THE UNIFORMED FAMILY PHYSICIAN

Spring 2020 • Vol. 13 • Num. 1 • Ed. 51

DEBRA A. MANNING, MD, MBA, FAAFP INSTALLED AS 2020-2021 USAFP PRESIDENT

SEE PAGE 8

Journal of The Uniformed Services Academy of Family Physicians

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THE UNIFORMED FAMILY PHYSICIAN

The Uniformed Services Academy of Family Physicians

1503 Santa Rosa Road, Suite 207
Richmond, Virginia 23229
804-968-4436
FAX 804-968-4418
www.usafp.org

USAFP e-mail

Mary Lindsay White: mlwhite@vafp.org
Cheryl Modesto: cmodesto@vafp.org

Newsletter Editor

A. Marcus Alexander, MD

VISION

The USAFP will be the premier professional home to enhance the practice and 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 joint readiness, health and wellness through education, scholarship, advocacy, and leadership.

This newsletter is published by the Uniformed Services Academy of Family Physicians. The opinions expressed are those of the individual contributors and do not reflect the views of the Department of Defense, Army, Navy, Air Force, Public Health Service or The Uniformed Services University of the Health Sciences.

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For Advertising info contact
Michele Forinash • 1-800-561-4686
mforinash@pcipublishing.com

Edition 51

your academy leaders

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PRESIDENT
Debra A. Manning, MD, MBA, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

PRESIDENT-ELECT
Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

VICE-PRESIDENT
A. Marcus Alexander, MD
AFPC, TX
antoin.alexander@us.af.mil

SECRETARY-TREASURER
Maria D. DeArman, MD, FAAFP
Corpus Christi, TX
maria.d.dearman@gmail.com

PAST PRESIDENT
Christopher E. Jonas, DO, FAAFP
USUHS, Bethesda, MD
jonaschris@hotmail.com

EXECUTIVE DIRECTOR
Mary Lindsay White, MHA
Richmond, VA

DIRECTORS

AIR FORCE
Heidi Gaddey, MD, FAAFP
Travis AFB, CA
heidigaddey@yahoo.com

Jeanmarie Rey, MD, FAAFP
Fort Belvoir, VA
alohagigi@gmail.com

Kattie Hoy, MD, FAAFP
Nellis AFB, NV
kattie.hoy@gmail.com

ARMY
Joshua S. Will, DO, FAAFP
Fort Benning, GA
joshua.s.will@gmail.com

Drew C. Baird, MD, FAAFP
Fort Hood, TX
drewbaird2002@yahoo.com

Meghan (Mimi) Raleigh, MD, FAAFP
Fort Leavenworth, KS
mraleigh32@yahoo.com

NAVY
Kelly G. Koren, MD, FAAFP
USMC Wounded Warrior Regiment
kelly.koren@usmc.mil

Kevin M Bernstein, MD, MMS, FAAFP
Naval Hospital Jacksonville, FL
kevin.bernstein@gmail.com

Francesca M. Cimino, MD, FAAFP
USUHS, Bethesda, MD
francescacimino@gmail.com

PUBLIC HEALTH SERVICE
Khalid A. Jaboori, MD, MPH, FAAFP
USCG Seattle
kjaboori@hotmail.com

Preciosa P. Pacia-Rantayo, MD, FAAFP
USCG Base Cape Cod, MA
Preciosa.p.pacia-rantayo@uscg.mil

RESIDENTS
Alexis Aust, MD
Eglin AFB, FL
alexisaust@gmail.com

Ryan M. Coffey, MD
Fort Benning, GA
Ryan.m.coffey7.mil@mail.mil

Chris A. Cruz, MD
Camp Pendleton, CA
cacruz2010@gmail.com

STUDENTS
Austin Fry
USUHS, Bethesda, MD
austin.fry@usuhs.edu

Anna Priddy
St. Louis University School of Medicine
St. Louis, MO
anna.priddy@health.slu.edu

AAFP DELEGATES
Douglas M Maurer, DO, MPH, FAAFP
Defense Health Headquarters
Falls Church, VA
douglas.m.maurer.mil@mail.mil

Christopher E. Jonas, DO, FAAFP
USUHS, Bethesda, MD
jonaschris@hotmail.com

ALTERNATES
Debra A. Manning, MD, MBA, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

CONSULTANTS

AIR FORCE
Michelle K. Anton, MD, FAAFP
JBSA-Kelly, TX
dr.michelle2002@hotmail.com

ARMY
Kevin M. Kelly, MD, FAAFP
Fort Bragg, NC
kmkellymd2003@yahoo.com

NAVY
James W. Keck, MD, FAAFP
Naval Hospital Jacksonville, FL
jkeck@usna94.com

COMMITTEE CHAIRS

CLINICAL INFORMATICS
Matthew G. Barnes, MD, FAAFP
Wright Patterson AFB, OH
matgbarnes@gmail.com

CLINICAL INVESTIGATIONS
Robert C. Oh, MD, MPH, FAAFP (Chair)
Madigan AMC, WA
Roboh98@gmail.com

Heidi L. Gaddey, MD, FAAFP (Vice Chair)
Travis AFB, CA
heidigaddey@yahoo.com

CONSTITUTION & BYLAWS
Barrett H. Campbell, MD, FAAFP
JBML, WA
Barrett.h.campbell@gmail.com

EDUCATION
Garrett J. Meyers, MD, FAAFP
Ft. Hood, TX
garrettjohn@yahoo.com

MEMBER CONSTITUENCIES
Janelle M. Marra, DO, FAAFP
Naval Hospital Camp Pendleton, CA
Jmarra08@gmail.com

MEMBERSHIP & MEMBER SERVICES
Janet M. West, MD, FAAFP
Naval Hospital Jacksonville, FL
Brun0186@umn.edu

Anja Dabelic, MD, FAAFP
Personnel Cmd. Millington, TN
anja.dabelic@gmail.com

NEWSLETTER EDITOR
A. Marcus Alexander, MD
AFPC, TX
marcusindc10@gmail.com

NOMINATING
Christopher E. Jonas, DO, FAAFP
USUHS, Bethesda, MD
jonaschris@hotmail.com

Debra A. Manning, MD, MBA, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

Aaron Saguil, MD, MPH, FAAFP
USUHS, San Antonio, TX
aaron.saguil@usuhs.edu

OPERATIONAL MEDICINE
Myro A. Lu, DO, FAAFP
Tripler AMC, HI
myrolu9@gmail.com

Adolfo Granados, DO, MHA, FAAFP
Naval Medical Center, San Diego
amem6842@sbcglobal.net

PRACTICE MANAGEMENT
Timothy L. Switaj, MD, MBA, MHA, FAAFP
Brooke AMC, San Antonio, TX
tim.switaj@gmail.com

Resident and Student Affairs
J. David Honeycutt, MD, FAAFP
Nellis AFB, NV
davehoneycutt@hotmail.com

Alexander C. Knobloch, MD
Travis AFB, CA
acknobloch@gmail.com

WELLNESS & RESILIENCY
TBD

2021 PROGRAM CO-CHAIRS
Kevin Bernstein, MD, MMS, FAAFP
Naval Hospital Jacksonville, FL
kevin.bernstein@gmail.com

Sajeewane Seales, MD, MPH
Joint Expeditionary Base - Little Creek, VA
phedre.e@gmail.com

president's message

DEBRA A. MANNING, MD, MBA, FAAFP

Debra A. Manning, MD, MBA, FAAFP
Bureau of Medicine & Surgery
Falls Church, VA
dr.deb.manning@gmail.com

My fellow FPs,

Thank you. Thank you for your leadership. Thank you for caring for your patients. Thank you for your Service to our Nation each and every day.

I am honored and humbled to serve as your President this year. I had a unique ceremony, socially distanced from CAPT (Ret) James Ellzy, AAFP Board Director, USAFP Past President , mission essential DHHQ personnel (as am I, which allowed for the ceremony) and my dear friend. We have asked Col (Ret) Lori Heim, AAFP Past President, USAFP Past President and mentor to many of us, to install officially, in person our new Board members at the Fall Board Meeting in Chicago. Our new board members attended the April lst board meeting with the past and present members.

I would be remiss if I did not extend a heartfelt thank you to Col Chris Jonas for his service, mentorship and leadership through this past year. It was a very difficult decision to cancel the annual meeting. I must also thank Kattie Hoy and Matt Hawks, our 2020 meeting planners. They have stepped forward with fantastic virtual CME, which is no replacement for the Annual meeting, but a great opportunity for CME while we are under restriction of movement.

I am excited to announce the 2021 USAFP Annual Meeting will be in Orlando, Florida at the Renaissance SeaWorld Hotel. The hotel is located across the parking lot from SeaWorld.

USAFP has weathered many storms over the years and I have no doubt we will continue to thrive. As Family Physicians we lead through change- implementing AHLTA, surviving the push for RVUs, large numbers of deployments, low recruiting years, residency closures, downsizing MTFs, implementation of medical home, GENESIS, DHA, markets, physician burnout, and now COVID-19. We will get through this, together.

How do you lead in these uncertain times? One foot in front of the next. "Do the next right thing", for those with *Frozen 2* fans at home. Family physicians are critical to this mission- to many missions. Disease non-battlefield injury is our specialty. Many of you have embraced the rapid expansion of telemedicine. Many of you are serving not at your home station, but at civilian hospitals across our Nation, and on the Mercy and the Comfort. You are manning drive-through clinics, and covering the inpatient wards and the labor decks.

Show everyone what Family Medicine Physicians can do in this fight and in any fight. They need us. Stand tall, be strong, take care of yourself, sleep, exercise, eat right and find the joy in what you do each and every day. You are making a difference in your patient's lives. You are there when their families cannot be with them. You show courage and compassion in the most difficult of times. Sometimes there are no thank yous. Some days are very hard but you can do this.

We are living history. Our great grandchildren will read about this time in their history classes. As Americans, we come together, as we did in the days of Rosie the Riveter, and we will get through this time. My daughter, Annabelle, and I got to meet one of the Rosies at a Girl Scout event last year- it was very powerful to hear her story. Now it is our time to make our story. Stay safe, follow guidance, be vigilant, and ride the wave. Calm seas are on the other side, my friends.

HAVE AN ARTICLE YOU WOULD LIKE TO SUBMIT IN THE UNIFORMED FAMILY PHYSICIAN?
PLEASE SEE THE INSTRUCTIONS FOR ARTICLES AT
WWW.USAFP.ORG/ABOUT-USAFP/UNIFORMED-FAMILY-PHYSICIAN-NEWSLETTER/

CORRECTION:
In the Winter edition of the Uniformed Family Physician, Heidi Gaddey, MD was omitted from the list of new Officers and Directors. Dr. Gaddey will serve a one year term as Director on the 2020-2021 USAFP Board of Directors

A. Marcus Alexander, MD
Vice-President
AFPC, TX
antoin.alexander@us.af.mil

editor's voice

A. MARCUS ALEXANDER, MD

Hello Uniformed Family Physicians.

Over the past few months, we have seen transition from times of unprecedented reform in the military health care delivery system to times of unprecedented worldwide change in response to the COVID-19 pandemic. Part of that change came in the form of sadness, as our USAFP leadership had to make the hard but essential call to cancel this year's annual meeting. For me personally, the annual meeting has long been an anticipated time of fellowship that often re-centered me to my core passion and purpose in family medicine. The spirit of family medicine abounded throughout the previous annual meetings, from the amazing research presentations and densely packed lectures, to "You Don't Know Jack" and the meals shared throughout the week. Thankfully, the members of USAFP have worked hard to allow us to still grow from the amazing research presentations and lectures, while also rejoicing in the contributions that family physicians have made to the COVID-19 response. There is no doubt that the spirit of Family Medicine is alive and well. As LTC Kevin Kelly stated so well in his Army Consultant update, we were built for this.

The Articles from the Army, Navy, Air Force, and CG/PHS Consultants all do an awe-inspiring job of sharing specific individual stories of sacrifice and service in addition to outlining our organization response to COVID-19. Although the tragedy and uncertainty of the situation is hard, we can all be very proud in the reminder of the value of Family Medicine that the world witnessed throughout this response.

There cannot be enough applause for the scholarly activity presented in the virtual research competition and to all of the award winners. Our academic foundation is indisputably top shelf. The dedication and effort is tremendous, and hopefully inspires many of us to carry on the torch and to commit to a research project to present at USAFP next year.

