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In This Issue:

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In My Opinion

Abortion and the Practice of Medicine: A Personal Perspective

Scott Sattler, M.D.

I grew up in Ohio in the 1950s and it wasn't until high school in the early 1960s that I first heard the word 'abortion.' It never appeared in newspapers or on the new invention called television. Rather it was whispered in the boys' locker room. I remember the aura of secrecy, illegality, danger and moral judgment that accompanied it. Back then teen sex was simply not a proper topic of discussion, unless of course you were a teen. Public dialogue regarding sexuality and reproduction was strictly taboo. There were no Viagra ads or tampon commercials. Actors were required to film bedroom scenes with one foot on the floor at all times. The Midwest, indeed the entire United States, was still under the yoke of the Comstock Laws.

The Comstock Laws:

To understand these laws one must go back to the time of the Civil War. Soldiers of both blue and gray were far from home and predictably horny. Photography had just been invented. For a few cents soldiers could buy photos of women posing in the nude, and buy them they did, spawning an entirely new industry.

In Connecticut a young, devoutly Christian Union soldier named Anthony Comstock, a committed Victorian moralist, was deeply offended by this practice and by the general immorality and profanity which he had observed within the army. When the war ended he created the New York Society for the Suppression of Vice and in 1873 he successfully lobbied Congress to pass a law to legislate public morality by restricting possession and distribution of all "obscene, lewd, or lascivious" material. Congress then commissioned Comstock as a special agent of the Post Office and vested him with the powers of arrest. They also provided free transportation so that he could enforce this law as he saw fit.

The Comstock Act banned all literature that contained information pertaining to human sexuality, sexually transmitted diseases, birth control and abortion. It also banned the mailing of medication or devices that could be used toward such ends. It banned the mailing of anatomy texts to medical students. Publications addressing homosexuality were forbidden under the Comstock Act until 1958. Comstock banned hundreds of books including James Joyce's Ulysses and novels by Oscar Wilde. He shut down Mae West's first starring role on Broadway. The penalty for each Comstock Act offense was six months to five years of hard labor in a penitentiary plus a fine of $100 to $2,000. Shortly before his death in 1915 Comstock bragged that he had convicted enough people to fill a 61-coach passenger train.

It is an interesting historical footnote that Comstock became a hero figure to a young lawyer named J. Edgar Hoover, who spent time with him, studied his tenacious methods of prosecution and then went on to become the director of the FBI.

Many states went on to pass similar laws that collectively became known as the Comstock Laws. For example Connecticut passed a law in 1879 prohibiting the use of any drug, medicinal article or instrument for the purpose of preventing conception. It remained illegal for anyone in Connecticut to use condoms, a diaphragm, birth control pills or an IUD until 1965 when the Supreme Court invalidated it for married couples on the grounds that it violated the "right to marital privacy". Unmarried people could not legally use contraception until 1972. To put this into my personal perspective, I graduated from high school in 1964, university in 1968 and medical school in 1973. This sexually repressive atmosphere defined the sexual social structure of my generation and that of my parents.

The Comstock Act as it relates to contraception no longer applies, but the remaining portions of the Act including those relating to abortion are still the law of the land. In fact, in 1994 Congress increased the maximum fine for a first offense from $5,000 to $250,000.

The Legalization of Abortion in the United States

There were no anti-abortion laws in the United States until Connecticut passed such legislation in 1821, but under Comstock's influence every state had passed such legislation by 1900. In some states abortion was deemed illegal under all circumstances, at all stages of pregnancy. In others, abortion was allowed in cases of rape or incest or when the mother's health was threatened by the pregnancy. There was no uniform law of the land. If a woman's home state abortion laws were more restrictive, those women who could afford to do so could seek abortion services in a more liberal state. Those women with fewer re-

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sources could not.

