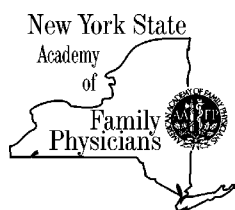


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Fall 2018

Family Doctor

A JOURNAL OF THE NEW YORK STATE ACADEMY
OF FAMILY PHYSICIANS



FEATURE ARTICLES:

- Oncology Care in Family Practice
- USPSTF Updates Cervical Cancer Screening Regimen
- Effect of Tobacco on Progression of Hepatitis C to Hepatocellular Cancer
- An Update in Psycho-Oncology



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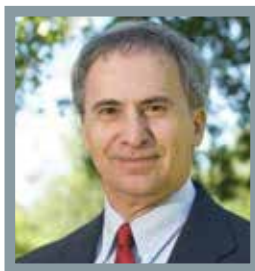


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From the Executive Vice President

By Vito Grasso, MPA, CAE



MS released the 2019 Medicare physician fee schedule and Quality Payment Program proposed rule on July 12th. The AAFP is reviewing this complex rule – more than 1,400 pages of complex and technical information.

The rule is published in the Federal Register and is available on the internet. Anyone can read it and try to understand how it will affect patients and medical practices. The reality, however, is that focused, expert attention is necessary to understand the intent and potential impact of the rule. It represents a significant departure from previous payment methodology. The intent is to reduce burdensome documentation. Furthermore, it presumes that better clinical outcomes and reduced overall costs will result from reducing the documentation burden currently imposed upon providers.

The Academy's initial assessment of this rule has determined that there are some consistencies with our policy, but that there are also some potentially serious adverse consequences for family physicians and other primary care providers.

NYSAFP lauds CMS for its attempt to simplify coding and reduce documentation. The

rule, however, combines the documentation, coding and payment provisions. We challenge this approach and argue that CMS should implement reduction in documentation and administrative burden regardless of changes in coding and payment requirements.

The Academy supports simplified coding. The proposed rule, however, would collapse payment for E&M levels 2-5 into a single amount for new and established patients. The proposal fails to account for the complexity of family medicine and does not support comprehensiveness and continuity.

NYSAFP has supported increased investment in primary care including increasing the overall spend rate on family medicine and primary care. The proposed rule, however, would only provide a \$5 bonus payment for primary care. A \$5 bonus will not significantly improve the financial condition of primary care practices and certainly does not reflect the complexity or comprehensiveness of family medicine.

The proposed rule also includes a 50% reduction in payment for procedures provided in conjunction with an E&M visit. Of course, the Academy is opposing this.

We have consistently worked to enable family physicians to provide comprehensive primary care in every visit. This proposal foolishly incents physicians to perform fewer services per visit and to conduct more visits per patient.

In many respects, the proposed rule is just another piecemeal attempt to fix a failed payment system. NYSAFP has developed and promoted a comprehensive payment reform – its Advanced Primary Care Alternative Payment Model (APCAPM). Details are available at <https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/PR-PTAC-APC-APM-41417.pdf>.

CMS has reviewed the APCAPM and has had some positive things to say about it. There are, however, many constituencies to appease in health care. CMS has not embraced APCAPM, perhaps because it is too innovative and would disrupt otherwise established economic norms in medicine. We have heard a lot of lip service about the importance of primary care at both the state and national levels. When opportunities occur to actualize that rhetoric, however, policy makers seem to keep coming up short.

The Academy will continue to work for real payment reform and greater actual investment in primary care. As we endeavor to do so, we are, of course, grateful for the support of members in lending your voices to the chorus clamoring for true reform and patient focus.

In many respects, the proposed rule is just another piecemeal attempt to fix a failed payment system.



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President's Post

By Marc Price, DO

As I sat, waiting for the return of a family member from the post-anesthesia care unit (PACU – formerly called the recovery room for some of us older physicians), I reflected on the concept of team care. My family member, let's just call her Annie One, was initially evaluated by a physician assistant (PA) at a specialist's office and rendered care following what seemed like an appropriate work-up. The initial treatment helped a little but caused side effects and Annie was told to wait it out by the PA. She was likely experiencing a temporary but expected side effect of which Annie had not been made aware. When she still didn't feel better, she contacted the medical office again and the same provider prescribed a medicine to treat the side effects of the first treatment. This second treatment didn't work either so she was finally evaluated by the physician.

The physician initially wanted to do more testing but was limited due to the schedules of her staff. Instead she prescribed yet a third medication and had Annie come back a few days later for both the requested test and for a follow visit immediately after it to review the results. As Annie was pulling into the doctor's office parking lot 15 minutes early for her scheduled appointment, she received a call from the office telling her she would have to reschedule since she had missed her appointment. Understandably upset, she parked and stormed into the office to demand to know how she could be late, presenting her appointment card with the hand-written time and date on it. She was told by the receptionist that the time written on the card was for the doctor's appointment and the test was to be done earlier, though this was never written down or mentioned to her. Further, since she had missed the testing appointment, she would have to reschedule the doctor's appointment

too. You can imagine Annie's reaction. Here she was, worried about a medical issue which was significantly impacting her quality of life, following all of the advice of her providers, showing up where and when she was told to be and now being informed that, through no fault of her own, she would have to reschedule her appointment, re-arrange childcare, take more time off from work and continue to have her quality of life be affected even longer. She was furious. She yelled, she cried, she became "that patient". The one that other patients in the waiting room stare at out of the corners of their eyes and try to act as if they aren't listening to. The patient that would get labelled as difficult by the front office staff. The patient that sends providers, upon hearing their voice, to quickly "hide" in the back office to avoid any unnecessary contact. Luckily, in this situation, the doctor who owned the practice and had seen Annie previously heard Annie's pleading and convinced the receptionist to squeeze her into the technician's schedule – even though she was "late".

When she finally sat in front of the doctor to review the test (a repeat of the test originally done by the PA), the doctor immediately came to a different diagnosis and questioned why the PA had not done the test prior to rendering the initial treatment. Only after Annie pointed out that the test had been done before, did the doctor find the previous test, which had been done in her own office by her own PA just a short time ago. She reviewed the chart, compared the two tests and commented that the original treatment should never had been rendered. And furthermore, major surgery to correct the problem may now likely need to be done. Annie was however, given a small glimmer of hope. A minor surgical procedure to improve her well-being could be tried first and, if it worked she wouldn't need the major

surgery. Obviously upset at the prospect of a major surgery, she prepared for the more minor procedure.

She jumped through all of the pre-operative hoops and Annie and I arrived at the hospital the morning of her procedure. Annie was greeted with a smile by a lovely nurse who, for the next 30 minutes proceeded to, per hospital protocol, double check all of the information on the pre-operative reports, computer and paper chart (all of which stated the same information each time). As she was finishing, an operating room nurse came in rushing the floor nurse through the remainder of her duties, looking obviously annoyed that she had to wait. There appeared to be a pecking order and the floor nurse was the low woman in that order.

The anesthesiologist then came into the room and both nurses exited. He, again, asked the same questions, per protocol, and Annie confirmed her uncomplicated medical history. Satisfied after less than two minutes and having Annie open her mouth to check out her dentition and oral cavity- the entirety of his exam - he left.

The nurses came back in to finish their required documentation, only to be interrupted by the surgeon gruffly demanding a copy of the consent from the chart then smiling and giving a cursory rub and squeeze to Annie's foot through her blanket, before walking out. I guess that was meant to make Annie feel more at ease for the surgery. The floor nurse continued to smile and do what was required, though I could have sworn she purposefully slowed her pace a little. The operating room nurse continued to scowl and roll her eyes. The surgeon reentered the room, looming over the floor nurse as she finished her duties, ahead of the scheduled surgical time despite her slowed

pace. The surgeon smiled and I, being trained in medicine (though the surgeon didn't realize it at the time), asked some questions for Annie's sake so that she knew what to expect after the procedure. Vague answers were provided before all of the medical personnel left.

There was a brief calm. For a moment Annie and I stared at each other. Fear and anticipation in her eyes, and me screwing up my face to try to make her laugh a little. Then, just as quickly, Annie was whisked away to the operating suite and I was left alone, sitting in a corner and waiting.

During my isolation, I made use of my time by remembering what all of the equipment hanging on the wall was for. I eavesdropped on conversations at the centralized nursing station. Mary was going to see a movie the following Friday with her new boyfriend who worked in the cafeteria and Susan was a single mom who needed to pick up something for dinner for her and her son following her shift.

Less than an hour later the doctor returned. She told me that everything went well and showed me images from the surgical procedure. Had I not been a physician, I would not have understood any of it. I asked my questions. Two brief questions as she had her hand on the door knob. She gave very quick answers and left.

After a short while, Annie came back to the room and though I saw the same smiling floor nurse sitting at the nursing station and caring for other patients, a different nurse attended to Annie's needs. A different woman (who never identified herself) also came into the room and directed Annie to drink her apple juice, unless she preferred cranberry juice. Less than 2 minutes later she returned asking if Annie had to "pee" and informing her she needed to do so before she would be allowed to leave. Eventually Annie was able to accommodate the request and, true to their word, they prepared her for discharge. She was given post-discharge instructions which were non-specific and told a pain medication was going to be phoned into the pharmacy by the doctor later that day. We left and headed home. No follow up visits were made for Annie nor were instructions provided about when to see her doctor again. All she had was the doctor's office phone number. I guess the expectation was that she should call it for more information later on.

If it didn't concern Annie's health and well-being, it would have been satirical. Like an episode of my favorite comedy sitcom. Only it wasn't funny. Instead it was a sad commentary on our country's medical care. Nurses, doctors, receptionists, physician assistant, technicians and nurses aides all did what was expected of them. They each played their role as they were supposed to. Even Annie and I played our roles. Unfortunately, all of these roles were disjointed. None of them complemented each other. From the first time Annie set foot in the doctor's office until the time she was discharged from the hospital, every participant in Annie's care was most interested in completing their job, often in spite of their coworkers. Each was more concerned about completing the requirements of their particular job without really seeing the bigger picture. They didn't focus on the patient. Or her concerns or fears or how these impacted her life. In short, they didn't focus on Annie.

I believe that, despite having excellently trained clinical physicians and the resources for second to none healthcare, we are losing a large part of our care when we lose sight of our patients. We get so involved with following protocols and procedures and regulations and rules set up to minimize medical errors, reduce liability, fulfill administrative tasks and keep schedules, that we miss the most important reason many of us entered healthcare. The patient should always be the center of what we do. And changes should be made keeping that in focus. Is the change going to benefit the patient in front of us? Will it benefit how we are able to take care of the patients who are under our care? Often the changes we make in our practices seem ridiculous and contrary to good patient care and turn out for the betterment of our patients. More often times, they don't. Team care, when done in a manner which enhances the patient's experience is one of those that does, or at least could. By remaining a constant voice for our patients and advocates for family medicine we can improve how healthcare is delivered in all facets, without losing sight of the most important piece of the equation, the patient.

As family physicians we are a strong force when we are unified in our efforts. There are many more physicians in the specialty of family medicine than in each other individual specialty. We need to leverage our numbers to drive change in a meaningful way. We need to sustain our primary care, and in particular, family physician workforce. We need to put our egos aside and learn what works best, not only from each other but from our brothers and sisters in different nations around the world. That's not to suggest that every practice needs to be uniform, but rather that we need to constantly evaluate if there is a better way, a more efficient way or a more patient centered way of caring for those who put their trust in us. We need to let the physicians and our healthcare brethren who work beside us and care for patients help direct this workflow, not non-clinical administrators and politicians.

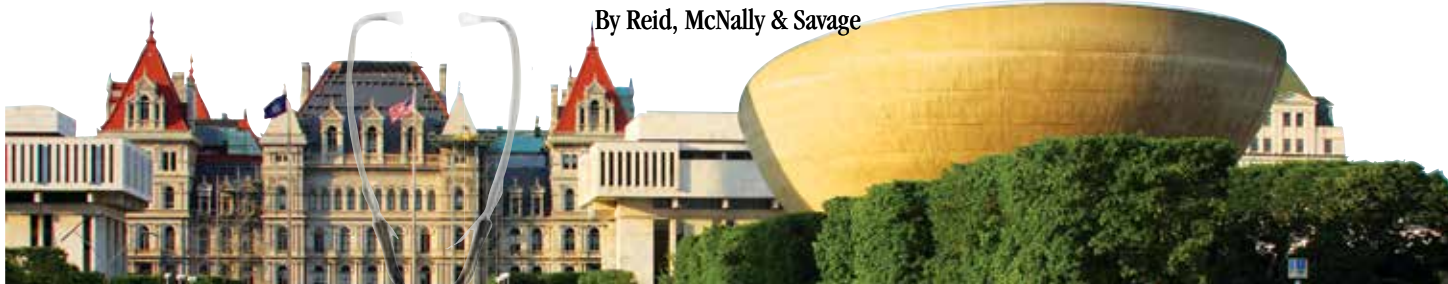
I ask every family physician, regardless of the type of practice setting or role you are in, to look with a critical eye at how you and your healthcare partners and coworkers perform your duties and care for your patients. And I challenge you to find ways to do it better. Make it more meaningful for both your patients and for you.

Epilogue

Since the initial writing of this editorial, Annie's medical issue continues. She continues to have communication problems with her surgeon, who has given her the options of using strong narcotic pain medicine on a more regular, long-term basis or having the major procedure she originally told her about. When she opted for the surgical route it took 3 days, instead of the promised 24 hours, to schedule the procedure and that was only after Annie called them numerous times. Now, despite having the procedure "on the books," we've decided that Annie would be better off getting a second opinion at a different office. For my part, I've contacted the new doctor to "grease the wheels" moving forward, something that shouldn't need to be done but, unfortunately is sometimes required. My only consolation is that her own family doctor's office has been a constant source of support and despite not making a huge difference, has tried to facilitate her care whenever possible.

Albany Report

By Reid, McNally & Savage



As the New York State Academy of Family Physicians prepares its fall edition of Family Doctor for print, we have developed an Albany Update focused on recent issues of interest that have picked up media attention over the summer.

Rand Corporation: An Assessment of the New York Health Act

The Rand Corporation in August released a study providing an assessment that a single-payer health system in New York is financially feasible and could curtail spending in future years.

The study surmises that the New York Health Act, which would provide universal insurance coverage with no copays, deductibles or premiums for all New Yorkers regardless of immigration status, would lead to higher utilization while lowering health plan and provider administrative costs — saving the system \$15 billion, or about 3.1 percent, by 2031, compared to current policies.

The findings come with several caveats that could bog down any effort to pass and implement single-payer in New York, particularly if Republicans continue to wield power in Albany and Washington.

The first being that the Trump administration would have to grant a federal waiver to redirect all federal, state and Obamacare funds used for Medicaid, Medicare and marketplace tax credits to the New York Health Act. Secondly, the legislation as written does not specify the revenue raisers needed for the estimated \$139 billion cost — a new tax schedule would need to be implemented.

Assemblyman Richard Gottfried, sponsor of the bill, declared the RAND report a “triumph” and said that he would raise the taxes on high-income earners to protect low-income earners. “RAND shows we can make sure every New Yorker gets the care they need and does not suffer financially to get it; save billions of dollars a year by cutting administrative costs, insurance company profit, and outrageous drug prices; and pay for it all more fairly,” Gottfried stated in a release.

The report is available at the URL below:

https://www.rand.org/pubs/research_reports/RR2424.html

NYS Mandates Medicaid Health Plans To Provide Coverage to Transgender, Gender Non-Conforming New Yorkers

Effective September 2018, mainstream Medicaid Managed Care plans, HIV Special Needs Plans and Health and Recovery Plans policies, procedures and coverage criteria for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria must comply with new standards issued by the Department of Health.

Plans must accept a treating physician’s determination that the gender affirming care requested is medically necessary. Plans may impose administrative prior authorization requirements but must accept the treating provider’s assessment. More so, when a provider makes this determination, plans cannot require enrollees submit photographs in order to document the need for treatment. Decisions on prior authorization for treatment must be made as fast as the enrollee’s condition requires. Before making an adverse determination, the plan must make at least one attempt to consult with the treating provider, and at least one of the plan’s clinical staff involved in the adverse determination must have expertise in the treatment of gender dysphoria.

“RAND shows we can make sure every New Yorker gets the care they need and does not suffer financially to get it”

-Assemblyman Richard Gottfried

Some of the items addressed in the guidance will serve to reduce arbitrary administrative demands that served to deny qualifying individuals' medically necessary care. The guidance clarified that plans cannot require that enrollees have at least 12 months of continuous mental health counseling prior to surgery, but instead must be dependent on the client's clinical profile, clarifying that this duration may be shorter as appropriate. Similarly, plans cannot require a year of hormone therapy prior to all procedures, and can only require hormone therapy if it is consistent with the enrollee's gender goals, clinically appropriate, and recommended by the treating provider.

