North Coast Physician

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"LARGE BRANCH & SURF 1"
Stephen Kamelgarn, M.D.

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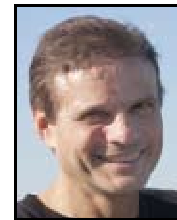
THE AGONY OF THE ERD's*
(Ethical and Religious Directives)



LEE LEER, M.D.

In January's editorial (It Is Time to Act), I discussed the unhealthiness of the Catholic Bishops' Ethical and Religious Directives (ERD's). I also implored the community to stand up and assert itself, and described how one community in Texas created a "win-win" situation by developing a "hospital-in-a-hospital." Today, I'd like to expand on this topic and again make a plea that we here on the North Coast seize the present opportunity to create a lasting, fair, and dynamic healthcare system for our region.

Some might think that the ERD's provide clear instructions, defining what affiliated institutions may or may not do. This is not the case. For example: though the ERD's permit Catholic hospitals to provide emergency contraception (EC) when a patient has been the victim of a sexual assault, a national survey found that only 28% of Catholic hospitals would actually allow this.(1) Then there are the "Catholic lite" healthcare systems – typically those in more liberal areas and with more liberal Bishops controlling them. Such systems often strike creative bargains with their secular partners.

For example, PeaceHealth, a Catholic health system in Washington State, "strongly respects the patient-physician relationship and decisions that are made jointly by physicians and patients in the best interests of those patients."(2) In practice, this means that PeaceHealth allows affiliated institutions to dispense birth control and do emergency abortions to save the life of the mother. Another Catholic system in Bremerton, Washington, Franciscan Health System, has secular partners that continue to allow women to receive post-partum tubal ligations.(2)

A larger scale example, also from Washington State, relates to the "partnership" between Swedish Health Services (a secular health system) and Providence Health & Services (a Catholic system). Their arrangement allows Swedish to continue to provide the full range of birth control services, including tubal ligations and vasectomies. Even here, though, flexibility went only so far. Swedish was not allowed to continue offering abortions. So, Swedish Health Services gave $2 million to Planned Parenthood to open a new clinic adjacent to their main Seattle hospital. Hardly an ideal solution, but one that at least maintained reproductive health services.

There are also examples from New York State. In Kingston, NY, after a merger of a Catholic and a secular institution, administrators set up a separate maternity unit that provides the full range of reproductive services, including abortion.(3)

Finally, Dignity Health, the huge Catholic system once known as "Catholic Healthcare West," voluntarily severed its ties with the Church thus freeing itself somewhat from the ERD's. Though its "Statement of Common Values" still prohibits any of its non-Catholic partner hospitals from doing abortions or in vitro fertilization, it makes no mention of any of the other 70 ERD's.(4)

One fact about Catholic hospitals: as a requirement of having hospital staff privileges, every physician must attest that they will abide by the ERD's. If a physician will not do so, he/she will not be granted privileges. A corollary to this, of course, is that a Catholic hospital unable to find physicians willing to sign on the ERD's could not provide adequate staffing to serve its mission.

Not that I'm suggesting this, mind you, but imagine what might evolve from a scenario in which the vast majority of physicians on a Catholic hospital's medical staff rose as one and rescinded their agreement to abide by certain interpretations of the ERD's? Well, in a large urban region, with more physicians than there are plumbers, the Catholic hospital could conceivably – though at great expense – simply hire an entirely new medical staff. But in a rural area?

No, I think in a rural setting, the Catholic health system would indeed be willing to sit down and negotiate with its medical staff and with the community upon which it depends for survival. I think a workable compromise could be achieved between the hospital's need to adhere to the ERD's and the physicians' and community's desire to allow women to exercise their own agency and choose healthcare that is appropriate for them.

For reasons that remain opaque to me, it has been the tradition locally for physician practices to be either totally separate from, or totally owned by, the St. Joseph Healthcare System. To my knowledge, there has not been a meaningful, long-term contractual relationship between St. Joseph's and an independent medical group that allowed the group autonomy and at the same time leveraged the potential benefits of such a relationship to both parties' advantage. And, to be fair, there probably hasn't been much need for such a relationship in the past.

But driving forces in healthcare have shifted within the past few years. We're now living in the age of Accountable Care Organizations (ACO's), and I doubt a day

"Agony", Continued on Pg. 19

"Agony", Continued From Pg. 4

goes by that St. Joseph's administration isn't trying to figure out how to take that bull by the horn. As of this writing the "Pioneer ACO's," those that were chosen as demonstration projects, are mostly proving successful. ACO's are here to stay, barring another major upheaval in public healthcare policy.

So we face a great opportunity in Humboldt County. There is tremendous outside pressure for coordination of health care resources. Across the country, hospital systems are trying to figure out how to capture outpatient dollars and how to truly coordinate care across the continuum.

