senators facing criminal charges. All three legislators have been suspended from the Senate, thereby erasing the upper house’s supermajority. This change in the political structure and its impact on legislative morale and public opinion has dampened the Legislature’s enthusiasm and its political potential in moving a more liberal agenda they hoped for in 2014.

Because both the Assembly Speaker and the President Pro Tem of the Senate are termed out in 2014, leadership of the Legislature will also change hands at some point in the year.

The 2014 elections are also in full swing. The June open primary will result in two top candidates for each open seat in the November elections. The new members elected will have the ability to serve a full 12 years in either house. Democratic supermajorities are expected to remain in both houses of the Legislature for the 2014 elections—although Republicans are trying their best to upset this current balance of power.

## 2014-2015 State Budget – Medi-Cal Cuts

Governor Brown released his Proposed State Budget for 2014-2015 on January 9th. Fortunately California’s fiscal situation is much better, so the Governor has proposed small increases in funding for most Departments. Education is the single largest focus of the Governor’s Budget, with a proposed \$10 billion increase in spending.

The Governor’s budget proposed \$18.8 billion for the General Fund for health programs—a 3.9% increase over 2013-14 estimated expenditures. His budget assumes about \$400 million in additional costs associated with implementing a simplified Medi-Cal eligibility and enrollment process under Medicaid expansion through the Affordable Care Act. The Governor proposes to exempt certain classes of providers—including physician services—from any retroactive recoupments of the Medi-Cal rate reductions, although he does nothing to remedy any of the prospective cuts for physician services in the Medi-Cal program.

The Legislature has spent the last three months reviewing the Governor’s proposed budget and including additional priorities into their hearing content. The Assembly Democrats released their

budget priorities for the 2014-15 state budget titled “Blueprint for a Responsible Budget.” Elements of the Assembly’s priorities include restoring Medi-Cal rates to providers and eliminating any retroactive or future cuts to the Medi-Cal program.

OPSC is supporting the Assembly’s efforts to restore cuts to the Medi-Cal program through the budget process and through supporting both AB 1759 (Pan) and AB 1805 (Skinner), which restore rates to physicians who provide services to Medi-Cal patients. AB 1759 extends the primary care provider reimbursement increase currently mandated by the ACA, which is set to expire on December 31, 2014, through 2015 and beyond. AB 1805 eliminates both the retroactive and prospective cuts to all Medi-Cal providers.

The Governor will release his May Revision to his January state budget on May 10th. The Legislature will have just one month to review these new proposals and act to pass a budget by June 15th. Then the Governor has until July 1st to sign or veto the budget bill and its accompanying trailer bills.

## MICRA Initiative and Legislative Activity

The trial lawyers and Consumer Watchdog have submitted a ballot initiative to the Attorney General’s Office for signature verification. The proponents have gathered over 800,000 signatures for the initiative since the beginning of the year. To qualify, the initiative will need approximately 505,000. It is expected that the MICRA initiative will qualify for the November ballot based on their signature count. Official word from the Attorney General’s office will occur by mid-May on the initiative’s qualification.

The initiative submitted to the Attorney General for signature verification would increase the cap on speculative, “non-economic” damages from the current \$250,000 to more than \$1.2 million (based on an adjustment mandated in the initiative). In addition, both measures include language requiring random drug testing by physicians and other punitive provisions related to medical providers.

OPSC serves as a member of the Californians Allied for Patient Protection (CAPP) Board, which has been in place since 1991 with the sole purpose of protecting MICRA. OPSC has contributed to the campaign to oppose the initiatives and has been asked to provide media spokespersons as well for the effort. If an anti-MICRA initiative goes forward in 2014, OPSC will be primed and ready to help defeat the effort.



## Spring Legislative Update

Continued from page 5

A legislative fight continues to be watched closely by OPSC and CAPP. As of this publication, there has been no specific movement or amended language that has progressed in Legislature.

### Health Care Workforce

OPSC is supporting a number of bills in 2014 that addressed shortages of primary care physicians in rural areas. AB 2458 (Bonilla) establishes the Graduate Medical Education Fund to finance additional positions at residency programs in California hospitals and health centers calling for additional funds to be invested in primary care resident programs. AB 2514 (Pan) would authorize tax credits for physicians that reside and practice in a rural health care professional shortage area.

Included in the Governor's budget is a proposal to provide \$2.84 million per year for three years to fund a pilot program to expand the Song-Brown program to provide grants to primary care residency programs and to expand eligibility to teaching health centers. OPSC will be working with the California Medical Association and the administration to ensure that osteopathic physicians are included in the pilot and the expanded programs.

### Residency and Clerkship Programs for DO Students

It came to OPSC's attention over the last year that a number of UC campuses were not accepting DO students for clerkships. OPSC spoke with representatives from the UC system earlier in the year and it was confirmed that some campuses were making it clear on their websites that they were no longer accepting DO students for clerkships. Unfortunately at that time, there was no resolution to the campus' actions. Since that meeting, OPSC has met with key legislators regarding the issue and has coordinated efforts with the CMA in communicating to the UC system regarding its concerns. As of April 1st, the campuses that were advertising on their websites that they were not accepting applications from DO students for clerkships have removed the inappropriate language from their websites. However, OPSC is still continuing its efforts along with the CMA to ask that campus policies are changed to allow all physicians to have the ability to apply and be accepted at UC medical schools for clerkship programs.

### Other 2014 Bills of Interest to OPSC

The Legislature has introduced over 1,800 new pieces of legislation in 2014. Of these numerous bills, OPSC is tracking over 100 bills for its members. The Legislative Committee has reviewed most

of these bills and have recommended positions on a majority of the measures. A list of the key bills are as follows:

**AB 1759 (Pan) Medi-Cal: reimbursement rates.** This is the Medi-Cal primary care provider reimbursement rate increase bill. It extends the primary care provider rate increase indefinitely, as allowed by federal law and as long as federal financial participation is available. OPSC Position: *Support*

**AB 1771 (V.M. Perez) Telephonic and electronic patient management services.** This requires telehealth services to be covered. Specifically, it requires health plans and insurers, for policies started or renewed on or after 2015, to cover telephone and electronic patient management services ("telehealth") provided by a physician at the same rate as in-office visits, as long as the telehealth services are similar in nature (length and complexity). OPSC Position: *Support*

**AB 1805 (Skinner) Medi-Cal: reimbursement: provider payments.** This restores the 10 percent cut to Medi-Cal provider reimbursement rates that was enacted in the 2011 State Budget and it eliminates any retroactive cuts to providers as well. OPSC Position: *Support*

**AB 1886 (Eggman) Medical Board of California.** This bill requires disciplinary and legal action against licensed physicians and surgeons to be posted on the Medical Board of California's (MBC) website indefinitely. Current law requires such information to be removed from the MBC website after ten years. OPSC Position: *Oppose*

**AB 1890 (Chau) Athletic trainers.** This licenses athletic trainers. The bill originally established the Athletic Trainer Licensing Committee under the Osteopathic Medical Board (OMBC), but has since been amended to remove the OMBC from the bill. OPSC Position: *Neutral as Amended*

**AB 2214 (Fox) Emergency room physicians: continuing medical education: geriatric care.** This bill would add geriatric care to the continuing education requirements for emergency room physicians by requiring the Medical Board's Division of Licensing, in determining those requirements, to include a course in geriatric care. OPSC Position: *Oppose*

**AB 2400 (Ridley-Thomas) Health care coverage: physician contracts.** This bill prohibits a contract between a physician or physician group with a health plan or insurer from requiring a physician to participate in any product unless that participation is negotiated and agreed to between the health plan and the physician. OPSC Position: *Support*

**AB 2458 (Bonilla) Medical residency training program grants.** This bill establishes the Graduate Medical Education Fund to administer and fund grants to graduate medical education residency programs located in California hospitals or teaching health centers. The bill appropriates \$25,000,000 from the General Fund in 2014-15 and \$2,840,000 per year for 3 years, starting in 2014-15 fiscal year, from the California Health Data and Planning Fund. OPSC Position: *Support*

**AB 2514 (Pan) Income taxes: credits: rural health care professionals.** This bill, in order to increase access to healthcare in underserved areas of the State, allows a tax credit for health care professionals who reside and practice in rural health care professional shortage areas, pursuant to an agreement with the State Department of Health Care Services, in a certain amount of the healthcare professionals' student loans. OPSC Position: *Support*

**SB 492 (Hernandez) Optometrist: practice: licensure.** This is one of three scope of practice bills introduced last year by Senator Hernandez. Specifically, this bill expands the scope of practice of optometrists by allowing them to use all therapeutic pharmaceutical agents approved by the FDA for use in treating eye conditions. This bill also allows optometrists to provide habilitative services, and expands optometrists' ability to diagnose and treat certain diseases. OPSC Position: *Oppose Unless Amended*

**SB 500 (Lieu) Medical practice: pain management.** This bill requires the Medical Board to update its standards regarding competent review in cases regarding the management, under-treatment, under-medication, and overmedication of a patient's pain, by July 1, 2015. The bill also requires the MBC to convene a task force to develop and recommend updated standards and to update the standards by July 1st every 5th year thereafter. OPSC has requested amendments that will include the OMBC in the task force. OPSC Position: *Support if Amended*

**SB 1083 (Pavley) Physician assistants: disability certifications.** This bill would amend the Physician Assistant Practice Act to authorize a physician assistant to certify disability, after performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with the act. The bill would correspondingly expand the definition of practitioner to include a physician assistant. OPSC Position: *Oppose*

**SB 1429 (Steinberg) Civil damages: medical malpractice.** This is the Pro Tem's bill to serve as a vehicle for a legislative compromise on MICRA. It is currently just an intent bill, stating the Pro Tem's desire to "bring interested parties together to develop a legislative solution to issues surrounding medical malpractice injury compensation." OPSC Position: *Oppose* ■



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# Update on Child and Adolescent Immunizations

► Lisa Warren, DO

*Ed. Note: This article is in follow up to Dr. Warren's presentation at the 2014 OPSC Annual Convention.*

Immunization recommendations are updated on an annual basis. Once FDA approved, recommendations from the Advisory Committee on Immunizations Practices (ACIP), the American Academy of Pediatrics, and American Academy of Family Physicians are provided and then published annually by the CDC in February. This article will provide information on how to stay up to date with the complexity of the schedule, an update on several recent immunization recommendations, and suggestions to improve immunization rates in order to meet compliance expectations.

Considerations in approval or modifications of immunization recommendations are determined by several factors. These include the severity of the disease, risk of disease related to morbidity and mortality at different age groups, as well as balancing the risk of being exposed, with or without being vaccinated. The impact of immunizations resulted in a significant decrease of disease prevalence, except for a notable rise in several diseases such as measles and pertussis<sup>1,2</sup>.

With Healthy People 2020, a national health initiative, specific goals for immunizations were set to meet science based national objectives. A specific goal for immunizations includes 90% coverage within 5 years of a new vaccine being added<sup>4</sup>. Current data suggest that many vaccines fall short of those goals<sup>5</sup>. This may be due to shortages, awareness, or public concern regarding those specific immunizations. In order to improve compliance, each of these categories needs to be considered and improved upon.

In the last 10 years, significant changes in the immunization schedule have been made.

Rotavirus is the leading cause of diarrheal disease in children under 5 years of age. It is attributed to nearly 450,000 deaths annually, with 90% of these deaths occurring in developing countries<sup>6</sup>. In the United States, over \$1 billion dollars of direct and indirect costs due to lost wages, emergency department or physician visits or hospitalization contribute to high economic burden<sup>6</sup>. A tetravalent rotavirus vaccine was initially introduced but quickly and voluntarily withdrawn in 1999 after concerns of associated risk of intussusception. In 2006, Rotateq, and in 2008, Rotarix were licensed<sup>6</sup>. Significant reduction on morbidity and mortality has been notated to improve outcomes. There still

continues to be reported clustered cases of intussusceptions events 3 to 6 days after the first dose of rotavirus vaccine<sup>7</sup>.

In 2006, CDC recommendations included replacement of Td to Tdap. This change was due to an increase of reported cases of pertussis since the 1980s. Increase of reported pertussis-related deaths in the 0-3 month age group has doubled in the last decade<sup>8</sup>. Estimated worldwide deaths are over 300,000 deaths per year. It is a highly contagious respiratory disease<sup>8</sup>. Infants' symptoms tend to be vague – often presenting with coughing, gagging, or apnea. This is contributed to a general decline in immunity within 5-10 years of administration of the vaccine. It has been suggested that this may result from a change of the whole cell to acellular components of pertussis vaccine. Booster administration of the pertussis portion of the vaccine would reduce the reservoir of virus and potentially reduce the incidence in the vulnerable age group and setting. Tdap coverage among adolescents, ages 13-17 years old, was at 85% in 2012<sup>9</sup>.

Meningococcal vaccine was initially recommended for those in high-risk environments. However, due to increased burden of disease in the 14-17 and 18-24 age groups, routine administration of the meningococcal vaccine has been implemented in the 11-12 year age group with a booster at 16 years of age. Historically, there are approximately 1,400 to 2,800 cases of meningococcal disease in the US each year with a high morbidity up to 20% and, due to its rapid course, mortality up to 10-14%<sup>10</sup>. The vaccine covers for the serotypes C, Y, A, and W-135, which account for 75% of cases in adolescents<sup>10</sup>. Vaccines that provide protection against serogroup B are in development. Recent outbreaks in 2013 at Princeton and University of California Santa Barbara emphasize the importance of universal coverage as well as continual push to include serotype B in vaccine coverage<sup>11</sup>.

Human papillomavirus is the most common sexually transmitted disease with nearly 1 of 6 individuals afflicted. The morbidity and mortality associated with HPV is significant with nearly 12,000 cases of cervical cancer diagnosed and 4,000 deaths annually<sup>12</sup>. Over \$4 billion dollars are spent on screening and management of HPV complications – primarily in the management of abnormal cervical cytology and treatment of cervical neoplasia<sup>12</sup>. Other associated cancers such as anorectal cancers are directly associated with HPV infection. Recommendations for routine vaccine include covering both males and females at ages 11 or 12 years of age. Vaccine can

be administered as young as 9 years of age. The 3 dose series vaccine overall coverage is low, ranging from 5-40%.

