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Easing the Transition from Training to Medical Practice

Volume 1 | 2021

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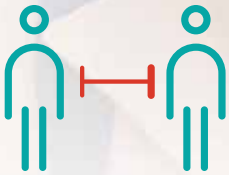

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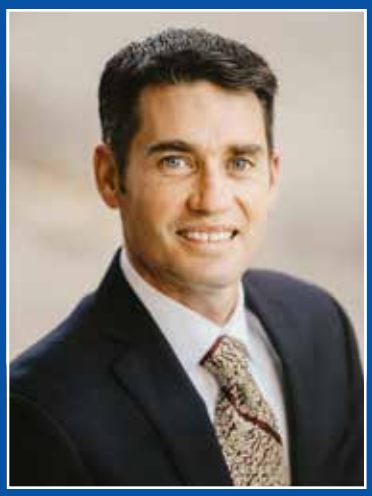

G. Kenton Allen, MD, MBA
NHMS President

...aim to further engage the physicians in our state in easing the transition from training to medical practice for our early career colleagues

President's Perspective
Easing the Transition from Training to Medical Practice

Embarking on a career in medicine is a life-defining event. It has been among the most exciting and rewarding times in my life and, I would expect, for many physicians and healthcare workers across the state. However, there were early challenges along the path that extended beyond the practice of caring for patients. In the coming year, we at the New Hampshire Medical Society (NHMS) aim to further engage the physicians in our state in easing the transition from training to medical practice for our early career colleagues. More specifically, we hope to address:

(1) Finding a practice that meets personal and professional goals,

(2) Identifying opportunities for career advancement, and

(3) Boosting literacy in personal finance

Finding the right practice

When I look back at my experience of finishing fellowship training and looking for a job that fit my personal and professional goals, there were three jobs that my wife and I were considering seriously. My introductions to these practices were all the result of friends I had in those practices who were hiring and who knew I was graduating my training program.

Each of these three practices differed from each other significantly. One was with a tertiary care academic medicine practice in New England as an employed physician largely supervising nurse anesthetists and residents. A second was with a private practice partnership in the Pacific Northwest with contracts at a level II trauma center and multiple, independent surgery centers providing physician-only anesthetics. The third was with a newly built hospital in Abu Dhabi, where the practice consisted of anesthesiologists from eight different countries and most closely resembled a tertiary care academic practice without teaching responsibilities.

There were aspects of each of these opportunities that were appealing and others that were imperfect. When we were weighing the pros and cons of each, we realized that we were trying to fit our personal and professional goals within the opportunities presented to us, as opposed to first understanding our own goals and then searching for a practice that most closely supported them.

As I have spoken with peers and colleagues around New Hampshire and beyond, it became evident that my experience was not unique. The vast majority found their first, and in many cases subsequent, position through connections with colleagues in their personal or professional network who presented them with job opportunities.

The limitation of such a system is that it results in choosing from opportunities to which you have a close connection, rather than those which may be the best fit. Furthermore, professional networking is a skill not often taught or practiced early in a career in medicine, potentially limiting the scope of a job search for physicians.

Take, for example, a New Hampshire resident who attended medical school in California, completed residency in Colorado, and upon graduating is interested in working in New Hampshire. Likely, their connections to job opportunities in New Hampshire are limited and finding a practice that fits their goals would be a daunting task.

This experience of finding a job after medical training is in stark contrast to the job search experience coming out of business school, where a significant portion of the educational experience is focused on not just matching a student with an industry (consulting, finance, healthcare etc.) but also which organization within that industry is the best fit for an individual. In medicine, there is great thought and guidance given to The Match, but significantly less from the time training ends. Over the course of the coming year, we aim to explore ways we can help with this process, particularly for young physicians.

Opportunities for career advancement

The first opportunities towards advancing an early career can be the hardest to find. They often must be actively sought after and can be limited. Whether it be through academic research, a role in public health policy or hospital administrative leadership, NHMS will look to help provide early career physicians access to these first opportunities.

Our New Hampshire Physician publication will offer the opportunity for young physicians to showcase their passions within medicine. In this issue, Dr. Melissa Scull offers her experience and insight into the field of obesity medicine. At our 2021 NHMS Scientific Conference we will include young physicians within our lineup of speakers, and we will continue to encourage early career physicians to apply to the NHMS-sponsored Physician Leadership Program at UNH.

Boosting literacy in personal finance

There is significant interest among young physicians in personal finance. In fact, as many as one in five physicians in the United States actively engage in social media groups, podcasts or blogs on the topic. However, finding trustworthy educational resources that address the physician-specific experience can be time consuming.

Interest in personal finance among young physicians is unsurprising, as the typical path to becoming a physician today includes amassing, on average, over $200,000 in student loans and having a period of three to eight years of relatively depressed compensation during residency. From the time of graduation, physicians consume above

average amounts of financial products – in the form of insurance, tax deferred savings plans and alternative investments.

When I look back at the financial products I have consumed in the first five years of practice, the list is long – personal disability insurance, term life insurance, umbrella insurance, car insurance, home mortgage, home insurance, car loan, car lease, malpractice insurance, employer 401(k), employer 403(b), employer-sponsored 457, state 529 plan, taxable stock account, whole life insurance, tail malpractice insurance, employer cash-balance account, student loan refinance, credit card debt consolidation (personal loan) and ROTH retirement plan.

