PHYSICIAN'S WEEKLY
PRIMARY CARE
Vol. XV • Issue No. 1 • January 2021
WWW.PHYSICIANSWEEKLY.COM

MEDPAGE TODAY'S
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Be an Upstander, Not a Bystander

By Aasna Shaukat, MD, MPH

I am a female immigrant gastroenterologist from Pakistan, practicing in Minneapolis. Having lived in this country for 22 years and married to a white man, I generally feel that I fit in pretty well. A couple weeks ago at work, I walked into a procedure room and introduced myself to a 66-year-old white male on whom I was about to perform a procedure. There were three other people in the room—a nurse and two techs. I explained the procedure in my usual cheerful voice and asked, "Do you have any questions?" like I always do at the consent process.

The patient said, "Yes, I do. Where's your burqa?" I was quite taken aback and wondered if I misheard.

Me: "I'm sorry. What did you say?"

Patient: "I said, where's your burqa?"

Me, confused: "Sir, why would I have a burqa?"

Patient: "Don't women like you wear one to cover themselves?"

Me (more confused): "What do you mean women like me?"

Patient: "Well, aren't you from Pakistan or Afghanistan? Aren't you Muslim?" I was at a loss for words and desperately wanted to end the conversation."

Me: "Let's not talk about me but about your procedure. Any questions about the procedure?"

The patient replied, "no," and we went ahead with the procedure and the rest of the day.

The incident bothered me all day and the following many days. I couldn't quite put a finger on what it was and brushed it aside and stopped thinking about it. In the wake of recent events, it dawned upon me that it wasn't the patient's comments that bothered me. It was the fact that no one standing in the room witnessing the conversation stepped in. Not during the conversation, and not after. Considering I've worked with my colleagues every day and in the same place for the last 12 years, I felt strangely betrayed.

Stories like this happen every day and are sadly more common than we realize. There will always be racist, insensitive, inappropriate comments by people across life. It's how we react to them that will shape our lives. Most individuals have asked how they can help. Well, start by being an upstander and not a bystander. That will mean the world to us people of color and immigrants.

And let's start teaching and training students in medical school, nursing, and technical schools how to identify and stand up to inappropriate comments. It may take us a few generations to make seismic changes, but we must start now.

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The Influence of Parental Marijuana Use on Children

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Data suggest that the ascendancy of medicalization, legalization, and social acceptability of marijuana has resulted in an overall rise of past-year marijuana use from 11.0% (25.8 million) in 2002 to 15.9% (43.5 million) in 2018 among the US population aged 12 or older. Paralleling these trends is mounting apprehension of the health consequences of marijuana, especially among adolescents. Evidence indicates that early versus later initiation of marijuana use is associated with higher rates of addiction, impaired cognition, pre-clinical or clinical symptoms of psychosis, schizophrenia, depression, suicidality, and reduced educational achievement or employment status. With peak marijuana use found to be among adults of child-bearing and -rearing ages, parental use conceivably poses a direct environmental risk of normalizing marijuana use and enabling easy access to marijuana for children living at home.

For a study published in *JAMA Network Open,* my colleagues (B. Han, W. Compton, C. Jones, E. Lopez, E. McCance-Katz) and I sought to determine whether intergenerational associations are detectable within specific substances, across substances, and across a broad age range of offspring (aged 12-30 years) living in the same household as a parent using marijuana. Most importantly, we simultaneously examined associations between parental marijuana use at detailed frequency levels and adolescent and young adult offspring substance use.

Parental Influence

We used repeated cross-sectional survey data on adolescents or young adults living with a parent (mother or father) from the nationally representative 2015-2018 National Surveys on Drug Use and Health. More than 24,000 father-offspring or mother-offspring dyads were sampled. Parental marijuana use status was compared with offspring's marijuana, alcohol, and tobacco use and opioid misuse.