Improving vaccination rates to meet the Healthy People 2020 goal of 90% coverage requires comprehensive evaluation on the potential barriers faced by physicians. The easy access to health information allows parents and families to come in with considerable amount of information. Time to effectively communicate regarding the benefits and safety profile is a difficult challenge. However, providing families with personal stories can be powerful. Providing written material or showing videos that feature families affected by vaccine-preventable disease may be effective. Involving support staff and leading by example allows for a consistent message. Engaging and empowering families by providing information handouts based on their language and level of literacy improves these outcomes. Parents also present with social and cultural expectations. Families are often confused by conflicting information provided by media, the physician's perceptions, and other medical related sources. Without adequate information and time, parents often tend toward opting out.

Reducing parental anxiety with adequate, timely information can improve immunization rates. Other barriers such as safety concerns can be overcome through awareness with information from the Vaccine Adverse Event Reporting System website. Parental concerns regarding pain and risk of overburdening a child's immune system often results in delayed or under vaccination. Utilization of combination vaccinations and providing measures to improve pain control can reduce this barrier.

Keeping up with the constant changes with immunization recommendations and remaining compliant with standard of care practices are a challenge for health care providers. Awareness of CDC recommendations and effective communication between support staff and families should improve vaccination rates to expected standards. Understanding the barriers, a consistent message paired with flexibility, and utilizing every visit as an opportunity to vaccinate is necessary to meet universal coverage. ■

## References

1. CDC. MMWR January 7, 2011; 59(52): 1704-1716.
2. [www.cdc.gov/mmwr/preview/mmwrhtml/mm5952md.htm?s\\_cid=mm5952md\\_w#fig1](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5952md.htm?s_cid=mm5952md_w#fig1)
3. [www.cdc.gov/vaccinesafety/activities/vsd.html](http://www.cdc.gov/vaccinesafety/activities/vsd.html)
4. [www.cdc.gov/vaccinesafety/activities/vsd.html](http://www.cdc.gov/vaccinesafety/activities/vsd.html)
5. [www.cdc.gov/vaccines/stats-surv/nis/](http://www.cdc.gov/vaccines/stats-surv/nis/)
6. <http://www.cdc.gov/rotavirus/index.html>
7. Intussusception After Rotavirus Vaccines Reported to US VAERS, 2006–2012 Penina Haber, Manish Patel, Yi Pan, James Baggs, Michael Haber, Oidha Museru, Xin Yue, Paige Lewis, Frank DeStefano and Umesh D. Parashar Pediatrics; originally published online May 13, 2013; DOI: 10.1542/peds.2012-2554
8. CDC, National Notifiable Diseases Surveillance System and Supplemental Pertussis Surveillance System, 2010
9. [www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a1.htm)
10. <http://www.cdc.gov/meningococcal/clinical-info.html>
11. <http://www.cdc.gov/meningococcal/outbreaks/vaccine-serogroupB.html>
12. MMWR 2010;59(No. 20):626-9

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# EMR Security for Physicians — An Introduction

► Scott Helf, DO, MSIT

There are potentially large blind spots when it comes to knowledge of EMR security and potentially dangerous computing habits. This series is designed to stimulate interest, increase awareness, and modify at least one bad habit regarding EMR security. And, it will do so in an easy to read, digest, and immediately actionable format. We hope you enjoy, and employ, the following articles in your daily practice:

- **EMR Security: Why it Matters to You and Your Patients**
- Roles, Documentation, and Auditing: Is Your EMR up to Snuff?
- EMR Physical Security: The Easiest Way to Violate HIPAA?
- When You Lay Down with Dogs: EMRs and the Importance of Machine Hygiene
- E-mail: Is it Secure?
- Passwords: Good Complexity Made Simple
- Condoms and Web EMRs: Of HTTPS, Man-in-the-Middle, and WiFing in Public
- Wrap Up

## EMR Security: Why It Matters to You and Your Patients

So, why should you care about EMR security? You have or your employer has tech people for that, right? While no one expects physicians to become computer security experts, there are certain moral and legal expectations of healthcare professionals.

Let us begin with a cautionary tale. In March, 2009, a Massachusetts General Hospital (MGH) employee lost the private health information (PHI) of 192 individuals on a subway. Because of this singular incident, MGH settled with the Department of Health and Human Services for \$1M, and agreed to enter into a Corrective Action Plan in February, 2011<sup>1</sup>. In addition to the monetary loss, MGH also received negative publicity, and references to this embarrassing incident are still made as examples of what can happen. This case highlights how expensive even a single breach of PHI can be in terms of dollars, publicity, and potentially, loss of patient and public trust. Although the MGH subway incident involved printed documents, the same liabilities exist for EMRs.

Liabilities for potential civil and criminal penalties are laid out in Section 13410 of the HITECH Act<sup>2</sup>. If due care and due diligence are not followed, fines can exceed \$1M per incident, and, for particularly egregious breaches, a physician could lose his or her license.



Due care is defined as “the care that a reasonable [person] would exercise under the circumstances—the standard for determining legal duty”<sup>3</sup>. Due diligence is defined as “the care that a reasonable person exercises to avoid harm to other persons or their property”<sup>4</sup>. The good news: if a physician exercises due care and due diligence through the use of EMRs in a secure manner, then the likelihood of violating HIPAA and suffering penalties is very low.

Far above the risk of civil or criminal penalties, physicians swear to keep in the greatest confidence their patients’ most sensitive and private information. Vigilance in good EMR security practices is vigilance in maintaining your patients’ privacy. A broad understanding of EMR security, as well as personal habits that might compromise that security, are highly consistent in keeping that oath.

As a physician, maintaining EMR security is absolutely essential and it matters deeply to you and your patients.

This series of short articles will guide you to practice due care and due diligence of the secure use of the EMR. In the next article, we discuss the importance of defining roles in, documenting, and auditing your EMR. Is your EMR up to snuff? ■

## References

1. Health Information Privacy. (2014, March 18). Retrieved from United States Department of Health and Human Services: <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/massgeneralracap.pdf>
2. HITECH Act. (2014, March 18). Retrieved from United States Department of Health and Human Services: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechact.pdf>
3. Dictionary.com. (2014, March 18). Retrieved from <http://dictionary.reference.com/browse/due+care>
4. Merriam-Webster. (2014, March 18). Retrieved from Merriam-Webster.com: <http://www.merriam-webster.com/dictionary/due+diligence>

# Non-Invasive Prenatal Testing: The Final Frontier in Prenatal Diagnosis

► Kristina Roloff, DO, MSc, FACOOG

*Author's note: This commentary is written as a follow up to a lecture presentation at the most recent OPSC conference in San Diego, CA in February. I decided to deviate from the topic of Preconception Counseling after thoughtful comments and questions were received from the audience, to give OPSC's members a little more information on new genetic tests used in the screening for aneuploidy, and my perception of these tests as a fellow of Maternal Fetal Medicine.*

Jean Luc-Picard himself would be impressed with the pace of change in genetic prenatal testing. Within the last five years, techniques to extract, amplify, and count fetal gene sequences in maternal circulation have come to market and have proven to be incredibly accurate for the detection of fetal aneuploidy in high risk pregnancies.<sup>1</sup> Recently, Bianchi et al. have published that non-invasive prenatal testing (NIPT), also called cell free DNA testing, maintains its sensitivity even in low risk pregnancies.<sup>2</sup> This exciting information will change dramatically how prenatal screening for aneuploidy is done for all women, but needs to be approached scientifically, with care and caution, appreciation of the limitations, and open informed discussion with parents about what they are buying into when they have NIPT done.<sup>3</sup> Here is a primer on the current state of NIPT, and some thoughts on where we may go next.

## How is NIPT done?

The great advantage of NIPT is in the first two letters of the acronym: Non Invasive. It turns out, the barrier between mother and baby is not quite as robust as once thought. Some fetal cells break down, and small segments of DNA are released and can cross the placenta into maternal circulation.<sup>4</sup> NIPT is a maternal blood test designed to pick up some of these small segments of cell free fetal DNA.<sup>5</sup> Admittedly to oversimplify, the blood DNA fragments (maternal and fetal) are then amplified and separated into their respective chromosomes. Fragments from each chromosome are then counted and if there are too many of chromosome 21, then a diagnosis of Down's syndrome can be made. If there are too many snippets of 18, 13, or XY then a diagnosis of Edwards, Patau syndrome or a sex chromosome abnormality, respectively, is suspected. There are currently four NIPT tests on the market: Harmony (Ariosa), Verifi (Verinata), Panorama (Natera), and Maternit21 (Sequenom). Each has a slightly different

mechanism for testing and slightly different reporting profile, but overall function clinically very similarly. Which test to use is largely dictated by the contracted insurance carrier.

## Why is NIPT so great?

From the maternal perspective, NIPT is great because it involves a much smaller needle targeted at a vein instead of her abdomen. From the scientist's perspective, NIPT is great because of its accuracy. There are few diagnostic tests in medicine that reach the sensitivity and specificity of NIPT. It can detect 99.9% of trisomy 21 with a false positive rate less than 0.1% in the high-risk population (advanced maternal age, family history of aneuploidy, etc.).<sup>1,6-7</sup> This detection rate is a marked improvement over the 85% detection and up to 5% false positive for trisomy 21 we have in the current California "MSAFP" screening program. And it can be done as early as 10 weeks into pregnancy (5% of samples can not generate enough fetal DNA to yield a result<sup>8</sup>), leaving ample time for the option of a safe and legal pregnancy termination should an abnormality be detected. Of note, NIPT is not perfect, and not considered a diagnostic test. Amniocentesis for confirmation of chromosome abnormality is still recommended for diagnosis.<sup>1</sup>

## What's the downside to NIPT?

While NIPT confers many advantages over current prenatal screening practices, it's equally important to be upfront about what NIPT doesn't do. Clearly it is a great test for trisomy 21. But trisomy 21 occurs in 1/700 live births, and 1/33 live births have some kind of birth defect. NIPT does not perform quite as well for trisomy 13 and 18, for which it has 80-98% detection rate.<sup>2</sup> And let's be clear, it tests for 4 chromosomal conditions: the three previously mentioned, and sex chromosome abnormalities, and nothing else. NIPT cannot detect structural defects, or neural tube defects, or cardiac anomalies, and does not predict pregnancies with increased risk for IUGR, preterm delivery, PPRM and preeclampsia like current serum integrated screening can and does.<sup>9</sup> The current California screening program for aneuploidy includes the nuchal translucency (NT) ultrasound, a measurement of the skin thickness of the fetal neck that is used in combination with first trimester analytes (HCG and PAPP-A) to give an early risk assessment for trisomy 21. An increased NT (greater than 3mm) is associated with trisomy 21, Turners syndrome (monosomy

## Non-Invasive Prenatal Testing

Continued from page 11

X), and has some association with congenital heart defects, anomalies that are a diagnostic challenge in the most expert of hands.<sup>10,11</sup> While first trimester ultrasound screening for anomalies has not been shown to be effective on its own, incidental early findings at the NT screen of anencephaly, holoprosencephaly, placenta accreta, and missed abortion can not be undervalued to the mom with that diagnosis.<sup>11</sup> And there is the additional advantage to the obstetrician in confirming or revising a much more accurate due date. So before we toss out the old, in favor of the latest greatest test, we need to consider what else is getting tossed with it.

### Invasive testing: to the graveyard, or more bang for your buck?

As mentioned above, one of the most attractive features of NIPT to parents is that it is a blood draw only; no longer do they have to dread a needle in the belly! And that is true, to a certain extent. But remember, NIPT detects 4 aneuploidies. What about all the other genetic syndromes out there? What about micro-deletions, duplications, translocations and the like? For these, we have a microarray, and back to invasive testing we go. Currently, amniocentesis can be done between 15 and 20 weeks of gestation, and CVS from 10 to 12. Fetal cells can be tested for all 4 of the above-mentioned aneuploidies, plus they can be reflexed if normal for microarray sampling for hundreds of known genetic mutations.<sup>13,14</sup> Invasive testing does come with a higher price, literally, and in the possible complications related to the procedure. In experienced hands, the chance of miscarriage with CVS is around 1/200, and for amniocentesis is around 1/700-1200.<sup>15-17</sup> But for many women, especially those at high risk of carrying an affected fetus and strong desire to abort an abnormal fetus, the small increase in financial cost, and rare risk of complications for such a huge amount of additional information is worth it.

### The future is now.

As we continue on the super fast freeway that is an analogy for how fast advances in technology for genetic testing are moving, it becomes easy to imagine a time when whole fetal genome sequencing is available through a maternal blood test. Panorama has begun advertising screening for micro deletions such as DiGeorge syndrome, but the studies showing validation are not yet done, and the company's ads indicate these tests have not been cleared or approved by the FDA.<sup>18</sup> But these tests are coming.

Sometimes it seems the future is now; parents (especially those in high risk groups such as Ashkenazi Jewish) already benefit from pre-gestational genetic testing and counseling. The preconception approach makes more sense in that prevention can be practiced through alternative forms of conception, i.e. pre-implantation genetic testing, in couples at high risk for a genetic mismatch. Perhaps all new couples should be tested. And as whole genome sequencing becomes available, dating websites may have to completely redefine a 'compatible match'!

In all seriousness however, NIPT marks the beginning of an exciting new frontier in prenatal diagnosis. It will somehow be incorporated into current screening programs and algorithms for all women, not just those at high risk for aneuploidy. One can only hope it will be available through a comprehensive program that includes a mechanism for patient education, greater access to genetic counseling for all women, and for informed decision making, while preserving the known benefits of our current screening program. ■

References available upon request

## OPSC Wants Your Stories



Now that Covered California has completed its rollout, we would like to know how it is affecting you and your patients. This will allow us to share your experiences with the program, work to improve patient access and minimize the negative impacts on you, our practicing physicians.

Write us at [publications@opsc.org](mailto:publications@opsc.org) to share your Covered California experiences.

