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Family Doctor

A JOURNAL OF THE NEW YORK STATE ACADEMY OF FAMILY PHYSICIANS

FEATURE ARTICLES:

New York State Academy of Family Physicians

Focus:

Controversies in Family Medicine

Breakfast After the Bell:

Fighting Food Insecurity

School breakfast can help children meet their nutrition recommendations. This may be especially true for the 1 in 6[1] children who live in a household faced with food insecurity.

Success starts early! With Breakfast After the Bell.

To help our nation's children whose households have limited access to adequate food, we are committed to increasing student participation in School Breakfast Programs.

Collectively we will work together to:

- **Increase awareness** of the impact School Breakfast Programs can have on nutrition security, diet quality and student health.
- **Provide resources** to empower schools to champion school breakfast.
- **Inspire families** and communities to embrace school breakfast.
- **Empower children** to take action to help increase access to breakfast in their schools.
- **Support initiatives** to move Breakfast After the Bell for better participation.

Maryland Academy of Family Physicians

NHMA National Hispanic Medical Association (North East and Metro Region)

National Medical Association (Region 1 and Region 2)

American Academy of Pediatrics Speaking for Maryland Kids! Maryland Chapter, American Academy of Pediatrics

New Jersey Academy of Nutrition and Dietetics

mand Maryland Academy of Nutrition and Dietetics

NYSAND New York State Academy of Nutrition and Dietetics

Delaware Academy of Nutrition & Dietetics

School Nurse Delaware School Nurse Association

DCMAND DC Metro Academy of Nutrition and Dietetics

MASHN Advocating for Excellence in School Nursing

New Jersey State School Nurses Association Leading, Teaching, Caring.

New York State Academy of Family Physicians

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN NYS AAP The NYS AAP is a Coalition of AAP NY Chapters 1, 2 & 3

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN New Jersey Chapter

AmericanDairy.com

[1]U.S. Department of Agriculture Economic Research Service. Household Food Security in the United States in 2015

YOUR MILK COMES FROM A GOOD PLACE

AMERICAN DAIRY ASSOCIATION NORTH EAST

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

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

Editor: Penny Ruhm, MS

Articles

Departments

Index of Advertisers

From the Executive Vice President

By Vito Grasso, MPA, CAE

The Trump administration's effort to establish a legal definition of sex (gender) under Title IX of the federal civil rights law represents disturbing evidence that political extremism is a serious threat to the fundamental principles of our democracy.

In October, the NY TIMES reported that the Department of Health & Human Services (DHHS) was leading an effort to establish a legal definition of sex under Title IX of the civil rights law. Title IX prohibits discrimination in education programs that receive federal funding. The TIMES reported that a DHHS memo argued that gender should be defined in explicit and uniform terms as determined on "a biological basis that is clear, grounded in science, objective and administrable." The agency proceeded to suggest that gender should be determined by the genitals a person is born with and that any dispute regarding someone's gender would be clarified through genetic testing.

It is unclear, to me at least, what the purpose of this definition is or why a definition is necessary in the context of application of the Civil Rights Act. Title IX was conceived to protect people against discrimination and sex was simply one of several identifying factors which were named to accommodate application of the protections afforded in the statute. The Civil Rights Act prohibits various forms of discrimination based on race, color, religion, sex or national origin. The various titles of this legislation expand the parameters of the law but apply those parameters to these same designated classes of people. Each class is clearly intended to apply generally to all members of that class. Race means anyone of any race. Religion means anyone of any religion. There is no exception made for sex that would narrowly apply the term to only some people, nor is there any requirement in the law that a standard be used to determine who qualifies for inclusion under each classification. Why, under the law, should biology be the standard for determining someone's sex while no standards are identified for determining someone's religion, race, color or national origin? The Civil Rights Act was enacted as a broad and inclusive statute to protect people. The Trump administration would have that spirit reversed by applying a definition of one protected class for the sole purpose of excluding people.

It seems, from a political perspective, that the impetus for the attempt to exclude transgender people from the protections of the Civil Rights Act is to appease that element of the ideological political spectrum which cannot countenance the idea that people are and have the right to be different. Isn't the purpose of this legislation to protect people against discrimination? Why is it offensive that this landmark legislation which has been a hallmark of American decency and egalitarianism, is a shield against discrimination for transgender people?

Why, under the law, should biology be the standard for determining someone's sex while no standards are identified for determining someone's religion, race, color or national origin?

President's Post

By Marc Price, DO

We are a diverse bunch. We are divided on many, if not most controversial medical issues. Whether it's medical marijuana, medical aid in dying, gun control, birth control, breastfeeding, single payer, induction of labor, issues related to our LGBTQ members and patients, Democrat versus Republican, Coke versus Pepsi, Mets or Yankees, Jets or Giants, "human sacrifice, cats and dogs living together – mass hysteria" - we'll never agree completely on every topic (kudos to whoever can name the movie of that last quote). You may be in the minority or you may be in the majority. And though we may never agree on how it should happen, I hope we can agree on one thing. We all want better healthcare for our patients and our communities.

The interesting thing I find is that when we disagree we actually become stronger. That's right, you read that correctly - when we disagree we become stronger. By having civil discussions between ourselves and others on crucial issues, we are better able to come to a compromise with which both sides typically are either equally happy or equally unhappy. And while these discussions and deliberations often take place during our Congress of Delegates, other meetings of the NYSAFP, the AAFP or other constituent chapters, they also occur around the dinner table, at the local watering hole, in the exam room with your patients or with your loud, know-it-all aunt or uncle at a family holiday meal. Sometimes listening to someone else's beliefs gets us upset and ignites our passion, but sometimes listening to an opposing opinion can enable us to understand the other point of view and the motivation behind their beliefs. That understanding can lead to more thoughtful and intelligent debate. And can better serve us when we speak to others outside the NYSAFP, to defend our established priorities and positions among other medical societies, our national AAFP and our elected officials.

I'm constantly impressed by the persistence and the passion of our members. I've witnessed resolutions put forth during our Congress, hotly debated and then not adopted. Many times during breaks, I see the person who most vigorously opposed the failed resolution speaking with its creator and discussing ways to improve it to be something they may be able to both support the following year. It's that willingness to compromise, that eagerness to help someone else understand their views and to learn from it that is important for the growth of our Academy. Without it, we would never move forward.

I think the trait to create harmony and educate is directly related to our profession. As family physicians, we are constantly trying to convince others of something, whether we realize it or not. We're trying to convince patients that our recommended course of action is the best option. We're trying to convince insurance companies that the drugs or tests we order are essential. We're trying to convince our staff of the most efficient means of caring for our patients. We're trying to convince government and other payers of the value of family medicine. We're trying to convince legislators to address the social determinants of health. We're trying to convince the public about the benefits of vaccines and how to live healthier. And in our efforts we are constantly battling misinformation, mountains of paperwork and stoic beliefs which may not match our own. It's one or the reasons why in 2014, the AAFP adopted their stance of "no more family medicine nice!" It's comforting to know that those hard fought debates within our own organization to develop policies on tough issues, could assist us in our efforts.

I'm glad that we don't shy away from tough topics and feel comfortable enough to speak our minds. I'm glad the NYS Academy fosters dutiful leaders who are comfortable voicing their opinions whether they are in the minority or not. I'm glad I had such wonderful mentors within my career and the Academy who demonstrated the principles of respectful debate and lead by example. And I'm glad that when I look at the next generation of physicians eager to serve our members, I'm comforted in the knowledge that the New York State Academy will be in good hands moving into the future. I'm honored to serve our members and I'm proud to be a member of the NYSAFP.

Legalizing THC – It's Not Marijuana Anymore

By William Klepack, MD

New York State is considering legalizing "marijuana" at the time of this writing. But in reality it is contemplating legalizing the principal psychoactive component of marijuana, which is tetrahydrocannabinol (THC). THC gives people the recreational effects they seek. The difference between THC and what we used to know as "marijuana" is significant. For the sake of our patient's health it is important to make this clear to them.

This article will argue two points. First that THC must be regulated properly. Second that we practitioners should: be knowledgeable about the difference between THC and marijuana, talk about the differences with our patients (even if legalization does not occur), and lastly use the term THC in our discussions for reasons I will make clear.

Legalized "marijuana" is not the marijuana people knew and used in the 1970s when it was 2-3% THC. The plant itself has been changed and today is upwards of 20% THC. Much of the market, though, is for products that are 30 or more times this strength (up to 98% THC). To use the term "marijuana" makes many consumers think of that plant of yesteryear and plays into the hands of corporations marketing the chemical. Although often perceived as being completely safe the new commercial "marijuana" is relatively poorly studied (studies of THC have been mostly of concentrations 16% and lower).[1-3] Research is emerging however, that the route of the drug (e.g. edible vs inhalant) and the product's THC concentration have important health implications.[4,5]

From studies we also know marijuana affects developing minds. Our minds are known to develop from in the womb into our early 20s (and indications are even longer). Use of marijuana affects the ability to learn and remember –important for our patients trying to graduate from school, learn a new job, get promoted, succeed at college and perform well at work.[6] THC specifically affects the parts of the brain responsible for memory, learning, attention, decision-making, coordination, emotions, and reaction time.[7]

Even more alarming, THC also alters brain development anatomically. When marijuana users begin using as teenagers or before, the drug not only may reduce attention, memory, and learning functions but also affects how the brain builds *connections* between the areas necessary for these functions. These effects may last years and be permanent.[7-9] THC's impact depends on many factors and varies between persons. Important factors are the THC concentration in the product that one uses, how often it is used, the age of first use, and whether other substances (e.g., tobacco and alcohol) are used at the same time.

Data indicate THC has fetal effects. Use by mothers *during pregnancy* may be linked to problems in their babies with attention, memory, and problem-solving skills after birth.[9-13] In addition, THC babies are more likely to be underweight and possibly require intensive care after birth.[1,3]

These facts support the argument that, like alcohol and tobacco, THC must be carefully regulated. New York State should define the maximum concentration of THC that is prudent for public health and it should put out warnings about its adverse health effects when used by pregnant moms, kids and young adults or when used inappropriately by adults. The legal age for consumption should be set to avoid THC's worst effects and at an age when one expects a person's judgment can help mitigate risks.

Careful Regulation is further supported by the fact that THC has become big business in states where legalization has occurred. Big tobacco and big alcohol have invested billions.[14] Past experience with big tobacco has shown what happens when corporatization of a substance occurs. In Colorado they have marketed THC in forms and concentrations far beyond what is prudent for public health (in my opinion) and beyond what has been studied. Like our experience with tobacco these corporations will likely stay within the law but, in effect, market to our children and young adults in their aggressive pursuit of profit. Also in Colorado THC has been applied to gummy bears, sold in packaging attractive to young people and sold without childproof safeguards.[2] Unfettered industry has shown (yet again) that it sees profit in creating products that are attractive to younger age groups. Advertising has been rampant and the general implicit message is that THC is safe when in fact, we know otherwise.

To be clear, I believe there is much positive to say about legalizing THC. People of color have suffered from marijuana laws disproportionately, the black market product is often impure and of variable concentration, and it is liberally available to young people and adults. Legalization would help to remedy many of these problems. The New York State Department of Health issued a report in July of 2018 that concluded the net benefit is in favor of legalization, in part due to the already extensive penetration of THC in our population.[15] The report did not address the rules and regulations NYS would use to control the THC market. Such rulemaking would follow legalization. My understanding of the legislation being proposed is that marijuana would be folded into the regulatory framework that is used for alcohol.[16]*

Full discussion of all THC issues is beyond

the scope of this article. My main point is that proper regulation of THC and THC-like cannabinoids is essential. By us advocating this as individual practitioners and through our Academy's advocacy we will be performing a service for our patients. A critical part of the rulemaking process will be for us to write the agencies involved and submit testimony at public hearings advocating that the product must be properly regulated in form, concentration and packaging as well as marketing practices and advertising.

Finally, from what I have said I hope you agree that the terms "marijuana" and "THC" convey decidedly different connotations. Marijuana (or cannabis) serves as a relatively euphemistic term for corporations seeking to expand their markets and profits since the word conjures up images of the plant of yesteryear, while "THC" evokes the reality that a chemical is being produced and sold. Chemicals deserve to be carefully regulated. If NYS required via regulation that the term THC be used in advertising rather than marijuana or cannabis, it could help to convey that important message.

Our patients are now getting THC from other states and on the black market and are not likely to be conversant with the information I have given you. By helping them connect the dots between marijuana and THC we may help them adopt healthier behaviors. In my discussions with people now I quickly go from using "marijuana" to explaining that it is really about "THC" and why that is important. I believe it is time we all did so.

*Governor Cuomo initially had included "marijuana legalization" in his budget proposal. This provision was dropped from the final budget but is expected to be a subject of debate in the legislature in this session.[16] Your Academy will be following developments in this area.

Endnotes

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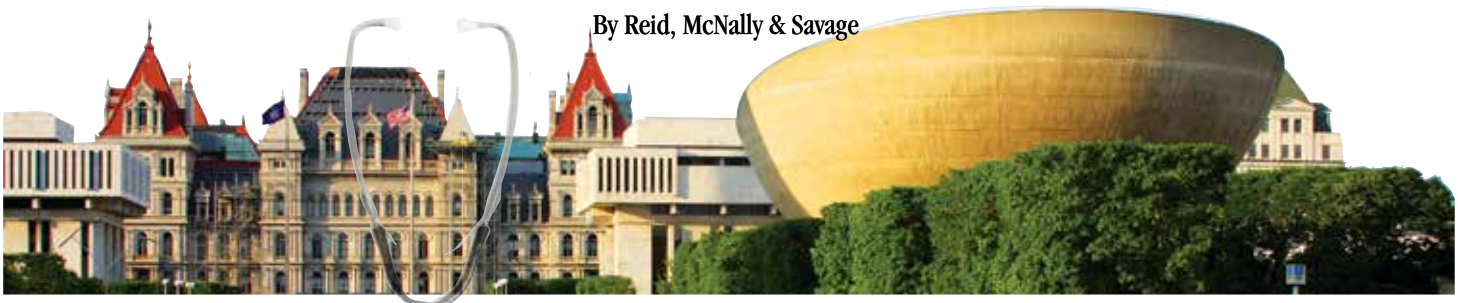
William Klepack, MD *is on the editorial board of Family Doctor. The views expressed in this article do not necessarily reflect the views of the Board or NYSAFP. He was in private practice for more than 40 years and continues as a medical director of his local health department where he has served for 28 years.*

Albany Report

By Reid, McNally & Savage



As the Academy prepares its spring journal, we have just completed another highly successful lobby day for NYSAFP and the focus in Albany is almost exclusively on state budget negotiations with a goal of reaching an on-time budget by April 1st.

Governor Andrew Cuomo released his SFY 2019-20 Executive Budget on January 15th totaling over $175 billion. On February 15th, the Governor also released 30-day budget amendments including additional proposals he claimed were needed to address a $2.3 billion budget gap that had recently been identified. In mid-March, the Senate and Assembly released their respective, one-house budget bills both responding to the Governor's proposals and staking a claim to priority items that they would like to see funded or otherwise included in the budget this year.

Following the release of these bills, both houses started to convene in joint budget conference committees to discuss and hash out their own differences. Three-way negotiations with the Governor begin with a goal of reaching an on-time budget by the constitutional deadline of April 1st- the start of the new fiscal year. After many years of late budgets, Governor Cuomo has made an on-time budget a priority and this year is not likely to be different.

Following our recent NYSAFP lobby day, we have outlined the key budget proposals that we thought would be of particular interest to Academy members and included the action taken by the Senate and Assembly on each in their one-house bills. **All are now subject to the ongoing three-way negotiations taking place in Albany**. We will provide further updates to NYSAFP, once the final bills have been passed and a budget for the next fiscal year is enacted. Please visit www.nysafp.org for an updated budget chart.

NYSAFP 2019 Lobby Day

Under the leadership of President Dr. Marc Price and Advocacy Chair Dr. Rachelle Brilliant, the 2019 NYSAFP lobby day on Monday, March 18th was a great success. Nearly fifty participants traveled to Albany to visit with their own State Senators and Assembly Members as well as legislators in key leadership positions, certain bill sponsors and other targeted legislators who are essential to achieving the Academy's goals.