Two letters from qualified medical providers must attest to the enrollee's need for the requested care. The guidelines now clarify that these letters must be viewed in tandem, and that each individual letter does not have to address all of the requirements for coverage; plans cannot require that the two qualified professionals submitting letters must work for different organizations; and plans cannot require time limits for the submission of clinical documentation that have the effect of delaying access to care. The state will now require that plans who want to adopt criteria for the authorization of gender dysphoria treatment must submit those criteria to DOH for approval.

The guidelines are available at the URL below:

https://www.health.ny.gov/health_care/managed_care/plans/docs/treat_gender_dysphoria.pdf

New Regulations Released to Insure Reproductive Health Coverage

In July, Governor Andrew Cuomo announced new actions to protect reproductive health through regulations by the Department of Financial Services and Department of Health. These regulations will ensure an insurer must cover over the counter emergency contraception in addition to all other contraceptive drugs, devices or other products for women approved by the Federal Food and Drug Administration, as well as the dispensing of 12 months of contraceptive at one time, all without co-insurance, co-pays or deductibles.

The updated DFS regulation mandates that health insurers:

- Expand coverage requirements for contraceptive drugs, devices or other products for women approved by the Federal Food and Drug Administration. Require coverage for emergency contraception with no cost sharing when acquired in any lawful manner including on an over the counter basis from an out of network pharmacy;
- Permit a woman to fill 12 months of a prescribed contraceptive at one time, removing the previously required three-month trial period;
- Cover voluntary sterilization procedures for women and over-the-counter contraceptives without cost-sharing; and
- Do not place restrictions or delays on contraceptive coverage not otherwise authorized under the regulation. This provision would prohibit quantity limits and other such restrictions.

The regulation codifies guidance issued in January 2017 regarding information that must be provided in formularies regarding contraceptives, including noting which contraceptives are covered without cost-sharing. Insurers will be required to publish an easily accessible, up-to-date, accurate and complete list of all covered contraceptive drugs, devices and other products on their formulary drug lists, including any tiering structure and any restrictions on the manner in which a drug may be obtained.

The accompanying DOH regulations permit a woman insured through Medicaid to fill 12 months of a prescribed contraceptive at one time, whereas previously, the limit was three months. Both regulations can be found at the URL below:

https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/DFS_DOH_Regs.pdf

Court of Appeals Upholds Flu Mandate

In June the NYS Court of Appeals decided unanimously that a 2013 rule enacted by the New York City Department of Health and Mental Hygiene mandating the flu vaccine for children attending regulated daycare and school-based programs will stand. The opinion is a reversal from the Appellate Division.

The New York City rule requires that any child more than six months old but less than six years old that attended a city-regulated child care or school-based program had to have an annual flu vaccination. There are exceptions for religious beliefs or if a doctor said the vaccine would harm the child.

The decision can be found at the URL below:

<https://www.nycourts.gov/courts/appeals/Decisions/2018/Jun18/64opn18-Decision.pdf>

HHS Reviewing Opioid Prescribing Guidelines

A story published in Politico in early August reported that the Trump administration will soon provide additional guidance for doctors prescribing opioids for patients with chronic pain. This comes after numerous complaints that the national crackdown on opioids has created barriers for pain treatment.

Politico reports that updated federal guidelines could include specific recommendations for certain scenarios, like what a patient should be prescribed after a standard knee surgery.

"HHS is reviewing the current evidence base to determine whether the scope of the guideline could be expanded to include specific recommendations for certain conditions or medical procedures," said Director of the National Institute of Drug Abuse at NIH Nora Volkow in an emailed statement to POLITICO. A spokesperson for HHS said the Trump administration stands behind the prescribing guidelines, which were issued during the Obama administration, and is only looking to expand upon them.

VIEW ONE

HPV VACCINATION UPDATE: A DECADE OF DATA

By Mackenzie Naert; Jordano Sanchez, MD and Rachel Rosenberg, MD



INTRODUCTION

HPV-related cancers cause significant morbidity and mortality in the United States and globally. Though the HPV vaccine could significantly decrease rates of HPV-related cancers, there have been many barriers to its utilization in the US. Recent epidemiologic data on the impact of the HPV vaccine is promising -- the prevalence of cancer-causing HPV strains is decreasing, which over time should lead to a decrease in HPV-related cancers. And achieving HPV vaccine completion is now easier than ever, with new recommendations from the CDC lowering the number of doses needed for teens less than 15 years old. When armed with the latest data on the HPV vaccine, family physicians should be able to confidently work toward routinely vaccinating all their adolescent patients, protecting them from future cancers.

History of the HPV Vaccine in the United States

The first HPV vaccine, Gardasil®, was approved in the US by the FDA in 2006. It protected against 4 strains of HPV: HPV 6, 11, 16 and 18, all of which are associated with cancer in both men and women. Initially, the HPV vaccine was only indicated for girls and women, but in 2011 the recommendation changed to a gender-neutral policy, and the CDC's Advisory Committee on Immunization Practices (ACIP) began recommending that the first HPV vaccine be given to all boys and girls at 11-12 years old. In 2014, Gardasil®9 was approved by the FDA. This is now the only HPV vaccine available in the US, and protects against five additional cancer-causing HPV strains. The safety of the Gardasil® vaccine is well established, with more than 10 years of post-licensure follow up studies showing no serious health risks associated with the vaccine.¹⁰ Common adverse effects of Gardasil include injection-site pain and syncope. Unfortunately, some anti-vaccination groups have spread misinformation about Gardasil®, including a claim that it led to an increased risk of primary ovarian insufficiency. This claim was recently debunked when a retrospective cohort study of over 200,000 adolescent girls showed no elevated risk of primary ovarian insufficiency.¹ Though the HPV vaccine should be given to 11-12 year olds along with the Tdap and meningococcal vaccines, vaccination rates for HPV lag far behind those for Tdap and meningococcal. Regional public health

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VIEW TWO

NYSAFP HPV VACCINE SURVEY RESULTS

By Lalita Abhyankar, MD, MHS



Interview: Over 3000 members received our survey via email and we received 117 responses. We posed the question below regarding the HPV vaccine:

Should NYSAFP advocate for HPV to be added to the vaccines currently required for school attendance?

Respondents were split fairly equally with their responses, with 37% in favor of a school mandate, 34% in favor of remaining silent and 29% opposed to supporting a mandate.

The question generated passionate debate on all sides of the issue, with seventy-nine respondents providing written comments to support their position on HPV vaccination and the Academy's role in its advocacy. A number of these comments, with their original language, are featured below:

"I would also add that people who are particularly upset about this requirement will likely pull their children out of school. Thus, those parents not wise enough to vaccinate their children will be entrusted with their children's education...Hmmm. Just because something is right does not mean it should be mandatory. It is "right" for people not to smoke, but we have not mandated that people should not smoke. The "nanny state" has been much ballyhooed without a whole lot of evidence. If we mandate a vaccine that causes a lot of controversy, we will give those who howl about the government mandating too much further ammunition. Finally, we should put our priorities in order if we are going to start mandating immunizations. Influenza cause MUCH more harm and damage and death and cost than HPV EVER will. If we must mandate, let us start there! Lastly, vaccines that are mandated should be only for diseases you can contract with your clothes on! That doesn't mean we should ignore the others, just not mandate them."

"EVERY LITTLE BOY AND GIRL SHOULD 100% GET THIS VACCINE. IT'S TIME TO FIGHT BACK AGAINST FAKE NEWS DECRYING THE DANGERS OF THE VACCINE. WE SHOULD PUSH FORWARD WITH A CAMPAIGN THAT SIMPLY SAYS IT IS AN ANTI-CANCER VACCINE. HOW COULD ANY PARENT REFUSE AN ANTI-CANCER VACCINE?"

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view one, continued

policies affect HPV vaccination rates, which vary widely among states. For example, in Rhode Island, where HPV vaccine is required for school entry, 73% of adolescent girls are up to date on their HPV vaccinations.¹¹ In states where HPV vaccination is not mandated, such as South Carolina, only 31% of adolescent girls are up to date.¹¹

Impact of HPV Vaccine

Data from several studies published in the last 10 years highlights the impact of the HPV vaccine on reducing HPV infections. According to one study in the United States, there has been a 71 percent reduction of the prevalence of HPV 6, 11, 16 and 18 in 14- to 19-year-old women and a 61 percent reduction in 20- to 24-year-old women when comparing cervical samples from the pre-vaccine era (2003 to 2006) to those from the vaccine era (2011 to 2014).² Of note, these findings were in a study population where only about 55 percent of the adolescent females received at least one dose of the vaccine.² Another study estimated a greater than 90 percent decrease in vaccine-type HPV in vaccinated women, again demonstrating the effectiveness of the vaccine.³ This same study also showed a decrease in vaccine-type HPV of more than 30% even in unvaccinated women in that community, suggesting that there may be a component of herd immunity.³ This was also observed in studies in Australia, where there was a 78% decrease in prevalence of these 4 HPV genotypes in unvaccinated men under 25 years old about 10 years after the introduction of a female-only HPV vaccination program in 2007.⁴ Scandinavian countries also saw this decline in HPV infections after the introduction of vaccination programs: among women 18-26 years of age in Norway, Denmark, and Sweden from 2006-2008 as compared to 2012-2013, HPV positivity in cervical cytology samples significantly declined from 54.4% to 48.1%, with a substantial decline in HPV types 6, 11, 16, and 18 from 22.3% to 16.6%.⁵

According to the CDC, about 41,000 new cases of HPV-associated cancers occurred in the U.S. each year from 2010 to 2014, the most common of which were cervical cancer among women and oropharyngeal cancers among men.¹² About 58% of HPV-related cancers in the US are in women, while 42% are in men.¹² Worldwide, 4.5% of all cancers can be attributed to HPV, which represents 630,000 new cancer cases per year.⁶ Because the HPV vaccine is relatively new, the effect of routine HPV vaccination on the incidence of cervical cancer and head and neck cancer will require longer-term research to demonstrate. However, preliminary studies are promising, with a recent Cochrane review finding that pre-malignant cervical abnormalities are down-trending.⁷ As the prevalence of cancer-causing HPV continues to decrease with HPV vaccination, we will likely continue to see a decrease in pre-malignancies and malignancies.

HPV Dosing Updates

In October 2016, the CDC updated its guidelines for HPV vaccination dosing. Based on the new recommendations, patients who begin the vaccination series prior to their 15th birthday only need two doses of HPV vaccine; previously the recommendation was to receive three doses. The second dose should be given 6–12 months after the first dose. In the 2-dose schedule, the minimal interval between the first and second dose is 5 months. If the second dose is given earlier than 5 months, a third dose should be administered. The dosing schedule was updated after studies by the CDC and Advisory Committee on Immunization Practices showed that the antibody response after 2 doses given at least 6 months apart to 9-14 year olds was as good as or better than the antibody response after 3 doses given to older adolescents and young adults, the age group in which efficacy was demonstrated in clinical trials.¹¹ Patients starting the vaccination series on or after the 15th birthday, as well as immunocompromised patients, still require three doses of the HPV vaccine. The second dose should be given 1–2 months after the first dose, and the third dose should be given 6 months after the first dose.

The CDC continues to recommend routine vaccination for girls and boys at age 11 or 12 years old, although the series can be started at age 9 years. The HPV vaccine is more effective when started before the initiation of sexual activity. Catch-up vaccination should be offered to unvaccinated females through 26 years old. Catch-up vaccination for males should be offered through age 21, although males age 22-26 may be vaccinated as well if they are at high risk.¹⁴

Barriers to Vaccinating Patients against HPV in the Primary Care Setting

Despite the recommendation to give the HPV vaccine at age 11-12 along with Tdap and meningococcal vaccines, rates of vaccination against HPV in the US remain significantly lower than rates of vaccination with Tdap and meningococcal vaccines.¹¹ There are many reasons for the relatively low uptake of the HPV vaccine. One systematic review published in JAMA Pediatrics found that health care professionals most commonly cited financial concerns and parental attitudes as barriers.⁸ Parents often had misperceptions about the vaccine, including the belief that their male children would not have a direct benefit from the vaccine, and that getting the vaccine may lead to increased sexual activity, both of which are disputed by evidence. Other barriers included low perceived risk of HPV infection, social influences, irregular preventive care, and the cost of the vaccine.⁸

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Overcoming Barriers

It is clear from the literature that one of the most important factors in parents' decision to vaccinate their children is their health care professional's recommendation to do so.⁹ Unfortunately, research has also shown that many primary care providers do not strongly recommend the HPV vaccine, and miss opportunities to vaccinate adolescents when they present for care.⁸ In order to overcome the barriers to vaccination and increase the number of adolescents vaccinated prior to becoming sexually active, it is critical that healthcare providers are well-informed when speaking to patients and parents about the benefits of the vaccine.

With the above data in mind, as family physicians we can recommend HPV vaccination more confidently than ever. We should be recommending the HPV vaccine as a routine vaccine along with the other 11-12 year old vaccines (Tdap and meningitis). We should offer catch-up HPV vaccination to unvaccinated adolescent patients whenever they present for care, including sick visits. Some counseling points to keep in mind if parents or patients express hesitancy about the HPV vaccine include the following:

- It is **safe**: Millions of adolescents have received the Gardasil vaccine over the past 12 years, and there is robust data showing its safety

- It is intended to **prevent cancer in both men and women**: HPV is implicated in over 40,000 cases of cancer in the United States each year; almost half of these are in men¹²

- It is **easier** to complete than ever: If given before age 15, only 2 doses are needed (at least 5 months apart)

- It is **effective**: Data shows that HPV vaccination decreases the prevalence of cancer-causing HPV strains in both sexes,⁴

- It **does not change sexual behavior**: If parents express concern that getting the HPV vaccine will affect their child's sexual activity, we can reassure them that research shows that this is not the case.¹³

Conclusion

It is a rarity in medicine to be able to provide such a simple intervention to prevent cancer. As health care providers, we have the unique perspective of knowing the devastation that cervical, anal, penile and head/neck cancers can cause. It is our duty to do everything we can to ensure that our patients are protected against the virus that we know causes the vast majority of these cancers. We must partner with parents, patients and families to overcome barriers to vaccination in order to prevent our patients from going on to develop HPV-related cancers later in life.

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Mackenzie Naert is a 4th year medical student at the Icahn School of Medicine at Mount Sinai in New York City. She recently finished her third year and is currently on a scholarly year pursuing a Master's of Science in Clinical Research. She is very interested in women's health as well as improving access to care in underserved populations.

Jordano Sanchez, MD is in his second year at the Harlem Residency in Family Medicine. He is interested in addressing mental health in underserved populations in the primary care setting. He is also excited to learn about ways to use technology and the electronic medical record to improve healthcare for both patients and providers.

Rachel Rosenberg, MD is the Assistant Program Director at the Harlem Residency in Family Medicine, and an Assistant Professor in the Department of Family and Community Medicine at the Icahn School of Medicine at Mount Sinai. Her interests include full spectrum reproductive health care in the primary care setting, and reducing disparities in reproductive health care. She is also enthusiastic about medical education, and mentoring future family physicians.

“Our Academy can take a pro-vaccination stand while simultaneously providing for an “opt-out” strategy for parents who refuse to immunize their children.”

“Vaccine adherence is best achieved through education and voluntary adherence. Mandated vaccine adherence is leading to a backlash against all vaccination to a point where parents are coming up with religious excuses and forgoing all vaccines (when they would likely be comfortable accepting some if they could choose), or even homeschooling to avoid mandated vaccination. NYSAFP should not push for mandatory vaccination of any type!”

“Of course we should do this. There are no large contraindications or side-effects, and the societal costs of vaccination are minuscule next to the costs of cancer surveillance or treatment.”

“I suggest that NYSAFP work together with NYS Academy of Pediatrics to issue one recommendation for HPV vaccine - working together would be vital given probable backlash to any recommendation. I would favor that NYSAFP and NYSAP together recommend mandatory HPV vaccine for school attendance with provision for parental opt out (but NOT opt out for other vaccines that prevent classroom illness).”

“Mandatory vaccines for school should be limited to those illnesses spread in the school such as pertussis, measles, mumps etc. Mandating other vaccines takes away from patient and family rights to make their own medical decisions. That should only be done in rare cases such as those illnesses mentioned above. We need to not advocate for acting like a paternalistic society!”

