



# DENVER MEDICAL BULLETIN

Official Publication of The Denver Medical Society

Volume 100/Number 1 January 2010

## 2010: Centennial Year for the Denver Medical Bulletin

*This year marks 100 years of publication of the Denver Medical Bulletin. Below we are reprinting the first issue. Throughout the year we will include excerpts from other issues in that first year of publication.*

### THE Denver Medical Bulletin

PUBLISHED BY  
The Medical Society of the City and County of Denver  
*Issued every Saturday except During June, July and August*

Address communications to A. J. Markley, M.D.,  
432 Metropolitan Bldg., Denver, Colo.

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#### MEETINGS THIS WEEK, MARCH 4TH TO 11TH.

Tuesday, 7th—County Society.  
Friday, 10th—Clinical and Pathological.  
Friday, 10th—Post Graduate.

#### Officers of the County Society 1911.

H. R. McGraw, M.D., President.  
W. H. Davis, M.D., Vice-President  
E. W. Lazell, M.D., Secretary.  
G. F. Libby, M.D., Treasurer.  
A. J. Markley, M.D., Librarian.

#### Trustees.

F. A. Kenney, M.D. Melville Black, M.D.  
W. A. Jayne, M.D. Edward Jackson, M.D.  
D. H. Coover, M.D.

#### Board of Censors.

C. E. Cooper, M.D. O. M. Shere, M.D.  
J. A. McCaw, M.D. W. A. Sedwick, M.D.  
J. D. Barry, M.D.

#### THE NEW BULLETIN.

At the last meeting of the County Society the following resolution was introduced and adopted:

“Resolved, That the trustees of the Medical Society of the City and County of Denver are hereby requested to arrange as soon as practicable for the publication, weekly, by this society of a bulletin in which shall be printed the notices of meetings of this and other medical societies, announcements and other matters of interest to our members.” In pursuance to this request the trustees therefore present this, the first number of “The Denver Medical Bulletin.”

The aims and purposes of this bulletin may not at first glance be apparent, but as its publication proceeds, it is confidently expected that it will become an indispensable part of the medical affairs of Denver.

Society meetings could be held at fixed dates without sending notices of each to the members. But universal experience shows that interest and usefulness are promoted by acquainting each member with the program of each meeting. There are other things beside the County Society meetings with which the medical profession of Denver should be kept in close touch. The work of the Post-Graduate Club, the progress of our library, the status of medical legislation, the existence of epidemics and many other matters should be regularly brought to our attention.

Do you know how many medical societies are meeting regularly in Denver? Where and when are clinical lectures given that are open to the profession? We often know more of the medical life of Chicago or New York than of that of Denver; and we have been disposed to correspondingly under rate the importance of Denver as a medical center.

This we propose to change. The Medical Society of the City and County of Denver undertakes the publication weekly of this Bulletin. Other societies are invited to assist in its support, and to share in its benefits. Plans will develop as we proceed. Our intention is to have the most useful medical publication, for its size and cost, that can be found between the Mississippi River and the Pacific Ocean.

**MEDICAL SOCIETY OF THE CITY AND COUNTY OF DENVER.**

Meeting Tuesday, March 7, 1911, at 8:15 p. m. in the hall of the society.

**Program**

1. "Blastomycosis of the Skin and Mucous Membranes, With Presentation of a Case"..... Drs. R. Levy and A. J. Markley
2. "Some Conclusions From 30,000 Primary Vaccinations..... J. W. Ames, M.D. Discussion opened by Drs. W. H. Sharpley and F. R. Coffman.

The Board of Censors will report upon the eligibility of the following applicants for membership: Dr. E. B. Diamond, Dr. G. H. Lee, Dr. J. W. Martin, Dr. F. G. Byles, Dr. W. Dreschsler, Dr. H. Auffmasser, Dr. T. L. Howard, Dr. W. M. Spitzer, Dr. G. C. Stemen, Dr. W. E. Stemen and Dr. A. B. Poppen.

