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MEDICINE

Stemming the Tide:

THE IMPERATIVE TO ACT AMID THE VAPING EPIDEMIC



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recounts the heartbreaking process of closing

Philadelphia Safe Injection
Site Legal Battle Update



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LETTER FROM THE PRESIDENT



James Cristol,
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THE NEW SCOURGE – VAPING

At the time this issue of *Philadelphia Medicine* went to press, 33 people had died in our country from vaping-related lung disease. One of those victims lived in Pennsylvania. Vaping is the newest national scourge to rear its menacing head. Our cover story written by Ryan Coffman, manager of the Philadelphia Department of Public Health, Tobacco Policy and Control Program, describes the public health danger caused by vaping. Coffman reports that “in a matter of just 10 years, vaping has gone from being regarded as a fleeting fad, to an epidemic among youth as defined by both the FDA and the Wolf Administration here in Pennsylvania.” Coffman offers a comprehensive plan for trying to free people, especially the young, from vaping.

We are also covering another menace to our city, state and country – the continuing opioid crisis. Safehouse, the non-profit that wants to open a safe injection site in the Kensington area, has won a significant battle in federal court. U.S. District Judge Gerald McHugh ruled that a 33-year-old law aimed at closing crack houses was not intended to apply to safe injection sites. U.S. Attorney William McSwain has vowed to appeal the ruling, and he has warned Safehouse not to try to open a safe injection site during the appeals process.

The FOP and several neighborhood associations filed amicus briefs in the case, siding with the government, but there are local drug counselors and other care givers who think safe injection sites are a good idea. Peter Clark, a Jesuit priest who is director of the Saint Joseph’s University Institute of Clinical Bioethics, released a study late last year with research from doctors and students, that concluded that well-monitored safe injection sites can do a lot of good. Father Clark said he’s not an advocate of illegal drug use, “but I am an advocate of treating people with dignity and respect, and I think we have to do that where they’re at.” And on October 27, the Pennsylvania Medical Society’s House of Delegates approved a resolution endorsing a safe injection site.

Dr. Marylin Howarth, occupational and environmental medicine physician at Penn, writes an article that gives us some hope in the battle against lead poisoning in Philadelphia. She reports that City Council has recently approved what she describes as a major milestone – a bill that requires landlords to obtain lead-free certifications for all their rental properties.

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THE NEW SCOURGE — VAPING

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She believes it will help protect hundreds of the city's children. Dr. Howarth writes that although the national rate of lead poisoning has decreased since the federal ban on lead paint in 1978, Philadelphia's children are still diagnosed with lead poisoning at a rate more than double the national average.

This issue also has an update on Hahnemann's closing, including a poignant piece by Dr. David E. Stein, who was professor and chair of surgery for the hospital's Department of Ophthalmology. He had the heartbreaking task of closing the department. We have a report on the Pennsylvania Medical Society's annual House of Delegates meeting in Hershey. And we have an article on the cautionary conclusions by the Epilepsy Foundation of Eastern Pennsylvania on the use of cannabis for epileptic patients. We also have some helpful hints on how physicians should prepare for their retirement.

Our magazine is just one of the many services we provide our members. We have a lot to offer. Help to be a part of the solution. If you're not a member of the Philadelphia County Medical Society, consider joining us. For more information contact our executive director, Mark Austerberry, at 215-563-5343, ext 101, or at www.philadmedsoc.org. •

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Stemming the Tide: **THE IMPERATIVE TO ACT AMID THE VAPING EPIDEMIC**

By: Ryan Coffman, Manager,
Philadelphia Department of Public Health,
Tobacco Policy and Control Program



In mid-September, the Centers for Disease Control and Prevention activated their Emergency Operations Center, a center reserved for responding to imminent public health emergencies. Since 2001, the center has responded to more than 60 serious public health emergencies. So, what was the public health emergency that warranted this significant response? It was not a hurricane, Zika or even Ebola – but vaping.

The use of electronic nicotine delivery systems, or ENDS, which are viewed as tobacco products by the Food and Drug Administration, is also referred to as “vaping.” In a matter of roughly 10 years, vaping has gone from being regarded as a fleeting fad, to an epidemic among youth as defined by both the FDA and the Wolf administration here in Pennsylvania.

This epidemic is reversing years of hard-fought progress in reducing youth tobacco use. It has produced the first increase in all tobacco product use for middle and high school students since 2017. In cities and suburbs around the country, vaping has produced kids

who now have difficulty getting through a school day without vaping in the bathroom, or even their classroom, due to their intensifying nicotine addiction. Many of these youth are not even aware that these products contain nicotine.

As we observe rampant use of ENDS by youth, we are learning about serious health concerns that are being reported and investigated by both the FDA and CDC. This includes reports of seizures and serious, sometimes fatal, cases of respiratory illness. Investigations are underway to pinpoint the constituent or constituents responsible for these tragic events. What is known at this point is that among the reported case most patients had a history of using ENDS containing THC and products containing THC and nicotine. There have been reported cases of ENDS use that just contained nicotine. A significant number of these cases involve minors and young adults.

What has been the response of the vaping industry in the face of such troubling information? The vaping industry is sticking to the same talking points they have used for years. They maintain that their products are not intended for use by minors, and that they are a valuable tool to helping existing adult tobacco users transition to their safer products. Let’s take a moment to unpack some of these statements.

ENDS products have not been approved by the FDA as a smoking cessation aid. ENDS use is much more common among youth and young adults, rather than by adults that are trying to quit. Where studies on the use of ENDS for tobacco cessation have been done, they have shown mixed results. Research findings indicate that adults are more likely to develop a pattern of dual use, where they are vaping and smoking, than to quit use of combustible tobacco products. Vaping manufacturers claim that they are both



trying to keep their products out of the hands of minors while their unregulated products help adults to quit – but the data show the weakness of these claims.

In the context of a larger discussion about the harm vaping causes our youth, it is vital to not lose sight of one particular vaping company. JUUL has emerged as the market leader within the vaping industry, commanding more than 70% of the vaping market share and is widely believed to have ignited the current youth vaping epidemic. JUUL is a type of ENDS with widespread popularity among youth, with use now so common that it has its own verb: “JUULing.” JUUL achieved this market domination through a combination of intense social media marketing to youth and an innovative chemical formulation. A “pod,” which is the nicotine-containing reservoir used with a JUUL device, contains a proprietary nicotine salt formation which delivers the nicotine equivalent of a pack of cigarettes. The nicotine salt formed through the addition of benzoic acid allows a much higher concentration of nicotine than earlier e-cigarettes contained and is tolerable because it buffers the harshness of the nicotine “hit.” Teens and pre-teens are much more susceptible to nicotine addiction than adults due to the developing adolescent brain.

These pods have been available in a variety of fruit and candy flavors which have been consistently demonstrated to entice and allure youth to experiment with these products. JUUL made extensive use of imagery and marketing channels designed to appeal to youth by promoting “JUULing” as part of an identity and social lifestyle. This is highly reminiscent of the decades of tobacco industry campaigns that sought to frame tobacco use in the very same light for youth. With these similarities, it is not at all surprising that the lines separating the tobacco industry and the vaping industry are blurring.

This year, Altria, formerly Phillip Morris and the largest tobacco company in the nation, invested \$13 billion for a 35% share of JUUL. In fact, Altria’s “chief growth officer” recently stepped in to lead the company after the sudden resignation of JUUL’s former CEO. JUUL has attempted to mitigate their role in the vaping epidemic by enhancing age verification to purchase their products, by removing certain flavors from the market, and by curtailing product marketing that could reach youth. But the recent Congressional investigation showed that behind the scenes, efforts to addict youth continued. There is no longer any doubt that JUUL is a tobacco company, despite their claims to the contrary.

Countless public health advocates, health care professionals and parents have worked tirelessly to drive down the rates of adult and youth tobacco use only to see these important gains eradicated by the vaping epidemic. With the timeline for definitive federal regulation of vaping uncertain and the voluntary self-regulation of the vaping industry at best being disingenuous, there is an undeniable imperative for state and local action to stem the tide of the vaping epidemic. Here are a few actionable items that a health care professional or member of the public can do to support state and local efforts to protect both youth and adults from the public health harms of vaping:

- **Share accurate and up-to-date information regarding vaping.**
- Given the recent incidents of severe respiratory illness due to vaping, the CDC recommends that adults and youth refrain from using any ENDS.

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More Facts About Vaping

Mayor Kenney has proposed a bill that would ban the sale of flavored, that is high-nicotine e-cigarettes, in stores that admit minors. He is also calling for a citywide education campaign to inform young people of the dangers of vaping.

(Statistics from CDC)

The median age of patients is 23 years.

The median age of patients who have died is 44 years.

70% of patients are male.

15% are under 18 years old.

In 2018, 3.6 million youth, including 1 in 5 high school students, and 1 in 10 middle school students used e-cigarettes.

E-cigarette use increased 78% from 2017-2018 among high school students.

As of October 15, 1,479 lung injury cases associated with the use of e-cigarette, or vaping, products have been reported in 49 states (all except Alaska).

Vaping-related lung disease is being blamed for 33 deaths in 24 states, including one death in Pennsylvania.

All the victims reported a history of using e-cigarette, or vaping, products.

