North Coast Physician

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Cover Photo
"HORSES ON THE BEACH 2012"
Stephen Kamelgarn, M.D.

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

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In My Opinion

The Community-Inclusive SJH Ethics Committee: Gone But Not Forgotten

Scott Sattler, M.D.

When I first came to Humboldt County in 1974 there were three hospitals operating in Eureka: The Union Labor Hospital at Harris and H, the General Hospital at 2200 Harrison and St. Joseph Hospital on Dolbeer Street. General Hospital was the county hospital serving all of Humboldt except Hoopa, which had its own small facility called Humboldt Medical Center-Hoopa which closed about 10 years later. But that's another story.

In the late 1970's the Union Labor Hospital folded into the General Hospital and in 2000 the General Hospital was purchased by St. Joseph. Google the North Coast Journal October 19, 2000 lead article for more insight into this transaction. For the past 15 years the situation has not essentially changed in structure. It is clear that this process has led to St. Joseph being the definitive community hospital of Eureka.

As the North Coast Journal (NCJ) article describes, this transition was not an easy one. There was much concern in the community about having the only Eureka hospital be one that could impose the Roman Catholic Ethical and Religious Directives on the community despite many residents' wishes to the contrary. Not surprisingly these concerns largely focused on the issues of women's reproductive autonomy and end-of-life care. As I saw it back then, one factor that made this transition to the St. Joseph Health System (SJHS) dominance more tolerable was the well-established presence of St. Joseph's community-inclusive bioethics committee.

In the 1980's and 90's many of us involved with SJH worked to establish and maintain an active, functioning central Bioethics Committee composed of health system ethicists (you may recall Sister Corrine Bayley, Barb and Johnny Cox, Jack Glaser), physicians (primary care docs, surgeons, oncologists et al.), nurses (Kelley Devlin-Lake, Jeanette Lackett, Kathleen Lutosky, Kathleen McVey and a host of others), hospital chaplains (Ken Meese, David Groe), social service staff and ethics-minded representatives (psychotherapists, other mental health workers) from the non-medical community. We met monthly over lunch at the hospital and discussed cases that had been brought to the committee's attention by staff, patients or their families.

This group worked closely with the SJHS legal staff. It was able to maintain confidentiality by carefully redacting all documents, removing identity references prior to distribution. Complex issues such as the discontinuation of artificial hydration and nutrition when these procedures served only to prolong the dying process in terminally ill patients were discussed at length. The committee also established a patient's right to demand and receive pacemaker deactivation under similar circumstances.

It developed a set of 'Intensity of Intervention' orders that were completed by the physician on admission and which established an agreed upon level of procedural intervention should cardiopulmonary arrest occur during that admission. This turned out to be a precursor of the current Physician Orders for Life Sustaining Treatment (POLST) form. Its spectrum of intervention ranged from "Full code" to "Comfort care only. Allow natural death." The committee also included a provision in this form that allowed physicians to exclude the option of attempted cardiopulmonary resuscitation if the patient's medical condition was such that this procedure was deemed futile. Issues involving reproduction in both men and women were also brought to the table and discussed in depth by the committee.

As the years went on, the Bioethics Committee created an additional episode-focused Clinical Ethics Response Team (CERT) that could respond in a timely fashion to provide support when clinical ethical challenges arose. These CERT response teams reported to the committee as a whole in follow-up.

The role of the bioethics committee was to provide input in response to clinical ethical dilemmas in a consultative mode only. It was not intended or empowered to enforce or demand compliance. And it did its work well for decades.

Unfortunately this community-integrated bioethical review committee no longer exists. At present there are multiple internal organizational review clusters at SJH that report ethical concerns to the hospital administration at various levels. But currently all ethical review is performed by those on the SJH payroll. This includes the physician members. For many years California hospitals were not allowed to employ physicians for it was felt that when physicians become employees they forfeit a significant degree of professional autonomy as they are subjected to institutional rules and regulations that persistently pressure them to practice according to mandated business patterns. When the bioethical

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review process is contained in its entirety within a sharply defined hierarchical corporate structure, unbiased review runs a significant risk of being compromised. Risk management oversight is not the same as bioethical consultation.

I find this ongoing lack of community involvement in the bioethical review process quite disconcerting. St. Joseph is a community hospital, and the community needs and deserves input into its bioethical process. However in the past few years requests by previous committee members to restore communal involvement in St. Joseph's ethical review process have been repeatedly dismissed. It is my impression that St. Joseph Hospital-Eureka and the community it serves would significantly benefit from such a restructuring of the hospital's bioethical review process.

And it has the potential to significantly bolster the current community-hospital relationship.

I feel that it is important for us as community physicians to urge St. Joseph to reinstitute this more broad-based review process. §

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with the full range of loan repayment or loan forgiveness programs open to our prospective recruits. This can be a valuable recruiting strategy.