The committee reports show the immediate impact made by some of our youngest and newest members, while we continue to receive the guidance of some of our senior members. The resident and student affair committee outlines how members can get engaged in USAFP and AAFP, and how they can even step into larger roles via appointment to AAFP commissions, selection as representatives to other national organizations, or election to AAFP positions. The Operational Medicine article gave great insight on the expanded capabilities of our enlisted medical force and served as a great reminder for how we as physicians can and should take a more active role in training, developing, and utilizing them. The member constituencies committee highlighted the national concern about heath care disparities seen amongst the COVID-19 outcomes and the medical community's emphasis on a need for collecting data that includes race, ethnicity, and primary spoken and written language.

Amongst all of these daily challenges, we are all still driven to improve ourselves as physicians and leaders, and to be as efficient and effective as possible. Col Oh's conceptual review of the seven habits of effective leadership was a perfectly timed reminder for me personally of some things I had started to take for granted, and of great resources if I wanted to grow as a leader. Last but not least, the "Top Medical Apps" article gives us an efficient means to stay up to date on Coronavirus guidelines and screening algorithms, resilience and well-being training, and pneumonia guidelines.

It is always truly amazing to see what our family medicine community is doing. Thank you for the humble privilege to serve as your Vice President and editor of the Uniformed Family Physician. If you have recommendations or articles you would like to submit, please email me at marcusindc10@gmail.com or email the USAFP staff.

Family Medicine Opportunities
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Dr. John Lay, MD
LTC(R), US Army
Regional Medical Director
Centurion of Florida

Correctional Medicine allows me to continue the mission of serving an underserved population. It has given me the opportunity to use the leadership skills that were developed during my military career while continuing to uphold the core values that were engrained in me. I also found that it was a great transition as I was moving from military to civilian life.

Dr. Clayton Ramsue, MD
Retired Lt. Col. US Air Force
Statewide Medical Director
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For more information, please contact Tracy Glynn at **844.475.8017** or **tracy@teamcenturion.com**

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Debra A. Manning, MD, MBA, FAAFP was installed as 2020-2021 USAFP President by USAFP Past President and AAFP Director James A. Ellzy, MD, MMI, CMQ, FAAFP. The installation took place on Monday, 6 April in Washington, DC.

Debra A. Manning, MD, MBA, FAAFP Installed as 2020-2021 USAFP President

Congratulations to the 2020-2021 USAFP Board of Directors who participated in their first Board Meeting on 1 April 2020. The newly elected Officers and Directors are:

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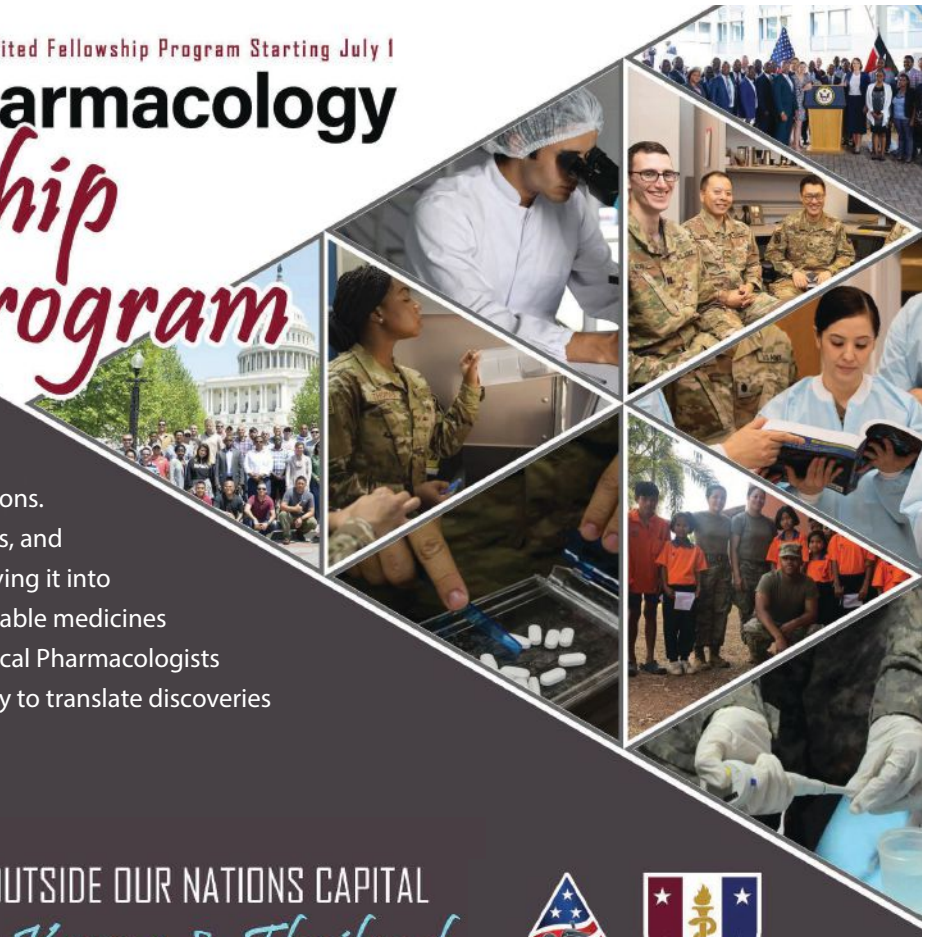
Clinical Pharmacology Fellowship Program



What is Clinical Pharmacology?

Clinical Pharmacology is the specialty of developing answers for modern medical limitations. Clinical Pharmacologists develop drugs, vaccines, and biologics by evaluating bench research and moving it into clinical trials. They also repurpose currently available medicines and monitor the safety of medicines in use. Clinical Pharmacologists work with government, universities, and industry to translate discoveries in the research lab to the beside.

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- Participate in continuing medical education, research seminars, and journal clubs.

Current Research Interests:

- Changes to antibiotic drug levels in soldiers exposed to exercise, heat exertion, traumatic brain injury.
- Exploring the use of pharmacogenomics in the military to optimize patient care and soldier readiness
- Defining risk factors for adverse drug reactions in deployment relevant medications.

Fellowship Eligibility Requirements:

- Active Duty Army PhDs /PharmDs (71A or 71B)
- Active Duty Army Physicians board eligible/ certified in primary specialty

For more information contact:
LTC Jeffrey Livezey, MD: jeffrey.livezey@usuhs.edu
or LTC Jesse Deluca, DO: jesse.p.deluca.mil@mail.com

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consultant's report
AIR FORCE

Michelle K. Anton, MD, FAAFP
JBSA-Kelly, TX
dr.michelle2002@hotmail.com

Five, Four, Three, Two, One! And the ball dropped. It was the first minute of the first day of the year 2020. We toasted with champagne flutes. We laughed. We had optimism and plans for the upcoming year. The massive crowds on TV in Times Square seemed commonplace. My biggest public health concern, as I stared at the screen and the thousands of revelers, had only been, "where and how do they pee?"

We are forever changed in how we look at the world and our roles as physicians. I am deeply saddened by the loss of life from the SARS-CoV-2 pandemic across our country and our world. Relatively speaking, it seems trivial to write about the sadness we all felt when our USAFP Annual Meeting was cancelled. But the sadness was deep, and that reflects the strength of our USAFP bonds; friendships and ties that are as strong as ever, even though we may only see each other once a year. Now in the "new normal," we stay connected with our friends, coworkers and patients in new ways like Zoom, Adobe connect, and Microsoft Teams.

This devastating event catapulted Family Physicians to the front lines and fueled appreciation for our value to the Military Health System. Our contributions to innovative solutions in primary care grew from the challenges COVID-19 presented. You did not miss a beat! You continued to care for our patients despite daily change in ops tempo. Travis, Lackland, Randolph, Little Rock, Eglin, and Vandenberg are just a few of the MTFs who shared innovative solutions to care. I know there were many more because you had to persevere while formal enterprise guidance was delayed. I couldn't be prouder to be your consultant at this time! Unfortunately, this is my last article and it is time to pass the torch. I will take this opportunity to present the information I was going to present at USAFP and discuss focus areas.

ASSIGNMENTS AND RETENTION

As of May 2020, we are 98% manned (294 assigned for 301 authorizations) in our clinical authorizations. After the summer losses, turnover and new accessions, we estimate eight gaps (unfilled authorizations) spread across our CONUS MTFs for the 2020-2021 assignment year. I know this will put a strain on those of you at those particular MTFs. The decisions on which bases to gap were not easy and made by looking at many factors: the mission of the wing and necessity to maintain an active duty medical presence, currency platform opportunities, the "4684" cuts, and the NDAA 703 (right sizing MTFs to AD only care). On the bright side, the Physician Assistant Consultant, Col Terry Mathews anticipates 100% manning in family health and Lt Col Damiani, your Nurse Practitioner Consultant, expects minimal gaps in family health. Additionally, many of our graduating PGY-3s received an assignment in their top ten list, with many getting a location in their top five. We had a robust response for the call for volunteers to Korea; it helped that Osan Air Base is increasing their number of Command Sponsored positions so more people can bring their families! As always, I encourage those of you who want an exciting, mission-focused assignment and a break from the routine of the CONUS-based clinic grind to consider doing an "operational" year at Incirlik or Kunsan Air Bases!

This summer we bid farewell to over 40 of our colleagues who are either retiring or separating. I have appreciated the feedback I received from many of you about your reasons for separation. Please don't forget to complete the Medical Corps Separation Survey available on the kx: https://kx.health.mil/kj/kx5/AFMedicalCorps/Pages/CorpsHome.aspx. For many, the reason for leaving is the need for stability. AFPC is still looking at the option to offer 6-year assignments at some of our more difficult to fill CONUS bases. Many of these bases are a family friendly, tight-knit community due to their remoteness from large metropolitan areas. If this is of interest to you, please reach out to your consultant or AFPC to get more information!

At the time of writing this article, stop-loss has not been instituted, but when COVID-19 hit and the primary care staffing in conjunction with support of COVID theater hospitals created strain, I put out a plea to those eligible to separate and asked for volunteers to stay in and help bridge the summer gap. At this time, we have had four volunteers who pulled their separation paperwork and have accepted assignments at 3 of our gapped clinics. We are so thankful to those members who filled a critical need. Thank you for all of you who served for any amount of years, you can be proud of your service to your country! For those that made it to retirement, CONGRATS, and I hope we can continue to connect at USAFP for years to come.

INFORMATION TECHNOLOGY

While I still don't have Alexa in my exam room to do my documentation and input my orders, I do have excitement about the direction we are heading with regards to virtual health and information technology that is user-friendly and enhances our daily life instead of hindering it! COVID-19 sparked the fuel for the appreciation and use of virtual visits. The Defense Health Agency's Healthcare Optimization Division is excited about increasing the use of virtual visits and is advocating for reliable platforms that are user-friendly to both the patient and clinical staff. More PCMs are open to the idea of "emailing" their patients utilizing secure messaging. Our patients have also embraced the benefit of virtual visits and secure messaging to address their health concerns. As a result, many MTFs are seeing an improvement in access without the backlog that was expected due to appointment cancellation at the onset of Restriction of Movement. You can ask about the DHA's plan for virtual healthcare and other activities at the weekly DHA Q&A teleconference. Dial in information is available on their SharePoint page: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/SitePages/Home.aspx.

READINESS

No article would be complete without discussing Readiness! Thank you again to all our deployers! We continue to deploy at least 25 members per band, which means 50+ of our USAF Family Physicians are deployed in a given calendar year. If you are in the "band" and have never deployed, you will be at the top of the list for these opportunities. The goal of the Consultant Balanced Deployments process is to ensure the frequency of deployment is spread fairly across the field. The data shows that most of us do not deploy more than once or twice in our time in the Air Force or more frequently than every 4 years.

Over the past two years, I have worked with the Air Force Medical Readiness Agency's R.A.C.E. (Readiness Analysis Comprehensive Evaluation) team. During this time, we visited many of your medical groups and discussed the Ready-Medic. For Family Physicians, this has been a beneficial opportunity to refocus on maintaining our full scope of skills and retaining the procedures that keep us current and ready to serve in the expeditionary environment. Additionally, the imperative for inpatient currency, initially fueled by discussions of a "near-peer" type of a conflict, was solidified by the COVID-19 Theater Hospital. Family Physicians are a crucial piece of the COVID-19 hospital expansion plan and we must maintain currency and competency in basic inpatient medicine/ward management. This will continue to be a challenge in the future for those stationed at small outpatient clinics.

