Family Doctor

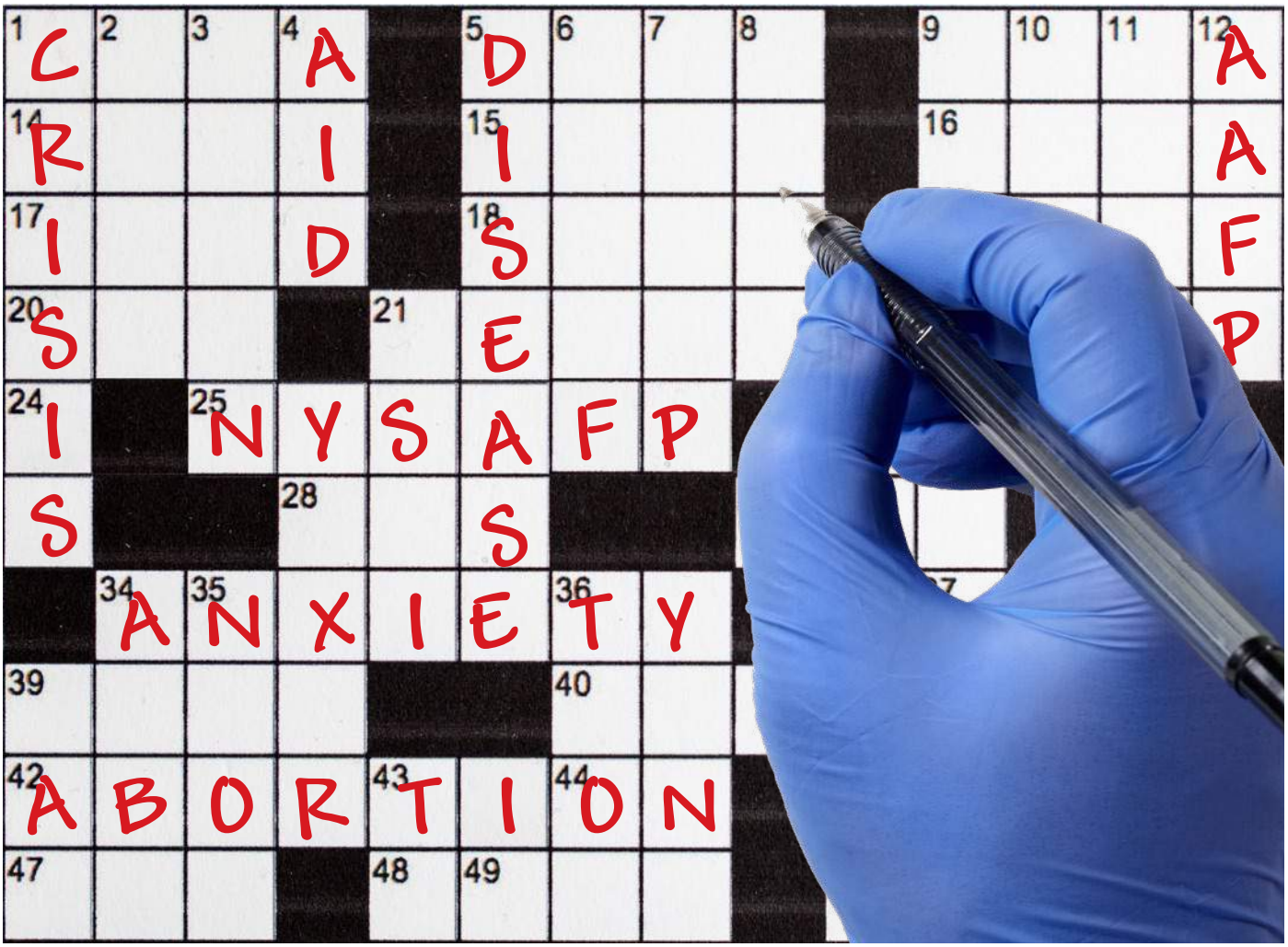
A Journal of the New York State Academy of Family Physicians

Summer 2022

Volume eleven, Number one

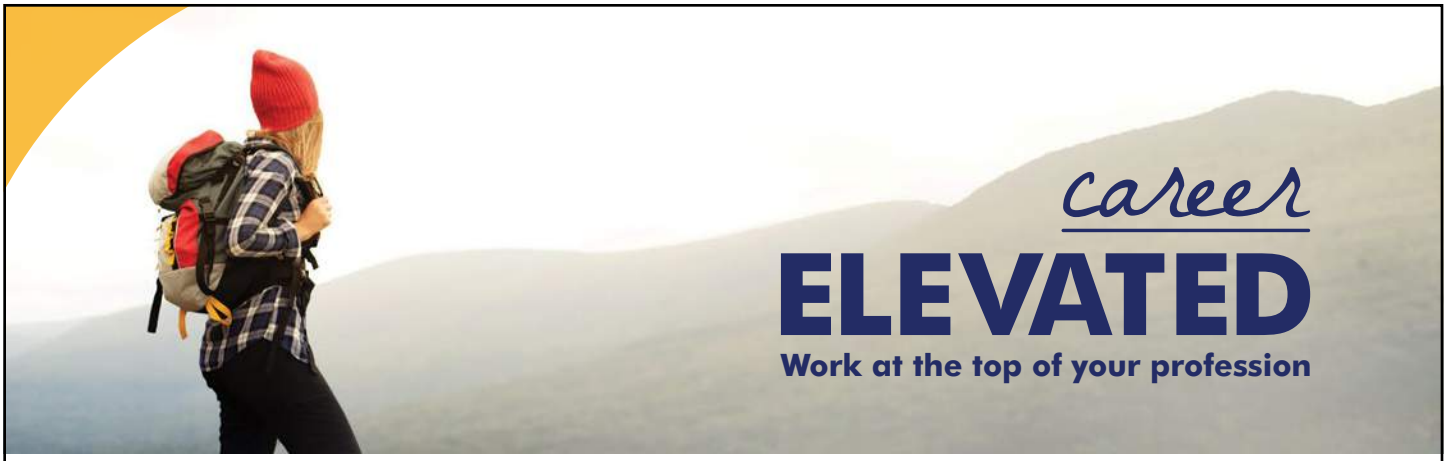
Focus:

Controversies & Challenges in Family Medicine



FEATURE ARTICLES:

New York State Academy of Family Physicians



GLENS FALLS HOSPITAL SEEKS PHYSICIANS TO JOIN OUR TEAM AT CAMBRIDGE MEDICAL CENTER

Practice Primary Care in Beautiful Cambridge, New York!

THE OPPORTUNITY

- Join an Albany Med Health System affiliate, ANCC Magnet®-recognized, 391-bed community hospital with a well-established practice in the Glens Falls Hospital Employed Provider Network.
- Full-time position, providing support to Primary and Urgent Care teams, flexible schedule options available.
- Attractive compensation package, benefits, sign-on bonus and **LOAN FORGIVENESS**.
- Strong nursing and administrative support.
- On-site medical imaging and point-of-care lab testing.
- Participate in telephone-only call schedule, approximately four weeks per year.

WANT TO KNOW MORE ABOUT THE REGION?

Cambridge, New York, situated between Saratoga Springs and Manchester, Vermont, is a safe, family-focused community with affordable housing and excellent schools. Cambridge is home to its own food co-op, an independent bookstore, a variety of restaurants and an abundance of arts and cultural experiences. Southern Vermont ski resorts, the Berkshires and the Adirondacks are all just a short drive away with hiking, camping, boating, skiing and golfing at your fingertips. Located within three hours from NYC, Boston and Montreal, and less than 1 hour from Albany International Airport, Cambridge is the perfect jumping-off point for you and your career.

FOR MORE INFORMATION CONTACT:

Antoinetta M. Backus, CPRP, Recruitment Manager
abackus@glensfallshosp.org | 518.926.6928
GlensFallsHospital.org/ProviderRecruitment

Glens Falls Hospital

ALBANY MED Health System

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

AMERICA'S BEST-IN-STATE EMPLOYERS
Forbes 2021
POWERED BY STATISTA

13 WAYS MILK CAN HELP YOUR BODY

One serving of milk contains many of the essential nutrients your body needs, including:

CALCIUM

Helps build and maintain strong bones and teeth.

25% DAILY VALUE

PROTEIN

Helps build and repair tissue. Helps maintain a healthy immune system.

16% DAILY VALUE

VITAMIN D

Helps build and maintain strong bones and teeth. Helps maintain a healthy immune system.

15% DAILY VALUE

PHOSPHORUS

Helps build and maintain strong bones and teeth, supports tissue growth.

20% DAILY VALUE

VITAMIN A

Helps keep skin and eyes healthy; helps promote growth. Helps maintain a healthy immune system.

15% DAILY VALUE

RIBOFLAVIN

Helps your body use carbohydrates, fats and protein for fuel.

30% DAILY VALUE

VITAMIN B12

Helps with normal blood function, helps keep the nervous system healthy.

50% DAILY VALUE

PANTOTHENIC ACID

Helps your body use carbohydrates, fats and protein for fuel.

20% DAILY VALUE

NIACIN

Used in energy metabolism in the body.

15% DAILY VALUE

SELENIUM

Helps maintain a healthy immune system, helps regulate metabolism and helps protect healthy cells from damage.

10% DAILY VALUE

ZINC

Helps maintain a healthy immune system, helps support normal growth and development and helps maintain healthy skin.

10% DAILY VALUE

IODINE

Necessary for proper bone and brain development during pregnancy and infancy; linked to cognitive function in childhood.

60% DAILY VALUE

POTASSIUM*

Helps maintain a healthy blood pressure and supports heart health. Helps regulate body fluid balance and helps maintain normal muscle function.

10% DRI

*Source: USDA FoodData Central. FDA's Daily Value (DV) for potassium of 4700 mg is based on a 2005 DRI recommendation. In 2019, NASEM updated the DRI to 3400 mg. Based on the 2019 DRI, a serving of milk provides 10% of the DRI. FDA rule-making is needed to update this value for the purpose of food labeling.

The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

NDC NATIONAL DAIRY COUNCIL™
nationaldairycouncil.org

AMERICAN DAIRY ASSOCIATION NORTH EAST
AmericanDairy.com

Family Doctor, A Journal of the New York State Academy of Family Physicians, is published quarterly. It is free to members of the New York State Academy and is distributed by mail and email. Non-member subscriptions are available for $40 per year; single issues for $20 each.

New York State Academy of Family Physicians
16 Sage Estate, Suite 202
Albany, New York 12204
www.nysafp.org
Phone: 518-489-8945
Fax: 518-888-7648

Letters to the Editor, comments or articles can be submitted by mail, fax or email to journaleditor@nysafp.org

Editor: Penny Ruhm, MS

Articles

Departments

Index of Advertisers

ALSO Instructor Course | Sept 15, 2022 | Arlington, VA ***

Course Director: Steve Ratcliffe, MD, MSPH | Co-director: Scott Hartman, MD

FAMILY MEDICINE EDUCATION CONSORTIUM, INC.

www.fmec.net

ALSO Advanced Life Support in Obstetrics

Course overview

The ALSO Instructor Course is a 2022 preconference workshop and is held in conjunction with the 2022 FMEC Annual Meeting. ALSO Instructor courses provide lifelong learning opportunities utilizing AAFP-produced material for use in learning skills to assist in teaching ALSO Provider courses.

This half-day course offers an interactive learning experience for ALSO Providers. Become an ALSO Instructor, and learn about adult learning theory and faculty development, as well as how to offer effective feedback, teach in small group workstations, and evaluate participants.

As a family medicine residency program director, your program will benefit immensely by having selected faculty and upper-level residents undergo training to become a certified ALSO Course Instructor. The clinical knowledge and systems-based training that these individuals will acquire will add value to your teaching of how to anticipate and respond to urgencies and emergencies in the maternity care setting. The time needed to free up a faculty member or upper resident to attend this course is a reason to make these scheduling changes before you begin the new academic year.

Course pre-requisite: Current ALSO Provider status as of Sept. 15, 2022, is required.

Registration Fees

Resident/Fellow FMEC Member: $550
Non-member $575

Healthcare Professional FMEC Member: $650
Non-member $675

CME Credits

The AAFP has reviewed ALSO Instructor Course and deemed it acceptable for up to 3.25 live AAFP Prescribed credits. Term of approval is from 9/15/2022 to 9/15/2022. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Hotel: Hyatt Regency Crystal City in Arlington, 2799 Richmond Highway, Arlington, VA 22202

For more information on the ALSO Instructor Course and other FMEC preconferences, visit 2022 Preconference Workshops. To register, visit FMEC 2022 Annual Meeting

Please reach out to: denise.steele@fmec.net with registration questions

Upcoming Events

2022

August 6
Summer Cluster
Marriott Buffalo at
LECOM Harborcenter

September 9
Erie County Resident
Meet-and-Greet

October 11
Nassau/Suffolk County Resident
Meet-and-Greet

November 6
Fall Cluster Board Meeting
(Commissions meet prior)
Albany Renaissance

2023

January 13-15
Winter Weekend
Virtual

February 26
Winter Cluster
Renaissance Hotel
Albany

February 27
Advocacy Day
Albany

May 20-21
Congress of Delegates
Albany

August 5-6
Summer Cluster
Edith Macy Center
Briarcliff Manor

For updates or registration information for these events go to www.nysafp.org

From the Executive Vice President

By Vito Grasso, MPA, CAE

There are many controversies in medicine today. Some have been around for years while others have emerged as technology has proliferated or as a product of continuing social, political and cultural change. Those controversies involving treatment are significantly influenced by the continued evolution of science and the introduction of new technologies and new therapies. Other controversies, however, reflect fundamental differences of opinion rooted in conflicting values and experience.

Reconciling differences of opinion is always challenging. It is sometimes possible to avoid the more serious ramifications of controversy by dialogue and education since much controversy is the result of misunderstanding. There are, of course, many controversies that emanate from competing interests and incompatible political, social or cultural values.

We have consistently been embroiled in controversy with advanced practice providers over their role in patient care and their relationship to the practice of medicine. Although others may disagree, I would classify this as a conflict of competing interests rather than the result of differences in values. The medical profession has enjoyed a certain standing in society, which has placed physicians at the top of the clinical pyramid. Expansion in the scope of practice of non-physician clinicians has encroached upon the authority of physicians and has contributed, as well, to the devaluation of the physician's status. Of course, physicians themselves haven't helped by leaving private practice for the security of employment with health systems, hospitals and large group practices.

As non-physician clinicians have been embraced by health insurance plans and by regulators to fill needs caused in part by a growing shortage of physicians, the utility and availability of non-physician clinicians has made it easier to resort to expanding their scope of practice to address access issues rather than to increase the supply of physicians. This is particularly true with regard to primary care physicians because payment for primary care is so poor that the specialties that comprise primary care have become increasingly unattractive to medical students.

This issue of ***Family Doctor*** includes a thoughtful article by Dr. Messina, which may help expand understanding of the nuances of the advanced practice movement and its impact on medicine.

There is probably no more controversial a topic in medicine or society generally than abortion. Medication abortion has emerged as a safe, effective and easy form of abortion. Its use, however, has been impeded by political developments fostered by five decades of resistance to the legal foundation upon which abortion has been based. Efforts by several states to prohibit abortion and to do so by penalizing physicians and other clinicians who perform abortions have created a new framework for continuation of the long-simmering abortion debate. Litigation challenging the constitutionality of state actions to prohibit abortion across state lines has already begun and will continue as more states act to prevent abortion. Drs. Faso, Schulte and Weber comment on the potential of medication abortion to provide a vehicle for NY physicians to help out-of-state patients obtain abortions even if they reside in states which have prohibited abortion.

And Dr. Thomas Rosenthal's provocative commentary on the association of contemporary controversies in medicine with the once universally accepted procedure of bloodletting places the entire theme of this issue of ***Family Doctor*** into perspective. At some point, evidence will emerge to address and resolve, at least for a period of time, current controversies. Of course, the anti-vaccine movement and the reversal of Roe suggest that some controversies just refuse to die.

I hope you enjoy this issue of ***Family Doctor***.

It is sometimes possible to avoid the more serious ramifications of controversy by dialogue and education since much controversy is the result of misunderstanding.

President's Post

By Andrew Symons, MD, FAAFP

I would like to offer the readers of Family Doctor some words of welcome, as this is the first issue of the journal of my term as NYSAFP President. I am a family physician in Buffalo. I practice outpatient and inpatient family medicine as well as addiction medicine, and am on faculty at the Jacobs School of Medicine of the University at Buffalo where I direct the first year clinical skills course and the family medicine clerkship. I am honored to have been entrusted with leadership of the NYSAFP.

Over the past two years, impacted by the pandemic, our Academy has been successful in continuing to engage our members in our core values of advocacy, education, and mentorship. During our virtual Advocacy Day, we articulated to our state representatives our Academy's legislative and budgetary priorities including investment in primary care through support of AHEC and DANY, support for payment reform such as telehealth payment equity and support for a single-payer system, protection of physicians' ability to provide reproductive care to patients, and advocacy for universal reporting of adult immunizations. Our educational programs continued in the virtual format, with a successful "Winter Weekend", including scholarly poster presentations by students, residents, and attending physicians. We also initiated an on-line CME series to expand educational opportunities throughout the year. While in-person opportunities were limited, students, residents and new members have been incorporated into the work of our commissions, which have been meeting virtually. We have excellent student and resident representation on our state board and commissions, as well as nationally through participation in AAFP's National Conference of Student Members and the National Conference of Resident Members. We also have excellent participation in the National Conference of Constituency Leaders (NCCL) and are among the few chapters to have sent a full delegation to NCCL every year since the inception of this conference.

As we begin to cautiously emerge from the isolation brought by the pandemic, I am looking forward to increased opportunities for engaging our members in advocacy, education, and mentorship activities. We look forward to regional in-person CME activities. We look forward to Academy leaders visiting residency programs and Family Medicine Interest Groups (FMIGS) to engage them in our Academy. We look forward to "meet-and-greet" events for family medicine residents to meet community family physicians who want to hire them and keep them practicing here in New York.

A hallmark of our Academy's educational mission has been the Family Doctor journal. I have always found the approach of the journal articles to be uniquely relevant to us as family physicians practicing in New York. This issue presents an eclectic collection of discussions of topics addressing emotional health and wellness, access to care, palliative care, approaches to team-based care, and, given the recent Supreme Court decision overturning Roe vs. Wade, a very timely discussion about the role of the family physician in providing reproductive care.

I wish you a good summer, and I look forward to a productive year of advocacy for our patients and our profession, education of students, residents and community physicians, and development of relationships that make the NYSAFP such a nurturing environment for those who engage in our activities.

With great admiration,

Andrew Symons MD, FAAFP
President, NYSAFP

...I am looking forward to increased opportunities for engaging our members in advocacy, education, and mentorship activities.

Albany Report

By Reid, McNally & Savage

As the NYSAFP summer journal goes to print, the 2022 New York State legislative session has just been completed. However, Governor Hochul has already hinted at the need to call an "extraordinary" session in response to anticipated Supreme Court decisions around gun laws and Roe v. Wade. In addition, it is an election year where all members of the Legislature and the Governor must run for election in November, with many, including the Governor, facing primary challenges. Primaries for the Governor and Assembly were held on June 28th and for the Senate in August due to redistricting issues and challenges this year.

With the focus of this Journal being on "controversies," it is important to note that few, if any, policies enacted at the state level are without controversy. In our experience, there are always at least two sides to every issue, no matter how straightforward or even mundane the topic. With that said this legislative session presented many challenges for the Academy but also resulted in the passage of many bills supported by NYSAFP, which we will now advocate Governor Kathy Hochul to sign into law.

To start, NYSAFP held a very successful Advocacy Day on February 28, 2022. Over fifty family physician, resident and student members participated in the virtual event under the leadership of immediate past-President Dr. James Mumford, Advocacy Chair, Dr. Jiana Menendez, EVP Vito Grasso, and support from our firm. Legislative meetings were held across ten regional teams with over fifty State Senate and Assembly offices who learned about the Academy's leading budget and legislative priorities of import to family physicians and patients this year. We greatly appreciate all who took the time to participate in this important advocacy effort related to NYSAFP's 2022 priorities. Having lawmakers hear directly from family physicians and students in their districts is one of the most important ways to affect the legislative process and gain support for NYSAFP's priorities.

A little more than a month after the Advocacy Day, the Governor and Legislature reached a final budget agreement which included many of the priorities that NYSAFP advocated for during Advocacy Day and since the session began in January. Below is an outline of key final budget outcomes of interest.

SFY 2022-23 NYS Final Budget

Funding

Regarding NYSAFP's funding priorities, the Academy scored some major financial wins this year. The final package added $2.2 million for Area Health Education Centers (AHECs) to support the primary care pipeline, more than doubled Doctors Across NY physician loan repayment and practice support to $15,865,000, included new funding to promote access to primary care by increasing Medicaid fees for evaluation and management (E&M) codes for primary care to 70% of Medicare, and included continuous funding for the Physician Excess Malpractice program at $102.1 million.

Excess Medical Malpractice Program

The final budget also rejected the Governor's proposal to restructure the Physician Excess Malpractice program, potentially pushing the cost onto physicians. This was opposed by NYSAFP and extended another year through 6/30/23.

Telehealth

The budget also included language to provide telehealth parity in payments at the same level as what is provided for in-person care under Medicaid and commercial insurance. It also included a required report on implementation of this policy and a two-year sunset, when it will be revisited.

Medicaid Rates

The final budget also included restoration of prior year across-the-board Medicaid cuts of 1.5% and a new trend increase under Medicaid of 1% for providers.

Prescriber Prevails

The final budget rejected proposed changes to prescriber prevails in Medicaid, as opposed by NYSAFP.

Nurse Practitioners

Unfortunately, despite strong, multi-year efforts by NYSAFP, working in collaboration with the Medical Society of the State New York and several other physician specialty societies, the final state budget included the Governor's proposal to remove the requirement in the state education law for a nurse practitioner with 3600 hours experience to have a collaborative relationship with a physician for the delivery of health care services. The language is set to sunset in two years when it will be revisited.

Post-budget Legislative Priorities & Outcomes

Insurance

Immediately following the passage of the state budget, NYSAFP turned its attention to its key legislative priorities. While NYSAFP continued its strong support and advocacy to urge advancement for the *New York Health Act* to achieve a single payer health system, we also supported a number of initiatives to try to address struggles with insurance companies experienced by both physicians and patients.

Assemblyman Richard Gottfried (D-Manhattan)

While it is disappointing that the *New York Health Act* was not taken up by either house, especially this year, when longstanding bill sponsor and champion Assembly Health Committee Chair Richard "Dick" Gottfried is retiring, a number of bills were passed by both houses to address some insurance concerns and issues.

A few priority highlights include:

Clinical Peer Reviewer Definition (S8113 Cleare/ A879 Gottfried)

This legislation amends the public health law and insurance law to clarify that a health plan's "clinical peer reviewer" or utilization review agent not only be a physician, as is currently required, but also be board-certified or board eligible in the same or similar specialty as the physician who typically recommends the treatment or manages the condition under review. Also requires all clinical peer reviewers to be licensed or certified in NYS. NYSAFP has been advocating for this legislation for many years and assisted with developing the bill. We are very pleased to see if was finally passed by both houses.

CoPay Assistance Programs (S5299A Rivera/ A1741A Gottfried)

This legislation requires state-regulated commercial health insurers to allow copay assistance programs for patient out of pocket drug expenses to count toward their cost sharing requirements. NYSAFP has been working closely with a broad coalition of patient and other provider groups to support this legislation. NYSAFP has joined sign on letters, participated in a press conferences and press releases providing quotes and other joint lobbying efforts and meetings due to its importance in assisting patients, not insurers, with using the benefits of copay assistance programs to help reduce their out-of-pocket costs.

Copays for Opioid Treatment Medication (S5690 Harckham/ A372 Rosenthal L)

This legislation requires state-regulated commercial health insurers to cover the treatment of an opioid treatment program with a copayment during the course of treatment. Opioid treatment program applies to treatment of individuals with an opioid antagonist treatment medication.

Step Therapy for Mental Health Treatment (S5909 Kaminsky/ A3276 Gunther)

This legislation prohibits state-regulated commercial health insurers from applying fail first or step therapy requirements for the diagnosis and treatment of mental health conditions including drug coverage.

OMIG Reform (S4486B Harckham/ A7889A Gottfried)

This legislation would provide protections for both Medicaid providers and consumer enrollees related to audits by the Office of Medicaid Inspector General (OMIG). Physician and other provider protections include:

- Requiring that recovery of an overpayment must not take place until at least 60 days after issuance of a final audit report and OMIG must provide a minimum of 10 days advance written notice to the affected provider;
- Prohibiting repeating a review or audit within the last three years of the same contracts, cost reports, claims, bills or expenditures unless OMIG has new information, good cause to believe the previous audit was erroneous, or a significantly different scope of investigation;
- Requiring OMIG to apply all laws, regulations, policies, guidelines, standards and interpretations that were in place at the time the claim or conduct occurred;
- Prohibiting OMIG from making a recovery from a provider based solely on an administrative or technical defect, except where OMIG has informed the provider of the error and given 30 days to correct it. If not corrected OMIG may take a recovery. Further, where a claim for a service was provided over 2 years prior to the audit, the provider may resubmit the claim or accept the disallowance;
- Requiring OMIG to provide an exit conference or detailed written explanation of any draft audit findings to the provider;
- Requiring that OMIG may only use statistically valid extrapolation methods for audits where extrapolation is permitted;
- Requiring OMIG to notify a provider if their compliance program is not satisfactory, and to allow the provider 60 days to submit a proposal for a satisfactory program; and
- Requiring OMIG to consult with the Commissioner of NYSDOH on preparing and filing an annual report on the impacts that all civil and administrative enforcement actions taken in the prior year had or will have on the quality and availability of medical services.

continued on page 10

continued from page 9

Reproductive Health Care

NYSAFP leaders including Advocacy Chair Dr. Jiana Menendez, Dr. Linda Prine, Dr. Maggie Carpenter, EVP Vito Grasso and our firm advocated for the passage of a "package" of bills this session to protect access to reproductive healthcare services for patients both in and outside New York. A series of meetings were held with Governor Hochul's office, key legislators and staff in both houses and others. The following four bills were passed and provide protections and the ability for NY to protect its providers when out of state patients travel here. An outstanding issue is whether and how New York could try to protect provider's use of telemedicine to provide care to out of state patients and we are continuing to have those discussions with other partners and with those in government.

NYSAFP Leaders meeting with Governor Hochul's Health team on reproductive health care legislation

Professional Misconduct and Reproductive Health Care (S9079B Kaplan/ A9687B Rosenthal)

This legislation would prohibit professional misconduct charges against health care providers who provide reproductive health care to patients who reside in states where such services are illegal, if the provider is acting within their scope of practice. The provider's license shall not be revoked, suspended or annulled solely on the basis that the provider performed such service for a patient who resides in a state where it is illegal.

Legal Protections for Abortion Service Providers (S9077A Krueger/ A10372A Rules (Lavine)

This legislation provides judicial protections for abortion providers in New York by providing an exception for extradition by the Governor, stating a police officer shall not arrest a person for performing an abortion, stating that no state or local law enforcement shall cooperate with or provide information to out of state agencies or departments regarding lawful abortions performed in New York State and the courts and county clerks shall not issue subpoenas in connection with out-of-state abortion proceedings which were legally performed in New York State.

Medical Malpractice and Reproductive Health Care (S9080B Hinchey/ A9718B Rosenthal)

This legislation prohibits medical malpractice insurance companies from taking any adverse action against a reproductive health care provider who provides legal reproductive health care.

Address Confidentiality Program (S9384A Cleare/A9818A Paulin)

This legislation allows reproductive health care services providers, employees, volunteers, patients, or immediate family members of reproductive health care services providers to enroll in the address confidentiality program run by the Department of State.

Primary Care Investments

In addition to the primary care rate increase included in the final state budget, NYSAFP also worked with other primary care organizations to support this legislation to establish a commission to study and recommend the level of primary care spending New York should be investing. We are now working to urge Governor Hochul to sign this bill into law and to seek an appointment on the commission for a family physician.

Primary Care Reform Commission (S6534-C Rivera/ A7230-B)

This legislation establishes the Primary Care Reform Commission, which will be tasked with reviewing, examining, and making findings on the level of primary care spending by all payers, and publish an annual report on the findings. The Commission is responsible for defining and measuring New York's baseline spending on primary care, setting targets for enhanced investments in primary care, and testing pilot programs to identify the most promising models that will improve primary care infrastructure and lower costs to patients or the total cost of health care.

Regressive Liability

While there were many problematic proposals that we were able to defeat this year, unfortunately despite strong opposition from NYSAFP, MSSNY and other medical societies along with the hospital associations and malpractice insurers, the following legislation was passed by both houses in the final days of the 2022 session. We are now working closely with others on a campaign to seek a veto by the Governor, saying these measures must instead be considered only as part of a balanced package of comprehensive medical liability reform.

Wrongful Death (S74-A Hoylman/A6770 Weinstein)

This bill would amend the estates, powers, and trusts law to authorize an award in a wrongful death action to include compensation for grief or anguish, the loss of love or companionship, loss of services and support, and the loss of nurture and guidance.

Vaccines

NYSAFP continues to advocate for the passage of legislation (S75A, Hoylman/A279A, Gottfried) to treat adult vaccines similar to child vaccines for the purpose of reporting to the State or NYC vaccine registries. We made more progress this year than before having the bill move to the Assembly floor for the first time. Unfortunately, the Senate was unwilling to advance any "controversial vaccine bills" this year. We thank all members for your strong advocacy including during the Advocacy Day, in other meetings held with NYSAFP leaders including immediate past-President Dr. James Mumford, President Dr. Andrew Symons, Vaccine Subcommittee Chair Dr. Phil Kaplan, EVP Vito Grasso and RMS, and the strong grassroots support. We will continue to press for the passage of this bill in hopes that next year will provide a new opportunity as a non-election year.

Office of Cannabis Management

In 2021, New York legalized the retail sale of adult cannabis. NYSAFP worked under the leadership of Dr. William Klepack to develop a white paper with recommendations for the State to consider regarding implementation focused on child safety, public health and other protections. We brought the white paper to the State Department of Health and to the Leadership of the Office of Cannabis Management (OCM) and had a series of meetings and discussions. We are pleased to share that OCM recently released and voted to advance a very strong regulation for publication/public comment regulating the packaging, labelling and marketing of such products to make them less appealing and accessible to children. NYSAFP issued a statement by President, Dr. Andrew Symons applauding this action and thanking OCM for hearing our concerns and recommendations.

Over 1,000 bills were passed by both houses this session, more than in other years. While we have provided the highlights above of particular interest and what NYSAFP has been involved in advocating for or against, our firm has created a comprehensive summary of all legislation in the health and mental hygiene area passed by both houses this session. This summary can be found at the following link: https://drive.google.com/file/d/1LnD059WbtvjGEb1k33Z3AHXZ0YbaVIEI/view

All of us at Reid, McNally & Savage wish you an enjoyable summer and look forward to continuing to work with NYSAFP leaders and members to achieve the priorities before state government of importance to family medicine and those you serve.

STATEMENT

For Immediate Release
June 3, 2022

NYS Academy of Family Physicians Applauds Action Taken by NYS Office of Cannabis Management to Regulate Packaging, Labelling and Marketing of Adult Use Cannabis Products.

– Statement by Andrew Symons, President MD, MS, FAAFP

TWO VIEWS: The Path Forward in Family Medicine

VIEW ONE

REDISCOVERING MEANING IN YOUR WORK

By Jennifer Baker-Porazinski, MD

Most family doctors I know were called to the medicinal profession to help others. But as patients get sicker, and administrative duties steal time away from them, many doubt their effectiveness in this simple, altruistic drive. Doctors don't mind working hard when their work is meaningful – when we believe we're improving the lives of the people we care for and making communities better. But the job of a doctor today is far removed from this compassionate objective. For some, the disconnect between their aspirations and reality leads to burnout. The consequences of burnout aren't just confined to the doctor suffering from it but are felt by their colleagues, families and patients. Burned out doctors are not only more likely to make mistakes but, when sacrifice and hard work don't bring fulfillment or joy, they're also more likely to leave medicine.

According to Medscape's 2022 Physician Burnout and Depression Report, 51% of family practice doctors suffer from burnout.[1] This alarming statistic doesn't reflect a weakness in doctors, who would've never made it through training if they didn't possess the fortitude or stamina required. When over half of doctors admit to burnout, there is clearly something wrong with the system. Tragically, burned out doctors have a much higher risk of suicide than the general population: 40% higher for male physicians and a 130% higher for female physicians.[2] Over one-third of doctors experiencing suicidal ideation report they would likely not seek help.

Given these frightening statistics, believing that this could never personally impact me would be denial. The sad truth is that burnout happens to doctors like me every day. While I'm grateful I didn't reach this level of crisis, I know that if I hadn't been offered a way out, I just might have. I'd already given up on the possibility that my work life would improve and, like many of my colleagues, was resigned to my unhappiness. The fast-paced, chaotic primary care office doesn't afford time for bathroom breaks much less self-reflection. How can doctors recognize if they're headed in a dangerous direction before it's too late?

The Agency for Research and Healthcare Quality defines burnout as "a long-term stress reaction marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment".[3] I met at least two out of the three criteria. While I'd convinced myself that "emotional exhaustion" was expected during a pandemic, my loss of a "sense of personal accomplishment" began long before the current crisis. For years I struggled working in a healthcare system that seemed to be lacking in both "health" and "care." Then, something miraculous happened.

Last summer Canyon Ranch contacted me to see if I was interested in joining their Health and Performance Team. I was hesitant at first. I

VIEW TWO

THE NEED FOR CAREER SUSTAINABILITY

By Timothy Hoff, PhD

The Great Resignation has been written about by many; a phenomenon of people quitting their jobs and often leaving the workforce altogether in large part due to their experiences during the Covid-19 pandemic.[1] However, the Great Resignation may be more a media concoction than a true reality.[2] In particular for health care, no one really knows how many workers are quitting their jobs. Various statistics are quoted, often from unreliable or incomplete data sources. The reality is that there have always been shortages in fields like medicine, nursing, and support occupations such as medical assisting. There has also been much burnout and job dissatisfaction.

There is no doubt that everyone's job has become more difficult over the past two years, regardless of what it is you do. As a professor, I had to move all my teaching online; adapt my research goals significantly given difficulties in gaining access to data and the organizations producing that data; and transform how I did my service work, working with colleagues on significant tasks and projects virtually. I had to spend a lot more time helping students manage their own challenges of learning and coping in a virtual world. Often, a week felt like a month of work. Everyone from Uber drivers to waiters to engineers have had to adapt, accommodate, sacrifice, and settle because of two years' worth of global pandemic. Many have had to work harder, and endure increased psychological strain, simply to accomplish what they did pre-pandemic.

Family doctors have had it tough. Forced to adopt telemedicine quickly, with which many had no experience; losing the rewards of face-to-face interactions with many patients; workloads that became more unpredictable; managing staff that were anxious and burned out; doing patient care with the added complexity of figuring out Covid-19 illness from every other illness; feeling the burden of keeping their practices afloat financially; and enduring the personal risks associated with an illness poorly understood at the start.[3] Add all of this to a job that for many was already fraught with a number of downsides, and what you have now in 2022 is a family doctor demographic that must reckon moving forward with how to maintain job satisfaction and enact a personally meaningful career for themselves over the long haul.