Financial principles are not commonly taught in medical school or residency. For many, financial decisions are outsourced to financial advisors or trusted colleagues, but this certainly is not a replacement for sound financial literacy. Recognizing the demand for and importance of physician-specific financial educational resources, the NHMS will work to sponsor CME-eligible financial educational resources for our membership over the course of the current year. ■

Michael Padmore,
NHMS Director of Advocacy

Legislative Update

This year's legislative session got off to a slower start than usual but will nevertheless be a busy one. NHMS has tracked over 200 bills, ranging from a telehealth expansion repeal, prior authorization reform, psychiatric collaborative care model, opioid alterative treatment, paid sick days, to a number of troubling reproductive health bills and anti-vaccine legislation.

House Bill 602 attempts to repeal the progress made by House Bill 1623, signed into law during the 2020 legislative session, that ensured telehealth reimbursement parity, expanded site of service, and enabled all providers to provide services through telehealth for Medicaid and commercial health coverage. HB1623 also created the "Commission to Study Telehealth Services" that would be tasked with understanding the broader impact of telehealth expansion in New Hampshire, a commission that NHMS sits on. NHMS supported telehealth expansion in 2020, and will oppose HB602 on the grounds that we have gotten feedback from our membership and the larger physician community that telehealth expansion has had a positive impact on their practices and patient care. Moreover, to repeal this law, in the middle of the COVID-19 pandemic, before this commission has even had an opportunity to complete its task, could throw our health systems into a frenzy as providers will be forced to adjust their practices yet again.

House Bill 247 aims to mandate that providers must prescribe an opioid alternative treatment when prescribing an opioid and requires no less that 4 hours of opioid alternative continuing medical education each year. While NHMS is open to legislation that would make opioid alternatives more accessible to patients, we are opposed to HB247. NHMS does not support any legislation that governs how medicine must be practiced. Plainly, HB247 goes too far.

As we move forward this session, your voice will be a critical perspective for our lawmakers to hear.

Senator Tom Sherman, a practicing gastroenterologist in the Seacoast, and Representative Mary Jane Wallner have each filed bills to mandate that employees have access to paid sick days. Even outside of the COVID-19 pandemic, paid sick days are an issue of health equity. Unfortunately, the majority of working families in the Granite State do not have access to paid sick days. We know that when people don't have paid sick days, they go to work sick! When people can afford to take time off from work because they are ill, our communities are healthier overall.

Several bills are filed this session to limit women's access to comprehensive reproductive health services and establish criminal penalties for physicians who perform such procedures. First, NHMS stands firmly opposed to any legislation that criminalizes physicians for performing medical procedures. Furthermore, NHMS believes that all women should have access to comprehensive reproductive health services. The decision to perform any medical procedure is a personal medical matter that should be made between a physician and his or her patient, free of external interference and subject to the physician's clinical judgment, the patient's informed consent, and the standards of good medical practice.

House Bill 221 would make the state's vaccine registry an opt in program rather than opt out. We have gotten consistent feedback from our membership for the need to have a strong state vaccine registry. That need has only been amplified because of the COVID-19 pandemic. NHMS stands opposed to HB221 and any other type of legislation that may contribute to vaccine hesitancy.

As we move forward this session, your voice will be a critical perspective for our lawmakers to hear. Please contact me at michael.padmore@nhms.org or 603.858.4744 with any thoughts or questions you might have along the way. ■

WANTED

Internal Medicine, Orthopedic, Neurologic, General or Family Practice Physicians interested in providing part-time or full-time staff medical consultant services for the Social Security Disability program, through the state Disability Determination Services office in Concord NH. Staff work involves reviewing disability claims on-site and requires no patient contact. SSA Training is provided.

OR

Physicians interested in performing consultative examinations in their office for the Social Security Disability program, through the state Disability Determination Services office. Compensation is provided per exam. All administrative aspects are performed by the DDS and no billing is required. Free dictation service and a secure web portal is provided for report submission.

Any interested physician must be licensed by the state of NH and in good standing. Please email inquiries to Anne.Prehemo@ssa.gov

Melissa Scull, MD
American Board of Internal Medicine
American Board of Obesity Medicine
New England Weight Management Institute, Catholic Medical Center
Manchester, NH

Young Physician Focus highlights young or early career physicians and their research/passions. If you'd like to contribute, please contact mary.west@nhms.org.

Young Physician Focus
Evidence-based Obesity Treatment: Comprehensive and Compassionate Care in New Hampshire

Obesity has long been understood as a risk factor for virtually every disease we treat. From the more obviously related conditions such as hypertension, diabetes and osteoarthritis, to more obscure connections such as autoimmune disorders[1] and cancer. Obesity is also an independent risk factor for severe COVID-19 infection[2] and a less robust immune response to vaccinations[3]. We all know that the epidemic of obesity is worsening. In medical school we are shown the CDC's map of the United States depicting the sharply increasing prevalence of obesity. However, the vast majority of practicing physicians have never been taught the pathophysiology of obesity or how to effectively use evidence-based treatment. Unfortunately, this leaves us ill-equipped to help our patients, and worse, can lead to further harm due to bias and misunderstanding[4]. Thankfully, the field of Obesity Medicine is rapidly growing. Interest and research are peaking and evidence-based approaches are slowly becoming more mainstream. In New Hampshire, my hope is that we can become leaders in compassionate, evidence-based obesity treatment which starts with the individual physician-patient relationship.

