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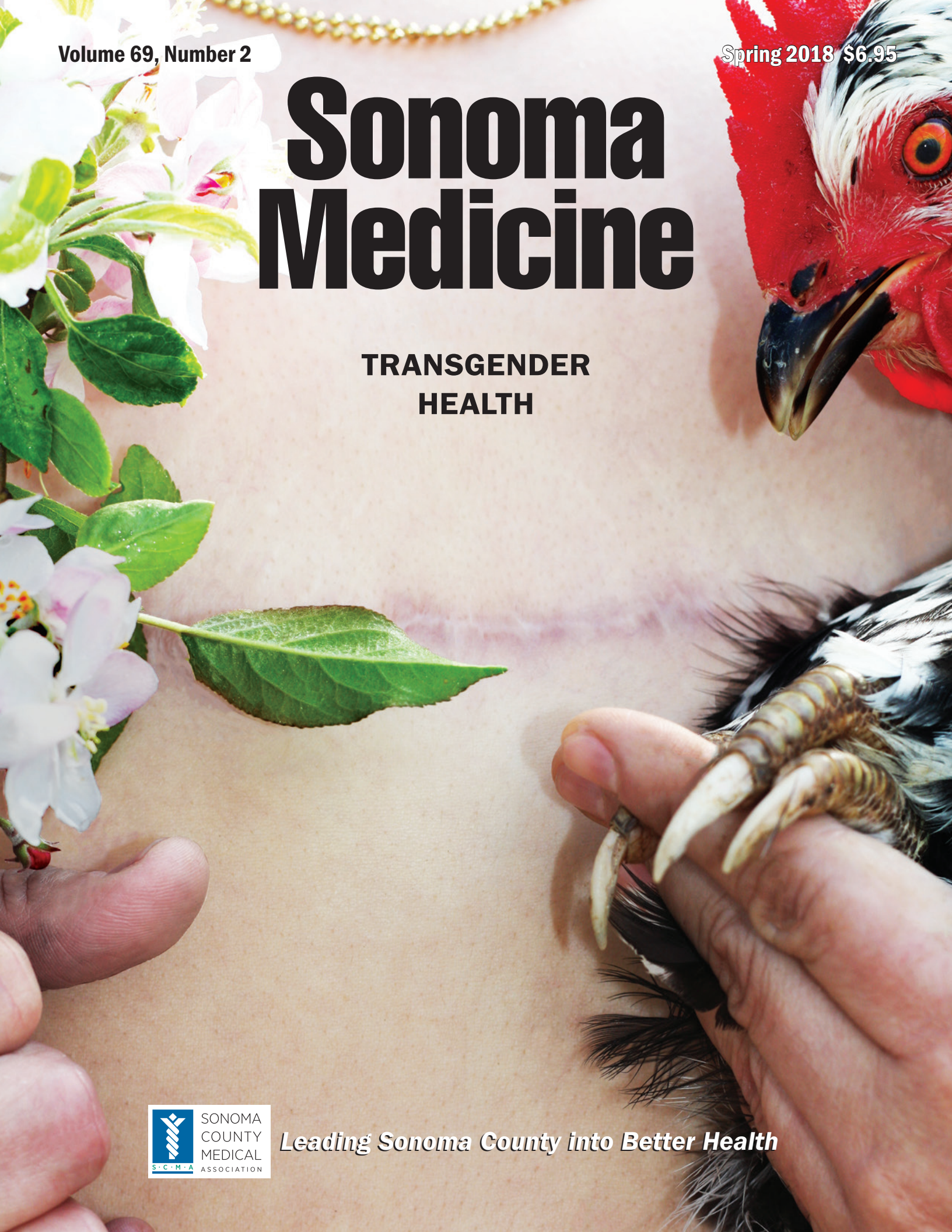
TRANSGENDER HEALTH



SONOMA COUNTY MEDICAL ASSOCIATION

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Leading Sonoma County into Better Health

Volume 69, Number 2 Spring 2018

Sonoma Medicine

The magazine of the Sonoma County Medical Association

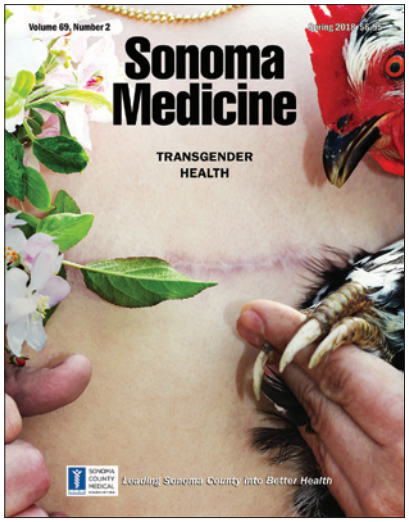
FEATURE ARTICLES

Transgender Health

Table of contents continues on page 2.

Page 25: Navigating treatment options. Illustration by Eli Sachse (detail).

Page 37: SCMA Large Group Leadership Dinner.



Cover: "Bursts and Buds." Photo by Santiago Manfrim (see more on page 28).

Sonoma Medicine

DEPARTMENTS

"Birds of Paradise"
(photography, page 28)

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Renewal, Growth, and Change

Peter Sybert, MD

As I write this letter it is springtime in Sonoma County, with clear skies, warm weather, plush grass, and flowers blooming. A time of renewal, growth, and yes, change. This will be my last letter as president of our medical association, so first and foremost, let me say: thank you! I am deeply grateful to have had your support this challenging year, and that of our wonderful staff, without whom little would be accomplished. I am also deeply grateful for a career of working professionally with an outstanding group of physicians, and having the support of members of my practice group.

"The only thing that is constant is change," is attributed to Heraclitus about 500 BCE. And so it is with us, also, 25 centuries later. Our association has grown membership strongly this year. That strengthens our voice both within our community and beyond as we represent more physicians. We have had multiple new sponsors, from both within and outside Sonoma County, supporting numerous events that many of you have attended. Our visibility within the house of medicine has increased as we have hosted the AMA president, AMA board chair-elect, two CMA presidents, the CMA's CEO and chief lobbyist, and the mayor of Santa Rosa, among others. That increased visibility, along with increased membership, allows for our collective voice and concerns to be better heard locally as well as in Sacramento, both at the CMA and the legislature.

Dr. Sybert is an anesthesiologist and outgoing president of SCMA.

The visibility also provides the opportunity to support physicians as we have in the aftermath of the firestorm. Initially a resource list was made available, and that was followed up with a well-attended and -received workshop providing information and resources to those who lost their homes. A second workshop was held just as this issue of *Sonoma Medicine* went to press, so watch for a report.

Opportunities for participation go well beyond the above. We have more outings scheduled including walks in Sonoma County and a day at the Mount Tamalpais Theater to relax, enjoy our North Bay home, and get to know each other better. Of course, we also have our Physician Appreciation event at La Crema on May 24. Mark your calendars!

You will notice that the next cycle will be somewhat different as your officers will be in position for 18 months. We are shifting so that leadership, membership, and financial tracks align with each other. This simplifies multiple functions, including financial planning. Our financial position is substantially improved this year because of the items above, and we look forward to developing reserves in line with benchmarks for societies of our size. It has been my pleasure to work on these items with SCMA Executive Director Wendy Young. Her leadership has been a key component in SCMA's repositioning.

The progress has also involved meetings of the Solo/Small Practice Forum to review common issues and concerns. In addition, as a follow-up to October's interactions, a group leadership dinner was held in March. Representatives from the large care systems and physician groups attended. A basic goal was to start to break through the "silos" we all work in to identify common interests and frameworks that increase the quality of life for our patients. It follows the initial cooperation seen in phone conferences in the days after the firestorm, when people and organizations not used to working together did so for the first time. There was broad support for a follow-on meeting in the fall.

The frameworks within which we care for our patients and community also will shift. A quick look at proposed mergers between insurers, pharmacy companies, health systems, and business coalitions reveals that the future of health care delivery will be very different. Then, of course, our state legislature is starting a new session with items that will also change our frameworks. It will be different, frustrating, and exciting. Still, in many ways it will be the same, with people working to deliver ever better health care to others in a time of need. It has been a wonderful way to live my life. ◇

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Shedding a Light on the Transgender Population

Anastasia Coutinho, MD, MHS

The last decade has highlighted evolving notions about what it means to be a man or a woman and the meanings of transgender, cisgender, gender non-conforming, queer, agender, and more. Although chromosomes may determine an individual's biological sex, XX and XY don't tell the whole story, and that narrative is finally being discussed.

Caitlin Jenner created a spotlight for transgender people, but there are approximately 1.4 million individuals throughout the United States who define themselves as transgender, with California leading as the top state. Nationally, the transgender population is now more than double that of a decade ago and is more racially and ethnically diverse than the population as a whole. Young adults are also most likely to identify as transgender, with the highest prevalence among those 18 to 24 years old.

A crucial reason to better understand the transgender population is the staggering rate of disparities, especially within physical and mental health indicators. Transgender youth appear to have two-to-threefold increases in the risk of negative mental health outcomes, including depression, suicidal ideation, and suicide attempts. Forty-one percent of transgender adults report a suicide attempt, compared to just 1.6 percent of the general population.

Dr. Coutinho, a third-year resident at Sutter Santa Rosa's Family Medicine Residency, serves on the editorial board of Sonoma Medicine.

Findings that youth of color have higher rates of transgender identification bring to light the known risks of the compounding effects of gender- and race-based discrimination. Additionally, youth in rural areas are equally as likely as their urban counterparts to identify as transgender, which highlights the issue of being transgender in an isolated environment. Despite these challenges in the United States, data from other countries, such as the Netherlands, demonstrate that when transgender youth are in a gender-affirming environment, they can become adults with an overall mental health status similar to that of the general population. Therefore, solutions do exist to bridge this gap and eliminate these disparities.

In 2013, California passed the School Success and Opportunity Act, which clarified existing anti-discrimination policies in the state education code that were not always followed. This established a precedent among states to recognize the need for equal treatment among individuals. Beyond California, news items have included the approval of transgender bathrooms in North Carolina, the prevalence of bullying directed toward transgender teenagers nationwide, and the question of transgender individuals serving in the Armed Services of the United States under the Trump administration.

The current issue of *Sonoma Medicine* provides an overview of the transgender population in Sonoma County and a hint of the exciting innovations afoot in medical care. We will learn the basics of transgender terms and definitions and hear from Dr. Toni Ramirez, a leading provider to this population. Shawn Giammattei, PhD, will teach us about child development and transgender health. Eli Sachse, RN, will describe the transgender surgical procedures available locally. And *Sonoma Medicine* Editor Tim Burkhard outlines initiatives under way at the West County Health Centers Gender Expansive Services Clinic.

All of these topics are incredibly important as the number of gender-affirming surgeries is increasing annually and more procedures are now being covered by Medicare or Medicaid than ever before.

For those who want to hear even more about these topics, head to the Sonoma County Rural Transgender Conference. Enjoy! ◇

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Gender Terminology 101: Language Is Key

Jacqueline Abdalla, MD, and Toni Ramirez, MD

Terminology on gender and identity has evolved and shifted rapidly over the years, allowing for better expression. Below are a few helpful definitions, clarifying clear differences between gender, sex, and attraction. Most importantly though, providers should both use and reflect the language their patients use.

