THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

AUGUST 2013

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Minnesota Medical Association

HOW THE "Loss of Chance" Malpractice Ruling AFFECTS YOU

A recent Minnesota Supreme Court ruling could have a profoundly negative impact on your practice. The ruling, called "loss of chance," changes how the courts look at malpractice in the state.

Now, a patient claiming malpractice only has to establish that a physician's negligence made survival or recovery less likely – even if survival is unlikely in the natural course of the disease.

Please plan to join the MMA for this important discussion and learn how you could possibly avoid legal issues in the future.

JOIN US:

Wednesday, Aug. 28, 2013

5:30 pm: Heavy appetizers, cash bar

6 - 8 pm: Program

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Minnesota Medical Association

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*Victoza® 1.2 mg and 1.8 mg when used alone or in combination with OADs.
†**Victoza® is not indicated for the management of obesity, and weight change was a secondary end point in clinical trials.**

VICTOZA®
liraglutide (rDNA origin) injection

Indications and Usage

Victoza® (liraglutide [rDNA origin] injection) is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise.

Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis.

Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

Victoza® has not been studied in combination with prandial insulin.

Important Safety Information

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Do not use in patients with a prior serious hypersensitivity reaction to Victoza® (liraglutide [rDNA origin] injection) or to any of the product components.

Postmarketing reports, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. Consider other antidiabetic therapies in patients with a history of pancreatitis.

When Victoza® is used with an insulin secretagogue (e.g. a sulfonylurea) or insulin serious hypoglycemia can occur. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia.

Renal impairment has been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment.

Serious hypersensitivity reactions (e.g. anaphylaxis and angioedema) have been reported during postmarketing use of Victoza®. If symptoms of hypersensitivity reactions occur, patients must stop taking Victoza® and seek medical advice promptly.

There have been no studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

The most common adverse reactions, reported in ≥5% of patients treated with Victoza® and more commonly than in patients treated with placebo, are headache, nausea, diarrhea, dyspepsia, constipation and anti-liraglutide antibody formation. Immunogenicity-related events, including urticaria, were more common among Victoza®-treated patients (0.8%) than among comparator-treated patients (0.4%) in clinical trials.

Victoza® has not been studied in type 2 diabetes patients below 18 years of age and is not recommended for use in pediatric patients.

There is limited data in patients with renal or hepatic impairment.

Please see brief summary of Prescribing Information on adjacent page.

0513-00015590-1 June 2013

Victoza® (liraglutide [rDNA origin] injection)
Rx Only
BRIEF SUMMARY. Please consult package insert for full prescribing information.

WARNING: RISK OF THYROID C-CELL TUMORS: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors *[see Contraindications and Warnings and Precautions]*.

INDICATIONS AND USAGE: Victoza® is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **Important Limitations of Use:** Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise. Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis. Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings. The concurrent use of Victoza® and prandial insulin has not been studied.

CONTRAINDICATIONS: Do not use in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Do not use in patients with a prior serious hypersensitivity reaction to Victoza® or to any of the product components.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-cell Tumors: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza® will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies. In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza®-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza®-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza® and one non-Victoza®-treated patient developed elevated calcitonin concentrations while on treatment. Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza® clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza®-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza® 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza® 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza®. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza® 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza® 1.2 mg, placebo and active control, respectively. Otherwise, Victoza® did not produce consistent dose-dependent or time-dependent increases in serum calcitonin. Patients with MTC usually have calcitonin values >50 ng/L. In Victoza® clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza®-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza®-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza®. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza®-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza®. The clinical significance of these findings is unknown. Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza®, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation. **Pancreatitis: Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with Victoza®. After initiation of Victoza®, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Victoza® should promptly be discontinued and appropriate management should be initiated. If pancreatitis is confirmed, Victoza® should not be restarted. Consider antidiabetic therapies other than Victoza® in patients with a history of pancreatitis.** In clinical trials of Victoza®, there have been 13 cases of pancreatitis among Victoza®-treated patients and 1 case in a comparator (glimepiride) treated patient (2.7 vs. 0.5 cases per 1000 patient-years). Nine of the 13 cases with Victoza® were reported as acute pancreatitis and four were reported as chronic pancreatitis. In one case in a Victoza®-treated patient, pancreatitis, with necrosis, was observed and led to death; however clinical causality could not be established. Some patients had other risk factors for pancreatitis, such as a history of cholelithiasis or alcohol abuse. **Use with Medications Known to Cause Hypoglycemia:** Patients receiving Victoza® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin **Renal Impairment:** Victoza® has not been found to be directly nephrotoxic in animal studies or clinical trials. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis in Victoza®-treated patients. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or hydration status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including Victoza®. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment. **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with Victoza®. If a hypersensitivity reaction occurs, the patient should discontinue Victoza® and other suspect medications and promptly seek medical advice. Angioedema has also been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to angioedema with Victoza®. **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

ADVERSE REACTIONS: Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety of Victoza® has been evaluated in 8 clinical trials: A double-blind 52-week monotherapy trial compared Victoza® 1.2 mg daily, Victoza® 1.8 mg daily, and glimepiride 8 mg daily; A double-blind 26 week add-on to metformin trial compared Victoza® 0.6 mg once-daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and glimepiride 4 mg once-daily; A double-blind 26 week add-on to glimepiride trial compared Victoza® 0.6 mg daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and rosiglitazone 4 mg once-daily; A 26 week add-on to metformin + glimepiride trial, compared double-blind Victoza® 1.8 mg once-daily, double-blind placebo, and open-label insulin glargine once-daily; A double-blind 26-week add-on to metformin + rosiglitazone trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily and placebo; An open-label 26-week add-on to metformin and/or sulfonylurea trial compared Victoza® 1.8 mg once-daily and exenatide 10 mcg twice-daily; An open-label 26-week add-on to metformin trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, and sitagliptin 100 mg once-daily; An open-label 26-week trial compared insulin detemir as add-on to Victoza® 1.8 mg + metformin to continued treatment with Victoza® + metformin alone. *Withdrawals:* The incidence of withdrawal due to adverse events was 7.8% for Victoza®-treated patients and 3.4% for comparator-treated patients in the five double-blind controlled trials of 26 weeks duration or longer. This difference was driven by withdrawals due to gastrointestinal adverse reactions, which occurred in 5.0% of Victoza®-treated patients and 0.5% of comparator-treated patients. In these five trials, the most common adverse reactions leading to withdrawal for Victoza®-treated patients were nausea (2.8% versus 0% for comparator) and vomiting (1.5% versus 0.1% for comparator). Withdrawal due to gastrointestinal adverse events mainly occurred during the first 2-3 months of the trials. *Common adverse reactions:* Tables 1, 2, 3 and 4 summarize common adverse reactions (hypoglycemia is discussed separately) reported in seven of the eight controlled trials of 26 weeks duration or longer. Most of these adverse reactions were gastrointestinal in nature. In the five double-blind clinical trials of 26 weeks duration or longer, gastrointestinal adverse reactions were reported in 41% of Victoza®-treated patients and were dose-related. Gastrointestinal adverse reactions occurred in 17% of comparator-treated patients. Common adverse reactions that occurred at a higher incidence among Victoza®-treated patients included nausea, vomiting, diarrhea, dyspepsia and constipation. In the five double-blind and three open-label clinical trials of 26 weeks duration or longer, the percentage of patients who reported nausea declined over time. In the five double-blind trials approximately 13% of Victoza®-treated patients and 2% of comparator-treated patients reported nausea during the first 2 weeks of treatment. In the 26-week open-label trial comparing Victoza® to exenatide, both in combination with metformin and/or sulfonylurea, gastrointestinal adverse reactions were reported at a similar incidence in the Victoza® and exenatide treatment groups (Table 3). In the 26-week open-label trial comparing Victoza® 1.2 mg, Victoza® 1.8 mg and sitagliptin 100 mg, all in combination with metformin, gastrointestinal adverse reactions were reported at a higher incidence with Victoza® than sitagliptin (Table 4). In the remaining 26-week trial, all patients received Victoza® 1.8 mg + metformin during a 12-week run-in period. During the run-in period, 167 patients (17% of enrolled total) withdrew from the trial: 76 (46% of withdrawals) of these patients doing so because of gastrointestinal adverse reactions and 15 (9% of withdrawals) doing so due to other adverse events. Only those patients who completed the run-in period with inadequate glycemic control were randomized to 26 weeks of add-on therapy with insulin detemir or continued, unchanged treatment with Victoza® 1.8 mg + metformin. During this randomized 26-week period, diarrhea was the only adverse reaction reported in ≥5% of patients treated with Victoza® 1.8 mg + metformin + insulin detemir (11.7%) and greater than in patients treated with Victoza® 1.8 mg and metformin alone (6.9%).

Table 1: Adverse reactions reported in ≥5% of Victoza®-treated patients in a 52-week monotherapy trial

	All Victoza® N = 497	Glimepiride N = 248
Adverse Reaction	(%)	(%)
Nausea	28.4	8.5
Diarrhea	17.1	8.9
Vomiting	10.9	3.6
Constipation	9.9	4.8
Headache	9.1	9.3

Table 2: Adverse reactions reported in ≥5% of Victoza®-treated patients and occurring more frequently with Victoza® compared to placebo: 26-week combination therapy trials

Add-on to Metformin Trial			
	All Victoza® + Metformin N = 724	Placebo + Metformin N = 121	Glimepiride + Metformin N = 242
Adverse Reaction	(%)	(%)	(%)
Nausea	15.2	4.1	3.3
Diarrhea	10.9	4.1	3.7
Headache	9.0	6.6	9.5
Vomiting	6.5	0.8	0.4
Add-on to Glimepiride Trial			
	All Victoza® + Glimepiride N = 695	Placebo + Glimepiride N = 114	Rosiglitazone + Glimepiride N = 231
Adverse Reaction	(%)	(%)	(%)
Nausea	7.5	1.8	2.6
Diarrhea	7.2	1.8	2.2

Constipation	5.3	0.9	1.7
Dyspepsia	5.2	0.9	2.6
Add-on to Metformin + Glimepiride			
	Victoza® 1.8 + Metformin + Glimepiride N = 230	Placebo + Metformin + Glimepiride N = 114	Glargine + Metformin + Glimepiride N = 232
Adverse Reaction	(%)	(%)	(%)
Nausea	13.9	3.5	1.3
Diarrhea	10.0	5.3	1.3
Headache	9.6	7.9	5.6
Dyspepsia	6.5	0.9	1.7
Vomiting	6.5	3.5	0.4
Add-on to Metformin + Rosiglitazone			
	All Victoza® + Metformin + Rosiglitazone N = 355	Placebo + Metformin + Rosiglitazone N = 175	
Adverse Reaction	(%)	(%)	
Nausea	34.6	8.6	
Diarrhea	14.1	6.3	
Vomiting	12.4	2.9	
Headache	8.2	4.6	
Constipation	5.1	1.1	

Table 3: Adverse Reactions reported in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Exenatide

	Victoza® 1.8 mg once daily + metformin and/or sulfonylurea N = 235	**Exenatide 10 mcg twice daily + metformin and/or sulfonylurea** N = 232
Adverse Reaction	(%)	(%)
Nausea	25.5	28.0
Diarrhea	12.3	12.1
Headache	8.9	10.3
Dyspepsia	8.9	4.7
Vomiting	6.0	9.9
Constipation	5.1	2.6

Table 4: Adverse Reactions in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Sitagliptin

	All Victoza® + metformin N = 439	**Sitagliptin 100 mg/day + metformin** N = 219
Adverse Reaction	(%)	(%)
Nausea	23.9	4.6
Headache	10.3	10.0
Diarrhea	9.3	4.6
Vomiting	8.7	4.1

Immunogenicity: Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients treated with Victoza® may develop anti-liraglutide antibodies. Approximately 50-70% of Victoza®-treated patients in the five double-blind clinical trials of 26 weeks duration or longer were tested for the presence of anti-liraglutide antibodies at the end of treatment. Low titers (concentrations not requiring dilution of serum) of anti-liraglutide antibodies were detected in 8.6% of these Victoza®-treated patients. Sampling was not performed uniformly across all patients in the clinical trials, and this may have resulted in an underestimate of the actual percentage of patients who developed antibodies. Cross-reacting anti-liraglutide antibodies to native glucagon-like peptide-1 (GLP-1) occurred in 6.9% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 4.8% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. These cross-reacting antibodies were not tested for neutralizing effect against native GLP-1, and thus the potential for clinically significant neutralization of native GLP-1 was not assessed. Antibodies that had a neutralizing effect on liraglutide in an *in vitro* assay occurred in 2.3% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 1.0% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. Among Victoza®-treated patients who developed anti-liraglutide antibodies, the most common category of adverse events was that of infections, which occurred among 40% of these patients compared to 36%, 34% and 35% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. The specific infections which occurred with greater frequency among Victoza®-treated antibody-positive patients were primarily nonserious upper respiratory tract infections, which occurred among 11% of Victoza®-treated antibody-positive patients; and among 7%, 7% and 5% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Among Victoza®-treated antibody-negative patients, the most common category of adverse events was that of gastrointestinal events, which occurred in 43%, 18% and 19% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Antibody formation was not associated with reduced efficacy of Victoza® when comparing mean HbA_{1c} of all antibody-positive and all antibody-negative patients. However, the 3 patients with the highest titers of anti-liraglutide antibodies had no reduction in HbA_{1c} with Victoza® treatment. In the five double-blind clinical trials of Victoza®, events from a composite of adverse events potentially related to immunogenicity (e.g. urticaria, angioedema) occurred among 0.8% of Victoza®-treated patients and among 0.4% of comparator-treated patients. Urticaria accounted for approximately one-half of the events in this composite for Victoza®-treated patients. Patients who developed anti-liraglutide antibodies were not more likely to develop events from the immunogenicity events composite than were patients who did not develop anti-liraglutide antibodies. *Injection site reactions:* Injection site reactions (e.g., injection site rash, erythema) were reported in approximately 2% of Victoza®-treated patients in the five double-blind clinical trials of at least 26 weeks duration. Less than 0.2% of Victoza®-treated patients discontinued due to injection site reactions. *Papillary thyroid carcinoma:* In clinical trials of Victoza®, there were 7 reported cases of papillary thyroid carcinoma in patients treated with Victoza® and 1 case in a comparator-treated patient (1.5 vs. 0.5 cases per 1000 patient-years). Most of these papillary thyroid carcinomas were <1 cm in greatest diameter and were diagnosed in surgical pathology specimens after thyroidectomy prompted by findings on protocol-specified screening with serum calcitonin or thyroid ultrasound. *Hypoglycemia:* In the eight clinical trials of at least 26 weeks duration, hypoglycemia requiring the assistance of another person for treatment occurred in 11 Victoza®-treated patients (2.3 cases per 1000 patient-years) and in two exenatide-treated patients. Of these 11 Victoza®-treated patients, six patients were concomitantly using metformin and a sulfonylurea, one was concomitantly using a sulfonylurea, two were concomitantly using metformin (blood glucose values were 65 and 94 mg/dL) and two were using Victoza® as monotherapy (one of these patients was undergoing an intravenous glucose tolerance test and the other was receiving insulin as treatment during a hospital stay). For these two patients on Victoza® monotherapy, the insulin treatment was the likely explanation for the hypoglycemia. In the 26-week open-label trial comparing Victoza® to sitagliptin, the incidence of hypoglycemic events defined as symptoms accompanied by a fingerstick glucose <56 mg/dL was comparable among the treatment groups (approximately 5%).

Table 5: Incidence (%) and Rate (episodes/patient year) of Hypoglycemia in the 52-Week Monotherapy Trial and in the 26-Week Combination Therapy Trials

	Victoza® Treatment	**Active Comparator**	**Placebo Comparator**
Monotherapy	**Victoza®** (N = 497)	**Glimepiride** (N = 248)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.7 (0.24)	25.0 (1.66)	—
Not classified	1.2 (0.03)	2.4 (0.04)	—
Add-on to Metformin	**Victoza® + Metformin** (N = 724)	**Glimepiride + Metformin** (N = 242)	**Placebo + Metformin** (N = 121)
Patient not able to self–treat	0.1 (0.001)	0	0
Patient able to self–treat	3.6 (0.05)	22.3 (0.87)	2.5 (0.06)
Add-on to Victoza® + Metformin	**Insulin detemir + Victoza® + Metformin** (N = 163)	**Continued Victoza® + Metformin alone** (N = 158*)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.2 (0.29)	1.3 (0.03)	—
Add-on to Glimepiride	**Victoza® + Glimepiride** (N = 695)	**Rosiglitazone + Glimepiride** (N = 231)	**Placebo + Glimepiride** (N = 114)
Patient not able to self–treat	0.1 (0.003)	0	0
Patient able to self–treat	7.5 (0.38)	4.3 (0.12)	2.6 (0.17)
Not classified	0.9 (0.05)	0.9 (0.02)	0
Add-on to Metformin + Rosiglitazone	**Victoza® + Metformin + Rosiglitazone** (N = 355)	**None**	**Placebo + Metformin + Rosiglitazone** (N = 175)
Patient not able to self–treat	0	—	0
Patient able to self–treat	7.9 (0.49)	—	4.6 (0.15)
Not classified	0.6 (0.01)	—	1.1 (0.03)
Add-on to Metformin + Glimepiride	**Victoza® + Metformin + Glimepiride** (N = 230)	**Insulin glargine + Metformin + Glimepiride** (N = 232)	**Placebo + Metformin + Glimepiride** (N = 114)
Patient not able to self–treat	2.2 (0.06)	0	0
Patient able to self–treat	27.4 (1.16)	28.9 (1.29)	16.7 (0.95)
Not classified	0	1.7 (0.04)	0

*One patient is an outlier and was excluded due to 25 hypoglycemic episodes that the patient was able to self-treat. This patient had a history of frequent hypoglycemia prior to the study.