“Despite the fact that HPV is not transmitted in the traditional sense, I believe that mandating the HPV vaccine will improve immunization rates and as a result be of great benefit to public health efforts to eradicate or lower infection rates.”

“We need to debunk all of the negative press on the internet by heavily publicizing and educating the public about herd immunization and how and why it works. And let them know the studies about the efficacy and safety of ALL vaccines. A nationwide campaign from the medical community (not the vaccine company).”

“Although I strongly support and recommend the HPV vaccine, I am compelled to agree with the ‘con’ viewpoint- given the current political climate, I do fear mandating this vaccine would empower anti-vaxxers to the level of the Supreme Court and could be devastating to personal liberties vs. public health struggle. I think aggressively promoting it, countering false information, and making it widely available at minimum cost would be better at this juncture.”

“To advocate for mandatory HPV vaccination for school entrance is ridiculous. This is not a health risk in the context of casual contact in school, which Influenza is. Influenza vaccination mandate should be advocated and to remain silent on that is detrimental. HPV vaccination rates would improve with more focus on oral cancer risk due to HPV, which has not been stressed enough. The continued attitude toward parents that “your child will be sexually active even if you do not admit it” has continued to isolate parents on this issue and has been counterproductive.”

“In my own practice I have seen an increased understanding for the prevention of HPV by students and their parents- I fully endorse the mandate for school entrance requirement. Hepatitis B is mandated. I would also add that any mandate with this view should also require funding for the HPV vaccine.”

“I would advocate for offering free clinics through the DOH or start having vaccination clinics at school that could really reduce a barrier.”

“The argument for such a mandate is rooted in the observation that the diseases prevented have frequent and severe consequences, and the minors whose parents decline immunization are exposing their children to great harm. Substituting state judgment for that of the parent has thus far been justified only when the non-immunized child presents a hazard to other children whose parents want their child protected. Such children may be in the minority of patients who do not develop immunity in response to a vaccine, or who have a medical contraindication for the vaccine. Protecting a child from the judgment of their own parent has been considered a legitimate state interest only in very narrow circumstances defined in statutes involving abuse and neglect.”

At their March 2018 meeting, the NYSAFP Board of Directors agreed to support an HPV vaccine mandate with parental opt-out. The opt-out would address concerns about using a vaccine mandate to prevent the spread of a communicable disease that is not transmissible in the classroom. It would also obviate the potential for litigation against NYS to fight the mandate. The consensus was that a mandate, even with an easy opt-out, is better than the status quo and might work to improve compliance. In the 2017-18 session of the NYS Legislature this bill did not pass, so there is no current mandate for school attendance. We expect the bill to be re-introduced next year and plan to support it as long as there is a parental opt-out. We also received a number of comments that many family physicians need more education on HPV and the HPV vaccine.

Thank you to Rachelle Brilliant, DO, Chair of the NYSAFP Advocacy Commission for the update.

USPSTF Updates Cervical Cancer Screening Regimen

By Chris Crawford



On Aug. 21, the U.S. Preventive Services Task Force (USPSTF) posted a final recommendation statement (www.uspreventiveservicestaskforce.org) and final evidence summary (www.uspreventiveservicestaskforce.org) on screening for cervical cancer.

The USPSTF recommended primary care physicians screen women ages 21-29 every three years with cervical cytology. For women ages 30-65, the task force recommended screening with either cervical cytology alone every three years, high-risk HPV (hrHPV) testing alone every five years, or hrHPV testing in combination with cytology (co-testing) every five years. These are “A” recommendations. (www.uspreventiveservicestaskforce.org)

The task force also recommended against screening women younger than 21, women older than 65 who previously have been adequately screened, and women who’ve had a hysterectomy with removal of the cervix and who have no history of a high-grade precancerous lesion or cervical cancer. These are “D” recommendations.

It’s important to note that the first three recommendations apply only to individuals who, regardless of sexual history, have a cervix and show no signs or symptoms of cervical cancer. The recommendations do not apply to women already at high risk for the disease, including those who’ve been diagnosed with a high-grade precancerous cervical lesion or who have a weakened immune system (such as women with HIV infection).

Story Highlights

- The U.S. Preventive Services Task Force recommended primary care physicians screen women ages 21-29 every three years with cervical cytology.
- For women ages 30-65, the task force recommended screening with either cervical cytology alone every three years, high-risk HPV (hrHPV) testing alone every five years, or hrHPV testing in combination with cytology every five years.
- The task force also recommended against screening women younger than 21, women older than 65 who previously have been adequately screened and certain women who’ve had a hysterectomy.

“Screening for cervical cancer saves lives and identifies the condition early, when it is treatable,” said USPSTF member Carol Mangione, M.D., M.S.P.H., in a news release. (www.uspreventiveservicestaskforce.org) “There are several effective screening strategies available, so women should talk to their doctor about which one is right for them.”

The task force called for more research to evaluate whether different screening strategies could further reduce deaths from cervical cancer; it said more research is needed to improve follow-up for current screening strategies and to ensure access to follow-up treatment across different populations.

“We know that some populations are affected by cervical cancer more than others,” said USPSTF Vice Chair Douglas Owens, M.D., M.S., in the release. “We need more research to determine how we can effectively reduce disparities among these women, and ultimately help save more lives.”

What's New

This final recommendation statement updates the USPSTF's draft recommendation from Sept. 12, 2017, and the task force's 2012 final recommendation, which the AAFP supported at that time.

The new final recommendation updates the draft version by adding back in a recommendation option from the 2012 guidance for co-testing every five years with hrHPV testing and cytology.

The draft version of this final recommendation statement was posted for public comment on the task force's website from Sept. 12, 2017, through Oct. 13, 2017.

Jennifer Frost, M.D., medical director for the AAFP Health of the Public and Science Division, told AAFP News the AAFP's Commission on Health of the Public and Science (CHPS) reviewed the USPSTF's draft recommendation statement and draft evidence review for cervical cancer screening and provided extensive comments during this period, including expressing concern about removing co-testing as an option.

"The USPSTF takes the comments of stakeholders seriously, and I was pleased to see that they made important changes that address the concerns shared by the AAFP," she said.

The task force said some of the commenters requested clarification on the differences between co-testing and primary hrHPV testing. Other respondents explained that there would be issues with implementing primary cervical cancer screening recommendations because of a lack of available FDA-approved tests.

In addition to adding the co-testing recommendation back in, the USPSTF responded to commenters by providing a table in the "Clinical Considerations" section (www.uspreventiveservicestaskforce.org) that presents detailed information about the available evidence on the effectiveness, strengths, limitations and unique considerations of each screening method.

Also, to further answer questions raised about the modeling study included, the task force added calibrated input parameter values, which, it said, "should enable informed readers to assess the estimates used."

Finally, the USPSTF added language throughout the final recommendation statement to emphasize several factors that affect overall screening effectiveness, including the primary screening test, screening ages, screening interval, test characteristics and follow-up protocols, including triage of screen-positive women.

Up Next

The AAFP's Commission on Health of the Public and Science plans to review the USPSTF's final recommendation statement and evidence review and determine the Academy's stance on the recommendation.

Frost noted that since the advent of widespread screening, the incidence of cervical cancer has markedly decreased.

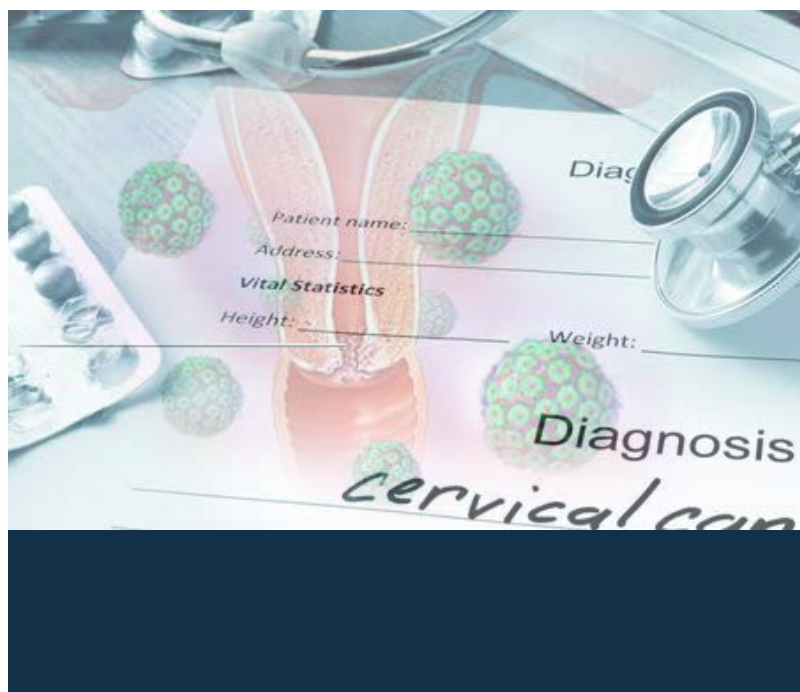
"The majority of cases of cervical cancer occur in women who have not been adequately screened," she said. "The message to family physicians is that screening for cervical cancer significantly decreases the incidence of and mortality from cervical cancer. The decision about how to screen -- using cytology, co-testing or primary HPV -- will depend on their resources and patient preference."

Related AAFP News Coverage

USPSTF Offers Updated Cervical Cancer Screening Regimen
Draft Recommendation Includes New Protocol for Women 30-65 (9/22/2017)

AAFP Recommends Against Pelvic Exams in Asymptomatic Women
Guidance Differs From USPSTF Final Recommendation (4/25/2017)

AAFP News, [August 24, 2018]. © American Academy of Family Physicians



Perspective on Traditional and Western Models of Health Literacy on Cervical Cancer Prevention for Shipibo Women

By Shilpa Darivemula, MD, MS; Arhant Rao, MD; Ivy Wilkinson-Ryan, MD; Inge Stege, BA; Silveria Pino, RN; Macarenas Arias, BS; Luzmila Monteluisa and Ann Rutter, MD, MS

In the United States, the incidence of cervical cancer has been on the decline since the advent of the HPV vaccination series, increased awareness of Pap screens and concurrent improved health literacy on the causes, risks, and prevention of cervical cancer.¹⁻³ Unfortunately, this reduction is not globally pervasive. Developing countries disproportionately suffer from greater than 50% of infection cases and carry 85% of cervical cancer death burden worldwide.³ The risk is especially high in Peru, where HPV-induced cervical cancer is the most common female cancer.³ Reducing cervical cancer-related mortality has been a goal of the Peruvian Health Ministry; both vaccines—Cervarix which protects against HPV types 16 and 18 and Gardasil which protects against 6,11,16,18 subtypes of HPV infection—have been approved by the Peruvian Ministry of Health in 2009 and 2006 respectively.^{5,6} Implementation of screening and vaccination programs in Peru have been substandard and infrequent, especially in the more remote regions of the Andes and the Amazon.⁶⁻⁹

I first met the Shipibo community of the Amazonian region of Pucallpa, Peru while travelling between college and medical school and was invited to create an arts-based empowerment program. The program ended up as a series of workshops in which I invited the young preteens of the communities near the city of Pucallpa to express themselves. In the United States, children are regularly asked about self-identity and encouraged to explore their personality, but in Pucallpa, those questions were met with silence. When I heard of the underreporting of cervical cancer data from Amazonian regions and the lack of follow-up for HPV infections and abnormal

Pap results, I believed Shipibo culture played a major role in public health endeavors. I became interested in whether a second series of workshops could explore how identity, health literacy, and health empowerment could mobilize change for the very Shipibo women I met so many years ago.

For indigenous communities in Peru, access to gynecological care and prevention of cervical cancer is a persistent challenge due to structural inequities in medical delivery of screening programs and health education.^{4-6,10-12} In fact, the Shipibo-Konibo community's attitudes and beliefs towards cervical cancer treatments and screenings have been the subject of several studies due to high incidence of cervical cancer noted. Risk factors for Shipibo women include limited Spanish skills, high burden of tobacco use, lack of protection during intercourse, the cultural norms surrounding female sexuality, and multiple sexual partners.^{6,12-15} Surveys state that only 23% of women with abnormal Pap smears from this community seek any follow-up treatment and the women who do seek treatment do not go to hospitals until they feel severely ill.^{6,12,13}

Many contemporary healthcare interventions for preventing HPV infection-induced cervical cancer are based on cultures with high-level infrastructure, well-trained personnel with adequate resources, and a community where women have higher levels of autonomy, agency and health literacy. The foundation of most medical STD prevention education is based on the woman's power to choose. This is extremely problematic for women's health education on the global stage, as the



Figure 1. Group circle for the lecture and condom use demonstration (Author's own photo with permission)

assumptions it makes are not universally true. Practices such as safe sex measures, limiting sexual encounters, and attending annual check-ups are often not available strategies for women in abject poverty with limited access to resources. Telling women to “choose better health” is not only impractical and neo-colonialistic on the global stage, but it is personally detrimental to indigenous women who leave without real solutions and without agency to make the changes needed for their cervical health.

Furthermore, basic understanding of human physiology is lacking in these communities, making education on symptoms, prevention, and treatment challenging. Studies on attitudes of Shipibo women towards Pap smears suggest a pervasive fear of the “extraction” involved in Pap smears. One account by a Shipibo leader included a description of this “extraction” saying, “They open this space and insert the apparatus. They grasp here and pull. So it comes out of here. The uterus comes out.”⁴ Addressing HPV vaccination and screening for cervical cancer in an empowering manner in the resource-constrained settings of the Shipibo people in the Bena Jema region around Pucallpa requires novel utilization of existing cultural infrastructure.

We created a series of workshops in conjunction with Alianza Arkana, a non-governmental organization, who worked with several women from the community of Bena Jema. We met Silveria, a Shipibo nurse who had been required to do workshops in the remote Ucayali River communities; Shirley, a Shipibo translator; and Luzmila, the niece of the Bena Jema leader. Together, we discussed the topics women would be interested in learning about. Our goal was seemingly simple: to design a collaborative, culturally-empowering workshop series for improved health literacy for the Shipibo women. After much discussion on how to achieve this “simple” goal, we created the following three workshops: *Cervical Cancer and HPV Infections*, *Sexually Transmitted Diseases*, and *Menstrual Cycle and Menopause*.

Alianza Arkana leaders and I discussed ways to make the workshops interactive, incorporate art, and have live demonstrations. Luzmila asked, “Interactive? Oh, you should bring food enough for leftovers

for women to take home. You should also approach the *jefe* [leader] of the community to request permission to use the schools. We also need desserts, drinks as well.” Respect in Shipibo community was achieved through food. We had been so quick to expect trust through our offering of medical knowledge that we didn’t realize how abiding to cultural norms would imply mutual respect nonverbally and perhaps more profoundly.

When we tried to design the workshop on STD prevention and regular Pap smears, we quickly learned that the only contraception available from the government physicians stationed in Bena Jema were condoms, and that these were expensive and rarely used. When I talked about the vaccinations, Silveria, Luzmila, and Shirley expressed disbelief that there was a vaccination series available to help prevent this cancer. The data I was reading on the vaccination programs and knowledge transmission by the government of Peru clearly did not reflect the reality of this group of women in front of me. Upon meeting the local physician (who, in the Peruvian medical training system, was on his one year of general community practice before applying for residency), I learned that vaccinations were only offered to school going girls between the ages of 12 and 14. In a community where teen pregnancy and household expectations remove young girls from school, this HPV vaccination strategy seemed inherently flawed.

Each workshop was attended by about thirteen women ranging in age from 18 to 30 and accompanied by their children or younger sisters or their babies. The first part of each workshop was a lecture on the basics of anatomy, pathophysiology, and the symptomatology of each disease. At first, I tried teaching with poster drawings—to no avail. Despite attempted positive reinforcement with snacks and drinks, I could see the women’s eyes divert after a few minutes of my Spanish lectures and the subsequent translated Shipibo meanings. It is known that global health workshops have short-lived effectiveness because of the lack of repetition and follow-up after such workshops.