Four budget items were identified as priority topics for the lobby day, as well as four legislative measures. These are summarized as follows:

Lobby Day Budget Priorities

- NYSAFP's support for the Governor's proposal to include a primary care rate increase under Medicaid to bring up to 100% of Medicare levels within three years (funded by reducing reimbursement for hospitals for avoidable admissions)
- NYSAFP's support for the Governor's proposal to include $127,400,000 in funding for the Excess Medical Malpractice Program
- NYSAFP's support for the Governor's proposal to include $4,705,000 for the physician loan repayment program and $4,360,000 for the physician practice support program as part of Doctors Across New York
- NYSAFP's opposition to the Governor's 30-day budget amendment to impose an across the board (0.8%) reduction on all Medicaid claims

Lobby Day Legislative Priorities

- NYSAFP's support for universal healthcare coverage through a single payer health system inclusive of rights for physicians to collectively bargain with the payer as well as limitations on the use of prior authorization *(New York Health - S.3577, Rivera / A.5248, Gottfried)*
  Status: Assembly Codes Committee/ Senate Health Committee *Note, this has passed the Assembly in the last four years
- NYSAFP's support for the Physician Protection Act to ensure physicians are protected against assaults in the workplace similar to other professionals *(S.1903, Funke/ A2460, Joyner)*
  Status: Assembly & Senate Codes Committees
- NYSAFP's support for expansion of childhood vaccinations by repealing non-medical exemptions from vaccination requirements for children *(S.2994, Hoylman/ A.2371, Dinowitz)*
  Status: Assembly & Senate Health Committees
- NYSAFP support for ensuring that all vaccines administered to adults in New York are included in the statewide and city immunization registries similar to pediatric vaccines *(S.4494, Hoylman/ A.Gottfried- bill to be introduced)*
  Status: Assembly & Senate Health Committees

2019 NYSAFP Lobby Day

SFY 2018-19 Executive Budget Proposals of Particular Interest to NYSAFP

SECTOR	INITIATIVE	EXECUTIVE	SENATE	ASSEMBLY
Multiple-Sectors	**Proposal**	**Executive Budget**	**Senate One House Budget**	**Assembly One House Budget**
	SHIN-NY	$30 million is allocated for the SHIN-NY. The funding is directed to the New York eHealth Collaborative, which will administer the funding for the SHIN-NY and Qualified Entities – formerly known as Regional Health Information Organizations (RHIOs).	Accepts	Accepts
	All Payer Database	Proposes $10 million for the operation of the All Payer Database (APD).	Accepts	Accepts
	Medical Marijuana Program	Proposes $9.8 million for the State's Medical Marijuana Program and relocates the program to the Office of Cannabis Management within the Division of Alcohol Beverage Control.	Rejects	Accepts
	Adult Regulated Cannabis Program	Establishes a regulated adult-use cannabis program and creates the Office of Cannabis Management (OCM) within the Division of Alcohol Beverage Control, creating a consolidated governance of adult-use, medical, and industrial hemp.	Rejects but commented in Resolution about general support and need for some modifications	Rejects
	Women's/ Reproductive Health Proposals	Includes the following proposals in Executive Budget: Comprehensive Contraceptive Coverage Act Codify Roe v. Wade/ Reproductive Health Act into State Law Establish Maternal Mortality Review Board	Rejected since RHA and CCCA already passed; Includes maternal mortality proposal	Rejected since RHA and CCCA already passed and working on maternal mortality as standalone legislation
	Universal Health Care Commission	Establishes a commission on universal access to health care to be supported by DOH and Dept. of Financial Services, and comprised of health policy and insurance experts to develop options for achieving universal access to high-quality, affordable health care in NY. This review process will consider all options for advancing access to care and would report its findings 12/1/19.	Rejects	Rejects
	Across the Board Medicaid Cuts	Includes a proposal to authorizes across the board reductions in Medicaid claims, with certain exemptions, for the period April 1, 2019 to March 31, 2021 to achieve reductions of up to $190.2 million in Medicaid state share savings in SFY 2019-20 and SFY 2020-21. An alternative method may be considered at the discretion of the Commissioner of Health and the Director of the Budget based upon consultation with the health care industry that achieves similar savings. The reductions will not impact payments required by federal law such a FQHCs, hospice or pursuant to the federal Medicare program, or direct payments authorized under the Mental Hygiene Law for providers under article 16, 31 or 32.	Rejects	Rejects
Physicians/ Healthcare Providers				
	Medicaid Primary Care Rate Increase	Proposes an increase to the practitioner fee schedule for both office and institutional places of service for the primary care codes (99201-99205 and 99211-99215) along with maternity and other high priority ambulatory. The goal is to increase from 40-50% of Medicare (where we are now depending on code and setting) to 100 percent of Medicare over three years (60 percent year one, 80 percent year two, 100 percent year three). This would apply to physicians, nurse practitioners and midwives. It would be funded through savings from cuts to hospitals for avoidable admissions.	Rejects	Rejects

continued on page 12

SFY 2018-19 Executive Budget Proposals of Particular Interest to NYSAFP

SECTOR	INITIATIVE	EXECUTIVE	SENATE	ASSEMBLY
	Excess Medical Malpractice Program	Extends the Excess program for one year through June 30, 2020 and includes level funding of $127.4 million.	Accepts	Accepts
	Doctors Across NY (DANY) Funding	Includes $9,065,000 in funding for physician loan forgiveness and practice support under DANY.	Accepts	Accepts
	Ban Conversion Therapy for Minors	Proposes to expand the definition of professional misconduct for professions licensed under the education law to include engaging in, advertising for, or allowing someone under one's direction or oversight to engage in conversion therapy with a patient under the age of eighteen years.	Rejects, enacted already	Rejects, enacted already
Pharmacy/ Pharmaceuticals				
	Medicaid Co-Payments	Increases the co-pay amount for non-prescription drugs and OTCs covered by Medicaid from 50 cents to $1; Gives DOH authority to modify the list of covered OTCs/non-prescription drugs.	Rejects	Rejects
	Prescriber Prevails	Eliminates prescriber's right of final determination in both Medicaid FFS and MMC allowing DOH to determine whether prescriber's justification for use is clinically supported.	Rejects	Rejects
	Pharmacy Benefit Manager (PBM) Regulation	Includes a detailed proposal to regulate pharmacy benefit managers (PBMs).	Accepts and Strengthens	Rejects, plans to do as standalone legislation
	Limitations on PBM Spread Pricing in Medicaid Managed Care (MMC)	Requires contracts between MMC plans and PBMs to be limited to the actual ingredient costs, a dispensing fee and an administrative fee for each claim processed to eliminate spread pricing.	Accepts and modifies	Rejects
	Opioid Excise Tax	Includes a proposal creating an excise tax on the sale of opioids which may be passed down to purchaser. The proposal is estimated to generate $100 million for the general fund.	Accepts; Suggests modifications in Resolution to protect consumers, hospitals, and treatment providers	Rejects
Public Health				
	School-Based Health Centers	Public Health funding for School-Based Health Centers is proposed at the same level as SFY 2018-19, a total of $17 million.	Includes $3.8 million in additional funding	Includes $3.8 million in additional funding
	Cancer Services Funding	Includes $19,825,000 in funding for evidence-based cancer services programs.	Accepts	Accepts
	Tobacco Control Program Funding	Includes $33,144,000 for the tobacco use prevention and control program and funding around administration of the program and tobacco control enforcement efforts.	Accepts	Accepts
	Cystic Fibrosis (CF) Program Funding	Includes $800,000 for the CF under 21 program.	Accepts	Accepts
	AHEC Funding	Includes appropriation of $1,662,000 for AHEC funding.	Accepts	Accepts
	Healthy Heart Funding	Includes appropriations of $506,000 and $186,000 for hypertension prevention, screening and treatment.	Accepts	Accepts
	Diabetes & Obesity Prevention Funding	Includes appropriation of $5,970,000 for diabetes & obesity funding.	Accepts	Accepts
	Spinal Cord Injury Research	Includes $8.5 million for spinal cord injury research.	Accepts	Accepts
	Type 2 Diabetes Prevention	Proposes to expand Medicaid to include coverage of evidenced-based prevention and support services recognized by CDC and provided by community-based organizations to persons at risk of developing diabetes.	Accepts	Accepts

SFY 2018-19 Executive Budget Proposals of Particular Interest to NYSAFP

SECTOR	INITIATIVE	EXECUTIVE	SENATE	ASSEMBLY
	Comprehensive Tobacco Policy	Includes the following proposals in Executive Budget: • Raises the minimum sales age for tobacco products from 18 to 21 • Prohibits the sale of tobacco products in all pharmacies or stores containing pharmacies • Restricts the sale of flavored e-cigarette liquids • Requires e-cigarettes be sold only by licensed tobacco retailers under Department of Tax & Finance • Restricts any discount or coupon provided by tobacco manufacturers and retailers • Restricts the visible display of tobacco products at retail locations • Prohibits smoking inside and on the grounds of all hospitals licensed or operated by the Office of Mental Health (OMH), as well as community mental health residences • Imposes a 20% excise tax on vapor products used in e-cigarettes. Is expected to generate $2 million in SFY 2019-20 and $19 million in subsequent years	Accepts	Rejects policies but accepts proposed tax on electronic cigarettes with some modifications; Assembly passed legislation to increase the tobacco purchase age to 21
	Reduce Lead Paint Exposure	Proposes to lower the blood lead level that constitutes an elevated lead level from 10 to 5 micrograms per deciliter. The proposal directs DOH to issue regulations establishing minimum standards for the maintenance of lead safe residential rental properties, including standards for maintaining painted surfaces and a schedule for maintenance. The proposal deems all paint on any residential rental property of which the original construction was completed prior to January 1, 1978 is presumed to be lead-based paint. The State invests $28.6 million towards addressing priority concerns related to childhood lead poisoning and prevention. Lowering the blood lead level is expected to drive an increase in inspections, which may generate up to $1 million in fines and penalties.	Modifies by: - Adding funding to assist municipalities in inspections and remediations of lead contamination - Requiring the Commissioner of Health to incorporate a lower threshold for elevated blood lead levels based on federal guidance - Requiring annual water supply statements to include information on all lead pipes located within a water system - Requiring municipalities to conduct testing of potable water supplies of parks	Rejects
	Reduce Reimbursement for NYC General Public Health Work Programs	Proposes to reduce State reimbursement for New York City public health programs above the State Grant from 36% to 20%. Currently NYS DOH reimburses counties for these costs with base grants and then covers 36% of the remaining costs.	Rejects	Rejects

continued on page 14

SFY 2018-19 Executive Budget Proposals of Particular Interest to NYSAFP

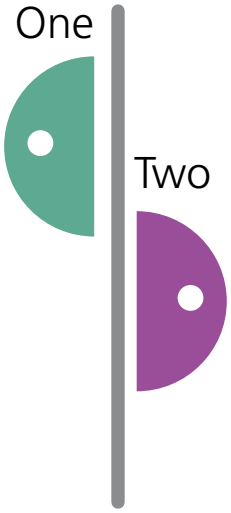
SECTOR	INITIATIVE	EXECUTIVE	SENATE	ASSEMBLY
Insurance				
	Behavioral Health Insurance Parity Reforms	Proposes a series of initiatives to increase access to BH services and enforce parity laws by: • Requiring minimum coverage standards; • Removing certain benefit limitations; • Prohibiting denial of medically necessary care; • Prohibiting multiple co-payments per day and requiring behavioral health copayments be equal to a primary care office visit; • Requiring insurance coverage of naloxone; • Prohibiting prior authorization for medication assisted treatment; • Prohibiting preauthorization and concurrent utilization review of SUD services during the initial 21 days of treatment (expanded from 14 days); • Prohibiting preauthorization and concurrent utilization review of inpatient psychiatric services for youth services during the initial 14 days of treatment; • Requiring MH utilization review staff to have subject matter expertise; • Allowing OASAS to designate a standard utilization review tool for in-State SUD treatment; • Prohibiting insurers from retaliating against providers that report insurance law violations to State agencies; • Requiring insurers to post additional detail regarding their behavioral health provider networks; • Requiring insurers to provide their most recent comparative analysis for insureds; Allowing OMH to review and approve clinical review criteria; and • Codifying parity standards in State law for both MH and SUD.	Accepts and strengthens	Rejects
	IVF Coverage	Mandates that large group insurance providers cover IVF and also requires large group, small group, and individual insurance providers to cover egg-freezing services for women with certain health conditions, including those undergoing cancer treatment.	Accepts	Rejects
	Applied Behavioral Analysis Coverage	Expands Medicaid to cover Applied Behavioral Health Analysis treatment for over 4,000 children with Autism Spectrum Disorders, including those that have aged out of the Early Intervention program. An investment of $6.4 million for SFY 2020.	Accepts	Rejects

SFY 2018-19 Executive Budget Proposals of Particular Interest to NYSAFP

SECTOR	INITIATIVE	EXECUTIVE	SENATE	ASSEMBLY
	Codification of the Affordable Care Act	Proposes to codify the federal Affordable Care Act in the State Insurance Law. Provision include but are not limited to: • Defining an essential health benefits package; • Providing authority for the Superintendent of Insurance to promulgate regulations to address covered preventive care services; • Expanding the guaranteed availability provisions for small and group coverage to include large group coverage and the requirement that health insurers offer and accept coverage for all employers in the State. • Prohibit insurers from imposing any pre-existing condition exclusions in policies. • Require insurers providing coverage for prescription drugs to publish their drug formulary and establish a process for an insured to request a formulary exception. • Prohibit insurers from discriminating based on sex, sexual orientation, gender identity or expression, transgender status, marital status and sexual stereotyping.	Accepts	Accepts
	Codification of the "NY State of Health" Marketplace	Proposes to codify in the Public Health Law, the "NY State of Health, the Official Health Plan Marketplace." The NY State of Health (NYSOH) was initially established within the Department of Health in 2012 through an Executive Order. The proposal defines the functions of the Marketplace including but not limited to: performing eligibility determinations for federal and state insurance affordability programs; certifying Qualified Health Plans; assigning an actuarial value to each Marketplace certified plan; standardizing the benefits available through the Marketplace at each level of coverage; maintaining an internet website through which enrollees and prospective enrollees may obtain information; setting minimum requirements for Marketplace participation; operating a toll-free telephone hotline through to respond to requests for assistance; operating a small business options program; and assisting eligible employers in qualifying for federal and State small business tax credits.	Accepts	Accepts
	Medical Indemnity Fund	**Extension and Movement** The program is extended until 12/31/20 and moved from DFS to DOH effective 10/1/19. **Programmatic Changes** Requires Qualified Plaintiffs to have a court order to be enrolled in the Medical Indemnity Fund. Plaintiffs qualified under the program will need either a court or jury finding that they have suffered malpractice as a result of a birth related neurological injury or have a settled suit for the same. **Acceptance of Payment and Rates** Mandates that health care providers accept the rates of payment established by the program.	Rejects	Rejects

VIEW ONE
NOT THE RIGHT OPTION

By Daniel Young, MD, FAAFP



As New York State moves closer to legalizing medical aid in dying (MAiD), physicians must think carefully about the role they will play. For more than 15 years Oregon has led the way in allowing physicians to write prescriptions for lethal doses of medications for patients who wish to end their life. Other states have more recently followed suit including Washington, California, Colorado, Vermont and Washington, DC. The involvement of physicians in this process has generated much debate, controversy and policy with no end in sight. The view taken in this article is limited to MAiD as defined as the practice of a physician providing a competent, terminally ill patient—at the patient's request—with a prescription for a lethal dose of medication that the patient intends to use to end his or her own life. Interestingly, advocates have pushed for the term MAiD rather than physician assisted suicide, which in my opinion perfectly describes the practice.

There is public support for MAiD as evidenced by a 2018 Gallup Poll.[1] In this survey 65% responded that assisted suicide should be allowed by law if the patient was incurable and in severe pain. The recent survey of physicians conducted by Compassion and Choice, a group that advocates for MAiD shows that a majority of New York physicians are in favor of making MAiD legal in New York.[2] In this survey it is interesting to note that although 34% strongly agreed with the legislation only 19% strongly agreed that they would be willing to write a prescription.

I believe that physicians should oppose legislation to make MAiD legal, and in states where it is legal physicians should use the opt out clause. This position is based on physician duty, morality and non-abandonment. There are medical groups that support this position. The American Medical Association's (AMA) code of medical ethics states "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life."[3] The AAFP endorses the AMA's code of medical ethics. The National Hospice and Palliative Care Organization opposes legalization of MAiD, while the American Academy of Hospice and Palliative Medicine takes a neutral stance.

Those that favor MAiD use the argument that the patient should have autonomy and control over the timing and circumstances of death. Again, this is the definition of suicide which is, in my opinion,

continued on page 17

VIEW TWO
PATIENT AUTONOMY AND THE LINE IN THE SAND

By Jocelyn Young, DO, MS

In our current healthcare system patient centered decision making has become a foundational component in providing good care. As family physicians, we strive to meet our patients where they are, understand their values, and work with them to reach their goals. This should extend through end of life decisions and should include medical aid in dying (MAiD) as an option for patients suffering from a terminal condition. This article will review the differentiation in New York State between what is considered acceptable end-of-life care and MAiD, as well as an opinion on why it can be considered an ethical addition to what we offer our patients.

In New York State there has been a line drawn in the sand regarding the end point of patient autonomy. Patients are able to choose which screening tests they would like, whether they want resuscitation efforts, and whether to end their life by stopping eating and drinking. They are however, not able to choose to hasten their inevitable death through MAiD whether it is a patient-directed, patient administered prescription medication or voluntary active euthanasia. There is strong evidence for patient autonomy in choosing screening tests. The United States Preventive Services Task Force (USPSTF) guidelines on prostate cancer screening are specific in stating that "before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinicians and to incorporate their values and preferences in the decision."[1] Similarly, it has been established that competent patients have the right to decline all efforts at resuscitation regardless of their health status, without taking into account whether the health care team agrees or feels morally comfortable with their decision.

Separate from MAiD, ethical and legal consensus already exists that patients do have the autonomy to potentially hasten death, via the spectrum of aggressive symptom management, withdrawal or withholding of life-sustaining measures, and the voluntarily stopping of eating and drinking (VSED).[2] Particularly relevant to the discussion of this arbitrary dividing line is the fact that there is consensus that discontinuing life support measures, such as the health care team actively removing an endotracheal tube, is acceptable.[3] Writing the prescription to allow for a patient to end their life on their own terms however, is not allowable in our state.

continued on page 17

inherently wrong. Often this argument is used as it relates to patients with unremitting pain and suffering. Both sides agree that excellent palliative care for patients at end of life is of the utmost importance. If in relieving a patient's pain and suffering death is hastened, then that is acceptable. Care of the living is acceptable whereas causing death is not. However, studies show that pain is not usually one of the top 3 reasons given for requesting MAiD.[4]

Another argument is non-abandonment. For advocates of MAiD, the physician's obligation to the patient extends to seeing the dying process through which outweighs any troubling ethics. Conversely, non-abandonment means continuing to do everything possible for the patient and that giving them the means to end their life is abandoning them in their greatest time of need. The physician-patient relationship is of the utmost importance and could be eroded if MAiD is legal. The patient may feel less confident that the physician is doing everything that is possible and that all options are available before requesting MAiD.[5]

When a terminally ill patient suggests a wish to die or asks for help, then a stepwise approach is helpful.[6] First clarify the request since often it is more nuanced than straightforward. Next, try to understand the motivation behind the request whether it is unremitting symptoms, loss of control or loss of dignity. Then affirm the physician's commitment to care for the patient and start addressing the patient's concerns. This may involve the help of social workers, care managers, community organizations and often, a palliative care consult.