THE LOGIC AND ACCEPTANCE OF A SUSTAINABLE CAREER IN FAMILY MEDICINE

How they might want to reckon with it is through the lens of *sustainable career building*. The idea of a sustainable career is one the field of management has written about for some time now.[4] A sustainable career is one in which the individual worker seeks out jobs and work experiences that allow them to not burnout; to remain

had a stable job working for a well-respected hospital just miles from my home. I was far from thriving at my work, though, so I decided to apply. As I began interviewing for the position, I took a closer look at my wellbeing, and became acutely aware of my fitful sleep, tight neck muscles, clenched teeth, and the sinking feeling in my chest when I headed into work each morning. Despite educating patients about the importance of self-care (especially during the pandemic), my own self-scrutiny revealed my hypocrisy: I'd become unhealthy in mind, body and spirit.

After 22 years working as a rural family doctor, I left primary care in January. Despite my guilt over leaving my patients and the addition of a long commute, I took a chance on a job promising less stress. In my new role, I'd guide people toward achieving health goals, not managing chronic disease. They'd be seeking my expertise in disease prevention – a radical departure from chasing symptoms with medications that inevitably caused more symptoms. With my leap of faith, something unexpected occurred. I caught a glimpse of what preventative medicine could be, given appropriate resources. I had stumbled on the medical system my heart always believed was possible.

PREVENTION: CHANGING LIVES *BEFORE* DISEASE SETS IN

Chronic disease account for 75% of health care costs in America.[4] Family doctors know that prevention is more cost-effective than treatment. We're in a unique position among all specialties because we often follow our patients throughout life. From this vantage, we've seen the patterns repeatedly, especially in poor and underserved areas. We know firsthand that we have the potential to intervene and could change lives *before* disease set in. Yet, we often feel powerless to do so.

I vividly recall my frustration when an insurance company denied a nutrition consult for a young, overweight girl because she was *not yet diabetic*. My sweet, precocious patient returned to me over the years as an overweight, depressed teenager. Eventually, as a young adult, I'd treat her for diabetes and metabolic syndrome – conditions that put her at high risk for cardiovascular disease. I knew she'd probably die much younger than she would have with more aggressive intervention. I understood the bleak statistics: chronic disease is the leading causes of death and disability for Americans, responsible for 70% of deaths each year.[4]

Prevention isn't simply more cost effective, though. It's also more humane. The repercussions of chronic disease (death and disability), combined with our impotence to effectively intervene on behalf of our patients, chips away at doctors' sense of purpose. We know our patients aren't simply inconvenienced by the cost of medications, bloodwork, and specialist appointments. They are suffering and they are dying. If even a portion of healthcare expenditures could be diverted to prevention, patients would undoubtedly be healthier (and happier). I'd argue that their doctors would be, too.

Approximately 80% of chronic diseases are caused by lifestyle.[5] Guiding patients toward changing modifiable risk factors and helping them set achievable goals is critical to improving their health. During acupuncture training, my professor claimed that village doctors in China were paid more when they saw fewer patients. While this concept initially seemed absurd to a lecture room full of doctors working in a fee-for-service payment model, his explanation was logical. The Chinese doctor was rewarded for keeping villagers from getting sick.

American doctors excel at treating acute illness. We're also fairly good at managing chronic disease. But ironically, in a profession dedicated to help

continued on page 14

job satisfied; and where employment is viewed as a contributor, rather than a barrier, to better work-life balance and a healthy state of mind. Sustainable careers enhance the prospects for individual well-being.[5] They put work, regardless of what it is, into the proper perspective of one's overall life. They put the employing organization in a position of helping the worker effectively manage and grow their careers. In my new book, *Searching for the Family Doctor: Primary Care on the Brink*, I interviewed a number of family doctors at all career levels who, by nature of their employment choices and how they talk about their work, jobs, and futures, as well as their career motivations, are engaged in the process of practicing career sustainability, whether or not they realize it.[6]

Even prior to the pandemic, these family physicians came in two groups: (a) those mid- and later-career family doctors who, by nature of their past work experience, have come to understand how difficult certain ways of enacting the generalist role are in the present health system, and (b) younger family doctors with little work experience who have simply decided from the outset that they wish for certain things in their lives, i.e. work-life balance, flexibility, a more favorable compensation-to-work effort ratio, greater personal control, easier workloads, and simply less hassle and stress in their daily lives. They want to be effective family physicians, but they place equal emphasis on these other goals. These two groups are different, but also very much the same. Their motivations may be a function of their career stage and personal preferences. But let's face it, they are also influenced by a similar perception of what the role of family doctor in its truest form requires in a hostile health system.

That health system may not get better any time soon. It remains one which rewards fragmented rather than holistic care delivery; facilitates specialist rather than primary care physician relationships with patients; diminishes the importance of longitudinal and comprehensive primary care; compensates family doctors much less than their work deserves; and pushes for patient loyalty to health care corporations rather than individual physicians. This type of health system is adversarial to the family doctor's true calling. It undermines the ability to be a comprehensive family doctor for a large group of patients over time. Big health systems, big insurers, and big tech companies continue to seek out more control over how the system is run.

Working and growing one's career as a family doctor in such a system presents certain realities that give family doctors greater opportunity to pursue sustainable careers. First, there are fewer types of organizations in which to work. For example, consolidation now produces too many family doctor jobs as salaried employees in large delivery systems, often hospital-centered. These jobs, perhaps the largest source of employment for family doctors in urban and suburban areas especially, enable more of a nine-to-five mentality to be embraced. They allow family doctors to have a life outside of work, spend more time with their friends and family, step away regularly from the

continued on page 15

continued from page 13

people live fuller, healthier lives free from suffering, we ignore the one area of health that should take precedence. We disregard the very thing that most impacts quality of life: keeping people from getting sick in the first place. While I regularly pivoted my focus to address depression and anxiety during the pandemic, I'm ashamed at how easily I pushed aside insomnia, weight gain, and escalating alcohol use because there just didn't seem to be enough time.

I know that this isn't novel information. Family doctors are well aware that a healthy lifestyle can prevent or slow the progression of chronic illness. We simply don't have the time (and may lack the expertise) to address this in a busy primary care practice. There are also reimbursement challenges, making the additional time spent on prevention harder to justify to administration. Given the magnitude of burnout among primary care providers just trying to get through another day, it's easy to imagine why some give up on this.

Fortunately, family doctors *are* comfortable with their role as gatekeepers. We accept that, while we can pursue training in a wide variety of interests, we don't have to know everything. We regularly coordinate care with our specialist colleagues when their expertise is warranted. This same multi-specialty care model could be accomplished in the microcosm of the primary care clinic. To improve the health of our patients, we need a system that supports us educationally and financially, as well as a team of providers working alongside us. My new job at Canyon Ranch provided a peek of this dream.

PREVENTION IN PRACTICE

Imagine having nearly an hour with a patient. In that time, you could get to know *the person* so that you could best motivate and inspire them toward health. Before I even see a guest at Canyon Ranch, they've already defined their health goals with a health coach and have had some screening tests done. This may include blood work, body composition (for baseline body fat, visceral fat, and lean muscle mass) and a bone density which will later help guide their personalized exercise regimen.

I spend nearly an hour with the guest, reviewing health history and exploring their health concerns. After our appointment, the guest sees the nurse educator to coordinate any additional testing we've determined necessary. The nurse will often attach a continuous glucose monitor to provide real-time feedback about how diet, exercise, and stress impact blood sugars. The guest may also be set up for an overnight sleep study, to evaluate quantity and quality of sleep and to screen for sleep apnea.

Over the next few days, the guest will see multiple experts. They'll see a nutritionist to review current diet and eating patterns (with a follow up a few days later to review blood glucose readings and assist in future meal planning). The guest will meet with a mental health provider for stress reduction techniques, cognitive behavioral therapy tools, or sleep education, depending on their particular needs. A guest in need of direction might have a session with a spiritual practitioner to connect their life purpose to their health goals, thereby providing an impetus to achieve them.

The guest will have a complete musculoskeletal exam to evaluate muscles and joints, followed by an appointment with a performance science expert to measure exercise capacity and baseline strength. Achievable activity goals are set based on muscle mass, body fat and aerobic fitness level. The guest may then see a personal trainer to tailor the recommended exercises to the guest's particular needs and to assure correct form.

After seeing all these experts, the guest will follow up with me to review blood work and sleep study results and to clarify questions that may have arisen from their multiple consults. The guest will meet with the health coach again to formulate a plan based on all the recommendations made by the team. In a few weeks, the health coach will reach out by phone to make sure the guest remains on track, and to offer assistance if they don't. Guests leave Canyon Ranch with a comprehensive understanding of their health, providing motivation to follow through with their personalized plan.

A PREVENTION PRESCRIPTION FOR PRIMARY CARE

While I believe a similar preventative approach is achievable for the general population, my decades working in a rural, underserved population provides me with insight into the barriers that exist to this kind of privileged care. For years, I tried to make changes to improve the wellness of my patients and staff. I appealed to my administration to offer group visits to allow more time for patient education. I arranged for a massage therapist to come in regularly to treat my stressed staff. I studied acupuncture and mindfulness-based stress reduction and became a certified yoga teacher. But despite small successes, my efforts fell short of my vision. Ultimately, the stress of the pandemic overwhelmed me. I lost my spirit.

Now that I'm in a healthier place (and have seen what is possible), I believe that prevention isn't a lost cause. In a supportive environment, small steps can lead to real change. In my dream of primary care's future, each office has a lead physician trained in lifestyle medicine. This person, along with a wellness coach dedicated to help patients with goal-setting and motivation, oversees a team of providers from multiple areas of expertise. Our own Academy has resources for incorporating lifestyle medicine into everyday practice, as well as peer support through their lifestyle medicine member interest group. For doctors wishing to take training even further, the American College of Lifestyle Medicine (ACLM) offers board certification. The ACLM recently partnered with The Mayo Clinic to incorporate a lifestyle medicine residency curriculum into medical residency programs, ensuring education of future doctors.

A preventative healthcare system must also prioritize mental health services since as much as 75% of primary care visits are driven by psychological problems. These include behavioral factors related to chronic disease management, mental health issues, substance use, smoking, and the impact of stress, diet, and exercise on health. Despite serving as the main source of mental health care in many communities, not all doctors feel comfortable (or are competent) to treat psychiatric disorders. The consequences of our shortcomings are real: 70% of individuals suffering from depression remain undetected in primary care while a shocking 40% of people who committed suicide had a primary care visit within a month of their death.[6]

Family doctors know that treating mental health disorders is essential for patients to make real lifestyle changes. Recognizing this need, in 2017 the Centers for Medicare & Medicaid Services (CMS) began offering new payment opportunities for primary care physicians to integrate behavioral health into their practices as an important step to increasing access.[7] This important initiative will improve the health of patients *and* their providers. Mental health disorders contribute significantly to family physicians' frustrations with the healthcare system.[8] The high volume of patients suffering, the increased time required, and the varying skills in addressing these problems can lead to physician burnout.[9]

continued on page 16

continued from page 13

challenges of their clinical jobs, and feel less guilty in the sense of knowing, for example, that if they go on vacation or leave for another job somewhere else, the organization that employs them will make sure (hopefully) that their patients are cared for. Salaried employment in a large organization may have meaningful drawbacks related to the family doctor's ability to have desired autonomy, or practice in the precise manner they wish. But as the many family doctors I have interviewed over the years have told me, it encourages thinking about one's career in sustainable ways.

Relatedly, the number of traditional family doctor jobs in smaller, physician-owned practices- jobs that encourage greater pursuit of the comprehensive clinical role, shrink each year as older family doctors retire or sell their practices to corporately owned delivery systems. Those older family doctors end up suddenly being presented with the opportunity to build a more sustainable career. Many choose to pursue it, working part-time, for example, or enacting their work role in a more nine-to-five manner, which they were precluded from doing when business owners. Finally, while employment variety has decreased in the sense of more family doctors with fewer options for the kind of organization in which they can work, there are more varied everyday jobs these doctors can perform in such organizations. Working in urgent care centers and emergency departments, or as hospitalists; and working these jobs through shift work that provides more time off, and gives greater opportunity to pursue sustainable career goals as well.

Some reading this will conclude that the notion of a sustainable career is anathema to enacting the family doctor role in a comprehensive manner, perhaps in a smaller office practice where there could be a wider scope of work, a stable cohort of patients, and greater holistic care delivery. That may be true in some cases, although not in others. First, without a sustainable career approach, many family doctors will find that they do not possess the personal well-being or capacity to assume the role of a more comprehensive clinician even when one comes along. But the other reality is that there are fewer opportunities now in the health system to be a comprehensive family doctor in the first place. Until those opportunities cultivate and grow, family doctors, shrinking in numbers, subject to burnout and career dissatisfaction in greater numbers, should be able to seek out career paths that meet their full range of needs as professionals and people. This will help improve the overall well-being of the specialty, which is imperative right now.

Post-pandemic, the job of a family doctor, regardless of place of employment, has increased in difficulty. We talk about the need for greater resilience, but resilience is not a bottomless glass from which to drink forever. It has limits for every individual. To the extent family doctors make job and career choices that balance work with non-work consistently; allow ample time to turn away from the stress of doctoring and do other things; and engage in patient care or community health-building that isn't comprehensive per se but still allows for meaningful work, the field will retain a cohort of individuals who can navigate their everyday worlds effectively for themselves, their patients, and those who work around them. This will lend to a field of family medicine in which the people hopefully are happier, more optimistic, and able to embrace their work roles with vigor. If we cannot have every family doctor be a comprehensive care provider right now, maybe this is the next best thing. It may disappoint some purists, many of whom never were given the chance to pursue their own version of career sustainability. But that was then, and this is now. And the now is a health care system that won't look out for the best interests of the family doctor. A health care system that still undermines the practice of comprehensive primary care. In such a system, and until it changes, sustainable career building for the family doctor may be as noble a pursuit as anything else.

Endnotes

1. Haounji J. The great resignation and the future of the workplace. Entrepreneur. 2021 Aug 15. Available at : https://www.entrepreneur.com/article/379886.
2. Thompson D. Three myths of the great resignation. The Atlantic. 2021 Dec 8. Available at : https://www.theatlantic.com/ideas/archive/2021/12/great-resignation-myths-quitting-jobs/620927/.
3. Horstman C, Lewis C. How primary care is fairing two years into the Covid-19 Pandemic. To the point (blog), The Commonwealth Fund. 2022 Feb. 24. Available at: https://www.commonwealthfund.org/blog/2022/how-primary-care-faring-two-years-covid-19-pandemic#:~:text=In%20the%20spring%20of%202020,and%20decreased%20in%2Dperson%20visits.
4. De Vos A, Van der Heijden BI, Akkermans J. Sustainable careers: Towards a conceptual model. Journal of Vocational Behavior. 2020 Mar 1;117:103196.
5. Van der Heijden BI, De Vos A. Sustainable careers: Introductory chapter. In Handbook of Research on Sustainable Careers 2015 Jun 26. Edward Elgar Publishing.
6. Hoff T. 2022. Searching for the family doctor: Primary care on the brink. Baltimore, MD: Johns Hopkins University Press.

Timothy Hoff, PhD *is Professor of Management, Healthcare Systems, and Health Policy in the D'Amore-McKim School of Business and School of Public Policy and Urban Affairs, Northeastern University, in Boston, Massachusetts. He also is an Associate Fellow at Green-Templeton College, University at Oxford, and Associate Scholar, Said Business School, University at Oxford. His most recent book is Searching for the Family Doctor: Primary Care on the Brink, published by Johns Hopkins University Press (2022). Before going into academia, Hoff worked in family practice administration and as a health care consultant.*

continued from page 14

In addition to mental health services, family doctors need practical support for patients, particularly in impoverished areas where people can't afford healthcare services. In my rural practice, it wasn't uncommon for patients to decline an appointment because they couldn't afford the gas to come in to the office. Patients frequently chose to feed their families over filling their prescriptions. A realistic model of prevention must, therefore, include social workers or case managers to assist patients impacted by social determinants of health. The AAFP developed The EveryONE Project to help primary care offices in this endeavor, providing tools to address health inequity. Though "The Neighborhood Navigator," patients can be connected with resources and social support in their area. The EveryONE Project also has tools for incorporating lifestyle medicine into practice, including information on reimbursement.

Although often neglected because of time constraints, patient education is paramount to preventative care. Group visits, run by a variety of experts, will increase opportunities for teaching lifestyle skills while easing the physician's burden. For example, a diabetic group may have a nutritionist address diet during one session, a physical therapist assist with physical activity during another, and a mental health provider address anxiety, depression, and sleep – all overseen by the lead doctor. Patients also benefit from the community support, accountability, and camaraderie of group visits. The Integrated Center for Group Medical Visits is offering a virtual conference this September entitled "Cultivating Community and Connection," to explore this added perk.

Shifting to a preventative model may simply involve a reallocation of resources already in place. For example, nurses or other personnel involved in pre-visit planning could be trained as health coaches, assisting in goal setting while preparing charts for upcoming appointments. Those working in hospital-owned practices could utilize the expertise of case managers to address psychosocial barriers. Experts already on-staff could lead group visits modified for specific diseases or health goals. IT departments might assist in harnessing the power of technology through smart apps or online modules to further patient education or teach real-life skills, like stress reduction or sleep hygiene. In short, the medical profession could work together as a team.

There are no limits, beyond the physician's own drive and creativity, to enhancing patient care and personal work satisfaction. One underutilized means of improving societal health is to encourage community involvement. Sharing office space after hours could allow outside practitioners to offer meditation, massage, acupuncture and other desired services. Aside from benefiting patient wellbeing, these opportunities also provide desperately needed social connection. In food deserts, community volunteers could plant gardens to provide free, healthy food for those in need. Neighborhood walks and fitness challenges might further enhance participation.

While I am no longer working directly in primary care, I remain passionate about the future of healthcare in America. Doctors struggling with burnout can envision a new way of practicing medicine – one that inspires them to remember what called them to medicine in the first place: personal fulfillment through helping others. As family doctors, we know that health isn't merely the absence of disease. True health encompasses the very things that are missing in the daily work of many primary care providers: the joy of connection, the ability to make a meaningful contribution to society, and a sense of purpose that makes the hard work worthwhile. It takes just one motivated doctor with a supportive administration to make this dream a reality. This could be lifesaving – for both doctors and patients.

Resources

Incorporating Lifestyle Medicine into Everyday Practice: https://www.aafp.org/cme/all/online/lifestyle-medicine.mem.html

Lifestyle Medicine Member Interest Group: https://connect.aafp.org/communities/community-home? CommunityKey=5d4c8f0b-6ba0-4221-8c22-66536b951fec

The American College of Lifestyle Medicine: https://www.lifestylemedicine.org/ACLM/About/ACLM/About/About.aspx?hkey=4697cec6- fc2c-4738-834a-2df3cfe2278d

Lifestyle Medicine Residency Curriculum: https://www.lifestylemedicine.org/ACLM/Education/Academia/LMRC/ACLM/Education/LMRC/Residency_Curriculum.aspx?hkey=0fa9daa4-25a4-42d8-9762-928c503fa7d2

The EveryONE Project: https://www.aafp.org/family-physician/patient-care/the-everyone-project.html

New Tools Guide Lifestyle Medicine Integration for FPs: https://www.aafp.org/news/health-of-the-public/20210603lifestylemed.html

The Integrated Center for Group Medical Visits: https://icgmv.org

Endnotes

1. Kane, L. (Jan 2022) Medscape. Physician Burnout & Depression Report 2022. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664
2. Schernhammer, E. Taking Their Own Lives — The High Rate of Physician Suicide. N Engl J Med 2005; 352:2473-2476. DOI: 10.1056/NEJMp058014.
3. Agency for Healthcare Research and Quality. (July 2017) Physician Burnout. https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html
4. Harvard CH Chan School of Public Health. The Nutrition Source: Disease Prevention. https://www.hsph.harvard.edu/nutritionsource/disease-prevention/
5. Cleveland Clinic. (Sept 2020) Wellness: 5 Healthy Habits That Prevent Chronic Disease. https://health.clevelandclinic.org/5-healthy-habits-that-prevent-chronic-disease
6. American Psychological Association. (Jan 2014). Briefing Series on the Role of Psychology in Health Care https://www.apa.org/health/briefs/primary-care.pdf
7. Miller-Matero LR, Dubaybo F, Ziadni MS, Feit R, Kvamme R, Eshelman A, Keimig W. Embedding a psychologist into primary care increases access to behavioral health services. J Prim Care Community Health. 2015 Apr;6(2):100-4. doi: 10.1177/2150131914550831. Epub 2014 Sep 16. PMID: 25231374.
8. Schrager, S. Integrating Behavioral Health Into Primary Care. Fam Pract Manag. 2021 May-June;28(3):3-4.
9. Huggard, D. Integrated behavioral health in a clinical primary care setting MGMA Insight. 2020 Sept

***Jen Baker-Porazinski, MD** worked as a family doctor in rural New York for over two decades before joining the Health and Performance Team at Canyon Ranch this year. She has an interest in integrative, lifestyle, and narrative medicine and is writing a memoir about working in the American healthcare system, sharing both her own and her patients' stories. She occasionally blogs at https://poundofpreventionblog.wordpress.com*

To the Editor:
Crypto Currency and Climate Change

I write to urge my colleagues across the state to recognize the threat that "proof of work cryptocurrency" poses to our goals to limit and control climate change. The excessively high energy consumption of proof of work cryptocurrency threatens to prevent NYS from achieving its energy goals. The favorable costs of electricity in many parts of NYS have led these companies to attempt setting up shop in widely disparate areas – urban and rural. Many have already succeeded and others are yet to be established. Municipalities are often poorly informed regarding their impacts. Those impacts range from climate change health dangers, economic implications, and environmental degradation to name a few categories.

Not all cryptocurrency is equal. Proof of work is the most egregious offender and the one to focus on. For those that want to look further into it I recommend this presentation given in January to the League of Women Voters. Skip to 3minutes and 50 seconds to begin it: https://www.youtube.com/watch?v=qIuMqn2ISA4

In my region, the advisory committee that I sit on for the Town of Lansing issued a white paper to outline concerns around this issue. I urge you to read it and use its talking points to speak with and write to your municipalities. Go to https://lfweb.tompkins-co.org/WebLink/DocView.aspx?id=64414&dbid=7&repo=Lansing to access it.

As of this writing the Assembly and Senate have passed the limited legislation mentioned in the video (A7389/S6486). It addresses a piece of this problem. More is needed since there are many paths for proof of work to exploit NYS's resources.

Family physicians are acutely aware of the adverse medical effects of a warming climate. Speaking out in our communities can help improve knowledge and raise concern. Social media posts, placing a letter in publications and speaking on radio and TV can also help.

Your state Academy has already raised its voice about this threat. But your voice is needed on the local level. Let your state assemblyperson and senator know as well as your municipalities. Urge them to take steps to prohibit any industry that uses such massive amounts of energy. Some might object saying that we are acting against a single industry. We are not. We are focusing on the factors that make an industry like proof of work so dangerous and taking action to control those impacts.

Dr. William Klepack
Tompkins County

Better Together? The Future of Primary Care Physicians and Advanced Practice Providers

By Renee Messina-Santiago, DO and Isabel Elliott

Introduction

With an impending physician shortage, many practices have moved towards models including advanced practice providers (APPs) including physician associates (PAs) and nurse practitioners (NPs), as cornerstones of patient care. Increasing demands on primary care paired with a consistently declining pool of trained physicians has left established providers at a crossroads; limit their own patient load or lean on APPs to expand their accessibility.

While PAs and NPs can be highly skilled providers, it is imperative to define the role of physicians in healthcare settings dominated by non-physicians. Emphasis is needed on creating a model for a symbiotic relationship between advanced practice providers and physicians that benefits patients and doctors alike. This article aims to explore these dilemmas and the future of newly certified family physicians in an evolving primary care landscape.

Background

By 2034, a physician shortage of up to 124,000 doctors is predicted nationwide. By all approximations, 1,220 of those will be primary care providers in New York State.[1,2] To prepare for this impending need, many states have granted APPs full practice autonomy. While the goal of primary care is to expand the accessibility of healthcare to a wider population, it is essential such care is provided in a safe, effective, and efficient manner. By expanding the types of providers within the primary care sphere, the role of physicians requires clarification, so they are not relegated to a managerial role where APPs are seen as subordinates instead of collaborators. In some current practice models, APPs do the bulk of patient interaction while physicians handle the more complicated cases and administrative tasks. In these scenarios, physicians are fulfilling an oversight position rather than contributing to their full clinical potential. The current perceived hierarchy between APPs and physicians has created a barrier to providing the most thorough, cost effective, and efficient care possible. Existing information demonstrates the potential for flourishing family practices where care is provided through partnerships of APPs and physicians in which both can fully utilize their expertise for the benefit of patients, practices, and providers.

In the most recent Association of American Medical Colleges (AAMC) models illustrating the role APPs could have in alleviating the predicted physician shortage, there is optimism as well as an air of caution. The report's emphasis is on the ability of physicians to care for more patients as members of a team whose skills and expertise complement one another. Stating, "quantifying the amount of improved efficiency is challenging with currently available data. Complicating the issue is whether the additional team members provide the same services the physician would have or additional services the physician would not have."[1] These AAMC models aim to elaborate on the roles of all members of a well-rounded medical team, and how their individual skillsets can best complement the overall goals of patient care. In exploring the possibility of APPs taking over some the practical roles of a physician, it is relevant to examine the differences in education and training times between these sets of professionals.

PA training curriculum can vary widely from institution to institution, but most programs are 2-3 years consisting of didactic training and hands-on clinical experience. PA students must complete

at least 2000 hours of supervised clinical practice before receiving their master's degree. Continuing education and recertification are akin to that of physicians with 100 hours of continuing education hours required every 2 years and recertification exams every 10 years. NPs are registered nurses who have completed additional didactic and clinical training to achieve a master's or doctoral level. They are required at least 1000 hours of focused clinical experience in their degree (pediatric, adults, or geriatric medicine). Primary care physicians enter the field with roughly 15,000 hours of clinical experience when considering both the clinical hours required to complete medical school and years of residency training.[3]

Currently, many states allow NPs to practice without physician oversight. PAs are authorized to practice with a supervising physician, though the degree of that supervision can vary immensely. There is suggestion that a more standardized set of competency-based standards are needed for both PAs and NPs due to the potential for suboptimal clinical rotations and shorter training time. Based on these differences in training time and clinical exposure prior to full practice autonomy, many physicians have questioned the safety of allowing APPs to care for patients without direct supervision.

Much of the data on patient safety and outcomes in environments with a large percentage of APPs comes from inpatient and emergency room settings. According to these studies, the number of patients seen exclusively by physicians in the emergency care setting has been declining and generally reserved for older or higher acuity individuals.[1] With this data being the most robust up to this point, its extrapolation into the primary care world offers the best estimate of the utility and safety of APPs in primary care.

One such study looked at the length of stay, hospital readmission, and overall cost of treatment in pediatric inpatient populations when cared for by teams either consisting of attending hospitalists and resident physicians or attending hospitalists and APPs. While this data does not directly reflect how these teams would perform in the primary care setting, it offers promising insight into the potential benefit of collaborative APP-physician teams. DeWolfe et al. found that pediatric patients cared for by teams including APPs and attending hospitalists accrued 13% fewer hospital charges and were one-sixth as likely to be readmitted within 3 days of discharge.[4] If these kinds of cost-saving care teams can be extrapolated to the outpatient care setting, there may be potential to increase the accessibility of such primary and preventative care by decreasing the financial burden on patients.

Many proponents of the wider use of APPs in primary care and family practice turn to the perceived financial incentives of hiring more NPs and PAs to take on many of the responsibilities of physicians. In New York, the average salary of PAs in primary care is $108,880 as compared with the average $206,402 earned by primary care physicians.[6,7] One study out of Hattiesburg, Mississippi sought to explore how this perceived fiscal benefit was translating to patients and insurance providers alike. Their data found that patients whose primary provider was a non-physician rather than a doctor ultimately incurred a higher cost to their insurance and more oversight scrutiny from bodies such as the Centers for Medicare and Medicaid Services. The difference in cost was attributed to higher numbers of laboratory tests, specialist referrals and emergency room visits.[5] The evidence of APPs in this environment, and many like it, illustrates their invaluable role in providing care for patients who may otherwise go without care, but the role of a physician remains essential. The Hattiesburg clinic responded to this by creating collaborative patient-centered teams including an APP and physician to provide for better patient outcomes and institutional financial efficiency. This data is unique as it offers perspective from a state that does not allow APPs to practice without physician oversight, thus making collaboration the rule instead of a, sometimes unwelcome, suggestion.

Discussion

Currently available information shows that neither physicians nor APPs can handle the impending imbalance in provider supply and demand alone. An equilibrium in responsibilities and scope of practice needs to be established so that physicians are not simply fulfilling a managerial role over APPs, and APPs are not medically managing patients beyond their expertise. A culture of mentorship and knowledge sharing should be created in lieu of the perceived rift and hierarchy currently existing between physicians and APPs. The knowledge of both fields is critical to patient health, safety, and clinical care.

Those nurse practitioners who have spent time as bedside RNs bring a depth of understanding in patient experience, while physicians bring a foundational understanding of pathology and management. Both are essential to effective patient care. Current research does present a need for more insight into the patient experience when cared for by NPs and PAs, however, existing data does show higher patient satisfaction with these providers. In a national survey analysis done by Kippenbrock, et al., using 0-10 point scales (10 = best provider possible, 0 = worst provider possible) of patient satisfaction, NPs scored an average of 9.16 and PAs an average of 9.02 as compared to the average 8.96 earned by MDs.[8] While this evidence does not explore the patient satisfaction when cared for by collaborative teams or delve into the differences in expertise between NPs who have spent time as RNs and those who have not, it does offer some promising insight into the patient perception of APPs.

Some argue the difficulty newly graduated physicians pursuing primary care and family medicine may face coming into practices with knowledgeable and, often, more experienced APPs. In such situations as the current hierarchy dictates, both the new physician and the practiced APP may feel more knowledgeable. Both can be true. A new physician has some of the broadest and most up-to-date knowledge that they will have in their career, while the APP knows the way a particular practice functions, the type of pathology seen most frequently in an area, and the most effective ways of navigating the health literacy in a specific community. In a practice culture that values transfer of ideas regardless of perceived hierarchy, the APP would be able to mentor the new physician in these skills as necessary for success in that particular patient population, in the same way the new physician can bring the APP up-to-date with the newest knowledge and research.

A significant barrier to the use of APPs and physicians to their fullest collaborative extent comes from their perceptions and regard for each other. The aforementioned commentary piece from Sarzynski and Barry highlights these areas of disagreement: "Two-thirds of physicians believe that doctors provide higher-quality exams and consultations than do NPs, whereas three-fourths of NPs disagree."[3] What this

continued on page 20

continued from page 19

represents in the rift between APPs and physicians is based not on actual clinical ability but on perceived value in primary care. To combat an unnecessary rivalry between highly skilled professionals, more data is needed to indicate the precise areas of practice best handled by physicians and APPs respectively. However, current information strongly points to the success of collaborative teams where complementary expertise serves to bolster both patient outcomes and patient satisfaction. Until we have evidence from which policy and guidelines can stem, primary care physicians should explore models within their own practices that allow APPs an opportunity for growth and mentorship so we may all become more thorough, knowledgeable, and empathetic providers.

Endnotes

1. IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: AAMC; 2021.
2. Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
3. Erin Sarzynski MD. Current evidence and controversies: Advanced Practice Providers in Healthcare [online]. AJMC. MJH Life Sciences. Available at: https://www.ajmc.com/view/current-evidence-and-controversies-advanced-practice-providers-in-healthcare
4. DeWolfe C, Birch S, Callen Washofsky A, Gardner C, McCarter R, Shah NH. Patient outcomes in a pediatric hospital medicine service staffed with physicians and advanced practice providers. Hospital Pediatrics. 2019;9:121–8.
5. Robeznieks A. Amid doctor shortage, NPS and PAS seemed like a fix. Data's in: Nope. [online]. American Medical Association. 2022. Available at: https://www.ama-assn.org/practice-management/scope-practice/amid-doctor-shortage-nps-and-pas-seemed-fix-data-s-nope
6. Glassdoor.com. 2022. Primary Care Physician Assistant Salaries. [online] Available at: https://www.glassdoor.com/Salaries/new-york-city-physician-assistant-salary-SRCH_IL.0,13_IM615_KO14,33.htm
7. Glassdoor.com. 2022. Primary Care Physician Salaries. [online] Available at: https://www.glassdoor.com/Salaries/new-york-city-primary-care-physician-salary-SRCH_IL.0,13_IM615_KO14,36.htm
8. Kippenbrock, T., Emory, J., Lee, P., Odell, E., Buron, B., & Morrison, B. (2019, November/
9. December). A national survey of nurse practitioners' patient satisfaction outcomes. Nurs Outlook, 67(6),707_712. https://doi.org/10.1016/j.outlook.2019.04.010.

