Sotto voce

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It is never a good idea for a doctor to get angry at a patient or family. I am sure it happens to all of us, even the most saintly. Nothing upsets me more than a patient who shows up late and then insists on taking time to describe trivial problems or simply to socialize, completely unconcerned about the patients waiting to be seen. I ask a question and get a tangential response, with the spouse adding an even more minimally related observation, or perhaps even a theory as to why the fried chicken was the real culprit.

I will admit that I have a problem with running late. I hate to keep people waiting. It runs in my family. We are almost never late for anything. I often feel miserable excoriating Mr. Jones in my mind when a secretary asks if I'll still see him, as he is 10 minutes late and that's the upper limit we use in my clinic. I agree, as I always do, and in totters an incredibly frail, elderly man with his equally frail and elderly wife apologizing for one of them having to stop in a bathroom, and for the accident on Route 95 which stopped traffic and which they had nothing to do with. I am a sinner, and know it. I think that I cover up pretty well, but who knows? When a patient arrives late, without an apology, or an excuse, I try not to ask what held them up, although I may tell them that if the next patient arrives on time, I might have to cut short the visit. But I apologize for this, as if this is my own fault, although I don't really mean it that way.

I was stunned recently to receive a copy of an office note from a primary care doctor describing an interaction with our mutual patient, who is, to be honest, sometimes rather demanding, hence, annoying. The PCP actually charted his loss of savoir faire. The patient, probably for the tenth time, including a few phone calls, asked why he was not responding to a medication I, not the PCP, had given him, and the PCP, obviously a bit beyond the end of his tether, said, "I'm not your f___ing neurologist. Go ask him!" The next note records the apology the doctor made to the patient. His inclusion of the interaction, with quotes, was, on the one hand, honest, brave and appropriately apologetic, while on the other, illuminating on the difficult interactions these two have had. Having shared many patients with this doctor, I have never heard any complaints about him, and certainly never had cause to wonder if he had a behavioral abnormality.

That office note made me reflect on my own sub-optimal patient interactions. Like most doctors, I spend a lot of time every day returning phone calls to patients. Many years ago I realized that when I became short with some annoying patients, I became a bit louder than usual. I'm sure many of us do that, but I realized that this was always a bad way to interact. I also sometimes cut them off, although ever mindful of the famous study that reported that American doctors, on average, allow their patients to speak for 17 seconds before interrupting. While I abhor the notion that I might be included in that statistic, I do sometimes fantasize that I could emulate it, but there is always a power differential between the doctor and the patient, whether the doctor perceives it or not, and that it should never be abused. I made a decision to try to always lower my voice when annoyed. I figured that was the easiest way to keep myself from showing anger. I might have to repeat a question or a request, and, if the patient was deaf, I could shout anyway without appearing to express annoyance. I don't think that any of the many medical observers, house staff and students, have ever remarked on my occasional soft voice. I, of course, find the use of the soft voice pretty obvious, and I have noticed that I often adopt the voice before I am consciously aware that I am annoyed. When I'm really angry, I think of gangster movies where the bad guy makes his most serious threats in an almost whispered voice. "When I asked you when the tremor began, I really meant, when did the tremor begin. I didn't ask what you were eating when

you first noticed it. I doubt that the jelly roll played much of a role." I think this is akin to the really bad guy telling the lesser bad guy, "I don't care why you needed the money. Who doesn't? I just need to know who hired you…or else."

No one has ever asked me, once I've lowered my voice, if I'm angry or upset. I think that's an indication of success. I hope that I don't use this technique to try to get away with bullying patients. The soft voice is reassuring to me. It reminds me that I need to monitor what I say and how I say it but also provides a sense of being better in control. It allows a degree of flexibility in how I say things. Sometimes I also slow down how fast I talk as I believe this conveys a sense of greater import to what I say, as if slower words are more important, that the slowness of phrasing carries a greater density of meaning.

I have no idea if this helps my patients or me in any way. I don't think anyone's noticed. I hope not. ❖

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Disclosures on website

CLARIFICATION

Physician/PA supervisory ratio

Since 1999 in Rhode Island, there are no limits placed on the number of physician assistants (PAs) a physician can supervise or collaborate with. A sentence in the August issue of the Journal, which focused on PAs in the state, misstated this in an early edition release, which was subsequently changed.