In June 1969 a Texas woman pregnant with her third child sought an abortion. As Texas only allowed abortion in the case of rape or incest, she attempted to obtain an illegal abortion, only to discover that the local police had shut down the clinic. She sought legal assistance and in the name of Jane Roe she sued the state of Texas as represented by the Dallas County District Attorney Henry Wade. The case of Roe v. Wade was decided by the district court in her favor (by which time the child had been born) in a decision based on the right to privacy. The state of Texas appealed to the Supreme Court and on January 22, 1973 the court voted 7-2 in favor of Roe, deeming that women have a fundamental constitutional right to abortion. All laws attempting to restrict abortion were to be subjected to a standard of "strict scrutiny" by the court. This scrutiny must weigh two competing interests: the health of the mother and the "potentiality of human life." The Court stated that whereas during the first trimester of pregnancy the risk of continued childbearing to the mother exceeded that of the abortion procedure, the decision whether or not to abort should lie solely between the mother and her physician. The state had the right to intervene in the mother's decision prior to fetal viability only if there was need to protect the health of the mother. After viability the states were allowed to regulate access to abortion, but only so long as there remained an exception that allowed abortion to preserve the health of the mother. The Court specifically rejected the fetal "right to life" argument. Again, on a personal level, the Roe v. Wade decision was handed down just a month before I started my internship.

Experiencing the Need for Abortion

A year later, in 1974, I found myself in solo private practice in a remote rural area in Northern California, facing patients with early unintended and unwanted pregnancies who were desperately seeking abortions. I had absolutely no idea how to help them. My medical education regarding abortion had been limited to the treatment of women who presented with complications of illegal abortion. It had included no teaching or discussion of the surgical technique itself. Academically I knew nothing about the procedure in terms of its relative morbidity and mortality. There was no domestic database for me to access. What data that existed had been accumulated mostly in European countries that had been doing abortions for decades, and there was no Internet to facilitate gathering this information. On a more personal level, I had never before had need to examine my own value system with regard to this issue, for prior to 1973 it had been moot. So I did the only thing I could do: I punted.

I found out-of-the-area physicians who would provide abortions for my patients. This was not an easy matter, for such physicians were few and far between. The Comstock atmosphere regarding overt professional involvement with abortion still dominated the profession. Nonetheless I sent my patients out of the area to have their needs met. The cost to them was considerable, for the procedure was expensive. Most had no insurance and for those who did, the insurance did not always cover the procedure. Most referrals required at least one overnight stay. Given the remoteness of my practice, the poverty of the population and the travel difficulties due to seasonal road conditions, it became clear that this referral system was simply not functional. Too many patients simply did not have the necessary resources or support and so went on to deliver unwanted children. I watched bright high school students drop out and become single parents. I watched other unwanted children being bounced from aunt to uncle to grandparent like a juggling act. I learned of an adolescent girl who had given birth into a toilet bowl with the subsequent drowning of the baby. The family said that the girl 'thought she was just constipated.' I saw an incredible amount of physical and emotional child abuse heaped upon these unwanted children. In time it became clear that I needed to consider providing the procedure locally.

Exploring the Medical Issues that Surround Legal Abortion

I did most of my research at the hospital medical library in Eureka. The data on the relative risk and danger of legal abortion, as compared to that of completing a pregnancy and delivering a child, surprised me. I had delivered several hundred babies during my medical training, but I had never fully realized the degree of risk that a woman accepted when she chose to bear a child. Current data (1) confirms that the incidence of death from pregnancy and childbirth is ten times greater than that from undergoing a legal abortion. The incidence of death from illegal abortion is much higher.

There was subsequent concern about abortion causing breast cancer, but the National Cancer Institute showed that this is clearly not the case. There were worries about the possibility of frequent post-abortion depression but the American Psychological Association concluded that there was no statistical increase in depression following a legal abortion. Quite the contrary, the dominant post-abortion emotion was found to be one of intense relief. The issue of abortion-induced difficulties with future pregnancies was raised and subsequent studies showed that vacuum aspiration abortions done before 13 weeks gestation carried no risk to future reproductive health. From a purely physical and mental health perspective, performing first trimester vacuum aspiration abortions was safe indeed, in fact much safer for a woman than continuing an unwanted pregnancy. As a physician how could I refuse

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WHATEVER HAPPENED TO… THE GENERAL HOSPITAL?

GEORGE INGRAHAM, M.D.

You've seen the old photos from the 1890's and early 1900's: stolid looking men and women…not many smiles in those old photos… looking at us across the century in blurred black and white, lined up in front of a dry goods store, a horse drawn wagon, or a locomotive: mustaches , plug hats and suspenders for the gents; long skirts, shirtwaists, and of course a lady never left the house without her little straw hat. They had a few churches, some hardware and grocery stores, any number of saloons and brothels, trolley cars that went along Myrtle Avenue, and out E Street to the park, and a railroad that didn't go much of anywhere there wasn't timber. If you became seriously ill and needed specialist care in a well equipped hospital, you boarded the steamer Pomona and made the overnight trip to San Francisco. If you had the money, that is. That, perhaps, is one reason so few of those folks in the old photos are smiling. No workmen's comp, no disability, no Social Security, no Medicare or Medi Cal, and…no public hospital. Get sick, get injured…or just get old: too bad.

