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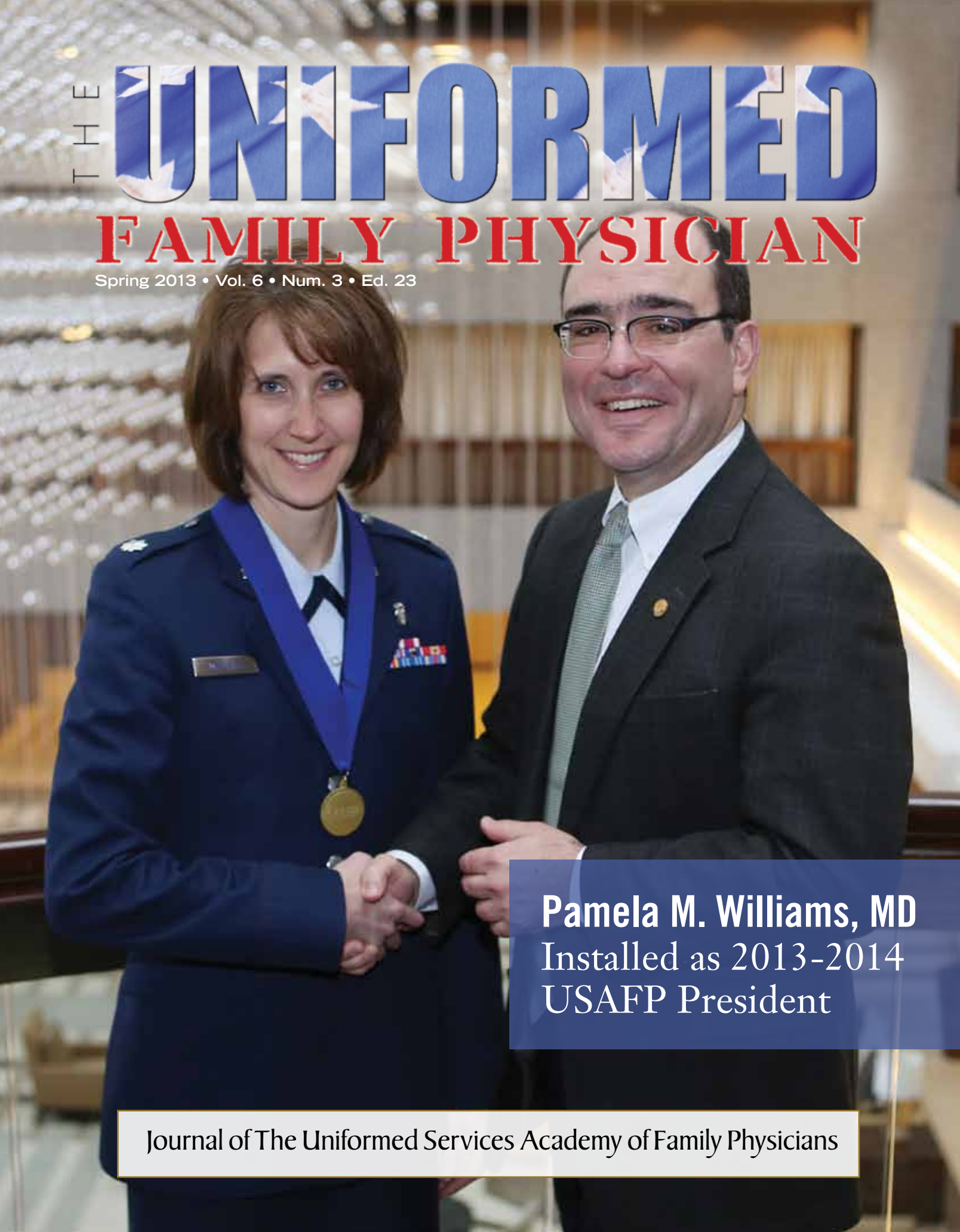

## Pamela M. Williams, MD
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Journal of The Uniformed Services Academy of Family Physicians

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## VISION

The USAFP will be the premier professional home that provides services to enhance the experience of current and future Uniformed Family Physicians.

## MISSION

The mission of the USAFP is to support and develop Uniformed Family Physicians as we advance health through education, scholarship, readiness, advocacy, and leadership.




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Edition 23

# your academy leaders

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# outgoing president's message

## MICHAEL PLACE, MD

Michael Place, MD
Ft. Carson, CO
Michael.place@us.army.mil

My friends and colleagues:

Thank you for the wonderful opportunity to serve as your President. The year has been tumultuous, but I am confident that with the tremendous professionalism and enormous dedication routinely displayed by each of you, we will continue to be the premier professional home to all Uniformed Family Physicians. Your Board of Directors will be working very hard in the days to come to ensure that the USAFP continues our growing tradition of providing the very best in education, scholarship, readiness, advocacy and leadership. Our collective creativity will be required, so please reach out to our elected leadership to share your thoughts and some of those wonderful novel solutions to the challenges that we face. I remain enormously proud to have served as your President and always honored to be counted among you.

Mike

# incoming president's message

## PAMELA M. WILLIAMS, MD

Pamela M. Williams, MD
Travis AFB, CA
Pamela.williams@us.af.mil

Greetings to each and every one of you wherever you are serving around the world! First and foremost let me say thank you for the opportunity to serve as your President. I relish this challenge and look forward to hearing from you about the course the USAFP needs to take on your behalf this year.

As many of you know, the AAFP has always been very supportive of our chapter, the members of the armed services, military families and veterans. Because our Annual Meeting was cancelled, the AAFP took time at their recent Annual Leadership Forum to publically acknowledge the sacrifices made by the members of our academy and to induct the executive committee of USAFP in front of all those who had gathered for this national leadership meeting. Later, AAFP President Jeff Cain attended our board meeting to induct the newly elected members of the Board of Directors. We feel humbled and thankful for their ongoing support.

This past year has certainly proven that one true constant in our lives is change. It was with a heavy heart that we made the difficult decision to cancel the 2013 Annual Meeting. This necessary change requires further action that is founded in the USAFP's mission and vision. To move forward as an organization, we need to consider our strengths and stakeholder's shared vision and values. As the board came together to meet in Kansas City, I

*continued on page 6*

> "Change does not roll in on the wheels of inevitability, but comes through continuous struggle. And we must straighten our backs and work for our freedom. A man can't ride you unless your back is bent."

challenged them to take this series of events as an opportunity to **SOAR** as an organization.

Using an appreciative inquiry model of strategic planning, your board engaged in a series of critical conversations. We discussed the **Strengths** of our Annual Meeting and organization and considered the **Opportunities** that have been created by recent events. We challenged each other to consider to what do we **Aspire** and what **Results** will mark that we are succeeding. As I facilitated this dialog, I was filled with pride as the board members you elected represented your interests, ensuring that the USAFP continues to deliver to its members even in a time of fiscal uncertainty. The energy in the room was truly remarkable.

I will share with you the bottom line up front: the board unanimously voted to move forward with planning an Annual Meeting for 2014. As was the case for the 2013 meeting, the board will remain good stewards of the financial assets of our organization throughout this process. The meeting will likely be different from those in recent years, but we are committed to making this signature event happen. We are also committed to focusing on new opportunities. The new website which is under active development will be the most visible face of these opportunities in the near future.

Martin Luther King, Jr said that, "Change does not roll in on the wheels of inevitability, but comes through continuous struggle. And we must straighten our backs and work for our freedom. A man can't ride you unless your back is bent." I look forward to standing tall and walking forward with you this year.

# editor's voice

## MARK J. FLYNN, MD, FAAFP

Mark J. Flynn, MD, FAAFP
Camp Pendleton, CA
Mark.flynn@med.navy.mil

By now you are all aware of the many challenges faced by our various military branches with regards to the budget, and our ability to satisfy our respective missions. The direct impact with our Academy was, of course, the cancellation of this year's Annual Meeting in Orlando. No doubt, each of you can cite any number of other changes and adaptations made locally, regionally, and DoD-wide which will be ongoing.

I wish to take this opportunity to speak to the purpose of this publication. We have always had what I would consider a robust newsletter, with no shortage of qualified authors and topics to easily fill our pages. This issue is no exception! However, because of the meeting cancellation, we are publishing the abstracts for all the winning submissions from the Annual Research Competition. Our Clinical Investigations committee, headed by Dr. Anthony Beutler, had the challenge of (with very little notice!) coming up with a fair way to assess each submission and still find a way to recognize those who devoted the time and effort on their works. Congratulations to each of the winners! We hope to do this live next year.

As for the future of this newsletter, your Board of Directors has discussed the possibility of augmenting our usual slate of articles. With the tight restrictions on our ability to travel for Continuing Medical Education (CME) credits, we are beginning to look into what it might take to add CME articles to our newsletter. It takes just one glance at a given month's *American Family Physician* to see how many military FP's are writing quality, evidence-based and peer-reviewed articles. We, as a group, have the talent and the drive!

You should also be aware that our new website is under development, and we are excited about the possibilities for how our membership can best benefit from its content and services. That is another portal to take advantage of for CME, and will likely play a larger role in coming years as our budgetary belt-tightening lingers.

As I turn over the reins for the newsletter to the very-capable Dr. Rob Oh, and step into the President-Elect position of our Academy, I want to express my admiration for our Board of Directors - much heavy lifting has been done and continues to be done to keep our Academy vibrant, strong, and flexible to meet the challenges of a changing reality. I also want to recognize our chapter staff for the incredible behind-the-scenes work they do every day to keep our chapter one of the best in the nation. And finally, for each of you and the work you do every day taking care of our soldiers, sailors, airmen, Marines, and all the dependents and retirees whom entrust us with their care. I am proud to be one of you!

### MEMBERS IN THE NEWS

The USAFP Board of Directors encourages each of you to submit information on USAFP "Members in the News" for publication in the newsletter. Please submit "Members in the News" to Mary Lindsay White at *mlwhite@vafp.org*.

### NEWSLETTER SUBMISSION DEADLINE

**REMINDER:** The deadline for submissions to the summer magazine is 20 July 2013.

### RESEARCH GRANTS

The Clinical Investigations Committee accepts grant applications on a rolling basis. Visit the USAFP Web site at www.usafp.org for a Letter of Intent (LOI) or Grant Application. Contact Dianne Reamy if you have questions. *direamy@vafp.org*.

### RESEARCH JUDGES

Applications for research judges are accepted on a rolling basis. Please contact Dianne Reamy (*direamy@vafp.org*) to request an application.

### DO YOU FEEL STRONGLY ABOUT SOMETHING YOU READ IN THE UNIFORMED FAMILY PHYSICIAN? ABOUT ANY ISSUE IN MILITARY FAMILY MEDICINE?

Please write to me...
Robert Oh, MD
*Robert.oh@us.army.mil*

# Installation of 2013-2014 USAFP Board of Directors

The 2013-2014 USAFP Board of Directors was officially installed by AAFP President Jeffrey Cain, MD during the AAFP's Annual Leadership Forum/National Conference of Special Constituencies April 25-27, 2013 in Kansas City, Missouri. The Officers were installed on Friday, April 26th during the ALF/NCSC Plenary Luncheon and the Directors were installed on Saturday, April 27th during the Board of Directors meeting. Congratulations to the 2013-2014 USAFP Board of Directors!!

| | | | | |
|---|---|---|---|---|
| **President**<br>*Pamela M. Williams, MD* | **Vice President**<br>*Robert C. Oh, MD* | **Army Director**<br>*Laurel A. Neff, DO* | **CG/PHS Director**<br>*Edgardo Alicea, MD* | **Army Resident**<br>*Haroon Samar, MD* |
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*Pictured left to right are: Sarah Avila, MD, Air Force Resident Director, James Ellzy, MD, Navy Director, Laurel Neff, DO, Army Director, Installing Officer AAFP President Jeffrey Cain, MD, Christopher Jonas, DO, Air Force Director, Haroon Samar, MD, Army Resident Director and Michelle Lynch, MD, Navy Resident Director. Not pictured is Edgardo Alicea, MD, CG/PHS Director.*


*AAFP President Jeffrey Cain, MD installs USAFP Officers during the ALF/NCSC Plenary Luncheon on Friday, April 26, 2013 in Kansas City, Missouri. Pictured left to right are Dr. Cain, USAFP Past President Michael L. Place, MD, USAFP President Pamela M. Williams, MD, USAFP President-Elect Mark J. Flynn, MD and USAFP Vice President Robert C. Oh, MD.*

# USAFP Board of Directors Meets in Kansas City

The 2012 and 2013 USAFP Boards of Directors met in Kansas City on April 27th for a joint meeting. 2012-2013 USAFP President Michael Place, MD presided over the first part of the meeting and 2013-2014 USAFP President Pam Williams, MD presided over the second part of the meeting. As noted in Dr. Williams Incoming President's Message, the Board voted to move forward with the plans and programming of a 2014 USAFP Annual Meeting. Stay tuned for more information on the specifics of the 2014 Annual Meeting!!