There are good arguments on both sides of this issue, but our professional ethos to care for patients and do no harm outweighs the patient's desire to control the timing of their death. The increase in use of advance directives, powers of attorney and medical orders for life-sustaining treatment has demonstrated that patients are allowed control of how they are treated at the end of their lives. Yet the controversy around MAiD remains, and the idea of writing a prescription separates us from what is really happening. If there is to be legalized aid-in-dying, why must it involve physicians?

Endnotes

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6 Nowels D, Vandekieft G, Ballentine JM. American Family Physician. 2018 March 1. Curbside Consultation: Medical Aid in Dying.

Daniel M. Young, MD, FAAFP *is a graduate of and the Program Director at United Health Services Wilson Family Medicine Residency Program in Johnson City. He is Chair of the Department of Family Medicine at United Health Services Hospitals, the Director of the STD clinic at the Broome County Health Department, a member of the medical team for the Child Advocacy Center and is finishing his term on the board of trustees of the Medical Society of the State of New York.*

There is significant controversy surrounding MAiD. As an organization, NYSAFP has a policy stating that we "support the expansion of options for end-of-life care to include medical aid in dying by means of a patient-directed, patient administered prescription medication." Interestingly, we do not have policy commenting on other forms of MAiD, such as voluntary active euthanasia. The varying positions of other medical bodies draw attention to the difficult conversations around this issue. These range from officially opposed such as the American Medical Association and the American Academy of Family Physicians, to officially neutral in the case of the American Academy of Hospice and Palliative Medicine, to officially supporting such as the American Medical Women's Association[3,4] and the NYSAFP.

It is important to consider the ethical arguments being used against MAiD and why they may actually not be applicable. Two of the arguments employed in this way are the doctrine of double effect and the active/passive distinction. A thorough discussion of the counter point to these ethical arguments was published in 1997, and this seminal article remains relevant to this conversation today.[6] The following are the ideas from this work as they apply to the ethical challenges facing patient autonomy and MAiD.

The doctrine of double effect refers to the distinction between the intended outcomes of an action and the foreseen but unintended consequences. In other words, if the intent is good then it is acceptable to perform an action that has foreseen consequences that would be wrong to intend. This is particularly relevant to the consensus that exists around use of aggressive symptom management, such as opioids for pain control. In this example, the use of high doses of opioids to control pain has the potential to shorten the time until death, though it is not the intent of this action. Some argue that because MAiD has patient death as an intended consequence it should not be considered acceptable. Unfortunately, this view does not take into account that the intentions of the physician may be given more weight than the intentions of the patient. Additionally, it ignores the relevance of ongoing, refractory patient suffering which is a consequence of *not* providing MAiD as an option.

Where the line has been drawn in NYS between appropriate end of life care and MAiD is problematic when looking through the lens of the doctrine of double effect. Specifically, it raises an issue with the ethical acceptability of a physician following a competent patient's decision not to utilize or to discontinue life-sustaining measures.

continued on page 18

view two, continued *(Patient Autonomy)*

There are instances when this choice is made by a patient who can continue living for some period of time without life-sustaining treatment but others for whom the choice will bring foreseen and intended death. From this ethical vantage point, there is precedent that at times, death is an acceptable outcome.

The second ethical argument that is used to deny MAiD as an option is that of active/passive distinction. This suggests that active measures that hasten death are unacceptable but passive actions that achieve the same end are allowed. Using this argument to distinguish between palliative end of life care and MAiD as different entities is problematic. There is some consensus that terminal sedation is a passive measure because the administration of coma-inducing medication does not cause the patient's death, rather death results from dehydration. Similarly, when considering why terminal extubation is considered passive, one can conclude that although the team physically removes the tube, the patient actually dies from the underlying disease. When considering patient-directed, patient administered prescription medication as an option, it too could be argued to be a passive action since the patient dies by their own hand. Through this viewpoint MAiD, as defined by NYSAFP policy, falls into the same category as an already acceptable option at the end of life.

As is clearly noted in the seminal article, "the application and the moral importance of both the active/passive distinction and the doctrine of double effect are notoriously controversial and should not serve as the primary basis of determining the morality of these practices."[6] There is a conflict that exists for all of us caring for patients with intolerable and unmitigated symptoms at the end of life that are not responsive to even the most state of the art palliative treatments. This conflict exists between our ethical and moral duties and the need to not abandon patients with suffering refractory to treatment. Should the ethics, values, and autonomy of a competent patient count for less than a physician's intent?

Any discussion of care at the end of life, including this discussion in support of MAiD, should include a reminder of the well-rounded care that we must offer. We must provide our patients with excellent palliative symptom management and take the time to differentiate between depression or delirium and requests for a hastened death.[3-5] Suggested questions to better understand this include: "What are you most worried about?" and "Tell me more about exactly what frightens you." If a patient is already experiencing challenging symptoms, some guiding questions might be: "What makes your situation most intolerable right now?" and "Exactly how are you hoping I can help you?"[3] These questions can help to guide better symptom management and understand the patient's values and emotional state. What is important for us to remember is that for some suffering patients, even the best symptom management that is available may not be adequate and this should open the door for the discussion of MAiD.

MAiD should be an available option for patients with terminal conditions. Certainly there is the need for safeguards to protect patients at risk of coercion or treatable depression when considering MAiD; including informed consent, prognostication of disease, and possibly second opinions. We owe it to our patients to offer expanded options to alleviate their suffering, specifically including patient-directed, patient administered prescription medication, at the end of life.

Endnotes

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Jocelyn Young, DO, MS *is a fourth year Chief Resident at the University of Rochester/Highland Hospital Family Medicine Residency Program. She has special interests in resident education, end of life care, and addiction medicine. After graduation she will be joining the teaching faculty at United Health Services in Johnson City NY.*

Dr. Ani Bodoutchian, an author on both articles, was raised in Bulgaria and Lebanon and attended medical school in Mexico. She has experienced both single and multi-payer health care systems, as both a consumer and physician.

The views and opinions expressed in this article do not always reflect the viewpoints of the authors but rather are an attempt to overview the benefits of both multi and single-payer health care systems in New York State.

VIEW ONE
IN SUPPORT OF SINGLE PAYER

By Cean Mahmud, MD, MBA; Niharika Pasumarty, MD; Gurpal Dhanjal, MD; Ani A. Bodoutchian, MD, MBA, FAAFP

The New York Health Act (NYHA), is a major legislative initiative that has recently garnered renewed interest in changing the status quo in New York towards a single payer system with the healthcare platform of the Democratic Congressional majority.

Although initially introduced four years ago, the NYHA was reintroduced in the 2017-2018 New York legislative session as bills A.4738 and S.4840 in the Assembly and Senate respectively. The bill aims to introduce a universal single-payer plan that would expand and improve current healthcare for every New York resident, and would apply to all regardless of whether they are covered by Medicare, Medicaid, private insurance or are uninsured. Presumably this would decrease costs as compared to anticipated projections of the status quo. Despite passage in the Assembly, the bill languished in the Senate due to inadequate support. Given the shift in power in Albany to triple Democratic control of the NY Assembly, Senate and Governorship, the bill has regained momentum with the renewed interest in healthcare reform. As family physicians, the onus is on each of us to understand the proposed legislation and provide a voice to advocate for changes that are in the best interests of our patients and will preserve our ability to practice medicine for the years to come.

Without implementation of the New York Health Act, adhering to the status quo represents continued increased spending without direct improved outcomes as shown in Figures 1 and 2.[2] According to the

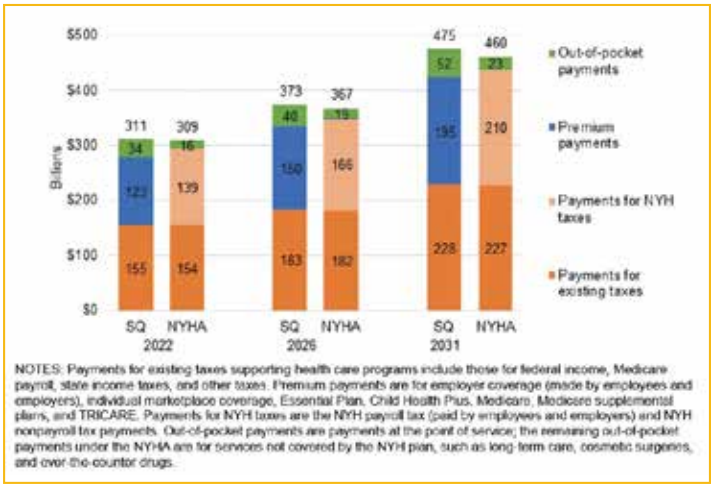

Figure 1: Health Care Spending Projections. Image from Liu et. al, 2018

continued on page 20

VIEW TWO
NOT THE SOLUTION

By Julio I. Hernández Rodríguez, MD; Wander Hurtado Martinez, MD; Ching Yeh Lin, MD; and Ani A. Bodoutchian, MD, MBA, FAAFP

As the cost of health care continues to rise, many countries are considering reforming their health care systems and deciding between single or multi-payer models.[1] In New York, there is proposed legislation, the New York Health Act (NYHA), which is the embodiment of a shift from our multi-payer model to a single-payer system. As a single payer model has never been implemented in the United States, the negative consequences of such a shift have not been fully considered. Upon careful scrutiny, we believe that the NYHA is not the solution to problems with our current healthcare system.

Since the early 1990s, this proposed legislation has been introduced annually to the state Assembly by Assemblyman Richard Gottfried. It has become a divisive political issue and the continual debate over the best way to finance the US health care system is at the forefront of the discussion once again. As the New York State Senate is now in Democratic hands, there is a significant possibility that this bill will be signed into law without full consideration of its negative consequences. The proponents of the bill use the RAND Corporation analysis to support this paradigm shift without fully considering the advantages of a multi-payer system. The NYHA's own fundamentals highlight concerns about its overall viability.

A compelling reason to continue to support a multi-payer system is advancements in innovation driven by competition, which lead to economic growth. Similarly, the competition between insurance companies works to drive down costs and meet diverse needs.[2] If innovation, technology and economic growth are not compelling enough to advocate for maintaining multi-payer, perhaps new taxes, decreased wages and hardships for families living in New York should also be part of the equation.

The RAND Corporation estimates that, assuming federal funds remain unchanged, New York State would need to increase its tax collection to 156% of what would be expected under the status quo to finance the new system under the New York Health Act.[3] This additional funding would originate from two new taxes: a NYH (New York Health) payroll tax and a NYH non-payroll tax which is a tax on interest, dividends, and capital gains. Details on the number of

continued on page 22

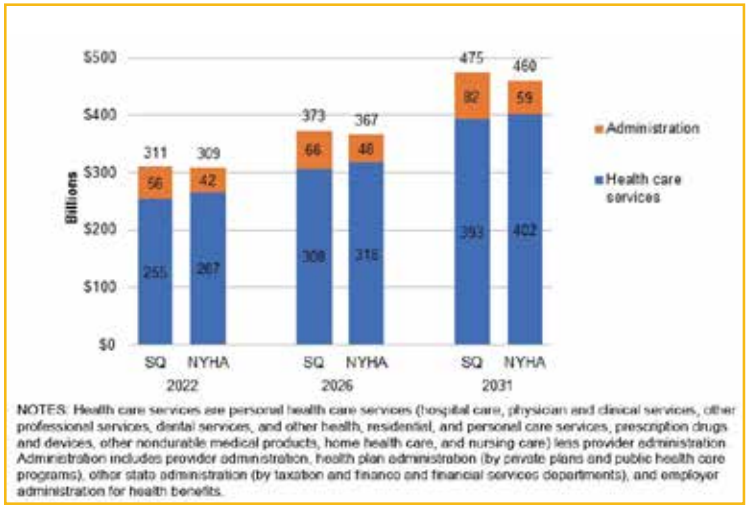

Figure 2: Health Care Payment Projections. Image Courtesy of Liu et al., 2018

NYS Health Foundation's 2017 report on health care trends, New York spends on average 20% higher than the national average along with the eighth highest per capita expenditure in the nation.[1] If the status quo remains, total health care spending would reach $311 billion in the year 2022 and rise to $475 billion by 2031.[2] This represents approximately 18% of the entire New York state GDP.[2] The rise in expenses does not address the critical issue of increasing insurance coverage for the 1.1 million New Yorkers that are currently without insurance.[2] In addition, the current environment in which the healthcare system operates is complex and convoluted. When reviewing Figure 3, our current payment structure, one might require the assistance of a GPS device to properly navigate the payment system. Each arrow represents a layer of administrative overhead that, if optimized, should yield cost savings to the entire system. The New York Health Act is estimated to yield a cost savings through reduction in this overhead through bureaucratic streamlining and improved workflows by utilizing a single payer. The projections outlined in Figure 1 represent this trend in administrative cost savings when comparing the status quo with the NYHA for an estimated $23 Billion in savings by 2031.[2]

As the political tides change, it is expected that support will only continue to increase for the NYHA. New Yorkers, under this single payer system, would receive comprehensive health coverage with no deductibles, co-payments or other out-of-pocket costs for covered benefits.[2] Patients would be able to enjoy the freedom to choose their own physician with no network restrictions in place and would also benefit from reduced costs for drugs and devices.[2] The NYHA would level the playing with equal access to care regardless of one's socioeconomic status.[2]

In addition to the benefits for patients, it is important to note that providers also stand to benefit in many ways in the proposed single payer healthcare system. Physicians would benefit with decreased time spent on complex billing systems and administrative tasks, allowing them to direct their attention and efforts to providing better quality care to patients.[3] When freed from administrative log jams and navigating the maze of multiple payers, a physician's focus can be on building better patient rapport and working towards improvements in preventative care. In this manner, the New York Health Act will make it more likely for physicians to attain a sense of personal accomplishment, and less likely to suffer from depersonalization and burnout, both of which have been noted to be on the rise in healthcare.[7] With the NYHA's ability to choose one's own physician, patients will be able to continue getting care with the same doctor regardless of changes in their job or financial status.[2] This continuity of care is pivotal in providing cost effective and quality care. There has also been increased financial strain on the healthcare system due to patients bouncing between hospitals and emergency rooms for acute exacerbations of chronic conditions. This results in often high priced repeat hospitalizations with outcomes that could otherwise be prevented with proper follow up in an outpatient setting.[9] This cost driver could likely be prevented in a single payer system.

Further, with reduced healthcare costs for patients, New Yorkers will be more eager to seek medical attention. This would create a greater demand for physicians, whose "incomes would benefit because there would be no New Yorkers who can't afford their out-of-pocket share of the bill."[3] Family physicians in particular are afforded a unique advantage with the single-payer system as attention would shift towards preventative medicine. Traditionally, private insurance companies are motivated by their bottom line and are less likely to promote measures that are patient centered.[8] While preserving their profit margins through protocols such as prior authorizations, payers caused 78% of physicians to report instances of abandoning treatment plans along with 92% reporting delays to patient care occurring with waits up to 3 business days to start needed medications.[6] This estimate does not include the costs associated with practices having to dedicate man hours to interact with payers to obtain said authorizations. Under the NYHA, there would be more incentive to keep the general population healthy with the New York Health Plan acting as the sole payer.

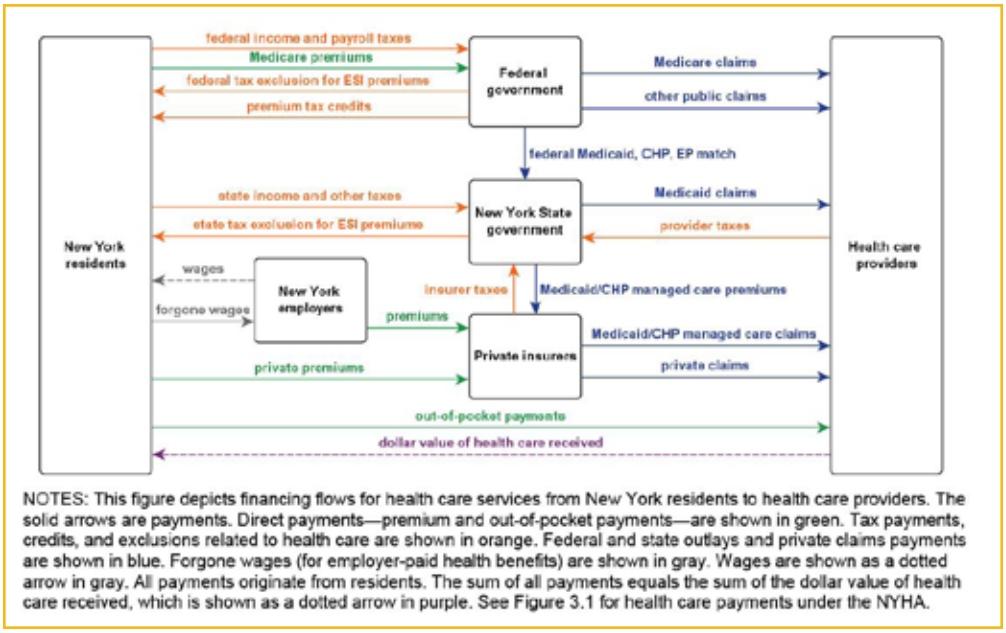

Figure 3: Health Care Payments Under Status Quo, Liu et. al, 2018

It is important to consider the systems adopted by single payer nations, with a similar standard of living as the United State when looking at the economic benefits of a single payer model. In 2016, the US spent 17.8% of its gross domestic product on health care, 8% of which was on administrative costs alone.[4] This is significantly higher than those countries utilizing single payer models such as Canada (10.3%) and the UK (9.7%).[4] Despite similar rates of health care utilization of other nations, the US spends twice as much with the majority spent due to the prices of labor, goods and administrative costs.[4] In 2016, the U.S. spent $9,364 per person on health care as compared to $4,094 in the UK.[5] In a single payer system, only a single universal administrative entity would be required, eliminating redundancies of multiple payers and reducing administrative costs.

