NEW HAMPSHIRE PHYSICIAN
A PUBLICATION OF THE NEW HAMPSHIRE MEDICAL SOCIETY

Prevention is the Best Medicine

Volume 2 | 2024

DISCOVER summer savings

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Do you or a colleague need help?
The New Hampshire Professionals' Health Program (NH PHP) is here to help!

The NH PHP is a confidential resource that assists with identification, intervention, referral and case management of NH physicians, physician assistants, dentists, pharmacists, nursing licensees, veterinarians, chiropractors, dieticians, licensed drug and alcohol counselors, mental health practitioners, midwives, optometrists, podiatrists and psychologists who may be at risk for or affected by substance use disorders, behavioral/mental health conditions or other is-sues impacting their health and well-being. NH PHP provides recovery documentation, education, support and advocacy – from evaluation through treatment and recovery.
For a confidential consultation, please cal Dr. Molly Rossignol @ (603) 491-5036 or email mrossignol@nhphp.org.

Cover photo: Participants in Advocacy Day for NH pediatric residents, a partnership of NHMS, NHAAP, Dartmouth-Hitchcock CHaD Residency Program, and New Futures, pose with Gov. Sununu.

Maria Boylan, DO
NHMS President

Prevention is the Best Medicine

Most people go to see a doctor when something is wrong. Emergency rooms, urgent cares, and specialty offices are filled with patients who are sick, ha a new pain or ailment, or are looking to manage a chronic medical condition. I constantly hear my patients say, "I don't like coming to the doctor," and "I only come in if I have a problem."

But, as doctors, we went to medical school because we wanted to help people avoid suffering. At our core, we want to prevent disease and keep our patients healthy. As a family doctor, this holds true in literally every patient interaction I have on any given day.

Imagine a world where every patient is able to see their doctor for routine checkups when they are healthy.

Imagine if we could prevent disease, catch cancer earlier, and counsel patients on things they can do to stay healthy.

That world exists! And it's in the primary care office

I often get asked if a routine physical exam is important to a healthy person, and my answer is always "yes!". However, the physical examination is probably the least important piece of the appointment. I spend the majority of the time asking my patients about their life, their habits, and their health goals. The comprehensive physical exam (CPE) time is perfect to discuss important screenings and preventative care the patient may be due for — including cervical, breast, lung, and colon cancer screening — as well as their reproductive and sexual health and other disease prevention.

It can be easy to fall into the routine of "checking boxes", but the time I spend discussing why we do certain things (like PAPs or vaccinations) is when I get to connect best with my patient. It helps me show them that I truly want them to be healthy. This is particularly important right now, as medicine is turning into a fast-food industry — with providers who don't really know the patient, treating acute needs only via telehealth or providing virtual services masquerading as primary care.

One of the things that's so exciting to me as a family medicine doctor is every day is different, and every patient is unique. When I see a 50-something female in the office, I will be talking about getting a mammogram routinely scheduling a colonoscopy, and doing her PAP to check for cervical cancer. If it's a 30-year-old, gay male, I'm spending that visit discussing safe sex practices, offering PrEP therapy, and talking about healthy diet, routine exercise, and limiting alcohol intake. A 65-year-old, male smoker may qualify for lung cancer screening, abdominal aortic aneurysm (AAA) screening, and may need vaccines. My recent favorite has been educating parents of one- and two-year olds on the dangers of lead exposure and doing in-office lead testing

To me, it's as easy as putting in an order or administering a vaccine — but to the patient, these simple things are critical to preventing illness and disease.

As physicians, we have the power to catch these diseases early with simple screening tests and intervene before a patient even has a symptom. Just a few years ago, we didn't have a way to routinely screen for lung cancer in high-risk patients. Now we're able to do so with low-dose CT scans. We have more vaccines for disease prevention than ever before. I can't tell you how happy I am and what a relief it is to parents to be able to vaccinate for RSV, an illness that causes nearly 80,000 hospitalizations a year! And just over the past decade of being a physician, I've performed fewer and fewer colposcopies

because of the effectiveness of the HPV vaccine in preventing cervical cancer.

