MARCH 2024 ISSUE

# Kansas City MEDICINE

JOURNAL OF THE KANSAS CITY MEDICAL SOCIETY

## Our Children are Not Alright

A look at the deterioration of our children and adolescents' mental health

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# A LETTER FROM *the President*

My name is Greg Unruh, and I am honored to be the President of the Society for 2024. By way of a short introduction, I practice anesthesiology at the University of Kansas Medical Center. I have been involved in and have held leadership positions in local, state, and national societies of organized medicine throughout the years, both in anesthesiology and non-anesthesiology societies. I was an officer in the Wy-Jo Medical Society when we merged with the Kansas City Medical Society and have remained on the Board throughout all of the reorganization. I am very proud of how far we have come, It has put us in position to speak for physicians on both sides of the state line. We have expanded our Leadership Council, and we have passionate members of our Board of Directors.

I want to commend our Immediate Past President, Dr. Carole Freiberger for her leadership in 2023. She provided us with an optimistic, can-do Presidency that advanced the Society and the practice of medicine in the KC area, so thank you Carole! In addition, we have welcomed the steady leadership of our executive director, Mr. Micah Flint. We appreciate him keeping us on track and organizing our many activities.

Several of the things I mention will be dealt with in more detail throughout this communication, but I wanted to highlight some the several areas the Board has chosen for our work this coming year:

- **Advocacy**
  We want to advocate on both sides of the state line working with both the Missouri State Medical and Kansas Medical Societies (MMSA and KMS) on behalf of physicians. On the Kansas side, the legislature is working on many issues that affect us including scope of practice, vaccinations, Medicaid reimbursement and Medicaid expansion. We are working with KMS to provide testimony and influence our legislative representatives.

- **Support for our Foundation**
  We want to support our crown jewel whole heartedly, the Kansas City Medical Society Foundation which continues to be a model for advocacy and education, as well as our charitable care program which provides immense benefits for our uninsured or under insured patients. The Foundation supported expansion of Medicaid on the Missouri side and is advocating tirelessly for expansion on the Kansas side. Ms. Karole Bradford is our Executive Director.

- **Opioid abuse**
  We have been working to help stem the tide of opioid abuse through education and visibility. We are in the process of putting together TikTok videos about the dangers of opioid abuse produced by local high school students and targeted at high school students at their level and their preferred communication platform. We also have activities targeted to school district officials and several of our Board members and members provide advice around opioid use disorder and school policies.

- **Wellness and Suicide Prevention**
  Our focus has been on removing the stigma that sometimes attaches to physicians help-seeking. We have been advocating for health systems and hospitals to remove credentialing language that could impede a physician from seeking help. Several systems are reviewing their language and are now trying to focus on current, not historical, mental health issues or substance use that could affect safe practice. We are also working to participate in Physician Suicide Awareness Day in September.

- Welcoming New Members
  If you are a current member, thank you! I hope you have found our activities to be meaningful for you and your practice. Please consider asking your colleagues to join our collective voices. If you are not a member, please consider joining-we'd love to have you!

In conclusion, I'm excited about the year to come and look forward to hearing any and all thoughts and ideas for the Society moving forward.

Thanks, and best regards,

*Greg*

Gregory Unruh, MD

2024 CONTRIBUTING *Editor*

# Can We Fix Our Broken Health System?

## Charles W. Van Way, III, MD

***Contributing Editor***

Dr. Van Way grew up in Washington, DC, attended Sidwell Friends School, studied history at Yale University and medicine at Johns Hopkins. He completed residencies in general and thoracic surgery at Vanderbilt. He has written over 450 papers, chapters, editorials, and several books. He was on faculty at the University of Colorado and then the University of Missouri–Kansas City (UMKC), where he served as Chair of Surgery. He is an Emeritus Professor at UMKC. He has served as President of several medical organizations, including the Missouri State Medical Association and the Kansas City Medical Association. He is a delegate to the American Medical Association. Retired from surgical practice, he continues to see patients (part-time) at Truman Medical Center in Kansas City.

He retired from the Army Reserve as a Colonel, after 25 years of service. He is a graduate of the Army War College. He serves as a volunteer and tour guide at the National World War 1 Museum and Memorial in Kansas City, MO. He is married to Gail and has three children. His other interests include photography, travel, amateur radio (N0CVW), and military history.

The phrase "broken health system" has become a cliché. Unfortunately, it's become one because it's basically true. The history of how we came to this point is perhaps interesting. But it's also pretty much irrelevant. What can be done to fix things? Can we fix things?

What's wrong with the system? On consideration, "broken" is probably an inaccurate adjective. The system still functions, after all. But health care costs too much, makes most patients unhappy, stresses out doctors and nurses, and annoys pretty much everyone who works in health care. Of course, cost is a major issue. According to one source (1), we spend more on health care than the gross domestic product of many countries. Like France, for example. For that kind of money, we should get a better system. Instead, we get… what we have.

There is a current national political debate. Congress, having mandated many of the dysfunctional elements of our present system, is now considering revamping the whole thing. This is a case of the fox repairing the hen house. Will it end well? Will Congress even be able to carry out such a project? After all, ClintonCare failed to pass, ObamaCare turned out to be just a patch on the present system, and BidenCare doesn't exist yet. Maybe TrumpCare? Let's not go there.

**We spend more on health care than the gross domestic product of many countries…for that kind of money we should get a better system.**

Alternatives range from a totally government run system (Medicare for All) (2), to Federal vouchers to pay for health insurance (3), to greatly increasing the role of the free market (1,4). Perhaps we will move further towards a federal health system, be it Medicare for All or some sort of voucher system. Perhaps we will remove many of the restrictions on the health care marketplace. From our standpoint as physicians, it is likely that most of us will continue to work for an organization of some sort, be it a health care system, a physician group, or the federal government. That being the case, let us focus on the present and future discontent among physicians, and what we can do to improve things.

Most doctors went into health care because they wanted to help people, at least initially. That's true for nurses as well, and for most other health care workers. The system tends to gradually leach out that idealism. Fortunately, most health care professionals make more than people with equivalent education and experience make in other lines of work. So, by the time idealism has been beaten out of them, they'll settle for the pay. Is this a cynical view? Yep. But is it wrong? When you're working just for the pay, that's one step from burnout.

The Physicians' Foundation has conducted physician surveys every other year for the last two decades. Their results show a progressive demoralization of physicians. (5) Several factors seem to play a role in this. Perhaps unsurprisingly, the dysfunctionality of medical information systems is near the top of the list. Whatever their advantages may be, turning physicians and nurses into data entry clerks has been a disaster.