# Polycystic Ovary Syndrome: What's Not in a Name?

► Joseph C. Gambone, DO, MPH

*Ed. Note: This article is in follow up to Dr. Gambone's presentation at the 2014 OPSC Annual Convention.*

When Stein and Leventhal first described a disorder that was named after them (Stein—Leventhal Syndrome) in 1935 they were reporting on a small group of young women who had external signs of androgen excess such as abnormal terminal hair growth (hirsutism), male pattern balding, and amenorrhea. The women they described were obese, hairy, and infertile and represented less than one percent of the female population. The disorder named after them came to be called Polycystic Ovary Syndrome (PCOS) or disease (PCOD) and about 8% of young women in the U.S. have the syndrome as we now know it. It is the most common endocrinopathy in young women today. Interestingly, recent studies show that as many as one-third of these women do not have polycystic ovaries. Furthermore, some women with polycystic ovaries do not have PCOS! These recent findings have experts meeting and talking about a new name for the syndrome.

Polycystic Ovary Syndrome (PCOS) is first and foremost a disorder of androgen metabolism characterized by insulin resistance and chronic anovulation. A significant percentage (about 20%) may not be overweight let alone obese. And most of them have oligomenorrhea rather than amenorrhea. Women with oligomenorrhea have fewer than 9 menses per year and are sub-fertile.

## Pathophysiology

The pathophysiology of PCOS is not fully understood. It may not be a primary disorder of the ovary, after all, with a great deal of evidence pointing to some defect in hypothalamic/pituitary control of the ovarian cycle as the initiating source of the problem. Gonadotropin releasing hormone (GnRH) is released in pulses from the hypothalamus and when the frequency of these pulses is abnormal (more frequent) the pituitary secretes more luteinizing hormone (LH) than follicle stimulating hormone (FSH)—see Figure 1. LH becomes elevated in the serum and causes one of the two main hormone-producing cells in the ovary, the theca cell, to produce more androgens (testosterone and androstenedione). The other hormone producing cell in the ovarian follicle, the granulosa cell, is supposed to convert the androgens to estrogens (estradiol [E2] and estrone [E1]), but is not able to convert all of it resulting in an

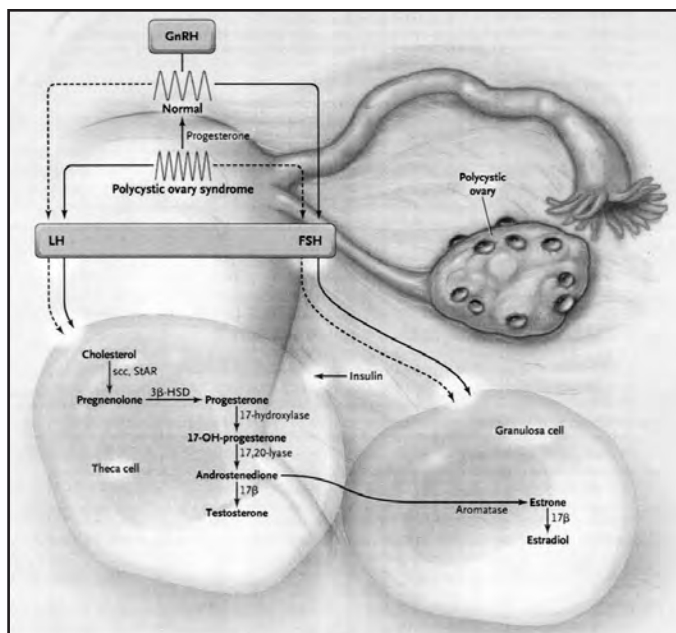


Figure 1. Presumed pathophysiology of PCOS illustrating the increased frequency of GnRH release leading to elevated LH which results in increased androgen levels. The relative deficiency of FSH leads to chronic anovulation and oligomenorrhea.

excess of androgens in the circulation. The relative lack of FSH has a negative effect on the development of the pre-ovulatory follicle in the ovary, resulting in chronic anovulation and oligomenorrhea. In severe cases, especially in women with the disorder who are obese, amenorrhea (absence of menses) occurs resulting in infertility. Many of the women with oligomenorrhea also have problems with fertility.

## Androgen excess and insulin resistance

The excess androgen affects hair follicles in the skin resulting in thicker terminal hair formation. Women who are severely hyperandrogenic may have facial hair, acne and male temporal balding. In rare cases the vocal cords may thicken from the androgens causing a deepening of the voice.

Androgens and excess body weight cause insulin resistance and women with PCOS are at significantly greater risk for developing Type 2 diabetes. The insulin resistance causes the pancreas to secrete more insulin and the insulin excess results in damage to blood vessels and to nerve tissue. In the severe form of PCOS the signs and symptoms

# Polycystic Ovary Syndrome

Continued from page 13

mimic those of the metabolic syndrome (syndrome X) and one of the new names for PCOS that has been proposed is Syndrome XX—the double ‘X’ representing the female karyotype. The predominant endocrine defects in PCOS are the excess androgens and insulin resistance and not all women will have polycystic ovaries.

## Make the Diagnosis Clinically

The diagnosis of PCOS is a clinical one. Laboratory tests may not always be helpful. Young women who persist with irregular menses from the time of menarche (first menses) and who have signs of excess male hormones (hirsutism and insulin resistance) most likely

have the syndrome. The only necessary blood testing would be to rule out a more serious (and far less common) cause of the hyperandrogen state such as ovarian or adrenal tumors. Also, less common than PCOS would be Cushing’s syndrome (hypercortisolism) excess growth hormone and adult onset congenital adrenal hyperplasia (elevated progesterone). Clinically, when there is severe hirsutism, clitoral enlargement (> 1 cm diameter at the base), deepening of the voice and temporal balding, an ovarian or adrenal tumor becomes more likely. Measuring total testosterone (should be less than 200 ng/dl) and dehydroepiandrosterone-sufate (DHEA-S) which should be less than 700 ug/dl, an ovarian or adrenal tumor is unlikely and

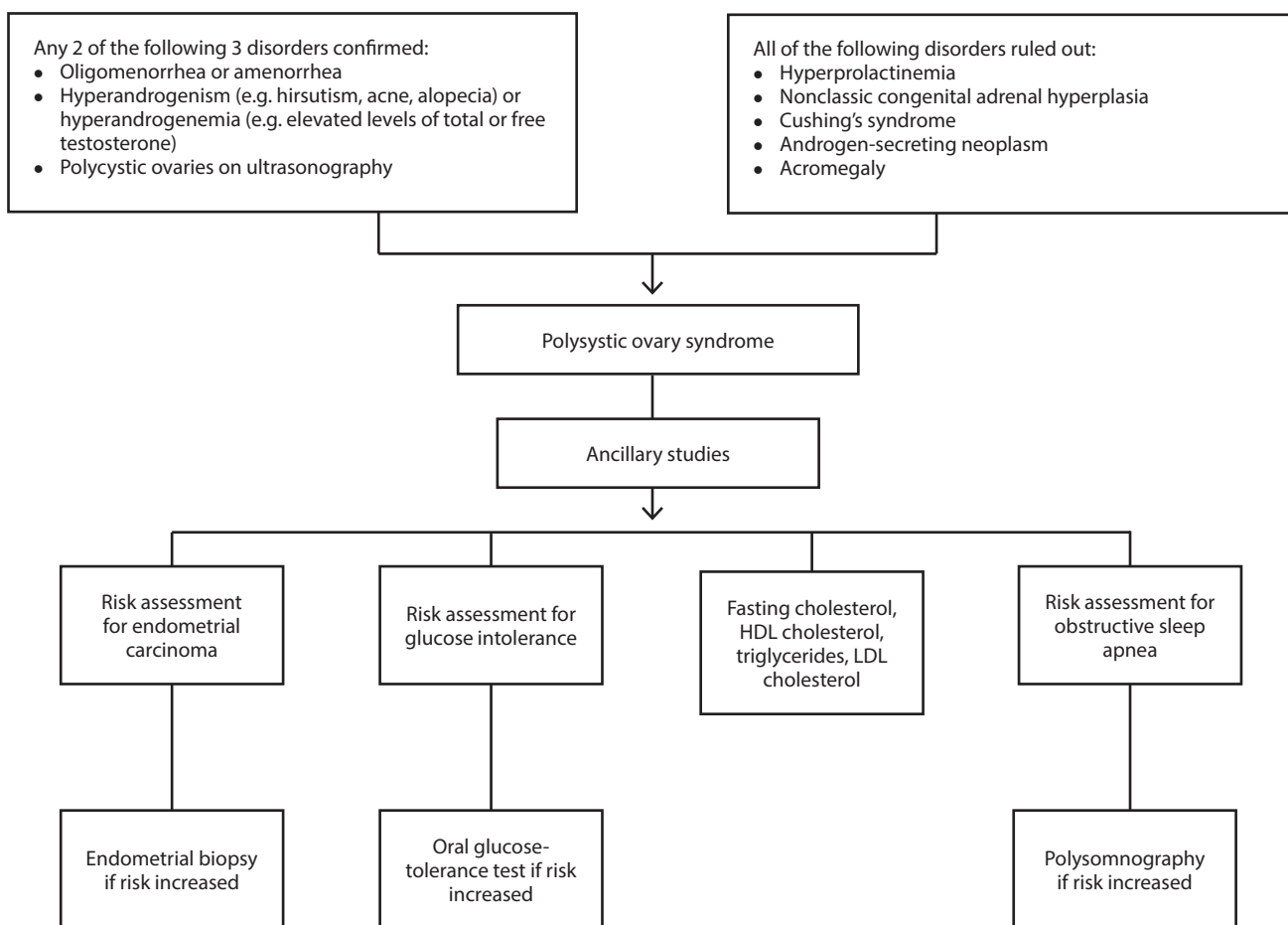


Figure 2. Flow chart for the diagnosis and risk management of PCOS. Not all women with PCOS will have polycystic ovaries and some women with polycystic ovaries may not have the syndrome.

PCOS is presumed to be the cause. Serum prolactin levels may be mildly elevated in PCOS likely due to excess estrogen production and not a pituitary adenoma. When there is galactorrhea and/or the prolactin level is over 100 ng/ml a pituitary adenoma should be ruled out, however. An MRI of the pituitary is an accurate way to do this.

Diagnostic criteria for PCOS are illustrated in Figure 2. Note that it is not necessary to have polycystic ovaries to have PCOS. And some women with polycystic ovaries do not have PCOS. Women with PCOS are at greater risk for endometrial cancer due to unopposed estrogen and should be checked for endometrial hyperplasia (a precursor to endometrial cancer). They should be tested for insulin resistance and diabetes. It is also important to test them for hyperlipidemias and sleep apnea (see Figure 2). The prevalence of diabetes, elevated lipids and obesity in women with PCOS establishes the link to metabolic syndrome and the rationale for calling it syndrome XX.

### Treatment depends on desire for fertility

The treatment of PCOS depends on whether fertility is desired or not. The best treatment for young women at the time of diagnosis who do not desire fertility is a low dose (< 50 microgram, estrogen dose) oral contraceptive. This will provide excellent bleeding control, keeping the uterine lining from hyper-stimulating and also provides excellent birth control. This treatment will also help with the hirsutism and acne over time. The levels of estrogen in the oral contraceptive will decrease LH and increase sex hormone binding globulin (SHBG) which will both decrease androgen production and cause more of it to be bound to SHBG and not be as available to stimulate oil glands and hair follicles. When women desire fertility they may need treatment with the antiestrogens clomiphene citrate (clomid) or letrozole (femara) and some will actually need FSH or even IVF to conceive.

An important part of modern treatment of women with PCOS is to continue to monitor the serious conditions for which they are at increased risk, such as diabetes, endometrial cancer, heart disease (secondary to lipid abnormalities and inflammation) and sleep apnea. With proper diagnosis and management, women with PCOS can have nearly normal fertility potential along with some prevention and medical management of the more serious conditions that they are predisposed to get. ■

## OPSC Announces the Winners of the 2013 Student Video Contest

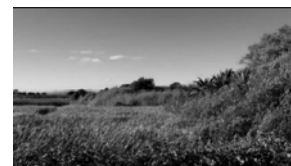
In the fall of 2013, OPSC presented a challenge to the students of Touro University and Western University's Colleges of Osteopathic Medicine – create a video recognizing and celebrating osteopathic medicine, while educating the public about osteopathic physicians. Winners were announced at the 2014 annual Convention and prizes were awarded for the top two videos from each school.

You can see the winning videos on YouTube. Simply search YouTube for “OPSC01” to find them.

### 1st Place:

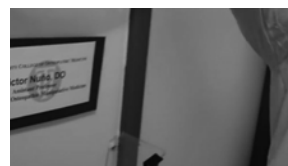


**“The Motivation”**  
by Michael Katirai  
(WesternU)



**“Nature”** by Zubin Sedghi  
(Touro)

### 2nd Place:

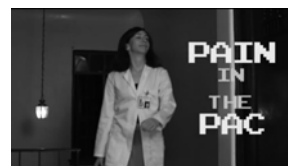


**“Gait”** by Michael Mun and  
Zubin Sedghi (Touro)



**“Glimpse”** by Julia Kim  
(WesternU)

### Honorable Mention:



**“Pain in the Pac”** by Olympia  
Kabobel (WesternU)

## OPSC's Website To Get a New Look!

This summer, OPSC will be rolling out a new website. OPSC staff will be available to help you navigate the new site so you can take advantage of all of the new features that it has to offer and still access old favorites. Look for email correspondence over the coming months regarding this exciting new phase in OPSC's web experience.

# 2014 Annual Convention Report

For OPSC's 53rd Annual Convention and Exposition, Program Chair David Connett, DO and the Education Committee, led by Wadsworth Murad, DO, put together 37 hours of quality CME. With topics such as opioids and diabetes leading the way, the program also included lectures on pediatrics and geriatrics, men's and women's health, and a look at various non-medical topics affecting physicians' practices, such as Covered California and electronic medical records security. Several presenters have also contributed articles in order to share additional material on their lecture topics with readers of the *California DO*.

OMM was featured as well. Virginia Johnson, DO, C-NMM/OMM and a number of volunteers ensured that the OMT Education Service Sessions were well staffed and ready, providing eight hours of hands-on education to help physicians sharpen OMM skills or learn new techniques. Please see the next page for a list of the volunteer educators who helped make the OMT Education Service Sessions a success.

With an eye toward innovation, the Education Committee incorporated the 1st Annual OPSC Poster Competition into Convention activities. Open to students, residents, and interns, the competition showcased research conducted by osteopathic medical students as well as those working their way through residency. Fourteen submissions were received for this year's competition. Prizes were

awarded for 1st, 2nd, and 3rd place and the abstracts for all of the submissions, along with the winners, can be found starting on page 18. OPSC thanks Stephanie White, DO for her efforts to bring the competition to fruition. We hope to expand the competition in future years to further expose researchers' work to their peers (and future peers!) and celebrate the osteopathic profession.