THC is present in most of the samples tested by FDA, and most patients report a history of using THC-containing products.

The latest national and state findings suggest that products containing THC, particularly those obtained off the street or from other sources – friends, family – are linked to most of the cases and play a major role in the outbreak.

The CDC recommends that no one should use e-cigarette, or vaping, products that contain THC.

The CDC goes on to say that since the specific cause of lung injury is not yet known, everyone should refrain from using all e-cigarette, or vaping, products.

The use of e-cigarette, or vaping, products are unsafe for all ages, including youth and young adults. Nicotine is highly addictive and can harm adolescent brain development.

E-cigarettes contain carcinogens, though lower amounts than burned in tobacco products.

E-cigarette aerosol is not harmless. It can contain harmful and potentially harmful substances, including nicotine, heavy metals like lead, volatile organic compounds, and cancer-causing agents.

All JUUL e-cigarettes have a high level of nicotine. According to the manufacturer, a single JUUL pod contains as much nicotine as a pack of 20 regular cigarettes. •



Stemming the Tide: THE IMPERATIVE TO ACT AMID THE VAPING EPIDEMIC

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- The Philadelphia Department of Public Health advises that no youth be exposed to nicotine in any form due to the potential harms to adolescent brain development. Any adult who is attempting to quit tobacco use should first use FDA approved medications and behavioral coaching and supports, such as 1-800-Quit-Now, which offers free medications and phone-based counseling support.
- **Health care providers can ask about vaping when assessing tobacco use and advise youth and adults to quit vaping or tobacco use in general.**
 - As vaping is still a relatively recent epidemic, there is not an abundance of evidence-based youth vaping cessation resources. Available resources include:
 - “This is Quitting” - Truth Initiative® has expanded its quit-smoking resources to include an innovative and free text message program at: truthinitiative.org, and thetruth.com, created with input from teens, college students and young adults who have attempted to, or successfully quit e-cigarettes. The program is tailored by age group to give teens and young adults appropriate recommendations about quitting. The program will also serve as a resource for parents looking to help their children who now vape. The program can be accessed by going to: <https://truthinitiative.org/research-resources/quitting-smoking-vaping/quitting-e-cigarettes>.
 - “My Life, My Quit” – My Life, My Quit, shares the truth about nicotine, vaping and other tobacco products. If you decide you want to quit, they are here to help you do it successfully. Text “start my quit” at 855-891-8989 or call to talk with a quit coach who is ready to listen and cheer you on. It’s YOUR LIFE and we’re here to help you live it YOUR WAY.
- **Include all ENDS products in clean indoor air policies to be totally tobacco and vape-free.**
- **Talk to your students and children about vaping.**
 - The Philadelphia Department of Public Health has created a toolkit to assist schools and parents in addressing youth vaping. The toolkit can be accessed by going to: <http://smokefreephilly.org/resources/downloadable-media/>. Schools and social networks can be a critical setting where youth are exposed to vaping.

You can reach Ryan Coffman by emailing him at Ryan.coffman@phila.gov. •

Pennsylvania Medical Society House of Delegates Approves PCMS Safe Injection Site Resolution

By: Mark Austerberry, PCMS Executive Director



The Pennsylvania Medical Society (PAMED) House of Delegates approved a resolution endorsing safe injection sites. The resolution called for an independently funded and studied pilot trial for such a site. PAMED's House of Delegates called for the facility to be in keeping with multinational evidence-based medicine.

The Pennsylvania Medical Society (PAMED) House of Delegates meeting was held Oct. 26-27, in Hershey. The HOD is the society's policymaking body. It is made up of nearly 275 elected members. During the two-day meeting held each year, it deliberates and acts on issues related to health policy, managed care, public health, programming, and society administration.

The Philadelphia County Medical Society (PCMS) delegation consisted of 63 voting delegates. Serving on the PCMS delegation carries with it the responsibility of representing the physicians of Philadelphia County, but it also provides an opportunity to influence the policies of organized medicine. This year the PCMS delegates deliberated on 30 resolutions and 15 reports and elected trustees and officers. For a complete listing of the 2019 PAMED HOD resolutions, please check out PAMED website at www.pamed.org.

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Emily Mapelli
McKayla Mawn

Pennsylvania Medical Society House of Delegates

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Below is a summary of other 2019 PCMS resolutions submitted on behalf of Philadelphia County:

Reference Committee B (Education & Science/ Public Health)

Adopted as amended

RESOLVED, that the Pennsylvania Medical Society (PAMED) support Graduate Medical Education (GME) programs' implementation of accommodative child care policies and flexible working environments for all residents in order to promote equity in all training settings; and be it further

RESOLVED, that PAMED take the need for innovative child care policy approaches for residency programs to the American Medical Association Annual 2020 Meeting.

Reference Committee C (Managed Care & Other Third-Party Reimbursement)

Resolution 19-303: Removing Opposition to Single-Payer Healthcare

Adopted as Amended

RESOLVED, that the Pennsylvania Medical Society (PAMED) revise existing policy number (165.997) to read:

165.997 Managed Competition

The society adopts the following policy position: Health system reform proposals that unfairly concentrate the market power of payers are detrimental to patients and physicians, if patient freedom of choice or physician ability

to select mode of practice is limited or denied. Single-payer systems that fall within such a definition, should continue to be opposed by the Society. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

Reference Committee D (Mcare Fund/ Tort Reform/ Other Legislation/ Regulations)

Resolution 19-407: Cessation of Youth Tobacco Use

Not Adopted

RESOLVED: that the Pennsylvania Medical Society promoted to the Legislature of the State of Pennsylvania, that legislation be passed to prevent tobacco sales to anyone born after January 1, 2009. And be it further

RESOLVED: That the Pennsylvania Medical Society introduce similar resolution for federal consideration at the American Medical Association interim meeting of 2019.

Reason for not adoption – current efforts and existing PAMED policy regarding tobacco, the reference committee believes that no further efforts are needed.

Resolution 19-408: Act 96 And Discretion of Physician Practice

Adopted

Resolved, that the Pennsylvania Medical Society seek immediate legislative relief from Act 96 such that those who can legally prescribe Schedule II through V controlled substances

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FEATURE CONTINUED



Pennsylvania Medical Society House of Delegates

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in the Commonwealth of Pennsylvania be permitted to do so by either written paper prescription or electronic prescription.

The resolution called on PAMED to advocate for physicians to be permitted to prescribe Schedule II through Schedule V controlled substances both electronically and with paper prescriptions and given that Act 96 contains numerous exceptions under which the concerns raised could be ameliorated and that DOH is currently developing regulations – the reference committee felt that additional actions were unwarranted and had this not for adoption.

The HOD also directed PAMED to:

- Reaffirm that medical care is a special and unique personal service differentiated from a common consumer good or service, and that restrictive clauses interfere with the ability of patients to have access to their physician;
- The society and relevant specialty organizations work with the Pennsylvania Legislature to modify or amend Act 112 of 2018;
- Recommend that Pennsylvania vaping/electronic cigarette legislation require sellers and producers of electronic cigarettes, vaping equipment, and products to inform all consumers about the risk of illness and death from electronic cigarettes/vaping and prohibit the sale of equipment, cartridges, and pods to minors;
- Prior authorization to continue efforts to reform, seek elimination of administrative burdens, and considers the use of prior

authorization an impediment to the physician-patient relationship and the timely delivery of medical care.

Other noteworthy news included:

Michael DellaVecchia, MD, PhD, FACS

– became president-elect for one year, in October 2020. He is a practicing ophthalmologist and former president of PCMS.

Lynn M. Lucas-Fehm, MD, JD

– a radiologist at Abington, will serve a second four-year term as the society's first district trustee. As the first district trustee, she'll represent physicians from Philadelphia County.

The past several years have brought with them many new challenges for physicians and medicine. Generally, more government regulations and policies that often impact how physicians care for their patients and our community. The annual HOD gives PCMS delegates a unique opportunity to offer advice to our lawmakers about specific legislation affecting the medical profession. The HOD will continue to allow all physicians an opportunity to shape the next generation of medicine in Pennsylvania. If you are interested in becoming a Philadelphia County Medical Society delegate, please reach out to me at mausterberry@philamedsoc.org. •



FEATURE

Backers of a Philadelphia Safe Injection Site Win First Court Test:

But the Federal Effort to Block Such a Site Continues

By: Alan Miceli, Editor

The U.S. Attorney for the Philadelphia area has promised to use all legal avenues he has available to shut down any safe injection site that opens in the city before the Justice Department has exhausted its appeals.

In a letter to Ilana H. Eisenstein, attorney for Safehouse, the non-profit seeking to open a safe injection site, U.S. Attorney William McSwain wrote that he will use drug seizures, arrests, and other methods to ensure the organization does not open such a facility. McSwain wrote that if Safehouse opens before the court fight ends, “you will force my hand, and I will have no choice but to take the steps necessary to maintain the status quo.”

The letter came in the wake of the October 2 decision by U.S. District Judge Gerald McHugh that a 33-year-old federal law aimed at closing crack houses, was not created to apply to a safe injection site. Supporters of Safehouse cheered the decision. Ronda Goldfein, vice president and secretary of Safehouse and director of the AIDS Law Project of Pennsylvania, told *Philadelphia Medicine*, McHugh’s ruling “is an important step forward. The decision supports our belief that federal law would not prohibit us from saving lives.”