But physicians are frustrated about other things. Administrative burdens, including dysfunctional electronic health records, were a major factor. Lack of adequate support, including shortages of nursing and ancillary personnel. Dealing with uninsured patients. Frustrations in dealing with insurance companies, especially prior authorization for even basic procedures and studies. Increased working hours, often combined with salary decreases. Performance measures have become increasingly arbitrary and burdensome and often fail to have any relationship with quality of care.

Physician burnout continues to increase. Overall, about 60% of physicians surveyed reported symptoms of burnout (5). About two-thirds of physicians surveyed were pessimistic about the future of medicine and medical practice.
Is there some progress being made?

With urging from the American Medical Association (AMA), the Center for Medicare and Medicaid Services (CMS) just announced much tighter rules on prior authorization (6). At least, for Medicare. More broadly, the AMA has outlined a process for improving physician well-being (7).

It's directed at hospitals and other health care organizations, defining how to treat physicians as employees. The AMA recognizes that a majority of physicians are employees of organizations. Some of those organizations are physician groups, but most are health care systems and hospitals. In any rate, here are the seven steps:

1. Manage workload and job demands, such as capping patient volumes and panel sizes.

2. Give physicians control over their work and flexibility over their time management.

3. Provide adequate support staffing, implement team-based care workflows, and improve functionality of electronic health records.

4. Provide opportunities and funding for research, leadership development, and continuing education.

5. Manage the organizational culture and values, keeping lines of communication open and minimizing hierarchy and bureaucratic obstacles.

6. Support work life integration, including reducing necessary work after the working day is over.

7. Establish social support and professional community, to encourage a sense of camaraderie.

**Physician burnout continues to increase. Overall, about 60% of physicians surveyed reported symptoms of burnout.**

Will health systems adopt these policies? Well, maybe. The AMA also outlined why organizations should do so. Some health systems simply don't care about their physician workforce. They may have a high turnover, but they can survive and prosper, even if they don't treat their physicians and nurses very well. If your working conditions are poor or marginal, could you just hunker down and accept them? Sure, you could. And many of us do just that. Which is itself a problem.

Our physician workforce has been trained, over the last three or four decades, to become employees. As a life-long educator, I don't make that comment lightly. Speaking as an academic, we've done no favors for our students. The tolerance of younger physicians for poor working conditions seems to be greater than it was in previous generations.

Frankly, younger physicians need to become their own advocates. Most universities today are hotbeds of activism, and many medical students are socially concerned. They are much more likely to agitate for fashionable causes like climate change than for improved working conditions for physicians. But young physicians seem to lose that activism during residency. Perhaps we should modify our residencies to include assertiveness training.

Things have become so bad that the AMA House of Delegates has recently discussed the advantages of physician unions. If hospital administrators had to deal with physician unions, would things improve? Who knows?

There are a lot of things which unions could do for physicians. Most of us are uneasy with the concept of unions, and especially of strikes, but we're also uneasy with our health systems. Perhaps our medical organizations, including the AMA, should become more militant.

Meanwhile, there is much that we as individuals and as a medical society can do. If you face workplace frustration, don't just cower down and accept it. Push back. The best cure for an adverse work environment may be a new job. If you're being nibbled to death by the bureaucracy, or you're not being supported, or your workload is being increased past capacity, then have a frank talk with your department head or your chief medical officer. Express your objections, state your needs, and follow through.

Meet with your colleagues. A group of physicians is much more effective than a single doc. That's why we have medical societies. Many of the things suggested by the AMA should be part of the employment of any high-value professional. I'm not suggesting that we should become chronic complainers. But if your legitimate needs aren't being met, do something.

And don't forget that national debate. Congress is talking about making changes in the health care system, although it will probably just tinker around the edges. There is much that physicians can do to influence legislation, both at the state level and nationally. The AMA runs the largest health care lobby in Washington.

**To sum up, our health system needs help... change for the better will happen only if we speak up and advocate for it.**

At the state level, we are all too familiar with legislation limiting this or that aspect of medical practice. The Missouri State Medical Association lobbies very effectively on the state level. But our organizations cannot do this without support from physicians. Individual physicians can influence legislators at both state and national levels.

To sum up, our health system needs help. We as physicians need help, as well. We have a potentially strong voice when we choose to speak up. Whether the issue is your local hospital or health system, or national legislation, change for the better

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KANSAS CITY
# MEDICAL SOCIETY FOUNDATION

kcmedicine.org/foundation

## WyJo Care Donor Spotlight

ASCENTIST HEALTHCARE

Ascentist Healthcare holds the fundamental belief that access to quality healthcare is a basic necessity. This multi-specialty healthcare group is committed to upholding this principle by ensuring that every individual who seeks medical assistance receives compassionate and comprehensive care within the means of the practice.

For this reason, the Kansas City Medical Society Foundation is proud to call Ascentist a partner in its Wy Jo Care program. Through this program, Ascentist and numerous other providers offer specialty health services to uninsured patients in Wyandotte and Johnson counties. Other providers donate services through Metro Care, which serves patients on the Missouri side of the Kansas City region.

**... access to quality healthcare is a basic necessity.**

**This multi-specialty healthcare group is committed to upholding this principle by ensuring that every individual who seeks medical assistance receives compassionate and comprehensive care.**

"We're very grateful to have high-quality providers like Ascentist make such generous contributions," said the Foundation's CEO, Karole Bradford. "Their participation in Wy Jo Care advances our efforts to make sure that uninsured patients receive much-needed specialty

*(Continued on next page)*

healthcare, from orthopedic surgeries to ophthalmological services."

The need is especially acute for those living in Kansas, which has not approved Medicaid (KanCare) expansion and has more than 240,000 uninsured residents. This makes it difficult for many working families to access comprehensive healthcare. Most of these individuals are non-elderly adults, from low-income households where there is at least 1 worker. Many must choose between paying for health insurance or food and housing.

By providing specialty health care services through Wy Jo Care, Ascentist demonstrates that the lack of insurance should never be a barrier to accessing essential healthcare services. They collaborate with local organizations, leverage partnerships, and dedicate resources to ensure that those without insurance coverage receive the medical attention they require. Their goal is to foster a supportive environment where everyone feels valued, heard, and cared for, regardless of their socioeconomic status.

"Ascentist has a commitment to providing care regardless of insurance status," Bradford said. "Through their donations they express the values of inclusivity, social responsibility, and the right to healthcare for all individuals within the community."