I bet you're all thinking, "There's so much to do and so little time to do it in such a short visit." You're absolutely right. But the beauty of being a primary care doctor is that you get to see the patient again, as many times as they need. You can prioritize and chisel away at each item, visit by visit, especially if you don't want to overload your patient with too much all at once.

It can be difficult to approach the CP in a way that allows the provider to touch on the important things we want to accomplish, while still balancing the patients' concerns and needs. I've come up with these key aspects of the preventative care visit that can and should be used by any provider, regardless of specialty.

1. Review important vitals with the patient. Each patient should walk out of the room knowing their blood pressure and weight — and why they're important. Teach the patient what their blood pressure goals are and why it's important to keep it that way. Talk to them about what a healthy weight is for them and make diet and exercise recommendations.

2. Use age and gender together to determine what cancer screenings your patients will be due for. Cervical cancer for women starting at 21, mammograms for women starting at 40, colon cancer screening for all patients starting at 45, and PSA testing with men at 55. Keep in mind that, for trans patients, we are notoriously bad at discussing these screenings. You need to take an "organ inventory". You should know if your patient, who is a trans woman, still has a prostate, or if your trans male patient still has a cervix. It's also important to learn about breast cancer screening recommendations for trans women on long-term hormonal therapy.

3. Always gather the social history. Smoking/vaping, alcohol, drug use, and sexual behaviors are the biggest indicators your patient could be at risk. With this knowledge, you can determine if they need any additional screenings, prophylactic treatments, or counseling. For a proper smoking history it may take time to get an accurate pack-year history, but they may qualify for lung cancer screening. Depending on their sexual history, the patient may be a candidate for PrEP or PEP therapy.

4. Consider family history. Trends in cancers, heart disease, and diabetes all make a difference in when you may want to screen for diabetes or hyperlipidemia. It may indicate your patient will need earlier colon cancer screening or want to consider genetic testing for breast cancer.

5. Don't forget the vaccines! There have been so many changes to vaccine recommendations along with new vaccines over the past few years. It is overwhelming for doctors and patients alike, but it's our job to be consistently on top of ACIP and CDC vaccine recommendations. In a time where there's so much misinformation and mistrust of vaccines, be the voice of reason and help our patients feel safe getting their immunizations.

I realize that not every physician reading this magazine is a primary care provider, but the beauty of preventative care is that it permeates all specialties. All of you can play a role in counseling patients on cancer screening, lifestyle recommendations, and the importance of vaccinations. That way patients have a consistent message that we want to keep them healthy and safe. If or when we identify a problem, you're there for them through that, as well.

Throughout this year, you'll see other articles from specialty providers on how they approach preventative care in their work. I hope we can all continue to have an appreciation of the hard work we all do day in and day out regardless of the type of medicine we practice.

Lastly, in the spirit of healing the healer and preventing burnout, be sure you are scheduling your CPE with your own PCP and getting the screening tests you need. I know doctors are notoriously bad at keeping up with their own appointments (some of you are my patients — you know who you are!). Your patients need you, and in order for you to continue being the amazing superheroes you are, you have to stay healthy yourself. Practice what you preach! ■

Ava Hawkes,
NHMS Director
of Advocacy

Fighting the Good Fight

With a record-breaking number of bills introduced this year, the Society's leadership, membership, and staff have been working diligently to ensure that the House of Medicine and the physician voice are represented in policy areas impacting patients, the medical profession and the health-care system as a whole, and public health measures in New Hampshire.

As a reminder, the NHMS Council determined that the 2024 legislative priorities include access to reproductive health care, access to gender affirming care, gun violence prevention measures and building up the healthcare workforce. NHMS has maintained an active and strong presence before the NH General Court to engage legislative initiatives in these policy areas.

This session, we have seen a litany of bills, in the House and Senate, that seek to dangerously expand the scope of practice for non-physicians. While, thankfully, some measures have been defeated, there are two bills of concern that are active before the Legislature.