In 1906 a number of private hospitals …converted houses… owned by physicians looked after a limited number of cases, but most Humboldt dwellers were born, got sick, and recovered or died at home; as did all but the citizens of larger cities. Lumbermen, farmers, and millworkers who suffered injuries had no proper place to be treated. Realizing that there wasn't going to be any hospital unless they built their own, a group of local labor unions formed the Union Labor Hospital Association. The Union Labor Hospital was constructed , and subscriptions were offered to workers: for an annual payment of five dollars, all necessary medical care was provided at the hospital. No State or Federal funding or other involvement. They built it with their own hands because they needed it. Weren't those old timers great? Eventually the hospital offered care to the rest of the population, and the name was changed to The General Hospital. In 1975, the General Hospital moved its operations to the former Humboldt Medical Center on Harris Street, which had been owned by the County as a hospital for the indigent. The campus and buildings were purchased by Province Healthcare of Nashville in 1997. The hospital having been the property of the Union Labor Hospital Association, the money ended up with the Association; which now had no hospital, but did have the problem of what to do with the money.

The Union Labor Hospital Association morphed into the Union Labor Hospital Foundation, which, as a part of the Humboldt Area Foundation, has invested the money and uses it to continue the mission of funding health related needs of the County. In the fifteen years of its existence, the Foundation has made grants totaling almost three million dollars to local organizations, and continues to do so. Some of these grants to clinics and organizations have been large; but some are very small, and very personal: travel money for a patient who must go away for treatment, dental care for a child with neglected teeth, perhaps a wheelchair or bedside commode, and for those with eye problems for whom the Medi-Cal program pays for the examination but no longer offers spectacles: a pair of glasses. This small grant program is called the Angel Fund, and any medical or dental practitioner can ask for a grant on behalf of a patient: the grants are small, necessarily, since the fund is limited, but the difference they make to a patient can be tremendous.

And so …that's what happened to the General Hospital. It is gone, but the money it produced continues to serve the same purpose for the same people for whom those those long dead pioneers labored to build it. The next time you find yourself looking at one of those hundred year old photographs: have a chuckle at the mustaches and the long skirts and the funny hats; but maybe you will want to send a silent "thank you" back down the years.

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Medical Societies Target Overused Cardiac Stress Tests

ANDREW D. MICHAELS, MD, MAS, FACC, FAHA

Chief, Cardiology and Director, Cardiac Catheterization Laboratory
St. Joseph Hospital, Eureka, CA

In a proactive effort to stem healthcare spending, nine medical specialty societies published their top five lists of unnecessary and overused tests in April 2012. As part of the Choosing Wisely campaign, the American College of Cardiology (ACC) identified several recommendations that can support patients and physicians in making wise choices about their care. Three of these recommendations focused on cardiac stress testing:[1]

1. Don't perform stress cardiac imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
2. Don't perform annual stress cardiac imaging as part of routine follow-up in asymptomatic patients.
3. Don't perform stress cardiac imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Overuse of Stress Testing

There is clear data that cardiac stress testing is overused in the United States. Researchers from Duke examined US practice patterns in the use of cardiac stress testing after revascularization. The authors reported that stress testing was performed within two years in 59% of patients after coronary stenting and 51% after bypass surgery.[2] Nuclear imaging was the predominant imaging method. There was substantial geographic variation in testing. Of those tested, only 11% underwent subsequent cardiac catheterization, and only 5% underwent repeat revascularization

Appropriate Use Criteria

The authors concluded that adherence to the current appropriateness use criteria (AUC) would have had a substantial reduction in stress testing. Nuclear stress testing is categorized as inappropriate in roughly 15% of studies performed.[3] Nearly 25% of these inappropriate stress tests are performed in asymptomatic patients. In a more recent study, stress testing following revascularization was more frequent among patients treated by physicians who billed for technical and/or professional fees compared with those treated by physicians who did not bill for these services.[4] The authors concluded that financial incentives may drive up more unnecessary stress testing.