Prior to attending obesity medicine conferences, I thought that obesity was considered a disease because it is a risk factor for so many other diseases. I did not believe BMI was a reflection of character and was somewhat aware that genetic factors seemed to be at play in obesity. However, I was not offering evidence-based obesity treatment with anywhere near the frequency I was offering treatment for dozens of obesity-related diseases. I thought that teaching patients to eat less and move more, or referring them to a

weight treatment center were my only options. When these interventions didn't lead to sustained results, or patients declined referral, all I could offer the patient was trying to motivate them to stick with their lifestyle changes. I distinctly recall a patient asking me in primary care, "Why is everyone so comfortable with prescribing medication for blood pressure and cholesterol, but no one wants to prescribe medication for weight?" I'm embarrassed to say my completely uninformed answer was, "The medications don't work that well and they're not very safe." In actuality, I was never taught how to treat obesity in medical school or residency, and I had passively absorbed a bias against treating it like any other disease. With this confession out, I want to do my part to help other physicians who are still in this mindset by imparting a cliff notes version of why obesity is a disease and the value and validity of medical and surgical obesity treatments.

Obesity is rarely a monogenic disease, but is most commonly a polygenic, heterogeneous condition. The interaction between environment and genetics is undeniable[5], but this is no different than most other diseases. Some simple facts important to understand are that patients with obesity tend to have higher hunger hormones and lower satiety hormones than people who don't struggle with weight. The amount we eat is tightly regulated by neurologic and hormonal pathways signaling when to eat and when to stop, and we do not all have the same signal[6]. Further, the majority of our current food environment is unnatural, does not send appropriate satiety signals, and hijacks the dopamine-reward pathway. Studies have shown that people overeat ultra-processed foods in comparison to whole foods even when they do not report a taste preference for one over the other[7]. It also has been shown that those with higher BMI have lower density of dopamine receptors in their central reward system, and therefore may need a stronger signal to achieve similar reward feedback[8].

When it comes to weight loss, evidence supports that we are adapted to conserve fat stores rather than tolerate weight loss. Some key challenges to weight loss are that metabolism decreases, hunger hormones increase and satiety hormones decrease in response to weight loss[9]. Unfortunately, this doesn't seem to be temporary. Studies have shown persistent metabolic slowing up to six years after lifestyle interventions[10]. Many other factors contribute to difficulty with weight loss including differences in the gut microbiome, pro-inflammatory signals that develop as adipose tissue accumulates, and numerous medications patients are commonly prescribed that can predispose to weight gain[6].

So, why is our understanding of this important, and how can it inform better treatment of obesity? If we understand the pathophysiology of any disease, we can better comprehend how and why medical interventions are necessary and valid. Simply put, dietary changes and physical activity will always be pillars of obesity treatment, but medication and surgery significantly increase the potential for substantial, sustained weight loss and for related health benefits. Offering these treatments is recognizing that obesity is chemistry, not character. In other words, obesity is not a disease of willpower. Nationwide <1% of patients eligible for bariatric surgery[11] and 1-2% of those eligible for medical weight loss treatment receive these services[12]. I foresee this will continue to improve but we have a long way to go. Thank you all for doing your part in educating yourself to provide compassionate care, and offer the best evidence-based treatment for your patients. ■

Resources for further learning:

Obesity Medicine Association, obesitymedicine.org

The Obesity Society, www.obesity.org

American Society for Metabolic and Bariatric Surgery, https://asmbs.org/

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Members' Corner
The Doctors' Lot

This article was adapted from a commentary published in the December 2020 issue of Cancer Cytopathology, a journal of the American Cancer Society, and later in Vox Populi, the opinion page of Dartmouth College https://news.dartmouth.edu/.

Edward J. Gutmann, MD, AM is an associate professor in the Department of Pathology and Laboratory Medicine at the Geisel School of Medicine at Dartmouth and directs the cytopathology fellowship program at Dartmouth-Hitchcock Medical Center.

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 james.potter@nhms.org

Establishing and maintaining collegial relationships among physicians and other health professionals can be challenging in the best of times. During a pandemic, this important framework, while more difficult to accomplish, is also more vital than ever.

These relationships are important for the well-being of the health care workers and for patient care. Responsible for preserving or restoring the health of our patients while preventing medical error, physicians practice a demanding and stressful profession. Fortunately, our burdens are lightened, and the likelihood of burnout is reduced, by the support and friendship of our colleagues. But opportunities for physicians to build this critical social capital have diminished in recent years, and the social distancing mandated by the COVID-19 crisis threatens to isolate us further.

However, I have found that connections with colleagues continue to be fostered, in a seemingly unlikely setting.

In my work as a cytopathologist at Dartmouth-Hitchcock, I often go to areas of the hospital where other physicians, including gastroenterologists, radiologists, and pulmonary doctors, are performing needle biopsies of lesions deep within the body. Using a microscope mounted on a cart, I quickly examine aspirated cells and provide immediate, in-person feedback to the physicians as to whether their needle has hit a targeted mass in an organ. I believe that my presence at these so-called "rapid onsite evaluations" ("ROSE" procedures) effectively builds social capital. The pathologists, radiologists, and clinicians who work together and get to know one another at these cases are more apt to pick up the phone and call or text one another for help with problematic cases of other kinds for which they share responsibility.

But social capital accrues in other, less formal, settings, too.

For example, our chats with colleagues from other departments at the physician group's annual December holiday party and at the occasional "state of the group" dinner meeting create bonds that both sustain us and facilitate teamwork in caring for patients. I mention these events because over the years they have been phased out. Although I don't fault my institution for eliminating them to achieve cost savings, they do represent lost opportunities for building relationships.