To impact health literacy, or at least the interest in it, I had to draw on the stories of the women. Some women were shy and avoided speaking,

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Figure 2. Drawing the anatomy of the female reproductive tract and lecture on the pathogenesis of cervical cancer (Author's own photo with permission)

but others, especially the elderly, talked about the rivers of blood that flowed from their sisters and daughters before they passed away. For the Shipibo, all of this bleeding was from cancer, whether diagnosed or not. The mode of transmission was subjective: for those who lived in the villages, curses and bad luck were the vector; others who lived closer to the city or had high levels of education saw it as a result of poor medical care and lack of screening. The diversity in understanding cancer, especially cervical cancer, was amazing. We began to exchange a dialogue. They would tell me a story, and I would try to explain it medically. Not only did this method of talk-back increase interest, but it had clearly levelled the power difference between these women and me. We had become equals in our search for answers—the women from me and me from them. I learned that tobacco use, one of the major risk factors for cervical cancer, was part of a tradition for warding spirits away and was part of daily life. I also learned about the many ways the Shipibo used medicines from plants as STD prevention. While no evidence exists on the quality, safety, and efficacy of plant medicine, the biological Amazonian world of the Shipibo is intimately connected with their culture, knowledge, and empowerment as women. Even the younger girls gleefully recited the recipes for permanent sterilization of the men, mixtures to decrease abusive energy in their men, and aromas to subdue sexual drive. I asked if any of them had used a condom before. Everyone erupted into giggles. We brought out bananas and asked each woman to try to use a condom on it. The laughter was instantaneous as the various permutations of condom use materialized. After demonstrating the proper technique, the women practiced sheathing the bananas; some of the women took a few of the condoms home with them, intending to use them there.

When I asked about Pap smears, the women stopped chatting and looked shocked; the doctor in the community was a male. I had met him and learned that he offered free Pap smears, free condoms, and if they had governmental insurance, could offer them contraception, including intrauterine devices. They avoided him because he was a male. As only one physician was allowed per region and the rules of government insurance stated that the women in that particular

area only see their local physician, they could not seek out an alternate provider. Resources were even more limited than initially understood and it was clear how medical systems could be underutilized due to disregard of cultural norms of indigenous communities. I asked them what happens in a Pap smear, and learned that they thought parts of them were removed, that the doctor impregnated them, that their souls were captured, that if they went, their husbands would beat them or that their uterus would be removed.

Silveria took over and acted like a doctor while I acted like a patient. I felt ridiculous with my legs lifted on the table as Silveria discussed the swabs and exam performed by the doctor. The women, however, were enthralled, asking questions about the process. Much like the condom use practice, the Pap smear enactment allowed for a visual and tactile understanding that could not have been achieved with a simple lecture on the process. We allowed for traditional discussions and art making on stories and cultural practices interspersed with lectures to transmit the health information on cervical cancer and screening. This novel method of co-dependent, collaborative presentation and exploration of health information not only helped improve health literacy, but it gave me an understanding of the cultural barriers and opportunities for improved screening in the Shipibo community. We had both become learners, each of us using inherent cultural strengths to mutually empower each other for improved community health outcomes.

At the end of the workshops, the elderly women stood up and stated that they wanted a health fair where the local doctor would do Pap smears here in their community of Bena Jema. We suggested creating a group of women who would collect health data on the community and work as community health workers. While the project has started slowly, we felt humbled and proud that the women chose to mobilize themselves for their community. The challenge of offering solutions without enforcing what we thought was best was addressed through mutual vulnerability in story sharing and collaborative hands-on experiences on different health interventions. Alianza Arkana continues to develop this program today with the women and has created a partnership with the local physician to address the needs of the women in the manner most respectful and



Figure 3. Pap smear demonstration and sharing food and drinks for the workshop (Author's own photo with permission)

empowering to them. Women's health is not just about physical health but incorporates mental and societal aspects. Our novel workshops mixing traditional and western models of learning were a small seed for this community to demand better.

Global health is often described as a methodological format with clear objectives and measurable outcomes.^{17,18} In fact, financial support and measurement of success is often by the data collected. For communities without a culture of assessment, without resources, without the power of choice and autonomy, and without a strong focus on western education, these measurements limit the spread of small stories of success. Global health needs new methods of measurement that take indigenous culture and indigenous goals into consideration. Like new projects in patient narratives and patient-physician collaboration on medical documentation, global health needs to have a deeper conversation with the people it serves and recalibrate its definitions of "success".

The trajectory of disease's "lifetime"—its birth, growth, and death—depends on how societies respond to it. Understanding the cultural context of disease will promote development of effective strategies to reduce its burden on a community and perhaps, one day, will lead to the true eradication of cervical cancer globally.

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The Role and Potential of Short-term Teams in Medical Education in Resource-Limited Settings

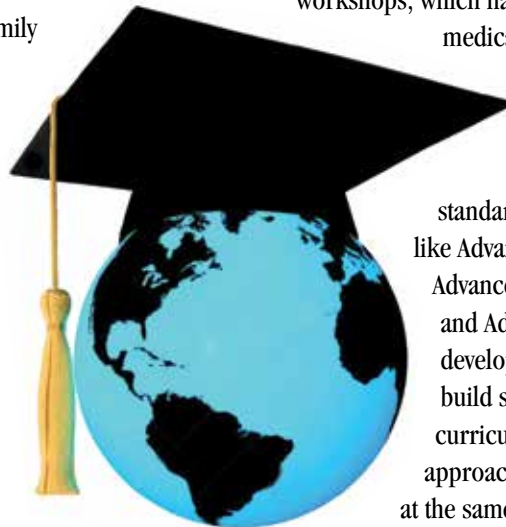
As global health curricula become increasingly commonplace in family medicine residency programs, there is a growing recognition of the myriad forms that short-term experiences in global health (STEGHs) can take. Global health is no longer defined solely by the classic “clinical mission trip” model, which has come under scrutiny in recent years.¹ Rather, the field of global health has sought to encompass broader areas of medical development with a focus on, among other things, medical education and faculty development. Successful global health experiences should aim to model a bi-directional exchange, whether academic or cultural. To this end, family medicine residency programs are well-positioned to offer educational and faculty development programs for host institutions, while simultaneously providing valuable opportunities for trainees to explore aspects of culture, education, medical practice and social determinants that collectively impact health.

Educational STEGHs are ideally learner-centered, specifically focused on the self-identified needs of the host community, and carried out at their request. Done well, with an emphasis on cultural humility, sensitivity and thoughtful preparation, initiatives fostering this ethos can be an important aspect of supporting infrastructure for improved healthcare systems in the developing world.

A Review of Benefits and Best Practices in the Global Health Educational Model

Drawing from current evidence-based literature, several global health education models with demonstrated benefit can help guide best practices. Procedural approaches, often sponsored by surgical training programs, typically emphasize direct, hands-on contact with host-nation physicians to provide focused technical coaching at the point of care.² Other exchanges incorporate distance-learning through online modules offered to clinicians.^{3,4} While this latter approach has the benefit of asynchronous accessibility and lower overhead related to travel expenses, it can also at times depersonalize the exchange, sacrificing the face-to-face encounters that are arguably beneficial to both parties. Another hybrid model employs didactic elements followed by hands-on, clinically-oriented

workshops, which has been shown to improve specific areas of medical knowledge and clinical skill.⁵



Still other means of executing this vision include observer-ship exchange programs, “train-the-trainer” models, and standardized, algorithm-based training workshops like Advanced Cardiac Life Support, Pediatric Advanced Life Support, Helping Babies Breathe, and Advanced Life Support in Obstetrics. Faculty development workshops are also available that build skills in areas such as effective teaching, curricular development and evaluation. These approaches ideally impart content-knowledge while at the same time developing leadership potential in trainees, who are themselves future clinical and academic team leaders.

The benefits accrued to communities of the sending team are also well-documented, with recent data suggesting that perhaps paradoxically, STEGHs appear to foster the growth and development of a nation’s own primary care workforce. When trainees are exposed to international experiences in medical and professional development, they are more likely to provide care to underserved populations domestically, such as those living in rural areas or urban inner-city settings.⁶ That said, there are also inherent risks associated with the cross-cultural immersion experience for both visiting and host communities, some of which are specifically relevant to medical education in developing world settings. Much work has been done on this front in recent years to develop guidelines that ensure a common understanding of best practices.^{1,7,8}

One increasingly recognized risk in the broader world of global health is the unintended effect of asymmetry in the visitor-host relationship, with the potential to disempower the host institution in subtle but profound and far-reaching ways. In the context of medical education STEGHs, the impact of “teaching the teacher” can create a perception of lower competency, and resultant loss of “face,” for the senior residents and faculty of the host institution among their own peers and trainees. To avoid this, teams must diligently create relationships based on mutual affirmation and respect, clearly conveyed through consistent demonstrations of courtesy and deference to the host team’s leadership. Implied here, of course,

is the principle that any educational session must be expressly welcomed by the host, and should focus on addressing any needs they themselves identify. It is imperative that teams adopt the ethos of currently-accepted best practices, including that of longitudinal, relational engagement.⁷

La Romana, Dominican Republic: One Global Health Immersion and Education Experience

Here we describe our experience of a week-long cross-cultural exchange experience undertaken in the context of one such longitudinal relationship, in the La Romana community of southeastern Dominican Republic. This was the inaugural global health trip of the Phelps-Northwell Family Medicine Residency Program, involving seven residents in their first post-graduate year and three core faculty members. It was contextualized as a component of our broader “community medicine” rotation, a one-month block during intern year dedicated to developing skills in assessing health and resources within the local community, as well as understanding the social determinants of health at a population level. This trip was an effort to further integrate the “GLocal” (global-local) model of global health education, as the majority of our residency’s ambulatory care clinic population identifies as Dominican. We were able to undertake this trip due to a newly-formed partnership with the Northwell Health system, which has made great strides in establishing fruitful, long-standing relationships with local community partners in La Romana, including the Jamie Oliver Pinot Residency Program located in nearby San Pedro de Macoris.

During our stay, we participated in the Pinot program’s daily rounds, joined residents for their formal didactic sessions, and then, at the invitation of the host institution, provided an educational session during one morning of allotted didactic residency time. The topic of the session was the sharing of the “VINDICATE” model, a simple, concise cognitive tool for developing a differential diagnosis, shared through a case-based, interactive format. The choice of this particular tool was based on an informal needs assessment completed by our team identifying an opportunity for support of a systematic approach to generating a differential diagnosis, which in turn serves as the foundation for rational patient assessment (accumulation of history, physical examination, diagnostic data) and the development of additional diagnostic and treatment plans. Our target audience for this session was roughly an equal mix of Dominican interns and residents at each stage of their post-graduate training, as well as a number of American- and Dominican-national medical students rotating with them. Also present were several Dominican attending physicians serving on the faculty of the residency program, totaling approximately 40 physicians and trainees in attendance.

Responses to a Bidirectional Educational Exchange

When we explored the response from our target audience, the intervention was received very positively, for several reasons. First, and perhaps most significantly, a solid groundwork had already been laid through the long-term relationship established through Northwell’s partnership with the program over many years, forming the background context for our own introductory participation. Additionally, conscientious efforts were made over the two days preceding the delivery of our presentation to build rapport and establish individual relationships between our group and the trainees of our host institution, accomplished through observation of their didactic sessions and collaborative participation in their emergency room care and inpatient-based rounding. We were careful to offer a sensitive delivery of the taught material, assiduously avoiding any language or tenor that could potentially highlight perceived educational disparities between the two training systems. During the didactic presentation itself, Spanish language translation was provided by several fluently bilingual Dominican trainees, further enhancing their role as teachers and co-collaborators in the educational process.

There was also a clear demonstration of our target audience’s own humility and willingness to learn and grow. This was particularly relevant in light of the recognition that significant moral distress can result from graduated responsibility and increased application of skills in clinical patient care, if the acquisition of those skills is not systematically taught and supportively reinforced within the indigenous medical educational system. Finally, the presenters from our visiting team made explicit efforts to affirm their collegial relationships with our host residents, creating a foundation of equal footing on which all trainees could learn collaboratively in a cross-cultural environment. As affirmation of the effectiveness of the brief intervention, we were encouraged to learn that the residents in the Pinot training program had continued to use the differential diagnosis tool (VINDICATE) during their daily case presentations, when informally polled six and nine months after our visit.

In the spirit of affirming the importance of a bidirectional exchange, it is relevant to comment on the experience of our own PGY-1 residents during the preparation and delivery of their presentation. The experience provided an opportunity to further develop their presentation skills, including the unique experience of employing translation services during their respective segments. They also gained faculty development in creating a presentation that emphasizes the systematic approach to patient assessment – at a time when they themselves are acquiring and honing those very same skills. Our interns shared that the experience afforded insight into the crucial foundation of rapport-building for any educational initiative to be successful, carried out respectfully and with sensitivity to avoid highlighting disparities. Even as gaps became apparent, emphasis during debriefing sessions was placed on the use of an asset-based community development approach, looking for insights into areas of strength and resiliency in the Dominican colleagues, who frequently work

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resourcefully with what they have available at their disposal, and to gain appreciation for some of the realities of medical practice in resource-limited settings.

Most significantly, however, the immersion experience and educational intervention provided valuable insights for our residents into the multifaceted nature of need in developing-world medicine, including the integral relationship with, and profound impact of, educational systems in a nation's healthcare delivery. They voiced a new appreciation for strengths of our own system, which emphasizes various elements of medical education that, though vital, can often be taken for granted: professionalism, medical knowledge, and the supervised training of procedural or clinical skills, to name a few. Over the course of the experience, our residents recognized various ways that information – and potentially, inaccuracies – can be passed down through an entire system, and gained deeper appreciation for the rigorous support of regulatory bodies (for instance, the Accreditation Council for Graduate Medical Education) to systematically ensure quality and accountability.

Reflections and Challenges Moving Forward

Given that this experience was both a positive and helpful one for both visiting and host institutions alike, with opportunities to grow clinical skills, develop faculty capacity, and foster leadership potential, our own residency program plans to continue annual participation with the Global Health team at Northwell, with the aim of supporting their partnership with the Jamie Oliver Pinot residency program. We are currently in the planning stages for year two of this longitudinal program, and hope to become more fully aware of specific challenges they might identify that a long-term partnership could help address.

One challenge astutely identified by our own resident team was that of inconsistent national standardization in medical education or clinical care. This has been identified as an issue plaguing the Latin American region more broadly, even as

steps are being taken at the regulatory and policy levels to address this concern.⁹ Organizations seeking to standardize medical education in Latin America include the Pan American Federation of Associations of Medical Schools (PAFAMS) and the Foundation for Advancement of International Medical Education and Research Distance Learning (FAIMER), which also has a clear foothold in sub-Saharan Africa and is yielding promising results. The content being taught is not always consistent with information being studied for US-based entrance and licensing exams or, reflects a disconnect between current standards of care and those being employed in actual clinical settings in which trainees are learning. This conflict potentially contributes to confusion and moral distress surrounding practical aspects of diagnosis and management, contextualized in an education system that fails to consistently provide a rational, evidence-based approach to care during training.

Attaining mastery of the corpus of medical knowledge is a complex and unwieldy task, requiring years of effort and patience under the best of learning conditions. Confusion introduced by inconsistent international standards and anecdotal- (rather than evidence-) based practice makes achieving this competency all the more difficult. In light of this, we feel that there is good reason, based on both existing evidence and commonsense rationality, to focus global health efforts largely on addressing these disparities in healthcare education, with the long-range aim of creating equity in healthcare provision at the systems-based level, through ongoing partnerships grounded in mutual respect and trust.

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Hajat Avdovic, MD is currently in his second post-graduate year at the Phelps Family Medicine Residency program. Originally from Sarajevo, Dr. Avdovic emigrated from Bosnia-Herzegovina to New York City as a young child, and he attributes his commitment to medicine and global health in part to this and subsequent cross-cultural experiences. He attended the Sophie Davis School of Biomedical Education in New York and graduated from Albany Medical College prior to joining the Phelps program. He plans to pursue a sports medicine fellowship upon completion of his residency training.



NATURAL DISASTERS: DISASTER MANAGEMENT IN INTERNATIONAL SETTINGS

By Rokhsanna Sadeghi, MD, MPH and Erika Sadeghi, MD

A disaster is the result of a vast ecological breakdown in the relation between humans and their environment, a serious event on such a scale that the stricken community needs extraordinary efforts to cope with it, often with outside help or international aid.¹ From a public health perspective, natural disasters are defined by what they do to a population, otherwise they are simply interesting geological processes. Natural disasters cause increased morbidity and mortality in developing countries. Greater than 3,000 deaths per disaster occur in low-income countries compared with the average 500 deaths per disaster that occur in high-income countries.¹ The impact of one natural phenomena may cause a disaster in one community but not another, if the resources to cope with the disaster have been overwhelmed. A well-developed disaster management plan will drastically reduce deaths and disability in many international settings.