# CONGRATULATIONS TO THE 2013 USAFP RESEARCH COMPETITION WINNERS!!

The USAFP Research Judges received 115 submissions for the USAFP Research Competition. Of these submissions, 38 were initially accepted for presentation at the USAFP Annual Meeting (10 Clinical Investigations, 2 Educational Research Projects, 11 Case Reports, and 15 Posters).

Following the cancellation of the USAFP Annual Meeting, the following two options were made available to all participants accepted to the 2013 Research Competition:

Of these submissions, 38 were initially accepted for presentation at the USAFP Annual Meeting (10 Clinical Investigations, 2 Educational Research Projects, 11 Case Reports, and 15 Posters).

**OPTION 1:**
**Defer acceptance to the 2014 USAFP Competition**

If option 1 (deferment) was chosen, the project would automatically be accepted for presentation AS A POSTER at the 2014 USAFP Meeting. If competing for a podium presentation slot, participant would need to re-apply before the Fall 2013 Call for Papers deadline. If not selected for podium presentation, presenter would still be guaranteed a poster presentation slot.

**OPTION 2:**
**Participate in the 2013 USAFP web-based Competition**

If option 2 (web competition) was chosen, the presenter was responsible to make and upload a YouTube video of the presentation. Poster videos were no longer than 5 minutes. Podium presentations were no longer than 10 minutes. The USAFP judges scored the presentation video and scores were calculated per the usual protocol. Projects in the 2013 web competition will only be eligible for presentation at future USAFP meetings in the "previously published/presented research" category.

Congratulations to the winners!

- **FIRST PLACE CLINICAL INVESTIGATION**
  OBESITY AND MUSCULOSKELETAL INJURIES IN THE U.S. AIR FORCE: ASSOCIATIONS AND IMPLICATIONS
  **Nathaniel S. Nye, MD**
  **RESIDENT CATEGORY**

- **SECOND PLACE CLINICAL INVESTIGATION**
  EAR ACUPUNCTURE FOR ACUTE SORE THROAT: A RANDOMIZED CONTROLLED TRIAL
  **David Moss, MD**
  **RESIDENT CATEGORY**

- **FIRST PLACE EDUCATIONAL RESEARCH**
  CURRICULUM CHANGES TO INCREASE RESEARCH IN A FAMILY MEDICINE RESIDENCY PROGRAM
  **Anna Oberhofer, MD**
  **RESIDENT CATEGORY**

- **FIRST PLACE CASE REPORT**
  BILATERAL PATELLAR TENDON RUPTURE AFTER LEVOFLOXACIN USE: A CASE REPORT
  **Jamie L. Krassow, MD**
  **STAFF CATEGORY**

- **FIRST PLACE CASE REPORT**
  SUBSEGMENTAL PULMONARY EMBOLISM: TO TREAT OR NOT TO TREAT
  **James T. Cassleman, MD**
  **RESIDENT CATEGORY**

- **SECOND PLACE CASE REPORT**
  HEART ASSAULT: A CASE OF ACCELERATED IDIOVENTRICULAR RHYTHM IN A SOLDIER WITH HEAT STROKE
  **Michael Bybel, DO**
  **RESIDENT CATEGORY**

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- **THIRD PLACE CASE REPORT**
  BISPHOSPHONATES: PUSHING THEIR UTILITY TO THE BREAKING POINT
  **Michael O. Needham, MD**
  **RESIDENT CATEGORY**

- **FIRST PLACE CLINICAL INVESTIGATION POSTER DISPLAY**
  STUDENT FITNESS: PEDOMETRY AS INCENTIVE?
  **Robert M. Lystrup, 2nd Lt**
  **MEDICAL STUDENT CATEGORY**

- **SECOND PLACE EDUCATIONAL RESEARCH POSTER DISPLAY**
  INCREASE IN RESIDENCY SCHOLARLY ACTIVITY AS A RESULT OF A RESIDENCY-LED INITIATIVE
  **Kyle Hoedebecke, MD**
  **RESIDENT CATEGORY**

- **FIRST PLACE CASE REPORT POSTER DISPLAY**
  SEIZURE AS AN UNUSUAL PRESENTATION OF OBSTRUCTIVE SLEEP APNEA (OSA)
  **Justin Huang, MD**
  **RESIDENT CATEGORY**

- **SECOND PLACE CASE REPORT POSTER DISPLAY**
  DON'T GO VANC-ING MY HEART: VANCOMYCIN ASSOCIATED MYONECROSIS IN A MALE WITH NO CARDIAC RISK FACTORS
  **Elisabeth J. Chang, MD**
  **RESIDENT CATEGORY**

- **THIRD PLACE CASE REPORT POSTER DISPLAY**
  "DON'T STREP ON ME" GROUP C STREPTOCOCCUS AND LEMIERRE'S SYNDROME
  **Shane L. Larson, MD**
  **RESIDENT CATEGORY**

## First Place/Educational Research RESIDENT CATEGORY

**CURRICULUM CHANGES TO INCREASE RESEARCH IN A FAMILY MEDICINE RESIDENCY PROGRAM**

**Anna Oberhofer, MD, LT, MC USN, Naval Hospital Jacksonville, Jacksonville, FL, 32214, Robert Lennon MD, JD, LT, MC USN, Naval Hospital Jacksonville, Jacksonville, FL, 32214 Vanessa McNair MD, MPH Naval Hospital Jacksonville, Jacksonville, FL, 32214**

**INTRODUCTION/BACKGROUND:** Scholarly activity is an important component of residency programs accredited by the American Academy of Graduate Medical Education (ACGME ). Amidst the many other ACGME and professional obligations, finding time and support for resident research can be challenging. Thus it is important to equip residents with the tools needed to perform scholarly activity both during and after residency.

**METHODS/INTERVENTION:** We conducted a retrospective study of the implementation of a series of curriculum initiatives on scholarly productivity at Naval Hospital Jacksonville. Beginning in 2010, educational interventions were rolled out in three parts. First, a faculty research coordinator (FRC) was established. Second, a scholarly activity point system was adapted from one published by Seehusen et al, along research and conference tracking systems. Third, a resident research coordinator (RRC) position was created. The FRC and RRC acted as liaisons between residents, faculty, and non-faculty staff, and created an annual scholarly activity workshop. An analysis of scholarly productivity was performed using descriptive statistics.

**RESULTS/OUTCOME:** In 2009, prior to the roll out of these curriculum changes, the number of resident scholarly projects per resident, defined as regional or higher posters/presentations and peer reviewed publications, was 0.07 with 4 residents involved. In 2012, the research per resident was 0.91, with 26 residents involved, showing an expansion in resident participation and a 13-fold increase in productivity

**CONCLUSION/DISCUSSION:** Our analysis reveals an association between our implementation of new curricular initiatives and increased research among residents, similar to growth demonstrated by the innovations of Seehusen et al, with the addition of increased participation. Limitations of this study include reliance on the accuracy of past records and a small sample size. We believe this is a model that could be implemented

## Second Place/Clinical Investigation RESIDENT CATEGORY

**EAR ACUPUNCTURE FOR ACUTE SORE THROAT. A RANDOMIZED CONTROLLED TRIAL**

**David A Moss, MD, Nellis AFB, Las Vegas, NV 89081; Heather Pickett, DO, Nellis AFB, Las Vegas, NV 89081**

**OBJECTIVE:** Does Battlefield Acupuncture (BFA), an ear acupuncture technique, reduce pain, medication usage, and missed work hours when added to standard therapy in patients with acute sore throat.

**DESIGN:** Unblinded randomized controlled trial.

**SETTING:** Nellis AFB Family Medicine clinic

Study Population: n=24; Men and non-pregnant women age ≥18 years with acute sore throat and pain level ≥5 on 0-10 scale.

**INTERVENTION:** Control group: Standard treatment (STD) consisting of NSAIDs and/or antibiotics. Treatment group: Standard treatment plus semi permanent gold ASP needles placed in BFA points in one or both ears until patient is satisfied with pain control or all 10 points are used.

**MAIN AND SECONDARY OUTCOME MEASURES:** 1) Pain scores at presentation, 15 min, 6 hrs, 24 hrs and 48 hrs post-randomization. 2) Ibuprofen doses up to 48 hrs post-procedure. 3) Total missed work hours up to 48 hrs post-procedure.

**STATISTICAL ANALYSIS:** 2 sided t-test

**RESULTS:** Similar initial pain scores between both groups (5.83 STD vs 6.42 BFA p=0.134). Lower pain scores in the BFA group at all other time points (15 min, 5.67 STD vs 3.00 BFA p=0.003; 6 hrs, 4.17 STD vs 2.92 BFA p=0.190; 24 hrs, 3.92 STD vs 1.75 BFA p=0.005; 48 hrs, 2.67 STD vs 0.67 BFA p=0.001). Less total ibuprofen doses in the BFA group at 48 hrs (4 STD vs 2.25 BFA p=0.115). Less hours of work missed in the BFA group at 48 hrs (6.75 STD vs 0.83 BFA p=0.010).

**CONCLUSIONS:** BFA decreases pain scores, and missed hours of work for up to 48 hours in clinic patients with acute sore throat. The decrease in NSAID doses was not statistically significant. As a technique easily learned by non-acupuncturists, BFA can be a valuable treatment option for sore throat pain.

## Second Place/Case Report Poster Display RESIDENT CATEGORY

**"Don't Go Vanc-ing My Heart": Vancomycin-associated Myonecrosis in a Male with No Cardiac Risk Factors** **Elisabeth Chang, MD and Shane Larson, MD, Department of Family Medicine, Tripler AMC, Honolulu, HI 96859**

**INTRODUCTION:** Chest pain is a common complaint with etiologies ranging from benign to life threatening. Recent advancements such as the troponin-I have increased physician's ability to detect myocardial damage shortly after symptom onset and with increased specificity. Presented is a young adult patient on monotherapy with Vancomycin who developed chest pain and troponinemia.

**CASE PRESENTATION:** 24 year-old Caucasian male with no cardiac risk factors admitted for intravenous therapy for cellulitis. Patient was started on Vancomycin and no other medications; while hospitalized, patient developed palpitations, diaphoresis, and acute chest pain immediately after the third IV administration of Vancomycin. Subsequent studies demonstrated peak troponin-I of greater than 8. Electrocardiogram, echocardiogram, cardiac computed tomography angiogram, and cardiac magnetic resonance imaging showed no evidence of ischemia, wall motion abnormality, or other irregularities. Cardiology consult obtained and patient given diagnosis of myonecrosis, likely secondary to Vancomycin.