In years past, physicians routinely would dine together in the cafeteria. Indeed, for decades, four of my departmental colleagues ate lunch together and had vibrant discussions about politics, science, and movies; physicians from other specialties often would take a seat at their table. One by one, those pathologists retired; the last of the four who still works now eats alone in his office. "Grab and go" back to one's desk to eat and do paperwork is the new norm for physicians—efficient, but lonely.

Electronic consultations are another means to increase the efficiency of physicians. Faced with a clinical question, a clinician can electronically que-

ry a specialist, whether or not he or she has previously met the consultant. A billable answer is received, but the question, "How are your kids doing?"—which might have been asked at the conclusion of a face-to-face clinical discussion—remains unasked.

Amid the ongoing, gradual attenuation of our social bonds, a worldwide health crisis has taken hold. As I write this in January 2021, nearly 360,000 deaths have been attributed to COVID-19 in the United States. Our mantra continues to be hand washing, masks, and social distancing. Holding a dinner meeting of 250 closely seated physicians is not possible.

How then do we build meaningful relationships with each other, especially when social distancing is mandated? Guidelines from the Centers for Disease Control and Prevention suggest a possibility: "Indoor spaces with less ventilation where it might be harder to keep people apart are more risky. Activities are safer if they are held in outdoor spaces."

Our clinics, endoscopy suites, and operating rooms all are indoors, of course. But our parking lots are not. Indeed, despite months of frigid Northern New England winter weather for which a parking garage would appear mandatory, all the physicians at my medical center park in a large outdoor lot. This turned out to be fortuitous.

Even before the pandemic, I recognized the value of the parking lot for establishing relationships. In the lot one Saturday a few years ago, I encountered someone I had not seen before, but from the "ID" badge dangling from his neck, I recognized the name of a new pulmonologist for whom I had recently rendered several cytologic diagnoses. We introduced ourselves and had a 20-minute chat that included exchanging information on where we had trained and worked, our partners, our hobbies, and the like. This new friendship eased communication in subsequent months when we shared diagnostically challenging cases.

The lot has assumed greater importance during the pandemic. It is a large space in which it is easy to maintain a safe social distance. The warm sun there this past summer, most welcome after a bitter cold winter, was pleasant for us and less hospitable to the COVID-19 virus. I listened to a tale of unpleasant divorce proceedings, asked a colleague about his progress on an academic article, discussed a difficult case with an oncologist, and was advised about good bicycling trails. My list goes on, and my own conversations are a small fraction of the many daily impromptu meetings in the parking area.

To be sure, the lot is a large, lifeless expanse of concrete. But it is also a unique liminal space where we transition from our private lives at home to and from our clinical lives caring for patients in the hospital. Reaching out, sharing news, discussing a case, or simply wishing a colleague "good day" or "good evening" all challenge workplace trends that keep us apart.

As a cytopathologist, I work cooperatively with cytotechnologists, cytopreparatory technicians, and administrative assistants. The cytology team is one of many essential groups in the medical center. Where we park does not prevent us from reaching out to other members of our team and those of other health care teams. Indeed, the parking lot can be viewed as a metaphor for general efforts to connect with others in the course, and service, of caring for patients.

Our conversations in the lot will likely be brief in the cold of this New England winter. But as we chip away at the ice on our windshields, we will chat. The bonds we form nourish us in all seasons. ■

The parking area is an important web for connection during a socially distanced time.

Benjamin Mitchell
Baystate Financial

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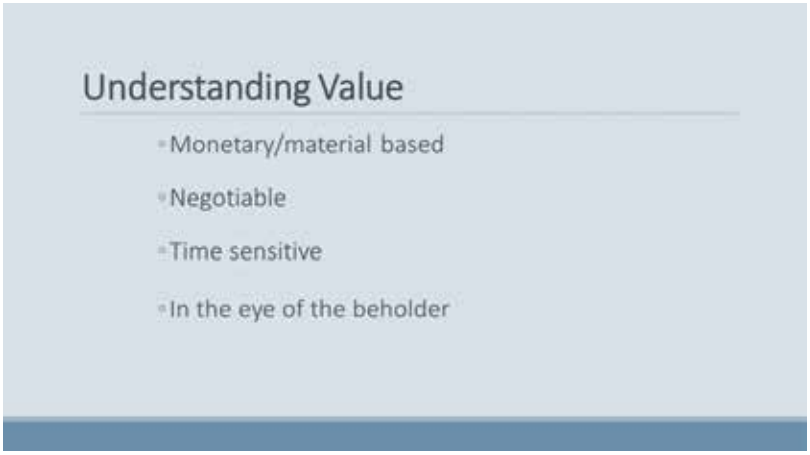
Establishing a financial planning strategy built on your enduring "values" rather than on the ever-changing list of things you "value"...

What a Difference an "S" Makes!

The NH Medical Society is committed to being the leading advocate for the well-being of our members. That effort includes providing timely articles, special topic seminars and CME courses. With financial stress being an ever more prevalent concern among physicians, we are continuing to team up with Baystate Financial to provide our members access to the financial education, professional expertise and technical resources you need to become more competent in your financial decision making. Baystate's 2021 kickoff article reminds you that an understanding of your "values" is as important as the "value" of your things, when you are initiating the financial planning process.

