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# Medicine Health RHODE ISLAND

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## Sexual Health

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## Commentaries

### Intimidation

**I am not a smiley, friendly-appearing person.** In medical school one friend nicknamed me, “Grim.” Luckily it didn’t stick. No one else called me that. Recently I forwarded an extremely funny e-mail to a friend, who showed it to his wife. This triggered an e-mail from her telling me not just how funny she found the vignette, but how much funnier it seemed because it came from me, someone who seemed serious all the time, not inclined to the humorous or frivolous.

For the annual meeting of the Parkinson Study Group, a consortium of 82 Parkinson’s Disease clinical research centers, I have been writing and producing a presentation of satirical abstracts on the “latest” breakthroughs for the past six years. I was the first to introduce Alien Abductions as a Risk Factor for the Development of Parkinson’s Disease in Southern California. At the same meeting I introduced the relatively revolutionary (but obvious) concept of the intellectual black hole, the power certain people have to lower the IQ of those around them. Of course I thought these concepts amusing, and they were well received, but, what I was told made them especially funny, was that they came from me. “Who’d a thought?” captures the response. “Who thought that guy had a sense of humor?”

I have a “serious” demeanor. While I collect jokes, frequently quip and think of myself as amusing, I do realize that I don’t smile and apparently always look like I’m about to impart bad news. “Grim.” When I picked my son up in Little League, another kid asked if I was the “one who looks like an assassin.” It bothers my wife, but not my children. My staff have frequently told me, over the years, about patients telling them, as they make a follow-up appointment, “Oh, Dr. Friedman is so nice. I was so surprised. He seems like such a serious man. I was afraid when I went into the office.” (Of course they don’t share the bad comments.)

Recently a 45 year-old man with PD told me that he was doing very well, and that although he had a lot of tremor in the office, he rarely shook at home. I made him nervous and anxiety worsens tremor. I was used to that. It

happens to most of my patients. He then told me that he found me “intimidating” and therefore preferred to see the nurse practitioner who worked with me. Obviously I was so affected that I’m writing this column. I responded immediately by yelling at him. No, actually I didn’t. I told him that I was very sorry that I made him feel that way, that I knew he wasn’t alone in that, and that I certainly wanted him to feel comfortable, so that perhaps he should switch his care to the nurse practitioner full-time (patients usually alternate visits) and that she would consult me when there were problems. He liked that idea but as the meeting came to a close he told me he felt much more comfortable and wanted to follow up with me in the usual routine, alternating with the nurse. That was better than his thanking me for telling him he didn’t *have* to see me again.

*Oh wad some power the giftie gie us  
To see ourselves as others see us.*

— Robert Burns

It is certainly a gift to see ourselves as others see us, and it isn’t always flattering. I know that I’ve always looked serious. I do have a sense of humor, but I am serious. I don’t smile much, but I’ve never thought of myself as intimidating. I get notes from my patients’ families thanking me for my patience and solicitude, for the pleasant ambience of the office, for the sense of caring the staff and I create. When I get a note from a family member after my patient dies it is always heart-warming. I must be doing something right. So I have concrete evidence that I don’t intimidate everyone, and that some people even view me fondly.

Last year I answered a phone call from an intern while I was on call and was my usual stern self. While the intern couldn’t see my unsmiling face, I guess the tone and inflection of my voice matched the facial expression, and when I asked why I was called, after the case was described, I guess I created the impression that someone should have done some more thinking before they disturbed me. Not unreasonable exactly, but my daughter, now a medical student, was in the same room. “Dad, you’re



terrible. That could have been me at the other end of the phone. I’d be crying if you spoke to me like that.” I haven’t been mean to a house-officer or student since. I go out of my way to sound nice, to sound interested, to try to make a few teaching points, comment about the challenges of the case and then express thanks for being called. I’ve tried hard to become a “nice guy” or at least sound like one.

I’ve tried to smile more at people since being called an intimidator. I can’t do it. Try it. Smiling takes a lot of work if you’re not used to doing it. Sounding nice on the phone is easy since the interactions are short. Try smiling for 20 minutes. But I haven’t changed my practice style. I never raise my voice. I’ve always listened to patients, tried to have them express themselves, and respond supportively. I never lecture patients. I never say, “My way or the highway.” I joke when I can. I have always maintained my role as an advisor, not as the director. I recommend. I don’t command. Unfortunately I do it without a smile. Some of my patients have taken to calling me by my first name, something I almost never do to them, having trained at a very WASP-ish Ivy League medical school. I always take that as a good sign.

Change begins with self knowledge. I don’t know if I can change. I do not think it is good to have patients, even a small minority of them, think their doctor is intimidating, even if he may be “the best” (whatever that means). An intimidating doctor can’t be very good because medicine is now and will always be an art. Knowing “everything,” and being clinically astute are important, but being a reassuring, compassionate and welcome anchor in the storm of a chronic disease is a gift beyond measure. Maybe that’s why I stress how disturbed some patients are by their “masked facial expression” when I talk about Parkinson’s disease.

— JOSEPH H. FRIEDMAN, MD

# The Right of the State To Sterilize

**Few now remember the name of Carrie Buck,** a citizen of Virginia who died in anonymity in 1983. Yet her name, and the legally sanctioned travails that she endured in the name of “the greater good of society”, have become crucial milestones in this nation’s struggles to define the margins of individual freedom and the safeguards of civil liberties.

Heritability of such qualities as intelligence and its alternative, feeble-mindedness, is a relatively recent concept. Social scientists in both England and Germany during the 19<sup>th</sup> Century were influenced by the discoveries that specific physical attributes, such as eye or hair color, were genetically transmitted to succeeding generations in a predictable manner. The work of Gregor Mendel on the breeding of flowering plants had demonstrated the inheritance of such physical qualities as color or shape of blossom. He postulated that botanical seeds carried packages of discrete genetic information – later called genes – which determined the physical traits of the offspring.

Francis Galton, in Britain, believed that still other human attributes might be passed on to the next generation; and that amongst these traits was the ill-defined “intelligence”. Simultaneously, other social scientists were devising ways of quantitating this attribute called intelligence.

The self-proclaimed guardians of the intellectual purity of future generations were being armed with ways of allegedly quantitating intelligence. Galton and others elaborated a new discipline which they called eugenics [defined by them as the science of improving the quality of the human species by selective breeding.] Crucial to this concept was the fervently held concept that humanity would be immensely enriched if those who were mentally defective were prevented from breeding. Galton and other eugenicists envisioned a future world blissfully free of the ignorant, the wastrel, the vandal, the prostitute and those with inherited criminal tendencies. This transformative purification was to be accomplished merely by eliminating “mental defectives” from the genetic pool. Galton’s eugenics influenced the thinking of many, including those who determined the ethnic restrictions incorporated in the immigration laws of the United States.

Switzerland, in 1886, was the first nation to translate eugenic theory to operative legislation when it sanctioned surgical castration for those with mental disabilities and “sexual neuroses”. Indiana, in 1907, was the first American state to authorize sterilization; and in 1924 Virginia adopted a law – in the interests of the greater society—allowing compulsory sterilization of those deemed to be mentally retarded.

The Virginia State Colony for Epileptics and Feeble Minded, on September 24, filed a petition to surgically sterilize Carrie Buck, an 18-year-old patient. Carrie’s mother, a 52-year-old woman, was said to have a mental age of 8 although this was never independently verified. She had borne three children, each with a different father. Furthermore, there was an allegation that she had once engaged in prostitution. Carrie, as a young child, was adopted and attended school until the sixth grade. She became pregnant at age 18 and because of “incorrigible behavior and promiscuity” was transferred to State custody. [Her pregnancy was later found to be caused by rape by a relative of the adopting family.]

Carrie sought relief from the courts to avoid surgical sterilization; the case [*Buck v. Bell*] eventually wound its way to the United States Supreme Court in the Spring of 1927. In an 8 to 1 decision [only Justice Pierce Butler dissenting] the Supreme Court upheld the judgment of the lower courts that the State of Virginia had the right to undertake the sterilization procedure.

The majority opinion, written by Justice Oliver Wendell Holmes, Jr, legitimized eugenic sterilization in this nation. In the opinion of the Court, “...the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives...without serious pain or substantial danger to life”. Justice Holmes’ opinion declared that “Carrie Buck is the probable potential parent of socially inadequate offspring”.

Does the enforced sterilization deprive a woman of her civil liberties? Holmes wrote that if society can ask individuals to sacrifice their lives for the protection of their country and if this nation may demand compulsory vaccination, then surely it may sanction compulsory sterilization for the general welfare. “It is better for all the world,” wrote Holmes, “if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.” And finally he declared, “Three generations of imbeciles are enough”.

The Court, in its sweeping pronouncements, made two assumptions which subsequently proved erroneous. First, that the diagnosis of “feeble-mindedness” can be accepted when based solely on the subjective judgment of a single observer. The subsequent lives of Carrie, her mother and her daughter indicated neither incapacity for self-care nor promiscuity. And second, that feeble-mindedness or criminality are discrete attributes, which are readily passed on, genetically, from generation to generation.

The compulsory sterilization statutes in 28 states resulted in the involuntary sterilization of 25,403 Americans between 1933 and 1937. The cited justification included diagnoses such as epilepsy, manic-depressive psychosis and schizophrenia. In Germany, where the procedure was carried out for political as well as medical reasons, the number of individuals sterilized exceeded 600,000 during that same interval.

Virginia’s sterilization law was repealed in 1974. There is still no scientific proof that promiscuity, ignorance, indolence, criminality or laziness are inheritable. Ignorance, particularly, remains as an easily nurtured trait needing no assistance from genes.

— STANLEY M. ARONSON, MD



# Sex, Culture, and Health: What Doctors Need To Know

**Why has cultural competence become a buzzword in health care?** Over the past few decades, it has been recognized that if providers do not pay attention to the cultural issues of their racial and ethnic minority patients, they may miss important information that may have great bearing in providing patient care. Clinically relevant cultural issues include whether patients use alternative/complementary therapies that are indigenous to their local communities, or have belief systems that may influence medication adherence. Minority patients may have different therapeutic and allergic responses to medications because of genetics, and may need educational materials translated into their primary languages or in a more understandable vernacular. Patients who perceive their providers as insensitive, judgmental, or ill-informed may hesitate to discuss salient concerns.

Some may ask whether the same considerations are relevant for the care of **gay men, lesbians, bisexual and transgender (LGBT)** individuals. Increasingly, the answers are "Yes." These groups may often be invisible, since many people who have same sex partners may appear "straight" and may even be married to a partner of the opposite gender. Sexual orientation is a complex concept that changes over time and differs among cultures, with at least three major domains: sexual attraction, sexual identity, and sexual behavior. Culturally sensitive providers can help their patients who have clinical concerns or questions related to their sexuality. Providers who are perceived as sensitive and aware may be able to play a vital role in their patients' health care at pivotal times, e.g. assuring adolescents that their same-sex attraction is not a "sin." The provider may be able to help adolescents obtain counseling in order to make life style choices which will have an impact on their subsequent development. The physician may be the first professional to whom a married man or woman confides an evolving same-sex preference. This trusted link is not only important for a patient's psyche, but may have public health implications, since the clinician can offer HIV and STD screening when appropriate, protecting heterosexual and homosexual partners.

In order to learn the most about patients' identity and behavior, it is often helpful to ask open-ended questions, to listen to how patients describe their partners, and to avoid making assumptions based on patients' appearance and superficial characteristics. For many sexual behaviors, it is more important to understand what people actually do with their partners than to make assumptions based on whether people label themselves as "gay" or "heterosexual" or "bisexual." For example, if a man engages in receptive anal sex, the clinician should screen for rectal gonorrhea, chlamydia, HPV, HIV, etc. independent of what the patient calls himself. If a woman says she is a lesbian, she may still need a cervical Pap smear because of prior sexual encounters with men. Many providers need to develop a comfort level, where they can ask questions about sexual practices and social identity with sufficient ease to inspire confidence on the part of anxious patients, who may have few other opportunities to discuss these highly personal, yet terribly important,

issues.

Clinical education around cultural competence generally involves two major components: an increased understanding of how members of a culture view themselves and their relations with the health care system, and an improved understanding of the illnesses that are most commonly manifested in specific population groups. For LGBT populations, providers should think about making their clinical practices user-friendly, ranging from providing health educational information that is inclusive of people with diverse patterns of sexual expression, to not presuming that patients' primary partners are necessarily of the opposite gender. In terms of knowing more about specific health care needs of LGBT populations, this issue of *Medicine & Health/Rhode Island* is a good place to start, with focused articles covering the medical and mental health needs of these LGBT populations. However, one short monograph cannot be exhaustive for such a diverse array of subpopulations and clinical issues. One excellent resource on LGBT health is a companion document created to complement the US Public Health Services Blueprint for National Health "Healthy People 2010," published by the Gay and Lesbian Medical Association ([www.glma.org](http://www.glma.org)). Other excellent resources include the American Medical Student Association's LGBT section ([www.amsa.org/adv/lgbtpm](http://www.amsa.org/adv/lgbtpm)), and the National Coalition for LGBT Health ([www.lgbthealth.net](http://www.lgbthealth.net)). The intent of this issue of *Medicine & Health/Rhode Island* is to begin a dialogue that leads to improved health outcomes for the 5%-10% of the Rhode Island population that identifies with one of these sexual minority populations. We hope that the information in this monograph will be informative. We welcome feedback from readers.

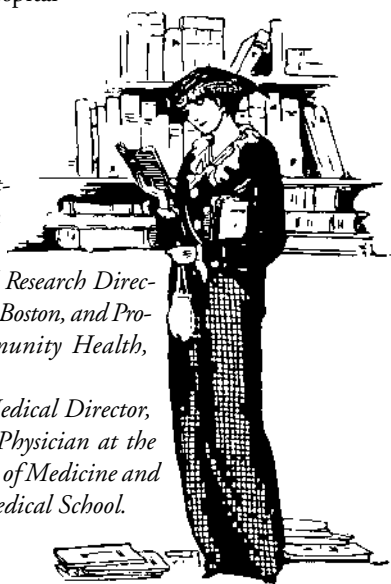
— KENNETH MAYER, MD, AND JOSIAH RICH, MD

## CORRESPONDENCE

Kenneth H. Mayer, MD  
Brown University/Miriam Hospital  
164 Summit Avenue  
Providence, RI 02906  
Phone: (401) 793-4711  
e-mail: Kenneth Mayer, MD

*Kenneth Mayer, MD, is Attending Physician at the Miriam Hospital, Director of Brown University AIDS Program, Medical Research Director, Fenway Community Health, Boston, and Professor of Medicine and Community Health, Brown Medical School.*

*Josiah D. Rich, MD, is Medical Director, Whitmarsh Clinic, Attending Physician at the Miriam Hospital, and Professor of Medicine and Community Health, Brown Medical School.*



# A Perspective on Gay Men's Health

Timothy Cavanaugh, MD, and David Abbott

**A patient meets his doctor for the first time.** Taking a history, the doctor jocularly asks, "You don't have sex with other men or nasty stuff like that, do you?" The patient, who is gay, leaves the office without revealing his sexual orientation and never returns. True story. And not an uncommon one.

Studying gay men's health is not about developing new diagnostic strategies or learning unusual therapeutic modalities, but about recognizing how we wittingly and unwittingly alienate some patients, depriving them of much-needed healthcare. We all are subject to culturally ingrained attitudes and often presume a heterosexual orientation. These attitudes and presumptions leave gay and lesbian patients struggling between suffering in silence or (once again) risking disapproval and rejection from a caregiver. The key to good health care for MSM (**men who have sex with men**), as with all patients, is frank and trusting communication, in a safe and tolerant environment.

Studies in the 1990s found 2.8% of the male population identified as gay or bisexual - over 30,000 people in Rhode Island. An additional 7.7% of men admitted to same-gender desire and 9.8% reported some history of same-gender sexual behavior.<sup>19,22</sup> Yet the medical community remains largely untrained in and uncomfortable with gay men's health. Half of US medical school Family Medicine departments offered no training in LGBT issues, and in those programs that did offer training, the average time dedicated to the subject was only 2.5 hours in the four-year curriculum.<sup>32</sup> In a 1989 survey, 35% of Internal Medicine and Family Practice residents agreed or were "unsure" that homosexuality was a mental disorder (25 years after the American Psychiatric Association removed homosexuality from the DSM); 20% weren't comfortable with homosexuals.<sup>16</sup> Nursing students revealed similar attitudes in a 1998 study: 8 - 12% "despised" LGBT people; 40-43% felt "that they should keep their sexuality private."<sup>17</sup> Understandably, many gay men are reluctant to reveal their sexual orientation to their providers. In

1992 the Gay and Lesbian Medical Association found 44% of gay men had not "come out" to their PCP; this number dropped to 23% in 2003.<sup>12</sup> LGBT and questioning youth were less forthcoming; in 1998, two-thirds had not discussed sexual orientation with their provider.<sup>1</sup>

Providers face a two-fold challenge: first, to familiarize and educate ourselves on the health issues that are particularly pertinent to this population, without pathologizing the patient and his lifestyle; second, to foster enlightened attitudes among staff.

Few medical topics are peculiar to gay men alone. Gay men share the same health concerns and present with problems similar to heterosexual men. However, we providers should be aware of specific issues; i.e., sexually transmitted infections, anal cancer, substance abuse and mental health.

