VERMONT MEDICAL SOCIETY RESOLUTION – PROPOSED AMENDMENTS

Legalizing and Commercial Sales of Non-Medical Marijuana in Vermont

Submitted for adoption at VMS Annual Meeting on October 27, 2018

Whereas, legalizing and commercial sale of ~~recreational~~ non-medical marijuana will create substantial risks to the health and development of Vermont's children and adolescents, and normalize use of the drug in ways that have great potential to increase youth and young adult use rates as well as intra uterine infant exposure;

Whereas, legalization ~~of any quantity~~ of marijuana~~, including 2 plants home grown,~~ and increased access through commercial sales, will likely lead to increased child poisonings;

Whereas, statistics show in Colorado, where commercial sales of marijuana began in 2014, instead of commercialization creating a tightly regulated, state-supervised market, there is now a thriving black market.

Whereas, currently more adolescents in Vermont seek out substance abuse treatment for marijuana than for all other illicit drug use combined;

Whereas, teens who use marijuana regularly are at increased risk to develop serious mental health disorders, including addiction, depression and psychosis and pre-existing mental illness is worsened, increasing cost of treatment, increasing inpatient hospital days and associated with 7 fold increased harm to self (suicidality);

Whereas, Vermont currently suffers from inadequate substance abuse treatment capacity, and more facilities are closing than opening;

Whereas, Vermont has inadequate psychiatric treatment facilities, especially for youth and teens, and our emergency rooms are full of patients waiting for psychiatric treatment;

Whereas, the Icelandic Model of Adolescent Substance Use Prevention focuses on both risk reduction and the enhancement of protective factors at various levels of prevention;

Whereas, studies observed a significant reduction in the proportion of substance use among Icelandic adolescents over a decade during which the Icelandic Model was implemented;

Whereas, on school days, the hours between 3-7 p.m. are the peak hours for youth to commit crimes, be in or cause an automobile accident, be victims of crime, smoke, drink alcohol, or use drugs[1];

Whereas, For every dollar spent on quality afterschool and summer learning programs (the third space), Vermont gets back $2.18 in long-term savings from reduced criminal activity and substance abuse treatment, as well as accruing additional benefits from increased high school completion and work productivity[2];

[1] https://www.ojjdp.gov/ojstatbb/offenders/qa03301.asp
[2] http://197yqv2yy2wnqk9ni14nx82z.wpengine.netdna-cdn.com/wp-content/uploads/2014/11/ROI-Summary-2014.pdf

Whereas, to reduce the safety risks and negative health impact of marijuana on the health of children, adolescents and families more work needs to be done; now therefore be it:

RESOLVED, that the VMS reaffirms its opposition to the legalization of non-medical marijuana; and be it further

RESOLVED, that the VMS is opposed to the commercial sales of non-medical marijuana; and be it further

RESOLVED, the VMS collaborate with the American Academy of Pediatrics Vermont Chapter and the Agency of Human Services to educate youth to counter the climate that portrays marijuana as a benign drug; considers models for preventing risky behaviors among adolescents such as the Icelandic Model[3] and/or the Third Space[4] Model; and support education directed toward parents and adults on the negative health impact of marijuana on parenting ability~~, the developing fetus and the dangers of second hand smoke~~; and be it further

RESOLVED, that VMS urge the Governor of the State of Vermont and Vermont General Assembly, to conduct appropriate research to determine actual effects and costs of legalization and commercial sales of non-medical marijuana to the entire system, including but not limited to – increased challenges recruiting health professionals, increased Medicaid costs, increased ER utilization, increased hospitalization rates, increased THC positive infants, increased traffic fatalities, workforce costs, economic productivity loss to existing industry, environmental impact costs, costs to the law enforcement system, and education costs; and be it further