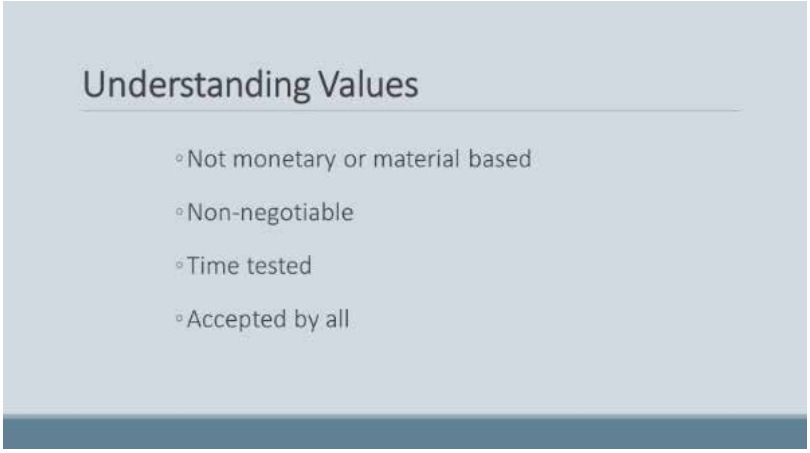
Embarking on the journey to bring your hopes for your financial future and the future of those you care most about into reality is the basis of the Financial Planning process. In order to properly evaluate all the options available to you along this journey, building a perspective from which you can make informed decisions that lead to wise choices is the first goal you strive to attain. A great place to begin is by examining how you look at the "value" of things that are important in your life.



You recognize that:

- value is normally a monetary or material-based determination;
- value is almost always negotiable;
- value is time sensitive;
- value is held in the eye of the beholder; and
- value is exchanged for money, hopefully in a mutually beneficial transaction.

Observe how that transforms into something much deeper simply by adding an "s" to "value," producing the concept of "values" for consideration.



Instantly we see what a difference that an "s" makes. "Values" are not monetary or material based. For your values to be worthy, they are non-negotiable. Rather than being time sensitive, we know that they are time tested, and rather than existing in the eye of the beholder, they are, although deeply personal, also universally accepted.

Establishing a financial planning strategy built on your enduring "values" rather than on the ever-changing list of things you "value" is how you effectively address your life-long financial priorities. ■

Benjamin Mitchell is a registered representative of and offers securities and investment advisory services through MML Investors Services, LLC. Member SIPC. Branch Address: 200 Clarendon Street, 19th & 25th Floors. Boston, MA 02116. 617-585-4500. CRN202301-276601

NHMS Welcomes New Members

Melissa Scull, MD

Bryan Bean, MD

Peter Eyvazzadeh, MD

Anthony Dinizio, MD

Marianne Petruccelli, MD

Alexander Stetsyuk, MD

Ashley Wood, MD

William Wrobel, MD

Elizabeth Clemente, MD

NHMS CORPORATE AFFILIATE PROGRAM SERVICES

Billing Services

Business Management

Collection Service

Dental Benefits

Electronic Medical Records

Electronic Payment Systems

Employee Benefits

Financial

Insurance

Legal

Office Supplies

Pharmaceuticals

Practice Management

Telecommunications

Uniforms, Apparel & Linens

Web-based Billing

NHMS CAP is a paid membership program whose members meet criteria as posted at www.nhms.org

Complete Medical Records: Your Best Defense

Medical Mutual
INSURANCE COMPANY OF MAINE

Excellent documentation supports medical decision-making and serves as a communication tool for all members of the care team. It will justify reimbursement from third-party payers, protect against allegations of medical malpractice, and meet statutory, regulatory and professional requirements for clinical and business purposes.

General Guidelines for Documentation of Patient Care.

- Be timely, comprehensive and objective.
- Authenticate, date and time entries.
- Avoid slang or euphemisms, such as "drug seeker" or "frequent flyer." Instead, document clinical assessment and treatment provided.
- Avoid unapproved, personal or informal abbreviations. Be aware of recognized dangerous abbreviations and do not use them.
- Document after patient care is complete. Never pre-document care.
- Refrain from criticizing a previous provider's care. Document a factual summary of pertinent clinical findings and the rationale for your plan of care. Refer questions about prior care to that provider.
- When documenting difficult patient encounters, be objective and document the facts. Place statements made by the patient in quotations. Note actions taken by staff/physician and final resolution.
- Include patient emails sent or received outside the portal.
- When using transcription and speech recognition technology, carefully review transcribed documents and edit as necessary. Prohibit notations such as "dictated but not read" or "I take no responsibility for the quality and validity of the information in this document."
- Include review of diagnostic test results and consultations, treatment or action plan, and notification of patient.
- Document failed appointments including all attempts to contact the patient to reschedule.

Paper Record Documentation

- Be sure your documentation is legible.
- Each page of the paper medical record should be labeled with the patient's name and date of birth or medical record number.