WyJo Care and Metro Care have been serving patients since 2006. Patients are most often referred to these programs by a safety net clinic where they are receiving primary care. Patients are screened for financial eligibility and then matched with a donating provider with the specific specialty needed.

The Foundation is always looking to add new providers to its network, especially for specialties for which people are waiting for care: orthopedic surgery, gynecology, general surgery, gastroenterology, and ophthalmology.

**If you are able to donate specialty care, please contact Kristi Neff at kneff@kcmedicine.org.**

**Learn more by visiting us at kcmedicine.org/foundation**

# SPECIAL THANKS TO OUR *Partners*





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We partner with hospitals and health systems throughout the Kansas City Metro area to provide group memberships to their medical staff. You are automatically a corresponding member of KCMS if you are on the active medical staff of a KCMS hospital partner, and there are no annual dues. Corresponding members receive communication and resources including advocacy, member events and leadership development.

**Contact us at kcmedicine.org to learn more about becoming a Partner today.**

KANSAS CITY

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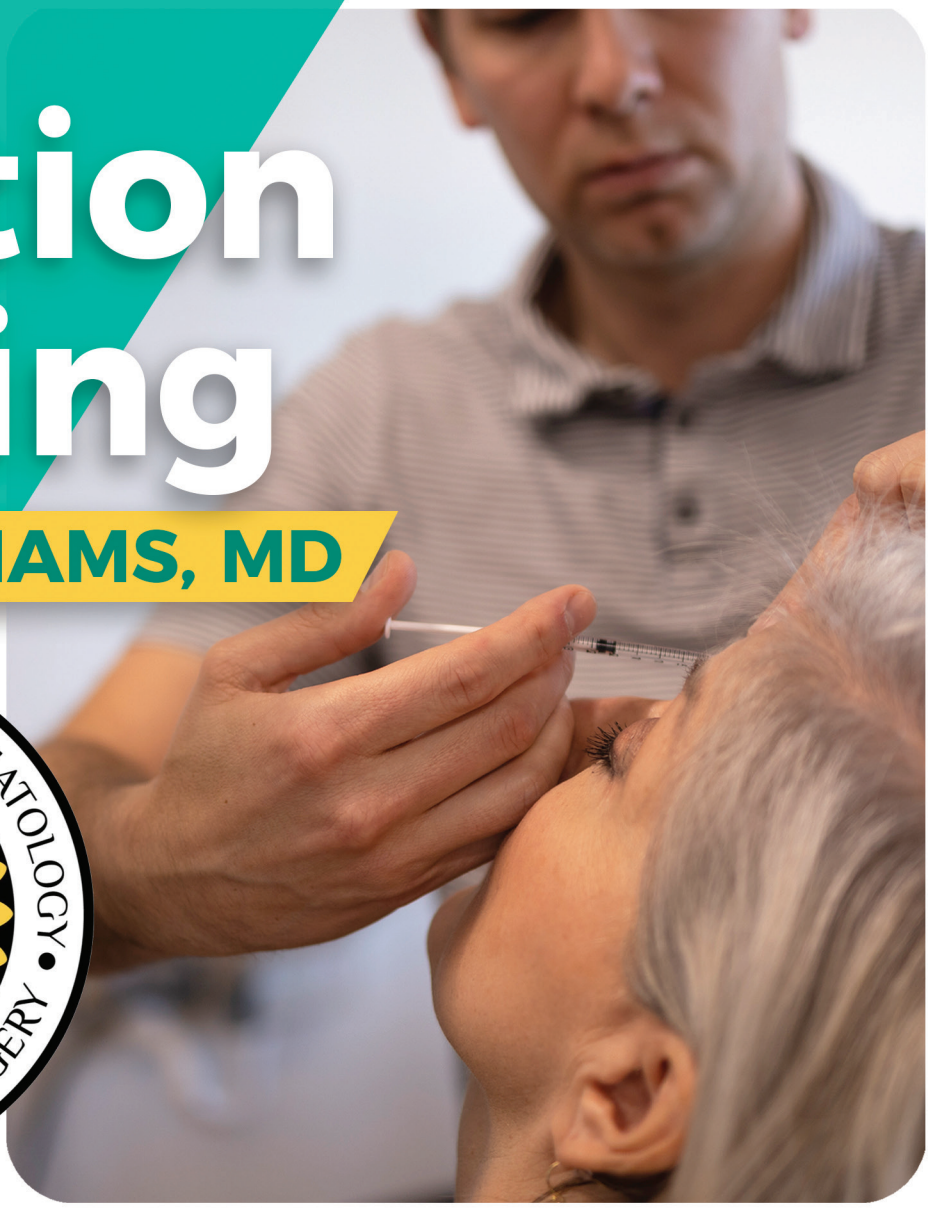

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# Too Much Exercise? Here's the Rundown


## John C. Hagan III, MD

John C. Hagan III, MD is a retired ophthalmologist, active medical researcher and editor of Missouri Medicine medical journal.


When it comes to exercise, it is possible to get too much of a good thing. Regular participation in appropriate mild-moderate exercise is one of the most important habits for optimal health. The kind of detrimental excess endurance exercise I'm going to implicate includes marathon distance running, 100-mile bike rides, Iron Man/Half Iron Man Triathlons and other flat-out, petal-to-the-metal exertions for more than an hour. Regrettably, I confess 'Been there, done that!'

Hyper-exercisers tend to be Type-A driven individuals. This fits the profile of many of us in Medicine. In case you haven't got the moderation message, especially those of you over 40 and running more than an hour, I'm going to share my experience. I'll include some of the research my cardiologist James O'Keefe, MD and others have published over the past 15 years. This discourse is a personal perspective, not a scientific paper, thus I will be using only a single reference. Relevant scientific papers can be found at this link: https://bit.ly/43mp5dL

"Marathons in the Long Run Not Heart Healthy" was published in Missouri Medicine in the March/April 2014 issue just prior to the Boston Marathon *(Figure 1)*. That issue elicited a significant outcry from the hyper-exercising marathon crowd. 'Outcry' perhaps does not do justice to the noise; it was an angry roar. What our detractors then labeled as mistaken and misleading has subsequently been proven by many published studies to be the real deal. These confirmatory studies come up easily with literature searches.