Gender/Gender Identity *(noun)*

The internal perception/labeling of one's gender. It may or may not correspond to the person's external body or assigned sex at birth. For some, it may fit into the binary of man or woman. For others, gender identity does not fit neatly into one of those two choices (see non-binary and/or genderqueer below). Gender identity may not be visible to others.

Sex *(noun)*

A medical term used to refer to the biologic characteristics (chromosomal, hormonal, and anatomical) that are used to classify an individual as female or male or intersex. This is often assigned at birth (or with prenatal ultrasound), typically based solely on external anatomy. Biological sex is not synonymous with gender.

Gender Expression *(noun)*

The external display of one's gender, through a combination of clothing, haircut, behavior, voice, name, pronouns, and/or body characteristics. Often described as either masculine or feminine. However, remember that these are socially constructed.

Transgender *(adjective)*

An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. A transgender identity is not dependent upon physical appearance or the use of hormones or medical procedures to bring one's body into alignment with gender identity.

- **Transgender Woman/Female.** A person assigned male at birth, but whose gender identity is female. **MTF:** Male to Female.
- **Transgender Man/Male.** A person assigned female at birth, but whose gender identity is male. **FTM:** Female to Male.
- **AFAB:** Assigned Female at Birth.
- **AMAB:** Assigned Male at Birth.

Cisgender *(adjective)*

A person whose gender identity and sex assigned at birth are aligned.

Genderqueer *(adjective)*

A gender identity and/or gender expression label used by some people who do not identify with the binary of man/woman; or as an umbrella term for **gender nonconforming** or **non-binary** identities (e.g. agender, bigender, genderfluid, pangender, third gendered, other gendered, etc). Individuals may identify with one or several of these identities.

Sexual Orientation *(noun)*

Describes the sexual, romantic, and/or emotional attraction one feels for others. Often labeled based on the gender relationship between the person and the people to whom they are attracted. Important to distinguish from gender identity. Transgender people may be straight, lesbian, gay, bisexual, pansexual, or queer.

Transphobia *(noun)*

An umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) that one may have towards members of the transgender community. The term can also connote a fear, disgust, or dislike of being perceived as transgender.

Dr. Abdalla is a third-year family medicine resident at the UCSF Santa Rosa Family Medicine Residency Program.
Dr. Ramirez is a family medicine physician who works for Santa Rosa Community Health (Lombardi Health Clinic site) and leads its Transgender Clinic.

Transition *(noun)*

Personal, medical, and/or legal steps towards one's gender identity (rather than assigned sex at birth). May include: telling one's family, friends, and co-workers; using a different name and pronouns; dressing differently; changing one's name and/or sex on legal documents; hormone therapy; and one or more types of surgery.

- The exact steps involved in transition vary from person to person. There is no such definition for "complete or full transition."
- Avoid use of the term "sex change."

Gender Affirming Surgery (GAS) *(noun)*

Surgical interventions that are part of some transgender people's transition process. This can include vaginoplasty, mastectomy, phalloplasty, gonadectomy, hysterectomy, etc. Not all transgender people desire or can afford to undergo GAS. Do not refer to someone as being "pre-op" or "post-op." Gender identity is not dependent on surgery. Also known as Sex Reassignment Surgery (SRS), but GAS is more affirmative.

Gender Dysphoria *(noun)*

The psychiatric diagnosis used in the DSM-V, defined as the presence of clinically significant distress associated with someone whose assigned sex at birth does not match their gender identity. This replaced the outdated term "Gender Identity Disorder."

Gender nonconformity is not in itself a mental disorder. The necessity of a psychiatric diagnosis remains controversial, although some transgender advocates believe it is necessary in order to advocate for health insurance that covers the medically necessary treatment for transgender people.

Cross-dresser *(noun)*

Someone who enjoys putting on clothing, accessories, and/or makeup that is traditionally worn by the opposite sex. One cannot infer gender identity or sexual orientation from this activity.

Drag King *(noun)*

Someone who performs for entertainment as a male, usually utilizing stereotypic masculine demeanor. Can involve singing, dancing, acting, etc. This person may personally identify as female, transgender or neither. It is important to note that this is a performer and one cannot infer gender identity or sexuality from a performance.

Drag Queen *(noun)*

Someone who performs for entertainment as a woman, usually utilizing stereotypic feminine demeanor. Can involve singing, dancing, acting, etc. This person may personally identify as male, transgender, or neither. It is important to note that this is a performer and one cannot infer gender identity or sexuality from a performance. ◇

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West County Clinic:
A Home for Gender Expansive Individuals

Tim Burkhard

West County Gender Expansive Services Clinic staffers (from top) Brooke Vezino, MD, Erin Elo, and Jill Rees, PhD.

Celebrating their one-year anniversary last month was a triumphant moment for staffers at the West County Health Centers Gender Expansive Services Clinic in Sebastopol. It was three years earlier, in 2015, when the clinic's early backers first presented their proposal for a medical home that would meet the unique needs of gender-expansive individuals and families in the area.

Those backers are today an interdisciplinary team leading the clinic's important outreach and treatment initiatives, currently serving the needs of a patient pool of about 80 that is growing monthly. Brooke Vezino, MD, Jill Rees, PhD, and Erin Elo, teen clinic manager, recently spoke with *Sonoma Medicine* about the exciting, innovative programs at the clinic.

Background

According to definitions previously provided by the National LGBT Health Education Center, the "transgender 'umbrella' includes people who were assigned female sex at birth who now identify as men (transgender men or trans men) and people who were assigned male sex at birth who now identify as women (transgender women or trans women). It also includes people who identify as both a man and a woman, as neither, or as a gender somewhere in between these two points on the gender spectrum."

The three Sebastopol clinic leaders emphasize that today, the familiar word "transgender" no longer accurately describes this community. Instead, they prefer "gender expansive," "nonbinary," "gender queer," "gender nonconforming," and "gender nonbinary."

Sonoma County's population in 2017 stood at 485,258. With gender-expansive individuals generally understood to be about 0.5 percent of the population, this translates to over 24,000 individuals potentially in need of this specialized care in one county alone.

According to documentation provided by the team, "transgender individuals have unique health needs that require knowledgeable, sensitive, and well-trained caregivers and environments. Unfortunately, access and quality are not the norm. In a recent study, 29 percent of transgender individuals reported needing to educate their health care professionals on basic transgender health issues."

Health statistics for the gender-expansive community are sobering. About one-third of transgender people and half of transgender men have avoided seeking preventative care. About 20 percent report being refused medical care due to discrimination. Sixty-two percent have experienced depression and approximately 40 percent have attempted suicide.

It was in answer to these pressing issues that Vezino, Rees, and Elo opened the Sebastopol clinic in April 2017.

As the group's resident physician, Dr. Vezino both sees patients at the clinic and also provides regular medical training for other providers new to the field.

Mr. Burkhard writes for and edits Sonoma Medicine.

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Rees provides mental-health counseling, training, and support services. And Erin Elo oversees special programs for teenage clinic visitors and is a lead trainer at West County to help educate the entire team in gender affirmative care.

Challenging Issues

Beyond providing medical care and psychological and emotional support, the team provides assistance and referrals across a host of very challenging issues faced by gender-expansive individuals: new identification papers including Social Security Numbers and passports; job applications; tax forms, and more. Simply obtaining a driver's license under an individual's new identity can become an enormous challenge.

The Sebastopol staff helps folks in all stages of transition: some are new to the discussion; some are experienced; and some come with family members for support as their transition begins. Visitors include those in their teens and others who are seniors. Some patients come to the West County Gender Expansive Services Clinic from as far away as San Francisco, because wait times for appointments there can be up to a year.

Dr. Vezino recalls with awe and respect a Spanish-speaking woman in her sixties who saw a promotional flyer for the clinic and scheduled an appointment. She said she finally felt welcome, safe, and protected in a medical setting for the first time in her life. Like many patients the team sees, she had not sought medical care of any type for years, simply out of fear of rejection or an otherwise insensitive medical provider.

The clinic offers an open-door support session on the first Wednesday of every month at its Sebastopol office. New visitors can get answers to questions about medical care and wellness; hormone management; surgical referrals; legal navigation and documentation; education; and social and emotional support. Rees and Elo coordinate and run the sessions, and visitors with immediate medical inquiries can consult with Dr. Vezino.

Jill Rees emphasizes that activism and education are big parts of this effort. She said that when training new staff she often witnesses what team members call the "Aha! moment," the breakthrough experience when the trainee realizes that this "world" is new, very important, and that the trainee has gained specialized knowledge that will provide critical assistance to members of an emerging community long victimized by ignorance and fear.

Erin Elo stresses the importance of "cultural humility" in the team's daily work, meaning the willingness to be open and sensitive to the cultural identity being adopted by the patients they deal with every day. The team emphasizes the need to avoid the use of restrictive pronouns such as "he" and "she," as they can be acutely inappropriate in an environment that is meant to be welcoming to those undergoing transition.

Going forward, the Sebastopol team has plans to add another clinic location, likely in Guerneville. Ultimately, Vezino, Rees, Elo, and fellow staffers have one overriding goal: to shift the culture at large via activism and education to be more open and welcoming to the gender-expansive population.

"We are proud of the 'yes culture' we have established here," Dr. Vezino stressed. "We work with and are welcoming to patients of all kinds: those with insurance; those with no insurance; non-English speakers; and patients of all types and varied backgrounds. Our team works to overcome disparities in care, and, on a more basic level, simply provide a welcoming environment to those who may have been previously afraid to receive any care at all." ◇

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The Ultimate Plastic Surgery

Kristen Yee, MD

Most people think that the "plastic" in "plastic surgery" refers to the implants we use, or the resemblance some cosmetic patients have to Ken or Barbie dolls. The field of plastic surgery predates the manufacture of plastic products, however, and the origin of the word is from the Greek *plassein*—"to mold"—that gave rise to the Latin *plasticus* and the French *plastique*. In English the word plastic came into use in the 17th century, and harkened back to the original Greek, meaning "able to be molded." The material plastic was therefore named for its capacity to be molded in many forms; similarly, in plastic surgery we reshape the body. I've also heard plastic surgery referred to as psychiatry of the body, as we can change patients' outlook and self-regard through surgery. I think that gender reassignment surgery is the apotheosis of this phenomenon, in the modern day.

The Johns Hopkins Hospital, where I was educated, was the first academic institution to perform sex reassignment surgeries, starting in 1965. Researchers were initially studying and working with intersex patients, and not patients with gender dysmorphia. This led to problems with researchers assigning a sex to the patient, then operating, rather than the patient determining for themselves what they wanted to be.

Dr. Yee is a Santa Rosa-based plastic and reconstructive surgeon with additional training in craniofacial surgery.

The program was dismantled in part due to a patient who was raised as a girl, after a botched circumcision, and later committed suicide. (You might also recall the reference in the movie "The Silence of the Lambs," when Hannibal Lecter suggests to Clarice that the criminal she seeks has gender-identity issues, and may have been considered for surgery at Johns Hopkins.) As a result, for many years there were no academic programs focusing on transgender issues or medicine.

Currently there are established guidelines, based in part in greater awareness and knowledge in the intervening decades, from the World Professional Association for Transgender Health. (All guidelines below come from its *Standards of Care,* 7th Ed.). It's important to be aware of this history of gender reassignment surgery, as the imperative for psychological evaluation and other prerequisites prior to referral and surgery then becomes clear. Ideally the surgical consultation is part of an interdisciplinary health care team. But in the absence of this, the surgeon must be confident in the assessment and treatment of gender dysphoria by the referring mental health professional because these procedures are irreversible; the surgeon is not a mere technician. At this time, multiple surgical specialties are involved with gender reassignment surgery, and patients have the option of how extensive they want their physical transformation to be.