In a pooled analysis of clinical trials, the incidence rate (per 1,000 patient-years) for malignant neoplasms (based on investigator-reported events, medical history, pathology reports, and surgical reports from both blinded and open-label study periods) was 10.9 for Victoza®, 6.3 for placebo, and 7.2 for active comparator. After excluding papillary thyroid carcinoma events *[see Adverse Reactions]*, no particular cancer cell type predominated. Seven malignant neoplasm events were reported beyond 1 year of exposure to study medication, six events among Victoza®-treated patients (4 colon, 1 prostate and 1 nasopharyngeal), no events with placebo and one event with active comparator (colon). Causality has not been established. **Laboratory Tests:** In the five clinical trials of at least 26 weeks duration, mildly elevated serum bilirubin concentrations (elevations to no more than twice the upper limit of the reference range) occurred in 4.0% of Victoza®-treated patients, 2.1% of placebo-treated patients and 3.5% of active-comparator-treated patients. This finding was not accompanied by abnormalities in other liver tests. The significance of this isolated finding is unknown. **Vital signs:** Victoza® did not have adverse effects on blood pressure. Mean increases from baseline in heart rate of 2 to 3 beats per minute have been observed with Victoza® compared to placebo. The long-term clinical effects of the increase in pulse rate have not been established. **Post-Marketing Experience:** The following additional adverse reactions have been reported during post-approval use of Victoza®. Because these events are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure: Dehydration resulting from nausea, vomiting and diarrhea; Increased serum creatinine, acute renal failure or worsening of chronic renal failure, sometimes requiring hemodialysis; Angioedema and anaphylactic reactions; Allergic reactions: rash and pruritus; Acute pancreatitis, hemorrhagic and necrotizing pancreatitis sometimes resulting in death.

OVERDOSAGE: Overdoses have been reported in clinical trials and post-marketing use of Victoza®. Effects have included severe nausea and severe vomiting. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

More detailed information is available upon request.

For information about Victoza® contact: Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, NJ 08536, 1–877-484-2869

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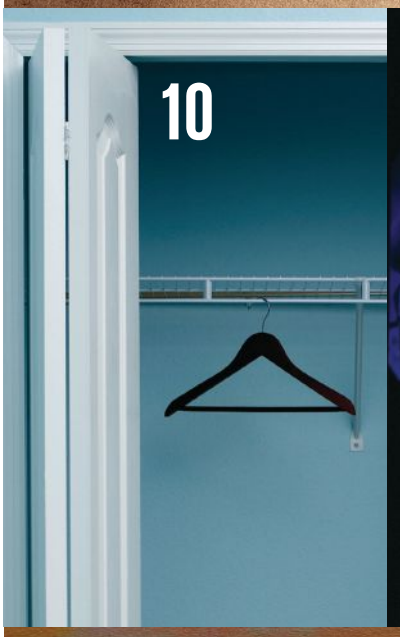

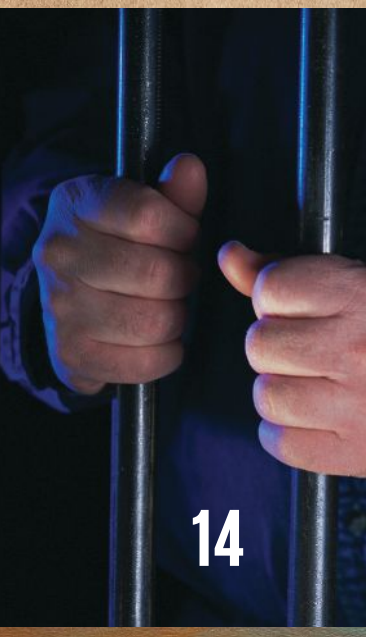

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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

Talking about the taboo

Every day physicians need to mention the unmentionable. As patients come into our offices clutching their most personal secrets, some meeting us for the first time, we play Perry Mason and start interrogating them about those secrets. We ask about antisocial behavior like belching and farting. We probe unsavory details of their physical existence like bowel movements and urinating. We insist on graphic descriptions of color, odor and consistency. And we matter-of-factly request that they tell us if they are anxious, depressed or suicidal. Seemingly any topic is fair game in the exam room. Yet for years, one taboo of polite cocktail conversation—sex—has been taboo in the exam room as well. As this month's issue indicates, that is changing. In 2013, sex has been outed into the full light of the medical exam.

Driving this change have been the latest chapters in the sexual revolution. Society is more open about discussing sex in print and portraying it in the arts. The shift toward accepting the gay and lesbian community into society with equal rights has been dramatized by the numerous states that have legalized gay marriage and by the recent Supreme Court decision upholding those laws. Openly gay men and women have become the rule rather than the exception in all areas of society including medicine. Transgender people are inching toward a place of acceptance as well. And recent surveys of seniors demonstrate that sexual activity doesn't retire with retirement. The startling diversity of human sexuality has become a topic worth investigating and discussing in the exam room.

That diversity makes a medical practitioner's job more difficult. No longer can you assume that you know the gender identity, sexual preference or sexual habits of the patient you are seeing. Knowing is vital for treating that patient, and asking is the only way to know. Unfortunately, human sexuality has been absent from the curriculum of many medical schools for years and physicians haven't learned how to ask about gender identity, sexual orientation or sexual behavior. Recent improvements should make the next generation of doctors as comfortable asking about sex as they are about green stools.

For something endlessly interesting and as old as Adam and Eve, it is odd that sex should still tongue-tie so many physicians, especially those of my generation. We do ask the suspected pregnancy or STD patient, "Are you sexually active?" But most studies suggest we don't include this question in our standard review of systems. Although the HIV epidemic has goaded practitioners into asking about risk factors, most of us only pursue the inquiry when prompted. That needs to change, say experts such as the University of Minnesota's Eli Coleman, because sexual health is foundational to overall health. Asking about it needs to be a regular part of our disease prevention and health promotion discussions.

For something endlessly interesting and as old as Adam and Eve, it is odd that sex should still tongue-tie so many physicians.

Likely some reticence about sexuality will persist for both doctors and patients. Those "Oh by the way, doc" conversations when the patient requests Viagra as you exit the exam room will still occur. But hopefully a new open atmosphere for discussing sexuality will reign if we just learn to mention it.

Charles Meyer can be reached at meyer073@umn.edu.

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Gay blood drive attempts to change FDA policy

BY KIM KISER

On a Friday in July, 19 men lined up at Memorial Blood Centers' St. Paul donation facility to participate in the first-ever National Gay Blood Drive. As none of the men were allowed to donate blood because of federal regulations, they instead were tested for HIV by the Minnesota AIDS Project. Organizers of the drive plan to deliver those results, along with others from around the country, to the Food and Drug Administration (FDA).

The event was part of an effort to get the FDA to lift the ban on blood donation by men who have had sex with men that has been in place since 1983. "The intent of the organizers was to demonstrate that there are quite a number of people in the male gay community who are, in fact, not HIV positive and at low risk of transmitting," says Jed Gorlin, M.D., M.B.A., medical director of Memorial Blood Centers.

Gorlin says that since the ban was put in place at the height of the HIV/AIDS crisis, much has been learned about the epidemiology and risk of HIV/AIDs; donor questionnaires have become more rigorous and are more likely to identify individuals who have blood-borne diseases; and nucleic amplification testing has reduced the amount of time it takes to detect the presence of the HIV virus in a person who has been infected from 56 to 11 days. In addition, donated blood is now screened for a number of infectious diseases including HIV, human T-lymphotropic virus, hepatitis B and C, and syphilis before it is made available for use.

"We're fortunate to have the world's safest blood supply," Gorlin says. "But it raises the question: If our testing is so good, do rules formulated 30 years ago still stand up to medical and scientific rigor?"

Since 2006, blood banking organizations including the AABB, America's Blood Centers (of which Memorial Blood Centers is a member) and the American Red Cross have been lobbying for changes to the indefinite or lifetime ban on blood donation by men who have had sex with men. In June of this year, the American Medical Association voted to oppose the restriction and encouraged the FDA to revise its policy.

But the decision isn't entirely up to the FDA, which is governed by its own regulatory oversight groups. The federal agency did propose limiting the ban to five years in 2010, but a Health and Human Services Advisory Committee on Blood Safety and Availability rejected the idea.

A number of countries have changed their policies on blood donation. In 2011, the United Kingdom lifted its ban and now allows men to donate blood if they have not had sex with another man in 12 months. In July, Canada began allowing men to donate if they have not had sex with another man in five years.

Gorlin says the push to change FDA policy isn't so much about increasing the blood supply as about being in line with scientific evidence. He says he wouldn't be surprised if the FDA watches what happens in Canada and other countries that have changed their policies before revisiting the issue. "Nothing moves fast in Washington." **MM**

Leaders in LGBT health care

Seven Minnesota health care organizations were named 2013 Leaders in LGBT Healthcare Equality by the Human Rights Campaign. They are:

- Hennepin County Medical Center
- Minneapolis Veterans Affairs Health Care System
- St. Cloud Veterans Affairs Health Care System
- Park Nicollet Methodist Hospital
- Regions Hospital
- Family Tree Clinic
- HealthEast Care System.

The Human Rights Campaign awards the designation to organizations that meet four criteria: patient nondiscrimination (having a patient bill of rights that includes the terms "sexual orientation" and "gender identity," for example); equal visitation (having a policy granting equal visitation to LGBT patients and their visitors that is communicated to patients and staff); employment nondiscrimination (having equal employment opportunity policies that include the terms "sexual orientation" and "gender identity"); and having staff receive training on LGBT patient-centered care.

OUT

The climate has changed for gay and lesbian physicians.

BY CARMEN PEOTA

As a first-year medical student, Dominic Decker wasn't sure how much to share with one of his preceptors about his personal life. The physician had been in practice more than a quarter of a century, and Decker thought he might not react positively if he learned Decker was gay. During a discussion about ear infections, the physician asked Decker if he had children. Decker said no and then divulged that he had a boyfriend.

Dominic Decker

The physician responded by telling him he was in a band that had released a music video in support of same-sex marriage. "That blew me away," Decker says. "That's just one example of how I have found the medical community to be more progressive than I expected."

For Decker, who disclosed his sexual orientation on his medical school application (his answer to a question about facing a challenge focused on coming to terms with his homosexuality while attending a conservative Catholic high school in St. Paul), being out in medicine has been easier than he expected. In addition to the welcome he's been given by physicians he's met in the community, he's had support from an advisor at the University of Minnesota Medical School who also is gay. "Knowing that there's someone who's gone through the same things that I have means a lot," he says.

A generation earlier, Decker's experience would have been different. Although medicine was ahead of other fields in recognizing that homosexuality is neither a choice nor a pathology (it was removed from the DSM in 1973), individual physicians differed in their views based on their cultural and religious backgrounds. So until very recently, gay and lesbian medical students and physicians in Minnesota were cautious about being out.

Group support

The recommendation for gay physicians when Eric Meininger, M.D., M.P.H., was applying for residency in the mid-1990s was to not disclose anything about your sexual orientation on applications because it might hurt your chances of getting a position. Even though Minnesota had passed a human rights ordinance in 1992 and amended it 1993 to prohibit discrimination on the basis of sexual orientation, gay and lesbian physicians were still worried that there would be career repercussions if they came out of the closet.

For some, there was good reason. Meininger says he knew of a physician who in the late 1990s had to drop out of residency because of his sexual orientation. "They said, 'You will never complete your research years successfully to complete your residency,'" he recalls.

Even if a physician didn't feel his or her career was in jeopardy, the atmosphere at work could be toxic. Dave Bucher, M.D., who began practicing as a family physician in the mid-1980s, remembers encountering prejudiced behavior toward gay and lesbian people. "As a person sitting and listening to some of the conversations, it

ADVICE ON COMING OUT

I tell people to be out and be consistent. Do your work well. Be a good example in how you live your life. Tell the truth. Recognize the closet is a place where you'll get comfortable about lying, and that's a bad thing for a physician.

– VAL ULSTAD, M.D.

was hurtful. Yet I didn't feel empowered enough to confront older colleagues at that time and say, 'You're being a jerk' or that you're being really inconsiderate of that person's life."

During the 1980s and '90s, gay and lesbian physicians typically were out only with a select group of friends and colleagues. In the Twin Cities, they often found one another through gatherings sponsored by a group called Lambda Docs, which organized social events such as potluck dinners three or four times a year, usually at a member's home.

At one time, as many as 90 people were on the mailing list, according to Meininger. "Some people wanted to leverage the number of physicians involved to make policy changes and advocate at a visible level," he says. But the decision was made to simply provide opportunities for people to meet and find support.

ADVICE ON COMING OUT

What I do say is to try to keep good boundaries with patients and the community. Try to have professionalism be a part of your demeanor. But I don't think cautioning is particularly valuable for most—the way society is moving. – DAVE BUCHER, M.D.

Later outings

One of the reasons medical students and young physicians weren't out of the closet 10, 20 and more years ago was that then people often didn't come to grips with their homosexuality until they were well into adulthood. Daniel Hall-Flavin, M.D., who attended the University of Missouri at Kansas City in the late 1970s, says he was still hoping his sexual orientation was going to be a passing stage during the years he was in medical school. In fact, it wasn't until he went to New York City for a fellowship at Cornell University Medical Center that he finally came out. "I was just amazed to be in a city where being gay was less of an issue," he says. "You could be yourself. That was wonderful." He now works as a psychiatrist at Mayo Clinic, where he is part of a committee on diversity.

For Val Ulstad, M.D., who attended the University of Minnesota Medical School in the late 1970s, medical school itself helped her do that. Although she knew she was different from her peers by the time she was 15, she hadn't yet identified as a lesbian when she started medical school. She recalls taking a sexual health class during which there was an open conversation about a range of human behaviors that physicians might be exposed to. In one session, as a lesbian talked to the students, the light bulb went on in Ulstad's head. "I can remember who she was, what she was wearing. I thought, 'Oh my God, that's the language,'" Ulstad says. "I'm smart, I'm well-trained, I've had every opportunity, but I've just now got the language for what it is I feel and who I am."

The University of Minnesota Medical School provided a similar experience for Soren Ryberg, M.D., who arrived in 1983 after attending a conservative Christian college and serving in the military. "I'm one of those gay people who always hid behind being intellectual," he says. "I was very academically focused and career-focused. I always thought I'm too busy with that to think about dating. In my own head, I was thinking that once I got to med school, I'd finally be on track and be around like-minded people and finally find a love connection there."

Instead, Ryberg found himself confronting what he had tried to ignore. He saw a counselor and began to unravel the knot of family, religious and social issues that had prevented him from recognizing who he really was. He credits faculty, including the dean, Albert Sullivan, M.D., for helping him through the process. "He was sympathetic and knew my background and how difficult it was for me and tried to make it easier," Ryberg says. Even for people who came from a much more liberal background, Ryberg says, it was hard to be out in those days. "I don't remember anyone being out in medical

ADVICE ON COMING OUT

Really, nowadays, being out and being gay is not that big of a deal. Certainly, if you're not out when you get to medical school, keep your ears open and find allies in your class who clearly won't have an issue with you being gay and come out to them first. Ninety percent of coming out is coming out to yourself, where you feel comfortable with you, because even if you came out to somebody—your best friend, your brother, your dad—and they rejected you, you'd have enough fortitude that you'd push past it, that it wouldn't stop you dead in your tracks.

– CHIP MARTIN, M.D.

school," he says. "I came out to myself and everybody else my senior year," he says. "It was traumatic."

For many, coming out was a lengthy process. Chip Martin, M.D., who did his pediatric residency in Minnesota in the late 1980s, says it was 10 years before he was comfortable telling people he was gay. In part, that was because he was struggling with whether he wanted one more label (he is African American). "I was already going to be the black pediatrics resident. I thought, I don't need to be known as the black, gay one, too." His strategy then was to let people figure it out on their own. "They may not have known but then sat up in bed at 3 in the morning, and said, 'Oh, I get it, he's gay.'" Martin says he wasn't truly out of the closet until he was asked to talk to a group of medical students at the University of Minnesota about being gay. "My heart must have been going a thousand miles an hour before I had to walk in front of that bunch of med students and say, 'I'm Chip Martin, and I'm gay.'"

ADVICE ON COMING OUT

I'd still say it's a personal decision. But I can't help but think that today, with awareness, with inclusiveness, the positives will far outnumber the negatives. I won't say what's right for one person is right for another. Yet there's little downside and lots of upside about being out.

– JOHN KNUDSEN, M.D.

For some, coming out was not something they did until they were well into their careers. Ulstad and her partner Kathy Ogle, M.D., waited until they were well-established in their respective practices. So did Mayo radiologist John M. Knudsen, M.D., who now regrets that he hid the fact that he was gay from colleagues in Jacksonville, Florida, for 10 years because he didn't want to be known as "the gay radiologist." When colleagues finally found out, they were hurt that he hadn't trusted them enough to tell them. "The longer you don't tell people, the more difficult it becomes to disclose. They ask, Why did you hold this back all this time?" he says.

Knudsen, who now works at Mayo Clinic, has been out since before he arrived there in 2000 (his partner Brian accompanied him on the recruitment visit). He initially wondered if there might be subtle ways that he would be excluded from opportunities at Mayo. But about a year into his tenure, those thoughts were dispelled when his department head asked him to lead a recruitment committee.

ADVICE ON COMING OUT

Whether you are out is a little contingent upon where you live. You might want to move to some place that's accepting. But I think everybody knows what the costs and benefits are for their circumstances. It's certainly easier if you're living in a more tolerant place, with more tolerant laws and with role models.

– SOREN RYBERG, M.D.

Working out

For the most part, the physicians who are out at work say their colleagues don't seem to care all that much. Martin, who now works at St. Cloud Hospital and CentraCare Clinic in St. Cloud, lives openly with his partner, Bill, and their two young children, is active in his church, posts pictures of his family on his office walls, and speaks out on issues affecting gay and lesbian families. He says his colleagues "could not have cared less that I was gay." He speculates that some physicians may not understand or condone his life's choices but says even they refer patients to him and are cordial. "It's one of those things that doesn't make a difference at work. Our job is to take care of patients."

Physicians differ with regard to what they tell patients. For Meininger, an adolescent medicine specialist at Gillette Children's Specialty Healthcare who sees young adults with disabilities as well as youths who are transgender, being forthright about his sexuality can be important. In fact, he used to wear a rainbow on his white coat to signal that it was safe to talk to him about matters of sexuality. That went away when he stopped wearing a white coat.

Other physicians say their being gay or lesbian is generally irrelevant to patient care and try to keep it out of their clinical encounters. If patients ask about his personal life, Ryberg, who practices at Noran Neurological Clinic, simply stops and thinks, What would a straight physician say? Bucher says his approach is to keep his sexuality "in his back pocket." "It's not

ADVICE ON COMING OUT

If a patient asks me if I have a girlfriend or am married, I make a decision as to how appropriate [talking about my sexual orientation] is to the conversation we're having. It's not about being out or not. It's about, Is this appropriate information to share?