Our updated Comprehensive Medical Readiness Program clinical currency requirements is in the final stages of the approval process. In the meantime, I would like to give you the following advice and tidbits. The "Inpatient Requirement" is broadening to be more inclusive of the evaluation and management of the urgent or emergent patient. This change in name also reflects the change of intent and paradigm. Spending "2 weeks" doing inpatient wards is the old way of looking at this requirement and while ward time is needed, depending on the census and caseload type, may not meet intended currency requirements. We now look at "number of events" or patient encounters. COVID-19 spurred the discussion as to how outpatient physicians will keep and hold critically sick patients until they can be moved to the appropriate level of care. Similarly, our requirements have expanded to include currency case-count for a patient who presents to the clinic in significant distress for whom you must stabilize in the treatment room, start intervention, and evaluate (IVF, monitor, EKG, labs, nebulizers, etc) and those you must hold until EMS transport can arrive. Furthermore, a Rapid Response or Code Blue response will also count.

In order to maintain comfort managing the acute patient, we need to change the paradigm where we "pop off all urgent care" when access gets bad, because that leaks currency. Additionally, if your MTF has inpatient services, work with the inpatient team to ensure you are notified if your patient is admitted and try to join the team for rounds or perform courtesy rounds on your own to review the record and fully understand the diagnosis and management. This is a great way to work up towards comfort with resuming independent inpatient care for those of us for whom it has been many years. What events specifically "count" may be hard to define beyond the CPT and E&M codes that will accompany the release of the checklist so feel free to reach out to the R.A.C.E. team or to your consultant with questions.

The CMRP "Pediatric requirement" will also continue to be a challenge for those who are assigned to care for Active Duty only. I encourage you to work locally with your SGHs, GPMs, and flight commanders to ensure you are continuing to see pediatric patients as part of your regular practice. One solution is to utilize Family Physicians to cover short term gaps in the pediatric clinic. Ask your GPM about upcoming pediatrician absences and proactively schedule the Family Physicians in their place. Another creative solution has been to allow a few continuity pediatric patients (children of your empaneled adults) in your empanelment, although this has not been formally endorsed in policy and has been a local solution approved at the local level. Prospective advance planning for readiness requirements is necessary so that readiness and currency are a part of our daily rhythm instead of an afterthought one half-day a month.

Remember women's health is not going away, no matter what squadron you are in. As I like to remind the audience, there are a lot of women in uniform and down range! Advocate for the continued ability to treat pregnant patients for non-obstetrical chief complaints. Advocate for prenatal care if you have the equipment, interest, privileges, and ability. Keep some of your procedural skills and partner with the Women's Health Nurse Practitioner and GPM in your clinic to ensure that "all things female" are not automatically shunted to the Women's Health Clinic by your appointment line.

The CMRP Minor Procedures requirement includes joint injection, dermatology procedures, suturing, toenail removals, I & Ds, etc. Check with your GPM and again, ensure that patients who call the appointment line or Nurse Advice Line with one of those needs are not immediately

continued on page 12

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continued from page 11

directed to off base Urgent Care, especially if they are Active Duty on base and the clinic is 5 minutes away from their duty station. You should have an opportunity to take that currency case! Sending Active Duty off base for non-emergent yet urgent issues only leaks currency opportunities and creates work for you later when you have to review the UCC note and do the profile/quarters form. For routine procedures, work with your GPM to stagger virtual appointments next to a procedure appointment, so that you can leverage a bit more time and your technician can have more time to prepare the room for you. This will make adding procedures to your schedule less of a hassle.

PHYSICIAN LEADERSHIP

Finally, I am beyond proud of how many of our Family Physicians were selected as SGH, Squadron Command, American Association for Physician Leadership Certified Physician Executive (CPE) Scholarship, and other leadership opportunities! Remember, you don't need a "leadership title" to be a leader every day! In the clinic, you are the Physician and the voice for evidence-based medicine. You must mentor your Advanced Practice Providers, technicians and nurses. Your attitude will determine the altitude your team reaches each and every day. You need to lead comprehensive care of your panel. Take control of your Active Duty Squadron's medical readiness. Reach out to the line squadron commander and build those bridges. We need to own our empanelment.

In closing, thank you again for supporting me as your Family Medicine Consultant. I will cherish the memories I have had working with all of you. You allowed me to jump on board with you and your career and life journey for the past 2 years—we discussed dreams and goals and made it happen. It is with a humble heart that I bid you farewell and pass the torch to... Lt Col Chris Jonas as the next Family Medicine Consultant!

consultant's report
ARMY

Kevin M. Kelly, MD, FAAFP
Fort Bragg, NC
kevin.m.kelly2.mil@mail.mil

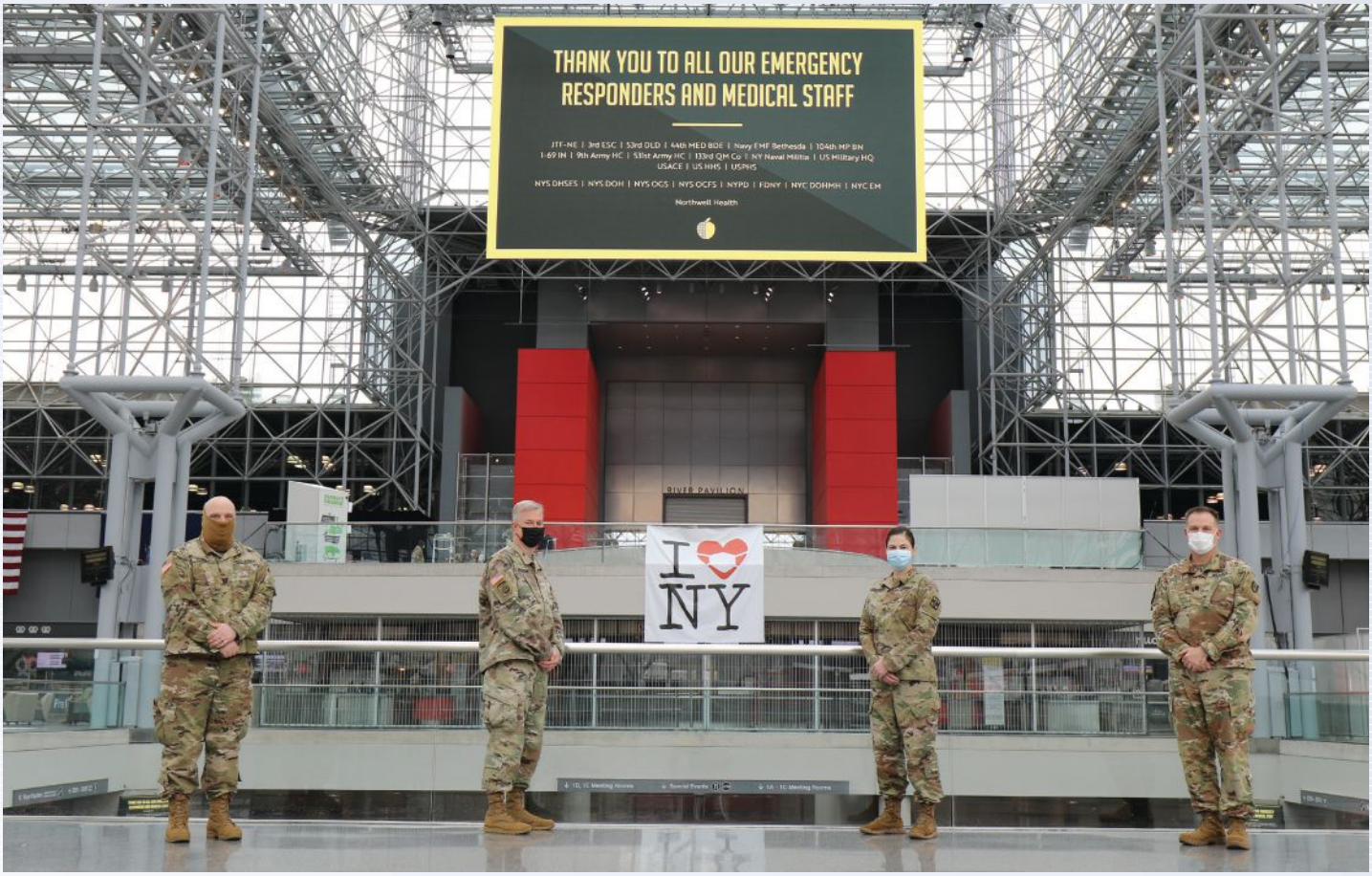
"We are at war against an invisible enemy, the COVID-19 virus, and what I saw here is tremendous teamwork, from the governor to the mayor to the real heroes of this fight, which are the doctors, the nurses, the medical professionals, and all the committed folks that are working against this."

-Army Chief of Staff, GEN James McConville

Greetings from the Javits New York Medical Station (JNYMS) in New York City. Medical professionals from the Army, Navy, Air Force, Public Health Service, and Coast Guard stood up a hospital in a convention center and treated nearly 1,100 COVID + patients over the course of a month. The team was part of the bigger effort orchestrated through FEMA, New York City, and New York state, and multiple partners. Defense Support to Civil Authorities (DSCA) is an important mission that many of our military units train to execute. This, however, was a different kind of fight than we typically train for. The team represented by all 3 COMPOS (Active, National Guard, Reserves) came together and performed remarkably well. I just had the opportunity to meet with 3 of our outstanding Army Family Physicians on the day that patient care operations at the JNYMS culminated. Major Jennifer Zuccarelli is assigned as MTOE Assigned Personnel (MAP) to the 11th Field Hospital out of Fort Hood, Texas which is part of 9th Hospital Center, 1st Medical Brigade. She additionally serves at William Beaumont Army Medical Center at Fort Bliss, Texas. Major David Navorska and Captain Jacob Bright are MAP with the 586th Field Hospital out of Fort Campbell, KY and part of 531st Hospital Center, 44th Medical Brigade. They both additionally serve at Blanchfield Army Hospital and also at Fort Campbell. I am truly inspired by their contributions during this unprecedented time in our Army's history.

All of them were integral parts of the deployment and employment of the field hospitals into the JYNMS. Each of them worked a rigorous schedule of shifts on the wards at the Javits, as we rapidly increased capabilities and sustained several days in which over a 100 patients were admitted per day. They provided care to a diverse and underserved patient population, all of whom were suffering from COVID-19. They provided inpatient medicine, including intensive care, as well as palliative care. Yes, in a convention center. Making clinical decisions in uncertainty without all the information you want is uncomfortable. Our training made it doable.

Dr. Bright works as a hospitalist at Blanchfield and provided care to patients in the Intensive Care Unit of JYNMS. He performed numerous central lines and other procedures and managed ventilators and drips. The ICU lead physician talked to me separately, making note of the incredible contributions of all 3 of our family physicians.



From left to right with social distance, From left to right with social distance, CPT Jacob Bright, MAJ David Navorska, MAJ Jennifer Zuccarelli, LTC Kevin Kelly

All of the care just described was made even more challenging by our own susceptibility to this disease. Given the patient care environment within a convention center, professionals were required to remain donned with full Personal Protective Equipment (PPE) for entire shifts. That is physically and mentally tough to do. It also created a barrier to the relationships that family physicians typically have with patients, but they found creative ways to connect with the patients who were otherwise alone. There were no visitors allowed in the Javits. They sat at the bedside as patients communicated with family using smartphone applications. Many patients did not speak English and phone translation was all that they could use. At times, just being with the patient at the bedside was all you could do.

It's no surprise that family physicians were also the answer for leadership. All three of these physicians stepped up to lead teams of doctors and nurses from all of our Services and of various professional backgrounds. They were especially impressed with the camaraderie and humility that all team members demonstrated- doctors looking out for nurses, relentless information sharing and learning, specialists asking for guidance from non-specialists. As Dr. Zuccarelli put it, "everyone checked their ego at the door and we just got the job done."

The Javits Center is on the Hudson River in close proximity to where Captain Chesley Sullenberger landed a plane with two blown engines on the water, saving the lives of 154 other people. His biography struck me in that his life prepared him for that very moment when others needed him the most. Military medicine and our military family physicians are uniquely prepared for the type of response needed in New York City during the COVID-19 pandemic. Our training in the full scope of family medicine and military medicine provided the skills in a way that few others could. We were built for this.

As you might imagine, despite the challenging environment, Drs. Bright, Navorska, and Zuccarelli will walk away with a positive experience, knowing they preserved life, alleviated suffering, and helped our fellow Americans in a time of great need. They are a beacon of hope for our Nation, and I am proud to serve with them. Stay ready! You may be next to the fight.