Renee Messina-Santiago, DO *is a board-certified family medicine physician with 15 years in practice, 13 of those years in solo practice on Long Island. She has been a clinical educator for Northwell medical students, Touro medical students, Stony Brook nurse practitioners, Molloy nurse practitioners, Cornell nurse practitioners, and St. Joseph physician assistants.*

Isabel Elliott *is a 4th year medical student at Touro College of Osteopathic Medicine and a graduate of Boston University where she studied neuroscience. Isabel is a recipient of the Health Professionals Scholarship from the US Navy, and served as a health volunteer and educator in the Peace Corps in Mozambique. Isabel plans to pursue pediatric primary care following graduation.*

Providing Abortion Pills in Primary Care

By Chelsea Faso, MD; Mayra Hernandez Schulte, MD and Caitlin Weber, MD

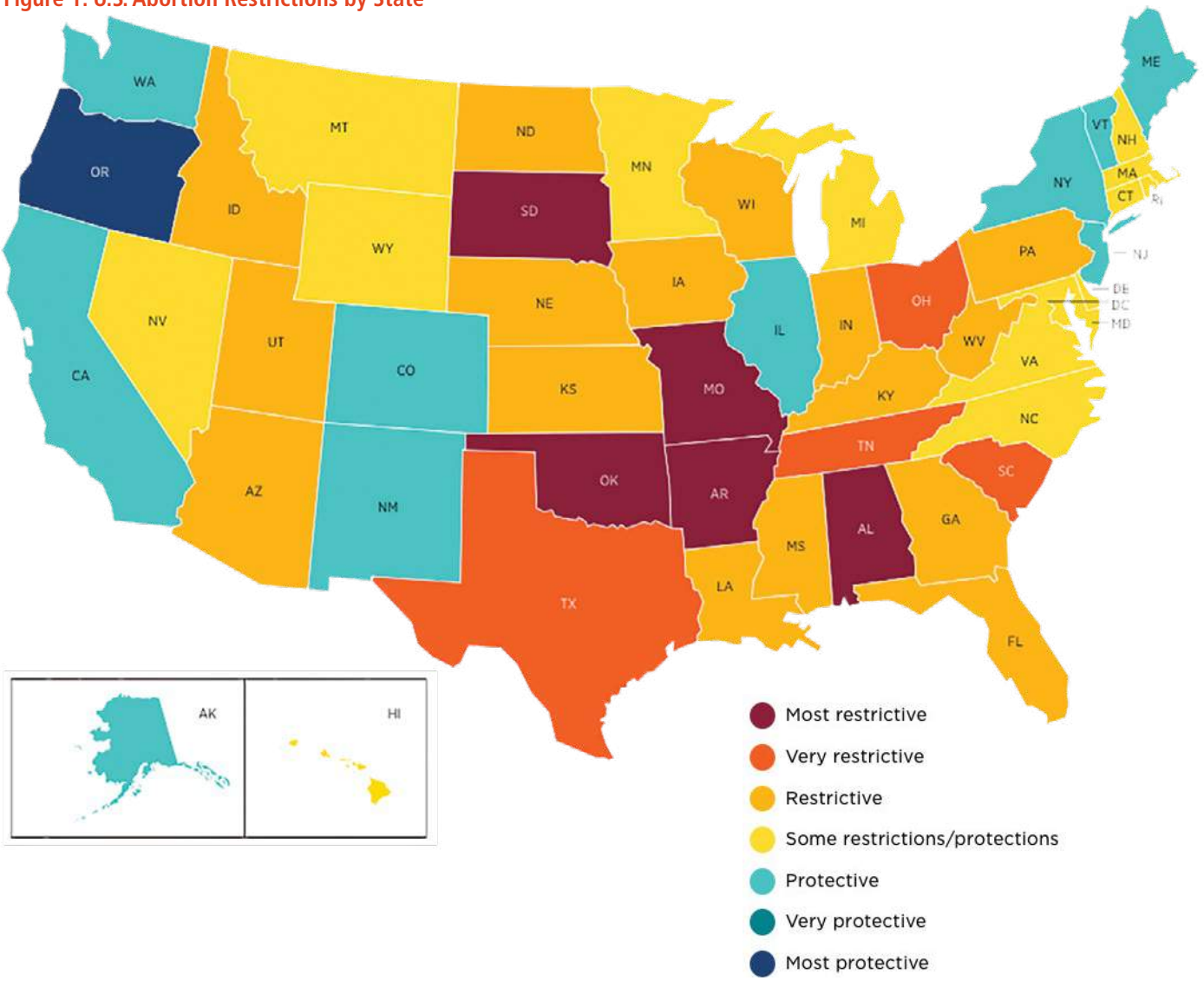
The American Academy of Family Physicians (AAFP) states that abortion is health care, that patients have the right to make their own decisions about their reproductive lives, and that politicians should not interfere in the patient provider relationship.[1,2,3] The Supreme Court's June 24 decision on *Dobbs v. Jackson Women's Health Organization* has effectively overturned the prior decisions in *Roe v. Wade* and *Planned Parenthood v. Casey*, thereby eliminating abortion access to more than half of the country, including many places where access had already been severely restricted prior to this decision. As of this article's publication, 13 states have trigger laws that have already gone into effect, with at least 13 other states expected to soon follow. The overturning of *Roe v. Wade* is already being felt across New York as well as the country as a whole, disproportionately harming already marginalized individuals and communities. As summarized by a recent statement from Dr. Sterling Ransone, president of the AAFP, "this decision negatively impacts our practices and our patients by undermining the patient-physician relationship and potentially criminalizing evidence-based medical care."[4]

Abortion is a common experience for people in the US, with 1 in 4 people with reproductive potential having an abortion by age 45.[5] 88% of abortions occur in the first 12 weeks of pregnancy. Most people who get abortions (59%) have 1 or more children who they are already taking care of. 75% of US abortions are for pregnant people living in poverty or earning low incomes. 62% of abortions are for patients who report a religious affiliation. White-race pregnant people make up the majority of abortions (39%), followed by Black (28%), Hispanic (25%), Asian/Pacific Islander (6%), and other-race (3%). Adolescents made up 12% of abortions in 2014, with only 4% being minors. As of July 2017, approximately 87% of US counties had no abortion provider despite 34% of the population living in these counties being of reproductive age, and this disparity is projected to worsen.[6]

State-based abortion restrictions have already created an inequitable health care landscape, isolating many communities to inaccessible out-of-state care. With the overturn of *Roe*, 26 states are certain or

continued on page 22

Figure 1. U.S. Abortion Restrictions by State



continued from page 21

likely to ban or significantly restrict abortion, as shown in Figure 1 (precise details are evolving as of the time of publication).[7] Middle- and higher-income folks, who are more likely to be white than Black, Indigenous, or people of color, will have greater financial flexibility and resources to travel, arrange childcare and lodging, and take time off work while traveling for abortion care. We are already seeing these patients from Texas in New York clinics since Texas' extreme 6-week ban, SB-8, went into effect in September 2021.

In New York, abortion care is available in person or via telemedicine. In 2019, New York codified the right to abortion in New York State through passage of the *Reproductive Health Act*. This act offers legal protections for accessing abortion care, regardless of *Roe* status.[8] States with legal protections like New York are currently identified as surge states. This means that New York is expected to see an even greater influx (or surge) in patients seeking abortion care from states where abortion restrictions are enacted given the fall of Roe. Some surge states may directly neighbor states with extreme abortion bans, but some states like New York have high accessibility for travel via air, train, or bus, for those who can afford it. This calls attention to the need to expand abortion access points in surge and other protective states. Without expanding access into primary care, the usual clinics will be flooded, and local patients may have difficulty getting appointments. Expanding access to medication abortion in primary care settings presents an opportunity to offload this demand.

Primary care clinicians – including family physicians, pediatricians, and internists – can and do provide abortion care. Depending on state laws, some advanced practice clinicians, including nurse practitioners, nurse midwives, and physician assistants are also providing medication abortion and aspiration abortion care.[9,10] Although subspecialty training in OBGYN and fellowships in reproductive health exist to provide intensive training in abortion care, complex family planning certification is not necessary to provide safe abortion care according to the National Abortion Federation's Clinical Policy Guidelines.[11]

The most common early abortion options are medication abortion and aspiration abortion. They are both safe, effective, and acceptable ways to end a pregnancy. Both methods can be done in the outpatient setting.[12] First trimester abortions do not increase the risk of infertility, ectopic pregnancy, miscarriage, birth defect, preterm or low-birthweight delivery, breast cancer, or depression.[12,13]

In 2020, medication abortion accounted for 54% of US abortions, which is a significant increase from 39% in 2017, suggesting its growing acceptance by patients and providers and the necessity for continued access to abortion care during the COVID-19 pandemic.[14] The regimen used in the US for medication abortion includes mifepristone followed by misoprostol.[15] Mifepristone is an anti-progesterone, which interferes with early pregnancy by competing with progesterone.[16,17] This prevents the pregnancy from growing and promotes cervical ripening. Misoprostol is a prostaglandin that causes cervical softening, uterine contractions, and expulsion of the pregnancy.[18] Multiple doses of misoprostol can be used to increase effectiveness of the regimen based on gestational age.[19,20] This regimen is detailed in Table 1.

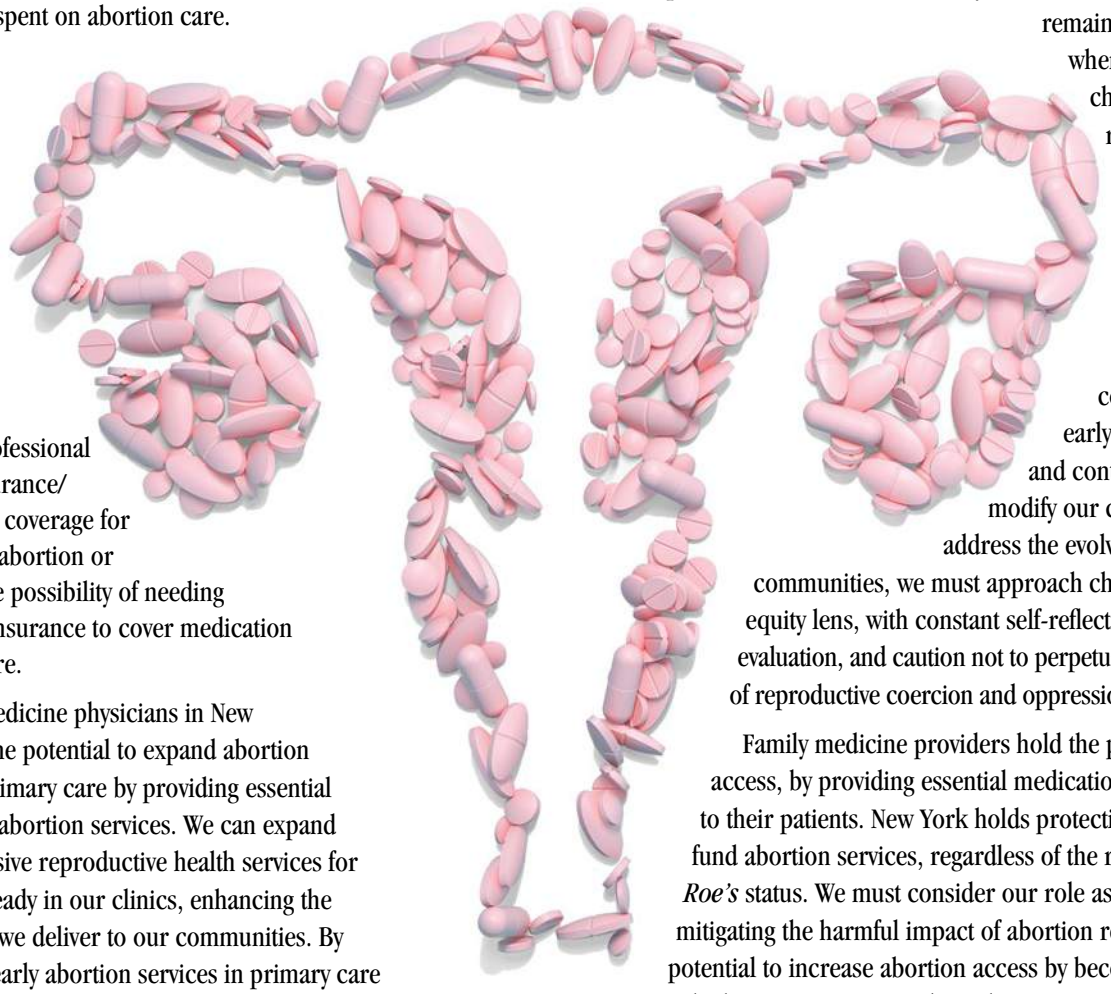
Medication abortion using mifepristone and misoprostol has been FDA approved since 2000 and has a proven safety and efficacy profile. The regimen, when used up to 11 weeks gestation, is between 98-99% effective, with rare complications as shown in Table 2. Medication abortion is safer than a colonoscopy, a common dental procedure, or taking Tylenol.[12] Despite the regimen's safety and efficacy profile, mifepristone is highly regulated by the FDA's Risk Evaluation and Mitigation Strategy (REMS), which imposes restrictions on medications with concerning safety profiles, such as common chemotherapy regimens and antipsychotic medications such as clozapine, for example.[21] One restriction under the FDA mifepristone REMS involves provider certification, requiring at least one clinician in a health center or system to certify they have the clinical knowledge to provide medication abortion (including ability to date a pregnancy, diagnose an ectopic pregnancy, and manage incomplete abortion). Other restrictions include mandated FDA patient agreement forms (in addition to any routine consent forms), and an in-person dispensing requirement. After a comprehensive review of the FDA mifepristone REMS in December 2021, which considered 20 years of safety data and evidence including remote provision of medication abortion during the COVID-19 pandemic, the in-person dispensing requirement was permanently lifted, allowing certified pharmacies or clinicians to dispense mifepristone in person or by mail. Prior to the mifepristone REMS review, researchers and experts found the REMS unnecessary, and advocacy efforts continue to remove the FDA Mifepristone REMS entirely.[22]

Medication abortion with mifepristone and misoprostol is highly effective and significantly minimizes surgical or anesthetic risks. Compared to aspiration abortion, some patients describe medication abortion as less invasive and more natural, as it is similar to the process of an expectantly managed miscarriage or early pregnancy loss. It may also offer enhanced privacy or a sense of control, as patients have autonomy over when, where, and with whom the abortion will happen. Compared to an aspiration, which is completed in a single day, the process during a medication abortion may continue over several days, with a longer bleeding duration. Its other advantage is that, with the lifting of the in-person dispensing requirement, it is more accessible in rural areas or in states with few abortion clinics since the consult can be via telemedicine and the pills may then be mailed.

Evidence shows that most patients do not require any lab tests or ultrasound before a medication abortion.[11,23] Gestational age can be confirmed with a sure last menstrual period (LMP). Minimizing the need for ultrasound is important for enhancing timely and accessible care. There are a few indications for sonogram listed in Table 3. Rh testing and rhogam administration are not necessary for early abortions up to 12 weeks gestation.[10] This allows patients the option to access medication abortion via telemedicine. Follow-up after medication abortion is optional and is offered 1-2 weeks after the initial visit. Completion of the abortion can be confirmed with a history assessment asking four cardinal questions: 1) Did you take the pills, 2) Did you have bleeding, 3) Did you have cramping, and 4) Do

you still feel pregnant? This assessment can be completed over the phone, video, or in-person. Ultrasounds and labs tests are not necessary to confirm completion of a medication abortion.[24,25] If desired by a patient, a home urine pregnancy test can be performed 4-6 weeks after taking the pills to confirm a negative result.

When starting medication abortion services in a clinic, there are some items to consider. Generally, clinics that receive federal funding maintain the ability to provide abortion care as long as funds going toward abortion services are not federal or otherwise restricted funds. Some states, including New York, allow state Medicaid coverage of abortion services, and federally qualified health centers (FQHCs) can and should bill Medicaid in these states. It is critical to identify allies and champions across departments for introducing abortion care services in your clinic who can form an organized planning committee to lead steps and activities toward starting new medication abortion services. One critical activity is to initiate discussions with staff about support for abortion care and to explore values and personal feelings. The planning committee should also identify a pharmacy or provider in your organization to sign up with a distributor (*GenBioPro* or *Danco*) to obtain mifepristone in your clinic. Additionally, clinic leadership often requires creating clinical policies, protocols, and procedures for new services. Explore billing and reimbursement, as special care needs to be taken in accounting departments to segregate costs so that no federal dollars are spent on abortion care.



Confirm professional liability insurance/ malpractice coverage for medication abortion or consider the possibility of needing additional insurance to cover medication abortion care.

Family medicine physicians in New York hold the potential to expand abortion access in primary care by providing essential medication abortion services. We can expand comprehensive reproductive health services for patients already in our clinics, enhancing the health care we deliver to our communities. By expanding early abortion services in primary care settings and thus not overwhelming our abortion clinics in New York, we also make room for out-of-state patients while we help preserve access. There are multiple organizations available to support family medicine physicians providing abortion care. The Reproductive Health Access Project (RHAP) trains, supports, and mobilizes primary care clinicians to ensure equitable access to sexual and reproductive health care, including abortion. RHAP is a source for patient-facing education materials, clinician guides, and technical assistance for integrating abortion services into practice.[26] Another organization, RHEDI (Reproductive Health Education in Family Medicine) aims to mainstream and destigmatize abortion care within family medicine through training and resources. These and other resources for providing abortion pills in primary care are included in Table 4.

Enhancing access to abortion care is directly related to addressing the maternal mortality crisis. States that restrict abortion have higher mortality rates than states that either protect or are neutral toward abortion, and evidence suggests that access to legal abortion substantially improves maternal health for minority race groups.[27,28,29]

Importantly, our role as clinicians is to facilitate a patient's choice in decisions about pregnancy and abortion, supporting them in exercising their bodily autonomy. Despite rapid changes in the legal landscape of reproductive health care, worsening health disparities, and pressures on our health care system and communities, we must remain patient-centered when discussing all choices related to reproductive health care, including modality of health care delivery (in-person vs telemedicine), pregnancy options counseling, exploring early abortion options, and contraception. As we modify our clinical practices to address the evolving needs of our communities, we must approach change with a health equity lens, with constant self-reflection, program evaluation, and caution not to perpetuate historical trends of reproductive coercion and oppression.[30]

Family medicine providers hold the potential to expand access, by providing essential medication abortion services to their patients. New York holds protections to continue and fund abortion services, regardless of the recent changes to *Roe's* status. We must consider our role as family physicians in mitigating the harmful impact of abortion restrictions and the potential to increase abortion access by becoming prescribers and advocating to protect the right to essential abortion care.

continued on page 25

Table 1. Mifepristone/Misoprostol Medication Abortion Protocol[15,19]

	Buccal Misoprostol	***Vaginal Misoprostol***
Maximum Gestational Age	77 days from LMP	77 days from LMP
Mifepristone Dose	200 mg orally	200 mg orally
Misoprostol Dose/Route	*< 9 weeks:* 800 mcg buccally (4 tablets) *9-11 weeks:* 800 mcg buccally x 2 (8 tablets) 4 hours apart	*< 9 weeks:* 800 mcg vaginally (4 tablets) *9-11 weeks:* 800 mcg vaginally x 2 (8 tablets) 4 hours apart
Misoprostol Timing	24-48 hours after Mifepristone	6-72 hours after Mifepristone

Table 2. Complication Rates for Medication Abortion Using Mifepristone and Misoprostol[19]

Complication	***Rate***
Need for unplanned uterine aspiration for reason other than ongoing pregnancy	1.8-4.2%
Ongoing pregnancy	0.8%
Hemorrhage requiring transfusion	0.03-0.6%
Undiagnosed ectopic pregnancy	0.02%
Pelvic infection	0.01-0.5%

Table 3. Indications for Ultrasonography Before Medication Abortion[19]

- Increased risk of ectopic pregnancy (mifepristone and misoprostol will not induce abortion if pregnancy is ectopic, refer for treatment if suspected)
  - » Adnexal mass or tenderness on exam
  - » History of ectopic pregnancy
  - » History of treatment for pelvic inflammatory disease
  - » History of tubal surgery, including sterilization
  - » Pregnancy with intrauterine device in place
  - » Vaginal bleeding or unilateral pelvic pain
- Unable to confirm gestational age less than 11 weeks
  - » Uncertain LMP or no menses after delivery, abortion
  - » Recently taking or stopping contraception

Table 4. Resources on Providing Abortion Pills in Primary Care

Reproductive Health Access Project (RHAP) https://www.reproductiveaccess.org/resource/mabfactsheet/ https://www.reproductiveaccess.org/resource/medication-abortion-protocol/ https://www.reproductiveaccess.org/resource/telehealth-care-for-mab-protocol/ https://www.reproductiveaccess.org/resource/access-delivered-toolkit/ https://www.reproductiveaccess.org/resource/toolkit-medication-abortion/ https://www.reproductiveaccess.org/resource/order-mifepristone/
Reproductive Health Education in Family Medicine (RHEDI) https://rhedi.org/optimal-medication-abortion-protocol/
Training in Early Abortion for Comprehensive Healthcare (TEACH) https://www.teachtraining.org/training-tools/early-abortion-training-workbook/
National Abortion Federation 2022 Clinical Policy Guidelines for Abortion Care https://prochoice.org/providers/quality-standards/
World Health Organization Abortion Care Guideline https://www.who.int/publications/i/item/9789240039483

continued from page 23

Endnotes

1. AAFP Policy. Reproductive Decisions. COD 2017. https://www.aafp.org/about/policies/all/reproductive-decisions.html
2. AAFP Policy. Reproductive and Maternity Health Services. COD 2018. https://www.aafp.org/about/policies/all/reproductive-maternity-health-services.html
3. AAFP, AAP, ACP, ACP. Joint Principles for Protecting the Patient-Physician Relationship. 5/23/2018. http://www.groupof6.org/dam/AAFP/documents/advocacy/legal/ST-Group6-LegislativeInterference-052318.pdf
4. Ransone, S. AAFP Statement: Supreme Court Decision Criminalizes Medical Care and Limits Access to Health Care. https://www.aafp.org/news/media-center/statements/supreme-court-decision-criminalizes-medical-care-and-limits-access-to-health-care.html
5. Jerman J, Jones RK, Onda T. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. New York: Guttmacher Institute, 2016.
6. Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2014. *Perspectives on Sexual and Reproductive Health*. 2017;49(1).
7. Nash E, Cross L. 26 States Are Certain or Likely to Ban Abortion Without Roe: Here's Which Ones and Why. Policy Analysis Guttmacher Institute. October 28, 2021.
8. NYCLU. What you need to know about the reproductive health act. New York Civil Liberties Union. 2022. https://www.nyclu.org/en/campaigns/what-you-need-know-about-reproductive-health-act
9. Weitz, T. A., Taylor, D., Desai, S., Upadhyay, U. D., Waldman, J., Battistelli, M. F., & Drey, E. A. Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver. *American Journal of Public Health*. 2013;103(3), 454–461. doi: 10.2105/AJPH.2012.301159
10. Abortion Care Guideline. Geneva: World Health Organization; 2022. License: CC BY-NC-SA 3.0 IGO. Abortion care guideline (who.int)
11. National Abortion Federation (NAF) Clinical Policy Guidelines 2022. Quality/Standards - National Abortion Federation (prochoice.org)
12. National Academies of Sciences, Engineering, and Medicine. 2018. The Safety and Quality of Abortion Care in the United States. Washington, DC: The National Academies Press. doi.org/10.17226/24950.
13. Boonstra HD, et al. Abortion in Women's Lives. New York: Guttmacher Institute. 2006.
14. Jones RK, Nash E, Cross L, Philbin J, Kirstein M. Medication Abortion Now Accounts for More Than Half of All US Abortions. Policy Analysis. New York: Guttmacher. February 24, 2022.
15. Reproductive Health Access Project. Protocol for Medication Abortion Using Mifepristone and Misoprostol. May 25, 2021. https://www.reproductiveaccess.org/resource/medication-abortion-protocol/
16. Herrmann WL et al. Effects of the antiprogesterone RU 486 in early pregnancy and during the menstrual cycle. Future aspects in contraception. 1984; Chapter 22: 249-70.
17. Swahn ML, Cekan S, Wang G, Lundstrom V, Bygdeman M. Pharmacokinetic and clinical studies of RU 486 for fertility regulation. In: Beaulieu EE, Siegel S, eds. The AntiprogestinSteroid RU 486 and Human Fertility Control. New York, NY: Plenum; 1985:249-258.
18. Baird D. Mode of action of medical methods of abortion. *JAMWA*. 2000; 35(3): S121-126.
19. MacNaughton H, Nothnagle M, Early J. Mifepristone and Misoprostol for Early Pregnancy Loss and Medication Abortion. *American Family Physician*. 2021; 103(8): 473-480.
20. Reproductive Health Access Project. How to use abortion pills fact sheet. 2021-06 How to Use Abortion Pills (reproductiveaccess.org)
21. US FDA: Mifeprex (mifepristone) Information. December 16, 2021. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information
22. Henne JE, Gayle HD. Time to Reevaluate U.S. Mifepristone Restrictions. *NEJM*. 2019; 381: 597-598. doi: 10.1056/NEJMp1908305
23. Raymond EG, Bracken H. Early medical abortion without prior ultrasound. *Contraception*. 2015; 92(3): 212-4. doi: 10.1016/j.contraception.2015.04.008
24. Raymond EG, Grossman D, Mark A, et al. No-Test medication abortion: A sample protocol for increasing access during a pandemic and beyond. *Contraception*. 2020; 101(6): 361-366. doi: 10.1016/j.contraception.2020.04.005
25. Andersen KL, Fjerstad M, Basnett I, Neupane S, Acre V, Sharma S, Jackson E. Determination of medical abortion success by women and community health volunteers in Nepal using a symptom checklist. *BMC Pregnancy Childbirth*. 2018; 18(1): 161. doi:10.1186/s12884-018-1804-3
26. Reproductive Health Access Project. Toolkit for Integrating Medication Abortion in Primary Care. November 18, 2018. https://www.reproductiveaccess.org/resource/toolkit-medication-abortion/
27. Addante, Amy N., et al. The Association between State-Level Abortion Restrictions and Maternal Mortality in the United States, 1995-2017. Contraception. 2021;104(5): 496–501. doi.org/10.1016/j.contraception.2021.03.018.
28. Farin, Sherajum M., et al. The Impact of Legal Abortion on Maternal Health: Looking to the Past to Inform the Present. 2021. doi.org/10.2139/ssrn.3913899
29. Vilda, Dovile., et al. State Abortion Policies and Maternal Death in the United States 2015-2018. American Journal of Public Health. 2021; 111(9): 1696-1704. doi/10.2105/AJPH.2021.306396
30. Roberts DE. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Vintage Books; 2017.

***Chelsea Faso, MD** is a fellow with the Reproductive Health Access Project at the Institute for Family Health in Harlem. She studied biomedical education at the Sophie Davis School of Biomedical Education (CUNY Med), completed medical school at NYU School of Medicine, and residency in family medicine at Montefiore Medical Center. She is also a current Leadership Training Academy Fellow with Physicians for Reproductive Health.*

***Mayra Hernandez Schulte, MD** is a fellow with the Reproductive Health Access Project at the Institute for Family Health in the Bronx. She completed both her undergraduate degree, in biological sciences, and medical degree at University of California, Riverside. She finished her residency in family medicine in Los Angeles at White Memorial Medical Center.*

***Caitlin Weber, MD, MS, IBCLC, FAAFP** is faculty at the Harlem Residency in Family Medicine, Assistant Professor of Family Medicine and Community Health at Mount Sinai Icahn School of Medicine, and Reproductive Health and Advocacy Fellowship Director at the Institute for Family Health in New York City. She attended Albany Medical College followed by residency at the University of Texas at Austin Dell Medical School and a fellowship in family planning at Columbia University.*

Who Knew Hemorrhoids Could Be Profound?

By Elena Hill, MD, MPH

For several years, I have worked as a physician with the Refugee Health Alliance, a non-governmental organization that provides health care to patients seeking asylum at the US-Mexican border. The clinic serves women, children, families and a considerable number of LGBTQ individuals. One such patient was Miss Lady, a transgendered woman from Cuba. In order to escape daily physical and sexual abuse in her own country, she had flown from Cuba to Guatemala, and then taken a series of buses to cross the border into Mexico, at which point she travelled her way north toward the US border. All in all, the journey had taken her 6 months.

She was 5 feet and 2 inches tall, wore a padded bra over her broad flat chest, and always had brilliantly colored nail polish. She had terrible teeth from years without access to dental care, but the sweetest smile nonetheless. I wanted to ask more about her journey to Mexico, which, like those of so many other refugees, had been harrowing.

But she was not to be distracted: she looked at me desperately across the exam table. "I'm very concerned about my problem," she said. "When I have intercourse, my partners think I have an infection and I can't convince them otherwise."

I did a quick exam and it was immediately clear that she had external hemorrhoids. I was happy to reassure her that hemorrhoids are, albeit annoying, benign. She said she knew that – another doctor had already told her as much. He had also told her there was a surgery she could have to have them removed. "Please help me," she pleaded. "I need them gone."

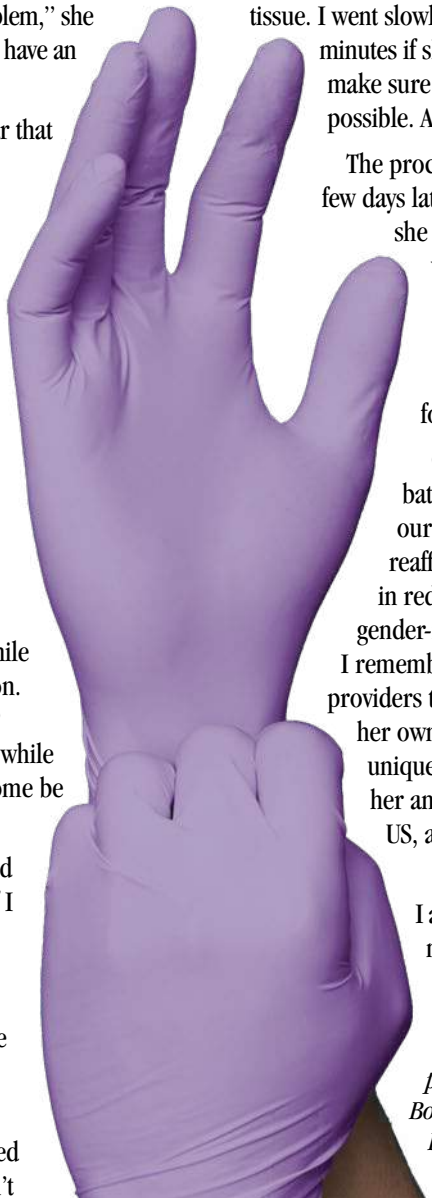
I hesitated. Conducting such a procedure in this setting was a little unorthodox, as well as a little risky. Our clinic consists of three exam rooms, none of which were the most sterile of environments. What if she got an infection? What about pain control? She would probably be quite tender for a week or two after the procedure. Moreover, I was a family medicine doctor, and while I removed skin tags all the time, I wasn't a surgeon. The anus is pretty vascular. What if she bled a lot? Would she be able to recover from the operation while living in a transgender shelter? Would her new home be sanitary enough to keep her wound clean?

In medicine, we carefully consider the risks and benefits of each thing we do to a patient's body. If I decided to proceed, I could cause her significant bleeding and pain. I could also leave her cosmetically worse off if I ended up leaving redundant tissue or scar tissue. Was this really the right thing to do?

"Doctora, listen," she said. "I came all the way from Cuba. I have been beat up, abused, and raped more times than I can count. Now this. Now I can't even be with my partner without them thinking I have some kind of disease. I want to feel comfortable when I am naked. I want to feel comfortable in my own skin".

Who could have thought that hemorrhoids could be such a profound problem? For me, as a doctor, they were simply an annoyance. For her, they represented much more: having endured a lifetime in the wrong body, this was just another thing that was "wrong" about her physical form, another aspect of her being that brought her shame instead of comfort. I couldn't give her the gender reaffirming surgery that she certainly wanted and deserved. However, I could fix this one small thing for her.

So in spite of my hesitancy, we decided to do it. The room was incredibly hot; sweat dripped down my face. I had her gently lie down on the table. I anesthetized around her anus. I then used clamps to cut off the blood supply as much as possible to the tissue. Then, extremely carefully and holding my breath, I began to cut away the redundant tissue. I went slowly, remembering to carefully ask her every few minutes if she was having any pain or discomfort. I wanted to make sure this experience would be as respectful to her as possible. After a lifetime of trauma, she deserved that much.



The procedure itself went smoothly. Miss Lady returned a few days later for a wound check and was pleased with how she was healing. "I feel so much more confident now with my partner. I know it's a small change, but to me it makes all the difference in how confident I feel about my body".

As humans, we cannot disconnect our physical form from our mental health. One informs the other.

Over the past months, we have seen the political battle over gender reaffirming care continue to rage in our country, with the forced closing of many gender-reaffirming clinics throughout the country, particularly in red states. As health care workers continue to fight for gender-reaffirming care both in this country and in others, I remember Miss Lady's story. I remember our chance as providers to give her back her dignity through giving her back her own body. As family medicine physicians, we have the unique opportunity to continue to fight for women like her and for gender dysphoric patients in New York, the US, and around the world.

"Who know a hemorrhoid could represent so much?" I asked her, maybe a bit unprofessionally as I cleaned off my equipment and escorted her to the waiting room.

In spite of ourselves, we both giggled.

Elena Hill, MD, MPH *is a family medicine physician. She completed her medical residency at Boston Medical Center. She currently practices in the Bronx, NY. Her clinical interests include underserved medicine, integrated health and chronic pain.*

The Anxiety of Treating Anxiety

By Jill Sisselman, DO, FAAFP

Family medicine has always encompassed a broad spectrum of ailments that could come across the exam table. However, just as COVID has permeated its way into every other aspect of life, it also has done so in the scope of our practices. Being the consummate caretaker with an empathetic ear, patients who needed a little more handholding would often gravitate towards me; I am the ultimate listener rather than speaker. Within this role, I have always practiced an aspect of mental health care and provided comfort and acknowledgment along with a prescription for anxiety or depression. Now, since March 2020 and the outpouring of anxieties that have accompanied COVID, I would say almost fifty percent of our day is spent on mental health visits.

It has frequently been difficult to obtain an appointment with a mental health provider for various reasons, namely insurance limitations, providers closed to new patients or poor appointment availability. The largest obstacle we have encountered is the prohibitive cost of therapy or counseling when it is not covered by insurance plans. If you have an immediate problem with a patient, one's only resource is oftentimes the emergency department.

Given the onslaught of isolation, bereavement and addiction brought about by the COVID pandemic and the lack of available psychiatrists and therapists, these visits have fallen on the PCP. Not all family medicine physicians are comfortable providing mental health support, prescribing sedating medications and controlled substances or having familiarity with them at all.[1] Where does the doctor's visit end and the counseling session begin?

Doctors like facts. We see a problem and have acquired knowledge through our training to address it. We are comfortable with numbers and answers- blood pressure can be measured, treated and results tangible through a reading.[2] Diabetes is similar - you start medication and watch a hemoglobin A1c come down. There is something satisfying in treating a patient and visualizing the fruits of your labor. What is difficult for doctors who live their lives by science is ambiguity, patience and the inability to measure success. Even when the pandemic began, one had a definitive diagnosis, positive or negative test, and could work from there. Juxtaposed on this, mental health issues push many doctors out of their comfort zone. Suddenly, you have a patient whose signs and symptoms are self-reported. Treatment is a joint decision based on a discussion and may or may not improve symptoms or be the correct one. Success is now subjective and no longer objective. This is not something that primary care physicians have a lot of training or experience in.[2] Prior to COVID you could keep a small armamentarium of medications in your pocket of knowledge, refer when a case became complicated or immediately after the initial visit. Now, given a global pandemic causing the numbers of patients in need to increase significantly, we find ourselves needing to rise to the occasion and provide mental health help to our patients.

continued on page 28

continued from page 27

Another obstacle in treating mental health within the primary care setting is time, or lack thereof. Any physician will tell you that the first scheduled patient that comes six minutes late to their appointment puts them ten minutes behind for the day. That does not include phone calls, lab review and other unforeseen problems within the day that will further contribute to this. Adding on the general panic of COVID, the influx of sick patients, testing and phone calls, where does one find the time to counsel a patient? Of course, a medication can be started, but that decision does not happen from quickly viewing a number. A mental health visit requires time to listen and time to counsel, something no fifteen-minute visit can accomplish.

The key to counseling is empathy. Patients want to feel that you listened; they want to feel heard. Above all, they want to feel normal; that they are not a leper for having mental health issues. Psychiatric conditions come with a stigma so strong that it prevents many people from seeking help at all. Patients need to be told how courageous they are for taking that first step and be assured that they are in good hands. Sometimes that alone can relieve a large burden and source of anxiety. Once you have gained their trust, together you can decide on the best way to start. You can provide some initial counseling but also set up a multidisciplinary team, which may include some outside sources that you collaborate with to either obtain advice or refer your patient to for more regular support. In my practice, we are part of a clinically integrated network with Mount Sinai Health Partners and they have been invaluable in helping to guide us. They provide regular educational sessions where other physicians, licensed social workers, psychologists and psychiatrists offer pearls and present complicated cases for additional treatment decisions.

Many holistic modalities have been shown to be beneficial in helping to treat anxiety. Cognitive behavioral therapy (CBT), mindfulness and forms of meditation are treatments you can offer patients. Certified counselors practice CBT whereas the latter two can be done from their own home. Many websites and apps offer these kinds of therapy and are free of charge in some cases.[3]

When counseling and conservative management is not enough, it is vital to let the patient know that there is still hope and the need for medication is common. Often patients try to say they can work through it on their own and do not need a medication. Assure them that anxiety is a disorder of the brain. Just as one would treat their heart with medication if needed, the brain is also an organ in need of treatment as well.

For those physicians that have not been treating mental health conditions prior to COVID, the good news is many medications have stayed relevant over the years; you can take comfort in being acquainted with old friends. A brief review of the common classes, their use and selection criteria are below and in Table 1.