– ERIC MEININGER, M.D.

at the front of my presentation to people. It's not all of who I am or what I'm all about. As we get to know each other and it becomes pertinent to our conversation, then I'll share that. In the same way, you don't walk in and start talking about your romantic or your emotional relationships with your spouse as a straight physician. Why would it be any different?"

On the other hand, he and others say there is a reason gay physicians ought to be forthright about who they are: Professionals who are out are positive role models. "If you know someone in your family or your doctor or your nurse or your clergy person is LGBT and know them as a person and you know their sexual orientation, that really changes people's minds," says Bucher, who now works at the United Family Medicine Clinic in St. Paul.

A new generation

The passage of same-sex marriage legislation this year is perhaps a clear sign the climate for gay and lesbian people has changed in Minnesota. For that reason, people entering medicine likely won't struggle with being out as much as their predecessors did. Deciding to come out ought to be a "no-brainer" for younger physicians, Knudsen says. "My experience is that there isn't any fallout at all. You're judged on the things that matter at work."

Young people themselves are very different from those of previous generations on matters of sexuality. "It's just refreshing how matter-of-fact our young soon-to-be colleagues are about issues of sexuality and sex and the health care issues related to that," Bucher says. "They're light years ahead of their colleagues who are two generations older. It's very encouraging to see how some of the baggage related to some of these things has started to fall away." **MM**

Carmen Peota is managing editor of *Minnesota Medicine*.

After 31 years together, Kathy Ogle, M.D., and Val Ulstad, M.D., plan to marry in September.

TOGETHERNESS

Val Ulstad and Kathy Ogle like to say they grew up together in medicine. The two women met the first day of medical school in 1978, became fast friends, came out to one another their senior year and did residencies together. But it wasn't until 10 years later, when both were well-established in their fields, Ulstad in cardiology and Ogle in oncology, that the two came out publicly.

Ulstad remembers the day that she and Ogle had the conversation about it. "We said, you know what, we're never going to lie again. No more pronouns that are vague. We're just going to tell the truth," she says. "We just really felt it was an act of integrity to come out."

Ulstad and Ogle did not just come out of the closet. According to Ulstad, they came "flying out." Ulstad began volunteering for the Human Rights Campaign, a national LGBT civil rights organization. Ogle volunteered for Philanthrofund (now Pfund), a foundation that funds LGBT causes. Within a year, Ulstad co-chaired a major local event for the Human Rights Campaign and Ogle was president of Pfund. Ulstad eventually became president of the Gay and Lesbian Medical Association and served on its board for seven years. The two successfully lobbied their respective employers (HealthPartners and Park Nicollet) about providing benefits for same-sex partners. "In newspapers, stuff was being written about us," Ulstad says. "So then we were that much more out there."

Ulstad, who also was a member of the university's faculty, found a steady stream of medical students knocking on her office door. "They would come through my door, then close it and blush and then tell me they were gay. For a while, I felt like I was the only out gay faculty at the U, which was scary, because it's a hierarchical place. So I mentored gay medical students, which I felt was important."

Ulstad says she experienced more sexism than homophobia during her career—"I was called a strong feminist. I was called an opinionated woman." Looking back, she says, coming out was a powerful experience. "I have to say in coming out, what I kept learning was that it's really hard for people to dismiss someone they respect and like for other reasons."—C.P.

View from the Hotel California

Is it possible to rehabilitate Minnesota's most serious sex offenders?

BY TROUT LOWEN

Minnesota's treatment program for for criminal sex offenders has been referred to as the "Hotel California," a nod to the 1970s song by the Eagles, the reference being that for the state's sex offenders who are ordered by the court into the program, "you can check out any time you like, but you can never leave."

Since 1994, the Minnesota Sex Offender Program (MSOP), which currently houses offenders in razor-wire-ringed facilities in Moose Lake and St. Peter, has released just two people. The first was recommitted shortly after for violating his discharge plan. The other was released on provisional discharge in early 2012 and remains in the community.

For that and other reasons, MSOP has come under harsh criticism in recent years. In 2011, some of MSOP's clients filed a class action lawsuit in federal court claiming, among other things, that the state's process of indefinite civil commitment violates their constitutional right to due process. Also in 2011, the state legislative auditor's office released a report questioning the validity of the civil commitment process and stating that frequent changes in leadership at MSOP since 2003 have affected its ability to maintain the consistency and continuity of its treatment program. With each change in leadership, clients and clinicians have had to learn a new treatment protocol and clients have had to be reassessed against the new program's guidelines. The report also cited MSOP's excessive cost and its failure to release patients who pose little or no threat to the community.

The state of the state

Minnesota is one of 20 states that use indefinite civil commitment—court-ordered commitment to treatment in a hospital (see next page)—to confine sex offenders who have served their prison sentences. In 2010, when the legislative auditor's report was compiled, the state had the third-largest population of civilly committed sex offenders in the country, following California and Florida, and the highest number of civilly committed offenders per capita. "In a decade we've released one person. Minnesota's clearly an outlier," says Michael Miner, Ph.D., director of research in the University of Minnesota's department of family medicine and community health's Program in Human Sexuality and

co-editor of the book *International Perspectives on the Assessment and Treatment of Sex Offenders: Theory, Practice and Research.* "Wisconsin does a much better job of getting people out the door than we do. Texas uses outpatient civil commitment. They don't have a facility like MSOP."

The use of civil commitment to indefinitely confine dangerous sex offenders has grown exponentially in Minnesota since the 2003 murder of University of North Dakota student Dru Sjodin by convicted rapist Alfonso Rodriguez, Jr. Rodriguez had been released from prison after a Minnesota Department of Corrections psychologist recommended against civil commitment. In 2002, MSOP housed 181 offenders. Currently, the population is 694. By 2018, it is expected grow to more than 1,000.

MSOP clients range in age from 19 to 90 years, with the average age being 46. They are predominantly white, almost exclusively male (there is one female); 280 are from the seven-county metropolitan area and 390 are from outside the metro. Approximately 22 percent have been committed for more than 10 years, and 75 percent for at least three years.

In response to the civil rights complaint filed by MSOP clients last August, a federal District Court judge ordered the Department of Human Services, which oversees MSOP, to create a task force to make recommendations to the Legislature on reforming the civil commitment process, less-restrictive options for housing offenders and procedures for release. In December 2012, the bipartisan task force came back with its initial report, which addressed just one of those issues. It called for the Legislature to require MSOP to develop a plan for housing some offenders in a less-restrictive environment. The task force is expected to report back on the other issues in December.

Jannine Hébert, executive clinical director of MSOP, says the program has made progress in working to release some clients. She points out that many more offenders are now in the Community Preparation Service (CPS) unit, the last stage of treatment before conditional discharge, than when she took over the program in 2008. "We have 10 or 11 down in CPS now," Hébert says. "Five years ago, there wasn't anyone in CPS. That tells me that people are moving in the right direction."

Hébert adds that she is less concerned about where clients are in the program—and how many are getting released—than about whether they

Civil commitment

Minnesota first enacted a law allowing for indefinite civil commitment of dangerous sex offenders in 1939. That law provided for the civil commitment of offenders with a "psychopathic personality," that is, those who engage in habitual sexual misconduct and exhibit a lack of ability to control their sexual impulses.

Civil commitment was not often used before the 1990s. In 1994, in response to court decisions, the Legislature modified the law, allowing for indefinite commitment of individuals with a "sexual psychopathic personality," described as someone who has engaged in harmful sexual conduct or is likely to as a result of a mental, personal or sexual disorder. After 1994, the number of civil commitments of "sexually dangerous persons," (those who have engaged in harmful sexual conduct or who have manifested a sexual, personality, or other mental disorder or dysfunction and are likely to engage in harmful sexual conduct) began to climb.

Currently, the Department of Corrections reviews the cases of convicted sex offenders near the end of their prison sentence to determine if they meet the statutory criteria for civil commitment. If so, the state refers the case to the county in which the offense was committed. If the county attorney chooses to pursue a petition for civil commitment, the case goes before a judge who makes the final determination. As of 2003, all Level 3 sex offenders—those determined to be at the highest risk of reoffending—are automatically evaluated for civil commitment. About 50 percent of all cases reviewed result in commitment. –T.L.

have genuinely changed their behavior. Current research indicates it takes eight to nine years on average for an individual to progress through a treatment program.

"That is a fair amount of time to be in treatment," Hébert says. "These are guys who have intense pathologies and who have had opportunities to change along the way and didn't do it. We want to make sure they're not just going through the motions."

> "You can't know anything about a treatment's effectiveness if you don't give it a chance to succeed or fail."
>
> –MICHAEL MINER, PH.D.

The treatment

Most MSOP clients have a long-standing pattern of sexual deviance; a large percentage also have personality disorders, mental illnesses and psychopathy, a mental disorder marked by egocentric and antisocial behaviors. Clients include pedophiles and rapists as well as some who have exclusively noncontact offenses. The common denominator, says Hébert, is a long-standing pattern of offending and a high likelihood of reoffending. To address those issues, MSOP (and most successful sex offender treatment programs) use cognitive behavioral treatment models that conform to risk-needs-responsivity principles.

The risk principle ensures that the offenders at greatest risk of reoffending get the most intensive treatment. (Research shows that over-treating low-risk offenders can actually increase their risk of recidivism.) The needs principle focuses on offenders' criminogenic needs—those factors that are related to criminal behavior such as hostility toward women and emotional identification with children. The responsivity principle involves customizing treatment to the client—for example, considering their life experiences and cognitive abilities.

MSOP's program is structured into three treatment phases. During Phase 1, clients learn how to comply with facility rules and learn basic treatment concepts. In Phase 2, they discuss their sexual offenses and work to understand their patterns of sexual abuse. Each client has a primary therapist and attends group sessions three times a week. In those groups, which are facilitated by two therapists, they discuss their behavior on the unit and present their assignments. Clients also attend psychoeducational groups one to five times a week. Those groups are facilitated by a therapist but are more educational.

In addition, clients participate in educational, vocational and recreational programs that provide them with opportunities to interact in more real-world type settings and for staff to assess their interactions. "I want to know how he's doing at his history class with a female instructor. I want to know how he's doing on his job assignment. Does he follow rules at work? If he's a pedophile, does he have trouble interacting with adults at the gym during a therapeutic recreation opportunity? How is he interacting with his peers?" Hébert says. "We want to be sure that they're making changes, and that they're not just going through the motion of it. Most of them are antisocial personality types, so they are fairly talented at being manipulative and at being superficial."

These first two phases of treatment are delivered at the Moose Lake facility. Phase 3 focuses on community reintegration; clients at this stage are housed at the St. Peter facility along with those who may have traumatic brain injuries or profound learning or developmental disabilities. Clients in Phase 3 are housed in a secure facility at St. Peter but have the opportunity to earn privileges such as staff-accompanied walks outside the secure perimeter and to and from activities on campus, staff-accompanied walks in the St. Peter/Mankato community and unaccompanied walks on campus grounds.

Clients who have earned such privileges and made sufficient progress on their treatment goals may, with approval of a Special Review Board and Supreme Court Appeal Panel, move into the CPS unit, a 23-bed residential unit located outside the secure area of the campus. In the CPS unit, clients continue to work with their primary therapist, participate in community-based treatment, and attend addiction and other support groups, vocational training, and classes on budgeting and saving, volunteering, and making healthy lifestyle choices. Clients who have met all their Phase 3 treatment goals can petition the courts for provisional discharge—a supervised release into the community.

How effective?

Although research suggests treatment programs that conform to the risk-needs-responsivity principles are most effective for sex offenders, it has been less than conclusive about those at high risk for reoffending. Two large-scale studies—one of sex-offender treatment in general and the other of the cognitive behavioral change model—produced different results. In the more general study, which was conducted in a secure forensic psychiatric hospital in California, inmates who participated in a two-year treatment program were

monitored for eight years after release. Investigators found those who participated in the program reoffended at the same rate as those who did not. The other study, conducted by the Minnesota Department of Corrections, followed 2,040 offenders for an average of nine years. It showed a 27 percent decrease in recidivism among those who participated in a three-year intensive Department of Corrections treatment program. Neither study involved offenders who had been civilly committed.

Miner, who was involved in the initial design of the California study, says it did show some positive effects of treatment. "There was a subgroup of people who were in this treatment program who apparently benefited from it, at least got the kind of things that the treatment program wanted them to get," he says. "And they in fact did pretty well."

Given those results, Miner says asking whether sex offender treatment works is probably the wrong question. He suggests a better one might be "What works for whom under what conditions?"

Determining that poses additional challenges. Miner says there are no good tools to identify who has changed as a result of treatment; therefore, it's not possible to assess when an individual's risk level has dropped to the point where it is safe to return them to society. And because so few civilly committed offenders are ever released, it's difficult to know whether treatment is effective. "You can't know anything about a treatment's effectiveness if you don't give it a chance to succeed or fail," he says. "And the only way to know if it succeeds or fails is to let people out."

That decision, however, resides not with the clinic staff but with the courts. "My piece of the puzzle is providing treatment to whoever comes our way, and to do the best treatment possible, and to provide opportunities for those clients to change, and then responsibly and ethically try to reintegrate them into the community if the courts permit," Hébert says. "I kind of have to focus on what our piece of the puzzle is. And I think our piece is pretty solid." **MM**

Trout Lowen is a freelance writer based in Minneapolis.

Sex offender classification

In 1996, Congress passed Megan's Law requiring all states to develop community notification procedures when sex offenders are released from prison. The following year, Minnesota implemented the Community Notifications Act, which established a three-tier classification system for sex offenders based on their risk for re-offense.

LEVEL 1 offenders have the lowest risk for re-offense. Notification of release is limited to victims of and witnesses to the crime, other law enforcement agencies and anyone the prosecuting attorney believes should receive the information.

LEVEL 2 sex offenders are at moderate risk for re-offense. In addition to those included in the Level 1 notification requirements, law enforcement may also notify local schools, day-care centers and other organizations where individuals who may become victims of the offender are regularly found. Organizations are not permitted to redistribute the information.

LEVEL 3 offenders are at the highest risk for re-offense. Law enforcement agencies are permitted to notify the community and the news media of their pending release and hold public meetings in the community where the offender will reside. Information is also posted on the Department of Corrections website.

Information can include general area of residence, a physical description (with photograph) and a description of the pattern of behavior that this offender has been known to display in the past.

Community notification is not required when clients move from St. Peter to Moose Lake or from the secure facility to Community Preparation Services. Such notification is required when clients are provisionally discharged into the community and whenever they change residences within the community. All MSOP clients are treated as Level 3 sex offenders upon provisional discharge. –T.L.


INSURANCE
POLICY

falling through the cracks

Health insurance policies increasingly include coverage for treatments related to gender dysphoria, but gaps remain.

BY HOWARD BELL

Ellen Krug sat alone at one end of a long table deep inside the offices of a large Minneapolis health insurance company. Seven health plan administrators sat at the other end. Looking younger than her 53 years, Krug, an attorney, was dressed in the outfit she wore whenever she had a jury trial—a light gray suit, white blouse, hose, heels and her lucky silver pendant shaped like a heart. "You cancelled my policy because I'm transgender," Krug told them. "That's discrimination."

The insurance company had requested Krug's medical records from her gynecologist after blood tests performed prior to a facial feminization procedure revealed high levels of female hormones, which showed that she was well into transitioning physically from a man to a woman. "Everything on my application form was truthful," she says. "I was never asked if I was transgender or if I was planning to have any surgery, so failure to disclose wasn't a reason to cancel my policy. I never asked them to pay for any gender-reassignment costs, and I never planned on asking because I knew they wouldn't. Even if I had asked, they could have just denied the claims. Instead, they cancelled my policy. I needed insurance for the same reasons any 53-year-old needs health insurance. Discrimination, fear and ignorance were at work here."

Krug's lucky pendant wasn't enough to get her health insurance back. But she's now insured through an individual plan for which her employer, a Minneapolis nonprofit, pays a portion of the premium. "My health insurance story may be getting stale," she says, "because the health insurance situation for transgender people is changing at lightning speed."

Ellen Krug

Adding it to the bucket

Less than a year after cancelling Krug's policy, that insurer started covering hormones, counseling

Ending transgender discrimination at the clinic

In July of 2012, Ellen Krug tripped on a sidewalk and dislocated her ring finger; it was two years after she completed gender reassignment surgery. When Krug gave her full name to the emergency department intake nurse, the nurse stopped typing and in a skeptical tone asked, "Is that your legal name?" "That hurt so very much," Krug says, but that was just the beginning. In radiology, the techs asked her to extend her finger as best she could. "Look," said one of the techs. "*He's* giving us the finger." "My hair was long," says Krug. "I was wearing earrings and a dress. They knew my name."

Discrimination at the clinic is often a bigger problem than insurance discrimination, says Deborah Thorp, M.D., an obstetrician/gynecologist who created and directs Park Nicollet's Transgender Clinic in Minneapolis. Often, what's perceived as discrimination is ignorance and discomfort. "Transgender patients pick up on this," she says.

To ensure such situations don't occur, Thorp offers gender competency training. Her "Transgender 101" primer explains transgender health issues, types of treatment, proper language to use and how to view gender identity as a spectrum. "As a society, we haven't reached the point of accepting that gender identity is not either/or. It's a spectrum, and each person sees themselves as being at a different point along that spectrum. A lot of clinicians just don't know how to handle that."

Thorp says it's common for transgender persons to go to the clinic with shoulder pain or something else completely unrelated to being transgender, and instead of being referred to an orthopedist, they get referred to Park Nicollet's Transgender Clinic. And when they do see the right doctor, the physician often gets side-tracked by their own curiosity. "They start asking a bunch of questions about being transgender instead of treating the problem the patient came in for," Thorp says.

"If it's not clear what gender or pronouns the patient would like you to use, ask them. Treat them with respect, using their preferred name and pronoun. Don't ask nosy questions that have nothing to do with the medical question at hand. Front-line staff don't need to be asking about hormones. Nursing staff rooming a patient for an orthopedic surgeon don't need to be inquiring about the patient's sexual practices," she says.