Financing such a venture could be problematic. Therefore, I also propose that all of the practices that are currently recruiting, contribute one-half of their recruiting budget to this effort. We should also be able to get funds from the county, and possibly some grant money to finance this thing. This will not cost our medical practices more than they're already spending on recruiting, but now, with a countywide effort, we can take advantage of economies of scale, and mount a much larger effort than one single practice can currently muster. Since the only truly non-partisan agency involved is the Medical Society, it can be the one to coordinate information and the recruiting effort.

If we wish to continue to deliver good medical care to the people of Humboldt and Del Norte Counties then it's time for us to recognize the severity of this crisis. It's time to think creatively enough to arrive at a strategy that will perform better than what we've been doing for the past several years. Otherwise, we all may have to drive to Santa Rosa or Redding to receive our medical care.

Sources

1. David Quilty "Where Should I Live? 14 Important Factors When Deciding the Best Place to Live" Money Crashers: Your guide to Financial Fitness http://www.moneycrashers.com/where-should-i-live-decide-best-places/

2. The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025 June 2010 www.aamc.org

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Northcoast Crisis

Stephen Kamelgarn, MD

While I was at the Eureka Internal medicine lab the other day, I talked to a patient there who had just finished his 12 week of course of Sovaldi and ribavirin for his chronic Hepatitis C. He mentioned to me that he had been getting his monitoring labs, but he didn't have a primary care provider to look at those labs. His practitioner had gone somewhere else, and he was struggling to find a physician. He's been taking powerful drugs that require periodic monitoring, and there is really nobody to monitor his status. That's just crazy.

I was over at the Medical Society office at about the same time, and I saw that yet one more local practice is having to discharge a number of patients due to the loss of one or more of their practitioners. This makes at least three practices that have had to discharge patients in the past several months. I did a rough "back of the envelope" calculation, and arrived at the conclusion that, countywide, at least 2400 people have lost their healthcare practitioner in the past six to eight months. 2400 people who used to have a practitioner are now having to scramble to find one.

The loss of primary care practitioners from this area has gone from being alarming to becoming a true crisis. Recruiters continue to recruit cardiologists and anesthesiologists–we now have 6 full time cardiologists and 19 anesthesiologists in our small county–but no one can find a new primary care doctor. The wait times to get in to those physicians that are taking new patients are ever lengthening. People are frustrated, and I've talked to a number of people who are seriously considering relocating to other areas, just because of our diminishing healthcare resources. The crisis has reached the point to where I feel that the economic viability of our North Coast communities is being threatened. No doctors, net loss of population as people emigrate in search of better healthcare resources.

According to moneycrashers.com[1] availability of good healthcare is one of the top 14 indicators of what people look at when deciding to relocate. If we wish to improve the economic status of our community: attract new businesses; increase tourism; and have a stable productive populace; it is imperative that we find other avenues to recruit both primary care and specialist practitioners to our area. Practices have been actively recruiting for years, yet we continue to lose both primary care and, except for cardiology and anesthesiology, specialist physicians. We need to come up with something creative since what we've been doing has, obviously, not been working, as more and more primary care practices are having to discharge patients.

Medical practice in this area is up against many competing imperatives from the outside: our relatively low wages, but a high cost of living, few of the amenities of big cities, and geographic isolation, to name a few. This is a countywide problem, so we must solve it in a countywide manner. Medical practice is not a zero-sum game where a new physician going to the Open Door System is a loss for Redwood Family Practice, for example. We are all in this together.

Therefore, I propose that we all band together with representatives of County government to form a "Physician Recruiting Task Force" (or some such bland name) that would recruit for all of the practices: small practices such as Redwood Family Practice and Eureka Family Practice as well as large practices like The Open Door System and St Jo's HMS.

According to the American Association of Medical Colleges (AAMC), this country will have a 70,000 primary care physician shortage by 2025[2]. What can we do to stand out, to make sure we can have our small, isolated area grab a piece of this diminishing resource? If we have a single entity represent our entire two county area: our recreational opportunities, our arts and culture and food, all of our practice opportunities, and not be too focused on presenting one particular medical practice in a good light, we just might be able to grab a few new physicians.

In order to stand out from the crowd, we could have our "recruiter" make personal appearances at Family Medicine or General Internal Medicine Residency Programs to sell the Northcoast. Our "recruiter" should ideally be a local resident, and should have some working medical experience from practicing up here. A retired or semi-retired local physician would fit the bill.

He/she would have all the information about all the practices that wish to recruit, not just any one specific practice. Hook the residents on our area, and then let them decide which type of practice they wish to settle on: hospital affiliated, FQHC, private practice, 95-210, etc. Residents get plenty of junk mail, both electronic and snail mail, from recruiters, most of which winds up in the recycling bin. If we can have someone go the extra mile to make personal appearances and answer questions on the fly, it may help mitigate against our perceived deficiencies.

Since the amount of debt that physicians in training are accumulating is astronomical, our recruiter would come armed

"Crisis", Continued on Pg. 20

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