The RAND study of the New York Health Act utilized multiple simulation models (COMPARE, PADSIM, TAXSIM, IMPLAN) to make estimations and projections over a 10-year period regarding the effect of the proposed NYHA policy on areas such as healthcare coverage, access, utilization, and spending. Financing the NYHA would be shared by all taxpayers based on a graduated individual tax bracket payroll contribution in lieu of premium payments to existing payers. Through consolidation of core services, the study predicts a "13% reduction in provider administration costs due to decreased administrative complexity under the NYHA."[2] This would effectively allow the healthcare system to provide more health care services through direct monetary savings. Single insurers benefit by being placed in a stronger purchasing position, "a monopsony power", granting a greater leveraging stance when negotiating payment rates, buying pharmaceuticals and medical technology in bulk. Estimations made by the RAND study predict savings of 22%-46% within this sector alone.[2] This is especially significant for New York as seen in Figure 4, which shows 17% of health care dollars statewide currently being spent on pharmaceuticals vs 12% nationwide. Under the single payer model, the insurer can set provisions for appropriate and cost-effective care by having vertical and horizontal scaling to control all available services, insuring all residents throughout their lifetimes and ensuring a healthier population through greater investment in preventative care.

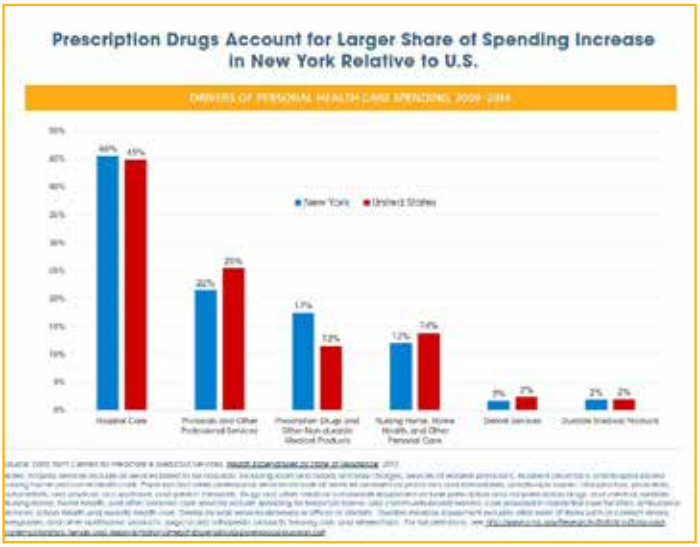

Figure 4: Prescription Drugs as Driver in NY Health Care Spending Vs National Average. Chart Courtesy of NYS Health Foundation, 2017

Given the current political climate on local, regional and national levels, along with the public's increased interest in health care reform, the New York Health Act is a step towards the implementation of a national single payer system. Passage and enactment of the New York Health Act would be a major victory for New Yorkers seeking to change the status quo and receive cost effective universal health care. The environment to achieve successful passage of the New York Health Act has never been better to make this legislation a reality.

Endnotes

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Cean Mahmud, MD, MBA *is a current second year and incoming family medicine chief resident at Northwell Health Southside Hospital in Bay Shore, New York. He received his medical degree from the American University of Antigua College of Medicine graduating summa cum laude. He completed his MBA with distinction from Davenport University in Grand Rapids, MI. He is a recipient of the AAFP Foundation Family Medicine Leads Scholarship.*

Niharika Pasumarty, MD *is a second-year family medicine resident at Northwell Health Southside Hospital in Bayshore, New York. She received her medical degree from St. George's University. Her research was accepted by the Society of Teachers of Family Medicine (STFM) annual spring conference in 2018, and the 2019 New York State Academy of Family Physicians Winter Weekend Conference.*

Gurpal Singh Dhanjal, MD *is a second-year family medicine resident at Northwell Health Southside Hospital in Bayshore, New York. He received his medical degree from St. George's University School of Medicine in Grenada. His research has been accepted by the 2019 Society of Teachers of Family Medicine (STFM) Spring Conference, 2019 New York State Academy of Family Physicians Winter Weekend Conference and 2018 North America Primary Care Research Group (NAPCRG).*

Ani A. Bodoutchian, MD, MBA, FAAFP *is a board certified in family medicine. She graduated from the Universidad Autonoma de Guadalajara School of Medicine in Mexico and received her MBA from University of Amherst, MA. She is currently Associate Clinical Professor of Family Medicine at Zucker Hofstra /Northwell School of Medicine and Associate Professor of Family Medicine and General Practice at St. George's University School of Medicine. Dr. Bodoutchian has numerous national publications and has presented locally, regionally, nationally, and internationally. She currently is Secretary of the Suffolk County Medical Society and Suffolk County Academy of Medicine as well as sitting on the board of the NYSAFP.*

tax brackets or proposals for specific rates have yet to be provided.[3] An estimation by RAND based on a three bracket approach sets the payroll tax between 6% and 20% depending on income.[3]

Considering that 2018 Federal tax reform placed a $10K cap on the amount of state and local taxes (SALT) that can be deducted on federal returns[4], targeting constituents in high-tax/"blue" states such as New York, might encourage wealthier households to leave NYS to avoid these added tax burdens.

The RAND analysis also warns that a big proportion of the new tax revenue generated under this law would fall on the shoulders of a small group of the richest taxpayers, resulting in a serious risk of underfunding the proposed system. If as few as <1% of these high-earners were to move out of state, this could pass the economic burden to lower and middle income filers.[3]

To achieve a single-payer system, NY would have to deliver Medicaid and Medicare benefits through NYH. The federal funding that is currently directed to these programs, as well as ACA marketplace tax credits, would need to be redirected to the novel NYH fund via waivers, increasing many administrative and implementation expenses in the government's calculation to obtain "budget neutrality."[3] To receive federal funding for Medicaid, NYS would need to develop a system to keep track of the individuals that meet federal eligibility criteria. Under the NYHA however, eligibility status will no longer be a condition for coverage. With no reason for these individuals to comply with eligibility rules, NYS stands to lose corresponding federal matching funds.[3]

The financial impact on businesses and wages would be significant. NYH would displace current employer-sponsored health insurance (ESI) coverage. When it comes to out-of-state employees, businesses have two unappealing options. First, they could stop offering coverage to these workers, making them eligible to seek ACA tax credits, which could make the company susceptible to tax penalties for not offering health insurance. Moreover, by halting coverage, firms could lose workers to neighboring states, especially if they are located close to state lines.[3] The second option would be to continue offering coverage. However, employers would likely be legally required to make such benefits available to all of their employees that are NYS residents as well. If these employees choose to enroll, some companies would then face double the cost for each worker by paying the NYHA payroll tax in addition to the cost of providing health insurance.[3]

The imposition of additional taxes on low income families will impose punishing financial hardship, as their net after taxes would be substantially less.[3] Companies could attempt to adjust to the new tax obligations by decreasing wages, although the concomitant push for a higher minimum wage could limit businesses' ability to adapt.

Self-employed physicians, currently not offering health coverage to their employees, must anticipate an increase in their contributions due to the imposition of a mandatory NYH payroll tax, and could expect to have a decrease in their income due to the new negotiated payment rates by NYH. It is likely that the NYH negotiated rates would be lower than the current rates from private insurance providers.[3]

Compared with the physicians in the United States, Canadian doctors in a single payer system have almost always earned less.[5] In Canada, many physicians claim that larger slices of the health care pie go to hospitals or to purchasing drugs rather than to medical services.[5] According to the RAND Corporation Analysis, restricting the growth of provider payment rates is one of the main factors that will theoretically reduce costs under the NYHA model. Although the bill allows for collective negotiations with provider organizations, final rates would depend on the ability of such organizations to advocate for the rights of their members for fair compensation.

The single payer model also disregards the shortage of family physicians or primary care providers in NYS to provide care for the additional patient demand that will result from eliminating premiums and out-of-pocket expenses. When the Canadian government, a single payer system, for example, provides a product "free" to consumers, inevitably demand escalates and spending increases.[6] Products provided at zero price are treated as if they have zero resource cost.[6] It has also been determined that providers don't increase the supply of services and their work hours remain unchanged, even when new patients are added.[7]

In 2017, an estimated cost of $1.9 billion dollars was incurred by Canadians who were waiting for treatment due to complications of prior diagnosis, causing problems for vulnerable populations, especially the elderly.[8] The yearly analysis by the Fraser Institute reveals that as of 2017, the waiting time from referral to specialist consultation in Canada was 10.2 weeks, with an additional 10.9 weeks wait from consultation to treatment.[9] In this case, attempting to guarantee healthcare to all people only guarantees a place in line.

At this time, the NYHA contains no provision for long term care. Including long-term care as a "benefit to NYS residents" would significantly escalate expenses in a single payer system by 39 to 42% according to RAND,[3] which would further increase estimates for new taxes.

There is no cost sharing on prescriptions under NYH. Drug prices, both brand and generic, would be negotiated with pharmaceutical companies as part of the inclusive health benefit package. Patients preferring brand-name drugs over their generic equivalent can potentially increase costs. Aggressive negotiations between the pharmaceutical industry and NYH could lead to negative outcomes such as higher launch prices of medications, or the extreme, not selling drugs to NYH.[3] The pharmaceutical companies would have the advantage in leveraging pricing which could lead to non-coverage of necessary prescriptions. In this setting, even prior authorizations for medication coverage, regardless of brand versus generic, would become obsolete. What is covered on the single payer drug formulary list will be the drug that is provided, regardless of patient need or physician recommendation, unless the patient is prepared to pay out of pocket.

A "one size fits all" approach is not the answer for controlling health care costs and providing better care for the people of New York state. While the current multi-payer system may be imperfect, the rush to enact the NYHA is short sighted and would result in untenable burdens for both physicians and patients.

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***Julio I. Hernández Rodríguez, MD**, is a second-year family medicine resident at Northwell Health Southside Hospital in Bay Shore, NY. He received his medical degree from Universidad Dr. José Matías Delgado in El Salvador. His research has been presented at the Society of Teachers of Family Medicine (STFM) annual conference in 2018.*

***Wander Hurtado Martinez, MD,** is a second-year family medicine resident at Northwell Health Southside Hospital in Bay Shore, NY. He received his medical degree from Universidad de Ciencias Medicas de Villa Clare in Cuba. His research has been accepted to the 2018 North America Primary Care Research Group (NAPCRG).*

***Ching Yeh Lin, MD,** is a third-year family medicine resident at Northwell Health Southside Hospital in Bay Shore, NY. He received his medical degree from Ross University School of Medicine. His research was accepted to the Society of Teachers of Family Medicine (STFM) annual spring conference in 2018.*

***Ani A. Bodoutchian, MD, MBA, FAAFP** is a board certified in family medicine. She graduated from the Universidad Autonoma de Guadalajara School of Medicine in Mexico and is currently Clinical Associate Professor of Family Medicine at Zucker Hofstra /Northwell School of Medicine and Associate Professor of Family Medicine and General Practice at St. George's University School of Medicine. She has numerous national publications and has presented locally, regionally, nationally, and internationally. She currently is Secretary of the Suffolk County Medical Society and Suffolk County Academy of Medicine as well a member of the NYSAFP Board.*

Breastfeeding: When "Baby-Friendly" Isn't Necessarily "Mother-Friendly"

By Lisa Wang, MD & Maureen Grissom, PhD

Perspective 1: Exclusive Breastfeeding Is Best for Babies and Mothers

Breastfeeding is often touted as natural and healthy—a necessity for any mother who wants the best for her newborn. In 2009, the World Health Organization (WHO) and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) which resulted in more than 20,000 facilities worldwide becoming designated as baby-friendly. This was an initiative to empower women to provide "the very best food for her infant," regardless of their socioeconomic status or education level.[1]

Breastfeeding Has Protective Effects for Infants

Breastfeeding benefits the infant by decreasing the incidence of morbidity from illness. Diarrhea is one of the leading global causes of neonatal deaths especially in developing countries and accounts for 22% of deaths in children younger than 5 years.[2] For infants aged birth to 5 months who are not breastfed, there is a 7-fold risk of death from diarrhea, and non-exclusive breastfeeding increases the risk of dying from diarrhea more than twofold.[2] In infants 6 to 11 months old, there is also a higher risk of death from infections like diarrhea and pneumonia.[2] Human-milk glycans act as soluble receptors that inhibit pathogens from binding to host receptors in the GI tract. Studies have shown that breastmilk inhibits the binding of enterotoxigenic Escherichia coli, certain strains of caliciviruses, cholera and campylobacter to their host cell receptors both in vitro and in vivo.[3] Human milk also contains lactadherin, also known as milk fat globule-EGF factor 8 protein (Mfge8), which has been shown to reduce symptomatic diarrhea from rotavirus infection in infants.[4]

Positive Long Term Effects of Breastfeeding

Breastfeeding has also proven beneficial in child development. Time dependent prolonged (at least 3 months) and exclusive breastfeeding have been shown to correlate with improved cognitive development measured by IQ and academic ratings by teachers at 6.5 years old.[5]

In addition, breastfeeding decreases the incidence of chronic disease development in both mother and baby. Breastfeeding decreases the rate of obesity in both the mother and baby.[6] When compared to formula-fed infants, breastfed babies have less acute and chronic otitis media, bronchiolitis, meningitis and necrotizing enterocolitis. Babies who are breastfed have a smaller chance of developing insulin-dependent diabetes mellitus. Breastfeeding mothers also have a reduced incidence of bone and ovarian cancer.[7]

Practices to Promote Breastfeeding

The WHO recommends exclusively breastfeeding in the first six months of an infant's life. The WHO and UNICEF also discourage the use of bottles or pacifiers to sustain exclusive breastfeeding practices.[8] Pacifier/artificial nipple exposure use can interfere with maternal nipple stimulation. Moreover, pacifiers are a non-nutritive device typically used solely to soothe infants, and have been shown to detrimentally impact breastfeeding duration independent of improper breastfeeding technique.[9] This is due to the effect of "nipple confusion", in which an infant has difficulty learning how to latch correctly and maintain an adequate sucking pattern when exposed to inconsistent feeding configurations between the bottle and nipple.[10] Studies have shown that increased pacifier use leads to shortened duration of breastfeeding [11] with a decrease in the number of mothers able to maintain breastfeeding for the first six months with concomitant pacifier use. [12,13] Pacifiers are also associated with an increase in the occurrence of otitis media in infants[14] as well as the development of posterior cross-bite and other harmful oral development effects especially when pacifiers are used beyond two years of age. Delaying pacifier introduction until breastfeeding habits are established can mitigate these detrimental effects.[15]

In some cases, factors such as medical illness may hinder a mother's ability to sufficiently supply breast milk for her baby. However, formula supplementation also has its own detriments. Breastfeeding exclusively for at least 16 weeks without concurrent formula or breastfeeding at least 26 weeks with concurrent formula was found to reduce the risk of obesity at 4 years of age among low-income, white children whose mothers were nonsmokers during pregnancy.[16] Formula supplementation or use of donated breast milk has also been found to shorten breastfeeding duration,[17] doubling the risk of cessation of breastfeeding by day 30 to 60, and tripling the risk of cessation of breastfeeding completely by day 90.[18]

Family physicians should encourage exclusive breastfeeding for at least 6 months as best for both mother and child. Moreover, the use of pacifier and formula supplementation should be reduced as much as possible to minimize the risk of breastfeeding cessation.

Perspective 2: Some Mothers Are Unable to or Choose Not to Breastfeed

There is no denying that breastfeeding has benefits for infants and mothers. The Baby-Friendly Hospital Initiative (BFHI) notes that women who are unable to breastfeed should be given the support for other feeding measures free from bias or commercial pressures. However, research with the population of mothers who have chosen not to nurse their infants suggests otherwise and this can put both infants and mothers at risk.[19] One study found that education of mothers regarding bottle-feeding was "patchy" following the introduction of the BFHI into hospitals.[20] There is a dearth of literature on this topic[19] in light of the

reported 16% of US women who, by the time they head home from the hospital with their babies, have decided not to nurse them.[21]

There Are Various Reasons Women Cannot or Do Not Chose to Breastfeed

While breast milk has been shown to be beneficial for infants, some situations may make it difficult or impossible for a new mother to breastfeed. For instance, maternal use of medications that may pose a harm to the infant, a history of breast surgery, smoking, previous negative experiences with breastfeeding, paternal opinion against nursing, multiple births and competing responsibilities may all factor into a mother's choice not to nurse.[22,23]

Trends in Breastfeeding

Prior to the development of formula, breastfeeding was the sole option.[24] However, hundreds and even thousands of years ago, there were still mothers who were unable to nurse or did not produce enough milk, and wet nurses breastfed the children of others in these situations.[25] Formula was introduced as a viable option as early as the 1920s and was even touted as superior to breastmilk.[26] Rates of breastfeeding in the US have varied over the years across various cultural and socioeconomic groups and in response to societal events and pressures.[25] Breastfeeding rates dropped precipitously in the early 1970's at a time when large proportions of mothers of young children entered the work force.[24] At the same time, advertising by manufacturers of formula has likely had an impact of the level of formula feeding as have breastfeeding advocacy groups (such as the La Leche League in the 1950s) and the advent of lactation consultation as a profession in the 1980s.[24,25]

While at one time in the US, breastfeeding was associated with mothers of lower socioeconomic status and immigrant status, it is now more closely associated with "privileged motherhood." More recently, breastfeeding is associated with mothers who can afford to take a longer maternity leave (or not return to work at all) and whose jobs offer the necessary flexibility and environmental support to continue breastfeeding and/or expressing milk upon the return to work. These mothers tend to be older, more educated, white and of middle class.[24] According to the most recent CDC data, more than 80% of women are breastfeeding when they are discharged following the birth of their baby, more than 50% were still breastfeeding six months later and close to 36% were breastfeeding at one year.[21]

The Response to Women Who Do Not Breastfeed

In recent history, women who have chosen not to breastfeed have reported feelings ranging from guilt and depression to feeling they are not good mothers or are failures.[20,27,28] This maternal distress holds potential harms for infants via the effect of mothers' mental health on her ability to parent effectively.[29] Non-nursing mothers have indicated that they have felt they were not given adequate information about how to formula feed and were given a lower level of care than mothers who chose to breastfeed.[19,28] This is not to say that all bottle-feeding mothers reported feeling unsupported or unhappy with their care. However, one study showed that in those who did report dissatisfaction, it even extended to support after they had left the hospital. They noted that information about breastfeeding helplines was readily available and provided via refrigerator magnets, whereas there was little to no information (never mind a phone line for questions) for formula feeding.[19]

One mother who was interviewed for the above study explained that in comparison to other duties of the staff, preparing a bottle was (understandably, in her opinion) not a high priority and she would prefer to prepare it herself rather than take someone away from caring for another patient and feel so dependent on staff. Prior to adoption of the BFHI, the hospital had a "milk room" with a sink and refrigerator and an area for the new mother to prepare formula themselves, as well as for the storage of expressed breast milk. Following the implementation of BFHI accreditation standards, a keycard had been placed on the door of the milk room restricting access to staff only.[19]

Methodological Issues with Breastfeeding Research

A great deal of research exists comparing the outcomes (health and development) of children who were breastfed to those who were formula fed with strong evidence of the benefits of breastfeeding. However, the research is complicated by issues such as the reliance on retrospective self-report of breastfeeding methods and studies that vary as to whether they consider breastfeeding to be exclusive breastfeeding versus predominantly breastfed or a combination of breastfeeding supplemented with formula.[30,31]

One of the biggest challenges in this area of research is study design. Understandably, cohort studies are used to assess the effect of breastfeeding versus formula feeding (it would be difficult to find an Institutional Review Board willing to approve a randomized control trial of breastfeeding versus formula feeding). While cohort studies and meta-analyses can adjust for maternal and paternal IQ, socioeconomic factors and family factors across groups, it may not be possible to account for every possible difference between mothers who choose to and feel they will be able to breastfeed their babies and those who do not. For instance, a 2014 longitudinal study determined that parenting factors such as maternal sensitivity and frequency of reading to a child mediated the relationship between breastfeeding and child cognitive development even after controlling for factors such as SES.[32]

How Can We Encourage Breastfeeding Without Shaming Mothers Who Do Not Breastfeed?