As always, I highly encourage that you read the Medical Corps Newsletters. They can be found on the MC Corps Sharepoint at https://mitc.amedd.army.mil/sites/AMP/AMC/Pages/MedicalCorps.aspx

Thank you for all you are doing. It's a great day to be an Army family doc! One Team, One Purpose...Conserving the fighting strength since 1775!

consultant's report
CG/PHS

Preciosa P Pacia-Rantayo, MD, FAAFP
USCG Base Cape Cod, MA
Preciosa.p.pacia-rantayo@uscg.mil

The pandemic from the Coronavirus has affected this year's conference in Anaheim, CA. Outgoing USAFP President Christopher Jonas, in collaboration with the Executive Committee, had to make a hard decision to cancel our annual event. But despite that set back, the installation of new officers and directors occurred, albeit virtually on April 1, 2020. The teleconference also included the Board of Directors meeting. Similarly, the USPHS Scientific and Training Symposium slated for June was likewise canceled. It has been postponed for June 2021; the location will remain the same.[1] Local and global reactions to the pandemic are evident. On the global scale, the US and other nations have had to make similar and difficult choices; this included total lockdown in countries like Italy, and the declaration of state of National Emergency in the US. Social distancing has become the norm.

Orange Team in Kaehler clinic -Ms Ponce(front), HS3 Hurlbut, HS3 Hasaan, CDR Eertmoed (back), HS2 Sekula, HS2 Serrato and HS3 Eagan(back)

RESPONSE FROM THE CORPS:

In this issue we will feature some of the pandemic response of the Commissioned Corps/PHS. It will include a few taskings of our Commissioned Corps officers, foremost of course is the immediate deployment of many PHS officers. In case of an emergency, such as the crisis brought by COVID-19, the Deployment and Readiness Directive 121.02 authorizes the Secretary of HHS (Health and Human Services) to deploy officers assigned to HHS OPDIV / STAFF DIV without supervisor approval.[2] Agencies like Indian Health Service or HRSA are examples of HHS OPDIV. Non-HHS agencies, such as the Coast Guard, will be deployed according to the MOU between Commissioned Corps and the non-HHS agency. Maintenance of readiness was reiterated.

PHS OFFICERS ROLE IN VARIOUS AGENCIES

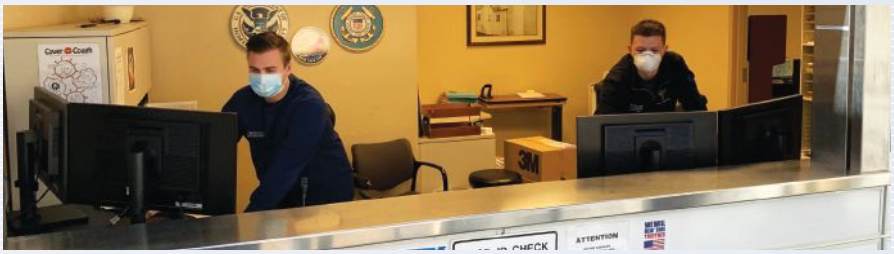
First the Commissioned Corps. Secretary of Health and Human Services Alex Azar, along with Assistant Secretary of Health Brett Giroir and Surgeon General Jerome Adams, have been heavily involved in the nation's response to the pandemic. As recently as this month, the Surgeon General can be seen on a video clip on the CDC's website. In this video he demonstrated how people can make their own face covering.[3] Here is a quick link to that video https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html

Other examples of active participation of Commissioned Corps are likewise worth mentioning. CAPT Tobe Propst, from Indian Health Service, has led their local tribe's medical team in their response to the changes related to COVID 19. CDR Elissa Meites, from CDC, was deployed to their Occupational Health Clinic. She set up a team that can perform text-based illness monitoring for the virus. Lastly, FDA's CDR Deborah Belsky, has been involved in reviewing proposals for various novel cellular therapies for the treatment of the coronavirus.

COAST GUARD RESPONSE

On April 3, 2020 CG Commandant ADM Karl L. Schultz expressed his belief in the resilience of the CG organization in protecting its people (from the outbreak) while maintaining its mission.[4] Likewise, CG Chief Medical Officer RADM Dana Thomas along with OPMED and the entire HSWL team are all immersed in providing the same support. The Coast Guard continually reviews the CDC, state and local recommendations, and delicately balances these with our specific operations. Additionally, we have adjusted our COVID 19 Risk Assessment and this has been modified to conform to the dynamic trend of the virus. Lastly, a dedicated CG website https://www.uscg.mil/coronavirus/ has been created. It is a one-stop site for directives in relation to the pandemic.

Orange Team Dental staff at Kaehler clinic Ms Whitney Holmes and Gail Bergen with CAPT Majure



Blue team's HS2 Joshua Gordnier and HS2 Andrew Pelchar covering our front desk

HS2 Marisa Franco as she reviews one of our patient's chart

LISTED BELOW ARE OTHER CG RESPONSES.

1. Telework Capabilities ALCOAST 121/20

   Social distancing and minimizing exposure to the virus has led to several changes. The creation of telework capabilities is one of them. Many units have modified their work schedules. Some opted to work 1 day on and 2 days "off" or 1 day on and 1 day off. The "off" days for many are actually remotely working from home.
2. Guidance on the Use of Cloth Face Coverings ALCOAST 142/20

   In alignment with the CDC's recommendation, the Guidance of the use of Cloth Face covering was created. Face cloth covering is encouraged if social distancing cannot be maintained.
3. COVID 19 Impacted Assignment YR20: PCS and HHG Shipments ALCOAST 127/20

   One of the most complicated issues to deal with in any time, let alone in a pandemic, is PCSing. The Coast Guard, unlike other services, PCS in June and July. To assist in the process this year the FLOAT PLAN has been made. It is a tool to help the member, receiving, and departing unit be on the "same page" (Plan). It provides the details of the member's travel, such as lodging, plans for housing, etc. Additionally, important resources such as the nurses help line are included.

CLOSER TO HOME

At our own base, Joint Base Cape Cod, the governor announced that a Coronavirus field Hospital will be created here.[5] The Army gym will be transformed into this infrastructure. This would be the third field hospital in Massachusetts designed to treat coronavirus patients.

FINAL THOUGHT

Though the end of the outbreak is hard to predict, and our sense of normal seems elusive, let us all continue to be strong and continue to stay well.

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consultant's report
NAVY

James Keck, MD, MBA, FAAFP
Naval Hospital, Jacksonville, FL
jkeck@usna94.com

Greetings, fellow FM'ers! Wow...what a historical adventure this past 2 months has proven to be! There is very little the COVID-19 pandemic has not touched, and will continue to impact all of us for some time to come. Professionally, this event has been an opportunity to grow as clinicians, educators, and leaders. I appreciate your patience with the multitude of emails during this time, and I know information overload may be starting to set in. In this report, I'll take the opportunity to move beyond the ever-evolving COVID clinical and administrative guidance, and provide you updates in other arenas (albeit most touched by the pandemic in some way.)

USAFP ANNUAL MEETING

Like all of you who were slated to attend our meeting in Anaheim, I was sad to see this premier event cancelled. But I am already looking forward to next year's event in Orlando, FL (28Mar-02Apr2021.) The spending ceiling impact of last cycle's conference approval process resulted in priority being given to those who are presenting (lectures or research.)

SPECIAL PAYS

As most are aware, the FY20 Special Pays Plan (released on 27Feb2020) included an unexpected cut in the amount of retention bonuses (RB), elimination of 4 year and 6 year contracts, and a restriction in renegotiating new contracts. It impacted not just Family Medicine, but a number of other communities. I heard from you, and I understand your surprise, angst, and frustrations. Despite being undermanned (90.2% as of 31Mar2020, representing a gap of 40 Family Physicians), our specialty was included in the group considered overmanned when viewed via the lens of a POM-20 end-strength perspective. As previously reported, the POM-20 cuts are on hold, and its future will no doubt play a part in subsequent RB decisions. Regardless, I want to assure you that Family Medicine continues to be highly valued by leadership and is considered a critical wartime specialty. Your response on the frontlines of the COVID-19 serves as only the most recent example of a highly capable and valued force that is mission critical, and I continue to share this perspective at every opportunity. I am heartened by the notion that Specialty Pays will again be evaluated for FY21, and I remain cautiously optimistic that current events and persistent manning challenges will factor favorably for future retention efforts. I am glad to talk with anyone who has questions, or that is facing a difficult career decision.

PROMOTION BOARDS

The Promotion Board schedule was not immune from the impact of our current events. As of this article's deadline, there are still plans to complete this cycle's promotion board schedule, albeit delayed. The timetable is yet to be determined, but I am looking forward to sharing an update when available.

LEAVE ACCRUAL

Due to the COVID-19 pandemic hindering service members from taking annual leave, the DoD has temporarily authorized members to carry a leave balance of up to 120 days (vice 60 days) across fiscal years. Members will be permitted to retain up to 120 days of unused leave until 30 September 2023.

JPME-1 UPDATES

In my last report, I passed on the new significance that JMPE-1 (Joint Professional Military Education Phase 1) now has in your promotion opportunity as you approach O-5 and O-6 (i.e. put it on your to do list before your next look!) In review, the Naval War College JMPE-1 process has been streamlined and can now be completed in 10 months. More information can be found at: https://usnwc.edu/college-of-distance-education/Online-Program. However, at last check, there is a waiting list to get into the Navy's on-line version. Luckily, Naval Officers can enroll in *any* War College...and at last check there is currently no wait for the Air Force on-line version. CAPT Keller, the MC Career Planner, put together a primer

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that includes all the options to get JPME-1... email me, and I will send you a copy.

NDAA 2020 / POM20 DIVESTITURES

BLUF: No changes. In review, POM20 (*Project Objective Memorandum 2020*) is an initiative that called for divestitures (cuts) in medical billets across all services. It was put on hold by Congress until a review of the medical manpower requirements under all national defense strategy scenarios can be completed. We are still within that review period, and one can only speculate as to the impact COVID-19 had on the timeline.

CO/XO OPPORTUNITIES & APPLICATION PROCEDURES

As I was typing this consultant update, the notice for CO/XO Opportunities and Application Procedures was released. Packages are due 15Jun2020. Check out the Office of the Corps Chief website (see link below under Communication section) for more info.

DHA TRANSITION UPDATE

Amid the coronavirus (COVID-19) pandemic, the Defense Health Agency (DHA) has paused its work to establish markets and transition military treatment facilities (MTFs). This pause will delay the establishment of the Wave 1 markets, the kick-off events for subsequent waves, and the Small Market and Stand-Alone MTF Organization (SSO) establishment. An updated Transition Timeline will be published in the future.

COMMUNICATION:

As has been my habit, I am going to continue to list the below venues as a means for us to stay connected as a community, corps, and service:

- Office of the Corps Chief Website: https://esportal.med.navy.mil/bumed/m00/m00c/M00C1/
- Milsuite.mil (https://www.milsuite.mil): Search: "Navy Family Medicine".
- Email: I send out periodic announcements to the community. If you haven't heard from you, then I probably do not have you in my email group. Send me an email at james.w.keck.mil@mail.mil, and I will get you added. Family Medicine leaders at local commands, I ask you to please check with your FP's to see if they are getting my emails to ensure they are in the loop.

As I wrap up this report, I want to once again thank you for all you do every day. That gratitude extends to our families and friends, especially during these challenging times. Remember to take care of yourself, as you also continue to look out for each other. Please don't hesitate to reach out to me with any questions or concerns. Stay well!

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Leadership through Tumultuous Times

Defense Health Agency transformation, Military Medicine cuts, and then a Global Pandemic. Who could have predicted this for 2020? How do we lead through these turbulent times? In the Leader and Faculty Development fellowship, we actually had a workshop planned entitled "Leadership through Tumultuous Times." Over one year ago, we planned a workshop to help our USAFP membership develop leadership knowledge, skills, and attitudes important for turbulent times. We fully expected that the DHA transition would be the narrative in April 2020 and we wanted to prepare our academy leaders for this transition. Fast forward one year, and the pandemic has changed the face of the USAFP annual conference and the world. We could have never expected this global pandemic, in the midst of major military health system transformation. The fact remains, that leadership principles are timeless. Learning these principles can help guide the people we've been called to serve in whatever times we are experiencing.

The leadership workshop touched on these timeless topics – 7 habits of effective leadership, cultivating emotional intelligence, personal leadership, and time management. As I reflect back on our workshop and the current state of affairs, I've come to realize that the central theme weaving throughout the workshop is the idea that constant growth is essential for leader development. If you are not growing as a leader, you have to step back and determine, why not? Growth and wisdom are learned basically two ways – through experience and by learning and implementing the wisdom of others. For example, if you send a reply-all email disparaging a fellow leader, not knowing that they were in the email reply chain, you will likely learn how to manage conflict quickly. Learning conflict management principles through workshops and practice is a better way to grow as a leader.

