The Stethoscope

Quarterly newsletter of the Erie County Medical Society

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A Note from Your President…

Controversial Cannabis

There are many controversies surrounding the dispensing and prescribing of cannabinoid derivatives also known as medical marijuana. Although they are similar to marijuana, there is one important difference to note in regard to marijuana versus cannabinoid derivatives. Cannabinoid products are THC free and therefore do not elicit the same side effect profile as marijuana does. Cannabinoid products/medical marijuana have been shown to have positive anecdotal success in the treatment of several life threatening and chronic disease processes by ways of reducing or eliminating many serious side effect panels. Pathologically, medical marijuana/cannabinoid products been shown to act as an anti-proliferative, anti-metastatic, anti-neoplastic and anti-angiogenic agent. There are certain factors that must be kept in mind that critically impact the effect of the drug. These cofounding factors include the dose; the strain and method of consumption; the environmental setting; the history of use, mindset or mood; diet and nutrition; and the biochemical characteristics of the drug. Cannabinoid products can exist in pill form, oils, vapors, liquid, and topicals.

Many chronic disease states have seen improvement of the torrential side effect profiles with the use of medical marijuana/cannabinoid derivatives. Some examples of these disease states include Multiple Sclerosis, Crohn's disease, various cancers, seizures, Autism Spectrum Disorders, ALS, and HIV/AIDs. By allowing the individual affected by these disease processes to consume the cannabinoid products, they have experienced anecdotal successes that include delaying of the disease process, pain relief, relief of nausea and vomiting, improvement of anorexia and weight loss, relief of anxiety and pain, and improvement of dysautonomia, for example.

Like all medications and medical therapies, restrictions must be in place to control these agents and attempt to prevent misuse. Prescribing this medication requires specific documentation that can only be obtained via appropriate training courses. Documentation must include the medical condition for which the patient would benefit from this treatment;

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review of the patient's past medical history as well as their current medication use; documentation and review of the PDMP; informed consent from the patient which must include the risk/benefits profile as well as alternative treatment options.

The medical record must support the clinical decision to recommend the use of medical marijuana/cannabinoid derivatives. There should be a periodic review of treatment efficacy and copies of any modifications included in the patient's health records. If the patient has violated or abused the treatment pathway with these agents, their treatment program must be revoked, and this must be communicated to the appropriate authorities. The department of health needs to know when a patient no longer suffers from the health condition for which the agents were prescribed for, and/or the cannabinoid derivative no longer satisfies a therapeutic or palliative need, and most importantly, when a patient has expired.

In our ever-changing world of evidence-based medicine, the use of medical marijuana/cannabinoid derivatives requires a culture shift into adapting and embracing our personal medical practices into utilizing this drug for the beneficial qualities it has to offer our patient populations. When practicing, we practice under the oath of Hippocrates, to do no harm. Rendering the care that our patients need, in order to achieve a quality of life free of the side effect profiles of many disease states, should be a top priority for all of us in the health care profession. In my opinion, we should do whatever we have in our medical powers to treat our patient populations appropriately, even if it may "rock the boat". If there is a patient who could benefit from these treatments despite the current controversy, I feel that we should render that treatment as long as it is ethical and will not cause harm to the patient.

What About Quality of Life?

By Amanda Wincik, DO, ECMS Resident Representative

No matter how you choose to define or measure quality of life (QOL), or health-related quality of life, the concept remains a subjective one. When I started residency, I was not naive to the debate surrounding quality of life. My life before medicine involved caring for people with developmental disabilities, which often generated comments from friends and strangers alike about how awful life must be for the individuals I worked with every day. "I feel so bad for them," "Poor thing," "What a way to live." It was obvious that what people saw was a person with an assumed low quality of life. What I saw were people who laughed and smiled all day, who enjoyed going out into the community and being around their friends and family. I saw people who were enjoying their life. As we get lost in the scientific quantification of someone's quality of life, we must take a closer look at how we are assessing it and must always remember that QOL is a personal perception of one's own life.

The term "quality of life" was introduced into medical literature in the 1960s. In 2013, based upon a May 2014 search by Marcel W.M. Post, PhD, there were nearly 4,000 quality of life references on PubMed. Based upon the sheer number of references, one would assume that QOL was a well-defined and understood component of today's medical society. The truth is, it remains quite the opposite, and there continues to be an inconsistency in how QOL is defined and measured.

The World Health Organization (WHO) defines QOL as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns." The University of Toronto Quality of Life Research Unit defines QOL as "the degree to which a person enjoys the important possibilities of his or her life" and in a QOL literature review, Post notes 10 different examples of definitions for the term.

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In an effort to better study and understand how health concerns, both chronic and acute, affect quality of life, the concept of health-related quality of life was created in the 1980s. The CDC has defined health-related quality of life as "an individual's or group's perceived physical and mental health over time". Measuring HRQOL makes it possible to scientifically identify the impact health conditions have on one's life.