RIMJ followed up with the American Association of Physician Assistants (AAPA) to determine the numbers nationwide and key provisions of the states' laws. While the majority of states place restrictions, as of July 2018, RI is one of more than a dozen states with no restrictions on the number of PAs a physician can oversee. Other states include: AK, AR, CT, ME, MA, MI, MN, MS, MT, NM (medical board), NC, ND, TN, VT.

For more information click: **Key Provisions in State PA Laws, July 2018**

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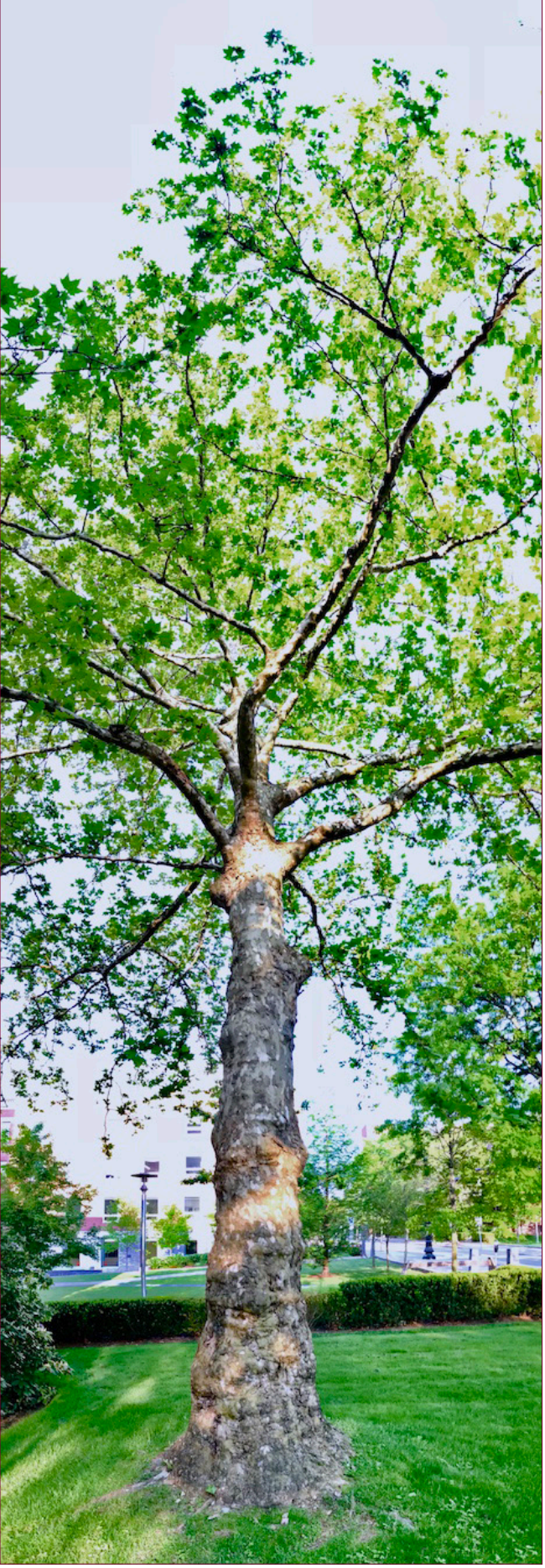

Figure 1. The Aronson Tree *(Both writers have taken the liberty to name this tree the "Aronson Tree")*

The Aronson Tree and the Roots of Brown's Medical School

SUTCHIN R. PATEL, MD; ANTHONY A. CALDAMONE, MD

Somewhere on the Brown University campus sits an unmarked tree, a descendent of the tree that Hippocrates taught under on the Greek island of Kos. The seedlings of the *platanus* tree were presented to the medical dean's office upon the founding of the Brown Medical School in 1972. It was nurtured by our founding dean, **STANLEY M. ARONSON, MD**, and planted on campus where it now stands proudly today.

We cannot think of a better symbol of our medical school. Dean Aronson nurtured the seedling prior to planting it and watched it grow into the tree that stands today, just as he nurtured our medical school as its founding dean and watched our school grow. When the medical school moved to its new home in the Jewelry District in 2011, it heralded an important step in the growth and evolution of our school. The seeds from this tree now grow in various places in Rhode Island and neighboring Massachusetts much like the graduates of our medical school, some who practice nearby and others who have spread outside of Providence to practice medicine.

