# Original Submissions: 2016 Open Issues

*Note: please refer to the document, "2016 Open Issues: Panel Recommendations to MMA Policy Council" for relevant MMA policy and staff-generated background information.*

## Open Issue #1:

**Topic**:
Minor consent for HPV vaccination

**Submitter's Request of MMA**:
That the MMA support legislation that adds HPV vaccination to Hepatitis B vaccination and other preventive care for which minors can consent.

**Background/Rationale from Submitter (ACOG; Janette Strathy, MD)**:
In Minnesota, minors can consent to STI testing and treatment, birth control and prenatal care. They can also consent to Hepatitis B vaccination without parental consent. HPV vaccination rates in minors are low in Minnesota. In addition to education of parents as to the value of the vaccine in preventing HPV caused cancers such as cervical, anal and oropharyngeal cancers in males and females, allowing minor consent to HPV vaccination may allow access to this preventive care to some minors where parental consent is a barrier. Legislation has been successful on this issue in California and other states and is supported by ACOG national and AAP (pediatrics).

**Issue Submitted by**:
MN-ACOG (Janette Strathy, MD)

## Open Issue #2

**Topic**:
Pornography as a public health crisis

**Submitter's Request of MMA**:
That MMA adopt policy and advocate against the acceptance of the use of pornography as a healthy, responsible activity in our society.

That MMA, in legislative hearings dealing with pornographic issues, play a crucial, integral part in efforts to establish legislation that would counteract the devastating impact of pornography on individuals, their families and society.

**Background/Rationale from Submitter (Carl Burkland, MD)**:
More than 30% of men surveyed said that they watched porn every day; 71% of men 18-34 watch porn at least once a month. Studies have concluded that obsessively viewing porn rewires the neural pathways of the brain, much like opiate drugs do. Like opiates, porn can be addictive; it can supplant – or destroy – all real-world relationships. It can also (ironically) deaden, rather than enhance, a person's actual sexual relationships with real people. Male consumption of pornography has a profound effect on how women are viewed, how sex is

viewed and the expectations on them sexually. In our hypersexualized society, porn is incredibly pervasive and has become normalized. It was recently reported that internet porn sites get more visitors each month than Netflix, Amazon and Twitter combined and that a staggering 36% of internet downloads are porn. One major free porn site reported 21.2 billion visits in 2015 (now consider that there are more than 4 million porn sites worldwide). Unlike the days of "girlie" magazines in brown paper packaging, internet porn offers the convenience of the 3 As – affordability, accessibility and anonymity. The average age an American child first views hard-core porn is 11; some 93% of males have viewed it by age 18.

Porn is overwhelmingly misogynistic – eroticizing subservience, humiliation and violence. Among the most-rented and bestselling porn films, almost 90% had physical aggression (such as gagging and slapping) and women were the recipients 94% of the time. Not surprisingly, studies on men who view porn show that they tend to objectify women as well as finding their partners, who lack the airbrushed perfection of the "actresses" less appealing. While no one has provided a causal link, there are numerous studies showing a correlation between porn use and sexual assault or rape.

Teenage girls and young women whose male partners use porn report markedly diminished self-esteem, body image and relationship quality as well as expectations to engage in sexual acts their partners see in porn. Increasing numbers of compulsive porn users are reporting erectile dysfunction when encountering a real partner. While males of all ages are at risk, young men are especially vulnerable to this because their brains are more plastic. Dubbed the "new drug," porn is recognized by neuroscientists as having powerful addiction-like effects. Porn wreaks havoc in relationships; in at least 56% of divorces in the US, heavy porn use by one partner was cited as a major contributing factor.
Rarely brought up in public conversations, porn permeates our culture under the radar, profoundly shaping attitudes and beliefs about gender roles and inequality, sexuality, relationships, and intimacy. Increasingly extreme, the vast majority of today's porn is devoid of respect, mutual concern and human connection. Michael Seto, a leading authority on porn and sexual assault, has stated that "the early and pervasive exposure to internet pornography among children and youth is the largest unregulated social experiment I'm aware of. We don't know what the effects will be." MMA policy on the issue would increase public awareness as well as make money available for education, research and development of strategies to counteract porn's harm.