As there are several different models of QOL, there in turn are several different ways to create a measurement. Scoring systems exist for almost every chronic disease or condition, ranging from overall general health to autism to spinal cord injury. What all of these scoring systems have in common is that they ask specific questions related to one's quality of life. For example, a questionnaire specific to assessing an autistic child's quality of life may ask them to rate how hard it is to play a sport, or do they have trouble getting along with other kids. A general QOL scoring system may ask a person to rate their overall health, or to quantify how many times they thought their mental health was considered poor in the past 30 days. The possibilities seem endless because QOL is a multidimensional concept. However, determining each person's own perception of their physical, mental, social, and functional health is always the goal.

When Potvin compared the health-related quality of life of children with high-functioning autism (n=30) to that of their non-autistic peers (n=31) she found that the children with high-functioning autism reported a poorer health-related quality of life than their peers, however when looking at the difference between the children's scores and parental scores there was a mismatch. It showed that children rated their quality of life higher than did their parents. This is possible for quite a few reasons. Potvin noted that the difference could indicate that children with high-functioning autism do not perceive their impairments as impacting their well-being to the same extent as their parents do. Also noted was that the parent's point of view could be skewed by their own negative feelings about their child's QOL.

While I have not, by any means, provided a complete review of QOL and how it can be measured, I would argue that as physicians caring for patients on a never-ending spectrum of physical, social, mental, and functional well-being, we must acknowledge our own biases when judging their quality of life. Whether you use a scientific method of measuring QOL for a patient with extensive co-morbidities, or you are seeing a person with developmental disabilities and their caregiver in the office, keep in mind that their perceived quality of life is most likely not the same as yours. We must take the time to ask the right questions and listen to the answers regarding how our patients are living and want to live.

References

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- WHOQOL: Measuring Quality of Life. World Health Organization. http://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/. Published March 11, 2014. Accessed November 14, 2018

Are you interested in submitting an article for consideration for a future Stethoscope Newsletter? Email Rebecca Doctrow at rdoctrow@pamedsoc.org.

Out and About with ECMS!

ECMS had a busy fall with our 9th Annual Health Expo in October and our Annual Meeting in November.

The Health Expo was a wonderful event which allowed the public to learn more about health resources in the area. ECMS also participated by teaching the mall patrons how to help save a life in a bleeding emergency with hands-on "Stop the Bleed" education.

At the Annual Meeting and Dinner in November, we recognized three members for 50-years of service, Peter P Barzyk, MD; Chong S Park, MD; and James J Thomas, MD. We also honored four members for being chosen for PAMED's Top Physicians Under 40 list, Klara Roman, MD; Lydia Travnik, DO; Rachel Wilderson, DO; and Amanda Wincik, DO. Following the awards presentations, Dr. Bhagwandien introduced our featured speaker, Geoffrey P. Dunn, MD, FACS, who gave a great talk titled "Reflections on Physician Burnout"

Telemedicine

Background

Two bills – SB 780 and HB 1648 – would establish a statutory definition for telemedicine, mandate that telemedicine services are reimbursed, and prohibit "audio only" services (video must be available if either the patient or provider requests it).

Current Status

SB 780 was unanimously approved by the Senate and was voted on favorably within the House Professional Licensure Committee. As of the writing of this update, telemedicine is awaiting second consideration on the House floor.

Next Steps

The government relations team is optimistic that this legislation could be passed into law this legislative session. PAMED is relying heavily on its members to respond to calls to action on this topic. For more information, visit www.pamedsoc.org/telemedicine.

Prior Authorization Reform

Background

PAMED is seeking a legislative fix to the prior authorization process to address patient care issues, such as delays in needed treatment. Our efforts are supported by a coalition of more than 50 patient and medical advocacy groups.

2018 Key Dates:

- Patient advocacy groups/stakeholders met in February.
- A call to action to physicians across the state took place in late April.
- Emails from PAMED to House Insurance Committee members took place in May.
- Provider advocacy groups/stakeholders met in August.

Current Status

HB 1293 was introduced and referred to the House Insurance Committee in May 2017.

Next Steps

In the 2019-2020 legislative session and at the request of insurers and lawmakers, PAMED will be working with stakeholders to make amendments to Act 68, rather than having a freestanding law. We are hopeful that an amendment to an existing law will gain more traction and get to the governor's desk.

Team-Based Care and Scope of Practice

Background

Both Senate Bill 25 and House Bill 100 would grant independent practice to certified registered nurse practitioners (CRNPs).

Current Status

Both bills are referred to the House Professional Licensure Committee, where they have remained since early-mid 2017 with no action taken.

Next Steps

PAMED strongly opposes any legislation that does not keep physicians as the leader of the health care team. The PAMED government relations team continues to educate legislators in the House Professional Licensure Committee and the public regarding our concerns with this legislation.

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Opioid Crisis

Background

More than 25 pieces of legislation regarding opioids have been introduced. Legislation ranges from Prescription Drug Monitoring Program (PDMP) requirements to prescribing limits.