Over 450 physicians attended this year's Annual Convention, representing more than 40 specialties and coming from as far away as Minnesota and New York. The Convention also showcased 22 exhibitors in the Exhibit Hall and drew eleven companies for the Career Fair.



## Introducing OPSC President David Connett, DO

Dr. Connett is the Vice Dean of the Western University of Health Sciences College of Osteopathic Medicine of the Pacific (COMP). He recently served as COMP's Associate Dean of Clinical Services and Associate Professor and Medical Director of the Western University Clinic System. He has been in clinic practice for 27 years in the disciplines of family medicine, emergency medicine, and flight medicine.

Dr. Connett was the Vice President and Chief Medical Officer at Garden City Hospital in Michigan and Medical Director of the Hospital Clinic System. He has also been the Medical Director of two large clinic systems in the Denver Metro system working for both Columbia HCA/Health One and Exempla Health Care. He is the former Program Director of the Family Medicine residency program in Denver and the former Chief of Aerospace Medicine at Los Angeles Air Force Base.



## New Officers and Board

Please welcome OPSC's newest officers and Board members.



### President-Elect John Kowalczyk, DO

Specialty: Urology  
Practice Location: Los Angeles  
OPSC Regional Affiliate: Los Angeles County  
Medical School: MWU/CCOM - 1989



### Vice President Abraham Pera, DO

Specialty: Diagnostic Radiology  
Practice Location: Vallejo  
OPSC Regional Affiliate: Sacramento  
Medical School: MWU/CCOM - 1977

## Board Members (2014 – 2017)



### Brian Loveless, DO

Specialty: Osteopathic  
Manipulative Medicine  
Practice Location: Pomona  
OPSC Regional Affiliate: San Bernardino County  
Medical School: WesternU/COMP - 2002



### Alexandra Myers, DO

Specialty: Sports Medicine  
Practice Location: San Diego  
OPSC Regional Affiliate: Los Angeles County  
Medical School: WesternU/COMP - 2010



### Minh Nguyen, DO

Specialty: Occupational Medicine  
Practice Location: San Diego  
OPSC Regional Affiliate: San Diego  
Medical School: KCOM/ATSU - 1999

## Thank You to OMT Volunteers

On behalf of Virginia Johnson, DO, OPSC recognizes those DOs who took time out of the busy Annual Convention schedule to volunteer as Educating Physicians for the OMT Education Service sessions.

Andrew Pomazal, DO  
Eugene Lenard, DO  
Daniel Hull, DO  
Eugene Pudberry, DO  
Randall West, DO

And, of course, thank you as well to Dr. Johnson for her time in coordinating the OMT Education sessions.





## OPSC Board Update

The OPSC Board of Directors met on February 5 and February 9, 2014 at the Hyatt Regency Mission Bay in San Diego, and took the following actions:

- Developed a plan of action to address UC campuses discriminating against osteopathic medical students
- Addressed the issue of health plans misclassifying OMT as chiropractic or physical therapy
- Provided guidance to the Legislative Committee on strategies for the May 5 Legislative Day in Sacramento
- Received a report on Maintenance of Licensure/ Osteopathic Continuous Certification
- Learned that five videos were submitted for the student video contest
- Were advised that OPSC has a contact with Noridian available to assist members with the Medicare transition from Palmetto
- Commended the Student Club/New Physicians Committee for their work on a Guide to Practice
- Held a high level discussion on the future of organized medicine
- Considered a template for Regional Affiliate Bylaws
- Each Board member agreed to meet with his/ her legislator to convey key talking points
- Modified OPSC policy on House of Delegates selection
- Selected David Canton, DO to continue as OPSC's Secretary/Treasurer for 2014-2015
- Approved the appointment of committee Chairs and Vice-Chairs for 2014-2015
- Selected Geraldine O'Shea, DO as the Chair of the California delegation to the AOA House
- Reviewed proposed resolutions for submission to the AOA House

# Poster Presentations

The Poster summaries presented here, in random order, are those submitted in advance by entrants into OPSC's 1st Annual Poster Competition, held at the 53rd Annual Convention in San Diego. Posters were on display in the Exhibit Hall and judging was conducted by a small panel of volunteer DOs. Thank you to Stephanie White, DO for her hard work to bring this new event to OPSC's Annual Convention.

## A. Premature Infant with a Two Vessel Cord and a High Pitched Cry

Inessa Dombrovsky, OMS III (WUHS)



Cri Du Chat is an autosomal deletion syndrome caused by a partial deletion of chromosome 5p. The syndrome is characterized by a high-pitched, catlike cry in infancy along with growth failure, microcephaly, cardiac defects, and mental retardation.

A 32 week G1PO was seen by her doctor in Mexico for a scheduled OB ultrasound. On exam, baby was noted to have a two vessel cord along with an abnormal head circumference. Patient was advised to seek further care in America. At 34 weeks, a premature infant was delivered. Infant was noted to have respiratory distress, microcephaly, a two vessel cord, hydronephrosis, a simian crease, and a very high pitched cry.

Genetic testing was performed, and 5p- syndrome, known as Cri Du Chat, was diagnosed.

This case illustrates a unique constellation of symptoms leading to a diagnosis of Cri Du Chat. A two vessel cord served as an indicator of an abnormal pregnancy secondary to a genetic syndrome allowing physicians to take the correct measures in caring for both mother and baby. Estimated to occur in 1 in 50,000 births, Cri Du Chat should be included as a differential diagnosis when considering genetic diseases in premature infants with abnormal in-utero presentation.

## B. Student Perceptions Regarding Preparedness for COMLEX PE

Kellie Morris, OMS IV; Stephanie White, DO (WUHS)

The goal of the research project is to evaluate student perceptions about the effectiveness of the standardized patient encounters that occur during the 3rd year of medical school in preparing them to take the COMLEX-PE exam. A secondary goal is to evaluate the current system of feedback to determine if there are any areas for improvement. Currently the feedback that is received regarding the performance on the OSCE's is a tape review and raw score. There is no

direct feedback given regarding the strengths and weaknesses of the students. It is up to the students' interpretation of their tape review to determine what areas they need to focus on for future encounters. The importance of these patient encounters cannot be underestimated, but perhaps an alternative system for feedback would provide students with greater confidence on future patient encounters and ultimately a better performance on the COMLEX-PE.

COMP DO-2014 students were sent an email invitation to complete an anonymous survey. The survey contained 18 questions related to the OSCE's and COMLEX-PE and 3 demographic questions.

The results of the survey are still pending. Preliminary data is suggesting that students feel they would benefit from an alternative form of feedback in the OSCE's to better prepare them for the COMLEX-PE; and that students feel an encounter that focuses on the integration of OMT into the standard time limit would be beneficial in preparing them for the COMLEX-PE.

## C. Acute Stroke In A Young Woman Taking Phentermine

Joshua Geeming Lee, OMS III, K. Ganesan MD, Department of Medicine, Rancho Los Amigos National Rehabilitation Center, Downey, CA.

**Objective:** To describe a case of acute stroke in a young woman taking phentermine diet pills.

**Background:** Phentermine is FDA approved for weight loss as Qsymia (with topiramate). Phentermine has a similar chemical structure to amphetamine, which has been associated with increased stroke risk. Although a study in 1999 suggested no increased stroke risk with phentermine, articles describing cases of acute stroke in young women taking phentermine appeared in Stroke in 1993 and Neurology in 2013.

**Case Presentation:** A 45-year-old woman presented to the emergency department with left-sided weakness, headache, and dizziness. She denied any past history of stroke, diabetes, hypertension, head trauma or smoking. She admitted to nine years of phentermine use, with increased use in the past two years. She noted her father had

## Poster Presentations

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a stroke at age 45. A hypercoagulable workup was unremarkable. RPR, ESR, CRP, and TSH levels were all within normal limits. Initial head CT without contrast was negative. MRI revealed an ischemic stroke in the right ACA area. MRA of the carotid arteries did not reveal stenosis. Holter ECG and TTE with bubble study showed no cardiac abnormalities. Besides family history, she had no risk factors for stroke. No other possible etiology for the stroke was found besides phentermine use.

**Conclusion:** As phentermine is widely used for weight control, it is important for the public to know of possible side effects. With case reports describing strokes in young, relatively healthy women taking phentermine, more research is needed to better understand the risk for stroke.

### D. PON1 lactonase activity and differential distribution in HDL subclasses in the postprandial phase; a pilot study

Michelle Burk OMSI, Russell Caccavello and Alejandro Gugliucci (TU-COM)

**Background:** Given the importance of oxidative stress in the postprandial period, studies should be undertaken to elucidate the role of PON-1, a key antioxidant enzyme in this phase.

**Hypothesis:** PON1 lactonase activity changes in the postprandial period.

**Methods:** Healthy volunteers (OMM students and faculty) were recruited for this study. A fasting (12 h) and 3 postprandial blood samples (at 1, 2 and 5 h) were taken from finger pricks, after a standardized mixed meal. PON1 lactonase and arylesterase activity, glycemia and triglycerides were measured in these samples. HDL subclasses are separated by native gradient gel electrophoresis (4-12%, Biorad, Hercules, CA), and PON1 activity was detected using our method.

**Results:** Lactonase activity significantly steadily decreased in 40% of the individuals, and significantly steadily increased in 30% of individuals. In several individuals where lactonase increased there was an increase of up to 78% in PON1 activity in small HDL<sub>3c</sub>.

**Conclusions:** This is the first study that shows that PON1 physiological lactonase activity varies after a mixed meal. Moreover, arylesterase activity, which correlates closely with PON1 concentration,

does not show significant change. This suggests a change in function rather than in quantity. Interestingly the change in lactonase varies among individuals, some increase, some decrease. Does this behavior correlate with lipoprotein changes? Is this a marker of postprandial protection against dietary oxidized lipids in some individuals and not in others? Further studies are being conducted to confirm these findings.

### E. A case of lithium induced thyroid storm and associated suicide

Nick Youssefi DO (WUHS), Christopher Russo DO (UCSF-Fresno)

**Introduction:** The purpose of this case report is to promote awareness of the possible adverse effects of Lithium, specifically hyperthyroidism, and its association with suicide. We report a case of suicide provoked by thyroid storm resulting from lithium use in a patient with Bipolar disorder.

**Clinical Case:** A 42 year old gentleman with history of Bipolar disorder, GERD, asthma who presented to the Internal Medicine clinic for routine follow-up. Patient had a long history of Bipolar disorder and was being followed by outpatient psychiatrist. Patient had been taking Lithium for one year. During clinic visit, patient had BP 145/91 HR 122. He described feeling anxious, palpitations, shaking of extremities, heat intolerance, and 10 pound weight loss in the past 3 months. At that time, TSH, Free T<sub>4</sub> was ordered and started on Metoprolol. TSH x <0.008, Free T<sub>4</sub> 6.30. Physician called patient with results but family notified physician that patient had committed suicide 1 week after clinic visit.

**Conclusion:** There have only been 4 cases reported in the literature describing suicide in patients with thyroid storm. Physicians should be aware of the adverse effects of Lithium, including hyperthyroidism, and its association with suicide.

### F. Predictors of Depression and Alcohol Use in Medical Students

Pallavi Joshi, OMS II (WUHS)

High prevalence of depression and alcohol use have been observed in physicians and medical students. It is important to identify predic-

tors of depressive symptoms and alcohol use during their first two years of medical education, a period during which behaviors and attitudes of physicians develop.

A survey using an anonymous self-administered questionnaire was performed with 61 first and second year medical student (36 male, 59 %) aged 21-30 years. The Beck Depression Inventory-II (BDI-II) and Alcohol Use Disorders Identification Test (AUDIT) were used to determine depressive symptoms and alcohol use. BDI scores of 14 or higher were categorized as depressive and AUDIT scores 8 or higher were considered harmful or hazardous drinking.

Of those surveyed, 8 males (22%) and 8 females (32%) had BDI score of 14 or greater. 21 males (58.3%) and 15 females (60%) drank alcohol at least 2-4 times a month. The individual subsets of the BDI and self-reported alcohol consumption variables were analyzed to understand their interrelationship and their dependence on gender and marital status.

## G. Giant Ovarian Cyst Presenting With Colon Cancer

**Evan Robinson OMSIII, Cesar Aguiluz DO, Andrew McCague DO, Vivian Joseph Davis DO (WUHS)**

Giant ovarian cysts have become rare, likely due to improved and more frequent imaging techniques, especially in the United States. We present the case of a 71-year-old female that presented with one of the largest documented post-menopausal ovarian cysts in the United States, measuring 26 cm and weighing 9.2 kg (20.28 lbs), with a concomitant colon adenocarcinoma. A total abdominal hysterectomy, right salpingo-oophorectomy, and right hemicolectomy were performed.

## H. Endoscopic Third Ventriculostomy for the Treatment of Neurosyphilis Induced Obstructive Hydrocephalus

**Tyler Carson DO, Katharine Schulz DO, Evan Robinson, OMSIII, Dan Miulli, DO, Javed Siddiqi, MD (WUHS)**

We report a case of neurosyphilis which originally presented as new onset schizophrenia in a 55 year old male. The patient was ulti-

mately referred to the neurosurgery service at Arrowhead Regional Medical Center for after a rapid decline in mental status, behavioral changes, and new onset aphasia. Organic etiology workup revealed ventriculomegaly. An MRI of the brain was obtained and showed transependymal flow of CSF and a normal 4th ventricle suggesting non-communicating hydrocephalus. An external ventricular drain (EVD) was placed and after drainage of CSF the patient's mental status improved to the point where he was responsive and answering questions. CSF and serum studies after placement of EVD confirmed the diagnosis of neurosyphilis and the patient was treated with IV Penicillin and Probenecid per the recommendation of infectious disease specialist. The patient underwent endoscopic third Ventriculostomy (ETV) and the EVD was removed without any further decline in mental status.