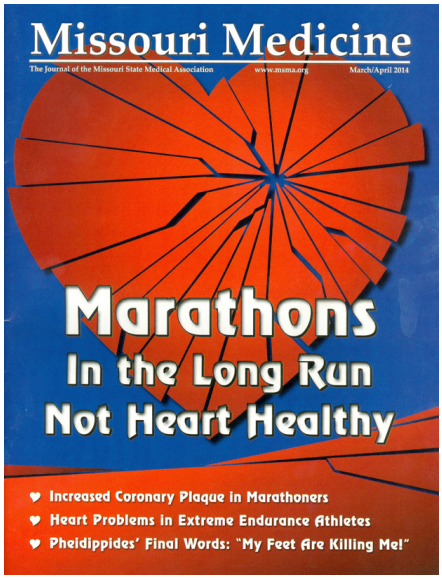


**Figure 1**

*This 2014 issue of Missouri Medicine was among the first in the world to point to excessive endurance exercise, such as marathon running, as not being heart healthy. A decade later in 2024 many subsequent studies have confirmed this.*

Google pulled up 18,700,000 hits in 0.36 seconds for "marathons are unhealthy".

Being of a certain age, I have seen many medical putative 'facts' turn into fiction. In spite of what the dogmatic Dr. Fauci says, sometimes if you 'follow the science' it will take you over a cliff. Here are a few select discredited shibboleths: in the 1950's smoking was good for chronic cough, calming the nerves, caused no health problems, certainly not cancer, and was a harmless makes-me-look-cool pastime; coffee caused heart attacks and ulcers, sugar was harmless, and recently shutting down schools during COVID is good science. Well, you get the idea.

My grandparents' and my parents' physicians felt that rest, indeed absolute rest, cured many illnesses. Doctors ordered patients 'to take to their beds" for heart disease, especially after a heart attack, after childbirth, after surgery. Vigorous activities such as walking, running, or swimming were considered dangerous. During my youth (yes, I was young once) men in their 40's had epidemic-like sudden deaths from heart attacks and other cardio-vascular disease. These deaths were often erroneously attributed to exercising too much or working too hard. These were 'take it easy' times.

The 'exercise is bad' mantra began to fade with the seminal studies of Scottish Cardiologist Jeremiah Morris, MD. The London Transport Workers Study (1948-1952) compared inactive bus drivers who sat their whole shift versus the conductors who spent their shift on their feet walking, often climbing stairs on 2-deck busses. The sedentary drivers had a higher incidence of cardio-vascular disease. The second giant in this field was American cardiologist Jeramiah Stamler, MD, an active exerciser, who was productive when he died at age 102. The Father of Preventive Cardiology, Dr. Stamler, in the 1970's, introduced the concept of cardio-vascular risk factors.

These subsequently have been modified to now include physical inactivity. The third giant in the 'exercise as medicine' movement is Kenneth Cooper, MD; he is now age 92, has run over 40,000 miles and is actively engaged in preventive cardiology. In 1969, Cooper published the book "Aerobics" *(Figure 2)* which explained the benefit of regular mild-moderate

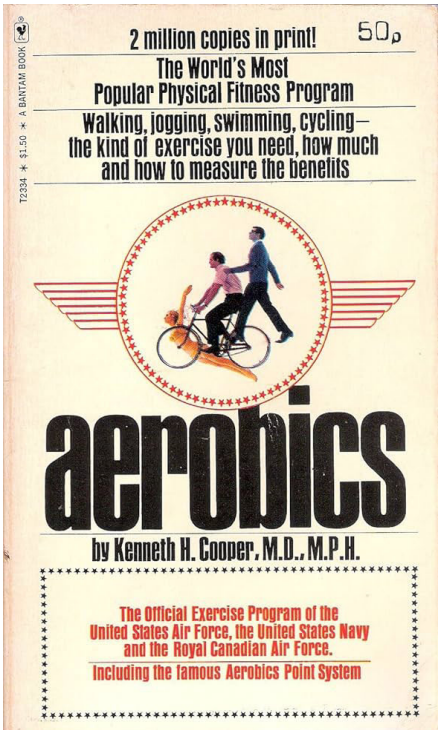


**Figure 2**

*Published in 1969, Dr. Cooper's book was a #1 Best-seller and has sold over 30 million copies and been translated into 41 languages. Dr. Cooper coined the now widely used term "Aerobics".*

exercise to the general public and quantitated healthy exercising.
I read most of the important Morris, Stamler and Cooper papers. I was beyond impressed. Exercise, something I had done mainly through sports since childhood, became my lodestar to

# Too Much Exercise? Here's the Rundown

keep healthy. The more exercise I do the healthier I will get, or so I erroneously thought.

I began long-distance running in 1967 while a medical student at Loyola University Stritch School of Medicine. I would rarely run for less than an hour and did so with the expectation that I was building a robust cardio-vascular system. An international movement of "exercise is good for you; do as much as possible" developed. Among their high-priests was pathologist Tom Bassler, MD. Dr. Bassler was an esteemed poo-bah in the American Medical Joggers Association of which I was a charter member. "The Bassler Hypothesis", long since disproved like the flat earth theory, was that running a marathon conveyed absolute immunity from coronary artery disease. Running events proliferated: 5K, 10K, half and full marathons, outlandishly difficult races like the Leadville (Colorado) 100 Mile Challenge run at an altitude of 10,158 feet. At the apex of hyper-exercise idiocy is the Self-Transcendence 3100 Mile Race. Since its inception in 1996 only 53 deranged runners have completed the entire course. How difficult is it? Over 4,000 people have climbed Mt Everest to the summit.

As an ophthalmology resident at Emory University, my first published paper of the some 225 that I written, was "The Doctor as A Coronary Candidate: Survival of the Fittest." Published in the August 1974 Resident & Staff Physician, I urged doctors to run as far as fast as they could. Mea Culpa!

Moving to Kansas City in 1975, I ran over 30 Hospital Hill Half-Marathons, three full 26.1-mile marathons, a half dozen Baptist Hospital Triathlons and two Half-Ironman Triathlons held at Smithville Lake. ***(Figure 3)*** The latter was 1.2-mile swim (my weakest event, I was usually last out of the water), 56-mile bike ride and 13.1-mile run. Like many runners of that era, I often managed gratuitously to work into conversations that I was a marathon runner.


**Figure 3**

*Here I am building a coronary artery calcium score of 1606. I'm finishing one of more than 30 Hospital Hill Half-Marathons and starting the bicycle segment of the Midwest Triathlon Championship: 1.2-mile swim, 56-mile bike and 13.1-mile run. I finished 3rd in my age group.*

When it came to talking about exercise, I was insufferable. Another Mea Culpa.

