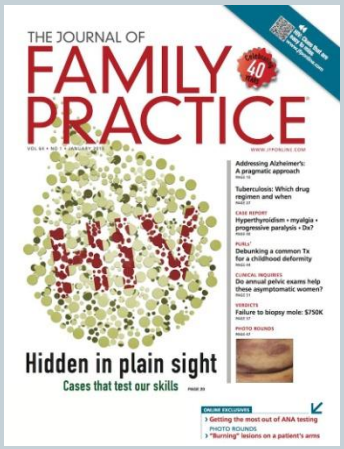
Key Articles & Clinical Developments of 2016 in Family Medicine

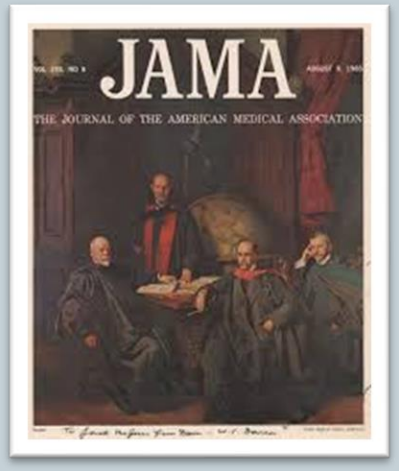
WHAT WAS IMPORTANT…

…AT LEAST TO SOME OF US

DAN WALDMAN, MD
UNM FAMILY AND COMMUNITY MEDICINE

A Survey of The Year's Stories





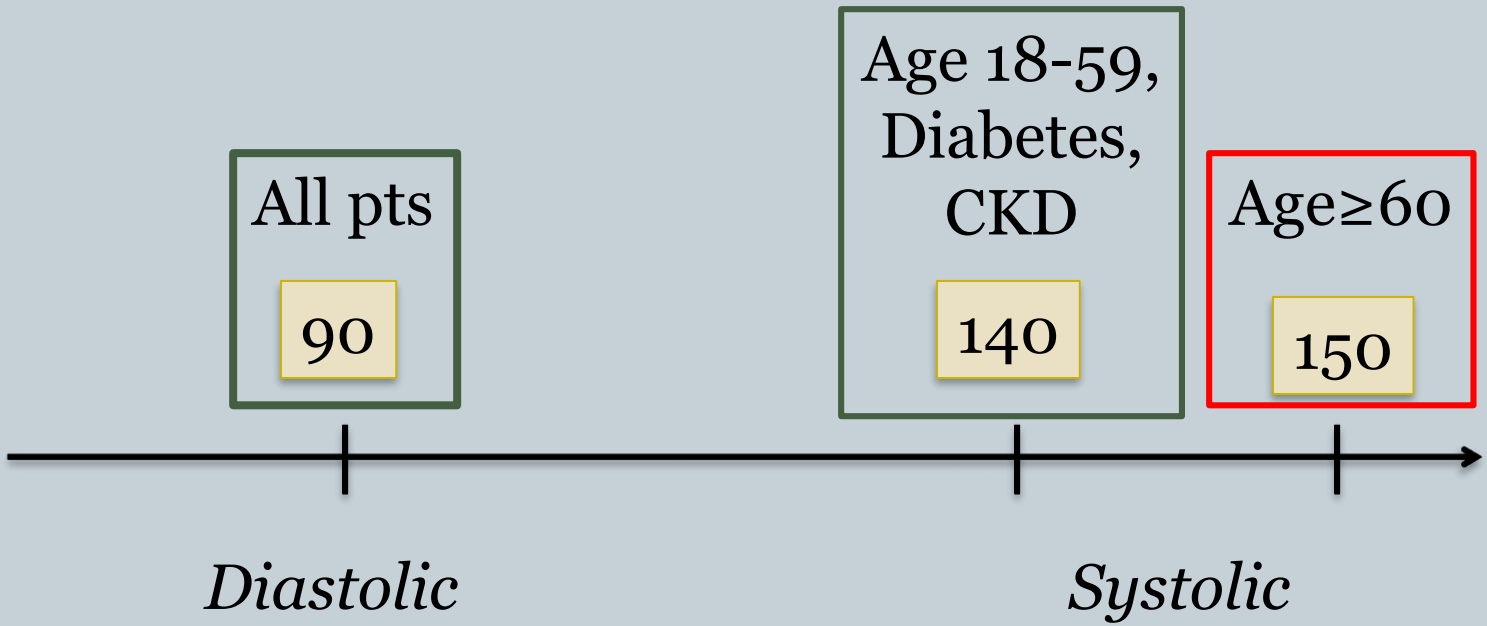
How Did I Choose What I Chose?

- Essential Evidence
- Journal Watch
- Our Faculty
- “Top of 2016” Lists

- Prioritized:
  - key areas of FM practice
  - might directly change clinical practice
  - might be leading to paradigm changes
  - Fun

The Blood Pressure Saga Continues

Reminder: JNC8 BP Goals (2014)



(*JNC8 was based largely on RCT data*)

2014-15

ADVANCE BP Trial: patients with DM

- no difference if SBP 120 or 140 (2014, NEJM)

SPRINT BP Trial: patients ***without*** DM, but with high CVD risk

- benefit for systolic 120 (2015, NEJM)

The NEW ENGLAND JOURNAL of MEDICINE

New BMJ Study: BP Goals for DM

Meta-analysis: studies stratified by average ***baseline*** SBP, see if goal <140 helps if…"

- Pt baseline SBP >140
- Pt baseline SBP <140

Brunstrom M, Carlberg B. Effect of antihypertensive treatment at different blood pressure levels in patients with diabetes mellitus: systematic review and meta-analyses. BMJ 2016;352:i717

Outcomes by baseline BP

49 studies

73,738 patients (most with type 2 DM)

<u>baseline BP > 140-150</u>

- treatment decreased all-cause mortality a little (relative risk [RR] 0.88; 95% CI 0.78 - 0.98 and RR 0.89; 0.88 - 0.99)
- CV mortality, MI risk, and development of ESRD decreased by 15% to 25%

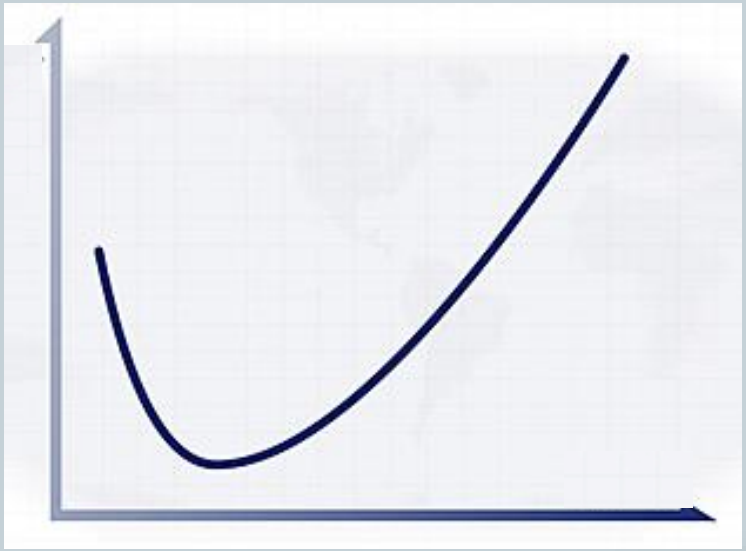
<u>Baseline BP <140</u>

- further treatment did not decrease all-cause mortality
- significant increase in the risk of CV mortality (RR 1.15; 1.00 - 1.32)

BMJ
British Medical Journal

New BMJ Study: BP Goals for DM

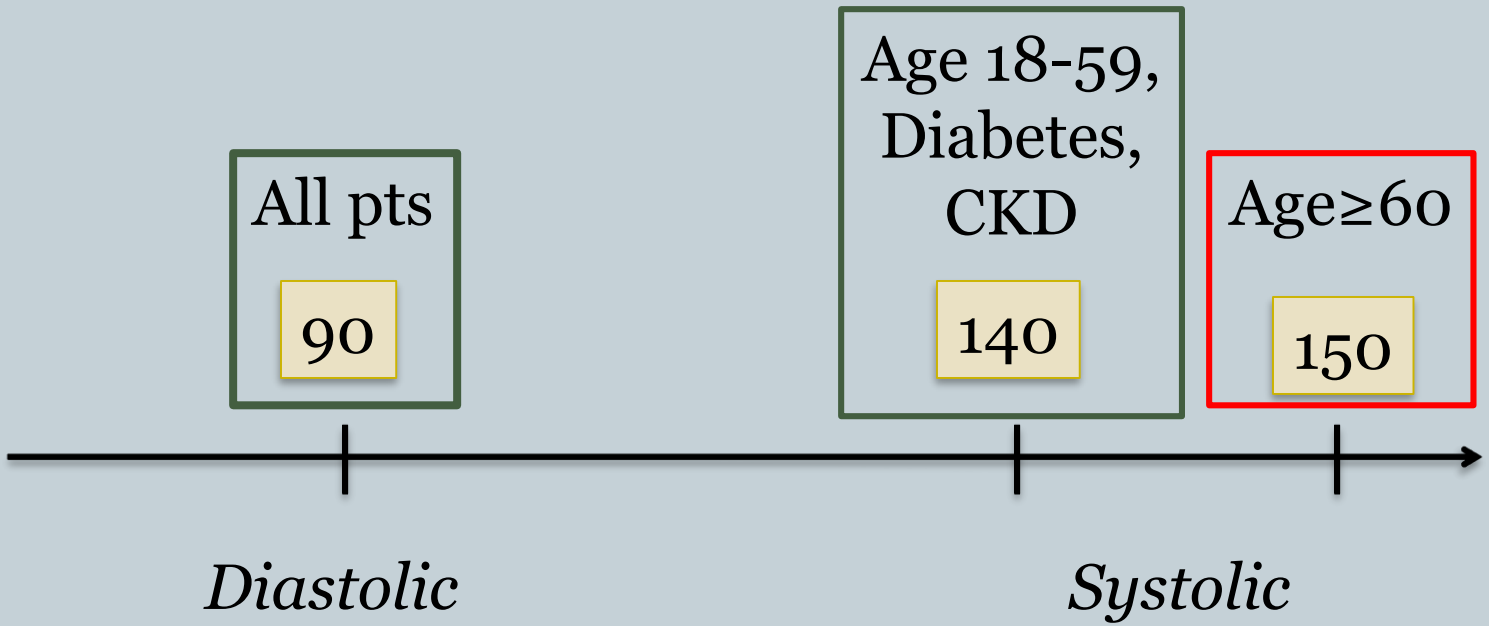
Take home: try to get diabetics <140 systolic.



Brunstrom M, Carlberg B. Effect of antihypertensive treatment at different blood pressure levels in patients with diabetes mellitus: systematic review and meta-analyses. BMJ 2016;352:i717

BMJ
British Medical Journal

Reminder: JNC8 BP Goals



(*JNC8 was based largely on RCT data*)

Subgroup analysis of adults >75 from SPRINT

- Excluded:
  - type 2 DM
  - CVA history
  - symptomatic HF in last 6 mo
  - LVEF <35%
  - Dementia
  - expected survival of <3 years
  - Nursing home residents
  - SBP <110 after 1 min of standing

Williamson JD, Supiano MA, Applegate WB, et al, for the SPRINT Research Group. Intensive vs standard blood pressure control and cardiovascular disease outcomes in adults aged equal to or greater than 75 years. A randomized trial. JAMA 2016 May 19. doi: 10.1001/jama.2016.7050

SPRINT

Table 1. Baseline Characteristics of Participants Aged 75 Years or Older

	Intensive Treatment (n = 1317)	Standard Treatment (n = 1319)
Female sex	499 (37.9)	501 (38.0)
Age, mean (SD), y	79.8 (3.9)	79.9 (4.1)
Race/ethnicity, No. (%)		
White	977 (74.2)	987 (74.8)
Black	225 (17.1)	226 (17.1)
Hispanic	89 (6.8)	85 (6.4)
Other	26 (2.0)	21 (1.6)

Composite Primary Outcomes
nonfatal MI, non-MI ACS, nonfatal CVA, decompensated HF, death from CV causes

Secondary Outcome
All-cause mortality was a secondary outcome.