Risks of Overtesting

Inappropriate stress testing leads to more testing overall. Repeat coronary angiography and revascularization exposes patients to procedural complications. Further revascularization procedures in low-risk, asymptomatic patients has not been shown to provide any clinical benefits, compared to medical therapy alone.[5]

Moreover, unnecessary nuclear stress tests expose patients to non-trivial radiation exposure. Cardiologists are responsible for 45% of the entire cumulative effective dose of 3.0 mSv (similar to the radiologic risk of 150 chest x-rays) per person per year in the US from all medical sources except radiotherapy. The average effective radiation dose for cardiac procedures include: chest x-ray (0.02 mSv), nuclear stress test (9 mSv), coronary angiogram (7 mSv), coronary stenting (15 mSv), and 64-slice CT coronary angiogram (15 mSv). Cardiologists should actively participate in efforts to reduce unnecessary exposure to radiation exposure from cardiac testing.

In summary, the practice of roboscheduling asymptomatic patients for their "annual" stress test should be squelched. Stress testing before minor, non-cardiac surgery (such as colonoscopy or basal cell excision) should not be performed. If stress testing with cardiac imaging in symptomatic, high-risk patients is indicated, using echocardiography instead of nuclear imaging should be encouraged to reduce the radiation exposure to patients. Adherence to these three ACC recommendations makes good clinical sense, and encourages smarter physician practice patterns.

References:

1. www.ChoosingWisely.org
2. Shah BR, Cowper PA, O'Brien SM, et al. Patterns of cardiac stress testing after revascularization in community practice. J Am Coll Cardiol 2010;56:1328-34.
3. Hendel RD, Cerqueira M, Douglas PS, et al. A multicenter assessment of the use of single-photon emission computed tomography myocardial perfusion imaging with appropriateness criteria. J Am Coll Cardiol 2010;55:156-62.
4. Shah BR, Cowper PA, O'Brien SM, et al. Association between physician billing and cardiac stress testing patterns following coronary revascularization. JAMA 2011;306:1993-2000.
5. Boden WE, O'Rourke RA, Teo KK, et al. Optimal medical therapy with or without PCI for stable coronary disease. N Engl J Med 2007;356:1503–16.

The Ida Emmerson Hospice House Will Serve Hospice Patients

JOHN NELSON, M.D.

Hospice of Humboldt Medical Director

For the last thirty years, Hospice of Humboldt has been helping patients die comfortably and peacefully. Most people want to die at home and a fundamental value of Hospice is to honor patient preferences and enable them to stay at home in a familiar environment, surrounded by loved ones.

I recently cared for a patient who was insistent that she stay at home and not go back to the hospital. She had young children and did not want to be separated from them. Yet, she was in excruciating pain from melanoma with brain mets. In the end we had no choice but to admit her to the hospital where she died two weeks later.

We are fortunate to have access to excellent hospital care here in Humboldt County. But one of the reasons people choose Hospice is because they are through with hospitals, diagnostics, interventions. At the end of their lives, our patients want, in the words of Dr. Michael Fratkin, "a human experience, not a medical experience."

However, when a patient has medical symptoms which cannot be managed at home we have no choice but to admit the patient to one of our local hospitals because there are no specialized end-of-life facilities on the North Coast.

Hospice cares for about 110 patients at any one time. Of these patients, there are always several who have challenging caregiver situations. For example, we recently cared for an elderly woman with dementia. She was bed bound and needed total care for all her activities of daily living. In addition, she had significant wounds. Her only caregiver was her daughter who provided loving care 24-hours a day. Eventually though, the daughter became exhausted.

Medicare Hospice regulations allow us to provide five-days of respite care at a time, but only in a facility with a registered nurse on-site 24-hours a day. In our community the local hospitals are the only facilities which meet this criterion. We placed the patient in the hospital while the daughter rested. The patient was then able to return home, where she died peacefully.

Another patient was admitted to Hospice after she was hospitalized from a stroke and had become comatose. She lived with her sister who was 102 years old. There was no one at home who could care for her and she could not afford private caregivers. Her only choice was staying in the hospital where she died some days later.

Hospice also cares for patients who reside in assisted living facilities. Hospice patients may reach a point when they need more nursing care than can be provided in assisted living facilities. A hospital is not the best place for patients such as these who need residential care, and it is certainly not the best use of our healthcare resources.