Goldfein added that the judge “saw that it was clear that our goal is to reduce drug use, not facilitate it.”

She said a safe injection site would help fight the deadly epidemic of drug overdoses in the city. Last year, 1,116 people died from drug overdoses in Philadelphia. Goldfein says a safe injection site would be supervised by a medically trained person, a case manager, and a peer specialist. In the case of overdoses, staff would be ready to revive the victims with naloxone.

Goldfein said the facility would be a sterile area that would allow persons to inject drugs under supervision. While such persons are at the facility, staff members would offer services to help them break

their drug addiction. “We hope that the first time somebody comes in they’ll see that we are not judgmental. Maybe they’ll take us up on the offer if not the first time, maybe the second. Or the 20th time or 25th time. Each time they return we’ll be offering the same support.”

Goldfein added that there’s obviously no quality control when it comes to illegal drugs on the street. A safe injection site would help deal with that serious, sometimes life-threatening problem. And a safe injection site would ensure that if there is an overdose, people are right there ready to help, as opposed to someone injecting drugs in a back alley somewhere. People are shooting up whether there is a safehouse or not. Goldfein said a safe injection site offers the hope that those people will be at least able to use drugs in relative safety.

Safehouse expects such a facility to attract hundreds of people each day. There are about 120 such sites in Canada, Australia and Europe. Goldfein says the evidence from those sites is fairly conclusive. “No fatalities at the sites, decreased fatalities in the vicinity of the site, reduced public consumption in the area, and reduced drug-related litter.” She said there are estimates that a safe injection site in Philadelphia would save at least 75 lives a year. She believes that’s a low estimate.

The local chapter of the Fraternal Order of Police is against a safe injection site. The FOP, along with six civic associations in city neighborhoods in and around the Kensington area where the safe injection site is being considered, filed Friend of the Court briefings in support of the U.S. Attorney’s case.

Shannon Farrell, head of the Harrowgate Civic Association in the Kensington area, said the Safehouse people have good intentions, but what they want to do will only make the drug problem in her neighborhood worse. She recently wrote that “Safehouse claims they can make drug use safe, but there’s no way they can make our

children safe from drug dealers who will want to supply the new centralized market of users.”

Farrell added “We all know the pain of addiction. Many of us have family or friends in the throes of addiction. We are nothing but compassionate about their experience and struggle. But a legalized injection site is not the solution.”

The issue has brought mixed reactions from people who counsel those with drug addictions. Dr. Jeffrey Berger, a local addiction medicine specialist, wrote that safe injection sites are “interventions of despair from a culture of abandonment.

“When you allow them (people with drug addictions) to live in that fantasy world with no consequence, you can never break through so that they can be healed.”

Peter Clark, SJ, disagrees. He is a Catholic priest and director of Saint Joseph’s University’s Institute of Clinical Bioethics. He helps doctors around the world wrestle with difficult ethical dilemmas and has given weekly ethical teaching rounds to four local hospitals. He told Saint Joseph’s University Magazine that safe injection sites can do some good.

In a study he led with a team of doctors and students, published in *The Internet Journal of Public Health* late last year, the professor and his team supported the creation of safe injection sites that would be staffed by health care professionals. Those professionals would

supervise intravenous drug use and provide syringes, disposable cookers, matches, bottled water and tourniquets.

Clark said his work was driven by one of the Catholic Church’s fundamental beliefs – that all human life is sacred. “We took a lot of pushback on (the safe injection sites). ‘Why are you, a Catholic ethicist, promoting giving clean needles to heroin addicts?’ But what we’re trying to do is based on the sanctity of life. Unless you’re ready for rehab, you’re not going to be successful. We’re trying to keep people alive until they’re ready to go into rehab. That’s our ultimate goal.

“I learned a long time ago that many people think ethics can be black and white. I think it’s gray in most places.”

Clark said he’s not an advocate of illegal drug use. “But I am an advocate of treating people with dignity and respect, and I think we have to do that where they’re at.”

Goldfein knows that people in the Kensington area are both angry and concerned about drug use on their streets, and afraid that things will only get worse with a safe injection site. “We hear what you’re concerned about. We want to address it.

“So, if you’re concerned public consumption, we’ll bring it inside. If you’re concerned about overdosing in front of your kids, we’ll bring that inside. If you’re concerned about drug litter, we’ll bring that inside. We want to have a safe neighborhood for everyone.” •



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THE PUBLIC HEALTH SIDE OF FRACKING

By: Walter Tsou, MD, MPH

His obituary reads like this. Luke Michael Blanock, 19, of Cecil, Pa., succumbed to his courageous three-year battle with Ewing's sarcoma Sunday, August 7, 2016, in his home, surrounded by his loving family. Born Tuesday, April 1, 1997, in Pittsburgh, he was a son of Kurt and Janice Graham Blanock. He was a member of St. Mary Parish, where he was an altar server and member of the youth group. He was a 2016 graduate of Canon-McMillan High School, where he was captain of the basketball team, a pitcher on the baseball team and a member of Spanish Club and National Honor Society.

He worked at Vocelli Pizza in Canonsburg and was an entrepreneur, selling on Craigslist.

Surviving are his soulmate and wife of five months, Natalie Britvich Blanock of Canonsburg and Cecil; parents Janice and Kurt Blanock of Cecil; sister Carla (Adam) Marratto Cumming.

Luke, still a teenager, was one of six students diagnosed with Ewing sarcoma in the Canon-McMillan High School District in Washington County in the past decade. Only 200 cases of Ewing sarcoma are diagnosed nationwide annually, so the presence of so many cases in one school district should disturb all physicians in our state.

It gets worse. In addition to the six students living with Ewing sarcoma in the Canon-McMillan district, 10 other rare childhood cancers have been diagnosed since 2008. The neighboring Fort Cherry School District has had 7 students with rare cancers and the Bethlehem Center School District has another 12 diagnosed cancers. It begs the question – what is going on?

Washington County, Pennsylvania, is at the epicenter of fracking with well pads, pipelines, compressor stations and heavy diesel traffic. Residents of Washington County have a strong suspicion that Ewing sarcoma is related to the myriad number of new gas wells being

drilled over the Marcellus Shale which is the biggest change in the area in the past decade.

On October 7, a community meeting by the state health department in Canonsburg reported that this is not a cancer cluster although audience members presented cases of Ewing that were never counted in the state's epidemiological study. No matter. Despite actual Ewing patients who spoke, the state health department closed the meeting with 50 people still in line ready to ask questions at the microphone. The state health department was remarkably unhelpful, stating that their current analysis showed no cancer cluster and they could not justify any effort to conduct an independent study.

Pennsylvania, where oil was first discovered in Titusville, is a veritable energy powerhouse. Our long history of coal mining and now, shale gas drilling, using unconventional drilling, using hydraulic fracturing of the shale (otherwise known as fracking) has made Pennsylvania the second largest state producer of gas in the United States. Not surprisingly, politicians have embraced fracking in our state as the new energy producer for the nation. And the gas industry has embraced the state legislature, donating more than \$67 million in political contributions to both parties over the past eight years. Are we surprised that the Republican majority state legislature and the Democratic governor both embrace the gas industry?

Pennsylvania is even more "blessed" because our gas wells, especially in the western part of the state, produce "wet" gas, which carries not only methane, the chief ingredient of fracked wells, but also "natural gas liquids" like ethane, propane, butane, etc. These liquid by-products of wells can be hydrogenated under extreme heat to produce ethylene, propylene, butadiene, etc. These volatile and highly reactive compounds are the precursors to plastics.

As natural gas liquids, they are very valuable, and Pennsylvania is building the first of several ethane cracker plants in order to create these plastic precursors. The unfortunate problem is that ethane cracker plants are heavy air polluters and also feed a growing problem of plastic pollution in our oceans. The industry sees Pennsylvania like a giant bowl of natural gas liquids and fracking is the straw.

A big problem is that the fracking wells are not near the ocean where they can transport natural gas liquids to other locations. As a result, companies have built pipelines, many through eminent domain, through people's backyards in order to transport natural gas liquids to Marcus Hook, a local port with access to the Delaware Bay and Atlantic Ocean. The controversial \$5.1 billion Mariner East pipeline is a 350-mile pipeline which will encourage even more fracking in the state and put volatile natural gas liquids within a blast zone of people's homes.

All of this is built on the Faustian deal of jobs created as we drill more wells and produce more fossil fuel energy for heat and plastics. Our state is already the third leading producer of greenhouse gases, which is dramatically contributing to climate change. Methane, the gas product of fracking, is a potent greenhouse gas and is 86 times more heat trapping than carbon dioxide, the other major greenhouse gas produced by burning fossil fuels. Climate change and greenhouse gases are largely ignored by our state legislators who can only see the short term bonanza of fracked gas. The DEP has happily granted over 27,000 well permits since 2011 all with the blessing of state leaders. So when the gas industry and government are aligned together, there is really no concern about inconvenient truths like the crisis of childhood cancers or contaminated air or water pollution.