She adds that trans-women (male to female) often have a more difficult time at clinics (and elsewhere) than trans-men (female to male). "It's much easier for trans-men to undergo masculinizing hormone treatments and completely pass as male than the other way around."—H.B.

and gender-reassignment surgery for its employees. And it started offering such coverage to other employers who wanted it in their health policies. Policy exclusions for transgender treatments are still legal, but they aren't as common as they once were, says Deborah Thorp, M.D., an obstetrician/gynecologist who created and directs Park-Nicollet's Transgender Clinic in Minneapolis. "I'm seeing more employers putting transgender coverage in the bucket of what's covered," she says. "Some just cover hormones and counseling and not gender-reassignment surgery; but even that's a step in the right direction."

Nearly every major health insurer in the state now offers trans-inclusive policies to any employer that wants one, according to Phil Duran, legal director of OutFront Minnesota, a Minneapolis-based advocacy group for the lesbian, gay, bisexual, transgender (LGBT) community and president of the Minnesota State Bar Association.

As of June 2013, 287 employers nationwide offered trans-inclusive policies that include gender-reassignment surgery, up from only 85 employers two years earlier, according to the Human Rights Campaign (HRC), a Washington-based LGBT advocacy group that engages with the insurance industry and annually publishes the Corporate Equality Index, a list of transgender-friendly employers. Twenty-five percent of Fortune 500 companies are now on that Index. Thirty Minnesota-based companies are named including 3M, Best Buy, Target, Medtronic, General Mills and United HealthGroup. All of them cover their employees for counseling, hormone therapy, gender reassignment surgeries and short-term surgical leave when they have been diagnosed with gender dysphoria—a new term that replaced "gender identity disorder" in the American Psychiatric Association's DSM-5, which was published in May. "It never was a disorder," says Thorp. "It's a medical condition with psychological aspects—a disconnect between a person's anatomical sexual characteristics and their gender identity—that can be treated and which produces adverse effects when left untreated." She says "transgender" is an

umbrella term that includes most people with gender dysphoria—including those who have transitioned, those who have not and those who may not want to.

Most trans-inclusive employer health insurance policies pay for surgery, if it's deemed medically necessary, as defined by the Standards of Care prescribed by the World Professional Association on Transgender Health (WPATH), says Katie Spencer, Ph.D., coordinator of Transgender Health Services for the Program in Human Sexuality at the University of Minnesota Medical School. "That's the tricky part," she says. "I spend a lot of time writing letters to insurance companies on behalf of clients explaining why surgery is medically necessary. That usually works; but sometimes there's a lot of red tape to wade through."

It's still common, however, for employers to add exclusions to their policies, meaning they'll cover a transgender employee for nontransgender-related services, but won't cover transgender-related treatments. "That's discriminatory," Spencer says, "because when a person has been diagnosed with gender dysphoria, treatment is considered medically necessary, according to accepted standards of care."

Public plans lagging

Despite the lingering use of exclusions and cancellations, private health plans are actually ahead of public plans in providing comprehensive trans-inclusive coverage. Medicaid, MinnesotaCare and Medicare cover hormones and counseling but not surgery. OutFront tried but failed during the last legislative session to get transgender surgeries added back into all of Minnesota's state-sponsored health plans, the way it was between 1977 and 2005. (The Legislature started chipping away at funding for such procedures in 1994 and terminated coverage completely in 2005.) "It'll happen eventually," says Duran, "but it'll be a lengthy process."

OutFront did help get the University of Minnesota's student health plan to add reassignment surgery on the grounds that not doing so violated Minnesota's Human Rights Act. The Act protects against discrimination based on sexual orientation, which is defined broadly to include transgender people. "The implication of this ruling," Duran says, "is that any health plan that is subject to state law may violate the Act if it contains an exclusion for transgender services, which may prompt other health plans, public and private, to move toward trans-inclusive policies."

Minnesota's Department of Corrections did so in 2007 when it updated its transgender prisoner policy. Transgender prisoners housed at all state and local prisons are now entitled to transgender care but not surgery. "Several federal court rulings say that when a prisoner is denied that care, it represents a violation of the U.S. 8th Amendment that protects all citizens from 'cruel and unusual punishment,'" Duran says.

Beginning January 1, 2014, the Affordable Care Act prohibits denying transgender people coverage for services other people are entitled to, Duran says. It also indirectly improves coverage for transgender treatments, at least in Minnesota, because the state adopted a HealthPartners trans-inclusive plan that covers reassignment surgeries to serve as its model plan, meaning all other plans that are sold on the exchange must offer the same level of coverage.

Other legal cases have expanded transgender people's access to health insurance as well. In April 2012, a federal judge in Minneapolis ruled that Christine Radtke of Red Wing was entitled to the benefits in her husband's employee health plan. Radtke is a trans-woman (male-to-female) whose health coverage was terminated on the grounds that her marriage constituted a same-sex marriage. The ruling, however, determined that if a man becomes a woman and marries a man (or vice-versa), it is not a same-sex marriage; therefore, each is entitled to coverage under their spouse's health plan. Such couples in Minnesota will not need the protection of that ruling starting August 1, when same-sex marriages become legal in the state.

Duran foresees a time when all large employers will be required to provide trans-inclusive coverage because of the evolving interpretation of Title VII of the Civil Rights Act of 1964. The Act prohibits employment discrimination on the basis of sex, among other things. Sex is defined broadly to include transgender people.

Meanwhile, the Equal Employment Opportunity Commission (EEOC) takes the position that an employer-sponsored health plan that excludes coverage for medical conditions associated with protected characteristics such as race or gender may be employment discrimination. "It may only be a matter of time," says Duran, "before these two legal analyses intersect and result in a ruling that an employee health plan that excludes coverage for transgender-related services may constitute Title VII employment discrimination. When that happens, it'll change the playing field."

"When a person has been diagnosed with gender dysphoria, treatment is considered medically necessary, according to accepted standards of care."

–KATIE SPENCER, PH.D.

Benefits greater than costs

Trans-inclusive health insurance is catching on for a couple of reasons, according to Thorp. For one thing, more transgender people are coming out, which is making for more of a mainstream discussion.

Another is that large employers are realizing that adding trans-inclusive health benefits is not as expensive as they thought. Reassignment surgeries, hormones and tests to monitor the effects of those hormones cost anywhere from $25,000 to $75,000, depending on how much is done, according to the HRC. But a very small percentage of employees need these treatments, so they represent a small additional cost for employers that cover a

Transgender care

In 1966, the University of Minnesota created the second transgender health program in the United States. The first was established at Johns-Hopkins University that same year. In 1970, a medical team at the University of Minnesota successfully performed surgery on a pair of brothers who both wanted to be women.

Today, the university provides clinical services including prescription of medications; psychological, physical and psychiatric evaluations; recommendations for reassignment surgery; and sex therapy. In addition, the U runs support groups for and provides psychotherapy to individuals, couples and families; it also has programs for children and adolescents.

A handful of Minnesota primary care physicians, dermatologists, surgeons and behavioral health professionals have made transgender medicine part of their practice. Twenty-seven are listed on the Minnesota Transgender Health Coalition's directory of trans-friendly health care providers (www.mntranshealth.org).

One physician who specializes in care of transgender patients is Deborah Thorp, M.D., who started Park Nicollet's Transgender Clinic eight years ago because women becoming men were uncomfortable being seen in the obstetrics/gynecology department. Thorp and her colleagues refill prescriptions and monitor hormone levels and the health risks that come with hormone therapy. Hormones for trans-men and trans-women can increase risk for obesity, blood clots and stroke. "It's not a huge increased risk," she says. "But it's there and it needs to be monitored."

The Transgender Clinic provides ongoing trans-related gynecological care and cross-gender care that includes pap smears for trans-men and prostate screening for some trans-women. And they provide post-op care for those recovering from reassignment surgery. Other than the pain and swelling that follows most surgeries, Thorp says, "We rarely see serious complications." She explains that reassignment surgeries are generally safe and effective, especially male-to-female procedures. Hysterectomies and mastectomies for trans-men and breast implants for trans-women are done in the Twin Cities, but most reassignment surgeries are done in other cities or countries, according to Thorp. Thailand specializes in vaginoplasty, although there are a few places in the United States that do it, too. Chicago is a good place to go for facial feminization surgery. "But when they come home," Thorp says, "they need post-op care just like anybody else who has surgery."

On Thorp's wish list is transgender-specific billing and diagnostic codes. "There's not a good way to code hormones-for-life," she says. "Some physicians code it as 'medical management,' or for trans-males, they call it treatment for male hypogonadism. We need specific codes, which will happen as insurance discrimination against transgender people continues to decline."

She foresees a day when treating gender dysphoria will be so widely accepted that there will be a board-certified subspecialty in transgender medicine. "It's 10 years away," she says, then, pauses. "Make that 15. We've got a ways to go."—H.B.

large number of employees. "The University of Minnesota found that the cost of adding trans coverage to its student health plan was negligible," Duran says.

Nationwide, only 15 to 20 percent of transgender people choose to have reassignment surgery, according to HRC. That number is likely to go up, as trans-inclusive coverage becomes more common. "In the Netherlands, where surgery is completely covered, a much greater proportion of people who want reassignment surgery have it," Spencer says.

Experience elsewhere suggests that insurers and employers need not fear a spike in health costs if they cover transgender services. When the City and County of San Francisco made their employee insurance plans transgender-inclusive in 2001, they added a per-employee per-month surcharge to premiums to offset the expected additional cost. By 2006, they had spent only $386,417 of the $5.6 million collected from the surcharge and stopped collecting it. They concluded providing coverage for transgender services was less expensive than covering many other more common services.

Not treating gender dysphoria may actually cost more than paying to treat it. Transgender people whose bodies do not match their gender identity have the highest incidence of depression, anxiety, substance abuse, suicide, unemployment and homelessness of any population group, according to Minneapolis-based WPATH. They're also far more likely to be victims of violence. "When there is no insurance coverage for what they need," Thorp says, "most can't afford to get what they need and that creates a host of medical problems that are costly to the health care system. Treatment stops them from circling the drain and helps them be healthy, productive members of society. We don't have many good studies; but what we do have shows that transgender treatments are worth it, even just in terms of health care cost savings."

Eighty different studies from 12 countries over the past 30 years show that treatment that includes gender-reassignment surgery, when medically indicated, is effective for gender dysphoria, according to WPATH. "Nearly every person who has reassignment surgery says it improved their quality of life and mental health," Spencer says. "We also know that support and therapy during transition builds resiliency and helps them cope with society's stigma toward them."

"None of this is cosmetic or whimsical," adds Thorp. "No one wants to be transgender. They just are." **MM**

Howard Bell is a medical writer and frequent contributor to *Minnesota Medicine*.

Can we talk about SEX?

SEVEN THINGS PHYSICIANS NEED TO KNOW ABOUT SEX AND THE OLDER ADULT

BY JEANNE METTNER

Talking to patients about sexuality can be awkward at best. And when managing the health of older adults, many physicians assume they're off the hook for having these discussions—that sexuality is somehow less relevant to this population.

That's not true. Sexuality is important to older adults, but the issues that they contend with may not be the same as those of concern to younger persons. By not asking about it, physicians miss out on an opportunity to discuss with patients a key component of their health.

Minnesota Medicine talked with several sexual health experts to determine what it is that physicians need to know about sexuality and aging. Here's what they had to say.

1 IF YOU THINK OLDER PEOPLE ARE NOT HAVING SEX, THINK AGAIN.

Although research on sexuality and aging is sorely lacking, the data that are available do show that older adults are more likely than not to be sexually active. The August 2007 *New England Journal of Medicine* included results of a study by University of Chicago researchers who surveyed 1,550 women and 1,455 men ages 57 to 85 years. They found that the majority of the respondents (51 percent) engaged in intimate sexual activity with a partner (not limited to sexual intercourse)—and "regard sexuality as an important part of life." They also found sexual activity was most common among those participants 57 to 64 years of age (73 percent), followed by those in the 65 to 74 age group (53 percent). More than a quarter of participants ages 75 to 85 (26 percent) reported engaging in sex.

An AARP survey of people age 50 and older conducted in 2010 found similar results. Of the roughly 1,500 respondents, 28 percent indicated that they had sex once a week. Eighty-five percent of men and 61 percent of women said sex was "important to their quality of life."

Physicians need to take such information to heart, says Sara Mize, Ph.D., a licensed psychologist and assistant professor with the University of Minnesota Medical School's Program in Human Sexuality/ Center for Sexual Health. "One of the most important things to realize is that people can be sexual throughout their entire lifespan," she says. "As a society and as health professionals, we need to be regarding people who are 'older'—however 'older' may be defined—as sexual beings."

2 SEX CAN BE GOOD FOR *ANY* BODY—ESPECIALLY AN AGING BODY.

Being sexually active has numerous health benefits. A Scottish study of 24 women and 22 men found having sex reduced stress and lowered diastolic blood pressure. Another study of Wilkes University college students found that those who had sex once or twice a week had higher levels of the IgA antibody. Others have shown that having sex burns calories and boosts self-esteem. "It's not all that different from eating right, exercising, getting enough sleep and having social connections," says Brian Zamboni, Ph.D., a clinical psychologist and associate professor in the University of Minnesota Medical School's Program in Human Sexuality. "All of those issues are about quality of life, and in some respects, sexuality is one of the last bastions of promoting well-being."

In addition, being sexually active can help keep sex organs healthy. As Dr. Ruth Westheimer said, "use it or lose it." For example, vaginal atrophy, or thinning of the vagina, can occur when sexual activity declines or ceases, particularly as a woman ages. This can result in vaginal dryness and pain during intercourse. For older men who may be struggling with erectile dysfunction, lack of sexual activity can lead to feelings of low self-esteem, which can exacerbate the physical dysfunction.

3 DISEASE AND TREATMENT, MORE THAN AGE, AFFECT ONE'S ABILITY TO ENJOY SEX.

"Age itself is not a pathology," says Phyllis Greenberg, Ph.D., associate professor of gerontology at St. Cloud State University. "But with age comes changes, and those changes can affect a sexual relationship."

One major change for many older adults is having a chronic disease. People with arthritis and other movement disorders, for example, may have chronic pain or lose their ability to move well. People with diabetes, which can affect the circulatory system, may have reduced blood flow to sex organs, causing men to have difficulty achieving an erection or women an orgasm. Heart disease can be associated with fatigue and reduced physical strength. Dementia can have a number of effects, including loss of emotional connection

with one's partner and the inability of the partner with dementia to consent to sex.

Medications used to treat some of these conditions also can affect sexual health. For example, beta blockers can affect erectile function, as can medications used to manage diabetes and depression (see below).

Finally, surgeries that affect the reproductive organs, such as a prostatectomy or hysterectomy, can result in sexual dysfunction including difficulty achieving erections for men, vaginal dryness for women and decreased libido.

4 OLDER PEOPLE ARE STILL AT RISK FOR SEXUALLY TRANSMITTED DISEASES.

According to the U.S. Centers for Disease Control and Prevention, the rate of sexually transmitted diseases (STDs) among adults age 45 to 65 years has more than doubled in the last decade. Cases of syphilis among that age group rose from 900 to 2,550, and the number of chlamydia cases climbed from 6,700 to 19,600. In addition, HIV cases in this age group nearly doubled between 2007 and 2009.

Some commonly cited reasons for the growth are the increasing number of older people having sex with more than one partner (due to divorce or death of partner), lack of knowledge about STD prevention and lack of condom use. In an AARP survey of a nationally representative sample of older and middle-aged adults, only 12 percent of single men and 32 percent of single women who were dating reported always using condoms during sex.

"We know a lot more about safer sex than we did decades ago, but the older population may not be used to thinking in those terms, and they may not be aware of what protection is available and/or what types of behaviors put them at greater risk," Mize says. "Education and improved communication will definitely play a key role as we work to improve the rates of STDs among older adult populations."

5 EXPECTATIONS ABOUT SEXUAL EXPERIENCES NEED TO CHANGE AS WE AGE.

Mize sees "older" clients who want to have a sexual experience similar to what they had when they were 20 or 25. "So much has changed since they were that young—in terms of hormones, physiology, psychological and physical maturity," she says. "They've gone from that hormonal surge of attraction when they were in puberty and gradually moved into a bonding stage, where they have a much different set of needs and ways of being. If they keep looking back to their youth, they are totally missing what's in the here and now."

Mize encourages her patients to focus instead on their emotions and what is happening in their bodies right now. "When they find themselves slipping and thinking about that interaction they had when they were 25, and how much their sex life is not measuring up, they need to bring themselves back to the present," she says. "It requires a mental shift, really, more than anything."

6 "SEX" MEANS MORE THAN WHAT SOCIETY DICTATES.

Expanding awareness of what sexuality encompasses is essential to adjusting people's perception of their sexual health. "As soon as you say 'sex,' people think intercourse, penile penetration," says Greenberg. "The problem with that narrow definition is that if physicians discern that people aren't physically capable of sexual intercourse, they are not considered to be sexual. That excludes and negates many people's sexual experiences, including some older adults, people with disabilities and, of course, the whole LGBT population."

According to Zamboni, redefining "sex" can also help people be more accepting of sexuality in an aging body. "In our society, we tend to focus almost exclusively—and

MEDICATIONS THAT CAN AFFECT SEXUAL FUNCTION

erroneously—on goal-oriented sex, the goal being orgasm," he explains. "What physicians and their patients need to understand is that a person can have open-ended sex, a sexual experience without an orgasm, without full arousal, without penetration. The point is being able to connect, to touch, to be playful and to enjoy each other sensually."

In some cases, being sexually healthy may involve not being sexually active at all. "Some people choose not to engage in sexual experiences, and if that is their choice and they are happy with that choice, that's sexually healthy, too," says June La Valleur, M.D., a retired obstetrician/gynecologist and professor in the University of Minnesota Medical School. "Some people opt to abstain from sex or be celibate, and that is just as valid a decision as deciding to maintain a sexual relationship with a partner."

7 PATIENTS WANT TO TALK ABOUT SEX.

For both patients and physicians, discussing anything related to sex can be uncomfortable. But patients want their doctors to bring up the issue. A survey of 391 women by the Women's Sexual Health Foundation found 72 percent said they would be comfortable if their health care provider initiated a conversation about their sexual health and 73 percent preferred that the provider broach the topic rather than bringing it up themselves. Yet only 9 percent of the women reported that their physicians asked them about female sexual dysfunction issues such as vaginal dryness, pain during sex, reduced libido and difficulty with arousal. Another study conducted by a team of University of Chicago researchers and published in the May 2012

"IN OUR SOCIETY, WE TEND TO FOCUS ALMOST EXCLUSIVELY—AND ERRONEOUSLY—ON GOAL-ORIENTED SEX, THE GOAL BEING ORGASM."