**Amendment**

Proposition to amend the by-laws, Article IX., Section 2 to read as follows:

The first regular meetings of March, May, September and November shall be known as business meetings, at which the order of business shall be as follows:

- 1st. The reading and approval of the minutes of the last regular meeting and any subsequent special meeting.
- 2d. Report of the Board of Censors.
- 3d. Balloting for candidates for membership.
- 4th. Reading of propositions for membership.
- 5th. Reports of officers and committees.
- 6th. Unfinished business.
- 7th. New business.
- 8th. Exhibition of patients.

- 9th. Scientific program, as arranged by the directors.
- 10th. Reports of cases, personal observations, exhibition of specimens, instruments, etc.
- 11th. Adjournment.

Sec. 3. All regular meetings other than the annual and business meetings shall be known as scientific meetings, at which the following order of business shall be followed:

- 1st. Reading and approval of minutes.
- 2d. Report of the Board of Censors.
- 3d. Balloting for candidates for membership.
- 4th. Reading propositions for membership.
- 5th. Exhibition of patients.
- 6th. Scientific program as arranged by the directors.
- 7th. Reports of cases, personal observations, exhibition of specimens, instruments, etc.
- 8th. Adjournment.

Section 3 to be Section 4.

Proposed amendment to Article IV. of the Constitution: For "regular meeting" substitute "business meeting" in lines 3 and 4.

Amendment to Article X. of the by-laws: In lines 1 and 4 for "regular" substitute "business."

The above amendments are submitted on behalf of the trustees.

MELVILLE BLACK,  
EDWARD JACKSON,

Committee.

Those desiring to read papers should communicate with the secretary.

E. W. Lazell, M.D.,  
432 Metropolitan building. Society Phone, Main 1616.

**THE DENVER CLINICAL AND PATHOLOGICAL SOCIETY.**

Meeting Friday evening, March 10, 1911, 8 o'clock sharp, at the office of Dr. W. W. Grant, 305 Mack Block, telephone, Main 2035.

(Continued on page 7)

**Denver Medical Bulletin:** Michael B. Keller, MD, DMS President and Publisher / Randall M. Clark, MD, Chair of the Board / Naomi M. Fieman, MD, President Elect / Lucy W. Loomis, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director / Barbara Kamerling, Program Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web [www.denvermedsociety.org](http://www.denvermedsociety.org). Email: [dms@denvermedsociety.org](mailto:dms@denvermedsociety.org). Postmaster: Send address changes to 1850 Williams Street.

## YOUR PRACTICE NEEDS A BUSINESS PLAN FOR DISASTERS!

*Preparing makes good business sense. Get ready now.*

Be prepared. Physician's offices are businesses. All physician offices should prepare for their business needs. Below are "tips" for making sure you are prepared for any disaster. You can also find a fillable form at <http://www.cms.org/disasterprep.html> that can help the process of making your plan as simple as filling in the blanks.

How quickly your office can get back to business after a terrorist attack, a tornado, a fire, or a flood often depends on emergency planning done today. While the Department of Homeland Security is working hard to prevent terrorist attacks, the lessons of the 1993 World Trade Center bombing, the 1995 Oklahoma City bombing and the September 11, 2001, terrorist attacks demonstrate the importance of being prepared.

When you also consider that the number of declared major disasters nearly doubled in the 1990s compared to the previous decade, preparedness becomes an even more critical issue. Though each situation is unique, any organization can be better prepared if it plans carefully, puts emergency procedures in place, and practices for emergencies of all kinds.

Continuity of operations planning:

1. Carefully assess **how your office functions**, both internally and externally, to determine which staff, materials, procedures and equipment are absolutely necessary to keep the business operating.
  - Review your **business process flow chart** if one exists.
  - Identify **operations critical to survival** and recovery.
  - Include **emergency payroll, expedited financial decision-making and accounting systems** to track and document costs in the event of a disaster.
  - Establish procedures for **succession of management**. Include at least one person who is not at the company headquarters, if applicable.
2. Identify your **suppliers, shippers, resources and other businesses** you must interact with on a daily basis.
  - Develop **professional relationships with more than one** company to use in case your primary contractor cannot service your needs. A disaster that shuts down a key supplier can be devastating to your business.
  - **Create a contact list** for existing critical business contractors and others you plan to use in

an emergency. Keep this list with other important documents on file, in your emergency supply kit and at an off-site location.