~~**RESOLVED, that VMS urge the Governor of the State of Vermont and Vermont General Assembly to conduct appropriate research to determine the impact of decriminalization of marijuana in Vermont and whether it has led to increased marijuana use or resulting harm in Vermont, and whether it has met criminal or civil justice goals by measuring the following benchmarks: Incidence of marijuana related harm to children; Incidence of marijuana associated Emergency Room visits; Incidence of marijuana associated highway fatalities; and Incidence of marijuana associated mental illness (including psychosis and PTSD); and be it further**~~

RESOLVED, that VMS urge the Governor of the State of Vermont and Vermont General Assembly, to oppose ~~legalization and~~ commercial sales of marijuana and to determine and meet appropriate benchmarks before commercialization is considered, including, but not limited to:

- **Increasing the percentage of Vermont adolescents who perceive marijuana as harmful;**
- **Increasing substance abuse treatment facilities~~, such that wait lists for programs are no longer a concern~~; and**
- **Decreasing the utilization of emergency rooms for holding areas for psychiatric admissions**

[3] https://www.ncbi.nlm.nih.gov/pubmed/19074445
[4] http://www.vermontafterschool.org/youthworkvt/

VERMONT MEDICAL SOCIETY RESOLUTION

Health Care Costs and Harm to Society of Commercialized Recreational Marijuana

Submitted by Catherine Antley, MD, Kim Blake, MD, John Hughes, MD and David Rettew, MD
for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS Vermont has now legalized possession, use, growing, and gifting of small quantities of marijuana; and

WHEREAS, after decriminalization in 2013, marijuana use rates by Vermont adults[1] increased by 80% among those 18-24, 40% among those 24-44, and 50% among those 45-64, and from 2015 to 2017 the use rate among all Vermont high school students[2] increased by a statistically significant 2% while the use rate among high school seniors increased by 10%; and

WHEREAS increased availability of marijuana and normalization of marijuana use has been shown to lead to further increases in use rates, such that every state that has instituted a commercialized retail system for recreational marijuana has seen large increases in marijuana use, particularly in the 18 to 25 age group but also in the younger and older age groups[3,4]; and

WHEREAS, as with tobacco and alcohol, heavy users account for an estimated 80% of marijuana sales[4,5], so that for-profit companies can be expected to focus on creating and maintaining these heavy users by creating more addictive products and targeting youth and young adults 18-25, which groups are more susceptible to the effects of psychoactive drugs; and

WHEREAS the marijuana industry in Canada and U.S. states that have legalized commercialized retail marijuana systems have seen consolidation of industry sectors into fewer and larger corporations[6,7,8,9]; and

WHEREAS such corporations are motivated by profit, not by concerns for public health[5]; and

WHEREAS our free speech doctrine makes it very difficult to restrict advertising and marketing to youth[10] unless, as with tobacco, decades of expensive legal action have amassed a body of evidence proving deceit and damage to public health under the Racketeer Influenced and Corrupt Organization (RICO) Act; and

WHEREAS state and local governments already spend over $90 billion annually on the social costs related to substance abuse and addiction[11], far more than the amounts projected to be raised by taxation of tobacco, alcohol, and marijuana combined, thereby increasing state budget deficits every year by those margins; and

WHEREAS active black markets have continued their activity in all states that have legalized commercialized recreational marijuana[12]; and

WHEREAS the price of marijuana has decreased steadily in the past few years[5,13], so that those states have had to reduce their tax rates[5] in order to undersell the black market, resulting in less tax revenue; and

WHEREAS conservative cost/income analyses of proposed systems for commercialized recreational marijuana in Rhode Island, Connecticut, and Illinois have calculated marijuana tax and fee income shortfalls ranging from $ 12.9 million to $114.5 million every year[14,15,16]; and