All was going well until age 60; while taking a shower I felt my heart beating very rapidly. I took my pulse and found it irregularly irregular. Atrial fibrillation (AF) how can this be? My running was supposed to make me invulnerable. A trip to North Kansas City Hospital and an extensive cardiac workup was done and normal except for the AF. Converted back to normal sinus rhythm, I started doing research and found that "lone atrial fibrillation", AF in an otherwise normal heart, was common in long distance runners and cyclists. This was news to my former cardiologists. Undeterred, I continued to run hours on end (6 hours is my record).

I began to read in Runner's World of marathoners dying while running, and having abnormal coronary artery angiograms and a need for heart artery by-pass surgery. Among the suggestions I saw several times was to have a CT Coronary Artery Calcium Score (CACS). Calcium is a surrogate for coronary artery atherosclerotic plaque burden. I asked my erstwhile cardiologist about taking that test. I was told it would not provide any useful information and was expensive. Being a compliant patient, I uncomfortably accepted.

Fortuitously my insurance changed and I needed to find a

new cardiologist. I knew of James O'Keefe, MD by reputation. I was extremely impressed by his emphasis on preventing cardiovascular disease. During my initial evaluation, I asked about a CT CACS. He readily agreed and the test was easy to schedule and inexpensive. A normal CACS is zero, and less than 100 usually non-concerning.

At home about three hours after taking the test, I got a call from Dr. O'Keefe's office. Would I have my wife drive me now directly to his office. My CACS was 1606. Another even more thorough cardiac workup was done. The primary abnormality was the sky-high CACS indicating coronary artery disease. I was put on statins.

"So why do I have more calcium in my heart than the water pipes of a 100-year-old house?", I asked. Dr O'Keefe indicated it was becoming evident as a complication of excess endurance exercising especially after age 40. Missouri Medicine, the medical journal I have edited for 23 years, received a manuscript from researchers in Minnesota, that reported increased coronary artery calcium in older runners compared with matched non-runners. I intentionally scheduled this peer-reviewed paper to be published just prior to the 2014 Boston Marathon. (Figure 2). The startling research was picked up by the national press and international running community. The response was bi-modal. The first, "Good to know, I'm cutting back on my mileage and intensity level." The second, "Something is wrong with your studies, I'm not cutting my mileage." An internationally known marathoning cardiologist from Harvard (that used to mean something) called and read me

the riot act. How could a medical journal from 'fly-over' country make that outlandish claim? How times change. That same cardiologist wrote in the February 11, 2024 Kansas City Star that he had given up long distance running and advises his patients to do the same. Graciously, he acknowledged that Missouri Medicine was among the very first medical journals to report elevated CACS in long distance runners.

There is some good news for those of us that cannot undo decades of excessive endurance exercise. There is a notable histological difference in the morphology of the coronary artery plaque in hyper-exercisers and the more usual non-exercising patient with multiple risk factors for cardio-vascular disease. The risk of a cardiac event varies between these two groups even for the same CACS, being lower in runners like me.

The exercise induced atheroma are low-lying, fibrotic, and have less lipid. The high-risk CV patient has elevated, lumen occluding, large, thrombotic-prone lipid plaques. This type of atheroma is more prone to cause sudden coronary artery occlusion. Nevertheless, a CACS of zero and no atheroma would be a happier story. As a reminder of my hyper-exercising past I am in constant AF and on Eliquis. My treadmill stress test for my age group puts me in the top 99 percentile for the longest time to exhaustion. I'm still insufferable talking about exercise.

So, what is the take-away here? First do not conclude that exercise is dangerous. I disabused you of that in the first paragraph. But like the medicines we prescribe it is important to get the dosage correct. I had hoped to get through this article without a reference but I find this one essential.1 Dr O'Keefe and colleagues have quantitated guidelines for optimal exercise. They call that exercise sweet spot "The Goldilocks Zone".1

How do I exercise now? Walking, gardening and most important swimming three times per week for about an hour. For the endurance athletes among us, recall the words of Dr. Cooper, "If you run more than 15 miles a week, it's for something other than aerobic fitness."

As the Greek poet Hesiod said in 700 BC "All things in moderation."

Amen to that!

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# Standard of Care Considerations When Recommending Cannabis (Marijuana) as a Medicine

The International Academy on the Science and Impact of Cannabis-IASIC
*https://iasic1.org*

**From the Board of Directors of IASIC:**
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Statutes that allow the recommendation of medical marijuana present a serious malpractice risk to physicians and medical providers. Despite a rapidly growing medical and recreational marijuana industry, there has been no definition of a standard of care for the use and recommendation of marijuana for medicinal purposes. This issue has been essentially ignored by Federal regulators and legislatures.

Most of the medical opposition to medical marijuana is borne from concerns over serious medical and social consequences in patients as a result of marijuana use. In most states the physician only documents a serious and debilitating/qualifying medical condition that they believe may benefit from cannabis. However, they do not write a prescription with product, dose, quantity, frequency of use and length of use, or provide a list of potential side effects. This then makes the patient dependent on the bud tender to make these recommendations and puts the patient at risk.

When considering what constitutes the "standard of care," it is important to embrace practices that reduce the medical risk to patients as well as reducing the risk of potential malpractice litigation of providers. In legal terms, the "Standard of Care" is the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. (1).

Pure Cannabis-based medicines such as Marinol, Cesamet, Epidiolex, and Sativex are currently FDA approved and on the market as medications that may be prescribed. Providers "recommending" state-approved cannabis are clearly recommending a non-FDA approved substance. The recommendation of marijuana as a medicine generally has malpractice risk because "recommendations" for the use of marijuana are lacking the standard safe practices required of modern-day medicine. To date, there are no medical conditions that Cannabis is considered

either the drug of choice or a reasonable alternative. Research demonstrates that the use of marijuana even for pain has fallen into question (2). Extensive literature review and several international organizations have concluded that the use of cannabinoids for chronic non-cancer pain is not yet supported nor proven by research and its use for pain is considered limited (3,4). Most of the supporting medical literature to-date has been poorly designed or case reports from a highly biased cannabis industry. The cannabis industry continues to push for rescheduling to schedule III even though it does not meet the long-held scheduling standards.

Questions must also be answered as to what form of the drug is to be provided (smoked, vaped, gummies, oils etc.), what doses are safe and effective, what side effects should be expected, and what long-term side effects might be experienced. Patients must also be notified and cautioned of these side effects and the problem that such delivery vehicles present unreliable doses to the patient.