SB 440 seeks to significantly expand the scope of practice for optometrists including the performance of eye surgeries using scalpels, lasers, and other surgical modalities by optometrists. This bill unanimously passed the Senate Executive Departments and Administration (ED&A) Committee and the Senate as a whole. In early May, SB 440 passed the House ED&A Committee on a vote of 14-6 with a positive recommendation. A vote of the entire House is pending. NHMS, the NH Society of Eye Physicians and Surgeons, and the AMA continue to fight hard to defeat thi legislation this session.

HB 1222, as introduced, sought to eliminate the requirement for collaborative agreements for physician assistants and allow for their independent practice in New Hampshire. This bill, as amended by the House, seeks to repeal the requirement for collaborative agreements in most circumstances. It would only require a collaborative agreement for PAs with fewer than "8,000 hours of clinical practice," with no competency assurances, in settings where a physician is not employed. This is an extremely narrow requirement as the majority of PAs work in settings where physicians are employed. Under this proposal, if a PA works in a setting where a physician is employed and available for consult by a PA (at the PA's discretion), no collaboration agreement or minimum hours are required for a PA to practice independently. This bill does not offer any provisions on oversight or regulation of PAs as, currently, collaborative agreements dictate PAs' scope of practice. Make no mistake, even with this amended language, this bill seeks to allow PAs to practice independently in NH.

The legislative history of this bill is worrisome. The bill, as amended, passed the House on a voice-vote in late March. In mid-May, HB 1222 passed the Senate Health and Human Services (HHS) Committee on a vote of 5-0 with a positive recommendation, although members of the committee verbally articulated concerns with the bill as drafted. A vote of the entire Senate is pending. NHMS, the AMA and other state medical societies around the country have opposed this bill and will continue the fight to defeat this bill.

On a more positive note, the Society championed prior authorization reform legislation, SB 561, with the help of countless stakeholders, including physician members, health care association representatives, New Hampshire's Insurance Department and the individual carriers, and legislators. SB 561, as amended, unanimously passed the Senate HHS Committee and the Senate as a whole. In late April, the House Commerce Committee held a public hearing, and the bill was very well received. In mid-May, the House Commerce Committee voted unanimously to pass SB 561 with a positive recommendation. This is a huge win for the House of Medicine. A vote by the entire House is pending.

The final session day is Thursday, June 13, 2024. Legislation that successfully passes both bodies, through the Committees of Conference process, will then be sent to Governor Sununu's desk; legislation will either be signed into law by the Governor, become law without his signature, or be vetoed by the Governor and sent back to the Legislature for a 2/3 majority vote to overturn the veto. Keep an eye out for NHMS Legislative Pulse emails for updates as well as a full legislative summary this summer.

I encourage members to stay connected and stay involved. Interested in taking part in the Society's advocacy efforts? Please contact me at ava.hawkes@nhms.org or at 603-406-5270 with your interest. Stay tuned for more information on a NHMS Advocacy Training 101 event scheduled for some time late summer 2024! ■

Marcosa J. Santiago, MD
Retired Child Psychiatrist

Members' Corner includes selections focusing on personal and professional issues impacting doctors in New Hampshire - a forum for sharing the "voices" of NHMS members. We also encourage "Letters to the Editor," responding to articles published in prior editions. Please submit articles for our Members' Corner to mary.west@nhms.org

Members' Corner

Not My Story: Time Will Erase Untold Stories

"You don't always have to tell your side of the story, time will. But if you don't, time will erase it." - is an unsourced quote, but I give due credit to whoever s/he may be. This beautiful string of simple words conjures meaning that gives broad latitude for interpretation.

This is where my interpretive latitude of that quote comes in. This narrative is not my side of the story. It is a mere event snapshot of three boys, standing out among many patients I encountered as a child psychiatrist. These snapshots have no plot or succession of events. For a story to be good, it should be imbued with an element of causality, and must have a beginning, a middle, and an end. These snapshots are just the middle part, hence for completion I am supplying the prologue and the epilogue.