Despite many health complaints lodged against gas well drillers, the industry has essentially silenced the opposition by having residents sign "non-disclosure" agreements (NDA) which include no participation in independent health research studies or public disclosure of health problems. This is frequently conditional in exchange for getting water buffaloes so that you can drink water. Somehow, it is considered legal to force people to sign these NDAs even though clean water is essential for life. Really, what choice do they have? And they can't sell their property which is worthless with contaminated well water.

Article 1, Section 27 of the Pennsylvania Constitution states, "The people have a right to clean air, pure water, and to the preservation of the natural, scenic, historic and esthetic values of the environment. Pennsylvania's public natural resources are the common property of all the people, including generations yet to come. As trustee of these resources, the Commonwealth shall conserve and maintain them for the benefit of all the people."

Whatever is going on in Washington County is not good, and a violation of the state Constitution. The old Iroquois Indian principle states that our decisions today should be made in the context of sustaining our children seven generations from now. It is hard to justify the pollution that currently is having an impact on our children today. And unless we change our dependence on fossil fuels, it will have an impact on their children seven generations hence. •

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Pennsylvania Begins Its Transition to a State-Based Exchange



By: Robert Miyamoto, PCMS Assistant Dir. of Communications and Marketing

Pennsylvania will implement a state-based exchange (SBE) for the 2021 health insurance plan year. The legislation was enacted in 2019 with the aim of making health insurance coverage more stable and affordable and allowing the state to have more control over its local individual market. Over 400,000 Pennsylvanians are enrolled through the market, which provides coverage for those who cannot receive health insurance through other means. Since the implementation of the Affordable Care Act in 2010, Pennsylvania has relied on the federal health insurance exchange HealthCare.gov. The state joins more than a dozen states that have built their own exchanges.

The user fee collected from Pennsylvanians by the federal government for services such as the HealthCare.gov website and the federal call center amounts to \$98 million in 2019, or 3.5% of premiums. For 2020, the user fee will drop to \$88 million, or 3%. A state-based exchange could operate at a significantly lower budget, approximately \$30-35 million annually. This figure was calculated based on discussions with other states currently operating their own SBEs as well as a health care consultant firm. Pennsylvania will continue to charge the same user fee as the federal government and use the savings to fund a reinsurance program. The reinsurance program is where the savings will go back to the enrollees, who will see an estimated 5-10% reduction in premium rates compared to the federally-run exchange.

The reinsurance program does not directly lower premium costs. It is directed towards insurers. The program will provide contributions to assist insurers in covering high cost medical expenses incurred by some members. These high cost expenses can drive up premiums. By alleviating them, insurers can lower their costs for all of their members. The program will be designed to be flexible, with specific parameters being adjusted year by year based on anticipated costs.

In addition to the state's own savings, the reinsurance program is expected to receive funding from the federal government as well. The federal government will save money as a result of the program. It would pay less in subsidies, which are relative to premiums for

individuals who have received their coverage through the exchange. (The federal government currently provides \$2 billion in health care premium subsidies to low-income Pennsylvanians.) Their savings would be put into the reinsurance program. The state will provide 25% (around \$40-50 million) of the funding while the federal government is expected to provide 75% (around \$150-\$250 million). A 1332 waiver would need to be approved for the state to receive the federal government's funding for the reinsurance program.

The 1332 waiver, also known as the Section 1332 State Relief and Empowerment waiver, allows states to use federal money currently being used for Affordable Care Act financial assistance programs for state-based initiatives. The Department of Health and Human Services (HHS) is currently encouraging states to use the waiver to form their own solutions for their health care systems instead of relying on the federal system which may not fully meet the needs of populations on a state level. To date, the Centers for Medicare and Medicaid Services have approved waivers from 13 states. Seven states had submitted waivers which were not approved for reasons including timing or incompleteness. The state government has been working closely with HHS to ensure its waiver's approval. States that have implemented a reinsurance program after being approved for the 1332 waiver have been able to reduce premiums by 6%-43.4% in the first year of enactment.

The state expects that Pennsylvania enrollees will save up to a combined \$250 million annually on their health insurance premiums.

While Pennsylvania has some oversight over the federal exchange's operations in the state, including regulating to an extent health insurers and reviewing products sold through the exchange, a state-based exchange would give Pennsylvania more control over determining which plans would be sold on the exchange as well as individuals' eligibility for enrollment and financial assistance, and would grant better access to enrollment data, which would allow the state to tailor the exchange to further meet the needs of Pennsylvanians. The transition would also allow the state to alter the open enrollment



schedule, conduct marketing and outreach and directly address consumer issues.

The state-based exchange would be developed so it matches the infrastructure of the federal exchange, in order to reduce any operational impact that the service may have to insurers or the Department of Human Services.

Pennsylvania has had interest in implementing a state-based exchange since 2012. A lack of information from HHS as well as technological hurdles made the idea unfeasible. In 2015, Pennsylvania was the first state to announce that it would create a state-based exchange in response to a potential Supreme Court ruling that would stop subsidies from being provided through HealthCare.gov, however, the Supreme Court upheld subsidies and Pennsylvania continued to use the federal exchange. The state's interest in an SBE has been renewed as there are now existing state-based health exchanges. As such, the state can implement that existing information technology infrastructure rather than develop their own, making the transitioning process faster and more cost-effective.

While the SBE will not be fully implemented until enrollment for the 2021 health insurance plan year, the market has entered a transitory phase for the 2020 enrollment by operating as a state-based exchange on the federal platform (SBE-FP), where the state takes on more oversight of the exchange's functions while still utilizing HealthCare.gov. Under this model, the user fee is reduced from 3% to 2.5%, however, similar to the full state-based exchange model, the user fee would remain the same for enrollees. Savings would go towards costs associated with the transition to an SBE.

Open enrollment for the 2020 health insurance plan year has begun and runs until December 15, 2019. Plan coverage starts January 1, 2020. For tips and other useful information for this year's enrollment, visit <https://www.healthcare.gov/>. •



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Philadelphia Makes Strides Against Lead Poisoning

By: Marilyn V. Howarth, MD, FACOEM

2019 has been a tremendously impactful year in the fight to protect Philadelphia children from lead poisoning. Last month, historic steps were taken in City Council to protect against lead poisoning with the unanimous passing of a bill requiring landlords to obtain lead-safe certifications for all their rental properties. This bill, an expansion of a 2011 bill that required lead safe certification only when renting to families with children under six, is a major milestone.

Considering that every year 1200 Philadelphia children have a newly identified elevated blood lead level and 65% of them live in rental housing, this ordinance is expected to protect hundreds of children in Philadelphia from lead exposure in their homes and those they visit. Physicians joined a broad community effort known as the Lead-Free Philly Coalition to add their medical and scientific expertise to inform the legislative conversation.

Even though the national rate of lead poisoning has been decreasing since the federal ban on lead paint in 1978, children in Philadelphia are diagnosed with lead poisoning at a rate more than double the national average. The primary source of lead exposure for children is peeling lead paint. However, even in a home with no overt peeling paint, lead dust created from opening and closing windows and doors can result in elevated lead levels in children living there. More than 90% of the housing in Philadelphia continues to have lead paint.

Even when covered by multiple layers of latex paint, there remains a risk. Even the smallest exposure to lead destroys brain cells and when repeated small exposures take place they put children at risk for irreversible neurological damage leading to cognitive and behavioral problems. Physicians recognize that we have no effective treatment to protect children from, or reverse the serious neurologic consequences of lead poisoning. Chelators have reduced the risk of death from very high levels but have been shown to be ineffective at reversing neurocognitive damage.

Given these serious consequences to children, it would seem that physicians and medical providers throughout Philadelphia would routinely test blood lead at 1 and 2 years of age, the time when children are most vulnerable to exposure due to their behaviors of spending time on the floor, putting items in their mouth including their hands and having a rapidly developing brain. In fact, the Pennsylvania Department of Health reports that only 44% of children in Philadelphia have had a lead test by age two.

There are many reasons for this disconnect. Some physicians have seen the national trends of decreasing lead levels and have not appreciated that the trends are less impressive in some communities. They may not know that most children have medical coverage which almost universally covers screening blood lead tests. In other circumstances when an elevated blood lead level has been identified, physicians may not be aware of the resources available to evaluate the sources at home, child care facilities and other places the child may spend time. The frustration of knowing of an ongoing harm and not being able to help can serve to disincentivize testing.


The most effective way to protect children from lead in the home is removing all the lead paint using an EPA certified lead contractor. Since that is extremely costly, secondary prevention approaches include thorough cleaning using wet mops and wipes. Sweeping and dry-dusting is not recommended since it spreads lead dust around the home. Surfaces in the home, especially windowsills and floors, should be wiped down at least once a week but ideally more frequently. All renovations done in a home built before 1978 should be done by a lead certified contractor or the entire home may become lead contaminated.

Although these strategies are expected to reduce overall lead exposure, they have not been proven to be effective at eliminating elevated blood lead levels. History has documented that solving the problem of lead poisoning nationally and in Philadelphia cannot be accomplished by counseling or treatment alone. For this reason, the Environmental Subcommittee of the Section on Public Health and Preventive Medicine of the College of Physicians of Philadelphia worked to produce and disseminate an Issue Brief detailing the scientific evidence supporting the need to take primary prevention steps. The issue brief, along with live testimony, provided City Council members with the science supporting the need for primary prevention of lead exposure and evidence that initiatives like the expansion of the lead-safe certification of rental housing law had been successful in other communities to protect children.

