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I recently reviewed an article submitted for publication in a neurology journal providing an “expert opinion” on how to use a new drug. The first surprise was that the first author was not a recognized expert in the field, and was primarily an administrator, who possibly had no experience using the new drug. Of the seven other authors, only one probably had any “hands-on” experience, and most probably had absolutely no experience treating people with the disease, let alone with the new drug. However, the authors represented only half the expert consensus panel. The other eight authors also, surprisingly, were not recognized experts. All were, however, paid consultants to the drug company that owned the drug.

I pointed this out to the editors, of course. And, while I know some of these experts, and am quite certain that none of them would be overtly biased by their financial relationship to the company, it could not look anything but suspicious to a reader who did not know these people personally. In my review, I pointed out that I, too, have actual experience with the drug, which, I believe, are at least informed by experience, but I’ve also published my experience, unlike all of the “experts.”

I have sometimes discussed in these columns the problems associated with medical decision making, deciding between “evidence-based medicine,” which is data driven, but based on data from trials which used stringent entry criteria. This is required to be sure that their population represented a relatively “pure” example of the problem to be treated, and also to maximize the chance that the experimental drug would be successful. However, the patients in most studies were most likely not exactly like the one in front of you in the office, and therefore not really in the database. Yes, they were diabetic, but no, they were not morbidly obese or intellectually impaired, or had asthma. “Experience-based medicine (EBM),” which often reflects the last two or three patients you saw with similar problems to the one in front of you, often suggests different approaches than evidence-based medicine. This type of EBM, of course, has its own problems, and my experience may be very different than yours.

There are always two sets of studies that spring to mind when I think about the two “EBMs.” One was on the use of quetiapine to treat psychosis in PD patients. While three double-blind, placebo-controlled trials were negative, most experts, myself included, think it does actually work and I continue to use it. The other was the CATIE study, an observational study to demonstrate that the second generation of antipsychotics caused less tardive dyskinesia than the first generation. The huge, multi-centered trial was developed by leaders in the field and turned out showing that there was no difference. That set the stage for various groups to publish papers explaining the “wrong” outcome of the study. Even we “experts” have feet of clay.

I did not think well of the article. My review recommended that the editors reject it. As of this writing I don’t yet know their decision. I doubt it will be accepted as my review was too harsh, and, my suggestion that an average reader, seeing that all the “experts” were paid consultants, and that the premise of the article was how, rather than why, this drug should be used, might surmise that this was a piece planted by the drug company. That thought, alone, is likely to kill the piece.
I don’t like rejecting articles, but each journal has its own standard, and articles pretending to be expert advice should come from experts in the field they are talking about, not “meta experts,” that is, people who are experts about issues related to the topic of interest but not really the topic itself. The set of experts who consulted on the bad manuscript, were international experts in pharmacology, but had absolutely no experience with the drug they were talking about in the niche of Parkinson’s disease. Having interacted with many experts in schizophrenia, I can assure you that being expert in schizophrenia does not readily translate into expertise in Parkinson’s disease.

I think that if I had reviewed the same article by authors who truly had expertise, I would have written the same critique I submitted to the journal editors, except for the criticisms based on their lack of actual experience. While I would have challenged their suggestions, citing my own experience, I would have recommended publication, believing that biological variation and human variation in the observers would account for the differing opinions. I would have asked the editors to invite a companion opinion piece, preferably by me. If that did not occur I would have written a letter to the editor when the article was published.

Since I wrote the above I have co-authored an expert set of guidelines for a different movement disorders problem, and, am happy to say, am not a consultant for any company involved in this field, and, I have actual, hands-on experience. I am, I think, an expert. This doesn’t mean I’m right and that my recommendations should be followed, but does mean they should be taken seriously.

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Disclosures on website
Coronary Stent Placement in Patients with Stable Angina – an Ongoing Debate
KENNETH S. KORR, MD, FACC

The results of the recent ORBITA trial [1] in Britain have re-ignited the discussion over the role of Percutaneous Coronary Intervention (PCI) in stable angina patients, prompting this recent headline in the New York Times: “Heart Stents Are Useless for Most Stable Patients…” [2] The unique feature of this trial included a “sham” intervention, unprecedented in stenting trials, marking this as the first double-blind placebo-controlled interventional trial, similar in design to more typical, randomized, placebo-controlled pharmacological studies. The intent of this design was to mitigate any perceived beneficial placebo effect among the stent patients. The trial included 200 patients with stable coronary artery disease (>70% single vessel stenosis) who received 6 weeks of optimal medical therapy (OMT) followed by randomization to either stent placement or a “sham” procedure without a stent. At 6-week follow-up, while still on OMT, there was no difference in exercise time on a treadmill stress test in the stented vs. the “sham” patients.