**DISCUSSION:** While this case cannot definitively prove an association with cardiac necrosis, our patient's unremarkable history, ancillary studies, and imaging are highly suggestive. Literature review reveals that Vancomycin has rarely been associated with sudden cardiac arrest, but these few cases were with rapid infusion in neonates. The pathophysiology behind this potential Vancomycin-induced myonecrosis remains uncertain, as known mechanisms of local tissue necrosis typically involve the integument. Without central venous access, this mechanism is unlikely in our patient. Another potential mechanism would include medication contamination, which is rarely described in literature. Our case would contradict previous findings in preoperative patients who underwent slow infusion of Vancomycin prior to cardiac surgery without evidence of tissue effect or depression.

**SCHOLARLY QUESTION:** Has Vancomycin previously been associated with myonecrosis?

**CONCLUSION:** This case presents a possible adverse drug reaction. Should further cases be encountered, surveillance studies may be warranted.

## First Place/Case Report RESIDENT CATEGORY

**SUBSEGMENTAL PULMONARY EMBOLISM: TO TREAT OR NOT TO TREAT** **James Cassleman, MD, Capt., MC, USAF; Air Mobility Command Travis Department of Family Medicine, Travis AFB, CA 94535**

**INTRODUCTION/OBJECTIVE:** Pulmonary embolism (PE) isolated to subsegmental arteries is an area of emerging research. Inadequate understanding about limitations of current decision models has potential to delay diagnosis of subsegmental PE while new studies suggest a dangerous trend of overtreatment. Presented is a case of sub-segmental PE in a healthy female who had a normal d-dimer and bilateral lower extremity ultrasound.

**CASE PRESENTATION:** 34 year-old female presented to the emergency room for transient episodic substernal chest pressure without dyspnea. History was remarkable for intercontinental air travel within the 10 months preceding symptom onset, during which time the patient experienced single episode self-limited bilateral lower extremity swelling. She had no other risk factors for PE. Heart, lung and extremity exams were normal. Labs showed normal d-dimer and mildly elevated troponin I. Chest x-ray, EKG and bilateral lower extremity Doppler ultrasound were normal. CT pulmonary angiogram revealed subsegmental PE to the left lower lobe. Subsequent workup excluded occult malignancy and hereditary thrombophilia.

**DISCUSSION:** Isolated subsegmental PE represents about 5% of all diagnosed PE. Its clinical significance remains unclear given many cases are asymptomatic and without increased morbidity/mortality. PE is thought to be reliably excluded when pre-test probability and d-dimer measurement are appropriately combined using validated clinical decision rules. However, d-dimer sensitivity for subsegmental PE is only 50%, raising concern about whether current diagnostic decision models are valid for subsegmental PE. Treatment decisions present similar challenge given recent research indicates that risks of anticoagulation to include major bleeding (as high as 7%) outweigh potential benefits for certain populations with subsegmental PE. Still, numerous organizations recommend treatment of PE regardless of subtype.

**CONCLUSION:** This case emphasizes the limitations of current diagnostic tests and decision models used for sub-segmental PE. It also highlights the available evidence regarding treatment decisions, which promotes prevention of potential dangers.

## First Place/Case Report STAFF CATEGORY

**BILATERAL PATELLAR TENDON RUPTURE AFTER LEVOFLOXACIN USE: A CASE REPORT**

**Jamie L. Krassow, MD, Capt, USAF, MC, Hurlburt Field, FL 32544**

**INTRODUCTION:** Tendon rupture is a rare but debilitating side effect of fluoroquinolones. Presented is a patient who suffered bilateral patellar tendon rupture after levofloxacin use.

**CASE PRESENTATION:** A 32 year old active duty male presented to a local clinic with complaints of two week history of sinus congestion, sinus tenderness and subjective fevers. He was diagnosed with acute bacterial rhinosinusitis and prescribed fluticasone nasal spray, a methylprednisolone dose pack, and levofloxacin. His symptoms improved. One month later, while playing basketball, he experienced abrupt pain in both knees. He was evaluated at the local emergency room where x-rays and exam demonstrated complete bilateral patellar tendon rupture. He was referred to orthopedics and ultimately underwent bilateral patellar tendon surgical repair. Despite surgery, nearly twenty months after injury, he still experiences pain and requires duty restrictions.

**DISCUSSION:** The fluoroquinolone class of antibiotics is a well-accepted therapy for multiple infectious processes. Tendinitis and tendon rupture are rare side effects of fluoroquinolones with rates reported of 0.14% to 0.4%. 90% of cases are localized to the Achilles tendon. Upon a literature review, this is the first reported case of bilateral patellar tendon rupture after levofloxacin use. Factors which enhance the risk of fluoroquinolone associated tendon pathology in our patient included: concomitant systemic steroid use and involvement in athletics shortly after use. Guidelines for fluoroquinolone use in athletes were first published in 2003 which include recommendations of avoidance of fluoroquinolones but close monitoring if used.

**SCHOLARLY QUESTION:** Given the inherent risk factors in athletes and military members, should fluoroquinolone prescribing guidelines be encouraged?

**CONCLUSION:** Military and athlete physicians should understand risk factors that increase the threat of tendon disorders with fluoroquinolone use given the physical expectations placed on athletes and military members. Physicians should consider adopting fluoroquinolone prescribing guidelines for these populations.

## First Place/Case Report Poster Display RESIDENT CATEGORY

**SEIZURE AS AN UNUSUAL PRESENTATION OF OBSTRUCTIVE SLEEP APNEA (OSA)**

**Justin Huang, MD, MAJ, MC, USAF, Family Medicine Residency, Travis AFB, CA 94535**

**INTRODUCTION/OBJECTIVE:** Obstructive sleep apnea (OSA) is an increasingly common diagnosis in the active duty population. Reviewed is a case of OSA initially presenting with seizures.

**CASE PRESENTATION:** A 39 y.o. AD male was seen after having seizures the previous night. Prior to the 30 minute event, his spouse reported apneas and facial cyanosis. He then became unresponsive with arms and legs rigidly extended, and was post-ictal afterwards for 30 minutes. Evaluation four months earlier for an identical episode demonstrated normal labs and head CT, and brain MRI was normal. The patient was referred to Neurology and ENT. The sleep study showed AHI=26 and arousal index of 38.4. EEG and MRI were normal. CPAP was initiated with no further seizures. The patient was diagnosed with seizures secondary to OSA.

**DISCUSSION:** OSA typically presents with daytime fatigue despite adequate sleep time, and commonly with a history of snoring and/or apneas. The literature does not describe OSA as the primary cause of seizures, although it has been known for hypoxia to cause seizures. There are publications documenting the coexistence of seizures and OSA, with 10% in adult and 20% in pediatric epilepsy patients. Seizures have also been shown in some cases to be worsened by OSA, however relation of the two continues to be vague.

**SCHOLARLY QUESTION:** Should OSA screening be part of initial work up for new onset seizures

**CONCLUSION:** As primary care providers, Family Medicine Physicians are often involved in the initial work up of seizures. This case presents the possibility of OSA causing seizures. Further study into the relationship between seizures and OSA may help determine if there is a role of the sleep study in the initial work up of new onset seizures.

## Second Place/Educational Research RESIDENT CATEGORY

**INCREASE IN RESIDENCY SCHOLARY ACTIVITY AS A RESULT OF A RESIDENT-LED INITIATIVE CPT Kyle Hoedebecke, MD, Womack Family Medicine Residency, Ft Bragg, NC 28307. Co-authors: CPT Caitlyn Rerucha, MD and MAJ Lloyd Runser, MD, Womack Family Medicine Residency, Ft Bragg, NC 28307**

**INTRODUCTION/BACKGROUND:** Scholarly activity is a fundamental component of Family Medicine residency training. Despite the flexibility and variety of options for scholarly activity that have been implemented in Family Medicine residency curricula nation-wide, the output of resident presentations and publications is disappointingly low and many residents voice frustration with fulfilling the research requirements.

**METHODS/INTERVENTION:** This project involves 1) increasing awareness of conferences for scholarly submission 2) assignment of research "champions" to head research efforts in each year group 3) pairing of interns/students with senior resident "mentors" with similar interests, 4) faculty to include 1 resident in all research projects, and 5) monthly resident research meetings to track research progress, share research ideas, and trouble-shoot areas of difficulty. The following goals were used to measure the success of this process improvement project: 1) Doubling the number of peer-reviewed published articles by residents and 2) Doubling the number of scholarly presentations at regional, national, or international conferences by residents.

**RESULTS/OUTCOMES:** Currently our residency has reached both goals with more than double the peer reviewed publications (increase from 2 last year to 5 this year) and scholarly presentations (increase from 3 last year to 24 this year) at regional, national, or international conferences. Sixteen residents participated in these events compared to 3 the previous year. Even more impressive is that these results occurred within the first 6 months of this academic year. With half a year remaining, there are still several scholarly presentations and publications pending acceptances that are not included in the above totals.

**CONCLUSION/DISCUSSION:** The implementation of this resident-led initiative has vastly improved our residents' scholarly footprint. The authors recommend that other residencies consider having more senior residents work in tandem with their junior colleagues in order to improve residency scholarly activity output.

## Second Place / Case Report RESIDENT CATEGORY

**HEART ASSAULT: A CASE OF ACCELERATED IDIOVENTRICULAR RHYTHM IN A SOLDIER WITH HEAT STROKE Michael Bybel, DO, CPT, MC, USA, Carl R. Darnall Army Medical Center Family Medicine Residency Program, Ft. Hood TX, 76544**

**INTRODUCTION:** Heat stroke is a potentially life-threatening condition encountered during summer months at military training facilities. Presented is a soldier suffering a heat stroke with an associated accelerated idioventricular rhythm (AIVR) which has never previously been described in the medical literature.

**CASE PRESENTATION:** A 24 year-old active duty male presented to the emergency department with heat stroke sustained during a road march on the final day of Air Assault School. At presentation he had altered mental status, fever of 105.3F, acute kidney injury, transaminitis, and sinus tachycardia. Laboratory investigation showed an elevated troponin-I of 0.44 ng/mL. The patient was admitted to the ICU, and on hospital day two he was noted on telemetry and electrocardiogram to have an AIVR. An echocardiogram showed mild enlargement of bilateral atria and right ventricle, and a mild pericardial effusion. The patient had no significant electrolyte abnormalities during hospitalization. With recovery from the heat stroke the AIVR resolved. Subsequent evaluation failed to yield any additional contributory etiologies.

**DISCUSSION:** AIVR may represent an abnormal ectopic focus in the ventricle that is accelerated by sympathetic stimulation and circulating cathecholamines or myocardial injury. In heat stroke there is a surge of catecholamines. Mechanisms of myocardial injury in heat stroke include increased oxygen demand due to high fever, tachycardia, and a hyperdynamic cardiac state, and diffuse coronary vasospasm due to endothelial damage. These mechanisms are a plausible etiology for the findings in this patient.

**SCHOLARLY QUESTION:** What is the incidence of AIVR in patients suffering heat stroke?

**CONCLUSION:** Uniformed Family Physicians will likely manage heat stroke during their career. When associated heat-related myocardial injury is present, resultant arrhythmia is a concern. AIVR is considered a benign cardiac rhythm which should be considered in this setting, and differentiated from more malignant rhythms such as ventricular tachycardia.

## Third Place/Case Report RESIDENT CATEGORY

**BISPHOSPHONATES: PUSHING THEIR UTILITY TO THE BREAKING POINT** **Michael O. Needham, MD, CPT, MC, USA, DDEAMC, Fort Gordon, GA, 30905 and Edwin A. Farnell, MD, MAJ, MC, USA, DDEAMC, Fort Gordon, GA, 30905**

**INTRODUCTION:** Bisphosphonate therapy has been shown to reduce the incidence of osteoporotic hip fractures; however, appropriate duration of therapy is still not well established, and therapy is not without risk.

**CASE PRESENTATION:** A series of three elderly women, all with osteoporosis on long term bisphosphonate therapy, developed femoral shaft cortical stress fractures which were diagnosed radiographically after the women presented with insidious onset of thigh pain. One patient progressed to a subtrochanteric mid-shaft fragility fracture of the femur requiring surgical fixation. She subsequently underwent prophylactic intramedullary nail fixation of the contralateral femur. Another underwent bilateral prophylactic intramedullary nail surgery by orthopedics, and the third continues to be managed medically.