BRIAN ZAMBONI, PH.D.

A number of medications have undesirable sexual side effects including erectile dysfunction, vaginal dryness, decreased libido and decreased sexual response. The following are some that can affect sexual function in both women and men.

STATINS AND FIBRATES

Prescribed to treat high cholesterol, these drugs can also affect the production of testosterone, estrogen and other sex hormones. This can lead to difficulty with arousal, erectile dysfunction and difficulty achieving orgasm.

BLOOD PRESSURE MEDICATIONS

Many blood pressure medications can have sexual side effects. Diuretics, for example, can affect the flow of blood to the genitals, while beta blockers can reduce testosterone levels, affect the nerve impulses associated with arousal and increase fatigue.

ANTIDEPRESSANTS

Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and norepinephrine and dopamine reuptake inhibitors (NDRIs), can be associated with difficulties with ejaculation in men and decreased libido in both men and women. –J.M.

STARTING THE CONVERSATION

One method for structuring a conversation about sexual health is the four-staged approach developed in the 1970s by psychologist Jack Annon known as PLISSIT:

PERMISSION

Ask the question—"How is aging affecting your sex life?" Doing this gives patients permission to start a dialogue about their concerns. "If you don't ask that one question, a message is being sent that you shouldn't be engaging in sex—or that it's not important at your age," says Sara Mize, Ph.D., a licensed psychologist and assistant professor with the University of Minnesota Medical School's Program in Human Sexuality/Center for Sexual Health.

LIMITED INFORMATION

Offer specific, relevant information regarding the patient's concerns. An example of limited information might be, "Yes, difficulty achieving an erection can occur with this medication."

SPECIFIC SUGGESTIONS

Provide the patient with strategies for improving sexual function. Erectile dysfunction might be ameliorated with medication, injections or implants, for example. Lack of mobility because of arthritis may mean that the patient has to try different positions with his or her partner. Physical fatigue may require the patient to rest briefly before sex—or to try it at different times during the day. A patient with heart disease may need to take sexual activity slowly or take frequent breaks. Blood flow problems associated with diabetes can be improved with medications or other modalities.

INTENSIVE THERAPY.

If the specific suggestions do not work, you may need to refer the patient to a sex therapist, urologist, gynecologist or another specialist. –J.M.

issue of the *Journal of Sexual Medicine* found that only 40 percent of ob/gyns ask patients if they were experiencing sexual difficulties and only about 29 percent routinely ask patients about satisfaction with their sex lives.

Experts note that some of the reasons why physicians don't bring up issues related to sexual health include lack of time, discomfort with the topic, and a perceived lack of solutions or treatments. Greenberg says she has known of health care providers who don't discuss STDs with older adults because they are "too embarrassed." "They may wonder whether they will offend their patient or client, but I would rather err on the side of offending people than not providing the information or allowing the spread of misinformation," she says.

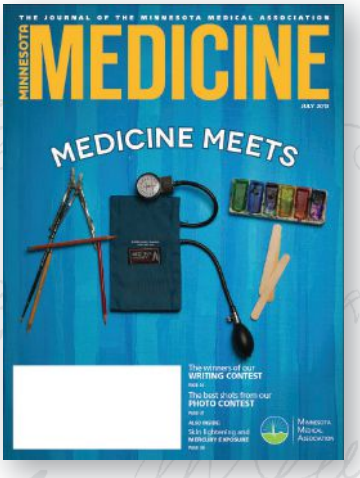
One reason physicians are uncomfortable asking about sex is that many of them didn't learn to talk about sexuality with their patients in medical school or residency and feel they don't have the background or skills they need to have the discussion. The University of Minnesota Medical School does require all first-year students to take a semester-long course on sexual health. One approach to broaching the conversation with patients is PLISSIT (see "Starting the conversation").

You don't have to have all the answers

Physicians cannot possibly know everything about managing patients' sexual health. "Medical doctors cannot expect themselves to be able to address the systemic, emotional and cognitive aspects of sexual concerns; they just can't know it and do it all," Zamboni says. But they can be there for their patients. And they can get to know other professionals with more expertise who can help ensure their patients' concerns are addressed. "The biggest job of the physician," he says, "is to offer awareness, recognition and hope that sexual functioning is possible for older individuals." MM

Jeanne Mettner is a frequent contributor to *Minnesota Medicine*.

CELEBRATE
A Decade of Musings



Join us for a special **Hippocrates Café** marking the 10th anniversary of *Minnesota Medicine*'s Medical Musings Writing Contest

Hosted by Hippocrates Café founder Jon Hallberg, M.D., the evening will feature professional actors reading poetry and prose by Minnesota physicians and medical students.

Enjoy music and light refreshments, socialize with your colleagues, and celebrate the creative side of medicine.

Thursday, September 19
7 pm
Mill City Clinic
901 S. Second St., Suite A
Minneapolis, MN 55415

To register go to mnmed.org/hippocrates

Sponsored by the Minnesota Medical Association

Minnesota Medical Association

Each morning at St. Damien begins with a funeral mass to honor those who died the previous day. Here Fr. Frechette says prayers over the bodies of deceased patients.

PHOTOS COURTESY OF DANIEL HOTTINGER

An ethic for working in Haiti

Solving the country's problems requires changing the hearts and minds of those who live and work there.

BY DANIEL HOTTINGER

For many foreigners (*blan* in Haitian Creole) like me, what we profess to know and what we write about Haiti only scratch the surface of reality for the country and its people. Part of the problem is that few of us learn about the country's origins and the events, values and beliefs that have shaped its people and led to its current condition.

We simply see Haiti as a failed state. Its institutions are weak and corrupt; it relies on foreign powers for financial aid and to keep the peace. But this situation didn't happen overnight; it developed over 200 years. The enslavement of African tribespeople by French colonists brutalized the Haitian psyche, instilling fear and ignorance. At the turn of the 19th century, after a series of wars to win independence from France, Haiti's national heroes ruled and rebuilt exactly as their French masters did—by forcing inhabitants to work plantations to support the crop-based national economy. They slaughtered experienced public administrators, which contributed to decades of economic stagnation.

An inability to forgive and a commitment to violence continue to take their toll on the country. A few months ago, a group of boys were swimming in a ditch that carries rainwater past St. Damien Hospital, where I worked this past year. One boy drowned inside the drainage pipe. The next day, his grieving family came in search of the other boys, accusing them of murder, and attempted to kill them. They could not accept that it was an accident, that boys just 8 and 11 years old, though foolish, didn't know any better.

Haiti also is held back by chasms of race and class. Twenty percent of its population is rich, white and educated. The other 80 percent are black, poor and uneducated. Religion, language and geography further divide people. Understanding these divisions is critical because they underpin all politics and impair compromise and development. Even the most promising and gifted Haitian ruler, Lysius Salomon, who entered office in 1879 with a national development plan and unique leadership style, was essentially incapacitated by racial and class divisions. In fact, the only times (outside the U.N. and U.S. occupations) that Haiti has not been beset by war, political upheaval and coup d'états have been when one ruler used violence to subdue vying political factions, always along racial, regional and class divisions. Sadly, this has been the only successful formula for long-term government stability.

Today Haiti is largely run by NGOs. Millions of donated dollars have been spent, with very little to show for that. The wealthy elite still oppress the poor masses. Government officials continue to rob the public of its wealth and future. Yet many NGOs ignore these realities. When their funding dries up, they leave, and the country's underlying problems remain.

Although much about the current situation is grim, there are bright spots. I saw them daily as I worked as a volunteer for Nos Petit Frères et Soeurs (NPFS) and the St. Luke Foundation for Haiti. I took a year off from my medical studies at the University of Minnesota to help manage a surgery program, assist in patient care, start a central pharmacy, and conduct research and quality improvement projects at St. Damien Pediatric Hospital and St. Luke Family Hospital. I had wanted to go to Haiti since spending a year before

medical school volunteering for NPFS in Honduras. There, I helped St. Paul orthopedic surgeon Peter Daly, M.D., as he built an outpatient surgery center for the poor. Although I was familiar with the medical care being provided by NPFS and St. Louke in Haiti, it wasn't until I lived and worked there for some months that I began to understand the depth and complexity of the country's problems.

But I also encountered dedicated Haitians working tirelessly to better the health and lives of their fellow citizens. One such person is Shedene, an ICU and OR nurse who often goes from a 12-hour shift at St. Luke to working the night shift at St. Damien. She is a tireless advocate for her patients, trying to get them the medical supplies they need in a hospital with scarce resources. Shedene is one of more than 2,200 Haitians working for NPFS and St. Luke who believe in advancing the country through education, industry and health care. And they give me hope for a better future for Haiti despite the overwhelming problems it faces.

St. Luke and NPFS are models for how foreign intervention should be: locally driven and invested in the long term. NPFS cares for more than 3,000 orphaned and abandoned children across nine Latin American countries. In Haiti, they operate St. Damien Hospital, a 120-bed facility that treats more than 100,000 patients a year and has high-risk maternity and neonatology services and an HIV clinic. NPFS in Haiti is directed by Father Rick Frechette, a dynamic American Catholic priest and doctor, who established the orphanage there 26 years ago. Some years later, he founded St. Luke to combat the poverty and disease that confront children when they leave NPFS and enter the broader community. Fr. Rick believed it was not enough to raise these children to adulthood; he also believed in working to better the conditions of the country they were inheriting. St. Luke educates some 9,000 children in 30 schools throughout Haiti, supports microbusinesses, builds houses in the slums of Cite Soleil, operates hospitals, clinics and cholera centers, and provides dignified burials. Collectively, these projects affect the lives of more than 150,000 Haitians each year.

ABOVE: Evidence of the 2010 earthquake in the historic market district in downtown Port-au-Prince. RIGHT: NPFS employees and children from the orphanage team up with foreign volunteers to participate in a soccer tournament.

In reality, what St. Luke and NPFS are doing is missionary work. They are seeking to change the hearts of those who would otherwise lie, steal, cheat or murder for the sake of self-preservation and increase the number of those who work for justice, peace and prosperity.

I've come to see that changing hearts is the only thing that will truly make a difference in Haiti. If the country is to move forward, its people will need to exchange fear, selfishness, hatred and violence for trust, selflessness and forgiveness. This means deeply divided factions must put past grievances behind them and work together rather than plot against one another. Haitians must put their faith in institutions, which until now have largely failed them, rather than individual leaders. Voodoo practices that prey on fear and divide people must be abolished. Foreigners working in Haiti must learn Creole. And, from time to time, U.N. peacekeepers must get out of their armored cars and tanks, put down their assault rifles and distribute food.

This all may seem idealistic; but if the missionary isn't hopeful, then we all might as well pack up and go home. Interventions that fail to change fundamental flaws are merely bandaging a wound, pouring aid dollars down a black hole, spitting in the wind. I arrived in Haiti a year ago just another ignorant *blan*, but I've learned from this experience that the real work is in changing hearts and minds—to elevate the consciousness of a nation. Although this may take years, at least we will know we are engaged in the right task. **MM**

Daniel Hottinger is a fourth-year medical student at the University of Minnesota. He volunteered for NPFS and St. Luke from July 2012 to April 2013.

The Olsen family in Kenya.

PHOTOS COURTESY OF PETE OLSEN

Fancy

My first delivery in Africa.

BY PETE OLSEN, M.D.

I had been wondering for months, maybe even years, what my first delivery would be like after we arrived in Africa. Would it be a vaginal delivery? A cesarean section? Would instruments be available? What about assistants? Would I even be in a hospital? You see, I'm used to the very best.

As a third-year resident in the Duluth Family Medicine Residency Program, most of the vaginal deliveries I've participated in involve two or more physicians—an attending, a resident and sometimes an intern. By the time the patient is ready to give birth, she and the baby have been carefully monitored for hours. We have a good idea of what to expect, and we have everything we need in case something doesn't happen the way it should.

For those deliveries that take an unexpected turn, we can change over for a cesarean section in about 10 minutes. By the time the patient arrives in the pristine operating room, an array of sterilized, neatly wrapped surgical tools is waiting for us, along with a team of trained surgical technicians who will later hand them to us when requested (often even before as they know each surgery so well). An anesthesia team is there to provide pain control and to intubate and breathe for a patient in case of a "crash section" (emergency surgery to save mom and/or baby). The Neonatal Intensive Care Unit has a resuscitation team and an incubator ready in addition to all the tubes, lines and cords needed for the most serious of resuscitations. Our awesome obstetric nurses are there, too.

I could go on, of course. But I'm not there. I'm in Africa. And it's different here.

It didn't start the way I expected it would. I was paged to Casualty (the emergency department) to attend to an 18-year-old who was pregnant with her first child. She hadn't reported any contractions or vaginal bleeding. I didn't have time to ask if she had felt her baby moving.

When I arrived in the small room crowded with eight beds and patients standing or sitting as they waited for care, the clinical officer (CO, similar to a physician's assistant) looked at me with panic. He pulled back a curtain to reveal a flurry of activity around a young woman lying on a bed. A nurse was hurrying to start an IV while humming a hymn. Another nurse had just arrived with an oxygen mask, freshly washed and ready for use.

The CO rapidly explained that two girls had dropped the patient off at the door. I felt the young woman's pedal pulse. It was weak and thready. I glanced up at her face. She looked slightly ashen and was gasping for air. Her uterus was at or below her belly button, meaning that the baby was either small or at about 20 weeks gestation or less. (A nurse confirmed she was 20 weeks pregnant shortly thereafter.)

Don't forget the ABCs, I told myself. Airway, Breathing and Circulation. She had a pulse, and she was breathing (albeit with difficulty), but she was losing her airway. As I moved to the head of the bed, a dark liquid began spilling from her nose and mouth. We suctioned, intubated and started breathing for her. Then we placed a nasogastric tube and suctioned another 200 mL or so of the black substance from her stomach. We still don't know what it was.

By now, the patient's heart rate was in the 130s. One of the nurses looked up and told us the initial blood pressure was 70/50 mmHg, but now she couldn't get one. I felt the patient's neck for a carotid pulse; there was none. "Start CPR," I said.

With the chest compressions we heard intermittent cracks (ribs breaking from the pressure). At two minutes, we checked for a pulse and gave epinephrine to shunt blood back to the heart and encourage cardiac activity. We kept doing CPR and giving her epinephrine every three minutes, checking for a pulse each time. After 40 minutes without a pulse, I called it. "Time of death: 10:24 a.m.," I said softly.

I helped the nurses clean the patient, remove the lines and apply fresh linens. Then I prepared for the hard part—telling the family that the mother and her baby had died.

Two days later, the family returned with one request: to have the opportunity to bury the mother and baby separately. I spoke with my supervising physicians who agreed this was reasonable.

I led the family to the morgue and had them wait in the office. It was time for my first delivery in Africa, a postmortem cesarean section.

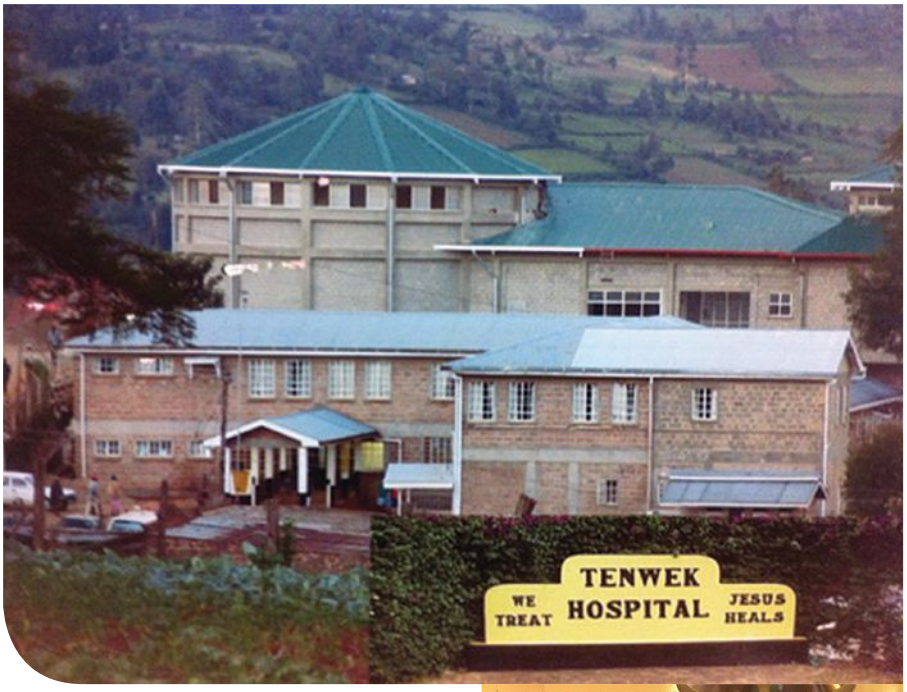
She lay draped in a perfect white sheet on a rusty, steel table. Even though the mother was dead, I used a surgical technique very similar to the one my attendings in Duluth had trained me to do. As I cut, the smell of formalin filled my nostrils. A moment later, I delivered a beautiful, tiny, lifeless little girl. I carefully closed the mother's tissues, using a subcuticular stitch to close the skin. It wasn't necessary, but it felt like the right thing to do.

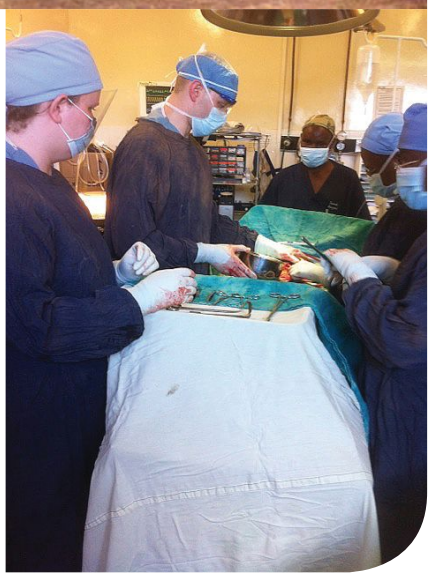
I draped the mother again and then carefully attended to her little girl, who was only slightly larger than my hand. I washed her gently and placed her in a new swaddling blanket, her arms gently folded.

One of the morgue attendants went to get the father and the rest of the family. They arrived, not knowing what to expect, but when dad saw me holding his baby girl, his eyes started tearing.