Some Methods and Results

BP measurements: after 5 mins of "quiet rest" taken 3 times at least 1 min apart

- Intensive treatment: SBP target <120 (got to mean 123.4)
- Standard treatment: SBP target <140 (got to mean 134.8)
- Followed up after 3.14 years

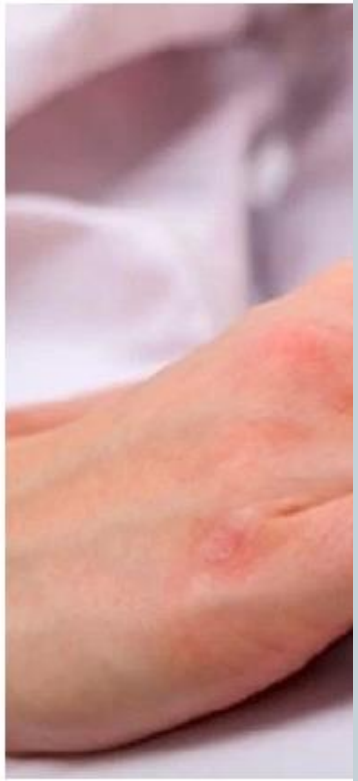
NNT to prevent primary composite outcome 27 (95% CI 19-61)

NNT for all-cause mortality: 41 (95% 27-145)

Absolute rate of "serious adverse events" (hypotension, syncope, electrolyte abnormalities, and acute kidney injury): all nonsignificantly increased

Even frail, older adults could benefit from intensive blood pressure reduction

January 3, 2017



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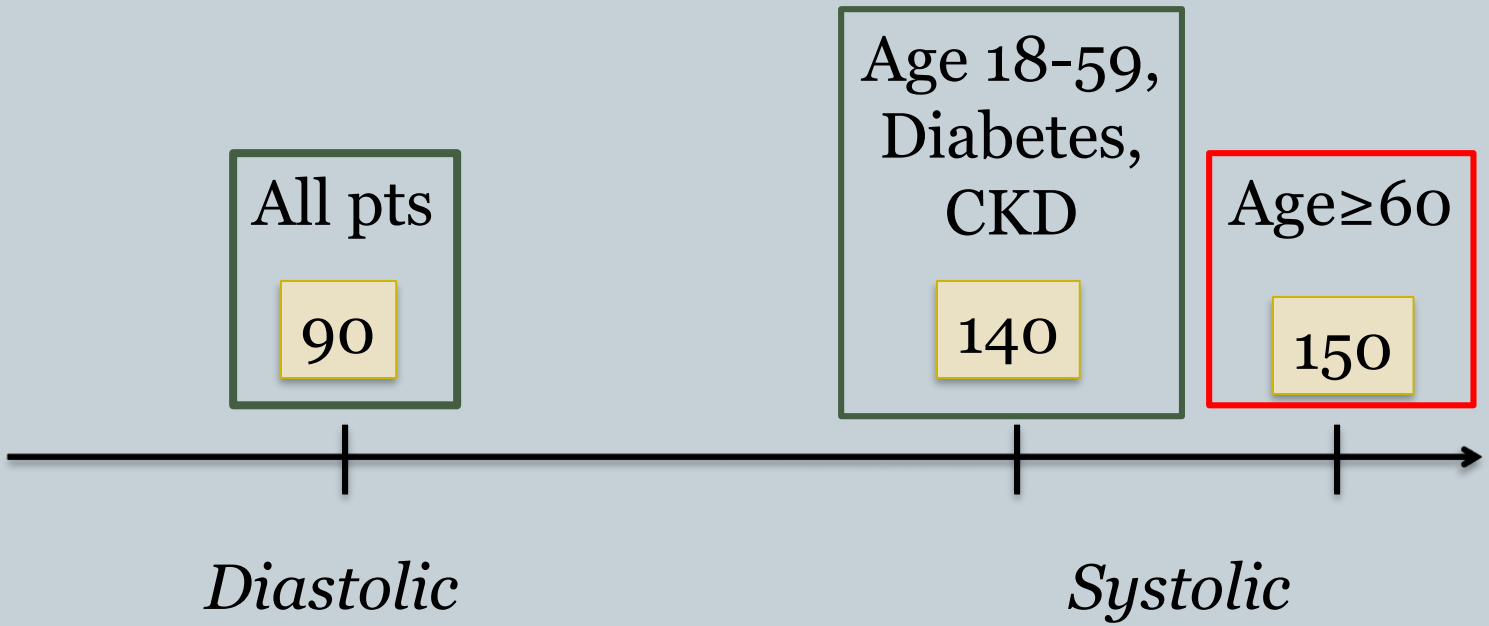
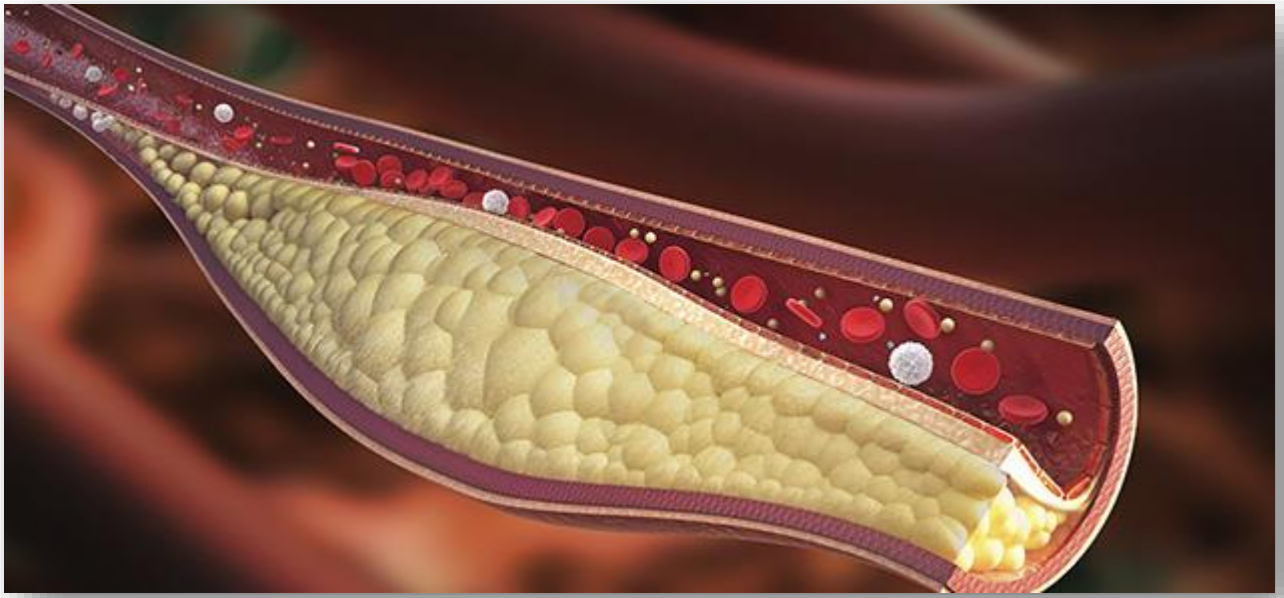
Reminder: JNC8 BP Goals

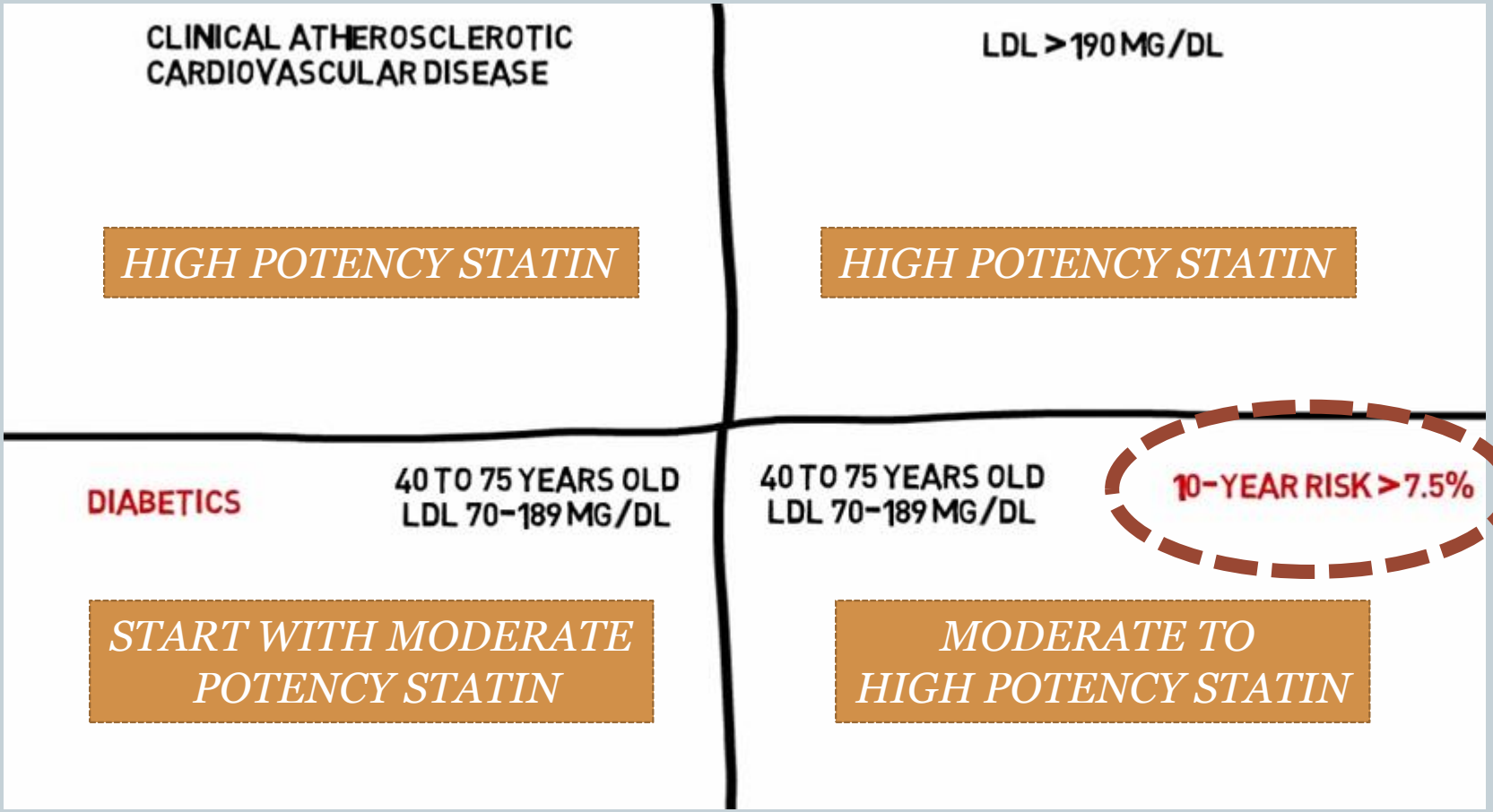


(*JNC8 was based largely on RCT data*)

The Cholesterol Story Also Continues



ACC/AHA Guidelines



USPSTP: Statins for Primary Prevention

<u>B Recommendation</u>

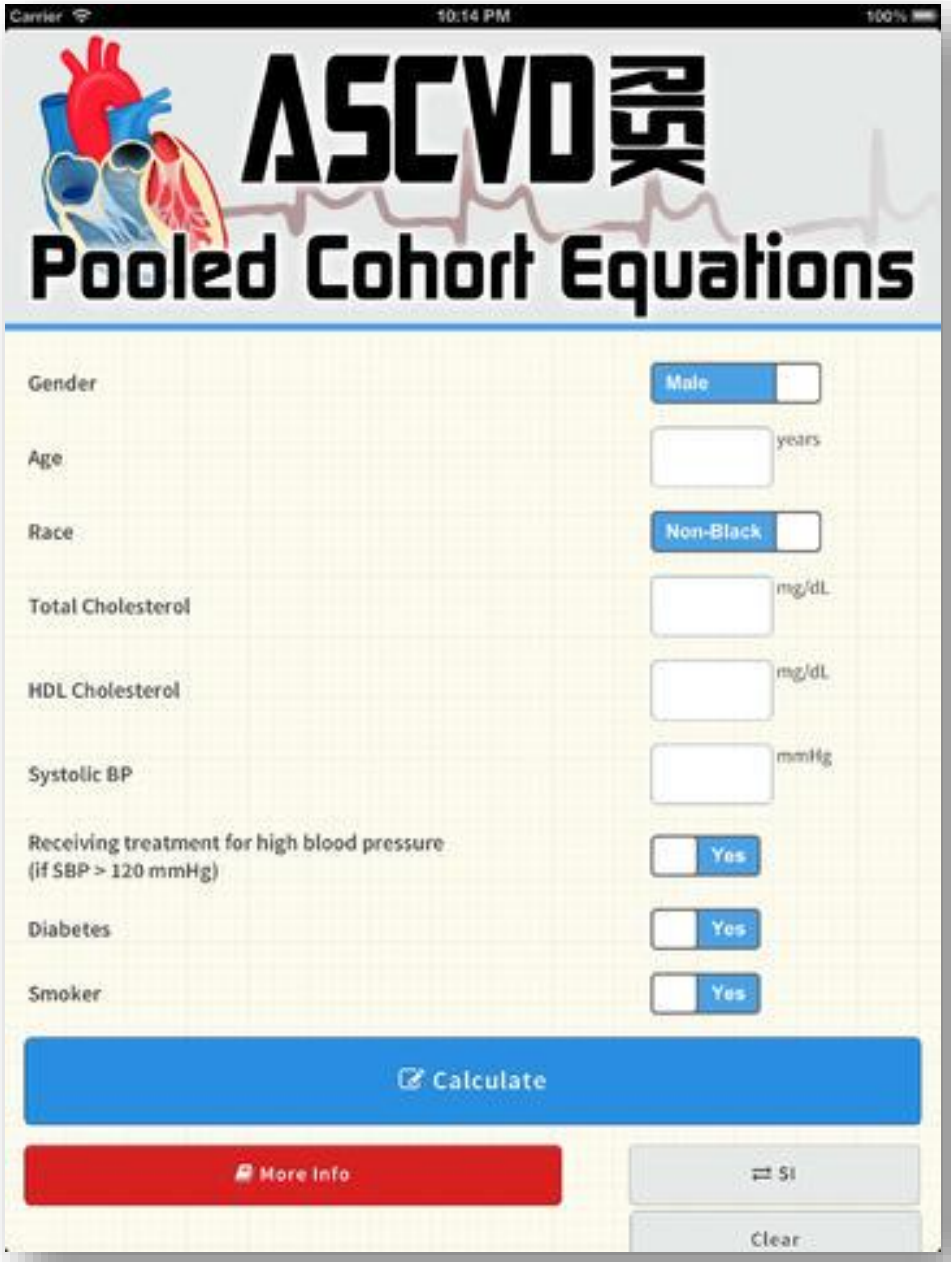
- 40 to 75 years old
- ≥1 CVD risk factor (ie, dyslipidemia, diabetes, hypertension, or smoking)
- calculated 10-year risk of CVD event of **≥10%** or greater