Prologue: I had a brief private practice in the very early 1990s, with limited offic hour practice, because I had other consulting jobs at area mental health centers and schools. My office was one room in a small industrial building owned by m husband where he was the only other occupant for his computer business. My office hours were timed when my husband was out of the building with his computer clients. The building had a spacious receiving room, and at the southern end was a door painted red leading to the largest room. Note that my husband was known as a "nerd" long before that word was coined. He was and still is a dedicated tinkerer, such that even before high school he started "inventing" electrical devices and entered local and national science competitions. One high school science project (a 3200 tube computer) won him a national fair second place and a scholarship to MIT. Beyond that red door was my husband's accumulated artifacts of many years plus additional "projects" over the years forming a giant pile of mess in my eyes. This was the office setting for the following snapshots of three youngsters I shield by giving them different names.

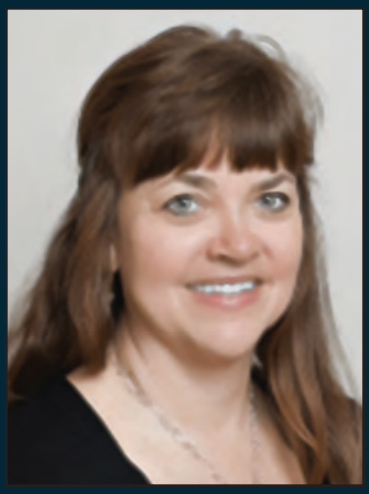
Joey, a bright boy of six, was referred by the school for disruptive behaviour in class. His teacher deemed his barrage of "why?" and "how?" went beyond curiosity, because he must know every minute detail of any new subject. At home he tinkered - he would disassemble any mechanical object but was often unable to put it together again. Since my first meeting with Joey, I immediately sensed Joey's curiosity about the red door at the south end of the waiting room. Then at the third therapy session, Joey asked me what was behind the red door. I casually told him that in there were things belonging to my husband. He then asked if I could tell him what were those things. I told him I had no liberty to tell, because it was my husband's property and he is the only one who would have the authority to disclose what was there. He then requested me if I could possibly ask my husband to let him see what was behind the red door. I told him that sometimes my husband drops by the building, so it would be best that he ask permission from my husband himself, and he should do so politely. That fateful day came. He asked me first if this was the right time. He indeed politely asked my husband to please allow him to see what was behind that red door. My husband delightfully agreed, then the three of us walked towards the red door. When the door opened, on display were piles and piles of computers, computer parts, motors of various kinds which looked like junk to me. Upon seeing that, Joey's eyes bulged with excitement just like any kid in a candy store. I said to him, "now you can see it is all junk." This boy suddenly turned with arms akimbo, and with angry facial expression looked straight at me and emphatically said, "Dr. Santiago, it is not junk, it is good stuff." My husband insightfully told Joey, "That's what happens when you don't follow your parents when they tell you to put things away." I could simply say the opportunity to see what was behind the red door put to rest his curiosity. It was an event my husband and I will never forget.

Danny was a nine-year-old boy referred to me by a group home because he was the source of frequent verbal and physical fights among the group hom

residents. In addition, he expressed hatred of black people and women. Although I can't change my tinted brownish skin and my gender, I accepted the seemingly formidable challenge to work with him. The diagnostic interview was of little account. He was surprisingly cooperative. In my practice, during the first visit, routinely inform young patients of my office rules - most important, n - body gets hurt, and no destruction of property in the office or building. In addition, therapy tools which others preferred to call toys are there for them to use but afterwards must be returned where they were previously. At his fourth session, it was winter then and falling snow had accumulated to about half an inch. The staff who dropped him off preferred to wait in the car and listen to a favorite radio station. Somehow this boy appeared agitated. Exploration and verbal intervention did not calm him down. In a short time, he pulled down the window venetian blinds and stepped on it. I firmly told him he violated on of my office rules, so I had to dismis him, and would not see him again, unless he was able to follow all my office rules. I opened the door to le him go. After briefly documenting the incident, I headed out the door to go home. What I saw on the snow were scribbled letters about a foot high saying "I am sorry." Subsequent sessions presented no behavioural outbursts. I would like to believe that this change in behaviour had a casual relationship to that one experience of boundary clearly delineated and discipline delivered with exactitude.