The fact that the investigators could successfully perform a placebo-controlled interventional trial was noteworthy in and of itself. Placebo-controlled device trials are uncommon and many physicians have ethical concerns with withholding an established therapy. The investigators demonstrated that such a trial is possible and safe, and this will likely serve as a stimulus for similar studies in the future. Beyond that, the results of the study were less than overwhelming. Increases in exercise time, as a surrogate for coronary ischemia, may not be the best measure of symptom relief, especially in patients on medical therapy with beta blockers. The sample size was small, only 200 patients compared to larger trials like the COURAGE study [3] discussed below. While there were improvements in incremental exercise time in the stent group, these did not reach statistical significance and might have achieved significance with a larger sample size. Furthermore, increases in exercise time are imprecise and subjective and change from week to week. A single stress test at 6-week follow-up may be a relatively short period upon which to base treatment conclusions. These methodological issues have caused many interventional cardiologists to question whether the results would have been more revealing if the study population had been 400–500 patients and with a longer period of follow-up of 6 months. Nonetheless, this study has stirred considerable discussion in the interventional and general cardiology communities and it is anticipated that the investigators will continue to present longer-term follow-up data in these patient groups going forward.

Looking at this from a broader treatment perspective, the role of PCI in the management of coronary artery disease has evolved considerably in the 41 years since Andreas Gruntzig performed the first percutaneous transluminal coronary angioplasty (PTCA) in Zurich in 1977. [4] The introduction of coronary stents in the late 1990s substantially improved the success and safety of PCI and reduced the incidence of emergency coronary bypass surgery (CABG) for failed PCI from 1.0% to 0.1%. The improved efficacy of coronary stenting made it particularly attractive as a treatment modality for patients with acute myocardial infarction (MI) and other unstable coronary syndromes, where it quickly became the preferred treatment approach.

Currently, PCI with coronary stent placement has been well established by numerous randomized control trials [5] as the standard of care for the majority of patients with ST elevation MI, non-ST elevation MI and other acute coronary syndromes. Interventional quality measures include door-to-balloon times of less than 90 minutes (the time from the patient’s arrival at the door to the ER until a balloon is passed into the occluded coronary artery) and many of these procedures are being performed...
in hospitals without onsite coronary bypass surgical back-up. The majority of PCI procedures are now performed for patients with acute unstable coronary syndromes.

But what about the role of PCI in patients with stable angina?

Stable angina pectoris is defined as reproducible exertional symptoms, usually chest discomfort, of at least 6 months duration while anything short of this is usually considered new onset and thus less stable or unstable angina. This may be an important distinction when applying trial results to individual patients. One of the earliest studies to address the role of PCI in stable angina patients was the ACME trial, (6) which compared balloon angioplasty to medical therapy in 212 patients with significant single-vessel coronary artery disease and found more freedom from angina and improved exercise duration among the angioplasty group at 6 months follow-up. It is hard to extrapolate and compare these results to present-day treatment options as the study was performed in the pre-stent era where the results of PTCA were less favorable and less durable than they are with current stent technologies. And medical therapy has also evolved considerably in the past 25 years.

In a more recent study of 2,300 patients with stable angina and predominately single vessel disease randomized to OMT alone vs. OMT plus PCI with stent placement, the COURAGE trial investigators (3) demonstrated no significant difference in rates of death, myocardial infarction or stroke up to 4.5 years of follow-up. The degree of angina relief, however, was significantly higher in the PCI group, although there was also substantial improvement in the medical-therapy alone group. Critics of this study have pointed to the difficulty in recruiting patients with very high grade stenoses [ie >90% proximal LAD stenosis] suggesting that the trial selected out a lower risk subset of patients who would do as well on medical therapy. However, similar results have been observed in other trials, none of which have demonstrated an advantage of revascularization over medical therapy in regard to death or MI. However, in many trials, up to 50% of patients “crossed over” to revascularization with PCI or CABG due to persistent symptoms that were refractory to antianginal drug therapy (7).