Selective serotonin reuptake inhibitors (SSRI's) became widely used dating back to the 1980s and are still a popular choice. They are extremely effective and generally well tolerated but that does not mean that they come without risks or side effects. Gastrointestinal disturbances, sexual dysfunction, weight gain and agitation are some of the more common symptoms that patients encounter. There are a handful of drug-to-drug interactions that can occur with them as well. SSRI's are generally safe to take in pregnancy. Studies show that mental health issues can lead to poor or no prenatal care so it is important to treat them during this time. When looking for the 'safest' one in pregnancy, some may say the one that works best is the one to choose.[4]

Serotonin norepinephrine reuptake inhibitors or SNRI's are similar to SSRI's but additionally inhibit the reuptake of norepinephrine. Their use and side effect profile are similar with the potential addition of constipation, weakness and dry mouth. Their downside consists of difficulty weaning off when the time may come.[5]

Bupropion inhibits the presynaptic reuptake of norepinephrine and dopamine and can be a good choice when a patient is concerned about the side effect profile of SSRI's. It is associated with weight loss and can, at times be added to an SSRI for additional

Table 1. Commonly Used Medications in Treating Anxiety and Depression

Name	Class	Use / Pearls	Common Side Effects
Sertraline	SSRI	Used in anxiety and depression. Safest if pregnant / breastfeeding	GI disturbances, weight gain and sexual dysfunction
Duloxetine	SNRI	Patients with chronic pain, fibromyalgia, migraines	Constipation and dry mouth. Difficult to wean
Buproprion	Inhibits reuptake of norepinephrine and dopamine	Use in anxiety and depression alone or an adjunct to SSRI or SNRI	Weight loss
Buspirone	Partial serotonin agonist	Approved for GAD, less sedation	Dizziness, headache
Clonazepam or Lorazepam	Benzodiazepine	Effective and rapid onset for anxiety, many side effects, longer half-life preferable over Xanax	Addiction potential, sedation, risk of dementia

Adapted from Mind Matters Echo, Mental Health Series, Mount Sinai Health Partners.

antidepressant and anti-anxiety effect as well as to help mitigate weight gain or sexual side effects.

Benzodiazepines can be used for anxiety but should be done so with caution. They are of good use when initiating other treatment to help mitigate symptoms until other medications can take full effect. Their side effect profile includes drowsiness, confusion and increased risk of dementia. Caution should be used in the elderly to prevent risk of falls. In addition, due to their increased risk of addiction potential, shorter acting agents, such as clonazepam can be chosen. Alprazolam with its longer half-life not only has a higher risk of addiction but of withdrawal symptoms too. Long-term use should be avoided in this group. If that need arises, tapering down under a physician's care is best.[6]

Buspirone effects the 5-HT1A receptors and is an anxiolytic that may be selected in place of a benzodiazepine or in addition to an SSRI. It has a low incidence of adverse reactions and is less sedating. The most common adverse effects are headache and dizziness.[7]

So where does one start? The choice of medication is different for each patient and should be tailored on an individual basis taking into consideration medical history, current medications and how the side effect profile could work in his or her favor. For instance, a patient who has a history of bulimia and a significant concern about weight gain, fluoxetine or bupropion would be a good choice since they are more weight neutral, as opposed to a more hyperactive high-anxiety patient where one might use paroxetine or buspirone for their sedating properties. A minimum of four weeks should be allowed to assess the effectiveness of the medication before upward titration is attempted and up to twelve weeks before changing or adding a medication. The addition of a second medication can improve symptoms significantly when one alone is not enough.

Frequent monitoring is necessary at the onset of drug therapy to help improve medication adherence rates and allow the patient to feel supported. Once symptoms begin to improve, visits can be spaced out but should take place on a regular basis.

As discussed earlier, availability of counselors and psychiatrists is at an all-time low since COVID-19. Thankfully, some avenues have opened up during the pandemic to help patients during this time. Telemedicine visits have become widely used for treating and counseling mental health patients. They allow for expanded hours as well as increasing the volume of providers readily accessible to patients. It has become a very successful tool in our office to see patients more frequently if necessary.

Of course, there are instances when your time, medication and counseling may not be enough. The correct form of treatment may, in fact, be knowing when to refer, and is an important tool to wield. Referral to a psychiatrist can help procure a more detailed diagnosis and perhaps an additional subset of medications that we, as general practitioners may not be as familiar or comfortable with. That too is good patient care.

COVID-19 is just one obstacle that has come our way and many more may arise in our future. Mental health is a growing concern that is in desperate need of our attention. We are the first stop for patients of all ages and have the ability to educate and open our arms and doors to make a profound difference. Perhaps just starting the conversation will be the first step in treating anxiety in doctors and patients alike.

Endnotes

1. Loeb, D. F., Bayliss, E. A., Binswanger, I. A., Candrian, C., & deGruy, F. V. (2012). Primary care physician perceptions on caring for complex patients with medical and mental illness. Journal of general internal medicine, 27(8), 945–952.
2. Wu, T., Jia, X., Shi, H., Niu, J., Yin, X., Xie, J., & Wang, X. (2021). Prevalence of mental health problems during the COVID-19 pandemic: A systematic review and meta-analysis. Journal of affective disorders, 281, 91–98.
3. Diagnosis and Management of Generalized Anxiety Disorder and Panic Disorder in Adults. Locke, A., Kirst, N., and Shultz, C. *Am Fam Physician*. 2015 May 1;91(9):617-624
4. Antidepressants and Pregnancy: Tips from an Expert. Johns Hopkins Medicine. Retrieved from: https://www.hopkinsmedicine.org/health/wellness-and-prevention/antidepressants-and-pregnancy-tips-from-an-expert
5. What are the differences between SSRIs and SNRIs? Medical News Today. Retrieved from: https://www.medicalnewstoday.com/articles/ssri-vs-snri
6. The benefits and risks of benzodiazepines. Medical News Today. Retrieved from https://www.medicalnewstoday.com/articles/262809
7. Buspirone: an update on a unique anxiolytic agent. Jann, MW. Pharmacotherapy. 1988;8(2):100-16

Jill Sisselman, DO, FAAFP *is board certified in family medicine. She graduated from NYIT- College of Osteopathic Medicine and went on to residency at St Francis Hospital in Wilmington, Delaware. As a native Long Islander, she chose to return to New York and is currently in private practice. She is an adjunct Clinical Assistant Professor at NYIT-COM and is Medical Director for the Half Hollow School District.*

The Role of Family Doctors in Diabetes Management and Tackling Therapeutic Inertia

By Nay Linn Aung, MD, BC-ADM and Lwin Lwin Khine, MD

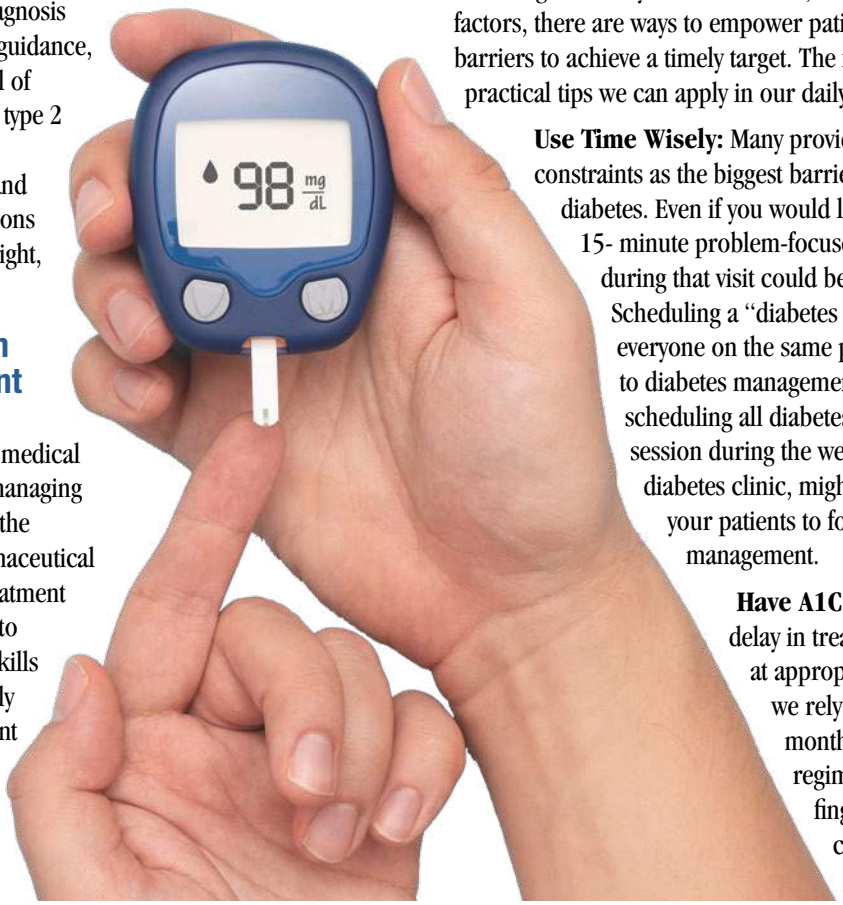
While the acute phase of the COVID pandemic seems to be subsiding, the danger of diabetes is still rising at an alarming speed. The pandemic highlights the vulnerability of people with diabetes, especially when their diabetes is not under control. The COVID pandemic itself is likely to serve as the precursor for a large wave of diabetes incidence in the future.[1]

Family Physicians at the Forefront of Diabetes Care

Family physicians have been the primary clinicians managing diabetes care for decades. According to the CDC, it is estimated that 23% of 37.3 million Americans with diabetes, and 80% of 96 million Americans with prediabetes do not know their diabetes status.[2] Primary care clinicians bear the responsibility of diagnosing and treating these populations appropriately. An expanding list of comorbidities and complications of diabetes requires comprehensive management. This is a daunting challenge for one specialist to provide alone, even if we are lucky to have resources in our community. Thus, the role of the family physician, as the patient's champion is to provide coordination of care for patients with complications who have been seeing multiple specialists. Preventative care and screening provided by the family physician are essential for patients at any stage of diabetes; in patients with prediabetes for early diagnosis and subsequent monitoring, guidance, and counseling, with the goal of preventing their transition to type 2 diabetes; and for people with diabetes, routine screening and early treatment of complications with goals to save life, limb, sight, and preserve quality of life.

Therapeutic Inertia in Diabetes Management

Although interventions for diabetes have been taught in medical schools, and we have been managing diabetes daily in our clinics, the development of newer pharmaceutical agents, technologies, and treatment approaches has required us to update our knowledge and skills continuously in order to apply these advances in our treatment approach. Failure to do so can make us the main drivers of therapeutic inertia in diabetes management.



Despite newer pharmaceutical agents and technology in diabetes management, Hemoglobin A1c (A1C) trends has not been significantly changed over time.[3] Many studies indicate that usage of the available resources is not impressive. In addition to that, many providers tend to use the approach of "treat to failure" rather than "treat to target." One study shows that it took from 1.6 to 7.2 years to intensify therapy when A1C was not at goal,[4] while another study indicated that an average of 3.7 years was spent to intensify therapy after initiating basal insulin despite A1C being >=7.5%.[5]

Therapeutic inertia is the lack of timely adjustment to therapy (either intensification or de-intensification) when a patient's treatment goals are not met. The phenomenon of "legacy effect" or "metabolic memory"[6] reveals the benefit of achieving target A1C early in the disease process. Delaying treatment intensification can cost our patients' their life, limbs and sight, besides the huge financial impact.[7] Hypoglycemia resulting from failure to de-intensify the treatment can also lead to mortality and morbidity.[8,9]

Practical Tips to Overcome Therapeutic Inertia

Although therapeutic inertia could occur for multiple reasons, including those beyond our control, such as system and patient factors, there are ways to empower patients to overcome some of the barriers to achieve a timely target. The following are some of the practical tips we can apply in our daily practice:

Use Time Wisely: Many providers have cited time constraints as the biggest barrier in treating patients with diabetes. Even if you would like to manage diabetes in your 15- minute problem-focused visit, the patient's focus during that visit could be anything other than diabetes. Scheduling a "diabetes visit" is a good way to get everyone on the same page since the visit is dedicated to diabetes management. If your schedule allows, scheduling all diabetes visits at a particular clinic session during the week, essentially creating a mini diabetes clinic, might prepare you, your staff, and your patients to focus more fully on diabetes management.

Have A1C Done Before Visit: One delay in treatment is not getting test results at appropriate times. Most of the time we rely on an A1C that was done months ago to decide the treatment regimen of today. Point-of-care finger stick A1C tests are available commercially and can be useful

to get A1C on the same day prior to the visit. If POC A1C testing is not feasible for the clinic, setting up workflow to order A1C within a week before the visit might be an alternative option for obtaining a timely A1C. This will reflect current glycemic control to better guide medication adjustment.

Continuous Glucose Monitoring Device: Although we have been using finger stick blood glucose and A1C to assess glycemic control, each have their own limitations. Finger stick blood glucose tests only give us information at a specific point of time, having a lot of variability, and may not reflect the overall glycemic control of the patient. A1C is the average blood glucose control over 3 months, and has been used as the standard test to monitor glycemic control. However, two different people with the same A1C can have a totally different blood glucose pattern. Someone who has marked variability of blood glucose, with extreme highs and lows, may have the same A1C as one who has stable glucose control within target range over time. A continuous glucose monitoring system enables both the providers and the patient to obtain a blood glucose pattern over 24 hours, which has proven to have good impact on blood glucose control if the data is used effectively. However, ordering the device, downloading the data and interpretation could be time and labor intensive and providers need special skills to interpret the data. For educational material on CGM, check out the American Diabetes Association's (ADA) Time in Range initiative page: https://professional.diabetes.org/content-page/time-range.

Utilize Treatment Algorithms: Currently there are 11 classes of non-insulin diabetic medications, with over 40 medications available on the market. Insurance coverage makes it more complicated in choosing appropriate medications. Using an algorithm from the professional organizations and making those accessible in the clinic will help clinicians in their efforts to tackle therapeutic inertia. ADA's 2022 algorithm can be found at https://diabetesjournals.org/view-large/figure/4085296/dc22S009f3.tif. The American Association of Clinical Endocrinologist's (AACE) latest algorithm can be found at https://pro.aace.com/pdfs/diabetes/AACE_2019_Diabetes_Algorithm_FINAL_ES.pdf)

Communication Tools: Communication with patients has always been the biggest driver for successful treatment. With telehealth and other communication technology, it is easier to have frequent communication with our patients. Recent meta-analysis showed that studies which have frequent patient engagement using different communication tools such as tele-monitoring, cloud-based patient education, technology-based case management, mobile diabetes management software supporting automated coaching, and patient -provider portals have better outcomes in achieving targets.[10]

Team Based Approach: Diabetes education is the cornerstone of diabetes management. While the diabetes self-management education and support program (DSMES) is an essential part of diabetes management, the diabetes prevention program (DPP) is the standard of care for prediabetes, to prevent progression into type 2 diabetes. Additionally, the meta-analysis shows that teams led by non-physician clinicians (pharmacists, case manager, etc.) who initiate and intensify diabetes treatment independently supported by the guidelines and protocol, are most successful in improving A1C.[10] Within your clinic, setting up the team with resources, or, researching the available resources and making those resources accessible to patients, will make the effort to tackle therapeutic inertia successful.

Be a Barrier Buster: Although "non-adherence" and "non-compliance" of the treatment plan by patients has been seen as one of the factors beyond our control, we may be able to help our patients in many ways to follow our recommendations. Inquiring why the patient is not following our treatment regimen and finding solutions to address those barriers may lead to success in achieving treatment goals. The social determinants of health (SDOH) play a big role in failure to adhere to the treatment regimen, so the patient's SDOH should be screened and addressed at every visit.[11] Any care plan without involvement of the patient is set to fail. A patient centered approach, with informed consent, and shared decision-making is important for a successful treatment regimen, which will lead to goal achievement.

Summary

Family physicians along with the other primary care team members have assumed a primary role in managing diabetes, and that is likely to continue in the future. Early diagnosis of undiagnosed diabetes and prediabetes, prevention of complications, and coordinating care among the different specialty teams, are primary responsibilities of the family physician as the leader and diabetes champion in the community. As we continue to bear the responsibility of treating diabetes, we need to make sure that we are well prepared to overcome the therapeutic inertia which has medical and financial implications at both patient and population levels. It is important to continue to ask ourselves whether we have done everything within our control to optimize therapy and to support adherence so that our patients can achieve their target goals in a timely manner.

For more information on overcoming therapeutic inertia in diabetes management, please visit: https://www.therapeuticinertia.diabetes.org/)

Acknowledgment: We thank Dr. Francis Chabot (Lead Preceptor, St Elizabeth Family Medicine Residency) for review and comment on our manuscript.

Endnotes

1. Barrett CE, Koyama AK, Alvarez P, et al. Risk for Newly Diagnosed Diabetes >30 Days After SARS-CoV-2 Infection Among Persons Aged <18 Years - United States, March 1, 2020-June 28, 2021. MMWR. Morbidity and mortality weekly report. 2022;71:59-65.
2. Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed [6/26/2022].
3. Fang M, Wang D, Coresh J, Selvin E. Trends in Diabetes Treatment and Control in U.S. Adults, 1999–2018. The New England Journal of medicine. 2021;384:2219-2228

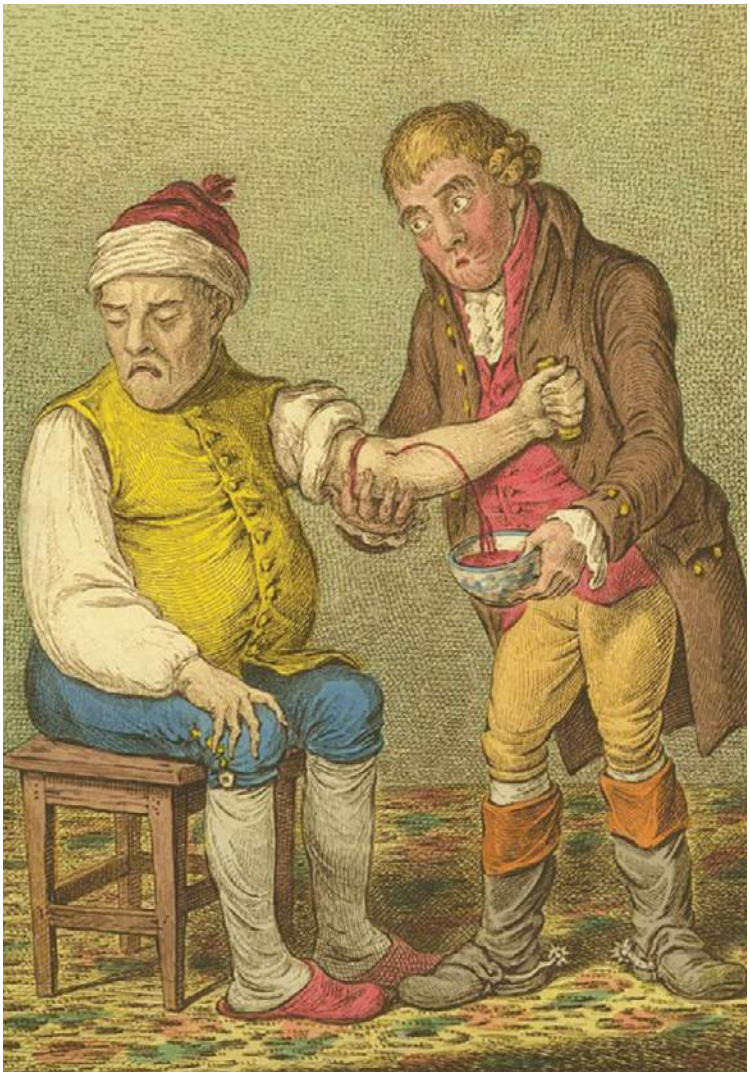
continued on page 33

Bloodletting Worked, or Did It?

By Thomas Rosenthal, MD

Prior to the twentieth century bloodletting was so common that the lancet and the barber's pole became symbols of healing services. Countless paintings depicted a doctor holding the arm of a languorous victim whose blood dripped from their antecubital space into a collection bowl. Two millennia after the ancient Egyptians perfected the bleeding cure, science struggled to appreciate its value.

Hippocrates' (BC 460-370) was the first to separate medicine from religion. He argued that disease was caused by environment, diet or habits, rather than divinity's punishment. The Greeks forbid human dissection, so with limited understanding of physiology or anatomy Hippocrates rationalized that disease was a disruption of an individual's natural balance; one patient's disease differed from another because of peculiarities of the individual. Treatment had little to do with diagnosis, rather the doctor needed to understand how a patient's unique imbalance of black bile, yellow bile, blood and phlegm, the four humors, produced symptoms. After a careful interview and focused observation, Hippocrates often resorted to prescriptions of honey and vinegar. He employed bloodletting sparingly.



Later, another Greek, Galen (AD 129-200) embraced Hippocrates' four humors. Galen settled in Rome after several years spent touring the world's great medical centers and learning anatomy by dissecting pigs and dead gladiators. He believed that diet, hygiene, and fitness regulated the liver's production of bile and blood, which he believed diffused through the body via the veins. Galen assigned each humor a particular temperament: blood made one extroverted and social; yellow bile contributed to passion and charisma; black bile made one melancholic; and phlegmatic people were dependable, kind but restrained. The physician was to promote wellness by first judging which body fluid was in excess and then making readjustments through sweating, urination, laxatives, vomiting or, Galen's favorite, bleeding. His conviction that blood, being hot and moist, must be released to reduce inflammation and fever cemented medical thinking for the next 1500 years. Ill patients were in bad humor, a condition prevented by semi-annual preemptive bleeding.

Three technics became popular to release blood: venesection, cupping and leeches. Each had its champion. Venesection involved tying a ribbon snuggly around the upper arm and using a lancet to cut an antecubital vein lengthwise. Porcelain bleeding bowls with volume markings collected 6 to 16 ounces of blood, the amount determined by a rising pulse or faintness. Patients regularly reported pain relief and even giddiness. Firm pressure using a cold vinegar-soaked compress for several minutes stopped the bleeding. A French doctor, Broussais (1772-1838), favored bleeding by one special fresh water leech, *Hirudo medicinalis*. He was so convincing that France exported over five million leeches annually for decades. Cupping, blistering or scarifying at the site of the affliction, or at the soles of the feet for a systemic effect, had their adherents also.

William Harvey's (1578-1657) proof that blood was pumped by the heart and circulated throughout the body set some doctors to questioning the benefit of releasing blood, a trend reversed in 1793 when yellow fever killed thousands of Philadelphians. The great Benjamin Rush (1746-1813) convinced himself, and many others, that all fever patients who submitted to his heroic bleeding and intestinal purging survived. Those that didn't survive had simply presented too late for the cure. Rush would later be the last of five physicians to recommend bleeding George Washington for an inflamed throat in 1799 and would himself die after being bled by one of his students in 1813.

In 1836, an experiment was designed to evaluate the hunches and rationalizations that supported bleeding. In one of the first published randomized trials, the French physician, Pierre

Charles Alexander Louis (1787-1872) proved that pneumonia patients bled multiple times fared worse than patients who were bled once. Over the next fifty years, experiments began to overshadow case reports in the medical literature. Louis Pasteur's (1822-1895) scientific methods finally disproved spontaneous generation and Robert Koch (1843-1910) proved that cultured anthrax bacteria caused anthrax in secondarily infected animals. Studies of contagions focused on bacteria, fungus and viruses replaced the concepts of miasma and humors and became known as germ theory.

There are three reasons why bloodletting dominated medical practice for millennia: 1. It was efficient; 2. It was defended by prestigious sources using a plausible cognitive rationalization, and 3. It was a dynamic, active procedure that patients agreed to pay for. Its decline was slow. As late as 1902, Osler's textbook made this statement about pneumonia, "To bleed at the very onset in robust, healthy individuals in whom the disease sets in with great intensity and high fever is, I believe, a good practice". Today only hemochromatosis, polycythemia vera, and porphyria cutanea tarda remain indications for bloodletting and leeches are used to prevent tissue necrosis and reduce swelling in reimplanted fingers, ears, toes and skin grafts.

Sadly, medicine has not abandoned entrenchment. *Helicobacter pylor*i was isolated from 88% of patients suffering peptic ulcer disease in 1982, but it wasn't until 1997 that the CDC recommended antibiotics replace sedatives and surgery. In 2007, studies proved bicycling was more effective than arthroscopy for treating osteoarthritis of the knee, but 750,000 arthroscopic knee procedures were performed in 2020.

The nineteenth century's enlightenment began with a trickle of facts. Today, discoveries yield an avalanche of data and changing habits remains difficult. It is the exceptional physician who knows the right moment for transformative change, and embraces it.

References

Greenstone, G. (2010). "The History of Bloodletting." BC Medical Journal 52(1): 12-14.

Louis, P. C. A. (1836). Researches on the Effects of Bloodletting in some Inflammatory Diseases and on the Influence of Tartarized Antimony and Vesication in Pneumonitis. Boston, Hilliard, Gray, & Company.

Milton, H. and H. Mercier (2015). "Universal cognitive mechanisms explain the cultural success of bloodletting." Evolution and Human Behavior 36(4): 303-312.

Osler W. (1902) Principles and practice of medicine. 4th ed. London & New York:Appleton & Co. p. 135.

Thomas Rosenthal, MD *is professor and chair emeritus of family medicine at the University at Buffalo and the author of* Bloodletting and Germs: A Doctor in Nineteenth Century Rural New York *(Amazon rating 4.76/5).*

continued from page 31

4. Khunti K, Wolden ML, Thorsted BL, Andersen M, Davies MJ. Clinical inertia in people with type 2 diabetes: a retrospective cohort study of more than 80,000 people. Diabetes Care 2013;36:3411–3417
5. Khunti K, Nikolajsen A, Thorsted BL, Andersen M, Davies MJ, Paul SK. Clinical inertia with regard to intensifying therapy in people with type 2 diabetes treated with basal insulin. Diabetes Obes Metab 2016;18:401–409
6. Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HAW. 10-Year Follow-up of Intensive Glucose Control in Type 2 Diabetes. The New England Journal of Medicine. 2008;359:1577-1589.
7. Ali SN, Dang-Tan T, Valentine WJ, Hansen BB. Evaluation of the Clinical and Economic Burden of Poor Glycemic Control Associated with Therapeutic Inertia in Patients with Type 2 Diabetes in the United States. Advances in therapy. 2020;37:869-882.
8. D'Ancona G, Bertuzzi F, Sacchi L, et al. Iatrogenic hypoglycemia secondary to tight glucose control is an independent determinant for mortality and cardiac morbidity. European journal of cardio-thoracic surgery.2011;40:360-366.
9. Kosiborod M, Inzucchi SE, Goyal A, et al. Relationship Between Spontaneous and Iatrogenic Hypoglycemia and Mortality in Patients Hospitalized With Acute Myocardial Infarction. JAMA : the journal of the American Medical Association. 2009;301:1556-1564.
10. Powell RE, Zaccardi F, Beebe C, et al. Strategies for overcoming therapeutic inertia in type 2 diabetes: A systematic review and meta-analysis. Diabetes, obesity & metabolism. 2021;23:2137-2154.
11. Hill-Briggs F, Adler NE, Berkowitz SA, et al. Social Determinants of Health and Diabetes: A Scientific Review. Diabetes care. 2020;2021;44:258-279.

Nay Linn Aung, MD, BC-ADM *is a primary care diabetologist and faculty at St. Elizabeth Family Medicine Residency program in Utica, NY. He is a family medicine graduate, and completed a one-year diabetes fellowship program at East Carolina University, Greenville, NC. He runs the diabetes clinic at Mohawk Valley Health System (MVHS), and also serves as co-leader of the Glycemic Management Quality Assurance Team at MVHS. He created an innovative diabetes sub-track program in the family medicine residency program in 2020 and is actively involved in the American Diabetes Association's activities as a volunteer.*

Lwin Lwin Khine, MD *is a graduate of Cerrahpasa Medical Faculty, Istanbul University. She has taken courses on public health and healthcare administration at New York Medical College and has been an active clinical research scholar at different university hospitals in the U.S.*

Paging Dr. Google:
The Ethics of Patient Care in the Age of COVID Vaccine Hesitancy

By Arielle Schecter, MD and Nina Piazza, MD

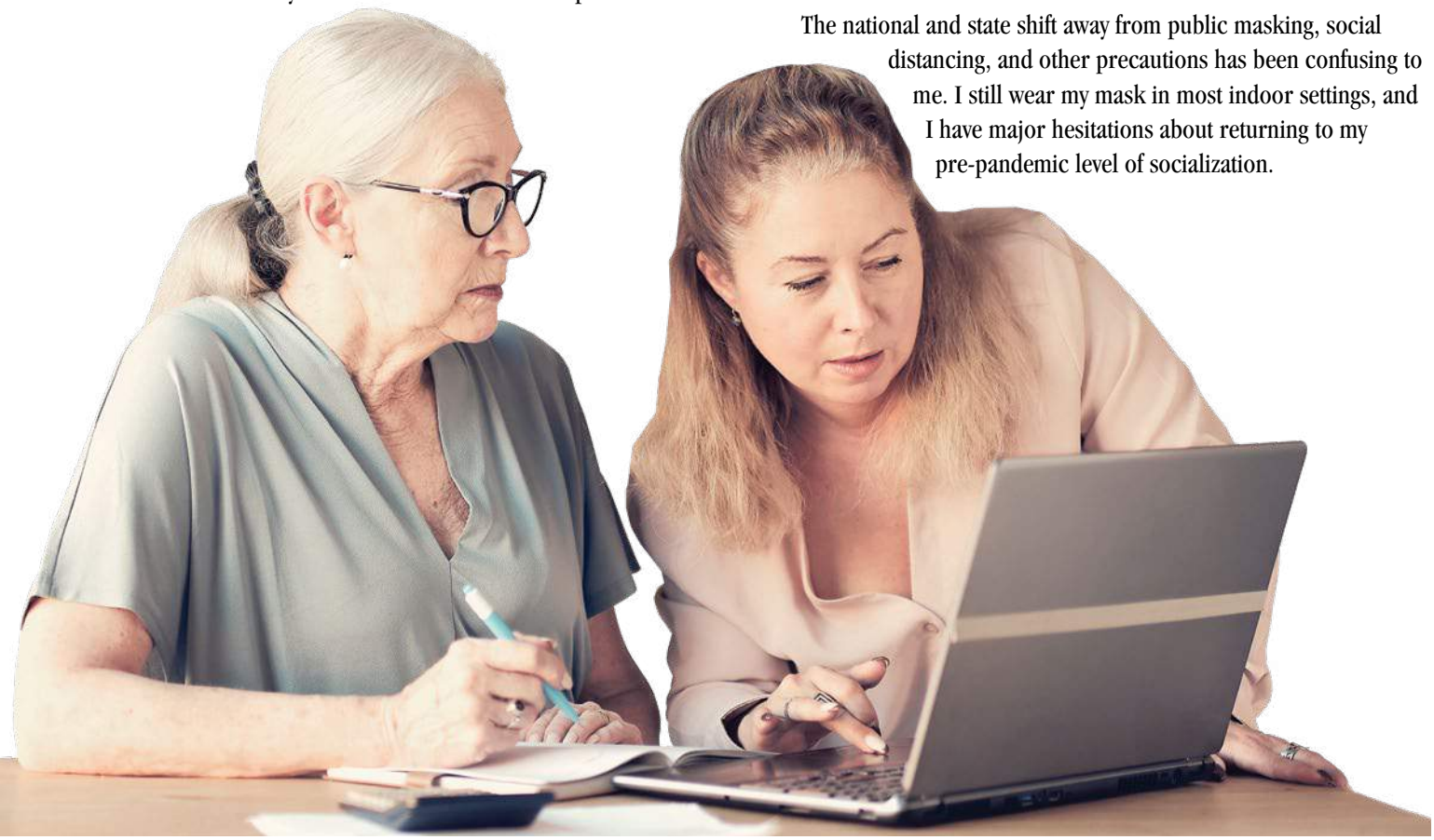
So much about the body is scary to patients. The theatre of outpatient healthcare - making an appointment, sitting in the waiting room, donning the gown, paying their co-pay, and so on - reinforces the mystique of medicine, and not usually in a way that invites reassurance. Patients seek trustworthy counsel to understand, articulate, and strategize around all manner of health problems. Sometimes they place their trust in realms that their own doctors might advise against. As a medical student, I have encountered many patients who begin their history with "I Googled it…" or "WebMD said…" or "I saw on Facebook that…"

Rather than judging this behavior as uninformed or ignorant, I find it more helpful to consider that people are truly interested in learning about their bodies, and they find it challenging to access the kind of information that would be meaningful to them. Small wonder, then, why patients might seek this information from outlets that *are* actually more accessible to them, such as social media networks, family members, friends, peers, and celebrities.

Because I studied medicine during the first years of COVID-19, I doubt I will ever really know the extent to which the pandemic has influenced my development as a physician. For example, handshakes have never been part of my practice because nearly all of my clinical work so far has been shrouded, literally, by the personal protective equipment designed to keep my pathogens away from my patients, and vice versa. Nevertheless, my experience with the pandemic certainly will continue to affect the way I navigate my patients' relationships to the truth about science.

For years, I have been trying my best to interpret the guidance of the CDC and the leaders of my medical school and hospital campus. I have counseled family members, friends, and patients on personal risk assessment, symptom management, and the granular logistics of obtaining nasopharyngeal swabs at area clinics. I have crossed the street to avoid the picketers outside my hospital who loudly share their aggrieved perceptions of epidemiology, pharmaceutical science, and civil liberties. I have studied for and taken two Step exams under threat of last-minute cancellation by the testing sites. I have mourned the deaths of people I was not able to bury. I have struggled to maintain my own wellness, as many of my usual coping strategies became unavailable.

The national and state shift away from public masking, social distancing, and other precautions has been confusing to me. I still wear my mask in most indoor settings, and I have major hesitations about returning to my pre-pandemic level of socialization.



Like many healthcare professionals and students, I eagerly awaited my turn for the COVID-19 vaccine. I had expected some degree of public hesitation around the vaccine, but was shocked by the degree of antagonistic passion that made its way through social media, journalism, and into doctors' offices. Although I tried my best to listen to my patients' concerns, answer their questions, and explain my understanding of public health and immunologic science, I felt like I was being put in a position to talk people into doing something they didn't want to do. I did not feel like I was meeting people where they were, because by the time they got to me, their understanding of the body and of medicine was, in many cases, thoroughly warped by a multifactorial reality of fear, miscommunication, and mistrust.

I was not comfortable with the care I was providing to these patients. I knew I was somehow misunderstanding what they were trying to tell me, or that I didn't have the professional or emotional means to give them what they thought they needed. I also felt increasingly angry that I was expected to wear my own mask at all times, actively endanger myself by treating COVID patients, and indefinitely continue to tell my mom I couldn't visit and hug her, while my patients refused to mask or get a vaccine. I felt - and continue to feel - deeply conflicted over my obligation to the patient in front of me, and my obligation to the public good.

One of my mentors in family medicine, Dr. Nina Piazza, encouraged me to consider the following framework when caring for vaccine-hesitant patients:

- Give yourself enough time to have the conversation.
- Start by learning more about the patient's perspective. Ask:
  - ▷ What have you heard about the vaccine? From where?
  - ▷ What concerns do you have?
- Ask for permission to share information and address their concerns.
- Address each concern one at a time, using patient-centered language. Avoid the use of medical jargon.
- Share vetted, patient-directed resources that answer FAQs such as those provided by the CDC <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fvaccines%2Fkeythingstoknow.html> and FamilyDoctor.org <https://familydoctor.org/debunking-common-covid-19-vaccine-myths/>.
- Practice your answers to common questions without the use of jargon. This will make it easier to have conversations that you anticipate will have some degree of tension.
- Make sure to give your recommendation that they do get vaccinated, but that in the end it is their choice.
- Review the advantages to getting vaccinated, tailoring it to their priorities.
  - ▷ If they value liberty, focus on the personal freedoms they will gain by being safer.
  - ▷ If they value purity, focus on boosting natural defenses to fight infection.
  - ▷ Discuss the people in their lives whom they can keep safer by getting vaccinated.
- Accept that this may take several discussions and that not every patient will agree with your assessment that it is best to get the vaccine.