It is precisely to provide an appropriate setting to care for these types of hospice patients – those who need acute medical treatment and those who have temporary or permanent caregiver limitations – that Hospice of Humboldt decided to build an inpatient facility.

The Ida Emmerson Hospice House will be designed to honor patient's preferences, provide acute medical care, and create a home-like environment for those patients who cannot remain at home. It will have unlimited visiting hours for family visits and family members may spend the night in the patient's room.

All patients who are admitted to the Hospice House will be enrolled in Hospice. The Hospice Medicare benefit, along with Medi-Cal and private insurance, pays for all hospice services: physician and nursing services, social worker and chaplaincy services, medications, medical equipment and supplies. For patients admitted to the Hospice House because of medical needs, the Hospice benefit also pays for room and board. For residential patients, room and board will be the responsibility of the patient and family. A sliding fee scale for room and board will be based on family income, and no patient who otherwise qualifies for admission to the facility will be turned away for financial reasons.

If you would like more information about the new Hospice House and our services, I am happy to talk with you. Please give me a call at 445-8443.

TIP. Practice revenue is lost when claims are under-paid, delayed or inappropriately denied. For a summary of the timeframes to appeal by plan type, see "Know Your Rights: Timeframes to Appeal," available free to members in CMA's on-line resource library at http://www.cmanet.org/resource-library.

Preventing Opiate Withdrawal in Neonates: Another Point of View

WENDY RING, M.D.

I can relate to Emily Dalton's distress as she describes babies suffering through opiate withdrawal in the newborn nursery and her desire to bribe their mothers into using contraception. While its true that contraception prevents pregnancy and that more contraception might prevent more pregnancies in heroin addicted women, the obsessive focus on obtaining drugs above all other considerations which is the hallmark of addiction, makes it difficult for addicted women to follow through with any kind of healthcare, including birth control. Faced with many similarly challenging patients I once invented a fantasy piece of medical equipment called the "InjectaChair", a piece of office furniture with hidden ports in the seat, containing Haldol Decanoate, Depo Provera, and a few other choice parenterals, which could be delivered at the push of a button. While I would NEVER actually inject such medications without a patient's consent, the mere contemplation of such a device during moments of duress somehow helped me find my way through my own frustration to a place where I could meet the patient and come up with a better solution.

If I were setting up an InjectaChair to prevent Neonatal Abstinence Syndrome, here's what I'd put in the ports:

1) RN home visiting programs for high risk families to decrease rates of childhood sexual abuse. (Childhood sexual abuse rates in women seeking treatment for heroin addiction in the US range from 70 to 90%).

2) A systematic approach to chronic pain management in our medical community including tightening up our prescribing practices and monitoring for diversion to limit the availability of pills which are the gateway drugs for heroin.

3) Increased access to substance abuse treatment. At this point the demand far exceeds our capacity. At Mobile Medical last year our buprenorphine treatment program routinely turned away 15 patients a day.

4) A non punitive approach to opiate addiction in pregnancy. Withdrawal in pregnancy is harmful to the fetus so the standard of care is to provide opiate replacement. Until recently methadone was considered the drug of choice but more recently studies have shown that babies of mothers who received buprenorphine required shorter duration of treatment for neonatal abstinence syndrome, smaller doses of morphine, and fewer days in the hospital than babies whose moms received methadone. We have local buprenorphine programs which can offer women treatment leading to recovery and reduce the harm to their babies but if women are afraid to disclose their addiction, they miss the opportunity for treatment.

National Institute on Drug Abuse, "Exploring the role of child abuse in later drug abuse", NIDA Notes, vol. 13, No. 2(1998) available at www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html

United States of America, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, National Evaluation Data Services, "Physically and sexually abusedwomen in substance abuse treatment", NEDS Analytic Summary Series, No. 19, July 2001.

Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure Jones, et alN Engl J Med 2010; 363:2320-2331December 9, 2010

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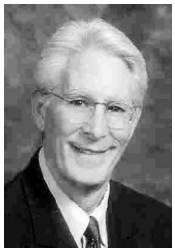
Importance of Local Hospital Governance - An Issue In Crescent City



MARK H. DAVIS, M.D.
Del Norte District Chair

Physician leaders and the medical staff of Sutter Coast Hospital have reached out to the California Medical Association (CMA) for an explanation of the potential impacts of incorporating their hospital into a regional governance structure.