So what is the current role of PCI in patients with stable angina?

Clearly, many stable angina patients can be well controlled for long periods of time with optimized medical therapy [including aspirin, beta blockers, nitrates, statins and ACE inhibitors]. For patients whose symptoms cannot be easily controlled, those who have lifestyle issues, cannot tolerate optimal medical therapy or in whom symptoms progress over time, PCI with stent placement clearly has a role. A 2008 reassessment of the role of PCI concluded that for patients with stable angina and well-preserved left ventricular function, already on an excellent medical regimen, the long-term outcome is usually excellent. In this setting, PCI may not decrease cardiac mortality, which should be already quite low. However, PCI remains very effective in decreasing symptoms and ischemia as well as markedly decreasing the need for subsequent procedures. (7)

It will be interesting to see if future randomized placebo-controlled interventional device trials will add further to our understanding of the role of PCI in these patients. Until then, PCI along with medical therapy will continue to have a role in the management of patients with varying degrees of stable angina.

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ABSTRACT
Unique clinical challenges arise with the growing number of patients who possess medical marijuana cards. Medical marijuana patients with mental disorders can have worsening symptoms with marijuana use. Often there is sparse continuity of care between the patient and the medical marijuana practitioner. Lack of communication between the patient’s treating practitioners and the practitioner who has authorized the medical marijuana can be problematic. This article is a discussion of the new clinical challenges practitioners are likely to encounter with the growing number of medical marijuana patients.

KEYWORDS: cannabis, cannabinoid, cannabidiol, medical marijuana

BACKGROUND
According to an article published in the Providence Journal in 2015, the number of Rhode Island medical marijuana patients increased from 4,849 in 2013 to 11,620 in 2015. The Rhode Island Department of Health issued a statement entitled, “Minimum Standards for Authorizing Medical Marijuana,” on September 30, 2011. This statement expressed that “The Rhode Island Department of Health’s Board of Medical Licensure and Discipline has concerns over its ability to safely regulate the management of patients seeking authorization for medical marijuana.” Physicians who choose to authorize medical marijuana cards should be aware that the Massachusetts Board of Medicine recently suspended the license of two physicians due to their practice of authorizing medical marijuana.

The endocannabinoid system is extremely complex, and we know relatively little about it. THC is one of more than 60 cannabinoids present in the cannabis plant. While there certainly may be medicinal properties of cannabinoid receptors, the current practice of dispensing a highly variable drug to the population at large and observing what happens is not only unscientific, it is dangerous. The Institute of Medicine gave the following statement upon review of the clinical uses of cannabis:

“If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug but rather to serve as a first step toward the development of nonsmoked rapid-onset cannabinoid delivery systems.”

Presently, potential clinical conditions with symptoms that may be relieved by cannabis include nausea, wasting syndromes (such as AIDS and cancer), chronic pain, inflammation, multiple sclerosis, some forms of muscle spasticity, and glaucoma. There is research suggesting that cannabidiol (CBD) has anti-epileptic and antipsychotic properties. There are special cases of severe conditions, such as treatment-resistant intractable epilepsy or end-stage diseases, for which cannabis extracts may be more beneficial than traditional FDA-approved anti-epileptic medications. However, working with patients who are using medical marijuana, even for appropriate indications, presents special challenges.

For example, I saw two patients in an outpatient, partial hospitalization day program who each reported to me during the initial intake session that they had an outpatient physician prescribing them medical marijuana. Both were daily smokers. One had become paranoid and delusional. The other was manic and had physically assaulted hospital staff. I advised both patients about the dangers of cannabis, and the potential for cannabis to worsen mania and psychosis. I was put in a difficult position when one of the patients responded by saying his outpatient psychiatrist gives him a medical marijuana card. Having two different doctors with seemingly opposing messages about cannabis confused the patient; one doctor saying it was good for the patient, and one doctor saying it was bad.

The following are issues commonly encountered in treating patients who use medical marijuana, and some suggestions for dealing with these challenges:

1. Gaining trust of the patient and forming a therapeutic alliance.

The patient may not know whom to trust. Another doctor with whom the patient has already formed a therapeutic alliance gives the patient the authority to purchase medical marijuana. This means the patient’s other doctor thinks marijuana is good for them. The patient likes using...
marijuana, and may even be addicted to its use. Now a new doctor tells the patient that marijuana is not good for his/her mental health.