**DISCUSSION:** The benefit of bisphosphonates for preventing hip and femoral neck fractures in patients with osteoporosis is well established. Studies observing bisphosphonate therapy for 3 to 5 years report up to a 50% decrease in the incidence of typical fractures (hip and femoral neck fractures) in osteoporotic women, as well as a reduction in mortality. Emerging literature now questions the safety of long term bisphosphonate therapy (greater than 3 to 5 years), and further, has brought into question the benefit of long term bisphosphonates. Higher incidences of complications such as atypical femur fractures, potentially related to prolonged bisphosphonate therapy, have been observed in patients on long term bisphosphonates. Studies suggest that the effects of bisphosphonate therapy continue for 3 to 5 years after discontinuation, while there is little improvement in femoral neck bone mineral density (BMD) or lumbar spine BMD with continued treatment versus discontinuation.

**SCHOLARLY QUESTION:** When does the risk outweigh the benefit for bisphosphonate therapy in osteoporotic women?

**CONCLUSION:** When treating osteoporosis, the risks and benefits of continued bisphosphonate therapy must be carefully considered, particularly after 3-5 years of therapy.

## First Place/Clinical Investigation RESIDENT CATEGORY

**OBESITY AND MUSCULOSKELETAL INJURIES IN THE U.S. AIR FORCE: ASSOCIATIONS AND IMPLICATIONS** **Nye Ns,[1] Carnahan Dh,[2] Jackson Jc,[1] Covey Cj,[1] Zarzabal La,[2] Bockhorst A,[2] Chao S,[2] Nellis Family Medicine Residency, Nellis AFB, NV 891912 Air Force Medical Support Agency, Healthcare Informatics Division, San Antonio, TX 78226**

**OBJECTIVE:** To describe relationship between obesity and incident musculoskeletal injuries in US Air Force personnel.

**DESIGN:** Retrospective cohort. Setting: Active duty US Air Force (USAF).

**STUDY POPULATION:** All personnel from fiscal year (FY) 2005 to FY 2011 who had ≥1 physical fitness test each year of this period were eligible for inclusion. Members with musculoskeletal injury ≤12 months prior to study period or other confounding conditions were excluded. Study sample included 67,904 individuals.

**INTERVENTIONS:** Observational study. Data sources: outpatient electronic medical records and USAF Fitness Management System database.

**MAIN OUTCOME MEASURES:** Documented new musculoskeletal injury relative to biometric data and time elapsed from start of study.

**STATISTICAL TESTS USED:** Subjects stratified by age, body mass index (BMI), adjusted BMI (aBMI), and abdominal circumference (AC). Cox proportional hazard regression and Kaplan-Meier analysis were used to estimate risk for musculoskeletal injury within each group.

**RESULTS:** Kaplan-Meier curves showed increased injury risk with successive increases in BMI, aBMI, or AC category. Cox proportional hazard regression revealed increased hazard ratios (HR) for musculoskeletal injury in those with high-risk AC (males: >39in., females >36in.) compared to low-risk AC (males: ≤35in., females: ≤32in.) in all ages (18-24 years: HR=1.68, 95% Confidence Interval (CI) 1.42-2.00; 25-44 years: HR=2.48, CI 2.35-2.61; 45+ years: HR=2.33, CI 1.73-3.16). Hazard ratios for obese (BMI≥30kg/m2) compared to normal individuals (BMI<25kg/m2) were significant only in younger age groups (18-24 years: HR=1.18, CI 1.08-1.30; 25-44 years: HR=1.42, CI 1.37-1.46, 45+ years: HR=1.16, CI 0.93-1.45). Only AC categorizations showed differences between all categories across all age groups.

**CONCLUSIONS:** Obesity is associated with increased risk of musculoskeletal injury for all age groups in a dose-response relationship in the USAF. AC, a measure of central obesity, discriminates musculoskeletal injury risk better than BMI. Effective treatment and prevention strategies for obesity may increase force readiness and decrease costs.

## First Place/Clinical Investigation Poster Display MEDICAL STUDENT CATEGORY

**Student Fitness: Pedometry as an Incentive?**
**Robert Lystrup, BS; Jennifer Hall, BS; Cara Olsen, EdD, MS; Mark B. Stephens, MD, MS; USUHS-Departments of Family Medicine and Biostatistics, Bethesda, MD 20814**

**OBJECTIVE:** To determine the extent to which pedometry mitigates changes in body mass index (BMI) and physical fitness scores during medical school.

**DESIGN:** Prospective, randomized, unblinded clinical trial.

**SETTING:** Uniformed Services University of the Health Sciences (USU).

**STUDY POPULATIONS:** 115 USU medical students.

**INTERVENTIONS:** Participants randomized to the intervention group receive an electronic pedometer and are encouraged monthly to obtain 10,000 steps per day.

**MAIN OUTCOME MEASURES:** 1) Service-specific physical fitness test scores. 2) Self-reported and pedometer-based step counts.

**STATISTICAL TESTS USED:** Basic descriptive statistics will be used for categorical variables. Mixed-model ANOVA for repeated measures followed by post-hoc tests for linear trends over time will be used to compare fitness scores. Changes over time will be assessed using a linear mixed model for repeated measures, with time as a within-subjects variable.

**RESULTS:** This is a work in progress. Baseline and preliminary data are presented. To date, randomization has occurred and physical fitness scores and BMIs were obtained for 2011 and 2012. Pedometers were distributed to the intervention group three weeks prior to the fall 2012 fitness testing cycle. To date, 30 (63%) students in the intervention group provided self-reported step counts. Interestingly, the 6 (13%) students who reported obtaining at least 10,000 daily steps maintained or improved their overall fitness scores over their 2011 baseline.

**DISCUSSION:** We have previously shown that physical fitness levels of USU students decline during their preclinical years. This study uses pedometry and step-count goals to motivate students to be physically active. We will prospectively examine this as one way to mitigate declines in fitness among USU medical students during their undergraduate medical education.

## Third Place/Case Report Poster Display RESIDENT CATEGORY

**"Don't Strep on Me…" Group C Streptococcus and Lemierre's Syndrome**
**Shane L Larson, MD, Amina Moghul, DO, Derek G. Zickgraf, DO , Department of Family Medicine, Tripler AMC, Honolulu, HI 96859**

**INTRODUCTION:** Called the 'forgotten disease', Lemierre's syndrome can be an elusive diagnosis, as symptoms include fever, sore throat, neck pain, and others commonly present in viral illness. Clinical suspicion along with appropriate imaging and lab studies allows for the diagnosis.

**CASE PRESENTATION:** 30 year-old Caucasian male admitted with a febrile illness, neck pain, dysphagia, and imaging suggestive of pneumonia noted to have Group C Streptococcus bacteremia on aerobic blood culture. Patient started on antibiotics and CT of the neck revealed deep soft tissue infection. CT scan repeated and revealed left jugular vein thrombosis. Clinical diagnosis of Lemierre's syndrome was made. Further imaging demonstrated pulmonary septic emboli. Long-term intravenous antibiotics and anticoagulation was initiated and patient recovered over months.

**DISCUSSION:** The largest meta-analysis conducted includes 86 studies and 114 total cases. Patient's complaints of sore throat and neck pain are predominant, seen in 20-33%. Radiographic consolidation exists in 75% of patients at presentation, with our patient being diagnosed with pneumonia. While anaerobic *Fusobacterium* species are most typically associated, aerobic organisms constitute less than 10% of pathogens. Streptococcus has rarely been described, with approximately 5 reported cases. Group C Streptococcus has not been described previously. Atypical organisms have previously been linked to cases in advanced age; our case suggests a new causal organism or disease variant.

**SCHOLARLY QUESTION:** Is Group C streptococcus associated with Lemierre's syndrome?

**CONCLUSION:** Supprative thrombophlebitis of the jugular vein, Lemierre's syndrome, is a serious infection which demands the full range of skills of the family physician, as a detailed history and examination can suggest the diagnosis and allow for appropriate lab studies and imaging to be considered. While classic pathogens are described, diagnosis should be considered in the setting of Streptococcus infection with classic symptoms. Treatment duration is not standardized but requires antibiotics with consideration of anticoagulation.

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# consultant report
## AIR FORCE

Michelle R Milner, MD
AF Chief Consultant for Family Medicine Services
San Antonio, TX
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We are living in austere times. Sequestration has changed how military medicine is viewed by the line and we find ourselves obligated to prove our relevance. How do we do this? We look in our own houses and ensure they are in order – ensure our technicians and nurses are allowed to work to their scope of practice. I know as you read that, many of you groaned and thought, "Yeah, you don't know my (nurse/tech)!"

I agree; there exist personality types that are challenging to work with. Also, some of your staff may be afraid of getting back into direct patient care. Consider this, as well, though: are you creating an environment that encourages expanding skills? Think about when you were in medical school – when did you feel the most comfortable and learn the most? Did you have faculty that gently pushed you ("So the ear hurts; what does it look like?" "He has a sore throat that is red and has pus. What do you think is going on?") or did you have faculty that encouraged self-exploration ("Perhaps you could look that up online – the Kx has numerous databases and USAFP is a great website for learning")? These same techniques will allow your nurse or technician feel comfortable growing their skills and refreshing their knowledge. You will find that the support you provide as they explore will pay off in a thoughtful technician who is a confident team member. Your nurse will trust you, will be able to discuss cases with you as an equal, so you can trust his/her judgment when s/he says a patient must be walked in. Your team mates will shift from working as individuals to working as a team – a benefit you and your patients will experience. Get familiar with the scope of care your team members can provide – discuss a piece of the CF-ETP at each huddle and then look for opportunities so your technician can work on that skill. Encourage your 4A, if you are lucky enough to have one, to truly be the office manager of your team. S/he should be able to run your schedule throughout the day, assist with keeping you on time, and provide handouts and documentation for ASIMS.

We also need to take full advantage of the electronic resources we have. If you don't have Secure Messaging/MiCare yet, it is coming. If you do, please know that there is a significant amount of up-front work but, much like the TSWF form, you will not know how you lived without it once you've reached the tipping point. Most facilities find they are extremely happy after they've accomplished a 30% or more registration level. A quick discussion of this: both my mother and mother-in-law (MIL) were diagnosed with the same pathology in the past month. One is part of the Cleveland Clinic medical conglomerate and one is reliant on hodge-podge care as pieced together by the PCM (Oncology, Surgeon based on who the PCM knows). Mom has the Cleveland Clinic version of MiCare – she has immediate access to her results, appointments, and her PCM team. At every step, she's felt very informed and in fact, has had minimal questions for me, the only medic in the family.

On the other hand, my MIL has had challenges simply ensuring her documents and images were available to the specialists responsible for her care. We've been to appointments where the provider had not seen the mammogram and ultrasound, the surgery appointment was scheduled without the actual diagnosis being attached (and therefore a potential delay that wouldn't have occurred had the reason for the appointment been clear) and the different teams are not talking to each other. Don't get me wrong, each provider is thoughtful and well respected. These are the roadblocks they are working around as only the PCM has electronic medical record and none have any sort of electronic communication with their patients. It becomes the responsibility of the patient and the PCM to ensure all these pieces are working in concert but neither have a tool to facilitate this.

Clearly, having Secure Messaging and an electronic medical record, including all the issues we are intimately familiar with, can revolutionize our communication with our patients and our colleagues. We need to use these tools to the fullest. Play around with the systems. Have you ever used the Task function in AHLTA? Do you know how to use reminders in Secure Messaging? Do you know about this Macro, developed by the Army (https://www.youtube.com/watch?v=wkq12C2dAxM&nofeather=True&hd=1 )? These are ways to get the most out of the tools you have. Be bold and share your secret tools with others.