3. Plan what you will do if your **building is not accessible**. This type of planning is often referred to as a continuity of operations plan, or COOP, and includes all facets of your business.
  - Consider if you can run the business from a different location.
  - Develop relationships with others to use their facilities in case a disaster makes your location unusable.
4. **Plan for payroll continuity.**
5. Decide **who should participate** in putting together your emergency plan.
  - Include co-workers from all levels in planning and as **active members** of the emergency management team.
  - Consider a **broad cross-section** of people from throughout your organization, but focus on those with expertise vital to daily **business functions**.
6. Define **crisis management procedures** and **individual responsibilities** in advance.
  - Make sure those involved know what they are supposed to do.
  - Train others in case you need back-up help.
7. Coordinate with others.
  - Meet with **other businesses in your building** or industrial complex.
  - Talk with first responders, emergency managers, community organizations and utility providers.
  - Plan with your suppliers, shippers and others you regularly do business with.
  - Share your plans and encourage other businesses to set in motion their own continuity planning and offer to help others.
8. **Review your emergency plans annually.** Just as your business changes over time, so do your preparedness needs. When you hire new employees or when there are changes in how your company functions, you should update your plans and inform your people.

Check out <http://www.cms.org/disasterprep.html> for an easy to use Office Plan guide, or visit the FEMA website: <http://www.ready.gov/business/plan/planning.html>.

## Using Reference Management Software

Reference management software is designed to maintain a personalized working library on your computer. The premise is to locate, then use these tools to import and save bibliographic information for later use. These product lines are user-driven to aid in research and publication, and in many cases interface with databases on the internet. Bibliographies can be generated in Word documents. The *Cite While You Write* tool generates the bibliography spontaneously, and note taking options are also available on articles that can be saved with collected citations. Much like a library, citation management software allows bringing order to that long list of pdfs, screenshots, graphs, images, and other files that accumulate on your desktop.

There are many different products that have hit the market making the choice seem daunting. Tailored to meet individual needs, bibliographic software packages are available that include an array of specialized tools. Selection can be driven by considering storage preferences. Space limitations on the hard drive may be a determining factor, or web-based product lines may be more suitable for collaborative research. The product that provides the most comfort or where navigation seems intuitive tends to increase satisfaction. If research projects require extensive collaboration, this might be another feature to consider. Keep in mind that it is possible to use more than one type of software, and limiting yourself to only one product may not be necessary since records can be transferred from one program to another. However, using the same product line for seamless file shares is helpful during collaboration and personal storage. No one program is perfect; each has its pros and cons, so it's a matter of personal taste.

When doing research, having the ability to organize citations captured in various formats from different databases and websites can be tedious to organize and proofread. There are several vendors that take similar approaches to these issues. Endnote and Reference Manager are two products from Thomson Reuters that attempt to solve these issues.

Endnote (<http://www.endnote.com/>) is an excellent choice for research and publication. Software must be purchased. Citation organization is more complicated only because this product offers many different options (950 bibliographic styles) for customization and formatting. Endnote can also handle a large amount of references. It is a desktop client software that has a web interface tool called Endnote Web. Endnote Web is compatible with certain databases. Once an article is selected, the metadata is resolved from the database and travels to desktop. This process minimizes errors in transcription. Integrating Endnote and Endnote Web permits using management software on any computer.

The Reference manager component is designed around networking. Projects can be personalized by creating synonyms for key works, authors, or references. Across databases, references can be collected, duplicates can be deleted, and bibliographies can be created to link references to the full text files, graphics, or web pages. Additions and edits follow the Word document, making the document a travel piece for the collaborators.

Endnote and Endnote Web are only two of the tools offered by Thomson Reuter. There is a complete line available from their website. They also offer trials of their products.

*Diane Tobin, Reference Librarian, Denver Medical Library—[tobind@denvermedlibrary.org](mailto:tobind@denvermedlibrary.org).*

### DMS Young Physicians

*Mark Your Calendar – February 25, 2010*

6:00-8:30 PM—Location to be determined

#### **Medical Home—Medical Neighborhood What's in it for You?**

Scott Hammond, MD, Medical Director  
System of Care/Patient Centered  
Medical Home Grant, practicing FP

Whether you're a primary care physician or a specialist, this program is a must. It's part of every health care reform effort under consideration, and you need to be informed if you're going to thrive in the new world order!