<u>C recommendation</u>

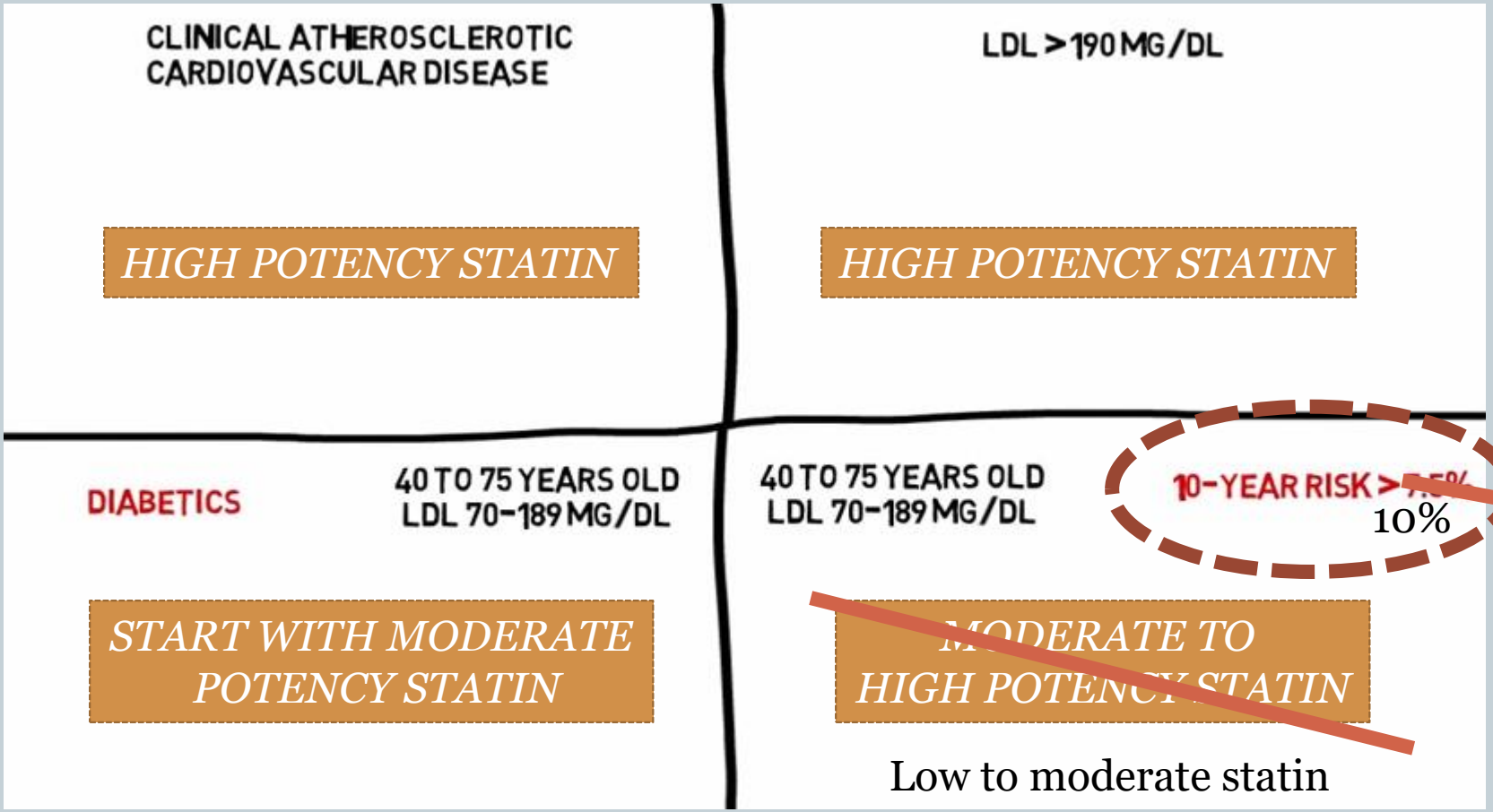
- 40 to 70 years old
- ≥1 CVD risk factor and 10-year CVD event risk **7.5%-10%**

(Insufficient evidence for 76+)

Bibbins-Domingo K; US Preventive Services Task Force. Statin use for the primary prevention of cardiovascular disease in adults. US Preventive Services Task Force recommendation statement. JAMA 2016;316(19):1997-2007.


Carrier
10:14 PM
100%
ASCVD Risk
Pooled Cohort Equations
Gender
Male
Age
years
Race
Non-Black
Total Cholesterol
mg/dL
HDL Cholesterol
mg/dL
Systolic BP
mmHg
Receiving treatment for high blood pressure
(if SBP > 120 mmHg)
Yes
Diabetes
Yes
Smoker
Yes
Calculate
More Info
SI
Clear

ACC/AHA Guidelines



Statin Therapy Intensity

High-Intensity	Moderate-Intensity	Low-Intensity
LDL-C reduction >50%	LDL-C 30%-<50%	LDL-C Reduction <30%
Atorvastatin (40)-80 mg **Rosuvastatin 20 (40) mg**	**Atorvastatin 10 (20) mg** **Rosuvastatin (5) 10mg** **Simvastatin 20-40 mg** **Pravastatin 40 (80) mg** **Lovastatin 40 mg** Fluvastatin XL 80mg **Fluvastatin 40mg BID** Pitavastatin 2-4mg	Simvastatin 10mg **Pravastatin 10-20 mg** **Lovastatin 20mg** Fluvastatin 20-40 mg Pitavastatin 1 mg

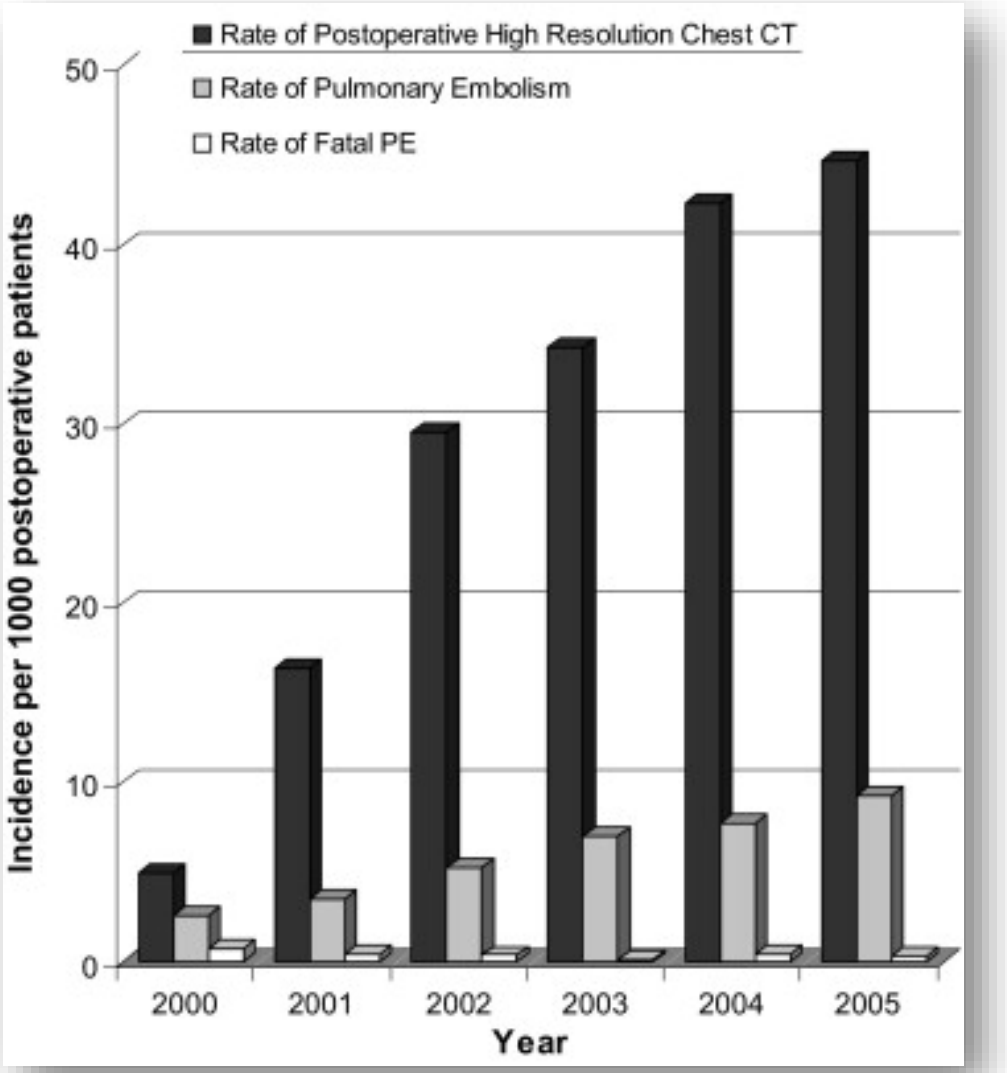
Stone et al. JACC 2013.

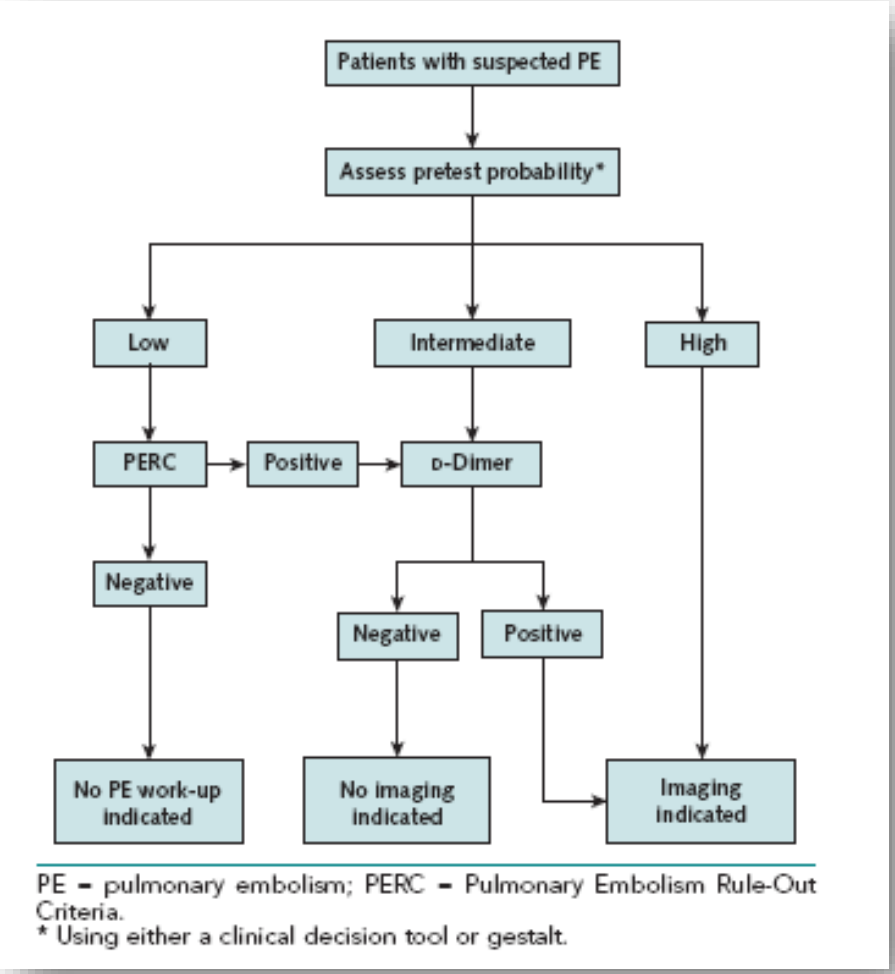
VTE

New VTE guidelines

- DOACs are suggested over warfarin for initial and long-term treatment of VTE in patients without cancer
- Routine use of compression stockings is *out* (for preventing post-thrombotic syndrome in acute DVT)
- Some patients with isolated subsegmental pulmonary embolism but no DVT don't need treatment

Kearon C, Akl EA, Ornelas J, et al. Antithrombotic therapy for VTE disease: CHEST guideline and expert panel report. Chest 2016;149(2):315-352.


Rate of Postoperative High Resolution Chest CT
Rate of Pulmonary Embolism
Rate of Fatal PE
Incidence per 1000 postoperative patients
50
40
30
20
10
0
2000
2001
2002
2003
2004
2005
Year



PE = pulmonary embolism; PERC = Pulmonary Embolism Rule-Out Criteria.
* Using either a clinical decision tool or gestalt.