Based on existing research, providers and institutions should promote breastfeeding as the healthiest choice for babies and provide encouragement and education to make nursing as safe and effective as possible. At the same time, however, providers and institutions must recognize that more than 15 percent of new mothers will choose not to breastfeed for a plethora of reasons.[19] Even if this is not the preferred choice of providers, it is incumbent upon them to offer the same level of care, support and education for these women and their babies regarding feeding their infants.[19] This is consistent with the WHO position that a BFHI is also responsible for supporting those mothers who are not going to breastfeed "to make informed decisions and to care for their babies as well as possible."[33]

Family medicine is about caring for the family—and while the newborn obviously does not have direct input into the maternal decision to breastfeed, we can consider the family unit in this decision with the goal of

continued on page 26

Breastfeeding... continued from page25

striking a balance between maternal psychological needs and the need for optimal nutrition for the infant.[34] This need for balance is also supported by the child development literature with regard to the impact of maternal health and well-being on affective bonding and the ultimate health and development of the child.[29] In other words, being wracked with guilt about not being able to breastfeed is likely to negatively influence a mother's ability to parent and may in turn negatively affect her child.

As family physicians, we pride ourselves on providing patient-centered, collaborative care. Applying this approach to discussions about breastfeeding would include:

- Acknowledgement that breastfeeding (while healthiest for the infant) can be a challenging process and that some situations may require supplementation.
- Opportunities to identify and potentially address barriers to breastfeeding. A collaborative approach, rather than one that may be perceived as more insistent, may facilitate this.
- Compassion (rather than implicit or explicit attempts to shame) for mothers that supports their psychological health and ability to parent.

A UNICEF/WHO BFHI training module for maternity staff in Baby Friendly Hospitals specifically outlines that in teaching proper breastfeeding technique to new mothers: "REMEMBER YOUR COMMUNICATION SKILLS [*original formatting*]- Listen, praise, inform, suggest – Do not command or judge."[33] This same advice should hold for approaching the issue of breastfeeding in general with new mothers.

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Note: In an effort to address both sides of this issue, the authors worked together and their respective pieces may not be fully representative of their personal views on this issue.

Lisa Wang, MD, *is a third-year resident at the Zucker School of Medicine Family Medicine Residency at Southside Hospital-Northwell in Bay Shore, NY. She completed her medical degree from Stony Brook University and has presented nationally on the topic of patients who are discharged against medical advice.*

Maureen Grissom, PhD*, is an Associate Professor of Family Medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell and Director of Behavioral Science at the Family Medicine Residency at Southside Hospital, both located on Long Island, NY. She completed her master's and doctoral degrees at the University of Notre Dame and has published and presented on topics related to medical education and psychosocial factors that contribute to patient and physician health and well-being.*

TRANSITIONING: BECOMING A BETTER PHYSICIAN TO TRANSGENDER PATIENTS - LESSONS LEARNED FROM A TRANSGENDER JOURNEY

By KrisEmily McCrory, MD, FAAFP

Sitting at a red light, my then eleven-year-old announced his gender dysphoria. In a moment, much of what I thought I knew about gender and self-identity turned on its head. My daughter had now become my son. While I had no preference to sons versus daughters, changing pronouns signaled a shifting mindset that permeated our lives. As a physician, I have cared for transgender patients at various times during my training and career, but like most of us, had minimal formal training in transgender specific care. As a cis-woman, I had not fully realized just how much gender permeates the world around us. Every form asks for gender but no EMR I have encountered has an effective way for describing anything outside the binary in the medical record. My son and I have been fortunate that doctors, dentists, and orthodontists have been accommodating in placing his preferred name in quotes next to his birth name and trying to put his pronouns somewhere in a comment or FYI box. But I know that this does not always occur. Transgender patients face barriers to accessing not only gender affirming treatment such as hormonal or surgical options, but also attaining everyday health care. From seemingly minor triggers such as the automated schedule reminder call using the patient's birth name, to more obvious insults like a physician's outright refusal to refer a transgender patient for hormone therapy because it will "just further enable the patient's delusions", patients with gender identity dysphoria often shy away from the health care system. Not only do they miss out on gender affirming therapeutic options, transgender patients are also less likely to obtain appropriate preventive screening tests and other routine medical care. Even when they do make it into the office, most physicians, myself included, have such little training that we may be more harmful than helpful.

For my son and me, understanding gender affirming therapies for adolescents came mostly from piecemeal internet searches. By the time we identified a physician willing and able to see my son, he had attained a Tanner staging that made puberty blockers unfeasible. Although not without controversy, puberty blockers are reversible and permit pubertal transgender patients an opportunity to avoid the additional stress brought on the inevitable development of secondary sex characteristics. For individuals trying to pass as their attested gender, moving from childhood to adolescence can be particularly challenging as adolescence marks an inescapable divergence of sexes. Girls develop breasts and hips, boys become more muscular and develop facial hair. While the prepubescent child may be able to throw on the gender appropriate clothing or style their hair in a more gender affirming way, once adolescence hits, passing becomes more difficult.

With no option for puberty blockers, we faced the decision on using testosterone supplementation ("T"). Many physicians will not provide this prior to sixteen years of age. Growing evidence suggests that properly screened and counseled patients do particularly well with T. Research does not seem to find that patients regret starting the supplementation. However, some consequences from this supplementation are irreversible so it must be considered with careful deliberation, particularly in younger adolescents. We travel almost two hours one way to see my son's gender wellness physician. He started T just prior to his 14th birthday. Every other week he injects himself. The first time it took him almost twenty minutes to overcome the inherent fear in causing self-pain. Even now, two year later, he continues to struggle with this aspect of his treatment-the part that will last the rest of his life.

The testosterone slowly deepened his voice and he has started to develop some more masculine hair patterns, but his body will always have a shorter stature and he cannot turn back the time on the breast development. As an active athlete, his breasts have created the most consternation for him. Every day he pulls on a chest binder that squeezes everything as flat as possible. This gives the illusion of a mostly flat chest for the limited time he can wear it. Binders should not be worn for more than eight hours day and he cannot participate in sports while wearing it due to limitations on breathing. So, we are onto the next challenge of top surgery, or removal of the both breasts.

Far more controversial than either puberty blockers which are reversible, or testosterone which can be stopped with only some permanent changes, surgery, especially in adolescents remains quite controversial. The idea of removing an otherwise healthy part of the body creates unease in many physicians. One resident, during a lecture on transgender medicine, could not fathom how this was any different than the multiple plastic surgeries individuals with body dysmorphic disorder undergo. At the time, I had no good answer, but now I understand as I have watched my son's struggle to look like a normal male. He does not find multiple flaws that will never actually be fixed with surgery. Patients with body dysmorphic disorder do not find relief with one surgery, their constant search for perfection frequently leads to an endless quest to fix new flaws. Transgender individuals allowed to undergo the desired gender affirming surgeries have decreased depression and improved mental health functioning.[1]

Figure 1

Fenway Health (https://fenwayhealth.org): An organization focused on healthcare for the LGBTQ community with multiple educational resources on all aspects of transgender health care. Includes resources for health care providers as well as patients.

TransYouth Family Allies (www.imatyfa.org): An organization focused on Allies with resources specifically for health care professionals as well as recommended reading.

The Center of Excellence for Transgender Health-USF (www.transhealth.uscf.edu): Organization with goal of increasing access to comprehensive affirming care to trans communities. Multiple resources for health care professionals, patients, as well as training and protocols for primary care offices.

continued on page 28

Transitioning... continued from page 27

As a mother, I worry about my children every day. For my son, I worry about his increased risk of depression and suicide that are associated with his gender incongruence. In the few years since he has transitioned, I have witnessed the link between his ability to represent himself as a male and his overall mental well-being. The more latitude he has been given to just be a boy such as his school using his preferred name on the roll call or letting him run on the boys' team, the less anxiety he manifests. I understand that surgery is fraught with risks such as infection or bleeding, and that he will be left with two large scars on his chest. Few surgeons possess expertise in transgender procedures, with even fewer feeling comfortable performing these procedures on minors. Guidelines, such as provided by the Endocrine Society leave the timing of top surgery to the clinical discretion of the team caring for the patient, based on physical and mental health of the individual with no specific age recommendations.[1] I strongly feel that, while any surgical decision should not be made lightly, the benefits of this procedure will far outweigh the potential risks for my son.

My experience with my son's gender incongruence has shed light on the lack of training I received in transgender care. As I learn as much as I can, I have worked to educate the residents and medical students I train in my position as a residency faculty. I advocate and speak to other physicians about the needs of transgender adolescents. Sometimes I get push back from even my own colleagues. When I offered information on a local counseling office with expertise on transgender adolescents, another physician expressed concerns about their agenda. Given the ever-present challenges transgender individuals face, ranging from depression and exclusion to outright harassment, assault, and even murder, I truly believe the necessary support appropriate mental health services provides far outweighs an unlikely agenda. My advice to family physicians looking to better understand how to care for all transgender patients, but especially transgender adolescents would be to identify support resources for your patients and educational resources for yourself and your staff (see Figure 1). Not everyone will be providing gender affirming services, but as primary care physicians, we all provide comprehensive care including appropriate specialty referrals. Knowing what your transgender patients need will help you to be a better physician for them. Providing a clinical space that embraces transgender patients removes a significant barrier to their care.

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KrisEmily McCrory, MD, FAAFP *serves as core faculty at Ellis Family Medicine Residency where she provides full scope clinical care including maternity care. In addition to patient care, she teaches allopathic and osteopathic family medicine residents and medical students. Her interests include women's health, increasing family medicine interest among medical students, and writing. She has recently worked on the Family Medicine for America's Health's national task force to increase medical student matching in family medicine and has served in multiple positions in the NYSAFP including several years chairing the NYSAFP Scientific Assembly "Winter Weekend."*

Gender Inequity Persists

Gender disparities in medicine remain a significant ongoing issue, and the field of family medicine is unfortunately no exception. Such disparities persist in the areas of salary and compensation, as well as promotion and leadership roles, both in the academic and clinical realms of practice. Family medicine, with its holistic, progressive ethos and emphasis on advocacy and systems-level change, is uniquely positioned to assume a leadership role in addressing this controversy – a controversy inextricably linked to health.[1]

GENDER & MONEY: COMPENSATION EQUALITY

The gender gap that exists in medicine with regard to pay equity and compensation has been well-documented in the literature. A review of National Faculty Survey data[2], for instance, looked at the salary disparity in academic medicine. In this longitudinal follow-up study published in 2016, researchers found that women earn, on average, an estimated $20,520 less than men, or 90 cents on the dollar, a trend that persisted over the study period of 17 years. When adjusting for covariates that predict academic salary differentials, such as change in employment setting or status, women still had a mean difference of $16,982 less than men within each specialty group studied; with further adjustment for consistent full-time status, a salary gap of $15,159 persisted for women, although this sub-analysis did not achieve statistical significance. In light of baseline salary data gathered at the start of the study, disparities observed at entry-level salaries appeared to be a main driver of the ongoing gender compensation gap over the course of subsequent career trajectories.[2]

A bold study exploring potential corrective actions against this salary disparity was undertaken more than a decade ago, with results published in 2007. An intervention on pay inequity at a public medical school was conducted in which salary data was obtained and analyzed by the research team, and the information provided to the institution's dean; he then discussed these disparities with department heads, making compensation adjustments on the spot as warranted. The results of this intervention were striking: 26 women (22.8%) were paid less than their male counterparts in comparable positions, leading to eight salary adjustments averaging $17,323 each. Also consistent with the findings of the longitudinal Freund study, these authors argued that even small annual salary discrepancies are impactful because the disadvantage they create is essentially cumulative over a longstanding career.[3]

Gender parity in clinical family medical practices unfortunately fares not much better, as captured by available data from various industry sources. The Center for Health Workforce Studies published a 2018 research brief on the gender wage gap for new physicians. Based on the New York Resident Exit Survey data 2014-2016 adjusted for hours worked, despite a growing proportion of new female physicians employed in the state, the gender wage gap persists and is in fact increasing. The difference in average income between male and female family physicians was more than $20,000; across specialties it ranged from between $2,759 for pathology to as high as $64,183 for cardiology. The report also specifically notes that the gap has widened over time, with the inflation-adjusted disparity less than $10,000 in 2005 and over $25,000 in 2016.[4]

in the Twenty-First Century

By Julia Miller, LMSW; Rebecca McAteer, MD, FAAFP and Shantie Harkisoon, MD, FAAFP

GENDER & POWER: PROMOTION EQUALITY

Current evidence demonstrates severely limited female leadership representation in academic medicine. An overwhelming number of medical school departments are chaired by men, and faculty rank is strongly linked to gender, with men maintaining the majority of the highest faculty ranks (professor and associate professor) and women filling the majority of instructor roles. In 2018, Association of American Medical Colleges data reveals that in family medicine departments at medical schools nationwide 467 men and 250 women held the role of 'Professor' while 182 men and 400 women held the role of 'Instructor'.[5]

The literature points to myriad manifestations of this disparity including discrimination in the form of recruitment and promotions practices, a lack of publishing opportunities and mentorship for women, disparities in pay for women and a mismatch with the standard academic career timeline and tenure demands during a woman's prime childbearing years.[6,7,8]

The cumulative effect of these patterns of discrimination is the "leaky pipeline" of academic medicine in which many women enter a career in academic medicine but few rise to the top ranks. In one commentary, authors speculate about potential reasons for inequity in grant funding, salary, publishing opportunities and promotions. They go on to suggest ways to address this, including transparency around starting salaries, provision of mentorship opportunities, ongoing exploration of discrimination in research funding, name-blind testing of applications, and enhanced career flexibility to better accommodate the timeline and work-life balance inherent in child-rearing.[9]

Building on these findings, a qualitative commentary spotlights the effect of family life on female academics, illuminating how early child-rearing years often coincide with the time in which women would be achieving early career publications, applying for grant funding and completing other time-intensive activities pivotal to ensuring a solid academic career trajectory that would give them the chance for promotion to the higher academic ranks where women are underrepresented. The commentary addresses the reality of a slow academic career start for women and suggests that career opportunities could be better structured to fit women's goals. The authors emphasize the role of recruitment practices in improving female representation in leadership including the importance of including women on search committees and encouraging committee members to think of a list of women as a part of a candidate search.[7]

With regard to leadership parity in the realm of clinical family medicine, there is a remarkable lack of data, available either publically or even upon request. The lack of transparency in collecting and disseminating such information creates systems-level challenges in ensuring that inequities are recognized and addressed, making it difficult even to assess the true scope of the issue, and creating a particular opportunity for additional research and advocacy.

A CHALLENGE TO CHANGE

In family medicine, a specialty with roughly equal representation of both genders, it is imperative that we study trends in gender equity not only for all its inherent benefits, but also to support optimal patient health. The AAFP policy statement on health equity emphasizes this, citing the Healthy People 2020 definition of health equity as "the attainment of the highest level of health for all people." It continues with a call to action: "Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[1]

Several actionable solutions have been proposed to achieve gender equity, including equitable and standardized starting salary packages, the review and correction of compensation inequities among current faculty, the provision of training in negotiation skills to enhance self-advocacy for new graduates and trainees, and administrative training on implicit bias, which may impact compensation disparities at the point of hire.[2,10] Other publications have challenged readers to change the status quo of complacency around the existing gender gap and assumed basis for it (child-rearing/ family decisions, time out of workforce, etc.) by implementing innovative structural changes that support shared family-rearing.[6,10]

CONCLUSION

Family medicine as a field is particularly well-positioned to address this ongoing controversy that persists in medicine writ large, because of its inherent emphasis on family, and its longstanding awareness of the need to address inequities at a structurally systemic level, utilizing the strengths of family physicians in advocacy and collaborative leadership that have effected significant changes to address myriad health-related controversies over the decades.