In addition to the lead-safe certification of rental housing law, it is now the law in Philadelphia that doctors must test children for blood lead at one and two years of age. Twenty states require blood lead testing; New York, New Jersey, Delaware and Maryland are among them. The Commonwealth of Pennsylvania is also considering universal blood lead testing. Bills on the matter are currently in committee (SB312, HB79).



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As more children are tested, we will be better able to assess the areas of highest risk and design targeted interventions. As physicians find children who have unexpected elevated blood lead levels, there should be renewed enthusiasm for testing and referrals to the Lead and Healthy Homes Program (<https://www.phila.gov/programs/lead-and-healthy-homes-program/>) which goes out to homes to evaluate lead sources and risks.

Some might say that physicians across the country have dropped the ball when it comes to testing at-risk children. But recent legislative initiatives in Philadelphia targeting primary prevention by reducing the lead risk in homes coupled with universal testing, may help us recover our own fumble. Eliminating lead poisoning completely will require our vigilance for as long as lead paint remains on the walls of our buildings.

Dr. Howarth is an occupational and environmental medicine physician who directs community engagement for the University of Pennsylvania's Center of Excellence in Environmental Toxicology. The Community Engagement Core (CEC) at the Center of Excellence in Environmental Toxicology (CEET) is committed to the study and mitigation of lead exposure in Philadelphia. The CEC is involved in numerous projects around the city, ranging from educational outreach on lead exposure, to informing legislators, regulators, and medical professionals, to testing lead in soil around the city. Visit our website at <http://ceet.upenn.edu/community-outreach-engagement/> for more information on our work in Philadelphia communities and resources on lead. •

HBV PreVNTT: The Latest effort to try to Combat Hepatitis B in Philadelphia

By: Chari Cohen, DrPH, MPH, Senior Vice President, Hepatitis B Foundation; Catherine Freeland, MPH, Public Health Program Manager, Hepatitis B Foundation; Meredith Henne, MPH, Hepatitis B Project Coordinator, Philadelphia Department of Public Health; Danica Kuncio, PhD, Viral Hepatitis Program Manager, Philadelphia Department of Public Health

Last year, a 32-year-old African man in Philadelphia woke up with pain in his side. By the afternoon the pain intensified, and he went to the ER. An MRI revealed that he had hepatocellular carcinoma, and blood tests found that he had chronic hepatitis B virus infection (hepatitis B). Unfortunately, the liver cancer was too advanced, and he died within three weeks. He did not know that he had hepatitis B, even though he likely lived with it for years. Had he been diagnosed, he could have been medically managed to prevent the liver cancer, or to detect it early.

Unfortunately, this is not an isolated incident. hepatitis B has been a hidden epidemic in Philadelphia, negatively impacting the lives of thousands often without their knowledge.

Philadelphia has a socioeconomically and culturally diverse population of approximately 1.6 million people. The city is home to many communities with elevated risk for infection with the hepatitis B virus, which causes chronic liver infection and a significantly increased risk of developing cirrhosis and liver cancer. Locally impacted communities include Asian, Pacific Islander, and African foreign-born communities, as well as LGBTQ+, homeless, and drug user communities. Pennsylvania has the fourth highest burden of newly reported chronic hepatitis B infection in the nation¹, and Philadelphia accounts for 74% of these cases. In 2016, Philadelphia had an annual HBV rate of 38.4/100,000 people¹. While the Philadelphia Department of Public Health (PDPH) has been made aware of 25,132 Philadelphians living with chronic hepatitis B infection, it is estimated that up to 65% of infected people remain undiagnosed, so there are thousands more Philadelphians who need to be diagnosed and linked with appropriate medical care. Additionally, Philadelphia is now seeing

an increase in acute hepatitis B infection, driven largely by the opioid epidemic and injection drug use behaviors.

Since 2012, the Hepatitis B Foundation, and its community coalition Hep B United, has provided free community-based hepatitis B education, and testing and linkage to care for high-risk communities. So far, we have screened 2,906 individuals and found an overall hepatitis B prevalence of 7.86%, which is among the highest prevalence rates found by community-based programs in the U.S. Additionally, 43% were found to be susceptible and in need of vaccination. Interestingly, 60% of those tested stated that they have a primary medical provider and had seen a doctor within the past 12 months – yet had never been tested for hepatitis B virus. We also found that there is very low awareness of hepatitis B among high-risk communities, and that hepatitis B-related stigma and myths about transmission and treatment serve as barriers to testing.

The World Health Organization is calling for the elimination of viral hepatitis by 2030², and in the U.S., we are working towards that goal through a national plan led by federal, academic, clinic, and community partners. We have the tools to eliminate hepatitis B in the U.S. – a preventive vaccine, a robust program to prevent mother to child transmission, and antiviral therapies that can control the virus and prevent liver cancer. The United States Preventive Services Task Force (USPSTF) and the CDC have clear guidelines for testing and vaccinating high-risk individuals. However, we are not seeing the increases in diagnosis or decreases in chronic hepatitis B infection that we should. In Philadelphia, with a high prevalence of hepatitis B infection and low diagnosis rates, there is much work to be done to eliminate hepatitis B.



Recently, PDPH was awarded a grant from the Office of Minority Health to execute a hepatitis B elimination demonstration project in the city of Philadelphia. The project, named HBV PreVNTT (Hepatitis B Virus Infection Prevention, Vaccination, Navigation, Testing, and Treatment), will improve citywide infrastructure to reduce transmission, deaths attributed to hepatitis B, and related health disparities of those experiencing hepatitis B. Over the next three years, PDPH and its project partners will initiate multiple activities at health systems, clinics, and among high-risk communities to increase testing and vaccination, and improve linkage to care and treatment availability for infected individuals. Activities will include culturally and linguistically competent community-based education and screening; provider-based education; harm reduction approaches; working with clinics, providers and health systems to conduct continuous quality improvement processes to increase appropriate hepatitis B vaccination, testing, care and treatment; and using local surveillance data to identify out of care individuals and perinatal HBV mothers to improve care services.

As we begin this three-year project in the fall of 2019, we look forward to partnering with medical providers throughout Philadelphia, to identify strategies and best practices for identifying and managing infected individuals and vaccinating high-risk adults, and to help us improve the capacity throughout the city of Philadelphia to eliminate hepatitis B. Together, we can save the lives of thousands of Philadelphians. If you are interested in learning more about this project and how you can participate, please contact Danica Kuncio (Danica.Kuncio@phila.gov) at PDPH or Catherine Freeland (Catherine.Freeland@hepb.org) at Hepatitis B Foundation. •

¹. Centers for Disease Control and Prevention. (2018). *Viral hepatitis surveillance, United States, 2016*.

². *Global Hepatitis Report 2017*. Geneva: World Health Organization; 2017.

If you are interested in learning more about this project and how you can participate, please contact Danica Kuncio (Danica.Kuncio@phila.gov) at PDPH or Catherine Freeland (Catherine.Freeland@hepb.org) at Hepatitis B Foundation.

CURE and EPILEPSY

By: Sabrina Andrews, Director of Operations, Cure Pennsylvania

In May the Epilepsy Foundation of Eastern Pennsylvania hosted its annual Lancaster Epilepsy Education Exchange, which included information about medical cannabis. In attendance was Paul Gockley, Registered Pharmacist and Compliance Director at Cure dispensary in Lancaster, who shared some highlights from the event. “Dr. Heather D. Harle (MD, Neurologist at Penn Medicine at Lancaster General Health Physicians) presented on the history of cannabis in medicine, the lack of access to quality research at this time, and how important patient-physician communication is when considering, or continuing, to use medical cannabis.” Attendees also got to learn from Dr. Claire Flaherty, PhD, Neuropsychologist of Penn State Hershey Medical Center. “Dr. Flaherty researches epilepsy and highlighted stress reduction as a tool to decrease the frequency and severity of seizures which medical cannabis may offer with benefits like improved sleep or lowered anxiety,” explained Gockley. Since the conference, Gockley and some of his fellow pharmacists at Cure provided information that prospective and new medical cannabis patients with epileptic conditions may find helpful.



and review quality research, communicate with their physicians, and consult the medical professionals available, by law, at Pennsylvania (PA) medical cannabis dispensaries.

The long-term effects of medical cannabis are unknown and there is a paucity of high quality clinical trials proving its therapeutic value. Medical cannabis may worsen symptoms in some patients. Brain development for adolescent users may be affected. There is potential for addiction or abuse by patients.

Patients should use extreme caution administering medical cannabis products to terminate acute episodes of seizures; an often overlooked risk of using medical cannabis to treat seizures is lack of consistent access or supply. If hospitalized, a patient may not have access to medical cannabis.