Essentially, there are two options: the hospital can either own and control all physicians and providers in its market area, or it can collaborate in meaningful partnerships with independent providers. Granted I'm biased, but the latter choice seems to be the ideal one. Successful practices can continue to be successful, doing what they do best. Independent practices would be able to continue providing the full spectrum of care that women in Humboldt County expect, need, and deserve. At the same time, the benefits of IT integration, shared contracts, and shared savings could provide necessary resources for the development of true Medical Homes and the healthy population management that would follow.

It's so pleasing to imagine the existence locally of an ACO that integrates the St. Joseph System, Mad River Community Hospital, an economically distinct women's healthcare center (that offers the full scope of care free from ERD's), physicians who already are and who want to be under the St. Joseph Health System Foundation's umbrella, and independent privately owned practices. This ACO could, as a single business entity, provide superior healthcare to everyone in the county. Such an ACO could also show the nation how Catholic healthcare systems and secular providers of all stripes can work together to improve quality and access to care for the communities they serve.

Truly, our community deserves nothing less. And truly, this is entirely possible, if we work together to enlighten the thinking of those who have the power to make it so.

1. The Facts about Catholic Health Care in the United States; Catholic Health Care Update, September, 2005; Catholics for a Free Choice.
2. Catholic Hospitals Grow, and With Them, Questions of Care; Propublica, Oct. 17, 2013.
http://www.propublica.org/article/catholic-hospitals-grow-and-with-them-questions-of-care
3. Unholy Alliance; The New Republic, February 22, 2102.
http://www.newrepublic.com/article/politics/magazine/100960/catholic-church-hospital-health-care-contraception
4.http://www.dignityhealth.org/Who_We_Are/Ethics/index.htm

"Siberia", continued from Pg 6

The patient rooms had army cot style beds, little in the way of oxygen, suction, or electrical outlets. This appearance has remained unchanged since my first visit. The quality of construction, not good, has not been upgraded. Stairs do not align with the floors smoothly, and they tend to tilt in various directions. Elevators are small and do not easily accommodate gurneys and wheel chairs. Accommodation for the handicapped is almost non-existent. And the brand new roof of the not-yet occupied building leaked so badly that extensive repair of the top 6 floors was required before it could be occupied.

On the brighter side, there are dedicated ICU wards in many of the more specialized hospitals. These usually provide modern electrical beds with sufficient electrical, oxygen, and suction outlets. Similarly, the infant and new-born ICU's usually provide state-of-the-art incubators. All the same, the lack of equipment and presence of very old equipment is much in evidence. In one burn ICU, for example, I saw a modern air-support bed standing next to an army cot with gauze mesh stretched across its frame and a warm-air blower underneath to keep the patient warm.

In 2012, I was able to visit several newly completed hospitals. These did not have the traditional floor plan. The wards were more open, having larger rooms with fewer patients in them, usually two, and more space for hospital staff to attend to the patients. No cots were in sight, and all of the equipment I could see was of current design and quality. Electronic monitoring equipment was everywhere, and tracked not only the patients' conditions but also those of that of the interior environment. Security was also being monitored electronically. The new operating rooms had laminar flow and ceiling-mounted pods for equipment, and electrified doors to assist with the movement of patients. Toilets in the patient rooms were private and well-maintained.

Clinical laboratory equipment is in transition. Many automated analyzers were provided to the hospitals in the 1990's by various charitable organizations, but, with the passing of time, this equipment has become outmoded, and the reagent cartridges for the devices are no longer available. Consequently, the equipment remains on display in the labs but is unused. Gradually, this equipment is being replaced by current models, but the availability of certain tests remains limited. In one city with a population of 700,000, for example, there was only one lab able to do culture and sensitivity tests in the year 2009. This problem seems to be more common at the hospitals fully funded by the government, and less so at the clinics which have a limited amount of private practice.

One cancer hospital in Krasno-

"Siberia", continued on Pg 21

HEPATITIS C

General Information

Can Hepatitis C be prevented?

Yes. To reduce the risk of becoming infected with the Hepatitis C virus:

- Do not share needles or other equipment to inject cosmetic substances, drugs, or steroids
- Do not use personal items that may have come into contact with an infected person's blood, such as razors, nail clippers, toothbrushes, or glucose monitors
- Do not get tattoos or body piercings from an unlicensed facility or in an informal setting

Is there a vaccine for Hepatitis C?

Although there is currently no vaccine to prevent Hepatitis C, research is being conducted to develop one.

What is hepatitis?

"Hepatitis" means inflammation of the liver. The liver is a vital organ that processes nutrients, filters the blood, and fights infections. When the liver is inflamed or damaged, its function can be affected.

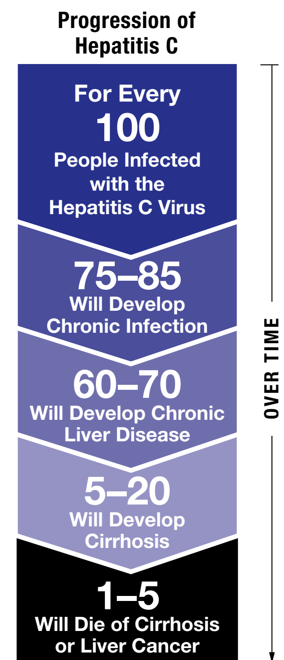
Hepatitis is most often caused by a virus. In the United States, the most common types of viral hepatitis are Hepatitis A, Hepatitis B, and Hepatitis C. Heavy alcohol use, toxins, some medications, and certain medical conditions can also cause hepatitis.