While there are numerous leadership principles, I wanted to give an overview of the 7 Habits talk and the concepts that we learn in the fellowship to help us grow as leaders.

Promoting Research in the Military Environment

Have a great idea for operational research but are unsure where to start or how to get approval?

Whether you are deployed or in garrison, the USAFP research judges can help!


Photo Courtesy of U.S. Army

Visit us online at http://www.usafp.org/committees/clinical-investigations/ for resources or to find a mentor.

7 Habits of Effective Leadership		
Habit	Explanation	Resource
Build the Team (before the vision)	Teams are often inherited; find the right jobs for the right people and the right people for the right jobs	Good to Great by Jim Collins The Advantage by Patrick Lencioni
Lead People, (Not Vision)	Vision Matters, but people drive the vision. People are the one that execute vision, not the other way around. See habit above.	Wisdom from Nehemiah, rebuilding the walls of Jerusalem
Know Thyself	What are your strengths? Where are your blind spots? Who can expose those blind spots? Consider personality inventories to learn about your inner strengths and how you respond during stress	I like Process Communications and the Enneagram, but the point is; learn more about yourself!
Stay Centered	Understanding yourself can determine what fills and drains your gas tank. Not everything you are doing may be filling you. Offload those and keep those that fill your tank.	Learn your fills and drains. Read Leading on Empty by Wayne Cordeiro
Live Quadrant 2	What are the important but not urgent things you should be doing today? Don't forget about these. Don't let your life be ruled in Q1 and Q3.	Steven Covey, 7 habits of highly effective People and the Eisenhower Matrix
Keep Growing	If we are not growing, we're dying. What are you reading, learning, listening?	Read something. Anything. Listen to podcasts. Learn something about medicine or non-medicine.
Find your purpose	What motivates you? What is your "raison d'etre?" Find it, seek it, and pursue it.	Read about "Ikigai." (look it up). Find your passion and motivation for life.

Leadership principles like these can be both taught and learned, to help guide the team in whatever circumstance you find yourself in. These timeless principles are touched upon at leadership conferences everywhere and are explored in our fellowship. In the fellowship we experientially learn these principles through *praxis*, action with reflection.[1] We strategize through our fellowship sessions and experientially learn, do and reflect upon these principles. Simultaneously we learn, teach, and advise the mission of the fellowship –building military physician leaders able to lead anywhere.

So, are you ready to grow as a leader? Are you intrigued about learning these timeless leadership principles? Are you striving to be an effective faculty and teacher in family medicine? Are you seeking an area to find personal growth, passion and purpose in your time in the military health system? If so, we invite you to consider the fellowship and ask your service consultant if this is the right time in your career for the fellowship. If you are interested, please reach out to me, or through the fellowship list serve on the global enterprise system. (usarmy.jblm.medcom-mamc.list.faculty-development-fellowship@mail.mil) We are excited to explore your desires to grow as a physician leader – to lead, equip and advance military medicine in these tumultuous times.

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Jeffrey L. Kinard, DO, FAAFP
Maxwell AFB, Montgomery, AL
kinardjl@gmail.com

Enlisted Medical Personnel: An Underutilized Deployment Force Multiplier

Working alongside sister service medical professionals is a standard expectation of modern deployments. While we do not question the competency and scope of practice of our physician colleagues, we often lack an understanding of nuanced differences among enlisted personnel. As a consequence, we underutilize our enlisted medical force in the operational environment. When viewed under the generic title of 'medic' or 'med tech,' we often associate the role with more basic roles and tasks. However, our enlisted force can be used for so much more. For this article, the Operational Medicine Committee reached out across the services to profile several enlisted medical specialties.

AIR FORCE

Role: Independent Duty Medical Technician (AFSC: 4N0X1C)

Independent Duty Medical Technicians (IDMTs) are Air Force medical technicians who undergo an additional 13-week course to receive their certification. They can see acute active duty visits and treat a variety of common ailments independently via established protocols. Exams and plans are staffed with a physician supervisor, but in remote locations this may involve a telephone call to another country. IDMTs also receive additional training in public health inspections, water testing, dental care, and immunizations. Most importantly, they are an amazing resource while deployed.

Beyond initial training, IDMTs require over 150 hours of annual refresher training, to include 80 patient encounters in addition to numerous occupational and public health inspections. Base IDMT programs are rigorously scrutinized, which is important since at many remote locations they are the only medical professional staffing the facility. Additional details on this career field can be found in Air Force Instruction (AFI) 44-103, *The Air Force Independent Duty Medical Technician Program*.

ARMY

Role: Combat Medic (MOS: 68W)
Author: MAJ Matthew Noss (Vilseck, Germany)

Clinicians should be aware that there are several different types of medics in the U.S. Army. The Army's main medic series are 68W, which are medics that can seek further training to become flight paramedics or expeditionary medics. Another type is 18D medics. These are Special Forces Medics that are assigned to Army and Joint Special Forces Battalions and Groups. In order to fully maximize a medic in the military treatment facility or aide station, it is important to understand these soldier's initial training and skills validation, ways they can be utilized, and the importance of sergeant's time and clinical training of medics.

The 68W is the medic that clinicians will most commonly work with in an MTF and conventional Army units. Training, tasks, and scope of these positions can be found in Army publications TC 8-800 and MC 40-50. A new medic joining a unit from Advanced Initial Training (AIT) will be minimally proficient in tactical combat casualty care (TCCC) and has some training in patient assessment. He or she will be Emergency Medical Technician (EMT) – Basic certified. AIT does not include garrison MTF type training; therefore, medics will need plenty of feedback when initially working in a clinical setting. To maintain 68W qualification, medics must complete biennial EMT recertification and Basic Life Support certification. Medics complete Table VIII training and assessment as part of their EMT continuing education hours and skills validation at a minimum of every other year. As part of this training, medics receive education and validation of trauma skills, airway management, intravenous access, medication administration, medical tasks, triage and evacuation, forced health protection, and a block of education on assessment of the OB/GYN and pediatric patient as well as assisting in vaginal delivery.

Most clinicians are aware of medic's understanding of TCCC. Many, however, have a poor understanding of medic education in procedural tasks, medical skills, or forced health protection.

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Truncated List of Medic Training Tasks per TC 8-800:

Intravenous access and medication management	- Intravenous (IV) and Intraosseous (IO) infusion - Intramuscular (IM) and Subcutaneous (SC) injection - Insertion of a Nasopharyngeal Airway (NPA) - Insertion of a supraglottic airway (i.e. King LT, I-Gel) - Perform a Surgical Cricothyroidotomy
Medical Tasks	- Medical Documentation: SOAP Note - Vital signs measurement to include visual acuity - Limited patient assessment: Musculoskeletal, HEENT, Pediatrics, and OB/GYN - Treatment of diabetic emergency, anaphylactic shock, and seizures - Us of Automated External Defibrillator
Force Health Protection	- Implementation of suicide prevention measures - Treatment of: altitude illness, heat/cold injury, insect bites/stings, snake bites

With additional training, medics can be utilized to initiate and manage IV infusions and administer IM or SC immunizations. Experienced medics and senior medics can be trained to apply the Army's Algorithm-Directed Troop Medical Care (ADTMC) system in a busy aide station or Soldier Centered Medical Home (SCMH). Medics should be encouraged to write SOAP notes, understand vital signs, assess a patient through physical examination, and appropriately report to a clinician. The U.S. Army Physician Assistant Handbook, Chapter 13, can be a good resource for battalion operations, such as sick call and triage.

Sergeant's time and clinical training of medics should be performed regularly and documented in the Soldier's Competency Assessment File (CAF) folder. Documentation of this training is important, as most medics will likely not be allowed to perform these tasks in the MTF setting without it. Formal training on a regular basis is important for medics to maintain their trauma and non-trauma medical skills. Medics often lose their TCCC skills when stationed in a clinic and lose their documentation and assessment skills when assigned to line units.

Far too often medics are utilized as medical support assistants in the clinical setting, tasked only to take vital signs and make appointments or to mop the motor pool when assigned to the line. It is important that we as clinicians take an active role in the training and development of our medics. This is the only way our medics can be proficient and competent when they are placed in a situation where they are alone and must be unafraid.

COAST GUARD

Role: Health Services Technician (HS)

Author: CAPT James Warner (USCG Sector Houston, TX)

The United States Coast Guard (CG) develop their own military medic program called health services technician's (HS) that provide both daily medical care and emergency healthcare services for Coast Guard personnel and their families. A HS begins their career after completing their basic training and enrolling into a five-month training school in Petaluma, California. HS training includes education in basic laboratory procedures with phlebotomy skills, anatomy lectures with clinical experiences, wound care, nursing skills, pharmacy education, asepsis and sterilization techniques, preventive medicine, nursing skills, clinical sick call, leadership, and clinic management. The HS school also teaches how to navigate the CG medical management information systems that include the Composite Health Case System, Provider Graphic User Interface, and Medical Readiness Reporting System. In addition, by graduation every HS is certified in Emergency Medical Technician Basic training.

An HS is normally assigned to a CG clinic, small sick bay ashore, or aboard a cutter. Typically, the first duty station of a newly trained HS is a large medical clinic where they have the opportunity to sharpen their skills under professional supervision with a CG medical officer. While assigned to these larger medical clinics, the HS will rotate among the different departments. Typical department tasking includes front desk operations & scheduling, laboratory management with phlebotomy, referral care management, supply, pharmacy technician, dental technician, physical and specialty exams, and outpatient medical care including sick call management and after hour care management. HS duty also extends to the public health management of their unit, outside of medical clinic, that includes duties of water testing, galley cleaning inspections, and hazardous waste management for all CG platforms, such as small boats, cutters, and aviation assets. Later in their careers, a HS may undergo training with the U.S. Navy independent duty corpsman training program and can be assigned independent duty aboard cutters or at small unit clinics where they provide direct medical care for all of the crew's medical needs. Additional specialty assignments include search and rescue, disaster response, and medical-evaluation missions.

A typical day usually includes assisting medical or dental officers in direct patient care. Throughout the day they will

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perform laboratory work, administer immunizations, triage patients, and assist in minor procedures. Due to the inherent breadth of work a HS is involved with on a daily basis, they must be extremely knowledgeable in many areas. All medical clinic management functions at the unit level are only achievable through the collective actions of the HS staff. From CPR training to suicide intervention, the CG HS is a highly versatile and skilled member of the CG medical team. Regardless of the situation, a HS must be ready to act in any emergency situation, while staying calm in any stressful environment. The CG HS plays a vital role in the CG medical system and are invaluable to the CG unit to which they are assigned.

NAVY

Role: Independent Duty Corpsman (L01A (NEC: 8425))
Author: LCDR Eric Vaught (US Naval Hospital Naples, Italy)

The U.S. Navy Independent Duty Corpsman (IDC), as outlined in OPNAVINST 6400.1D, is an enlisted sailor who has received additional training and functions as a provider extender onboard ships, submarines and with Marine units around the world. The Navy Medicine Education, Training and Logistics Command provides the IDC certification course in San Diego, California to prepare IDCs for billets where they are expected to function as independent medical providers. All Navy IDCs are supervised by an assigned clinical supervisor who is responsible for ensuring the quality of care provided in alignment with established primary care standards. A comprehensive list of IDC competencies can be found in NAVMED 6400/2 Competencies Defining Independent Duty Corpsmen Scope of Care. IDCs may assess, triage, and treat all active duty service members, including members of other services and foreign military members via indirect supervision to include writing consults and ordering medications within their scope of practice.

FINAL THOUGHTS

This article gives a superficial overview of several enlisted medical specialties across the services. Hopefully it offers an appreciation for the range of skills and training across the enlisted force and leads to more effective utilization of these personnel while deployed. Be sure to ask your enlisted members what capabilities they offer and make an effort to familiarize yourself with their regulations. Just as important, ask what they are interested in and what you can teach them. Demonstrating an interest in their personal and professional growth is an easy step to build rapport and make the deployed experience more valuable to both parties. You never know when the skills you share will come in most handy, such as the time my IDMT at a remote location sutured my forehead (...but that is a story for another time).

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robohmd@gmail.com

The 2020 Virtual USAFP Research Competition

Congratulations to all the following winners in the 2020 USAFP Virtual Research Competition! Members stepped up to the challenge and delivered stiff competition that the research judges mulled over a Zoom meet late April.