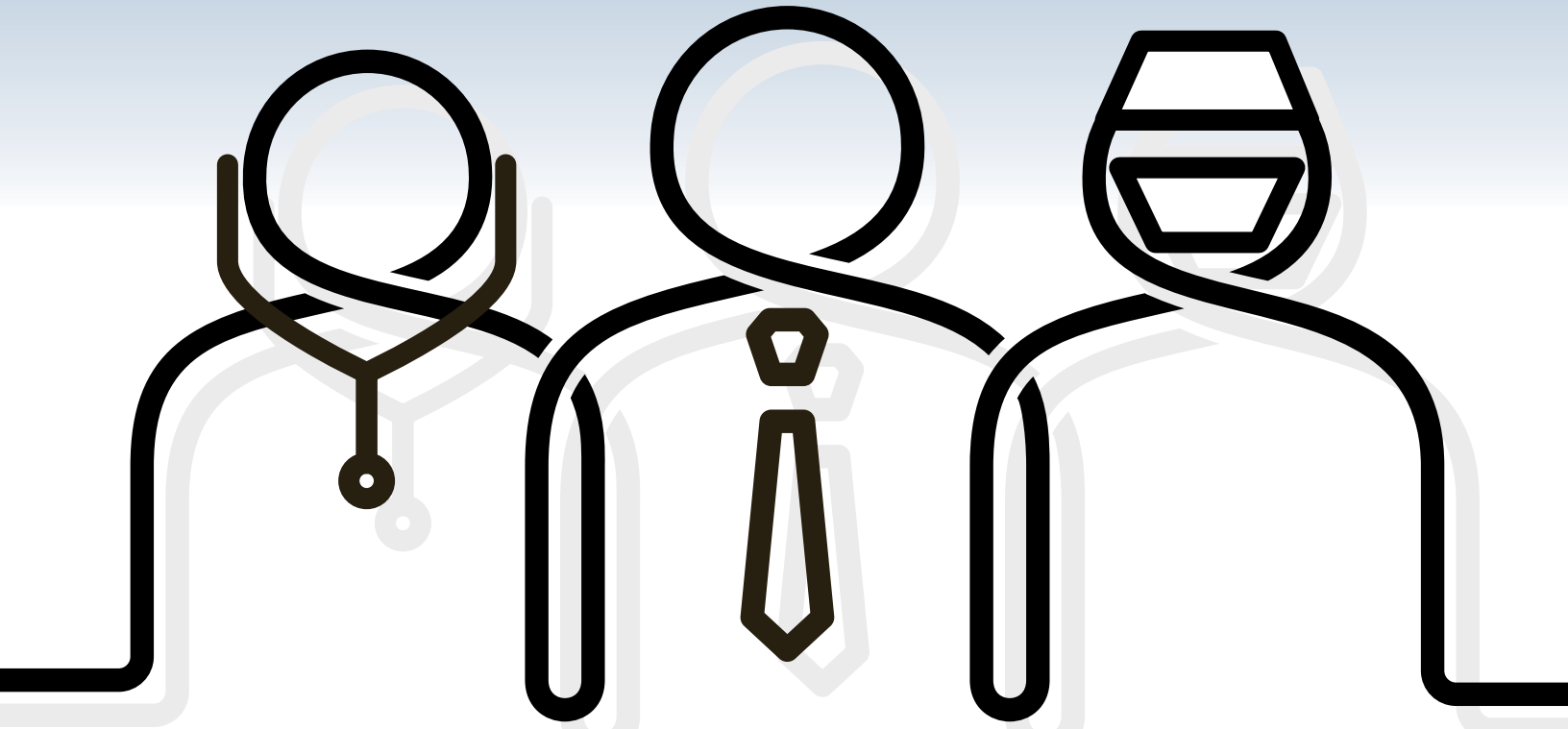
Electronic Health Records

- Discourage the use of copy and paste function.
- Information added to an electronic health record can never be permanently deleted; it will always be retrievable in the metadata.
- Amending a Medical Record: It may be necessary to correct an entry in a medical record. Reason for amending an entry could include correcting erroneous information, adding a late entry, adding information to a previous entry or deleting erroneous information, such as documenting on the wrong patient. Develop policies and procedures on the appropriate steps to follow when amending your medical records. Never make changes to a medical record after receiving notice of a potential claim.
- Alterations: An alteration of a medical record is a deliberate attempt to change rather than correct a medical record. Alterations of medical records almost always guarantees settlement of even medically defensible cases. Therefore, never alter a medical record!

Adverse Events: If an adverse event occurs, document facts of the event in the patient's medical record, including treatment provided. Adverse events should be disclosed to patients. ■

Medical Mutual'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.

Partners in patient safety & medical liability protection



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James G. Potter
NHMS Executive Vice President

The Next Epidemic in New Hampshire that Can Be Averted

While the COVID-19 pandemic has consumed the medical community for the last year causing more than 500,000 deaths nationally, the Granite State is in a unique situation to avoid mistakes taken by other states that have commercialized marijuana and learn from them through a public health perspective. A good example is Colorado, which played a prominent role in the transformation of cannabis in medicinal legalization in 2000, and more significantly in 2012, with recreational commercialization.[1] Beyond personal preferences, the public health impacts of cannabis on Granite Staters – particularly our youth – should not be overlooked.

The most comprehensive data on cannabis use and correlated outcomes features adolescents and young adults collected nationally through the Youth Risk Behavior Surveillance System (YRBSS) and Monitoring the Future survey.[2,3] Marijuana use among the 19- to 22-year-old age group is reported at or near its highest level in 40 years. This is in large effect due to the current vaping epidemic, with annual prevalence reaching 43 percent and 1 in 7 young adults using cannabis on a daily or near-daily basis.[2]

This trend of cannabis is particularly concerning when considering the health care implications of frequent use. Marijuana-related emergency service utilization by Colorado adolescents increased over 270% in the first five years following recreational commercialization of marijuana.[4]

The established effect of marijuana on our adolescent population deserves our close attention especially as vaping increases and adolescents reach for more potent THC formulations which have dramatically increased from 1-3% in the 1960s-1980s to legal purchases in Colorado averaging between 17%- 28%.[5]

... heavy marijuana use can be detrimental to cognitive function and to mental health.