CLASSIFICATION OF DISASTERS

Disasters can be classified by 3 categories: (1) hazards causing disasters, (2) speed of onset, and (3) acts of nature or acts of humans.⁶ Primarily, the type of hazard, may vary depending on the location. The hazards themselves are not disasters, but rather are factors in causing a disaster. Secondly, the hazard can be further classified by the speed of onset. The hazard may be rapid, such as earthquakes, tornadoes, hurricanes, landslides, avalanche, or fires or the onset may be chronic such as drought, famine, environmental degradation, deforestation, or

desertification. Epidemics of water-, food-, or vector-borne disease, as well as person-to-person transmission of diseases, such as an Ebola outbreak, may also result in an acute onset of a disaster. Lastly, hazards are classified as acts of nature or acts of humans. Examples of disasters caused by humans include chemical or industrial accidents, environmental pollution, transportation accidents and political warfare. This separation is now thought to be artificial since most disasters result from the actions or inaction of people and their corresponding political, social and economic structures. As humans continue to degrade the environment and overpopulate urban centers, the likelihood for a natural disaster increases.

DISASTER IMPACT

In many international settings, specifically developing countries, there is greater impact on a community's health and economy when a natural disaster occurs. Poverty and social inequality cause increased human vulnerability. For better perspective, 95% of deaths that are the result of natural disasters occur among 66% of the world's population that live in the poorest countries.² Lower social economic classes are unable to afford housing that can withstand seismic activity and often live along coasts where hurricanes, storm surges, and tidal waves can affect them. Furthermore, these populations may live on unstable slopes that are susceptible to landslides or built next to hazardous industrial sites. Lack of governmental infrastructure and function limit the amount of operational planning. Political tension and instability

may decrease access to international aid. For example, when Cyclone Nargis struck the Irrawaddy Delta of Burma in 2008, it took a week before the military blockade of international aid was officially lifted. One week after the disaster, only one in ten people who were homeless, injured or threatened by disease had received aid. More than two weeks later, relief had only reached 25% of people in need.³ Acute onset disasters, such as the one in Burma, can be viewed as a continuous time sequence of five different phases diagramed in Figure 1. Phases may last from just a few seconds to months or years, with one phase merging into the next. For each phase, new knowledge exists about how to design appropriate prevention measures for different types of natural disasters.

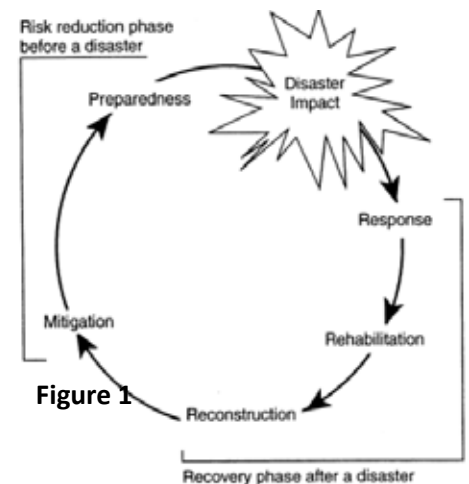
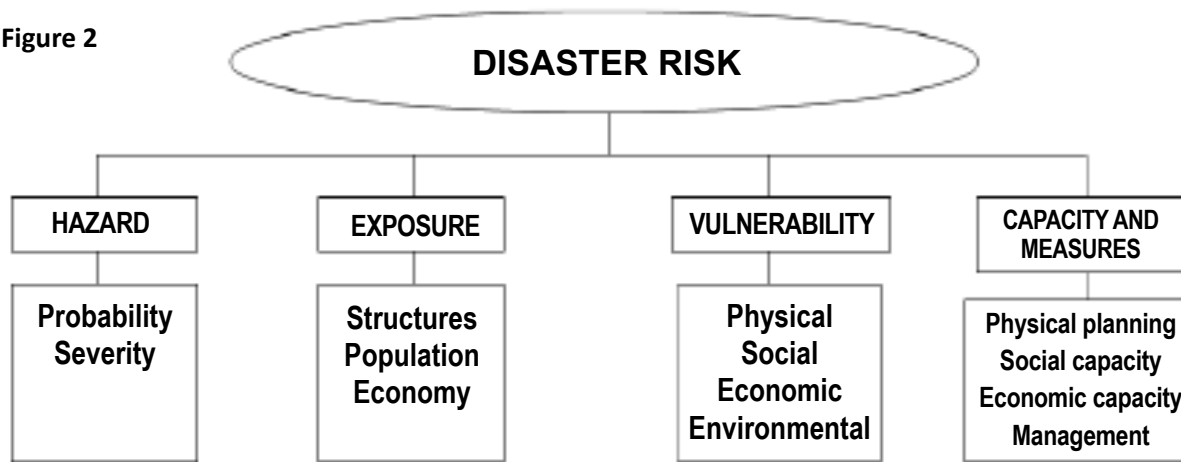


Figure 1
Pan American Health Organization. *Natural disasters: Protecting the public's health*. No. 575. Ch. 2. Pan American Health Org, 2000.

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Figure 2



Dewan A.M. (2013) Hazards, Risk, and Vulnerability. In: Floods in a Megacity. Springer Geography. Springer, Dordrecht

DISASTER PREPAREDNESS MEASURES

Minimizing the disaster impact depends on the effectiveness of the country to prepare and respond in the recovery phase and risk reduction phase diagramed in Figure 1. However, the execution of these phases varies from country to country depending on disaster risks outlined in Figure 2. Anticipating these risks with disaster preparedness measures, as summarized in Table 1, includes response mechanisms such as evacuation procedures, ensuring timely disaster preparation and coordination amongst multiple organizations. There needs to be a mutual trust and coordination of efforts between local organizations, civil defense, government emergency structures, fire brigades, health departments and clinics, and international agencies. In 2010, 16 miles outside of Port-au-Prince, an earthquake on the 7.0M Richter scale hit Haiti. Three million people were affected and the death toll ranged from 100,000-160,000.⁷ Many countries dispatched aid, including 20 countries sending military support, but there was confusion as to who was in charge. A more coordinated effort includes prior planning so that each agency understands each other's aims, objectives, and capacities to avoid duplication and identify gaps.

Table 1: Disaster Preparedness Measures

Hazard, risk, and vulnerability assessments
Response mechanisms and strategies
Preparedness planning
Coordination
Information management
Early warning system
Resource mobilization
Public education, training, and rehearsals

"Introduction to Disaster Preparedness". International Federation of Red Cross and Red Crescent Societies. June 2000. www.ifrc.org/Global/Publications/disasters/all.pdf

The consequences of poor preparedness lead to delays in aid distribution, looting, angry appeals from survivors and aid workers, and sporadic violence, as was seen with Haiti. In addition, the rainy season approached several months later as the survivors were still living in tents. Floods were a catalyst for spreading diseases such as cholera and worsening sanitation and malnutrition.

MASS CASUALTY TRIAGE

Sudden impact hazards that overwhelm the resources of a given health system often require mass casualty triage. During the response phase of a disaster, it's essential to prioritize sick and injured people according to the seriousness of their condition. Primary triage is the first contact with the injured patient. At this time, the patient is assigned a triage tag: black, red, yellow or green, as listed in Table 2. This initial assessment should take 30 seconds or less to complete and includes assessment of respirations, perfusion, and mental status. Furthermore, during the primary survey, life- and limb-saving measures should be performed. These procedures include, but are not limited to airway maneuvers, control of major bleeding,

Table 2. Mass Casualty Triage Classification

Classification	Classification Meaning	Clinical Condition
Black	Deceased or expectant	
Red (1)	Immediate	Critical patient
Yellow (2)	Delayed	Serious patient that could wait until all reds have been transported
Green (3)	Ambulatory	Minor injuries, walking wounded

"START" System of Triage. Mass casualty presented by the QAEMS department. https://www.blessinghealth.org/sites/default/files/users/user15/EMS_START_Triage_SMART_Tags_2017.pdf

Oncology Care in Family Practice

Alissa Correll, MD, Sonya Narla, DO, MA and Colleen Fogarty, MD, MSc, FAAFP

needle thoracostomy, pericardiocentesis, and joint reductions. Non-ambulatory patients in severe distress should be attended to first. The one hazard in which this is an exception is for electrical injuries, for the unresponsive patients may require immediate defibrillation. The patients who are in the green category, also known as the walking wounded, should be directed to a safe area to await secondary triage once critical patients have been treated and transported.

CONCLUSION

Natural disasters have claimed 3 million lives worldwide during the past 20 years and adversely affected the lives of at least 800 million more people.² Natural disasters have a great impact on the public health of a community and the local health infrastructure may be destroyed. Beyond the initial morbidity and mortality from the impact of the disaster, there are long term consequences as well, including psychological problems, malnutrition, population movement that may overwhelm the resources of another community, and increased risk for outbreaks of communicable diseases. Consideration of these factors and the development of an integrated disaster plan will help reduce the impact of a natural disaster.

Endnotes

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Family physicians encounter disease processes in various stages, including acute presentation, chronic management, remission and recurrence. As the patient's primary contact within the medical system, the family doctor may request specialist consultation at any of these stages, with the expectation of ongoing care collaboration. However, in the care of the patient with cancer, the role of the family doctor becomes less clear as a comprehensive oncology team becomes the primary team. Confusion on both the part of the patient and physician regarding who is "driving care" may lead to a mismatch in expectations from both parties.¹ The average United States family physician will have 2-4 patients with new malignancy diagnoses annually,² and given the aging US population and increasing burden of chronic disease, we may expect this number to increase. Therefore, a framework for approaching malignancy in our patients with cancer diagnoses represents an important tool for all family physicians.

This article will provide a summary of current roles and expectations for family physicians in cancer care, review patient perspectives and expectations as well as specialist roles and expectations in the care of patients with cancer. We will discuss where family physician training can provide strength to the team care of patients with cancer using the models proposed by Norman et al., to describe care sharing between family medicine and oncology: sequential (no FM involvement), parallel (involved for non-cancer problems) and shared (both teams with elements of cancer care).³

Diagnosis

Family physicians are often the first to detect malignancy through their role in routine healthcare maintenance, including cancer screening. Although data across all cancers is difficult to obtain, Aubin et al. found 60% of new lung cancer diagnoses were first directed to a specialist by a family physician, with 80% having help from their family physician in making the appointment.¹ In contrast, patients' perceptions of a "shared model of care" is at its lowest when establishing oncologic care. Additionally, nearly 60% of patients identified the oncology team as primarily driving care.¹ Also

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notable during this period is the gap in patient wishes for family physician follow up, particularly for emotional support. Studies have shown that patients agree with family physicians' as the "ultimate support" and "patient advocate,"⁴ when nearly 80% of cancer patients expect their family physician to provide counselling regarding emotional aspects of cancer, yet only 20% of such patients feel they receive it.⁵

Oncology Management

After initial diagnosis, the largest gaps between physician practice and patient expectation seem to be during the ongoing management of cancer. As the patient attends appointments with the oncology team to develop a management plan, both patient and FP may struggle to find the family physicians' role. It is at this point that most patients follow the sequential, oncology-directed patient care model. Surgical, medical, and radiation oncologists suggest that the family physician could play a key role in managing comorbidities including nausea, pain, depression, family coping, coordinating cancer care and interpreting complex medical information.⁶ Family physicians, too, identify similar roles for themselves. However, many barriers exist, including inaccessible records, and notably, the "trust gap" between patient and family physician and specialist and family physician.⁶ Does the patient trust their family physician in the management of comorbidities and surveillance once therapy has been completed? Does a working and trusting relationship exist between family physician and specialist? And if so, is this mutual trust conveyed to the patient from both the specialist and family physician? Addressing such concerns without direct communication between oncology and family physician may lead to poor continuity of care, particularly during the sequential phase of treatment.

Follow up

During treatment, family physicians are unsure whether they should schedule routine follow up, whether these appointments may become bothersome, fatiguing or anxiety-provoking for their patients, and which parts of care they are responsible for managing.² The majority of patients, however, would prefer more involvement by their FP during this phase of care.¹ We suggest that routine follow up continue during stable phases of disease. At this point, the parallel model of care is ideal. We suggest adopting a system for direct communication with the oncology team—for example, a direct phone number for oncology office nurse—along with a clear role for the FP regarding management and follow up to avoid miscommunication and redundancy. In this parallel model, patients managed by their FPs are more likely to receive preventative care and care for non-cancer chronic illness in concordance with guidelines, have fewer ED visits, and for those in the terminal stages, may be more likely to die at home than those patients followed solely by the oncology team.² Open communication and clearly defined roles between oncology and FP is vital to the parallel model.

Remission/Relapse

As defined by the shared model of care, cancer patients in remission who no longer require the services of the oncology team can be followed by their family physicians. This can be a source of anxiety for physicians as patients transition out of active treatment. In order to decrease physician and patient anxiety, individualized parameters for return to cancer care should be clearly defined prior to transition. Ongoing surveillance for comorbidities should remain during this period.

Case Example- EC

EC is a 66 y/o male well known to your practice who presents with three weeks of increase in cough and malaise. His medical history includes mild COPD, HTN,

depression and 40 pack-years of smoking, however he successfully quit 2 years ago. You provide outpatient treatment for COPD exacerbation and discuss screening lung CT with him at today's appointment. He agrees to the study.

One month later you receive an electronic radiology report notable for new apical lung mass, with follow up recommended. Though your regular practice is to phone patients with abnormal imaging results, you ask your offices' secretary to make an appointment with EC and his wife as soon as possible to discuss the findings. At the appointment, EC tearfully asks whether "it's cancer" and how he might proceed. After providing supportive listening regarding EC's stressors (he worries about leaving work and disappointing his children), you explain that at this time you will be completing a referral to oncology for further testing. You explain specialists will manage testing moving forward, however you will have access to these records and continue to provide chronic care for his other medical conditions. At this time EC and his wife voice understanding and wish to make the oncology appointment as soon as possible.

Diagnosis

One week later you again receive an electronic copy of the oncology note showing that EC has been diagnosed with small cell lung cancer via bronchoscopy. Per the oncology note, he has been offered chemotherapy and radiation, and currently is considering his options at home with his wife. You would like to once again bring EC into the office for a discussion, however you see that he has been assigned a Care Coordinator RN, so you first reach out to the oncology office via electronic inbox/ phone call with the following queries:

1. Prognosis for EC with or without treatment, treatment options
2. Clarify roles – what will the oncologist be taking over? Oncology states they prefer to manage pain and nausea, but that further cancer screening, hypertension, smoking cessation and depression should be managed by PCP
3. Introduce yourself to care manager- clarify what support groups and social resources oncology office offers and what family physician offers
4. Establish best route of communication for future questions: you state direct messaging via electronic inbox is best for you, oncology states that paging RN is best for them

After communication is established, you document this encounter in EC's chart so others can reference it and update his problem list, carefully adding the cancer care plan and care manager contact. At this time, you once again ask for EC and his wife to be scheduled in the office with you.

At EC's first visit after his diagnosis, he has many questions he forgot to ask his oncologist, and you are able to answer him with some confidence regarding general options for his treatment plan. His mood has declined significantly since his diagnosis, so you provide information for a community cancer support group, and discuss medication and talk therapy options for depression. You are able to bring in your practice social worker for a brief intervention during the encounter. You discuss EC's preferences for further follow up at your office, and he requests to be scheduled monthly while "this is all playing out."

Follow Up

EC elects to undergo chemotherapy and radiation and continues to present to your clinic to discuss his progress and for depression monitoring. On several occasions he complains of fatigue and nausea, and via

a page to the oncology RN, you are able to start EC on an improved nausea regimen that day in your office. EC stops work one year after his diagnosis due to increased weakness, and while he achieved some regression in tumor size with oncology he eventually elects to stop treatment, and several months later requests home hospice. Your office completes the referral and care coordination, and three years after diagnosis EC passes away at home in accordance with his wishes.

Helpful Tips for Family Medicine Physicians for Patients with Cancer

- Patient expectations and reality of practice are out of sync: clearly state your goals for involvement and limits of your expertise, as well as areas you plan to assist and collaborate
- Discuss possibility of care extending further than the clinic visit- if available, including home and after-hours care
- Support/counseling surrounding cancer diagnosis- provide it as you are able, and be familiar with community support resources
- Ask for specific role from cancer team- pain management, specific follow up plans in written or verbal form- phone calls work best
- Establish a "hotline" or point person for contact with oncology team for warm handoffs
- Collect community resources for cancer patients and their families
- If appropriate advocate for discharge to FM care for follow up if low risk with specific instructions

Clinical Parameters to Divide Amongst Teams/Discuss at Each Visit

- Family coping, systems of support
- Pain, nausea, sleep, mood, nutrition status
- Screen for catastrophic complications of therapy: neutropenic fever, spinal cord compression, hypercalcemia, tumor lysis et cetera

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An Update in Psycho-Oncology

By Edward T. Carey; Bennett Wechsler; and Kamalpreet Buttar, MD

Case

Mr. R. was a patient in his 60s with end stage prostate cancer, admitted to our service with severe constipation. He failed numerous previous treatments with systemic therapy and his ultimate prognosis was poor by the time he reached our floor. Accompanying his malignancy, there were clear signs that his diagnosis was weighing on him and negatively affecting his life. In addition to his flattened affect during rounds, he expressed anxiety about what the “next steps” were in his treatment and their possible outcomes.