Great work everyone, I hope you enjoy the print recap of the competition. Printed in this edition of the Uniformed Family Physician are all the abstracts of the winners as well as those that were accepted to the juried competition. We look forward to your feedback on the Research Competition. Already we are ginning up for the 2021 USAFP Research Competition in Orlando, Florida. Stay tuned for instructions coming soon!

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / NAVY

Naval Hospital Jacksonville Family Medicine Residency, Jacksonville, FL

CAPT Kristian Sanchack – Program Director

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / ARMY

Carl R. Darnall Army Medical Center, Family Medicine Residency, Fort Hood, TX

LTC Drew Baird – Program Director

OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY / AIR FORCE

Scott Air Force Base Family Medicine Residency, Belleville, IL

Col James Jablonski – Program Director

ALL AROUND OUTSTANDING ACHIEVEMENT IN SCHOLARLY ACTIVITY

Womack Army Medical Center Family Medicine Residency, Fort Bragg, NC

LTC Wes Theurer – Program Director

FIRST PLACE CLINICAL INVESTIGATION / STAFF CATEGORY

MILITARY FAMILY PHYSICIAN ATTITUDES TOWARD RUNNING GAIT RETRAINING

Alexander C. Knobloch, MD, CAQSM; Capt, USAF, MC; Travis AFB, CA

SECOND PLACE CLINICAL INVESTIGATION / STAFF CATEGORY

ACUPUNCTURE FOR PLANTAR FASCIOPATHY: A RANDOMIZED CONTROLLED TRIAL

Stephen Cagle, Maj, MD, 375th MDG, Scott Air Force Base, Illinois; Jennifer Farrell, Capt, DO, 375th MDG, Scott Air Force Base, Illinois; Paul Crawford, Col (Ret), MD, 99th MDG, Nellis Air Force Base, Nevada

FIRST PLACE CLINICAL INVESTIGATION / RESIDENT CATEGORY

HOW FAMILY PHYSICIANS DISCUSS AND DOCUMENT DIABETES REMISSION

Fulleborn S, Capt, MD; Family Medicine Residency Clinic, Eglin AFB, FL; Ledford CC, Lt Col, MD; Family Medicine Residency Clinic, Eglin AFB, FL; Seehusen DA, COL (Ret), MD, MPH; Department of Family Medicine, Augusta University, Augusta, GA; Crawford P, Col (Ret), MD; Family Medicine Residency Clinic, Nellis AFB, NV; Rogers T, CPT, MD; Madigan Army Medical Center, Tacoma, WA; Ledford CJW, PhD; Uniformed Services University of the Health Sciences, Bethesda, MD

SECOND PLACE CLINICAL INVESTIGATION / RESIDENT CATEGORY

PHYSICIAN EDUCATION AND CONFIDENCE ON BREASTFEEDING MANAGEMENT

Ashley Yano, MD Carl R Darnall Army Medical Center, Fort Hood, Texas, Catherine Gill, MD, FAAFP, Carlisle, Pennsylvania, Michael Kim, MD, Scott Air Force Base, O'Fallon, Illinois

FIRST PLACE EDUCATIONAL RESEARCH

CREATING AN ASSESSMENT TOOL FOR MUSCULOSKELETAL KNOWLEDGE

2LT Jonathan Yu, ENS Alexander D. Li, Jeffrey C. Leggit, MD, CAQSM Uniformed Services University of the Health Sciences, Bethesda, MD

FIRST PLACE CASE REPORT

A GRAVES' MATTER: POOR WEIGHT GAIN IN A BREASTFED INFANT

Janean Wedeking, DO, 55th MDG, Offutt Air Force Base, Bellevue, NE; Dillon Savard, MD, FAAFP, 55th MDG, Offutt Air Force Base, Bellevue, NE

SECOND PLACE CASE REPORT

UTERINE DIDELPHYS: A TROUBLED CASE OF LABOR INDUCTION

Bentley Michael, CAPT, MD and Michael Kim, CAPT, MD; Southwest Illinois Family Medicine Residency, Scott Air Force Base, IL

THIRD PLACE CASE REPORT

A SMOKER'S LUNG CANCER IN A POSTPARTUM NON-SMOKER

CPT Douglas May, MD; Martin Army Community Hospital Ft. Benning, GA

THIRD PLACE CASE REPORT

BABY YOU TAKE MY BREATH AWAY

LT Scott Meteer, DO, Naval Hospital Jacksonville, Jacksonville, FL; Micah Pastula, Naval Hospital Jacksonville, Jacksonville, FL; Rachel Carter, Naval Hospital Jacksonville, Jacksonville, FL

FIRST PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

PRIZEN: NON-OPIOID PAIN RELIEF USING BATTLEFIELD ACUPUNCTURE IN PRISON

LT Jacqueline Rine, MD and CAPT Rochelle Nolte, MD; Department of Pediatrics, NMCSD USCG Sector San Diego

SECOND PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

RACIAL DISPARITIES IN PAIN MANAGEMENT DURING VAGINAL CHILDBIRTH

Faraz Ghoddusi MD; Jenene Geske, PhD; Stacey Ghoddusi, MPH; Kevin Sisk, DO; Shana Miles, MD: University of Nebraska Medical Center, Omaha, NE; Offutt Family Medicine Residency, 55th Medical Group, Offutt AFB, NE

THIRD PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

A QUALITY IMPROVEMENT INITIATIVE TO INCREASE HUMAN PAPILLOMAVIRUS VACCINE RATES IN YOUNG ADOLESCENT MALES

LT Osmund Nogra, M.D., Gloria Calderon, DNP, Naval Hospital Jacksonville, FL

FIRST PLACE POSTER DISPLAY / EDUCATIONAL RESEARCH

IMPLEMENTING A REFLECTIVE PRACTICE CURRICULUM IN A FAMILY MEDICINE RESIDENCY

MAJ Nathaniel Watts, DO; Juliana Ee, PhD; CPT Kassandra Pellegrini, MD; MAJ Zachary Bevis, MD; Ashley Adams, BA; COL Matthew Hing, MD; Womack Army Medical Center, Fort Bragg, NC

FIRST PLACE POSTER DISPLAY / CASE REPORT

SILLY RABBIT, KAWASAKI IS FOR KIDS! A RARE CASE OF ADULT-ONSET KAWASAKI DISEASE

Ethan Harris, MD, LT, USN; Rachel Concepcion, DO, LT, USN; Shira Paul, MD, LT, USN; Naval Hospital Camp Pendleton, Oceanside, CA

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SECOND PLACE POSTER DISPLAY / CASE REPORT

THE BEE'S KNEES: TAKING THE STING OUT OF ANTERIOR KNEE PAIN WITH HYDRODISSECTION OF THE INFRAPATELLAR FAT PAD

CPT Emily Buck, MD; CPT Stephanie Skelly, MD Family Medicine Residency, Madigan Army Medical Center, JBLM, WA

SECOND PLACE POSTER DISPLAY / CASE REPORT

NEEDLES OVER NAUSEA: ACUPUNCTURE FOR PREVENTION OF MOTION SICKNESS

Brooke Organ, DO and Christopher Ledford, MD; Eglin Family Medicine Residency, Eglin Air Force Base, FL

THIRD PLACE POSTER DISPLAY / CASE REPORT

BATTLEFIELD ACUPUNCTURE USED AS ADJUNCT FOR PAIN MANAGEMENT IN HEAT STROKE: A CASE SERIES

Samantha Green, MD, CPT, MC; Audrie Konfe, MD, CPT, MC; Mary A. Noel, MD, MAJ, MC Martin Army Community Hospital, Fort Benning, Georgia

THIRD PLACE POSTER DISPLAY / CASE REPORT

A MISBEHAVING SCAR: MAKING THE DIAGNOSIS OF SARCOIDOSIS FROM ATYPICAL SKIN FINDINGS

CPT Kristen Barta MD, CPT(P) Amanda Nopakun MD, CPT James Kwon MD, Tyler Raymond DO, MPH, FAAFP, Gary Clark MD, MBA, FAAFP, MAJ John Fowler MD; Madigan Army Medical Center, JBLM, Tacoma, WA

2020 Juried Podium Abstracts

FIRST PLACE CLINICAL INVESTIGATION / STAFF CATEGORY

MILITARY FAMILY PHYSICIAN ATTITUDES TOWARD RUNNING GAIT RETRAINING

Alexander C. Knobloch, MD, CAQSM; Capt, USAF, MC; Travis AFB, CA 94535

Introduction: Emerging evidence suggests that running gait retraining plays an important role in the treatment and prevention of running-related injury. Studies have utilized protocols that are impractical in a busy clinic, and it is unclear how gait retraining is being utilized by family physicians. By surveying military family physicians and residents, this study is the first to investigate the frequency of gait retraining discussions with patients with running-related injuries, barriers to these discussions, and physician confidence and perceived value in engaging in these discussions.

Methods: Design: Cross-sectional survey

Setting: 2019 USAFP Annual Meeting, St. Louis, MO

Study Populations: 532 military family physicians and residents attending the 2019 USAFP Annual Meeting

Intervention: None.

Main Outcome Measures: 1) Frequency of, 2) confidence in, and 3) value of discussions of running gait retraining with patients with running-related injuries. 4) Obstacles to discussing gait retraining.

Statistical Tests Used: Descriptive statistics for categorical variables. Spearman's correlation, independent *t*-test, and one-way ANOVA for bivariate analyses.

Results: The majority of respondents (82%) feel discussions of gait retraining with patients are at least somewhat valuable. However, 63% of respondents speak with few to mostly no patients on the topic, while 71% of respondents feel only slightly confident or not confident at all in engaging in these discussions. Frequency of these discussions is strongly positively correlated with confidence ($r_s = 0.73$; $p < 0.0001$), and value of these discussions shows a weak positive correlation with both frequency ($r_s = 0.33$; $p < 0.0001$) and confidence ($r_s = 0.20$; $p = 0.0004$). The most frequently reported obstacles are lack of knowledge (55%) and time (24%).

Conclusions: While military family physicians find value in discussing running gait retraining with their patients, discussion frequency and physician confidence are low. Efforts to improve confidence and frequency should be targeted at interventions aimed to increase physician knowledge, as well as developing non-time-intensive approaches to gait retraining.

SECOND PLACE CLINICAL INVESTIGATION / STAFF CATEGORY

ACUPUNCTURE FOR PLANTAR FASCIOPATHY: A RANDOMIZED CONTROLLED TRIAL

Stephen Cagle, Maj, MD, 375th MDG, Scott Air Force Base, Illinois 62225

Jennifer Farrell, Capt, DO, 375th MDG, Scott Air Force Base, Illinois 62225

Paul Crawford, Col (Ret), MD, 99th MDG, Nellis Air Force Base, Nevada 89191

Introduction: Plantar fasciopathy (PF) affects 1% of troops per year and significantly impacts military readiness. Acupuncture improves pain and many physicians practice acupuncture. Our objective was to determine if a simple, quick acupuncture technique, plus a home exercise program (HEP) improved pain and function, more than a HEP alone.

Methods: We conducted a randomized controlled trial with a crossover at two AF MTFs. DoD beneficiaries ≥18 years with

an active diagnosis of PF were recruited. An acupuncture technique, KB-2, was performed every 2-weeks for 4 treatments in addition to a HEP. Primary outcomes were reduction in pain and function using a 11-point Numerical Pain Rating Scale (NPRS) and the Foot Function Index-Revised (FFI-R) score, secondary outcome was compliance with HEP. Scores were obtained at baseline, each of the 4 visits, and 6-weeks post treatment for both groups. Immediate post treatment NPRS scores, for the acupuncture group, were also completed for visits 1-4. We defined clinical significant (CS) as decrease of ≥ 30% in NPRS. A repeated measures ANOVA was performed pre-crossover and a repeated point displacement-design post crossover.

Results: 94 subjects with mean age of 43 were randomized. 51% of the subjects were female. After 12-weeks, subjects who performed the HEP-only program had a 21% reduction in NPRS scores ($p < 0.05$). The acupuncture/HEP group had a > 50% reduction in NPRS immediately post acupuncture ($p < 0.05$) and a 37% cumulative reduction at 12-weeks ($p < 0.01$). Subjects who crossed over into the acupuncture arm after 12 weeks, experienced >50% reduction of NPRS acutely and a 30% reduction at 12-weeks post acupuncture ($p < 0.05$). FFI-R scores improved but were not statistically different ($p = 0.535$).