If there are such potential risks and perhaps no benefit in certain patients, why would anyone try medical cannabis for epileptic conditions? Despite the lack of evidence-based science, success stories shared by medical cannabis patients at Cure and in literature have included reports of reduced number of monthly seizure activity. One Cure caregiver has reported that RSO (Rick Simpson Oil) has been beneficial as a rescue therapy for their pediatric patient with epileptic conditions. Patients may use medical cannabis for a variety of reasons, but the most common goals of those with epileptic conditions are to decrease the frequency and severity of seizures, reduce the need for traditional anti-epileptic medications, shorten recovery time and improve mood and sleep.

To establish the utility of medical cannabis for prevention or treatment of seizures in any patient population, especially children, more data and research is needed. Cannabis remains a Schedule I substance federally, therefore patients and caregivers should utilize state programs, such as the PA Medical Marijuana Program, which has regulatory standards in place for production and testing. Only registered patients and caretakers with a certified physician's recommendation may purchase medical cannabis in the state of PA. For information on how to get a patient card or become a caregiver of a patient, visit the Pennsylvania Department of Health's website. •

Common questions patients and caregivers ask about using medical cannabis for treating epileptic conditions include:

1. What are the starting doses and what forms are best?
2. Does cannabis affect cognitive development or learning?
3. Does it have addictive properties?
4. Will it have negative impacts on memory?
5. Can medical cannabis interact with prescription medications?
6. What are the side effects of medical cannabis?
7. How much do medical cannabis products cost?

All of the above are valid questions. Therefore, patients and caregivers need to advocate for themselves (or for their patients)

MEMBER NEWS: ENRIQUE HERNANDEZ, MD, FACOG, FACS, FCPP



Enrique Hernandez, MD, FACOG, FACS, FCPP, is among a group of 83 esteemed surgical educators inducted into membership in the American College of Surgeons (ACS) Academy of Master Surgeon Educators™. The Academy's second induction ceremony occurred on October 4, 2019 at the John B. Murphy Memorial auditorium in Chicago.

Academy membership is conferred in three categories, Member, Associate Member, and Affiliate Member. Dr. Hernandez was inducted as a member of this prestigious academy. He is the Abraham Professor and chairman of the Department of Obstetrics, Gynecology and Reproductive Sciences at the Lewis Katz School of Medicine at Temple University. •

Enrique Hernandez, MD, FACOG, FACS

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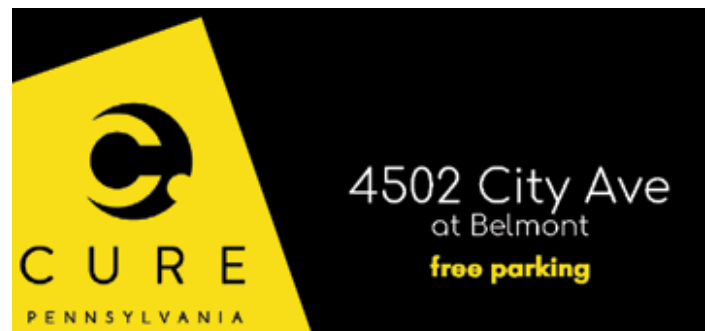
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No More Tuesdays at Hahnemann: The Painful Process of Closing a Surgery Department

By: David E. Stein, MD, Professor and Chair of Surgery, Director of Operations,
Department of Ophthalmology



Closing a department is like nothing I have ever experienced in my life. The sense of loss is palpable everywhere, it is inescapable. It is so pervasive I need to walk out and catch my breath numerous times throughout the day, as I find staying in my office suffocating. As a leader of physicians, staff and residents, I have always strived to keep an even emotional keel. You want to be calm, reassuring and encourage resilience among your team. Of course, there are times it becomes impossible to maintain composure, especially when something hits you so incredibly hard. The last time I cried at work was when my friend and colleague Dr. Andres Castellanos was diagnosed with a terminal illness, and I had to break the news to our department. When we experience tragedy, we often understand how the tragedy occurred, but we still struggle with why it occurred. In the case of our closure, I understand both how and why it occurred.

Drexel University College of Medicine's Department of Surgery was built on the legacy of the Hahnemann Medical College and the Women's Medical College of Pennsylvania, which was renamed Medical College of Pennsylvania. In fact, I serve as the endowed Alma Dea Morani chair of surgery. She graduated from the Women's Medical College in 1931, completed a surgical residency there in 1935 and rose to prominence as the first female plastic surgeon in America. Hahnemann was known for many Philadelphia firsts, from performing the area's first kidney transplant, to founding the first Level One Trauma Center with the first helicopter MedEvac services and more recently being the first hospital in the region to offer organ transplants from HIV positive donors to HIV positive recipients via the HIV Organ Policy Equity (HOPE) Act. Yet none of the storied history actually mattered.

If I offered you an opportunity to invest in a free-standing for-profit academic medical center, with no feeder hospitals or regional referral base, that needed extensive capital investment, that cared for the sickest and poorest patients of the city and had been losing money for years, would you actually invest? Would you even think about it? Would you expect a return on your investment? Is the not-for-profit world any different?

Sister Irene Kraus, a nurse who tended the sick, got an MBA and eventually became the first president of the Daughters of Charity Health System, is credited with coining the expression “no margin, no mission.” The bottom line is if you cannot cover your expenses and pay your staff, no matter how noble the cause, you will eventually close your doors. According to the American Hospital Association, there were 6,210 hospitals in the United States in 2017. How many will there be in 2020? Numerous articles have been written about the finances of the U.S. health care system, and until the financial issues are solved, we can expect more hospital closures in the future.

The closure of Hahnemann University Hospital impacted the training of over 500 residents, 2,500 employees and countless patients. Due to the closure, Drexel University College of Medicine gave notices of termination to all of their clinical faculty shortly afterwards, impacting almost a thousand employees, including physicians, nurses and staff. All told, the closure of Hahnemann and Drexel University Physicians is a devastating tragedy for Philadelphia health care, negatively impacting over 5,000 people and thousands of patients. Many of these patients have Medicaid insurance products that are not accepted at other Philadelphia hospitals, affecting their ability to seek care elsewhere. These patients have a profound understanding of what has occurred.

Ms. S is a 56-year-old woman who we first saw in our office for gastrointestinal symptoms. She hated doctors but trusted her nurse practitioner who referred her to us. She was HIV positive, had behavioral health issues and felt a mass. She was so anxious the first time we met she cried throughout the visit, and we encouraged her to come back again just to talk. Getting her to relax so we could do a thorough examination took us about 20 minutes. We eventually succeeded, biopsied the mass and diagnosed her with cancer. She underwent treatment and has been disease free for the past four years. She routinely comes in for her follow up appointments, and although there has been less crying, there is always some anxiety around the visit and we have to coax her for an exam to ensure no recurrent cancer.

She came in last week crying hysterically, and we were concerned that she felt a new mass. She told us that now she was going to die, because very few practices in the city take her insurance, and even if she finds a practice that does, no one will have the patience to put up with her like we do. She then said, “They just take, take, take and take, and we got no more to give.” It was the first time I cried at work since Andres died.

Continued on next page >

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As physicians, we strive to be empathetic with all of our patients and their family members. Empathy, defined as the ability to understand and share the feelings of another, is incredibly important and allows us to establish a rapport with a patient. As a colorectal surgeon this is incredibly important, because let's face it, no one actually wants to see a colorectal surgeon when they are a patient. That rapport allows my patients to trust me, and then we can go through the treatments required as a team, whether it is a cancer diagnosis, Crohn's Disease or even a simple hemorrhoid.

That team mindset extends beyond the doctor-patient relationship, it also encompasses our departmental staff. Letters informing our patients that Drexel Surgery is closing went out earlier this month. Patients have been calling and trying to comfort our patient navigators and administrative support teams. In addition to chatting with them, it is not uncommon for me to receive the following message from my staff, "Mr. X called. He wants to talk to you to wish you the best and thank you himself for all that you have done for him. He said you are not just his doctor, but his friend. OMG I'm going to cry."

Our department's administrative leadership team is an incredible group of highly intelligent, industrious and motivated people. They embody our departmental values of integrity, transparency and ownership and live by our guiding principle of "Excellence in Serving our Patients and our People." Their ability to engage with everyone and understand what is occurring on the front lines, and then develop sustainable solutions, has been incredible to watch. Their drive and energy to make all of us better was contagious, and allowed the department to fire on all cylinders. It has been a privilege

to work with them, to problem solve together and strategize how to continuously improve, to never be complacent.

How strange is it that I now feel guilty for recruiting them. Their energy and drive have been replaced by despondence. They are all staying to the very end, and will serve as a skeleton crew to ensure that every aspect of the department's closure is handled perfectly, whether it is finalizing the disposition of all medical records and personnel files, decommissioning equipment or closing out business accounts. They have passed on job offers because it would have been wrong to leave these tasks to someone else. It is who they are. There is a profound sense of loss among each one of us, and a concern that this kind of team chemistry may not be replicable in whatever new positions we find.