We found substantial past-year marijuana use of 7.6% to 9.6% (Table) among mothers or fathers living with offspring. Parental past-year marijuana use was consistently associated with increased unadjusted prevalence of past-year marijuana, tobacco, and alcohol use and opioid misuse among both adolescent and young adult offspring. Even among parents with lifetime but no past-year marijuana use or relatively less frequent use (<52 days in the past year), unadjusted prevalence of past-year substance use among offspring was generally elevated.

Multivariable models adjusting for potential confounders related to offspring, familial, and environmental factors suggested that parental marijuana use was a specific risk factor for marijuana and tobacco use by both adolescent and young adult offspring, as well as for alcohol use by adolescent offspring.

Adolescent offspring's substance use appeared to be particularly associated with mother's marijuana use status. Our study indicates that a mother's marijuana use status could have a pivotal role in the development of her adolescent offspring. Environmentally mediated normalization of substance use and increased access to substances at home are possible explanations. Regardless of mechanisms, providers and parents alike should be aware of the significant influence of parenting, parental marijuana use, and the poor prognosis of early marijuana initiators.

Protecting Children

Given the poor prognosis of substance use disorders for long-term outcomes, direct and indirect screening of family members and counseling for marijuana use in pediatric and general medical settings is an important and achievable goal. A positive screen should trigger counseling of parents on risks posed by using and storing marijuana, tobacco, or opioids at home, educating parents on risk and protective factors, and offering reassurances that substance use is modifiable.

Future research should focus on the feasibility of pediatrician and other primary care physicians performing screening for substance use of parents and offspring living in the same households, and whether screening alone or combined with counseling alters parental substance use.

Table Past-Year Substance Use by Parental Marijuana Use Status

Parental Marijuana Use Status	Marijuana Use, Past y	Heroin Use or Rx Opioid Misuse, Past y	Tobacco Use, Past y	Alcohol Use, Past y
Offspring aged 12-17 who lived with a parent born 1955-1984				
Mother				
Never use	8.4%	2.5%	6.1%	16.1%
LT use, not in past year	15.6%	4.0%	11.8%	25.8%
<52 days use in past year	21.3%	6.7%	12.5%	28.4%
≥52 days use in past year	21.2%	5.0%	13.7%	25.4%
Father				
Never use	6.8%	1.7%	5.5%	15.1%
LT use, not in past year	13.3%	3.2%	11.6%	23.6%
<52 days use in past year	25.1%	6.1%	9.8%	34.2%
≥52 days use in past year	17.5%	4.0%	15.7%	25.0%

Parental Marijuana Use Status	Marijuana Use, Past y	Heroin Use or Rx Opioid Misuse, Past y	Tobacco Use, Past y	Binge Alcohol Use, Past mo.
Offspring aged 18-30 who lived with a parent born 1955-1980				
Mother				
Never use	22.7%	5.8%	29.2%	30.3%
LT use, not in past year	41.2%	9.4%	43.6%	36.7%
<52 days use in past year	50.5%	12.9%	43.2%	48.8%
≥52 days use in past year	61.2%	20.2%	50.2%	37.1%
Father				
Never use	21.1%	4.8%	27.7%	27.8%
LT use, not in past year	32.7%	7.6%	39.5%	43.4%
<52 days use in past year	41.9%	9.2%	51.4%	47.2%
≥52 days use in past year	58.9%	10.5%	51.1%	27.8%

Abbreviations: LT, lifetime; mo, month; y, year.

Source: Adapted from: Madras B, et al. *JAMA Netw Open.*

Dealing With Non-Compliant Patients: Avoiding Liability

The first step in avoiding liability due to patient non-compliance is identifying that the patient actually is non-compliant. Then, ask about the reason for it and do what you can to counter it. Your record must reflect your attempt to determine what correctable issues underlie the non-compliance and what steps you took to counter it. If non-compliance is not solvable as a single issue and verbal reminders are not fruitful, you can consider a treatment contract, which breaks the compliance into specific acts of patient cooperation that may be easier to follow. Your last option is an "at risk" letter that states the specific non-compliant acts and their clinical consequences. This can include the warning that a failure to correct the non-compliance will result in termination from the practice. You should not create a "decline" note in which the patient signs their refusal to comply. You would be retaining the patient in your practice despite being unable to treat them as you believe is proper.