I asked if she had a name. "Fancy … Fancy is her name," he said, barely audible. "Well, Fancy is a beautiful little girl," I said, handing the swaddled baby to dad. "I'm sorry that her time with us was so short, but I believe that she is now with Jesus where there is no pain and no suffering … where we'll all be together again."

I began to pray, my two fingers on the side of Fancy's head as we invited God to be with us and bring His peace. Everyone, now in tears, slowly filed out of the room. Dad stayed a moment, took one last look at Fancy, handed her to me, and said, "Asanti" (thank you).





ABOVE: Tenwek Hospital, where the author spent two months this past year as part of his residency training. RIGHT: Performing an emergent cesarean section at Tenwek Hospital.

The rain refreshed us as we walked from the morgue back to the hospital, where we parted ways. It was early evening, and I was done for the day. I loosened my tie and draped my white coat over my arm to the let the rain gently wash over me on the way home.

I was greeted by a beautiful little girl who came dashing up to me yelling, "Daddy, Daddy, I have an umbrella for you." I scooped Ella into my arms and kissed her. I walked toward apartment No. 7 and let my eyes meet Angela's. She knew instantly. She simply has a way of knowing that no one else does. I kissed and snuggled Sam, our son, before she quickly swept both children into their bedrooms for the night. I let the warm shower wash off the formalin, then I dressed and sat on the living room couch, reflecting on what had happened.

Hester Lynch Piozzi, an 18th century British author, once said, "A physician can sometimes parry the scythe of death, but has no power over the sand in the hourglass." It's true.

But it's also true that one of the most compassionate things we can do for one another is to relieve suffering and pain—to make room for healing. And tonight, when one dad looked back at another, there was a silent understanding that healing had begun, and then a quiet "Asanti." **MM**

Pete Olsen practices emergency medicine at Cloquet Memorial Hospital in Cloquet, Minnesota. He was at Tenwek Hospital in Bomet, Kenya, through World Medical Mission for two months this year. He and his family eventually plan to move to Africa where he will train family physicians. To read more about his experiences go to www.littleolsen.blogspot.com.

This story received honorable mention in *Minnesota Medicine's* 2013 Medical Musings writing contest.

PHOTO BY JULIANA MILHOFER

A FEW MINUTES WITH…

Carol Falkowski, Minnesota's foremost drug abuse expert

BY DAN HAUSER

Carol Falkowski has been busy the past few months, which is both good and bad. It's good because it means her new consultancy, Drug Abuse Dialogues, is off to a great start. It's bad because it means that prescription opioid abuse continues to be a concern in Minnesota.

"We have a prescription opiate problem in this country and in this state, the likes of which we have never seen," Falkowski told physicians and other health professionals who gathered in Duluth for an MMA-sponsored forum in mid-May. The event was the third of four such forums Falkowski has taken part in this year.

Prescription opioid abuse is a serious issue that needs serious attention, she says.

- It is the fastest-growing drug problem in the United States
- Approximately three out of four prescription drug overdoses are caused by prescription opioids
- An estimated 35 million people age 12 and older report using prescription pain relievers nonmedically at least once in their lifetime
- In 2010, 210 million prescriptions for opioid medications were filled at retail pharmacies (there are 313.9 million people living in the United States)
- More emergency department visits are related to prescription drug misuse than illicit drug use.

Given these facts, it should be clear why Falkowski is often requested to appear on local and national news programs or at forums such as those sponsored by the MMA.

Falkowski says she founded her consultancy in October 2012 to advance the understanding of drug abuse through education and dialogue. Before that, she served as drug abuse strategy officer for the Minnesota Department of Human Services, where she developed Minnesota's first statewide substance abuse strategy in collaboration with a number of other state agencies. She is an expert on the epidemiology of drug abuse, addiction and public

policy related to drug abuse and is author of the reference book *Dangerous Drugs*.

We were able to get a few minutes of her time between guest appearances to discuss her work with Minnesota physicians and how they can help stem the crisis.

You recently took part in a series of forums with the MMA on prescription opioids. In your interaction with the physicians at these events, what was your big take away?

If we continue business as usual, this problem will only continue to escalate. All physicians who attended the forums were aware of the emerging challenges regarding opioids and addiction. These forums were an effective mechanism for sharing their experiences, learning new information and initiating dialogue about effective solutions. My hope is that these forums are just the beginning and that they will serve as a catalyst for decisive action.

Did the physicians bring up any issues that surprised you?

Among physicians and other health professionals there is a pressing need for basic education about addiction—what it is, how to identify it and how to treat it. While many doctors are experts in this area, others simply lack training and, now in the midst of Minnesota's opioid epidemic, find themselves in immediate need of additional education and answers.

Also, I was struck by how many physicians were confronting this [opioid misuse] every day and have been for quite some time.

How does Minnesota compare with the rest of the country in terms of combatting prescription opioid abuse?

Some states have been much more effective and expeditious than Minnesota in responding to the prescription opioid crisis. Multiple state agencies developed Minnesota's first-ever State Substance Abuse Strategy that was released in September 2012. It identified opiate and heroin abuse as the No. 1 priority and called for three action steps. Yet none of those specific recommendations were acted upon in the last legislative session. So Minnesota has a plan but apparently not the political will to make it happen.

PHOTO COURTESY OF TWIN CITIES PUBLIC TELEVISION

Carol Falkowski (right) recently appeared on a public television program on heroin use in Minnesota. Here, she talks with host Mary Lahammer.

Consequently, some Minnesota doctors have continued to unknowingly prescribe opiate medications to active addicts. Pain patients have developed opiate addiction and some have moved on to heroin. Some professionals diverting prescription opiates have continued to escape detection.

> Approximately three out of four prescription drug overdoses are caused by prescription opioids.

More pharmacies and homes have been robbed. More overdoses have been treated in hospital emergency rooms. More Minnesotans have buried their loved ones due to opiate overdose death.

Policies cannot be realized without the political will to make them happen. Minnesota policymakers must act decisively and promptly to turn the tide of prescription opioid and heroin addiction.

What are the basic tactics physicians can employ to address the issue?

Physicians can re-examine their opiate prescribing practices and protocols; start screening all patients for substance abuse; educate themselves about addiction and its treatment, pain management and opiate prescribing; and always use the state's Prescription Monitoring Program (http://pmp.pharmacy.state.mn.us/). And when they encounter practical roadblocks and operational barriers, physicians must proactively develop and advocate for needed changes and improvements.

For example, if there are barriers to making the Prescription Monitoring Program useful, they must step up, weigh in and help make it better.

What will it take to solve this problem?

These issues will not subside without changes in medical practice around the use of opioids, period. There is a role for everyone to play, especially physicians. MM

News briefs

Appeals court rules against Avera medical staff

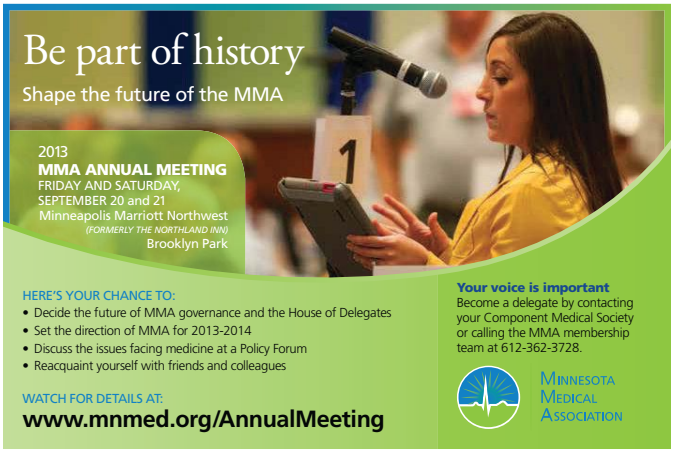
In late July, a three-judge Minnesota Court of Appeals panel affirmed a district court's ruling that the Avera Marshall Medical Center staff is not a legal entity with the capacity to sue. In addition, the panel upheld the lower court's ruling that bylaws do not constitute a contract between the medical staff and the hospital.

2013 Annual Meeting registration now open

This year's Annual Meeting September 20-21 at the Minneapolis Marriott Northwest in Brooklyn Park promises to be a lively one as delegates debate the future of the MMA.

After years of study and deliberation, this year's House of Delegates is set to decide how the organization will be governed in the future.

The discussion will cover a range of options from providing the House of Delegates with more authority to abolishing the group altogether.



In addition to the governance debate, the Annual Meeting provides members with a great opportunity to:

- Set the direction of the MMA for 2013-2014
- Express their opinion at a Policy Forum
- Reconnect with friends and colleagues.

Your voice is important. Become a delegate by contacting your Component Medical Society or calling the MMA membership team at 612-362-3728.

For more information, go online to www.mnmed.org/AnnualMeeting.

Insights explores the future of the MMA

What does the future hold for the MMA? That question is explored in the latest edition of *Insights*, the MMA's quarterly opinion piece on topics of interest to Minnesota physicians. MMA Board Chair Dave Thorson, M.D., discusses whether the current governance structure needs to change in order for the MMA to better engage its members. Go to www.mnmed.org/Publications/Insights.

Forum to discuss how "loss of chance" malpractice affects physicians

The MMA will host a forum to discuss the Minnesota Supreme Court's ruling on the Dickhoff v. Green case on August 28 at 6 p.m. at the Ramada Plaza Minneapolis.

The event will allow physicians to discuss the May 31 decision that reversed law that had held that a physician may only be liable for harm a patient actually incurs. Under the old law, a patient had to establish that the physician's negligence more likely than not caused his or her alleged harm in order to prevail on a claim for medical malpractice. Now, a patient merely has to establish that the physician's negligence made survival or recovery less likely—even if survival was unlikely in the natural course of the disease.

Minnesota joins approximately 25 other states that recognize "loss of chance" claims for medical malpractice. The ruling has the potential to generate a significant increase in medical malpractice claims, most of which will likely be missed cancer diagnoses.

The event will feature Mark Whitmore of the Minneapolis-based firm, Bassford Remele, and Martin Stillman, M.D., J.D., of Hennepin County Medical Center.

Cost is $25 for members and $10 for residents and medical students ($40 for nonmembers). To register, visit www.mnmed.org/courts.

Minnesota delegation supports successful resolutions at AMA Annual Meeting

Minnesota's delegation had a successful trip to the AMA Annual Meeting in Chicago this past June in terms of the resolutions it supported.

The Minnesota-supported resolutions that were considered included:

- Resolution 9, which called for the AMA's Council on Ethics and Judicial Affairs (CEJA) to undertake an in-depth study of all the issues related to restrictive covenants. This resolution was drafted by the MMA's Committee on Ethics and Legal Affairs and was approved by the MMA Board of Trustees because of the growing use of restrictive covenants by large hospital and

clinic systems. It was referred to the AMA Board since CEJA is already studying this issue.

- Resolution 215, which asked that the AMA support the creation of a new advisory board to review and recommend U.S. Farm Bill budget allocations to ensure that any government subsidies only be used to help produce healthy and sustainable foods. It also asks that advisory committee members include physicians, public health officials and other public health stakeholders. It originally recommended that existing AMA policy be reaffirmed in lieu of this resolution. However, Minnesota delegate and MMA Past President Benjamin Whitten, M.D., convinced the House of Delegates to adopt this new resolution.

The House also acted on a resolution that was first introduced in 2012 by Minnesota and referred to the Board for study. The resolution asked the AMA to examine the current training environment to ensure that residents receive the needed exposure to procedures to master their skills. The AMA recommendations were included in the Council on Medical Education's Report 8 "Changing Training Environment: Access to Procedural Training for Residents and Fellows." The report recommends that the AMA adopt policy supporting the concept that procedural training is a critical portion of resident education and the augmentation of patient care by nonphysician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.

The MMA was represented by six delegates and six alternates as well as its President, President-Elect, Board Chair and four staff members.

MMA concerned with policy changes at large retail pharmacies

A policy change at large retail pharmacies such as Costco, Walgreen's and CVS has the MMA concerned that some pharmacists may be overstepping their roles in dispensing prescriptions.

Because of increased DEA scrutiny, large retailers have asked their pharmacists to take additional precautionary steps when filling prescriptions for controlled substances, including opioids. In some cases, this has included calling the prescribing physician to confirm the prescription. But in others it has involved requesting the ICD-9 code, quizzing a physician about a patient's diagnosis or simply refusing to fill a legitimate prescription.

"We understand the desire for increased scrutiny regarding the prescribing of controlled substances," says Juliana Milhofer, MMA policy analyst. "But the MMA is concerned that these policies may be creating barriers to the proper prescribing and dispensing of controlled substances."

If you have experienced excessively intrusive requests for information associated with a controlled substance prescription or have had patients who have had a legitimate prescription denied by a pharmacist, please contact the Minnesota Board of Pharmacy at 651-201-2825. Also, please alert Teresa Knoedler, J.D., MMA policy counsel, at tknoedler@mnmed.org so we can keep track of the issue.

George Schoephoerster, M.D.

MMA to focus on administrative burdens with new consultant

George Schoephoerster, M.D., a family physician from St. Cloud who works with Geriatric Services of Minnesota, will consult with the MMA over the next six to nine months on ways to reduce the hassles associated with prior authorization of prescription medications.

"Dr. Schoephoerster will bring an excellent perspective to what has become a top strategic priority for the MMA," says Janet Silversmith, MMA's director health policy. "Being a practicing physician and dealing with the various administrative burdens on a daily basis will prove invaluable to our work."

Schoephoerster has been active with the MMA for the past 30 years. Last year, he received the President's Award, which recognizes physicians who have given much of their free time to serve the association and make it better. He is also a member of the AMA, the American Geriatric Society, the American Academy of Family Physicians and MEDPAC. In addition, he has served on MMIC's Board of Directors.

Survey says: Minnesota physicians value MMA programs and services

Nearly two-thirds of MMA members who responded to a recent value/satisfaction survey said they see value in MMA programs and services and are satisfied with how the organization is performing. Only about 10 percent of respondents said they saw little or no value in MMA programs and were unsatisfied with its performance. These results are similar to those from the 2012 survey.

"'Focused for Success,' the MMA's strategic plan, seems to be gaining traction," says Terry Ruane, MMA director of membership, marketing and communications, who oversaw the survey, which was sent to members and nonmembers throughout Min-

nesota. Fifty-four percent of respondents said they were satisfied with the MMA's strategic direction compared with 46 percent in 2012.

One new question had disappointing results, however. The survey included a "Net Promoter Score" question ("How likely would you be to recommend MMA membership to a colleague?"). This type of question is used by organizations as another way to look at value.

"Unfortunately, the MMA didn't fare as well as we would have liked," Ruane says. With a scoring range of minus 100 to plus 100, the MMA received a minus 12. Any score above zero is considered good, and scores above 50 are considered excellent. Companies that have scored above 50 include Trader Joe's, Costco, Apple and Amazon.

Members said that the most valuable MMA services are its support of the medical profession, which includes the MMA's work on behalf of physicians at the Legislature, at state agencies and in the courts; its educational programs; and its news and information services.

Respondents also indicated that the MMA offers great value to physicians, brings integrity and leadership to medicine in Minnesota, offers effective advocacy and provides quality communications. Some of the concerns members and nonmembers listed included the price/value of membership, the fact that the MMA does not have an impact on physicians' practices, and the MMA's political views, which were described by respondents as everything from conservative to liberal to socialist.

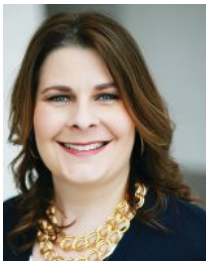
Major concerns physicians have for the future included reimbursement and compensation, administrative burdens, the future of health care, physician shortages and malpractice/tort reform. The MMA plans to work on several of those issues in the coming year.

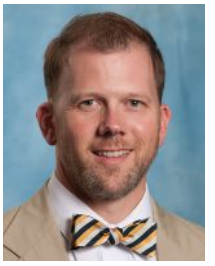
More than 670 physicians, residents and medical students completed the survey—a 70 percent increase over the number who responded in 2012. Results were presented to the Board of Trustees in July and will be used by the MMA as it develops 2013 and 2014 programming.

Members making a difference

Kathryn Lombardo, M.D., began her first term as the new president and Board of Governors Chair for the Olmsted Medical Center (OMC) on July 1. Lombardo joined OMC's department of psychiatry and psychology in 1994 and most recently served as that department's chair. Lombardo succeeds internist **Roy A. Yawn**, M.D., who served two three-year terms as OMC's president beginning in 2006.

The National Alliance on Mental Illness (NAMI) honored **Jonathan Uecker**, M.D., psychiatric medical director at Nystrom & Associates, Ltd., with its annual Exemplary Psychiatrists Award at the American Psychiatric Association's annual conference in May. He was among 20 psychiatrists throughout the United States who were honored. NAMI state organizations and affiliates nominate psychiatrists who have "gone the extra mile" in their commitment to excellent mental health care and by working alongside NAMI members in their communities for public education and advocacy.


Kathleen Baumbach


Brian Strub


Dave Renner


Lyle Swenson, M.D.

MMA in action

Kathleen Baumbach and **Brian Strub**, the MMA's managers of physician outreach, attended the University of Minnesota's resident orientation in mid-June and again in early July. They also attended the University of Minnesota's family medicine orientation in mid-June.

Baumbach and Strub took part in a seminar on "Working with Medical Interpreters" at Smiley's Family Practice Clinic in Minneapolis in June and for a group of care coordinators at Park Nicollet in July.

Baumbach and **George Lohmer**, MMA CFO, attended a retirement party for MMA Board of Trustees Member Roy Yawn, M.D., in Rochester in late June. The event was hosted by the Olmsted Medical Center Board of Governors and Administration.

In June, **Dave Renner**, MMA director of state and federal legislation, conducted a listening session and legislative update at Grand Itasca Clinic and Hospital in Grand Rapids. He also held a listening session with leaders from the Minnesota Academy of Family Physicians.

In late June, Strub and MMA Immediate Past President **Lyle Swenson**, M.D., and MMA Board Chair, **David Thorson**, M.D., held a listening session at St. Croix Orthopedics in Stillwater. The event was hosted by Twin Cities Medical Society Board Member Nicholas Meyer, M.D.

Swenson and Strub also held a listening session at Metro Urology in Woodbury in mid-July.

In June, **Terry Ruane**, MMA director of membership, marketing and communications, attended The Physician Foundation's Physician Leadership Academy at the Kellogg Business School on the campus of Northwestern University in Evanston, Illinois. There, he and association leaders from across the country learned business techniques from Kellogg professors and networked about issues they are facing in their state associations.