Conclusion: A simple acupuncture technique, KB-2, acutely reduces pain by >50% in PF and when combined with HEP achieved greater sustained CS reduction in pain at 12-weeks than HEP alone.

FIRST PLACE CLINICAL INVESTIGATION / RESIDENT CATEGORY

HOW FAMILY PHYSICIANS DISCUSS AND DOCUMENT DIABETES REMISSION

Fulleborn S, Capt, MD; Family Medicine Residency Clinic, Eglin AFB, FL 32542 Ledford CC, Lt Col, MD; Family Medicine Residency Clinic, Eglin AFB, FL 32542 Seehusen DA, COL (Ret), MD, MPH; Department of Family Medicine, Augusta University, Augusta, GA, 30905 Crawford P, Col (Ret), MD; Family Medicine Residency Clinic, Nellis AFB, NV 89191 Rogers T, CPT, MD; Madigan Army Medical Center, Tacoma, WA 98431 Ledford CJW, PhD; Uniformed Services University of the Health Sciences, Bethesda, MD 20814

Introduction: A new area of inquiry is "remission" of diabetes (T2DM) and prediabetes (preDM), which occurs when lab values have improved and are no longer in the diabetes or prediabetes range. PreDM establishes a continuum of hyperglycemia. It is unclear if physicians document and discuss remission from T2DM to preDM to euglycemia. Physician coding and communication influences how a healthcare team manages disease alongside the patient. We need to better understand how physicians document and discuss these disease states to improve both patient and team communication. This study aims to identify if family physicians document and communicate about 1) preDM and 2) remission of T2DM.

Methods: Cross-sectional survey of family physicians registered for the 2019 USAFP assembly. 72.7% response rate. 284 respondents included in analysis.

Main Outcome Measures: Percentage of physicians coding and communicating about preDM, T2DM, and remission of T2DM.

Statistical Tests Used: Descriptive statistics, logistic regression, and analysis of variance.

Results: 70.8% of respondents correctly coded an A1C in preDM range, though 40.3% of those would not use the word "prediabetes" in counseling. Of physicians who correctly coded for preDM, 58.7% documented and 36.8% communicated remission to euglycemia with the patient. All of the 90.1% of physicians who correctly coded for T2DM would use the word "diabetes" in counseling. 14.8% of these charted and 2.3% communicated remission to preDM with the patient. Family physicians were more likely to document remission of preDM as compared to T2DM ($\chi^2(1) = 10.67$, $p < .001$).

Conclusions: Physicians avoid labeling "prediabetes" when counseling patients. Physicians are more likely to document regression from preDM to euglycemia, than from T2DM to preDM. We posit that physicians should document and discuss preDM and remission of T2DM. Further study regarding physician knowledge and behavior about these concepts should investigate why physicians are not doing so.

SECOND PLACE CLINICAL INVESTIGATION / RESIDENT CATEGORY

PHYSICIAN EDUCATION AND CONFIDENCE ON BREASTFEEDING MANAGEMENT

Ashley Yano, MD Carl R Darnall Army Medical Center, Fort Hood, Texas, Catherine Gill, MD, FAAFP, Carlisle, Pennsylvania, Michael Kim, MD, Scott Air Force Base, O'Fallon, Illinois

Introduction: Breastfeeding is the most beneficial source of nutrition for infants and is recommended for at least one year. Furthermore, mothers also experience multiple lifelong health benefits. Family physicians fulfill the unique role to support breastfeeding yet may feel unequipped to do so. We present a cross-sectional study to evaluate the confidence of uniformed family physicians to support breastfeeding and assess the correlation to formal training.

Methods: Design and Setting: Cross-sectional study using voluntary, anonymous data from 2019 Uniformed Services Academy of Family Physicians (USAFP) Annual Meeting Omnibus Survey.

Study Population: USAFP Members, registered attendees.

Intervention: None

Main Outcome Measures: Confidence in educating mothers on initiation and maintaining breastfeeding. Measurements ranged from not, slightly, somewhat, fairly, and completely confident. This was correlated with the amount of formal and informal breastfeeding education (none, <3 hours, 3-8 hours, >8 hours).

Statistical analysis: Descriptive statistics and chi-square.

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Results: There was a 73% response rate (387/532). 33% (n=127) and 34% (n=130) of physicians felt fairly to completely confident educating breastfeeding mothers on starting and maintaining breastfeeding, respectively. Of the study population, 44% (n=169) reported no to minimal (<3 hours) formal education on lactation medicine. 39% (n=152) had spent no to minimal time on informal education. 60% (n=232) of the study population believed they should receive more training in lactation medicine. Descriptive analysis did not demonstrate statistically significant correlations between any of the confidence measures and amount of education.

Conclusion: Despite the importance of breastfeeding, only 33% of military family physicians felt confident on counseling a patient. Notably, reporting on training is significantly affected by recall. A majority of respondents believe family physicians should receive more lactation medicine training. While confidence did not correlate with the hours of training, these results support a greater need as well as an active interest in lactation medicine education.

FIRST PLACE EDUCATIONAL RESEARCH

CREATING AN ASSESSMENT TOOL FOR MUSCULOSKELETAL KNOWLEDGE

2LT Jonathan Yu, ENS Alexander D. Li, Jeffrey C. Leggit, MD, CAQSM Uniformed Services University of the Health Sciences, Bethesda, MD, 20814

Introduction: Studies show that medical school curriculums and standardized exams do not prepare graduates to manage the most common musculoskeletal (MSK) injuries they will encounter in the outpatient setting. This study proposes a new multiple-choice assessment to evaluate individual deficiencies and identify areas for curriculum improvement.

Methods: This 36 question MSK assessment tool (MSK30+6) was distributed to medical learners at various stages of training. An earlier pilot trial was performed at a single medical school. This iteration expanded the subject population to primary care residents and multiple medical schools to test its wider applicability as well as increasing the number of participants for greater statistical analysis.

Design: Multi-group.

Setting: United States Medical Schools and Primary Care Graduate Medical Education Programs.

Study Groups: MS3/4's at USUHS, Penn State and University of South Carolina; Transitional Interns from WRNMMC and Family Medicine Residents from MAMC, Nellis, Fort Belvoir, St. Louis University/Scott AFB, Travis AFB, Fort Bragg, Fort Gordon, Fort Benning, and University of Utah.

Educational Interventions: Medical students took the exam after completing their core clerkship year; residents took the exam near the beginning of their respective academic year.

Main Outcome Measures: Average exam score (overall, by year-in-training, MD/DO, military/civilian), percent correct for each question, overall exam reliability.

Statistical Tests Used: mean with standard deviation, ANOVA, and Cronbach's alpha.

Results: Overall average score of all examinees was 77.5% with statistically significant improvement based on training years (P=0.028). No statistical difference between MD/DO, male/female or military/civilian. Overall reliability determined by Cronbach's alpha of 0.631 corresponds to moderate reliability.

Conclusion: The MSK30+6 is a statistically valid and reliable method of determining cognitive knowledge in basic MSK topics, identifying individual deficiencies, and highlighting gaps in training programs' MSK curriculums.

FIRST PLACE CASE REPORT

A GRAVES' MATTER: POOR WEIGHT GAIN IN A BREASTFED INFANT

Janean Wedeking, DO, 55th MDG, Offutt Air Force Base, Bellevue, NE 68113; Dillon Savard, MD, FAAFP, 55th MDG, Offutt Air Force Base, Bellevue, NE 68113

Introduction: Poor weight gain, or failure to thrive (FTT), has myriad possible etiologies. Presented is a breastfed infant with FTT in the setting of unknown, uncontrolled maternal Graves' disease.

Case Presentation: A normal breastfed infant began to have slowed growth at four months of age. The social situation was optimal and laboratory work-up was normal. The mother's only medication was etonogestrel-releasing contraceptive implant. The mother engaged in breast massage and supplemented with expressed breast milk. Full fats were also added to the infant's solid diet, yielding no improvement in growth. Unknown to the infant's physician, from 4 to 11 months postpartum the mother lost 30 pounds, had palpitations, and exophthalmos. She began methimazole for Graves' disease and, once optimized, the infant's weight rapidly normalized.

Discussion: Data is lacking regarding Graves' disease's effects on lactation and breastfed infants. In rats, induced maternal hyperthyroidism is associated with milk stasis and lower weight gain in rat pups. In the infant reported here, decreased growth was likely related to uncontrolled maternal Graves' disease, given that growth dramatically responded to maternal treatment.

Scholarly Questions:

1) What is the pathophysiology of maternal hyperthyroidism that specifically leads to infant FTT; an induced malnourished state in the mother leading to decreased milk volume, altered macronutrient content of milk, or something else? 2) Can treating maternal hyperthyroidism correct this?

Conclusion: Family physicians routinely encounter infant FTT. This case illustrates the importance for clinicians to include a broad range of maternal health causes in their differential for FTT in breastfed infants,

including hyperthyroidism. Also, treating maternal Graves' disease may improve lactation for breastfed infants. Family physicians are optimally positioned to deliver inclusive infant and maternal pre/postnatal care. Employing this model of care may have facilitated earlier identification and treatment of this infant's FTT and maternal Graves' disease.

SECOND PLACE CASE REPORT

UTERINE DIDELPHYS: A TROUBLED CASE OF LABOR INDUCTION

Bentley Michael, CAPT, MD and Michael Kim, CAPT, MD; Southwest Illinois Family Medicine Residency, Scott Air Force Base, IL

Introduction: Uterine didelphys is an uncommon mullerian duct abnormality (1 in 3000) with limited evidence-based recommendations. This uterine anomaly does not typically affect a woman's fertility. We present a case of a pregnancy with uterine didelphys that underwent an unsuccessful induction of labor (IOL) at 40 weeks gestation.

Case: A 29 year old G1P0 presented for IOL at 40 weeks gestation. Her prenatal care revealed uterine didelphys with fetus in the right uterus. Cervical ripening was accomplished with prostaglandin E2 followed by low dose oxytocin and mechanical balloon dilation. Once the right cervix was dilated to 4cm, artificial rupture of membranes was performed and an intrauterine pressure catheter was placed. Contractions were minimal to non-existent (measured by Montevideo units) despite maximum dose oxytocin. No cervical change was made after 7 hours. A decision was made to proceed with cesarean section, which resulted in the delivery of a healthy neonate.

Discussion: Although uterine didelphys is associated with an increased risk of cesarean section, it is not a contraindication to vaginal delivery. Both the American College of Obstetrics and Gynecology and the American Society of Reproductive Medicine do not have guidelines on labor induction or management for uterine didelphys. Some cases in the literature have shown successful labor induction, however, the majority of cases have resulted in cesarean section. The cause is mostly attributed to malpresentation. However, our case shows despite a normal fetal vertex position, there was no response to oxytocin administration.

Scholarly Question: Are there un-identified predictors of successful vaginal deliveries for patients with uterine didelphys?

Conclusion: There are no evidence-based guidelines for labor induction and management for congenital uterine anomalies. This case had no response to oxytocin, indicating a potential correlation with the uterine abnormality. Physicians should consider uterine didelphys as a strong risk factor for cesarean section when managing labor.

THIRD PLACE CASE REPORT

A SMOKER'S LUNG CANCER IN A POSTPARTUM NON-SMOKER

CPT Douglas May, MD Martin Army Community Hospital Ft. Benning, GA 31905

Introduction: Lung cancer is a life-changing diagnosis due to its aggressive nature and poor prognosis. Small cell lung cancer (SCLC) is associated with smoking in 97% of the patients. This case describes the presentation of a postpartum, non-smoking female who developed SCLC.

Case Presentation: A 35-year-old non-smoking female presented to primary care for upper respiratory symptoms one month after the delivery of her third child. After failed symptomatic treatment, a chest radiograph obtained 5 months later for her persistent cough demonstrated a right lower lobe infiltrate with small effusion. She was treated for suspected pneumonia. Her cough persisted, and three months later repeat imaging demonstrated a persistent lesion for which she was treated with antibiotics for presumed pneumonia. After five more weeks with no resolution, a computed tomography scan showed a right lower lobe lung mass with hepatic and adrenal involvement. Over the next month, she developed hemoptysis and had a biopsy performed. She was diagnosed with small cell lung cancer with hepatic, adrenal, and skeletal metastases. She has since undergone four cycles of chemotherapy.

Discussion: Literature review demonstrates 2.8% of SCLC cases are non-smoking females (no non-smoking males) with mean age of 63.0 ± 15.7 years. Evidence shows that estrogen activity is associated with the physiology of lung adenocarcinoma in women; this patient presented following a hyper-estrogenic state with pregnancy. No studies to date show an association with SCLC and hyper-estrogen state, though systematic review shows a strong association with adenocarcinoma.