For our patient, his primary diagnosis was clear and confirmed via pathology. What remained less clear cut were the existential worries, guilt, and depression that often plague cancer patients like him. Mr. R's mood changes could be understood in the context of his cancer diagnosis, but what muddies the etiology of his mood symptoms includes the fatigue that many patients with cancer have due to their fast-growing tumors, extensive surgeries, radiation, and toxic chemotherapy. This is especially true in patients with metastases, as systemic disease and treatment often cause extreme fatigue.¹ Primary or secondary brain cancer can cause a wide variety of symptoms, including anxious and depressive states, body dysmorphia, and psychosis.² Some cancers also cause paraneoplastic Cushing's syndrome and hypercalcemia, which can produce a variety of psychiatric effects.^{3,4}

Understanding the emotional roller coaster that cancer patients often endure can be difficult, and treating them even more so. Adjustment disorder is at the top of the differential diagnosis for Mr. R's emotional distress. Adjustment disorder is defined by the DSM-5 as “the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).”⁵ These patients have a change in function after a major life event, such as a divorce, job loss, or in Mr. R's case, a cancer diagnosis. Another possibility for Mr. R is major depressive disorder, which is a common mood disorder seen in cancer patients. The side effects of chemotherapy, radiation, and surgery should also be considered as confounders for psychological symptoms cancer patients are facing, as all of these can cause extra emotional and physical stress on the patient. Furthermore, recent research has shown the impact “financial toxicity” can have on patients as they undergo treatment, as money is just one more thing they have to worry about.⁶ There is a wide range of distressing emotions that cancer patients can display on being given their cancer diagnosis. This can range from mild anxiety and depression, to less frequently, suicidal ideation and attempts.^{7,8}



Epidemiology

A study by Derogatis et al. (1983)⁹ found that adjustment disorder is the most common psychiatric diagnosis in cancer patients. In 215 cancer patients screened for psychiatric diagnoses, 47% met criteria. Of these, 68% of patients had adjustment disorder. This diagnosis is significant, as it can progress to suicidal depression, impact function, and worsen mindset as treatment continues. Unfortunately, what Mr. R is showing is common and important to treat in this population. Straker echoed these findings in his 1998 paper¹⁰, as well as adding some depth to the stages of grief and despair patients express after receiving their diagnoses. In it, he finds that the first phase of cancer care is diagnosis, which is often met with shock and disbelief, and accompanied by feelings of guilt. Often, highly active and healthy patients see this as unfathomable, that their life of healthy habits did not pan out as planned. Additionally, many patients with unhealthy habits, such as smoking, can feel guilt and shame on top of the distress of their diagnosis. However, many patients were buttressed by hope and social support during this stage, with some even having increased survival time after diagnosis when compared with peers.¹⁰

Akechi et al. (2004)¹¹ found risk factors for psychiatric complications after cancer diagnosis included lower initial Karnofsky performance status index scores, concerns about being burdensome to family, and insecurities about available social support. Thorsteinsdottir et al. (2017)¹² found that patients who had uncertain cure, uncertain prognosis, and unclear possible side effects were more prone to psychiatric distress. This echoes Mr. R's concerns of uncertainty, which is clearly a multifaceted and common concern in cancer patients. Furthermore, this corroborated Akechi et al.¹¹ and posited that poor health prior to diagnosis was a risk factor. They also found that younger age (under 55), cancer related pain, and alcohol abuse

were also risk factors for depressive and intrusive thoughts. These are risk factors that should raise flags for clinicians who may want to screen these cancer patients for symptoms of depression and/or suicidality.

Medical Treatments and Results

Patients with psychiatric complaints alongside their cancer diagnosis have many options for potential treatment. It is important for cancer patients and their care teams to find the right solution to match the patient's concerns, comorbidities, cancer diagnosis and prognosis.

Selective serotonin reuptake inhibitors (SSRIs) are very common in the treatment of anxiety and depression in the general population, as well as in cancer patients. However, physicians and patients must be aware of side effects, especially interactions with chemotherapy agents, and other drugs that cancer patients may be taking.¹³ Because many of the SSRIs ultimately impact the cytochrome P450 system, they have the potential to alter the metabolism of a large swath of chemotherapy agents. Citalopram and sertraline would be a good choice to use in cancer patients, as they have the most minimal effect on the P450 enzymes.¹⁴ Fluoxetine and paroxetine, on the other hand, have the most significant effects on these liver enzymes¹⁴, and may want to be avoided in these patients. Serotonin-norepinephrine reuptake inhibitors such as duloxetine can be particularly helpful in cancer patients suffering from chronic or neuropathic pain, as well as mood symptoms, as these drugs have efficacy with both conditions.

Razavi et al. (1996)¹⁵ compared 45 patients who received fluoxetine to 46 controls and found that patients receiving fluoxetine showed significant improvement in both depression and anxiety symptoms in 5 weeks of treatment. Although a small study, this demonstrates the positive effects that SSRIs can have for anxiety and depression in treating cancer patients, albeit the unfortunately long amount of time that they need to take effect. Laoutidis et al. (2013)¹⁶ found that SSRIs not only help in clinical depression but their meta-analysis found a significant improvement in psychiatric symptoms in those with cancer and subclinical depression. This analysis further supports the safety and efficacy of SSRIs in the treatment of cancer related mood symptoms. SSRIs and SNRIs are not the only options available for clinicians. Moss et al. (2006)¹⁷ offered 21 cancer patients open label bupropion, and their patients demonstrated significant improvement in depressive and fatigue symptoms.

Many patients with advanced cancers and poor prognosis are also afflicted with existential distress, often leading to their anxiety or depressive symptoms.¹⁸ Receiving or processing a fatal diagnosis can elicit thoughts that life was or is purposeless, and can often

trigger spiritual concerns.¹⁹ In patients with these feelings, a recent study by Griffiths et al. (2016)²⁰ has shown potential of the classic hallucinogenic drug psilocybin in mitigating end of life anxiety and depression, with 80% of patients showing clinically significant reductions in mood symptoms after a single treatment with the drug in a controlled setting. The degree to which the patient responded positively to the medication was directly related to the self-reported scores on a "mystical experience" questionnaire, indicating that it may be the experience itself that is eliciting relief. While this type of research is still in its infancy, studies like Griffiths show the potential that an induced mystical experience could have on terminally ill patients.

Ultimately, although clinicians may not be able to fully cure a patient's cancer, there are many effective pharmacotherapeutics that can be used to treat and help alleviate the associated distress.

Psychotherapy Treatments and Results

Many patients with a new cancer diagnosis feel as though they have no one to talk to about this complex and emotional topic.²¹ Some find that peers in the community, and family members either do not know enough about cancer or shy away from such emotionally charged and difficult conversations. Moreover, cancer patients find it difficult to describe their daily and broader challenges regarding their diseases.²² As a result, they often feel they need to keep their diagnoses secret from friends and family.²³

Many patients are very future focused, and harp on the uncertainty inherent in their diagnoses. Some may, for example, hang on to whether this is the last Mother's Day, Thanksgiving, or anniversary they will celebrate. It can be helpful for counselors to suggest patients take on their diagnosis and uncertainty one day at a time. Clinicians can help patients identify what is important to them and what goals they have. For example, a clinician can focus treatment on getting patients to achieve specific goals, such as attending a family wedding, a golf outing or a vacation. This can help restore focus, purpose, motivation, as well as reduce uncertainty.

Similarly, it is also common and reasonable for patients to express a "loss of control." Supportive and empathetic listening and counseling can be helpful in patients with these complaints. Clinicians can help patients identify areas of continued control, those that are uncertain, and those beyond our reach. Once these areas are identified, clinicians and patients can tailor and go about treatment keeping these in mind.

Group therapy can also be helpful for these patients, as it can show them they are not in their fight alone. It can help patients feel comfortable with peers who understand their challenges and worries and allow patients to draw upon group strength and use resources, tips,

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and tricks their peers have found helpful in managing the stresses of cancer care. Classen et al. (2001)²⁴ demonstrated the effectiveness of group therapy in this population. 125 women with metastatic breast cancer were enrolled in this study, with 64 randomized to weekly supportive-expressive group therapy for 1 year, and 61 randomized to control with standard care. Those who underwent group therapy demonstrated greater decline in stress symptoms and total mood disturbance.

Individualized psychotherapy has also been found to be particularly helpful in cancer patients. Brief courses of CBT were found to significantly improve emotional symptoms over standard treatment in those who were suffering from physical and mental distress from melanoma. These results were long lasting, and had significant impact on well-being up to 6 months after therapy ended.²⁵

Survivorship

With advanced diagnostics, chemotherapy, immunotherapy, and advanced surgical techniques, patients are living with cancer for longer periods than in the past. The trauma of the experience of cancer diagnosis and treatment, and the uncertainty of total “cure,” often leads to a fragile sense of stability. Somatoform complaints that arise from anxiety about their malignancy returning, are common in these patients who have survived longer with the disease.²⁶

Mitchell et al (2013)²⁷ used a 43 paper meta-analysis of cancer survivorship literature to demonstrate similar but slightly contrasting findings. They found higher rates of anxiety than depression in cancer survivors and their spouses. Anxiety was seen in 17.9% of 48,000 cancer survivors ($p=0.0039$, relative risk 1.27). Depression was found in 11.6% of 51,000 survivors. Rates of depression and anxiety were similar between cancer patients and their spouses, and both were higher than in the general population. This demonstrates the toll cancer takes not just on patients, but on their families as well, which must be considered in clinical care.

Conclusion

These findings demonstrate sizable existing and new challenges for the cancer care community and for cancer patients. More cancer centers are recognizing these unique problems, and are establishing psycho-oncology, palliative care, and survivorship programs to help care for cancer patients throughout and after their bouts with cancer. Many have found that through these centers, healing continues long after the last infusion or last radiation treatment.

Further research and follow up needs to be done to better understand the psychosocial concerns of long term cancer survivors, and how to best address these issues. Additionally, more research can be done on identifying and treating patients with high risk of psychological distress. One potential research focus might

address how the presentation and underlying pathophysiology of psychiatric symptoms in cancer patients differs from those patients with depression who are not affected by cancer diagnoses. We are hopeful that the field of psycho-oncology evolves and is integrated into primary care practice, as the number of people surviving a cancer diagnosis with resultant emotional tolls increases.

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Upcoming Events

2018

November 11
Fall Cluster Board Meeting
Hilton Westchester, Brook, NY

2019

January 17-20
Scientific Assembly/ Winter Weekend
Hyatt Regency, Rochester, NY

March 17-18
Winter Cluster and Lobby Day
Renaissance Albany Hotel, Albany, NY

RE M I N D E R : 2018 Meaningful Use Registration for Public Health

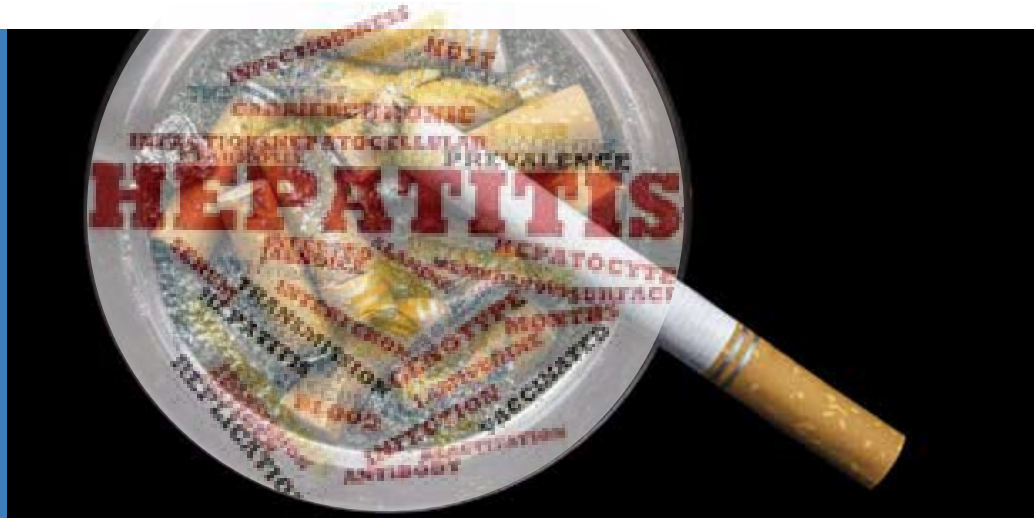
In order to meet the 2018 Meaningful Use Public Health Reporting requirements for the NY Medicaid EHR Incentive Program, providers must complete their registration of intent in the Meaningful Use Registration for Public Health (MURPH) System. Registration of intent must be completed before or within 60 days of the start of the provider's 2018 EHR reporting period.

The last 90-day EHR reporting period available in 2018 is October 3, 2018 - December 31, 2018. Therefore, the final day a registration of intent may be submitted for that period is December 1, 2018.

Note: Only one registration is required. If you previously completed your registration in MURPH, then you do not need to submit a new registration. You may edit an existing registration as necessary.

More information about Meaningful Use Public Health Reporting, including webinars, MURPH registration guides, and FAQs are available at www.health.ny.gov/ehr/public-health. For additional assistance, please contact program support at 1-877-646-5410 Option 3 or MUPublicHealth-Help@health.ny.gov.

Effect of Tobacco on Progression of Hepatitis C to Hepatocellular Cancer



By Rashmi R. Bhuyan, MD;
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Ana Maria Emeh, MB, BCH, MPH

Overview

Our study evaluated the occurrence of hepatocellular cancer (HCC) in patients infected with hepatitis C virus (HCV) among smokers and non-smokers in a family medicine clinic in a teaching hospital located in New York City. A relative risk of developing HCC is calculated as 2.713 with 95% confidence interval of 0.085 to .716 among smokers vs. non-smokers.

Introduction

Hepatocellular cancer (HCC) is the leading cause of cancer-related death worldwide.¹ Fujiata et al. shows that cigarette smoking is associated with significant increased risk of HCC only among anti-HCV positive cases.² In the United States, there are 20,000 new cases of HCC each year and, hepatocellular carcinoma related to HCV infection has become the fastest rising cause of cancer related deaths.³ Subsequent risk of HCC persists even after patients with chronic HCV infection are treated with direct-acting anti-viral agents (DAA) and sustained virological response (SVR) is achieved.⁴

According to a New York State report from 2016, 2.4% of New York City residents older than 20 have hepatitis C which equates with approximately 146,500 people.⁵ There is marked variability in the severity and

progression of liver disease in different patients with HCV infection, and this variability is not clearly explained although host, viral and environmental factors have been suggested.⁶ Although smoking has been shown to cause liver injury in rats due to oxidative stress and lipid peroxidation, the additive effect of tobacco on liver after hepatitis C infection (Figure 1) has not been well studied clinically.⁶ According to a Surveillance, Epidemiology and End Results (SEER) Medicare database study for the period 1993-2005, there is a documented increase in infectious hepatitis related increase in HCC, however the recent increase of HCC incidence by 20-50% cannot be fully explained.⁹ The racial/ethnic variation and geographic distribution of the disease epidemiology is quite variable.⁹ Another population-based SEER registry shows that the overall annual age-adjusted incidence rate of HCC has doubled from 1.4 per 100,000 in 1975-77 to 4.8 per 100,000 in 2005-07, and the greatest recent increase in incidence was seen in Hispanics and Blacks among ages 45-65 years.¹⁰ A study on the impact of smoking on histological changes of the liver shows a clear relationship between daily tobacco consumption and the severity of histological activity in patients with chronic hepatitis C.⁷

Methodology and Statistical Analysis

This study was a retrospective cohort study conducted at Fulton Wellness clinic in the family medicine department. The

population under study was from a multi-cultural significant poverty-stricken urban area, comprised mostly of Africans and Hispanics, in South-Bronx of New York. Participants were retrieved from My Patient Portal, already with predefined HCV in the database, and data was collected retrospectively for the last 10.5 years. The pre-requisites were age of more than 18 years and any history of HCV infection past, or present. Once the prerequisites were met, the health record was retrieved from the database and, added to the subject list. The end-point (hepatocellular cancer) was obtained from Bronx-care hospital Allscripts EMR system, searched with ICD 10 code C22.0, C22.9, B18.2, or 573.9. The HCV positive status is defined as positive HCV RNA PCR test. Tobacco use status was recorded from the history in the patients' charts, as verbally reported by the patients in numbers of cigarettes per day. The average retrospective follow-up period was 10 years.