Little accurate data are available concerning the incidences, but MSM probably have disproportionately high rates of sexually transmitted infections. Recent increases in primary and secondary syphilis in the US have been attributed almost exclusively to MSM.<sup>5</sup> Many communities have seen increasing rates of gonorrhea in MSM, compounded by fluoroquinolone-resistant strains in areas with large gay populations.<sup>3</sup> MSM are at higher risk of Hepatitis A and B: the 1993 San Francisco Young Men's survey showed 20% had been infected with Hepatitis B.<sup>20</sup> In our own hepatitis vaccination program at a Rhode Island bathhouse, nearly 1/3 of men had been previously infected with hepatitis B.

HIV is a major concern for this population. According to the CDC, in 2004, 48% of all persons diagnosed with HIV were MSM, and MSM represented 67% of all persons living with HIV.<sup>4</sup> Providers need to educate their patients on the implications of co-infection, how infection with one organism can affect the transmission of other organisms and the course of other infections.

Human papilloma virus poses particular risks for MSM. In a 1998 study, 61% of HIV-negative men and 93% of

HIV-positive men showed evidence of HPV infection.<sup>25</sup> As with cervical cancer, HPV infection has been strongly associated with anal cancer. Thus, although the risk of anal cancer in the general population of men is 7 per million, the risk is 35 per 100,000 in MSM (rivaling the rate of cervical cancer in women prior to the introduction of routine Pap smears).<sup>7</sup> The rate of anal cancer in HIV-positive men is twice as high as in HIV-negative men.<sup>21</sup> Although it has not become standard of care, experts now recommend anal Pap smears for high-risk men. Abnormal Pap smears would be evaluated by referral for anoscopy. Data on outcomes are limited, but the sensitivity of anal Pap smears has approached 98%, although the specificity for predicting severe dysplastic changes is much lower.<sup>2</sup> Surgical treatment of anal HSIL has shown excellent results in small numbers of HIV-negative men; unfortunately, HIV-positive men have had high rates of recurrence.<sup>6</sup>

Without stereotyping gay men as promiscuous, providers need to address the role that sexual activity may play in their patients' lives. In a recent behavioral survey of gay men, 75% had more than one partner in the past year; 27% had 10 or more.<sup>24</sup> Some gay men find their sex partners at bars, bathhouses, private sex parties, public "cruising" areas like parks and rest stops, and, increasingly, on the internet. Others have traditional dating experiences, and many gay men have been happily partnered for years, despite their inability to legally marry. A longstanding relationship does not ensure sexual monogamy: many gay men have sex outside their relationships, often with the consent of their primary partners. There is growing concern for a perceived rise in the rates of unsafe sexual practices. Several surveys show that 10 to 50% of gay men are having unprotected anal intercourse;<sup>10,13,15,18,34</sup> the surveys do not probe how or why men decide to engage in such behavior.

In our experience, while most MSM are aware of "safe sex" messages, these somewhat simplistic guidelines do not always address the complexities of their social and erotic lives. Providers must assist

men in negotiating their individual strategies of harm reduction, through realistic discussions of sexual health that respect the sense of eroticism and the role that sexuality plays in their patients' lives. In practical terms, patients need accurate information regarding symptoms and transmission of STIs in relation to different sexual practices. Men who report multiple or casual partners should be offered regular (every 6 to 12 month) testing for STIs from urethral, oral and anal specimens. And these men should be tested for and vaccinated against Hepatitis A and B; surveys of Hepatitis vaccination rates amongst MSM show vaccination rates of only 35 to 50%.<sup>11, 20, 23, 28</sup>

Data about substance abuse in MSM are hampered by severe methodological flaws. Studies in the 70s to early 90s reported rates of alcohol abuse around 30%.<sup>8</sup> However, a 1998 study showed no significant differences in alcohol consumption overall when compared to the general population; interestingly, the data were skewed by the findings that gay men were twice as likely to be heavy drinkers and also twice as likely to be abstainers.<sup>30</sup> The study did find that drinking rates do not decrease with increasing age as quickly as in heterosexual populations. Tobacco abuse was also more prevalent in gay men – 41.5% versus 28% of the general population.<sup>31</sup> Rates of abuse of other substances were not clearly documented; the scant data showed rates of use, but not rates of addiction, that were higher than in hetero populations.<sup>30</sup>

Providers need to ask about use of “club drugs;” e.g., Ecstasy, ketamine, GHB, “poppers,” and methamphetamine. Their use has become popular among some groups in the gay (as well as the non-gay) community. The popular and the professional media have highlighted methamphetamine (or “crystal meth”) because of its strong addiction potential and its association with high-risk sexual behavior and HIV transmission. Users may take one or more drugs within a short time frame to enhance or counteract the effects of other drugs; e.g., Viagra and similar medications can counteract the sexual side effects of methamphetamine. Providers should familiarize themselves with the physiologic effects of these substances. An interesting perspective with advice on harm reduction for users can be found at [www.DanceSafe.org](http://www.DanceSafe.org).

One shouldn't assume that every gay man abuses alcohol or drugs, but their use has permeated the fabric of gay culture. Many gay men “come out” and find community within gay bars and clubs. Many may rely on bars and parties for socialization. In a recent survey of gay men in southern New England, only 22% reported discussing substance abuse with their providers. (personal correspondence)

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## A provider must consider sexual identity.

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Providers should be cognizant of mental health. Although studies on depression lend mixed results, many find higher rates of affective and adjustment disorders, often linked to high-risk sexual behavior.<sup>8</sup> Body-image disorders may be more prevalent in gay men. A 2001 Harvard study showed 20% of gay men suffered from anorexia and 14% from bulimia.<sup>29</sup> Gay men may be more likely to have been sexually abused. In a 1992 study of 1001 gay men, 37% reported sexual encounters with an older or stronger male before the age of 17; of these episodes, 93% met the investigator's definition of abuse.<sup>9</sup> Several studies from the late 1990s demonstrated rates of suicidal ideation and attempts that were 3 to 7 times higher in gay and lesbian youth.<sup>8</sup> In a 2002 survey of young MSM, 4.7% had attempted suicide in the past year and a third reported at least one suicide attempt at some time in their lives.<sup>26</sup> Being able to discuss issues of sexuality with MSM, especially young men, may open the door to identifying those with mental disorders.

A provider must consider sexual identity. “In addition to examining normative, age-specific developmental tasks, it is also important to look at stages in the development of lesbian/gay identity... Where is the individual along the continuum of integration and consolidation of his gay identity versus internalized homophobia and conflict about being gay?”<sup>33</sup> Sexual identity may be a source of shame and self-loathing, or may have engendered great strength and resiliency, sense of humor, and dedication to community. These issues are not just crucial to the younger patient. A body of recent literature dedicated to ag-

ing and end-of-life issues in gay men has replaced “the stereotypes of lonely, alienated and despondent older gay men” with a more accurate picture of “successful” aging related to the process of coming out and adapting to a largely homophobic culture.<sup>27</sup> Providers can help patients tap into these special strengths.

Harrison and Silenzio outlined four steps to appropriate care for gay and lesbian patients: 1) maintaining a non-homophobic attitude, 2) distinguishing sexual behavior from identity, 3) communicating clearly and sensitively using gender-neutral terms, and 4) recognizing how our attitudes affect clinical judgments.<sup>14</sup> The first requires us to acknowledge and step outside our prejudices. We may need to put aside personal feelings of uncertainty, discomfort, even disgust, to provide appropriate care. As health professionals we like to think that our decisions are based on a dispassionate synthesis of clinical knowledge and fine-tuned diagnostic skills. But our emotional responses can color our perceptions and distort our conclusions.

Providers need to become comfortable taking a sexual history, treating it as a routine part of a patient encounter. Use gender-neutral terms such as “partner” or “significant other” and remain open to the possibility of non-traditional relationships. Distinguish between sexual identity and behavior; asking a patient if he is “gay, straight or bisexual” is different from asking if he “has sex with men, women or both.” The patient who identifies as “straight” may be having sex with other men. Conversely, not every man who identifies as gay has multiple partners and needs immediate referral for HIV testing. In adolescents who are not yet sexually active, ask whether they think about men or women when they fantasize about sex; acknowledging that it may be “normal” to be attracted to the same sex and that you are open to discussing such issues may open the door to future discussion for teens who are not yet able or willing to address their sexuality. Take care in using medicalized terms (like “anal receptive”), and acknowledge unfamiliarity with certain sexual practices without appearing shocked.

Ensure that staff use appropriate language and are familiar with LGBT issues. The Gay and Lesbian Medical Association's website includes links to other sites and access to the “Healthy



people 2010 Companion Document for LGBT Health.” Consider scheduling an in-service for staff on LGBT health. Have an informal discussion with a gay patient on how the practice works for him. The provider may want to consult with a physician or mental health professional who is knowledgeable about the gay community.

Make the office environment more welcoming. Post a non-discrimination policy that includes sexual orientation. Distribute written intake materials that use culturally inclusive, gender-neutral terms; ask about “relationship” status rather than “marital” status and include non-traditional responses. Consider displaying pamphlets and posters with gay-friendly and gay-positive images. Include gay-oriented publications in the waiting room, like the *Advocate*, a national magazine written for the LGBT community, and *Options*, a Rhode Island bimonthly newspaper.

When a provider assists a patient through a major life experience, like pregnancy or bereavement, the insight that the provider gains into that patient’s life and the enduring influence on that patient’s health often reach beyond the presenting problem. Addressing sexuality with a patient can provide the same impact, especially for the gay, lesbian, or bisexual patient who has been culturally defined by his sexuality. The medical provider’s open attitude can help to create a strong therapeutic relationship with every patient.

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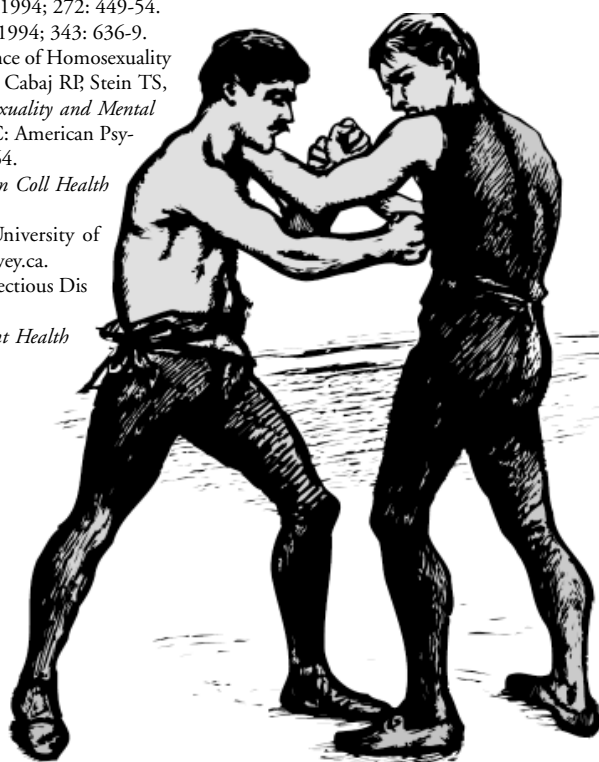
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*Timothy Cavanaugh, MD, is a physician with the Family Health Services/Comprehensive Community Action Program, Medical Director for The Men’s Health Collaborative, and Associate Clinical Professor, Department of Family Medicine, Brown Medical School.*

*David Abbott is Director of the Men’s Health Collaborative, AIDS Project RI.*

## CORRESPONDENCE:

Timothy Cavanaugh, MD  
Family Health Services  
1090 Cranston St.  
Cranston, RI 02920  
Phone: (401) 943-1981  
e-mail: [cav79@msn.com](mailto:cav79@msn.com)





# Caring For Your Lesbian Patients

Kelly A. McGarry, MD, and Megan R. Hebert, MA

**An estimated 2.3 million women in the United States identify themselves as lesbian.**<sup>1</sup> The 2000 United States Census reported 293,000 households headed by female same-sex partners. Rhode Island, with 1,299 same-sex unmarried lesbian partnered households, ranked 12<sup>th</sup> in the nation by percentage of coupled households that are gay or lesbian.<sup>2</sup> The Human Rights Campaign estimates that the US Census count of gay and lesbian partnered households may be underestimated by 62%.<sup>3</sup>

In 2004, the Rhode Island Foundation and Equity Action released the first comprehensive survey of Rhode Island's **lesbian, gay, bisexual, and transgender (LGBT)** population.<sup>4</sup> Respondents identified 10 issues as "top priorities" for Rhode Island's LGBT communities. Among the top 3 was expanding access to welcoming health care. While 84% of the sample reported having regular medical care, only 48% reported being "out" to their providers, and 19% had not disclosed their sexual orientation to providers. Overall, the 2 most important factors in choosing health care services were quality (82% of respondents) and confidentiality (64% of respondents).

In 1996 the Council on Scientific Affairs of the American Medical Association stated: "the physician's nonjudgmental recognition of sexual orientation and behavior enhances his or her ability to render optimal patient care in health as well as illness... the physician's failure to recognize homosexuality or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems." Furthermore, physicians must be educated to "recognize the physical and psychological needs of their homosexual patients."<sup>5</sup> Locally and nationally there is a call for health care providers to improve care delivered to gay and lesbian patients. In this article, we provide health care providers with some tools to do so.

## WHAT IT MEANS TO BE LESBIAN

Being lesbian is not a homogeneous experience. The racial, ethnic, and socioeconomic diversity of the United States population is mirrored in the lesbian com-

munity. Not all women who have had or are engaging in same-sex intimate contact label themselves lesbian. Many women, regardless of sexual orientation, identity, and behavior, are uncomfortable discussing sexual histories with providers. Conveying respect for lesbians' lives and partners helps to facilitate an open, honest medical encounter.

## INTERACTING WITH THE HEALTH CARE SYSTEM

In 1999, the Institute of Medicine ("Lesbian Health: Current Assessment and Directions for the Future") reported little funding for research on the health of lesbians, despite increased emphasis on women's health research in the late 1990s.<sup>1</sup> To date, there have been no large-scale and representative investigations into lesbian healthcare. Many studies have been qualitative and/or exploratory. Despite these shortcomings, the literature consistently identifies common problems.

The experience of lesbians in the health care system can be examined from the provider and the patient perspective. From the provider perspective, Westerstahl found that among 76 general practitioners, only 28 reported having a lesbian patient (4 providers had inquired directly about their patient's sexuality while 24 patients informed their provider); no provider who was unaware of having any lesbian patients had ever inquired about a patient's sexuality.<sup>6</sup> The most common reason cited for not asking was that sexuality was unimportant or was the patient's responsibility to mention. Another study found that general practitioners reported not being knowledgeable about sexual practices of lesbians and felt a barrier during discussions about sexual health with lesbian patients.<sup>7</sup>

In a survey of over 1,000 physicians, using the **Heterosexual Attitudes Toward Homosexuality (HATH)** Scale, Tellez found that male physicians, those who work in small cities compared to larger cities or rural areas, physicians who did not know a gay or lesbian family member or friend, physicians who had not knowingly worked closely with a gay or lesbian

health care professional, and physicians who had not knowingly treated a gay or lesbian patient held significantly more negative attitudes toward gays and lesbians. Perhaps most disturbing: nearly 10% of the overall sample reported being less accepting of gays and lesbians due to the AIDS epidemic.<sup>8</sup> More than half of the Gay and Lesbian Medical Association physician members surveyed in 1994 reported having witnessed colleagues providing sub-optimal care or denying care to patients based on sexual orientation; 88% had heard colleagues make negative remarks about gay and lesbian patients.<sup>9</sup>

From the patient's perspective, lesbians are less satisfied with their healthcare experiences.<sup>10</sup> Additionally, lesbians delay care and fail to get Pap smears and breast exams.<sup>1,11</sup> A 1990 study revealed that due to negative experiences with providers, almost 50% of lesbians rarely or never sought care despite being professionals with adequate access to health care.<sup>12</sup> Compounding the problem, studies show when lesbians do seek screening such as Pap smears, providers often discourage them from having preventive exams, based on the erroneous belief that they are unnecessary.<sup>13</sup> Eliason found in a study of lesbians, gay men and bisexuals, only 37% disclosed their orientation to their provider. A prominent reason for nondisclosure was fear of receiving inadequate care.<sup>14</sup> Avoidance of routine medical care may be the most significant health risk for many lesbians.<sup>15</sup>

## OVERCOMING HETEROSEXISM

Heterosexism, analogous to sexism and racism, stigmatizes any non-heterosexual form of behavior and identity; e.g., the continuing ban against gays and lesbians in the military; the lack of legal protection from antigay discrimination in employment; and federal and state laws against same-gender marriage. Examples of heterosexism in the health care provider's office include medical intake forms that acknowledge only single, married, widowed and divorced patients; asking all women what form of birth control they need; and omitting cervical cancer

screening when a woman identifies as a lesbian. Heterosexist attitudes are inadvertently communicated to patients, making it more difficult to disclose since the patient must correct the assumption of heterosexuality. Assuming heterosexuality introduces a barrier to open communication with patients, which leads to a host of negative outcomes ranging from distrust to inadequate care, misdiagnosis, and reduced adherence to recommendations. Health care providers can ensure that all office personnel use gender-neutral language, and that questions on intake forms and during patient care are not heterosexually biased.

## HEALTH CONCERNS

### Risk Factors for Disease

While a lesbian identification alone confers no increased risk of illness, lesbians as a group have a higher prevalence of risk factors for several diseases than heterosexual women; e.g., nulliparity/fewer pregnancies, higher dietary fat intake, higher prevalence of overweight/obesity and higher rates of alcohol consumption and cigarette smoking.