Several of the elements necessary for the standard of care to be met are listed below, and these elements are generally not required in existing state statutes.

Medical Evaluation- As with any medical disorder, a thorough and complete medical evaluation (including vital signs with emphasis on blood pressure) must be performed, documented, and updated regularly by a licensed medical provider. It is inconceivable that any medical drug treatment would not have a specific diagnosis documented to justify its use. This is a central and essential part of any medical evaluation. This process should also include specific documentation of other medical treatments and other successful or failed medications and potential medication interactions. Over 500 interactions are known with Cannabidiol and 300 are known with Delta-9-THC. The documentation of these elements must be entered into the patient's medical record which is appropriately retained, stored, and made readily available for other providers also treating the patient. The patient's mental health history must be explored as cannabis use can impact mental health. (5) The few Cannabinoid products that have been approved for use by the FDA, including Epidiolex (a CBD product), Marinol, and Cesamet (synthetic THC) have extensive warnings of the many risks of use. The FDA drug label for Marinol issues a warning that the drug "may cause psychiatric and cognitive effects and impair mental and/or physical abilities. Avoid use in patients with psychiatric history."

Concentration/Dose - Research is now suggesting that THC concentrations should not exceed 10% (4), and that higher concentrations have been associated with psychosis and other psychiatric disorders. It is worth also noting that state statutes allowing "medical" applications of marijuana include smoking, oils, vaping for example that can have toxic concentrations of 70-90% THC.

Failure to warn – The question of side effects and whether a less problematic and less toxic medication might be available, must be made available to the patient, and there must also be a rationale provided if the practitioner proceeds in recommending marijuana over a less toxic medication. The patient must be warned on any drug interaction which may harm them or render a medically necessary drug for the patient (such as coumadin) dangerous or ineffective. This rationale and patient notification must be clearly documented in the medical record. Numerous heavy metals have been identified in cannabis, likely because of its tendency to readily absorb them. Warnings should include the information that there is Substantial Evidence from research that the regular use of marijuana increases the risk of psychosis, suicide,

cannabis use disorder, and memory impairments. Evidence statements | Monitoring Health Concerns Related to Marijuana (colorado.gov)

Failure to monitor- Ongoing monitoring of symptoms, toxicity, need for dosage change, need for additional medication are all elements of good medical care.

REMS - Risk Evaluation and Mitigation Strategies are widely used for high-risk therapies such as opiates. While REMS for marijuana administration are not widely used, as they become available it is strongly recommended to be a requirement for prescribing/ recommending providers.

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She came to the White House as chief of the emergency department at Scripps Mercy Hospital in San Diego. In 2012, she established and chaired the San Diego Prescription Drug Abuse Medical Task Force, the first of its kind in California that integrated physicians of various specialties along with hospitals, law enforcement, hospital administration, treatment programs and public health for the purpose of decreasing deaths and mortality from prescription drugs. Lev's medical publications known as the "Death Diaries" studied the details of prescription patterns of people who died from accidental medication drug overdoses, giving insight to the causes of overdose and directing prevention efforts.

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She has a strong interest in public health and effective prevention as well as exploring the impact of policy on the prevention of use disorder and resulting health care costs. Dr. Antley has co-authored several Vermont Medical Society resolutions on cannabis. She recently contributed a chapter "Cannabis in Dermatology" to the textbook "Cannabis in Medicine, an Evidence Based Approach" edited by Dr. Ken Finn and published by Springer Nature.

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She has been actively incorporating complementary treatments into treatment programs, including the 5-point ear acupuncture NADA (National Acupuncture Detoxification Association) protocol and BST (Brain Synchronization Therapy), to help patients recover from addiction as well as trauma which often underlie addiction and chronic pain issues. Her current mission is to educate as many people as possible on the un-intended consequences of the commercialization of marijuana in Colorado, focusing primarily on the deleterious effects of high potency THC on the developing brain.

# Our Children are Not Alright

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A joint policy statement from the American Academy of Pediatrics, the American College of Emergency Physicians and the Emergency Nurses Association was released this past fall1. The groups are calling for local communities to increase access to mental health services for children before emergency care is needed. Locally, over three thousand children visited the Emergency Department at Children's Mercy Hospital for behavioral health emergencies in 2022. That number increased to nearly 4000 in 2023. Children as young as six are being seen, and some are speaking about suicide.

The statistics regarding youth mental health is staggering. Suicide is the second leading cause of death for children ages 12-18. More than 1 in 10 youth in the United States are suffering from depression. Sixty percent of youth with major depression do not receive treatment, and nearly 20% of children and young people ages 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder[2]. A recent meta analysis concluded that "pandemics cause stress, worry, helplessness, and social and risky behavioral problems among children and adolescents."[1] Several studies have also reported deterioration in children and adolescents' mental health along with an increase rate of suicide ideation and attempts in children during the height of the COVID-19 pandemic in 2020. [3,4]

In 2021, Children's Mercy made a commitment to address the pediatric mental health crisis and set a course to provide more behavioral health services to children in our region. Children's Mercy formed the largest local pediatric behavioral health initiative, Illuminate, investing over $275 million in combined fundraising and CM dollars in fourteen projects over the next five years, with the vision of serving over 80,000 additional children in the region. Because this crisis is so large, the organization is partnering with the community to help our children.

One initiative is early intervention. Children's Mercy will increase the number of behavioral health specialists embedded into primary pediatric care practices. If a parent, physician, or the child believe the child is struggling with behavioral health issues, the child can be seen by a licensed behavioral health professional. Interventions may include brief, solution focused therapy, or a connection to more

## Suicide is the second leading cause of death for children ages 12-18.

comprehensive community services.

Children's Mercy is working to expand specialty behavioral health services. In February of 2023, the Depression and Anxiety (DAY) Clinic for youth opened. This clinic serves teens who are specifically experiencing moderate to severe depression and anxiety. The program is intended to be finite, offering specialized therapy, medication management and group therapy for up to a year with the intention of stabilizing the child's symptoms and referring the child to a community resource after stabilization has occurred. The clinic has treated over two hundred children since opening and successfully graduated twenty-five patients to community resources.

The clinic is steadily adding clinicians to the autism diagnostic team, and in January 2024, added a new program, the Autism Continuity Clinic. The purpose is to give parents and their child a chance to "check-in" with a behavioral health professional three to six months after their child has received an autism diagnosis. These visits can be very reassuring to parents, while also addressing any new concerns and ensuring their child is connected to all the resources they need on their journey.