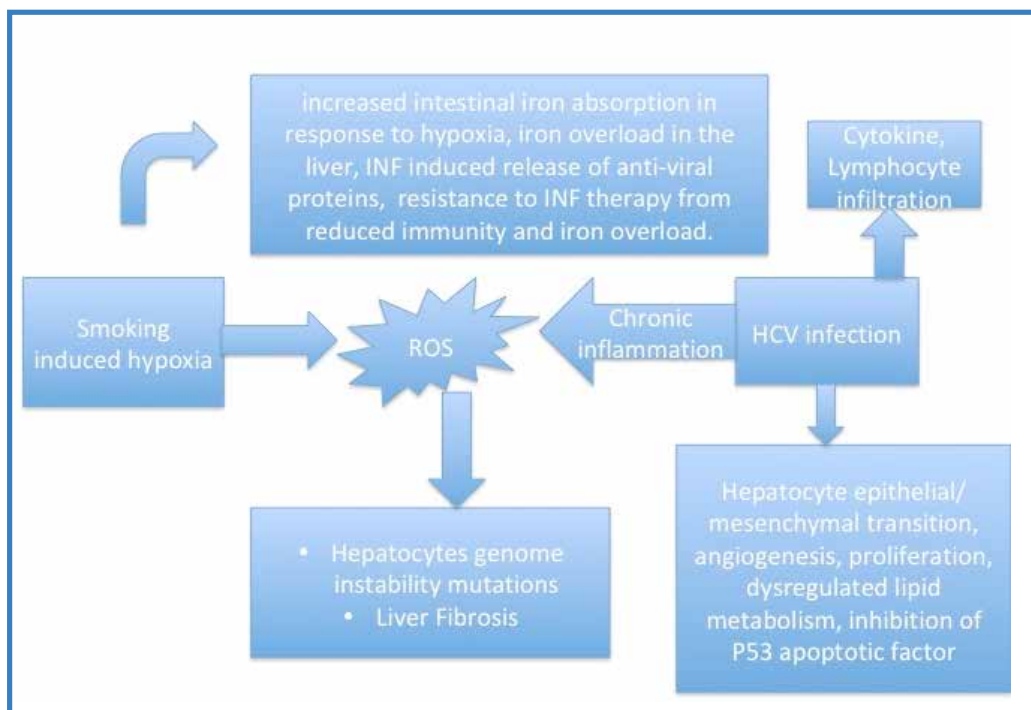
Table 1 below illustrates presence of HCV infection and HCC in different age groups of patients, in men and women, in different demographics, and in smokers, depending on the number of cigarettes consumed.

Results are expressed in means (SD) and percentages. A contingency table was constructed from all HCV positive cases following from 2007 to 2018. Fisher's exact test was conducted using the contingency table in StatCrunch software to calculate the P value. P value of <.05 is considered to be significant. Relative Risk (RR) is calculated from the contingency table, and is presented at the 95% confidence interval.

Figure 1: Additive Effect of Smoking and Hepatitis C Infection on the Pathogenesis on Hepatocellular Cancer.^{7,8}

ROS=Reactive Oxygen Species

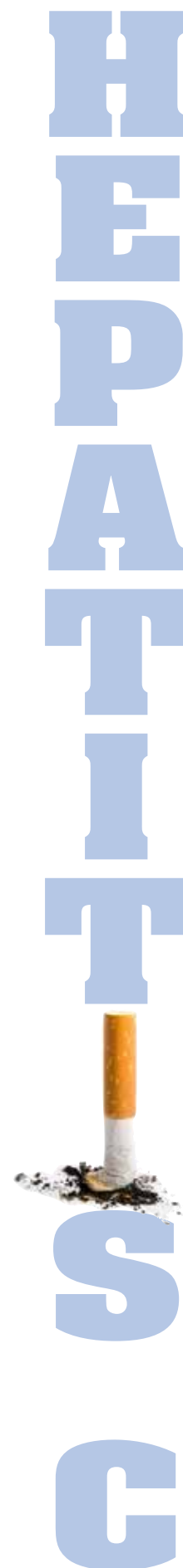
INF=Interferon



Axley et al. (2017) and El-Zayadi-A (2005)

Table 1

Baseline characteristics of 32 patients infected with chronic HCV infection and 16 patients infected with HCV and having diagnosed with hepatocellular can		
Characteristic	Patients infected with HCV	Patients diagnosed with HCC
Age groups in years	55.52 (SD 11.15)	67.4 (SD 8.7)
Sex: Men (%)	21 (65.6%)	10 (62.5%)
Women (%)	11(22.5%)	6 (37.5%)
Ethnicity/Race		
Non-Hispanic Black	13	5
Non-Hispanic White	2	2
Hispanic	4	4
Arabic origin	1	0
Other races (not specified in medical chart)	11	5
Recent smoking history (cig/day)		
0	10	3
<10	3	3
>10	19	10



continued on page 36

Results

The 2×2 contingency table with Fisher's exact test is presented in Table 2. The P value here is .0359, which is statistically significant ($<.05$), supporting the alternative hypothesis that cigarette smoking does have effect on the progression to HCC from HCV infection.

Table 2: Contingency Table Results

Rows: var1

Columns: None

	HCC positive	HCC negative	Total
Smoker	12	7	19
Non-smoker	3	10	13
Total	15	17	32

Fisher's exact test

P-value = 0.0359

Relative Risk (RR) is calculated as 2.731 with a 95% confidence interval of 0.085 to 0.716 (Table 3), indicating 2.731 times increased risk of HCC in the smoker group infected with HCV than the non-smoker group infected with HCV.

Table 3

Two sample proportion summary confidence interval:

p1 : proportion of successes for population 1

p2 : proportion of successes for population 2

p1 - p2 : Difference in proportions

95% confidence interval results:

Difference	Count1	Total1	Count2	Total2	Sample Diff.	Std. Err.	L. Limit	U. Limit
$p_1 - p_2$	12	19	3	13	0.40080972	0.16093995	0.085373213	0.71624622

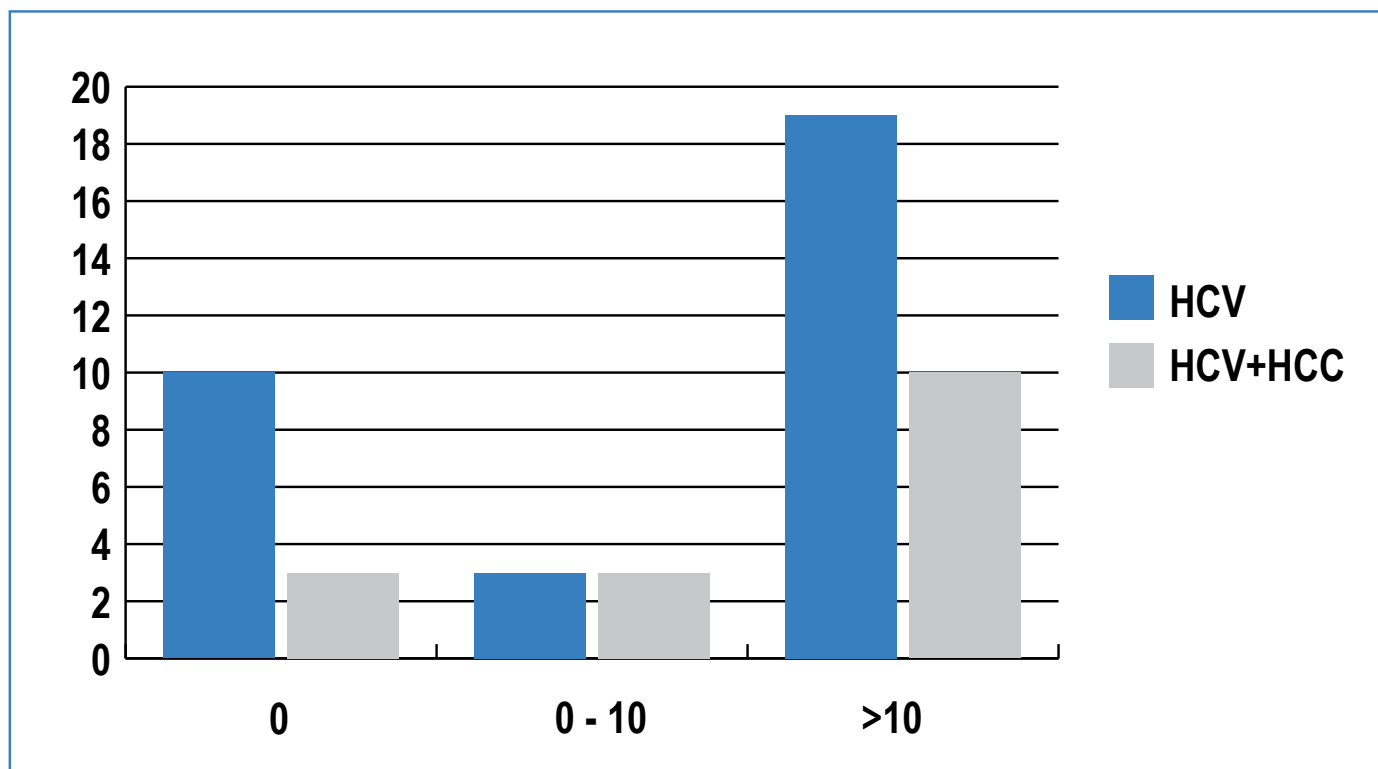
Discussion

This study clearly shows relationship between tobacco consumption and hepatocellular cancer both in males and females in patients infected with HCV. Indeed, the percentage of patients progressing to HCC from HCV infection is 63.15% among smokers (>10 cig/per), whereas the percentage of the same among non-smokers (0 cig/day) is 23.07% ($p = .0359$). Since tobacco smoking is associated with certain socio-economic and cultural factors, the study is limited to some specific demographic profiles. Potential confounders of the study are environmental factors, such as alcohol consumption, use of illicit drugs, presence of other infections associated with that behavioral group, such as HIV and hepatitis B, other co-morbid conditions and genetic pre-disposition. Inclusion and exclusion criteria were used to overcome the confounders. The total number of subjects included in the study was 100. The inclusion criteria used were adults above 18 years of age having positive lab results for HCV RNA, present and past tobacco smokers, and receiving a confirmed

diagnosis of HCV by liver biopsy. The exclusion criteria were having diagnosis of HIV, co-existing HBV, and having alcohol dependency. Many cases were dropped from the experimental group because of the presence of co-existing HIV, or HBV infection and history of consumption of alcohol.

A study in 2008 reported synergy between cigarette smoking and HCV in men in the etiology of HCC.¹¹ At present there are a very limited number of existing studies that establish a definite association of smoking with HCC. Additional studies are required to address the influence of tobacco smoking clinically on the both the rapidity of progression from chronic hepatitis to HCC and the actual occurrence of HCC. Our study showed that daily smoking could aggravate the pathogenesis of HCC in HCV infected patients. Additional studies are needed to test the role of cigarette smoking as an inducing agent for HCC in the presence of HCV infection.

The following bar diagram was constructed showing the number of patients developing HCC among patients infected with HCV in three different categories of smokers: 0, <10 and >10.



Endnotes

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Jose Tiburcio, MD, MS, FAAFP is Associate Chair and Program Director at BronxCare Health System Family Medicine Residency, Bronx, NY. He completed a HIVMA Fellowship in HIV/Hepatitis C and has been treating Hepatitis C since 2004.

Ana Maria Emeb, MB, BCH, MPH is a research assistant at BronxCare Health System.

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Winter Weekend 2019 Schedule

NYSAFP Scientific Assembly (Winter Weekend) is January 17 – 20 in Rochester, NY. The program has both clinical and office management content and is worth approximately 18 credits. Topics include: diabetes, sports medicine, medical marijuana, depression, HIV, and Nexplanon training. A hands-on workshop welcomes medical students as they practice injections, suturing and casting. Residents, students and attending physicians are welcome to submit a proposal for the annual poster presentation. The planning committee is excited to announce Dr. Gary Morsch as the plenary speaker on Saturday. He is a family and emergency physician and a founder of Heart to Heart International; he has received several awards for his humanitarian work including the President's Volunteer Action Award. Go to www.nysafp.org to see the complete schedule and to register.

FRIDAY, JANUARY 18, 2019

– TRACK A –

7:45am – 8:45am

HIV: Lessons from the Epidemic of Our Time – Dr. Chris Murphy
Presentation objectives:

Understand bias in the face of the unknown Speak to the three objectives for ending the epidemic: 1) Dx. and Treat 2) Prevention 3) PrEP Understand the science behind U=U

8:45am – 9:45am

Update on Miscarriage Management - TBD

10:15am – 11:15am

Cook Book Travel Medicine – Dr. Phil Kaplan

Presentation objectives:

Demonstration of tools for assembling and providing a travel plan for your own patients

11:15am – 12:15pm

Type 2 Diabetes Pharmacotherapy: Patient-Oriented & Evidence-Based – Dr. Josh Steinberg

Presentation objectives:

1) physicians will know the patient-oriented criteria by which medications should be chosen; 2) physicians will learn what the evidence shows for each of the 10 categories of diabetes medications 3) physicians will learn how to choose medications based on evidence-based patient-oriented criteria and patient factors

2:45 – 3:45pm

Newborn Screening – Dr. Bob Ostrander

3:45pm – 4:45pm

Sports Related Concussion – Dr. Christine Persuad

Presentation objectives:

Diagnose SRC - Manage SRC; Treat SRC; Know when to refer

– TRACK B –

7:45am – 8:45am

Understanding and Treating Alcohol Use Disorder as a Family Disease – Dr. Marianna Worczak

Presentation objectives:

Understand the current scope of alcoholism in the US, Discuss and use current screening and treatment recommendations for alcoholism, Understand the impact of alcoholism on family members, Develop strategies for treating alcoholism as a family disease

8:45am – 9:45am

Sports-Related Concussions – Dr. Christine Persuad

Presentation objectives:

Diagnose SRC - Manage SRC; Treat SRC; Know when to refer

10:15am – 11:15am

Patient-Centered Contraception for Adolescents: Updates on the Evidence – Drs. Kelita Fox, Kelly Kirkpatrick

Presentation objectives:

1) Discuss rates of unintended pregnancy and contraceptive use in teens 2) Apply evidenced-based guidelines to contraceptive provision using the CDC medical eligibility criteria. 3) Provide contraceptive options using a patient centered model

11:15am – 12:15pm

HIV Prevention Update: The Role of Clinicians in Ending the AIDS Epidemic – Kelly Farrow

Presentation objectives:

Discuss New York State clinical guidelines for pre- and post-exposure prophylaxis (PrEP, PEP); Review best practices for family medicine providers implementing PrEP and PEP in their clinical practice

2:45pm – 3:45pm

Medical Marijuana in New York State – Drs. Elizabeth Loomis and Jocelyn Young

Presentation objectives:

1. Understand NYS law around medical marijuana 2. Understand process of becoming certified to certify patients for medical marijuana in NYS 3. Identify clinical conditions that could benefit from medical marijuana 4. Understand the evidence for medical marijuana in the above clinical conditions and possible side effects

3:45pm – 4:45pm

Type 2 Diabetes Pharmacotherapy: Patient-Oriented & Evidence-Based – Dr. Josh Steinberg

Presentation objectives:

1) physicians will know the patient-oriented criteria by which medications should be chosen; 2) physicians will learn what the evidence shows for each of the 10 categories of diabetes medications 3) physicians will learn how to choose medications based on evidence-based patient-oriented criteria and patient factors

– TRACK C –

7:45am – 8:45am

Newborn Screening – Dr. Bob Ostrander

8:45am – 9:45am

The Intersection of Genetics and Primary Care – Dr. Melanie Leu

Presentation objectives:

Recognize more genetic conditions and genetic contributions to presentations and patient care

10:15am – 11:15am

Treatment for Hepatitis C: New Tests, New Drugs, and New Recommendations – Dr. Anthony Martinez

Presentation objectives:

Describe epidemiological trends of hepatitis C (HCV) in New York and key populations; Discuss laboratory testing and diagnosis of HCV infection; Design a therapeutic regimen and monitoring plan for the treatment of HCV

11:15am – 12:15pm

What's Causing My Older Patient's Memory Loss? – Ian Deutchki, MD

Presentation objectives:

Distinguish between normal age-related changes in memory and changes more likely to be pathologic. Identify patients with cognitive changes related to depression that are likely to have co-morbid dementia. Define Mild Cognitive Impairment and recognize its significance as a potential precursor of dementia

2:45pm – 3:45pm

Patient-Centered Contraception for Adolescents: Updates on the Evidence – Drs. Kelita Fox, Kelly Kirkpatrick

Presentation objectives:

1) Discuss rates of unintended pregnancy and contraceptive use in teens 2) Apply evidenced-based guidelines to contraceptive provision using the CDC medical eligibility criteria. 3) Provide contraceptive options using a patient centered model

3:45pm – 4:45pm

Depression Care for Children and Adolescents – Dr. Molly Scharf

Presentation objectives:

1) Be familiar with the screening recommendations for depression in youth according to the USPSTF 2) Be familiar with, and apply in assessing youth, the DSMV criteria for MDD 3) Gain comfort level with assessing the severity of depression and how to treat youth who are mildly, moderately, and severely depressed

6:00pm – 9:00pm

Nexplanon training (Additional pre-registration required)

SATURDAY, JANUARY 19, 2019

– TRACK A –

7:45am – 8:45am

Medical Marijuana in New York State – Drs. Elizabeth Loomis and Jocelyn Young

Presentation objectives:

Understand NYS law around medical marijuana 2. Understand process of becoming certified to certify patients for medical marijuana in NYS 3. Identify clinical conditions that could benefit from medical marijuana 4. Understand the evidence for medical marijuana in the above clinical conditions and possible side effects

8:45am – 9:45am

Shouting Doesn't Help – Dr. Baysa Herbert

Presentation objectives:

Use different communication strategies with patients who have hearing loss, using devices when hearing aids are not enough, referring to non-for profit educational organizations, awareness of the health priorities of patients with hearing loss to better care for them

10:15am – 11:15am

How to Speak to the Media – Dr. Grissom

– TRACK B –

7:45am – 8:45am

Bronchiolitis: Helping the Wee Wheezer – Dr. William R Sonnenberg

Presentation objectives:

Risk factors for bronchiolitis; Indications for aggressive treatment including hospitalization; Utilize comprehensive, evidence-based, and cost effective strategies for evaluation of bronchiolitis; Appropriate prevention strategies for children at risk ; Appropriate supportive care

8:45am – 9:45am

Teens & LARC: Fact, Fiction, and First-Line Contraception – Dr. Amy Potter

Presentation objectives:

Easily identify benefits and potential side effects of LARC methods for different patient populations. Determine the medical eligibility of LARC for different patient populations. Define reproductive justice

10:15am – 11:15am

Depression Care for Children and Adolescents – Dr. Molly Scharf

Presentation objectives:

1) Be familiar with the screening recommendations for depression in youth according to the USPSTF 2) Be familiar with, and apply in assessing youth, the DSMV criteria for MDD 3) Gain comfort level with assessing the severity of depression and how to treat youth who are mildly, moderately, and severely depressed

– TRACK C –

7:45am – 8:45am

New Models of Preconception & Interconception Care - Dr. Josh Steinberg

Presentation objectives:

On completion of this session, participants will be able to: 1) know the elements of preconception care 2) take advantage of broader opportunities back in practice to deliver preconception care 3) understand and join innovative models of preconception and interconception care

8:45am – 9:45am

Must Have Mental Health and Substance Use Screening Tools in Primary Care: Child/Adolescent – Dr. Katherine Warden

Presentation objectives:

Participants will leave the program with an understanding of the most common screening tools for mental illness and substance abuse concerns in children and adolescents and they will be able to practically incorporate those tools into their practice with the knowledge of how to administer and interpret the screening tools as well as what to do with the information once they have it

10:15am – 11:15am

Updates on Medication Abortion – Dr. Linda Prine

Presentation objectives:

Characterize the safety and efficacy of medication abortion provision in the family medicine setting; Counsel using current FDA guidelines for mifepristone; Identify patients who need additional evaluation with ultrasound prior to medication abortion; Identify the most common complications of medication abortion and appropriate management

– TRACK D –

Hands-on Student Workshop

GENERAL SESSIONS

11:15am – 12:00pm

MSSNY / NYSAFP Update – Drs. Marc Price, President, NYSAFP & Thomas J. Madejski President, Medical Society of the State of New York

12:00pm – 4:30pm

Lunch & Plenary speaker – Dr. Gary Morsch

Dr. Gary Morsch is a family and emergency physician and a founder of Heart to Heart International. He retired from the U.S. Army Reserve in 2012 with the rank of Colonel and has been deployed as an Army physician to Kosovo, Iraq, Kuwait and Germany. Dr. Morsch has received several awards for his humanitarian work including the President's Volunteer Action Award, the Points of Light Award, two honorary doctorate degrees, and was honored with the first Humanitarian Award from the American Academy of Family Physicians. An avid writer, Dr. Morsch has authored a handful of books focused on humanitarian work. He believes in the power of service and has dedicated his life to inspiring and mobilizing people to serve.

4:30pm – 5:30pm

Poster presentations & cocktail hour

SUNDAY, JANUARY 20, 2019

– TRACK A –

7:45am – 8:45am

The New Well Woman Visit – Dr. Heather Paladine

Presentation objectives:

Attendees will evaluate their own model for an updated, evidence-based preventive visit for women. Attendees will analyze preventive recommendations from different sources and be able to counsel patients on these recommendations. Attendees will be able to apply smartphone apps and online tools at the point of care to facilitate their preventive care for women.

8:45am – 9:45am

Nutrition – Amanda Ronzo

9:45am – 10:45am

BPH/LUTS – Drs. Flanagan & James Mumford

Presentation objectives:

Form a systematic approach to the diagnosis and treatment of BPH and LUTS in men.

– TRACK B –

7:45am – 9:45am

Student information session - Dr. Tochi Iroku-Malize



Past, Present & Future

Past, Present & Future

This year, because of the Congress of Delegates being held in New Orleans, I have had time to ponder who I am and what family medicine means to me. I have reflected on how the American Academy of Family Physicians has helped define our specialty to me.

I have been a member of the AAFP for almost 20 years. I started in residency (thanks to an astute program director, Dr. Richard Bonanno). Little did I know that signing the application form as a first year resident would help shape my work as a family physician. When I began residency, the medical records were on paper and we used beepers in the hospital. The iPhone did not exist and our social gathering was in the resident's lounge and later in the doctor's lounge (when I became an attending). I was allowed to take my time to examine a patient and was able to get a detailed history that would help inform my diagnosis.

As a practicing physician early on, I was able to care for my patients in my office, the hospital, the nursing home/rehab and in their own homes. I maintained privileges in all of these sites and knew the staff and colleagues by site. I could do curbside conferences with people over coffee and met up with colleagues at CME events locally or nationally.

As time progressed, the development of hospital medicine slowly pushed family medicine physicians outside the hospital walls and new regulations and requirements meant they had to document in a new manner via the electronic medical record. Writing turned to clicks and our chairs faced the computer by day and our beds housed our laptops by night. Payment changed based on the data entered into clouds and sometimes fines were imposed far after we knew what they were for.

But through it all, our Academy has worked to stay abreast of the times. Offering resources in tool boxes that they were not sure would still be valid based on external forces, year to year. Adjusting our CME programs to accommodate virtual meetings and online learning; CDs became MP3s and animated YouTube videos took the place of DVDs. Through it all, our Academy also had to step up the game of advocacy to ensure that our colleagues could survive the brunt of their independence being stripped away and their shoulders needing to bear a heavier financial burden from our inefficient health care system. Our Academy had to help us maintain our certification when the American Board of Certification for Family Medicine (ABFM) changed the rules mid-play.

And so, we are here today with the our Academy at a tipping point – well known as a voice in health care within political circles but not quite there in terms of capitalizing on this new role. For tomorrow – we will need to fully embrace reform that will help restore our autonomy and empower our patients. We may have to think outside the box and find ways to create venture products to offer our members. Products like scribes, certification, collective bargaining and opportunities with different payor sources for graduate medical education. We are going to have to find a way to prepare our new doctors for patients who will not come into the office (telemedicine) and may send us their DNA report as part of their family history (precision medicine). We could bury our heads in the sand, but our specialty has yet to back away from the unknown. We usually set precedence.

So the challenge is this, how do we continue to honor the past and protect the present while creating our future? By always remembering that collectively our specialty has been built on patient-physician relations. We need to ensure that advocacy protects our ability to care for any patient, anywhere, anytime. And we must seize the opportunity to create the space in which techno-medicine requires our presence to be successful.

It requires boldness.

We're family medicine.

#WeveGotThis

Tochi Iroku-Malize, MD, MPH, MBA



Tochi Iroku-Malize, MD, MPH, MBA, is the inaugural chair of family medicine at Northwell Health and professor and chair of family medicine for the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell. She has been involved in numerous leadership capacities with NYSAFP and the AAFP since her residency years, serving as a past president of NYSAFP, and currently as the alternate delegate from New York to the national Congress. Dr. Iroku-Malize has worked for over the past three decades on clinical, research and academic initiatives to enhance health and equity for providers and patients across various communities locally, nationally and internationally, and has been active in advocacy work on behalf of the Academy in both Albany and DC for over a decade.

The NYSAFP is pleased to share the following news from the AAFP Congress of Delegates recently held in New Orleans:

NEW YORK CANDIDATE ELECTED TO AAFP BOARD OF DIRECTORS AAFP DELEGATES CHOOSE NEW LEADERS FOR 2018-19

The AAFP Congress of Delegates elected Gary LeRoy, M.D., of Dayton, Ohio, to be the Academy's president-elect. Others elected or chosen by acclamation for the following positions are

- Speaker of the Congress -- Alan Schwartzstein, M.D., of Oregon, Wis.
- Vice Speaker -- Russell Kohl, M.D., of Stilwell, Kan.
- Directors -- James Ellzy, M.D., M.M.I., of Washington, D.C.; Dennis Gingrich, M.D., of Hershey, Pa.; and **Tochi Iroku-Malize, M.D., M.P.H., M.B.A., of Islip, N.Y.**
- New physician Board member -- LaTasha Seliby Perkins, M.D., of Alexandria, Va.
- Resident Board member -- Michelle Byrne, M.D., M.P.H., of Chicago
- Student Board member -- Chandler Stisher, of Brownsboro, Ala.

Congratulations Dr. Tochi Iroku-Malize!

Experience Bassett

Work, Lead, Learn, Grow



Family Medicine MD/DO

Bassett Healthcare Network strives to help each of our Primary Care Providers develop a practice mix that allows them to reach their professional goals. As a major teaching affiliate of Columbia University, Bassett offers unique opportunities for its providers. We are seeking a full-time Family Medicine MD/DO to join our progressive health care team.

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- ◆ Monday—Friday 8:00 AM—5:00 PM practice
- ◆ No Weekend Calls—PA/NP Coverage
- ◆ Group Employed Model
- ◆ Comprehensive Benefits Package
- ◆ No OB
- ◆ EPIC EMR
- ◆ Teaching Opportunities
- ◆ NYS Loan Forgiveness Programs

With its abundance of recreational and cultural pleasures, central New York provides a great place to live for both individuals and families. The surrounding areas have an abundance of lakes, streams and mountains that form the Catskill Mountain Range and the Adirondack State Park.

Bassett's primary care practices are NCQA Patient-Centered Medical Home, Level 3 Recognized practices or pursuing recognition as new health center sites.

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phone: 607-547-6982
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web: www.experiencebassett.org



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4th Annual Writing Contest

Please enjoy the last of our four winning entries from our 2018 writing contest:

Episodes - Now and Then

By Robert Morrow, MD

South Bronx – 2/2018: Driving on the Concourse to a meeting of a coalition of community based organizations. Passing 168th, it looks the same as 1974, cars even bigger. Traffic of course, street construction as I head to Hostos Community College. I have a triggered flash back to:

9/1974 – 168th St. - Morrisania Hospital-open wards, people largely getting better, some die. The heroin epidemic moving through like carpet bombing, like napalm. Rousing people my age from the dead with naloxone. Some drug treatment available, but methadone still considered immoral by most, a continuation of addiction. Very young doctors with very little supervision. Fires and community anger. Very dirty floors, very little sleep.

One night at 3am I manage the impossible. I can go to a call room to sleep, walking through steam tunnels with huge cats with luminous eyes watching, on rat patrol. In the elevator, a large mass of bees on the ceiling.

I ride four floors, get out, sleep til 7am. Were the bees a dream? In the elevator, the door opens on the floor covered with crawling dying bees. Maybe the exterminator had fogged them. I take the stairs.

In the cafeteria, a quick breakfast, no one talking. I asked my call team, quietly, ‘ah...did anyone see the bees?’ They wake up and chatter: ‘yeah, wow, what was that all about?’ I am relieved, not a dream. I never again get to go back to the on-call room.

10/1974 – Another night with a sick patient all night, needs emergency cardiac care. I ride in an ambulance with the patient, with him, at dawn, 6 miles uptown to Montefiore. It seems so quiet and clean, spacious and orderly. Not like when I was an intern there, two months earlier. Then the four-bedded rooms, the two patients in the TV room and halls filled with patients seemed crazed. What a difference with the perspective of working in a South Bronx hospital! I feel disheveled, confused after a troubled sleepless night. Angry. Dismayed. Helpless.

11/1974 – I recall another night when an elderly Latino gentleman appeared off the elevator in septic shock to Morrisania at 168th, with a big mass on his chest wall full of infection. Swollen face. How did this happen? He didn’t have a doctor or money. He was delirious for days, filled with fluid. We worked and worked and he got better, and was wheeled in a chair out of the hospital to rehab some weeks later.

A month after his exit, as I walked through the hospital, a dapper bearded man walked up to me to say hello, and smiled broadly. He had indeed gotten better, and was thankful. I was astonished, and thanked him.

Not like the baby with meningococemia who despite our efforts became more and more mottled and quiet, and died in a few hours.

2/2018 – when I drive past Crotona, I always think of Harry. As a medical student, without the school’s knowledge, I plunked myself down in the teen drug unit, every Tuesday afternoon for three years [I would tell any supervisors that I had to see patients in my clinic, which was true]. Harry taught me about counseling and street life, never opening up about his own heroin history. He lived on Crotona. He died ten years later there of a drug overdose, so I’m told.

3/1974 – going for an interview for residency in one of the nation’s first neighborhood health centers. I ride the subway to the Bronx from East Harlem on the Third Avenue El, now gone. The rattling train rained bolts on the street, the wicker seats were worn and ripped. Ceiling fans not working. The borough was badly burned already, with worse to come, and I felt like I was flying in low to Berlin after WW2, devastation all out my window. The rattle of old steel wheels and grind of bends evoking a rough landing.

I had hoped to go to a progressive residency in Seattle, and leave NYC. Nope. I didn’t navigate out of the event horizon around the singularity of the Bronx. Hawking and his radiation didn’t help. I was profoundly...disappointed. Four years in medical school in East Harlem was not to be the end of my NYC valley of disparities.

6/1977 – having almost finished my residency, I walked from my old VW to go to a meeting at a health center. In those days of hope I had an Afro and a leather jacket. So I shouldn't have been surprised when a police car pulled up to me on the street and a cop pointed a gun out of the car window at me.

'What's under your coat!!!'

I slowly raised both hands, tilted my upper body sideways to reveal my belt, and said in my best white Yalie accent: 'It's my beeper.'

The cops burned rubber and did a u-turn and left me with hands up.

That has been the only time in 48 years that my wellbeing was threatened in the Bronx.

February 2018-my non-academic non-career continues in the Bronx and contiguous South Yonkers. Perhaps 100,000 patient visits later, 15 or so national academic publications, 4 kids, 2 grands, 1 wife.

Working with professional-community coalitions, fighting for prevention and equity. Not a small part of the corporate slow hurricane of health 'systems' flooding our country. Enjoying 37 years of independent practice as part of a community.

The Hostos meeting is warm and exciting, with planning for health equity and a heard voice for the Bronx communities. I am welcome.

I don't miss Seattle.

Bob is a family practice physician in independent practice since 1980 in the Bronx. Bob has been involved in leading community based, patient centered research involving coalitions of stakeholders and patients. He has a research interest in continuing education in the health professions, and has published several research articles on education and networking as a tool for improved patient outcomes. He currently is collaborating with Health People [a community-based peer education organization], QTAC [The Quality and Technical Assistance Center of NY] of the State University of NY at Albany, the Yonkers YMCA, and several others to bring diabetes self-management to the South Bronx and Yonkers, using linked networks of community coaches, academic detailers in health teams, and public health implementation experts.



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