## I. Accidental Acute Alcohol Intoxication in Infants: Review and Case Report

**Gabriella Minera DO, Evan Robinson OMSIII (WUHS)**

Acute alcohol intoxication in children less than 18 months old is both rarely documented and rarely fatal. Previous case reports suggest hypoglycemia and faster than normal rates of alcohol elimination found in children with acute alcohol intoxication compared to adults, but data is lacking. A two-month-old infant presented with a decreased mental status after accidental ingestion of alcohol. He was diagnosed with acute alcohol intoxication with a blood alcohol level of 330 mg/dL and was hyperglycemic (167 mg/dL). Alcohol elimination rate was calculated to be 21.6mg/dl/hr, similar to that of adults. To our knowledge, this case is the youngest documented patient with accidental alcohol intoxication via ingestion in the United States. Although rare in the literature, poison control data suggests that alcohol poisoning in very young children is not rare. Emergency physicians should be prepared for the management of infants with alcohol poisoning. This case report and review brings attention to this subject, and briefly discusses ethanol metabolism in infants.

## Poster Presentations

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## J. Fat Emboli Syndrome in an Adolescent Occurring Less than Twelve Hours after Long Bone Trauma

Mary Welch DO, Elliott Chinn OMS III, Evan Robinson OMS III (WUHS)

Fat emboli syndrome (FES) is classically described as the triad of respiratory distress, altered mental status and petechial rash, classically presenting 12-72 hours after long bone trauma. This case report aims to support a growing body of literature revealing that FES can occur even more acutely. A 16-year-old female presented to our emergency department after being involved in a highway MVA with possible ejection. Upon arrival she was AOx3 and complained of LOC at the scene, headache, abdominal pain and severe left leg pain. Exam was significant for a contusion to the left chest and a left leg deformity. Her initial vital signs and labs were normal, including a negative UDS and EtOH level. CT of the brain, chest, abdomen, and pelvis were significant only for a left scalp contusion and benign liver hemangioma. In the ED her femur fracture was placed in traction. The patient appeared to be doing well but approximately six hours after the incident she suddenly became unresponsive with pinpoint pupils and a GCS of 7T. Initial differential diagnosis was FES versus delayed brain bleed. Initial MRI was normal but repeat MRI 36 hours later demonstrated new FLAIR signal hyperintensity in the gray-white matter junctions and another MRI performed 24 hours later showed multiple bilateral cortical cerebral vascular accident, supporting the diagnosis of FES. The patient continued to require ventilator management and eventually required a tracheostomy and g-tube. On day nine she was lost to follow up after being transferred secondary to insurance status.

## K. Oxytocin Treatment Reduces Parkinson's Symptoms in an Efficacy Trial

Arbar, M., OMS II, Swope, D., MD, Zak, P.J., PhD (WUHS)

Three male patients diagnosed with Parkinson's Disease (PD) were evaluated for the effect of oxytocin (OT) therapy on their symptoms. OT is a neuropeptide which modulates prolactin (PRL) secretion by stimulating dopamine binding within the tuberoinfundibular dopa-

minergic (TIDA) neurons. Intracerebroventricular administration of OT stimulates TIDA neurons, thus increasing DA release (2006, Zung, et al.). A recent study by Erbas et al., demonstrates that OT may have a cryoprotective and restorative effect on dopaminergic neurons against rotenone-induced injury. This study also provided evidence of OTs ability to diminish apoptotic cell death in injured neurons by blocking death receptors as well as mitochondrial pathways (2012, Erbas, et al.). The observed association between OT administration and stimulation of dopaminergic neurons prompted further investigation in a clinical setting.

A pilot experiment was run to see if OT would alleviate PD symptoms and serve as an additional therapeutic agent. Experimental sessions were performed in the morning and participants were asked to abstain from taking their PD medications. All participants gave written informed consent and IRB approval was obtained from Loma Linda University and Claremont Graduate University. Participants were given 40ml of intranasal Pitocin. Participants were evaluated before and after treatment with the motor portion of the Unified Parkinson's Disease Rating Scale (UPDRS), performed by a board certified movement disorder neurologist. Each patient experienced a reduction in motor disturbance after administration of intranasal Pitocin. Our results suggest that OT therapy for PD should be further tested in a full double-blind trial.

## L. Colon Cancer: An Unusual Presentation



Fadi Arodaki OMS IV (WUHS), Elizabeth Barrera DO (Downey Regional Medical Center), Airani Sathananthan MD (WUHS, Western Diabetes Institute)

**Clinical Case:** 72-year-old Hispanic male with PMH of diabetes on oral agents was found unresponsive on the floor and was taken to the emergency room. Venous blood glucose was found to be 62 mg/dl. The previous day he had a fingerstick glucose of 47 mg/dl but was asymptomatic. Further history revealed a recent diagnosis of normocytic anemia. On physical exam, he was noted to be a thin male with hepatomegaly. Abdominal ultrasound showed hepatomegaly with multiple echogenic foci, and abdominal CT showed numerous metastatic lesions in the liver. Colonoscopy confirmed the diagnosis of invasive adenocarcinoma of the colon. He was found to have an

elevated insulin-like growth factor-2 (IGF-II) level of 460 ng/ml (normal 47-350 ng/ml).

**Background:** Non islet cell tumor induced hypoglycemia (NICTH) is a rare paraneoplastic syndrome that presents late in the course of malignant disease. The differential diagnosis of hypoglycemia includes  $\beta$ -cell pancreatic tumors, adrenal insufficiency, and hypoglycemia secondary to exogenous administration of insulin or sulfonylureas. The pathogenesis of hypoglycemia in NICTH involves a variety of mechanisms, but ectopic secretion of IGF-II seems to be the most common explanation in typical NICTH.

**Conclusion:** Adenocarcinoma of the colon may present atypically as NICTH, which is a rare paraneoplastic syndrome that manifests itself in late stages in the course of colon adenocarcinoma. Recommendations: While a diagnosis of NICTH may be very likely in this case, a sulfonylurea drug screen and a c-peptide level should have been ordered to completely rule out an exogenous cause of the hypoglycemia.

## M. Comparison of Tuberculin Skin Test and interferon gamma release assay in Routine Latent TB Screening in the setting of Healthcare worker Screenings

Majid Ashfaq, OMS (WUHS), Trena Rich, RN (Student Employee Health), Nishita Patel, MD (WUHS), Edgie-Mark Co, OMS, PhD (WUHS)

Second  
Place

The Tuberculin Skin test (also known as the purified protein derivative/PPD) has been the mainstay of Latent tuberculosis (LTB) screening. This test involves a subcutaneous injection of PPD and measuring a patient's reaction to the antigen. However, the method is fraught with issues including poor specificity, poor patient compliance and a potentially expensive and prolonged antibiotic regimen. Many medical facilities and states have already adopted the interferon gamma release assay (IGRA) as a primary screening test for healthcare workers, an alternate test approved for use in 2001 which only involves a single blood draw. California however still mandates that the PPD be the gold standard in the screening of LTB for healthcare workers. In this study, we compared the relative specificity, compliance and cost of these two tests in a medical student population. We

retrospectively examined the records of two student populations: one in California and one in Oregon, a state where the IGRA is an approved screening test. We found that overall, the IGRA showed less false positives compared to the PPD. Furthermore, there was better compliance in the population where the IGRA is used. Finally, medical students in Oregon incurred a smaller cost with testing compared to students in California as the former did not have to undergo a confirmatory chest x-ray. Thus, we recommend that California adopt the IGRA as an initial screening test for LTB.

## N. A Comparison of Contemporary Methods to Prevent A Wet Cast

Shawn Nguyen, OMS, Mitchell McDowell, DO, John Schlechter, DO

**Background:** There are many traditional methods and commercially available products designed to prevent a wet cast, however there is a paucity of literature regarding the optimal strategy. This study was designed to compare effectiveness, cost, and ease of use of some commonly used methods to prevent a wet cast.

**Methods:** Using a synthetic leg model, a short leg cast was applied and six different methods were tested: Glad© Press and Seal, plastic bag with rubber band, plastic bag with duct tape, double plastic bag with duct tape, CVS©, Reusable Cast Protector and Dry Corp© Dry Pro Cast Cover. Casts were submerged in water for two minutes and weighed. Each group underwent 10 individual trials. Effectiveness was measured by calculating amount of water absorption using cast weights before and after submersion in water. This was then compared to a control group. Cost analysis and ease of application were also evaluated.

**Discussion:** Our findings conclude that the six methods tested are effective in preventing the majority of water saturation. Although abstaining from contact with water is the most prudent approach, if a cast cover is to be used, we found that double plastic bags with duct tape (100% prevention, \$13) or the CVS© cast cover (100% prevention, \$13) are the preferred contemporary methods to prevent a wet cast. ■

# Randall Shue, DO

## What position do you currently hold?

Currently, I am Medical Director at SynerMed, an MSO, and to many of its client IPAs.

## What was your motivation to take a leadership position?

I pursued this position due to its proximity to the massive changes in healthcare that I could foretell. I wanted to be able to have some input as to how patient care would be delivered.

## What steps did you take to prepare for your current position?

I have reached this level of knowledge and proficiency by experiencing the changes in managed care from the primary provider standpoint, to ownership and administration of an IPA, to directing 750,000 lives. Learning and understanding each level of the medical delivery system is important in being able to serve the providers that will challenge us in our future.

## What do you find rewarding/challenging about serving in a leadership role?

The challenging aspects of being Medical Director for large groups is in how to provide quality care while working in an environment of increasing regulation and financial strains on medical service providers. There is great reward in finding the “win-win” situations in the delivery of healthcare to patients.

## Skills/traits required for successful physician leadership?

To be successful as a physician leader you must be able to cooperate, communicate, and collaborate with people, have the knowledge to direct and guide terminations to solutions to problems, show appreciation of others' thoughts and ideas, and have the vision to see beyond the current situation and plan for the future.

## Why should physicians consider serving in leadership positions?

Physicians should be involved and serve as leaders to shape and lead the medical profession into the future. Who best to know what is needed to provide quality care to generations to come?

## Background

I graduated from WesternU/COMP in 1983 and completed my Family Practice residency at Core/Meridia South Point Hospital in Ohio. I am Board certified by the American Osteopathic Board of Family Physicians.

I've maintained a private practice in Los

Angeles since 1985. I am married with two daughters and one son. I enjoy car racing, shooting sports, and motorcycling.



## Why did you choose to become an osteopathic physician?

I chose to become an osteopathic physician because I believe in the osteopathic philosophy and its tenets of patient care.

## Why are you supportive of OPSC?

I am strongly supportive of OPSC because we need a strong political voice and presence in Sacramento, and OPSC has shown to be effective in protecting and furthering osteopathic interests. They support their membership with educational programs and by informing them of current issues affecting our profession. ■



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# 2014-2015 OPSC Committee Rosters

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David Canton, DO  
John Kowalczyk, DO  
Abraham Pera, DO  
Alesia Wagner, DO

## Awards

**Alesia Wagner, DO [Chair]**  
David Canton, DO  
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## Budget & Financial Review

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**Richard Riemer, DO [Vice Chair]**  
David Connett, DO  
Lionel Katchem, DO  
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**Gary Gramm, DO [Vice Chair]**  
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Joachim Brown, DO  
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Sheikh Latif, DO  
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Michael Luszczak, DO

Richard Mack, DO  
John Merrill, OMS  
Katherine Miller, DO  
Dan Miulli, DO  
Muhammad Mowjood, DO  
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Mark Schneider, DO  
Jeffrey Tsai, OMS  
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## Ethics/Peer Review

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Rose Cunningham-Ahumada, DO  
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## Legislative

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Richard Pitts, DO  
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Glenn Thiel, DO  
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Patricia Rehfield, DO  
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William Henning, DO

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Mary Koumas, DO

## 2014-2015 OPSC Committee Rosters

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**Public Relations** Continued

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 Vivian Le, OMS  
 Janet Lee, OMS  
 Brian Loveless, DO  
 Deborah Lucas, DO  
 Pamela Lux, DO

**Publications**

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 Akiba Green, DO  
 Mohammad Jamshidi, DO  
 Denise Kellaher, DO  
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**Resolutions**

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 Manika Talati, OMS  
 Jeffrey Tsai, OMS  
 Alesia Wagner, DO  
 Randall West, DO  
 Blake Wylie, DO  
 Marcus Zachary, DO

**Student Club/New Physicians**

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 Anthony Anguille, OMS  
 Melissa Arbar, OMS  
 Elizabeth Barrera, DO  
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 Robert Chang, DO  
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 Maika Talati, OMS  
 Jeffrey Tsai, OMS  
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**Bernyce Peplowski, DO [Chair]**  
**David Matian, DO [Vice Chair]**  
 Atul Bembi, DO  
 Mark Bernhard, DO  
 Richard Bernstein, DO  
 Ernest Cheng, DO  
 David Connett, DO  
 Gary Hatcher, DO  
 Mohammad Jamshidi, DO  
 Michael Lee, DO  
 Minh Nguyen, DO  
 Andrew Pomazal, DO  
 Neil Speth, DO  
 Elaine Tonel, DO  
 Paul Wakim, DO  
 Joseph Zammuto, DO

**Have you renewed your OPSC membership?**

OPSC's membership renewal period is in full swing! Don't let the opportunity to continue your membership slip away. Renewing has never been easier. Simply log on to [www.opsc.org](http://www.opsc.org) and click the Renew Now link on the OPSC homepage. Once you have clicked this link, you will be requested to sign-in using your username and password and to pay, via credit card, through our secure site.

Once you have renewed, we would appreciate it if you take a moment to update your contact information by clicking the "My Info" button on the top of payment confirmation page. OPSC's directory is utilized daily by the public and fellow physician members to locate osteopathic physicians in their area. Please make sure that your contact information is complete and up-to-date.

# An Open Letter to the Membership

► **Stephanie White, DO, Vice-Chair of Membership Committee**

**W**hen studying evolution in college I was most impressed by the origin of flight. It seemed impossible that a series of happy accidents could lead to hollowed bones, feathers and an enlarged cerebellum. With each generation, a small change brought these creatures closer to achieving the miracle of flying. I often wondered about that moment when a small bird looked out from a great height and gathered the courage to leap into the air. I am inspired by the notion that unexpected change and a fierce desire to survive can influence the direction of countless species.

As DOs, we have been taught that function follows form. We each have been formed, not from happy accidents, but from generations of wisdom, dedication and genuine love of our profession. The Osteopathic philosophies and practices are the evolution and expression of our core values. We embody the perfect marriage of the health sciences and the art of healing.