The bottom line is this: we are not going to see an influx of cash anytime soon. Therefore, we need to make the most of our team and the tools we have in order to show our relevance to the line. But in the end, it is really about making the patient experience look more like my mom's and less like my mother-in-law's. Isn't it?

# consultant report
## ARMY

Mark Reeves, MD
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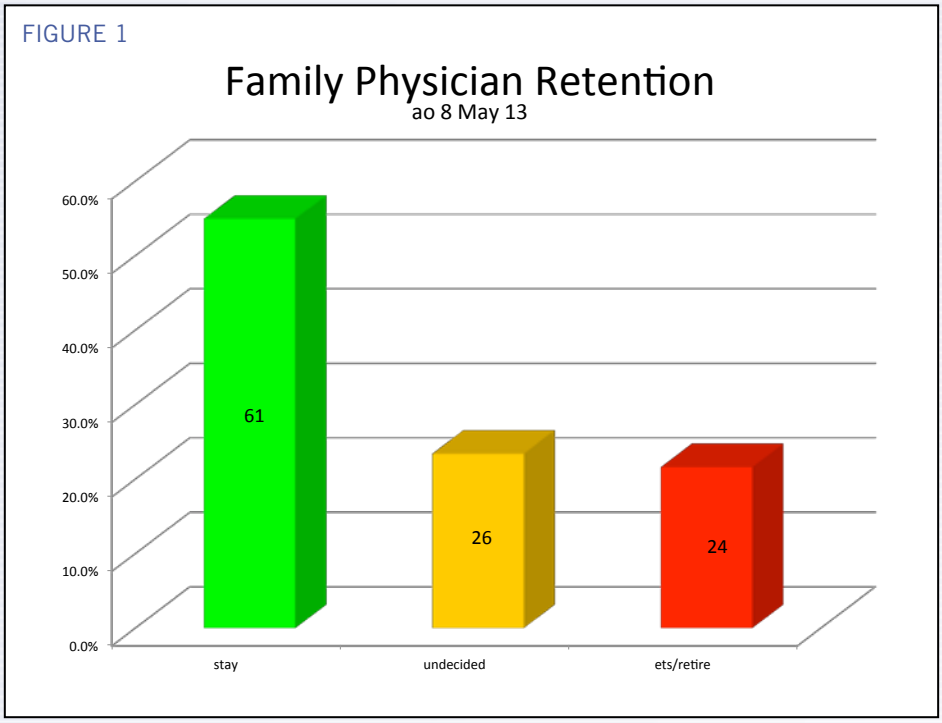
These are interesting, dynamic, and challenging times in which we live. We're twelve years into the war on terror. North Korea and Iran remain areas of interest while the conflict in Syria continues to escalate and then we see terrorism within our own borders during the Boston marathon. Interestingly, many of the first responders, the hospital based medical staff cited their experience, new techniques, and technology developed during recent deployments as incredibly beneficial in the acute and ongoing care for those injured in the bombing incident. No question, the world remains a dangerous place. No question about the relevance of military medicine. In addition we face other threats with ongoing sequestration, DoD budget cuts, a restructuring military and military health system, fiscal constraints requiring carefully considered, swift and decisive action with long lasting implications. No question, there have been frustrating changes (hiring freeze, TDY regulation, USAFP cancelled, etc). No question, we all must be well informed leaders and subject matter experts at every level, committed to the mission, to those we serve, and to one another. Just as the Army will be reshaped, so will Army medicine. Rest assured Army Family Medicine, Army Family Physicians will be at the forefront in these important times. Now, onto a few routine updates.

FIGURE 1




### RECRUITING/RETENTION:

To date, 61 Family Physicians (FPs) with active duty service obligations (ADSOs) thru January 2014 elected to continue to serve in uniform; five of whom changed their minds after submitting their paperwork. Twenty-four FPs made the decision to separate either by retirement or elective termination of service (ETS). Twenty-six FPs remain undecided (see figure 1). Among our majors, 22 elected to stay, 11 separated, and 14 are undecided. "Iron Majors" lead as clinic/practice officers-in-charge and brigade surgeons or junior faculty and truly are essential for the future of Family Medicine. Tremendous opportunities exist for FPs at this level; truly the possibilities are nearly infinite. MAJs Lee, Knight, and I, among others are actively engaged with this group and will continue to work to find viable options to retain these quality officers and their Families within the Army Family Medicine Family. Please help us make sure these quality professionals know their value to the organization. Civilian accessions are numerous for Army Reserve, but have become rare for AD service. LTC(P) Tom Hustead has been selected to lead as the physician lead at Recruiting Command beginning this summer. His addition should bring big dividends to medical student and physician recruiting!

### ASSIGNMENTS:

We're down to the last few assignments at this point. Family Physicians remain in exceedingly high demand for clinic/hospital based, operational, and leadership positions. We'll have approximately 260 assigned to military treatment facilities, 80 assigned as battalion, brigade, group or regimental surgeon positions. Of note, this year sub-specialists accounted for 20% of newly assigned operational surgeons. FPs were selected to lead in 23 of 48 60A positions as, Command Surgeons, Chiefs of Clinical Operations, Deputy Commanders for Clinical Services, Division Surgeons jobs, or senior staff officers at OTSG or AMEDD C&S. Sixteen FPs were se-

FIGURE 2

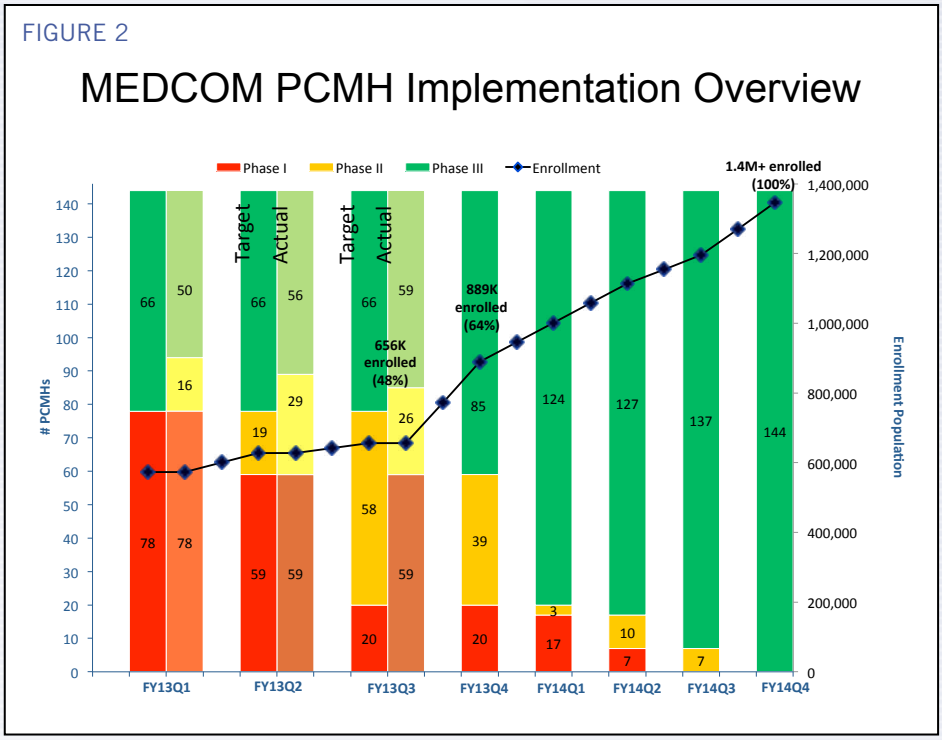
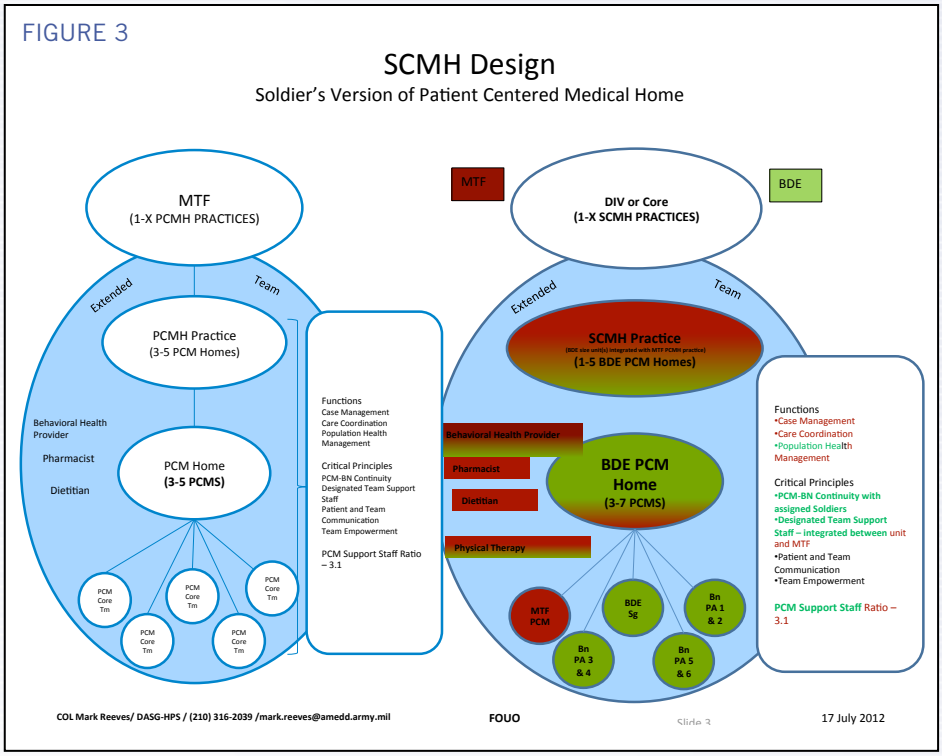



FIGURE 3




lected as primaries or alternates for 06 and 05 Command (LTC(P)s Bailey and Costello, COLs Kyle, Leggit, O'Connor, and Smith). Five FPs of 13 total from the AMEDD were selected as principals for Senior Service College (COLs Dominguez, Murray, Place, Bailey, Krueger). Clearly FPs are leading the way as physician leaders and Soldier docs. The fact that we make up nearly half of these boarded, selected leaders speaks volumes about the exceptional professionals and to the quality preparation throughout the 61H community. We're proud of each of you and thank you for your selfless service and continued dedication.

## QUICK HITS:

PCMH/SCMH is rolling along. Currently at 48% complete with 59 validated Army PCMHs with 656K enrollees in NCQA recognized practices. Criteria to be a valid Army PCMH include: 1)readiness assessment score (evaluates state of manning, training, and equipping) >7.5, 2)successful staff assistance visit utilizing the transformation assessment tool (equivalent to OIP checklist), 3)level 2 or above NCQA recognition. We project 85 practices by end of this FY, 124 practices by Dec13, all 144+ by 30Sep14 to be thru initial implementation (see figure 2). Regional Medical Commands briefed BG(P) Lein on their plan to implement Soldier Centered Medical Home (SCMH) on 21 installations around the world. SCMH is the Soldiers' version of the PCMH, intends to provide 90% of all Soldier care on site, and is exactly the same as all other PCMHs EXCEPT: 1)integrated staffing model including the organic medical staff from the line units in combination with MTF staff to make a complete team, 2)augmented with additional behavioral health capability and capacity, and 3)includes physical therapy capability on site. All these SCMHs will be located in CAT500 buildings owned and operated by the MTF, include basic lab, RAD, and pharmacy on site. They will be located in "close proximity" to the Soldiers primary work area. Priority of effort will be determined by the line units assigned to the SCMH practice. Healthcare standards will be defined and upheld by the Director of Health Services (MTF Commander). These SCMHs will support no smaller than a brigade size and no larger than a division size population (see figure 3). At present RMCs project 45 SCMH practices, most of which will be modified PCMHs rather than established de novo. USASOC and TRADOC specific

*continued on page 22*

FIGURE 4

## MG Phil Volpe
## Family Physician, Leader, Mentor, Hero!

**Thank YOU!**

models are still being confirmed in conjunction with these Commands.