Options for male-to-female transition:

"Top surgery." Breast augmentation can be performed with implants or with fat grafting. It is recommended that these patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better aesthetic results.

Prerequisites:

1. Persistent, well-documented gender dysphoria.
2. Capacity to make a fully informed decision and to consent for treatment.
3. Age of majority.
4. Well-controlled comorbidities, if present.

"Bottom surgery" can simply be orchiectomy, or extend to vaginoplasty as well. For both of these, all of the above prerequisites apply. In addition:

- Twelve months of hormone therapy, unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones. The aim of hormone therapy prior to gonadectomy is to introduce a period of reversible testosterone suppression, before a patient undergoes irreversible surgical intervention.
- For vaginoplasty, also 12 continuous months of living in a gender role that is congruent with their gender identity. This is based on expert clinical consensus that this experience provides ample opportunity for patients to socially adjust in their

desired gender role before undergoing irreversible surgery.
- Of note, not all centers adhere to these guidelines. I once took care of a patient who had decided to have vaginoplasty in Thailand, without telling his family beforehand about his plans. On her return, her parents refused to refer to her as a female, and threw her out of the house. Her social isolation corresponded to a complicated postoperative course as well, as she had not prepared for the wound care required and could not follow up with her surgeon abroad.

Other procedures, including facial feminization surgery, Adam's apple reduction, and voice modification surgery do not require referral by mental health professionals. But these providers can play an important role in helping patients make a fully informed decision about the timing and implications of these procedures in the context of the social transition. I find that patients see these as a "finishing touch," where they can present without makeup and strangers do not assume they are male.

A well-trained plastic surgeon can perform male to female "top surgery." However, someone with specific experience should perform a vaginoplasty. For now, there are not well-established training programs in transgender surgery, so a regional or national expert should be sought. Facial feminization surgery includes work on the bones of the forehead and jaw, as well as rhinoplasty, and is best performed by a craniofacial surgeon comfortable with reconfiguring the bone in these areas. Laryngoplasty is also best performed by a specially trained laryngologist; Adam's apple reduction can be performed by a plastic or ENT surgeon.

Options for female-to-male transition:

"Top surgery." Creation of a male chest involves mastectomy and reset of the nipple-areola complex. Hormone therapy is not a prerequisite.

Prerequisites:

1. Persistent, well-documented gender dysphoria.
2. Capacity to make a fully informed decision and to consent for treatment.
3. Age of majority.
4. Well-controlled comorbidities, if present.

"Bottom surgery" can be just hysterectomy and ovariectomy, or also phalloplasty. For both of these, all of the above prerequisites apply. In addition:

- Twelve months of hormone therapy, unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones. The aim of hormone therapy prior to gonadectomy is to introduce a period of reversible estrogen suppression, before a patient undergoes irreversible surgical intervention.
- For phalloplasty, also 12 continuous months of living in a gender role that is congruent with gender identity. This is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

Other surgeries for body masculinization, including liposculpture and voice modification surgery (rarely necessary with hormone therapy), do not require referral by mental health professionals, but these providers can play an important role in helping patients make a fully informed decision about the timing and implications of these procedures in the context of the social transition.

A general surgeon can perform "top surgery" in women transitioning to men; however, the nipple-areola complex may not be preserved; a plastic surgeon can use techniques from gynecomastia and aesthetic breast surgery to create a male chest contour. For phalloplasty, a microsurgical free flap is the standard so a plastic surgeon or urologist trained in microsurgery would be the specialist of choice.

As with many other aspects of health insurance, the extent to which these procedures are covered benefits varies and is in flux. Due to social and cultural changes, however, I think we can expect to see more and more of these patients and for their care to be covered benefits. Hopefully the increased availability of these procedures will lead to fewer mental health problems in this often vulnerable population. ◇

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Transgender and Gender Expansive Youth: Understanding Treatment Options Through a Gender-Affirmative Lens

Shawn Giammattei, PhD

Gender identity development has long been understood to be a socially constructed, binary experience that follows a standard and predictable progression.[1] This is a pervasive assumption in the research on gender development and is based on the fact that for most people their sex aligns with their gender identity. However, transgender and gender-expansive (TGE) people experience a gender identity that does not align with the sex they were assigned at birth. This discrepancy can cause profound pain due to the experience of gender dysphoria (GD) as well as the discrimination, oppression, and violence they may experience when interacting with a cis-normative and often transphobic environment. The mental and physical health outcome data for TGE youths has shown significantly higher rates of suicidality, substance abuse, self-harm, depression, and anxiety than their cisgender peers. This increased burden appears to be the result of the impact of social stressors such as family rejection, bullying, violence, victimization, discrimination, and untreated gender dysphoria.[2,3] The suicidality compared to cisgender peers in particular (41 percent vs. 1.6 percent)[4] has motivated many providers and parents to take action to improve the lives and treatment of TGE children and adolescents.

Shawn Giammattei, PhD, is a clinical psychologist practicing in Santa Rosa and San Francisco.

Fortunately, over the past 15 years there has been a significant shift in how TGE youths are viewed and treated by professionals, their families, and the general public. Stories of TGE youth are in our collective awareness due to an increase in mainstream media representation, internet access to the transgender community, as well as an increase in the number of TGE youths presenting for care. Providers are increasingly embracing a gender-affirmative model (GAM) of treatment in which gender diversity is seen as a natural expression of human experience, rather than a mental illness or arrested development, and negative health outcomes are understood in the context of trauma as a result of how these youth have been treated. Despite this increased visibility and shift away from pathologizing views, there are very few studies that explore the developmental processes and health of TGE youths who are affirmed in their gender and supported in aligning their bodies and minds. The longitudinal studies needed to address this have only recently begun collecting data, but the preliminary results are promising.[5-8]

These studies, which are focused on youth who are treated with a GAM, reveal that negative health outcomes are not inevitable. Previous attempts to help a TGE child embrace the gender that matches their sex assigned at birth have been a dismal failure, perpetuating negative health consequences. In contrast, the GAM does not enforce a particular gender presentation or privilege one's assigned sex at birth; it follows the child's lead and helps them align their external representation to their internal sense of self, thus achieving authenticity. It also acknowledges that what creates this sense of authenticity is not static and may shift or change as a child matures. The support these children receive from parents and providers who are affirming helps mitigate both the societal pressures and the impact of GD so much so that the health outcomes for these youth are on par with their cisgender peers, with only slightly elevated levels of anxiety.[4]

Gender development studies of cisgender children show early attunement to cues about gender. Infants are able to discriminate male and female faces by 6 months of age and can accurately match gendered voices to faces by 12 months. Children begin to acquire knowledge of gender labels and reveal preferences for objects and people associated with their own gender by 2 years of age. From ages 3 to 5, gender is an organizing principle for preferences and behaviors, such as clothing,

toys, and playmate choices. At this age, gender guides their expectations of others' appearances and activities, as well as what is considered appropriate for one's gender. Recent studies show that socially transitioned transgender children exhibit similar patterns of gender responding in behavior, preferences, clothing choices, and stereotyping when measured as a function of gender rather than sex assigned at birth.[9] Transgender adolescents also display gender-typical responses when living in their affirmed gender.

I have theorized, in light of recent studies and after interviewing multiple TGE and cisgender people regarding their gender identity, that we humans have a mental gender map that tells us what we are supposed to look like when we look in the mirror. For cisgender people, their mental map, their body, and their physical/social mirrors match. TGE people on the other hand experience incongruence between their mental map and the physical and/or social mirror, which can create a profound anxiety. For children the mirror is social: the child is validated by the fact that their parents and the social world "see" them, thus creating a secure attachment. To not be seen in this frame is tantamount to not existing.[10] Gender identity appears to have a biological component that is not swayed by parenting; no amount of behavioral intervention has been able to change this internal sense of self, and authentic alignment appears to be key to positive health outcomes for TGE youth.[11]

As TGE children enter adolescence, if they have been able to manage the incongruence in childhood (sometimes with magical thinking), the onslaught of puberty often brings the discrepancy to the forefront, and they may experience the changes in their body as a betrayal. This change may be even more difficult for non-binary youth. When the body begins to change, social/physical mirrors (including use of the wrong pronoun/name) constantly trigger dysphoria, leading to an increase in negative behavioral and health outcomes. It is often at this point that a family and child seek help and come to the attention of providers.

The social and medical interventions for youth suggested by many of the world's leading health organizations are moving toward a GAM to address the impact of GD and subsequent minority stress. The GAM is a multidisciplinary approach that involves a team of professionals (medical, mental health, legal, educational) and family members that support a child in aligning their internal sense of gender with their external expression.[12] Parents may approach a medical or mental health provider (MHP) when they suspect that their child is not cisgender. They may have already socially transitioned their child and want to set up a gender team, or they may be confused about their child's presentation and need help knowing what action, if any, to take. In some cases parents have been trying to get their child's gender to align with their sex without success, or a child or adolescent may come out and request help. Regardless, the child and the child's family are usually referred to an MHP who is a gender specialist for evaluation and support.[13]

The gender assessment varies depending on the presenting issues, but in all cases an MHP trained in the GAM will listen to the gender narratives of the child,

while supporting the parents in understanding, processing, and navigating next steps. A gender narrative, regardless of gender identity, is an insistent and consistent expression of their gender identity that is persistent over time. A transgender child may clearly state, "I am a boy," or "I am a girl." As they get older and learn what is socially appropriate, they may start saying, "I wish I were," "I should have been born . . . ," or "I am really a . . . ." The narratives of GE youth often push against the binary and will often include statements like, "I am not a boy/girl." In most cultures, we struggle to conceptualize and name genders outside of the male/female binary; without language to describe their authentic gender identity, they are left to push against the only choices given. Many TGE children, if they have been struggling to be seen, will present with psychological difficulties such as anxiety, depression, and oppositional behavior. If the assessment reveals that the child is TGE, then interventions are explored. This usually starts with a partial or total social transition, often involving changes in hairstyles, clothing, pronouns, and names. TGE children who are allowed this level of authenticity, more often than not flourish as a result and the other clinical issues tend to disappear or become easily manageable.

When the child reaches Tanner stage II, and it is clear that entering the puberty of their assigned sex would be highly dysphoric for them, they may be started on GnRH agonists to temporarily block puberty, greatly reducing the need for surgical interventions later. Social transition and puberty suppression are also options offered to GE youth who are expressing significant distress as a result of puberty. Both social transition and puberty suppression are reversible. Throughout this process, children and parents are always made aware that if the child begins to feel more aligned with their body, they can stop or shift at any time.

Often those who oppose social transitions and puberty suppression believe that children cannot possibly know their gender at such an early age. I have heard this argument proposed for youth as old as 17. Yet, when we look at gender development for cisgender children, we see that they are clearly aware of their own and others gender by 12 to 24 months.[1] This is as true for TGE children as it is for their cisgender peers. There is only divergence with when we privilege the body over the internal sense of self. One caveat to this is when a child is on the autistic spectrum, as these children have a different relationship to gender and their bodies. Despite the higher co-occurrence of TGE with high functioning autism, one does not negate the other, but it may invite a more thorough assessment and focused treatment.