Recently, shock waves have reached our community with the announcement of a single united pathway for graduate medical education. This represents the next opportunity for evolution. As we embark on this journey, it is natural to wonder what will happen to

our identity and our uniqueness. How will we honor our past while embracing our future?

The Osteopathic Physicians and Surgeons of California members are leaders in the medical community. We define who we are. Our community is strong, proud and highly accomplished. Our patients all over this state and in every discipline of medicine reinforce our identity with quiet praise, profound appreciation and trust in our competence and our uniqueness.

When we step in to the patient's room we see a whole person in the context of a family, a society and a larger world. We see a body designed to heal itself, in which all parts are interconnected and the function follows its form. We see through the eyes of a DO and we treat with care, evidence and art. We can never unlearn who we are and how we have been formed.

These next few years will present many challenges, much like the last hundred years. We have always been survivors and now is our chance to thrive. Let us support each other, express our pride in our identity and welcome home the many DOs in California who quietly persevere and serve in all corners of our state. ■

## WELCOME NEW MEMBERS

### Active

Kenneth L. Anderson, III, DO, San Diego, CA  
 Noemi Arrieta, DO, Los Angeles, CA  
 Erik Austin, DO, San Diego, CA  
 Rahil Bandukwala, DO, Encinitas, CA  
 Mark D. Bernhard, DO, Pasadena, CA  
 Nikolas Capetanakis, DO, Encinitas, CA  
 Amy Victoria Chilingirian, DO, Encinitas, CA  
 Jason Chu, DO, Gardena, CA  
 George Tahon Chuang, DO, San Francisco, CA  
 Charles David, DO, San Diego, CA  
 Marilyn de Guzman, DO, Chula Vista, CA  
 Shiang Do, DO, Moorpark, CA  
 Zahra Esmail, DO, Redondo Beach, CA  
 Gregg Garner, DO, San Diego, CA  
 Megan Hamreus, DO, Encinitas, CA  
 Anil Hanuman, DO, South Pasadena, CA  
 Lanny Hsu, DO, San Ramon, CA  
 Erick Huang, DO, San Diego, CA  
 Daniel Hull, DO, San Diego, CA  
 Nelson Hwynn, DO, Orange, CA  
 Michelle Kim, DO, Diamond Bar, CA  
 Mary Jo Kinsella, DO, San Diego, CA  
 Frederick Wayne Knapp, Jr., DO, Oceanside, CA  
 May Lin, DO, Walnut Creek, CA

Charlie Lin, DO, Covina, CA  
 Kieu-Loan Luc, DO, Woodland, CA  
 Pamela Renee Archer Lux, DO, Colton, CA  
 Thach Diep Mai, DO, La Mesa, CA  
 Larry John Miller, DO, Prather, CA  
 Katherine Nandor, DO, Rancho Cucamonga, CA  
 Chidao Nguyen, DO, Upland, CA  
 Dan Q. Nguyen, DO, Harbor City, CA  
 Son Lam Nguyen, DO, Union City, CA  
 Tam Nguyen, DO, Roseville, CA  
 Todd Nguyen, DO, Sunnyvale, CA  
 Stephen Oh, DO, Murrieta, CA  
 Rachel Palma, DO, Encinitas, CA  
 Payal Parikh, DO, San Diego, CA  
 Neha Patel, DO, San Jose, CA  
 Jessica Pierog, DO, Dana Point, CA  
 Vicki Quan, DO, San Marino, CA  
 Kirk Raeber, DO, Jamul, CA  
 Taib Rawi, DO, San Diego, CA  
 Tedde Marie Rinker, DO, Los Altos, CA  
 Michael Roberts, DO, Long Beach, CA  
 Sayuri Tokutake, DO, Fontana, CA  
 Norman Wall, DO, Saint Helena, CA  
 Christopher Ward, DO, Lake Almanor, CA  
 Kevin Thomas Washington, DO, Los Angeles, CA  
 Oscar Young, DO, Madera, CA

### Associate

John Michael Cruickshank, DO, Albuquerque, NM  
 Evelyne Leone, DO, Miami Beach, FL

### Military

Debra Arsenault, DO, Escondido, CA  
 Miguel Krishnan, DO, Loma Linda, CA  
 Richard Welsh, DO, Murrieta, CA

### Resident

Armin Arasheben, MD, Encino, CA  
 John Geiss, DO, Fullerton, CA  
 Bradley Alan Jacoby, DO, Los Angeles, CA  
 Sana Khan, DO, Rancho Mirage, CA  
 Clarissa Menard, DO, Downey, CA  
 Joshua Wang, DO, Tustin, CA

### Retired

Paul Anile, DO, Long Beach, CA  
 Edward N. Fishman, DO, Las Vegas, NV  
 Gary Gaffield, DO, Concrete, WA  
 Virginia Rutz, DO, Tucson, AZ  
 Jeffrey L. Topkis, DO, Newport Coast, CA

## Touro Dean's Report

▶ Michael Clearfield, DO, Touro University COM

### Campus News

- In January TUC announced the appointment of former Nevada Congresswoman Shelley Berkley to the position of CEO and Senior Provost of Touro's Western Division.
- Plans continue to convert building H-89 on our campus into a multi-functional clinical facility that will house student health services, student counseling services as well as function as an on-campus site for translational clinical trials, inter-professional clinical training labs and services.

### COM News

- For the 5th consecutive year, TUCOM-CA was recognized for meeting one of its key missions, to provide quality primary care providers. TUCOM-CA was ranked 15th nationally by U.S. News and World Report for having 53.8% of our graduates (from 2010-13) entering primary care residencies.
- In December, the AOA site visit team completed a 2 day accreditation visit to OPTI-West. While the review was very positive the final decision awaits the spring AOA Council on OPTI and the Bureau of Education meeting which we anticipate will result in a 5 year continuing accreditation award.

### Student News

- Harjot Toor, OMS II, won the student leader of the year award from OPSC and its Board of Directors. Congrats to Student Doctor Toor on her amazing efforts at rejuvenating the OPSC student Club and hosting events this year.
- During OPSC's 2014 Annual Convention the winners of OPSC's Student Video Contest were announced. Zubin Sedghi, OMS II, received the 1st place award for a video he produced to educate the public about osteopathic medicine.

### Alumni News

- The new alumni section on the TUC website which offers alumni profiles was developed by Jennifer Whitty, the University Director of Alumni Relations.

### Primary Care and Solano County Clinic

- Congratulation to Abraham Pera, DO as the newly elected Vice President of Osteopathic Physicians and Surgeons of California (OPSC) and Patricia Rehfield, DO, MPH as new OPSC board member.

- Congratulations to OPSC Physician of the Year – Richard Reimer, DO, neurologist, Adjunct Clinical Faculty for Touro California COM.
- Alesia Wagner, DO represented the Osteopathic profession and Touro COM as a speaker at the California Association of Physician's Assistants (CAPA) mid-year conference in Napa on February 22 as a speaker.
- Cathy West, MD will be representing Touro University California in a new statewide preventive medicine/public health initiative spearheaded by the California Academy of Preventive Medicine.
- Congratulations to Alesia Wagner, DO on completing her year as OPSC President. Dr. Wagner will remain on the OPSC board as immediate past president.

### OMM

- Dr. Melissa Pearce, participating in the Costin leadership development program, will study Reducing Inflammation with Osteopathic Therapy (RIOT) as part of her program.

### Basic Sciences

- The anatomy faculty in collaboration with Dr. Pera implemented a newly designed integrated-computer-based x-ray, CT and MRI radiology component to the curriculum that synchronizes with real-time ultrasound enhancing the OMS I and OMS II clinical-learning-experience for each anatomical region.

### Research Updates

- Congratulations Dr Miriam Gochin, who has collaborated with Dr Joseph Wu at New York Medical School to receive seed funding for a grant on Prostate Cancer Prevention mechanisms and targets by resveratrol.

### Student Research at OPSC

- Student Doctor Michelle Burk, OMS I represented us at OPSC in San Diego on February 7, 2014. She presented a poster of her research work on campus.
- The COM Class of 2016 Pinning Ceremony is scheduled for May 16th.
- The COM Class of 2014 Commencement Ceremony will be held at the Marriott Marquis Hotel Ballroom, 55 Fourth Street in San Francisco, on May 23rd beginning at 10 a.m. ■

## Touro Student's Report

► Anthony Anguille, OMS

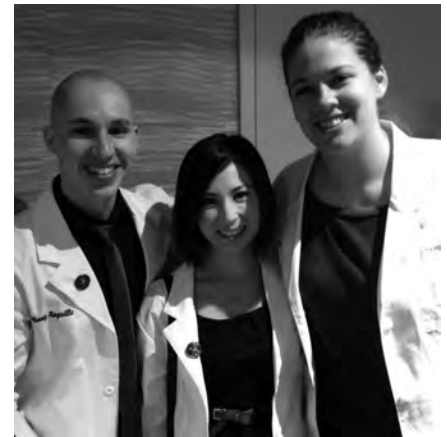
Following transition into my new role as President of our OPSC chapter in early February 2014, I focused my attention on setting goals for my term. In typical fashion, these goals were prioritized based on the current state of our organization, potential ease in bringing them to fruition, and the perceived immediate (versus extended) need. Our previous President, Harjyot Toor, OMS-II, was clear to describe the trials and tribulations she faced in reenergizing OPSC's presence on our campus, so her input assisted me in establishing my priorities and gave me a realistic perspective as to what I should I expect logistically.

Our early successes beginning in February 2014 included the appointment of our new Vice President, Amber Ruiz, an official statement to our parent organization regarding our collective goals for the year, budget estimation and request via our Student Government Association, and prospective talks with our immediate advisor, Dr. Alesia Wagner, and adjunct, Dr. Abraham Pera. We, additionally, were able to meet with OPSC's Executive Director, Kathleen Creason, on February 20, 2014 on the Touro campus to discuss leadership transition, hot-button topics (e.g. GME merger, UC rotation challenges, etc.), club-parent organization support systems, expectations, and future goals. Combined, these experiences provided SD Ruiz and I the necessary tools to forge ahead in our endeavors.

On February 20, immediately preceding our meeting with Kathleen Creason, we brought our first official event of 2014 to fruition. In conjunction with ACOFP and SAAO, we offered a brown-bag lunchtime lecture with Dr. Alesia Wagner where she discussed Covered California and Medi-Cal to a diverse group of inter-professional students and faculty members. Based on the success of the lecture, a student-pharmacist, representing SNPhA, a pharmacy organization, offered OPSC the opportunity to take part in an inter-professional health fair in early April to disseminate this information to the Vallejo community. Logistics of this event are still being solidified; however, we have agreed to partner with a local organization, the Solano County Coalition for Better Health, to properly educate the community on health care options. The AOA has also agreed to provide "What is a DO?" pamphlets for the event to ensure that we simultaneously educate the public on the existence, skill, and approach of osteopathic physicians.

Beyond Covered California related event planning, SD Ruiz and I added an additional member to our leadership board. Hassie Cooper, OMS-I, was named our External Relations Chair. She was brought on at a dire point, as SD Ruiz and I sorted out our initial tasks related to the coordination of a community drug take-back event tentatively

(From L to R) Anthony Anguille, OMS; Amber Ruiz, OMS; and Hassie Cooper, OMS at the Women's Caucus at the CA Democratic Convention in March 2014.



to be held in late April 2014. The majority of our efforts over the last (nearly) two months have been focused on bringing this event to fruition. It certainly has not been without its struggles based on the need for various levels of approval beyond our campus administration. Thus far, we have received administrative approval for the event, successfully added inter-professional partners from the College of Medicine and College of Pharmacy, established a local venue, and discussed state requirements/codes with the DEA. We maintain confidence that we will be able to make this event a success.

Throughout March, we have focused on a number of other initiatives while planning the aforementioned event. At the request and sponsorship of the California Medical Association, our board traveled to Los Angeles to attend the California Democratic Convention where our task was to educate voters on the proposed MICRA legislation. Additionally, we worked with the AOA to acquire DO pledge pins for our first and second year class. These will be dispersed immediately following our Spring Break in mid-April in celebration of National Osteopathic Medicine (NOM) week, as well as the first annual celebration of California Osteopathic Medicine (COM) week.

With a number of events on the immediate horizon, we are still focused on a number of campus-related initiatives as well. In conjunction with Touro's external relations team, SD Cooper is focusing on the creation of our "club brand" (including logo, informational brochures, collateral, etc.). We are continuing to increase our social media presence by sharing our successes and important profession-related information with our followers on Facebook. Plans for general interest meetings, appointment of our Internal Relations Chair, presence at OPSC's legislative day in early May, and an elementary school health fair are also on our immediate radar. All in all, our true hope is to solidify a structure to ensure that our OPSC campus chapter continues to thrive well beyond our term; our actions over the last two months are derived from our will to make this a reality. ■

## Western U/COMP Student's Report

▶ Andy Qia Zhang, OMS I

In the midst of the 2013-14 academic year, the WesternU OPSC Student Club introduced six new officers to the executive board. We would like to take this opportunity to briefly report some of the events that have transpired our campus and beyond.

After months of discussion, the AOA, along with the Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Colleges of Osteopathic Medicine (AACOM), have agreed to a single accreditation system for graduate medical education programs in the United States, defined as the graduate medical education (GME) accreditation system. At WesternU, both President Philip Pumerantz, PhD, and Dean of COMP, Paula Crone, DO '92, expressed their views toward this merger, using terms such as "historic time", "unique opportunity" and "our osteopathic future is brighter than ever".

Within one week of the merger, AOA President Norman Vinn, DO, visited WesternU. Dr. Vinn is an osteopathic family physician from San Clemente, Calif., and founder of Housecall Doctors Medical Group, Inc., a home care network that provides onsite clinical services to more than 1,000 homebound elderly in Southern California. He told students of COMP that the creation of a single medical accreditation system will bring tremendous opportunities, but we must keep exemplifying the osteopathic philosophies. This is not just the manipulative treatment, but osteopathic thinking and humanism.

In the meantime, WesternU students continue to embrace the tradition of creativity and innovation: a phone app was developed by student doctor Tyler Owens (OMS II). It is called "Hungry Students" and is available in Google play/App Store. Students will receive discounts from over 24 local restaurants and participating businesses in the Pomona area of Los Angeles County. The app has been a success within the WesternU community. Its proceeds are intended for the Montclair Medical Clinic, a non-profit clinic worked by residents and students providing health services to individuals lacking proper insurance.