WHEREAS these analyses were able to use data from Colorado, Washington state, and Oregon to make conservative approximations of quantifiable costs for such factors as administrative and regulatory enforcement, increased drugged driving fatalities and other vehicle related property damages, short term health costs, and increased workplace absenteeism and accidents, but were not able to approximate the additional costs due to increased rates of heavy marijuana use and co-drug use, such as costs for addiction treatment and recovery, family and child services, prevention programs, continuing black market activity (particularly the black market to under-age users), and long-term health costs for conditions known to be linked to marijuana use, including respiratory problems, cardiovascular problems, anxiety disorders, bipolar mania, suicide, psychosis, and schizophrenia[17,18]; and

WHEREAS these additional harms combined with increased numbers of users would increase costs significantly[19,20], such that, for example, an estimated additional cost of $4.9 to $11.1 million per year would be needed for the treatment of schizophrenia alone, based on the increase in marijuana consumption predicted by the RAND report[21]; and

WHEREAS the increased health and social harms due to increased marijuana consumption are accompanied, not only by dollar costs, but by increases in human suffering due to job loss, mental illness, death of loved ones, divorce, child neglect and abuse; and

WHEREAS Vermont physicians have sworn an oath to do no harm;

RESOLVED that the Vermont Medical Association is opposed to the creation of any system for retail sales of marijuana over and above what already exists for the sale of medical marijuana.

REFERENCES

1. Vermont Behavioral Risk Factors Survey System (BRFSS), 2015
2. Vermont Youth Risk Behavior Survey (YRBS), 2017
3. National Survey of Drug Use and Health (NSDUH), 2012 through 2017
4. Monitoring the Future Survey (MTF), 2012 through 2017
5. Jonathan Caulkins, "Against a Weed Industry," National Review, March 15, 2018
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7. Lisa Bernard-Kuhn, "Four marijuana firms to form multinational company, continuing industry consolidation," Marijuana Business Daily, May 15, 2018
8. Nick Kovacevich, "With A Wave Of Consolidation, The Cannabis Industry Rises To The Next Level," Forbes, Aug. 29, 2018
9. Chriss W. Street, "Big Business is About to Consolidate California's Marijuana Industry," Breitbart, June 26, 2018
10. Jonathan Caulkins, "Marijuana Legalization is a Process and We Haven't Reached the Midway Point," ATTC/NIATx, May 11, 2017
11. "Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets," The National Center on Addiction and Substance Abuse at Columbian University, 2009
12. Tom James, "The Failed Promise of Legal Pot," The Atlantic, May 9, 2016
13. Eli Pace, "Wholesale cannabis prices at all-time low in Colorado," Vail Summit Daily News, Oct. 3, 2017
14. "Working Paper on Projected Costs of Marijuana Legalization in Rhode Island," Smart Approaches to Marijuana, April 2017

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18. "Marijuana Regulation in Vermont 2017 Literature Review Update," Vermont Department of Health
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21. Dean Whitlock and Christine L. Miller, Ph.D., "Marijuana in Vermont and the Increased Economic Burden of Schizophrenia," Smart Approaches to Marijuana - Vermont, January 2016

VERMONT MEDICAL SOCIETY RESOLUTION

Regulation of Recreational Drugs

Submitted by Joseph McSherry, M.D., PhD
for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS, the Vermont Medical Society (VMS) policy is to oppose legalization of cannabis and the Legislature has legalized possession of small amounts and production for personal use; and

WHEREAS, the marijuana that is available to buyers of any age is illegal, untested and of unknown composition and this market is not affected by the legal cannabis individuals over 21 produce for personal use; and

WHEREAS, VMS supports regulation and denial of access to person under 21 years for recreational drugs including tobacco, alcohol and cannabis as a public health issue to minimize development of addiction and harm to developing brains; and

WHEREAS, the Health Impact Assessment of the Department of Health, January 2016 includes best practices for regulation of recreational drugs in pages 49-60 and Vermont needs to improve regulation of alcohol and tobacco by restricting access to venues for 21 years and older persons, restriction of density of venues, marketing restrictions; and

WHEREAS, alcohol at a blood alcohol level of 0.08, the current DUI limit, is associated with a 4 fold increase in driving accident risk and any alcohol in combination with other drugs is associated with increased risk of driving accidents; now therefore be it

RESOLVED, VMS urges the Legislature to adopt best practices regulation of recreational drugs (alcohol, tobacco and cannabis) including restriction of marketing to tested products and sales to venues accessible by persons 21 years old and above, limiting hours to minimize impulse use, and controlling wholesale distribution of tested products for any marketable products; and be it further

RESOLVED, VMS urges the Legislature to require drug free driving by lowering the acceptable limit BAC for alcohol to 0.0%.