Learn how reconnecting primary and non-primary physicians through improved coordination of care, common values and strengthened relationships not only improves patient outcomes but helps regain the joy of medical work through a work/life balance.

Watch for registration materials soon.

Program generously sponsored by



*Denver Medical Society**proudly teams up with the**Arapahoe-Douglas-Elbert Medical Society &  
Aurora Adams County Medical Society**to present...***Legislative Night 2010****Tuesday, January 26, 2010****6:00 - 8:00pm****Warwick Hotel - Millennium Ballroom****1776 Grant Street, Denver**

The Arapahoe-Douglas-Elbert, Aurora-Adams and Denver Medical Societies are proud to team up and present an evening with our Denver Metro State Legislators. We hope this gathering will help to create a dialogue between legislators and physicians through the sharing of ideas that may make this a better place to live, practice medicine and provide better care to the citizens of Colorado.

Members of AACMS/ADEMS/DMS and one guest may attend at **no cost**. Valet parking is included. Reservations are required to attend this function. Email your reservation to [dms@denvermedsociety.org](mailto:dms@denvermedsociety.org) or call 303-377-1850 by January 20<sup>th</sup>.

***SPANISH IS COMING!      SPANISH IS COMING!*****Make learning or improving Spanish your 2010 New Year's resolution.**

**DMS and Rios Associates** is again offering intensive Spanish for the Medical Professions, only this time the class will cover **four days**. Included in the \$499 price for DMS members is a textbook, a corresponding set of 10 CDs and **45 CME credits through the ACEP (Emergency), AAFP (Family Practice) or AANP (Nurse Practitioners) or 43 CMEs through the AMA!**

Mark your calendars now **Friday May 21 – Monday May 24, 2010**, at the Denver Medical Society building. Registration materials will be mailed in January.

## The Debate Over Selling Insurance Across State Lines

*One of the hotly debated issues in health reform has been the value of allowing consumers to purchase insurance coverage across state lines. Kaiser Health News recently offered a short primer on the issue.*

### **Q. What currently restricts insurers from selling policies outside of their home states?**

States have primary regulatory authority over insurance. As a result, insurers are allowed to sell policies only in states where they are licensed to do business. Most insurers obtain licenses in multiple states. States have different laws regulating benefits, consumer protections and financial and solvency requirements.

### **Q. What do advocates say are the main advantages to allowing insurers to sell across state lines?**

The individual health insurance market is dominated in many states by just a handful of companies, so this provision would allow consumers to shop broadly for cheaper policies, supporters say. "You want to have greater competition in the insurance market and this does that," said Douglas Holtz-Eakin, a fellow at the Manhattan Institute and top health advisor to McCain during his presidential campaign.

Proponents say consumers may be able to buy "less expensive" policies in other states because of variations in laws and regulations. While some states may require insurers to pay for a particular treatment of autism, for example, others don't. Insurers bristle at many of these mandates, saying they drive up costs, but studies generally show their impact on rates is limited.

"This is absolutely a way to get around some of those state mandated benefit laws that are counterproductive and drive up insurance costs," said Merrill Matthews, Jr., executive director of the Council for Affordable Health Insurance, which represents companies selling individual health insurance.

### **Q. Why is there skepticism about this concept?**

"It always sounds appealing to offer more choice," said Kenneth Thorpe, an Emory University health policy expert and a Health and Human Services official in the Clinton administration. "But if you do look at it more closely, it does raise issues of regulation."

Regulation is important, critics of the proposal say. In addition to requiring coverage of certain problems and treatments, some states require insurers to sell policies to all applicants and price them uniformly within the same geographic area regardless of individuals'

health status.

If insurers can sell beyond state lines, the concern is that consumers would be attracted to the least comprehensive policies because they'd be cheapest. "You get what you pay for in these policies (and) consumers won't realize it until they are sick and it's too late," said Jerry Flanagan, health care policy analyst for Consumer Watchdog, a California consumer health group.