Lastly, over 20 COMP students attended the 53rd OPSC Annual Convention in San Diego. This year David Connett, DO, was inaugurated as the President of OPSC. The conference also added a poster competition for the first time.

The WesternU OPSC Club is proud to help connect students to the profession's state organization which has always been there for all of us. We will continue to share our passion for osteopathic medicine by empowering our student body and by finding new ways to serve our community. To those looking to become involved in the organization, we encourage you to contact us at [OPSCclub@westernu.edu](mailto:OPSCclub@westernu.edu). ■

## STUDENT DO HIGHLIGHT

**Name:** Harjyot Toor

**Osteopathic Medical**

**School:** Touro University  
California

**Expected year of  
graduation:** 2016

**Where did you grow up?**  
Toronto, Canada



**What are your life goals?** I aspire to one day organize medical missions to impoverished areas in both the U.S and abroad.

**What specialty are you leaning toward?** Critical Care

**Why did you choose to become an osteopathic physician?** I was immediately drawn to the Osteopathic philosophy; that as physicians we facilitate the health of our patients by caring for the mind, body and spirit rather than simply analyzing a list of symptoms.

**Do you have relatives in the medical profession?** No

**Did you have a profession prior to medical school?** I worked as an Emergency Department Scribe for 2 years prior to beginning medical school.

**What are your hobbies?** I love to travel! I've been fortunate to experience Africa, South Asia and Europe but I still have a "laundry list" of places I would love to visit.

**Why are you supportive of OPSC?** As an Osteopathic medical student, I see the challenges and discrimination our profession faces and the OPSC not only represents us as physicians but also protects our interests as Osteopathic doctors.

**Suggestions on how to improve the osteopathic profession in California?** If Osteopathic physicians and medical students can continue to stand united and show strength in numbers then our profession will thrive in this otherwise dynamic medical arena, bringing notoriety to Osteopathic Medicine. ■

# The Yardbirds

► Taryn Parks, OMSIII, Touro University College of Osteopathic Medicine

I had never been so concerned about a band-aid. The tiny strip of mesh fabric commonly used to cover the skinned knees of children was now posing a significant threat. The routine action of this item being given to a patient caused my heart to race. Was this okay? Was this allowed? Would people be safe? I looked around the room for confirmation that this transaction wasn't concerning to anyone else. In that moment, I feared that the band-aid was no longer going to serve its intended purpose of wound assistance. The band-aid, the sweet unassuming band-aid, had now become raw material for a potential weapon. As the patient left with his possible shank-in-the-making, it was clear that this environment was unlike any other that I had ever been in. For even the simple task of handing out a band-aid becomes a big deal when you are behind bars in the prison medical facility inside of San Quentin State Penitentiary.

Seeing patients inside a California State Prison was, of course, not a required medical school activity. In fact, I was only there because I had asked for the opportunity to go inside the facility. As a third year medical student in the middle of clinical rotations, I was interested in seeing all aspects of medicine, including those areas that might otherwise be undesirable. The idea of entering San Quentin, the oldest California State Prison and only state facility housing male death-row prisoners, didn't alarm me. In fact, not only was I not nervous about entering, I was genuinely excited. Ever since I was young, I had always had a strong fascination with prisons. I would find myself inherently curious about the details of how they operated. From the series of events that led someone into becoming a prisoner, to that person's life behind bars, to the interaction between prisoners and prison staff; the entire societal microcosm was infinitely intriguing to me. San Quentin may have been full of people wanting to leave, but I couldn't wait to enter.

Entering the prison, I soon found out, was nothing short of intense. The clacking and buzzing sounds that the San Quentin gates make as you walk through seem to echo with every step. Like a portal between dimensions, entering through the gates allows you to be both closer to the prison world and simultaneously farther removed from the free world from which you came. As I entered the prison with nothing but my identification and car key in the pocket of my white coat, it dawned on me that this was the most empty my white coat had ever been. Usually weighed down with books and instruments, I had been asked to carry only what was necessary into the prison. In what was likely to be the heaviest environment in which I would rotate, my white coat had paradoxically managed to be the lightest. In addition to noticing my empty pockets, I had also never been so

aware of wearing my white coat before. In the hospital setting, a white coat is common and expected. In the prison setting, where orange jumpsuits, blue chambray, and denim are the common attire, a white coat sticks out like a sore thumb. Since I was here to help treat sore thumbs, among other ailments, I wasn't sure how I felt about being one myself.

Once inside the prison, the physician with whom I was rotating and I made it to the medical facility, where we were given a room to examine patients. Our room looked like any other standard patient room with the exception of a view of the prison yard outside the window. Down below, the prisoners were walking the track, playing sports, and indulging in much desired exercise. Mingling among the boys in blue were unexpected companions -- geese. The San Quentin yard was full of geese, tons of them in fact, all sharing the yard with flocks of prisoners. There for the grass and food, the geese were completely unaware that they too were imprisoned inside San Quentin. I felt an odd kinship to these birds as they, like me, had come to the facility voluntarily. Their presence reminded me of the old-fashioned term "yardbird", meaning prisoner. Here at San Quentin, there were both yardbirds in the way of prisoners, and yard birds, in the way of the geese. Somehow, this poetic coincidence seemed apropos for the setting. From our view in the medical facility a few stories high, we could see not only the exercise yard full of prisoners and geese, but also the area beyond the walls of the prison. Breathtaking waterfront views were visible surrounding nearly the entire area of San Quentin's real estate. I hadn't realized before my visit that the prison was built upon such a desirable piece of land. From this window in the medical facility, ironically, both freedom and confinement were visible in the same glance.

After settling into the prison medical facility, it wasn't long before our first prisoner patient arrived. I could hear the patient coming long before I could see his face. The rattling of the chains and handcuffs were always the first clue that a prisoner was being escorted around the corner. Though I wasn't used to patients having a guard escort or being brought in wearing handcuffs, the additions didn't bother me. Though my surroundings were quite different, I saw my role as completely unchanged. I had no relation to the past crimes of the prisoners before me; I only had relation to their present health. Prisoner or not, the common prescription for any patient with whom I have contact with is a healthy dose of respect and courtesy. To show this respect, I intentionally chose to address each prisoner by his full name, and purposefully did not utilize the more commonly used department of corrections number as identification. Hearing their

name being spoken from me, a complete stranger in a white coat, would always cause the men to react in surprise. It had likely been awhile since some of them had heard their own name said in such a considerate context. With nearly all of their freedoms removed, their name was one of the last few personal things that they had left. As I stared into the eyes of the handcuffed man in front of me, the relationship had never been more simple: I was a medical student, the person in front of me was a patient, and I was here to help him.

Helping the prisoner patients, though, required quite a concerted effort. Let's take, for example, a patient coming in with a chief complaint of shoulder pain. In order to assess his pain, we needed to see the range of motion on his affected shoulder. In order to examine the range of motion of the shoulder, we needed to get his handcuffs off so that he could move the joint freely. In order to get the patient's handcuffs off, we needed to get a guard to unlock them. The guard would release one shoulder at a time to allow us to examine it, and then immediately re-cuff the patient's wrist after we were through. Though this process was done to ensure the safety for everyone involved, it certainly was never something that became comfortable for anyone. There was always a background feeling of helplessness in the air. The patient felt helpless that he couldn't just raise his arm without needing the help of a guard, and we, the medical staff, felt similarly. The recurrent visual of an otherwise healthy man not being allowed to move a joint on his own accord was a constant reminder that I was not in proverbial Kansas anymore.

From rotator cuff tears, surgical consultations, and attending to fresh trauma on the prison yard, I was able to see quite a bit of pathology during my days at the facility. Just as the prisoner ailments varied, so did the amount of time on their individual prison sentences. Some patients were only going to be in San Quentin for a handful of years. Others were "lifers," or those with extended stays, and others still were sitting on death-row. I still remember the face of the first death-row patient that sat in front of me. A baby-faced young man, younger than me even, was presenting to the clinic with the ending to his life story already written in stone. I can still hear the guard casually alerting me that this patient was "condemned." Condemned. The word pierced my consciousness like a prison shiv. An adjective that I had previously associated with dilapidated buildings and run-down structures was now being used in the context to describe the state of a human being. I found it odd that I felt more comfortable with the term "death-row" than I did with the term "condemned." The word, and all that it represented, seemed to resonate the entire room. In an attempt to break the silence that followed the utterance of the word,

the "condemned" inmate chuckled and said, "yeah, I'll be seeing the needle man soon." It took me a long slow-motion moment to realize "the needle man" he was referring to was the doctor who would at one point administer the lethal injection during his execution.

Not knowing how to react, I lightly smiled and nodded my head as if I understood. In truth, there was no way I could ever understand this young man's life, or the series of events that had led him to this moment of being an inmate at San Quentin and morbidly joking about his own imminent death. At that moment, I felt completely confused and utterly torn. Though I had no judgment surrounding his crimes, the realist in me knew that he had likely done something of significance if a jury of his peers found him guilty and supported the death penalty. In contrast, the student doctor in me, the one who embodied the idea of assisting others, wanted to help him to the depths of my ability. Recognizing my internal conflict and limitations, all I could do was address him by his full name, listen to his complaint intently, and send him off with wishes for a pleasant rest of his day. Beyond being kind and utilizing my limited understanding, there was no help that I could truly offer him. Though the prisoner was the one with the physical handcuffs on, I too felt like my hands were tied.

Through my visits at San Quentin, I was able to meet many interesting men. From a prisoner who became an author after teaching himself how to read and write behind bars, to another who was soon to be released into the care of a program that would train him to fight fires, nearly all of these men had a story to tell. One prisoner was set to be released within a week of his visit to us. He had been incarcerated for 23 years and he spoke candidly with me about the anxiety surrounding his release. He couldn't remember a time that he hadn't been in prison, and openly wondered how he would survive outside the walls. He had never owned a cell phone, had never used the Internet, and was afraid that the outside world had long since surpassed him. It's an interesting conversation when a man who has been behind bars for nearly a quarter of a century speaks about how it will be hard to leave. Though his body was soon to be released from the prison walls, it didn't mean that his mind was ready to go. Routine, even one behind the walls of a prison, is hard to break when you've been living it for so long. In the middle of my thoughtful conversation with this prisoner, one of the many alarm bells rang out across the prison. A loud wail, similar to that of an annoying alarm clock, reverberated out from every speaker. These alarms happened for a wide variety of reasons, and often we had several of them a day, so I was well familiar with the expected procedure. When one of these alarms occurred, the prisoners were expected to squat, and

## The Yardbirds

Continued from page 31

the non-guard staff like myself were told to remain in place. Just as I was chuckling to myself about how I was starting to get used to the frequency of these sounds, the prisoner, as if he could read my mind, said, “I’ll tell you one thing, I won’t be missing these.”

On my last day at San Quentin, as I prepared to see prisoner patients for the last time, I found myself reflecting about all that I had learned during my time behind bars. The prison, the prisoners, had all produced invaluable learning experiences. Though likely to be the most unconventional setting that I would ever rotate in, I was, ironically, reminded of some of the most conventional life lessons. As a medical student, and future physician, working in the prison reinforced my responsibility to treat each patient with respect and dignity, no matter the setting. Whether the patient arrives as white collar, blue collar, or orange jumpsuit, they are all, quite simply, valued patients. The prison bars may physically separate the incarcerated from those who are free, but humanity knows no bounds. As I watched the San Quentin gates close behind me for the last time, I couldn’t help but remember being fearful of that band-aid when I had first entered the prison. Just as I was grinning about how far I had come since then, I found one in the pocket of my white coat. ■

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## Keep It Pure

Continued from page 3

getting paid. If you are one of those DOs with questions I encourage you to contact OPSC for further details. I know I was able to attend a SBCOMA presentation by OPSC President-elect John Kowalczyk, DO that answered a lot of my questions.

Yet through all this turmoil one constant remains, and that is the amazing job we do with our patients. Daily I am reminded of the words attributed to Dr. Still on his death bed: “Keep it pure, boys, keep it pure.” The power of Osteopathic Medicine, whether through OMT, simply touching our patients, or evaluating and incorporating the whole-patient approach to care, we are doing something different with the patients, and they love us for it.

Let’s keep doing what we do, and loving our patients and each other for it. Dr. Vinn has introduced, or reminded us, of our secret DO handshake, the Osteopathic Hug. Make sure you share it with a colleague, a loved one, or maybe even a patient who needs it. Show them the DO difference! ■

## Issues We’ll Confront This Year

Continued from page 2

United States—cost, quality, and access for our patients. The current rendition of the ACA attempts to address some issues of patient access with the reduction of an uninsured population from approximately 47 million people down to 30 million people. In addition, it does very little to address cost or quality in its current format. California is the most productive state in the United States, as measured by our GDP (gross domestic product) of \$2 trillion, which is equivalent to the GDP of Russia and Italy. California physicians should be on the forefront in providing influence nationwide regarding healthcare reform as opposed to subjugating these decisions to bureaucrats in Washington, DC.

I have asked every member of the OPSC Board of Directors to reach out to their own state legislators, to build an alliance with them and provide them with medical consultation on legislative issues that affect both patients and physicians. This is important to assure all legislators, especially those who represent OPSC leaders, understand issues of importance to patients and physicians.

We were pleased to have AOA President Norman Vinn, DO and AOA Executive Director Adrienne White-Faines, MPA attend OPSC’s annual meeting in San Diego. I would like to recognize OPSC staff members Karl Baur for his exceptional work in administering an outstanding conference, Cassandra Mallory for her ongoing support, and Kathleen Creason for her exceptional management and organizational skills that have made my role extremely effective. I would also like to thank my friends and colleagues at Western University of Health Sciences, my fellow alums from COMP, and friends who participated in my installation as OPSC President in San Diego. Special thanks to the medical students who took a break from studying to travel down to San Diego and support me during my installation ceremony. Our students are the future of our profession and we are in good hands.

The last issue that I would like to address, in brief, is the consolidation of the AOA and ACGME residency accreditation systems. This issue has been polarizing for some in our profession. I have listened carefully to all sides of the argument and understand there are some fears and concerns for those regarding the future of the osteopathic profession regardless of the path we take. I believe, as does our national osteopathic leadership, that we can achieve a path of residency consolidation that provides our students with unfettered access to any and all residency training programs in the United States while assuring the osteopathic heritage, culture, and identity are preserved. This includes assurances that osteopathic leadership is integrated at all levels of ACGME to include their governing board.