My Tuesday office hours routine that started in 2003 has now come to an end. For the last 16 years I saw patients in our office every Tuesday from 9 am to 5 pm. I have seen over 3,000 patients over just the past few years and thousands more over the prior decade. I have seen colleagues and staff, hospital leaders, university presidents, deans and fellow chairs come and go. Yet the constant throughout was my Tuesday clinic, a day I loved to hate. Hated it because of all the paperwork and electronic health record charting the day and subsequent night required. Loved it because I met so many new fantastic people. Loved it because I had the opportunity to improve a patient's quality of life or cure them of disease. Loved it because I was able to bond with the surgical residents, medical students and staff. Now it's all gone forever, and on that last Tuesday, I cried for the last time at Drexel. •

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IF YOU'RE THINKING ABOUT RETIREMENT, Here are a few Things to Consider

By: Mark Austerberry, PCMS Executive Director

The average age of active licensed doctors is 51. In a 2017 survey of physicians age 50 and older by health care staffing firm CompHealth, respondents, on average, said they intend to retire at age 68. By comparison, the average retirement age for all Americans is 63.

Physicians contemplating this step in their careers have a number of things to consider -- like what to do about your medical license, medical malpractice insurance, and medical records. And, even though these issues may be the tip of the iceberg (and maybe not even high on your list of priorities) when it comes to the many retirement issues you will need to think about, they are definitely still worth your time and attention.

Medical License and Retirement

Retiring Pennsylvania physicians have a few things to figure out regarding your medical license to practice. Below are options available. Each option has its own conditions and requirements.

Keep an Active Medical License: You may decide that you want to keep your Pennsylvania license active after you retire. Why? The reasons why physicians choose this option are myriad. But, from what I've learned through conversations with physicians taking this step, some believe that they might return to practice at some point in time and do not want to go through the "hassle" of meeting the requirements to reactivate their license. Others, although technically "retired" from their day-to-day practice, plan to (eventually) consult or moonlight at their convenience.

If you decide to keep your active license, you must meet all of the current licensure requirements:

- Complete the biennial application and pay required fee to maintain your license
- Meet continuing medical education (CME) requirement
- Fulfill mandatory child abuse recognition and reporting training, as a condition of license renewal
- Maintain medical professional liability insurance, including participation in Mcare

If you want to keep your active license, but will not practice at all, you may qualify for an exemption from the state's medical professional liability insurance requirements. To confirm your exemption from the malpractice requirement, complete the Mcare Declaration of Compliance form at www.insurance.pa.gov/mcare.

Instructions for completing the form are available. You may also contact Mcare by phone to request this information (717) 783-3770, Ext. 280.

1. Get an Active-Retired Medical License: Pennsylvania physicians can also apply for an active-retired license. With an active-retired license physicians are only allowed to write prescriptions for themselves and immediate family members who live with them.

Physicians with an active-retired license are required to do all of the following:

- Complete the biennial application and submit the required fee to maintain the active-retired license
- Fulfill the mandatory child abuse recognition and reporting training, as a condition of license renewal.

Active-retired physicians are not required to have medical professional liability insurance, participate in Mcare, or meet 100 credit CME requirement.

Go to inactive status: Total retirement means you are no longer licensed to practice medicine in the state. You do not have to:

- Complete the biennial application and required fee to maintain your license
- Complete the CME requirements
- Complete the mandatory child abuse recognition and reporting training
- Maintain medical professional liability insurance or participate in Mcare

Medical Malpractice Insurance—Tail Coverage

Whether or not you maintain medical malpractice insurance depends on your license status.

Pennsylvania requires tail coverage for physicians who cancel their claims-made coverage. The tail covers losses and expenses occurring during a claims-made coverage period. The one-time fee paid for the tail coverage would protect the physician indefinitely for any claim made after the cancellation, termination, or non-renewal of the claims-made coverage in Pennsylvania.

Your malpractice carrier is required to offer tail coverage upon cancellation, termination, or non-renewal of claims-made coverage. Physicians must purchase tail coverage to be in compliance with state law, but they are not required to purchase it from their current malpractice insurance provider. You can shop around for alternative malpractice carriers. You should contact your medical malpractice provider or broker for additional details.

Medical Records – Now What

Medical records must be retained in compliance with Pennsylvania law regardless of whether the physician who created the records retires, passes away, or closes their practice.

In Pennsylvania, physicians must retain an adult patient's medical records for at least seven years from the last date of service. Requirements differ slightly for minor patients. The State Board of Medicine requires MDs to retain a minor patient's medical records for at least seven years after the last date of service or one year after the patient's 18th birthday, whichever is longer.

The State Board of Osteopathic Medicine requires DOs to retain a minor patient's medical records for at least seven years after the last date of service or two years after the patient's 18th birthday, again whichever is longer.

The physician or practice that maintains the medical records is generally considered the owner of the records. However, in a hospital setting, a patient's medical records are owned by the hospital. Nevertheless, although patients do not own their medical records per se, patients do have a right to view and copy their records at their request.

So what should I do about retiring now?

Written notice of your impending retirement should be provided to all of your patients. This notice should include the date of your retirement and information on how patients can obtain copies of their medical records or authorize transfer of their records to a new physician.

If you are part of a group practice, the group may retain your records. However, the practice must provide patients with copies of their records or have records transferred to a patient's newly chosen physician upon a patient's request for such.

If you were a solo practitioner, you may choose to safely store the records themselves. However, if you sold your practice or patient records will be stored by another practice, hospital, or other custodian, this information should also be provided to patients. Patients must be informed on the location of their records, and how they can access them.

As always, if you have questions about any of the information, please reach out to PCMS staff at 215-563-5343. •

A Physician Wedding – Surviving and Thriving in its Midst

By: Susan Shelly

Among the 25,000 or so weddings that take place in Philadelphia every year are a number that celebrate the nuptials of a physician or member of a physician's family.

And, while weddings involving doctors vary dramatically depending on style, venue, type of service and so forth, we wondered if there were common denominators that set physicians' weddings apart from others.

Philadelphia Medicine decided to take a look at factors affecting these weddings. We wanted to know how they might be different from other weddings, and if so, how. We wanted to find out if weddings involving physicians tend to be current and trendy, or if they lean toward traditional.

And, we wanted to understand particular challenges that may pop up while juggling a busy medical career with the job of thinking about and planning for a wedding.

To learn those things and more, we went to the pros – wedding planners who have worked with doctors and doctors' families to plan memorable weddings, while helping to keep everyone sane along the way.

Finding time to plan

Practicing physicians normally spend long days in hospitals or offices, and evenings can be consumed with catching up with email, messages from patients and colleagues and other work. Planning for a wedding – even thinking about planning for a wedding – can seem overwhelming, particularly if you don't even live near the wedding venue.

Nancy Ellen, owner of Montgomery County-based Can Do Events, was preparing to step in as coordinator on the day of an upcoming physician's wedding in Center City when we caught up with her for an interview.

The groom, she explained, is a plastic surgeon in California, and his fiancée an attorney in the same state. While they had located vendors, they were not in a position to deal with the plans as they evolved.

Ellen was hired by the mother of the groom to manage late-stage details of the event and coordinate activities on the day of the wedding.

"They were looking for someone to pull it altogether in the last six to eight weeks and be present on the day of," Ellen said. "It was tricky because of the bride's and groom's schedules and working East Coast/West Coast, but we did a lot of emails and videoconferencing and we made it work."

While many people dream of planning every detail of their own wedding, for others it's simply not a practical goal and the task of planning the event becomes frustrating and overwhelming.

Finding time to plan can be equally, or even more, difficult for medical students and residents. If there's any way you can manage it financially, it may be well worth your time and money to hire some help, advised Amy Jones, owner of Philadelphia-based Amy Champagne Events.

"Trying to manage and handle all the details of an event with multiple vendors when you already have an extremely demanding schedule could take the enjoyment out of the process and the event," Jones said. "As the wedding approaches, it's important for the couple to use their down time doing things they enjoy instead of being consumed with a multitude of wedding tasks."

The different flavors of wedding planners

There are many types of wedding planners, from full service to someone who steps in to help on the day of the event. There are planners and designers and event stylists and coordinators. Here's a rundown:

- **Full service.** A full-service planner is with you from the very beginning until the wedding is a memory. The planner can help you draft a budget; find a venue, come up with a timeline; and recommend, hire, and manage vendors. He or she will be on site the day of the wedding to assure that everything goes smoothly.
- **Partial planner.** This is someone who takes some aspects of planning off of your plate, but is not responsible for handling all aspects of the wedding plans. For instance, a partial planner might identify and negotiate with vendors who meet your needs, but not be responsible for site planning, menus or day-of management.
- **Day-of planner.** Also called a wedding day manager, this type of planner understands your vision of exactly what you want the wedding to look like and how it should proceed, and



works on the day of the event to make sure that happens.

- **Month-of coordinator.** A month-of coordinator works with you for a prescribed amount of time, typically for four to eight weeks before the wedding. So, you'd find and negotiate with vendors, locate a venue, plan a menu and so forth, leaving the coordinator to step in and handle any last-minute problems or overlooked details that pop up close to the wedding day. The coordinator also would be on hand the day of the wedding.

- **Event manager.** An event manager also typically comes on board later in the planning process to do things like review final contracts with vendors, schedule and run a final venue walk through, take care of last minute details and manage the rehearsal, wedding day and any other wedding events.

- **Stylist.** Some people hire a stylist in addition to a planner. A stylist pays attention to every detail of the event, focusing on design and visuals and making sure that everything is perfect.

Merida Alexander, owner of Philadelphia-area Events by Merida, urged those planning a wedding to at least hire a day-of-planner to manage details on the day of the wedding.