Last November the local hospital board voted to preliminarily accept a "regionalization" plan through which the hospital would fully merge into the Sutter Health West Bay Region. The local hospital board would cede all governing authority over the hospital to a regional board that sits roughly 400 miles away in San Francisco and oversees approximately 14 other health care facilities, all in the Bay Area.

Physician leaders in Crescent City felt the local hospital board made this decision without adequate input from the medical staff and community stakeholders. It is also believed that the local hospital board did not fully consider the consequences of giving up responsibility to oversee the hospital and the importance of local control over governance issues that affect the medical staff, such as oversight authority on peer review, privileging and medical staff bylaws.

In response to concerns raised by the medical staff and other community leaders, the local hospital board has now halted further implementation of the regionalization plan. CMA is working with the medical staff to evaluate and understand the full impact of the proposal, including how regionalization might hinder medical staff self-governance and impair local community control over the hospital. CMA also hopes to help the medical staff find a way to maintain local control over its hospital within the framework of regionalization.

MORE INFORMATION: Contact OMSS at (800) 786-4262 or medstaffhelp@cmanet.org.

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CMA RELEASES 2012 ANNOTATED MODEL MEDICAL STAFF BYLAWS

The California Medical Association (CMA) recently released its new Model Medical Staff Bylaws. The bylaws provide important guidance and lay a strong foundation for medical staff self-governance.

This publication incorporates all updates and changes under new state and federal laws, regulations and hospital accreditation standards, including telemedicine, credentialing, peer review processes and medical staff officers.

It also includes new amendments on topics such as the role of the chief medical officer, duties of the medical executive committee, and the relationship between the medical staff and the hospital governing body.

The 2012 model bylaws are available free to any medical staff that has a current membership in CMA's Organized Medical Staff Section (OMSS).

TAKE ACTION: If your medical staff is not already an OMSS member, you can join by completing and submitting the OMSS membership application, available at www.cmanet.org/membership/for-hospital-medical-staffs/. The model bylaws are also available to non-OMSS members for $1,000. For more information visit the CMA resource library.

FOR MORE INFORMATION: Contact OMSS at (800) 786-4262 begin_of_the_skype_highlighting (800) 786-4262 end_of_the_skype_highlighting or medstaffhelp@cmanet.org.

"Perspective" Cont. From Pg 5

to provide such treatment? Certainly, based on medical and psychological grounds, I could not.

Contemplating the Spiritual Issues

And then there were the spiritual questions. For many patients and physicians this was not an issue, but for some, including me, it was. When did personhood occur? Was abortion ending the life of a person? Common sense said to me that this was clearly not the case. Raised on a farm, I'd cracked open many a chicken egg. When I found a streak of blood and a little white gelatin material attached to the yolk, I knew that it was a fertilized egg. But no one in his right mind would have called it a chicken. That would be like calling an acorn, an oak tree or a caterpillar, a butterfly. There is potential there, but that's a different matter. I listened to those who wanted to call the human embryo a person and give it all rights of personhood. They would make aborting a fertilized egg equivalent to murder of a human being. I could not understand this mental machination no matter how hard I tried. I could not sense any truth to it.

Then I decided to look into the history of the Catholic Church's position on abortion, for it was so outspoken in its anti-abortion stance that I figured it must know something that I didn't. I found a very well documented booklet entitled The History of Abortion in the Catholic Church (2) which I recommend highly. It confirmed that historically the Catholics weren't all that sure about the timing of 'becoming a human' either. Saint Augustine (354-430 C.E.) taught that hominization, or personhood, occurred at 40 days for a male embryo and at 80 days for a female. Abortion before hominization was not considered homicide. It was considered a sin primarily when it was used to hide the much more heinous sin of having intercourse for pleasure and not for the sole legitimate purpose of procreation. The Church held this view for hundreds of years. Under Irish canon law a priest could forgive an early abortion if it were performed for economic reasons, such as large family size.

Catholic theologians continued to argue over this issue for centuries. It was not until 1869 under Pope Pius IX that the Church decreed abortion at any stage to be homicide, an excommunicable sin. As there was no clear support for this position in the Bible, it was decided not by the Church's theological body, but by its legislative body. Thus it remains to this day a position that is not linked to papal infallibility. I also came to realize that even today there remains a strong minority of Catholic theologians who maintain that the current Church position on abortion is based on faulty theology. In short, I did not find any clarification of the issue from pursuing the Catholic history on the subject. And when I looked into the positions of other Christian and Jewish congregations, I found wide-ranging support for a woman's right to choose abortion.