Please send me your comments or concerns on this or any issue that OPSC may provide you with representation. ■

## A Day in the Life

Continued from page 4

to be extremely knowledgeable about physician issues and statistics. It's clear that he's passionate about the issues facing California, and could talk at length about them.

Finally, we have a Resolutions Committee conference call from 7:00 – 8:30 this evening. Dan Miulli, DO does a great job of reviewing background and working with delegation Chair Geraldine O'Shea, DO to plan strategy for resolutions that have been drafted for California to submit to the AOA House of Delegates. It has been gratifying to see California develop strong national influence in recent years.

### Thursday

Thursday morning starts with a meeting with staff leadership of the California Academy of Physician Assistants. This organization has worked hard to establish positive relationships with the physician community and to develop reasonable legislative goals, maximizing PA authority within their education and training abilities. Today we're talking about legislation that would expand physician oversight of PAs from four to six, and they ask about our position on medical assistants handing medications to patients. Our Legislative Committee has not yet met so I can't give an official position, but we discuss pros and cons of these bills.

There's a meeting of the Los Angeles County Osteopathic Medical Association (LACOMA) tonight. Thanks to the strong efforts of LACOMA President Virginia Johnson, DO, this is one of OPSC's most active Regional Affiliates. Because the topic of this meeting is Covered California, and the meeting is being funded by a grant received by OPSC, I'm especially interested in attending. I've started to take advantage of my travels throughout California to meet with members in other areas. Today, after a quick flight to LAX, I meet with David Matian, DO, a Family Practice physician with a private practice in Sherman Oaks and Donna Cashdan, DO, also a private practice FP in Valley Village. Both meetings are interesting, as I enjoy learning more about OPSC members and the challenges they face. It's also a nice opportunity to tell them about some of the OPSC benefits of which they may not be aware. The LACOMA meeting goes extremely well thanks to presenter John Kowalczyk, DO, OPSC's President-elect. The group has good follow-up questions, which he adeptly answers. There's something about the group from LA; they're always engaged - and fun! Makes a long day enjoyable. Off to the hotel for a short night's sleep.

### Friday

I've discovered that I need to stay active in order to keep up with the demands of my position, so I try very hard to exercise during my travels. This is somewhat complicated by my bad knees, both of which experienced traumatic injury known as the "unhappy triad" – ACL/MCL/meniscus – more than a decade ago. I find a gym near the hotel that has equipment I can use, and get in a good workout before my flight out this morning.

Back in the office, I have a meeting with OPSC's insurance broker to discuss ACA implementation and options for staff health care coverage. Following the meeting, I research Covered California and discover that the broker was correct; the best choice for OPSC's situation is to maintain our current coverage.

Later in the morning, Karl and I participate in a conference call for Covered California grant recipients. Thanks primarily to Karl's efforts, OPSC is meeting our targeted goals for the grant. After the call, I work on development of talking points for Joseph Zammuto, DO, OPSC Board member Emeritus, who will be meeting with his congressional representative. Cassandra has some thoughts about a new membership promotion activity, so we take some time to talk about that. The remainder of the day is spent making plans for participation in upcoming meetings, including:

- Health Services Advisory Group, California's Medicare Quality Improvement Organization, on which OPSC holds a Board seat
- OPSC's annual legislative reception, which will feature structural changes this year
- New student leader orientation
- AOA's Advocacy for Healthy Partnership meeting that I'll be attending with Dr. Kowalczyk
- AOA's Bureau of Osteopathic Education, on which I serve
- AOA's Bureau of Federal Health Programs and DO Day on the Hill where we'll be pushing for Medicare payment reform

Another diverse and interesting workweek has come to a close. I've got a fun weekend planned – my son's high school basketball team will be playing in the state championship game (!) tomorrow, and I have plans to play sand doubles volleyball on Sunday. But as I close up the office and reflect on the rewarding work that has transpired throughout the week, I find myself thankful once again that I have the opportunity to represent such a distinguished and passionate profession. ■



## 25th Annual Fall Conference

September 12-14, 2014  
Monterey Plaza Hotel & Spa

Greetings to everyone!

I would like to officially extend a personal invitation for you to join your osteopathic colleagues in Monterey, California for our 25th Annual Fall Conference. This year, the Conference will be held September 12th – 14th and we will be returning to the beautiful Monterey Plaza Hotel on Cannery Row.

The program will offer you the opportunity to earn up to 22 hours of category 1-A CME over the course of the Conference, including multiple courses on:

- Pain Management
- Osteopathic Manipulative Medicine
- Ultrasound
- Central Nervous System Infections
- Plus hands-on sessions to explore and practice OMM and ultrasound techniques

I look forward to seeing you in Monterey!

Abraham Pera, DO  
2014 Fall Conference Program Chair



## CME Dinner

Saturday evening's CME dinner is an optional program and is not included in your Conference registration fees. To reserve a seat for the CME dinner, please check the appropriate boxes on the registration form. You may reserve seats for yourself and one guest, if desired. Evaluation and Attestation of hours for this session will be conducted separately from the main Conference.

**CME Hours Anticipated: Two (2) category 1-A credits**

**Fee: \$30 per person**

### CME

OPSC anticipates that the AOA CCME will approve this program for a maximum of **22 hours** of AOA Category 1-A CME Credit CME credit (including optional dinner program).

Approval is currently pending.

## Program Schedule

### Friday, September 12

10:00 am - 5:30 pm	Registration Desk Open
12:30 - 1:00 pm	Opening Session
1:00 pm - 6:30 pm	CME sessions
6:30 - 7:30 pm	Welcome Reception

### Saturday, September 13

6:30 am - 5:00 pm	Registration Desk Open
7:00 am - 6:00 pm	CME sessions
6:30 pm - 8:30 pm	Dinner CME program [Additional Fee Applies]

### Sunday, September 14

6:30 am - 12:30 pm	Registration Desk Open
7:00 am - Noon	CME sessions

Updated schedule and session information will be available on the OPSC website ([www.opsc.org](http://www.opsc.org)) as it is confirmed.



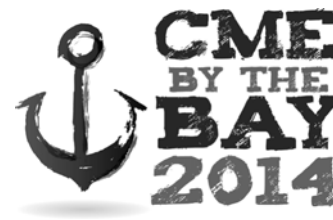
## Make Your Room Reservations Early!

OPSC has obtained a special conference rate for room accommodations at the Monterey Plaza Hotel located at 400 Cannery Row, Monterey, CA 93940-1489. Room rates are \$225 single/double occupancy (inland view rooms only).

Reservations must be made by **5:00 pm PDT on August 20, 2014**.

To make your room reservations please contact the Monterey Plaza Hotel directly by phone: **(800) 334-3999** or online at **www.opsc.org**. To receive the conference room rate please inform the hotel that you are with the OPSC conference when making your reservations.

# Registration Form



25th Annual Fall Conference | September 12-14, 2014  
 Monterey Plaza Hotel & Spa  
 400 Cannery Row, Monterey, California 93940

Name \_\_\_\_\_ AOA Number \_\_\_\_\_

Home  Work Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email address \_\_\_\_\_ Specialty \_\_\_\_\_

Check here if we may provide your email address to Fall Conference Exhibitors.

College \_\_\_\_\_ Year of Graduation \_\_\_\_\_

Special Needs or Dietary Requests \_\_\_\_\_

**GUEST REGISTRATION:** Guests (including children over 4 years of age) must purchase tickets to participate in meals. Please make sure to check the appropriate registration category.

Guest/s \$95 each

Number of Guests \_\_\_\_\_ Guest Name/s \_\_\_\_\_

**REGISTRATION FOR SATURDAY EVENING CME LECTURE** *Note: This program is not included with your Fall Conference registration.*

Physician Reservation (includes 2 additional hours CME): \$30  Guest Reservation: \$30

## REGISTRATION FEES

	Before 9:00 pm PDT 8/17/14	8/17/14- 9/7/14
<input type="checkbox"/> Member Physician <sup>1</sup>	\$ 345	\$ 395
<input type="checkbox"/> Member Retired Physician	\$ 275	\$ 325
<input type="checkbox"/> Military Physician	\$ 345	\$ 395
<input type="checkbox"/> Non-Member Physician	\$ 645	\$ 695
<input type="checkbox"/> Student/Intern/Resident - Full Registration <sup>2</sup>	\$ 95	\$ 95
<input type="checkbox"/> Student/Intern/Resident - Program Only <sup>2,3</sup>	\$ 0	\$ 0
<input type="checkbox"/> Allied Professional	\$ 295	\$ 345

## MEMBERSHIP FEES:

<input type="checkbox"/> Active 3 or more years in practice	\$ 475
<input type="checkbox"/> Active in 2nd year of practice	\$ 350
<input type="checkbox"/> Active in 1st year of practice	\$ 250
<input type="checkbox"/> Retired	\$ 100
<input type="checkbox"/> Military	\$ 100
<input type="checkbox"/> Associate (out of State DO)	\$ 75

All registrations after **September 7, 2014** must be submitted at the OPSC registration desk on-site. Onsite registrations will be accepted as space permits. Rates may be higher.

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 and CME credits not included.

Syllabus will be provided online prior to the conference for download and a jump/flash drive will be provided onsite at no charge. Complimentary internet connectivity will be provided in the meeting room. Please bring your laptop! Hardcopies of the syllabus are available for pre-order only for \$25 each.

\$ _____	Registration Fee Total
\$ _____	Guest Fee Total
\$ _____	CME Dinner Total
\$ _____	Syllabus Hardcopy (\$25)
\$ _____	Membership Fee Total
\$ _____	Total Enclosed/Due

## PAYMENT INFORMATION

Check enclosed  Visa  Mastercard

Card Number \_\_\_\_\_

Exp. Date \_\_\_\_\_ CVV# \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_

Billing address \_\_\_\_\_  
 if different than above

**Cancellations:** All cancellation requests must be made in writing and received by OPSC no later than **August 20, 2014**. A \$50 processing fee will be assessed for all cancellations.

Registration fees are not refundable after **August 20, 2014**.

Mail this form to:  
 2015 H Street, Sacramento, CA 95811

Fax this form to:  
 (916) 822-5247



Register online at  
[www.opsc.org](http://www.opsc.org)



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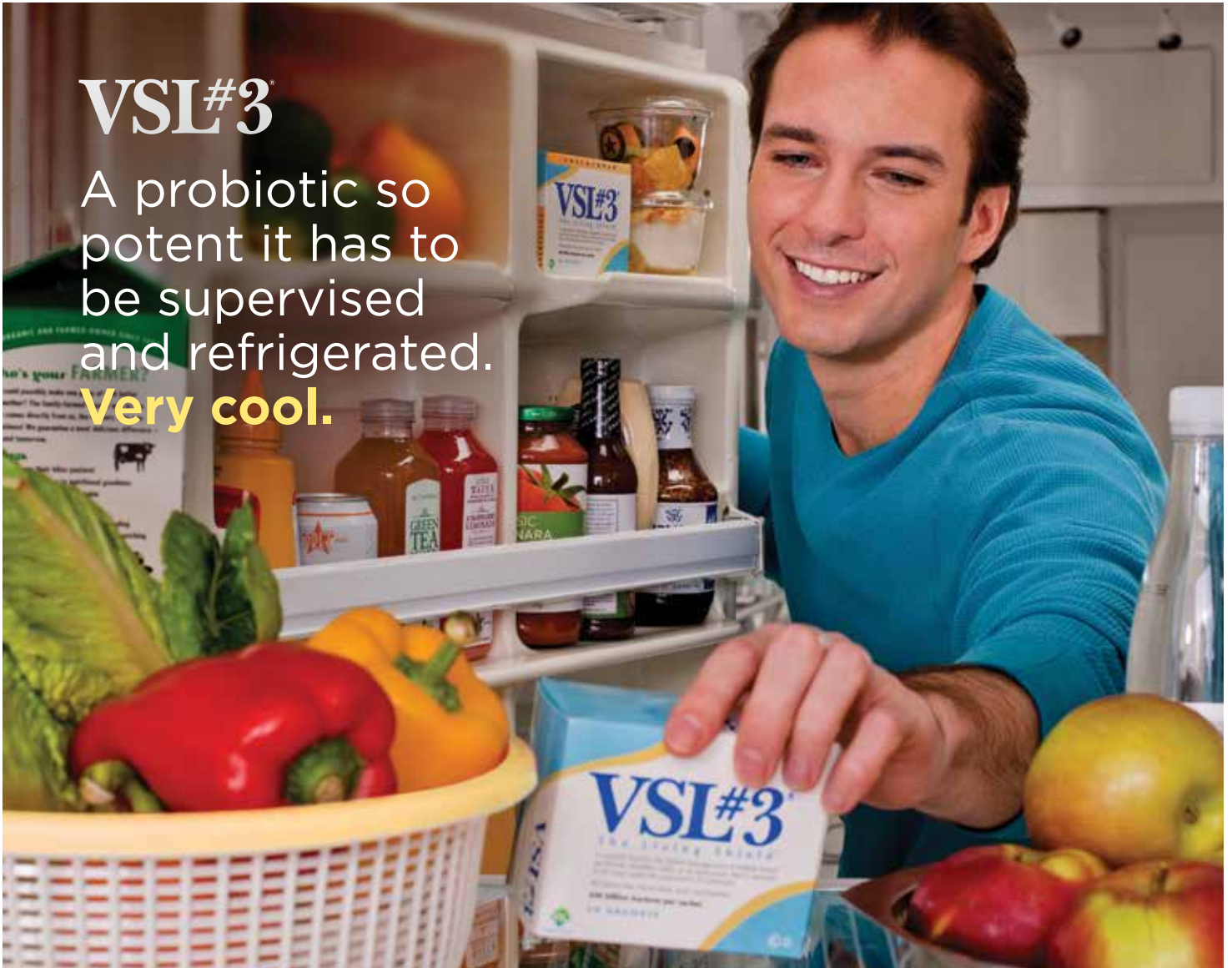
  
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1. Source: AC Nielsen 12.2009 Average CFU claimed by product manufacturer was approx. 4 billion CFU per capsule or tablet



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