VIEWPOINT

Physicians need help in the courts

PHOTO BY STEVE WEWERKA

Dave Thorson, M.D.

The results from the recent MMA value/satisfaction survey confirm that our members are satisfied with the association's work at the Capitol and with the Department of Health, Department of Human Services, the Board of Medical Practice and other state agencies. This is great news. But, it's our work in the courts that really gets my attention. Each year, it seems another case comes along that can drastically alter how we practice medicine. I, along with many of the survey respondents, am very concerned about the future of malpractice and the place of health care in the courts.

As physicians, we are used to calling the shots. We are well-trained decision makers. But when it comes to the legal arena, we sometimes feel powerless and that is concerning. That's why so many of us grade the MMA's legal advocacy so highly on value/satisfaction surveys. Physicians need help in the courts.

And you couldn't find a more perfect example of this than the Dickhoff v. Green case recently reviewed by the Minnesota Supreme Court.

The Court ruled that a claim for medical malpractice exists if a physician's negligence causes a patient's chance of survival to be reduced. The 3-2 decision reversed law that had previously held that a physician may only be liable for harm a patient actually incurs. Under the old law, in order to prevail on a claim for medical malpractice, a patient had to establish that the physician's negligence more likely than not caused the patient's claimed harm. Now, a medical malpractice claim may prevail if a patient merely establishes that the physician's negligence made survival or recovery less likely—even if survival is unlikely in the natural course of the disease.

With this ruling, Minnesota joins approximately 25 other states that recognize a "loss of chance" claim for medical malpractice.

If this Supreme Court ruling isn't on your radar already, it should be. This ruling has the potential to generate a significant increase in medical malpractice claims, most of which will likely be missed cancer diagnoses.

What can physicians do? That's a tough question. As physicians, we know how to treat our patients but in a court of law so much is out of our hands.

This sense of powerlessness is the reason why you should plan to join the MMA as it discusses the Dickhoff v. Green ruling on August 28 at the Ramada Plaza Minneapolis (go to www.mnmed.org/courts for more information on registering). Our special guest at the event will be Mark Whitmore, an attorney from Minneapolis-based Bassford Remele. He filed an amicus brief with the Supreme Court on our behalf and certainly knows the ins and outs of the case.

Perhaps with a lively, engaging discussion we may be able to develop a strategy that the MMA can use to help us combat or influence malpractice laws in the future. This topic is too important for us to just sit on our hands and remain quiet.

That's the true value of the MMA. To help us, help ourselves. To alert us, corral us and then motivate us to action so that we have a voice in the discussion and ensure that Minnesota physicians are heard on this, and every other topic, that affects us, our patients and our practice.

"When it comes to the legal arena, physicians sometimes feel powerless and that is concerning. That's why so many of us grade the MMA's legal advocacy so highly on value/satisfaction surveys."

Promoting Sexual Health

Why it's every physician's responsibility.

BY ELI COLEMAN, PH.D.

There is little physicians do that does not relate to their patients' sexuality. Nearly all medical and surgical treatments can affect a person's sexual health. For example, drugs for common conditions such as hypertension and depression can affect sexual desire and performance. Then there are the myriad problems that are sexual in nature that physicians must help patients face (eg, sexually transmitted infections, reproductive health issues, sexual and domestic violence, and sexual dysfunction). Along with recognizing that illness and treatment can affect sexual health, physicians also need to understand that promoting sexual health is part of their role, as it is critical to a person's overall health, quality of life and well-being.

Understanding the Concept of Sexual Health

To promote sexual health, you have to understand what it is. Unfortunately, the concept is woefully misunderstood. Most people still think sexual health means being free of sexually transmitted diseases or sexual dysfunction. But it's really so much more. Even though the World Health Organization developed a very expansive definition of sexual health in 1975[1] that went beyond it being the absence of disease, society has been slow to grasp its broad nature and complexity.[2]

So what does it mean to be sexually healthy? Recently, the American Sexual Health Association (ASHA) took that question to heart and came up with a statement that can help physicians better understand what sexual health is and what they can do to promote it: "Sexual health is the ability to embrace and enjoy our sexuality throughout our lives. It is an important part of our physical and emotional health."

According to the ASHA, being sexually healthy means

- Understanding that sexuality is a natural part of life and involves more than sexual behavior
- Recognizing and respecting the sexual rights we all share
- Having access to sexual health information, education and care
- Making an effort to prevent unintended pregnancies and STDs and seek care and treatment when needed
- Being able to experience sexual pleasure, satisfaction and intimacy when desired.[3]

Like the original WHO definition, this one emphasizes the concept of well-being in various dimensions of life. It also considers sexuality in its broadest sense—not just the sex act—and it includes all aspects of sexual expression and relationships.

The implications for physicians are clear. Sexual health care is important throughout the lifespan and to practitioners of all specialties. In other words, all physicians need to recognize that humans are sexual beings from birth until death, and they need to take responsibility for bringing up the topic and asking questions about their patients' sexuality. They need to inquire not only about sexual functioning but also about the quality of sexual activity (ability to experience pleasure and satisfaction) and relationships. They also should educate their patients about sexuality and provide sexual health care when needed (or refer them to experts who can help).

Physicians need to go beyond ensuring that adverse outcomes related to sexual activity including HIV and other STIs, viral hepatitis, unintended pregnancy, reproductive tract cancers, and sexual violence are prevented or properly addressed. Optimally, they should be discussing sexual health in a proactive way, as they would nutrition.

Why is this so important? If physicians treat sexual health as a routine and normal part of health care, patients might feel less shame and discomfort about discussing it and worry less about how providers might

react to hearing about a sexual problem or concern. Ultimately, this might encourage them to seek help for problems early on, and addressing problems early might reduce the burden of disease related to sexual and reproductive health problems.

Physicians should be aware that the nature of these conversations will change as patients face various stages of sexual development, ranging from curiosity about sex and confusion and discomfort about changes in a pubertal body to concern about menopausal and andropausal changes. When appropriate, they should provide patients with opportunities to learn about anatomy and talk about sexual identity development (gender identity and sexual orientation), sexual functioning (including pleasure and problems), sexual behavior, communication, intimacy and relationships in the context of being a healthy person.

The Main Barrier to Sexual Health Care

So why does this not happen more often? Certainly lack of time and resources get in the way of physicians' ability to provide comprehensive health care. But oftentimes physicians don't address patients' sexual health simply because they haven't been taught to do so. In a classic study by Merrill et al., doctors failed to address their patients' sexuality for three reasons: They were embarrassed to do so; they did not believe the patient's sexuality was relevant to their chief complaint; and they did not feel they were adequately trained to talk about sex.[4]

Training is essential. The results of a recent study of 2,261 medical students support this premise. Researchers found a strong association between having adequate training in sexual health during medical school and feeling comfortable discussing patients' sexual health.[5]

Fortunately, Minnesota has been on the forefront of promoting sexual health and providing physician education on it. Since 1970, the University of Minnesota has required medical students to complete a course on human sexuality.[5] In addition, students can take clinical electives in sexual health. These courses are taught by the faculty from the Program in Human Sexuality (PHS), which is part of the department of family medicine and community health. Faculty from the PHS also assist in teaching at Mayo Medical School.

Our state is more fortunate than others. Most medical schools in the United States and Canada have cut back on their teaching about sexuality. Many at best have a lecture or two devoted to sexual health. Clearly, we need to better prepare medical students so they are able to attend to the myriad sexual health problems that their patients will face—and we are trying to make that happen.

In the fall of 2012, the University of Minnesota's Program in Human Sexuality brought together 55 experts from around the country for a summit on medical school education in sexual health. The purpose was to examine the situation, discuss the challenges and opportunities, share lessons learned and make recommendations for ensuring that medical students are properly trained to address the sexual health needs of their patients as they go into practice. The following recommendations came out of the summit:

- Sexual health education should be integrated longitudinally throughout the four years of medical school
- Sexual health education should be introduced early and often
- Sexual health education needs to be extended to students from a variety of disciplines because all will one day be working as part of a health care team
- Medical schools need to develop evaluation mechanisms to help them understand how to best teach sexual health
- Faculty members need content and curricula and to build their skills in talking about sexual health.[6]

Although the scope of the summit was limited to medical school, participants recognized that education must extend into the residency years and beyond. Because not every physician in the state was trained here or received much education on sexual health in their residency programs, it is important for them to take advantage of continuing education opportunities to fill in the gaps and learn about new developments in sexual health care.

Participants also brought up the fact that because those who are socioeconomically disadvantaged, young, and/or members of ethnic and sexual minorities especially feel uncomfortable talking with physicians about matters of sexual health, extra effort needs to be taken to help physicians better understand the needs of these populations.

Conclusion

Practicing physicians need to step up and promote sexual health. They need to do this both in their everyday interactions with patients and in their work in their communities. Clearly, one of the best ways to make that happen is to better train medical students, residents and practicing physicians about sexual health and patients' needs throughout their lives.

Sexual health is fundamental to overall health and happiness. Helping people achieve it is the only way to help them live healthier, more satisfying and pleasurable lives. **MM**

Eli Coleman is director of the Program in Human Sexuality at the University of Minnesota. He is a founding editor of the *International Journal of Sexual Health* and has been a consultant to the World Health Organization.

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Toward Better Care for Lesbian, Gay, Bisexual and Transgender Patients

BY DIONNE HART, M.D.

Studies have shown that the health status of lesbian, gay, bisexual and transgender (LGBT) people generally is worse than that of the population as a whole. This is in part because these individuals have not been well-served by the health care establishment. This article describes ways physicians can begin to better care for this population and provides tips for making practices more welcoming to LGBT patients.

As an African-American woman, psychiatrist and program manager of the Lesbian, Gay, Bisexual and Transgender Affirmative Action Committee at the Federal Medical Center in Rochester, I am very aware that treating patients well requires having knowledge not only about their physical symptoms and medical condition but also about their ethnicity, sexual preference and socioeconomic circumstances.

My own background has influenced my thinking about this issue. I was raised in suburban Chicago by a father born in 1920 and a mother born in 1941. Their 20-year age difference alone was significant, but so were their perspectives. My father came of age during the time of Jim Crow laws; my mother during the civil rights era. When I was growing up, I was exposed to both my father's fear of the consequences of breaking barriers and my mother's drive to fight against oppression. All my life, I have struggled to balance these two influences both personally and professionally. That experience has proved invaluable as I have worked with patients and sought to raise awareness among my peers and colleagues about the issues faced by groups that are marginalized.

Like many others, my thinking has been influenced not only by personal experience but also by changes in society. Our thinking about homosexuality has been changing rapidly. Last fall in Minnesota, we saw a proposal to amend our Constitution and ban gay marriage defeated. This year, we saw passage of a bill to legalize same-sex marriage, which Gov. Mark Dayton signed into law in May. A month later, the U.S. Supreme Court ruled the Defense of Marriage Act unconstitutional, therefore bestowing federal benefits upon married same-sex couples.

The medical community's understanding of the needs of LGBT people has been evolving for some time. For example, homosexuality was listed as a medical disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) up until 1973; gender identity disorder wasn't replaced until May 2013. In recent years, clinicians and public health researchers have become increasingly aware that there are disparities between the health of the LGBT population and that of the general public.[1] A 2008 issue of the *Journal of Homosexuality* delineated factors that contribute to those inequities: lack of access to health care, utilization of care, training of medical and mental health providers, and preparation of clinical offices and waiting areas.[2]

With Minnesota's gay marriage law and the Supreme Court's ruling, LGBT individuals may now feel more comfortable being out about their sexual orientation. They'll have better access to health care, as many will now be eligible for health insurance coverage through their spouse's employer. In addition, provisions in the Affordable Care Act will bring more people onto health insurance rolls, some of whom will be LGBT. For those reasons, physicians and other health care providers will likely be seeing more LGBT patients in their practices.

To best serve these patients, we need to become knowledgeable about their health needs and work to make our practices more welcoming to them.

Become Knowledgeable

Physicians can do a number of things to become more competent at providing care to LGBT individuals. The first is to become educated about this population and the health conditions for which they are at risk.

Nearly 4% of Americans and 2.9% of Minnesotans identity themselves as a sexual minority (lesbian, gay, bisexual, transgender).[3] Lesbians and gay individuals are those who are sexually attracted to members of the same gender. A bisexual person is attracted to people of both genders, and a transgender individual is one whose gender identity or expression differs from their birth sex.

LGBT individuals are often considered a hidden minority. Unlike ethnicity or cultural background, sexual orientation often is not apparent. In the clinical setting, LGBT patients may be unlikely to reveal information about their sexual orientation because they fear discrimination. Furthermore, physicians and other health care providers may be hesitant to ask about it. On average, medical students receive less than 10 hours of education about taking a person's sexual history over the course of their training.[4] Because they haven't been taught to do so, physicians may feel uneasy asking questions about a patient's sexual behaviors and may not bother to do so. This can shut down communication between a physician and patient, which can influence health outcomes, as a poor patient-physician relationship can affect treatment compliance. If an LGBT individual has a negative encounter with a physician or other health care provider, he or she will be less likely to return for future appointments or to comply with recommendations.[5] Studies have shown that lesbians delay getting health care at more than twice the rate of heterosexual women (27% vs. 12%) because of previous negative experiences with health care providers.[6]

Health Concerns

LGBT individuals are at risk for a number of health problems. They are 40% to 70% more likely to smoke than heterosexuals. Because homosexual men use tobacco at a much higher rate than heterosexual men, they have an increased risk of lung disease, lung cancer, heart disease and high blood pressure. Lesbians are between 1.5 and two times more likely to smoke than heterosexual women.[7] A number of studies have also suggested that lesbians are significantly more likely to drink heavily than heterosexual women, and bisexual women report more hazardous drinking than heterosexual or lesbian women.[8-11] One study in the metropolitan Chicago area found lesbians to be almost three times more likely to report problems with alcohol use than heterosexual women.[10]

Alcohol and drug abuse may contribute to risky behaviors such as having multiple sexual partners and engaging in unsafe sexual practices. Homosexual men, especially those who are members of minority groups, are at a higher risk for contracting HIV and other sexually transmitted infections (STIs) than the general population; lesbian women are underdiagnosed with STIs because of their perceived lack of risk.[12]

African-American and Hispanic lesbian and bisexual women are more likely to be overweight or obese, which puts them at risk for such problems as polycystic ovarian syndrome, sleep apnea, dyslipidemia, hypertension, type 2 diabetes, coronary heart disease and cerebrovascular events.[12] And because they are less likely than heterosexual women to have had a full-term pregnancy (and therefore had less exposure to the hormones thought to protect women against various cancers), lesbian women may be at higher risk for breast, endometrial and ovarian cancers.[12]

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Resources for Health Care Providers

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American Medical Association. "Patient Sexual Health History: What You Need to Know to Help." (www.ama-assn.org//ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/glbt-resources/communicate-lgbt-patients.page)

Petros, L, Drescher J, Barber ME: *LGBT Casebook*. Washington, D.C., American Psychiatric Press, 2012

Gay and Lesbian Medical Association (www.glma.org)

Transgender Care (www.transgendercare.com/default.asp)

Human Rights Campaign (www.hrc.org)

Top Health Issues for LGBT Populations Information and Resource Kit- Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

CDC Lesbian, Gay, Bisexual and Transgender Health (www.cdc.gov/lgbthealth)

HHS Healthy People 2020 (www.healthypeople.gov/2020/default.aspx)

Fenway Health (www.fenwayhealth.org)

National Coalition for LGBT Health (http://lgbthealth.webolutionary.com/content/resources)

Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx)

The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide* (www.jointcommission.org/lgbt/)

National LGBT Health Education Center. Learning modules (www.lgbthealtheducation.org/training/learning-modules)

Members of the LGBT community are also at greater risk for violence and mental health issues than the general population. Studies have shown that lesbian women and gay men report experiencing harassment or physical violence from family members due to their sexual orientation. In addition, when compared with straight adults (17.5%), a significantly higher percentage of lesbian or gay adults (56.4%) and bisexual adults (47.4%) report experiencing intimate partner violence.[13] Lesbian women are also less likely to report domestic violence.[12] LGBT youths are twice as likely as heterosexual youths to have attempted suicide. In one Minnesota school district, nine teenagers committed suicide and a number of others attempted it between 2009 and 2011.[14] Some of those victims were homosexual, perceived as homosexual, or did not dress according to their birth gender. In Rochester, my community, a 17-year-old jumped to his death from a pedestrian bridge last year after being tormented for being gay.[15] One study showed nearly one-third of all adolescent male suicide attempts are linked to a crisis over sexual orientation.[16]

In 1996, Cochran and colleagues found that the prevalence of panic attacks and major depression was greater in homosexual or bisexual men than in heterosexual men (17.9% vs 3.8% and 31% vs 10.2%). Lesbian or bisexual women had a greater 12-month prevalence of generalized anxiety disorder (14.7%) compared with heterosexual women (3.8%).[17] That study also found gay or bisexual men and lesbian or bisexual women used mental health services more often than heterosexual men and women.[17]

Questions to Ask

Once they are aware of the health concerns of LGBT patients, physicians need to know whether their patients are at risk for them. Often, this requires broaching the topics of sexuality and sexual behavior. Physicians should be direct in their approach—the goal being to elicit information that helps them ensure that patients receive appropriate screenings and care. Questions to ask might include: How do you identify in terms of sexual orientation? Do you have any questions, concerns or comments about your gender or gender identity? Have you had sex with men, women, transgender men or transgender women? When you have sex, do you have oral sex, vaginal sex or anal sex? How often do you use condoms when having oral sex, vaginal sex or anal sex? When is the last time you had sex without a condom? Do you have a primary sexual partner? Do you have a casual sexual partner? When was the last time you were tested for HIV? What were the results?

Once they have answers, physicians can ask about issues such as drug an alcohol use and help those who may be substance-dependent get into treatment; make sure patients are screened for chronic diseases and cancers for which they may be at risk; and ensure that mental health needs are identified and addressed.

Create an LGBT-Friendly Practice

In addition to becoming schooled in the potential health problems of LGBT patients, physicians and clinic staff can do a number of things to make the clinic a comfortable environment. First, they should become familiar with terminology used by and to describe members of the LGBT community. For example, "sexual orientation" refers to an individual's physical and/or emotional attraction to members of the same and/or opposite gender. "Coming out" (of the closet) refers to disclosing one's same-sex orientation to others. "Gender identity" is a person's basic sense of being male or female, in between or neither. "Gender expression" refers to an individual's appearance, personality and behavior. A "transgender person" is one whose gender identity or gender expression differs from their birth sex.