The full process of assessing and treating adolescents cannot be fully addressed in this article. But, in brief, it is not until adolescence that the options for irreversible medical interventions are discussed. If an adolescent has been living in an affirmed gender for several years and has remained insistent, consistent, and persistent in that identity, the next step is usually cross-sex hormones around ages 13 to 16 when the dysphoria begins to increase. It is also common for transmasculine adolescents to request chest surgery

if they have developed breasts, as they are the most gendering and dysphoric aspects of their body. Transfeminine adolescents who have experienced some masculinization may want treatments to ameliorate those, such as a tracheal shave. Genital surgeries are generally not approved before the age of 18, despite the necessity for some. In all cases, irreversible medical interventions are explored in depth and both parents and adolescents are fully informed about the positive and negative consequences of each intervention.[13]

Gender development is a lifelong process for TGE and cisgender people alike. TGE youth achieving authenticity and coherence between their gender identity and their physical body/gender presentation is a key to positive physical and mental health outcomes. For some, social transitions will be all that is needed. For others, medical interventions will be necessary. Regardless of what path a TGE youth takes, the help of a knowledgeable multidisciplinary team to support the child and their family is key to successful outcomes. ◇

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References

1. Martin CL, Ruble DN, "Patterns of gender development," *Annu Rev Psychol*, 61:353-381 (2010).
2. Greytak EA, Kosciw JG, Diaz EM, "Harsh realities: The experiences of transgender youth in our nation's schools," New York, NY: Gay, Lesbian and Straight Education Network (GLSEN), 978-1-934092-06-4 (2009).
3. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M, "The Report of the 2015 U.S. Transgender Survey," Washington, DC: National Center for Transgender Equality (2016).
4. Shumer D, "Health disparities facing transgender and gender nonconforming youth are not inevitable," *Pediatrics,* Feb 5, 2018.
5. Olson KR, Durwood L, DeMeules M, McLaughlin KA, "Mental health of transgender children who are supported in their identities," *Pediatrics,* 137(3):e20153223-e20153223 (2016).
6. Durwood L, McLaughlin KA, Olson KR, "Mental health and self-worth in socially transitioned transgender youth," *J Am Acad Child Adolesc Psychiatry,* 56(2):116-123 (2017).
7. Katz-Wise SL, Budge SL, Orovecz JJ, Nguyen B, Nava-Coulter B, Thomson K, "Imagining the future: Perspectives among youth and caregivers in the trans youth family study," *J Couns Psychol,* 64(1):26-40 (2017).
8. de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT, "Young adult psychological outcome after puberty suppression and gender reassignment," *Pediatrics,* 134(4):696-704 (2014).
9. Fast AA, Olson KR, "Gender development in transgender preschool children," *Child Development* (2017).
10. Wallace R, Russell H, "Attachment and shame in gender-nonconforming children and their families: Toward a theoretical framework for evaluating clinical interventions." *International Journal of Transgenderism,* 14(3):113-126 (2013).
11. Vance SR Jr, Ehrensaft D, Rosenthal SM, "Psychological and medical care of gender nonconforming youth," *Pediatrics,* 134(6):1184-1192 (2014).
12. Hidalgo MA, Ehrensaft D, Tishelman AC, et al, "The gender affirmative model: What we know and what we aim to learn," *Human Development,* 56(5):285-290 (2013).
13. Hembree WC, Cohen-Kettenis PT, Gooren L, et al, "Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline," *J Clin Endocrinol Metab,* 102(11):3869-3903 (2017).

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Surgical Treatments for Gender Affirmation in the Bay Area

Eli Sachse, RN

The journey of a transgender person is lifelong and arduous. It is also constantly evolving, especially now, in what is being called "the transgender moment." This is for a whole host of reasons, not limited to changing societal pressures and permissions, accessibility of treatment, and the constant revising of treatments as research advances and techniques improve. The result is a confusing landscape of social, pharmacological, and surgical choices for patients to navigate.

Complicating matters is the fact that these treatments have not had long-term, robust studies yet completed, due to their relative newness and historical rarity. Patients and providers are thereby working in somewhat uncharted territory, by definition. Complication rates are falling for all surgeries and pharmacological treatments are nearing some standardization, but these rapid advances make for a lively discussion among patients trying to choose procedures and providers. This involves lots of speculation, anecdotal accounts, and the reading of far-flung papers from other countries, in the relative absence of evidence-based facts for providers to draw from and thus advise their patients.

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Regarding surgical interventions, the providers with the longest experience are accordingly impacted. Some patients are choosing to be on a waiting list for three to four years in order to get a procedure from their preferred surgeon. In the Bay Area, I am tempted to generalize that there is one relative expert in each of the main surgical techniques (nearing 10 years of experience), and then a host of their students and other newcomers beginning to offer treatments with which they have less than two years' experience. The choice can be difficult for this highly at-risk population with a suicide-attempt rate of near 50 percent (some studies estimate less, some more).

"Can I wait another few years?"

"Do I choose to get it done sooner, and risk not being fully satisfied?"

But also keep in mind that in comparison with other parts of the country, the Bay Area is spoiled with an abundance of choice. Patients in other regions routinely travel hundreds of miles for these procedures.

Medical tourism to other countries for gender-affirming surgeries is falling out of fashion as more domestic providers offer these procedures, but it is still undertaken. One example of a procedure that people continue to travel to other countries for, notably Thailand, is intestinal vaginoplasty (also known as bowel vaginoplasty or colovaginoplasty). Intestinal vaginoplasty involves constructing a vagina from a section of small bowel or colon. This procedure is commonly offered to cis female patients in the U.S. with a congenital absence, malignancy, deformity or stenosis of the vagina. Intestinal vaginoplasty is preferred by some as return to sexual function is quicker, and the fact that the tissue is mucosal, thicker, and more flexible leads some people to speculate that this offers greater sexual satisfaction than other methods.

The less expensive and less complicated penile inversion vaginoplasty is more commonly offered to transgender patients in the U.S. Penile inversion vaginoplasty creates a neo-vagina with existing penile and scrotal tissue, resulting in a surgically created clitoris utilizing the glans tissue, and a sensate vaginal canal, preserving sexual sensation. The vaginal cavity must undergo lifelong dilation to stave off a natural contraction.

An intestinal vaginoplasty must also be dilated, but less frequently. An intestinal vaginoplasty can preserve sexual sensation if the glans is used to construct a neo-clitoris, but the vaginal canal is insensate.

Orchiectomy is a necessary prerequisite, sometimes done years beforehand for hormonal reasons.

A common minor complication after vaginoplasty is hypergranulation tissue forming inside the vaginal canal discovered by bleeding, possibly months after the procedure. This can be easily treated in a physician's office with silver nitrate therapy as the vaginal canal is largely still insensate at this stage.

Regarding sexual sensation and function, Colin Close's study, "Affirming Gender, Affirming Lives," shows that the majority of transgender people who have had gender-affirming surgery are

not only more satisfied sexually, but also find a stronger connection between sex and emotional intimacy.

I feel like a whole new human being sexually. I really enjoy intimacy in a way I never could as a female, and more importantly as a person who was not being fully embracing of my true identity.

—Anonymous participant

A majority of participants reported that after genital surgery they experienced increased "joy, hope, love, and safety" in their daily lives, along with decreases in "sadness, despair, anger, and fear." Interestingly, having begun hormone therapy and transitioning socially did not affect participants' answers to these questions in the way that genital surgery did.

For trans women, other procedures that affirm include breast augmentation, hip and buttock enhancing implants, or alternatively Botox for said enhancements, facial feminization, and the "tracheal shave" (reducing the laryngeal prominence) procedures. Trans patients taking estrogen generally experience some or all of the following, the extent of which depends on genetics: natural breast growth, thinning of facial and body hair, redistribution of body fat in a feminine shape, and muscle loss. The above surgical procedures then are best done after at least one year of hormone therapy, if the patient plans on continuing hormone therapy post-surgery. This is to realize the natural changes the body will make before surgery, which naturally leads to better surgical outcomes and less need for revision. Revisions, however, continue to be common, as the body continues to change for many years while receiving hormone therapy, and as surgical techniques improve and evolve and patients become interested in these improvements.

Happily, complications resulting from female breast augmentation are well understood by the average physician and other emergency professionals, and so these patients at least have one fewer barrier to treatment post-operatively, and a much greater choice of surgeons.

Affirming surgeries for men are less well-known, and thus offer considerable challenges for patients requiring emergency care post-operatively, or revisions, especially if they have traveled far to access a surgeon. One surgical option that commonly requires corrections and revisions for transmasculine patients is phalloplasty. Phalloplasty is far from being perfected, with a high complication rate, which is at this time based only on physician anecdote. Phalloplasty is the construction of a penis from tissue donated from the patient's forearm, thigh or abdomen.

Suitable nervous and venous tissue must also be harvested from the donor site, resulting in long recovery time and risk of complications at that site. The donor site is then covered with a skin graft from elsewhere on the patient's body. Months or years of physical therapy are a must to rehabilitate the arm, which is the most common donor site due to size and sensitivity. Complications from constructing an extended urethra from mucosal tissue donated from the vagina or cheek are common, including strictures, fistula or necrosis. Complications that lead to irreparable failure are not yet uncommon, and one of the collateral results is a large scar at the donor site, resembling a large trauma plus burn (because of the skin graft pattern). But the end result, barring major complications, is a sexually sensate phallus from which one can urinate.

Achieving an erect penis capable of sexual penetration for these patients involves implantation of semi-rigid or inflatable devices at a later stage. These are the same devices available for cis men with erectile dysfunction. Later complications from these devices, including eroding through the neo-phallus, especially if full sensation had not been achieved, are unfortunate possibilities. Still, many men continue to choose this procedure over the alternative, and report greatly improved sexuality, body image, and overall satisfaction, despite having to overcome complications. Some men report assigning emotional meaning to their scars as "badges of honor," and find comfort in recognizing these marks on others of their fraternity.

An accompanying scrotoplasty can be achieved with labial tissue and saline implants.

One compelling reason that patients continue to choose phalloplasty is that it is the only procedure offering a result that resembles a natal male. The current affirming alternative for men is metodioplasty, which does not achieve this. To explain metodioplasty, I must begin with

a brief synopsis of the natural changes the body makes after at least one year on testosterone therapy: permanent voice changes, male-patterned hair distribution (scalp and body: including irreversible male pattern baldness if it is in the patient's genetics), increased muscle mass, increased RBC production, and an enlarged clitoris.

The clitoris and penis being biological homologues, testosterone in an adult patient can stimulate the clitoris to grow to a total length of 2 to 4 cm with about a 1 cm diameter. The clitoral hood extends similarly, resulting in essentially a small penis including a moveable foreskin. Metodioplasty releases the penis from the rest of the labia majora it is entrapped by and severs a ligament so that it gains more forward prominence. This procedure is fairly simple and inexpensive, and has a much shorter recovery time when compared with phalloplasty. It has a fraction of the complications and a high success rate. Urologic surgeons with experience with repairing hypospadias report finding the techniques similar and thus surgeons offering metodioplasty often have this background. Patients choose metodioplasty because the result is a penis that can become erect when aroused, and if large enough and depending on body habitus, can penetrate a partner, and offers the least risk to sexual sensation.