**Submitted by**:
Carl Burkland, MD

**Open Issue #3**

**Topic**:
Chemical abuse as a chronic condition

**Submitter's Request of MMA**:
Develop a clear, definitive position statement that chemical abuse is a chronic, relapsing medical condition and state that it should be treated as a disease and not as a moral or behavioral problem.

Address the immediate need for acute, evidence-based treatment programs, advocating for state and insurance development of these programs.

Recognize and advocate for the long-neglected rehabilitation/recovery monitoring phase of treatment – assisting the patient to return to a normal socially functional life.

Continue MMA's ongoing development of preventive programs such as: the physician training regarding opioid use and chronic pain treatment, advocating for tobacco tax increases, education about "smokeless" products and flavored tobacco, etc.

**Background/Rationale from Submitter (Dennis Callahan, MD)**:
Recent media attention has brought to light what has been termed "the Opioid Epidemic." As in previous "crises," this has elicited multiple "knee jerk" responses. Much of the recent attention has been focused on the "iatrogenic physician misuse" of opioids in the treatment of chronic pain, which ironically was partially the response to the previous "crisis" of inadequate pain treatment of chronic pain by physicians. I do not wish to underrate this real and deadly problem of the need to develop appropriate methods to manage chronic pain and educate physicians as well as patients about this problem. However, there are several important issues that remain to be addressed.

Presently the MMA has limited/unclear positions recognizing chemical abuse as a chronic, relapsing medical disease similar to other conditions such as asthma, diabetes, heart failure, MS, etc. Before addressing the development of any treatment programs we need to have a clear and unequivocal position that chemical abuse is in fact a medical disease and should be treated as other chronic relapsing conditions. Treating this condition as a medical disease will enable the MMA to champion evidence-based medical treatment as well as lobby for insurance coverage and legislation to improve its care.

The chemical abuse problem really needs a three-pronged approach. We do need to address the prevention and educational aspects (such as the MMA's Pain, Opioids and Addiction lecture series). We also need to address the shortage of acute treatment programs, which are sorely lacking in Minnesota and in the entire country. It is estimated that 22 million patients need treatment while only about 2 million are actually receiving any form of treatment, outcome-based or not. This will require pressure on the insurance industry, the provider networks and the legislature to provide the evidence-based programs and the funding for them.

An area that has been long-neglected is the rehabilitation/recovery monitoring phase. Once the acute issues are addressed, the ongoing recovery needs to be addressed to assist the patient in returning to a normal, socially functional life. This may involve job training, educational support, employment counseling, etc. This is analogous to the rehabilitation of a stroke patient who may need speech therapy, muscular strengthening, balance assistance, the use of assistive devices, etc. The way chemical abuse is currently treated would be analogous to telling an obese smoker who presents to the ER with an acute MI that he should return when he loses weight and quits smoking, or telling a patient presenting with seizures that we may be able to get them an appointment in three weeks with a neurologist who can work up their seizures and manage them. Clearly such scenarios are ludicrous and would be considered malpractice or even criminal. Yet this is the manner that chemical abuse is routinely treated, instead of as a real medical problem.

The MMA bears a responsibility to first publically recognize chemical abuse as a chronic, relapsing medical disorder similar to DM, MS, HTN, Heart Failure, etc., as well as assisting in the development of the acute treatment and rehabilitation programs through education of the medical community and the public and to use its legislative lobbying resources to advocate for the programs.

**Submitted by**:
Dennis Callahan, MD

**Open Issue #4**
**Topic**:
Pharmacist Prescribing of Hormonal Contraceptives

**Submitter's Request of MMA**:
No specific position requested; rather, the MMA Policy Council is interested in physician input on the pros, cons, and other issues that may be associated with allowing pharmacists to prescribe hormonal contraceptives.

**Background/Rationale from Submitter (MMA Policy Council)**:
There appears to be some interest by the MN Department of Health and the MN Board of Pharmacy to expand pharmacists' scope of practice to allow them to prescribe self-administered hormonal contraception.