VERMONT MEDICAL SOCIETY RESOLUTION

Wellness of the Physician Workforce

Submitted for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS, most physicians enter medicine following a calling, rather than a career path, with a desire to help people and ensure the best care for their patients; and

WHEREAS, the health care environment has become increasingly business-oriented and physicians must consider a multitude of factors other than their patients' clinical best interests when deciding on treatment (financial considerations, electronic health records, a fear of litigation, patient satisfaction scores); and

WHEREAS, rapid changes and requirements in the practice of medicine are layered onto new expectations with regard to technology, quality reporting, increased clinical volume, and numerous other initiatives required by payers, employers, state medical boards; and

WHEREAS, the environment in which physicians practice is leading many to experience a lack of control and autonomy, lack of support, growing isolation, and loss of opportunities for socializing with colleagues; and

WHEREAS, burnout affects a significant proportion of the U.S. physician workforce; a 2012 study showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout and the rate had increased by 9% when repeated only three years later;[1, 2] and

WHEREAS, growing evidence is showing that physician burnout may impact patient safety and contribute to medical errors[3, 4]; and

WHEREAS, suicide rates among physicians is between 28 to 40 per 100,000 - more than two times the overall population[5]; and

WHEREAS, a positive cultural change is needed to reduce stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own; therefore be it

RESOLVED, that the VMS promote dialogue among key stakeholders (physician groups, health-system decision makers, payers, and the general public) to:

- **increase awareness of the importance of physician wellness, both individually and organizationally;**
- **discuss best practices for promoting physician wellness and how to help physicians identify, manage and prevent burnout throughout their career;**

[1] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc, 90:1600-1613.

[2] Physician Wellness and Burnout, Report and Recommendations of the Workgroup on Physician Wellness and Burnout, Adopted as policy by the Federation of State Medical Boards, April 2018, available at http://www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

[3] James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. Journal of Patient Safety, 9(3):122-128

[4] Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. Mayo Clin Proc, 92:129-146

[5] https://www.physicianleaders.org/news/-preventing-physician-suicide-recognizing-symptoms-improving-support

- **work with the University of Vermont College of Medicine and Medical Center to incorporate self-care into professional development curricula for students, physician residents and fellowship trainees as well as teaching them to identify behavioral changes in their colleagues; and**
- **encourage employers/practices to make resources and programs available to physicians, including time and space for making connections with colleagues and pursing goals that add meaning to physicians' work lives; and be it further**

RESOLVED, that the VMS will work with the Vermont Practitioner Health Program and the Vermont Board of Medical Practice to ensure the availability of resources for promoting physician wellness and addressing burnout; and be it further

RESOLVED, that the VMS work to ensure that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness; and be it further

RESOLVED, VMS work with the Vermont Association of Hospitals and Health Systems to educate hospital leaders on the importance of physician leadership and input in all aspects of the health system, especially those that directly affect patient care and workforce.