Metodioplasty can be done alone or paired with other procedures, including those to lengthen the urethra (with the goal being able to urinate while standing), vaginectomy (commonly performed as a deep ablation of the vagina, generally after hysterectomy, resulting occlusion of the vagina it heals together, as opposed to a radical vaginectomy that is sometimes required of cis female vaginal cancer patients), and scrotoplasty.

Metodioplasty and the dizzying choice of accompanying procedures illustrates my previous point about some patients feeling overwhelmed while attempting to navigate this landscape.

Trans male patients will generally choose to pursue chest reconstruction as a first step in their surgical journey, as this step is not dependent on or affected by time taking hormones. Chest reconstruction can be achieved with several mastectomy techniques including "keyhole" techniques that spare the nipple-areolar complex, or "flap" techniques that require grafting the nipple to the new appropriate location. Complications are few but include failed nipple grafts and puckering at the incision. The latter can be corrected, but the former cannot.

Gender non-binary people will choose from these procedures, or variations of them. For example, some may choose a dramatic breast reduction, as opposed to mastectomy. Some may pursue genital surgery; some might never. An experienced provider will help guide the patient into articulating what the ideal body they envision looks like, what their sexual goals are, and what their social goals are (how they wish to be perceived by society). This is an exciting exploration that patients, providers, and society are undertaking together, in the service of people who have always been told they do not exist.

Trans people face difficulty accessing care because of social stigma; uncooperative or unwilling medical personnel; co-morbid mental health problems; lack of income; employment or insurance; lack of safe housing in which to receive post-operative care; inability to travel to surgeons; or simple ignorance of the availability or nature of treatments. One quarter of transgender people avoid medical care entirely due to fear of mistreatment and/or past mistreatment, according to the "2015 U.S. Transgender Survey Report." We have to do better. Luckily, there are many easy ways to start.

Start by following some trans celebrities on social media. Some California-grown favorites of mine are Addison Rose Vincent and Trân Xuân Thu. Start getting a passive education on trans folks' emotional take on current events.

Then take the next step: get familiar with prescribing gender-affirming medicine. The rewards are huge and the risks minimal. There are a host of educational resources, notably from UCSF and The Fenway Institute, including ongoing web seminars. The more providers who get familiar with navigating patients through this most challenging of journeys, the better access and outcomes become for this severely, historically underserved population. ◇

Email: elis@srhealth.org

Santiago Manfrim

www.santiagomanfrimphotography.com

Observation

Snakes off the Plane

Captive Audience

Through the Windows

Thrones

Room 106

Everywhere to Go

Amused

Blue Room

Of Brazilian and Palestinian descent, proud father, transman, immigrant, and freelance photographer Santiago Falcão Manfrim began practicing photography in his early teens. He currently resides in Northern California. | *Instagram: @santiagomanfrim*

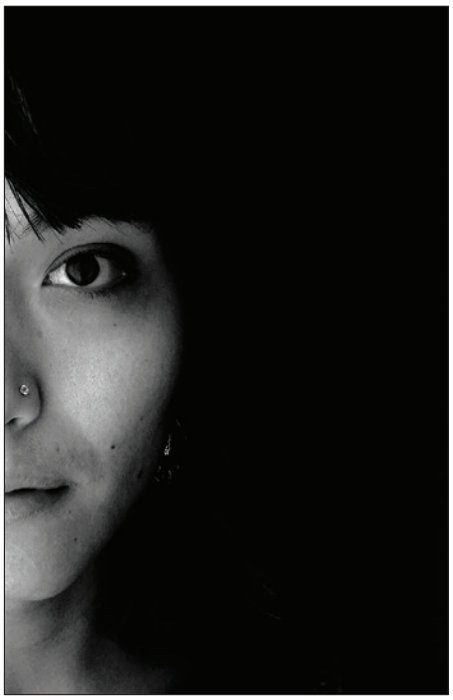
Trans Health and Media Portrayals

Kaiya Kramer

An initial Google search of "transgender media" yields results that include words such as victim, villain, scary, and genitalia. So when a transgender person, someone who identifies "across or beyond" the gender they were assigned at birth, tries to seek medical care, they wonder whether or not their medical professional or mental health professional has attached one of the above keywords to their health care assessment. In order to understand why broad generalizations about a diverse trans population are harmful, it's important to understand that "transgender" is simply an umbrella term encompassing a wide range of people.

While trans depictions in media typically focus on transgender women, the transgender community is also composed of transgender men, genderqueer identified people, gender non-conforming identified people, and many more. The trans community identifies along the gender spectrum in very diverse ways. So when the media only show a very narrow definition of what it means to be transgender, our cultural understanding of who trans people are becomes severely skewed. Only by taking a closer look at how transgender people are portrayed in the news, television shows, and cinema can we identify trans misrepresentation in the media.

Kaiya Kramer hosts the syndicated radio show, "The Queer Life." She is an activist and premedical student at UC Berkeley and Santa Rosa Junior College.



Kaiya Kramer

When Caitlyn Jenner announced to the world that she was finally coming out as transgender in 2017, Diane Sawyer and the rest of the media circled to ask this former Olympian about her public transition. "Do you plan on having 'the surgery'?," Diane Sawyer asked in a nationally televised interview. It's important to note that while Caitlyn Jenner is being given a huge platform to speak and advocate for our community, she is now under the spotlight of typical transgender representation in the media. Literally the first line of questioning for Caitlyn Jenner, a respected public figure in American culture for decades, is a question about her genitals.

Transgender people, whether or not they opt to undergo gender-affirming surgeries, are nearly always shown as either being "pre-op" or "post-op." Janet Mock, an accomplished author and career magazine editor, was asked whether she "had the operation" by television host Piers Morgan. Most transgender women in the spotlight have learned to answer the question gracefully, such as Laverne Cox, reminding Katie Couric in 2016 that focusing so much attention on transgender people's bodies further objectifies them. Choosing to fixate on transgender women's genitals only further silences the voices of the rest of the transgender community.

A look at trans representation in cinema reveals mostly transgender women, sparse few transgender men, and never gender-queer representation. In the film "Hedwig and the Angry Inch," (2001) the supposedly transgender female character is shown receiving a botched vaginoplasty, alluding to the title of the film. The transgender character is played by the writer/director who is also a cisgender man (a cisgender person is someone who identifies with the gender they were assigned at birth). Other than a further fixation on the transgender woman's genitals, the actor is literally not a transgender identified person.

When cisgender identified people (the majority of the population) act as transgender people in cinema, we perpetuate the idea that being transgender is just an act. Flash forward to 2013's "Dallas Buyer's Club," featuring actor Jared Leto portraying a trans woman in the 1980s hooked on drugs, engaged in sex work, and carrying HIV. In this case, this transgender woman is shown as someone who is on the fringes of society, as in "Hedwig" and many other films. These representations of transgender women's genitals,

connection to sex work (valid or not), use of drugs, or connection to the HIV epidemic of the 1980s, causes a cultural misunderstanding that transgender people are simply transgender women and that transgender women are solely the simplistic generalities presented.

In television, actor Jeffrey Tambor first led the charge with the award-winning show, "Transparent" (2012). The main character is an aging transgender woman named Moira, played by Tambor, who was later dismissed from the program due to sexual-harassment allegations. While his performance is considered very good by the trans community, unfortunately this is still another cisgender actor playing one of the very few prominent transgender roles in American television and cinema. This, in turn, perpetuates the idea that any cisgender person can simply research our transgender status and emulate our assumed collective behaviors.

"Transparent" indeed had a few positive trans representation notes that earned it accolades. For one, the program actually cast transgender actors in transgender supporting roles. Even rarer is the presence of transgender identified producers and writers on the show. The presence of trans actors, producers, and writers signifies a marked change in representation, from an imitation model to a self-representation model. Even the most well-intentioned and educated producers/actors/writers still fall short of accurately portraying transgender stories and identities.

I would be remiss if I didn't mention "RuPaul's Drag Race" (2009), which features drag queens competing for a cash prize and a public stage on which to launch their careers. This show is not about transgender women, but one of the most common questions a newly out trans person gets asked by cisgender identified people is, "have you seen 'RuPaul's Drag Race'?" Therein lies a subconscious association of drag queens with transgender women. This becomes problematic in terms of identifying the needs and identities of transgender populations. Drag queens are typically and historically cisgender, gay, male identified individuals. Transgender women are assigned male at birth but identify as female and range on the spectrum of sexual orientations. RuPaul has been an advocate for the LGBTQI communities for several decades before even launching his show, but while supportive of the queer community in general, he does nothing to educate his viewers about the difference between drag queens and transgender women. This became skewed further when he aired his sixth season's mini-challenge called "Female or Shemale?," which asked contestants to decide whether images of women were in fact those of cisgender women or transgender women.

First, "shemale" is considered an out-of-date term by the transgender community and is associated predominantly with trans-female pornography. Next, by tasking contestants with identifying "physical characteristics" that differentiate cisgender women and transgender women further perpetuates a culture of identifying "flaws" in transgender women. This creates the social suggestion that transgender women need to adhere closely to the standard of beauty for cisgender women (which is problematic already, regardless of gender identity).

After exploring examples of trans representation in the media above, it's now important to identify how the transgender community would like to be seen in the media. The focus should be primarily on trans identities, and secondarily, on trans bodies. By focusing on trans identities in the media and in health, we can increase awareness that transgender people do validly and medically identify as the gender "across or beyond" the gender they were assigned at birth.

It is important to validate transgender men, genderqueer, gender nonconforming, and those who reject the gender binary. Also, the use of transgender actors, producers, and writers allows a closer, more authentic look at true transgender people across all spectrums of life. Portraying transgender people in careers other than sex work, drug-dealing, and criminal behavior allows the cisgender community to see that transgender people are capable of occupying positions such as physicians, lawyers, and engineers. Allowing transgender people to appear "organically" in the media as simply another minority group, rather than as a sideshow spectacle, better allows the transgender community to become productive members of society. ◇

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Profile: Toni Marie Ramirez, MD

Transgender Physician

Tim Burkhard

Toni Marie Ramirez, MD

Dr. Toni Marie Ramirez gained her sensitivity to the suffering caused by economic and social disparities during her youth, growing up in El Paso, Texas, long listed among the nation's most poverty-stricken regions. From there it was a natural progression of sorts to her current status of one of the North Bay's leading medical experts on transgender treatment and care.

Dr. Ramirez is a family medicine specialist with Santa Rosa Community Health. She received her undergraduate degree from Brown University in 2008 and her medical degree from Brown's Alpert Medical School in 2013. She completed her residency at Sutter Health's Santa Rosa Family Medicine Residency, a UCSF affiliate, in 2016.

What initially piqued Dr. Ramirez's interest in the underserved transgender community in particular was a medical school mentor. As a pediatrician and associate professor at Alpert Medical School, Dr. Michelle Forcier is a nationally recognized expert in gender issues. It was under Dr. Forcier's tutelage that Dr. Ramirez became aware of gender dysphoria—a condition causing the patient to experience clinically significant distress related to a mismatch between gender identity and sex assigned at birth.

A second mentor solidified Dr. Ramirez's commitment during her residency, when she trained under Dr. Suegee Tamar-Mattis, DO. Dr. Tamar-Mattis is a family medicine specialist who began Santa Rosa Community Health's transgender treatment program. The program provides comprehensive primary care in addition to evidence-based hormonal management, post-operative care, and emotional support for those who identify as transgender or gender non-conforming. Tamar-Mattis's expertise and leadership in this area induced Dr. Ramirez to stay with the program, which she now runs.