WELLS Score (PE)

• Clinical signs and symptoms compatible with DVT	3
• PE judged to be the most likely diagnosis	3
• Surgery or bedridden for more than 3 days during past 4 weeks	1.5
• Previous DVT or PE	1.5
• Heart rate > 100 min^{-1}	1.5
• Hemoptysis	1
• Active cancer (treatment ongoing or within previous 6 months, or palliative treatment)	1

≤ 4 : LOW (or "PE Unlikely") pretest probability
4.5 - 6 : MODERATE pretest probability
>6 : HIGH pretest probability

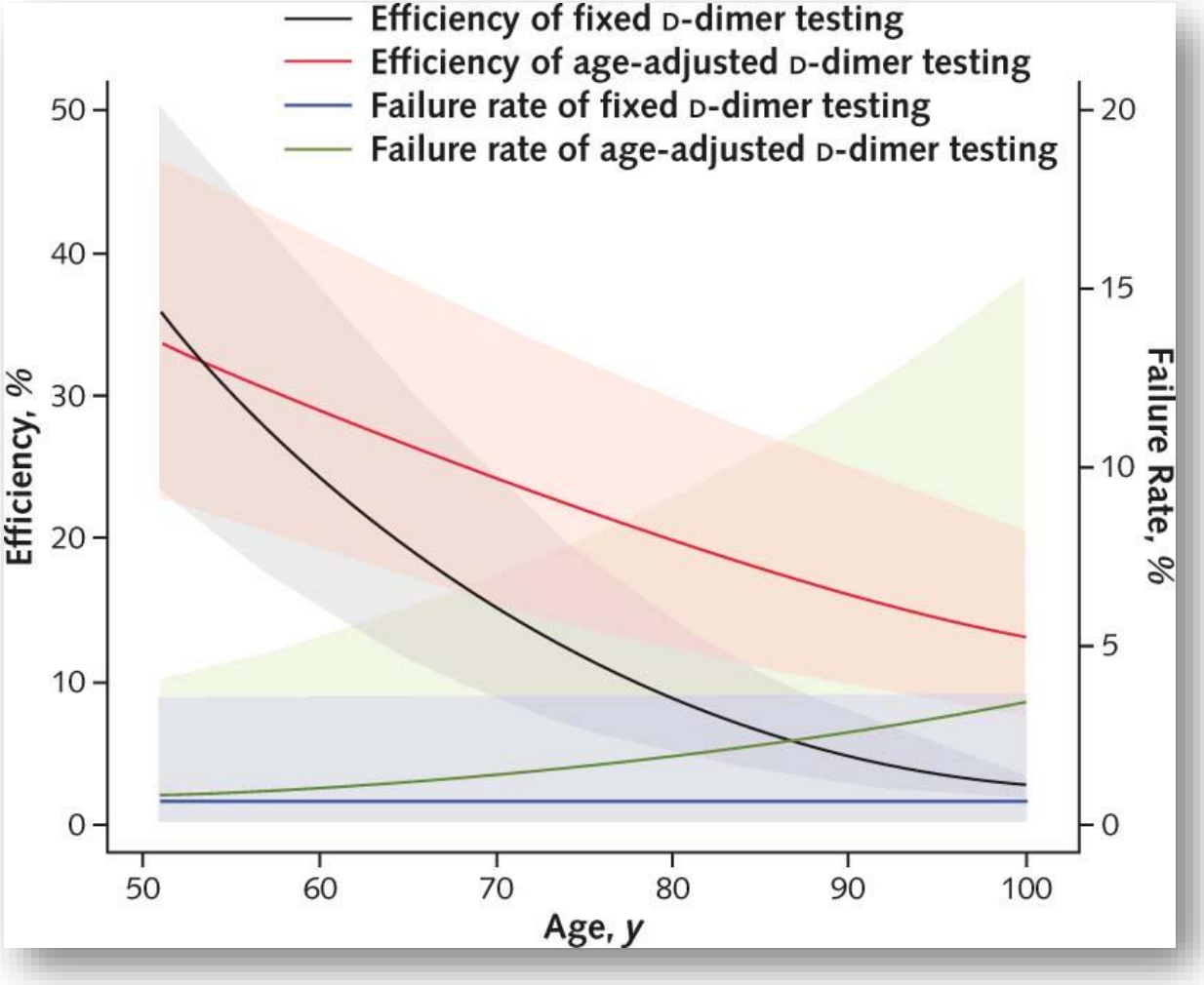
Wells PS, et al. Thromb Haemost 2000; 83: 416-20
Kearon C, et al. Ann Intern Med 2006; 144: 812-21

Pulmonary Embolism Rule-Out Criteria

Variable
Age <50 years
Pulse <100 beats per minute
SaO_2 ≥95% on room air
No hemoptysis
No exogenous estrogen use
No prior venous thromboembolism
No surgery or trauma requiring hospitalization within the past 4 weeks
No unilateral leg swelling

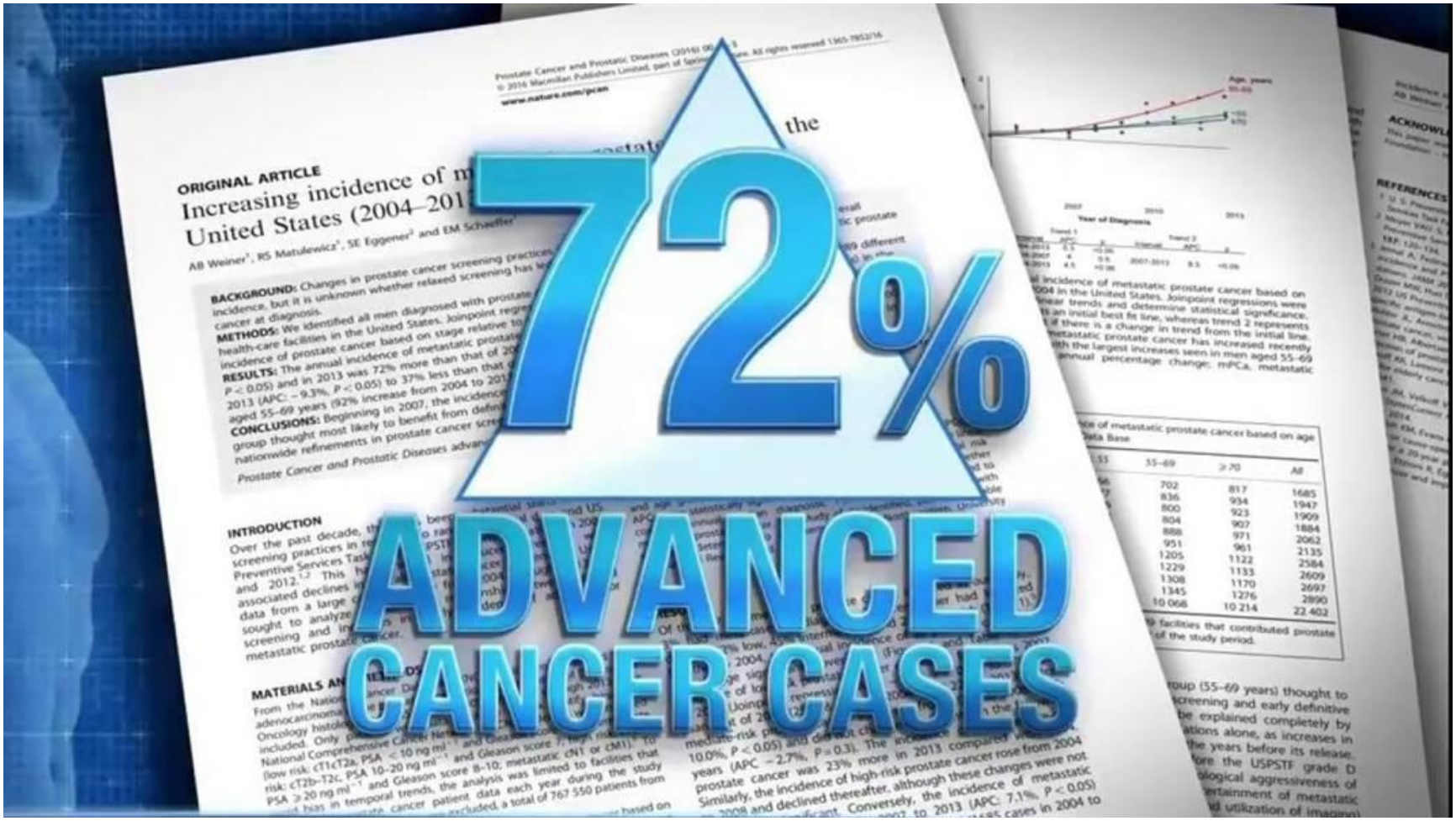
Journal WATCH

(neg PERC = no for all)



Van Es N, Van der Hulle T, Van Es J, et al. Wells rule and d-dimer testing to rule out pulmonary embolism. Ann Intern Med 2016;165(4):253-261.

Prostate CA



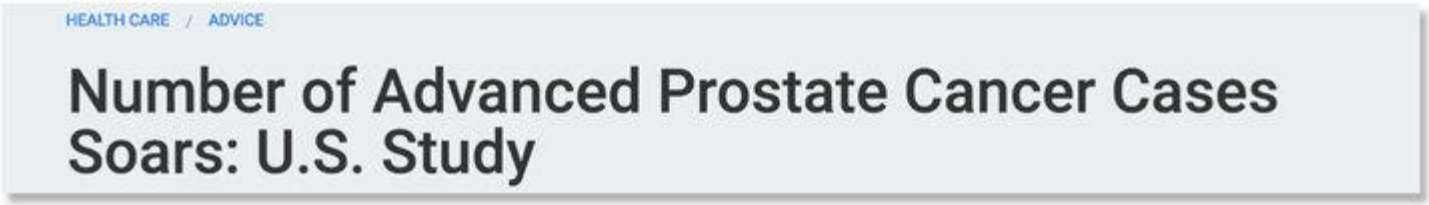
Weiner AB, et al. Increasing incidence of metastatic prostate cancer in the United States (2004–2013). Prostate Cancer and Prostatic Disease (2016) 19, 395–397; doi:10.1038/pcan.2016.30; published online 19 July 2016

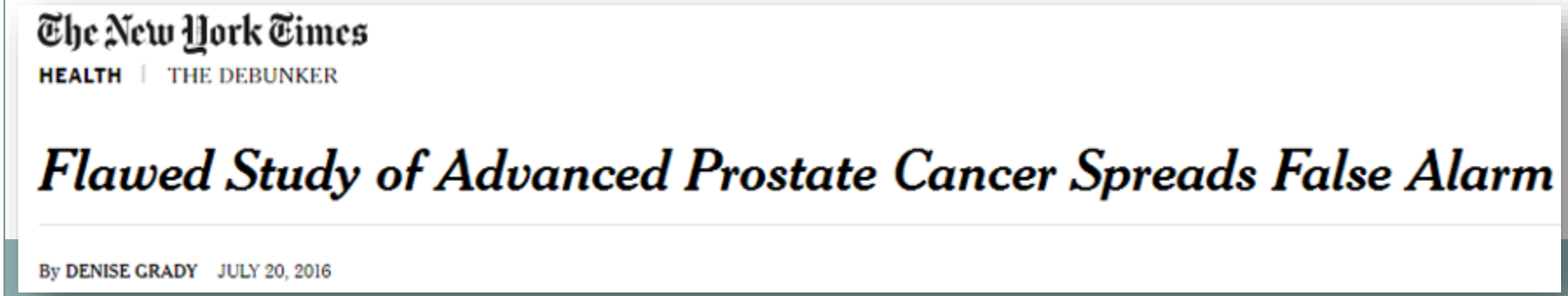

HEALTH › MEN'S HEALTH
HEALTH CARE DIET & FITNESS MENTAL HEALTH WOMEN'S HEALTH
HEALTH
JUL 19 2016, 5:54 PM ET
Cases of Aggressive Prostate Cancer on the Rise, Research Finds

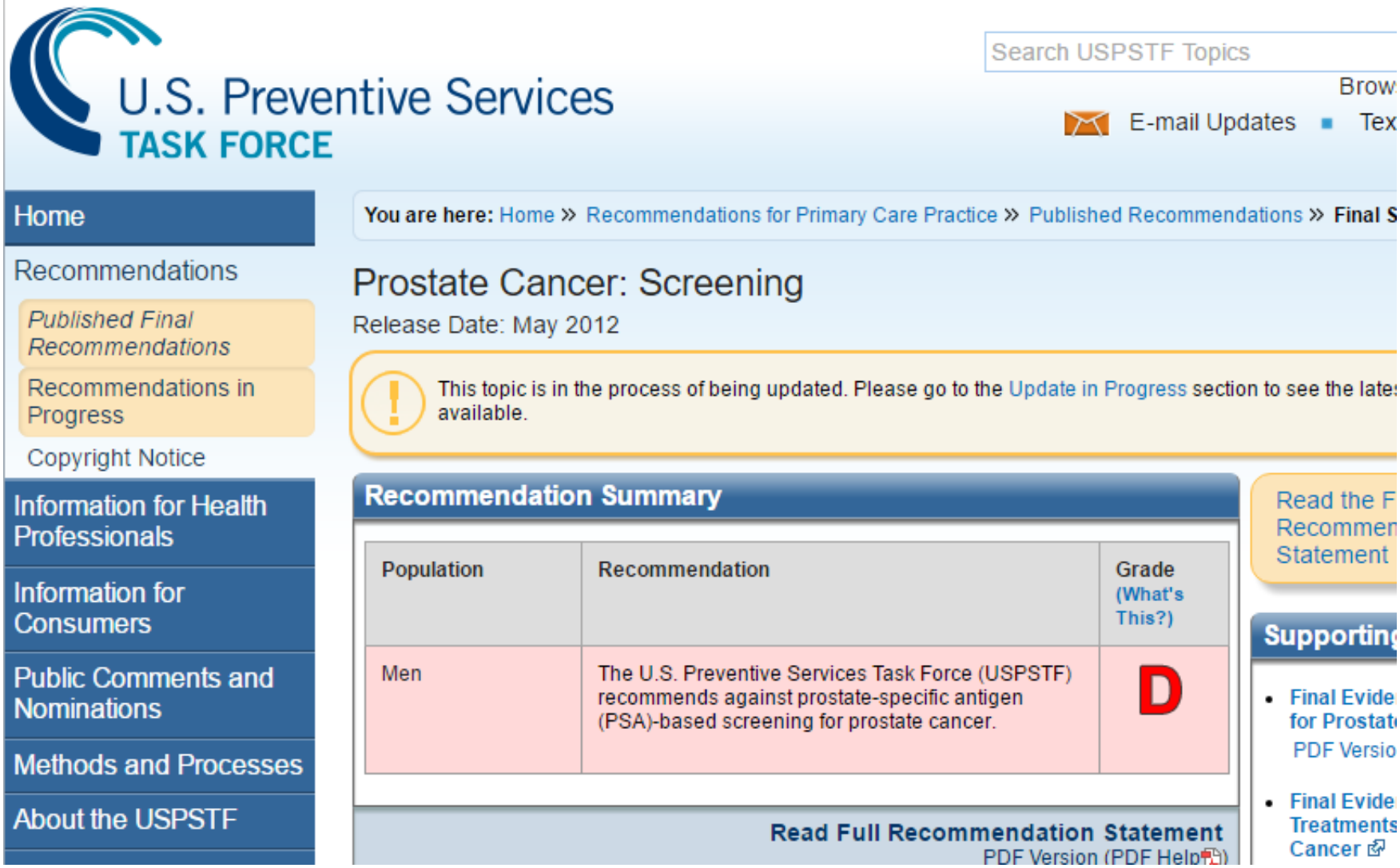

Health Home
Men's Health
Women's Health
Children's Health
Alternative Medicine
Diabetes
Heart Health
Nutrition & Fitness
PROSTATE CANCER
Metastatic prostate cancer cases rising, study finds


Health – Health & Science
Metastatic prostate cancer cases surge, adding to screening controversy


HOME / HEALTH NEWS
Metastatic prostate cancer rate skyrockets in last decade
Patients are being diagnosed later with worse metastatic disease, which cannot be cured with treatment, researchers say.