Your records need to demonstrate that the patient is being non-compliant rather than just being ill-informed. Descriptions of the patient's non-compliant conduct should state the fact of the non-compliance undeniably but without condemnatory or self-serving language. But it should not be so removed as to become meaningless in convincing a reviewer that you are not an appropriate target or in closing off patient claims that you never said something you actually did.

When the therapeutic relationship is irrevocably broken down and it is necessary for you to step away because the patient is actually preventing you from practicing medicine properly, you will have to terminate them from your practice. You will then have to consider abandonment. If you are going to take the maximum step against someone who is already in opposition to you, do so carefully. Non-compliance leading to no option but termination is a gradual process by definition and so an evaluator will want to see that it was handled that way.

You should also consider stating the reason for the termination in a letter. The general rule is to not give a specific reason, but here stating *"As we have discussed, and as outlined in the treatment contract that you agreed to, it was essential that you follow through on prescribed care. Due to your continued refusal to follow treatment guidelines, this practice will no longer be able to retain you as a patient as of (date)"* may stop a retaliatory process before it starts.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.

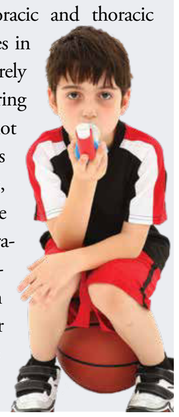
In Case You Missed It

Online Program, Population Health Management Combo Aids Weight Loss

Combining population health management with an online program can aid primary care patients in achieving small, but statistically significant, weight loss at 12 months, according to a study published in the *Journal of the American Medical Association*. Researchers evaluated the effectiveness of an online weight management program plus population health management (298 patients) versus an online program only (216 patients) or usual care (326 patients). Electronic health records were used to measure weight change at 12 months among the primary care participants with overweight or obesity and hypertension or type 2 diabetes. The study team observed significant differences in mean weight change at 12 months: usual care, −1.2 kg; online program only, −1.9 kg; and combined intervention, −3.1 kg. Findings were similar at 18 months for the mean weight change: usual care, −1.9 kg; online only, −1.1 kg; and combined intervention −2.8 kg. "To our knowledge, this is the first study to demonstrate that an online program can be integrated with existing population health management support delivered by nonclinical staff without any specialized training in nutrition or weight counseling and be implemented in routine primary care," the authors write.

Final Diagnosis Often Differs From Referral Diagnosis for EIS

For children with exercise-induced respiratory symptoms (EIS), diagnosis at an outpatient clinic often differs from that proposed by the referring physician, according to a study published in *Pediatric Pulmonology*. Investigators compared the diagnosis proposed by primary care physicians to the final diagnosis from respiratory outpatient clinics where children were referred for EIS. Data were included for 214 children (mean age, 12). The final diagnosis was asthma, extrathoracic dysfunctional breathing (DB), thoracic DB, asthma plus DB, insufficient fitness, chronic cough, and other diagnoses in 54%, 16%, 10%, 11%, 5%, 3%, and 1% of patients, respectively. In 54% of the children, the final diagnosis differed from referral diagnosis. Almost all patients underwent spirometry, body plethysmography, and exhaled nitric oxide measurement; one-third underwent exercise-challenge tests; and none underwent laryngoscopy. Of the children with a final diagnosis of asthma, 91% were prescribed inhaled medication; 505 of those with DB were referred for physical therapy. "Extrathoracic and thoracic DB were common diagnoses in children with EIS but had rarely been suspected by the referring physician and were also not well followed up," the authors write. "Increased awareness, both among primary care physicians and among respiratory specialists of how common DB are in children with EIS, might lead to faster referral to specialized clinics and better treatment."



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