Certainly, patients have different reasons for their vaccine hesitancy, and I sometimes struggle with how to reduce my own bias in assessing and responding to these reasons. For example, a patient may come from a historically marginalized community that has survived real structural violence perpetrated by the medical field. This patient may be disinclined to trust most medical messaging, especially when it is delivered with the urgency we have adopted during the COVID pandemic. Another patient may be motivated by an ideology of personal liberty that supersedes a sense of belongingness and responsibility to a social system such as a neighborhood or community. I myself may sympathize or disagree with these patients' premises, and I need to acknowledge my response as an important part of the physician-patient relationship.

I know that COVID-19 will continue to impact my ability to communicate with my patients, assuage their fears, and demystify the physical and social pathologies that have already taken huge tolls on us all. I hope to rely on the literature and my mentors in the field to gain further insight and the strength to be the doctor my patients need me to be.

Additional Resources:

https://www.aafp.org/family-physician/patient-care/prevention-wellness/immunizations-vaccines/conversations-improving-adult-immunization-rates-video.html

https://www.aafp.org/journals/fpm/blogs/inpractice/entry/countering_vaccine_hesitancy.html

https://www.aafp.org/family-physician/patient-care/current-hot-topics/recent-outbreaks/covid-19/covid-19-vaccine/patient-education-resources.html

https://www.cdc.gov/vaccines/covid-19/hcp/tailoring-information.html

https://www.ama-assn.org/delivering-care/public-health/covid-19-vaccine-hesitancy-10-tips-talking-patients

Arielle Schecter, MD *is an incoming family medicine intern at the University of California - San Diego. She graduated in May 2022 from the University of Rochester School of Medicine & Dentistry.*

Nina Piazza, MD *is a senior instructor in family medicine at the University of Rochester School of Medicine & Dentistry. She directs the family medicine acting internship and advises the Family Medicine Interest Group.*

The Scope of Practice of a Generalist:
Moving Beyond the "Jack of all Trades, Master of None" Label

By Louis Verardo, MD, FAAFP

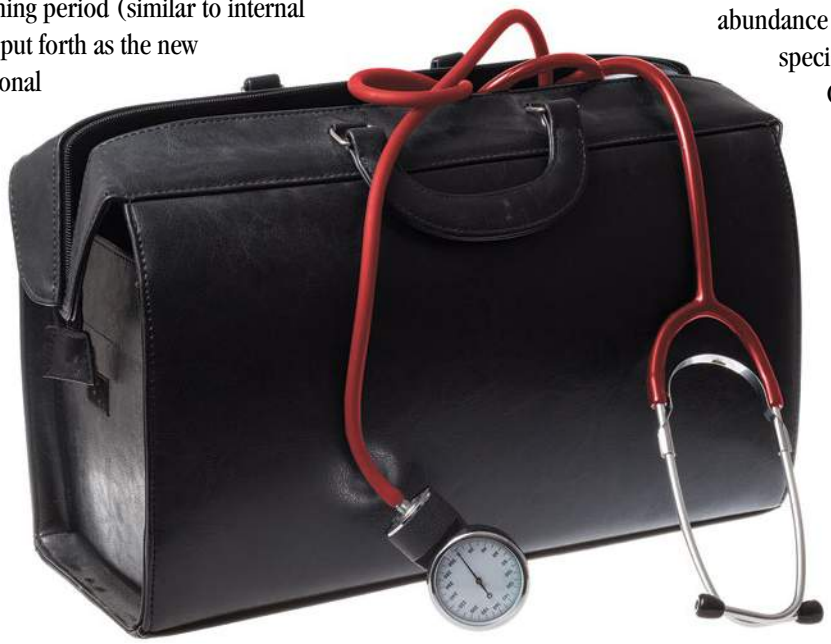
When the American Board of Family Practice (now the American Board of Family Medicine) was created in 1969, it was the culmination of years of effort by dedicated GPs who were trying to re-tool their discipline to reflect the realities of an expanding fund of medical knowledge *and* the medical care needs of the public as stated in several national reports and commissions. Patients had become frustrated with being shuffled from specialist to specialist for clinical care; this created fragmentation of medical management, and they wanted one doctor for them and their family, someone who was competent in diagnosis and skilled enough in procedural tasks to assume responsibility for the overall management of their healthcare needs. For some time, the majority of US medical school graduates had chosen to pursue a career in a specialty discipline, rather than enter general practice, and there were many different reasons for this change from earlier decades. For some it was the ability to focus their work on a single field of study, even a single organ system. For others, it was the recognition of their aptitude for surgical procedures, or maternity care, or even research associated with clinical care. Financial issues, geography, even prestige also played a role in selecting a career path. Whatever the reason, it became clear that the GP concept needed an "upgrade" to assume parity, first within the realm of graduate medical education, then within the broader field of medical practice.

And that's what happened. Residency training in the late 1960s ranged from 3 to 7 years, depending on the discipline. The rotating internships and the few 2-year general practice residencies available at the time were seen as inadequate to properly train a modern physician, so a three-year training period (similar to internal medicine and pediatrics) was put forth as the new standard. In contrast to traditional training being done at the time, the focus of work would be ambulatory, not hospital-based; furthermore, behavioral science and prevention would play critical roles in residency teaching. There would be procedural training opportunities provided for both office-based and hospital care situations, including special tracks for residents considering rural practice.

From the outset, this plan raised concerns and objections within the medical community. Those being kind said it was overly ambitious, and the less kind stated that it would dilute the inpatient care experience and produce "an inferior product." The program directors in these new residencies were not only cognizant of these concerns: in some instances, they shared them. They worked diligently to identify a recognizable core fund of knowledge for this new discipline, while simultaneously endeavoring to keep their trainees and graduates well situated within the customary domains of medical practice.

One of the most difficult challenges was the interdisciplinary nature of family medicine, which often made it hard to compartmentalize these clinicians into traditional roles within a healthcare system. Hospital work in particular created problems as family physicians needed multiple chiefs-of-service to sign off on a variety of privileges (inpatient/critical care, maternity, pediatric, and surgical) to certify competency, a situation not typically seen in graduates of traditional residencies. One solution utilized was to require mandatory consults for specific practice areas, such as critical care units or operative deliveries; most family physicians were comfortable with such mandates and were able to quickly prove their competency in handling cases in these clinical situations. Eventually, the scope of practice for these family doctors became a non-issue.

Where scope of practice remained an issue was twofold: one external, the other secondary to the individual doctor's temperament. In geographic areas where there was an abundance of physicians in the traditional specialties of pediatrics and OB-GYN, this limited the incorporation of newborn and infant care into one's practice. Cross coverage with other family physicians or pediatric colleagues was challenging at best, resulting in added call responsibilities for those family doctors providing nursery and C-section care. The internal issue reflected a physician's comfort level with pediatric care, which was usually directly proportional to his



or her pediatric training volume in residency. Programs in more rural locations often were able to offer higher caseloads of maternal-child patients and could provide residents with the volume experience needed to foster their confidence in this area of clinical work.

Surgery training in family medicine residencies was focused on the following: making trainees feel comfortable with the principles of pre- and post-operative care; the practice of appropriate wound care and techniques of minor office procedures; and exposure to the subspecialties of ENT, urology, ophthalmology, and orthopedics. While most graduates would not go on to incorporate a large percentage of surgical work in their clinical practice, the benefit of this training was to allow family physicians to communicate more easily with surgical colleagues as they referred to and co-managed patients with them.

So how did this all play out since 1969? Did family physicians maintain the scope of practice envisioned by the creators of this re-imagined primary care specialty? Short answer: yes and no. The "yes" response belongs primarily to those individuals who went into practice in the more rural portions of the country and became those better-trained physicians needed to respond directly to the critics of the earlier GP model. Some doctors were even able to deliver full comprehensive care in an academic setting, an environment initially hesitant to fully embrace the new discipline of family medicine. One prominent example is Dr. John Saultz, former editor of STFM's *Family Medicine* and senior faculty at Oregon Health and Science University, who recently retired after a 40- year career providing full scope family medicine services to his patient population.

The "no" response includes what I believe is the majority of the rest of us family physicians, and that is not to suggest that we are "less than" our colleagues who embrace full scope practice. Rather, we have found that providing primary care in an ambulatory setting has resulted in the identification of a body of knowledge, which encompasses a number of inter-related disciplines, including traditional internal medicine, adolescent pediatrics, behavioral mental health and psychiatry, office musculoskeletal conditions, outpatient procedural skills, emergent and urgent care management, and preventive medicine. Added to this is the opportunity to care for family units in a comprehensive fashion, one of the core tenets of early architects of our discipline. One loss experienced due to changing practice mores has been the use of hospitalists for in-patient care; this has excluded not just family physicians, but also our general internist colleagues as well, from active participation in the hospital care of our patients. Attempts to facilitate cross-communication between office and hospital have generally had limited success, although some doctors have used "social rounds" as a way to maintain contact with the treatment team. The re-entry of those patients back into office practice has been challenging as a result, although that can be ameliorated by the timely receipt of a well-written discharge summary explaining the full hospital course of evaluation and treatment. One "plus" of this new way of practice has been the ability of physicians to anticipate a stable office schedule and more relaxed on-call duties, given that they do not have to accommodate departures to the emergency department during the day or evening to handle unexpected urgent situations at the hospital.

Another change from earlier practice models is in regards to maternal and child care. Responding to both identified medical need and patient pressure, many hospital facilities which are part of larger networks have in-house neonatologists available 24/7 to provide newborn assessments in the delivery suite. Family physicians providing nursey care generally can see their patients the following morning rather than at night, plus they have the ability to request consultation on any infant experiencing unexpected difficulties.

Obstetrical delivery is not something that most family physicians routinely include in their practice currently, although those who do can take advantage of fellowships offered post-residency which provide a volume experience in maternity care and the experience of co-managing cases with obstetrical and midwife colleagues. The high cost of malpractice insurance is a major factor in any decision to include this care in your scope of practice. What many family doctors *do* provide is medical maternal care, mostly on referral from an OB-GYN colleague, and primarily involving infectious disease issues or cardiopulmonary concerns.

Returning to the scope of practice question for most family doctors, I believe most in our discipline find themselves dealing with both acute and chronic problems in their office practice, and I also think they are serving in the role described so many years ago as a "first contact clinician" for undifferentiated patients. More importantly, the identification of behavioral health as a core component of a family physician's training and practice has led to important innovations in care provision, including the co-location of primary care clinicians and mental health practitioners in the same practice. I can attest to how being involved in such a practice at Stony Brook greatly enhanced my communication with the psychiatrist, psychiatric nurse practitioner, and social worker assigned to our unit, as well as improving my clinical skills in identifying and managing mental health concerns within my patient population.

Let me also address several other "plus" situations relevant to current family medicine practice. Serving a specific patient population, whether it is school-aged children or older individuals, often provides an impetus to dive deeper into an area of medical care and develop a practical expertise beyond the basic training done in medical school and residency. Sometimes this can even result in a decision to pursue a certificate of added qualifications, such as in adolescent medicine, sports medicine or geriatric medicine. But even if that doesn't occur, several things result from this additional interest: you become energized about the subject, explore additional reading and study on the topic, and also become a source of informal consultation for your practice partners. GPs in the UK all practice as generalists, but within a group, individual doctors are identified and utilized for their additional expertise in skin diseases, or care of children, or elder care. I believe this was the model

continued on page 38

continued from page 37

adopted by the ABFM when they chose CAQs, rather than subspecialty board designations, to officially acknowledge those physicians who distinguished themselves by enhanced learning above and beyond that required for board certification in our discipline.

To be sure, there remain many unconvinced of the merits of family medicine as a separate discipline. They point to combined residencies in internal medicine-pediatrics as an acceptable alternative (and one more palatable to some of the more traditional medical schools and academic health centers), or they envision expansion of programs for NPs and PAs as the preferred method to expand healthcare access. The medical literature cited in my references include some of the justifications for such proposals. Having worked and trained with med-peds, NP, and PA colleagues, I can attest to their clinical acumen and overall expertise. Having said that, and admitting to my own bias, I believe family physicians remain unique for the combination of skills possessed to interact with both their patients and the various components of the healthcare system. Having no allegiance to any one discipline, they offer no threat to any, while even providing a possible referral source to others. Due to their ambulatory positioning, they are more aware of and utilize outpatient resources, and they provide bridging between medical venues and the community at large. They face a variety of patients in their daily work, they serve as an early-warning system for the presence of severe illnesses of a public health nature, and they are in a position to perform practice-based research. The family physician regularly has to deal with undifferentiated patients, often with vague symptoms: this makes the importance of differential diagnosis critical and a skill we need to continually work on. Just as often, though, his or her role with a patient may be more of serving as witness and companion in those cases where the diagnosis has been made and the challenge now is to manage the condition, hopefully to a cure, but sometimes when such an option does not exist. For all these reasons, the "jack of all trades, master of none" is an inaccurate description of what we do, and it is often said in ignorance of our training and our real work within the medical community.

References

Saultz, John. *An Insubstantial Pageant Faded*. Fam Med 2022; 54 (4): 257-258

Woo, Beverly. *Primary Care – The Best Job in Medicine?* N Engl J Med August 31, 2006; 864-866

Rosenblatt, Roger, et. al. *The Content of Ambulatory Medical Care in the United States: An Interspecialty Comparison*. N Engl J Med October 13, 1983; 892-897

Krimmel-Morrison, Jeffrey and Dhaliwal, Gupreet. *How to Keep Training – After Residency Training*. J Gen Intern Med May 2022; 37 (6): 1524-1528

St. Peter, Robert, et. al. *Changes in the Scope of Care Provided by Primary Care Physicians*. N Engl J Med December 23, 1999; 1980-1985

Grumbach, Kevin. *Primary Care in the United States – The Best of Times, The Worst of Times*. N Engl J Med December 23, 1999; 2008-2010

Petersdorf, Robert. *The Doctors' Dilemma*. N Engl J Med September 21, 1978; 628-634

Perkoff, Gerald. *Sounding Boards: General Internal Medicine, Family Practice or Something Better?* N Engl J Med September 21, 1978; 654-657

Colwill, Jack. *Sounding Boards: Primary Care Education in Multiple Specialties: Dilemmas and Opportunities*. N Engl J Med September 21, 1978; 657-660

Okie, Susan. *Perspective: The Evolving Primary Care Physician*. N Engl J Med May 17, 2012; 1849-1853

Newton, Wayne. *Family Physician Scope of Practice: What It Is and Why It Matters*. J Am Board Fam Med; November-December 2011; 24 (6): 633-634

Coutinho, Anastasia, et. al. *Comparison of Intended Scope of Practice for Family Medicine Residents Compared with Reported Scope of Practice Among Practicing Family Physicians*. JAMA 2015; 314 (22): 2364-2372

Reitz, Randall, et. al. *Factors Influencing Family Physician Scope of Practice: A Grounded Theory Study*. Fam Med 2018; 50 (4): 269-274

Anthony, David. *Scope of Practice and Family Medicine Match Rates: Results From a CERA Clerkship Directors Survey*. Fam Med 2017; 49 (3): 177-182

Zomahoun, Herve, et. al. *Effects of the scope of practice on family physicians: a systematic review*. BMC Family Practice 2021; 22:12

Baxley, Elizabeth, et. al. *Family Medicine and Comprehensiveness of Care: What are the Risks of Declines in Scope of Practice?* The Ohio Family Physician; Spring 2020

Dakkak, MaryAnn. *Yes, You can Practice Full-scope Family Medicine*. blogpost at the AAFP website Fresh Perspectives: New Docs in Practice

White, Brandi. *Are the Edges of Family Practice Being Worn Away?* Fam Pract Manag February 2000; 7 (2): 35-40

Multiple authors. *Readers Speak Out on Family Physicians' Scope of Practice*. Fam Pract Manag May 2000; 7 (5): 43-46

Bush, Jennifer. *Family Medicine Takes Center Stage*. Fam Pract Manag November-December 2003; 10 (10): 43-47

Backer, Leigh Ann. *Caring for Children: Re-examining the Family Physician's Role*. Fam Pract Manag July-August 2005; 12 (7): 48-52

Reichman, Mara. *Expanding Your Practice Through Niche Services*. Fam Pract Manag June 2005; 12 (6): 49-54

Boyle, Ginger, et. al. *Sharing Maternity Care*. Fam Pract Manag March 2003; 10 (3): 37-40

Reddy, Sumana and Mahasamudram, Jaydeep. *Scope of Practice: Reclaiming Young Patient Care*. Fam Pract Manag September-October 2019; 26 (5): 26-31

***Louis Verardo, MD, FAAFP** completed his medical degree at the University of Bologna, Italy, and is currently on the voluntary faculty of the Renaissance School of Medicine at Stony Brook University. He is a member of NYSAFP and serves on the Editorial Board of Family Doctor.*

IN THE SPOTLIGHT

Congratulations to 2022-2023 NYSAFP Board Officers and Members

Andy Symons, MD – President

Heather Paladine, MD – President-Elect

Rachelle Brilliant, DO – Vice President

Ani Bodoutchian, MD – Secretary

Dan Young, MD – Treasurer

Francis Faustino, MD – Director (Term expires 2023)

Kristin Mack, DO – Director (Term expires 2023)

Joyce Robert, MD – Director (Term expires 2023)

Scott Hartman, MD – Director (Term expires 2024)

Jocelyn Young, DO – Director (Term expires 2024)

Keisha Guerrier, MD – Director (Term expires 2024)

Lily Eisenberg, MD – Director (Term expires 2025)

Jane Simpson, DO – Director (Term expires 2025)

Wayne Strouse, MD – Director (Term expires 2025)

Christine Doucet, MD – Speaker, Congress of Delegates

Thomas Molnar, MD – Vice Speaker, Congress of Delegates

Jiana Mendez, MD – New Physician

Ray Ebarb, MD – Delegate to AAFP Downstate

Barbara Keber, MD – Alternate Delegate to AAFP Downstate

Ani Bodoutchian, MD – Delegate MSSNY

Paul Salzberg, MD – Alternate Delegate MSSNY

James Mumford, MD – Immediate Past President

Eric Burge, MD – Resident Rep Upstate

Terence Meehan, MD – Alternate Resident Rep Upstate

Aerial Petty, DO – Resident Rep Downstate

Lewis Wong, MD – Alternate Resident Rep Downstate

Sarah Theiner – Student Rep Upstate

Alicia Ciringione – Alternate Student Rep Upstate

Naveed Nikpour – Student Rep Downstate

Jacqueline Liu – Alternate Student Rep Downstate

AAFP Foundation Announces 2022 Scholars for Family Medicine Leads Emerging Leader Institute

The AAFP Foundation recently announced the 2022 class of scholars for the Leads Emerging Leader Institute Program. This year- long initiative provides extensive training to develop leadership potential in select scholars from around the country. Throughout the program, the scholars will work with a mentor to complete a leadership project related to one of three tracks: Policy & Public Health Leadership, Personal & Practice Leadership, and Philanthropic & Mission-Driven Leadership.

Among these future leaders, NYSAFP would like to congratulate NYSAFP members Drs. Aerial Petty and Smita Sinha, as 2022 scholarship recipients.

Addressing Psychiatric Disease with Cultural Competence in Refugee and Asylum Populations

By Afreen A. Siddiqui, MS; Victoria Lazarov, BS; Alyssa Reese, BA, BS; Katelyn C. Donnelly, MPH; Erika W. Zheng, BA; Andrea Alfonsi, BS and Kim Griswold, MD, MPH

Introduction

With the current political climate contributing to global displacement, we anticipate a growing refugee and asylum-seeking population within our state. Although not officially recognized as a sanctuary state, New York is home to a large number of both refugees and asylum seekers, with 6% of the US refugee population settling in the state last year.[1] Refugees and asylum seekers are defined as those seeking international protection from dangers present in their home country, with asylum seekers awaiting final government review of such status. Practitioners of family medicine serve a pivotal role in helping this population establish care. Additionally, the role of family medicine is further amplified by the prevailing cultural stigma commonly seen in these populations against pursuing psychiatric help. For this reason, family medicine maintains a large role in closing the gap to equitable psychiatric care. Multiple studies conducted in this arena have highlighted the high prevalence of PTSD, depression, and anxiety disorders in this population.[2,3] Working within a diverse immigrant population, it can be difficult to determine what is "normal" versus what is "pathological" especially when treating those who speak rare languages that do not allow for easy interpretation. Our paper aims to address the cultural framework that exists within the DSM-V and provide a comprehensive description of available tools for practitioners.

Cultural Contexts in the DSM-V

The 5th version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) was published in May of 2013 and updated in March of 2022, offering clinicians a practical and

Figure 1. Subcategories Within the Cultural Formulation Interview (CFI)

Sub-Categories	Rationale
Cultural Definition of Problem	• Elicits an individual's view of core problems and key concerns. • Understand how individuals frame the problem for members of their social network. • Focus on aspects of the problem that matter most to individuals.
Causes	• Reveals the meaning of the condition for the individual. • Focuses on the views from an individual's social network; these may be diverse and vary from the individual's experiences.
Stressors & Support	• Elicit information on the individual's life context, focusing on resources, social support, and resilience. May also ask about other support from participation in religion or spirituality. • Focuses on stressful aspects of the individual's environment. May also ask about relationship problems, difficulties at work/school, or discrimination.
Role of Cultural Identity	• Elicit aspects of identity that make the problem better or worse. • Explore reasons for clinical worsening of symptoms resulting from discrimination due to migration status, race/ethnicity, or sexual orientation. • Explore migration-related problems; conflict across generations or due to gender roles.
Self-coping	• Clarify self-coping mechanisms.
Past Help-seeking	• Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). • Clarify the individual's experience and regard for previous help.
Barriers	• Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment (e.g., money, work, family commitments, stigma, discrimination, or lack of services).
Preferences	• Ask about the patient's social network and their perspectives on mental health care.
Clinician-Patient Relationship	• Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.

functional guide to aid in the diagnosis and treatment of mental disorders.[4] However, the authors of the manual acknowledge the limitations of the guide regarding cultural differences. They note, "culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis".[4] This particularly applies to the diagnosis of psychiatric disease in refugees, asylum seekers, and New Americans seen in the primary care and psychiatry setting. In comparing the DSM-V to the first edition of the DSM, one can see that an effort has been made to improve the way in which the manual addresses cultural differences that may impact diagnosis. Two of the pertinent additions include the Cultural Formulation Interview (CFI) and the Glossary of Cultural Concepts of Distress. Both serve to address the potential barriers of the use of specific criteria in the diagnosis of patients with different cultural backgrounds.

The CFI is a tool that clinicians can utilize when making cultural assessments for the purpose of diagnosis and treatment planning.[5] The CFI contains a total of 16 questions that fall under nine sub-categories, which are listed and described in *Figure 1*.[6] Once clinicians become familiar with the questions of the interview, administration should take approximately 20 minutes.[7] Use of the CFI has increased since its release in 2013, and research has investigated its utility in clinical practice in multiple countries, including the United States, Canada, Kenya, Peru, the Netherlands, India, and Mexico.[5] Numerous studies have elucidated the benefits of CFI in the clinical setting.[7,8,9,10] However, there are also clear barriers of the CFI that must be addressed. These include determining the relevance of the CFI to the patient's presentation, lack of familiarity with the CFI, and utilizing the questionnaire during encounters with children, and patients with severe symptoms.[7,11] *Figure 2* summarizes this above-mentioned approach and provides examples of how a patient interview may be approached.

The Glossary of Cultural Concepts of Distress is found within the appendix of the DSM-V and is only five pages long. Within these five pages, one can find a total of nine highlighted idioms of distress: *ataque de nervios, dhat syndrome, khyâl cap, kufungisisa, maladi moun, nervios, shenjing shuairuo, susto, taijin kyofusho*.[4] It is of note that the DSM-IV contained more idioms of distress and culture-bound syndromes than the DSM-V, as 25 were present in the DSM-IV.[12] It is suspected that this decrease is the result of the questionable diagnostic validity of culture-bound syndromes.[13,14,15]

In asylum work, the validity and applicability of these idioms of distress is also a point of concern. Although it can be beneficial for clinicians to understand specific elements of a patient's culture while formulating a diagnosis, many variations exist within specific cultures. The DSM-V discusses the idioms of distress in the context of large groups of people. For example, *ataque de nervios* or "attack of nerves" is discussed as a syndrome among individuals of Latino descent.[4] Thus, the DSM-V is attempting to generalize this condition to many different countries and cultures. This inherently presents an issue to a provider attempting to apply this concept to individuals from various countries and a plethora of different cultures. Overall, more research regarding the utility of these idioms in practice should be implemented and clinicians should be cautious when employing these tools during the process of diagnosis.

Challenges for the Family Physician

As family medicine physicians are considered front line healthcare professionals in caring for refugee, asylee, and New American populations, it is important to acknowledge the difficulty of their role. Family physicians who intend to provide comprehensive care to these patients must not only be an expert in medicine, but are required to adopt the role of an advocate to overcome the multiple barriers that prevent this population from accessing and receiving appropriate medical attention.[16] Other clinician- and system-specific challenges that prevent the family physician from providing healthcare services for these patients include gaps in physician training; limitations of interpretation services; time constraints; truncated continuity of care; availability of evidence-based guidelines; and the lack of intentional intersection of community engagement and healthcare.[17] It is imperative to acknowledge that many family physicians who lack the support of integrated behavioral health providers consider themselves unprepared to manage such cases appropriately.[18]

Challenges that exist from the patient perspective include their unfamiliarity with local medical providers; difficulty understanding medical problems, cultural beliefs that contradict suggested medical therapies; distrust in American healthcare workers; barriers to transportation; and difficulty accessing interpretation services.[19] Refugee and asylum populations make up demographically diverse groups that are at an elevated risk for mental health comorbidities as a result of the adversities they have endured throughout their lifetime.[18] Once in the United States, immigrants face social hardships that frequently compound their preexisting traumas. Nevertheless, many refugees may not be referred to mental health services due to a demonstrated and perceived sense of emotional resilience.[18] In this case, family physicians' role in broaching the topic of mental health is even more critical as refugees and asylum seekers are more likely to present to care for a medical concern rather than a conspicuous mental health referral.

Given cultural and familial stigma surrounding mental health care in asylum seeking and refugee communities, primary care centers are most commonly an individual's first exposure to healthcare when arriving in the United States. Thus, family physicians may be perfectly positioned to garner the trust necessary for these patients to begin discussing their mental health needs over multiple appointments.[16] Those who wish to address the neglected health care needs of refugee and other immigrant populations have a daunting but not insurmountable set of challenges to overcome.

Tools to Overcome Barriers

While the importance of cultural competence in the clinical setting is universally accepted, Hwang *et al*. suggests that "professionals who want and need to be culturally competent are left with the message that culture matters but continue to struggle with how to be a more culturally competent practitioner in concrete terms".[20] Lau *et al.* proposes that culturally competent techniques for providers may be distinguished into two themes: individual and organizational.[21] From an individual perspective, self-awareness, cultural humility, and respect for cultural diversity have been highlighted as the three most important facets of cultural competence. This involves examining

continued on page 42

continued from page 41

one's own culture, race, ethnicity, gender, and class in relation to patients from refugee and asylum-seeking backgrounds and accepting a diverse range of beliefs regarding health and well-being as opposed to emphasizing differences in health care practices. This theme also highlights the importance of recognizing one's own limitations when providing care for this population and, in turn, referring patients to more specialized services when appropriate. Cultural knowledge is another individual tool providers may utilize to understand gender norms, religious beliefs, develop rapport, and predict potential ethnopharmacological effects that differential diets or medicinal herbs could have on psychotherapeutic medications.[22]

From a systems-based perspective, primary care clinics should prioritize establishing a welcoming, culturally empathetic environment that is integrated with the surrounding community. A previously published study by our group reports that establishing a welcoming, culturally diverse healthcare setting is the first step to dismantling linguistic, religious, and perceived social barriers to care.[22] As a feasible, first step to creating this environment, our group recommends placing pictures of providers in the lobby with corresponding signage (e.g. position, title) translated into languages most commonly spoken by the clinic's patient population. Similarly, we suggest that clinics offer introductory handouts detailing what to expect at primary care appointments in the most representative languages of the surrounding community.

Federal law requires that health clinics receiving funds from Health and Human Services take "reasonable steps" to provide "required" language services to persons with limited English proficiency.[23] In turn, we recommend the use of in-person interpreters when possible to facilitate interactions with healthcare staff and accurate completion of pre-visit documentation. This will fulfill the dual purpose of increasing patient comfort and ensuring that patients understand all the potential services, including mental health care, available at a primary care appointment. Hiring staff that represent the target population also plays a critical role in promoting patient trust and comfort in the clinical setting. Moreover, we also recommend that clinics dedicate spaces to accommodate a variety of religious practices, such as a room to perform prayer, or *salah*, that may need to take place during the hours of a primary care visit. From the patient's perspective, these changes show consideration and will help garner more trust.

Considering the intersectionality of socioeconomic, geographic, and cultural barriers to care among these populations, a behavioral health liaison and psychiatric care basic tool kit may serve as beneficial guides to both providers and patients while navigating both an initial mental health consultation and ongoing follow-up visits. For instance, a liaison may help arrange transportation and/or electronic access to follow-up care, discover avenues to mitigate the cost of needed pharmacological therapy, and unpack emotional concerns regarding how receiving mental health care may affect an individual's interpersonal relationships within their community. By creating partnerships with refugee resettlement agencies, family physicians may easily connect patients with behavioral health lisasions in a manner that avoids the need for additional bureaucratic barriers and protects physician time spent per patient encounter. This collaborative care model allows a clinic to manage complex care needs that are sequela of trauma experienced by this population. Additionally, institutional partnerships with local organizations led or informed by individuals from various ethnic communities may function as a conduit of information between providers and community members that can help clinics continually evolve and improve care models in line with community input.

Of the 178 clients served by a student-run asylum clinic in Western New York, it was found that the most prevalent forms of physical torture were physical abuse (77%), blunt trauma (75%), and penetrating injury (e.g. stabbing, gun wound) (26%), while death threats (52%), killing of a family member (46%), and threat against family (44%), and witness to beating of a family member (42%) were the most prevalent forms of psychological torture among asylum seekers.[24] While primary care is often a crucial point of contact for people who have experienced

traumatic events or adverse childhood experiences, practitioners often report discomfort in discussing traumatic experiences with their patients resulting in undetected and untreated trauma-related symptoms.[25] We recommend that clinics serving asylum seeking populations adopt a trauma informed care framework that aims to reframe, as opposed to overcome, traumatic experiences.

This notion of reframing has been hypothesized to result in mending the tension between one's potential in theory and one's potential in actuality, thereby allowing an individual to recover a sense of autonomy and sociopolitical agency.[26] This may be applied to a discrete event that perhaps could have precipitated the need to seek asylum or over the course of an individual's life. In the latter, narrative exposure therapy has been proposed as an effective method to examine the entire life history of a person and, in turn, their trauma-stress continuum.[22] Considering this population's baseline reluctance to discuss potential sequelae of torture, healthcare professionals in this space should aim to apply these principles universally to all clinical interactions as opposed to limiting trauma informed care approaches to psychiatric encounters. Providers may develop these skills through trauma-informed care training and simulated patient encounters designed to increase provider comfort asking about traumatic events, introducing the theme of mental health care, and counseling patients through the initial steps of reframing a traumatic life experience that has led to them now seeking care in your office. Simulated encounters should also incorporate the presence of an interpreter to promote provider comfort holding these conversations through a third party mediator. Throughout these experiences, providers should aim to align with the AAFPs' guidelines on appropriate use of medical interpreters with particular attention towards addressing the patient directly and in the first person, emphasizing the importance of sentence-by-sentence interpretation, and seating an interpreter next to or slightly behind a patient.[27]

From the providers end, *decentering* or distancing oneself from one's own cultural biases and attachments, helps avoid a monolith lens of care.[28] This can be further progressed by establishing boundaries of mutual engagement, a concept stemming from the "I-Thou" model which allows for flexible, culturally-cognizant and individually-tailored communication.[29] Extending mind-body treatment modalities such as mindfulness, yoga and other exercise-based interventions can not only help with better health outcomes, but can also be a familiarity for those whose cultures use similar forms of expression. In fact – returning to the basics may provide more benefit than expected; simply conducting a detailed history that encompasses the history of trauma, migration and education can prove beneficial in establishing a bigger picture.[30]

Finally, there are tools specific to illness states like PTSD, depression, and anxiety that have been developed in refugee populations or adapted for use with refugees. Some of these are screening tools while others are longer, more comprehensive, and not intended for screening. These include the Harvard Trauma Questionnaire (HTQ) and the Vietnamese Depression Scale (VDS) as screening tools, and the New Mexico Refugee Symptom Checklist-121 and Hopkins Symptoms Checklist-25, as comprehensive tools not meant for screening. Of these, and in the case of PTSD, the HTQ employs a cross-cultural lens in examining exposure to trauma and sequelae of trauma experienced by refugee populations. Its questionnaire template allows for efficient and multipurpose scoring.[31] Description of these tools is beyond the scope of this paper, but extensive literature exists covering the reliability and validity of these methods, and we recommend that practitioners prioritize familiarizing themselves with them. Overall, combining old and new practices tailored to individual patient needs allow for more effective, mindful, and culturally competent treatment.

Conclusion

While refugee and asylum seekers often present with a unique combination of social, psychological, and legal difficulties, this patient cohort has also been proven to demonstrate unparalleled resilience, resistance, adaptability, hopefulness, purpose, and flexibility. Employing techniques, such as the Cultural Formulation Interview, and using screening tools adapted for specific populations and languages can build rapport, provide thorough care, and help achieve health equity. Investing in a collaborative care model that prioritizes input from refugee and asylum-seeking populations allows for a beneficial and effective relationship between the physician and patient.