Contrary to claims of cannabis lobbyists (increasingly now owned by tobacco manufacturers[6]), adolescents who use marijuana regularly are more likely to develop additional substance use disorders and, according to the most recent YRBSS data, "having ever used cannabis" is the greatest risk factor for future opioid misuse in this age group.[1,7]

Studies increasingly show strong statistical associations between cannabis use and the development of schizophrenia and other psychoses. A recent meta-analysis reports a pooled odds ratio of 3.90 and dose-dependent association for psychoses among cannabis users compared to non-users.[8]

Marijuana use is also associated with increased suicidal ideation, suicide attempts, and likelihood of suicide completion among adolescents and was the most common drug identified in completed adolescent suicides in Colorado, at nearly 33 percent.[9,10]

This growing evidence correlating cannabis use and reduced cognitive function has prompted Surgeon General Jerome Adams to formally state that heavy marijuana use can be detrimental to cognitive function and to mental health.

Finally, the deadly outcomes for adolescents directly tied to marijuana-related traffic fatalities have increased from 15 percent to 25 percent of all traffic fatalities. Over 30 percent of Colorado's adolescent marijuana users reported operating motor vehicles under the influence of cannabis.[11]

The need for science and evidence to inform public policy has never been more apparent given our most recent experiences with the COVID-19 pandemic. Considering the broad and potentially lethal impact that marijuana has created among Colorado's youth – as well as a new feeder pool for the illicit fentanyl and growing methamphetamine epidemics – the medical community needs to be just as ardent on the necessity of evidence to guide the Granite State's approach to prevent a new marijuana epidemic here.[12,13] ■

Endnotes

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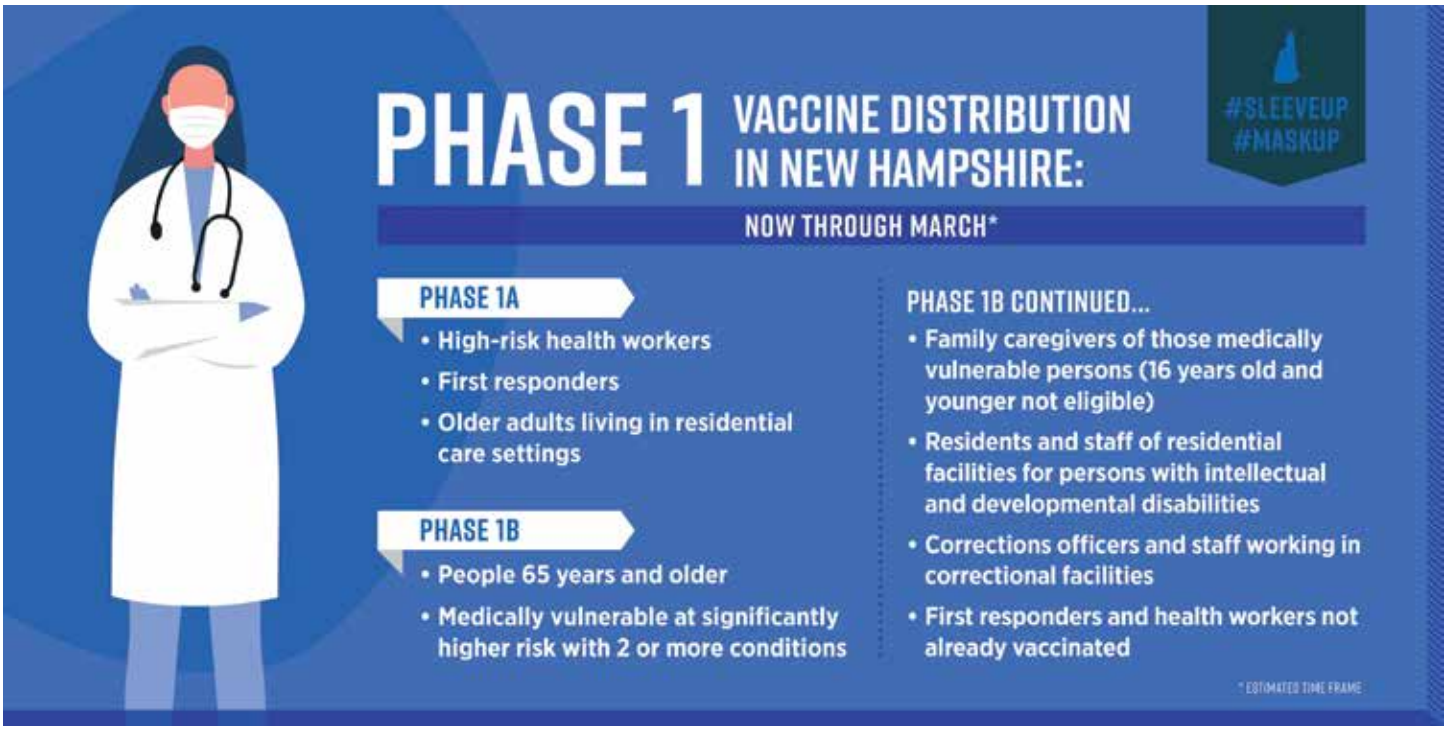
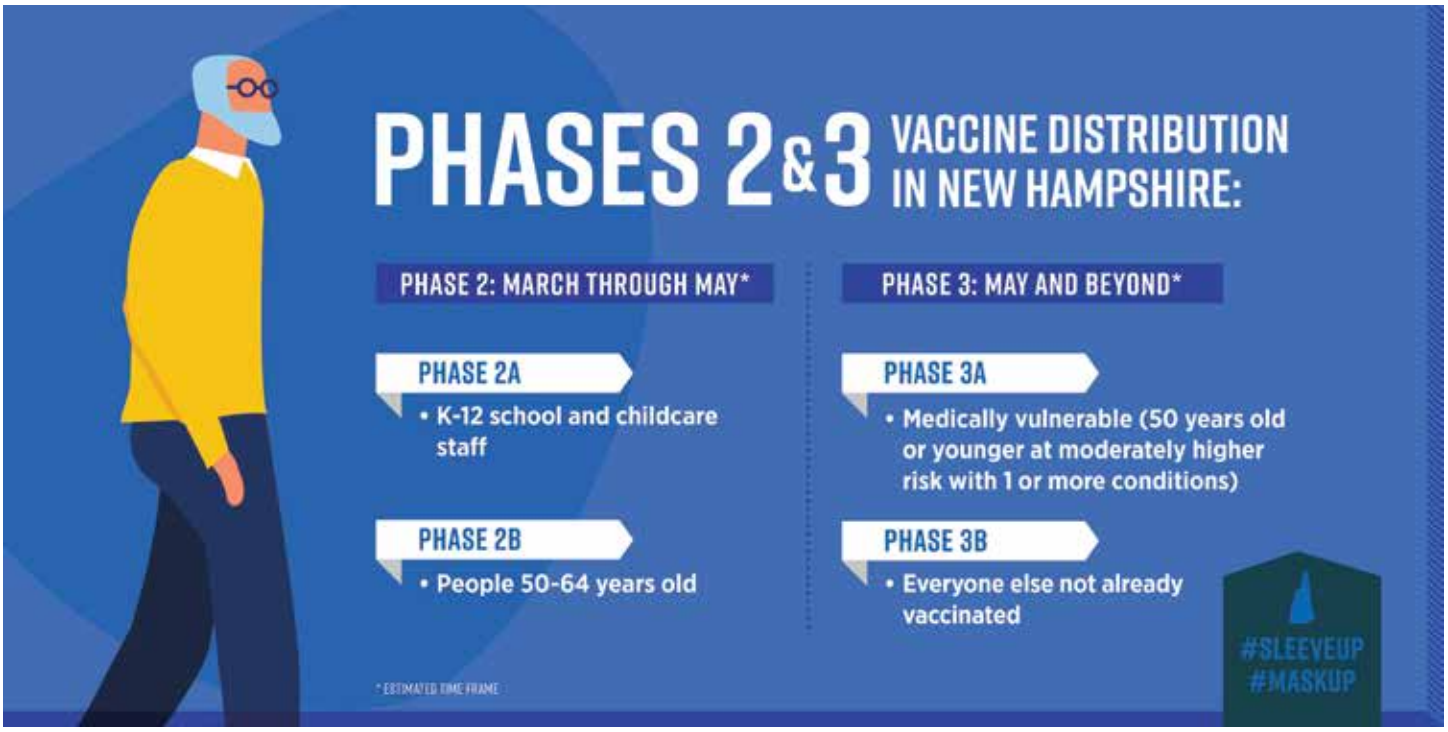