For the patient who is manic with no insight into the mania and enjoys being manic, it is easier to continue with the marijuana-prescribing doctor and fire the doctor opposing the use of marijuana. For the patient who has paranoid delusions that are real in the patient’s mind, and now hears that the delusions are being exacerbated or caused by the marijuana, it is easier to trust the marijuana-prescribing doctor.

2. Treating the patient’s mental illness knowing that the patient will continue to use marijuana.

If the patient wants to continue to use marijuana but is also accepting treatment, should the doctor agree to start treatment knowing that the patient will continue to use marijuana? A similar question could be asked of a patient who has a stimulant-induced mania and is unwilling to stop the stimulants. Should the doctor treat with antipsychotic or mood-stabilizing medicine to counteract the stimulant-induced mania knowing that the patient has no intention of stopping the offending agent?

3. Contacting the outpatient provider who is providing the patient with the medical marijuana card when the patient does not want providers communicating with the medical marijuana-authorizing provider.

Patients may not give you permission to contact the marijuana-authorizing doctor because they are afraid if you talk to the marijuana-authorizing doctor, they will no longer be able to renew the medical marijuana card from that doctor.

I suggest the following for outpatient providers who are faced with the above challenges:

1. As the new provider, you should be well educated about the research accounting for the dangers and benefits of cannabis in different areas of medicine. I suggest starting the conversation with the patient by acknowledging the confusion he or she might be experiencing. By explaining the science, the patient is more likely to view you as an expert on the subject, which will make it easier for the patient to trust you.

2. I suggest continuing treatment if the patient trusts you enough to start engaging in treatment, but does not want to stop the cannabis use. With treatment, either medication or psychotherapy, the patient may gain a better understanding of the ways in which cannabis is affecting his/her mental health and agree to discontinue its use. The alternative is that the patient may continue the cannabis use without the treatment you could provide.

3. If the patient does give permission to contact the marijuana-authorizing doctor, I would suggest doing so to provide the doctor with information about the patient’s mental state while using cannabis. If the patient does not give you permission, I would suggest not breaching confidentiality unless there is an emergency, because you are likely to drive the patient out of treatment if you do so. Furthermore, marijuana is easy enough to obtain. The patient is likely to continue its use even if you breach confidentiality and the marijuana-authorizing doctor agrees not to continue providing the patient with a medical marijuana card.

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Child sexual exploitation: cautionary lessons from England

ANISH RAJ, MD

KEYWORDS: commercial sexual exploitation of children, domestic minor sex trafficking, abuse

The sexual exploitation of children is an issue that continues to be under-recognized and inadequately confronted by those with the moral and professional responsibility to protect vulnerable youth. Recent studies have demonstrated that both healthcare providers and law enforcement personnel are often unaware of the presenting characteristics and legal status of victims. This unfamiliarity is further exacerbated by prevailing misconceptions. Child sexual exploitation and abuse, including forms such as the trafficking of minors, have historically been incorrectly regarded as exclusively international practices; ones perpetrated by violent men against foreign girls with the notion of human smuggling falsely being equated with the trafficking of persons. Largely due to the lack of empirical data and absence of standardized guidelines, first-line providers in many institutions lack the knowledge base or appropriate means to intervene. However, it is imperative that we recognize that inaction, regardless of etiology, is unacceptable.

The child protection scandal that yielded substantial international media coverage during the summer of 2014 and led to the development of widespread awareness campaigns throughout England was the revelation of decades of organized child sexual abuse in the town of Rotherham. Of note, these findings and subsequent movements garnered remarkably minimal attention in the United States. While the absence of any such scandals stateside involving organized child abuse on the magnitude of Rotherham’s is certainly comforting, it does beg the question: Have the seeds already been sown, and we simply have not uncovered them yet? It stands to reason that our children would best be served by reviewing and learning from the procedural lapses that transformed lives in Rotherham, so that we can strive for a proactive approach to get ahead of the issue instead of relying on a reactionary one.