The most robust data on lesbian-health comes from the **Women's Health Initiative (WHI)**, where 500 women

identified themselves as having partnerships/sex exclusively with women during adulthood. Compared to those who reported partnering with men/heterosexual, those who partnered with women had a higher prevalence of alcohol use, smoking, and being overweight.<sup>16</sup> In another community study, lesbians and their heterosexual sisters were compared: lesbians were more overweight, had higher alcohol consumption and were more likely to smoke. Using the modified Gail Breast Cancer Risk model, the investigators found that lesbians had a significantly higher 5-year and lifetime risk for developing breast cancer than their heterosexual sisters.<sup>17</sup> The WHI is the only trial to study the incidence of breast cancer in lesbians. There was a nonsignificant trend toward higher rates of breast cancer among the lesbian and bisexual participants compared to heterosexual women.<sup>16</sup> Since lesbians may be less likely than heterosexual women to undergo mammography, this trend is worrisome.<sup>18</sup> No data are available on the incidence of uterine, ovarian and lung cancer in lesbians.

### Sexually Transmitted Infections

Traditional thinking has been that women who have sex with women are at

negligible risk for **sexually transmitted infections (STIs)**. However, more than 10% of women with exclusively female partners have a history of STIs. Viral STIs, including herpes and **human papillomavirus (HPV)**, *Treponema pallidum*, and *Trichomonas vaginalis* have been transmitted between women.<sup>19</sup> Thus far, reports of sexual transmission of gonorrhea and Chlamydia between women are anecdotal. Lesbians who are HIV-positive almost always have a history of intravenous drug use or sex with men.<sup>20</sup> Because HIV has been isolated from vaginal secretions, woman-to-woman transmission of HIV is possible. Bacterial vaginosis, not generally considered an STI, seems transmissible between women and is frequently found in both members of monogamous lesbian couples.<sup>21</sup>

Screening for STIs and counseling around safe sex depend on the sexual practices of the individual. Taking a thorough and unbiased behavioral/sexual history from lesbian patients is a prerequisite for education/harm reduction strategies. Because lesbians in monogamous relationships where both individuals are free of STIs are at negligible risk for acquiring infections, exploring sexual practices is unnecessary except to identify any problems they wish to discuss. For lesbians with than 1 sexual partner or involved with a partner who may have an STI, physicians need to counsel on safer sex/harm reduction. Lesbian sexual practices include high-risk (oral-vaginal contact, tribadism which is genital to genital contact, digital stimulation, oral-anal contact and sharing of sex toys) and lower risk behaviors (kissing and rubbing genitals to her partner's body). Safer sex can be achieved through use of dental dams, surgical gloves, or plastic wrap with water-based lubricant, all of which serve as barriers to vaginal secretions or rectal exposure. Overall, lesbians are less likely to engage in safe sex practices.<sup>22</sup> While lesbians may be at lower risk for STIs, they are not risk-free and must be counseled according to their own sexual practices.

### Cervical Cancer

The rate of Pap smear testing is lower among lesbians.<sup>18</sup> Lesbians may have a false sense of security about their risk for cervical cancer; they are significantly more likely to be survivors of childhood sexual

**TABLE 1. DEVELOPING A PATIENT FRIENDLY ENVIRONMENT**

#### Office Environment

- Have a non-discrimination policy visible to patients
- Provide reading materials (magazines, health education pamphlets) that address the specific needs of lesbian patients
- Ensure that the staff are comfortable with lesbian patients and their families
- Ensure confidentiality
- Make sure intake forms include options for non-married partners

#### Interviewing

- Use gender neutral language  
"Do you have a significant other?"
- Use language free of heterosexist assumptions  
Don't ask "Are you married?" or "What form of birth control do you use?"
- Ask about prior heterosexual intercourse and assess safe sex behavior  
"Have you ever been sexually active with men, women, or both?"  
"Are you presently in a sexual relationship with a woman or a man or both?"
- Ask who the patient lives with, who is important to them, who would care for them if they were sick
- Ask the patient how they would like to be referred to and/or how to refer to their partner
- Encourage lesbians to have legal documents regarding who can make medical and/or legal decisions for them (Durable Power of Attorney for Healthcare and Finances)

abuse; they may have previous real or feared negative interactions with the health care system; and their health care providers may view them at low risk and not do Pap smears.<sup>23,24</sup> Between 50 and 80% of lesbians have had heterosexual intercourse at some point.<sup>25</sup> Having fewer male partners may reduce a lesbian's risk for cervical cancer; however, low risk doesn't mean no risk. Additionally, women can acquire HPV from female partners without having had heterosexual intercourse.<sup>26</sup> Data from the WHI trial showed higher rates of reported cervical cancer among women who identified as lifelong lesbians, compared to heterosexual women, suggesting that lesbians who may be at high risk for cervical cancer do not recognize this risk and do not get screening.<sup>16</sup> Lesbians should be encouraged to be screened for cervical cancer using the same guidelines as for heterosexual women.

## **PSYCHOSOCIAL AND PSYCHOLOGICAL CONSIDERATIONS**

### **Coming Out/Self-Acceptance**

Growing up, many lesbians consistently received the message that same-sex attraction was wrong. For self-acceptance, a woman must recognize her same-sex attraction, act on her feelings and be willing to negotiate pre-existing relationships (with those who previously thought the individual was heterosexual). The risk in "coming out" is rejection from family, friends and colleagues. Many lesbians do not disclose their identity, or limit disclosure to a small circle of confidants. This lack of social support can cause considerable psychological distress. Evidence suggests that "out" lesbians are more satisfied in their personal lives.<sup>27,28</sup>

### **Depression**

In a study of 1925 lesbians from 50 states, over half had had thoughts of suicide. Eighteen percent attempted suicide, 37% had been physically abused as a child or an adult, 32% had been raped or sexually attacked, and 19% had been in incestuous relationships while growing up. About 75% had received counseling at some point: half of those women cited sadness or depression as the reason.<sup>29</sup> In the WHI, lesbian women were more likely to be taking antidepressants.<sup>16</sup> When asked about causes of their depression,

lesbians reported stress from isolation, inferior societal status and lack of support from family and friends.<sup>30-32</sup>

Gay and lesbian adolescents may be most vulnerable. An estimated 30-40% of gay teens have attempted or seriously considered suicide, 6 times the national average, according to the Report of the Secretary's Task Force on Youth Suicide.<sup>33</sup> Youth are at risk for high-risk sexual behaviors, substance abuse, anxiety, depression, and homelessness. In one study, gay, lesbian, and bisexual youth were 5 times more likely to use cocaine, 10 times more likely to use crack or free-base cocaine and 10 times more likely to use injection drugs compared to their heterosexual peers.<sup>34</sup> Though most gay youth grow up well-adjusted and lead productive lives, physicians need to understand that gay adolescents are an "at-risk" group and should counsel them around high-risk behaviors.

### **Alcohol**

Older data suggest a higher rate of alcohol abuse among lesbians. Several recent studies suggest that lesbians may drink more often than heterosexual women, but the rates of heavy, abusive drinking may be no different.<sup>11,35</sup> However, the WHI found a higher incidence of heavy drinking among lesbians compared to heterosexual women and a 2003 study found that despite lower rates of heavy drinking compared to previous studies, lesbians were more likely to have been in treatment for alcohol problems and to be in recovery than heterosexuals.<sup>16,36</sup>

### **Family/Child Rearing**

Lesbian couples are not granted the same legal protections that US laws confer to heterosexual couples. In the US, civil marriage contracts exist only in Massachusetts and civil unions have been conferred in Vermont, California, and Hawaii. Thirty-eight states have legally prohibited recognition of same sex marriages from other states and 3 states have prevented recognition of other states' domestic partnerships or civil unions. Without legal recognition, same-sex partners are not covered by the state and federal laws that protect married couples.

Nevertheless, approximately 75% of Americans support laws to protect gays and lesbians from discrimination in em-

ployment and housing and to provide them with employment benefits, inheritance rights, employer-provided health insurance, and social security benefits.<sup>37</sup> The Kaiser Foundation found that 66% of Americans believe that homosexual behavior is a normal part of some people's sexuality. Over half support military service for gay men and lesbians and more than 75% of Americans believe gay men and lesbians experience significant prejudice and discrimination. The majority of lesbians in relationships are committed and monogamous, the same as heterosexuals. "Families" for lesbians often involve a partner and a network of close friends as a family-of-choice. This is especially true if their family of origin has rejected them.

Several million gay and lesbian parents are raising between 6 and 14 million children.<sup>38</sup> Children raised in lesbian households develop normally in domains of sexual orientation, self-esteem, moral judgment, and intelligence.<sup>39</sup> One study found that lesbian co-mothers were more involved in their children's lives, more nurturing, and exhibited greater harmony in their parenting than heterosexual couples.<sup>40</sup> Lesbians may conceive through a variety of methods including self-insemination or clinic-based donor insemination. An Australian study that reported 33% of lesbian-parenting couples conceived via insemination methods highlights the need for providers to make appropriate referrals regarding insemination options, donor screening, and fertility issues.<sup>41</sup> When counseling lesbian couples about child-rearing, encourage both parents to adopt the child to ensure their permanent legal relationship to the child. Clinicians should also urge lesbians in committed relationships to obtain durable power of attorney contracts for a surrogate decision-maker in the event they are unable to make their own decisions.

## **CONCLUSION**

Our lesbian patients seek a safe, nonjudgmental environment and validation of their lifestyle. If we simply avoid the assumption of heterosexuality by using gender-neutral language, we will make our offices more welcoming. If we explore our patients' social history, we will validate the importance of their significant others/partners in their lives. For

those in committed relationships, providers should educate around issues of the durable power of attorney, conception options and legal adoption of children. We should target prevention efforts and harm reduction strategies for lesbian patients at high risk for diseases due to lifestyle. Recognizing stressors faced by lesbians, we should inquire about stress and depression specifically and make referrals when necessary. Taking an active role in the lives of your lesbian patients will enhance the health care lesbians receive.

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Kelly A. McGarry, MD, is Associate Program Director, General Internal Medicine Residency, Rhode Island Hospital, and Assistant Professor of Medicine, Brown Medical School.

Megan R. Hebert, MA, is Research Program Coordinator, Substance Abuse Research Unit, Rhode Island Hospital.

## CORRESPONDENCE

Kelly A. McGarry, MD  
Division of General Internal Medicine  
Rhode Island Hospital  
593 Eddy Street  
Providence, RI 02903  
Phone: (401) 444-5953  
E-mail: kmcgarry@lifespan.org



# Molecular Tests for Detection of the Sexually-Transmitted Pathogens *Neisseria Gonorrhoeae* and *Chlamydia trachomatis*

Kimberle C. Chapin MD

Diagnosis of the two most common bacterial sexually transmitted diseases (STDs), *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (GC) has changed dramatically in the last 10 years. This paper will present the epidemiology of these pathogens, the suggested screening parameters and the molecular methods for CT and GC diagnosis that will familiarize the provider with options for testing.

## EPIDEMIOLOGY OF CHLAMYDIA TRACHOMATIS AND NEISSERIA GONORRHOEAE

The CDC estimates that 19 million STDs occur annually.<sup>1,2,3</sup>

CT and GC are the two most common reportable bacterial STDs, with about 3 million cases of CT and 350,000 cases of GC reported annually. Forty-six percent of Chlamydia cases are reported in women 15-19 years of age and 33% in women 20-24 years of age. Black women are disproportionately affected with a 7.5 fold greater rate reported than that of white women.<sup>1,2,3</sup> Screening for CT and GC is extremely important because of the additive factors of severe health consequences and the fact that more than 70% have no discernable symptoms.<sup>1,2,3</sup> The possible consequences of *untreated* infections include **pelvic inflammatory disease (PID)** (40% of patients), infertility (20% of those with PID), ectopic or life threatening pregnancy (9%), and debilitating chronic pelvic pain (18%). Like other inflammatory STDs, women with CT and GC are 3-5 times more likely to acquire HIV if exposed. In addition, newborns of untreated women are at greater risk for conjunctivitis, pneumonia and death.<sup>2,3</sup> Complications among men are less commonly reported but may include epididymitis and urethritis, fever and sterility. Greater screening in men could reduce transmission to their partners and slow the revolving door of infection.

The direct medical costs and economic impact of STDs reach as high as 15.5 billion annually. For CT alone, healthcare costs exceed 3.5 billion per year. The Centers for Disease Control and Prevention (CDC)

estimate that for every dollar spent on CT testing and treatment, \$12 is saved in complications from untreated cases of CT.<sup>4,5</sup>

The CDC's *Current Sexually Transmitted Diseases Treatment Guidelines—2002* are published in the MMWR ([www.cdc.gov/STD/treatment/rr5106.pdf](http://www.cdc.gov/STD/treatment/rr5106.pdf)). Basic screening recommendations for CT include annual screening for any woman under the age of 26 and screening for older women with risk factors such as new or multiple partners.<sup>2</sup> Despite other published initiatives as well as the CDC's STD guidelines, screening remains below 25% of the recommended population and results in a missed opportunity for early diagnosis and treatment.<sup>6</sup>

Why are healthcare providers doing poorly adhering to these guidelines given a non-invasive, self-collected urine specimen tested by one of several reliable molecular methods exists? Data from a recent survey presented to physicians nationwide in six specialty areas highlighted some concerns. Physicians were asked to respond about their knowledge of STD guidelines, parameters for patient evaluation, and current test method and specimen collection prefer-

ences. Notably, responding physicians did not use urine as a specimen by molecular methods because of concern about reliability of a molecular assay with urine compared to a swab specimen (23%), unfamiliarity of molecular methods and/or specimens appropriate for testing (55%), and urine was not an available specimen option at the laboratory where testing was performed (30%). Interestingly, physicians stated that ease of collection and test performance were the most critical issues when prioritizing what the preferred test method for diagnosing these STDs. Importantly, all physician groups stated that they would increase screening by 14-26% in both asymptomatic and symptomatic males and females if a reliable noninvasive specimen were available.<sup>7</sup>

## MOLECULAR CT AND GC TESTING OPTIONS

In the last 10-15 years, the optimal method for diagnosis of GC and CT has changed. Culture was the standard of practice for both CT as well as GC, but multiple studies have shown that culture methods are only 60-75% as sensitive in detect-

Table 1 Comparison of Current Molecular Methodologies for Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*

| Method                           | Amplification Methods                                                                    |                                               |                                                           | Hybridization Methods                     |                                                  |
|----------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------|-------------------------------------------|--------------------------------------------------|
| Assay Name                       | COBAS AMPLICOR                                                                           | APTIMA COMBO 2                                | BIDProbe-Tec                                              | PACe 2C                                   | Hybrid Capture II                                |
| Manufacturer                     | Roche                                                                                    | Gen-Probe                                     | BectonDickenson                                           | Gen-Probe                                 | Digene                                           |
| Molecular Technology             | Polymerase chain reaction (PCR)                                                          | Transcription Mediated Amplification (TMA)    | Straud Displacement Amplification (SDA)                   | DNA probe to rRNA target                  | DNA probe to DNA target                          |
| Target                           | DNA                                                                                      | RNA                                           | DNA                                                       | RNA                                       | DNA                                              |
| Specimen Types                   | Urine<br>Endocervical<br>Urethral                                                        | Urine<br>Endocervical<br>Urethral             | Urine<br>Endocervical<br>Urethral                         | Endocervical or urethral swab<br>NO Urine | Endocervical Swab<br>NO MALT testing<br>NO urine |
| Approved for Assay               |                                                                                          | Vaginal <sup>1</sup>                          |                                                           |                                           |                                                  |
| Transport <sup>2</sup>           | Urine must be refrigerated RT <sup>3</sup> for swab specimens, liquid cytology medium RT | All specimens RT or liquid cytology medium RT | All specimens RT<br>Urine cup must add preservative pouch | Swab specimens RT                         | Swab Specimens or liquid cytology medium RT      |
| Confirmatory amplification tests | No                                                                                       | Yes, both CT and GC                           | No                                                        | NA <sup>4</sup>                           | NA                                               |

<sup>1</sup> Self-collected or physician-collected

<sup>2</sup> Each manufacturer has a specific specimen collection/transport tube required for preservation of the nucleic acid target

<sup>3</sup> Room Temperature

<sup>4</sup> Not Applicable

**Table 2**  
Comparison of Three Amplified *Chlamydia trachomatis* Assays<sup>1,2,3</sup>

| Manufacturer<br>Assay            | Gender | Specimen | Sensitivity | Specificity |
|----------------------------------|--------|----------|-------------|-------------|
| Gen-Probe™                       | M      | Swab     | 95.9%       | 97.5%       |
| APTIMA                           |        | Urine    | 97.9%       | 98.5%       |
| COMBO 2                          | F      | Swab     | 94.2%       | 97.6%       |
|                                  |        | Urine    | 94.7%       | 98.9%       |
| BectonDickenson<br>BD Probe-Tec™ | M      | Swab     | 94.6%       | 94.2%       |
|                                  |        | Urine    | 94.5%       | 91.4%       |
|                                  | F      | Swab     | 92.8%       | 98.1%       |
|                                  |        | Urine    | 80.5%       | 98.4%       |
| Roche<br>COBAS AMPLICOR™         | M      | Swab     | 97.4%       | 97.5%       |
|                                  |        | Urine    | 88.7%       | 93.7%       |
|                                  | F      | Swab     | 95.5%       | 98.2%       |
|                                  |        | Urine    | 90.6%       | 97.5%       |

<sup>1</sup> Data is from package inserts for BD and Gen-Probe and includes both symptomatic and asymptomatic patients. Final data was determined using patient infected status, which compares at least two separate amplification methods to each other.