What is Hepatitis C?

Hepatitis C is a contagious liver disease that results from infection with the Hepatitis C virus. When first infected, a person can develop an "acute" infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization.

Acute Hepatitis C is a short-term illness that occurs within the first 6 months after someone is exposed to the Hepatitis C virus. For reasons that are not known, 15%–25% of people "clear" the virus without treatment. Approximately 75%–85% of people who become infected with the Hepatitis C virus develop "chronic," or lifelong, infection.

Chronic Hepatitis C is a long-term illness that occurs when the Hepatitis C virus remains in a person's body. Over time, it can lead to serious liver problems, including liver damage, cirrhosis, liver failure, or liver cancer (see chart).



How is Hepatitis C spread?

Hepatitis C is usually spread when blood from a person infected with the Hepatitis C virus enters the body of someone who is not infected. Today, most people become infected with Hepatitis C by sharing needles or other equipment to inject drugs. Before widespread screening of the blood supply began in 1992, Hepatitis C was also commonly spread through blood transfusions and organ transplants. Although uncommon, outbreaks of Hepatitis C have occurred from blood contamination in medical settings.

Can Hepatitis C be spread through sex?

Yes, although scientists do not know how frequently this occurs. Having a sexually transmitted disease or HIV, sex with multiple partners, or rough sex appears to increase a person's risk for Hepatitis C. There also appears to be an increased risk for sexual transmission of Hepatitis C among gay men who are HIV-positive.

Can a person get Hepatitis C from a tattoo or piercing?

There is little evidence that Hepatitis C is spread by getting tattoos in licensed, commercial facilities. Whenever tattoos or body piercings are given in informal settings or with non-sterile instruments, transmission of Hepatitis C and other infectious diseases is possible.

MARCH 2014

How is Hepatitis C treated?

Since acute Hepatitis C rarely causes symptoms, it often goes undiagnosed and therefore untreated. When it is diagnosed, doctors recommend rest, adequate nutrition, fluids, and antiviral medications. People with chronic Hepatitis C should be monitored regularly for signs of liver disease. Even though a person may not have symptoms or feel sick, damage to the liver can still occur. Antiviral medication can be used to treat some people with chronic Hepatitis C, although not everyone needs or can benefit from treatment. For many, treatment can be successful and results in the virus no longer being detected.

What can people with Hepatitis C do to take care of their liver?

People with chronic Hepatitis C should see a doctor regularly. They also should ask their health professional before taking any prescriptions or over-the-counter medications—including herbal supplements or vitamins—as they can potentially damage the liver. People with chronic Hepatitis C should also avoid alcohol since it can accelerate liver damage.

How common is Hepatitis C?

An estimated 3.2 million people in the United States have chronic Hepatitis C. Most are unaware of their infection. Each year, about 17,000 Americans become infected with Hepatitis C.

How serious is Hepatitis C?

Chronic Hepatitis C is a serious disease that can result in long-term health problems, including liver damage, liver failure, and liver cancer. Approximately 12,000 people die every year from Hepatitis C-related liver disease.

What are the symptoms of Hepatitis C?

Many people with Hepatitis C do not have symptoms and do not know they are infected. Even though a person has no symptoms, the virus can still be detected in the blood.

If symptoms occur with acute infection, they can appear anytime from 2 weeks to 6 months after exposure. Symptoms of chronic Hepatitis C can take up to 30 years to develop. Damage to the liver can silently occur during this time. When symptoms do appear, they often are a sign of advanced liver disease. Symptoms for both acute and chronic Hepatitis C can include fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, grey-colored stools, joint pain, and jaundice.

How is Hepatitis C diagnosed?

Doctors can diagnose Hepatitis C using specific blood tests that are not part of blood work typically done during regular physical exams. Typically, a person first gets a screening test that looks for “antibodies” to the Hepatitis C virus. Antibodies are chemicals released into the bloodstream when a person becomes infected. The antibodies remain in the bloodstream, even if the person clears the virus. If the screening test is positive for Hepatitis C antibodies, different blood tests are needed to determine whether the infection has been cleared or has become a chronic infection.

Who should get tested for Hepatitis C?

Testing for Hepatitis C is recommended for certain groups, including people who:

- Currently inject drugs
- Injected drugs in the past, even if it was just once or occurred many years ago
- Have HIV infection
- Have abnormal liver tests or liver disease
- Received donated blood or organs before 1992
- Have been exposed to blood on the job through a needlestick or injury with a sharp object
- Are on hemodialysis

For more information

Talk to your health professional, call your health department, or visit www.cdc.gov/hepatitis.

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