PHASE 1 VACCINE DISTRIBUTION IN NEW HAMPSHIRE:
#SLEEVEUP
#MASKUP
NOW THROUGH MARCH*
PHASE 1A
• High-risk health workers
• First responders
• Older adults living in residential care settings
PHASE 1B
• People 65 years and older
• Medically vulnerable at significantly higher risk with 2 or more conditions
PHASE 1B CONTINUED...
• Family caregivers of those medically vulnerable persons (16 years old and younger not eligible)
• Residents and staff of residential facilities for persons with intellectual and developmental disabilities
• Corrections officers and staff working in correctional facilities
• First responders and health workers not already vaccinated
* ESTIMATED TIME FRAME


PHASES 2&3 VACCINE DISTRIBUTION IN NEW HAMPSHIRE:
PHASE 2: MARCH THROUGH MAY*
PHASE 2A
• K-12 school and childcare staff
PHASE 2B
• People 50-64 years old
PHASE 3: MAY AND BEYOND*
PHASE 3A
• Medically vulnerable (50 years old or younger at moderately higher risk with 1 or more conditions)
PHASE 3B
• Everyone else not already vaccinated
#SLEEVEUP
#MASKUP
* ESTIMATED TIME FRAME

New Hampshire
MEDICAL SOCIETY
ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

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Mission: *Our role as an organization in creating the world we envision.*

The mission of the New Hampshire Medical Society is to bring together physicians to advocate for the well-being of our patients, for our profession and for the betterment of the public health.

Vision: *The world we hope to create through our work together.*

The New Hampshire Medical Society envisions a State in which personal and public health are high priorities, all people have access to quality healthcare, and physicians experience deep satisfaction in the practice of medicine.

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Jane Coen Tewksbury
NHMS Chief Operating Officer

New Hampshire Medical Society Hires New Chief Operating Officer

The New Hampshire Medical Society is pleased to announce the hiring of Jane Coen Tewksbury as its new Chief Operating Officer. She has more than 25 years of business management experience, which includes 13 years at the Business & Industry Association where she most recently served as Senior Vice President of Operation & Finance.

"We are excited to have Jane's vison and expertise in developing and managing both personnel and operational policies join the Medical Society's team," said James Potter, Executive Vice President/CEO.

Jane holds a Bachelor's Degree from Plymouth State University with course emphasis in Administrative Policy, Interpersonal Relations and Human Resource Management. She is a Leadership Greater Concord graduate and has served as a Board of Director for many organizations including Best Buddies, Concord Babe Ruth, COPOCO, Womenade of Concord and YMCA. Jane lives with her two children in Concord. ■