Patients Educating Physicians

About 0.5 percent of the nation's population at large identifies as transgender, meaning that over 1.6 million people nationwide fall into this category. Dr. Ramirez is emphatic that the country's medical profession has not sufficiently come to grips with this reality. Hormones can be hard to obtain in many settings, forcing patients to obtain them from foreign sources, such as Mexico. Lacking physician guidance, many patients who feel ostracized turn to YouTube "how-to" videos for instructions on injecting hormones. Special networks have formed online for transgender/gender nonconforming people who feel shut out or have been made fearful by physicians unsympathetic to this community. And an alarming percentage of transgender/nonconforming patients report that they have had to educate their health care providers on the basics of transgender health issues.

In the absence of well-trained and sensitive medical care, transgender persons can become isolated and despairing. The community suffers from high incidences of depression, substance abuse, and suicide attempts. Many trans people avoid seeking basic preventative care, as well as sexual and reproductive care, due to fear of discrimination. Nineteen percent report being refused care by

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Mr. Burkhard writes for and edits Sonoma Medicine.

a physician altogether, and almost 30 percent report being verbally harassed in a health care setting.

To correct these sad realities, Dr. Ramirez's goal is to integrate transgender care into family health practices broadly. The idea is to "mainstream" transgender care, and to have programs that are not dependent on the leadership of just one or two people, so that all such initiatives achieve sustainability over the long haul.

Passion for Advocacy

Outside of the workplace Dr. Ramirez has a passion for advocacy. She is the co-founder of H-PEACE, whose name is an acronym for "Health Professionals for Equality and Community Engagement." The common conviction of H-PEACE members is that health is a human right, and that all human beings deserve to be treated with dignity and respect regardless of country of origin, immigration status, race, religion, gender identity, sexual orientation, or any other factor.

In her spare time she enjoys taking her bicycle on long rides through Sonoma County's many scenic venues. She also enjoys camping trips, and will take greater advantage of those opportunities when she eventually relocates to her hometown of El Paso, sometime in the future.

Dr. Ramirez believes that while the medical community as a whole has made great strides in understanding and dealing with transgender issues, much more needs to be done. "When you have 20 to 40 percent of a given population afraid to seek out even basic care, you are not doing enough," she says. Her message to those new to the trans health field is simple. "We will never know precisely how our trans patients feel. But simply recognizing that fact, and reminding ourselves of it, is an important first step. We in the medical field need to educate ourselves so we do not fail in our duty to make all of our patients feel safe, no matter their individual circumstances, and show respect for them at all times," she said.

"We can, and we must, do better. And I'm confident that we will," she smiles. ◇

Email: tonimarieramirez@gmail.com

The California Medical Association and the Sonoma County Medical Association

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SONOMA COUNTY MEDICAL ASSOCIATION

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AT A GLANCE: MEMBERSHIP BENEFITS IN THE SONOMA COUNTY AND CALIFORNIA MEDICAL SOCIETIES

Advocacy - Representing physicians and their patients in the Legislature, the courts, and to regulators.

Examples:

- Laws, litigation, and voter initiatives to create and preserve moderate malpractice insurance rates while ensuring proper compensation for injured patients
- Limiting the scope of practice of various practitioners based on their level of training/education
- Eliminating unfair business practices against physicians and patients
- Preserving physician authority over clinical decision making in health care settings
- Promoting good public health policy (examples: motorcycle and bicycle helmets; smoking bans; childhood immunization requirements)

Public Health & Community Health

- Promoting appropriate public health policy at the state and local level
- Working with public health agencies to combat public health threats
- Addressing public health concerns (examples: opioid abuse; end-of-life care; smoking; student health)
- Working with other state and local health care organizations to promote access to care

Promoting the Physician Community

- Bringing physicians together for networking and educational events locally and in statewide programs
- Promoting physician health and well-being through educational programs and support
- Supporting physicians-in-training

Practice Survival, Guidance, and Personal Support

- Providing direct assistance with practice management or payment recovery issues
- Providing guidance through "how-to" publications, seminars and webinars, and direct assistance
- Providing an extensive online library of guidance on medical-legal, regulatory, practice management and a host of other issues affecting the practice of medicine
- Providing group programs to address personal and professional needs (examples: Life, health and disability insurance; Workers' Compensation Insurance; HIPAA compliance programs; HR management services; medical waste management svcs.)

Opportunity to Influence Health Care Policy - Through the local and state governance processes of SCMA and the CMA, members have the ability to come together to develop well thought-out health care policy and then speak through a unified voice to policymakers and the public to make those policies a reality.

Join Your Colleagues in the SCMA/CMA – Go to www.cmanet.org/join

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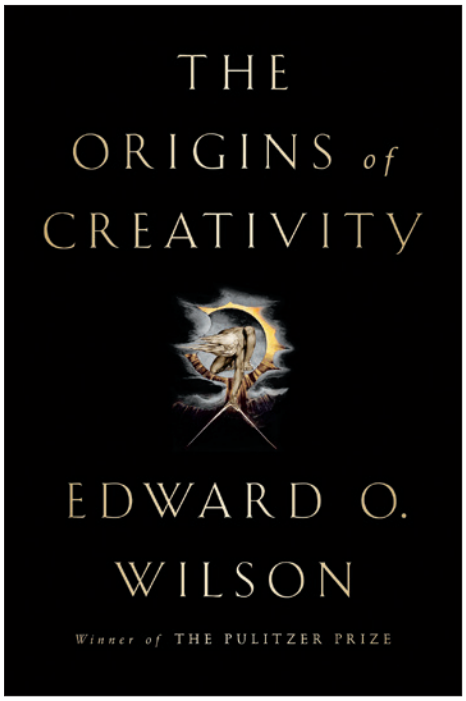
Nature Rules

Brien A. Seeley, MD

The Origins of Creativity, Edward O. Wilson, 243 pages, Liveright Publishing (2017).



Ever since majoring in biological science at UC Berkeley, I have been interested in promoting its importance to wider appreciation. No one does this better than E. O. Wilson, the foremost biological scientist of the last century, whose Pulitzer Prize-winning writings have a humanistic eloquence that articulates into popular appeal the big-picture importance of the non-fictional worlds of biology, ecology, and evolution.

Neuroscience tells us that to ponder the big picture, one must get away from focused deliberations amidst the everyday clutter and noise. With this in mind, Annie and I took a writer's retreat to a secluded rustic cabin in St. Orres, in the North Coast redwoods. This seemed the perfect place to savor the expansive themes in E.O. Wilson's new book, *The Origins of Creativity*. It seemed entirely fitting to be writing this review on Earth Day, as Wilson is ever looking out for Earth. He frames his assertions about nature with their meaning for this planet and the survival of its species. He sees Earth itself as a giant super-organism on which everything is related.

At 89 years of age, Wilson still crafts understandable explanations of complex subjects with clarity. And while the new book contains some tangential rambling, it consists primarily of entertaining personal anecdotes that remind us of our humanistic hunger for stories well told.

In *The Origins of Creativity,* Wilson defines creativity as the innate quest for originality, and claims that creativity is judged by the "magnitude of the emotional response that it creates." To me, this definition is off-base. Creativity is not a quest; rather, it is the capacity for making or conceiving something new. The human's innate drive to seek, discover, and create novelty engenders creativity. Happily, this minor point does not injure the portent of this book, for Wilson goes on to effectively clarify his meaning:

"The two great branches of learning, science and the humanities, are complementary in our pursuit of creativity. They share the same roots of innovative endeavor. The realm of science is everything possible in the universe; the realm of the humanities is everything conceivable to the human mind."

Wilson supports this assertion with a series of fascinating chapters on topics as diverse as "The Birth of the Humanities," "Aesthetic Surprise," "Irony," "Gardens," "The Hunter's Trance," "Metaphors," "Archetypes," and "Human Nature."

Later in the book, Wilson reprises many of the momentous findings from his previous works and uses them to elucidate the humanities as the valuable co-equal to science in the quest for understanding human nature. He views evolutionary group selection, which promotes altruism and cooperation, as a major contributor to the development of the traits considered most noble: generosity, bravery, self-sacrificing patriotism, justice, and wise leadership. The biological inheritance of these traits makes for heroes all around us, he says, providing a "safety net" for civilization and a reassurance that the origin of morals did not require a threat of divine retribution. Similarly, he points out that natural selection has made us innately cherish nature, open space, and wildlands, since they evoke the original homelands on which prehistoric humans subsisted.

Wilson has a penchant for listing ingredients for each of his main topics. For example, his components of the "Big Five" areas of biological science that can explain humanity are paleontology, anthropology, psychology, evolutionary biology, and neurobiology. Notably absent from that list are physics, mathematics, and chemistry. Wilson's four core ingredients of human nature are the senses, reflexes, nonverbal expression, and language. His three preconditions for the evolution of humans from chimps are nest-building,

Dr. Seeley, a Santa Rosa ophthalmologist, serves on Sonoma Medicine's *editorial board.*

group cooperation, and language. This list-making is helpful in showing the breadth and complexity of human nature and in emphasizing the prominent role of the humanities in it.

One particular topic merits special mention. Explaining how evolution and natural selection affect features of human nature, Wilson cites the "Baldwin effect." This is the increasingly important effect by which gene-culture coevolution cements new traits into human nature. It works as follows: "when a variant in a learned behavior proves advantageous and is repeated often, mutations prescribing it rather than leaving it as merely a learned option will increase in frequency, and in time the new trait will become fixed [i.e., genetic]." This interaction not only helps explain how we evolved from prehistoric times; it also informs us how future generations will evolve.

Consider, for example, that those future youth with tendencies that make them particularly gifted at computer science or use of the Internet will likely have reproductive advantages over those not so gifted. These advantages will favor an increase in that trait's frequency in future populations. Those without the trait, even though highly gifted, say, in the arts, will struggle to compete in a world that increasingly demands computer proficiency. A future that amounts to an "Age of the Geek" can be imagined, one in which we must guard against an extinction of genes that code for supreme artistic, altruistic, or athletic talents.

The steering of future ideal gene sets may "hit the wall" when it comes to genetic engineering, where parents may, in the future, choose from a menu of desirable traits they wish to have genetically implanted into their offspring. Wilson's book serves as a warning, that, like the experience with genetically modified organism (GMO) crops, we must beware of unintended consequences. The genes that make us human, even those that strain social graces, are genes that survived in us across millions of years, for exquisitely appropriate purposes. They determine not just physical size and strength, acuteness of senses, and fertility. They also profoundly affect behavior, emotional stability and intelligence of all kinds. Wilson wants to be sure that those who will decide on their future combinations in both children and in artificially intelligent humanoid robots, will be those with a healthy reverence for, and understanding of, the humanities.

Wilson's concern in this regard is expressed clearly in the following excerpt:

"The human enterprise has been to dominate Earth and everything on it, while remaining constrained by a swarm of competing nations, organized religions, and other selfish collectivities, most of whom are blind to the common good of the species and planet. The humanities alone can correct this imperfection. Being focused on aesthetics and value, they have the power to swerve the moral trajectory into a new mode of reasoning, one that embraces scientific and technical knowledge."

Not long ago, we saw budget shortfalls in our local schools result in policymakers deciding to terminate classes and programs in the arts. *The Origins of Creativity* is an illuminating, entertaining, and effective treatise on why that policy should never again be employed. I recommend this book for physicians and lay people alike. ◇

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SCMA Large Group Leadership Dinner

Features Speakers, Dialogue on State and Local Issues

Dr. Drexler outlines initiatives for the house of delegates.