HEALTH CARE / ADVICE
Number of Advanced Prostate Cancer Cases Soars: U.S. Study


The New York Times
HEALTH | THE DEBUNKER
Flawed Study of Advanced Prostate Cancer Spreads False Alarm
By DENISE GRADY JULY 20, 2016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About the USPSTF
You are here: Home » Recommendations for Primary Care Practice » Published Recommendations » Final S
Prostate Cancer: Screening
Release Date: May 2012
This topic is in the process of being updated. Please go to the Update in Progress section to see the late
available.
Recommendation Summary
Population
Recommendation
Grade (What's This?)
Men
The U.S. Preventive Services Task Force (USPSTF) recommends against prostate-specific antigen (PSA)-based screening for prostate cancer.
D
Read Full Recommendation Statement
PDF Version (PDF Help)
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Recommen
Statement
Supportin
Final Evide
for Prostat
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Final Evide
Treatments
Cancer

Otis W. Brawley, M.D.

In the study, the doctors examined the records of 767,550 men with prostate cancer diagnosed from 2004 to 2013. Using the number of cases of metastatic disease in 2004 (1,685) and 2013 (2,890), they reported an alarming increase of 72 percent.

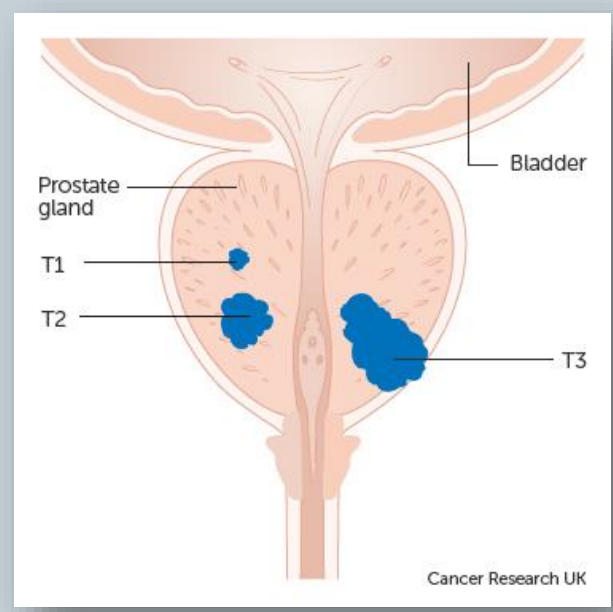
But for the United States population, that percentage could be meaningless. On the cancer society website, Dr. Brawley said that to measure whether a disease was becoming more common, researchers could not rely on just the absolute number of cases. They need to calculate rates, meaning the number of cases per a certain number of people.

"Epidemiologists learned long ago that you can't simply look at raw numbers," he wrote. "A rising number of cases can be due simply to a growing and aging population among other factors."

American Cancer Society®

Localized Prostate Cancer: Active Surveillance

- Clinically localized prostate cancer: confined to the prostate gland)
- 82,429 British men 50 to 69 years got PSA
- 2664 had grade T1c or T2 cancer, 1643 participated



Hamdy FC, Donovan JL, Lane JA, et al, for the ProtecT Study Group. 10-Year outcomes after monitoring, surgery, or radiotherapy for localized prostate cancer. N Engl J Med 2016;375(15):1415-1424.

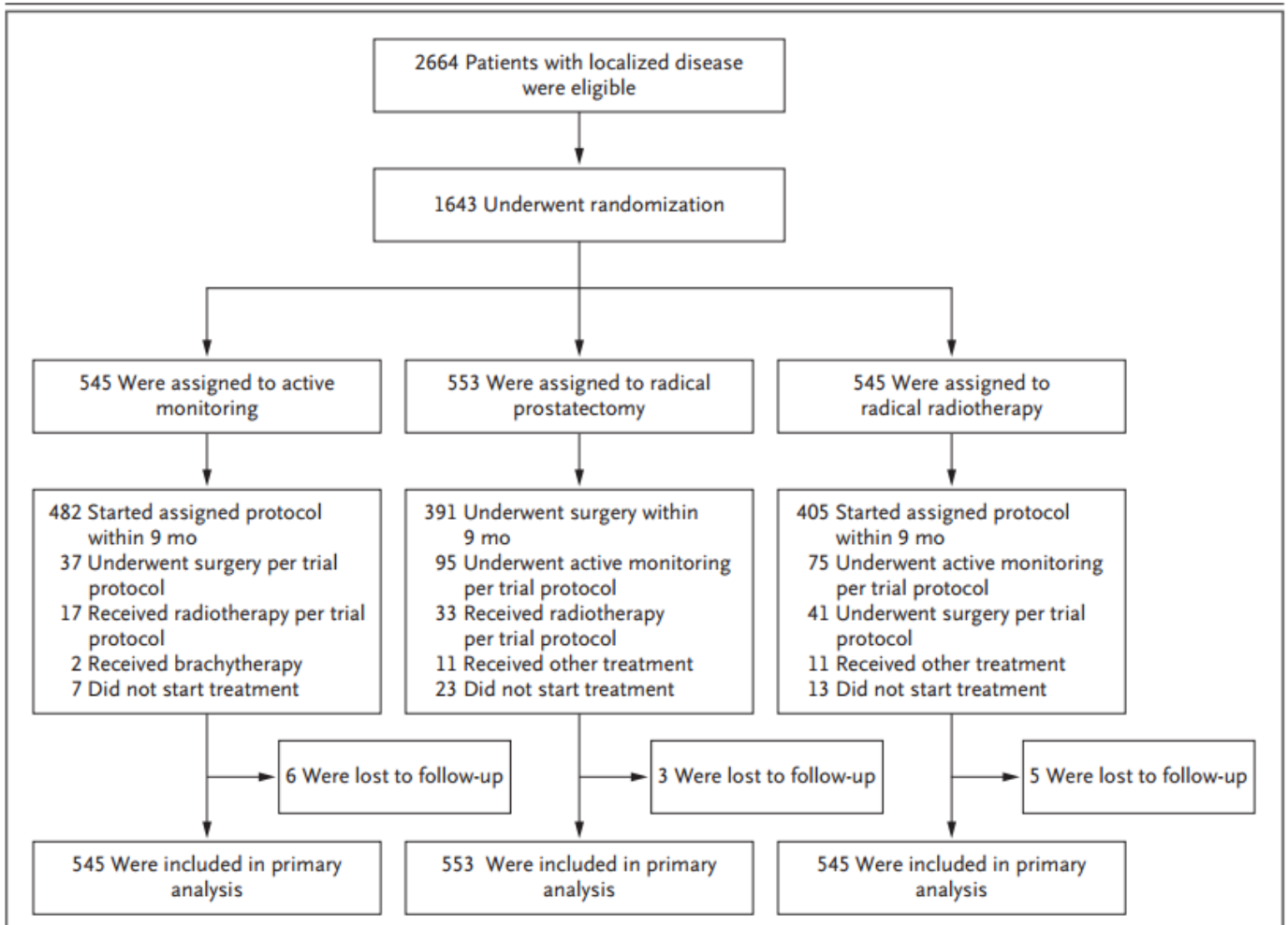


Figure 1. Randomization, Treatment, and Follow-up.

A total of 88% of the men assigned to active monitoring, 71% of the men assigned to surgery, and 74% of men assigned to radiotherapy received the assigned treatment within 9 months after randomization. A total of 14 patients were lost to follow-up for secondary outcomes, but data on deaths were captured for all participants.

Definition of AS and Results

- Active Surveillance: frequent PSA tests (q 3 months year, and q6-12 months). Rise of 50% or more triggers eval for possible biopsy/treatment if indicated.
- No difference between groups in mortality due to:
  - prostate cancer
  - prostate cancer–specific survival at 5 or 10 years
  - all-cause mortality.

Other Outcomes

- Greater likelihood of developing metastatic disease in the AS group: ~ 3 more metastatic cancers detected/1000 person-years than in the surgery or radiotherapy groups (P = .004)
- Clinical progression more common in the AS group: ~13 additional patients progressing per 1000 person-years
- Much better outcomes in AS for erectile dysfunction and incontinence

Table 1. Prostate-Cancer Mortality, Incidence of Clinical Progression and Metastatic Disease, and All-Cause Mortality, According to Randomized Treatment Group.

Variable	Active Monitoring (N=545)	Surgery (N=553)	Radiotherapy (N=545)	P Value*
Prostate-cancer mortality				
Total person-yr in follow-up	5393	5422	5339	
No. of deaths due to prostate cancer†	8	5	4	
Prostate-cancer–specific survival — % (95% CI)†				
At 5 yr	99.4 (98.3–99.8)	100	100	
At 10 yr	98.8 (97.4–99.5)	99.0 (97.2–99.6)	99.6 (98.4–99.9)	
Prostate-cancer deaths per 1000 person-yr (95% CI)†	1.5 (0.7–3.0)	0.9 (0.4–2.2)	0.7 (0.3–2.0)	0.48
Incidence of clinical progression‡				
Person-yr of follow-up free of clinical progression	4893	5174	5138	
No. of men with clinical progression	112	46	46	
Clinical progression per 1000 person-yr (95% CI)	22.9 (19.0–27.5)	8.9 (6.7–11.9)	9.0 (6.7–12.0)	<0.001
Incidence of metastatic disease				
Person-yr of follow-up free of metastatic disease	5268	5377	5286	
No. of men with metastatic disease	33	13	16	
Metastatic disease per 1000 person-yr (95% CI)	6.3 (4.5–8.8)	2.4 (1.4–4.2)	3.0 (1.9–4.9)	0.004
All-cause mortality				
Total person-yr in follow-up	5393	5422	5339	
No. of deaths due to any cause	59	55	55	
All-cause deaths per 1000 person-yr (95% CI)	10.9 (8.5–14.1)	10.1 (7.8–13.2)	10.3 (7.9–13.4)	0.87

* P values were calculated with the use of a log-rank test of the null hypothesis of no difference in effectiveness across the three treatments. The planned adjusted analysis was not possible owing to the low number of events.

† Deaths due to prostate cancer were defined as deaths that were definitely or probably due to prostate cancer or its treatment, as determined by the independent cause-of-death evaluation committee.

‡ Disease progression was defined as death due to prostate cancer or its treatment; evidence of metastatic disease; long-term androgen-deprivation therapy; clinical T3 or T4 disease; and ureteric obstruction, rectal fistula, or the need for a permanent catheter when these are not considered to be a complication of treatment.

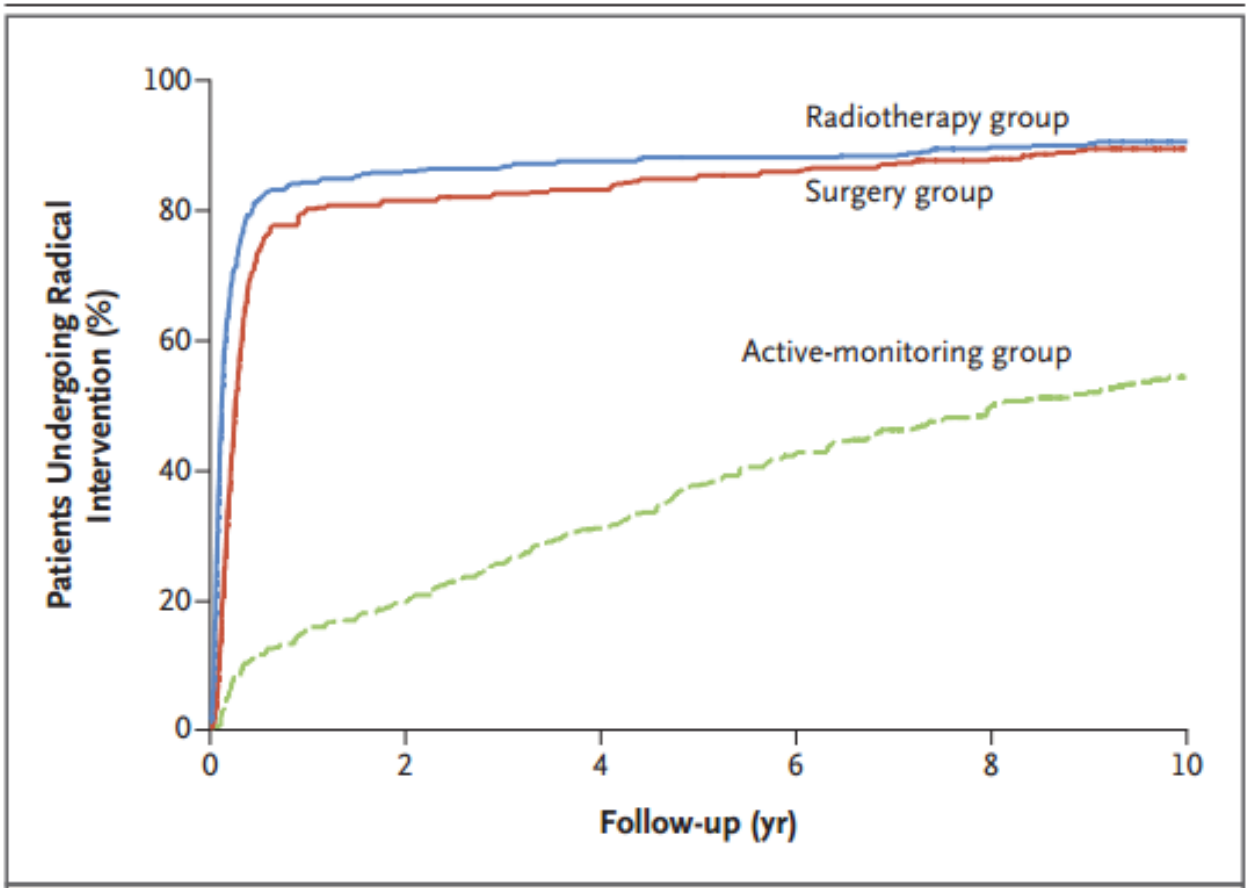


Figure 2. Kaplan–Meier Estimates of the Cumulative Probability of Undergoing Radical Intervention during the Follow-up Period, According to Treatment Group.