<sup>2</sup> Data for Roche is with the same patient mix but PCR results compared only to culture and DFA.

<sup>3</sup> Chernesky et al compare the 3 assays with non-invasive specimens and report the APTIMA Combo 2 assay as having the least inhibition and highest sensitivity

ing infection as compared to **nucleic acid amplification tests (NAATs)**. In fact, NAATs are recommended as the preferred testing method over all other methods, including hybridization probes, enzyme immunoassay, and culture for detection for both of these pathogens.<sup>2,8</sup> In addition, the availability and reliability of non-invasive and/or self-collected specimens, such as urine or vaginal swabs instead of invasive endocervical or urethral specimens, allow the capability of screening in non-traditional settings and for either sex. Recent data using NAATs from alternative sites of collection, such as the conjunctiva, pharynx and/or rectum, show NAATs equivalent or more sensitive and specific than culture as well. Testing at these alternative sites identified additional patients infected with STDs that would otherwise not be identified when testing urogenital sites alone. These patient groups included neonates, sexually active teens and **men who have sex with men (MSM)**.<sup>7,8,9,10</sup> In short, molecular and specifically, *amplification* technology, has opened a door to the diagnosis of STDs that allows clinicians to diagnose all patients who may be at risk for these infections as well as provide a more informative picture on the pathology and epidemiology of these pathogens.

The exquisite specificity of molecular technologies relates to the basic base pairing rules of nucleic acids that make up DNA and RNA, that is cytosine only pairs to guanine and thymine (uracil in RNA)

only pairs to adenine. Knowledge of a unique nucleic acid sequence in an organism (target) allows a specific complementary probe to be constructed that will pair with the target and form the natural, and very strong double-stranded helix. The molecular reaction itself (hybridization or amplification) determines the sensitivity for detection of that target. Table 1 shows a comparison of current molecular assays and their associated manufacturer. Two points should be noted. First, Roche COBAS Amplicor performance is only compared to culture and **direct fluorescent antibody (DFA)** testing because no other amplifi-

cation assays were available for comparison at the time the assay was approved; subsequently, this assay is less sensitive than the other amplification assays noted in Table 1. Second, the specificity of all these assays is generally higher than reported in the package insert because discrepant testing is not part of the submission process to the Food and Drug Administration. A recent comparison of these same methods has been published for detection of *Chlamydia trachomatis* with particular emphasis on urine and non-invasive specimens.<sup>12</sup>

There is a significant difference between the molecular reaction used in different assays. Hybridization technology relies on the number of copies of nucleic acid (RNA or DNA) inherently available in a patient's sample because the specimen is probed directly. Thus, specimens in which the numbers of pathogens may be small, such as poorly collected urethral or endocervical as well as urine specimens, hybridization technology will not be adequate in sensitivity to detect GC and/or CT in many instances. Hybridization methods include; the PACE 2C test by Gen-Probe which uses a DNA probe to target the naturally amplified rRNA in a sample (usually 2,000 copies per cell) and the Digene (Gaithersburg, MD) Hybrid Capture II GC/CT test, which targets single copy DNA but enhances the signal attached to the probe. Providers should note that the assay sensitivities promoted in the package inserts for these hybridization assays, which

**Table 3**  
Comparison of Three Amplified *Neisseria gonorrhoeae* Assays<sup>1,2</sup>

| Manufacturer<br>Assay          | Gender | Specimen | Sensitivity | Specificity |
|--------------------------------|--------|----------|-------------|-------------|
| Gen-Probe™                     | M      | Swab     | 99.1%       | 97.8%       |
| APTIMA                         |        | Urine    | 98.5%       | 99.6%       |
| COMBO 2                        | F      | Swab     | 99.2%       | 98.7%       |
|                                |        | Urine    | 91.3%       | 99.3%       |
| BectonDickenson<br>BDProbeTec™ | M      | Swab     | 98.4%       | 94.8%       |
|                                |        | Urine    | 97.9%       | 94.4%       |
|                                | F      | Swab     | 96.6%       | 99.5%       |
|                                |        | Urine    | 84.9%       | 99.4%       |
| Roche<br>COBAS AMPLICOR™       | M      | Swab     | 99.4%       | 96.2%       |
|                                |        | Urine    | 95.3%       | 98.5%       |
|                                | F      | Swab     | 95.9%       | 98.7%       |
|                                |        | Urine    | No Claim    | No Claim    |

<sup>1</sup> Data is from package inserts for BD and Gen-Probe and includes both symptomatic and asymptomatic patients. Final data was determined using patient infected status, which compares at least two separate amplification methods to each other.

<sup>2</sup> Data for Roche is with the same patient mix but PCR results compared only to culture and DFA.

show very high sensitivity for detection of CT and GC (>90%) are compared to culture isolation (only 65% sensitive) and not amplification technology.<sup>2,8</sup> In addition, the Digene assay is not approved for male specimens. Neither test has a claim for urine specimens. While sensitivity is lacking, specificity of hybridization technology is excellent and approaches 100%. The Digene Hybrid Capture II GC/CT test is also marketed as a combined test with **Human Papilloma Virus (HPV)** from a liquid cytology medium. However, this is the same hybridization test described above and is not as sensitive as amplification tests for the CT and GC pathogens.<sup>2,12</sup>

Current STD amplification methods include **polymerase chain reaction (PCR)**, **transcription mediated amplification (TMA)**, and **strand displacement amplification (SDA)**. These methods differ from hybridization methods in that they take the small copy number of the nucleic acid targets in the sample (DNA or RNA) and through the unique cycling reaction for the technology, amplify the target up to a billion times. Thus the sensitivity is superior to hybridization methods and able to be used for just about any specimen type. Many NAATs exist and are marketed by different manufacturers. Examples of amplification technologies that are FDA-approved for detection of GC and CT include APTIMA Combo 2 (Gen-Probe, Incorporated, San Diego, CA) COBAS AmpliCor (Roche Molecular Diagnostics, Indianapolis, IN), and the BD Probe Tec (Becton Dickinson, Maryland).



As with any test method, there are advantages and disadvantages to each methodology. Issues with amplification technology include false negatives if there is inhibition of the reaction and false positives if there is contamination or cross reactivity with other bacterial species. Almost all test methods employ controls so that these issues can be identified at the time of patient testing.

The physician should be aware of the test method offered by the laboratory serving his/her patients and be assured that the specimen types are collected, transported and handled in an appropriate manner. Stated sensitivities, and specificities of current NAATs are listed in Tables 2 and 3 for CT and GC, respectively. Data, from package inserts, include both male and female patients, urine and swab specimen types, as well as symptomatic and asymptomatic patients.

The sensitivity and specificity results for all of these amplification tests are evaluated in terms of patient infected status, which means that 2 or more amplification methods had to be in agreement for a patient to be considered positive. These tests were not compared to culture only. In addition, while all of the assays are acceptable and better than culture or hybridization methods, there are some notable differences. Physicians should note the assay performance parameters and assess them in relation to the population or specimen type being tested. For example, in a low prevalence population, the healthcare provider would want an assay with a high specificity and/or know that the laboratory uses confirmatory amplification assays for all positive samples.

In conclusion, NAATs have been shown to be highly reliable for detection of GC and CT. Healthcare providers becoming more comfortable using molecular technology and non-invasive specimens should facilitate appropriate screening for these STDs.

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Kimberle C. Chapin MD, is Director of Microbiology, Lifespan Academic Medical Centers, and Associate Professor of Pathology, Brown Medical School.

## CORRESPONDENCE

Kimberle C. Chapin, MD  
Rhode Island Hospital  
593 Eddy St.  
Providence, RI 02903  
Phone: (401) 444-2526  
e-mail: kchapin@lifespan.org



# The Psychotherapy of Sexual Minorities

Barry W. Wall, MD

## The psychotherapy of sexual-minorities has had a checkered past.

For most of the twentieth century, social, legal, religious and medical constructions left no room for variation from the heterosexual majority. Any form of sexuality other than heterosexuality was conceptualized as a pathological medical/psychological condition. The main focus of treatment was to change homosexuals into heterosexuals; common therapies included psychoanalysis, hypnosis, religious counseling, hormone treatment and behavior aversive therapy with electric shocks or apomorphine. Because these treatments worsened depression and anxiety, lowered self-esteem, and increased social isolation and shame, most homosexuals stopped treatment.<sup>1, 2</sup>

In 1973 the American Psychiatric Association removed homosexuality from its manual of mental disorders.<sup>3</sup> Since then, clinicians have better understood the similarities between the therapy of heterosexuals and sexual-minorities, as well as better understood and treated the issues unique to sexual-minorities. Sexual orientations, identities, and expressions of human beings are diverse and complex, and sometimes cannot be defined by the widely used term **lesbian-gay-bisexual-transgendered (LGBT)**. Sexual-minorities have the same problems and respond to therapy from using the same psychological theories and therapeutic techniques as heterosexuals. However, such persons are more likely to access mental health services and may have a higher incidence of mental illness over the course of their lifetimes.<sup>4</sup>

This article begins with a discussion of treatment issues common to both heterosexuals and sexual-minorities, then reviews general developmental and treatment issues for almost all sexual-minorities, and ends with a discussion of the unique treatment issues for some members of the LGBT population.

## THERAPY ISSUES COMMON TO BOTH HETEROSEXUALS AND SEXUAL-MINORITIES

Broadly speaking, the patient enters therapy to develop a framework to understand his/her life and problems, to de-

velop insight into choices, and to make changes to ease suffering and improve functioning. Even though therapy involves discussing choices, sexual orientation and sometimes even other sexual identities are not choices that a person can change. But everything else is: as with heterosexuals, all decisions made by sexual-minorities about life in general, and about sexual life in particular, are choices whose conscious or unconscious motivations can be understood in therapy.<sup>5, 6</sup>

Sexual-minorities can act upon non-sexual psychological conflicts by their sexual behaviors. Multiple sex partners, sex addiction, trouble forming close relationships, and other intimacy problems that arise from splitting emotion from sexual behavior can occur. However, these problems are not exclusive to LGBT persons, nor do they stem from sexual orientation.<sup>5</sup>

## GENERAL SEXUAL-MINORITY THERAPY ISSUES

The overall data indicate that the vast majority of homosexuals function well in society and relationships.<sup>7</sup> This may be less so for bisexual and transgendered individuals, at least for those who seek treatment, as discussed later. When sexual-minority patients present for therapy, it is important to understand some general themes related to their development and day-to-day life not found in heterosexuals, including the nuances of sexual identity; development in the face of prejudice; ongoing stigma; and the process of coming out.

## Sexual identities

In addition to sexual orientation, it is important to understand other components of sexual identity when conducting therapy with a sexual-minority patient; that is, biological sex, gender identity, and social sex-roles. Biological sex, usually assigned at birth, is something about which most patients are certain, with the exception of some transgendered individuals. Gender identity, a person's internal conviction of being male or female, is usually fixed by age three. With the exception of transgendered individuals, gender identity

usually corresponds to biological sex. While gays, lesbians, and bisexuals occasionally describe various degrees of gender-identity confusion, this is rare. Usually, gays have a basic sense of maleness and lesbians have a basic sense of femaleness. In contrast, social sex-role confusion is common among sexual-minorities. Because of stigma, such individuals experience varying degrees of conflict about whether and how they can or should conform to stereotyped gender roles – that is, to be labeled masculine or feminine. One common manifestation of sex-role confusion is the use of cross-sex linguistic terms; for example, gay men may refer to other gay men as “she” and “girl”.<sup>5</sup>

## Development in the face of prejudice

It is generally accepted that biological and psychological influences interact in complex ways to determine sexual orientation during development.<sup>8</sup> While growing up, gays and lesbians are on a different, nonpathological developmental track than heterosexuals.<sup>9</sup> The dilemma for developing homosexuals and bisexuals is that they must negotiate the typical tasks of becoming a sexual being in the face of negative social attitudes toward non-heterosexual sexuality.<sup>10</sup> For example, boys often equate derisive terms like “sissy” or “fag” with being feminine and homosexual, and children so labeled are often ostracized or abused.<sup>11,12</sup> Problems reported by LGBT youths are often associated with specific environmental stresses due to their sexual minority status, such as discrimination, family rejection and peer harassment. Attempts to conform to society's definitions of sexuality compromise a sexual-minority adolescent's ability to be him/herself – hardly a good developmental experience for someone struggling to form and accept his/her own identity. The higher incidence of disorders in LGBT persons is not viewed as an inherent result of their sexual identities, but a result of the social stressors that begin in childhood and persist into adulthood. In contrast, self-acceptance of one's sexual minority orientation correlates -.87 with the existence

of psychological difficulties.<sup>10</sup> This can be an important message for the therapist to convey to the patient.

### **The effects of stigma**

Sexual-minorities react to stigma in many ways, including becoming depressed or anxious, abusing substances, acting out or withdrawing sexually. Internalized homophobia can influence one's sense of self, self-esteem, and the ability to make and keep relationships. Self-loathing can contribute to a propensity for guilt and punishing oneself. External aspects of homophobia may include overzealous "heterophobic" attitudes, like over-identifying with gay movements (even though gay pride and LGBT organizations are generally helpful on a macro-level).<sup>5</sup> Therapy can focus on the genuine acceptance of one's sexual orientation and provide a safe place to discuss stigma.

An affirming experience for sexual-minorities is to discuss sexual activity openly to the therapist. The sexual activity of sexual-minorities is similar in many ways to heterosexuals, but different in others. The ability of the therapist to listen to erotic material and discuss homosexual fantasy without excessive anxiety strengthens the therapeutic alliance.<sup>12</sup>

Internalized homophobia is negatively correlated with the capacity of a gay or lesbian to keep romantic relationships intact. Individuals with high degrees of it have greater difficulty responding to their partner's anger or criticisms in constructive ways.<sup>7</sup> This becomes important for the therapist to incorporate into treatment when marriage and other forms of long-term commitment become topics in therapy, discussed below.

### **Coming out**

The coming out process usually has two stages. First, the person acknowledges his/her minority status to him/herself. Next, he/she comes out to his/her environment, which is often a gradual process.<sup>8</sup> Disclosure can cause great harm to persons in unsupportive environments. One focus of therapy can be to decide when and how to come out to family and friends.

### **SPECIFIC SEXUAL-MINORITY THERAPY ISSUES**

Some topics become a focus of treatment for only certain sexual-minority in-

dividuals. These include bisexuality, HIV, transgender issues, marriage and children, and whether to attempt 'reparation' therapy.

### **Bisexuality**

Bisexuals can be viewed as psychologically and sexually richer than monosexual, homosexual, or heterosexual individuals because the range of possibilities is wider. However, bisexuals who seek therapy often report suffering from the disadvantages of both worlds, rather than enjoying their respective advantages. Because they are marginalized in both the homosexual and heterosexual communities (for example, homosexuals accuse bisexuals of denying their "real" homosexuality), bisexuals can internalize negative messages from both sides. Often, the focus of treatment is to realize that being bisexual is not the torture that dogmatic heterosexuals and homosexuals describe. Ideally, in therapy bisexuals increase their tolerance for ambiguity, learn that they have the potential to fulfill many emotional and sexual roles, and become comfortable with their "masculine" and "feminine" traits.<sup>5</sup>

### **Transgendered issues**

In its purest form, the term transgender refers to individuals who live full-time in a social role not typically associated with their biological sex, but who do not resort to sexual reassignment surgery to change their gender presentation. While transvestites episodically change their clothes and transsexuals permanently change their genitals, transgenders make a sustained change of their social gender through non-surgical means. Practically speaking, transsexuals are often included in the transgender paradigm.

In 1980, the American Psychiatric Association added Gender Identity Disorder to its manual of mental disorders to describe persons with a persistent and strong cross-gender identification and discomfort with their biological sex. There is controversy regarding the inclusion of this diagnosis for adults. The International Conference of Transgender Law and Employment Policy and the National Center for Lesbian Rights issued a statement on Gender Identity Disorder and the transgender movement. With respect to adults, they acknowledged that self-iden-

tified transsexuals must receive the diagnosis of Gender Identity Disorder to get hormone treatment and surgeries for sexual reassignment and that the diagnosis has also been used to gain legal protection for transgendered people. Therefore, their statement did not advocate an immediate elimination of Gender Identity Disorder without other ways of ensuring continued access to and reimbursement for medical treatment and continued legal protection. They believe Gender Identity Disorder should be eliminated as a psychiatric disorder and that transsexualism should be redefined as a medical condition. The Harry Benjamin International Gender Dysphoria Association publishes an extensive set of clinical management guidelines for treatment of adults with gender identity disorder.<sup>14</sup>

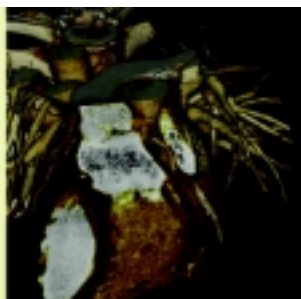
For some transgendered individuals, sexual relationships may not be a focus of therapy because they are monosexual or asexual. Many transgendered individuals, regardless of their sexual orientation, find greater acceptance within the homosexual community, as it is often more tolerant of sexual diversity. Some benefit from therapy to resolve conflicts about the communities in which they wish to associate. Transgender individuals are more depressed but fail to get appropriate mental health treatment because prejudice against such persons is pervasive within American medicine.<sup>15</sup>

### **HIV**

All sexually active gay and bisexual men are at some point concerned with HIV transmission. For those without HIV, HIV counseling is effective in reducing risk behaviors.<sup>16</sup> For those with HIV, many forms of therapy have been used to help cope with the disease, with varying degrees of success.<sup>17,18</sup> Whether HIV positive or negative, therapy can be a place to discuss identifying with HIV as a defining characteristic of oneself. Gay men may have experiencing multiple AIDS-related losses, and therapy is an ideal setting for coming to terms with such losses.<sup>19</sup>

### **Marriage**

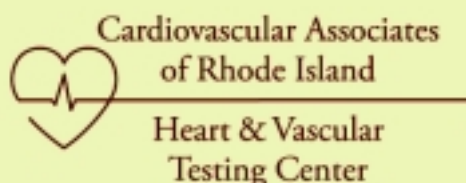
Many gays and lesbians have committed relationships, and gay civil marriage and civil unions have become increasingly important to many gays and lesbians. Like their heterosexual counter-



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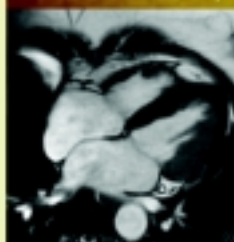
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parts, homosexuals' commitment to their love relationships is the best predictor of staying in it. The same healthful interdependence processes that characterize heterosexual relationships also characterize homosexual ones.<sup>20,21</sup>

About half of gay men and over sixty percent of lesbians are in romantic relationships, many of which are long term. The early data from Massachusetts indicates that about two third of married lesbian couples have children and about one third of married gay couples have children. Many of these individuals were in committed relationships with each other for years before they married.<sup>22,23</sup> Stigma can contribute to conflicts some LGBT persons can have about marriage/civil commitment, and the therapist should be supportive about the desires of sexual minorities to have legally sanctioned relationships.