The Sonoma County Medical Association hosted its first Large Group Leadership Dinner on March 29 at Santa Rosa's scenic Mayacama Golf Club. Executives and leaders from Kaiser, Sutter, St. Joseph Health, CMA, and large medical groups discussed collaboration in serving community; advocacy issues that affect large groups and hospitals; and medical and evacuation lessons learned as a result of the October 2017 firestorm.

With SCMA President Dr. Peter Sybert providing opening remarks and SCMA Executive Director Wendy Young acting as discussion leader, speakers and attendees addressed a wide range of topics of interest to Sonoma County's medical community.

CMA Speakers

Senior Vice President Janus Norman outlined in detail CMA's statewide legislative initiatives in Sacramento so far this year, along with objectives for the remainder of 2018 and beyond.

Vice President of Membership and Component Relations Mike Steenburgh discussed CMA's considerable efforts in support of Sonoma County's fire-recovery efforts, and announced yet another generous donation toward the recovery goals outlined last year by SCMA Executive Director Wendy Young.

Senior Director of Medical Group Engagement Hjalmer Danielson highlighted CMA's medical group engagement initiatives and pointed to an upcoming "state of reform" event that will further progress in this important pursuit.

SCMA Speakers

SCMA President-Elect Dr. Patricia May, whose term begins July 1, discussed board of directors' nominations, and the fact that terms of service will expand in 2019 to two years. She noted that nominations open in October 2018 for terms that will begin Jan. 1, 2019.

House of Delegates member Brad Drexler, MD, discussed the upcoming schedule for the council on legislation and encouraged a broader participation in this critical area.

Sonoma Medicine Editor Tim Burkhard made a brief pitch to encourage additional physicians to join the magazine's editorial board, stressing that *Sonoma Medicine* is the magazine of, and for, SCMA members, and additional voices can ensure that more viewpoints are represented.

Finally, Dr. Sybert and Wendy Young discussed with attendees the possibility of holding a similar event in the fall. Judging by group reaction, this appeared a likely outcome, with further discussion and feedback to follow during the summer months. ◇

OPEN CLINICAL TRIALS
IN SONOMA COUNTY

Sonoma Medicine lists open clinical trials in Sonoma County to increase awareness of local medical research and to benefit physicians who may wish to refer patients. This list includes research groups that both responded to our request for information and are conducting open trials. The clinical trials at other research groups are only open to their own patients.

Each listing includes the group's name and address, along with the phone number and email address of the appropriate contact person. As the list is subject to change, contact the individual research groups for the latest information.

If you know of other local open trials, contact SCMA at 707-525-4375 so the information can be listed in the next issue. This section is provided as a free service by *Sonoma Medicine*, and we rely upon voluntary input from the medical community in order to provide it. ■

NORTH BAY EYE ASSOCIATES

104 Lynch Creek Way #12, Petaluma
Contact: Angela Reynolds
707-769-2240
research@northbayeye.com

Glaucoma

- **Sustained-release punctal plugs**
  Criteria: OHT or OAG (no PEX or PIG), IOP ≥24 and ≤34 off meds. Stable inhaled steroids OK. Pachy >480 and <620. C/D 0.8 or less.
- **Japanese glaucoma patients**
  Criteria: OHT or OAG (no PEX or PIG). 1st gen Japanese or 2nd gen Japanese-American. OAG IOPs (off meds) ≥15mmHg and < 35mmHG. OHT IOPs (off meds) ≥22mmHG and <35mmHg. No PIs or SLT/ALT. No LASIK.
- **Sustained-release, P.F., biodegradable implant**
  Criteria: OHT or POAG (secondary glaucoma ok- PEX or PIG). IOP ≥22 and ≤32 off meds. Pachy ≥480 and ≤620. No asthma or COPD.
- **SLT or implant for NON-COMPLIANT PT'S**
  Criteria: OHT or POAG (secondary glaucoma ok- PEX or PIG). Not compliant with drops or unable to get drops in. Suitable candidate for SLT. IOP ≥22 and ≤34 off meds at washout. Pachy ≥480 and ≤620.
- **Generic Brinzolamide**
  Criteria: OHT or OAG (secondary glaucoma ok- PEX or PIG) or OHT OU, IOP (off Meds) >22 and <34, CD. < 0.8, VA 20/200 or better. Pachy <600.

Chalazion

A transdermal patch for the eyelid
Criteria: Subjects aged ≥6 years with SINGLE chalazion for ≤21 days, > 2mm from lid margin. No glaucoma, IOP ≥22mmHg or steroid responders.

Blepharitis

New treatment for blepharitis
Criteria: Subjects >1 year, Active blepharitis (eyelid redness, swelling, debris, irritation) IOP >8 and < 22 in either eye, no mod to sev dry eye, preferably no eyelid medications or steroid use w/in 14 days.

Ptosis

An eyedrop for Ptosis
Criteria: Dx of blepharotosis, VA 20/80 or better.

Dry eye

A new eyedrop for dry eye.
Criteria: Dx of moderate to severe dry eye, blurry vision caused by dry eye, no Omega 3or 6 or herbal supplements, no contact lens wear during the study.

Anterior segment uveitis

Easy treatment given using a device in the office
Criteria: Patients diagnosed with non-infectious anterior segment uveitis with AC cell count ≥11. No glaucoma gtts/treatment or IOP ≥25.

Bacterial conjunctivitis

- Criteria: Suspect bacterial conjunctivitis w/discharge and conjunctival injection. Symptoms <4 days. No topical ophthalmic medications or ATs w/in 2 hours. NO topical ophthalmic antimicrobial or anti-inflammatory agents w/in 48 hours.
- Criteria: Subjects of ANY age. Suspect bacterial conjunctivitis w/discharge and injection. Symptoms ≤ 3 days. No antibiotics (topical or systemic) within ≤ 7 days. No topical oph. products (ANY) w/in 2 hours of Visit 1.

Adenoviral conjunctivitis

Only potential treatment for viral conjunctivitis
Criteria: Subjects of ANY age. Suspect adenoviral conjunctivitis w/watery discharge and injection. Signs/symptoms ≤ 3 days. No antivirals or antibiotics w/in ≤ 7 days; topical NSAIDs w/in ≤ 1 day; Top/systemic steroids w/in ≤14 days.

REDWOOD DERMATOLOGY RESEARCH

2725 Mendocino Ave., Santa Rosa
Contact: Liza Marie, RN
707-755-3946
liza.marie@ncmahealth.com

Molluscum contagiosum (pediatric to adult). VP-102 topical film-forming solution for subjects 2 years old and older with molluscum contagiosum.

Psoriasis (adult). Handheld Luma light therapy system for adults 18 years and over with mild to severe psoriasis.

Psoriasis vulgaris (adult). Calcipotriene/betamethasone dipropionate, weight/weight 0.005%/0.064% cream for adults 18 years and over with mild to moderate psoriasis vulgaris.

NORTH BAY NEUROSCIENCE

7064 Corline Ct, Suite B-1, Sebastopol
Contact: Anna Aaronson
707-827-3593, Fax 707-861-9465
anna.aaronson@northbayneuro.org

Alzheimer's disease

- Crenezumab for prodromal to mild AD.
- Efficacy and safety of CNP520 in participants at risk for the onset of clinical symptoms of AD.
- Effect of LY3202626 on mild Alzheimer's disease.
- Aducanumab in the treatment of mild Alzheimer's disease.
- Gantenerumab in patients with prodromal to mild AD.

ST. JOSEPH HERITAGE HEALTH

3555 Round Barn Circle, Santa Rosa
Contact: Kim Young
707-521-3814
kimberly.young@stjoe.org

Bladder cancer

- Chemotherapy versus combination checkpoint inhibitor therapy in metastatic bladder cancer.
- Durvalumab in locally-advanced and metastatic bladder cancer.

Breast cancer

- Post-operative adjuvant NeuVax vaccine and Herceptin in patients with high-risk HER2**+** tumors.
- Post-operative adjuvant NeuVax vaccine and Herceptin in patients with high-risk HER2**–** tumors.
- BriaVax vaccine for patients with metastatic breast cancer.
- Fulvestrant with or without venetoclax in metastatic disease after progression on a CDK4/6 inhibitor.
- Post-operative study of genetic risk factors in lymphedema (UCSF).

Colon cancer

- Chemotherapy with or without a stem cell inhibitor for patients with metastatic colon cancer.

Endometrial cancer

- Sodium cridanimod and progestins in metastatic or recurrent endometrial cancer.

Head and neck cancer

- Chemo/radiation with or without pembrolizumab for locally advanced head and neck cancer.
- Pembrolizumab with or without epacadostat versus chemotherapy in recurrent head and neck cancer.

Kidney cancer

- Cabozantinib with or without a glutaminase inhibitor in relapsed renal cell carcinoma.

Lung cancer

- Pre-operative chemotherapy with or without pembrolizumab for resectable stage IIB/IIIA disease.
- Post-operative adjuvant chemotherapy plus a third-generation tyrosine kinase inhibitor.
- Pembrolizumab and hyaluronidase in patients with metastatic tumors expressing hyaluronan.
- ErbB3 receptor blockade in patients with heregulin-expressing metastatic lung cancer.
- Maintenance therapy with rovalpituzumab following chemotherapy for small cell lung cancer.
- A Notch receptor inhibitor (rovalpituzumab) versus chemotherapy in recurrent small cell lung cancer.
- Biomarker study of concordance between non-invasive and tissue testing for EGFR T790M mutation.
- Pembrolizumab with or without interleukin-10 in first line metastatic disease with high PDL1 expression.
- Nivolumab with or without interleukin-10 in second line metastatic disease with low PDL1 expression.
- Osimertinib with or without a CDK4/6 inhibitor in metastatic lung cancer containing an EGFR mutation.
- Chemotherapy with or without pembrolizumab in EGFR-mutated, TKI-resistant lung cancer.

Lymphoma

- A novel PI3K inhibitor in patients with relapsed follicular, marginal zone or mantle cell lymphoma.
- An anti-PD-1 combined with an anti-LAG3 antibody in relapsed diffuse large B-cell lymphoma.

Multiple myeloma

- Pomalidomide/dexamethasone versus ixazomib/dexamethasone for relapsed/refractory myeloma.

Myelodysplasia

- Roxadustat for patients with transfusion-requiring low grade myelodysplasia.

Ovarian cancer

- Niraparib maintenance following chemotherapy for patients with platinum-sensitive ovarian cancer.

Pancreatic cancer

- Chemotherapy with or without hyaluronidase in patients with metastatic tumors expressing hyaluronan.

Prostate cancer

- Androgen deprivation with or without enzalutamide in metastatic hormone-sensitive prostate cancer.
- Rucaparib in patients with HRD-positive metastatic castration-resistant prostate cancer.

Skin cancer

- Pembrolizumab for recurrent squamous cell carcinoma of the skin.
- Epicadostat/nivolumab with ipilumumab or lirilumab in first line for metastatic melanoma.

Solid tumors

- Fruquintinib for recurrence in multiple solid tumor types.
- An anti-PD-1 combined with an anti-LAG3 antibody in refractory solid tumors.

Stomach cancer

- Maintenance therapy with a PARP inhibitor after chemotherapy for unresectable/metastatic disease.