A five-year-old boy I'll call Nino cam from a deeply religious Catholic family and was referred by his kindergarten school. Although deemed bright he was restless and so fidgety at school which seemed to be interfering with his learning capability and not functioning according to potential. The family was cohesive, parents were nurturing, but puzzled as to what was deeply bothering him. To my chagrin, I had to admit I could not figure i out either. This was one concrete case where in any medical practice, especially psychiatry, the tool we most rely on was the information given to us, but many times it is the unspoken information that holds the key to solving the situation. Apparently, Nino is a devoted adherent to his parents' religiosity, attends religious services on Sundays and holy days of obligation. On countless occasions, at Nino's pleadings he had been allowed by parents to talk to different officiating priests after mass. Nino was secretive as to what he talked about with these priests. One time they visited a family out of state. Sunday came, and as usual, at the end of the mass Nino rushed to talk to the priest. That time it was an elderly priest with a calm, warm, comforting and assured presence. Nino for the first time wa observed by parents to be so happy and content after the encounter with this priest. That also marked the time when he stopped seeking officiatin priests after attending mass. It also marked the beginning of better than expected school performance and commendable deportment, as if night time suddenly switched to daylight. At the family session with me immediately after these positive developments, I asked Nino if he told his parents about his conversation with the priests, especially the last one. Nino's reply, "No, because they did not ask me. But now, because you asked, I will tell them and you." Nino said he asked this last priest the same question he asked the previous priests. "Why do I have to wait 'til I am seven years old to receive communion." Apparently, the patent answer given to him by previous priests, was at age seven is when a person knows what is right or wrong, and what is good and bad. These repetitive answers were unsatisfactory to him because he firmly believed he alread knew those. Those priests then just gave him blessing and dismissed him piously. But at long last here is what this elderly priest said to Nino, "My son, there will be enough bread when you turn seven." This experienced elderly priest's insightful and simple answer definitely put Nino's mind a peace. His therapy ended soon.

Epilogue: These anecdotes were just a snapshot in time of these three boys. They had in common emotional unrest manifested as behavioural problems in school, home, or both. When I knew them *then*, these children were responsive to verbal interventions - education, information, supportive guidance, and discipline. Since it is known that personality traits and behaviours observed in childhood are robust predictors of adult behaviour, I can't help but wonder where they are *now?* The only guess I'll venture is that they are essentially the same persons - one remained a tinkerer, one continued to test extent of boundaries but responds to limits set by laws, and the other would be a thinker. The unknown here is the nature of life events across time that could impact their behaviour. My wish is that they have positive influences from family friends, and others who touched their lives, plus opportunities making them all productive and orderly members of society. ■



Anna DeYoung, MD

"My Story" is a collection of wellness success stories from New Hampshire physicians.

My Story:
The Messy Middle We Live In

I've been thinking a lot about my medical training and conditioning and the culture of medicine and the role it's had on my life.

Like many in medicine, I was a sensitive child and went into the medical field to be of service to others. I was obviously motivated, hard-working and striving. I had initially planned to become a physical therapist and spent time volunteering in the physical therapy/wound department at the University of Michigan where I was studying. The director of that department, who was also an advisor, thought that I would be a better physician than physical therapist. She said that I didn't seem to relate to patients physically, but rather, more intellectually. I wasn't at all sure what that meant then, but I believe now that I was already spending more time in my head and far less in my body.

Medical training would ensure that being in my head was the only way to survive. I remember so many moments of being physically exhausted and feeling like there was no option but to keep pushing. I remember being at times sad, scared, overwhelmed, angry, devastated and in grief. There was no time for these feelings. I pushed them down and kept going and then played this on repeat. The joy, happiness, connection, comradery, and sense of accomplishment was there too, but again, no time to feel these emotions either - just keep going.

I remember once being the surgeon in a devastating case of loss. My attending (who was crying) grabbed my hands and said, "You have to keep yourself together". He was right, and I did, but we never came back to revisit this tragedy and I walked into the next patient's room as if all was OK with me. It most certainly was not. I am sure that while training others I have suggested that they push that feeling or emotion away and keep going. I knew no other way and I'm not sure many of us do.