Endnotes

1. Monin K, Batalova J, Lai T. Refugees and Asylees in the United States. https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-2021. [Accessed May 4, 2022]
2. Morina N, Akhtar A, Barth J, Schnyder U. Psychiatric Disorders in Refugees and Internally Displaced Persons After Forced Displacement: A Systematic Review. Front Psychiatry. 2018;9:433. doi:10.3389/fpsyt.2018.00433
3. Mellor R, Werner A, Moussa B, Mohsin M, Jayasuriya R, Tay AK. Prevalence, predictors and associations of complex post-traumatic stress disorder with common mental disorders in refugees and forcibly displaced populations: a systematic review. Eur J Psychotraumatol. 2021;12(1):1863579. doi:10.1080/20008198.2020.1863579
4. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed., American Psychiatric Association, 2013.
5. DeSilva R, Aggarwal NK, Lewis-Fernandz R. The DSM-V Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry. Psychiatric Times. 2015;32(6).
6. Cultural formulation. 5th edition. Arlington (VA): American Psychiatric Association; 2013.
7. Jarvis GE, Kirmayer LJ, Gómez-Carrillo A, Aggarwal NK, Lewis-Fernández R. Update on the Cultural Formulation Interview. Focus (Am Psychiatr Publ). 2020 Jan;18(1):40-46. doi: 10.1176/appi.focus.20190037
8. Muralidharan A, Schaffner RM, Hack S, et al: "I got to voice what's in my heart": participation in the Cultural Formulation Interview: perspectives of consumers with psychotic disorders. J Psychosoc Rehabil Ment Health 2017; 4:35–43
9. Díaz E, Añez LM, Silva M, Paris M, Davidson L. Using the Cultural Formulation Interview to Build Culturally Sensitive Services. Psychiatr Serv. 2017;68(2):112-114. doi:10.1176/appi.ps.201600440
10. Lewis-Fernández R, Aggarwal NK, Lam PC, et al. Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: mixed-methods results from the DSM-5 international field trial. Br J Psychiatry. 2017;210(4):290-297. doi:10.1192/bjp.bp.116.193862

continued on page 45

Figure 2. Case Study: Modified Cultural Formulation Interview (CFI) Strategies for Psychiatric Interviewing Refugees and Asylum Seekers

Cultural Definition of the Problem	
Sample Questions	**Our Experiences**
I. How would you describe your current problem to your family, friends, or other people from your community (or [country of origin])?	Asylum seeker who experienced female genital cutting in adolescence, denies dysuria and sexual pleasure; reports mild dyspareunia, night-time awakenings, hypervigilance, and intrusive memories related to rape by officers in her home country.
II. What troubles you most about your problem?	Interferences with sleep and intrusive memories were the most bothersome to the patient at the time of presentation.
Cultural Perception of Causes, Stressors/Support, & Cultural Identity	
Sample Questions	**Our Experiences**
I. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?	Asylum seeker states that she feels guilt surrounding her nonconsensual sexual encounter; states this has hurt her relationship with her husband who has been experiencing symptoms of night-time awakenings, hypervigilance, and intrusive thoughts since being in the United States.
II. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?	The client and her husband live at a local refugee shelter with dormitory style living where bedrooms are separated by gender and multiple residents sleep in bunk beds in the same room; husband attributes the client's symptoms to crowded, unfamiliar conditions of the shelter.
III. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?	Client's children also live at the refugee shelter with her and her husband, and she states spending time with them brings her joy.
IV. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money or family problems?	She is not eligible for a work visa while living at the shelter, so she is unable to work at the moment; she believes that if she was busy working, she would not have as much time to think about her traumatic past experiences.
V. For you, what are the most important aspects of your background or identity?	Client reported that religion was a central, salient part of her identity as she purposefully chose to convert to her current religion of Christianity in late adolescence; client's family practiced polytheism.
VI. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?	Client cited her inability to speak English very well and lack of public transportation near the shelter as factors that she felt were worsening her symptoms.
VII. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?	It is forbidden to speak about 'initiation' (female genital cutting) to individuals outside of the tribe; client states that she knows she would be killed by the tribe leader if she were to return because they would assume that she spoke to someone in the United States about initiation; client's mother is the tribe leader of her home village; client's mother would be the person who would need to kill her.
Cultural Factors Affecting Self-Coping & Past Help Seeking; Barriers Present	
Sample Questions	**Our Experiences**
I. People often have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?	Client believes she coped with traumatic experience of 'initiation' by pursuing higher education in a city so she could leave the village and become financially independent.
II. Often people look for help from many different sources, including different types of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?	Reported that she had a few sessions with a mental health counselor in her home country but lost contact with them.
III. What types of help or treatment were most useful? Not useful?	States that she enjoyed the sessions but ultimately did not have the time to continue attending as she was also studying at a university during this time in her home country.
IV. Has anything prevented you from getting the help you need?	Living at the refugee shelter has made it difficult to create a space that she feels is her own, aforementioned barrier of not being able to work and obtain financial stability due to legal status.
Cultural Factors Affecting Current Help Seeking – Preferences & Client-Patient Relationship	
Sample Questions	**Our Experiences**
I. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?	Client thinks that being able to work would be the most helpful opportunity for her. Client is being connected with mental health services while living at the shelter but is unsure how much this is helping.
II. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you? III. Have you been concerned about our relationship and is there anything that we can do to provide you with the care you need?	Many of the other residents at the shelter are also connected with mental health services including her husband. Some of the women she has befriended at the shelter recommend listening to music and going for walks in the neighborhood as well.

continued from page 43

11. La Roche MJ, Bloom JB. Examining the effectiveness of the Cultural Formulation Interview with young children: A clinical illustration. Transcult Psychiatry. 2020 Aug;57(4):515-524. doi: 10.1177/1363461518780605.
12. Diagnostic and Statistical Manual of Mental Disorders: DSM-4. 4th ed., American Psychiatric Association, 2000.
13. Ventriglio A, Ayonrinde O, Bhugra D. Relevance of culture-bound syndromes in the 21st century. Psychiatry Clin Neurosci. 2016 Jan;70(1):3-6. doi: 10.1111/pcn.12359.
14. Bhugra D, Sumathipala A, Siribaddana S. Culture-bound syndromes: A re-evaluation. In: Bhugra D, Bhui K (eds). Textbook of Cultural Psychiatry. Cambridge University Press, Cambridge, 2007; 141–156.
15. Sumathipala A, Siribaddana S, Bhugra D. Culture-bound syndromes: The story of dhat syndrome. Br. J. Psychiatry 2004; 184: 200–209
16. Pottie K, Masi R, Watson B, Heyding R, Roberts M. Marginalized patients. A challenge for family physicians. Can Fam Physician. 2000;46:15-25
17. Mishori R, Aleinikoff S, Davis D. Primary Care for Refugees: Challenges and Opportunities. Am Fam Physician. 2017 Jul 15;96(2):112-120
18. Walden J. Refugee Mental Health: A Primary Care Approach. Am Fam Physician. 2017;96(2):81-84
19. Pottie K, Batista R, Mayhew M, Mota L, Grant K. Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies. Can Fam Physician. 2014;60(1):e32-e40
20. Hwang W-C, Myers HF, Abe-Kim J, et al. A conceptual paradigm for understanding culture's impact on mental health: the cultural influences on mental health (CIMH) model. Clin Psychol Rev. 2008;28:211–227.
21. Lau LS, Rodgers G. Cultural Competence in Refugee Service Settings: A Scoping Review. Health Equity. 2021 Mar 16;5(1):124-134. doi: 10.1089/heq.2020.0094
22. Griswold KS, Loomis DM, Pastore PA. Mental Health and Illness. Prim Care. 2021 Mar;48(1):131-145. doi: 10.1016/j.pop.2020.09.009
23. Jacobs B, Ryan AM, Henrichs KS, Weiss BD. Medical Interpreters in Outpatient Practice. Ann Fam Med. 2018;16(1):70-76. doi:10.1370/afm.2154
24. Mohammad Y, Alfonsi A, Coluccio M, Schlosser K, Griswold K. Psychological Torture Endured by Clients of the Human Rights Initiative. Poster presented at University at Buffalo Celebration of Scholarship, June 2021
25. Goldstein E, Murray-García J, Sciolla AF, Topitzes J. Medical Students' Perspectives on Trauma-Informed Care Training. Perm J. 2018;22:17-126. doi:10.7812/TPP/17-126
26. LaMothe R. Psychoanalysis, Trauma, and Giorgio Agamben. Psychoanal Rev. 2022 Mar;109(1):39-65. doi: 10.1521/prev.2022.109.1.39
27. Juckett G, Unger K. Appropriate Use of Medical Interpreters. American Family Physician. 2014 Oct 1; 90(7): 476-480
28. Grasser LR. Addressing Mental Health Concerns in Refugees and Displaced Populations: Is Enough Being Done?. *Risk Manag Healthc Policy*. 2022;15:909-922. Published 2022 May 6. doi:10.2147/RMHP.S270233
29. Shors MK, Kroll J. To cross or not to cross: Clinical boundary considerations with persons who are refugees. *Transcult Psychiatry*. 2022;59(2):165-174. doi:10.1177/1363461519878289
30. Bäärnhielm S, Schouler-Ocak M. Training in cultural psychiatry: Translating research into improvements in mental health care for migrants. Transcultural Psychiatry. 2022;59(2):111-115. doi:10.1177/13634615221089384
31. Berthold SM, Mollica RF, Silove D, Tay AK, Lavelle J, Lindert J. The HTQ-5: revision of the Harvard Trauma Questionnaire for measuring torture, trauma and DSM-5 PTSD symptoms in refugee populations. Eur J Public Health. 2019;29(3):468-474. doi:10.1093/eurpub/cky256

Afreen Siddiqui, MS *is a third-year medical student at the Jacobs School of Medicine and Biomedical Sciences and a New York native. She received her BS in Biomedical Sciences from the University at Buffalo, and a MS in Biomedical Sciences from Rutgers University. She currently serves as the Director of Advocacy & Public Relations of the Human Rights Initiative.*

Victoria Lazarov, BS *is a fourth-year medical student at the Jacobs School of Medicine and Biomedical Sciences. She received her BS in Global and Public Health Sciences from Cornell University. She currently serves as the co-Director of the Human Rights Initiative and Physicians for Human Rights Student Advisory Board (PHR SAB) Liaison and consultant to New York State asylum clinics.*

Alyssa Reese, BA, BS *is a third-year medical student at the Jacobs School of Medicine and Biomedical Sciences. She received her BS in Biomedical Sciences and BA in Social Sciences Interdisciplinary with a concentration in legal studies from the University at Buffalo. She currently serves as Assistant Director of the Human Rights Initiative and is a member of the Global Health and Surgery committee of the Physicians for Human Rights Student Advisory Board.*

Katelyn Donnelly, MPH *is a second-year medical student at the Jacobs School of Medicine and Biomedical Sciences. She received her BS in Chemistry and International Service from Valparaiso University and her MPH in Epidemiology from the University of Illinois at Chicago, where she was the recipient of a David L. Boren Fellowship for isiZulu language studies at the University of KwaZulu-Natal in Durban, South Africa. She currently serves as Research Coordinator for the Human Rights Initiative.*

Erika Zheng, BA *is a fourth-year medical student at the Jacobs School of Medicine and Biomedical Sciences. She received her BA in Biological Sciences from the University of Chicago. She currently serves as the co-Director of the Human Rights Initiative.*

Andrea Alfonsi, BS *is a third-year medical student at the Jacobs School of Medicine and Biomedical Sciences. She received her BS in Biology from the University of Florida and her BS in Health Sciences from the University of Central Florida. She serves as Research Coordinator for the Human Rights Initiative.*

Kim Griswold, MD, MPH *is Professor Emerita of Family Medicine, Psychiatry and Public Health and the Health Professions at the Jacobs School of Medicine and Biomedical Sciences, SUNY at Buffalo. She serves as Medical Director for the Center for Survivors of Torture, Jewish Family Services of Buffalo, and Erie Country, and as faculty liaison to the Human Rights Initiative at UB. She is an affiliated member of the Physicians for Human Rights Asylum Network.*

Homelessness and Its Impact on Patient Compliance and Mental Health

By Melinda Seide, MBA, MBS and Elaine Kang, MD

Introduction

Homelessness is a public health crisis plaguing communities in the United States and worldwide. Homeless people "are individuals without permanent housing who may live on the streets; may stay in a shelter, mission, single room occupancy facility, abandoned building, or vehicle; or who are in any other unstable or nonpermanent situation."[1] One may also be considered homeless if their circumstances require them to stay with family or friends or if they have been released from the hospital or prison with no definitive housing.[1] Homelessness can affect all genders, races, ethnicities, and age groups, with about half a million homeless on any given night in the US.[2]

Numerous factors can cause homelessness. For instance, within the past few years, there has been a rise in the poverty rate and a decrease in the availability of affordable housing.[1] Additionally, there are socioeconomic factors that increase a person's risk of homelessness which include lack of higher education, low wages, domestic violence, mental illness, physical illness, inability to secure stable employment, lack of access to affordable healthcare, and of course, the continuing COVID crisis.

Tackling the issue of homelessness may seem daunting, but with the right tools, healthcare providers can guide patients to the right resources. Currently, there is no questionnaire or screening tool to efficiently assess homelessness. Clinicians could use such a screening tool to quickly determine a patient's housing status; correlate housing status with their mental health and ability to comply with medication regimens; and improve health care follow-up. This information will allow clinicians to provide a genuinely holistic approach to treating patients and make great strides in addressing the issue of homelessness and its effects on patients' health.

Subsequent sections of this article will discuss homelessness and its impact on patient compliance and mental health. We will provide two questionnaires, the PHMH-2 and PHMH-9 (Patient Home-lessness and Mental Health questionnaires 2 and 9), that healthcare providers can utilize in various healthcare settings. Both questionnaires will allow health care providers to gain further insight into their patients' lives, build deeper relationships with them, and stratify a patient's ability to comply with their health care regimen. Lastly, this article will provide potential steps providers can take to connect their patients to current resources and offer possible solutions to ameliorate this problem in the long term.

Impact of Homelessness on Mental Health

Homelessness tends to lead to the inability to care for one's mental health.[3] Basic needs such as food, water, and shelter tend to take precedence over seeking psychiatric treatment.[3] Psychiatric conditions tend to be addressed in crisis situations rather than in the early stages. About 20-30% of homeless people have a mental illness, while 30-50% of homeless people have a substance abuse disorder or dual diagnosis.[1] Common mental health pathologies among the homeless are bipolar disorder, major depressive disorder, and schizophrenia[1], as well as alcohol and drug dependence.[3] Some findings correlate homelessness to increased levels of psychiatric distress and decreased perceived levels of improvement from a psychiatric pathology.[3]

Impact of Homelessness on Patient Compliance

Patient homelessness and its correlation to medical compliance is a multifaceted issue. Barriers to adherence include transportation, cost of care, communication, and discrimination.[3] Homeless individuals often lack access to transportation, which inhibits them from attending medical appointments and picking up medications.[3] Often, public transportation may not be available, may require multiple transfers, or may not be affordable for the patient.[3] Homeless patients may not be aware of programs such as the Affordable Care Act or Medicaid that provide access to routine health care and mental health treatment.[3]

Additionally, communication is a significant issue for the homeless population. Many do not have access to a cell phone or are unable to keep their phone charged, as they frequently do not have access to electricity or funds to pay for a phone bill.[3] Many homeless people also lack access to the internet, which diminishes their ability to obtain valuable health information, while others may have language barriers.[3] Additionally, there is the stigma of being homeless and the notion that homeless patients are mentally ill and prone to violence.[3]

It has been found that medication non-compliance is mainly patient-related.[4] Patients frequently run out of medication, do not attend follow-up visits, and mismanage their medications.[4] Many patients forget to take their medications. Homeless patients frequently have had their medication lost or stolen due to a lack of adequate storage or housing. In addition, low health literacy can make compliance difficult.[4]

Unfortunately, the inability to find adequate solutions to these barriers has been linked to an escalation in morbidity and mortality in the homeless population. Homeless patients have a higher incidence of various illnesses such as cardiovascular disease, infectious disease, cancer, homicide, suicide, diabetes, hypertension, tuberculosis, and unintentional injury.[3]

PHMH-2 and PHMH-9 Questionnaires (Patient Homelessness and Mental Health Questionnaires)

In an effort to increase awareness of the prevalence of homelessness and its effects on a patient's health, we created two screening questionnaires that model the PHQ2 and PHQ9 screening tools for depression. Health care providers can use the PHMH-2 questionnaire in various medical settings to inquire about a patient's current living condition. If a patient indicates that they are homeless or have unstable housing, clinicians can then ask more about the patient's living conditions using the PHMH-9 questionnaire.

Depending on the patient's response to the PHMH-9, the clinician can then formulate a tailored approach to the patient's medical care and a management plan for each patient's unique situation. Like the PHQ-9 for depression, the PHMH-9 can be used to screen and monitor a patient's housing status and its effects on medication compliance and mental health.

PHMH-2 (Patient Homelessness and Mental Health Questionnaire-2)

1. Are you homeless?
   ☐ Yes ☐ No

2. Where do you live?
   ☐ Homeless shelter/Temporary housing ☐ Street
   ☐ Couch surfing ☐ In a house ☐ In an apartment
   ☐ SRO (Single room occupancy) ☐ Group home

PHMH-9 (Patient Homelessness and Mental Health Questionnaire-9)

1. Where do you live?
   ☐ Homeless shelter/Temporary housing ☐ Street
   ☐ Couch surfing ☐ SRO (Single room occupancy)
   ☐ Group home ☐ In a house ☐ In an apartment

2. How long have you been in your current living situation?
   ☐ Less than a month ☐ Less than a year
   ☐ 1-5 years ☐ 5 years or more

3. Do you feel safe where you live?
   ☐ No ☐ Yes
   3a. If no, please explain.
   _____
   _____

4. Do you have any medical conditions that require medication?
   ☐ Yes ☐ No
   4a. If yes, do you take them as prescribed?
   ☐ No ☐ Yes
   4b. If no, what are barriers to taking your medications as prescribed?
   _____
   _____
   _____

5. Does your current living situation affect whether or not you can take your medication?
   ☐ Yes ☐ No
   5a. If yes, how so?
   _____
   _____

6. Has your current living situation affected your mental health?
   ☐ Yes ☐ No
   6a. If yes, please explain.
   _____
   _____
   _____

7. Did your mental health condition contribute to your homelessness?
   ☐ Yes ☐ No ☐ Not Applicable
   7a. If yes, how so?
   _____
   _____
   _____

8. Did being homeless make your mental health condition worse?
   ☐ Yes ☐ No ☐ Not Applicable
   8a. If yes, please explain.
   _____
   _____
   _____

9. Was your mental health condition caused by homelessness?
   ☐ Yes ☐ No ☐ Not Applicable
   9a. If so, how?
   _____
   _____

continued from page 47

Immediate Solutions to Address Homelessness in Healthcare

There are immediate actions that health care providers can take to address homelessness in their patient populations. According to The Canadian Family Physician, clinicians can take four practical steps:[5]

The first step is to provide accessible care, which includes: creating a welcoming environment that promotes diversity; being conscious of barriers to care such as transportation; partnering with community groups to contact patients; creating culturally safe spaces; simplifying the process of scheduling appointments and communicating with the care team, and waiving accessory fees.[5]

The second step is to provide patient-centered comprehensive care, which includes: practicing trauma-informed and anti-oppressive care during treatments; using open-ended questions to establish the patient's plan; obtaining a full social when red flags appear; being sensitive when a patient is emotionally triggered; creating a management plan with evidence-based options (i.e., referring patients to supportive housing, connecting patients to income support, referring patients to mental health programs, giving patients access to opioid agonist therapy for opioid use disorder and helping patients with system navigation when using case management.)[5]

The third step is to provide continuity of care which includes: maintaining an ongoing connection to care via outreach workers; keeping the patient's contact information updated; having an automated health care provider reminder in place when a file is inactive; having advanced access models, for instance, same-day access to primary care services; having flexible hours, and recruiting volunteers to aid in the healthcare process.[5]

The fourth step is to provide accountable social care, which includes assisting patients in getting treatment and care (e.g., referrals); working with health institutions, community partners, and people who have experienced homelessness to bridge systemic gaps; advocating for systemic changes to prevent homelessness and housing precarity; establishing partnerships with local organizations with expertise in this area, igniting local constituencies and supporting them in being heard; and encouraging shifts in social norms through education, research and by raising awareness.[5]

Lastly, clinicians can use the Aunt Bertha website/app to further aid patients, connecting them to housing, food, and employment opportunities throughout the USA within seconds, just by inserting a zip code.[6]

Long Term Solutions to Address Homelessness in Healthcare

Finding a solution to housing the homeless may seem unattainable, but many providers do not let statistics deter their determination to minimize this dilemma. Health care providers understand that if patients do not have a home or have unstable housing, it is not safe to discharge them from medical institutions.[7]

Hospital systems are investing in real estate as a potential solution to this issue. The lack of adequate housing has resulted in patients remaining in hospitals longer than necessary, resulting in deficits in hospital budgets and a reduction in available bed space for other patients.[7] To address this issue, some hospitals are forming community partnerships that allow them to create affordable housing for patients. For example, the University of Illinois Hospital and Health Sciences System began a collaboration with the Center for Housing and Health in Chicago to create support services and stable housing via the Better Health through Housing program. This resulted in a 42% drop in patient health care costs, a decrease in inpatient stays by 57%, and emergency room use by 67%.[7]

Conclusion

Homelessness is a multifaceted dilemma that impacts society globally. Despite the intricacies of this issue, there are practical steps clinicians can take to influence their patients' lives. By using the PHMH-2 and PHMH-9 questionnaires and following the steps in the immediate solutions section, health care providers can assess their patient's risks, gain further insight into their lives, and create management plans tailored to each patient's unique situation. On a systemic level, clinicians can advocate for funding for homeless programs and collaborate with local community organizations for affordable housing.

Though the task may seem daunting, it is important to stay encouraged. It doesn't matter if you change just one patient's life; you never know who is connected to that person and how your influence can create a cycle of change.

Endnotes

1. Maines, D.L., & Khan, M. (2014). Care of the Homeless: An Overview. *American Family Physician*. Retrieved May 18, 2022, from https://www.aafp.org/afp/2014/0415/p634.html.
2. United States Interagency Council on Homelessness. (2021, July 28). *Key Findings of 2020 Point-in-Time Count* https://www.usich.gov/tools-for-action/2020-point-in-time-count/.
3. Balasuriya, L., Buelt, E., & Tsai, J. (2020, May 29). The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality. Psychiatric Times. https://www.psychiatrictimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality.
4. Coe, A.B., Moczygemba, L.R., Gatewood, S.B.S., Osborn, R.D., Matzke, G.R., & Goode, J-V. R. (2015). Medication Adherence Challenges among Patients Experiencing Homelessness in a Behavioral Health Clinic. *Research in Social and Administrative Pharmacy*, 11. (3), 1-17. DOI: 10.1016/j.sapharm.2012.11.004.
5. Andermann, A., Bloch, G., Goel, R., Brcic, V., Salvalaggio, G., Twan, S., Kendall, C.E., Ponka, D., & Pottie, K. (2020). Caring for patients with lived experience of homelessness. *PubMed*. Retrieved May 17, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7430777/
6. Aunt Bertha. (2022). *Find food, health, housing and employment programs in seconds*. https://www.auntbertha.com/widget/660x234?c=2F8BC5&d=connectva.
7. Bhatt, Jay. (2019, December 12). *Hospitals offering housing for improved patient care*. AHA. https://www.aha.org/news/healthcareinnovation-thursday-blog/2019-12-12-hospitals-offering-housing-improved-patient-care.

Melinda Seide MBA, MBS *is a medical student. She holds a Bachelor's in French Language and Civilization from CUNY Hunter College, a Master's in Biomedical Science from Rowan University and a Master's in Business Administration with a specialization in finance from Louisiana State University at Shreveport.*

Elaine Kang, MD *is currently a member of the Public Health Commission for the New York State Academy of Family Physicians. She practices at multiple organizations throughout New York City. She is affiliated with the Institute for Family Health, New York City Health and Hospitals, CityMD, Planned Parenthood and Early Options.*

Lumps and Bumps in the North Country:
Exploring Local Physician Attitudes Toward Upstate Mobile Mammography

By Myranda Steingraeber, MD; M. Lynn Pisaniello, MD, FAAFP and Carrie Roseamelia, PhD

Background

Mobile health screening clinics have been hailed as cost effective and successful ways of delivering care to uninsured, low income, and minority populations in underserved areas.[1,2,3,4] Women living in underserved areas and in poverty have higher breast cancer mortality rates than the general US population, and have lower annual screening rates compared to women living in higher income areas. Mobile mammography clinics improve overall access to serve these at-risk populations effectively, with reportedly better patient communication relative to fixed mammography sites.[4]

Despite effectively serving target populations, the drawbacks of mobile mammography include low patient retention rates, low rates of patient follow-up on abnormal or inconclusive results, and lack of diagnostic imaging capabilities.[4] Mobile mammography patients are 2.1 times more likely than patients at fixed sites to experience delays in diagnostic follow up, even after controlling for other healthcare use behaviors.[5] Mobile mammography has been associated with greater percentages of incomplete reports (BIRADS-0) compared to fixed sites, with lack of access to prior mammograms as a contributing factor.[6] Additionally, mobile mammography clinics have higher depreciation and maintenance costs compared to other types of mobile clinics.[2] There may also be prejudices related to affiliated or funding institutions, though this has not yet been explored; 66% of mobile clinics are affiliated with hospital systems, academic institutions, health centers, insurance companies, or faith-based organizations.[1] Such drawbacks may make mobile clinics controversial for local providers and patients.

Recently, SUNY Upstate launched the Upstate Mobile Mammography Clinic (UMMC) to serve Onondaga, Oswego, Oneida, Madison, Herkimer, Jefferson, Lewis and St. Lawrence counties (https://www.upstate.edu/mobile-mammography/who-is-eligible.php). Prior to launching the project, they sent letters to each county's mayor/town supervisor and public health department director, visited public libraries in Onondaga, Madison, and Oneida counties, and did internet outreach in the North Country counties. UMMC advertises clinics through TV and social media ad, grassroots efforts, and information sent by mail or email to primary care and ob/gyn offices nearby.

The van includes an exam room, a waiting and registration area, a changing room, and a mammography area with wheelchair access. The team on-site includes a registered mammography technologist, registered nurse, outreach and registration staff, and a driver, while off-site staff include radiologists, a program manager, assistant, and director of testing and innovation. Annual screening mammography is offered to women aged 40-75 years, with mammograms read by SUNY Upstate radiologists. Appointments are made by patients online or via phone. For any given location, there must be at least 10 patients scheduled 2 weeks in advance, otherwise the site visit is rescheduled (the team is lenient about this, knowing the importance of mammograms to individuals). Patients without an order (those who have no PCP) or those without insurance must schedule a clinical breast exam with UMMC to receive a standing order from Upstate radiologists or coverage from the NYS Cancer Services Program (CSP), respectively. Although clinical breast exams (CBEs) are not recommended for screening where routine mammography is available,[7,8,9] patients with abnormal findings on CBE require imaging at a fixed mammography center rather than a mobile clinic, and are offered assistance in scheduling this. CBEs are commonly included with mobile mammography programs.[10]

Mammography results are sent to both the patient and their primary provider. Films can be requested, and a nurse reaches out to the PCP office to determine who will arrange follow up imaging if needed. UMMC's recorded rates of timely patient follow up for diagnostic imaging were 100% (April 1st, 2021 - March 31st, 2022), 45% (April 1st, 2020 - March 31st, 2021 - height of Covid-19 pandemic impact on UMMC), and 99% (April 1st, 2019 - March 31st, 2020).[11]

continued on page 50

continued from page 49

Table 1 - Table courtesy of Wendy Hunt, of UMMC

County	Total Patients 6.2019-6.2022
Oswego	***217***
Onondaga	**798**
Madison	**166**
Oneida	**263**
Herkimer	***129***
Lewis	***27***
Jefferson	***239***
St Lawrence	***106***
Franklin	2
Hamilton	39
Albany	1
Broome	2
Cayuga	38
Chemung	1
Chenango	2
Cortland	6
Delaware	1
Erie	2
Essex	2
Monroe	1
Otsego	1
Rensselaer	1
Suffolk	1
Tompkins	2
Wayne	1

Between June 2019 and June 2022, UMMC served 2,054 patients total, 372 (18%) from the northernmost counties of St. Lawrence, Jefferson, and Lewis County. See Table 1.[11] At the time of this project, UMMC was grant-funded by Health Research Inc., and the NYS DOH. The grants ended 03/31/2022; current funding is through Upstate, under direction of the radiology department.

The region covered by UMMC is both urban and rural; descriptive statistics are shown in Table 2. Of this group, St. Lawrence County has the least population per square foot, the greatest percentage of persons in poverty, and the greatest percentage of population without insurance.[12] Rural northern New York, colloquially known as the North Country, is the emphasis of this investigation.

We assessed the attitudes of North Country primary care physicians (PCPs) regarding the Upstate Mobile Mammography Clinic. Do physicians perceive the clinic as helpful or harmful to patient care?

Methods

Recruitment was offered via email and phone to a convenience sample of physicians practicing in St. Lawrence, Jefferson, Lewis, and Oswego counties. Thirteen physicians were invited, one declined, five interviewed, and the remaining six did not respond to multiple requests. Onondaga, Oneida, and Madison counties were excluded despite being in UMMC range, as they were not deemed part of the North Country. This project was approved by the SUNY Upstate Medical University IRB board.

In structured phone interviews (Figure 1), physicians were asked about their awareness of UMMC, if their patients had utilized it, what their attitudes are towards it, and how it could improve. Additionally, physicians were asked what they perceived as their patients' greatest barriers and attitudes toward routine breast cancer screening. Data was also collected on demographics, training background, practice type, and length of time practicing in total and in the North Country.

Figure 1

Aim 1: determine how PCPs perceive the Mobile Clinic overall (10 questions total)

(Introduce self, introduce project, explain to participant the risks and benefits of participation, emphasize that they are free to decline any question or stop interview at any point.)

1. *Are you aware of the Upstate Mobile Mammography Clinic? Have any of your patients used this for their screening Mammography?*
2. *What are your attitudes towards the Upstate Mobile Mammography Clinic? (if participant asked for clarification, prompt with asking them to describe the pros and cons of the mobile unit as they have experienced them)*
3. *What do you believe to be the biggest barriers of your patients toward breast cancer screening?*
4. *What are their (your patients') attitudes towards breast cancer screening?*
5. *Which guidelines do you follow for breast cancer screening recommendations?*
6. *If the mobile unit could improve on one thing, what would it be?*

We are also collecting demographic data on our participants, please describe your...

- age, gender, race/ethnicity
- training background (type of residency, fellowships or additional certifications/degrees),
- length of time practicing & length of time practicing in this region (North Country)
- how would you describe your practice setting (private practice, hospital/healthcare affiliate, academic appointment, FQHC, etc.)?

additional thoughts:

Table 2:[12]

COUNTY	POPULATION APRIL 2020	UNINSURED POPULATION	% WOMEN	PERSONS IN POVERTY	LAND AREA SQ MILES 2010	POP PER SQ MILE, 2010	HS GRAD OR HIGHER (AGES 25+)	BACHELORS DEGREE OR HIGHER (AGE 25+)
St. Lawrence	108,505	5.70%	49%	14.70%	2,680.38	41.8	88.70%	23.80%
Onondaga	476,516	4.80%	51.80%	12.80%	778.39	600	91.00%	35.90%
Oswego	117,525	5.30%	49.90%	14.20%	951.65	128.3	88.20%	19%
Oneida	232,125	5.30%	50.20%	12.40%	1,212.43	193.7	88.50%	25.70%
Madison	68,016	4.30%	50.60%	10.40%	654.84	112.2	92.00%	26.20%
Herkimer	60,139	4.70%	50.40%	12.10%	1,411.47	45.7	89.80%	21.50%
Jefferson	116,721	4.80%	47.50%	13.10%	1,268.59	91.6	91.00%	22.20%
Lewis	26,582	5.00%	49.30%	11.40%	1,274.68	21.3	90.10%	18.40%
TOTAL	Sum: 1,206,129	Avg: 4.99%	Avg: 49.84%	Avg: 12.64%	Sum: 10,232.43 Avg: 1,279.05 Range (654.84 - 2,680.38)	Avg: 154.325 Range (21.3 - 600)	Avg: 89.91% Range (88.2% - 92.0%)	Avg: 24.09% Range (18.4% - 35.9%)

Responses were categorically coded by themes that arose in literature reviews and interviews. Attitudes were coded into positive and negative categories. Perceived patient barriers were categorized into literature-derived categories of cost, pain, bad news,[4] stigma, or cultural attitudes.[13,14] After reviewing survey answers collectively, categories of transportation, logistics, and education were added. Improvement for UMMC and additional comments are reported in paraphrase.

Results

Responding Physician Characteristics: All five responding physicians are family medicine trained and board certified, three identified as male (60%), two as female (40%). All responders (100%) identified as white, and one (20%) reported Hispanic heritage. Responding physicians practice in St. Lawrence (N=3, 60%) or Lewis County (N=2, 40%). Three (60%) work in hospital-based/hospital-affiliated clinics, and two (40%) in private practice clinics. Total time practicing ranges from 6 months to 43 years, and four out of five responders (80%) have spent their entire career in the North Country. The respondent who had practiced elsewhere has spent the majority of their career in New York's North Country (24 years).

Physician Survey Responses:

Awareness: Three respondents (60%) were completely unaware of UMMC; one read about it in local newspapers, and another heard of it from patients who utilized it - this was the only respondent with direct interaction with UMMC. The remaining questions were answered hypothetically by those who had no interaction with UMMC.

Attitudes: Physician overall attitudes toward UMMC included three positive responses, one diplomatic-neutral response, and one strongly negative response. The more positive responses came from responders with less clinical experience (6 mo. – 7 yrs.) and included the participant whose patients had utilized UMMC. The responder with the most experience in the North Country held the strongly negative view. Positive attitudes emphasized increased coordination and patient communication, increased convenience with less travel (especially in small towns), and possible benefits of a clinic under university leadership with institutional funding, procedure standardizations, and quality control. The respondent with direct interaction had 5-6 patients utilize UMMC with no abnormal results. Their office received the results directly in all cases but one, wherein the patient received her results and the clinic procured a copy easily once notified by the patient. Another respondent emphasized that the positive impact of a mobile mammography clinic is contingent on proper follow up with primary care teams.

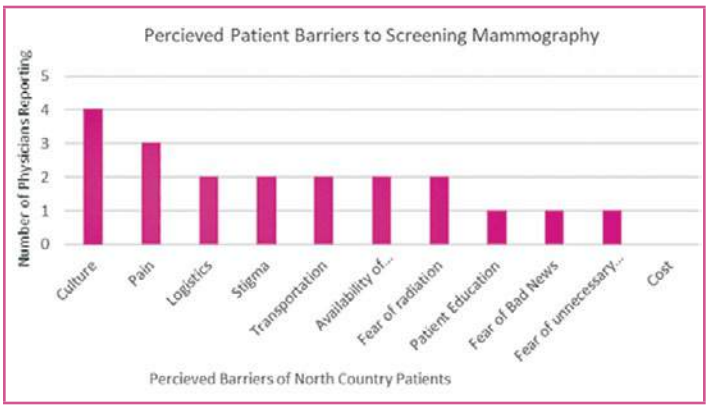
Negative attitudes included comments that UMMC was not addressing the true issues of the region, and may interrupt care continuity. Specifically, transportation was not seen as a major barrier since most people living in the North Country have cars, and fixed mammography sites have extended hours and all female technologists. Another concern was that UMMC does not address a regional issue of site-to-site variability in imaging quality and follow up protocols. Another concern was that PCPs want to discuss films and protocols with radiologists. The most strongly negative attitude was described as the intrusion of an outside entity with risk of lost follow up and loss of vital physician-physician collaboration (PCP to radiologist) particularly in cases of abnormal results. The respondent described it as *"another bad idea that comes between a patient and their doctor. Health care is not a box to be checked off; it is a relationship of trust that results in better health."* The physician whose patients utilized UMMC did not have any negative attitudes but noted that all results were normal, with only one delayed report, which the patient had already received on time.

Perceived Patient Barriers: The frequency of themes mentioned by percent of responding physicians was thus: culture (80%), pain (60%), stigma (40%), logistics (40%), transportation (40%), availability of mammography (40%), fear of radiation (40%), patient education (20%), fear of bad news (20%), fear of unnecessary test or biopsy (20%) (Figure 2). However, the themes of culture, stigma, transportation, and availability of mammography were conflicting in their perceived influence over patients' decision to screen for breast cancer. Interestingly, the barrier of cost, much discussed in literature, was not mentioned.

continued on page 52

continued from page 51

Figure 2:



Four responders (80%) mentioned culture, although they disagreed about its influence on patients' decisions to be screened. Three of these four mentioned a local cultural/religious preference against any kind of cancer screening, while the fourth referred to the greater US culture of support for breast cancer screening (i.e.: celebrity endorsements, public service announcements, and breast cancer awareness month). It seems local cultural preference against screening competes with the greater US sentiment in favor of breast cancer screening.

Pain was the second most frequently mentioned barrier to patients' breast cancer screening, listed by three out of five responding physicians (60%), one of whom specified that pain is the primary barrier for their patients.

Two physicians (40%) mentioned stigma, which also had conflicting influence. One emphasized that stigma was largely removed by the US cultural push for breast cancer screening, but another respondent stated that the Covid-19 pandemic created a stigma against visiting healthcare settings.