An independent inquiry published in 2014 and commonly referred to as the Jay report shed light on the alarming prevalence of child sexual exploitation in England and the widespread systematic failures that facilitated its perpetuation. The comprehensive investigation conservatively estimated that between 1997 and 2013 over 1,400 British children were sexually exploited in Rotherham – a moderately sized town with a population of 258,400. All the affected youth were under 16 at the time of initial exploitation. Nearly half of these children came from a home with domestic violence; a fifth had a parent struggling with addiction; over a third had a parent with mental health issues. More than a third of the victims had previously interfaced with child welfare services, and almost two-thirds had documented truancy. The appalling forms of coercion and abuse included, but were not limited to, girls as young as 11 being “raped by multiple perpetrators, trafficked to other towns and cities in the north of England, abducted, beaten, and intimidated.” One victim even disclosed that she considered gang rape “a usual part of growing up in the area of Rotherham in which she lived.” Fear-invoking tactics also involved violent threats or actual assaults on victims’ families. One of the most concerning aspects was the lack of coordinated action by law enforcement and social services despite years of mounting evidence of the organized abuse. The 2014 Jay report and subsequent inquiries noted that multiple testimonies submitted by residential staff and youth workers were suppressed or altogether ignored for years. The reasons for this negligence reek of bureaucracy, but were also complicated by survivors often being labelled as unreliable witnesses or consenting to their situations. Furthermore, while social services had identified child sexual exploitation as a referral category in 2001, the local police department did not have a similar designation until 2013. Consequently, cross-communication of information between disciplines was markedly hindered, and many lives...
were impacted. As Gladman and Heal declare, “It should not have occurred. It did not need to happen. It was all so unnecessary.”

Strikingly, few accounts even mention the role of pediatricians (or general practitioners). At best, this reflects an oversight. However, at worst, these constitute numerous missed opportunities to intervene. Outside of acute hospital visits for suicide attempts or the completion of sexual assault kits, much of the provisioned health care in Rotherham seems to have been facilitated by outreach programs and sexual health service organizations. The irony is that one of the cornerstones of pediatric medicine is continuity of care and recognizing the subtle warning signs of physical, mental, or social decline. A United Kingdom general practitioner observed in the aftermath of Rotherham that “sometimes there is a pattern” – a pattern that should be within our scope to identify and gives us the opportunity to intervene.

The children and families of Rotherham were systematically let down at every step. Preventative measures were unsuccessful, early identification and intervention were absent, inadequate support was provided by child welfare services, and the legal system did not strengthen victims’ resolve to disclose. Recognizing these failures brings us back to our central question: If there is not already an undiscovered Rotherham brewing in the United States, what can be done to prevent one? Given the lack of standardized practice and nationwide variability in responses, our young persons are certainly not immune from a situation like that in Rotherham. When even one child is at risk, no child is safe.

Similar to England in the 1990s and early 2000s, there is presently no consensus on the scale of child sexual exploitation in the United States. We must prepare by educating ourselves and those around us, especially as the literature base grows on identifiable risk factors and recommended trauma-informed approaches. We also need to account for children that are frequently absent from care. Missing scheduled appointments and chronic truancy are red flags that should be noted and followed up on. Pediatric patients, by virtue of their age, have an adult responsible for them. Providers should liaise with child welfare services and law enforcement to ensure that no child falls through the cracks [e.g. patients for whom a wayward petition has been filed]. When encountered, exploited youth should be identified as victims and survivors. As a healthcare worker states in a British mini-series, “There’s no such thing as a child prostitute. What there is, is a child who is being abused.” Words matter. Extensive linguistic research, especially in the realm of addiction medicine, has demonstrated that terminology with traditionally negative connotations can influence attitudes during care provision and contribute to stigma. Clinical experience suggests most youth do not disclose their involvement initially and possibly ever. We must believe them when they do. While federal legislation [e.g. Trafficking Victims Protection Act] mandates broad protection for minor victims, states contrast in their interpretation of regulations. As of late 2015, 34 states had passed variations of Safe Harbor legislation designed to decriminalize youth involvement and divert away from juvenile justice systems. Whereas Rhode Island has not yet formally secured Safe Harbor legislation, a multi-agency collaboration recognized as the Rhode Island Human Trafficking Task Force (RI HTTF) produced a state-wide protocol to ensure that pediatric survivors of commercial sexual exploitation are not criminalized and instead plugged in with recovery services as soon as possible. States also tend to differ on whether sexual exploitation that does not involve household members or caregivers falls under the purview of child welfare services (i.e. mandated reporting). In light of the RI HTTF protocol, any individual in the state of Rhode Island that suspects commercial sexual exploitation of a child, regardless of perpetrator, is to notify the Division of Children, Youth & Families (DCYF) immediately.