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Julia Miller, LMSW *is a graduate of Northwestern University and received a Masters of Science in Social Work from Columbia University. She is the project coordinator at the Phelps Family Medicine Residency Program.*

Rebecca McAteer, MD *is a graduate of the College of William and Mary, and received her medical degree from New York Medical College. She completed residency training in family medicine at Lancaster General Hospital in Pennsylvania, followed by a faculty development fellowship at Georgetown University with a focus on medical humanities. In addition to working as an attending hospitalist, Dr. McAteer also served as a full-spectrum family physician in rural Nepal from 2013-15, before accepting her present faculty position with the Phelps Family Medicine Residency Program.*

Shantie Harkisoon, MD, FAAFP *is a graduate of the Transylvania University in Lexington, KY, and received her medical degree from the University of Kentucky College of Medicine. She completed residency training in family medicine at Saint Mary Hospital (University of Medicine and Dentistry of New Jersey), followed by a faculty development fellowship at the Institute for Urban Family Health in New York. She is the founding program director of the Phelps Family Medicine Residency Program in Sleepy Hollow, NY and is an active member of the Association of Family Medicine Residency Directors.*

By Orlando Sola, MD

Firearm Violence – A Time for Action

Firearms play a prominent role in the United States, popular as tools used for self-protection, hunting and sport since our country's founding. For centuries the health risks posed by firearms were outweighed by their benefits, a balance that has shifted in the last century. Firearms, including hand-guns, rifles and shotguns, represent a significant public health risk that affects large proportions of our population, from rural to urban communities, old and young, black, brown and white. The lax regulatory oversight on firearms in the United States, as compared to our economic and cultural counterparts,[1] has helped to maintain our national epidemic of urban crime-related firearm deaths, accidental deaths and firearm-related suicides.[2] Family medicine, a field that specializes in disease prevention across a broad spectrum of demographics, is uniquely placed to advocate for our patients regarding dangers such as firearm violence.[3] Moreover, recent elections in the New York State Senate have created a state legislature amenable to firearm regulatory reform. Family medicine physicians and the New York State Academy of Family Physicians now have the opportunity to pursue regulatory reform, such as improved mental health screening and preventing purchase of trigger modifiers such as bump-stocks, which are generally accepted by constituents in both parties. However, to truly address our ongoing crisis of firearm violence, we must take a more aggressive stand and pursue evidence-based legislation to protect our communities from unnecessary sources of injury and death.

Advances in clinical care have driven large reductions in preventable death across our society. This has left a burden of morbidity and mortality from non-traditional sources, often founded in our cultural norms and societal activities. Injury and death from firearms, a phenomenon governed by human action, is a paradigm of one of several negative forces on the health of our communities. The potential risks of firearms in a primary care practice is supported by a large body of evidence. Household ownership of firearms is an independent risk factor for preventable death.[4] Research completed by the Center for Disease Control[6] reports 61% of firearm victims die from their own hands, either through suicide or accidental discharge. The risk of adolescent death from firearm discharge is now 15 times that of infectious diseases, and is the leading cause of death for black adolescents. Though we have developed efficacious treatments for depression, 50% of all suicides are completed with firearms. Moreover, despite the oft reported safety benefits provided by carrying handguns, firearms are 43 times more likely to be used on a friend or neighbor then on a household assailant. Overall, firearms are responsible for 36,000 deaths and 100,00 injuries each year, each leaving behind a family unit disrupted by a preventable, defined and well understood risk factor.[6]

In reviewing the effect of firearms on our healthcare system, it is helpful to draw comparisons with other preventable causes of morbidity and mortality. Motor vehicle accidents, a cause of death that also has a disproportionate affect on young adults and the elderly, represented 8.4 deaths per 100,000 individuals in 2001.[9] This rate improved to 5.6 per 100,000 after implementation of evidence-based policy reforms aimed at preventing common causes of motor vehicle related deaths.[9] Data collected on motor vehicle deaths continues to drive policy change, with momentum building to improve pedestrian and bicyclist safety, advance car safety features and improved enforcement of current laws against speeding, reckless driving and passenger restraints. Additional private-public partnerships have funded advertising and social media campaigns against driving under the influence and to encourage seat-belt use.[11] The benefits of a successful public health campaign, where clinical and political goals are synergized, is exemplified by the impact on motor vehicle deaths. In comparison, similar rates of firearm mortality have not resulted in any bipartisan movement leading to innovative regulatory reform.

Past regulatory reform has focused on areas of bipartisan agreement, such as safety mechanisms and guidelines on storage. Even in these areas there is room for improved regulatory oversight. Technology now exists that effectively personalizes firearms, limiting use of the firearm to the licensed owner.[12] Mechanical safety devices are well established, but are rarely integrated into firearms construction. Data has shown the safety benefits of ensuring safe storage of ammunition and firearms through educational campaigns and community outreach, yet 43% of households with handguns and children under 18 years old are unsecured.[13,14]

New York State has benefited from relatively strict regulatory oversight of firearm access and safety measures, as compared to national averages. Though over 900 people die each year in our state due to firearms, our mortality rate is the third lowest in the country, a laudable achievement for a state home to 3 major cities and a center of economic and cultural activity.[7] New York has demonstrated, as have states such as New Jersey, Hawaii and Massachusetts, a link between strict state-driven firearm regulations and lower rates of firearm mortality.[1] Yet, if New York were

considered an independent country, it would rank amongst the top 25 countries for highest rates of firearm-related mortality.[8] New York has shown leadership in regulatory oversight of firearms, but will need to continue to innovate to reach international standards.

Proponents for firearm regulation can produce a long list of regulatory goals, ranging from increased funds for research to allowing product safety liability litigation against manufacturers, and requiring universal background checks for all weapon purchases. These are areas of reform familiar to the voting public, but have faced opposition set by political actors such as the National Rifle Association. However, our state congressional leadership has publicly expressed an interest in firearm regulatory reform, and with a supportive executive branch, has the opportunity to push the national discourse towards more sensible reforms that can address the true drivers of firearm morbidity. Improving safe storage, and limiting the production and purchase of firearms will represent progress, but is not a final solution addressing the root cause of firearm deaths.

Handguns currently play the largest role in New York's epidemic of firearm related deaths, and should be specifically targeted by our elected officials. Handguns owned by citizens are largely used for self- defense, as reported by civilian gun owners and opponents of regulatory reform. Yet beyond anecdotes, no empirical evidence can be found to support the supposition that owning a firearm decreases your risk of violent death or injury. In fact, research has shown quite the opposite.[17] Future reform needs to be built from this fact, and lead to an environment with fewer guns, resulting in safer communities.

The logical intervention is clear and calls for the removal of handguns, along with shotguns and rifles, from the state with exceptions made for sport and non-civilian usage. Comparisons of regional firearm mortality rates and levels of regulation show lower rates of suicides and homicides where handgun regulations are more strict.[15,16] The United Kingdom, a country which shares many historical and cultural norms, was able to achieve one of the lowest firearm related death rates in the world in part through the removal of handguns from general circulation. Based on these successful examples, and our understanding of the firearm epidemic, the family medicine community is well positioned to advocate for the removal of handguns from general circulation. New York state can, and should, act as venue for the testing and refinement of these novel regulatory actions to address firearm mortality.

Removal of a majority of firearms from civilian circulation cannot be taken in one step. Intermediate reforms must focus on graded improvements in firearm safety, including storage and limitations on firearm sale, ownership and usage. As we take steps towards changing our political, regulatory and cultural norms around firearms, more data will be needed to evaluate and compare specific interventions. Grounding future actions in evidence will require additional investments from both state and federal actors. Family medicine physicians, as intergenerational health providers immersed in our local communities, will be best suited to usher in this new age of progressive, evidence-based regulatory reform.

Opponents of novel firearm regulatory oversight quote several reasons for their position, often including needs for self-defense and their constitutional rights under the second amendment. However, arguments based on self-protection have failed to stand up to legitimate empirical investigations, highlighting the need for targeted policy reforms. In contrast, firearms used for sporting and non-civilian purposes, such as the militia uses identified within the Second Amendment of the United States constitution, can reasonably be exempted from these policies. Whether constitutional rights for firearm ownership, made during an era of United States history with different economic and social norms, should continue to prevent us from addressing the needs of our patients is the existential question we must ask ourselves. The evidence is clear that access to firearms, especially handguns, leads to unsafe households and urban communities, and increased risks for poor clinical outcomes in mental health. Though a physician must understand the cultural norms of our patient communities, we are beholden by our oaths to improve health and advocate for our patients, to use evidence-based approaches to health care and public health, and to put aside our personal beliefs for the betterment of our communities. It is clear, more handguns lead to more preventable deaths, in spite of the regulatory patches and oversight thus far provided. Military-grade weapons should only be owned by the military, and our Academy of Family Physicians should advocate for common-sense, innovative regulatory reform that will protect our patients, and ourselves, from the dangers posed by free flow of firearms through our communities.

Current Bills Before the NYS Legislature

- S2438: An Act to amend the penal law, in relation to access to foreign state records

Passed Assembly & Senate

  - Opens access to foreign state records concerning mental health for firearm license applicants

- S8719: An act to amend the penal law, in relation to prohibiting the possession, manufacture, transport and disposition of trigger modification devices

In Senate committee

Limits use of firearm modifications creating functionally automatic weapons, such as bump-stocks.

continued on page 32

Firearm Violence continued from page 31

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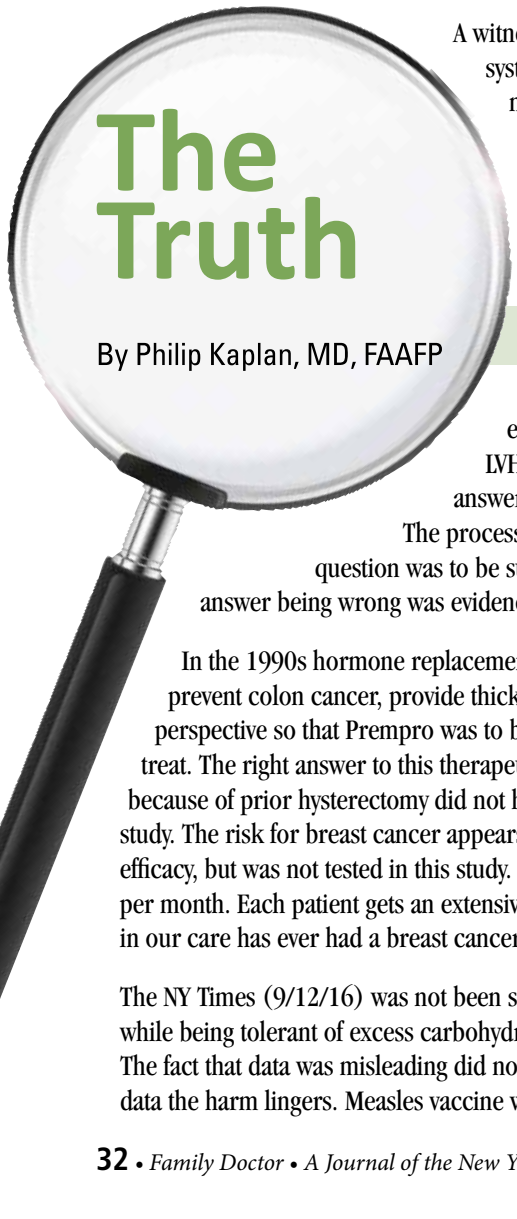
Orlando Sola, MD *grew up in New York and Massachusetts with a family of socially-active individuals. He completed his undergraduate studies at McGill University, attended medical school at Columbia College of Physicians and Surgeons and obtained his MPH at Johns Hopkins University in Health Policy and Management. Prior to medical school, Orlando was an AmeriCorps intern in East Los Angeles. He completed his residency training in family medicine at the Institute for Family Health Harlem program, and now works as a core faculty member at SUNY Downstate.*



The Truth

By Philip Kaplan, MD, FAAFP

A witness pledges "to tell the truth, the whole truth, and nothing but the truth." In our criminal justice system, the jury arrives at a definition of truth by a standard of "beyond a reasonable doubt." In civil matters the standard is less stringent: "the preponderance of evidence" which is 'likely true' rather than 'absolutely true.' So too in medicine, I suggest, without formally stating this duality, we care for patients according to two standards – evidence-based truth and experience-based truth. Purist physicians criticize their colleagues for deviating from the orthodoxy of an evidence-base. Such criticism is misplaced for two reasons: (1) evidence-based truth is not always true, and (2) experience-based truth is often true, but yet unproven or unprovable.

1) Evidence-based truth is not always true

When I took my second board exam a question about initial treatment options for hypertension excluded the use of thiazides as a correct answer, because evidence indicated thiazides did not prevent LVH. Six years later at my next board exam a similar question allowed the use of thiazides as a correct answer. Around 1984 I had the privilege of participating in the writing of draft questions for the ABFM. The process for developing a question was rigorous – each right and each wrong choice for a multiple choice question was to be supported by six literature references. The selection of a right answer and the proof of an alternative answer being wrong was evidence-based, but in the interval between two examinations a wrong answer became right.

In the 1990s hormone replacement therapy for postmenopausal women would provide eternal youth, vigorous intellect in old age, prevent colon cancer, provide thicker hair and a brighter smile. The Women's' Health Initiative Study of 2002, 2004[1] changed that perspective so that Prempro was to be feared and shunned. Truth evolves, and during such evolution a physician must evaluate and treat. The right answer to this therapeutic question is more nuanced. The WHIS used daily progesterone. Women who took estrogen alone because of prior hysterectomy did not have the statistically significant increase in breast cancer demonstrated in the Prempro arm of the study. The risk for breast cancer appears related to progesterone. Cyclic progesterone prevents uterine risk from estrogen therapy with equal efficacy, but was not tested in this study. I have treated postmenopausal women for 45 years with HRT including progestational agent ten days per month. Each patient gets an extensive informed consent conversation so we may individualize priorities. None of these women who remain in our care has ever had a breast cancer. Am I to deprive these patients of comfort because of partial evidence, or may I rely on experience?

The NY Times (9/12/16) was not been shy about critiquing the 'evidence'[4] that misled us for decades regarding demonizing fat in the diet while being tolerant of excess carbohydrates including sweets. Not only may 'data' be wrong, it may be influenced by the funders of research. The fact that data was misleading did not prevent it from being acted upon. Even after the recognition and retraction of wrong or incomplete data the harm lingers. Measles vaccine will cause autism for at least a generation.

Orthodox views can become entrenched by orthodox clergy, preventing challenge. About a dozen years ago I had been concerned about my adult patients' vulnerability to measles and mumps. I was doing titers though CDC advice was to just be sure two doses had been given. And titers were not recommended. A look back over a two- year span at data run by our contracted clinical lab demonstrated that 10% of tested patients were lacking immunity to measles, and 16% to mumps. Factoring the cost of titers and the cost of individual vaccine doses then available for measles and for mumps, I demonstrated that using titers for those without clear evidence of two doses of MMR and just immunizing those missing proof of immunity to one disease, was cheaper than giving a second dose of MMR to each potentially vulnerable individual. I sent this data to a correspondent at CDC who expressed interest and approached my academic chairman to get small funding to do a more formal study. I was especially concerned about the cohort of patients who were born after 1957 but finished freshman year of college before 1989 when we started boosting vaccination for these illnesses, because these patients most likely had only one dose of MMR. My chair responded that this study would not pass an institutional review board because I was providing care that was opposed by the CDC.

2) Experience-based truth is often true, but unproven or unprovable

Infectious disease lectures and published reports insist that treatment of streptococcal sore throat minimally impacts the clinical course of illness. The same is spoken and published about the impact of Tamiflu on the course of a case of flu, reducing symptoms by a couple of days at most. Forty years ago while camping with my 5-year-old son, he awoke with a 104-degree fever. I cultured his red throat and gave him a dose of penicillin. The next morning, he was well. His subsequent culture result was grA strep. Last March I came to my office midday and suddenly felt abject misery. 'This has to be flu.' I jammed the viral swab into my nasopharynx, took a Tamiflu, and went to bed. I was well in 24 hours, not just improved. My NP swab was type A flu. Clearly treating in the first few minutes of illness has a profound effect on the clinical course. It is likely impossible to gather enough such patients with such ready access to diagnosis and treatment for a statistically significant study, but common sense and my personal experience have taught me a lesson which informs my care.

A patient once informed me of the superiority of Vosol HC for cerumen disimpaction and for the treatment and prevention of swimmer's ear. No longer available, this is generically available as hydrocortisone-acetic acid otic in Surescripts. It contains propylene glycol, anhydrous acetic acid and hydrocortisone. And it makes cerumen easy to irrigate. I suspect it dries the ear, prevents inflammatory debris from adhering to the cerumen, stops the pain, uses acetic acid to suppress pseudomonas, and doesn't cool the drum like alcohol would. I have successfully used this for decades yet I find no mention of it in any published material. There is no profit to be made in such a study; there is no harm to my patient from using this approach.

There is a robust literature that for DVT prophylaxis full intensity warfarin has risk, that low intensity treatment is not safer and is not effective. My experience suggests otherwise. At a juncture when evidence suggests stopping such treatment, I give the patient a choice to stop, or to continue at low intensity. Values of the patient play a role in this decision. I have yet to have an embolic tragedy or a neurologic catastrophe in such patients. When the data and common sense conflict, half way measures which compromise between risk and benefit seem logical, and so far have worked for me.

Three rules flow from this distinction between evidence-based care and experience-based care:

1. If it is harmless, painless and cheap, just try it.
2. Healthy skepticism should greet evidence that is counterintuitive or which conflicts with experience.
3. Truly informed consent should be a part of every treatment that is not evidence-based, and for some that are 'evidence'-based.

Failing to adequately define a limit on interventions requiring evidence to proceed led to a delightful caricature of evidence-based medicine in the BMJ.[3] Gynecology residents published a convincingly constructed article advocating that we subject the hypothesis that parachutes reduce injuries from jumping out of airplanes to a double blind, placebo controlled cross-over study. "The first volunteers should be those who insist on an evidence-base for everything their colleagues do."

I try to be evidence-based on important matters, visiting UpToDate at least daily, being sure to read the POEMS section of AFP first. But I am also shaped by:

- The wisdom of my observations – my gaze is fixed on the patient's face when I examine an abdomen for tenderness, but gaze is fixed on the breast when examining the breast. Emotional contact is required in the first instance and needs to be more distant in the second.
- The wisdom derived from observing colleagues in action – my PA has skills in observation, motivation, physical assessment, diet control that far exceed mine, derived from her 30 years of practice. I am matured by watching her effectiveness.
- The wisdom of other physicians' observations – Jerome Groopman, MD[2], encouraged me to think differential diagnosis out loud to make the patient an ally in arriving at a diagnosis.
- The wisdom of lay observers – a sermon once emphasized "we are defined by our stories." The intent of the title was to develop a thesis regarding how an ethnic group is defined by their stories of origin. We individually are also defined by our stories. Listening to our patients not only helps in diagnosis, but allows the patient an opportunity for self-definition.