“Even if you don't need a full-service planner, please have a day-of coordinator so you and your family can be present and have fun on your wedding day,” Alexander said. “They'll help you take care of all the little details and help you when things go wrong. Remember that you don't get a do-over.”

Planning a wedding on a budget

Planning a big, fancy wedding can be exciting and great fun, but not if you're stressed out about every dollar you're spending and not sure how you'll pay your rent, much less come up with money for a dress, flowers and all the other wedding essentials.

It's no secret that medical school is expensive, and many students, residents and young doctors have very significant student debt.

With the average cost of a wedding at more than \$35,000 you need to decide what makes sense for you and what you can afford. Don't be pressured into spending more than is reasonable for you. It will only prove to be stressful and put you even further into debt.

Thein Tun Aung, a physician with ties to the Philadelphia area who now practices in Ohio, hired Sharon Pellechia, owner



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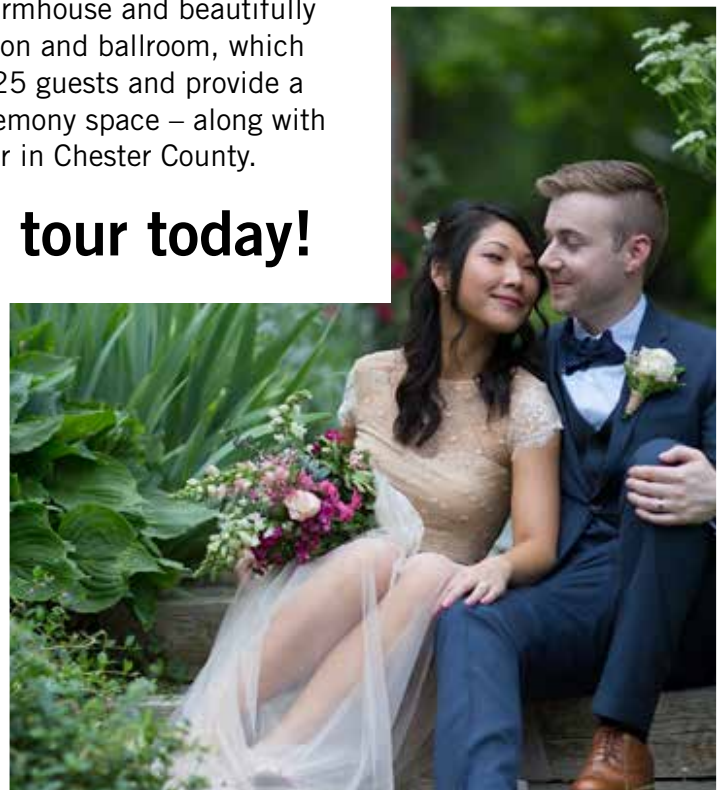


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MANAGING WORK/LIFE BALANCE

A Physician Wedding – Surviving and Thriving in its Midst *continued from page 33*

of the Lehigh Valley-based An Affair to Remember by Sharon, to plan his 2017 wedding to his wife, Swe Zin Mar Win Htut Oo.

While he was at first reluctant to pay Pellechia's fees, he feels they actually spent less with her help than they would have on their own.

"If you try to manage everything yourself, you can easily be overcharged," he said. "By having a wedding planner, you can control your budget better."

Having said that, however, as long as you're going to be spending money, look for a credit card with a great rewards incentive and charge all your wedding expenses to it to reap the benefits. Just be sure you know how you're going to pay the bill when it comes due.

Destination weddings

About 25 percent of all U.S. weddings these days are destination weddings, and they bring with them a whole other set of opportunities and challenges.

A new subset of wedding planner is the destination planner, who scouts out locations and venues in far-flung locations when you're not able to do so. He or she also can help guests with travel plans, identify activities near the wedding site, arrange for vendors and assist guests with any cultural or practical matters that might arise.

Picking a date

There's more than the weather to consider when picking a wedding date. Doctors may also have to work around work schedules, the needs of colleagues and other practicalities. Medical students and residents need to consider class schedules, exams and rotations, among other things.

Also, keep in mind that your wedding might not be the only game in town on the date that you choose.

Sure, a spring wedding at the posh Stotesbury Mansion on Walnut Street sounds lovely, but wait . . . Remember that the Broad Street Run that attracts more than 40,000 runners and tens of thousands of onlookers to the city, and the Rittenhouse Row Spring Festival that brings more than 50,000 to Rittenhouse Square are both held in May.

If your event is in Center City, do you really want it to be on a weekend when the Eagles are playing at home?

Consider any pre-scheduled, large events, and don't forget about holidays that might make it difficult for guests to attend or make the cost of travel and lodging more expensive.

Factoring in diversity

Physicians practicing in the U.S. tend to be a pretty diverse group, and many guest lists include relatives and friends who will be traveling not just from another town or state, but another country.

This can be a factor when considering wedding venues, guest

accommodations and transportation, advised Pellechia, who planned the wedding for Thein Tun Aung and his wife in Newark, New Jersey.

The venue, located near major airports, made it easier for international guests, and assured that there were plenty of hotels and restaurants nearby, Pellechia said.

Establishing a Guest List

Your wedding budget really will dictate the number of guests you'll have, as about half of total wedding costs typically go toward food and drink for guests.

According to tripsavvy.com's Wedding Statistics and Honeymoon Facts & Figures, the average number of wedding guests is 136, with a per-guest cost of \$268. If you do the math, that comes to \$36,448.

Jones said most physician weddings are medium-sized affairs. They often have a higher-than-average decline rate, she said, due to the fact that invited guests tend to include other physicians with complicated schedules.

Choosing a Venue

Philadelphia and the surrounding area are rich with a variety of wedding venues. There are those with great historical significance, such as The College of Physicians in center city, restored neighborhood industrial sites like Moulin in East Falls, beautiful country locations similar to The Farmhouse at Peoples Light, and museums, hotels or country club sites – or you could go "down the shore" and get married by the ocean.

Philly weddings even include events in sports venues such as Citizen's Bank Park or Lincoln Financial Field!

A top venue choice for doctors is the beautiful and historic College of Physicians of Philadelphia's 22nd Street building, which was designated as a National Historic Landmark in 2002. Founded in 1787, the College of Physicians is one of the oldest professional medical societies in the United States.

While the College continues to work toward its original mission of advancing the cause of health and upholding the ideals and heritage of medicine, it also provides a special place for anyone, but perhaps especially doctors, to be married.

Every year, about 30 physician couples of all backgrounds from the Delaware Valley exchange their vows at the College.

Susan Norcross, owner and wedding director of The Styled Bride, Philadelphia, explained that while venues for physician weddings vary, she notices a trend toward locations that have the capacity to accommodate various events.

"Doctors might gravitate toward an upscale hotel that can host the rehearsal dinner, welcome drinks and brunch all in one location," Norcross said. "Many of them don't have a lot of time, so it's nice to have everyone in one place for the weekend." •

MANAGING WORK/LIFE BALANCE

PCMS BOARD MEMBER DR. DANE SCANTLING *Gets Married*

When and Where did you both meet?

My wife, Izzy, and I met in Western Massachusetts while we were still students more than 10 years ago. I saw her in a diner and asked for her phone number out of the blue. A few weeks later we went on our first date and have been together ever since. I worked as a paramedic and firefighter before moving to Philadelphia for medical school at Philadelphia College of Podiatric Medicine (PCOM) in 2014. Izzy followed shortly thereafter to work at Chase in Wilmington, Delaware, where she's been ever since.



Did you have a wedding planner?

Izzy did the vast majority of the planning, but worked with Kelly Soule of Kelly Elizabeth events for the last month.

Where did you buy your engagement and wedding rings?

Her ring was a family ring that was re-made with the help of Bernie Robbins Jewelers in Marlton, NJ. My ring was purchased from Bernie Robbins.

Where did you pop the big question?

I proposed on the roof of a riad near the Atlas Mountains in Fez, Morocco, while on the way to Valencia, Spain to present research at a conference.



Where did you buy the wedding dress, tuxedo and shoes?

Izzy found her dress at the Sample Rack in Philadelphia and her shoes at Bloomingdales. My tuxedo was from Bloomingdales in King of Prussia as well.

Where did you have the wedding and reception if different?

The reception and wedding both took place at a family cabin in Chilmark on Martha's Vineyard, Massachusetts. The cabin is an old fishing hut that has been moved back from the eroding cliff edge three times and overlooks Stonewall Beach. The ceremony itself was up on the edge of the cliff overlooking the ocean, the dinner was by the house and the dancing and after-party were in a heated tent on the bluff.

Who was the photographer/videographer?

We hired Imani Dixon. It was a wonderful experience!

Who did your flowers?

Romy Moser was our florist. She also happens to be Izzy's aunt. She did an excellent job. romymoserfloraldes6.wixsite.com/website



How was Philadelphia a part of your special day?

I'm a surgical resident in Philadelphia, and Izzy and I have both been Philadelphians for about nine years, so our Philly friends joined us and had active roles in the wedding. Several of our friends joined us at the cabin for the week leading up to the event. Bobby Kucejko and Matthew Pontell (both surgical residents with me at Drexel University College of Medicine) were our DJs. •



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