### Children

Overall results of research to date indicate that children of lesbians and gays have normal peer relationships and that their relationships with adults of both sexes are also good. The data do not suggest elevated rates of homosexuality among the offspring of lesbian or gay parents. Fears about these children being abused by adults, shunned by peers, or isolated in single-sex gay or lesbian communities are unfounded. Instead, the information suggests that two parents are better than one, regardless of gender.<sup>24,25,26</sup> This data can be useful for the therapist to convey to a sexual-minority patient who has concerns about parenting.

### Reparation therapy

The term reparative therapy refers to psychotherapy aimed at eliminating homosexual desires. People who do not think homosexuality is one variation within human sexual orientation, but believe it is a mental disorder, use the term. A balanced review of the scientific literature indicates that sexual orientation is fixed in the vast majority of individuals. A major study reporting successful outcomes of reparation therapy has been criticized in part because the sample consisted predominantly of activists recruited from "ex-gay" ministries: they were highly motivated to report that they had changed their sexual orientation.<sup>27,28</sup> Reparation therapy may include ethical violations

such as improper pressure, fiduciary responsibility to the patient's best interest, confidentiality, and informed consent.<sup>29</sup> The mainstream medical profession does not recommend this therapy.

### CONCLUSION

For sexual-minorities to benefit maximally from therapy, therapists should understand the development of sexual-minority identity and to be aware of distinct LGBT lifestyle and relationship issues. Furthermore, the therapist's response to sexual-minority issues can either alleviate or exacerbate psychological distress.<sup>10</sup> Compared to a generation ago, more positive images of sexual-minorities and advances in research inform therapists' working practices. As a result, therapy now has much more to offer to sexual-minorities.

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Barry W. Wall, MD, is Director, Forensic Service, Eleanor Slater Hospital, Cranston, Rhode Island, is in private clinical and forensic psychiatric practice in Providence, Rhode Island, and is Clinical Associate Professor, Department of Psychiatry and Human Behavior, Brown Medical School.

### CORRESPONDENCE:

Barry W. Wall, MD  
184 Waterman Street  
Providence, RI 02906  
Phone: (401) 273-1010  
e-mail: bwall@mhrh.ri.gov



# Specialized STD Care In Rhode Island

Josiah D. Rich, MD, MPH, Marie Ghazal, RN, MS, Bernadette Mansfield, NP, Stacy Ramsey, NP, Doreen Donnelly, NP

**Rhode Island has only one free** confidential Sexually Transmitted Disease (STD) Clinic, the Whitmarsh Clinic, located at 557 Broad Street in South Providence. Under the aegis of the **Providence Community Health Centers, Inc. (PCHC)**, a federally funded community health center, the Whitmarsh Clinic is funded through the **Rhode Island Department of Health (HEALTH)**, using federal and state funds.

PCHC is the largest provider of primary care services in Rhode Island. With multiple medical, dental, school-based and administrative sites across Providence, PCHC provides primary care to one in every six Providence residents and one in every three school-aged children.

The Whitmarsh Clinic welcomes referrals from physicians, medical offices and other providers throughout the state. The clinic is staffed by a consultant Medical Director, three full-time Nurse Practitioners experienced in the treatment of STDs and a bi-lingual medical assistant. Appointments can be made Monday-Friday 7:30am-3:30 pm. All services including the clinic visit, any treatment provided and medications are free; donations to the clinic are gladly accepted. Patient confidentiality is maintained for all services. At this time, clinic visits are by appointment only. Walk-ins may be seen but are not encouraged. The wait time for comprehensive STD screening is 6-7 days; symptomatic patients are usually seen within 1-2 days.

## SERVICES PROVIDED

Routine confidential STD screening includes an assessment of risk factors, physical examination and/or testing for HIV, chlamydia, gonorrhea, syphilis, genital warts, molluscum, NGU, cervicitis/PID, vaginitis (bacterial vaginosis, yeast,

trichomonas), scabies and culture testing for suspicious lesions to rule out herpes. HIV blood testing can be done confidentially or anonymously. Hepatitis B vaccine is provided for patients who have not been vaccinated. The Whitmarsh Clinic does not provide onsite Pap smears or pregnancy testing although referrals are made to other PCHC sites. Dermatology visits are available twice monthly after patient screening has been completed. Providers are strongly encouraged to contact the staff for consultation. We have interpreter services.

The clinic providers work closely with the Department of Health on disease monitoring and partner counseling, as well as on the HIV Partner Notification Program: partners are confidentially contacted and informed about their risks (and where to go for free testing), and the public is educated about STD risk, testing, treatment and responsible sexual practices.

## PROGRAM DATA

In 2004 there were 5003 patient visits, a 14% increase from 2003. The population is comprised primarily of men (74%) ages 20-34. Thirty-eight percent are Black, 30% are Hispanic and 29% are White. These visits included 494 cases of chlamydia, 152 cases of gonorrhea, 40 cases of syphilis and 15 newly positive HIV tests. The number of syphilis and HIV cases has increased over the years. In addition, the clinic screened and treated 18 cases of herpes, 154 cases of bacterial vaginosis, approximately 145 cases male genital warts and molluscum contagiosum (many of whom returned for Dermatology treatments). Along with STD screening and treatments, 436 of the Whitmarsh Clinic patients were offered Hepatitis B Vaccination and 186

initiated the vaccination series. Most of the patients were from Providence County with significantly fewer from Bristol, Washington, Kent and Newport Counties.

## CONCLUSION

Patient visits to the Whitmarsh Clinic are primarily made by "word of mouth" and self-referral. In addition, community health centers, schools, colleges, emergency rooms, and treatment centers across the state provide information to patients for referral. Private medical offices refer a small proportion of patients. The clinic welcomes all types of provider referrals for free STD treatment. We need documentation of testing and diagnosis in order to provide the appropriate treatment for the person with the STD. If you give the person with the STD diagnosis a letter requesting that his/her partner be treated, we can provide this service. The Whitmarsh Clinic is an important statewide resource for patients who otherwise cannot afford testing and treatment.

Information about the clinic can be found on the PCHC Website: [www.providencechc.org](http://www.providencechc.org) <<http://www.providencechc.org/>>; the HEALTH, STD website: [www.health.ri.gov/disease/communicable/std/testing.php](http://www.health.ri.gov/disease/communicable/std/testing.php).

*Josiah D. Rich, MD, MPH, is Medical Director, Whitmarsh Clinic, Attending Physician at the Miriam Hospital, and Professor of Medicine and Community Health, Brown Medical School.*

*Marie Ghazal, RN, MS, is Vice President of Patient Care & Nursing, Providence Community Health Centers.*

*Bernadette Mansfield, NP, is the Coordinator/Nurse Practitioner, Whitmarsh Clinic.*

*Stacy Ramsey, NP, is a Nurse Practitioner, Whitmarsh Clinic.*

*Doreen Donnelly, NP, is a Nurse Practitioner, Whitmarsh Clinic.*

## CORRESPONDENCE

Bernadette Mansfield, NP  
Whitmarsh Clinic  
557 Broad Street,  
Providence, RI 02907  
Phone: (401) 444-0483  
e-mail: [bmansfield@providencechc.org](mailto:bmansfield@providencechc.org)

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Phil Barber, Disease Intervention and Health Promotion Specialist  
Cell 401-639-6315, Beeper 401-786-9831, Office 401-462-0703

### Patients should contact:

Rhode Island Department of Health, Office of HIV/AIDS and Viral Hepatitis. 401-222-2320

Rhode Island HIV/AIDS Hotline 1-800-726-3010





# Images In Medicine

## Successful Exclusion of Abdominal Aortic Aneurysm Using an Endograft

Gregory Dubel, MD

Open surgical repair has been the gold standard for repair of abdominal aortic aneurysms. For patients medically able to undergo the procedure, surgery remains the optimal treatment. Many patients, however, pose a prohibitive risk to open repair. **Endovascular Abdominal Aortic Aneurysm Repair (EVAR)** has emerged as a safer option for these patients. EVAR has been documented to shorten ICU and hospital stay, decrease perioperative morbidity and mortality, and decrease the need for blood transfusions.<sup>1,2</sup>

Figure 1a demonstrates the pre-EVAR CT of a 72 year-old patient with prostate cancer, **chronic obstructive pulmonary**

**disease (COPD)**, and **coronary artery disease (CAD)**. The CT demonstrates a 5.6x5.1cm infrarenal aneurysm that had increased in size by 8mm over the preceding 12 months. He was deemed high risk for open repair of his aneurysm after consultation with Cardiology, Pulmonology, and Anesthesiology. EVAR was successfully performed using an AneuRx (Medtronic/AVE, Santa Rosa, CA) bifurcated device (Figure 1b). His right internal iliac artery origin was coil embolized prior to EVAR to



Figure 1a.



Figure 1c.

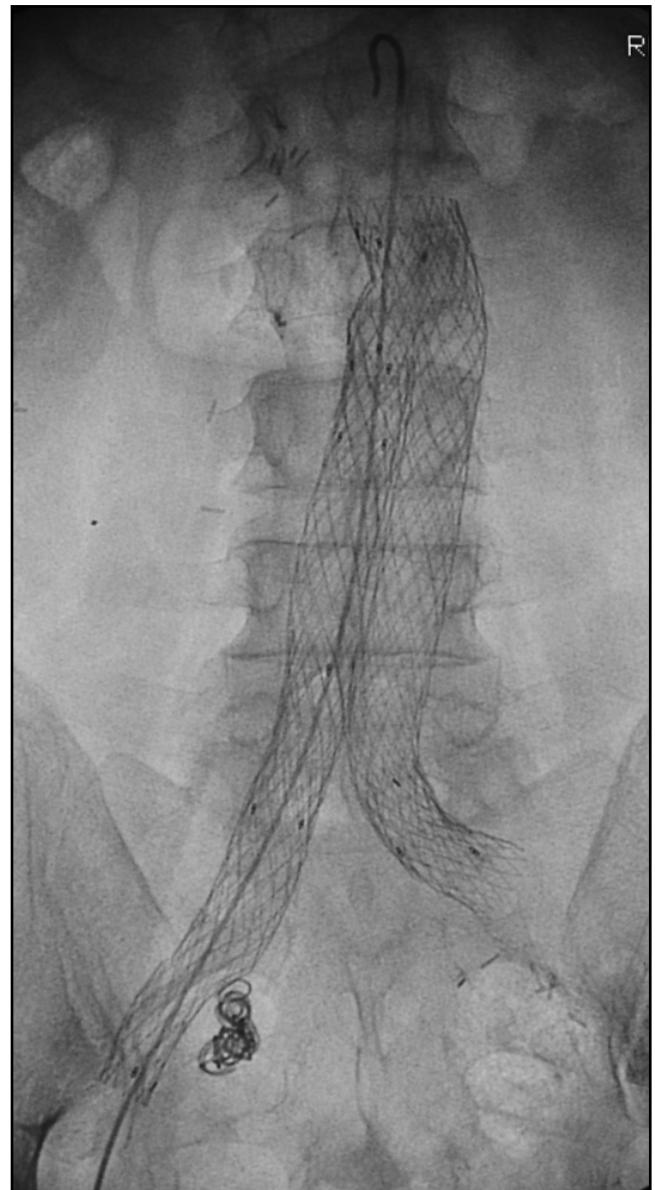


Figure 1b.

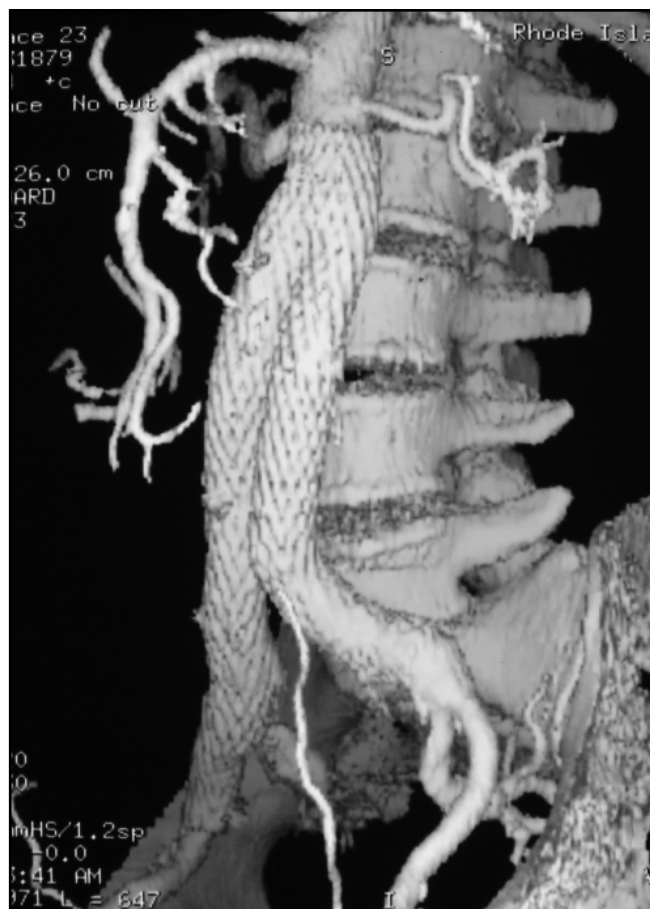


Figure 1d.

prevent retrograde filling of the aneurysm sac. Follow-up CT (Figure 1c) demonstrates complete exclusion of the sac as well as a reduction in size of the aorta which now measures 3.3x3.8cm. No endoleak (persistent filling of the aneurysm sac via poor sealing at end of graft or via collateral vessels, i.e. lumbar arteries) was seen on delayed venous phase imaging. Figure 1d demonstrates 3D reformatted image of the graft.

This case demonstrates the effectiveness of EVAR for selected high-risk patients. This technology has been improved significantly over the past 12 years; however, problems can still arise. Close CT surveillance is warranted for the lifetime of the graft to monitor for complications which may include aneurysm growth, graft migration, graft disruption, endoleak, and infection.<sup>1,2</sup>

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*Gregory Dubel, MD, is Assistant Professor of Diagnostic Imaging, Brown Medical School.*

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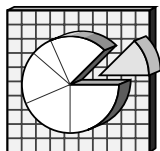
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## Trends and Patterns in Cesarean Section Rates In Rhode Island

Samara I. Viner-Brown, MS, and Rachel Cain

Over the past decades, high rates of cesarean section deliveries have been a concern both at the national and state level. During the late 1980s and early 1990s, the rate of cesarean section deliveries in Rhode Island decreased and appeared to be heading for the national target of 15% by 2000.<sup>1</sup> During this time, vaginal births after cesarean section deliveries (VBACs) were encouraged. However, the downward trend in c-section rates reversed in 1995, and in Rhode Island the c-section rate rose to 28.8% in 2004, the highest rate reported for the state. Currently, more than one out of four babies born in Rhode Island are delivered by cesarean section.

### METHODS

Cesarean section rates for Rhode Island were calculated using information reported on the Rhode Island birth certificate, including whether the delivery was a primary or first-time cesarean delivery, a repeat cesarean delivery or a VBAC. The overall cesarean section rate was defined as the number of cesarean deliveries, primary and repeat, per 100 births. The primary cesarean rate was defined as the number of primary cesarean deliveries divided by the total number of deliveries minus the number of previous cesarean deliveries (including VBACs). The repeat cesarean rate was defined as the number of repeat

cesarean deliveries divided by the total number of repeat cesarean deliveries and VBACs. Because of concerns about the completeness of VBAC data on the birth certificate, the VBAC rate was reported from the state's Hospital Discharge Database.<sup>2</sup> The VBAC rate was defined as the number of VBACs divided by the total number of repeat cesarean deliveries and VBACs.