Our profession is one of great privilege, joy, intimacy and continual growth.

I feel it but I can't prove it.

I appreciate this opportunity for self-definition.

Endnotes

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Philip Kaplan, MD, FAAFP *practices family medicine in a private group practice in Manlius, NY. He is a Past-President of NYSAFP.*

By Karen Birgit-Pols, MD, FAAFP

ASSESSING AND RESPONDING TO HEALTHCARE PERCEPTIONS OF RURAL

Healthy People 2020 states that, "LGBT health requires specific attention from health care and public health professionals."[1] To begin to address these disparities, it is valuable to consider the environment in which family physicians practice. While the data upon which the Healthy People 2020 recommendation was based came primarily from urban communities, New York State is incredibly diverse, with communities that span the spectrum from urban to rural. While access to healthcare in urban communities is far from perfect, patients in rural communities face different barriers to health care, including expansive geography, limited, if any, mass transit, and health care provider shortages. For LGBTQ+ people these challenges are magnified.

Over the last years, urban and rural communities have continued to become more distinct along demographic lines. Urban communities are younger, more diverse, and more likely to be college educated. Rural populations are older, more likely to live in the state of their birth, and more likely to have served in the military.[2] On an important bellwether issue, recently published data suggests that rural residents are more likely than their urban counterparts to believe that same sex marriage is a bad thing for the US.[3] This lack of acceptance creates barriers to disclosing identity to providers, can instigate stigma (internalized, anticipated, and enacted), and limits access to culturally sensitive and competent providers.[4-10]

Quinn and Earnshaw proposed a model of concealed stigmatized identities suggesting that socially devalued and negatively stereotyped identities will be hidden from others. Disclosing LGBTQ+ identity allows connection and social support and, for patients, is essential for access to culturally sensitive healthcare. However, those living in communities where they feel they will not be accepted will likely hide their LGBTQ+ identities.[4]

Internalized stigma results in LGBTQ+ patients believing negative stereotypes about themselves. This devaluation results in significant deterioration in health and well-being. For instance, Hatzenbueler et al., compared National Epidemiologic Survey Data from 2001-2002, prior to the implementation of same sex marriage bans in disproportionately rural states, to 2004-2005, after the implementation of these bans, discovering significant increases in mood and generalized anxiety disorders. Notably, these increases did not occur in states that had not implemented same sex marriage bans.[5]

LGBTQ+ patients can anticipate stigma and expect negative experiences with health care if they disclose their identity.[6,7] Due to the proximity of rural communities, it is inevitable that community members will cross paths in unexpected ways. Personal relationships with healthcare providers or other staff members are more likely, in such circumstances, and patients can be forced to give up anonymity. Not surprisingly, fear of disclosure grows. The result is that, often, prior negative experiences – personal or related by others – can create substantial barriers to care. They can be so powerful and extremely experienced that they prevent patients from seeking care.[6, 7]

By disclosing LGBTQ+ identity, patients face the real risk of enacted stigma. There are currently no explicit federal protections for LGBTQ+ people against employment and housing discrimination, and currently only 21 predominantly urban states provide such protections.[8] When LGBTQ+ people in more than half the states are not assured such basic rights, the risk of enacted stigma in healthcare becomes very real. In fact, in rural Hawaii, Stotzer et. al. found that 12.5% of respondents reported being refused treatment or being treated poorly.[9]

Even those LGBTQ+ patients who are able to disclose their identities, and confront the powerful stigmas that can be attached to their identities, face significant challenges in engaging with healthcare. While patients hope for culturally-sensitive healthcare, they absolutely have a right to competent care. Tellez et al. reported that more than 20% of rural physicians sometimes felt uncomfortable treating lesbian or gay patients.[10] Patients and patient care cannot help but suffer under those circumstances.[10]

The same forces, acceptance, inclusiveness, diversity, and opportunity, that draw LGBTQ+ patients to urban areas also draw culturally competent LGBTQ+ healthcare providers to those same urban areas. An indirect measure of this is that the overwhelming majority of the more than 200 LGBT Health Clinics listed by the Centers for Disease Control and Prevention are in urban areas.[11] While it would be misleading to assume that these are the only culturally competent healthcare providers for LGBTQ+ patients, it is not unreasonable to suspect that physicians, like patients, would also find these indicators of acceptance. As a result, it can be difficult for LGBTQ+ patients in rural areas to identify culturally-sensitive healthcare providers.

There are more challenges faced by LGBTQ+ patients residing in rural areas. While all marginalized communities are unique, the moniker LGBTQ+ might be described

AND URBAN LGBTQ+ PATIENT POPULATIONS

as conflating the distinct needs of the more than the five communities represented by its initials. In fact, it is only recently that these communities have coalesced under the umbrella of these initials. Within these initials, there has been a natural and long desire to identify and connect like identifying people.

Here stigma worked to bring people together to combat discrimination. Martos et al. propose that Marcarthyism ("A vociferous campaign against alleged communists in the US government and other institutions carried out under Senator Joseph McCarthy in the period 1950–4. Many of the accused were blacklisted or lost their jobs, though most did not in fact belong to the Communist Party."[12]) spawned The Mattachine Society, Daughters of Bilitis, and later Transvestia among the earliest publications addressing gay, lesbian, and transgender identity development.[13] In 1969, the Stonewall Riots can be regarded as turning point, changing the focus from identity development to civil rights advocacy.

Chronologically, this shift in focus coincided with the establishment of the first community health centers in the United States. In 1965, as part of the War on Poverty, the Office of Economic Opportunity, a demonstration program (testing the viability of models in real world situations) funded community health centers tasked with, "using the health care system to change the health and lives of their communities' residents."[14] The LGBTQ+ community, along with other marginalized communities, created community based organizations to advocate for the healthcare needs of their constituents.

As the third edition of *Diagnostic and Statistical Manual* removed homosexuality and added Gender Identity Disorder of Childhood, and the Equal Rights Amendment was passed by Congress and sent to the states for ratification, LGB groups began distancing themselves from the very transgender people that were central to their formation.[15] In New York City, it was not until the mid-1990s that the "T" was added to the name of the Lesbian, Gay, Bisexual & Transgender Community Center and to the mission of the Callen-Lorde Community Health Center (the city's LGBTQ+ community health center).

Shannon Minter, the legal director of the National Center for Lesbian Rights points out that "LGBT community encompasses a diverse range of groups that do not yet represent a community. We need to talk about the LGBT community as an aspiration."[16]

How does the aspiration of an LBGTQ+ community differently affect rural areas? Marriage equality has been a prominent victory for the LGBTQ+ community, and a polarizing issue for the United States. As discussed previously, it has been disproportionately opposed in rural areas. It also might not be the most important issue for rural LGBTQ+ people, who can still legally be discriminated against in employment and housing. The LGBTQ+ moniker suggests an inclusive continuum that experience and history do not substantiate.

While urban areas are better positioned to respond to various intersections, limited scale and resources in less populated areas can focus attempts at inclusiveness on subsections of this aspiring continuum. Just as marriage equality was not the most important oppression for many members of the LGBTQ+ community, so might an effort to improve access to HIV testing might be received as marginalizing by those in the community not at HIV risk.

So, how can physicians, urban or rural, create welcoming spaces for their LGBTQ+ patients? The AMA (American Medical Association) has a number of suggestions.[17]

Healthcare professionals can start by making it easier for patients to find physicians and practices that want to take care of them. GLMA: Health Professionals Advancing LGBTQ Equality is the world's largest and oldest association of lesbian, gay, bisexual, transgender and queer (LGBTQ) healthcare professionals. Individuals can join its provider directory free of charge. Similarly, patients looking for providers can access this directory without cost and are encouraged to ask LGBTQ+ welcoming providers to create listings. However, a recent review of this incredible resource shows that even in the most populated U.S. cities there are shortages of providers accepting new patients.[18,19]

Practices can also sign up and monitor their ratings on the Healthcare Equality Index (HEI) created by Human Rights Campaign. The HEI "evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ patients, visitors and employees." More than 600 healthcare facilities nationwide were evaluated this year.[20]

When patients manage to find physicians and practices, visual cues should be provided to indicate safety and inclusiveness. Practices can display educational material targeted to LGBTQ+ health concerns. Staff can wear symbols (e.g. rainbow ribbons, pronoun indicators) that will indicate openness to LGBTQ patients. Nondiscrimination statements can be posted prominently. Important dates (e.g. National Coming Out Day

continued on page 36

on October 11th, World AIDS Day on December 1st, Pride Month in June) can be recognized. Collaboration with any local LGBTQ+ or HIV/AIDS organizations can be created and featured prominently in waiting rooms and local media. Unisex restrooms can be created.

The patient intake process should be reviewed from the perspective of LGBTQ+ patients. "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community" by The Joint Commission advises inclusive language that would allow LGBTQ+ patient the choice to self-identify.[21] Since announcing sensitive information to a registrar can be difficult, many institutions recommend the use of patient completed forms to collect sensitive information. The AMA highlights the intake forms from Fenway Health as a template.[22]

The Gay, Lesbian, Bisexual and Transgender Health Access Project, a collaborative, community-based program funded by the Massachusetts Department of Public Health, is cited by the AMA as taking this one step further. They have developed Community Standards of Practice as, "a benchmark for both providers and consumers in the development of and search for welcoming, culturally competent and responsive care." Reviewing a practice against these standards can assist physicians in creating safe environments for LGBTQ+ patients to access care improving quality and access.[23]

With all of this in mind, it can seem like there is too much to do, that creating welcoming spaces for LGBTQ+ patients is overwhelming. It can be easy to rationalize, as so many did early in the HIV epidemic, that finding the right pathway to help is too difficult. To that the only response is: don't let the perfect be the enemy of the good. This is a dynamic, constantly changing terrain, where acceptance, a smile, and a willingness to learn can change the health and life arc of your patients.

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Karen Birgit Pols, MD, FAAFP *has been involved in LGBTQIA+ healthcare and advocacy throughout her career, most notably as the first full-time Medical Director of the Callen-Lorde Community Health Center, which is New York City's LGBTQIA+ health center. She is currently a Faculty Attending Physician at Jamaica Hospital Medical Center's Family Medicine Residency Program.*

A big thank you to Dr. Richard Bonanno, who retired from his position as Chair of Family Doctor's Editorial Review Board with the publication of our winter issue. Dr. Bonanno served the journal well since its inception in 2012 and his leadership and experience have contributed greatly to the growth and success of Family Doctor. We wish you many happy edits to come!

NYSAFP Advertising

We welcome Jill Walls to Family Doctor as our new Advertising Consultant. Jill will be working to find additional advertising resources for Family Doctor, as well as other NYSAFP programs and activities and can be reached at 518-489-8945 x5 or jill@nysafp.org.

Editorial Notes

Due to the popularity of our winter issue on LGBTQ health, we have several "overflow" articles in this issue. Due to space constraints, we could not fit them all in our winter issue and appreciate the patience of our authors and readers.

Upcoming Events

2019

June 15-16
Congress of Delegates
Hilton Garden Inn Troy

Aug 3 – 4
Summer Cluster
Hilton Garden Inn, Roslyn

2020

Jan 23 – 26
Winter Weekend
Lake Placid, NY

Timing of Elective Induction of Labor

By Caitlin Weber, MD, MS, FAAFP; Mackenzie Naert; and Lara Weiss, MD

The ideal timing of elective induction of labor (IOL) has long been an important issue for family physicians practicing obstetrics as well as the patients they care for. The decision to induce labor involves a careful balance of maternal health, fetal health, and systems-level constraints. Recommendations regarding the ideal timing of elective induction have shifted over time, often influenced by imperfect data pertaining to rates of cesarean deliveries, adverse maternal and fetal outcomes, length of hospital admissions, and costs.

Since 2013, the recommendations from Choosing Wisely have advised family physicians to "avoid elective, non-medically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable,"[1] however more recent evidence including the results of the ARRIVE trial[2] have reopened the discussion around this topic and the optimal timing of delivery. In this article, we will review the body of evidence informing current practice recommendations regarding the optimal timing of elective IOL, discuss the findings of the ARRIVE trial, and consider how this information may be used by family doctors practicing obstetrics.

Observational Studies Comparing IOL to Spontaneous Labor

Historically, recommendations to avoid labor induction prior to 41 weeks have been based on several studies demonstrating increased risks to the mother. One study of 1017 nulliparous women who were induced without an identified indication, compared to 3603 women in spontaneous labor found that 19.4% of women in the IOL group underwent a cesarean delivery compared to 9.9% of controls (RR 1.77).[3] Another study supported these results, with 17.5% of nulliparous women (n=143) undergoing cesarean compared to 7.8% of women in spontaneous labor (n=1143) (RR 1.89).[4] Additional studies further support these findings, but include women induced for both elective and indicated medical reasons, which can bias the data due to risks associated with the underlying medical reasons for induction.[5,6] Other adverse maternal outcomes associated with elective induction of labor vary by study. In 2000, Dublin et al. found that women undergoing IOL were more likely to have a delivery requiring the use of vacuum or forceps (OR 1.2),[3] and multiple studies have shown an increased risk of hemorrhage among patients undergoing IOL.[7,8]

Other critiques of elective IOL revolve around health-systems level concerns. Studies in both nulliparous women and populations of mixed parity have found that women undergoing induction spent 3-4 hours longer in the hospital from admission to delivery than women in spontaneous labor.[4,9] Other studies have shown increased intrapartum interventions for patients undergoing IOL including internal fetal monitoring and epidural anesthesia.[10-12] Costs associated with the management of IOL have been calculated to be 17.4-25% higher when compared to women in spontaneous labor across multiple studies,[4,9] and increased costs have been borne out in studies controlling for parity and cervical exam as well.[13]

Studies Comparing IOL to Expectant Management

A major issue with the commonly cited observational studies described above is that they compare women undergoing IOL with those in spontaneous labor. The problem with this is that it is not reliable to assume that a woman who is not induced will go into spontaneous labor at 39 weeks. Thus, the clinically meaningful comparison group would be patients undergoing expectant management.[14]

Most randomized trials comparing elective labor induction with expectant management have failed to demonstrate differences between the groups in terms of rates of cesarean delivery, operative vaginal delivery, or other maternal and perinatal morbidities; however these trials have been small and underpowered to detect differences even if present. One randomized controlled trial from 1992 did find fewer cesarean deliveries among those undergoing IOL (21.2%) compared to those managed expectantly (24.5%).[15] Among observational studies comparing women undergoing IOL with those undergoing expectant management at the same gestational age, one study showed a higher chance of cesarean delivery in expectantly managed patients (Adjusted Odds Ratio 1.80).[16] Another study showed no difference in the chance of cesarean between the two groups but longer time in labor and delivery and greater use of oxytocin in the women who were induced.[17]

The above heterogeneity of data as well as limited quality and generalizability of many of these studies has resulted in a wide range of local practices around the ideal timing of IOL. Few have directly examined maternal and fetal morbidity associated with earlier IOL compared to expectant management. As a result, the recently published ARRIVE trial has prompted a significant shift in the discussion on this topic and may result in major changes in practice, as the first large, randomized controlled trial sufficiently powered to examine such clinically relevant outcomes.

Results and Review of the ARRIVE Trial

The ARRIVE trial is a multicenter trial designed to address outcomes of elective induction of labor at 39 weeks with regards to perinatal death or severe neonatal complications and caesarean delivery. Low risk nulliparous women between 38 weeks 0 days to 38 weeks 6 days from 41 hospitals in the Maternal Fetal Medicine Network Unit were eligible to participate. Of the 22,533 women eligible to participate, 27% agreed to participate. Women were randomized to two groups, induction at 39 weeks 0 days to 39 weeks 4 days versus expectant management. In the expectant management group, women were not induced until 40 weeks 5 days to 42 weeks 2 days unless medically indicated.[2]

The primary outcome was a composite of several complications related to severe neonatal adverse outcomes including perinatal death, Apgar score of less than 3, hypoxic-ischemic encephalopathy, and other clinically significant adverse outcomes. The primary outcome occurred in 4.3% of neonates of women in the induction group and 5.4% of neonates of women in the expectant management group, and was not statistically significant as these outcomes are fortunately rare (p=0.049).[2]

The main secondary outcome was rate of caesarean section delivery, which was significantly lower in the induction group than in the expectant management group, at 18.6 % vs. 22.2%. Another important finding was that there was a significant decrease in hypertensive disorders of pregnancy in women in the induction group versus the expectant management group (9.1% vs. 14.1%, P<0.001). Other secondary perinatal outcomes such as birth weight, shoulder dystocia, and other less severe neonatal outcomes were not significantly different between the two groups.[2]

While a potential reduction in cesarean delivery is notable, the ARRIVE trial does have several important limitations, particularly in regards to generalizability, which many reviewers have acknowledged. Participants in this trial were younger than the average woman giving birth for the first time, at 23 in the induction group and 24 in the expectant management group, compared to a mean age of 26.6 in the US as of 2016.[18] In addition, 53.5% of women in the study population were obese, compared to an average rate of 36.5% of women of similar age group in the US.[19] Because of the demographic differences between the study population and the general population, generalizability of results is limited, and of course provide no information regarding the management of multiparous women. Furthermore, the higher average body mass index of study participants may limit the generalizability to women considered low risk, as identified by several letters to the editor accompanying the publication of this study.[20]

Although this is a randomized trial, potential biases still exist, most notably ascertainment bias as blinding is not feasible in a study of this nature. Caution should also be advised in interpretation of the study outcomes in regard to neonatal and maternal outcomes. As mentioned above, there was no difference in this study's primary outcome of severe neonatal adverse outcomes. The primary outcome was a composite of many rare perinatal outcomes, and this study was not powered to detect differences in less common outcomes, both neonatal and maternal. This questions whether or not further outcomes should have been explored in this study and if a statement can truly be made that IOL at 39 weeks did not result in greater frequency of adverse outcomes.