I've been a practicing physician for 25 years and through these years I have tried to find ways to seek balance and practice self-care. What I had been unable to learn was how to be in my body and feel the feelings that are part of the minutes, days, weeks, and years. I have not allowed myself to feel all the grief and sadness and the joy and connection. I am learning that now, after an injury and subsequent surgery has sidelined me.

My hope for those of us in medicine and those who are becoming physicians is that we can find a better way to inhabit our full humanity in an embodied way. Perhaps this is a path we take out of our current epidemic of burnout. ■

WANTED

NH Licensed Physicians to perform consultative examinations in your office for the Social Security Disability program. Perform as many, or as few exams per week, or month as you like. Disability exam training is provided, as are free dictation services and secure web portal access to transact your reports. All exam scheduling is provided by the NH DDS. No billing is required and payment is processed upon receipt of the report. You are not rendering a disability determination but providing current medical evidence for disability claim adjudication.

Please contact Anne.Prehemo@ssa.gov or call (603) 271-4138 for additional information.

OR

NH Licensed physicians specializing in Internal Medicine, Neurology, Orthopedic, General or Family practice interested in providing part-time or full-time staff medical consultant services for the NH Social Security Disability program in Concord. This position requires the successful completion of a federal background check and a minimum of 24 hours of on-site SSA disability program training per week, before a successful candidate can work remotely. There is no patient contact, so insurance is not a requirement.

Please contact Anne.Prehemo@ssa.gov or call (603) 271-4138 for additional information.

NHMS Physician Health Committee is SEEKING New Members!

The mission and vision of the NHMS Physician Health Committee is to guide New Hampshire physicians on a path to deep satisfaction, cultivating integration between their personal and professional lives, through access to diverse options that effectively address stressors inherent in the culture of medicine to help them improve their value and success with their patients and community.

If you want to join us or learn more, please send a letter of interest and credentials to nhmedicalsociety@nhms.org.

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Closing Your Practice

When closing a practice for whatever reason, providing notice to patients in a timely manner promotes continuity of patient care, avoids allegations of abandonment, and fulfills contractual and regulatory obligations

Existing Staff Considerations

- It is strongly recommended to consult an employment law attorney several months prior to closing to ensure compliance with state and federal statutes and to facilitate a smooth transition for employees. Employee benefits such as health insurance, vacation/PTO, retirement plans, and severance, if applicable, will need to be adequately addressed. Employee transition could vary greatly depending on whether the practice is being acquired or permanently closed.

Notification of Patient

- Ensure all active patients have been notified at least ninety (90) days in advance of the practice closure date.
- Notify patients by letter sent via first-class mail. Place a copy of the notification letter in each p - tient's medical record.
- Enclose a records release authorization form for patients currently undergoing treatment or who were seen at the practice within the past 2-3 years if the practice will be run by another provider. If the practice will be fully closing, enclose a records release authorization to all patients with directions on how to access in the future. Third-party medical records custodians can be utilized to ensure HIPAA compliance and facilitate continuity of care.
- Sixty (60) days prior to closing, complete formal

- referrals for the patients who require ongoing care and treatment and confirm acceptance, if feasible. Consult state statutes for specific handoff/referral requirements.
- For complex or actively compromised patients, strongly consider initiating a "warm" handoff with the new provider by setting up doctor-to-doctor phone calls or other means to transfer information and care.

Insurance

Contact your liability insurance carrier to determine if you need to purchase tail insurance to protect you from a claim filed after you discontinue your practice

- Inform each insurance company providing any form of coverage for the practice (e.g., facility, vehicles, and employees) of your plans.

Advertisement

- Publish an announcement in area newspapers serving your patient population. Consider the use of social media in addition to print advertisements. Include the following information:
  - Office closing date
  - Last scheduled appointment date.
  - Process to request transfer of medical record (copy) to another physician.
  - Explanation of how a patient may obtain a copy of their medical record.