While Children's Mercy has behavioral health professionals in the emergency department to work with children and families who visit due to behavioral health concerns, the hospital will be taking this work even further. Children's Mercy will open an Emergency Mental Health Crisis Center as a separate wing within the emergency department in 2025. This Emergency Mental Health Crisis Center will be staffed with behavioral health professionals, nurse practitioners, and psychiatry. The center is designed to provide a therapeutic environment where children can be assessed and receive safety planning and connections to community services or prepare to transition to an inpatient psychiatric hospital. In addition, Children's Mercy is developing a Bridge Clinic to provide temporary behavioral health services for children seen in the Emergency Mental Health Crisis Center. This clinic is a short-term therapy and medication management clinic that enables a child experiencing moderate behavioral health issues to receive services while waiting for a longer-term community provider.

Children's Mercy is also partnering with Camber Mental Health to open a 72-bed inpatient psychiatric unit with forty-eight child and adolescent beds in Olathe, KS at the end of this year. This partnership will increase the number of pediatric inpatient psychiatric beds available in the community and reduce bottlenecks in emergency rooms, eliminating some of the long wait times families experience while seeking inpatient placement.

In addition, in 2025, Children's Mercy will open a specialized partial hospitalization program to serve child and adolescent populations who currently have no access to intensive day treatment. The program will serve youth with neurodevelopmental diagnoses, including autism, children who have medical needs that cannot be met by other partial programs, and children under the age of twelve, for which no partial hospitalization program exists. The program provides evidence-based care and a multidisciplinary team, including psychologists, therapists, pediatricians, psychiatrists, a teacher, and board-certified behavior analysts.

Many children with complex medical and developmental conditions do not have access to inpatient psychiatric services when their mental health needs become acute. To better serve this vulnerable patient population, Children's Mercy is opening a medical unit with psychiatric services in 2026. The inpatient unit will serve children who are hospitalized for medical needs yet have co-morbid psychiatric needs to provide treatment simultaneously and shorten length of stay.

There is currently a paucity of literature describing the appropriate care of a pediatric patient experiencing a psychiatric or behavioral emergency during a first-responder emergency medical system (EMS) transport or an interfacility medical transport. Historically, Children's Mercy Critical Care Transport (CMCCT) team deferred all high risk or high acuity pediatric patients experiencing

an acute psychiatric or behavioral emergency if they required restraints, anti-psychotic medications, or sedation due to lack of our team's experience and unavailability of anti-psychotic medications. These patients were historically transported by an adult EMS crew. As the adult EMS agencies became overwhelmed with increased volume and staffing shortages during the pandemic along with an increase in pediatric psychiatric and behavioral emergency transport requests, CMCCT had an increased number of transports for this specific patient population during the pandemic.

EMS and transport providers face increased risk when transporting patients with mental health disorders due to the unpredictability of the patient behaviors, the small work environment in a moving vehicle, need for vehicle safety restraints, and lack of personnel and resources in their working environment.[5]

Additionally, there is literature offering evidence-based guidance for the medication management for adults during transport however, evidence is lacking related to recommendations for rescue medications in pediatric patients experiencing a mental health crisis during transport. The American Association for Emergency

Psychiatry has recently published Best Practices for Evaluation and Treatment of Agitated Children and Adolescents in the Emergency Department.[6]

In response, CMCCT has created a clinical practice guideline for the acute management of pediatric patients experiencing a behavioral or mental health emergency to facilitate safe interfacility transport for children in crisis. CMCCT is also working with local EMS agencies through the Pediatric Pandemic Network grant to develop specific protocols for first responders who care for children with behavior or mental health emergencies. For more information, contact Dr. Jennifer Flint, MD, Medical Director of Pediatric Critical Care.

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# Outpouchings of skin over the abdomen and shoulder

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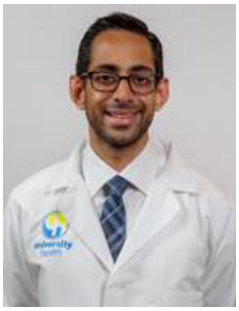

**Abstract:**

Primary anetoderma (PA) is a rare skin disorder caused by loss of elastic fibers in the dermis. The infrequency with which it is encountered and the subtle clinical findings can make anetoderma a diagnostic challenge.

A 22-year old female presented with 2-months of isolated skin changes. Physical exam revealed multiple skin-colored, atrophic papules over the trunk that herniate inwards with palpation. Serum antinuclear antibody was borderline elevated. Punch biopsy showed diminished and fragmented elastic fibers, consistent with a diagnosis of PA. PA has been reported in association with many systemic diseases and lab abnormalities, but the most common and consistent is with antiphospholipid antibodies, so all patients with PA should be screened. Although numerous potential treatments have been studied, none have been efficacious, so the mainstay of treatment is reassurance. This case illustrates the classic presentation and associations of PA to aid clinicians in the diagnosis and work-up of PA.

# Outpouchings of Skin Over the Abdomen and Shoulder

A 22-year old female with no past medical history presents to the dermatology clinic with a 2-month history of isolated skin changes without accompanying symptoms or preceding rash. Physical exam reveals multiple discrete 1cm skin-colored, soft papules over the abdomen (Figure 1), right flank (Figure 2), and left supraclavicular area. The papules are atrophic and herniate inwards with light palpation. Surrounding skin is normal. Serum antinuclear antibody was borderline elevated. Punch biopsy of the right flank shows diminished and fragmented elastic fibers. Trichome stain reveals focally concentrated and compacted collagen.

The patient's clinical presentation and microscopic findings are consistent with primary anetoderma (PA). The pathogenesis of PA is driven by near complete loss of elastic fibers in the papillary and reticular dermis,[1] which causes the skin to have a wrinkled appearance on physical exam. This patient reported no preceding rash ruling out secondary anetoderma. PA has been reported in association with many systemic diseases and lab abnormalities, but the most common and consistent is with antiphospholipid antibodies, so all patients with PA should be screened. Antiphospholipid antibodies can be an isolated laboratory finding or part of antiphospholipid syndrome or other autoimmune conditions, such as systemic lupus erythematosus. In fact, anetoderma's association with antiphospholipid antibodies has led to the scientific community viewing anetoderma as a cutaneous sign of underlying autoimmune conditions. It is hypothesized that the ischemia from the thrombosis may contribute to the degeneration of elastic fibers seen in anetoderma.[2]