The barrier of logistics was mentioned twice (40%). This is minimally discussed in literature, and in many cases, this burden falls maximally on the patient. This category includes finding time for the appointment, remembering it, and navigating around unfamiliar hospitals or imaging centers. Logistical barriers are largely systemic, depend on multiple individual factors, and level of difficulty and patient responsibility varies by clinic, but they should not be ignored.

Transportation, one of the main barriers addressed by mobile clinics, was controversial as seen by two (40%) respondents. One respondent strongly believed that all rural patients have access to cars out of necessity and therefore transportation is a non-issue. The other discussed how alleviating the burden of transportation would most benefit patients in small towns, and mentioned the difficulty of transportation in winter months. The latter unfortunately applies to UMMC as well, which does not travel very far from its Syracuse base in wintertime because of the high opportunity cost of weather-related road conditions and potential cancellations. North Country locations also require overnight stays by staff, an additional year-round challenge.

Availability of fixed mammography sites was discussed by two respondents (40%) and again was controversial. In one respondent's area, there is plenty of availability through a nearby fixed mammography site with extended hours and all-female staff. The other respondent pleaded the case of patients in more rural small towns, who could benefit greatly from a mobile mammography clinic.

Fear of radiation was reported as a barrier to routine screening mammography by two physicians (40%).

Patient education was mentioned by one (20%) respondent twice. Once regarding patients not understanding the importance of screening for breast cancer, secondly regarding women who missed the task "assignment" at a busy annual appointment.

Fear of receiving bad news (20%) and fear of unnecessary testing/biopsy (20%) were each mentioned once in this survey. Unnecessary testing was suggested as contributing to the cultural preference against screening, while unnecessary biopsy was mentioned in conjunction with the barrier of pain. The literature-derived theme of cost was not mentioned in the initial survey, potentially related to the statewide Cancer Services Program.

Perceived Patient Attitudes: Most physicians agreed that the majority of patients have positive attitudes toward breast cancer screening, for reasons described above: supportive US culture, lots of advertisement, and awareness campaigns. Perceived negative attitudes were related to a regional culture of avoiding screening, the discomfort of mammography, and fear of radiation. One physician mentioned that their patients aged 40-50 years were most compliant, while patients aged 50-65 tended to be less diligent despite their increased risk.

Suggestions for Improvement: Three respondents recommended increasing awareness about UMMC through newspaper and radio announcements or by distributing a schedule of locations at primary care clinics. Another suggested focusing efforts on more specific populations like refugees and minority women. Another re-emphasized the importance of high quality mammography and a uniform approach to abnormal imaging. This respondent also suggested basing the mobile clinic out of a North Country site, more locally known and available than Syracuse. One respondent skipped this question.

Additional Comments: One respondent (with positive overall attitudes) highlighted the need for follow up with patients and communication with primary care physicians, stating that "ownership of the patient" by all healthcare players is essential for good outcomes. This respondent emphasized that success is contingent on proper documentation and communication of results – *"pros outweigh the cons **if** there is proper follow up."* Another respondent emphasized the importance of knowing regional culture, geography, resources, and stakeholders. A third respondent commented that mobile mammography creates a frustrating disconnect between PCPs, their patients, and specialists – in essence that mobile clinics cut away at the core continuity of primary care, worsening patient care. Two respondents skipped this question.

Addendum: A follow up call was made to clarify root causes of apprehension towards UMMC. One respondent mentioned the potential risk of negligence on PCP licenses should a delay in follow-up occur. Similarly, the respondent whose patients utilized UMMC acknowledged that this might be a concern but assumed (correctly) that UMMC would have follow-up protocols to prevent such delays. A third respondent

stated that the potential of delayed results or lost patient follow-up would not limit their utilization of UMMC, rather their greatest apprehension was about image quality as impacted by travel. A fourth respondent was not apprehensive, rather they were concerned about resource allocation, mentioning the need for improved insurance coverage for mammography at their county level, stating that women might be more likely to get mammograms if there were zero out of pocket charges. This was the first and only mention of cost as a barrier to patients. Finally, the respondent with the most negative attitude emphasized that their apprehension was related to PCP's losing connection with their patients, being unable to see if the mammogram was completed, and the challenges of introducing a system with unknown radiologists, unknown quality controls, unknown protocols and loss of local radiologist as resources in cases of unclear results. In sum, the issue is not a fear of liability on PCP licenses, but other systemic factors that create negative attitudes and apprehension among local family physicians.

Discussion

Underserved regions both urban and rural have a higher burden of breast cancer mortality. Mobile mammography clinics may offer a solution. While they are effective at removing some barriers for patients, these mobile clinics may not be appropriately addressing the challenges faced by this region, and there is the risk of scattering patient care. This project was undertaken to uncover the attitudes of local primary care physicians toward the Upstate Mobile Mammography Clinic in the eastern North Country.

In this survey, only two respondents (40%) were aware of UMMC, one through advertising, another through patients; and only one physicians' patients used the mobile clinic, and of those 5-6 patients, all results were normal. This lack of awareness is a major limiting factor in our findings, and indicates that UMMC may not be optimally utilized in the North Country. If providers are not aware, they cannot offer this option to patients. The impact, good or bad, of any mobile clinic is limited immediately by whether or not patients and physicians are aware of its presence.

Overall, physician's attitudes are highly variable toward UMMC. Physicians newly in practice held more positive views than those with decades of regional experience. The strongest emphasis was on ensuring follow up of results - however, this was not emphasized by the physician who had direct interaction with UMMC. Mobile clinics aim to "catch" people who fall through the proverbial cracks, but some physicians felt that a mobile clinic from a distant institution might increase the risk of lost follow up for patients. Similarly, it may disrupt continuity of patient coordination, with unintended losses in patient care quality. To this end, UMMC designates an RN to connect with PCP offices to ensure communication of results, offer to have films sent, and for coordination of further imaging as needed. There were also apprehensions about the mammography quality, given potential damage in transit, and about the protocols followed for abnormal scans. Thus, some apprehension is related to unknowns from the perspective of family physicians, and may be alleviated by more direct outreach and education by UMMC.

Another concern was that UMMC might be missing the mark, and therefore a misallocation of resources. In rural regions, it is nearly impossible to survive without transportation, thus, one of the main barriers removed by UMMC may not be the main barrier in this region. Physicians described sub-regional differences in need – for example, the conflicting views on transportation and access to fixed sites suggest that a mobile clinic would better serve extremely rural or impoverished communities. However, mobile mammography clinics are reported to alleviate other logistical challenges, including waiting times, availability of appointments, work scheduling, and reminders of appointments, therefore may still be of value to patients in larger communities.[4,18]

Pre-existing barriers to mammography, including geographic access, have been worsened by the covid-19 pandemic.[16] UMMC adapted and persevered in providing services during this pandemic, and physicians noted a shift in patient preferences away from crowded healthcare facilities, which may play a role in the popularity of mobile mammography clinics in the future, if this preference persists.

Culture is a well-established factor impacting breast cancer screening rates. In the North Country, there exists a culture against malignancy screening. While patient autonomy is not to be ignored, this cultural preference should be explored for underlying reasons. If the root cause is suspicion of healthcare systems, religious reasons, fear of bad news, or lack of patient understanding, the physician approach individually and at the population level may need retooling. Fear of radiation may also contribute to this culture, but mammography has one the lowest average doses of radiation exposure compared to other diagnostic imaging modalities, and screening benefits outweigh its risks for patients on a routine screening schedule.[7,17] Peterson et al describes the impact of personal provider education and recommendation regarding cancer screenings, including breast cancer screening. Thorough explanations and discussion of patient barriers increased patient adherence to cancer screening.[15] Thus, UMMC's success may be enhanced by local physician partnership and cultural sensitivity.

Based on preliminary patient surveys, UMMC succeeds in offering convenience, speed, professionalism, and a welcoming environment for a stressful and uncomfortable procedure. Additionally, UMMC removes barriers by having on-site CBEs, a standing mammography order, and coordinating coverage through the NYS CSP. They also succeed in manifesting the literature findings that patients find mobile clinics more communicative and personable than fixed sites.[18]

Limitations: This project is limited by sample size and respondents' lack of direct interaction with UMMC, save one. There was also limited ethnic and geographic representation due to the small sample size.

Future directions include quality improvement studies of follow up procedures, exploring possible partnership with local physician and healthcare entities, and identification of locations that would maximally benefit from mobile clinics. A much broader question is whether mobile clinics are more suited to serving rural or urban underserved populations. If not mobile clinics, what resources are better suited to underserved rural regions?

continued on page 54

continued from page 53

Conclusions

UMMC, like other mobile mammography clinics, effectively increases accessibility, and addresses the barriers of transportation, logistics, cost, and lack of PCPs. It generates a preferred patient experience with better patient communication than fixed sites. However, UMMC is controversial because of the risks of lost results, lost patient follow up, and loss of connection within local healthcare communities. UMMC is under recognized and likely underutilized in the North Country, giving cause to question its success in serving this area. Local physician attitudes toward UMMC are variable, sometimes quite strongly negative. This clinic could be improved by increased advertising, creating a more stable presence in the North Country, and perhaps most of all by increasing purposeful partnership with local primary care physicians.

Disclaimers: The authors have no competing interests to declare.

Acknowledgment: The authors thank and acknowledge Ms. Wendy Hunt and the Upstate Mobile Mammography Team for their assistance and promotion of medical education.

Endnotes

1. Malone NC, Williams MM, Smith Fawzi MC, Bennet J, Hill C, Katz JN, Oriol NE. *Mobile health clinics in the United States*. Int J Equity Health. 2020 Mar 20;19(1):0. doi: 10.1183/s12939-020-1135-7. PMID: 32197637; PMCID: PMC7085168.
2. Attipoe-Dorcoo S, Delgado R, Gupta A, Bennet J, Oriol NE, Jain SH. *Mobile health clinic model in the COVID-19 pandemic: lessons learned and opportunities for policy changes and innovation*. Int J Equity Health. 2020 May 19;19(1):73. doi: 10.1186/s12939-020-01175-7. PMID: 32429920; PMCID: PMC7236869.
3. Young SG, Ayers M, Malak SF. *Mapping mammography in Arkansas: Locating areas with poor spatial access to breast cancer screening using optimization models and geographic information systems*. J Clin Transl Sci. 2020 Mar 24;4(5):437-442. doi: 10.1017/cts.2020.28. PMID: 33244433; PMCID: PMC7681135.
4. Vang S, Margolies LR, Jandorf L. *Mobile Mammography Participation Among Medically Underserved Women: A Systematic Review*. Prev Chronic Dis. 2018 Nov 15;15:E140. doi: 10.5888/pcd15.180291. PMID: 30447104; PMCID: PMC6266518.
5. Vang SS, Dunn A, Margolies LR, Jandorf L. *Delays in Follow-up Care for Abnormal Mammograms in Mobile Mammography Versus Fixed-Clinic Patients*. J Gen Intern Med. 2022 Feb 25. doi: 10.1007/s11606-021-07189-3. Epub ahead of print. PMID: 35212876.
6. Roubidoux MA, Shih-Pei Wu P, Nolte ELR, Begay JA, Joe AI. *Availability of prior mammograms affects incomplete report rates in mobile screening mammography*. Breast Cancer Res Treat. 2018 Oct;171(3):667-673. doi: 10.1007/s10549-018-4861-4. Epub 2018 Jun 28. PMID: 29951970.
7. Khan M, Chollet A. *Breast Cancer Screening: Common Questions and Answers*. Am Fam Physician. 2021 Jan 1;103(1):33-41. Erratum in: Am Fam Physician. 2021 Mar 1;103(5):263. PMID: 33382554.
8. Myers ER, Moorman P, Gierisch JM, Havrilesky LJ, Grimm LJ, Ghate S, Davidson B, Mongtomery RC, Crowley MJ, McCrory DC, Kendrick A, Sanders GD. *Benefits and Harms of Breast Cancer Screening: A Systematic Review*. JAMA. 2015 Oct 20;314(15):1615-34. doi: 10.1001/jama.2015.13183. Erratum in: JAMA. 2016 Apr 5;315(13):1406. PMID: 26501537.
9. Menes TS, Coster D, Coster D, Shenhar-Tsarfaty S. *Contribution of clinical breast exam to cancer detection in women participating in a modern screening program*. BMC Womens Health. 2021 Oct 19;21(1):368. doi: 10.1186/s12905-021-01507-x. PMID: 34666735; PMCID: PMC8524962.
10. van den Bruele AB, Sevilimedu V, Jochelson M, Formenti S, Norton L, Sacchini V. *Mobile mammography in New York City: analysis of 32,350 women utilizing a screening mammogram program*. NPJ Breast Cancer. 2022 Jan 21;8(1):14. doi: 10.1038/s41523-022-00381-6. PMID: 35064104; PMCID: PMC8782895.
11. Hunt, Wendy. (2022). [unpublished raw data from Upstate Mobile Mammography Program, received electronically 06/13/2022]. Upstate Mobile Mammography Program.
12. U.S. Census Bureau (2020). *QuickFacts Onondaga county, New York; Oswego county, New York; Oneida county, New York; Madison county, New York; Herkimer county, New York; Jefferson county, New York; Lewis county, New York; St. Lawrence county, New York*. Retrieved from [https://www.census.gov/quickfacts/fact/table/US/PST045221]
13. Al-Azri M, Al-Rubaie K, Al-Ghafri S, Al-Hinai M, Murthi Panchatcharam S. *Barriers and Attitudes toward Breast Cancer Screening among Omani Women*. Asian Pac J Cancer Prev. 2020 May 1;21(5):1339-1347. doi: 10.31557/APJCP.2020.21.5.1339. PMID: 32458642; PMCID: PMC7541873.
14. Abelson J, Tripp L, Brouwers MC, Pond G, Sussman J. *Uncertain times: A survey of Canadian women's perspectives toward mammography screening*. Prev Med. 2018 Jul;112:209-215. doi: 10.1016/j.ypmed.2018.04.021. Epub 2018 Apr 18. PMID: 29678617.
15. Peterson EB, Ostroff JS, DuHamel KN, D'Agostino TA, Hernandez M, Canzona MR, Bylund CL. *Impact of provider-patient communication on cancer screening adherence: A systematic review*. Prev Med. 2016 Dec;93:96-105. doi: 10.1016/j.ypmed.2016.09.034. Epub 2016 Sep 28. PMID: 27687535; PMCID: PMC5518612.
16. Tsapatsaris A, Babagbemi K, Reichman MB. *Barriers to breast cancer screening are worsened amidst COVID-19 pandemic: A review*. Clin Imaging. 2022 Feb;82:224-227. doi: 10.1016/j.clinimag.2021.11.025. Epub 2021 Dec 7. PMID: 34896935; PMCID: PMC8648670.
17. Mettler FA Jr, Huda W, Yoshizumi TT, Mahesh M. *Effective doses in radiology and diagnostic nuclear medicine: a catalog*. Radiology. 2008 Jul;248(1):254-63. doi: 10.1148/radiol.2481071451. PMID: 18566177.
18. Steingraeber, M.A., Roseamelia, C. (2022). [Unpublished raw data on patient attitudes toward Upstate Mobile Mammography Clinic]. SUNY Upstate College of Medicine, Rural Medicine Program.

Myranda Steingraeber, MD *graduated from SUNY Upstate/Norton College of Medicine in May. She created this project for her microcredential in rural medicine because of her interests in mobile healthcare and women's health. Myranda begins at Albany Medical Center's Family Medicine Residency in July.*

M. Lynn Pisaniello, MD, FAAFP *practices full spectrum family medicine in Lewis County, with special interest in holistic maternity care. She precepts medical students and residents, serves as the Chairman of the Maternal Child Health Committee, and is past president of the medical staff at Lewis County Health System.*

Carrie Roseamelia, PhD *is Assistant Professor of Family Medicine, and Assistant Dean of Rural Medicine at SUNY Upstate Medical University. She serves as the program director for the SUNY Upstate Rural Medical Scholars Program at the SUNY Upstate Norton College of Medicine.*

Medical Aid in Dying:
Ethical, Legal, and Medical Considerations

By Jane M. Simpson, DO and Jensy Stafford, MD

Introduction

Medical aid in dying, physician aid in dying, death with dignity, and physician assisted suicide all describe the same medical treatment that has gained traction in mainstream media over the last several decades. The concept of medical aid in dying (MAID) is not new, but its increasing cultural acceptance and codification in law in states and nations has changed the conversation on this topic.[1] As the population ages and medical therapies keep patients alive longer, the issues of quality of life and appropriate end of life care have become even more important. The debate about the ethical, legal and medical implications of MAID continues in the literature, in our local and national governments, and within our profession. As family physicians, our patients may ask for our guidance around the practicalities of MAID, both in regards to their current medical care and their future plans.

Medical aid in dying refers to providing a patient with the means to end their own life, usually through a prescription cocktail that the patient must administer themselves.[2] It is not the same as a situation in which a physician administers the medications to the patient. MAID must be requested by the patient, usually more than once over a legally dictated timeline, and the patient must be deemed competent to make the request. In the United States, the patient must be suffering from a life limiting illness that will cause pain and suffering if the patient's life continues.[2] The two most common diagnoses receiving MAID are cancer and neurological conditions,[3] such as ALS.

Recent History

The first US state to legalize MAID was Oregon in 1994, in a public general election. The bill went into effect in 1997, and later that year, Oregonians voted down a separate bill attempting to repeal MAID.[4] Also in 1997, several physicians and patients in New York sued the state attorney general over a bill making MAID illegal in New York. They brought the case (Vacco v. Quill) to the Supreme Court and argued the bill violated the equal protection clause in the constitution. The Supreme Court unanimously decided that the bill did not violate equal protection, which left individual states to decide on its legality.[5] Currently Oregon, Colorado, California, District of Columbia, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington all have laws or legal precedence that codify the right to MAID for terminal patients.[6]

After Vacco v. Quill,[5] the NY state court of appeals also heard the case for state constitutional protection of MAID in 2017 with Myers v. Schneiderman.[7] The court ruled that the right to die with a physician's assistance did not exist under New York State law.[7] In 2015, the "Death with Dignity Act" was introduced to the New York State Senate, but did not pass. The bill continues to be reintroduced and was discussed as recently as the current judicial session.[8]

continued on page 56

continued from page 55

In organized medicine, MAID has been debated at the local, state, and national levels. As recently as early 2018, the American Academy of Family Physicians (AAFP) was officially opposed, the American Medical Association (AMA) was officially opposed, and the American Academy of Hospice and Palliative Medicine (AAHPM) maintained a neutral stance. The AAFP moved to a position of engaged neutrality on MAID in late 2018.[9] As of 2019, the AMA now states that physicians may provide MAID "according to the dictates of their conscience without violating their professional obligations" but the organization remains in opposition.[10] The Medical Society of The State of New York (MSSNY) currently stands in opposition pending a constituency survey to determine the attitude of its membership.[11] NYSAFP changed its position from one of neutrality in 2015, to one of support in 2017.[12]

What do our patients think about MAID? Since 1947, Gallup has been asking the question "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?"[13] In 1947, 37% of Americans were in support. Support rose to 53% in 1973, to 65% in 1990, and by 2018, 72% of Americans were in support. As of 2018, 73% of those identifying as liberal, and 51% of those identifying as conservative, were in support of "physician assisted suicide" being legalized.[13] 54% of Americans believed "physician assisted suicide" to be morally acceptable.[12] A Marist poll of New Yorkers in 2021 showed that 58% of New Yorkers support legalizing MAID, including 55% of republicans, 60% of democrats, and 68% of independants.[14]

Core Ethical Principles

The four main ethical principles we discuss in medical or clinical ethics are autonomy, nonmaleficence, beneficence, and justice.[15] Autonomy, or the ability to make medical decisions for oneself based on one's own values and judgements, has become increasingly important to the American medical landscape over the past century. Historically, a physician's decisions for what was best for the patient were seen as having more inherent value than the patient's decisions.[16] In modern American medical ethics, autonomy is generally the foremost ethical principle.[17] Autonomy gives us the basis for informed consent, and requires us to offer patients options and give recommendations rather than dictate care.

"First, do no harm," the well-known adage translated from Hippocrates' *Of the Epidemics* invokes the ethical principle of nonmaleficence.[18] Physicians must strive to prevent actions from causing harm to patients.[19] Next, there is beneficence, or doing good. Patients' interests should be at the forefront of medical decision making and their thoughts, ideas, culture, morals, and preferences should be considered when making medical recommendations.[20] Sometimes, to solve problems or treat patients, some harm is incurred (i.g. surgery). In these cases, the intent of the action is to do good, and so any harm that occurs is ethically acceptable. This is referred to as the principle of double effect.[21] For instance, if a patient has appendicitis, pain as a result of the appendectomy is ethically justified, because the intent is saving the patient's life, and surgical pain is a side effect of that life- saving treatment. Similarly, we consider the routine practice of administering the combination of opioids and benzodiazepines to ease the pain and agitation at end of life as ethically justified, as the intent is to ease suffering, and the small possibility of hastening death is a side effect of that symptom management.

Of the elements of justice, the principle of distributive justice is the one most often considered in debates about MAID. The concept of distributive justice is the fair allocation of medical resources among patients based on need.[15] This principle is in action when considering how much time to spend with each patient, when treating uninsured patients equally to those who are insured, and when triaging patients in the emergency department.[15] All patients who present to the emergency department are treated regardless of their ability to pay, but they are prioritized based on the severity of their condition, not in the order they arrive.

Opposition

Opposition to MAID is often based on personal or religious morals that are in opposition to the intentional act of ending one's life. Some may cite religious edicts in the argument against MAID, as many major religions have teachings against suicide. Others may be opposed due to personal morals. While morals may help discern the right course of action when ethical considerations are conflicting, it is important to remember that morals are personal, and not widely generalizable, in contrast to ethical principles.

Medical paternalism favors placing the physician's moral beliefs above the patient's own beliefs. Though the medical field has moved away from paternalism and towards patient autonomy over the last century, physicians are not required to provide care they find morally objectionable. However, physicians are obligated to refer a patient to a colleague who does provide the requested or needed care.

The ethical principle that is regularly cited in opposition to MAID is nonmaleficence, or do no harm. One may invoke the principle of double effect and argue that ending a patient's life while trying to end suffering may be permissible as the ending of suffering is the primary goal, but in the case of MAID the primary goal is ending the patient's life. Seeking MAID to end suffering or prevent suffering in the future is a common reason given by patients,[3] however suffering is not a required element in the process. Allowing a patient to end their life may feel like the physician is causing inherent harm when not considered within the larger context of life limiting illness.

The argument against MAID also considers that there is inadequate palliative care at the end of life, and patients are not receiving the support or pain control needed to prevent suffering. Some may argue that the resources used to support MAID may be better allocated to strengthen palliative and hospice care, and that

physicians should offer additional reassurance about these resources at end of life. If patients know their suffering will be treated and their decisions respected, there may be decreased need for MAID.

Opposition to MAID in its current form may also be due to concerns about the disparities in access. In retrospective studies, the majority of patients who received MAID identified as non-Hispanic white, were insured, and had at least some college education.[3] This does not fit a model of distributive justice. Access issues certainly exist and need to be examined more closely in future research.

Support

The primary ethical argument for MAID, and an explanation as to why support for MAID has gained traction over the last century, is the increasing importance in western medical ethics of patient autonomy. Through this lens, a patient's wish to end their own life is paramount to all other arguments. When a patient's disease is terminal and they fear future suffering and indignities, does the physician have a right to tell them they cannot? Certainly this argument does not compel any individual physician to participate, but makes the case as to why MAID should be a legal option.

Do no harm, or nonmaleficence, can be applied to ending one's own life to prevent suffering. If a patient is expected to experience intense suffering or loss of dignity at the end of the disease course, some may argue that providing MAID would prevent this harm. Similarly, beneficence, or doing good, may be to offer patients this option of avoidance of suffering. This argument does not take the view that death is inherently wrong, but a normal part of lived experience, and that suffering in itself is worthy of avoidance.

The opposition's argument that there is inadequate palliative and hospice services at the end of life does not detract from the argument to support MAID. Palliative care and hospice care aim to limit suffering and increase dignity. Since end of life care is primarily about the patient's goals, and those of their loved ones, those that support MAID argue that it is an important option for patients at the end of life as it increases dignity and decreases suffering.

Only a narrow subset of the population, both geographically and socioeconomically, currently has access to MAID. Those that support MAID argue that the existing disparities in access should not be a reason to abandon efforts to enact it. Instead, when a viable treatment option is not justly distributed, access should increase. When considering distributive justice, it is unfair to offer MAID only to those who happen to live in an area where it is legal. Oregon recently ruled that it will drop its residency requirement for its Death with Dignity law and so will not discriminate based on a patient's location.[22] Increasing access, options, and care at the end of life is important for both sides of the argument.

The Medical Practicalities

Prescribing the medications for MAID is complicated because of the medications involved and the dosages of these medications. There is no governing body that regulates or recommends what medications and dosages should be used. Generally, in states where MAID is legal, physicians providing this care work with compounding pharmacies to determine what medications to administer and what dosages to prescribe. A combination of 3-4 medications, an opioid, a benzodiazepine, and a third and/or fourth agent is usually chosen. The third agent was traditionally a barbiturate, but as barbiturate prices have risen in recent years, and supply chain problems persist, the other agents can include a beta blocker and a cardiac glycoside, among other medications.[23] DDMP refers to the combination of diazepam, digoxin, morphine, and propranolol. For perspective, hospice patients are often started on 2-5 milligrams of morphine for mild pain,[9] and in DDMP the dosage of morphine is anywhere from 1-10 grams.[24] Other regimens include DDMP2 (with a higher dose of morphine), DDMA (with amitriptyline in place of propranolol), DDMA-Ph (with phenobarbital)[25] and others. There are very few published papers that discuss dosages and methods, and more research is needed to determine optimal medication regimens. In states where MAID is legal and data is being collected, the number of patients receiving prescriptions for MAID who actually filled and administered those prescriptions was between 48-87% depending on location and year.[3]

The Current State of Death with Dignity

After several state and federal court cases, New York ruled that MAID is not a constitutional right and that new legislation would be needed to provide MAID. A "Death with Dignity" bill has been introduced to the legislature since 2015 but has not passed. The legislature is currently considering the 2022 bill.[8] The NYSAFP now speaks out in favor of the bill and MSSNY is considering its viewpoint before speaking out further in either direction.[11,12] A majority of New Yorkers polled are in support of the bill, including a majority of republicans (although with a smaller margin than democrats).[14] No matter what side of the issue you are on, it is important to engage with organized medicine and make your carefully considered viewpoint and voice heard. This highlights the importance of engaging our patients on end-of-life decision making, and increasing symptom-based care at end of life.

Endnotes

1. Buchbinder M. Access to Aid-in-Dying in the United States: Shifting the Debate From Rights to Justice. Am J Public Health. 2018;108(6): 754-759
2. Nowels D, VandeKieft G, Ballentine JM. Medical Aid in Dying. Am Fam Physician. 2018 Mar 1;97(5):339-343
3. Al Rabadi L, LeBlanc M, Bucy T, et al. Trends in Medical Aid in Dying in Oregon and Washington. JAMA Netw Open. 2019;2(8):e198648
4. Oregon's Death with Dignity Act. Oregon Health Advisory. https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx Accessed May 12, 2022.
5. US Reports: Vacco Vs Quill. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL. V. QUILL ET AL. https://tile.loc.gov/storage-services/service/ll/usrep/usrep521/usrep521793/usrep521793.pdf Published 1997. Accessed May 12, 2022.

continued on page 58

continued from page 57

6. Physician-Assisted Suicide Fast Facts. CNN. https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html#:~:text=Physician%2Dassisted%20suicide%20is%20legal,and%20California%20via%20court%20decision. Updated June 1, 2021. Accessed May 12, 2022.
7. Myers v. Schneiderman. Casetext: Smarter Legal Research. https://casetext.com/case/myers-v-schneiderman-33 Published Oct 16, 2015. Accessed May 12, 2022.
8. Assembly Bill A4321A. New York State Senate. https://www.nysenate.gov/legislation/bills/2021/A4321 Accessed May 12, 2022.
9. Palliative Care Pain Management Guidelines. Northern Rivers Area Health Service. Palliative Drugs. https://www.palliativedrugs.com/download/COMPLETEMORPHINEVARIABLEDOSECHART2.pdf Published October 2004. Accessed May 12, 2022.
10. Physician-Assisted Suicide. American Medical Association. https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide Accessed May 12, 2022.
11. New York Physicians' Attitudes toward Medical Aid in Dying 60.996. MSSNY Position Statements. Medical Society of the State of New York. https://www.mssnypositionstatements.org/47-2/ Accessed May 12, 2022.
12. Mumford J. Why Family Doctors Support Medical Aid in Dying. NYSAFP. https://compassionandchoices.org/docs/default-source/new-york/maid-statement-mumford-april-2022_-nysafp.pdf?sfvrsn=80484b29_1 Published April 25, 2022. Accessed May 12, 2022.
13. Brenan M. Americans' Strong Support for Euthanasia Persists. Gallup. https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx Published May 31, 2018. Accessed May 12, 2022.
14. Marist Poll. Marist. https://maristpoll.marist.edu/wp-content/uploads/2021/10/Marist-Poll_NYS-NOS-and-Tables_202110110852.pdf Pubished October 2021. Accessed May 12, 2022.
15. Varkey B: Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30:17-28
16. F. Will, Jonathan. A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making. Chest. June 2011. 139, 6 (6): 1491–1497
17. Varelius J. The value of autonomy in medical ethics. Med Health Care Philos. 2006;9(3):377-388
18. Hipocates. Of the Epidemics. http://classics.mit.edu/Hippocrates/epidemics.1.i.html Accessed May 12, 2022.
19. Hughes G. First do no harm; then try to prevent it. Emerg Med J. 2007;24(5):314
20. Kinsinger FS. Beneficence and the professional's moral imperative. J Chiropr Humanit. 2009;16(1):44-46
21. Nockler NJ. The Principle of Double Effect and Proportionate Reason. Virtual Mentor. 2007;9(5):369-374
22. Razek R. Oregon will stop enforcing residency requirement in state's Death with Dignity Act. CNN. https://www.cnn.com/2022/03/29/us/oregon-stop-residency-requirement-death-with-dignity-act/index.html Published March 29, 2022. Accessed May 12, 2022.
23. Dear J. The Doctors Who Invented a New Way to Help People Die. The Atlantic. https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/ Published January 22, 2019. Accessed May 12, 2022.
24. Simone L. The Pharmacist's Role in Medical Aid-in-Dying. Oregon State Pharmacy Association. https://oregonpharmacy.org/wp-content/uploads/2019/10/The-Pharmacists-Role-in-Medical-Aid-In-Dying.pdf Published October 5, 2019. Accessed May 12, 2022.
25. Oregon Public Health Division, Center for Health Statistics. Oregon Death With Dignity Act: 2021 Data Summary. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf Published February 28, 2022. Accessed May 14, 2022.

Jane M. Simpson, DO *is a Clinical Assistant Professor of Family Medicine at SUNY Upstate Medical University. She serves as academic faculty for the United Health Services Family Medicine Residency Program, and as an attending of palliative medicine at Wilson Memorial Hospital in Binghamton, NY.*

Jensy Stafford, MD *is an Assistant Professor in Medicine and Family Medicine at the Warren Alpert Medical School of Brown University. She serves as the program director of the Brown Hospice and Palliative Medicine fellowship program. She is also the founder and co-director of the Arts and Ethics in Palliative Medicine course.*

Facing the Public Health Crisis of Pediatric Sex Trafficking

By Ann DiMaio, MD, FAAP and Pascal J. de Caprariis, MD, FAAFP

Introduction

Awareness of sex trafficking has received increased attention in the mainstream media, as well as the lay and medical community. The increasing number of children and adolescents who have been victimized was instrumental in the US Congress' passage of the Trafficking Victims Protection Act (TVPA) of 2000. It defines sex trafficking when "a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.[1]

The United Nations International Labor Organization estimates there are 4.9 million victims of sexual exploitation globally, with 3.9 million being adults and 1 million children.[2] Estes and Weiner estimate over 200,000 children as victims of commercial sexual exploitation in the United States.[3] While both males and females are trafficked, women and girls tend to predominate.[4] This may actually represent an under reporting of males caused by a lack of self-identifying as victims, or being unrecognized by the medical community or social services.[5] While the magnitude of these statistics is alarming, the available data may be obscured since many victims are reluctant to come forward for a variety of reasons. There is a lack of recognition by social services and the medical community due to a lack of education and training, which can lead to under reporting. Suniega et al. have noted that sex trafficking is underestimated for minors;[6] hence what is presented may only be the tip of the iceberg.

Traffickers generally target children between the ages of 12 and 14 because they are easy to manipulate, often lack good judgment and can be impulsive. Some children are even more vulnerable to traffickers due to certain personal risk factors such as prior physical or sexual abuse, neglect, addiction or mental illness. Traffickers find these children on the streets, schools, parks or online. Another target for recruitment are runaway and throwaway kids, and within 48 hours of living on the street, a trafficker will approach these children, befriend them, shower them with attention, gifts and the promise of a bright future.[7] This 'relationship' then turns dark with demands made to earn money by having sex, 6 to 7 nights a week with 10 to 15 clients each night. The trafficker may physically, and/or sexually assault and threaten them until they submit, working to isolate them and control their every move.

Victims of trafficking often seek medical care while experiencing exploitation. Lederer and Wetzel found 88% of female adult and adolescent victims sought treatment.[8] The sites most commonly visited were emergency departments (53%), followed by clinics at 39%.[9] Unfortunately, despite presenting themselves for care, they often go unrecognized by medical professionals as trafficking victims.[8] Greenbaum found that between 28% and 50% were not identified during their encounters with clinicians,[10] primarily due to lack of education and training of health care professionals (HCP).[11] In addition, victims themselves often do not self-identity. Shame, guilt, fear of retaliation from the trafficker and distrust of authority are some of the reasons why self-disclosure is difficult, which confirms why many victims remain unrecognized or unreported.

Family practice physicians, with their expansive training in both adult and pediatric medicine as well as expertise in gynecology, makes them a great fit to work in an emergency department, an urgent care center or a walk- in clinic where victims of sex trafficking (VST) may present for treatment. Once identified, a family physician can offer not only medical care but also make the connection with appropriate services. It is important to educate all health care providers on the basics of trafficking - providing the clues that raise the suspicion of trafficking and how to respond.[5] These steps, which are overviewed in detail below include I) Dynamics of the presentation, II) Common medical complaints, III) The interview, IV) Medical exam and treatment, V) Connecting VST with the legal and community services.

Suspecting Trafficking and How to Respond

I. Dynamics of the Presentation Between Patient and Escort

When a pediatric or adolescent VST presents for medical care, they are often accompanied by someone who introduces himself or herself as a relative, guardian or close friend. In reality, this "escort" is the trafficker. They are there to ensure the victim will not disclose their situation or flee. The physician's suspicion should be quickly aroused by the dynamics between the patient and the escort as it is not one of caring or concern that one would expect. The "escort" is domineering, controls the interview, answers questions and does not allow the patient to provide a medical history or answer any personal questions.[12] Any answers provided seem deliberately vague and lacking in detail. The "escort" is impatient, does want to wait for tests or results and does not appear truly concerned about the health of the patient. The trafficker's objective for the medical visit is immediate therapy instead of health care – the sole goal is "treat and street." If you ask for privacy with the patient, they refuse to leave. During the visit, the patient usually avoids any eye contact with the health care provider, are submissive to the "escort", do not actively participate in the interview process and look to the "escort" for permission to answer any questions. When a victim is allowed to respond, answers are often vague. The provider may also notice that the patient does not acknowledge the escort is a relative or friend.