In today's world of technologic innovations in medicine, the Aronson Tree serves as a quiet reminder of the roots and history of our medical school on the Brown University campus and our humanistic roots. We should all take the time to read something other than medicine under the many trees on campus and escape, if only for an afternoon, the hectic pace of medicine today.

For Brown medical students today and those interested in our school's history, we leave you with this treasure hunt. To find the tree's location, search and read the writings of our founding dean. Hopefully you will gain an appreciation for the writings of a true medical humanist and you will also make the not-so-far trip to the roots of our medical school.

[Please check next month's *Rhode Island Medical Journal* for the location of the Aronson Tree]

References

That would be cheating! Search Stanley Aronson's writings for an appreciation of our founding dean and to find the location of the Aronson Tree.

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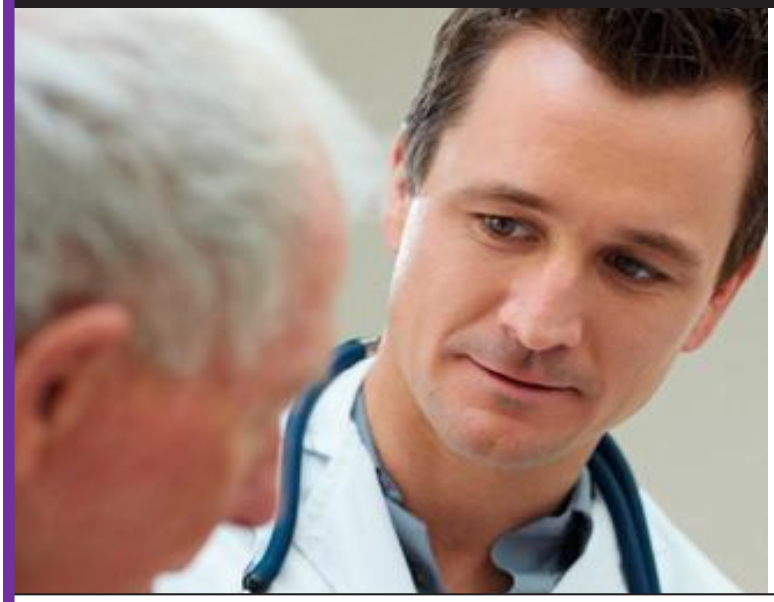

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Eliminating parental consent for adolescents receiving human papillomavirus vaccination

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ABSTRACT

Human papillomavirus (HPV) is a sexually transmitted infection (STI) causing nearly all cases of cervical carcinoma and genital condyloma worldwide. While HPV vaccination rates are higher in Rhode Island compared to other states, still 27% of female adolescents are not fully vaccinated. The requirement for parental consent for vaccination administration poses a barrier to HPV vaccine uptake and hinders adolescent autonomy. This requirement lies in stark contrast to the goals of the Family Planning Title X Program, which provides all adolescents with access to contraception and STI prevention and treatment without parental consent. In this commentary, we propose that HPV vaccination should be available to all pre-teens and adolescents as part of teen reproductive and sexual healthcare, and thus be exempt from parental consent in a similar way to other reproductive and sexual health services such as STI testing and contraception.

KEYWORDS: HPV, parental consent, vaccination, Title X, sexual health

Human papillomavirus (HPV) is a sexually transmitted infection (STI) with an annual incidence of 14 million in the U.S. and causes nearly all cases of cervical carcinoma and genital condyloma.[1] To aid in prevention of HPV-related diseases, the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommend HPV vaccination for girls and boys between ages 11 and 12.[1,2] Rhode Island requires HPV vaccination for entry into 7th grade.[3] According to the most recent available data from 2016 as described by Kim et al. in the *Rhode Island Medical Journal* in March 2018, 73% of girls and 69% of boys aged 13- to 17-years-old were fully vaccinated against HPV with a three-part series, demonstrating clear "missed opportunities for vaccination".[4] These numbers stand in contrast to a 2015 CDC report that 97% of RI youth have had at least one vaccination for tetanus and meningitis.[5] What factors contribute to these missed opportunities for vaccination and long-term cancer prevention?