Congratulations to Col (select) Jeff Kueter and LTC(P) Tim Caffrey for their selection to lead as the Department Chair and FT Belvoir and FT Benning, respectively. Both will do a great job in two of our most important 61H leadership positions. They will shape the future of Family Medicine as they train and lead residents and faculty. We're counting on them as leaders with vision, passion, vast experience, and commitment to excellence in Family Medicine and scholarly activity.

Speaking of excellence in scholarly activity, congratulations to the Army winners in the USAFP annual research competition! CPTs Kyle Hoedebecke (R3, Bragg), Mike Bybel (R3, Hood), Mike Needham (R2, Gordon), Shane Larson (R3, Tripler), and Dr. Elisabeth Chang (R3, Tripler) stand out for their academic and scholarly excellence with award winning original research, case reports, and/or poster presentations. They, along with Lt Col Anthony Beutler and the judges' panel, stand-out not only for their scholarly accomplishments but also for their innovation, resilience, and commitment to complete this event utilizing the virtual space as a consequence of the cancelled assembly. Job well done by all! Thanks for leading on the cutting edge of Family Medicine.

When it comes to excellence in leadership as a premier Soldier doc, Army Family Physician, role model, advisor, and mentor to all, no one stands above MG Phil Volpe. On 5 April we celebrated a 30 year career in which he excelled as a clinical, academic, operational leader and Commander at every level during deployments to Panama, Somalia, Haiti, hurricane relief in Florida and North Carolina as a junior faculty and department chair in two FM residency programs, Academy President, a Command surgeon with 82nd, JSOC, VIII Army/US Forces Korea, Commanding General for 44th Medical Command/XVIII Airborne Corps, WRMC, and culminating at the AMEDD C&S leading Warrior medics in a joint environment where it all begins. MG Volpe truly embodies the Army core values: Loyalty, Duty, Respect, Selfless Service, Personal Courage and the Warrior Ethos: always place the mission first, never accept defeat, never quit, and never leave a fallen comrade. MG Volpe, You truly are an American hero in every sense of the word and leave an enduring legacy for which we are eternally grateful (see figure 4).

To date, 61 Family Physicians (FPs) with active duty service obligations (ADSOs) thru January 2014 elected to continue to serve in uniform; five of whom changed their minds after submitting their paperwork. Twenty-four FPs made the decision to separate either by retirement or elective termination of service (ETS). Twenty-six FPs remain undecided.

### CONCLUSION:

Thanks to each of you for all you do every day! Serving to Heal, Honored to Serve!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Greenville, South Carolina is a beautiful place to live and work. We enjoy a diverse and thriving economy, excellent quality of life and wonderful cultural and educational opportunities. Greenville Health System is an equal opportunity employer which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

**Please submit letter of interest and current CV to In-House Physician Recruiter, Kendra Hall, kbhall@ghs.org, Ph: 800-772-6987.**

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*no correspondence or contact from recruitment firms*

# FAMILY PHYSICIAN OPENING IN FORT WALTON BEACH, FLORIDA

Magnolia Medical Clinic is a well-established Family Practice Clinic located in sunny Fort Walton Beach, Florida. We have an *immediate* opening for a board certified family physician to join our four physicians, two of whom are retired military and current USAFP members. Our offer is for employment to partnership with excellent benefits.

The clinic is within minutes of the Gulf of Mexico. The Emerald Coast's white sandy beaches are breathtaking! Water sports, deep-sea fishing, boating, golfing, hunting and a wide variety of activities along the coast are part of daily living in northwest Florida. We are located close to Eglin Air Force Base and Hurlburt Field in a military-friendly town. We have an excellent school system. Okaloosa County rated the highest number of "A" schools in the state of Florida. The excellent three-season weather and quality schools make this a wonderful place to work and raise your family!

Our reputation for personalized and outstanding patient care combined with our established relationship and network with specialty physicians make our practice rewarding. You will find autonomy to practice medicine to your liking, within the security of a well-run group practice. We are affiliated with the Fort Walton Beach Medical Center.

Our clinic has a full service laboratory and imaging department that includes X-ray and Dexascan. We provide the full spectrum of out-patient family medicine. No OB or in-patient care requirements. Call is phone only. Our physician income is consistently in the top 5-10th percentile of family physicians nationally while working a four-day work week. Additionally, Florida is notable for having no state income tax.

If you are interested in joining our very successful medical home, please call Peter Senechal, MD FAAFP (USAF retired) or Chris Pappas, MD FAAFP (US Army retired) at (850) 243-7681. Don't miss out on an opportunity of a lifetime!

Matthew Barnes, MD
Lackland AFB, TX
Matgbarnes@gmail.com

# Finding Out *GASP* Your Numbers…

As a Junior Staff, there's only one thing that scares me more than a challenging patient, having an emergency, or just being hated: it's going to that infamous hallway with the royal blue carpeting, with the solid oak furniture and discussing the "business of medicine." Most new providers are scared by ghastly appointment numbers, goulish RVUs, and that always looming "bottom line" – how much can you prove that you work? When are summoned to the frightening hallway, you have two choices: 1) you can ignore the business of medicine, and emotionally plead your case, or 2) you can learn a tool that's only a couple of clicks, but may allow you to argue your case in a Commander's language.

When are summoned to the frightening hallway, you have two choices: 1) you can ignore the business of medicine, and emotionally plead your case, or 2) you can learn a tool that's only a couple of clicks, but may allow you to argue your case in a Commander's language.

It requires no computer expertise to do this, and most reports can be run in a minute or so. Follow these instructions to see what information you can gather.

**Step One:** Open AHLTA.
**Step Two:** Open the "Reports" tab.
**Step Three:** Choose a Report from the drop-down menu. Under "With Scope Of" click provider, and name the provider (this can be any provider you're mapped to). Enter an appropriate time period – the shorter the time period, the less time it takes to run a report.
**Step Four:** Click Run Report.
**Step Five:** Wait and be amazed.

## NUMBER OF APPOINTMENTS:

This is the most basic of reports. When you choose the appointment reports, you'll see a quick list of the appointments seen, how many charts are open, how many no-showed, and how many were cancelled.

Uses:

- A raw number of the patients that you've seen in a given amount of time – this is your raw workload.
- This can be used to create goals for your team – for instance, you could track your no-show rates, bookable appointments, etc…
- By seeing the notes "in progress", you'll know how many charts you have open – a big ticket issue.

Pitfalls:

- An appointment is an appointment -- specialty clinics (like an EFMP clinic) will count the same as other appointments, even though they may require less work.
- It does not take workload into account. A complicated 84 year old cardiac patient will count exactly the same as that healthy 21 year old with a cough.

## E&M CODE:

Another method to prove your workload – this counts the appointment of coded appointments. You can use this in conjunction with the Procedures report to capture other areas of workload – EKGs, Pulse Ox, and Peak Flow.

Uses:

- More appropriate measures of workload.

Pitfalls:

- Most visits are 99214s; even complicated ones.
- If you have open charts, they won't count.
- These numbers can be meaningless without comparing to a universal standard.
- If you code well, you'll look great. If you code poorly, you won't look so great.

## DIAGNOSIS:

This counts the numbers of each diagnosis that you've seen (i.e. in the past month, you've seen 90 cases of back pain, 40 cases of high blood pressure, etc.)

Uses:

- You can use this to prepare for your clinic the best way possible.
- Where are you going to get the most "bang for your buck" as it applies to training your techs and nurses?
- What diagnoses will run rampant in 6 months time, possibly being mitigated through PCMH activities (pharmacy and nursing protocols)?

Pitfalls:

- Last year's numbers don't always mean this year's numbers.
- If you aren't coding the same diagnoses persistently, your data won't be as strong.

**Most new providers are scared by ghastly appointment numbers, goulish RVUs, and that always looming "bottom line" – how much can you prove that you work?**

### MAMMOGRAM AND PAP REPORTS:

Beware. When the warning says this takes a few minutes, it's not lying. This report generates those that are delinquent for mammograms (by USPSTF guidelines).

Uses:

- Can use your team to proactively manage disease. Your techs, with a script, can encourage women to get mammograms.

Pitfalls:

- If the patient has a civilian or VA mammogram, then they'll still be shown as delinquent.
- If the patient is over 75 years old (above the USPSTF guidelines, they'll still be placed on the list).

### Radiology/Medication Reports:

Do you MRI everything that moves? Are you giving Aciphex when you should be giving Nexium? Run these reports to understand your practice patterns.

Uses:

- Medication reports can be run by your local pharmacist (especially clinical pharmacists) to see what medications are cheaper and more effective to prescribe.
- Radiology reports can be great to cater your exam and practice patterns. If you see a lot of L-Spine MRIs, make your back exam as strong as it can be (refer to the CPG).

Pitfalls:

- There are no standards on how many MRIs are standard practice, nor how many medications. These numbers can vary WILDLY from month to month, and from case to case.
- If you have a complicated panel, you'll order complicated medicines.

Boo. See? Not scary. No monsters in your closet. Make your data work for you. Not against you.

You can find Procedures Counts, Provider Top 20 Drugs, ER Top Utilizers and much more within AHLTA. Give anything you want a try. You never know when it will come in handy.

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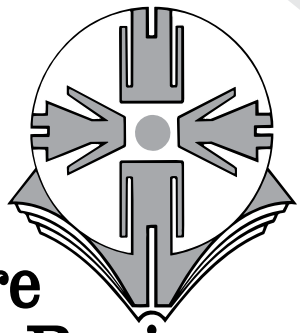

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# "What Are You Listening To? Podcasts and Quality Medical Information for the Mobile Family Physician"

Shortly after the launch of the original iPod in October 2001, users began to look for ways to obtain "news" on their devices in addition to music. Already available as RSS feeds, developers began releasing these feeds as MP3 files for download to Apple's wildly popular music player. In 2004, Apple introduced Podcasts to their iTunes software and podcasting as we now know it was born. Today there is an estimated 100,000 different podcasts available for mobile devices running a variety of operating systems. Luckily for the average family physician, there are some high quality medical podcasts available. This article will review some of the "best" podcasts available for family physicians. This list is not meant to be exhaustive and I welcome your feedback on what podcasts you have found useful.

1) The Therapeutics Education Collaboration (TEC) is by far my favorite podcast. Introduced to me by Dr. Reese, this podcast most closely resembles NPR's Car Talk with Click and Clack. Dr. Mike Allan, a family physician, and Dr. James McCormack, a PharmD, from Edmonton and Vancouver, Canada, respectively, provide chatty evidence-based podcasts every week on numerous primary care topics. The podcasts are completely free, though a "premium membership" ($50.00) gets you access to additional podcasts. Occasional audio issues occur as they record their podcasts using Skype, since they are over 700 miles away from each other, but overall the audio quality is quite good.

   Website: *http://therapeuticseducation.org/* or available through iTunes free of charge.

   Almost as good as their podcast, are their numerous free web-based resources! First, Dr. Allan and his colleagues have created "Tools for Practice". Think of this as the Canadian version of the Family Physicians Inquiries Network (FPIN), but for FREE! They have evidence-based summaries on over 200 topics available here: *http://www.acfp.ca/WhatWeDo/ToolsforPractice.aspx*

   Dr. McCormack and Dr. Allan have also created an online Journal Club of sorts providing short summaries of several hundred of the most discussed primary care articles called MyStudies. You can access MyStudies at https://mystudies.org or download their beautiful iPad (only) app from the iTunes App Store. A one-year subscription to MyStudies is $10 and includes both web and iPad access. Finally, Dr. McCormack has released a free iPad (only) book entitled, "How to Critically Appraise an RCT in 10 minutes". This interactive book is a fantastic review for seasoned EBM gurus and a great introduction for those who are still a bit hesitant to jump into the deep end of the EBM pool. You can find it in the iTunes Bookstore on your iPad or via this link: *https://itunes.apple.com/us/book/how-to-critically-appraise/id524600667?mt=11*

2) "Patient Oriented Evidence that Matters", the POEM of the Week Podcast, is another outlet to review the POEMs that have become one of the mainstays of EBM in the United States. Created in the 1990's by Dr. Mark Ebell as InfoPOEMS/InfoRetriever, the company is now owned by Wiley and called Essential Evidence. Dr. Ebell still leads the weekly podcast covering evidence-based summaries of recent research important to primary care physicians. Audio quality is excellent, but if you already receive the Daily POEM (which is available for free to all USAFP members), the POEM of the Week Podcast may be redundant. Simply reading the Daily POEM email is significantly less time consuming. You can find the podcast

*continued on page 30*

here: *http://www.essentialevidenceplus.com/subscribe/netcast.cfm* or free of charge via iTunes.