Though there are quite a few pieces of legislation regarding opioids, PAMED is highlighting SB 655, which would create an Advisory Council within the Department of Health that could mandate physicians follow guidelines, such as the current voluntary guidelines, when prescribing opioids. This legislation has the potential to saddle physicians with a "no win" decision: follow the mandated guidelines knowing it's potentially not the best course of treatment for their patient or break the law in the interest of appropriate patient care.

An educational campaign kicked off in late September, aimed at House Health Committee members. This campaign is designed to educate legislators that **"cookie-cutter medicine"** is a recipe for disaster. PAMED supports commonsense, patient-centered solutions that allow physicians to treat their patients as unique individuals.

Current Status

Passed Senate (49 yeas / 0 nays). Sent to House – referred to House Health Committee.

Next Steps

PAMED plans to monitor this legislation closely. If it is determined that this legislation will be voted on in committee or on the House floor, PAMED will rely heavily on its members to respond to calls to action.

Informed Consent

Background

In a June 2017 ruling, the Pennsylvania Supreme Court held that, under the MCARE Act, a physician's duty to obtain a patient's informed consent is a non-delegable duty. Under the MCARE Act, except for emergencies, physicians must obtain informed consent from their patients, or their authorized representative, prior to conducting the following procedures:

- Performing surgeries (including the related administration of anesthesia)
- Administering radiation or chemotherapy
- Administering a blood transfusion
- Inserting a surgical device or appliance
- Administering an experimental medication

Current Status

PAMED's legal and government relations teams have been working with the Hospital and Healthsystem Association of Pennsylvania (HAP) to draft legislation that aims to address physician and hospital concerns with this ruling.

Next Steps

The PAMED government relations team is hopeful that a bill will be introduced in the 2019-2020 legislative session.

Maintenance of Certification (MOC)

Background

Per House of Delegates (HOD) policy, PAMED continues to work toward improvement of the MOC process and ultimately seeks to introduce legislation which makes certain MOC cannot be used as criteria for credentialing by insurers or hospitals. PAMED also seeks to prohibit physician licensing boards from using MOC as a condition of licensure. While physicians agree that lifelong learning is essential to their profession, many have expressed concerns that the current recertification process is not transparent and is not always an accurate measure of clinical competency.

Current Status

The American Board of Medical Specialties (ABMS) launched its "Vision for the Future" initiative to review the MOC process for physicians. PAMED Past President Charles Cutler, MD, MACP, is one of 26 members chosen to participate in the initiative's Vision for the Future Commission. The Commission's goal is to provide a set of recommendations about the future of continuing board certification for consideration by ABMS.

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ABMS released the results of its MOC stakeholder survey. Survey responses were received from more than 36,000 participants. 34,616 of the respondents were physicians, 96 percent of whom are board certified. Physician respondents were given the opportunity to choose up to four top MOC concerns from a list. The top concerns were:

- Cost (58%)
- Burdensome (52%)
- Does not accurately measure my ability as a clinician (48%)
- Does not help me improve my practice in a meaningful way (43%)

Next Steps

Stay up to date at www.pamedsoc.org/MOC.

Drug Formularies

Background

Under current law, insurers are not required to provide practitioners with drug alternatives when a prescribed drug is denied for not being in the patient's insurance drug formulary.

Current Status

Practitioners must expend time and resources to figure out what alternatives are available as part of a patient's insurance coverage. PAMED's Government Relations Team is working to engage lawmakers on the topic with the goal of getting legislation introduced to fix the process.

In the meantime, here are the top four ways to access drug formulary information to make the process less stressful:

1. Use an all payer portal, like NaviNet, that connects insurers and physicians in one online location to ease the process of understanding the prescription drug tiered system.
2. Configure the EMR system in your office to make drug formulary information more accessible at the time of prescribing.
3. Create shortcuts on office computers to directly connect to payer portals online.
4. If all else fails, call the insurer to request specific details related to the latest drug formulary.

Next Steps

PAMED's government relations staff are continuing to educate lawmakers on the topic in an effort to identify sponsors or co-sponsors of legislation that would reform the drug formulary process.

Member News

September 1, 2018 – October 31, 2018

New & Reinstated Active Members

Maggie K. Benson, MD • Shaun R. Black, DO • Alberto M. Cabantog, MD • Balachandra R. Chekka, MD
Myriam Elkosseifi, MD • Jeffrey J. Esper, DO • Adrienne L. Gerhart, DO • William P. Greissinger, DO
Matthew E. Johnson, MD • Sean Paul, MD • Ross Calvin Peterson, MD • Geoffrey R. Sinner, MD
Richard W. Petrella, MD • Justin P. Puller, MD • Aaron T. Rucks, DO • Shawn M. Simko, DO • Sahr Syed, MD

New Resident Members

Jacob Bingham, MD • Guneet Sahota, DO

New Resident Members

Elizabeth A. Mannarelli • Zachary M. Weisner

Reinstated Affiliate Members

Paul J. Gmuer, MD • Lawrence M. Kuklinski, MD • Aung P. Lee, MD

In Remembrance

Our sincere condolences to the family and friends of Forrest Mischler, MD, ECMS member since 1969.

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