HPV vaccination is accessible through RI's school-based "Vaccinate Before You Graduate" program or through any primary care provider. The Rhode Island Department of Health (RIDOH) immunization requirements include medical and religious exemptions, and parents have the right to refuse any vaccine if they have a "deep conviction" against it, reducing access for eligible children/adolescents.[3] Hence, parents who have strong beliefs about adolescent and/or premarital sexual activity may impact HPV vaccination programs.[6] While there is a wide diversity of adolescent privacy protections varying state-by-state across the U.S., this lack of patient autonomy stands in stark contrast to the aim of the Family Planning Title X Program, which gives all adolescents access to contraception and STI prevention and treatment without parental consent.[7]

Title X was created in 1970 and expanded in 1978 to include services for adolescents.[7] This federal program encourages adolescents to discuss their reproductive healthcare decisions with their parents/guardians, while also protecting adolescents' access to confidential care. With these statutes in place, many adolescents, who do not feel comfortable discussing these issues with parents, can have greater autonomy in decision-making when it comes to certain sexuality-related topics.

Several studies have explored what specific factors fuel parents' resistance to HPV vaccination and have found that parents express concerns about: 1) how the vaccine is related to adolescent sexuality, 2) how the vaccine might interfere with joint parent-child decisions, and 3) potential side effects.[3,8,9] We will address the first two parental areas of concern.

Among parents, the HPV vaccine may be categorized differently than other vaccines administered to teens because HPV is predominantly sexually transmitted. Interestingly, the hepatitis B vaccine also targets a sexually transmitted disease, yet timing of vaccination (recommended during infancy) and other predominant modes of transmission are likely factors in less parental pushback.[10] The HPV vaccine is a harder sell as some parents express concern that adolescents will view the vaccine as permission to engage in sexual activity.[11] Research on this subject consistently demonstrates that this is not true. For example, one retrospective cohort study of 1398 females found no association between HPV vaccination and increased sexual activity-related outcomes (i.e. STI testing) in 11- to 12-year-olds.[11] We expect that some parents may not be comfortable addressing

sexuality issues when talking with their pre-teen, and so are uncomfortable with a discussion of HPV vaccination that brings these issues to the forefront.

Misinformation is a barrier for parents appreciating how HPV vaccination might offer preventive benefits. A Canadian study found that many parents who distrusted the vaccine agreed with the following two statements: "not important for daughter to get HPV vaccine before sexual debut" and "daughter is too young to need HPV vaccine".[9] Thus, incomplete understanding of HPV infection biology and discomfort around teenage sexuality raise unnecessary concerns about promoting early sexual debut/promiscuity. These concerns appear to play a critical role in parental resistance to immunization efforts.

Some parents also believe that waiving parental consent for the HPV vaccine directly interferes with joint parent-child decision-making. One survey found that 86% of adults against waiving parental consent agreed that vaccination against "HPV should be a parent's decision".[12] Interestingly, this belief stands in contrast to the fact that most of these same adults also support laws that allow adolescents to receive medical care for STIs and contraception without parental consent.[12] Additionally, some parents have argued that giving the HPV vaccine requires a discussion with their children about sex and takes away their parental right to pick an appropriate time.[3,12] In reality, primary care providers, school nurses, educators, and peers also contribute to adolescents' understanding of sexuality-related topics; parents play an important role in these conversations, but certainly not the only role.

It is unrealistic to assume that all parental concerns about the HPV vaccine can be adequately addressed through education, especially when concerns are oftentimes deeply rooted in religious, cultural, or personal beliefs. So, what can we do to ensure that all adolescents have access to effective, safe and potentially life-saving preventive STI-related healthcare?

One approach would be policy change through legislation. An important strategy to protect pre-teens/adolescents may be to waive the requirement for parental consent for the HPV vaccine. There is precedent that HPV vaccination may be considered STI prevention akin to other methods of STI prevention (i.e. barrier methods) which have long been supported by medical, public health, and policy experts. As long as receiving the vaccine is not medically contraindicated, adolescents should be given the opportunity to make this decision for themselves.[13]

The Title X program recognizes the importance of providing confidential preventive and reproductive healthcare to adolescents.[7] Since the HPV vaccine is a form of STI prevention, it should fall into the same category as other Title X services. In 2018, approximately 13,000 women in the U.S. will be diagnosed with cervical cancer and 4,000 of these women will die.[14] Removing requirements for parental consent would align the HPV vaccine with other STI-related services provided to adolescents and aid in further reducing the burden of HPV-related morbidity and mortality for RI's youngest citizens, now and for years to come.

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Disclaimer

The views expressed herein are those of the authors and do not reflect the views of the Warren Alpert Medical School of Brown University, Women & Infants Hospital of Rhode Island, or Hasbro Children's Hospital.

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