While Rhode Island has made progress in recent years, considerable work remains to be done, and it will be important to review corresponding outcomes and determine which interventions prove the most effective. As soon as possible, all states will need to come together and determine a consistent, evidence-based, and multi-disciplinary approach to protecting vulnerable youth.

As healthcare providers, we must be aware of our local regulations and resources. If a child is seeking help, it is our responsibility to know where referrals ought to be made and what services can be offered. It is said that those who fail to learn from history will inevitably repeat it. Thus, let us learn from the experiences of our British counterparts so that we can best serve all children going forward.
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The elephant – or donkey – in the exam room

VISHAL KHETPAL, MSC; MADELINE PESEC, AB

KEYWORDS: physician-patient communication, medical school, culture of medicine, political polarization

With the commission of the Flexner Report in 1910, leaders in medicine sought to characterize the profession as pure and objective, encouraging their colleagues to recede from traditional pursuits in the public arena. And today, most strive to rise above the mud-slinging of politics, at least publicly.

Today's medical students find themselves studying medicine in a time of profound political change as global populist movements take rise and as our country is embroiled in hyper-partisanship. Fellow students, here and elsewhere, are creating new groups and organizing around issues like abortion and racial injustice. Lectures on subjects normally inert to shifting political trends, like neuroanatomy and brain tumors, feature digressions into concerns over the potential elimination of biomedical research funding from the National Institutes of Health (NIH). One of our psychology exams even featured a vignette about a boy suffering from adjustment disorder after his father was deported, a question which took on a political undertone given the persistent rhetoric regarding deportation espoused by the current administration.

In all fairness, most medical students of any era have probably attended a lecture in which a professor detours into an unwarranted, but well-intentioned, commentary on topical political debates, like the legalization of medical marijuana or the bioethics of abortion. But what used to be an occasional (and memorable) event has morphed into a regular presence in our lecture hall, perhaps unbeknownst to our professors. During our first year in medical school, it wasn't uncommon to hear two, or even three, of these diatribes daily in the immediacy of the new administration.

At our clinical mentoring sites, idle conversations about the weather and basketball have been replaced by the latest scoop in Washington. The political tumult over the past year has even forced itself past the waiting room, as the psychosomatic symptoms of post-election stress disorder, described by a number of mental health professionals in recent months, still invariably creep into our case write-ups and oral presentations to our preceptors. On one occasion, we witnessed a patient's adjustment disorder from the outcome of the election, likely contributing to recent episodes of nausea and anxiety, go undiscussed during his follow-up visit for diabetes. Would the resident have dived into this recent development if the patient's case of adjustment disorder was due to something less socially uncomfortable, like losing his job, or a death in the family? Perhaps so.

It seems that we're not alone in making these observations. An editorial written by Dr. Reshma Jagsi, in JAMA Oncology (January 2017), chronicled how concerns over continued insurance coverage, fear of religious discrimination, and other contentions of politics have invaded her exam rooms since the recent election. And although Jagsi and other prominent physicians often note that their training discouraged them from discussing politics in the clinic, evidence from a study of primary care physicians conducted in 2006 suggests that this advice is often discarded in medical practice. Most providers [83%] had indeed discussed politics with patients in the past decade and nearly 50% had initiated such discussions themselves.

More recently, we've also come to understand that politics is not an inert factor in the clinic; it impacts medical decision-making by physicians. One notable study, published in the Proceedings of the National Academy of Science in 2016 by Hersh and Goldenberg, found that physicians registered as Democrats or Republicans dramatically differ in their medical counsel when presented with politically charged issues, like gun stewardship, marijuana, sex work, and abortion.

Taken together, these statistics paint a reality that substantially differs from common wisdom: that politics are trivial for objective medical practice, and
certainly not an appropriate topic for the exam room. Given its prevalence and influence, it is strange that appropriate ways to navigate politics in the exam room have not been taught to us in our medical school, nor at others, to the best of our knowledge.