Radical intervention was defined as radical prostatectomy, per-protocol radiotherapy, nonprotocol radiotherapy (including brachytherapy), or high-intensity focused ultrasound therapy.

Localized Prostate Cancer: Perceptions

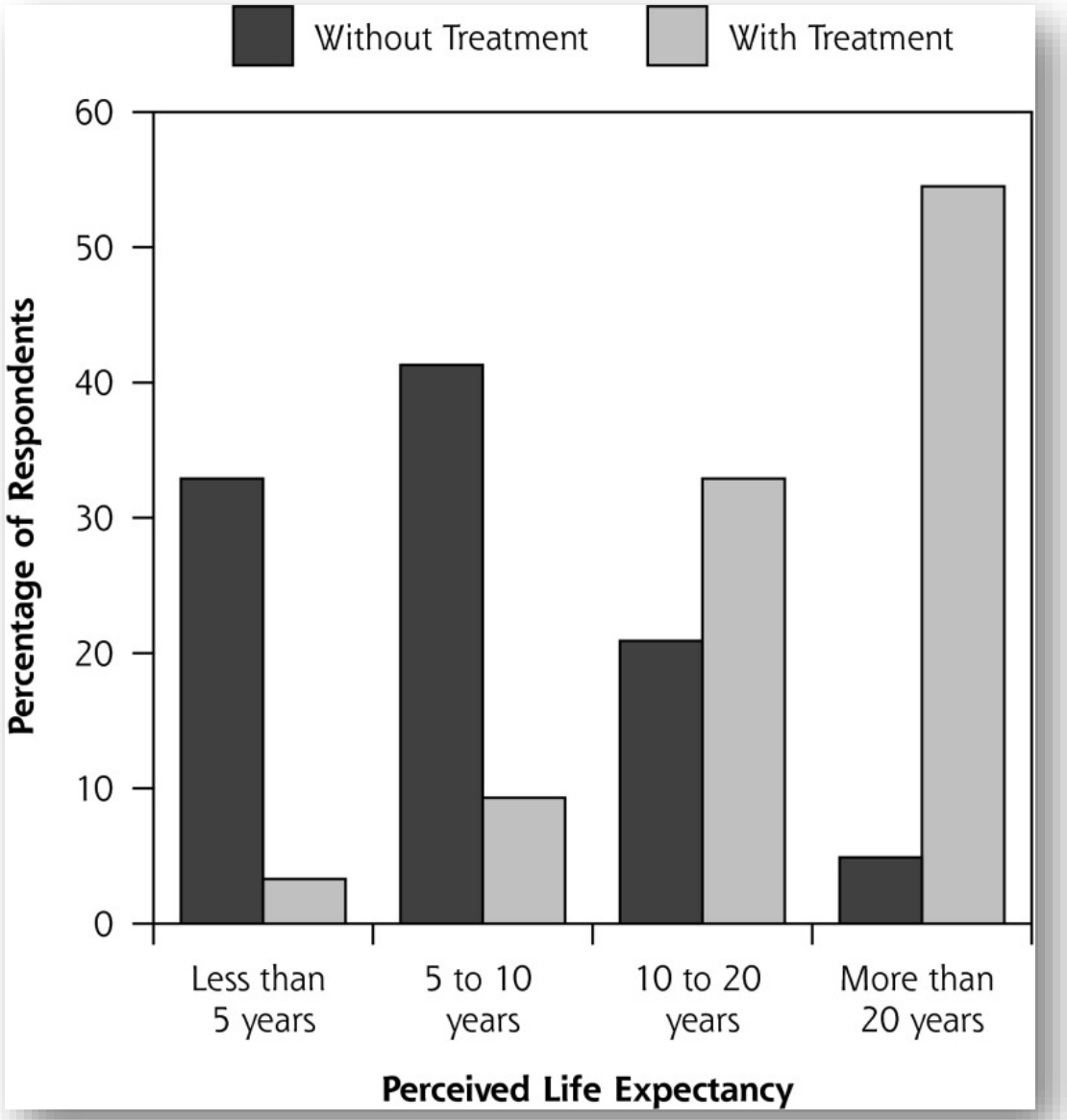
Localized Prostate Cancer: Perceptions

Metropolitan Detroit Cancer Surveillance System: 118 black men, 119 white men <75 years old with localized prostate cancer, asked:

1. *"How long do you expect you would live without any treatment for your prostate cancer?“*
2. *"How long do you expect you would live with your treatment of choice for your prostate cancer?"*

Xu J, Janisse J, Ruterbusch JJ, et al. Patients' survival expectations with and without their chosen treatment for prostate cancer. Ann Fam Med.2016;14(3):208-214.

ANNALS OF FAMILY MEDICINE



ANNALS OF FAMILY MEDICINE

Reality…

Only 25% of all patients in this study expected to live more than 10 years

Actual Data:

- More than 95% of patients with localized prostate cancer live beyond 10 years after diagnosis
- Between 86% and 98% of men diagnosed with localized prostate cancer will not die from their cancer

Quicker Summaries

Pediatrics

1. Exclusively formula-fed infants: larger bottles (≥180 mL or 6 oz) for infants at 2 months of age associated with greater weight gain at 6 months of age (prelim prospective cohort study)

Wood CT, Skinner AC, Yin HS, et al. Bottle size and weight gain in formula-fed infants. Pediatrics 2016;138(1):e20154538.

2. Dilute apple juice (cheap) effective in mild to moderate gastroenteritis for kids 6 mo to 6 years

K, Schuh S. Effect of dilute apple juice and preferred fluids vs. electrolyte maintenance solution on treatment failure among children with mild gastroenteritis. A randomized clinical trial. JAMA 2016:315(18):1966-1974.

Infant Sleep Guidelines

Infant Sleep Guidelines

1. Share a bedroom with parents, but not the same sleeping surface, preferably until the baby turns 1 but at least for the first six months
2. Place baby on his/her back on a firm sleep surface (crib or bassinet) with tight-fitting sheet
3. The crib should be bare: avoid soft bedding, crib bumpers, blankets, pillows and soft toys
4. Avoid exposure to smoke, alcohol and illicit drugs.

Moon RY, SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment. Pediatrics. 2016 Nov;138(5). pii: e20162940

DM Care: Are We Getting Better?

From 2006 to 2013, usage of:

- Metformin increased from 47.6 to 53.5%
- DPP-4 inhibitors increased (0.5 to 14.9%)
- Insulin increased (17.1 to 23.0%)
- Sulfonylureas decreased (38.8 to 30.8%)
- thiazolidinediones decreased (28.5 to 5.6%)

Lipska KJ. Trends in Drug Utilization, Glycemic Control, and Rates of Severe Hypoglycemia, 2006-2013.Diabetes Care. 2016 Sep 22. pii: dc160985

DM Care: Are We Getting Better?

Also from 2006 to 2013:

- Proportion of patients with HbA_{1c} <7% declined (56.4 to 54.2%)
- HbA_{1c} ≥9% increased (9.9 to 12.2%)
- The overall rate of severe hypoglycemia remained the same (1.3 per 100 person-years)

Lipska KJ. Trends in Drug Utilization, Glycemic Control, and Rates of Severe Hypoglycemia, 2006-2013.Diabetes Care. 2016 Sep 22. pii: dc160985

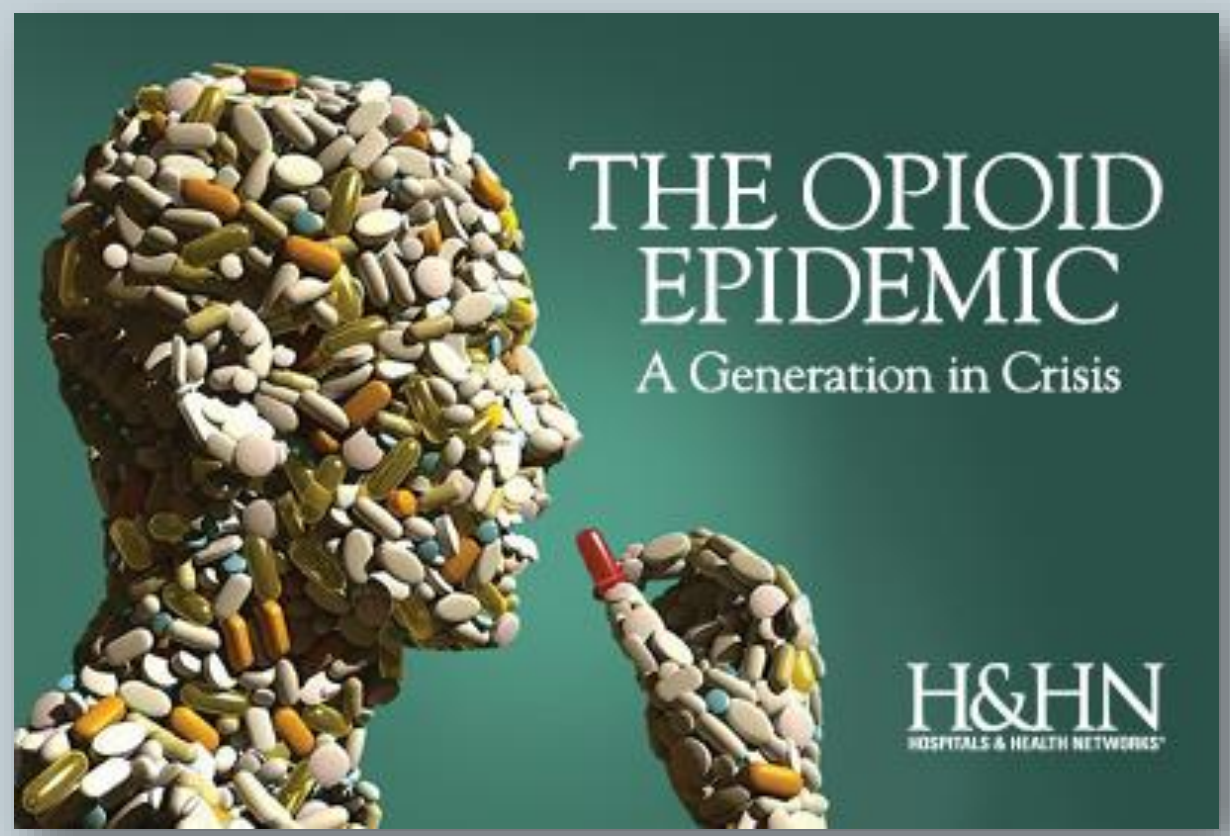
Diabetes Medication Developments

Liraglutide (Victoza), in patients with baseline high CV risk, after median of 3.5 years:

- primary composite outcome of CV death, nonfatal MI, nonfatal CVA less likely in the liraglutide group (13.0% vs 14.9%; P < .01; [NNT] = 53 for 3.5 years)
- reduction in all-cause mortality with liraglutide (8.2% vs 9.6%; P = .02; NNT = 71 for 3.5 years)

Marso SP, Daniels GH, Brown-Frandsen K, et al, for the LEADER Steering Committee and the LEADER Trial Investigators. Liraglutide and cardiovascular outcomes in type 2 diabetes. N Engl J Med 2016; 375(4):311-322.

Opioid Epidemic



Opioid Epidemic

- New CDC Guidelines

Dowell D, Haegerich T, Chou R. CDC guideline for prescribing opioids for chronic pain - United States, 2016. JAMA 2016;315(15):1624-1645.