VERMONT MEDICAL SOCIETY RESOLUTION

Streamlining Credentialing

Submitted for adoption at VMS Annual Meeting on October 27, 2018

Whereas, Hospital credentialing is the practice by which hospitals evaluate and verify the qualifications of their healthcare professionals to ensure that each individual practitioner possesses the necessary qualifications to provide medical services to patients; and

Whereas, hospital credentialing involves verification of education, training, experience, and licensure to provide services and can include submission of proof of education, training, experience, current competence, board certification, state licensure, malpractice liability certificate, curriculum vitae (CV), letters of recommendation and case reports;[1] and

Whereas not just hospitals and health care facilities but private and public payers have their own credentialing forms, processes and timelines; and

Whereas, many entities require frequent updates to credentialing, often meaning new applications or submissions multiple times per year; and

Whereas, the time and paperwork involved in hospital and payer credentialing adds to the overall administrative burden placed on health care professionals, especially those in small or independent practices or who practice at multiple locations; and

Whereas, Vermont law and regulation require that health insurers and hospitals use the CAQH credentialing application form for initial applications and for applications for re-credentialing, however additional supplementary forms or documentation can be required;[2]

Whereas, delegated credentialing is the process by which a health plan agrees to turn over a portion of their credentialing review process to a qualified entity such as a hospital; now therefore be it

RESOLVED, that the Vermont Medical Society will work with the Vermont Association of Hospitals and Health Systems, health plans, Medicaid and other interested parties to pursue methods of streamlining the credentialing process, including:

- **Promulgating a uniform reappointment cycle for hospitals and health plans**
- **Urging health plans to recredential participating physicians and physician assistants no more frequently than every two years**
- **Encouraging hospitals and other health care facilities to seek out delegated credentialing agreements with payers**
- **Reducing the number of supplementary documents or forms that must be submitted in addition to the CAQH application form.**

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[1] https://www.aafp.org/practice-management/administration/privileging/credentialing-privileging-faqs.html

[2] 18 V.S.A. § 9408a; see also http://www.dfr.vermont.gov/insurance/health-insurance/uniform-provider-credentialing

VERMONT MEDICAL SOCIETY RESOLUTION

Recognizing and Addressing Bias Within the Health Care System

Submitted for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS, Implicit bias refers to associations or stereotypes outside our conscious awareness that can lead to a negative assessment of a patient or other health care professional based on race, gender, ethnicity, sexual orientation, disability, socioeconomic status and other demographic characteristics; and

WHEREAS, Studies demonstrate disparities exist in the diagnosis and treatment of patients based on health care professionals' implicit biases related to race, gender, ethnicity, sexual orientation, disability, socioeconomic status and other demographic characteristics;[1] and

WHEREAS, Disparities in health care treatment result in poorer health outcomes, higher rates of disease, multiple chronic health conditions, longer lengths of stay in the hospital and lower life expectancies;[2] and

WHEREAS, in 2003, the Vermont Medical Society adopted a resolution, "Improvement of Vermont's Health Care System," in which it committed to "patient-centered health care." Patient-centered health care was defined as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions;"[3] and

WHEREAS, health care professionals and medical trainees face discrimination from patients and their families, supervisors, nurses, peers, and other health care professionals from implicit and explicit bias based on race, gender, ethnicity, sexual orientation, disability, socioeconomic status and other demographic characteristics;[4] [5] therefore be it

RESOLVED, The Vermont Medical Society will educate its members to recognize and combat bias in the health care delivery system towards patients on the basis of race, gender, ethnicity, sexual orientation, disability, socioeconomic status and other demographic characteristics; and be it further

RESOLVED, The Vermont Medical Society will educate its members regarding recognizing and combating bias in the health care system towards health care professionals from their patients and peers on the basis of race, gender, ethnicity, sexual orientation, disability, socioeconomic status and other demographic characteristics; and be it further

RESOLVED, The Vermont Medical Society will support the development and implementation of organizational processes and support systems designed to mitigate biases within the health care system and to work to mitigate the unequal treatment of patients and health care professionals.