Further introspection led me to realize that my bottom-line spiritual principal boils down to "be of love," and when I looked at this issue from that point of view, the answer became clear. If these women were family to me - sisters, aunts or daughters - how could I ever refuse to help them safely abort an unwanted pregnancy if I had the ability to provide such a service? I could not. And with this insight came the acknowledgement that we are all family, and it is our duty as physicians to treat each other as such.

So in 1976 I went to the newly formed Eureka Planned Parenthood (it had taken me a while to work this through) for help. They referred me to Sacramento Planned Parenthood who was providing first trimester vacuum aspiration abortion services. I trained with them, returned to my practice, ordered the necessary equipment and added this simple potentially life-saving procedure to my professional repertoire. I didn't advertise. I didn't do it as a moneymaker. I offered it as a simple service of compassion.

I soon realized that part of my role in doing this work was to make certain that the woman was there because she was the one who wanted the abortion, not her father, her mother or her boyfriend. We would also discuss birth control, noting that no birth control was perfect but that most were way better than nothing. If she felt guilt, I found

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"Perspective" Continued

it important to share with her that it was my sense that there wasn't such a thing as time and space where future children hang out, and that she had every right to ask any future child to go back and wait until she had her nest ready, and that she would let it know by stopping birth control. And if it got pushy and came despite the condom or the pill, she had every right to ask it to go back and wait some more, for doing so was an act of love and respect to both her own self and the child.

When Planned Parenthood of Eureka opened its abortion clinic in 1979 they asked me to help out, and I did so for many years. Then other docs came who had the desire to take on this service and by then I had kids of my own who needed my Saturdays. The Planned Parenthood staff there were among the finest people I have ever known.

Even though the Comstock Act still technically applies to abortion, times have changed. Most folks now agree that sexuality is an integral part of ongoing healthy loving relationships and is no longer restricted to procreative duty. Most agree that birth control is a needed and appropriate aspect of enjoying one's sexuality. But many seem to forget that no birth control is perfect. One in 200 women taking the pill faithfully will get pregnant every year. There is no perfect birth control except total abstention, and folks just can't do that. Sex is too much fun and too deeply ingrained into the human genetic code. So until a perfect and reversible contraceptive is made readily available, there will remain the need for abortion. And for the women whose wanted pregnancy has gone terribly wrong, there will be that need. It is my fervent wish that there will always be physicians who are willing to meet this need, despite the ignorance and intolerance of those who would restrain them and do them harm.

(1) http://www.prochoice.org/about_abortion/facts/safety_of_abortion.html#n5

(2) The History of Abortion in the Catholic Church by Jane Hurst. Catholics for a Free Choice, 1436 U Street, NW, Washington, DC 20009 §

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collectively consent in writing to such action. Such written consent or consents may be obtained through facsimile transmission (fax) or electronic mail, and shall be filed with the minutes of the proceedings of the Executive Board. An action by written consent shall have the same force and effect as a vote of the Executive Board.

SECTION 10. RECORDS. ~~Minutes of the committee meeting(s) will be forwarded to the Executive Committee for review and approval.~~ *All of the acts and proceedings of the Executive Board shall be recorded by the Secretary and kept on file at the Medical Society office. Unless otherwise provided for in these By-Laws, these minutes shall be submitted for authorization or ratification and approval by the Executive Board at its next regular meeting.*

SECTION 11. QUORUM. The presence of three (3) members of the Executive Board shall constitute a quorum. *The President shall serve as the chairperson and shall vote only when it is necessary to break a tie vote.*

ARTICLE 13
COMMITTEES: SELF-SUPPORTING

SECTION 1 A. HUMBOLDT-DEL NORTE CONSORTIUM FOR CONTINUING MEDICAL EDUCATION COMMITTEE

ByLaws, Continued on Pg 21

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WANTED - FAMILY PRACTICE PHYSICIAN Full or part time. Aviation Medical Examiner preferred. Contact George Jutila, M.D., 725-3334 or home.md@suddenlink.net *(GJ)*

CNM NEEDED. *Contact Barb 725-6108. (ja512)*

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