The differential diagnosis for PA is broad and includes focal dermal hypoplasia, papular elastorrhexis, mid-dermal elastolysis, and perifollicular elastolysis. Focal dermal hypoplasia is a multisystem disorder inherited in an X-linked fashion that primarily involves the skin, skeletal system, eyes, and face. Most patients have patchy areas of skin aplasia and atrophy that

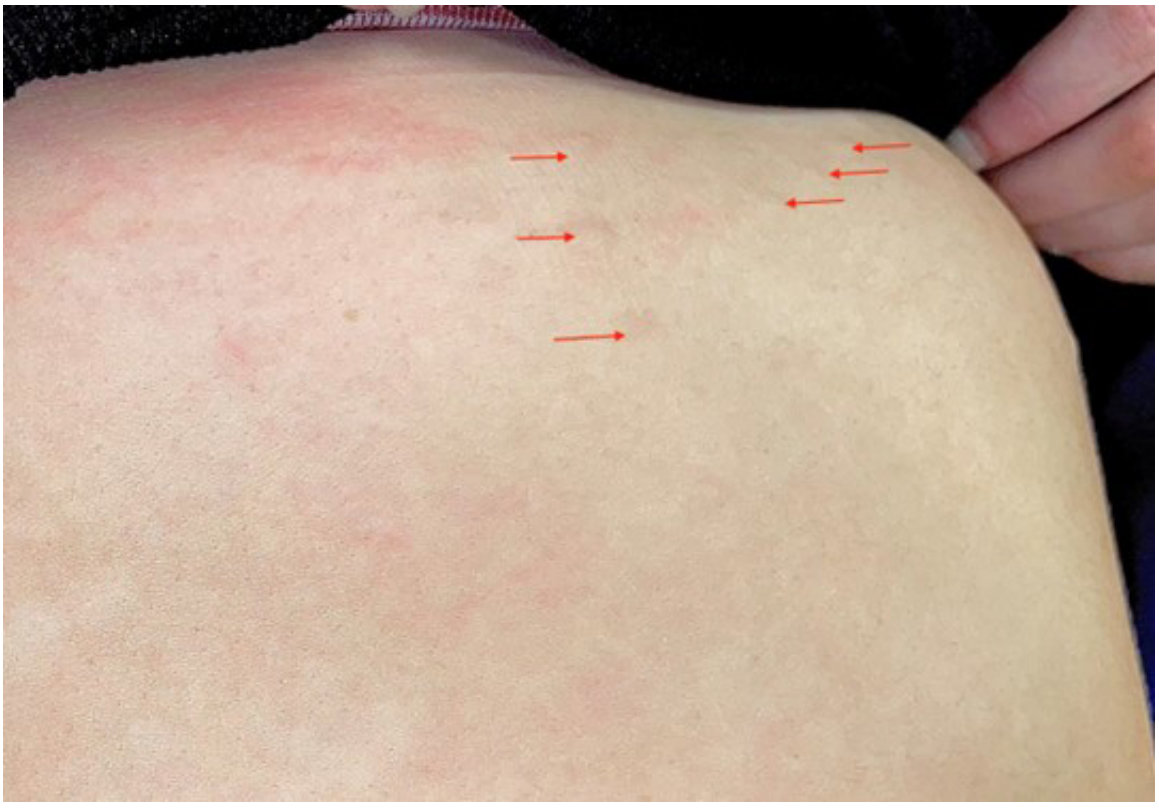

**Figure 1**
*Primary anetoderma lesions on the abdomen*

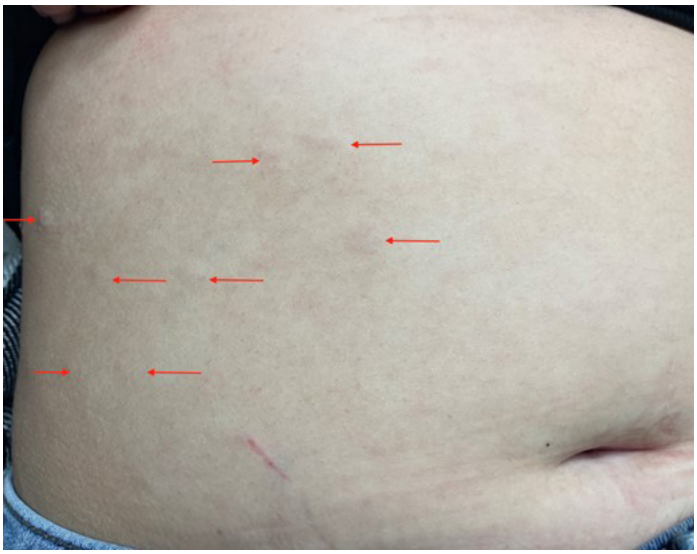

**Figure 2**

*Primary anetoderma lesions on the right flank.*

follow lines of Blaschko. Other major findings of focal dermal hypoplasia that this patient lacks are skin hypo/hyperpigmentation, nodular fat herniation, dysplastic nails, telangiectasias, and limb malformations. Papular elastorrhexis is a rare, acquired disorder of elastic tissue, with approximately 31 previously described cases in literature. It is characterized by multiple small asymptomatic skin-colored papules on the trunk and extremities. It often presents in the second decade. Histopathological examination shows fragmentation and loss of reticular dermis elastic tissue.[3] Mid-dermal elastolysis has a band-like loss of mid-dermal elastic fibers, as opposed to loss throughout all layers of the dermis in PA.[3] Mid-dermal elastolysis presents with widespread, well-defined, thin, and wrinkled plaques commonly on the trunk and upper arms. Lastly, perifollicular elastolysis can present similarly to PA with wrinkled papules. However, histology will show almost complete loss of elastic fibers around hair follicles, without inflammation.[3]

Numerous potential treatments have been studied for primary anetoderma, including phenytoin and dapsone, however, none of them have been established to be efficacious.[4,5] Limited case reports have found laser treatments to be effective in reducing the appearance of lesions, but more data is needed.1 Therefore, the mainstay of treatment for PA is providing patients with reassurance. Patients may elect to have their lesions excised, however, this may result in scarring.

In conclusion, PA is a rare skin disorder that involves the loss of elastic fibers in the papillary and reticular dermis.[1] Patients will have very subtle clinical findings, as was the case in this patient. In regards to associations to be aware of in these patients, it is important to screen them for antiphospholipid antibodies, as this is associated with PA. Additionally, it is thought that the ischemia from thrombosis may play a role in the degradation of the elastic fibers seen in anetoderma.[2] In regards to treatment options for these patients, the mainstay of treatment is providing patients with reassurance.

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