Although specifics are still unclear, early proposals called for the prescribing to be based on protocols developed by the state that would include, at a minimum, a patient self-screening tool, a written record of the contraceptive for the patient, and referral to the patient's primary care provider upon furnishing the contraceptive or determining it was not recommended.

**Submitted by**:
MMA Policy Council

**Open Issue #5**
**Topic**:
Firearm Safety

**Submitter's Request of MMA**:
That the MMA promote conversations between providers and patients on responsible firearm ownership and safe storage in the home (much like current conversations on the use of child-restraint systems in the car).

That the MMA join the growing movement for common-sense changes to our gun laws to promote responsible gun ownership and support efforts in Minnesota to require criminal background checks on all purchases and transfers/exchanges of firearms with reasonable exceptions for immediate family and law enforcement and military acting in an official capacity.

That the MMA call for elected leaders to ensure that law enforcement officials have adequate resources to enforce the laws that hold sellers accountable when they sell firearms to prohibited purchasers.

**Background/Rationale from Submitter (Jim Hart, MD; Caleb Schultz, MD)**:
Firearm injuries and the use of firearms in violent acts are a threat to the wellbeing of all Minnesotans and Americans. Every week in the United States, an average of 645 people lose their lives to firearm violence (accounting for about 7 % of premature deaths).[1] An average of 1,565 people each week are treated in emergency departments for firearm-related injuries.[12] Firearms are the second leading cause of death by injury for youths 17 and under.[2] 90% of women, 91% of children aged 0 to 14 years, 92% of youth aged 15 to 24 years, and 82% of all people killed by firearms in high-income countries were from the United States.[3]

In 2014, there were 377 firearm fatalities in Minnesota, and suicide by firearms account for 80% or more of Minnesota's gun deaths annually.[4]

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[1] Leahy, Eileen. "Gun violence: experts explore critical issues from multiple angles." Elsevier: Special Issue on the Epidemiology and Prevention of Gun Violence. Volume 79. October 2015 available at: https://www.elsevier.com/connect/gun-violence-experts-explore-critical-issues-from-multiple-angles

[2] Webster, Daniel PhD & David Hemenway PhD. "Increasing Knowledge for the Prevention of Firearm Violence." Elsevier: Special Issue on the Epidemiology and Prevention of Gun Violence. Volume 79, p 3-4. March 2016 available at: http://ac.els-cdn.com/S009174351500198X/1-s2.0-S009174351500198X-main.pdf?_tid=5fb3569a-4790-11e6-a957-00000aacb361&acdnat=1468259789_cb19d64da5a3d84a114c3ba5b39aa0ea

[3] Grinshteyn, Erin PhD & David Hemenway, PhD. "Violent Death Rates: The US Compared with Other High-income OECD Countries, 2010." American Journal of Medicine. Volume 129, Issue 3, p 266-273. March 2016 available at: http://www.amjmed.com/article/S0002-9343(15)01030-X/abstract

[4] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2014) [cited May 16, 2016]. Available from URL: http://www.cdc.gov/injury/wisqars/index.html.

States that require criminal background checks for all firearm sales report a lower rate of suicide,[5] domestic violence homicide,[6] and police killed with handguns in the line of duty.[7]

Devising an effective public health approach for Minnesota must recognize: the health impact of the misuse of firearms; the right of law-abiding citizens to own and use firearms responsibly; and all firearm deaths, including murder, unintentional deaths and suicide by firearm.

**Submitted by**:
James Hart, MD; Caleb Schultz, MD

[5] Everytown for Gun Safety "State Background Check Requirements and Suicide" available at: http://every.tw/1Aj9CVz

[6] Everytown for Gun Safety "State Background Check Requirements and Rates of Domestic Violence Homicide" available at : http://every.tw/1Aj9HZj

[7] Everytown for Gun Safety "State Background Check Requirements and Rates of Firearm Homicide Against Law Enforcement" available at: http://every.tw/1Aj9JAy