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392 Tesconi Ct., Santa Rosa
Contact: Leny Engman
707-623-9803, Ext 118
leny.engman@summitpainalliance.com

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Meet SCMA's Business & Supporting Partners

SCMA's **BUSINESS PARTNER PROGRAM** adds a valuable new benefit for SCMA members. The program is dedicated to offering products and services designed to support the business and personal needs of practicing physicians. Physicians benefit from discounts and referrals to quality services, and partners benefit from ongoing visibility with the medical community. Endorsed Partner and Partner levels are available to qualified companies.

The **SUPPORTING PARTNER PROGRAM** offers local businesses an opportunity to affiliate with SCMA. Our supporting partners are recognized as advocates of the medical profession and the contributions made by physicians to the well-being of our community.

Current partners are listed below. The programs are open continuously for new annual memberships beginning at the date of approval. For more details and program applications, contact SCMA today: Susan Gumucio at **707-525-0102** or susan@scma.org. Application and details are also available at **www.scma.org.**

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BENEFIT: Exchange Bank has designed special checking benefits and discounted residential and auto loans exclusively for SCMA members. Our staff is available to review these programs and benefits with you—contact our Customer Care Center at 707-524-3000 or visit a local branch. Please indicate you are an SCMA member when you call; have your membership ID number available. **www.exchangebank.com**

In addition, Exchange Bank has developed five Community Rebuild Loan Programs that offer flexible lending options to those who experienced a direct property loss during the North Bay fires. Our local, experienced lending consultants are available to discuss which program works best for your needs. Contact us at **communityrebuild@exchangebank.com** *or call Dennis Harter, VP, Rebuild Loan Programs Coordinator at* ***707-541-1482.***

BUSINESS PARTNERS

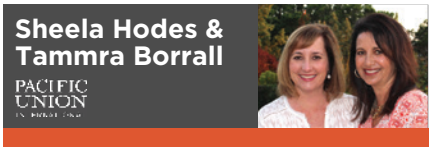
Real Estate Services

Sudha Schlesinger/Pacific Union: Since moving to Sonoma County with my physician husband in 2007, I have been actively representing physician families in the local housing market. My savvy and experienced team at Pacific Union repeatedly exceeds expectations with customized marketing and purchase strategies; efficient execution; tough negotiating skills; and state-of-the-art marketing tools.

Sellers receive consultations for home/landscape staging and buyers enjoy tours of housing, inventory and analysis of neighborhood, amenities and schools available.

BENEFIT: SCMA buyers receive an exclusive $1,000 voucher toward closing fees. SCMA sellers also receive a free Pest Inspection, $1,000 toward staging costs, and if selling lot only—a complimentary estimate of value. Please let me know how we can help you in this challenging post-firestorm market. **707-889-7778** or **sudha@sschlesinger.com. | www.winecountryluxuryhomes.com**

BUSINESS PARTNERS, cont.



Real Estate Services

Sheela Hodes & Tammra Borrall/Pacific Union: Business partners since 2007, we have consistently ranked in the top 1% of realtors in the county. Our priority remains quality over quantity; we have built a team of professionals who provide personalized service focused on individual clients. Over the past 11 years we have served the medical community in Sonoma County, helping more than 50 local physician families buy and sell property—and build connections in the community.

BENEFIT: SCMA buyers package: Professional services including home design consultation and comprehensive 1-year home warranty (up to $1,000 value). SCMA sellers package: Professional services to prepare home for sale, including staging, landscaping and trade consultations/services (up to $1,500 value).

Contact us at 707-547-3838 or Team@SonomaWineCountryHomes.com.

SUPPORTING PARTNERS

AUDIOLOGY ASSOCIATES

Bringing improved hearing and better communication to our patients' lives is our passion. As an elite AudigyCertified™ provider, the experts at **Audiology Associates** dispense personalized and individualized hearing health care using patient-friendly, advanced technologies available under the AGX brand name. A comprehensive Better Hearing program is available for all auditory patients. We also provide solutions, ongoing care and management programs for balance and tinnitus problems. **www.audiologyassociates-sr.com.**

CONTACT: Peter Marincovich, PhD, CCC-A • **707-523-4740** • **pmarincovich@audiologyassociates-sr.com**

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Add your company to this exclusive list of organizations that support the professional and personal well-being of Sonoma County physicians. Contact SCMA today: Susan Gumucio at **707-525-0102** or **susan@scma.org.**

In Memoriam

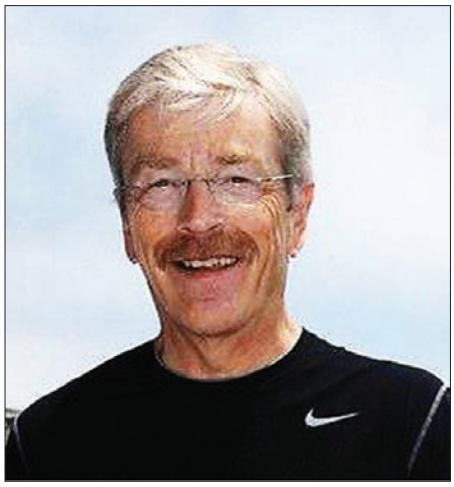
DAVID STAPLES, MD

37-Year Member of SCMA

Longtime Santa Rosa gastroenterologist **Dr. David Staples** passed away in April after a brief illness. Born in Maine in 1944, Dr. Staples dedicated himself to creating a life of meaning and opportunity. He graduated from the University of Maine in 1966 and the University Of Vermont College of Medicine in 1970. He served as a physician in the U.S. Army from 1970 to 1979 and received his medical training at Walter Reed Army Medical Center, Washington, D.C., and Letterman Army Medical Center, San Francisco.

In 1979 Dr. Staples moved to Santa Rosa to begin private practice, where he served patients for 30 years. "I loved the challenge of medicine and was fully committed to being the best physician I could be," he said.

In retirement Dr. Staples became an avid cyclist and fly-fisherman and loved sharing these activities friends. David loved his life and will be remembered by all who knew him for his compassion,



helpfulness, and humor. He is survived by his wife, Charlene, and several children and grandchildren. A celebration of his life will be held at 4 p.m., Saturday, May 19 at Kenwood Ranch, 9250 Sonoma Highway, Kenwood, Calif., 95452.

This article is reprinted from the Press Democrat.

WELCOME NEW SCMA MEMBERS!

Alexis Alexandridis, MD, Surgery, 246 Perkins St., Sonoma, New York Med Coll 2006

James O'Dorisio, MD, Thoracic Surgery, 76 Brookwood Ave., Santa Rosa, Univ Colorado 1982

Summit Pain Alliance

Eric Lee, MD, Physical Medicine & Rehabilitation*, Pain Medicine*, 392 Tesconi Ct., Santa Rosa, Boston Univ 2008

The Permanente Medical Group (TPMG)
3900 Lakeville Hwy., Petaluma

Ellie Rogers, DO, Family Medicine*, Touro Univ 2007

*board certified

PHYSICIANS' BULLETIN BOARD

IN THE NEWS

- Sonoma's **Dr. Clinton Lane is retiring and moving to Thailand.** After 40 years of selfless dedication to his primary care patients, Dr. Lane is closing his practice. His son and granddaughter have been living in Thailand, where Dr. Lane enjoyed his visits enough to decide to spend half his retirement time there.

  Dr. Lane grew up in Marin County, was an undergrad at Stanford, and earned his medical degree at UC San Francisco. His first position in Sonoma Valley was at the Sonoma Development Center. In addition to his private practice, Dr. Lane was also the medical director of Valley of the Moon Hospice in its early years and continued on to serve on the board operating council at Hospice by the Bay.

  A longtime SCMA member, Dr. Lane was twice honored with SCMA's annual award for outstanding contribution to the medical association, in appreciation of his exemplary leadership and service to the organization and community.

- A paper by **Drs. Stan Jacobs** and **Eric Culbertson** has been accepted by the European Academy of Facial Plastic Surgery. Dr. Jacobs will travel to Regensburg, Germany in September 2018 to present the paper, which reports study results for biophysical effects of a topical mandelic acid skin care product on facial skin. The two physicians used a Cutometer to evaluate and measure skin elasticity. In the study, 29 women and one man, ages 40 to 62, used the agent for four weeks; skin elasticity increased 25 percent on average.

FOR LEASE

- **Dr. Peter Bretan would like to sublet** all or a portion of his Novato office. Approximately 1,100 sq. ft. Bathrooms are not ADA approved, hot water only in patient bathroom. Rent $800–$1,500 depending on usage. Please call or leave a message at **415-892-0904**.

FOR SALE

- **Urology supplies at Sebastopol Specialty Center.** We closed our Urology Department and have many new supplies still in original containers—ranging from from Foley catheters to drainage bags to basins to Uro-jet lidocaine jelly. Willing to sell $6,000 worth of supplies for $2,000. Our loss is your gain. Call Laurie at **707-823-2336, Ext. 220**, for more information and a list of supplies.

To post an item on the Bulletin Board, contact Rachel at 707-525-4375 or rachel@scma.org.

SCMA 2018 Calendar of Activities

For updated activities, see *News Briefs,* delivered to your Inbox monthly!

JANUARY
- **17:** Fire Recovery Resources Dinner — at Medtronic
- **23:** SCMA Board Meeting — at Exchange Bank

FEBRUARY
- **5–7:** MEC Retreat
- **10:** Discover Sonoma County — Wellness Hike – at Pepperwood Preserve
- **15:** Solo/Small Group Forum — SCMA with Debra Phairas, Practice & Liability Consultants*: Thriving in Private Practice*
- **20:** SCMA Executive Committee Meeting
- **26:** Editorial Board Meeting

MARCH
- **13:** SCMA Board Meeting
- **15:** SFMMS 150th Anniversary Gala
- **17:** Discover Sonoma County — Wellness Hike — at Jack London State Historic Park
- **29:** Large Group Leadership Dinner — at Mayacama Golf Club, Santa Rosa
- **30:** National Doctors' Day

APRIL
- **14:** Discover Sonoma County—Wellness Hike — at Pepperwood Preserve
- **18:** CMA Legislative Day in Sacramento
- **23:** Editorial Board Meeting

MAY
- **2:** Fire Recovery Resources Dinner — at Medtronic
- **17:** SCMA Board Meeting
- **17:** PMF Lunch & Learn Seminar — "Work Smarter, Not Harder!"
- **24:** SCMA Physician Appreciation Mixer — at LaCrema winery

JUNE
- **10:** Mountain Play — *Mamma Mia* — at Mt. Tamalpais Outdoor Theatre
- **19:** SCMA Executive Committee Meeting

JULY
- **10:** SCMA Board Meeting
- **16:** Editorial Board Meeting

AUGUST
- **21:** SCMA Executive Committee Meeting

SEPTEMBER
- **11:** SCMA Board Meeting:
  - First review of 2019 budget
  - Call for leadership nominations

OCTOBER
- **13–14:** CMA House of Delegates
- **15:** Editorial Board Meeting
- **23:** SCMA Executive Committee Meeting — 2nd review of 2019 budget

NOVEMBER
- **6:** SCMA Election Day
- **13:** SCMA Board Meeting | MSSC Annual Meeting — Finalize 2019 budget

DECEMBER
- **TBD:** SCMA Gala Reception at TBD location
- **18:** SCMA Executive Committee Meeting

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- Well women exams

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