If an unaccompanied adolescent presents for medical care, though alone, they are still being closely monitored by their trafficker. The psychological and physical threats from the trafficker may prevent an unaccompanied victim from asking for any help from the clinical staff. Much of the sex trafficking business is conducted via phone and the phone is a tool a trafficker uses to keep control of his/her "property." It is not uncommon for a victim to have more than one phone. If a young patient has more than one cell phone, especially one that is repeatedly ringing, suspicion should be raised that he or she is a victim of trafficking. Traffickers will have the victim keep the phone on during the visit with the HCP so they can monitor the conversation.

continued on page 60

continued from page 59

II. ***Common Medical Complaints***

The medical complaints may also offer clues that the patient is a victim of trafficking. The most common presenting complaints among females and males are sexually transmitted infections (STI), genital and anal injuries. For females, vaginal bleeding and pregnancy concerns are also very common. Victims will be brought in for a medical complaint only when they are no longer able to work for the trafficker. They present as ill with no history or evidence of preventive or routine medical care. Since a VST is often subjected to violent physical and sexual assaults, a physician may find that the history provided does not adequately explain the injuries that are present.

When faced with an overbearing controlling "escort", and a submissive adolescent with serious medical complaints, suspicion should be aroused that the patient is also a VST. The health care provider must next arrange to conduct a cursory forensic interview in a safe environment. (Figure1)

III. The Interview

A cursory forensic interview is essential since it may confirm the status as a victim of sexual trafficking, and provide a possible pathway for their escape, or it can help identity those at risk for being trafficked. For a successful interview, separate the patient from whomever has escorted them. When carefully done, it should not arouse the trafficker's suspicion. The physician simply states they are bringing the patient as protocol to the bathroom and then another room for the GYN exam where the "escort" is not permitted. This precaution is essential to create a safe environment and facilitate a sense of trust for the VST.

It is preferably that the interview is conducted by someone who has experience in performing non-traumatic interviews, such as a social worker. If not available, someone who has training speaking with psychologically traumatized victims is preferred. They should conduct the interview, following a prepared script of open-ended screening questions.[13] Traffickers have indoctrinated their victims to be distrustful of the outside world, telling them that no one will help them, so the interviewer will need to overcome this barrier. The interviewer should not re-traumatize the victim with their questions by being respectful and patient during the interview. Allow a VST to answer at their own pace, without appearing shocked or judgmental. It is important to be cognizant of their emotional response to the questions. If a victim becomes agitated, move on to a less stressful question. Once the interview is completed, thank the VST for allowing the conversation. This provides a sense of control, and it may possibly help them disclose that they are being sex trafficked.

If there is a disclosure of status as a VST, provide them with assurance of their safety, and that they will not go back to the room with the "escort". A health care provider should inform the "escort" that the patient will not be returning to the room, and is now under the protection of the local authorities. The "escort" is told that they can now leave.

Local law enforcement should be contacted because of the patient's admission as a victim of sexual trafficking (Figure1). The physician should also contact the New York Office of Children Services, which has a 24-hour hotline. The reporting physician should follow the instructions provided by local law enforcement and the Office of Children Services.

If the patient does not disclose a status of sexual trafficking, then provide the information that your medical site is always here to provide care in the future if needed and offer a location of services if the medical site is closed for the night. The interview is very helpful even if a victim does not make a disclosure. It reinforces that there are people available who are willing to help. Curtis found that 87% of teens wanted to leave that life[4] but did not because they did not know how to reach out for help. By talking to victims and providing them with a contact for services, it may be their first step to escape.[5]

IV. Medical Exam and Treatment

Once the interview is completed, the next step is the medical exam. With or without a disclosure, you should perform a comprehensive head to toe medical exam since there was a suspicion of trafficking. Remember, you may be dealing with a victim who is not self-identifying and for many of these victims, this may be the only medical care they receive. Routine medical and preventive care are not made available to them by the trafficker.

For the patient who has disclosed their status as a VST, a forensic medical exam must be performed. The treating physician may discover additional findings as listed in Table 1. This reinforces the importance of documenting injuries old and new, scars, deformities, and the completion of a forensic evidence kit with the victim's permission. Reports have indicated that 47% of trafficked victims have contracted sexually transmitted infections.[14] When examining the patient, testing should be performed for suspicion of all STIs as indicated in Table 2, and when necessary, initiate empirical or preventive treatments.[15] Testing for HIV should also be seriously discussed since the potential for exposure to HIV is high considering the high-risk behavior these victims are forced to engage in. Consider offering them HIV post exposure prophylaxis as per New York DOH or local community guidelines. Finally, pregnancy screening should be considered and addressed since 31% have reported a history of pregnancy.[10]

V. Connecting to the Necessary Legal and Community Services

Once ensnared into sex trafficking, a child or adolescent enters a cycle of psychological manipulation, sexual and physical abuse. Most are ill equipped to escape the isolation and fear at the hands of their traffickers. The emergence of crippling mental illness, development of

Table 1

- General appearance, thin or malnourished, tired appearing, poor hygiene and inappropriate attire to the setting or the weather.
- Findings of non-disclosed traumatic injuries, lacerations, burns, bruises, ligature marks, old scars, oral injuries, orthopedic deformities.
- Heart murmur or surgical scars not nondisclosed in the history.
- Evidence of extensive disease process that was not provided through the history.
- Extensive or multiple sexually transmitted infections.
- Unique Tattoos: bar codes, crowns, dollar signs, men's names, "daddy" "property of."
- Tattoos in very intimate locations such as necks, breasts, upper inner thighs, mons pubis.
- Signs of drug use.
- Multiple cell phones that ring throughout the medical visit.

Table 2[23]

Common STIs and Treatment
Modified from Summary of CDC Treatment Guidelines 2021*

- **Gonococcal Infection***
  - » Adults & adolescents <150 Kg uncomplicated infections of cervix, urethra, rectum and pharynx: Rx with ceftriaxone 500 mg IM in a single dose
- **Chlamydia**
  - » Adults and adolescents: Rx doxycycline 100 mg orally 2x/day for 7 day
  - » Children weigh ≥45 kg and <8 years: Rx azithromycin 1 gm orally in a single dose
- **Trichomoniasis**
  - » For women: Rx metronidazole 500 mg 2x/day for 7 day
  - » For men: Rx metronidazole 2 gm orally in a single dose
- **Herpes***
  - » Primary: Rx acyclovir 400 mg orally 3x/day for 7–10 day OR famciclovir 250 mg orally 3x/day for 7–10 days OR valacyclovir 1 gm orally 2x/day for 7–10 days
- **Syphilis***
  - » Adults: Rx benzathine penicillin G single dose 2.4 million units IM
  - » Children: Rx benzathine penicillin G 50,000 units/kg body weight IM, up to the adult dose of 2.4 million units in a single dose
- **Human Papillomavirus Infection (HPV)**
  - » For vaginal or urethral meatus: Refer to dermatology
- **HIV**
  - » For presentation or treatment: Follow CDC or local DOH guidelines
- **Pelvic Inflammatory Disease (PID)***
  - » Admit to hospital for IV antibiotics and oral antibiotics
  - » Outpatient therapy: Intramuscular antibiotics and oral antibiotics

*For alternative therapy or for complicated cases treatment see the CDC treatment Guidelines 2021 https://www.cdc.gov/std/treatment-guidelines/pocket-guide.pdf

substance addiction, acquired infections and physical injuries receive little or no medical attention. Sadly, many die from an untreated disease or illness, a drug overdose or suicide. Studies have demonstrated that these victims seek medical care most commonly in emergency departments and clinics and since VSTs often don't self-identify, the physician must be astute in not only recognizing their status, but in helping them get legal and community support. See Figure 1.

Educational Support for Family Physicians

Medical education and residency trainings about victims of sexual trafficking are insufficient. Greenbaum reported that 63% of health care providers including physicians, nurses, physician assistants, and social workers surveyed stated they had never received any training in the recognition of trafficking victims.[15] Medical schools and residency programs need to expand their programs on how to recognize and care for VSTs. Both the American Academy of Family Physicians[16] and the America Academy of Pediatrics[17] have taken positions that the curriculum for medical students and residents should receive training in the recognition, assessment and management of human trafficking. Providers have noted that a lack of a formal policy or an organized protocol has limited their abilities to respond effectively and connect the victims to the services they need.[10] To enhance their skills with this complex issue, practicing family physicians can utilize CME courses, seminars, and webinar presentations.[18,19,20] Stoklosa et al. noted that after training on sex trafficking victims, health care providers have more confidence in their abilities to recognize, assess and respond appropriately.[21]

Medical facilities need to have a policy on clinical practice guidelines that specifically focus on the management and care for these victims. This will provide the necessary steps to coordinate a strategic response (i.e. medical, legal and social service support). If a medical site does not have organized policy or protocol, there are trainings that exist which help in the development of VST protocol.[10,20,21,22,23] Once a protocol is in place, it provides the necessary steps to coordinate a strategic response.

As health care providers, educators, and child advocates we must be prepared to recognize, assess and provide the needed care and services for these victims.[22] This can only be accomplished through education and training. It is up to the physician to identify, provide care and to connect victims of sexual trafficking with appropriate services. We recommend educational programs on the recognition of and response to trafficking victims in medical schools and residency programs, as well as medical conferences and through CME courses. In addition, every health care facility should put into place clinical practice guidelines that address the recognition, assessment, treatment and referral for these victims.

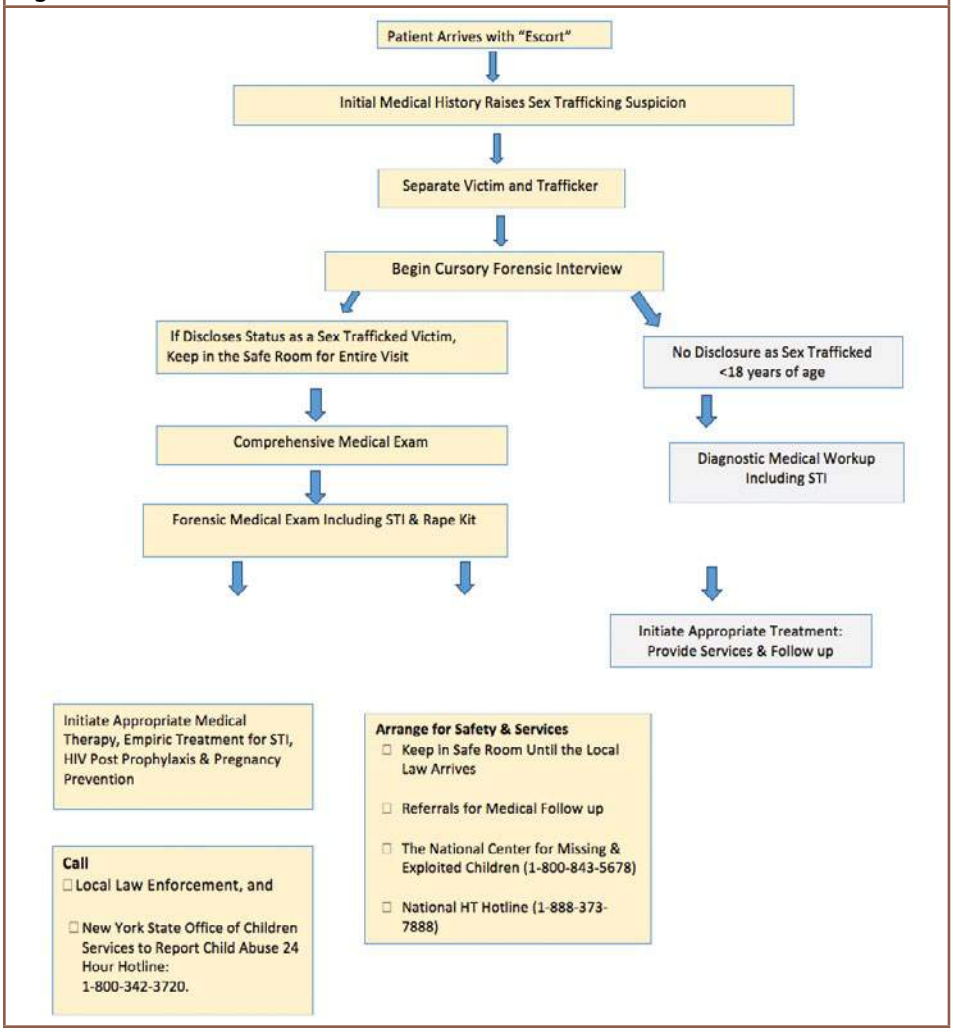
Endnotes

1. Public Law 106-386-Oct 28,200, 114 STAT.1470 https://www.congress.gov/106/plaws/publ386/PLAW-106publ386.pdf [Accessed May 19,2022].
2. International Labour Organization, Global Estimates of Modern Slavery: Forced Labour and Forced Marriage, Sept 2017, https://www.ilo.org/global/publications/books/WCMS_575479/lang--en/index.htm, [Accessed May 19,2022].
3. Estes R, Weiner N, The commercial sexual exploitation of children in the US, Canada and Mexico, University of Pennsylvania School of Social Work, Center of Study of Youth Policy, Sept 2001. https://maggiemcneill.com/wp-content/uploads/2011/04/estes-weiner-2001.pdf, [Accessed May 19,2022].
4. United Nations, Global Report On Trafficking In Persons 2020, https://www.unodc.org/documents/data-and-analysis/tip/2021/GLOTiP_2020_Global_overview.pdf, [Accessed May 19,2022].
5. Curtis R,Terry K, Dank M, Dombrowski K, Khan B. "The commercial sexual exploitation of children in New York City Volume 1: The CSEC population in New York City Size, characteristics and needs Washington DC National Institute of Justice". US Department of Justice 2008, US Department of Justice, Sept. 2008, https://www.ojp.gov/pdffiles1/nij/grants/225083.pdf [Accessed May 19,2022].
6. Suniega E, Krenek L, Stewart G, Child Abuse: Approach and Management, Am Fam Physician, 2022 May ;105(5):521-528.
7. Clawson HJ, Dutch N, Solomon A, et al, Human Trafficking Into and Within The United States; A review of the literature, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, , 2009, 1-55. https://aspe.hhs.gov/reports/human-trafficking-within-united-states-review-literature-0 and https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43241/index.pdf [Accessed May 19,2022]

continued on page 62

continued from page 61

Figure 1



8. Lederer L.J., Wetzel C.A.*The Health Consequences of Sex Trafficking and their Implications for Identifying Victims in Health Care Facilities*, Annals of Health Law Vol 23, 2015 page 61-88.
9. Goldberg A, Moore JL, Houck C, et al, Domestic Minor Sex Trafficking Patients: A Retrospective Analysis of Medical Presentation, J Pediatr Adolesc Gynecol, DOI: 10.1016/j.jpag.2016.08.010
10. Greenbaum J., Crawford-Jakubiak JE, Committee on Child Abuse and Neglect, "Child Sex Trafficking and Commercial Sexual Exploitation Health Care Needs of Victims", J Pediatrics 2015 Mar;135(3):566-74, doi: 10.1542/peds.2014-4138.
11. Chambers R., Ravi A., Paulus S, Human Trafficking: How Family Physicians Can Recognize and assist victims, American Family Physician, 2019, Vol 100, N (4), 202-204.
12. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS, Identification of human trafficking victims in health care settings. Health Hum Rights. 2011; 13 (1), e36-e49.
13. Comprehensive Human Trafficking Assessment, National Human Trafficking Resource Center (Nhtrc), Polaris Project, 2011, https://humantraffickinghotline.org/sites/default/files/Comprehensive%20Trafficking%20Assessment.pdf, [Accessed May 19,2022]
14. Greenbaum J, Identifying Victims of human trafficking in the emergency department, Clinc Ped Emer Med 2016, 17: 241 248.
15. Greenbaum J, Child Sex Trafficking and Commercial Sexual Exploitation Health Care Needs of Victims Pediatrics, Vol 135 Number 3 March 2015.
16. The American Academy of Family Physicians policy on human trafficking,https://www.aafp.org/about/policies/all/human-trafficking.html [Accessed May 19,2022].
17. Greenbaum J, Bodrick N, Committee on Child Abuse and Neglect, et al. American Academy of Pediatrics, Policy statement: Global Human Trafficking and Child Victimization, Pediatrics (2017) 140 (6): e20173138, https://publications.aap.org/pediatrics/article/140/6/e20173138/38241/Global-Human-Trafficking-and-Child-Victimization?searchresult=1 [Accessed May 19,2022]
18. DiMaio A, Modern Day Slavery-Child Sex Trafficking, Southern Medical Association CME Course, https://sma.org/?s=Sex+traffic&post_type=sfwd-courses[Accessed May 15,2022].
19. Combating Human Trafficking, American Hospital Association, Webinars and Video, https://www.aha.org/combating-human-trafficking [Accessed May 19,2022].
20. Countering Human Trafficking in a Humanitarian setting, International Organization on Migration, United Nations (IOM-UN), https://www.youtube.com/watch?v=hL__UwJSt0c&t=4s ,[Accessed May 19,2022]
21. Medical Education on Human Trafficking, Stoklosa H, Grace AM, Littenberg N, AMA Journal of Ethics, 2015;17(10):914-921., https://journalofethics.ama-assn.org/article/medical-education-human-trafficking/2015-10, [Accessed May 19, 2022]
22. Brown T, Powell C, Pelletier A L, Physicians Must be Vigilant for Sex Trafficking in Unaccompanied Minors, AM Fam Physician 2015 May 15;91 (10)674-676.
23. CDC, Sexually Transmitted Infections Summary of CDC Treatment Guidelines—2021, https://www.cdc.gov/std/treatment-guidelines/pocket-guide.pdf [Accessed May 19,2022.]

Ann DiMai, MD, FAAP *graduated from SUNY Downstate College of Medicine, Brooklyn, NY. She completed her internship and residency in pediatrics at New York Hospital Weill Cornell Medical Center and was Associate Professor of Pediatrics and Director of Pediatric Emergency Department at Cornell School of Medicine. She relocated to St. Louis where she joined the emergency department at St. Louis Medical Center and was appointed Associate Professor of Pediatrics as St. Louis University School of Medicine. She is board certified in pediatrics, pediatric emergency medicine and child protection.*

Pascal J. de Caprariis MD, FAAFP *received his medical degree from the University of Bologna, Bologna Italy. He completed his family practice residency at the Lutheran Medical Center, Brooklyn, NY and his infectious disease fellowship at the Queens Hospital Center of Long Island Jewish-Hillside Medical Center in NY. He holds a public health certificate from the Albert Einstein College of Medicine Center for Public Health Sciences, Bronx, NY. He was Assistant Professor in the Department of Medicine, Division of Infectious Diseases at Downstate Medical School/University Hospital, Brooklyn New York and an adjunct instructor in the Department of Medicine at NYU School of Medicine. He was a consultant to the WHO Geneva, Switzerland. He is an active member of the NYSAFP/AAFP.*

Rolling out Legal Cannabis:
What Family Physicians Need to Know

By William Klepack, MD

The goal of this article is to provide an overview of MRTA enabling you to put its provisions into context with your patient's health care, and to outline topics important for you to address when counseling your patients. It is beyond the scope of this article to summarize the literature on THC (tetrahydrocannabinol) although brief mention of some pertinent aspects of the chemical will be made.

In the spring of 2021 the NYS legislature passed, and Governor Cuomo signed into law, the Marijuana Reconciliation and Taxation Act of 2021 (MRTA). For years, the Congress of Delegates (COD) of the NYSAFP had periodically debated resolutions regarding our position on THC, the principle psychoactive cannabinoid in marijuana. THC is commonly called recreational marijuana, although MRTA terms it "adult use marijuana". The COD had consistently rejected resolutions endorsing the legalization of THC. With the passage of MRTA, we quickly recognized that our most constructive position would be to create a factual paper (a "white paper") detailing our concerns and suggestions regarding its legalization. In December of 2021, we presented our white paper to the Office of Cannabis Management (OCM), which was created by MRTA in the division of Alcoholic Beverage Control. In January, we met virtually with OCM's key administrator focused on public health and its public relations head. Our paper and our discussion were met with appreciation and respect. Since then we have monitored OCM's actions and stood ready to comment further. In contrast, some of our colleagues in other societies initially took what I would term a less constructive approach and voiced the opinion that MRTA should be overturned - a position that was not at all likely to be successful.

MRTA got off to a slow start due to Governor Cuomo not appointing individuals to OCM's leadership. With the end of the Cuomo administration, Governor Hochul made many of the needed appointments in early fall 2021.

Because of that delay, OCM has been delayed in achieving its goals:

- Reconciliation (the recognition and attempted mitigation of inequities caused by historical marijuana penalties for use and possession, disparate impacts on communities, and economic inequities)
- Taxation (the significant revenues that are projected to come to NYS and local governments from the propagation, production, and marketing of THC products), and
- Its many public health goals

To address these let us go back to 2018.

In July 2018, the NYSDOH issued a paper detailing the then status of THC in NYS. (https://cannabis.ny.gov/system/files/documents/2021/09/marijuana_legalization_impact_assessment_7-13-18.pdf). Unregulated, and illegal, its use was found to be significantly prevalent throughout NY. Products were (and continue to be) obtained by many means (via the web, direct sales in other states, etc.). THC of uncertain purity and of much increased potency was being consumed without an effective public education program regarding the growing literature concerning risks. Lack of regulation extended to packaging, which often was not child resistant and could feature pictures and product shapes and sizes attractive to children and adolescents. Public health messaging was largely absent about the need for safe storage away from children and adolescents. Messaging was inadequate about the pronounced differences in pharmacokinetics between inhaled and ingested THC. These differences (in addition to inappropriate concentrations of THC per unit of ingestion) had been primary factors leading to overdoses. Nationally, calls to poison control center about ingestions in children under five were, and are, increasing year by year. Given the prevalence of usage in NYS, the NYSDOH concluded that regulation of and public education about THC would help mitigate the risks, and that the benefits from regulation would significantly exceed the risks of legalization.

THC Risks

- Impairment of:
  - » Learning, memory, attention, decision-making, coordination, reaction time
  - » Anatomical alteration of developing minds
  - » Psychiatric effects (including deaths by suicide and psychotic behavior)
    - – Psychosis especially in susceptible people
    - – Individuals with serious mental illness use THC at higher rates and if continue use worse outcomes and functioning
    - – Dependency (lack of consensus – estimates range from 9 to 30%)
  - » Acute overdose syndromes and deaths
- Harmful to lungs if smoked (and we know vaping has health issues)
- Pregnancy: Babies exposed during pregnancy
  - » lower birth weight
  - » Increase likelihood of intensive care after birth

Source: NYSDOH fact sheet 2018

continued on page 64

continued from page 63

From the 2018, NYSDOH paper sprang the push that put MRTA over the finish line.

First, let us clarify the organizational structure of OCM:

The OCM is comprised of:
- Executive Director – Governor appoints, and Senate confirms – 3 yr. term
- Chief Equity Officer
- Deputy Director of Public Health and Safety
- Budget = $37 million
- Annual report required

It is governed by a Cannabis Control Board:
- 5 members
- 2 members and the chair appointed by the Governor
- 1 appointment by the Assembly and 1 by the Senate
- 3- year term
- Members geographically and demographically representative of NYS and communities affected by the war on drugs

It is advised by a Cannabis Advisory Board:
- 13 members (Governor =7, Senate=3, Assembly=3) Members shall have statewide geographic representation that is balanced and diverse in its composition with expertise in public and behavioral health, substance use disorder treatment, rehabilitative treatment, homelessness and housing, economic development, environmental conservation, criminal justice, etc. Members serve to provide recommendations to the Cannabis Control Board and administer and govern the distribution of social equity and community reinvestment grants.

Many of these positions were only filled in the early months of 2022 given the delayed start detailed above.

Besides Adult Use Marijuana (THC) MRTA charges OCM to administer two other programs. The Medical Marijuana Program and the HEMP/CBD program. The former you are already familiar with. The latter is the industry which puts all those CBD products on retail shelves. Formerly regulated in only a very limited manner, the OCM in its first couple of months revised that program, imposing new regulations to achieve safety, purity, and appropriate claims for efficacy.

Regarding Legal Possession

MRTA allows individuals over twenty-one years of age to possess, display, purchase, obtain, or transport up to 3 ounces of cannabis (THC) and up to 24 grams of concentrated cannabis. It also allows individuals over twenty-one to have home possession of 5 pounds of cannabis that must be kept in a secure location away from anyone under the age of 21.

The Act further states that:

- No finding or determination of reasonable cause to believe a crime has been committed shall be based solely on evidence of the odor of cannabis, the odor of burnt cannabis, the possession or suspicion of possession of cannabis in legal amounts, or the presence of cash or currency in proximity to cannabis, etc. However, law enforcement may find reasonable cause as to the odor of burnt cannabis when the individual is operating a motor vehicle.
- Home grown shall be allowed in the following amounts 18 months from the first sale of adult-use cannabis, subject to rules and regulations:
  - » -3 mature plants and 3 immature plants for adults over the age of 21.
  - » -6 mature plants and 6 immature plants per household.
- A county, town, city, or village may enact and enforce regulations to reasonably regulate the actions and conduct in this section, but any violation may be punishable by no more than an infraction and punishable by no more than a civil penalty of 200 dollars or less. Local regulation may not completely or essentially prohibit a person from engaging in the conduct authorized in this section.
- Medical home grown: 6 months from the effective date of this article the cannabis management board shall issue regulations governing home grown.
- Not allowed to process or use volatile solvents to process cannabis at home

Now let's look at the revenue goals.

Revenue
- 9% sales tax on cannabis to NYS
- Additional 4% tax split between
  - » County = 1%
  - » 3% going to cities
  - » Additional tax based on THC content
    - – 0.5 cents per milligram for flower
    - – 3 cents per milligram for edibles

All cannabis taxes directed to the "New York State Cannabis Revenue Fund." The revenue will cover the costs to administer the program. 40% of the remaining money would go to a community grants reinvestment fund, 40% to education, and 20% to drug treatment and public education programs.

Progress in Promulgating Rules and Regulations

There are many steps in the process of turning a marijuana plant into a consumable THC product. A key provision in the law is the effort to prevent vertical integration in order to prevent monopolies and to give priority to disadvantaged populations and communities in all phases, including agriculture. For example, regarding the latter, a grower cannot be in the manufacturing business nor can either of them be in the retail business.

The first area that was tackled by OCM in late winter was the agricultural component. Who could get a permit to grow THC and what qualifications would be required? Agriculture had to get guidance first because the spring planting season was imminent and without crops in the ground, there would be no product to regulate in the summer or fall.

- MRTA creates a two-tier licensing structure which would prohibit licensed growers and producers from also owning a retail license to protect the market from monopolistic competition.
- License Types: cultivator, processor, distributor, nursery, cooperative, microbusiness, retail dispensary, on-site consumption, and delivery.
- All license types will be subject to quality control, public health and consumer protections including lab testing, packaging, labeling, marketing and advertising restrictions and requirements.
- Social and Economic Equity Program
- Law provides for municipalities (not counties) to opt out of retail sales, or consumption facilities, or both
- The municipal opt outs have been completed as of 12/31/21 and can be viewed here: https://rockinst.org/issue-areas/state-local-government/municipal-opt-out-tracker/
- A municipality that opts-out may opt back in at any time.
- 774 of 1521 municipalities opted out of retail (called "dispensary" sales
- 883 of 1521 municipalities opted out of allowing consumption sites

In early April, OCM launched the first phase of the public education campaign, as highlighted below:

Drug Treatment and Public Education Fund

- Expended to the Commissioner of OASAS
- Disbursed, in consultation with the Commissioners of NYSDOH, OMH, the Office of Cannabis Management and NYSED to cover costs related to:
  - » Administration of the Fund
  - » Development and implementation of a youth-focused public health education and prevention campaign, including school-based prevention, early intervention, and health care services and programs to reduce the risk of cannabis and other substance use by school-aged children
  - » Statewide public health campaign focused on the health effects of cannabis and legal use, including education of the general public on legal use of cannabis and importance of preventing youth access, preventing secondhand cannabis smoke exposure, information for pregnant or breastfeeding women, and the overconsumption of edible cannabis products
  - » For SUD treatment programs for youth and adults, with an emphasis on programs that are culturally and gender competent, trauma-informed, evidence-based and provide a continuum of care for behavioral health needs

OASAS is required under the bill to issue a written annual report by February of each year related to the dispersal of monies from this new Fund

Next, the OCM turned its attention to THC product packaging and marketing. In June, the Cannabis Control Board approved regulations that would prohibit cannabis packaging and advertisements from including any cartoon characters, neon colors, bubble letters, candy references or other features that might appeal to those under 21 (the legal age to consume cannabis in New York). Images of celebrities or other individuals who appear to be under 21 would also be prohibited. Misleading claims about health benefits and any indication that a product is 'safe' or 'organic' would be outlawed.

What remains to be done is a considerable amount of work to regulate processors, distributors, microbusinesses, retail dispensaries, and on-site consumption sites. As rules and regulations are proposed, there is the ability for public comment.

In Conclusion

The challenge now for the OCM is to market a regulated product in NYS that will be appealing in its effects, taste, appearance, and price. Regarding the latter, a product that is overpriced would struggle to compete against the illegal market even though it could tout its quality, safety, and purity from contaminants.

Rules and regulations are progressively being rolled out and it will not be until the fall at the earliest that we are likely to see products being sold.

The challenge for family physicians is to understand the literature about THC's effects on the developing brain, the performance of adults at work, and on social relationships. How to avoid vehicular incidents and overdosing are additional topics for us to counsel patients appropriately. Data indicates that human brain development

continued on page 66

continued from page 65

is ongoing at least until age 25, which has special implications for teenagers and young adults regarding learning. The risk to mental health (including of psychosis) needs to be understood especially by those with existing mental health challenges. Physicians should be ready to tout discuss the superiority of regulated products compared to those purchased illicitly.

MRTA's Impacts

- Youth have less easy access
- Less chance that THC product may be adulterated*
- Marketing more controlled
- Dosing of THC more regulated
- Public education messaging funded
- Social costs such as arrest/incarceration reduced
- Packaging of product regulated
- Risks of inhalation/vaping mitigated
- Corporate control of the market subject to regulation

*other drugs, herbicides, insecticides, chemicals

Other Useful Information

Consumption

- Smoking or vaping of cannabis is prohibited anywhere smoking tobacco is prohibited
- Property owners, landlords, and rental companies can ban the use of cannabis on their premises
- Cannabis cannot be consumed when operating a motor vehicle

Penalties

- Sales
- Unlawful sale of cannabis = any amount: violation, $250 fine
- Criminal sale of cannabis in the third degree = sells over 3 ounces or knowingly sells or gives to a person less than 21 years of age: misdemeanor
- Criminal sale of cannabis in the second degree = over 5 pounds: Class E felony
- The legislation creates automatic expungement or resentencing for anyone with a previous marijuana conviction that would now be legal under the law.

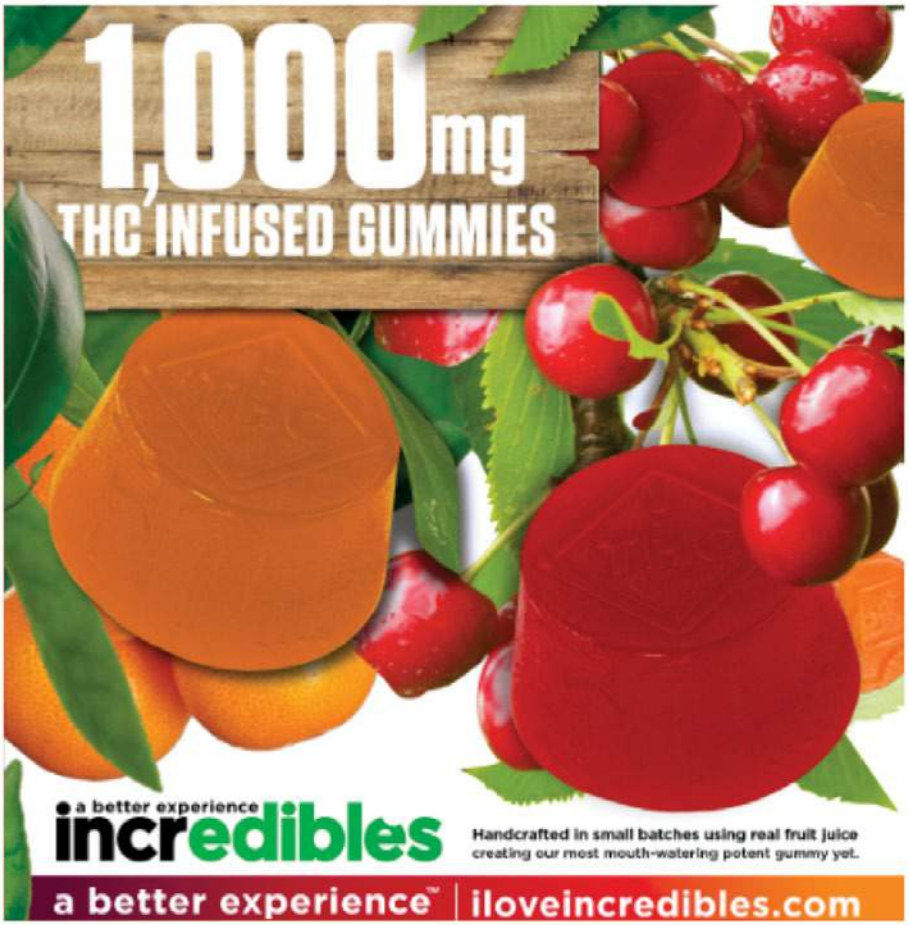
Traffic Safety

- The NYS Department of Health is to launch a research study, partnering with different universities, evaluating methodologies and technologies that could detect cannabis-impaired driving.
- Additional funding for drug recognition experts will be available.

Further information about the act is available at https://cannabis.ny.gov/

William Klepack, MD *serves as medical Director for the Tompkins County Health Department. Dr. Klepack recently retired from family practice and is an active volunteer with the NYSAFP and member of the Family Doctor Editorial Board.*

Serving size is the euphemistic term illegal products use the suggested initial "serving" is usually 10 mg but products may vary from 10 mg to 100 times that much as this pre-MRTA ad shows.



New York State Academy of Family Physicians
16 Sage Estate, Suite 202
Albany, New York 12204

PRSRT STD
US POSTAGE
PAID
PERMIT #203
ALBANY, NY

Re**MEMBER** your **BENEFITS**!

NYSAFP Membership Provides:

Advancing our Specialty, Saving Members Time, Maximizing Values of our Dues

- Representation at the AAFP
- Representation of the local county chapters at the NYSAFP Congress of Delegates
- Promotion of family medicine in the medical schools and support of student programs
- Support of family medicine residency & fellowship training programs
- Representation of family medicine in the federal & state legislatures and policy makers through the PAC

Saving Members Time

- Hosting of relevant and interactive CME workshops
- Hosting of ALSO instructor and provider courses
- Opportunity to interact with fellow family physicians throughout the state
- Reliable source of relevant and current events
- Weekly e-NewsBrief
- Quarterly peer reviewed journal – *Family Doctor*
- Timely access to current events of Academy via social media (NYSAFP Facebook | NYSAFP Twitter)

Maximizing the Values of our Dues

- Sponsorship of students and residents to Academy meetings (Winter Weekend, Regional Family Medicine) and the Congress of Delegates
- Cultivation of the next generation of family physicians by offering scholarships and awards to pre-medical students, medical students, and residents to participate in family medicine conferences and programs
- Support of residents and new physicians in development of leadership skills and practice opportunities

AAFP Member Services: http://www.aafp.org/online/en/home/membership/resources.html

- A list of the AAFP professional resources
- A list of the AAFP "Member Advantage"
- Additional Partnerships: http://www.nysafp.org/index/resources-6/partner-programs-106.html
- Jobs Board