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[1] Fitzgerald, Chloe and Hurst, Samia. (2017) Implicit bias in healthcare professionals: a systematic review.
[2] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.
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VERMONT MEDICAL SOCIETY RESOLUTION

Reduce the Use of Electronic Nicotine Delivery Devices Among Youth and Never Users

Submitted for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS, JUUL is a brand of electronic cigarettes that looks like a USB drive, has a higher amount of nicotine concentrate as other e-cigarette brands and is one of the most popular vaping devices among youth;[1] and

WHEREAS, Nicotine is a highly addictive drug and exposure to nicotine during adolescence can cause addiction and have negative consequences on youth brain development; and

WHEREAS, Sixty-three percent of JUUL users between the ages of 15 and 24 did not know the product contains nicotine;[2] and

WHEREAS, According to the 2016 *E-Cigarette Use Among Youth and Young Adults* Surgeon General Report, e-cigarette use among youth and young adults is a major public health concern, as use of e-cigarettes has grown by 900% between 2011 and 2015;[3] and

WHEREAS, E-cigarettes are marketed as a harm-reduction tool, but there is substantial evidence that e-cigarette use increases the risk of "ever using" a combustible tobacco product;[4] and

WHEREAS, JUULS come in a variety of flavors that appeal to youth like Crème Brulee and Mango that public health experts and an Attorney General argue targets youth, as the majority of youth who experiment with tobacco begin with a flavored product; now therefore be it

RESOLVED, The Vermont Medical Society will work with the Vermont Department of Health, the Vermont Department of Liquor Control, the Vermont Department of Education, the Attorney General, school administrators and other prevention specialists to:

- **Educate youth on the dangers of electronic nicotine delivery devices**
- **Support advancing technology that can prevent the use of electronic nicotine delivery devices**
- **Support raising the age of all tobacco products, including electronic nicotine delivery devices, to 21**
- **Support flavor ban policies**
- **Strengthen marketing restrictions of these products to youth**

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[1] Public Health Concerns About Youth & Young Adult Use of JUUL. *Public Health Law Center*. Accessed August 15, 2018.
[2] Willett JG, Bennett M, Hair EC, et al. Recognition, use and perception of JUUL among youth and young adults. [published ahead of print April 18, 2018]. Tob Control. Accessed August 15, 2018.
[3] E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General 2016. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Public Health Service. Office of the Surgeon General
[4] http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx

VERMONT MEDICAL SOCIETY RESOLUTION

Tick Borne Illness

Submitted by David Charnock, M.D.
for adoption at VMS Annual Meeting on October 27, 2018

WHEREAS, the increasing incidence of tick-borne illness presents a significant threat to the health and well-being of all Vermonters; Lyme disease in particular is spread by the bacterial spirochete *Borrelia bergdorferi* and is a common infectious disease carried by deer ticks (*Ixodes scapularis*) throughout New England and many states in America; and

WHEREAS, deer ticks may carry other pathogens causing disease and illness, including bartonella, babesia, anaplasmosis, powassan virus, and erlichosis, all of which have been found in Vermont; and

WHEREAS, the Centers for Disease Control and Prevention states that Vermont had 491 confirmed cases of Lyme disease in 2015, along with another 219 suspected cases, and that Vermont had the second highest incidence of Lyme disease per capita in the nation at 78.1 cases per 100,000 residents in 2016; and

WHEREAS, accurate diagnosis of tick-borne infectious disease is important recognizing these illnesses that may affect many of the body organs and systems and can mimic other diseases and disorders; and

WHEREAS, climate change is expected to increase human exposure to Lyme disease; as global temperatures rise, areas in the northern United States are expected to become more hospitable to *I. scapularis* and suitable habitat for the deer tick is expected to increase by 213% by 2080; now therefore be it

RESOLVED, the Vermont Medical Society will work with the Vermont Department of Health and other state agencies; experts such as epidemiologists, biologists, entomologists and foresters; and Vermont institutes of higher education to:

1. **determine the most effective strategies to mitigate the growth of Vermont's tick population with the goal of limiting exposure to tick-borne illness; and**
2. **disseminate education and outreach programs/materials for the public and clinicians on tick-borne illnesses in Vermont, limiting exposure, identification, testing and treatment.**