3) Hospital Medicine Podcast is excellent for the family physician who continues to provide inpatient care. This podcast is not from The Society for Hospital Medicine, but rather an independent producer, Dr. Gil Porat, MD. Hospital Medicine Podcast provides brief reviews on a variety of topics ranging from end-of-life care to immune thrombocytopenia. Be aware of occasional sound issues and editorializing. Available only via iTunes: *https://itunes.apple.com/us/podcast/hospital-medicine-podcast/id541752791*
4) ercast is an outstanding evidence-based, but mostly interview driven, podcast providing great reviews of common emergency medicine topics. Chatty and fun at times with good audio quality, ercast is produced by Dr. Rob Orman who also runs his own blog. You can access ercast from Dr. Orman's blog: *http://blog.ercast.org/ or via iTunes: https://itunes.apple.com/us/podcast/ercast/id353141357*
5) Keeping Up Podcast from the Vanderbilt University Department of Emergency Medicine provides brief (4-10 minute) reviews of current articles in emergency medicine and acute care for free. The Keeping Up website contains links to show notes with articles to review. Great sound quality with some editorializing and practice pointers as well. *http://keepingup.vanderbiltem.com/index.php?option=com_content&view=section&id=9&Itemid=75* or through iTunes: *https://itunes.apple.com/us/podcast/keeping-up-emergency-medicine/id458709587?ign-mpt=uo%3D4*
6) Pediatrix University Grand Rounds is a podcast provided by a large accredited academic group of general and subspecialist pediatrics and OB/GYN providers with a focus on grand rounds style presentations in neonatal and maternal/fetal medicine. Somewhat dry, but good topics from expert speakers covering areas we all could improve at anyway. *http://media.pediatrix.com/audio/* or via iTunes.
7) Pedcasts are pediatric podcasts from the University of Arizona Pediatrics Residency Program. Due to duty hour constraints, the residency moved to a completely podcast based curriculum for their residents. The Pedcasts are interview based with expert discussion and occasional POEMS with an emphasis on prevention. Audio quality is good. *http://www.peds.arizona.edu/residency/podcast.asp* or via iTunes.
8) Audio Digest is really the "gold standard" in audio medical education. They have been providing tapes, then CDs, and now MP3 files for over 60 years. Best of all you can access this outstanding resource for free as a USAFP member. The USAFP provides free access to several Audio Digest categories including: Family Medicine, Pediatrics, OB/GYN and Emergency Medicine. These can be a bit dry, but the audio quality is outstanding. Audio Digest has their own iPhone/iPad app that works great with our USAFP membership. Please e-mail *mlwhite@vafp.org* to obtain the user id and password to access Audio Digest MP3 files.

Luckily for the average family physician, there are some high quality medical podcasts available. This article will review some of the "best" podcasts available for family physicians.

# Congratulations to the USAFP Members that Received the AAFP Degree of Fellow

The Degree of Fellow recognizes AAFP members who have distinguished themselves among their colleagues, as well as in their communities, by their service to Family Medicine, by their advancement of health care to the American people and by their professional development through medical education and research. Fellows of the AAFP are recognized as Champions of Family Medicine. They are the physicians who make family medicine the premier specialty in service to their community and profession. From a personal perspective, being a Fellow signifies not only 'tenure' but one's additional work in your community, within organized medicine, within teaching, and a greater commitment to continuing professional development and/or research.

Congratulations to the following USAFP members!
Courtney Ann Dawley, DO, FAAFP
Amanda S. Cuda, MD, FAAFP
Devin P. McFadden, MD, FAAFP
Erich R. Heinz, MD, FAAFP
Theodore R. Brown, DO, FAAFP

# NOTICE FROM THE MEMBERSHIP AND MEMBER SERVICES COMMITTEE

If you are looking for opportunities to complete face-to-face CME, please visit the AAFP's Chapter Meeting Site via the link below or attend the AAFP Scientific Assembly September 24-28, 2013 in San Diego, CA.
*https://nf.aafp.org/MyAcademy/contactmychapter/Index/ChapterMeetings*

# The AAFP National Conference of Family Medicine Residents and Medical Students is quickly approaching!!

Join your peers for leadership forums, nationally recognized speakers, a huge Expo Hall, hands-on sessions, workshops, and social events.

**National Conference Important Deadlines**

* **JUNE 27**
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* **JULY 3**
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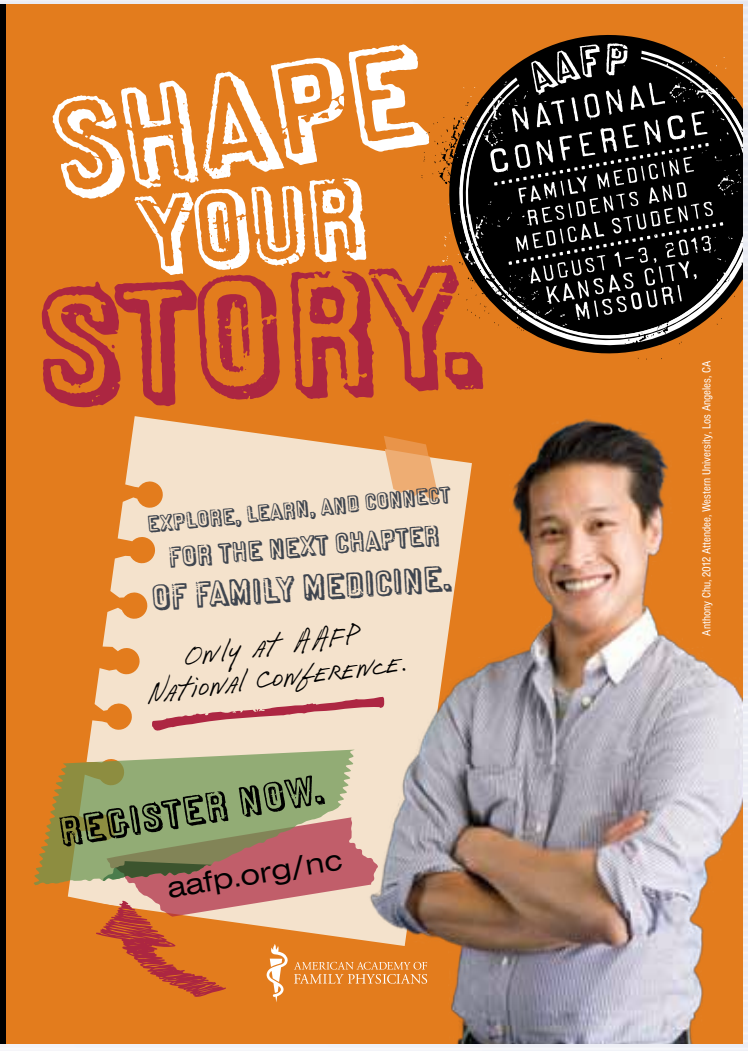


Amanda S. Cuda, MD
Faculty Development Fellow,
Madigan Army Medical Center, JBLM, WA
amanda.cuda@us.army.mil

# Marketing Family Medicine and Our Clinics: I'm Lovin' It…Just Do It… It Gives You Wiiiings!

Dr. Payne suggested in last quarter's Practice Management committee article that practice managers "ride switch", or try new things to keep their practice interesting and dynamic. Marketing is a very interesting business concept that has great potential for interesting and dynamic application for practices. Management professionals recognize the enormous benefit of marketing on their business. Wikipedia defines marketing as "the process of communicating the value of a product or service to customers." Marketing may well be the spark that transforms our practices and our specialty. Family Medicine needs effective marketing right now.

Marketing in military medicine is obviously not intended to increase financial profits, but consider other profits that might increase with marketing: the shares of patient enrollment, patient satisfaction and loyalty (especially to family medicine), front line employee satisfaction and productivity, retention and recruitment of family physicians and staff loyal to family medicine. Perhaps medicine, particularly military medicine, has shied away from traditional business models because "medicine is not a business." Medicine may not be a business like Apple or Nike, but those of you in practice management roles recognize that business management principles are alive and well in our practices, especially when it comes to people. And that's who marketing is all about: people. Entire courses are dedicated to marketing principles. Three are presented here with immediate applications that may or may not be feasible in your practice. Take these brainstorming seeds, plant them, and see what grows in your specific environment.

## "I'M LOVIN' IT": BRANDING

This key concept to marketing theory was adopted from cattle owners in an effort to differentiate their animals from another rancher's cattle. The marketing application is obvious: the symbol, design, or name that differentiates one product from another. You will think quickly of logos of your favorite consumer products. You may then think of the logo of your Service, your Medical Command, your Hospital… how about your Clinic? Consider the impact of an identifying, unifying symbol on your patients and your front line employees. T-shirts, website, front desk, business cards, letterhead…within financial reason, of course. It might not have any impact, or it might build confidence and loyalty among your patients, potential patients, and employees.

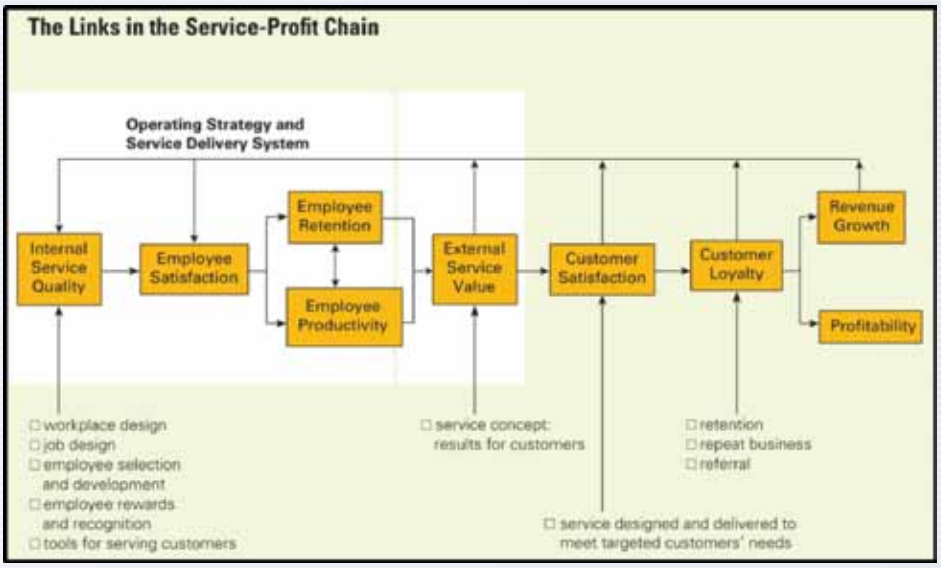
The evolution of the Family Medicine identity seems to be centering on the brand of the "Personal Physician". Decide with your medical staff if this is how the family physicians and providers in your clinic will be branded. Perhaps your practice will have a slightly different brand: "My Health Coach", "My Doc", or "My Medical Home". By having the discussion, you may help lead your family physicians and providers to a values based vision for the practice: does the clinic provide full spectrum care, holistic wellness, patient centered care, soldier centered care, or all of the above. Create a brand and inspiration may follow.