All staff including the clinic's schedulers should be expected to find out about and use patients' preferred pronouns (for example, to find out whether a transgender person prefers he or she) and gender-neutral terms such as partner and co-parent. They also should ask for the patient's chosen name and legal name, and provide a blank space in forms for gender.

In the examination room, physicians and other staff should refrain from making assumptions about a person's gender identity or sexual orientation. Physicians and other providers should always ask how patients identify and wish to be addressed. Providers and staff should use the pronoun the patient prefers even when the patient is not present, and they should explain to patients that for legal reasons their preferred pronoun may not be used in all documentation, as some insurance companies and government programs need to know the person's legal sex in order to ensure payment.

Clinics also can place LGBT-friendly and gender-neutral signs and materials in waiting and other areas. They can display symbols such as the rainbow flag, the pink triangle or the Safe Zone image to convey that it is a safe place for LGBT patients. Attending pride events and observing National Freedom to Marry Day (February 12), Day of Pink (April 10) and National

The DIVERSE Approach to Creating an LGBT-Friendly Practice

- **D**isplay LGBT-friendly symbols and signs.
- **I**dentify yourself as an LGBT-friendly provider in the Gay and Lesbian Medical Association's online directory (www.glma.org).
- **V**erify that you and your staff are meeting the needs of your LGBT patients by asking about it in post-visit surveys.
- **E**ducate yourself and your staff about the health issues faced by LGBT patients.
- **R**efrain from making assumptions about a person's sexual orientation or gender identity.
- **S**upport the LGBT community by attending and acknowledging events.
- **E**nsure gender-neutral language is used on forms and in communications when possible.

Coming Out Day (October 11) will speak volumes to both your staff and patients.

After the visit, clinics should follow up with patients to find out how they were treated by staff. Did they feel welcome? Were their needs met during care planning and treatment? Their feedback can help you make the clinic more welcoming. And by asking for such feedback, the clinic is building a positive relationship with the patient.

Becoming familiar with resources in the community for LGBT people is also important to providing excellent care. Build a network of experts and organizations to which patients can be referred. The Gay and Lesbian Medical Association (GLMA) has an online searchable directory of primary care providers, specialists, therapists and dentists who are LGBT-friendly (www.glma.org).

It is important that you and your staff understand that making your clinic LGBT friendly is an ongoing process. Attending LGBT-focused continuing education courses, sharing articles and online resources, and talking about the issue at staff meetings are ways to continue to improve the care you provide.

Conclusion

The physician-patient relationship remains a critical factor in determining health outcomes. In part, that's because patients who have a good relationship with their doctors are more likely to disclose accurate information and comply with their recommendations. Passage of the Affordable Care Act and Minnesota's same-sex marriage law and the recent Supreme Court decision to strike down the Defense of Marriage Act should ensure greater access to health insurance and health care for LGBT patients. But unless these patients feel they are being understood by and can trust their physicians, having access to care will only go so far in improving health.

As physicians, we have a moral obligation to address health care disparities. Becoming more knowledgeable about and making our clinics and hospitals more hospitable for our LGBT patients is the least we can do for this long-overlooked population. **MM**

Dionne Hart is a psychiatrist and program manager of the Lesbian, Gay, Bisexual and Transgender Affirmative Action Committee at the Federal Medical Center in Rochester. She also chairs the Minnesota Medical Association's Minority and Cross-Cultural Affairs Committee.

Resources for Patients

Gay and Lesbian Medical Association (www.glma.org)

Parents, Family and Friends of Lesbians and Gays (www.pflag.org)

Human Rights Campaign (www.hrc.org)

The Trevor Project (www.thetrevorproject.org)

Suicide Prevention Resource Center: Preventing Suicide among LGBT Youth Kit (www.sprc.org/LGBTYouthWorkshopKit.asp)

Mayo Clinic video on teen suicide (www.youtube.com/watch?v=3BByqua7bhto)

True Colors (http://ourtruecolors.org)

Gay, Lesbian, Bisexual and Transgender Helpline (888-340-4528)

The Pride Institute (800-547-7433)

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Sex Matters for Personalized Care

BY VIRGINIA M. MILLER, PH.D

The basic biological variable that distinguishes half the population from the other, sex, is rarely considered integral to the development of personalized treatment strategies. Yet sex is a fundamental aspect of human physiology. This article reviews evidence showing how sex influences patient outcomes and identifies ways to facilitate evidence-, sex-based approaches to patient care.

In this era of personalized care, the phrase "sex matters" easily could be dismissed as so obvious that it is not worth stating. However, the sex and gender of each patient is rarely considered in the clinical setting beyond the initial description in case reports that M. Jones is a 52-year-old female or J. Smith is a 52-year-old male. Yet evidence is increasingly showing that the fact that M. Jones is female and J. Smith is male has implications for the type, expression and progression of disease; it also affects potential treatment options and their efficacy. In other words, sex matters.

Both sex and gender influence the health of an individual, and clarity in the definitions of each of these terms is worth emphasizing. Sex is "being male or female according to reproductive organs and the functions assigned by chromosomal complement (XX for female and XY for male)."[1] That is, sex is biology. Gender is everything else, including psychosocial and cultural factors.[1] Although gender is an important determinant of health, as it can influence medical strategies, this article is focusing on the influence of sex.

Diseases associated with reproduction and with organs of the uro/genital system are sex-specific. However, sex also explains why some diseases are more prevalent in one sex than the other and why some may present differently in one sex compared with the other.[1] For example, erectile dysfunction and prostate cancers are disorders specific to males, while pregnancy and pregnancy-associated hypertension are specific to females. Autoimmune diseases, pulmonary hypertension, heart failure with preserved ejection fraction and postural orthostatic tachycardia syndrome are examples of conditions that affect both sexes but are more prevalent in females than males; and myocardial infarction is an example of a pathology that presents differently in females and males. These differences reflect the underlying physiology as directed by the sex chromosomes in conjunction with interactions of the sex steroid hormones on the entire genome.

Chromosomal-Hormonal Interactions

Information is accumulating about how sex differences expressed at the cellular and molecular levels affect disease progression and treatment outcomes. Sex is encoded in the genetic material in every cell in the body; that is, every cell has a sex.[1] In males (genetic XY), development of the testes is driven by genes of the Sry locus on the Y chromosome. However, genes of the Sry locus also regulate tyrosine hydroxylase, an enzyme required for the synthesis of norepinephrine within the sympathetic synapse and may contribute to development of hypertension. In support of this concept, transfection of a Y chromosome from a hypertensive male rat into a normotensive one increased blood pressure, while the reverse procedure, transfection of the Y chromosome from a normotensive male into a hypertensive male, reduced blood pressure.[2] Furthermore, transfection of Sry into the adrenal medulla of normotensive male rats increased tyrosine hydroxylase activity resulting in elevated systolic blood pressure and plasma catecholamines.[3] Thus, increased tyrosine hydroxylase activity in males due to Sry expression may partially explain why men are at greater risk for developing hypertension as compared with women of the same age.[4] Other genes on the Y chromosome influencing development of cardiovascular disease include those regulating cholesterol and interactions of immunity and inflammation,[5,6] explaining, in part, inherited cardiovascular disease from father to son.

Males carry one X chromosome. Therefore, polymorphisms of genes on the X chromosome will be expressed in males. For example, the gene for the androgen receptor is on the X chromosome and ge-

netic polymorphisms of that gene could result in androgen insensitivity. However, women have two X chromosomes, portions of one of which are inactivated. Inactivation of genes on the X chromosome is random, resulting in a mosaic expression of these genes in every organ of the body. This mosaic expression pattern accounts, in part, for greater variability in disease expression and responses to treatment in women as compared with men. In addition, it is difficult to interpret how variants of genes on the X chromosome will affect disease risk in women because the chromosome carrying the variant will not be expressed in every cell. Thus, women may carry the genetic variant for the androgen receptor but will express a gradient in androgen insensitivity and response to exogenous testosterone treatments.[7]

Production of sex steroids, which include androgens, estrogens and progestogens, varies across the life span. Picture a 7-year-old girl and boy and how their phenotypes change as they grow into adults and eventually senior citizens. Varying levels of testosterone and estrogen in their blood interact with the underlying physiological processes that result in these phenotypic changes directed by the sex chromosomes. Some hormonal effects are organizational, resulting in an irreversible commitment of a tissue to a phenotype, eg, development of the penis (androgen in men) and closure of the epiphysis in bone (estrogen in men and women). Other effects, known as activational effects, are reversible with changes in production of endogenous hormones or with administration of exogenous hormones during adulthood.

Activational effects of sex steroids cause menstrual cycling in women and the structural and functional adaptations in the cardiovascular and musculoskeletal systems that support the development of and delivery of a fetus. Pregnancy may be considered a type of cardiovascular "stress test," which may signal hypertensive disorders including hypertension of pregnancy, preeclampsia and eclampsia in some women. It remains unclear whether these disorders result from a pre-existing cardiovascular condition that is exposed by pregnancy or whether factors associated with pregnancy and problems with maternal/fetal circulation cause the hypertension. Regardless of the causal mechanism, exposure to a hypertensive disorder of pregnancy increases a woman's lifelong risk of cardiovascular disease and can affect the health of her offspring.[8-10] Whether hypertensive pregnancy disorders pose a risk for cognitive decline in women as they age is a research focus for Mayo Clinic's Specialized Center of Research on Sex Differences.[11] The ultimate goal of this work is to help obstetrician/gynecologists and primary care physicians appropriately monitor women who are at risk.[12]

Decreases in production of endogenous hormones results in the loss of activational hormonal effects. In some women, loss of ovarian hormones by surgical or natural menopause results in sleep and mood disturbances, vascular instability (hot flashes) and changes in the uro/genital system. Incidence of chronic diseases such as cardiovascular disease, osteoporosis and cognitive decline also increases in women when the activational hormonal effects are lost with surgical and natural menopause.[13-16] Administration of exogenous hormones can restore some activational hormonal effects in women and slow development of osteoporosis.[17-19] However, it remains controversial whether such treatments prevent or slow progression of cardiovascular disease and cognitive decline. Timing of the initiation of such treatments may determine whether a particular activational effect directed by the hormones is indeed reversible. The concept of a "window of opportunity" for treatment may explain, in part, contradictory data from observational and randomized clinical trials regarding effects on progression of cardiovascular disease in women.[20-22]

More research is needed to understand the activational, physiological consequences of loss of endogenous testosterone or "low T" in men and whether there is a window of opportunity for exogenous supplementation of this hormone in men and women. Challenges in investigating these effects include determining the appropriate assay for testosterone (total, free or bioavailable) and the fact that testosterone is metabolized to other biologically active hormones including estrogen.[23-27]

The Role of Sex in Evidence-Based Medicine

Preventive, diagnostic and treatment strategies are developed from evidence compiled from studies conducted in isolated cells, on experimental animals and in clinical trials. Unfortunately, much medical research has failed to consider sex as a fundamental aspect of health and disease. In many studies, the sex and the hormonal status of the materials used in basic science experiments are unknown or the material comes only from male sources.[28,29] Similarly, in clinical trials, women have been under-represented and, when they are included, results of the studies may not be reported by sex.[30-34] Yet results from clinical trials are the evidence upon which treatment options are based.

Excluding women from clinical trials and not reporting data based on sex when women are included has real consequences. We now know that eight of 10 drugs withdrawn from the market between 1997 and 2001 posed greater health risks to women than men.[35] More recently, the Food and Drug Administration modified the dosage recommendation for zolpidem (Ambien) because of excessive side effects in women. Another example showing the importance of including women in clinical trials and reporting data based on sex is a study showing a greater association between statin use and the risk of type 2 diabetes in women than men. In a meta-regression analysis, the odds ratio for incident diabetes was directly proportional to the percentage of women enrolled in the trial.[36] The authors of this analysis hypothesize that for some women, the incident risk of diabetes may outweigh the lipid-lowering benefit of the statins.[36] Studies to assess dosing and sex-specific treatment strategies have far-reaching consequences not only related to reducing the risk of cardiovascular disease but also

to the management of anesthesia, pain, depression and substance abuse, immunization, cognitive decline, bleeding disorders and anticoagulation, lung and pulmonary diseases, design and implantation of medical devices and physical rehabilitation.[11,37-46]

In order to reduce disparities in health outcomes between men and women, it will be essential for scientists and clinicians to consider sex differences as one of the underlying physiological mechanisms of disease. Work is needed to identify regulatory pathways in cells of male and female origin, to study integrated physiological control mechanisms in male and female experimental animals, and to include women in all phases of clinical testing accounting for hormonal status. To accomplish this work, it may be necessary for funding agencies to mandate inclusion of male and female material in experimental designs or to require scientific justification for the study of only one sex. Furthermore, it will be imperative that scientific journals require researchers to report the sex of the experimental material so that others can reproduce their work. In addition, more women should be included in clinical trials. Researchers also should report clinical trial data by sex and not just use sex as a confounding variable. This will increase the amount of sex-specific information in the literature so that sex-specific outcomes can be reported through meta-analysis of collected data sets.

Having access to such information will help patients and physicians make decisions about care and treatment. Imagine how different the conversations between physicians and patients might be if we knew not only that drug X increased the risk of diabetes in 25% of all patients but also that it increased the risk in 49% of women and 14% of men.[47]

Conclusion

Viewing the patient through a sex and gender lens is part of personalizing care. But before we can practice sex-based medicine, the evidence upon which sex-specific decisions are made needs to be improved. As a first step, basic scientists need to provide more data regarding the regulatory pathways in males and females. In addition, clinical trials to evaluate drug and device performance should be designed to account for differences in the underlying physiology of men and women. Sex-specific outcomes need to be reported and analyzed. Finally, the concepts of sex and gender need to be incorprated in the education of health care professionals.[48] Clinicians, clinical investigators and educators all need to recognize that sex matters when it comes to making decisions about treatment. **MM**

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Resources

NIH-Funded Specialized Centers of Research on Sex Differences

(http://orwh.od.nih.gov/interdisciplinary/scor/index.asp)

Textbooks

- Legato M. *Principles of Gender-Specific Medicine*. Elsevier. 2011. 2nd ed.
- Oertelt-Prigione, Regitz-Zagrosek. *Clinical Aspects of Gender Specific Medicine*. Springer. 2012.
- Schenk-Gustafsson K, DeCola PR, Pfaff SW, Plsetsky DS. *Handbook of Clinical Gender Medicine*. Karger. 2012.
- Regitz-Zagrosek V. ed. *Sex and Gender Differences in Pharmacology.* Springer-Verlag 2012.
- Mattison,DR. ed. *Clinical Pharmacology during Pregnancy*. Elsevier, 2013.

Web-based Continuing Medicine Education Courses

- NIH ORWH *Sex and Gender Differences in Health and Behavior*

(http://sexandgendercourse.od.nih.gov)

- NIH ORWH *The Basic Science and the Biological Basis for Sex and Gender Differences* (http://sexandgendercourse.od.nih.gov)
- TTUHSC Laura W. Bush Institute for Women's Health. *Y Does X Make A Difference?* (www.laurabushinstitute.org)
- Women's Health Info Site: *Sex and Gender Resource for Clinicians and Trainees*

(http://whepducom.blogspot.com)

- National Association of Women's Health Medical Educators Faculty Guide (NAWHME)
- Listing of various educational modalities to use in integration efforts (www.drexelmed.edu/Home/OtherPrograms/WomensHealthEducationProgram/Resources.aspx)

Web-based Research and Educational Resources

- Sex and Gender Women's Health Collaborative (www.sgwhc.org)
- Stanford University's Gendered Innovations (http://genderedinnovations.stanford.edu)
- Canadian Institute of Gender Health. What a Difference Sex and Gender Make.

(www.cihr-irsc.gc.ca/e/44082.html)

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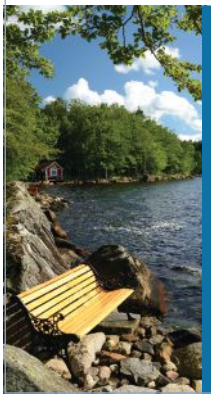

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AA/EOE

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If interested, please contact Dr. Nick Schneeman, CEO and Lead Physician of Geriatric Services of Minnesota at nick.schneeman@gsmllc.org.

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- Pediatrics
- Psychiatry
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- Rheumatology
- Urologist

For additional information, please contact:

Kari Bredberg, Physician Recruitment
karib@acmc.com, 320-231-6366
Julayne Mayer, Physician Recruitment
mayerj@acmc.com, 320-231-5052

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- Family Medicine
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- Occupational Medicine
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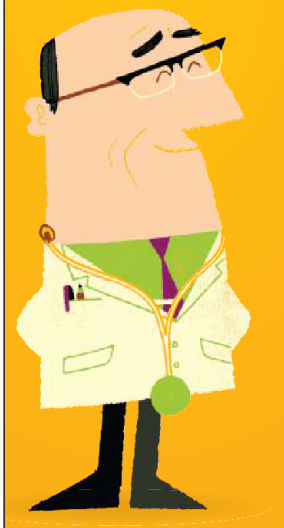

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EOE

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www.siouxfalls.va.gov

Diastole

BY DIANE M. PITTMAN, M.D.

I have seen the sweaty lip
the furrowed brow
anxious eyes that see
something beyond
wires and needles
urgent murmurings
frantic beeps jagged lines
on screens, on walls of the emergency room.

Sometimes the heart,
that gristly bag of muscle and blood,
escapes the baton of its conductor.
Drives itself,
one beat, demanding the next, and another
in frenetic succession
until contracted chambers
shrink and quiver,
once steady pulsing blood
weakens to a trickle.

I have given the orders.
Adenosine, shock.
Watched the line slow, flatten for seconds,
which seem like hours,
while no one breathes.
The heart stops.
Rests.
Blood rushes to the flaccid center.
Then with a twist and a slamming of valves
it contracts mightily.
One beep, and another
a steady, proper pace.
Cheeks blush, smile blooms, eyes focus on
wife, instructions, going home.

I have learned the lesson.
Diastole.
60 times a minute
pause

let your heart be filled.

Diane Pittman practices family and emergency medicine in Bemidji, Minnesota. Her poem received honorable mention in *Minnesota Medicine's* 2013 Medical Musings writing contest.

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