Challenges to Changing Practice

While earlier IOL may help improve maternal outcomes for select patients, other factors must be considered for any potential change in practice, particularly in regards to the impact such a change could have on healthcare systems. Feasibility will vary greatly by healthcare system and region. Cost, hospital bed availability, and staffing are all potential barriers.

Several economic analyses have addressed the question of cost. This includes those reviewed above, as well as work out of the UK and other countries which will be less applicable to the US healthcare system.[21] While labor induction will result in longer hospital stays and increased costs compared to spontaneous labor, the reduction in cesarean delivery rates as well as maternal and neonatal morbidity associated with earlier induction must be weighed against these costs.

Different practice patterns around labor induction may also alter the generalizability of these results. While in the United States current standard of care is to initiate labor induction in the hospital, outpatient induction with a variety of methods has been studied and is currently practiced in some countries. However, safety data is currently insufficient.[22,23] It is possible that should outpatient labor induction become more widely utilized, some of the potential cost-related barriers to universal IOL at 39 weeks could be overcome and hospitalization duration could be decreased, however, further study of this topic is needed.

Conclusions

Historically, the data regarding optimal timing of IOL has been mixed. While the ARRIVE trial suggests potential benefits to induction at 39 weeks for low-risk nulliparous women, particularly in regards to decreasing cesarean deliveries and hypertensive disorders of pregnancy, further research is certainly needed prior to making significant changes in practice given the limitations discussed above.

Furthermore, while some healthcare systems may have the staffing and beds available to allow for longer labor and delivery stays, this will not be the case in all settings. Some physicians may be able to advocate for earlier inductions for appropriate patients, yet hospital policy may prohibit this for others. Likewise, while some patients may be eager to pursue induction at 39 weeks, others are likely to prefer waiting for labor to begin on its own.

It is essential for the family physician practicing obstetrics to understand the potential advantages and disadvantages of labor induction at 39 weeks in order to have well informed conversations with patients, particularly as more and more popular news outlets are reporting on this topic.[24,25] The results of the ARRIVE trial are interesting, yet not sufficient to change practice at this time. The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine have both endorsed a shared decision making approach to this topic, taking into account the limitations of healthcare systems and infrastructure.[26] As with many decisions in pregnancy as well as medicine in general, the ongoing relationship between the family physician, their patient, and their patient's family creates an ideal environment for such conversations, including the careful application of available evidence as well as patients' preferences.

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continued on page 40

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Caitlin Weber, MD, MS, FAAFP *practices family medicine with obstetrics and supervises family medicine residents. She is faculty at the Harlem Residency in Family Medicine and is an Assistant Professor at the Icahn School of Medicine at Mount Sinai in New York City. She attended Albany Medical College, followed by a residency in family medicine at the University of Texas at Austin Dell Medical School and a fellowship in family planning at Columbia University Medical Center in New York.*

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

Lara Weiss, MD *is a first year resident at the Harlem Residency in Family Medicine. She is interested in geriatric, palliative and primary care in underserved populations.*

Trans-Affirming Primary Care: What Family Physicians Need to Know

By Zil Goldstein, NP; Joshua D. Safer, MD, FACP; Cheyenne Stewart, MPH; Terri L. Wilder, MSW and Antonio E. Urbina, MD

Family physicians are the front line in patient care, both being the first medical provider to evaluate a patient in a primary care setting, and being responsible for their patients' holistic well-being throughout the life span. There are an estimated 76,800 transgender people in New York State (NYS), and recent trends show more transgender people presenting to care[1]. At the same time, family practice practitioners are challenged with both limited training, and difficulty finding evidence-based primary care guidelines for transgender care. Available data report significant health disparities in this population, including increased rates of human immunodeficiency virus (HIV), poor rates of engagement in preventive care, and challenges accessing necessary health services, showing the importance of culturally and medically competent care for these individuals.[2]

In addition to specific medical knowledge around the assessment and provision of primary care, there are many aspects of culturally competent care that should be addressed to make transgender people feel welcome to access and engage in care. Transgender people often change their names from the name given at birth, and often use pronouns (i.e. she/her/hers) that are inconsistent with sex recorded at birth. It is important for all health care staff to use patient-indicated names and pronouns. This information should be collected on intake forms and displayed in the medical record such that all staff who interact with patients have access to the correct names and pronouns.[3] Staff who do not interact directly with patients should still undergo basic cultural competency training as to avoid missteps.

It is important to keep cultural competency concerns in mind during the clinical encounter as well. Transgender patients may use terms other than the anatomical names of body parts to refer to their bodies. For example, transgender men (people with male gender identity who were female-recorded at birth) may say "chest" instead of "breasts," and may use a variety of terms to describe their genitals. Regardless of the patient's gender identity, the family physician should wait for the transgender person to describe their body using terms that make the patient comfortable, and repeat that language when referring to that body part. Transgender patients may also be reluctant to undergo a physical exam, and may be wearing garments that help pad or compress their body into a more masculine or feminine shape. It may be important to only expose the body part being examined rather than to ask someone to change into a gown as this helps the patient feel as though they are less exposed, and more comfortable during the exam. Lastly, when working with transgender individuals, family physicians need to remember that someone's gender identity does not determine what body parts (i.e. mammary tissue, a cervix, or prostate) they have or their sexual activity, and both should be ascertained in order to take a complete history.

Primary Care for the Transgender Patient

Primary care for the transgender patient does not significantly differ from primary care for the cisgender patient (people whose gender identity aligns with sex recorded at birth) with the exception that gender identity and expression are not indicators of what body parts require screening. An organ inventory is an important part of history taking with transgender patients to assess what body parts are present and require appropriate screening. This inventory should specifically determine if the cervix, uterus,

ovaries, mammary tissue, prostate, and testes are present as these organs all have significant implications in the care of the transgender patient or require routine screening that will need to be discussed. Please see Table 1 for screening recommendations.

Cervical cancer screening in transgender men with an intact cervix is one area that requires special consideration. Transgender men have both lower rates of adherence to cervical cancer screening and higher rates of unsatisfactory cytology results.[4,5] A speculum exam may be more uncomfortable for transgender men on testosterone due to atrophic vaginal changes that accompany testosterone treatment, and this may worsen gender dysphoria. To facilitate screening, consider self-swabs for human papilloma virus (HPV) which have been shown to be as sensitive as provider-collected specimens in detecting high-grade disease, and are often preferred by transgender men to a speculum exam.[6,7]

Eliciting a sexual history from a transgender patient can be difficult if either the physician and/or the patient are uncomfortable talking about the transgender person's body. Mismatch in terminologies may result. As an example, patients may refer to the "front" of their genitals, meaning the penis or vagina, and the "back" of their genitals, meaning their rectum. Open-ended questions such as, "What are the genders of your sexual partners?" and "How do you like to have sex?" can help create an environment in which the patient can choose the language most comfortable to them to describe their bodies. These questions can help start a dialogue between patients and physicians to open a discussion about specific sex acts, and whether or not barriers are used, to determine the best practices for screening for sexually transmitted infections, post-exposure prophylaxis (PEP) or pre-exposure prophylaxis (PrEP).

Contraceptive and Fertility Counseling

While hormone therapy does make conception more difficult, it is not a reliable form of contraception for transgender patients.[8] Transgender individuals require some form of contraception to avoid pregnancy during sex. Transgender women are encouraged to use barrier protection during insertive sex, both to prevent sexually transmitted infections and avoid pregnancy if their partner is capable of becoming pregnant. If transgender men are having receptive sex that puts them at risk for pregnancy, barrier and/or hormonal birth control are warranted. Hormonal contraception in transgender men should avoid estrogens, as they will promote feminization. Medroxyprogesterone acetate injections, levonorgestrel intrauterine devices, or etonorgestrel implants are the preferred methods of hormonal contraception in transgender men.[9] Any transgender person practicing receptive sex with multiple partners of unknown or uncertain HIV status or a known HIV+ partner, should consider starting PrEP, a daily pill that can help prevent HIV.

The most important times to discuss fertility preservation for transgender patients is prior to the initiation of hormone therapy and prior to gonadectomy. While hormone therapy is not effective birth control, it does reduce fertility, stopping or dramatically reducing sperm production in transgender women, and stopping oocyte maturation in transgender men.[10] Puberty suppression in transgender youth followed by masculinizing or feminizing hormone therapy can lead to life-long infertility. Transgender men are often able to get pregnant after stopping testosterone, and have demonstrated good response to egg harvesting techniques.[11] Less is known about the effects of stopping feminizing hormone therapy in transgender women, though existing data suggest that sperm production returns to viable levels after discontinuation of hormone therapy.[12]

HIV Prevention for Transgender Patients

There is a higher prevalence of HIV and elevated risk of becoming infected with HIV in transgender communities, particularly for transgender women.[13] An estimated 21.6% of transgender women in the United States are living with HIV, and rates are higher amongst female transgender racial and ethnic minorities.[14] Factors such as high unemployment, housing instability, discrimination, violence and poverty all contribute to increased risk of HIV infection amongst transgender women.[15] Given the high prevalence of HIV, a discussion about PrEP and PEP as possible bio-behavioral interventions for patients who are HIV-negative should be considered in most instances.

PrEP

Providing PrEP to persons at-risk for HIV is the third step of Governor Cuomo's three-point plan to end the HIV epidemic in NYS by 2020.[16] PrEP is a preventative intervention consisting of two HIV antiretrovirals (tenofovir disoproxil fumarate and emtricitatbine—brand name TruvadaTM) in a once daily single-tablet to prevent HIV infection. PrEP has been shown to be effective across various populations, including transgender populations, men who have sex with men, persons who inject drugs and heterosexual populations.[17] Individuals who are at high-risk for HIV should be offered PrEP, including candidates who self-identify as at-risk, even without disclosing risk behaviors. HIV high risk behaviors include unprotected anal or vaginal intercourse with partners who have an unknown HIV status, untreated HIV, or a detectable viral load while on treatment for HIV. They also include having barrier-free

Table 1: Routine Screening for Transgender Patients

Organ	Test	Who is it for?	Special considerations
Mammary tissue	Mammogram	Transgender women over 50 y/o and on hormone therapy >5 years; Transgender men >50 y/o without chest masculinization	Transgender women often have dense breast tissue; consider ordering U/S in case mammogram is insufficient
Mammary tissue	Clinical chest exam	Transgender men s/p chest masculinization surgery	Palpate for any new lumps or bumps after surgery; lymph nodes may be enlarged at baseline
Cervix	HPV and/or cytological screening	Transgender men without hysterectomy	Consider HPV self-swab
Prostate	Prostate specific antigen (PSA) or digital exam	Transgender women	Individual consideration for each patient; PSA ULN should be lowered to 1.0 if androgens are suppressed

continued on page 42

Trans-Affirming Primary Care.... continued from page 41

sex with multiple or anonymous partners, engagement with transactional sex or with partners who are involved in transactional sex, and injecting substances or having partners who inject substances, including hormones and illicit drugs. If someone has had an STI in the previous twelve months or has received multiple courses of PEP, they are also considered to be a candidate for PrEP. Clinicians should provide baseline HIV testing to determine whether the patient is HIV negative and eligible for PrEP.[18]

Many transgender people are willing to take PrEP, but there are many potential barriers to accessing it and achieving high adherence amongst this population. Transgender people often have lower access to care and more complicated housing and employment factors that can affect adherence.[29] The lack of trans-inclusive marketing for PrEP and medical mistrust also present barriers.[30] Effectiveness of PrEP depends largely on adherence, so it is important to address this frankly.

Some transgender women may have concerns about PrEP interactions with feminizing hormones.[31] PrEP does *not* have significant effects on levels of feminizing hormones, and it is important to share this information with your patient.[35] One study showed that feminizing hormones decreased tenofovir levels by 17%. Although this is a non-significant decrease, further research is needed to fully understand this interaction. Overall, PrEP confers protection against HIV acquisition if adherence is followed.[19]

NYS has worked to make sure access to PrEP is not a barrier to those who need it. Most insurance plans, including New York State Medicaid, cover Truvada™ for PrEP. The NYS Department of Health AIDS Institute also has a PrEP Assistance Program (PrEP-AP) to reimburse providers for costs of providing care and laboratory testing of uninsured and under-insured patients.[20] Gilead also has a PrEP Medication Assistance Program for eligible adults.

PEP

For individuals who are not taking PrEP but report a high risk exposure, PEP is a post-exposure intervention, consisting of a 28 day regimen of triple combination HIV antiretrovirals started (ideally) within two hours of HIV exposure, but no later than 72 hours after exposure.[21] The sooner PEP is started, the better. It is best practice to conduct HIV testing at baseline, before prescribing, but lack of access to laboratory testing should not delay initiation of PEP. Testing for HIV infection should be repeated at 4-6 weeks and 3 months after exposure. When counseling patients about PEP, providers should also talk to them about whether PrEP might be right for them, beginning it immediately following the course of PEP.[22]

Resources

The New York State Department of Health Clinical Education Initiative (CEI) provides free CME trainings for physicians in NYS. This spring, CEI is launching 5 new CE-accredited courses on transgender-affirming care available for in-person trainings. To request a training or to view online courses, please visit www.ceitraining.org. To speak with a clinician experienced in HIV, HCV, STIs, PEP, or PrEP, call the CEI Line toll-free at 1-866-637-2342.

CEI is also offering a clinical conference for medical providers on transgender-affirming health and medicine in New York City on June 28th, 2019. For more information email Terri.wilder@mountsinai.org.

Additional Resources

Truvada for PrEP Medication Assistance Program: https://www.gilead.com/responsibility/us-patient-access/truvada-for-prep-medication-assistance-program

Clinical Education Initiative Website: https://ceitraining.org/

NYS Pre-Exposure Prophylaxis Assistance Program (PrEP-AP): https://www.health.ny.gov/diseases/aids/general/resources/adap/prep.htm

The Center of Excellence for Transgender Health: http://transhealth.ucsf.edu/

Mount Sinai Center for Transgender Medicine and Surgery: https://www.mountsinai.org/locations/center-transgender-medicine-surgery

Endnotes

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Zil Goldstein, NP *is the Associate Medical Director for Transgender and Gender Non-binary Health at Callen-Lorde Community Health Center. She is also an Assistant Clinical Professor of Medical Education at the Icahn School of Medicine at Mount Sinai. Ms. Goldstein provides education and training in transgender-competent care for providers and residents throughout the Health System. She is a published author on transgender and sex worker health and is a nationally recognized leader in both fields.*

Joshua D. Safer, MD, FACP *is the Executive Director of the Center for Transgender Medicine and Surgery, Mount Sinai Health System and Icahn School of Medicine at Mount Sinai. Dr. Safer is the president of the United States Professional Association for Transgender Health (USPATH) and a board member of the World Professional Association for Transgender Health (WPATH). Dr. Safer's research interests focus on quality of life improvements attributable to increased access to medical care for transgender individuals.*

Cheyenne Stewart, MPH *is a program coordinator at the HIV/HCV Center of Excellence at the Mt. Sinai Institute for Advance Medicine in New York City. After completing a Watson Fellowship investigating empowering maternity care internationally, she completed her MPH at the University of North Carolina Chapel Hill, where she specialized in sexual health and LBGTQ health.*

Terri L. Wilder, MSW *is the Director of the HIV/HCV Center of Excellence at the Mt. Sinai Institute for Advanced Medicine in New York City. She has worked with the HIV and LGBT community since 1989 providing social services and coordinating education programs for clients and medical providers.*

Antonio E. Urbina, MD *is the Medical Director for the Mt. Sinai Institute for Advanced Medicine Downtown Clinic in New York City. Dr. Urbina serves as a Medical Director for the Clinical Education Initiative of the New York State Department of Health AIDS Institute as well as Associate Professor of Medicine at the Icahn School of School of Medicine at Mount Sinai.*

Stony Brook Medicine

School of Medicine
Department of Family, Population, and
Preventive Medicine
Stony Brook, NY 11794-8461

TEL: 631.444.8430

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To the Editors of Family Doctor:

In this issue of Family Doctor focusing on controversies in medicine, I want to express my dismay when I learned that the **Delegates of the Academy of Family Physicians** adopted the position last October to remain **neutral on physician assisted suicide** as well as changing the language to "Medical Aid to the Dying". This is a euphemism that is misguiding. Family doctors along with our palliative care colleagues have always provided care to the dying so that our patients' deaths are peaceful and painless. Physician assisted suicide is ending a person's life when they are not in the dying process. Changing our language and taking a neutral stance could result in unethical treatments in ending the lives of vulnerable populations because we think we are providing compassionate care when we are really making judgments about quality of life. I am relieved that the code of medical ethics of the **American Medical Association** has not changed and states: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." (AMA Principles of Medical Ethics: I, IV). Elie Wiesel at his Nobel Peace Prize acceptance speech stated: "Neutrality helps the oppressor, never the victim." As physicians, we have the privilege of helping our patients and their families at the end of their lives but I do not have the right or authority to end someone's life.

Sincerely,
Jeanine Morelli MD
Clinical Assistant Professor

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

Highlight on VACCINATIONS 4 TEENS

Features a robust Resource Library of materials for family physician offices, including:

- **Back-of-office materials**
  - Q&A to address questions from teen patients and parents/guardians
  - Three educational videos from Dr. Margot Savoy, MD, MPH, FAAFP and AAFP liaison to ACIP, on:
    - The value of the immunization platforms and making the most out of the 11-12 and 16-year-old visits
    - Tips for using the schedule
    - Standing orders and activating staff as champions
  - Links to other educational videos on meningococcal and HPV vaccination
  - A fact sheet on the importance of addressing under-vaccination

- **Front-of-office materials**
  - Reminder communications for parents/guardians
    - Letters/emails
    - Postcards
    - Text messages
  - Teen vaccination overview poster/handout
  - Template digital and social media content directed to teens and parents/guardians
  - Personal testimonials

Visit www.aafpfoundation.org/vaccinations4teens to download these resources.