- 91% of patients experiencing nonfatal opioid overdose continued to receive prescription opioids, and 7% had a repeat OD

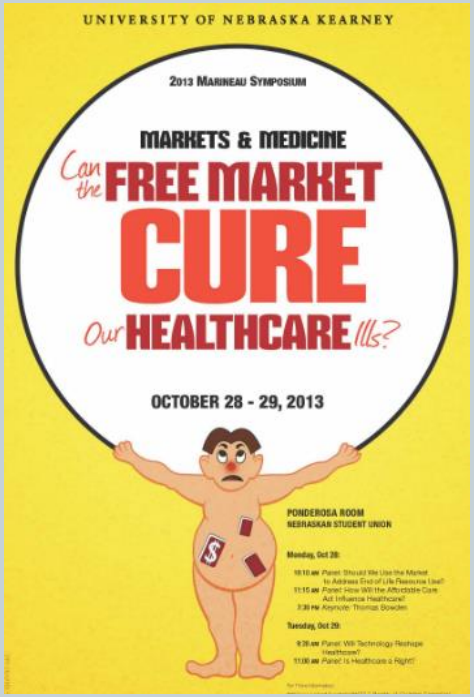
Larochelle MR. Ann Intern Med. 2016 Sep 6;165(5):376-7. doi: 10.7326/L16-0168. Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose.

- Chronic opioids: associated with small increased all-cause mortality: HR 1.64 (95% CI, 1.26-2.12) with a risk difference of 68.5 excess deaths (95% CI, 28.2-120.7) per 10,000 person-years

Ray, WA, et al. Prescription of Long-Acting Opioids and Mortality in Patients With Chronic Noncancer Pain. JAMA. 2016 Jun 14;315(22):2415-23. doi: 10.1001/jama.2016.7789.

Misc.

- Providing price information doesn't seem to change patient decisions, including out-of-pocket spending (outpatient)



Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association between availability of a price transparency tool and outpatient spending. JAMA 2016;315(17):1874-1881.

Misc.

Hypertensive Urgency: low major adverse CV event rate in short term:

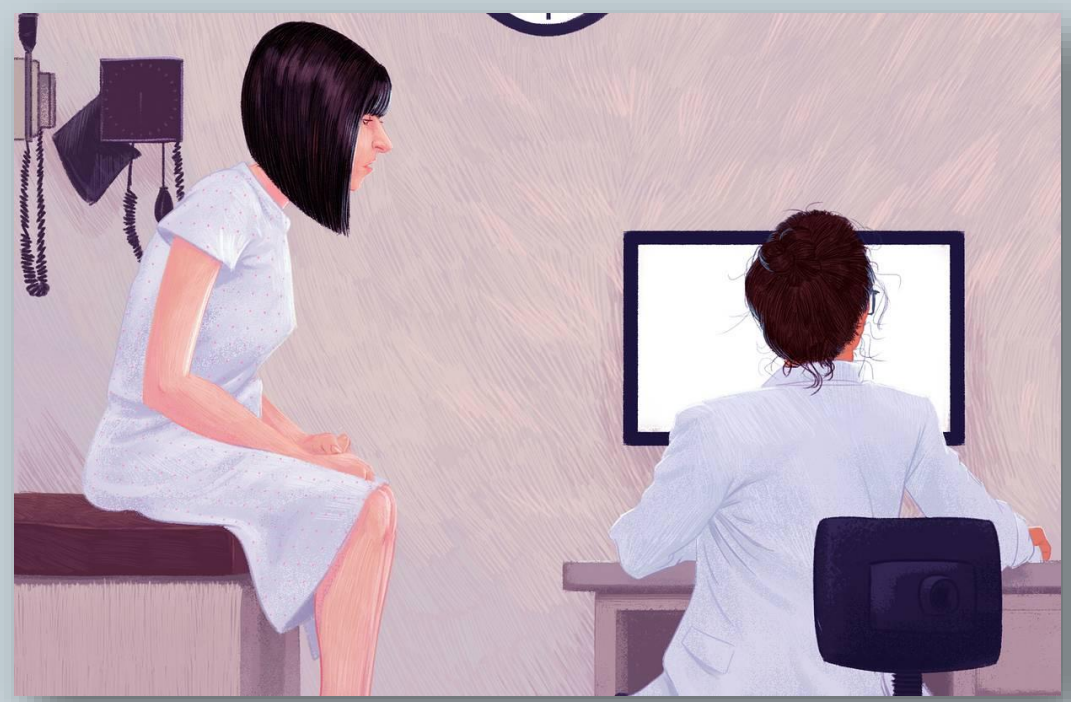
- 0.1% in 7 days
- 0.2% in 8-30 days
- 0.9% in 6 months
- Hospitalization didn't change outcomes

JAMA

Patel KK, Young L, Howell EH, et al. Characteristics and outcomes of patients presenting with hypertensive urgency in the office setting. JAMA Intern Med 2016;176(7):981-988.

Misc.

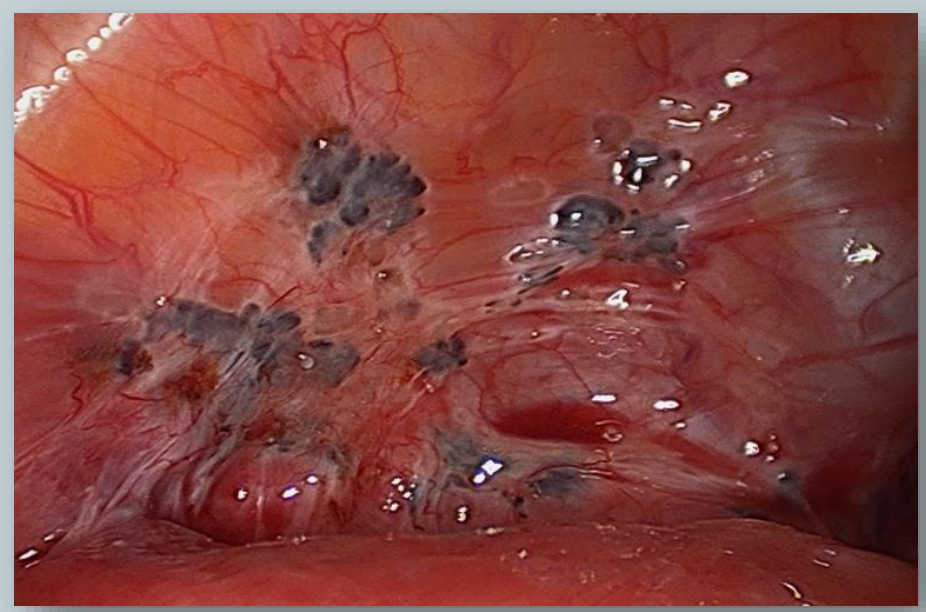
Physicians spend about 2 hours on EMR and desk work per hour of direct clinical (face-to-face) care



Sinsky C, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016 Dec 6;165(11):753-760. doi: 10.7326/M16-0961. Epub 2016 Sep 6.

Misc.

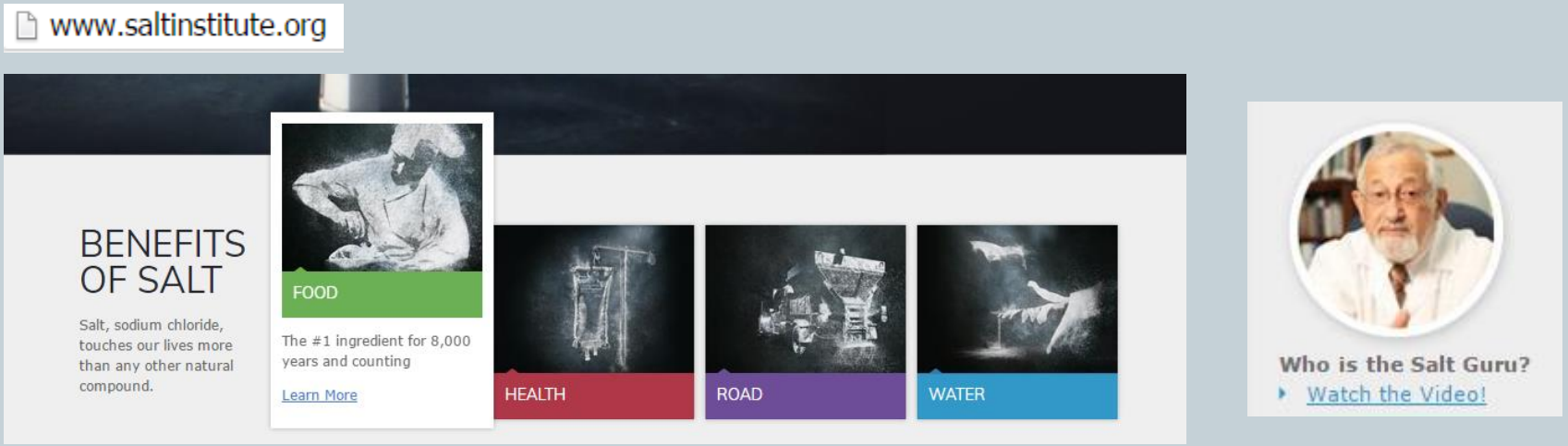
Role for CA125 in dx of endometriosis? For symptomatic women, pooled sensitivity was 52% and pooled specificity was 93% in a meta-analysis. (If test positive, pelvic US needed)



Hirsch M, Duffy J, Davis CJ, Plana MN, Khan KS, for the International Collaboration to Harmonise Outcomes and Measures for Endometriosis. Diagnostic accuracy of cancer antigen 125 for endometriosis: a systematic review and meta-analysis. BJOG 2016:123(11):1761-1768

Misc.

Evidence for long-term, direct relationship between sodium intake and mortality



NR Cook, LJ Appel, PK Whelton Sodium Intake and All-Cause Mortality Over 20 Years in the Trials of Hypertension Prevention. J Am Coll Cardiol; 2016 Oct 11; 68 (15)1609-1617;

Misc.

3 years of data for >4500 acute-care facilities:

- ***inverse*** relationship between readmission rates and mortality scores in patients treated for heart failure, COPD and stroke.
- No association in mortality rates for MI, pneumonia or CABG

Daniel J. Brotman, Erik H. Hoyer, Curtis Leung, Diane Lepley and Amy Deutschendorf. Associations between hospital-wide readmission rates and mortality measures at the hospital level: Are hospital-wide readmissions a measure of quality? Journal of Hospital Medicine, September 2016 DOI: 10.1002/jhm.2604

Misc.

- Among women >35, induction of labor at 39 weeks (compared with expectant management) had no significant effect on the rate of cesarean section and no adverse short-term maternal or neonatal outcomes

Walker KF, Randomized Trial of Labor Induction in Women 35 Years of Age or Older. N Engl J Med. 2016 Mar 3;374(9):813-22. doi: 10.1056/NEJMoa1509117.

- Administration of betamethasone to women at risk for late preterm delivery (34-36 weeks) significantly reduced the rate of neonatal respiratory complications

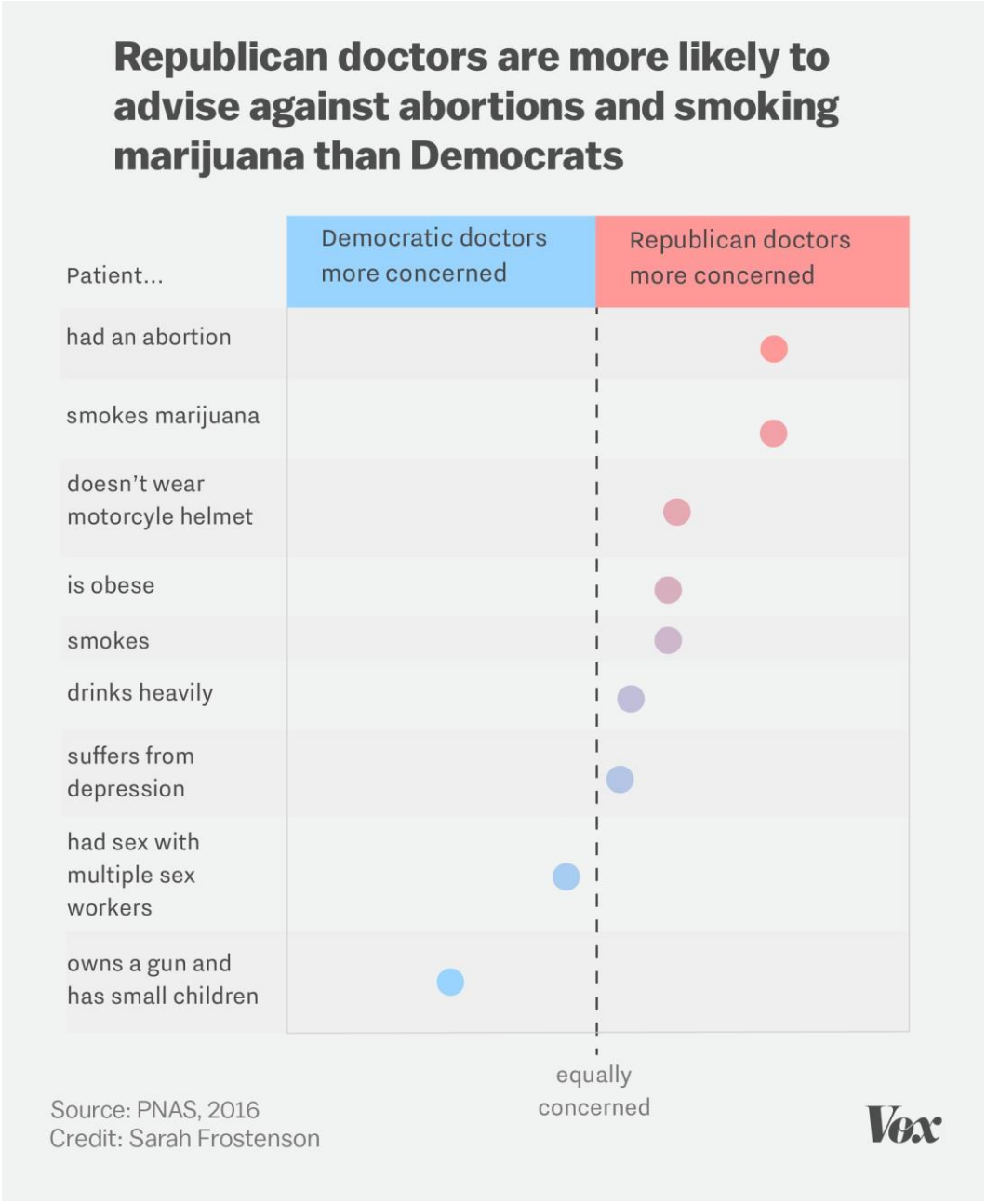
Gyamfi-Bannerman C et al. Antenatal Betamethasone for Women at Risk for Late Preterm Delivery. N Engl J Med. 2016 Apr 7;374(14):1311-20. doi: 10.1056/NEJMoa1516783. Epub 2016 Feb 4.