Key Entities to Notify

- State licensing board
- State and local medical societies
- Drug Enforcement Administration (DEA). Discard controlled drugs in accordance with DEA procedures and return your DEA license.
- Hospitals
- Associates
- Medicare
- Medicaid
- Third-party payers and managed care organizations you are credentialed with
- Professional associations you belong to, such as the American Medical Association

For a complete list of the above considerations, see our Closing Your Practice Worksheet at https://www.medicalmutual.com/risk/checklists.

Notice

Medical Mutual Insurance Company of Maine's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice

Brenna C. Strapp, DO; FACOG

Cervical Cancer -
A Unique Opportunity in Cancer Prevention

Spring is finally here! Grass and flowers are blooming and spring sport are in full swing. What better time to use a baseball analogy to talk to your patients about cervical cancer (wait, just hear me out)!

Cervical cancer is the third most common gynecological cancer in the world. However, its incidence has been on the decline in the US and other developing countries due to a combination of preventive strategies. Since HPV can be found in >99% of cervical cancers, it has made cancer prevention a whole new ball game! (See!!) Think of our preventive strategies as the bases on a baseball diamond. You're the pitcher and your patient is at bat.

Pitch the idea of **Vaccination** as the first line of prevention. The Huma Papillomavirus (HPV) family encompasses more than 200 related viruses - some do nothing, others cause warts, and some high-risk strains can cause cancer. The vaccine currently available in the US covers nine strains of HPV. Completing the vaccine prior to the onset of sexual activity is >99% protective against those strains. The target age for kids is 11-12 years old but it's approved for men and women through 45 years old - better late than never! Vaccination is like teaching your kids to wear a helmet - put it on before you get to the plate!

Your patient takes a swing and charges down the baseline, **Protection by Selection** is first base. HPV is a numbers game. The virus is present in more than 85% of sexually active adults and more than one strain can be present at a time. The more sexual partners one has, the greater the chance of exposure. Condoms can be helpful in preventing transmission. However, viral particles can be present on the base of the pelvis - so this isn't a fool-proof plan. We need to be realistic in counseling our patients on their role in protecting themselves. Rather than telling them to sit on the proverbial bench, encourage patients to choose their lineup wisely.

Second base is **Early Detection** through Pap smears and HPV screening. The guidelines have undergone many changes over the years, but the underlying goal is the same. Identify the high-risk HPV strains and early changes in the cervix that *could* progress to cancer. Fortunately, an intact immune system will quite often resolve an HPV infection over time. However, some changes will evade the immune system and progress. HPV is a slow-growing virus, taking anywhere from 10-15 years from exposure to develop cancer. This gives us a long time to step in!

Third base is **Early Treatment** with procedures to remove pre-cancerous changes. HPV incorporates itself into the DNA of cervical cells and uses them to churn out more HPV - which then takes over more cervical cells. We can identify these altered cells on colposcopy and remove them - allowing the immune system to fight the HPV virus itself

What if your patient gets tagged out by HPV? The game isn't over! Patients will often ask if there's anything they can do to help resolve an HPV infection. If that patient is a smoker, quitting is the most important change they can make. The carcinogens in cigarette smoke are known to promote the development of cervical cancer. Otherwise, keep encouraging prevention as the most effective treatment. Ensure good follow-up for any abnormal pap finding so we have the time and opportunity to stop progression. Swing for the fences - educate your patients and give them the tools to protect themselves. Let's play ball! ■

Off to the Next Adventure!

This is my last issue as editor of New Hampshire Physician. It has been a privilege to serve the Society for the last decade. I truly appreciate all the support and encouragement I've received over the years. When I was hired, Mary Pyne said the NHMS team was like a family. Indeed, it has often seemed that way, as we shared trials, but also joys, in that big old Victorian house. I will forever be grateful for the lessons learned, friendships made, and generosity shared.

What's next? I am excited to enjoy the summer with my soon-to-be first grader and ponder the next phase of this wild and precious life. Many have questioned my desire to leave. Perhaps this Rumi quote will help explain: "Let yourself be silently drawn by the strange pull of what you really love. It will not lead you astray."

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