## "JUST DO IT": CUSTOMER SERVICE AND SATISFACTION

Alarm bells going off again? "Patients are not customers?" Again, business theory helps us with this. Specifically, take a look at the following diagram from the Harvard Business Review. Heskett etal describes the diagram in the article: "here's how the chain works: enhancing internal service quality (equipping employees with the skills and power to serve customers) raises employee satisfaction, which fuels employee loyalty and productivity, which boost external service value-which then increases customer satisfaction and loyalty."[1]

Again, do not emphasize revenue or profits in this model; rather consider the progression of concepts. Internal service quality and employee satisfaction will drive customer satisfaction. The current furlough has not been satisfying to many employees, especially those on the front lines of our clinics. How can we best market the furlough to our employees? New programs and process improvements, including the Patient Centered Medical Home change the way employees do business, or the internal service quality. Consistent with most change management theory, this model confirms that progressive changes should be marketed to the employees as well as patients.

Consider creative communication strategies to reach your employees other than email. Record a




monthly video update and post to a shared site with a creative title like "The Monthly Show". Schedule lunch walks with your front line employees, especially the Medical Support Assistants, Nursing Assistants, and Enlisted administrative support. Consider a "personalized" welcome letter or secured email to new patients as a method of establishing lines of communication. Invite new patients to a "meet and greet" with the providers, clinic staff, and clinic leadership. It could be held on a semi-annual interval, located in the clinic or other centralized place.

## "IT GIVES YOU WIIIINGS!": CHALLENGE (AND CHANGE) YOUR MENTAL MODELS[2]

This MIT Sloan Management review article calls the business world to ideals that our clinics and specialty could seek to achieve, as well: "we need to rethink our mental models to embrace the evolving segment of empowered consumers with new ways of understanding their behavior, capturing the data on their behavior, analyzing it, and designing strategies to affect their behavior in a way that is consistent with the company's objectives."2 Creativity and innovation are required in the marketing of Family Medicine clinics, the PCMH, and the specialty of Family Medicine to the Military Health System. This is the fun part, but does require diligent knowledge of all the links in your clinic's service profit chain.

The article suggested an interesting application called "reverse mentoring". Experienced managers would seek the understanding of "younger" mentors in order to learn about new markets and technologies. Young medics have consistently been a wealth of ideas and energy for practice managers. Seek the feedback of a variety of generations and perspectives from among your employees and your patients.

## BEST PRACTICES

Whether you knew what you were doing or not, perhaps you have already applied many of these marketing principles and ideas to your practice. Maybe you have ideas for how to market specific aspects of Family Medicine clinics, the PCMH, or Family Medicine as a specialty? Would you email those best marketing ideas and practices to the Practice Management Committee? We'd love to collect them and post them to our new area on the USAFP website: *elizabeth.duque@us.army.mil* and *amanda.cuda@us.army.mil*.

**Can you match the brands and the slogans?**

| | |
|---|---|
| **I'm Lovin' It.** | **Redbull** |
| **Just Do It.** | **McDonalds** |
| **It Gives You Wiiiings!** | **Nike** |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# EVERY DOC CAN DO RESEARCH

Have you wanted to do a research project but were not sure how? Would you like a user friendly workbook to help you over the inertia of starting a project? The Clinical Investigation Committee is pleased to offer user friendly tools for organizing, planning, and starting a research project.

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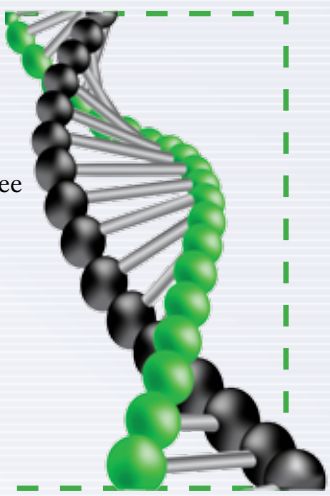

# Family Medicine Faculty Positions at UT-Jackson Family Medicine

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# What Every Deploying Doc Should Know About Aeromedical Transport

1. **Safe approach:** Helicopter and fixed wing aircraft save lives every day in deployed operations, but they can also kill. A number of medical personnel have been seriously injured or decapitated by inadvertently walking into an aircraft's 'danger area.' Do not approach an aircraft without a clear hand signal from a crewmember. Never approach toward a rotor system or jet engine blast area, especially from downsloping terrain.
2. **Manage physiologic stresses of flight:** Trapped gas expands. Once in flight, even small amounts of trapped gas can grow into a significant medical problem. The jury is still out on the benefits of filling the endotracheal tube cuff with normal saline. No one doubts the wisdom of nasal gastric tubes for patients who have recently undergone abdominal surgery or who are otherwise at risk for ileus. Afrin can help relieve the sinus pressure that occurs with altitude changes in patients with upper respiratory infections. Unless other life-threatening injuries are present, do not air evac a patient with trapped air in the globe until cleared by an optometrist. If a chest x-ray is unavailable, err on the side of inserting a chest tube in a patient with suspicion for a pneumothorax. A small pneumothorax can rapidly expand in flight. Prepare for increased pain requirements.

   Pain from fractures typically increases two-fold with rotary wing transport. Aggressively prevent hypothermia and hypoxia. Temperature and oxygen saturation drops predictably with altitude. Angel Warmers or other thermal blankets are life-savers for poly-traumatic patients; temperature dots placed on a casualty's forehead can help monitor dangerous temperature drops. Flying patients without adequate warming measures, even in a desert environment, sets them up for coagulopathy. Patients without an oxygen requirement on the ground may develop one in flight due to altitude alone. If even the thought of 'intubation' enters your head, the time is probably right to definitively secure the airway of that patient preparing for a long air transport. Likewise, it is best to wait 24 hours after an extubation to fly. Intubation is challenging in-flight especially when complicated by evasive maneuvers, vibration and poor lighting. Anticipate the need for anti-emetics and, unless contraindicated, load your patient prior to flight. Casts should be bi-valved unless a full cast is critical to the integrity of a fracture. Similarly, any casualty with a wired jaw should be transported with equipment to cut the wire in the event of airway problems.
3. **Stay current and train before you go:** Aeromedical transport skills can be just as perishable as critical care skills. Seek extra or refresher training if you know you will be involved with aeromedical transportation. CENTCOM Clinical Practice Guidelines are updated routinely in order to reflect best practices for aeromedical transport based on outcome evidence: *http://www.usaisr.amedd.army.mil/.*
4. **Patient packing techniques:** There is no one "right way" to package. Focus on: safety, access, organization.
5. **Know the right way to communicate:** Be sure every patient that you send out through fixed wing transport has a patient movement request (AF3899). The documentation you provide ensures that the right patient gets to the right location with the right receiving medical support and bed space. Be sure to annotate as needed medications. Once air transport is underway it will be very difficult for an in-flight team to get in touch with you for verbal pain, sedation or nausea medication orders. If flying MEDEVAC, follow the lead of the en-route care team and do not use white light during night operations, which can mark the aircraft to the enemy.

Pain from fractures typically increases two-fold with rotary wing transport. Aggressively prevent hypothermia and hypoxia. Temperature and oxygen saturation drops predictably with altitude.

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# Direct Observation of Learners

*"There is no more difficult art to acquire than the art of observation, and for some it is quite as difficult to record an observation in brief and plain language."* – Sir William Osler

## WHY DIRECT OBSERVATION?

Sir William Osler was prophetic in his thoughts on observation, perhaps especially when it comes to medical education. Core clinical skills including history-taking, physical examination, and patient education rely heavily on observation. Several studies exist suggesting that deficiencies in these areas persist, both amongst learners and even faculty. (Holmboe, 2008, p.120) Given the well-established importance of accurate history and physical exam findings in correct diagnosis, a high emphasis must be placed on resolving these shortcomings. One critical evaluation tool available to educators is direct observation (DO) of learners. Both the ACGME and the LCME mandate continual assessment of learners' clinical proficiency, including direct observation. Further, the Next Accreditation System (NAS) will incorporate milestone assessment semi-annually, requiring increased specificity in reporting learner behaviors. Direct observation of trainees with actual patients is a cross-competency evaluation tool, retaining high utility even as standardized patients and simulation gain further prominence in medical education.

Challenges to increased use of direct observation include the need for dedicated time in a 1:1 faculty to learner ratio, initial faculty and learner discomfort, and a need for repeated episodes to increase reliability, validity, and learner perception of value. These challenges may account for clear evidence in the literature noted by Holmboe (2008, p. 121) and others that direct observation is lacking in both frequency and quality in medical education. Conversely, a national survey of students and residents found that increased direct observation is associated with perception of increased educator knowledge of learners, and a resultant increase in feedback (Mazor et al., 2011). Tools for implementation of DO with accompanying faculty development methods have emerged to ease development of the art of observation, both for educators and medical learners.

Similar to feedback, a culture in which DO is routine and expected will help to improve learner, patient, and faculty comfort with the technique, and improve accuracy of and satisfaction with evaluation. Train faculty, choose a tool, and the difficulty noted by Osler can be significantly alleviated.

## EFFECTIVE IMPLEMENTATION

Two primary steps exist in assuring accurate direct observation. First, faculty must be trained to ensure consistency. Second, selection from amongst several available tools can improve ratings' validity, reliability, and increase error detection.

Faculty training can use one of several published approaches:

- **Behavioral Observation Training** combines increased observation episodes, use of observational tools such as those described below, and preparation of specific DO learning objectives.
- **Performance Dimension Training** (PDT) specifically familiarizes raters with detailed criteria for trainee behaviors, using a deeper understanding of specific norms and benchmarks to standardize ratings across faculty.
- **Rater Error Training** (RET) extends PDT to focus on the levels of performance of the learner in each performance dimension or competency.

The transition to the NAS with milestone reporting will make some form of PDT and RET highly valuable for residency faculty. Novel approaches being described include rating standardized residents, using an audience response system to rate videotaped learner scenarios, and Objective Structured Teaching Examinations focused on evaluation. A full description of these approaches and re-

sources for their implementation can be found in Eric Holmboe's Practical Guide to the *Evaluation of Clinical Competence* (2008), cited below.

Various authors have described step-by-step approaches to DO, including Holmboe in the *Practical Guide.* Common lessons from various authors include:

1. Clearly establish protocol and expectations with the patient and the learner alike, and consider obtaining patient consent.
2. Ensure appropriate positioning. Rater presence should not physically interfere with the exchange between the learner and the patient, but faculty need to be in a position to adequately assess the interaction.
3. Avoid interjecting if at all possible. Once a rater injects himself into the learner-patient interaction, it is altered irretrievably. Corrections and discussion are best left for the end of the visit.
4. Provide a clear, structured debriefing employing the principles of effective feedback.

## TOOLS

A systematic review conducted by Kogan et al. (2008, p. 1316) identified and compared 55 tools for direct observation of actual patient encounters published in the medical education literature. Eleven of these had validity evidence, and 26 described associated faculty training. The tool with the most robust evidence is the Mini-Clinical Evaluation Exercise (Mini-CEX). The mini-CEX is designed to be employed in daily practice, with faculty observing learners in various settings and for varying lengths of time. A 9-point rating scale is used to evaluate specific skills, assess overall competency, and structure feedback. Tools can also be as simple as checklists, which have been shown to increase detection of errors in learner performance, although not to improve overall assessment of competence.

Tools may be constructed and tailored to the specific needs of a learning event, or accessed through several online resources. The STFM Residency Competency Assessment Toolkit is a robust resource for DO tools, as well as further exploration of direct observation. The RC Toolkit is available at http://www.stfm.org/RCtoolkit/Tools_Observation.cfm.

## SO WHAT?

The bottom line for direct observation? Do it early, and do it often. Similar to feedback, a culture in which DO is routine and expected will help to improve learner, patient, and faculty comfort with the technique, and improve accuracy of and satisfaction with evaluation. Train faculty, choose a tool, and the difficulty noted by Osler can be significantly alleviated.


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