Misc.

"Weekend warrior" and other leisure time physical activity patterns characterized by **1 or 2 sessions per week** may be sufficient to reduce all-cause, CVD, and cancer mortality risks

Association of "Weekend Warrior" and Other Leisure Time Physical Activity Patterns With Risks for All-Cause, Cardiovascular Disease, and Cancer Mortality. JAMA Intern Med. Published online January 9, 2017. doi:10.1001/jamainternmed.2016.8014

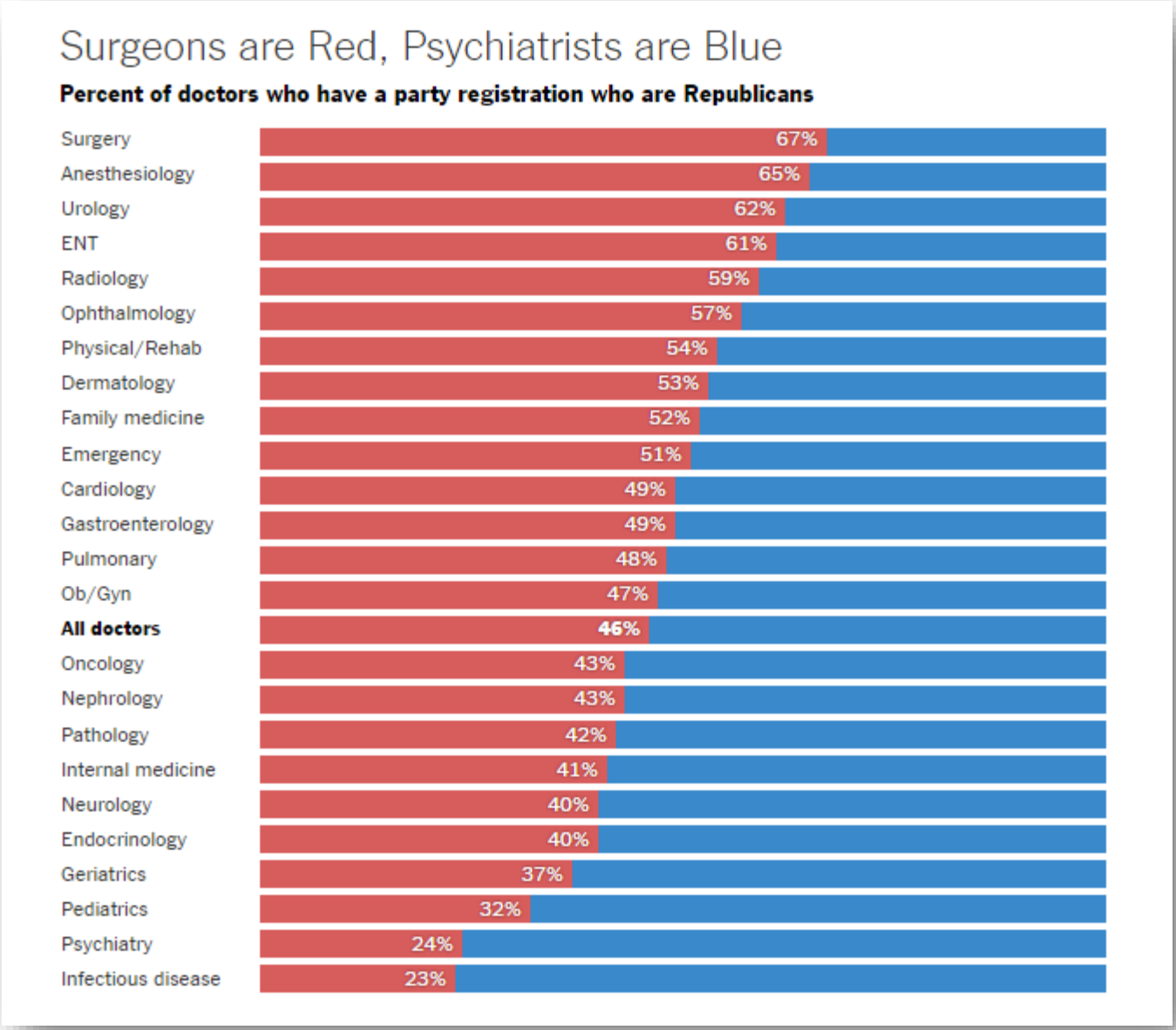
Most Importantly…



Hersh ED et al. Democratic and Republican physicians provide different care on politicized health issues. Proc Natl Acad Sci U S A. 2016 Oct 18;113(42):11811-11816. Epub 2016 Oct 3.

The New York Times

"Your Surgeon Is Probably a Republican, Your Psychiatrist Probably a Democrat"

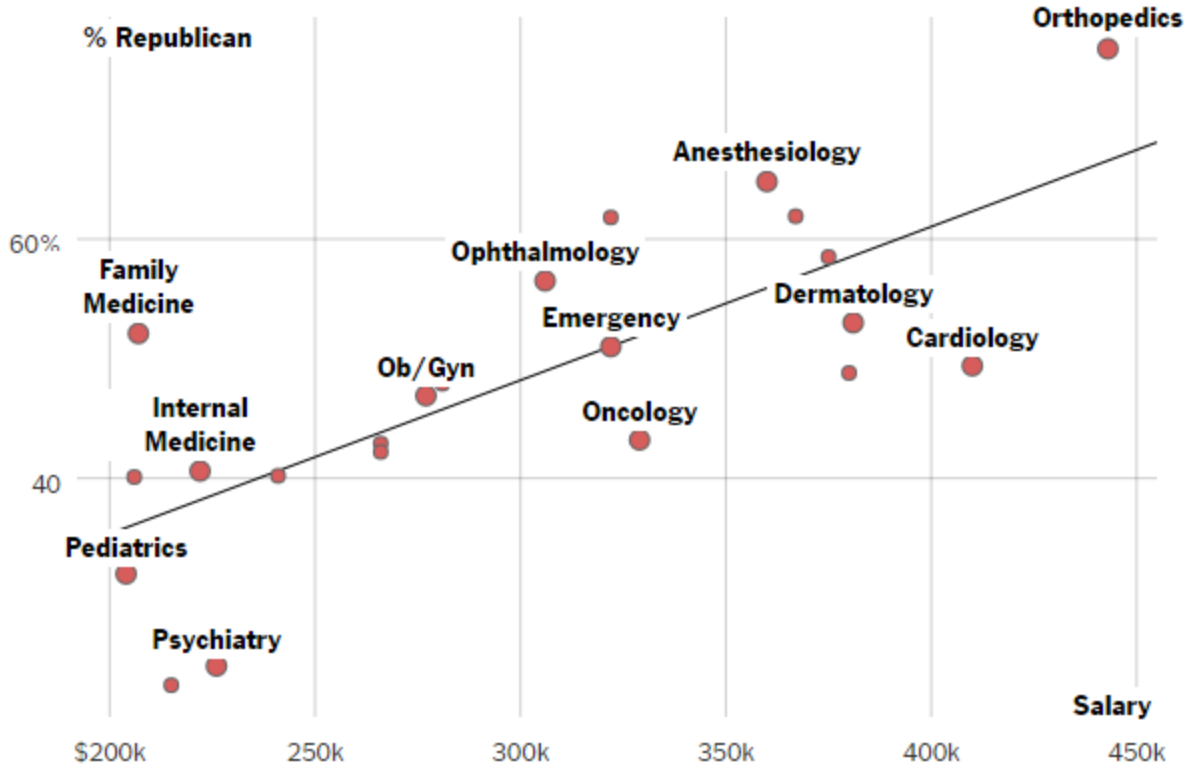


The New York Times

"Your Surgeon Is Probably a Republican, Your Psychiatrist Probably a Democrat"

Republicans Cluster in High-Paying Specialties

Cause or effect? On average, the specialties with the highest salaries tend to have the most Republicans.



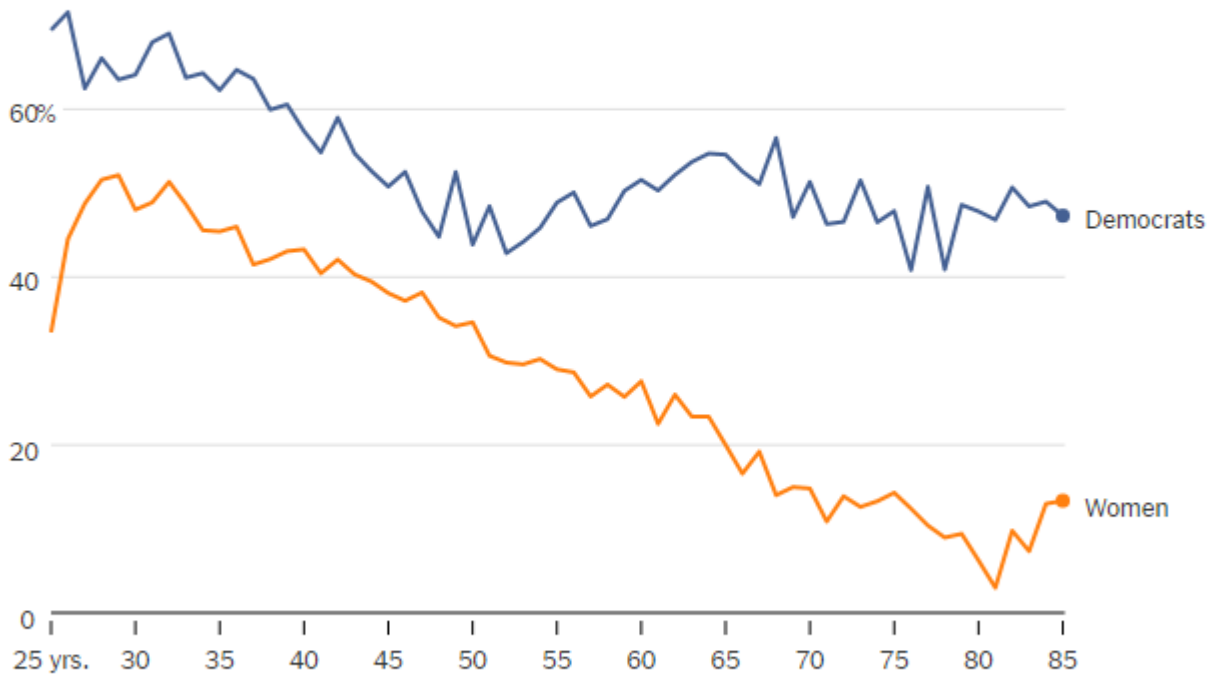
Data come from a sample of 34,532 doctors in 29 states.

Source: Analysis of the National Provider Identifier File, and Catalist LLC voter file data, by Eitan Hersh and Matthew Goldenberg; Medscape Physician Compensation Survey 2016.

Younger Doctors Are More Liberal

The trend can be explained, partly, by an increasing share of female physicians, who are more likely to be Democrats.

Percent of doctors, by age



Data comes from a sample of doctors in 29 states.

Source: Analysis of the National Provider Identifier File, and Catalist LLC voter file data, by Eitan Hersh and Matthew Goldenberg.

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OF 2016

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Abstract

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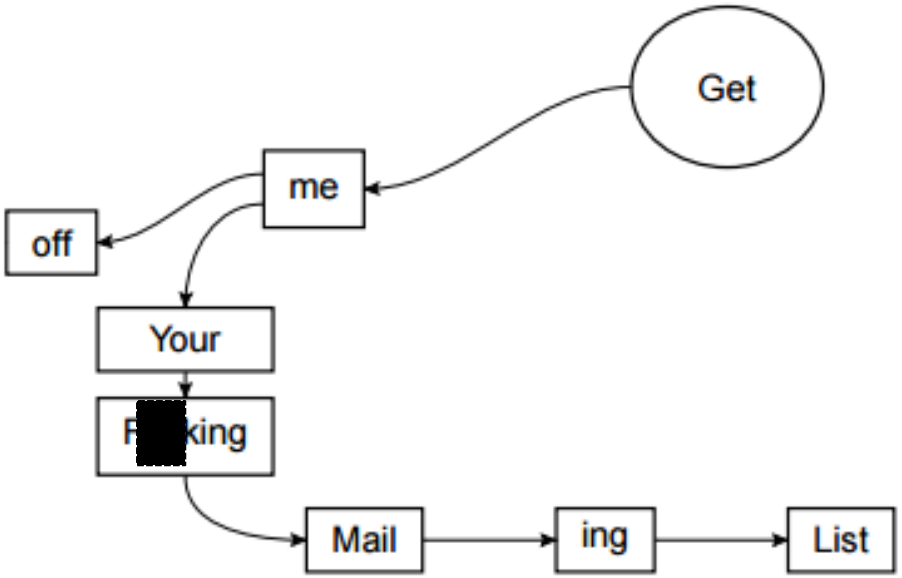

Figure 1: Get me off your f[redacted]king mailing list.

10 pages!

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- Journal Watch
- Essential Evidence (free podcast “POEM of the Week”)
- Run your own clinic “journal club”

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