Comparative data for the United States were taken from a published source.<sup>3</sup>

### RESULTS

**Overall Trends.** In 1986, the cesarean section rate in Rhode Island had risen to 23.8%, but by 1994, this figure had dropped to 17.3%. In 2004, 3,681 (28.8%) of the 12,778 births among Rhode Island residents were by cesarean section. Between 1990 and 2004, the overall cesarean section rate in Rhode Island increased by 57.4%, from 18.3 to 28.8. (Figure 1) Although c-section rates among Rhode Islanders had been lower than national rates during the 1990s, by 2003, the Rhode Island rate (28.2) had surpassed the nation (27.5). (Figure 1) Increases in c-section rates during 1990-2003, were more pronounced in Rhode Island compared to the nation. While the c-section rate rose by 21.1% in the nation, the rate in Rhode Island rose by 54.1%.

**Primary and Repeat Cesarean Sections.** During 1990-2004, the primary c-section rate among Rhode Islanders rose more sharply than the overall rate, from 12.1 in 1990 to 21.1 in 2004, a 74.4% increase. (Figure 2) In 1990, 71.7% of births to women with previous c-sections were by repeat c-section; by 2004, this rate increased to 83.6%. However, between 1990 and 1994, the repeat rate decreased by less than a quarter, but then increased by 53.1% between 1994 and 2004.

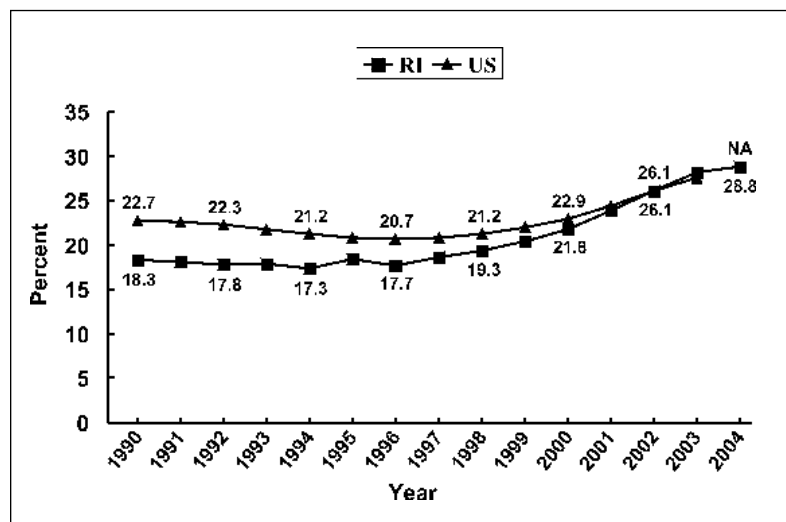


Figure 1. Overall Cesarean Section Rates, United States and Rhode Island, 1990-2004

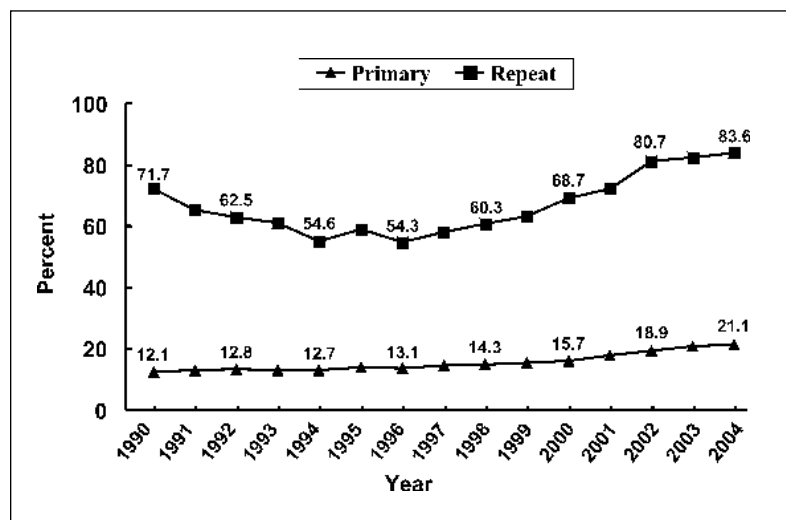


Figure 2. Primary and Repeat Cesarean Section Rates, Rhode Island, 1990-2004

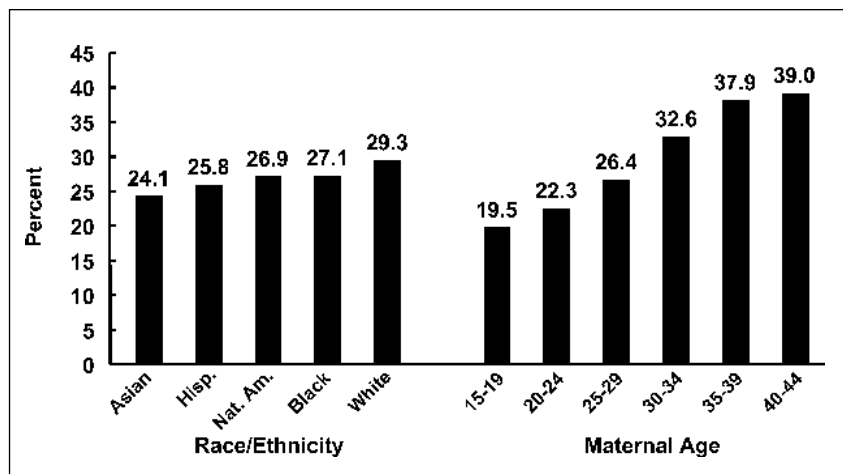


Figure 3. Cesarean Section Rates by Race/Ethnicity and Age, Rhode Island, 2004

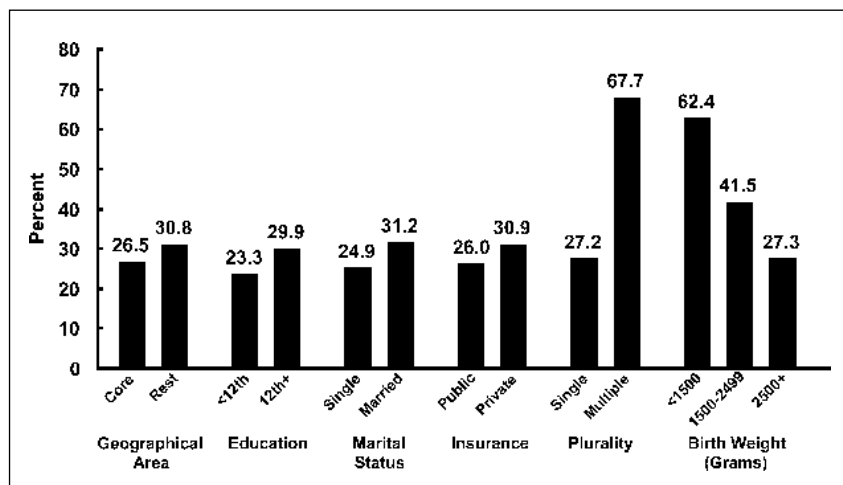


Figure 4. Cesarean Section Rates by Other Maternal and Infant Characteristics, Rhode Island, 2004

**VBACs.** The percentage of births that were VBACs decreased from 28.3% in 1990 to 16.4% in 2004. Contrary to the trend seen for repeat sections, the VBAC rate increased by 60.4% during 1990-1994, but then decreased by 63.9% during 1994-2004.

**Maternal and Infant Characteristics.** Disparities in c-section rates also exist among racial/ethnic groups and vary by maternal age, education, marital status, insurance and geographical area of residence. During 2004, Whites had the highest c-section rate (29.3%) while Asians had the lowest (24.1%). (Figure 3)

C-section rates rise with women's age. In 2004, women aged 40-44 (39.0%) were twice as likely to have a c-section than teens aged 15-19 (19.5%). (Figure 3) However, between 2000 and 2004, the rate among teens rose by 53.5% compared to 17.8% among women aged 40-44.

Although in 2004, women with less than a high school education (< 12<sup>th</sup> grade) had lower c-section rates (23.3%) than women with higher educational levels (29.9%), c-section rates among women with less than a high school education grew more sharply. Between 2000 and 2004 c-section rates among women with less than a high school education increased by 42.9% compared to 30.6% among women with higher educational levels.

During 2004, married women were more likely to have a c-section (31.2%) than single women (24.9%). Higher c-section rates were seen among women with private insurance

(30.9%) than among women with public (Medicaid/RIte Care) health insurance (26.0%). Women who resided in the core cities were less likely to have a c-section (26.5%) than women who lived in the rest of the state (30.8%). Women who had multiple gestation births (i.e., twins and triplets) were approximately 2.5 times more likely to have a c-section (67.7%) compared to women who delivered a singleton birth (27.2%). Low birth weight was also a risk factor for c-section, where 62.4% of very low birth weight babies (<1500 grams) were delivered by c-section compared to 27.3% of normal birth weight babies (≥2,500 grams). (Figure 4)

## DISCUSSION

Cesarean section rates have risen in Rhode Island and the nation for the past decade. Primary and repeat rates have risen to their highest levels, and VBACs are at their lowest. Cesarean rates in Rhode Island have increased across all races and ages. Women are more likely to have cesarean deliveries if they are older, have multiple births or low birth weight babies. Contributing factors to the rise in c-section rates include increases in maternal age (delays in childbearing), increases in multiple births, and changes in policies or guidelines. The decrease in VBACs may be due to fear of malpractice lawsuits and changing opinions on their safety (e.g., uterine rupture).

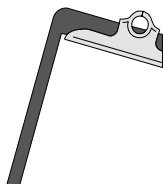
Although cesarean delivery versus vaginal delivery must be determined at the individual level, there is disagreement as to the appropriate rate of cesarean deliveries overall. Specifically, there is a lack of consensus regarding elective cesarean deliveries, the safety of VBACs and the risks and benefits of vaginal delivery.<sup>3</sup> In the face of these uncertainties, it is doubtful that Cesarean section rates will return to the low levels achieved in the previous decade.

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*Samara Viner-Brown, MS is Chief, Data and Evaluation, Division of Family Health, Rhode Island Department of Health.*

*Rachel Cain is a Senior Health Promotion Specialist, Division of Family Health, Rhode Island Department of Health.*



## Controlling Cancer of the Cervix Uteri in Rhode Island: Preliminary Evidence of Success In Eliminating Disparities

John P. Fulton, PhD

Cancer of the *cervix uteri* (cervical cancer) is a preventable disease. Despite the prevalence of human papilloma virus (HPV) in today's population, methodical screening with the Pap test can identify virtually all lesions of the cervix in a precancerous state, or as cancer *in situ*. Thus, all cases of invasive cervical cancer may be interpreted as "screening failures."

Rhode Island is blessed with a compact, urban infrastructure, in which geography does not present much of a barrier to gynecological care, especially among women of low income, most of whom live in close proximity to hospitals, community health centers, and other providers of medical care. Of course, other barriers limit women's access to gynecological care, but other things being equal, access to care is better in urban than in rural settings. For this reason, Rhode Island has traditionally had lower than average cervical cancer mortality among the states, despite higher than average cancer mortality overall.<sup>1</sup> Currently, for example, Rhode Island has the 18th highest age-adjusted cancer death rate (all cancers) for females among the 50 states and the District of Columbia, but 39th highest age-adjusted cervical cancer death rate.<sup>2</sup>

In the United States, age-adjusted incidence and mortality rates from cervical cancer are higher among non-Hispanic Blacks ("Blacks") and Hispanics than among non-Hispanic Whites ("Whites"). For example, in the period 2000-2003, age-adjusted incidence of cervical cancer in the United States was 8.5/100,000 among Whites, 11.5/100,000 among Blacks, and 14.2/100,000 among Hispanics.<sup>2</sup>

To eliminate disparities such as these, the federal government provides free gynecological care for women enrolled in

Title X family planning programs and free cervical cancer screening, diagnosis, and treatment for uninsured women of low income. Both services are offered in Rhode Island, family planning services since the 1980s, and additional women's cancer services since 1995. As well, gynecological care has been offered to Rhode Island women enrolled in Rlticare, the state's Medicaid waiver program, since 1995.

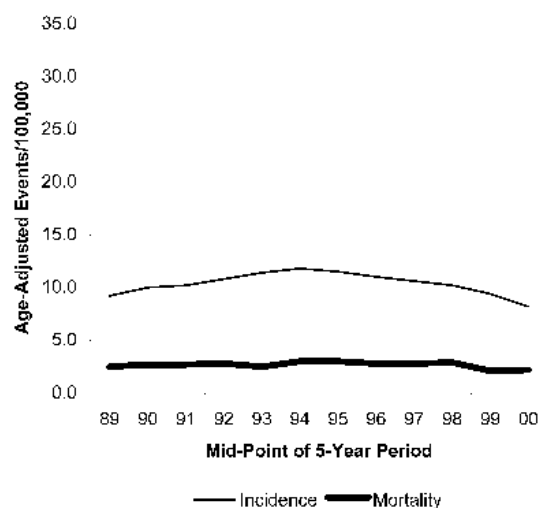
Using the latest available data on cancer of the cervix among Rhode Island women, the Rhode Island Cancer Registry constructed age-adjusted incidence and mortality rates to evaluate progress in the prevention of cancer of the cervix over time, and also to assess disparities in rates of cancer of the cervix among Whites, Blacks, and Hispanics.

### METHODS

#### Incidence Rates for Whites and Blacks

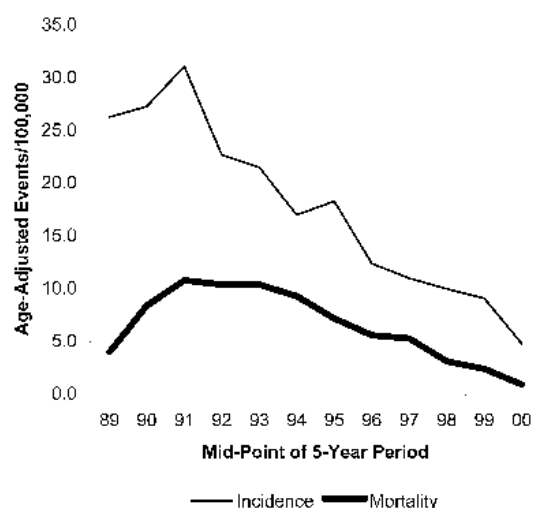
Inter-censal estimates of population were constructed for resident Rhode Island Whites and Blacks by year, sex, and age group for the years 1987-2003, using backward extrapolation (1987-1989), linear interpolation (1991-1999), and forward extrapolation (2001-2003), from 1990 and 2000 US Census counts. Data on resident cervical cancer cases identified as White or Black were extracted from Rhode Island Cancer Registry case reports for the years 1987-2003 and aggregated by race, age group, and year of event. Cancer case counts were combined with estimates of population to construct age-adjusted cancer incidence rates. The year 2000 standard US population was used for age-adjustment.

Fig. 1 - Cancer of the Cervix in Rhode Island  
White Women

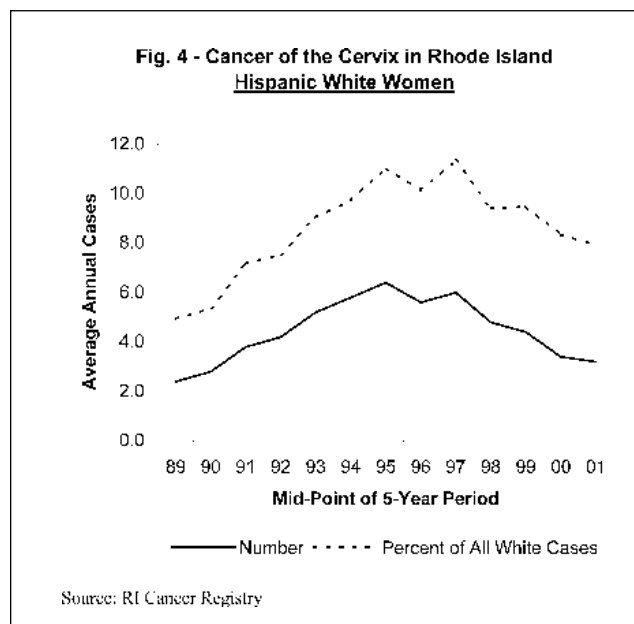
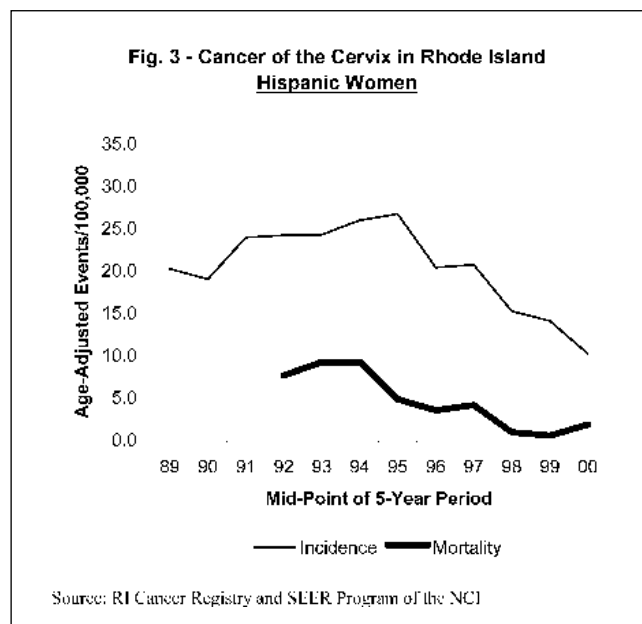


Source: RI Cancer Registry and SEER Program of the NCI

Fig. 2 - Cancer of the Cervix in Rhode Island  
Black Women



Source: RI Cancer Registry and SEER Program of the NCI



### Counts and Incidence Rates for Hispanics

New inter-censal estimates of population were constructed for resident Rhode Island Hispanics by year, sex, and age group for the years 1987-2000, using backward extrapolation (1987-1989) and linear interpolation (1991-1999), from 1990 and 2000 U.S. Census counts. New U.S. Census inter-censal estimates for resident Rhode Island Hispanics (by age group and sex) were obtained for the years 2001-2003.<sup>3</sup> Data on resident cervical cancer cases identified as Hispanic were extracted from Rhode Island Cancer Registry case reports for the years 1987-2003 and aggregated by age group and year of event. Alternative counts of cervical cancer cases for resident Rhode Island Hispanics were estimated using a validated US Census technique for identifying Hispanics by maiden name and surname.<sup>4</sup> Synthetic aggregates of Hispanic cancer cases were created by adding the additional cases classified as Hispanic on the basis of the name analysis to those cases identified as Hispanic in case reports.