On a national level too, it seems that politics has been regarded *persona non grata* in the exam room. The American Medical Association’s Code of Medical Ethics offers relatively little guidance on the subject, noting that “physicians have the right, and even occasionally the moral obligation to undertake political action themselves,” but in ways which are “not disruptive to patient care.”

The section focuses on maintaining good relationships with co-workers and avoiding litigation, rather than offering recommendations for clinical comportment, an important component of professionalism.

Because of these factors, medical students are left with little advice on how to grapple with politics in the exam room, when it inevitably presents itself. This lack of protocol is certainly not because politics is controversial; medical schools regularly teach students how to talk about other uncomfortable topics. Indeed, of the three topics traditionally excluded from dinner table conversation as social taboos – sex, religion and politics – we have received extensive training on two. We learn how to discuss the complexities of religion, both as sources of conflict or solace for our patients, through opportunities to practice conversations and engage in thorough discussions about this topic with our mentors. Early in our experiences in medical school, we are also taught non-judgmental methods to broach the topic of sexual practices, the diseases that may be transmitted, and specifics on protection. Like actors in a theater company, we practice asking standardized patients about the most personal elements of their social and sexual history until our faces no longer flush red with embarrassment. Yet among our preparations for the more uncomfortable topics that may arise in the exam room, politics is rarely, if ever, mentioned.

When it does surface in the clinic, medical students are handed down a folk wisdom of sorts, built on hunches and previous missteps. Searching for answers, we directly asked three physicians, who serve as mentors for medical students at our university, about how they approach the subject of politics in the exam room. And perhaps unsurprisingly, we received three thoughtful, but different, answers.

Dr. A shared that her approach is patient dependent, and relies upon her experienced ability to “read a room.” As an internist, she stressed the importance of subtle, but noticeable, self-disclosure in long-term relationships with patients. Her approach, after the election, has involved using pins on her white coat, presenting her support for the LGBT community and the Black Lives Matter movement, to communicate her views non-verbally. In conversations, Dr. A avoids discussing politics unless relevant to health, such as in the case with our patient’s adjustment disorder, presenting with political stress disorder, “tor-patient relationship.” For the patient presenting with political stress disorder, his advice emphasized employing the clinical gaze, and using objectivity to understand how the patient’s processing of events impacts their health.

Finally, Dr. C looked to his past training in the Israeli healthcare system to shape his attitude toward political conversation in the exam room. In Israel, politics are pervasive, even violent at times. In response to this tense political climate, Dr. C shared that physicians have become extremely apolitical figures within their communities. He notes that while different groups may face discrimination outside of the clinic, in his decade in the country, he never fielded a complaint about differential treatment inside the walls of the clinic. While it is general wisdom in the United States not to talk about politics with patients, Dr. C observed this taboo to be much stronger in Israel, where physicians and patients alike make a strong effort to steer clear of political topics. But in the United States, Dr. C has observed politics gradually creeping into the exam room in recent years, and reports seeing many patients, especially after the last presidential election, whose anxiety about politics complicates their comorbidities. His advice to young doctors is to work with the patient to design
an intervention – which could include political engagement or advocacy – that will be helpful to them in alleviating their anxiety. However, he adds, “when in doubt, stay neutral.”

It is abundantly clear, from our conversations with three physicians, that previous generations of physicians have learned how to navigate politics by observing their own mentors and accumulating good clinical sense over time. But in this time of political turmoil, perhaps more formalized guidance is warranted, for both medical students and weathered physicians.

What this guidance should look like isn’t for us, as untested medical students, to say. Perhaps one option could be to take the path of Dr. A, and offer self-disclosure of political stances non-verbally, through office signs and pins, while limiting any verbal discussion of politics to relevant issues of health for our patients. Another could be to take Dr. B’s advice, and effectively serve as an impartial sounding board for our patients, as they process political issues alongside other elements of daily life, whether positive or negative. We could learn from physicians like Dr. C and look to our counterparts who practice abroad in countries like Israel, marked by severe political division. And finally, we could seek advice from other professions, like teaching, which also have had to contend with a new reality of political polarization while maintaining inclusive and objective environments.

These approaches and others, tempered by trial and error, surely exist in our country’s clinics and wards. Before taking any path, however, a frank discussion within the medical school community, as well as outside of it, is needed for the sake of tomorrow’s doctors, and ultimately our patients.

References

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