The states with the most comprehensive policies often mandate that coverage—for example, one state could require that insurers cover diabetic testing supplies, another might not. Critics say that—at best—selling insurance across state lines might not save much money, and point to a 2005 CBO report that says: "if only those benefit mandates imposed by the states with the lowest-cost mandates were in effect in all states, the price of individual health insurance would be reduced by about 5 percent, on average."

There are also fears that consumers dealing with out-of-state companies would have difficulties resolving disputes, since their state insurance commission would have no authority over companies not licensed in their state.

Critics say insurers selling across state lines would market policies to younger, healthier individuals. Older and sicker individuals would face ever-rising rates—or face being turned down—because their insurers would have fewer healthy people to spread risk. And, since health costs vary geographically, insurance purchased in one state might not cover as much of the cost of care in a more expensive state.

### **Q. Do the Democratic bills allow some form of insurance selling across state lines?**

Yes, but with much tighter restrictions than are favored by advocates. The House Democrats' bill would allow states to form compacts enabling consumers to buy policies from insurers licensed in any of the states governed by the agreement. A consumer's home state would retain authority to handle disputes. The National Association of Insurance Commissioners, which represents state regulators, would have primary authority to develop rules, but if it failed to do so, the job would fall to the HHS Secretary.

The Senate Finance Committee bill would enable insurers to create nationwide plans. Insurers would have to be licensed in each state where they sell these plans, but would have the authority to offer only those benefits mandated by the majority of states. Thus, benefits required by relatively few states would not have to be in the plans. States, however, could decline to make such plans available to their residents.

## Reducing Risks in Telephone Triage

The phone is a key area of responsibility for front-line staff, and it is critical for physicians to make certain that protocols for this important point of contact with patients are set, reviewed and followed. Otherwise, the practice is at risk.

While at one time it was merely a scheduling tool, phone interactions have become an integral part of practice. Phone triage is a critical tool in managing care delivery. It is frequently the first interaction with a patient and the care team, and can help determine the patient experience. Office staff picking up the phone can rank the caller's health problems according to urgency, potentially educate and advise clients, as well as making safe, effective and appropriate dispositions. All of this, however, is done without the benefit of seeing the caller who is speaking and has risks. Without proper training and management, telephone triage can result in improper diagnosis and management, as well as legal liability.

Consider the following recommendations regarding the telephone triage system in your practice to reduce potential risk:

- Outline in written protocols the questions to ask the caller, the recommended responses for minor problems, and which calls should be referred immediately to a doctor or scheduled for an office appointment.
- Recognize top priority calls and instruct the patient to dial 911 for emergency situations that involve, but are not limited to, allergic reactions, chest pain, eye injuries, burns or shortness of breath/wheezing.
- Only physicians or qualified staff such as RNs, NPs and PAs provide telephone triage.
- Document all calls and the triage decision in the medical chart, indicating the protocol used and the advice provided. As much as possible, use the caller's own words to describe the reason for the call. Many practices use specific forms - either paper forms or notes in the electronic records - to memorialize telephone calls. These forms then become part of the patient record and are available for other members of the health care team to review.
- Review all telephone triage decisions for appropriateness of actions taken.

Contributed by The Doctors Company. For more risk management tips, articles and information, please visit [www.thedoctors.com/knowledgecenter](http://www.thedoctors.com/knowledgecenter).

## Denver Medical Bulletin Centennial (Continued from page 2)

### THE DENVER POST-GRADUATE CLUB.

Meeting Friday evening, March 10, 1911, 8:15 p.m., Metropolitan building, Sixteenth and Court place.

#### Program.

#### SURGICAL INFECTIONS.

1. "Infections Occurring in Surgical Diseases and Conditions—Toxaemia, Septicaemia, Pyemia". . . . . Dr. B. H. Matthews
2. Etiology and Pathology. . . . . Dr. G. K. Olmsted

### Coming Next in the

### Solo & Chamber Music Concert Series

Rainer Auditorium at Saint Joseph Hospital

Tuesday, January 26, 2010

*Paul Primus, solo violin*

5:30 p.m. Cocktails and Hors d'oeuvres

6:15 p.m.—Concert

6:45 p.m.—Mingle with colleagues and musicians

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