Cancer case estimates were combined with the estimates of population to construct age-adjusted cancer incidence rates. The year 2000 standard US population was used for age-adjustment.

### Mortality Rates

Age-adjusted cervical cancer mortality rates stratified by state of residence, race, and ethnicity were obtained from the Surveillance, Epidemiology, and End Results (SEER) program of the National Cancer Institute. The year 2000 standard US population was used by SEER for age-adjustment.<sup>5</sup>

### RESULTS

Recent trends in Rhode Island's rates of cervical cancer are very encouraging. Although rates among Whites increased in the early 1990s, they decreased thereafter. (Figure 1) Rates among Blacks dropped consistently throughout the 1990s. (Figure 2) Rates among Hispanics increased in the early 1990s, but saw dramatic improvement after 1995. (Figure 3) Looking at the trend in cases of invasive cervical cancer newly diagnosed among White Hispanics suggests a substantial contribution to the trend in cervical cancer incidence among all Whites. (Figure 4)

### DISCUSSION

Racial and ethnic disparities in the incidence and mortality of cervical cancer have been all but eliminated in Rhode Island, suggesting equal access to cervical cancer screening among Whites, Blacks, and Hispanics.

The Rhode Island Cancer Registry will analyze available data in greater depth to evaluate the separate contributions of the RItcare and Women's Cancer Screening programs, both established in the 1990s, to the elimination of disparities.

Virtually all new cases of cervical cancer are preventable by finding and treating precancerous lesions. We must profile women who develop invasive cervical cancer and address those factors appearing to contribute to negative outcomes.

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*John P. Fulton, PhD, is Associate Director of Health, Rhode Island Department of Health, and Clinical Associate Professor of Community Health, Brown Medical School.*



## Health IT E-Newsletter

Mary Ellen Casey, RN, BS, M.Ed, COS-C

With this month's feature, Quality Partners of Rhode Island begins a series of updates on the adoption and spread of **Health Information Technology (HIT)** in Rhode Island. Rhode Island has distinguished itself as a national leader in HIT adoption. These updates are meant to provide the physician community with information on local initiatives that will impact the practice of medicine in our state. For further information contact Mary Ellen Casey at [mcasey@riqio.sdps.org](mailto:mcasey@riqio.sdps.org).

### Rhode Island Builds a Community Health Information Exchange:

With funding from the **Agency for Healthcare Research and Quality (AHRQ)**, Rhode Island has begun to plan, develop, implement, and evaluate an electronic "backbone" to facilitate interoperability and sharing of patient data between hospitals, physician offices, labs and other healthcare providers. The State and Regional Demonstration in HIT Project, also known as the **AHRQ-HIT Project**, is a five-year, \$5 million dollar demonstration project that was awarded to the Rhode Island Department of Health in 2004 and will continue until

2009. Rhode Island is one of six states participating in this demonstration project.

This project has taken an important step forward this month. **The Request For Proposal (RFP)** for a vendor to build the initial solution was released January 4, 2006, and the Department of Health received thirteen proposals. The review process is underway with a contract award anticipated this summer. A number of advisory groups from the healthcare community have been convened. The Physician Advisory Panel, a group of physicians working to advise the project on clinical and provider needs, is considering security and consent issues and continues to make recommendations to the system. The Policy and Legal Workgroups are working through the multiple security and confidentiality issues. Members of the Physician Advisory Panel and the Policy and Legal Workgroup met on April 26th. A Consumer Engagement Committee, which convened on March 17<sup>th</sup>, met again on May 10. The Administrative Data Exchange Committee is under development. For more information, visit: [www.healthit.ahrq.gov](http://www.healthit.ahrq.gov) or contact Mary Ellen Casey at [mcasey@riqio.sdps.org](mailto:mcasey@riqio.sdps.org)



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## 2nd Annual Health Information Technology Fair:

The 2nd Annual Rhode Island HIT Fair, held on March 4<sup>th</sup> at the Providence Marriott, drew over 130 attendees and 17 vendors. Dr. Karen Bell, Director of HIT Adoption at the Office of the National Coordinator for Health IT, the keynote speaker, spoke on the Transformation of Healthcare and Health Information Technology. The program also included reports from Laura Adams, Rhode Island Quality Institute, Dr. Deidre Gifford, MD, MPH, Quality Partners of Rhode Island and Amy Zimmerman, MPH, Department of Health on key state-wide Health IT initiatives, highlighting the significant progress achieved during the past year. A five-member physician panel discussed their experiences, highlighting both barriers and successes, with implementing an **electronic health record (EHR)**. Panel members included Dr. David Candow, Dr. Fred Crisafulli, Dr. Ralph Earp, Dr. Michael Migliori, and Dr. Miguel Prieto. Panelists related their overall positive view of implementing information technology in their offices, but also noted some potential pitfalls. They noted the need for careful planning, inclusiveness of the entire staff, importance of project management and a planned rollout of different technology features. Participants spent time with vendors learning about different products and hardware options to help with successful EHR implementation.

Quality Partners of Rhode Island launched an EHR Users ListServ on Monday, May 1<sup>st</sup>, 2006. To join our ListServ, contact Mary Ellen Casey: [mcasey@riqio.sdps.org](mailto:mcasey@riqio.sdps.org).

## Deidre Gifford, MD, of Quality Partners of Rhode Island spoke on the role of Quality Improvement Organizations and Health IT Adoption to a Capitol Hill audience March 6th

The Rhode Island AHRQ Health IT project was featured in a briefing on Capitol Hill on March 6, 2006. Dr. Deidre Gifford of Quality Partners of Rhode Island joined Janet Marchibroda of the eHealth Initiative, Francois DeBrantes of Bridges to Excellence, and Dr. John Nelson, out-going AMA president, to discuss the role of **Quality Improvement Organizations (QIOs)** in Community Health Information Exchange initiatives around the country. Dr. Gifford highlighted the key role that Rhode Island providers are playing in the design and implementation of our health information exchange, and the importance of early and genuine provider engagement in HIT adoption in general. Mark Bennett, CEO of HealthInsight (the Utah QIO) and Greg Linden, CIO from Stratis Health, the MN QIO, spoke about their organizations' roles in **Health Information Exchange (HIE)** development.

[http://app2.topiksolutions.com/ct\\_track.ts?c=84605&u=1798277&i=3634&ct\\_attrib=http%3A%2F%2Fwww.healthcareitnews.com%2Fstory.cms%3Fid%3D4623](http://app2.topiksolutions.com/ct_track.ts?c=84605&u=1798277&i=3634&ct_attrib=http%3A%2F%2Fwww.healthcareitnews.com%2Fstory.cms%3Fid%3D4623)

## Health Information Technology Resources

The Agency for Healthcare Research and Quality (AHRQ) launched a suite of "Learning Resources" to help healthcare providers adopt HIT more quickly and efficiently. The site provides emerging lessons from the field; a knowledge library with links to more than 5,000 HIT information resources; an evaluation toolkit to help those implementing HIT projects; a sum-

mary of key topics; plus other resources pointing to current HIT activities, funding opportunities, and other information: <http://www.healthit.ahrq.gov>

## E-prescribing in Rhode Island has renewed focus

A new committee has formed out of the Department of Health to advance e-prescribing in Rhode Island. The focus is to explore integration of pharmacy data into the statewide system and increase the percentage of prescriptions in Rhode Island that are submitted electronically. Dr. David Gifford, Director of Health, and Jeffrey Newell, Chief Operating Officer for Quality Partners of Rhode Island and sub-committee member of the AHRQ Health IT project, will continue the work started by the Rhode Island Quality Institute and SureScripts. This work focused on introducing and increasing e-prescribing activity in Rhode Island. Working together, Dr. Gifford and Mr. Newell will direct the team, which is represented by chain and independent pharmacies, prescribers, hospital systems, Department of Health, Rhode Island Quality Institute, Brown University, University of Rhode Island College of Pharmacy and SureScripts, and focus on policy and technical issues that will enhance the process. The broad adoption of e-prescribing will affect patients and all healthcare professionals by having timely information that will reduce medication use issues and continue to improve patient safety.

Achieving statewide adoption of e-prescribing includes three goals. By the end of 2007:

- 75% of all prescriptions for residents of Rhode Island will be completed electronically
- Two-thirds of all Rhode Island physicians will utilize electronic prescribing mechanisms for new and/or renewal prescriptions
- 100% of pharmacies will be capable of accepting electronic prescriptions in accordance with NCPDP standards

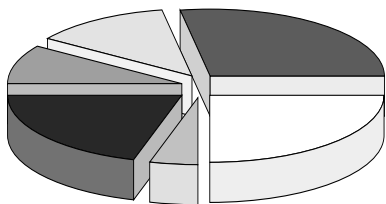
The committee will track progress toward the three goals by reporting on the three measures of success quarterly to the RIQI Board.

## CORRESPONDENCE

Mary Ellen Casey  
Quality Partners of Rhode Island  
235 Promenade Street, Suite 500  
Providence, RI 02908  
e-mail: [mcasey@riqio.sdps.org](mailto:mcasey@riqio.sdps.org)

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# Health Insurance Update

## An Introduction to the Office of the Health Insurance Commissioner

*John Aloysius Cogan Jr, MA, JD, and Patricia E. Huschle, MS*

**The Office of the Health Insurance Commissioner (OHIC)** is just over a year old. Over the next few months we will explain how its regulatory responsibilities affect physicians. In this inaugural column, we explain the OHIC's genesis, its jurisdiction and mission, and recent developments.

### THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER

The "Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight" (the Act)<sup>1</sup> established the OHIC and gave it exclusive jurisdiction over health insurance matters.<sup>2</sup> The **Department of Business Regulation (DBR)**, which formerly had jurisdiction over health insurance, provides infrastructure and staff to the OHIC.<sup>3</sup> As a stand-alone agency, the OHIC is overseen by the Health Insurance Commissioner and is directly accountable to the Governor.

The General Assembly mandated that the OHIC:

- Guard the solvency of health insurers;
- Protect the interests of consumers;
- Encourage fair treatment of health care providers;
- Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.<sup>4</sup>

This charge gives the OHIC greater authority to hold insurance companies accountable to consumers and health care professionals than previously given to the DBR.

The Act also created the **Health Insurance Advisory Council (HIAC)**, a roundtable of consumer, business, labor, and medical representatives that makes recommendations to the Commissioner. The HIAC examines issues such as health insurance company reserve levels, billing and reimbursement procedures, health insurance rate increases, and the insurer's role in promoting high quality healthcare.<sup>5</sup>

### THE PROFESSIONAL PROVIDER-HEALTH PLAN WORK GROUP

In 2005 the General Assembly amended the Act to add a subcommittee to the HIAC, the Professional Provider-Health Plan Workgroup, to address areas for administrative improvement.<sup>6</sup>

This Workgroup has been charged with developing a plan

to implement the following five changes to the provider/insurer relationship:

1. By January 1, 2006: Develop a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;
2. By April 1, 2006: Produce a plan for a standardized provider application and credentials verification process for the purpose of verifying professional qualifications of participating health care providers;
3. By September 1, 2006: Create a uniform health plan claim form to be utilized by participating providers;
4. By December 1, 2006: Craft contractual disclosure requirements of the mechanisms for resolving health plan/provider disputes; and
5. By February 1, 2007: Develop a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.<sup>7</sup>

Table 1 describes the composition of the Workgroup.

**Table 1. Professional Provider-Health Plan Workgroup**

The following individuals have participated in the Professional Provider-Health Plan Workgroup for either or both the fee schedule and application initiatives. Membership of the Workgroup fluctuates based on subject matter.

Jean Amaral-Care New England  
Lois Booth-RI Hospital/Medical Staff Office  
George Brier-Neighborhood Health Plan  
Maureen Brousseau-Neighborhood Health Plan  
Robert Cambio-BCBSRI  
Paul Carey-RI Urological Specialties  
Fernanda da Costa-RI Department of Health  
Charlene Denton-Lifespan/Physicians PSO  
Steven Detoy-RI Medical Society  
Christopher Dooley-Women & Infants Hospital PHO  
Dan Egan-Hospital Association of RI  
Stephan Katinas-BCBSRI  
Joel Kaufman, MD - Lifespan/Physicians PSO  
Jason Martiesian-UHNE  
Lorraine Roberts-Lighthouse, MD  
Craig Syata-HARI  
Donna Valletta-RI Department of Health  
Holly Vota-BCBSRI

## FEE SCHEDULE DISCLOSURE

The Workgroup's first initiative was to streamline the way the three predominant local health plans (Blue Cross, United and Neighborhood Health Plan) disclose their fee schedules to contracted providers. The Workgroup agreed that an online fee schedule look up capability was the ideal.

Currently only United has online fee schedule inquiry capability for commercial products. Blue Cross and Neighborhood Health Plan have agreed to create for provider access an internet look-up for all codes for their standard fee schedules for all locally marketed products by December 2006. The Workgroup also established a standard process for providers to obtain this information in the short term that includes both telephonic and email/fax options for the providers' office.

Additional details on how providers can obtain fee schedule information is available on the OHIC web site<sup>8</sup> and is being distributed electronically throughout the provider community.

## STANDARDIZED PROVIDER APPLICATION AND CREDENTIALS VERIFICATION PROCESS

For the second mandate, a standardized application and verification process, the Workgroup membership added representatives of hospital medical staff offices. At the initial meeting the Workgroup agreed that:

- collection of the providers' data for credentialing and re-credentialing purposes was the primary concern for the provider's offices; and
- identifying a common credentialing verification organization is something that will be addressed later.

The Workgroup opted to adopt the Council on Affordable Quality Healthcare (CAQH)'s electronic "data collection tool" as the Rhode Island standard, rather than to establish a statewide application as Massachusetts and other states have done. [CAQH is a not-for-profit alliance of health plans, networks and trade associations, created to promote collaboration among health plans towards administrative simplification.]

United already requires the electronic CAQH application; and Blue Cross and Neighborhood have agreed to adopt the paper CAQH, with Blue Cross accepting the electronic version as its standard on January 1, 2007. Hospitals in the state are considering the usefulness of the CAQH application in streamlining their internal processes. These will be significant advances for the medical community.

## FUTURE ACTIVITIES FOR THE WORKGROUP

The Professional Provider-Health Plan Workgroup will be addressing the remaining issues identified in the mandate over the coming months in an effort to alleviate some of the administrative frustrations experienced by the provider community.

## FUTURE COLUMNS

When establishing the OHIC, the General Assembly sought to hold health plans accountable for their effects on the costs, quality and access to health care in Rhode Island. The OHIC will keep Rhode Island's physicians informed about our progress in these efforts, as well as the activities of the Workgroup and HIAC. Please visit [www.dbr.state.ri.us/health\\_insurance.html](http://www.dbr.state.ri.us/health_insurance.html).

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2. RI Gen. Laws § 42-14-5(d).
3. RI Gen. Laws § 42-14.5-1.
4. RI Gen. Laws § 42-14.5-3.
5. R.I. Gen. Laws § 42-14.5-3(c).
6. PL 2004, ch. 273.
7. RI Gen. Laws § 42-14.5-3(d).
8. [www.dbr.state.ri.us/pdf\\_forms/insur/HI-060320\\_Workgroup\\_Leg\\_Report.pdf](http://www.dbr.state.ri.us/pdf_forms/insur/HI-060320_Workgroup_Leg_Report.pdf).

*John Aloysius Cogan Jr, MA, JD, is Counsel and Executive Assistant for Policy and Program Review, Office of the Health Insurance Commissioner.*

*Patricia E. Huschle, MS, is Provider Liaison, Office of the Health Insurance Commissioner.*

## CORRESPONDENCE

Patricia E. Huschle, MS  
Office of the Health Insurance Commissioner  
233 Richmond Street  
Providence, RI 02903  
phone: (401) 222-5428  
e-mail: [phuschle@db.state.ri.us](mailto:phuschle@db.state.ri.us)

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## JUDICIAL DIAGNOSIS

### Must My Doctor Tell My Partner? Rethinking Confidentiality In the HIV Era

Jacob M. Appel, JD

The principle that physicians ought not divulge the medical confidences of their patients dates back to the Oath of Hippocrates, and has long been recognized by both English common law and the statutes of most states.<sup>1</sup> However, the scope of this obligation has been subject to frequent limitations—particularly when the revelation of personal medical information furthers the public welfare. Certain exemptions and affirmative disclosure duties have been recognized nearly universally. For instance, to receive federal funding under the **Child Abuse Prevention and Treatment Act (CAPTA)**, every state requires physicians to report the mistreatment and neglect of minors.<sup>2</sup> The majority of states have mandatory reporting provisions for bullet wounds, communicable diseases and individuals unfit for certain occupations.<sup>3</sup> A canon of the American Medical Association's **Council on Ethics and Judicial Affairs (CEJA)**—widely followed by most state licensing authorities—imposes an additional duty on physicians to report the misconduct or “unfitness” of colleagues under their care.<sup>4</sup> In addition, to varying degrees, CEJA guidelines and several state court decisions impose an affirmative duty on physicians to break confidences when patients pose a serious bodily threat to other individuals.<sup>5</sup> Yet by far the most controversial exceptions to physician-patient confidentiality arise with regard to **sexually transmitted diseases (STDs)**, including HIV, which often pose a direct health threat to the sexual partner or partners of the patient.

#### PRIVACY RIGHTS VS. PUBLIC HEALTH

Contact tracing—tracking down all individuals exposed to an STD patient—probably originated in the inspection of nineteenth century prostitutes; by the 1930s, at the impetus of US Surgeon General Thomas Parran, it became the centerpiece of the New Deal's battle against syphilis.<sup>6</sup> Health workers notified the partners of infected individuals, forcibly treated non-compliant patients and quarantined those who continued to spread the disease. However, these treatments—both the arsenic-based Neosalvarsan and live malaria inoculation—had limited effectiveness. The widespread availability of the far more potent penicillin after World War II cut the number of syphilis deaths from 10.7 deaths per 100,000 persons in 1940 to 0.2 deaths per 100,000 in 1970.<sup>7</sup> This victory for public health curtailed Parran's experiments in contact tracing. Whether those efforts were effective remains controversial to this day.<sup>8</sup>

At the outset of the AIDS epidemic in the early 1980s, some public health officials advocated the adoption of a contact tracing and partner notification system modeled on the earlier work with syphilis. However, critics charged that such a program would jeopardize the privacy rights of patients while proving largely ineffective. They noted that AIDS has a much longer incubation period than syphilis, that the lack of effective treatment would anguish notified partners, that such a program would be inordinately expensive, that partner anonymity among high-risk groups would subvert the process, and—most sig-

nificantly—that the risk of stigmatization and exposure might drive HIV-infected individuals away from the health care system.<sup>9</sup> They cited the experiences of South Carolina, where an experimental mandatory reporting law led to a rapid drop in the testing rate among gay men, and Oregon, where the repeal of such a requirement led to a concomitant increase in testing.<sup>10</sup> In a widely-reported statement, at a time when AIDS was still largely perceived as a disease of homosexual men, California Medical Association President Laurens P. White explained: “It always seems like I'm a gay apologist who says you can't take a chance on the gay person losing privacy or insurance....[Yet] if you could toss the civil liberties [of patients] out the window and control the disease with contact tracing, I'd toss them out the window. But not only is AIDS not controlled [by the process], a lot of people can be injured by it.”<sup>10</sup> California voters rejected a ballot initiative (Proposition 102) in 1988 that would have required such an approach.<sup>11</sup> California remains among the minority of states that do not mandate reporting.<sup>12</sup>

New York followed the California model through the 1980s and early 1990s. However, after public furor over the case of Nushawn Williams—an HIV+ twenty-one year old man convicted of exposing a dozen upstate teenagers to AIDS through unprotected sex—the state legislature defied powerful AIDS-activist groups and enacted the most sweeping reporting and notification program in the nation.<sup>13</sup> Although prior to this act, state law allowed physicians to notify partners or to ask health authorities to do so, few—if any—actually did. The Mayersohn-Veella Bill, strongly backed by the New York State Medical Society, mandated a three step process: First, doctors were required to report the names of HIV-infected patients to the state Health Department; second, public health workers contacted those individuals for the names of partners whom they might have exposed; finally, the partners were to be told that they had been exposed, but not specifically by whom. However, the law continued to permit anonymous AIDS testing and imposed no penalty on patients who refused to share their partners' names—but the extent to which those patients contacted by the state still mistakenly believe that they must share their partners' names remains unclear.<sup>14</sup> A majority of states have systems similar to that of New York. Congressmen Gary Ackerman (D-NY) and Tom Coburn (R-OK) repeatedly introduced nearly identical legislation at the federal level, but their efforts proved unsuccessful.

#### PARTNER NOTIFICATION IN RHODE ISLAND

Rhode Island has attempted to strike a balance between the privacy rights of STD patients and the protection of third parties with a policy less stringent than New York's but allowing more disclosure than California's. Rhode Island Department of Health regulations require mandatory reporting of all HIV+ patients, but the reporting is done anonymously through code numbers.<sup>15</sup>

In addition, Rhode Island was one of the first states to criminalize the disclosure of the results of an AIDS test without the written consent of the patient.<sup>16</sup> The statute includes exceptions for such contingencies as informing persons exposed in the course of their occupational duties, including medical personnel, and informing the director of the Department of Children, Youth and Families in cases where minors are tested involuntarily. The Department of Health has also established a voluntary "Partner Notification Service" similar to that in California.

State law permits physicians to reveal a patient's HIV status to partners under narrow circumstances:

"[A physician may] inform third parties with whom an AIDS-infected patient is in close and continuous contact, including but not limited to a spouse; if the nature of the contact, in the physician's opinion, poses a clear and present danger of AIDS transmission to the third party; and if the physician has reason to believe that the patient, despite the physician's strong encouragement, has not and will not warn the third party."<sup>17</sup>

Note the "may": this is permissive, non-mandatory language.

A physician must "repeatedly encourage patients to inform partners directly or through the state's Partner Notification Service before he or she undertakes to notify the partner" and is responsible for documenting every step in the process.<sup>18</sup> While the physician *may* engage in such notification, if he so chooses, he is not required to do so. Also, since the state's prohibition on disclosure is broad, while the exemption mentions only physicians, non-MDs in the health professions, including psychologists, most likely *may not* notify partners. However, neither the legislature nor the Department of Health has spoken with clarity on this subject, and the rights and duties of non-MDs with regard to partner notification remain murky.

## TOWARD A FLEXIBLE MODEL

Rhode Island's decision to permit—but not compel—partner notification by individual physicians strikes a balance between the rights of patients, doctors and third parties. It presumably allows medical professionals to act in cases where all other methods of intervention prove ineffective and where the threat to innocent bystanders remains significant. At the same time, the approach does not require physicians to betray patients' trusts or to meddle excessively in their private lives—for example, by trying to verify independently the veracity of the patient's claims about numbers and identities of sex partners. Flexibility, in other words, allows physicians to exercise judgment in the context of treating patients whom they know personally. However, as desirable as such flexibility may be, it may also be illusory. While extensive research by Michael Stein at Brown University has shed considerable light on partner notification by HIV+ patients in Rhode Island,<sup>19</sup> no parallel data exist for physician-initiated partner notification. The frequency and outcome of such interventions remains unknown—and would make an excellent area for future study. What is clear is that the current legal structure doesn't yet effectively protect "non-notifying" physicians from lawsuits by third parties.

Although Rhode Island courts have never overtly adopted an affirmative "Tarasoff" duty,<sup>20</sup> requiring physicians to warn third parties

of imminent threats from patients generally, such warnings are permissible and have become the standard of care in many states, including Rhode Island. As a result, a careful physician could easily believe that, in order to shield himself from third party law suits, he must inform the partners of all HIV+ patients that they are at risk. He might even conclude he has an affirmative obligation to err on the side of "over-informing," for instance, by contacting a broad swath of former partners. This is clearly not the outcome intended by the legislature in adopting a flexible notification statute. However, unless the state enacts a law specifically shielding doctors from tort suits by un-notified partners who contract HIV, the judicious course for providers is always to inform partners, even when doing so may unnecessarily threaten the trust between provider and care recipient. It also encourages a sooner-rather-than-later approach, even when such haste is not desirable. If the state is truly committed to a flexible model of physician-to-partner notification, it should back up this policy with legal muscle. The time has arrived for the state to adopt a first-in-the-nation "non-notification shield" law that would protect doctors from such suits. Until it does so, prudent physicians have no choice but to interpret the current statute's flexible "may" as a more rigid "must."

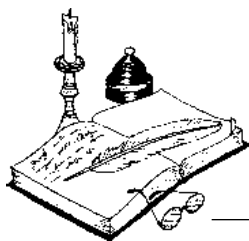
## REFERENCES

- 1 Rhode Island common law did not historically recognize such a duty. See *Banigan vs. Banigan* (1904), 26 R.I. 454; 59 A. 313; 1904 R.I. Lexis 104. However, the Confidentiality and Health Care Communications and Information Act of 1956 (CHCCIA) mandates such confidentiality, except under a certain enumerated circumstances. R. I Gen Laws 5-37.3-4 (2006).
- 2 See Rhode Island Code, Chapter 40-11 ("Abused and Neglected Children") for the specific requirements. Federal funding guidelines under CAPTA are available at 42 U.S.C. 5101.
- 3 Rhode Island requires physicians to report gunshot wounds. See Rhode Island Code 11-47-48. Rhode Island also requires the reporting of communicable diseases—and has done so since a 1741 act requiring tavern keepers to record such illness. See Rhode Island Gen Laws 23-8-1. A list of the diseases is available at <http://www.health.state.ri.us/disease/communicable/labsumtrans.pdf> Rhode Island criminal law does not apparently *require* physicians to report individuals who pose occupational hazards (eg. alcoholic bus drivers), but it does permit such disclosures. See RI Gen Laws 5-37-3.4 (2006) Section 9. However, it is possible that physicians who do not report such behavior could be subject to third-party tort liability.
- 4 AMA Canon E-9.031 "Reporting Impaired, Incompetent, or Unethical Colleagues."
- 5 AMA Canon E-5.05 "Confidentiality." See also *Tarasoff vs. Board of Regents*, S.F. No. 23042, Supreme Court of California, July 1, 1976; *Hedlund v. Superior Court of Orange County*, 34 Cal. 3d. 695 (1983). Rhode Island does not impose such an obligation.
- 6 Gostin, L. Hodge, J. Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases, 5 *Duke J of Gender L & Policy* 9.
- 7 Brandt, AM. Sexually transmitted disease. *Annals Intern Med* 1990;112. Idsoe O, et al. Penicillin in the treatment of syphilis; *Bull WHO* 1972;47: 1-68.
- 8 Amstery J. The political history of syphilis and its application to the AIDS virus. *Women's Health Issues* 1994;Spring: 16-9.
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Jacob Appel, JD, is Adjunct Assistant Professor of Community Health, Brown University.

## CORRESPONDENCE

Jacob Appel, JD  
140 Claremont Ave #3D  
New York, NY 10027  
phone: (212) 663-3643  
e-mail: jma38@columbia.edu



# Physician's Lexicon

## Those Visceral Words

**The anatomical contents of the abdominal cavity** [sometimes referred to colloquially as the guts, from an old German word meaning a channel as in the English word, gutter] are generally called the viscera [singular, viscus]. The word, viscus, is of Latin origin meaning to bend or to twist and is probably related to the Latin, *viere*, meaning to curl; but is unrelated to words such as viscous or viscosity.

A synonym for viscus is the English word, organ. a word derived from the Latin, *organum*, meaning a musical instrument which, in turn, is from a Greek word meaning secret rites [as in the English word, orgy] and is related to a parallel Greek word meaning work [as in English words such as ergon, energy, and organize.] It is also related to a Greek term meaning paroxysm or spasm [as in the English word, orgasm.]

The word, abdomen, is also Latin and represents the conjunction of the prefix, *ab-*, meaning away from; and the Latin root *-dere*, meaning to hide; and thus the intended meaning: that which is hidden away from view.

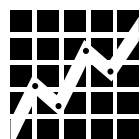
Mesentery is from the Latin prefix, *meso-*, meaning the middle of; and the Latin, *enterium*, meaning intestine. The umbilicus is related to the Latin, *umbo*, meaning the boss of a shield and earlier is derived from the Greek, *omphalos*, meaning navel. The Latin, *umbo*, has taken on another meaning, namely the viscera of the deer [called the umbles] and thus has provided the metaphor of eating umble pie, which is etymologically unrelated to the English, humble.

The diaphragm is from the Greek prefix, *dia-*, meaning through [as in English words such as diabetes, dialog, dia-

dem and dialysis] and the Greek root, *phragma*, meaning to enclose or fence off.

And *peritoneum*, a Latin word, is from the Greek prefix, *peri-*, meaning around; and *tonein*, a Greek root meaning to stretch [with related English words such as tone, baritone, intone, atonic and monotonous.]

— STANLEY M. ARONSON, MD



RHODE ISLAND DEPARTMENT OF HEALTH  
DAVID GIFFORD, MD, MPH  
DIRECTOR OF HEALTH

## VITAL STATISTICS

EDITED BY ROBERTA A. CHEVOYA, STATE REGISTRAR

### Rhode Island Monthly Vital Statistics Report Provisional Occurrence Data from the Division of Vital Records

| Underlying Cause of Death             | Reporting Period |                                 |           |           |
|---------------------------------------|------------------|---------------------------------|-----------|-----------|
|                                       | June 2005        | 12 Months Ending with June 2005 |           |           |
|                                       | Number (a)       | Number (a)                      | Rates (b) | YPLL (c)  |
| Diseases of the Heart                 | 241              | 3,031                           | 283.3     | 4,635.5   |
| Malignant Neoplasms                   | 184              | 2,450                           | 229.0     | 6,500.0** |
| Cerebrovascular Diseases              | 36               | 503                             | 47.3      | 747.5     |
| Injuries (Accidents/Suicide/Homicide) | 39               | 428                             | 40.0      | 6,762.0   |
| COPD                                  | 38               | 535                             | 50.0      | 475.0     |

| Vital Events             | Reporting Period |                                     |        |
|--------------------------|------------------|-------------------------------------|--------|
|                          | December 2005    | 12 Months Ending with December 2005 |        |
|                          | Number           | Number                              | Rates  |
| Live Births              | 990              | 13,212                              | 12.4*  |
| Deaths                   | 894              | 10,162                              | 9.5*   |
| Infant Deaths            | (5)              | (89)                                | 6.7#   |
| Neonatal Deaths          | (2)              | (72)                                | 5.4#   |
| Marriages                | 400              | 7,473                               | 7.0*   |
| Divorces                 | 198              | 3,183                               | 3.0*   |
| Induced Terminations     | 391              | 5,129                               | 388.2# |
| Spontaneous Fetal Deaths | 138              | 941                                 | 71.2#  |
| Under 20 weeks gestation | (127)            | (863)                               | 65.3#  |
| 20+ weeks gestation      | (11)             | (78)                                | 5.9#   |

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

(b) Rates per 100,000 estimated population of 1,069,725

(c) Years of Potential Life Lost (YPLL)

**Note:** Totals represent vital events which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.

\* Rates per 1,000 estimated population

# Rates per 1,000 live births

\*\* Excludes 1 death of unknown age

## NINETY YEARS AGO, JUNE 1916

An Editorial, "Roentgenology in Hospitals," called for a specialist-physician to head these new departments: "The increasing accuracy of this method of diagnosis and the growing dependence of the surgeon upon its revelations make it extremely desirable that such a department shall be administered by a physician specially trained in this line. The policy of placing an orderly or other untrained person whose only recommendation for the position is his ability to do the mechanical work of taking the picture, and expect him to interpret the fine points in a plate, is 'penny wise and pound foolish.'"

A second Editorial, "Anatomy up to Date," railed against the Amina Company, on Moore St, in Providence, which advertised a fake cure for women, under "Causes of Leucorrhoea and Displacements." The treatments promised to build up the nervous system, force blood back to heart and lungs, reduce inflammation, strengthen ligaments, and shrink the womb.

George Blumer, MD, in "The Importance of Anaphylaxis in Clinical Medicine," described this phase in the process of immunization.

Frank M. Adams, MD, in "Laryngeal Paralysis in Tabes," described this condition {"the tired voice of a singer or orator"} in a 54 year-old male clerk, whose history included childhood measles, scarlet fever, whooping cough, mumps and chicken pox. Four years earlier, the patient had felt pain in his feet. Over the years the symptoms had abated, then progressed to choking spells, a "phonetic whooping cough," an inflamed, crossed, left eye, and a "peculiar dryness and numbness of palate and tongue." Dr. Adams prescribed opiate, but the patient, unable to swallow, died.

## FIFTY YEARS AGO, JUNE 1956

Raymond N. McAndrew, MD, contributed "Drains? Whim and Fancy." He started his paper by citing Hippocrates, said to be the first to use tubes for pulmonary empyema.

Alton M. Powell, MD, in "Acute Hemorrhagic Enterocolitis: A Case Report," described the progression in a 57 year-old man admitted to Rhode Island Hospital in a coma. Ten days before admission, the patient responded to oxytetracycline, but later went into congestive heart failure. Four days after admission the patient died. Dr. Powell cautioned, "...sudden onset of watery or bloody diarrhea should make one suspicious of the diagnosis of acute hemorrhagic enterocolitis," often mistaken for acute mesenteric thrombosis.

## TWENTY-FIVE YEARS AGO, JUNE 1981

Charles E. Millard, MD, and William J. Waters, PhD, each contributed papers, both titled, "The Benefits and Pitfalls of Health Planning." The two shared the Fiske Fund Prize Dissertation award of 1979. Dr. Millard noted that the government's role in health planning began in 1873, when Congress enacted the national port quarantine system. He cited as potential pitfalls of health planning: "the danger of politicized medicine," where political concerns overrule rational ones; the dangers of cost-containment; and the dangers of regulatory overload.

Williams J. Waters, PhD, noted benefits; i.e., "more effective and efficient allocation of resources," which would let society "shape events rather than react to them."

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