Scholarly Question: Does estrogen play a role in small cell lung cancer similar to the pathophysiology of adenocarcinoma?

Conclusion: In patients who have been exposed to a hyper-estrogenated state, either secondary to pregnancy or hormone-replacement therapy, providers should be aware of increased risk of lung adenocarcinoma. Further research may demonstrate an association with SCLC.

THIRD PLACE CASE REPORT

BABY, YOU TAKE MY BREATH AWAY

Scott Meteer, Naval Hospital Jacksonville, Jacksonville, FL 32214; Micah Pastula, Naval Hospital Jacksonville, Jacksonville, FL; Rachel Carter Naval Hospital Jacksonville, Jacksonville, FL

Introduction: Up to 68% of patients with peripartum cardiomyopathy (PPCM) are hypertensive, and because symptoms of heart failure late in pregnancy can easily be attributed to preeclampsia, diagnosis and treatment of PPCM is often delayed. This case illustrates how treatment of preeclampsia can unmask previously undiagnosed PPCM, suggesting the need to reevaluate the guidelines for treatment of acute, severe hypertension in pregnancy.

Case Presentation: After admission for preeclampsia, a 21 year-old primagravida at

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35 weeks gestation became progressively hypoxic after successive doses of labetalol for severe-range pressures. Point-of-care ultrasonography (POCUS) yielded an estimated ejection fraction (EF) of 39%, and the patient was found to have a pro-BNP of 6800, suggestive of PPCM. She successfully had a vaginal delivery after induction, but required positive pressure ventilation and ICU transfer postpartum. Pulmonary embolism, infection, and cardiac ischemia were ruled out. Formal echocardiogram revealed an EF of 20% with a nearly akinetic left ventricle, consistent with PPCM.

Discussion: PPCM is heart failure with left ventricular dysfunction that occurs without another identifiable cause in the peripartum period. Labetalol is a frequently used antihypertensive in pregnancy with the potential to provoke acute decompensated heart failure. This case illustrates the need to rule out PPCM when patients with preeclampsia have pulmonary compromise. Pulmonary edema in pregnancy is more likely to be due to underlying cardiac disease than preeclampsia, and our patient had clinical suggestion of pulmonary edema prior to labetalol-induced decompensation. POCUS and a pro-BNP can help differentiate between PPCM and preeclampsia when clinically necessary.

Scholarly Question: How should acute-onset, severe hypertension in pregnancy be managed when there is clinical suggestion of PPCM?

Conclusion: PPCM should be ruled out with POCUS or a pro-BNP prior to using labetalol in patients with primarily cardiopulmonary manifestations of preeclampsia. In these cases, hydralazine may be considered the first-line option.

"IT'S NOT SMOKE, IT'S VAPOR": ACUTE LUNG ILLNESS IN A HABITUAL E-CIGARETTE USER

Robert Dunn, Capt, MD, 96th MDG, Eglin Air Force Base, Florida 32542

Cody Holmes, Capt, MD, 96th MDG, Eglin Air Force Base, Florida 32542

Alexander Schloe, Capt, MD, 96th MDG, Eglin Air Force Base, Florida 32542

Objective: While advertised as a safe alternative to smoking, e-cigarette use is linked to hundreds of cases of acute pulmonary illness. The following is a case of severe lung injury in a patient with E-Cigarette use.

Case: A 19-year-old male e-cigarette smoker presented to the hospital with acute on chronic emesis and abdominal pain. Due to profound leukocytosis he was admitted and started on antibiotics for suspected infection. On presentation he had a normal pulmonary examination and chest x-ray. Antibiotics were discontinued, however he remained symptomatic and developed an oxygen requirement on hospital day three. New multi-lobar infiltrates were appreciated on chest x-ray and antibiotics were initiated for presumed pneumonia. He continued to require oxygen and, on hospital day four, developed pleuritic chest pain with tachycardia. A CT-PE was performed which demonstrated extensive bilateral ground-glass opacities concerning for acute respiratory distress syndrome (ARDS). He was transferred to an outside hospital where he underwent diagnostic bronchoscopy and had dramatic improvement with systemic steroid treatment.

Discussion: There were 193 vaping associated lung injury cases reported by the CDC between June and August 2019. Cases range from mild respiratory illness to ARDS. Our patient's presentation fit this developing syndrome; which includes symptom onset within 90 days of e-cigarette use, absence of pulmonary infection on initial presentation, and bilateral ground-glass opacities on CT chest. These patients pose a diagnostic challenge due to vague symptoms, broad differential, and acute onset of respiratory distress.

Scholarly Question: Should ingredients used in E-cigarettes be regulated by the FDA and fully disclosed to consumers?

Conclusion: The CDC has recently published Surveillance Case Definitions for vaping induced lung injury. As this medical challenge continues to unfold, it remains of utmost importance to discuss vaping with patients in order to consider this diagnosis and provide an opportunity to discuss cessation.

DON'T TRUST THE LABS: A CASE OF SEVERE LIPEMIA AFFECTING MANAGEMENT OF DKA

CPT Victoria Hall, MD Martin Army Community Hospital Ft. Benning, GA 31905

Introduction: Very severe hypertriglyceridemia (>2000 mg/dL) affects <0.11% of those tested for hyperlipidemia and causes lipemic interference. Significant lipemia causes inaccurate interpretation of common serum labs which has profound implications in patient management. Presented is a patient with significant lipemia whose accurate laboratory data were essential in making appropriate treatment decisions for suspected diabetic ketoacidosis (DKA).

Case Presentation: A 38 year-old obese male presented to the ED with one week of worsening polyuria, polydipsia, and frothy urine. Labs demonstrated hyperglycemia (408 mg/dL), hypertriglyceridemia (>4425 mg/dL), hyperlipidemia (511 mg/dL), hyponatremia (126 mmol/dL), indeterminate potassium, and "normal" anion gap of 15. The clinical presentation, however, was consistent with DKA. This led to further investigation of the reported lab values to determine accurate electrolyte values based on the lipemic index. The patient was admitted to the ICU and treated for DKA with hypertriglyceridemia. He was stabilized and discharged the next day.

Discussion: Severely elevated triglycerides causes lipemia which affects the accuracy of serum lab values analyzed via light microscopy. Laboratories establish a local lipemic index above which they may not report certain values, and even the published values must be interpreted with caution. This patient was found to

have a pseudohyponatremia (commonly seen in hypertriglyceridemia) secondary to the volume displacement caused by severe lipemia. Considering the effects of lipemia, the treatment team avoided treating hyponatremia, thereby dodging a potentially deadly iatrogenic hypernatremia.

Scholarly Question: What is the rate of adverse outcomes secondary to mismanagement due to lab errors for patients with severe lipemia?

Conclusion: Severe lipemia caused by hypertriglyceridemia is a significant impedance in correct interpretation of patient labs and can lead to harmful patient outcomes due to mismanagement. Through close partnership with lab personnel, physicians can make appropriate management decisions for labs skewed by severe lipemia to avoid potentially harmful outcomes.

WHAT A JERK! : NICOTINE GUM AS A POTENTIAL CAUSE OF SYMPTOMATIC MYOCLONUS

MAJ (P) Mark Jeffords, MD, Madigan Army Medical Center, Tacoma, WA 98431

Introduction: The USPSTF recommends asking all adults about tobacco use and advises them to stop using tobacco (Grade A). There is no current recommendation from the CDC or USPSTF to inquire about other nicotine products, although these may result in significant adverse side effects and health outcomes.

Case Presentation: A 58yo male with a history of hyperlipidemia and chronic neck pain presented to the primary care clinic with complaint of restless legs and "muscle jerks." Physical exam demonstrated 3-4+ reflexes globally. Over six months, the patient underwent multiple trials and evaluations, including discontinuation of duloxetine, brain MRI, and Neurologist evaluation without any identified cause of symptoms. The social history developed as he grew more trusting, and heavy alcohol use was identified, then curtailed. The myoclonus persisted. Eventually, he revealed a greater than 10-year history of chewing Nicorette gum, more than 20 4mg pieces per day. Upon reducing Nicorette gum use, the patient's symptoms resolved.

Discussion: Nicotine products act as nicotinic receptor agonists affecting the autonomic ganglia and causing stimulation, followed by depolarization block. Central nervous system effects may include tremors, convulsions, and vomiting. These effects are typically only seen in nicotine overdose, but this is a case of potential effects at a high therapeutic dose. The social and substance history informs the formulation of appropriate differential diagnoses, and the current standard of screening for tobacco use may overlook alternative nicotine sources.

Scholarly Question: Can nicotine replacement therapy, alone or in combination with other factors, precipitate adverse neurological symptoms?

Conclusion: As nicotine replacement therapy is a common practice, healthcare teams should adjust practice to ask about nicotine history rather than only tobacco history. Further study should be undertaken to develop a better understanding of the adverse effects of prescription and recreational nicotine.

INFECTIVE ENDOCARDITIS MANAGEMENT: A CASE REPORT OF ISOLATED PULMONIC VALVE INFECTIVE ENDOCARDITIS MANAGED MEDICALLY IN A PREVIOUSLY HEALTHY SPECIAL FORCES CANDIDATE

Laura Kennedy MAJ, Carl R. Darnall Medical Center, Fort Hood, Texas, 76544; Marc Aming CPT (P); Dorothy Shum MAJ

Introduction: Isolated pulmonic valve endocarditis (PVE) is rare, devastating, and often difficult to diagnose expediently. Early surgery may be required for vegetations greater than 1.5 cm. Presented is a Soldier with a 2.6-cm vegetation in the setting of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia managed medically.

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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 Cheryl Modesto at *cmodesto@vafp.org*.

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Case Presentation: A 26-year-old Active Duty male presented with fever, pain, and purulent discharge from the site of a peripheral intravenous (IV) line placed one week prior. Ultrasound was consistent with superficial thrombophlebitis. Blood and wound cultures identified MRSA. Transesophageal echocardiogram (TEE) was obtained to evaluate for infective endocarditis (IE) in the setting of MRSA bacteremia and demonstrated a 2.6-cm mobile vegetation on the pulmonic valve. The patient was treated with six weeks of IV daptomycin without cardiac surgery. Follow-on cultures and echocardiogram showed clearance of vegetation and bacteremia.

Discussion: The diagnosis of isolated PVE is challenging due to lack of symptoms commonly seen in left-sided or tricuspid valve endocarditis unless other valves are affected. Patients with *Staphylococcus aureus* bacteremia, fever with rising inflammatory markers despite adequate treatment, and high risk groups should be evaluated with TEE for IE and to identify complications necessitating early surgery. The decision for surgical versus medical management of IE is controversial. Suggested indications for early surgery include antibiotic failure, heart failure, valvular disease, embolic events, or large vegetations (greater than 1.5-cm). Antibiotics may be attempted initially in select patients with close monitoring.

Scholarly Question: In the treatment of PVE, when is medical management safe and superior to surgical management?

Conclusion: IE is important to consider in patients with *Staphylococcus aureus* bacteremia and should be ruled out with TEE. Although large vegetations can be an indication for surgical management, presented is an example of the type of patient in which initial intervention with antibiotics and close monitoring can be attempted.

METHYLSULFONYLMETHANE FOR TREATMENT OF LOW BACK PAIN

Robert Lystrup, MD, 355th MDG, Davis-Monthan AFB, Arizona 85705

Frederick Nielson, MD, 52nd MDG, Spangdahlem AFB, Unit 3690, APO, AE 09123

Amanda Crawford, MSHS, 99th MDG, Nellis Air Force Base, Nevada, USA 89191

Paul Crawford, MD, 99th MDG, Nellis Air Force Base, Nevada, USA 89191

Introduction: Patients are consuming Methylsulfonylmethane (MSM) even though there is an absence of evidence-based assessments of its usefulness in lower back pain. The objective of this study is to assess whether Methylsulfonylmethane (MSM) + standard of care naproxen improves symptoms of lower back pain versus standard of care naproxen + placebo.

Methods:

a. Design: A randomized, double-blind, placebo-controlled trial.
b. Setting: Mike O'Callaghan Military Medical Center.
c. Study Population: Randomly selected sample of 100 active duty military members, and retired military members and their families with back pain.
d. Intervention: 6000 milligrams of MSM + standard of care naproxen taken for 12 weeks.
e. Main Outcome Measures: Complete Blood Count, Comprehensive Metabolic Panel, Pain Impact Questionnaire-6, Roland-Morris Disability Questionnaire, Visual Analogue Scale (VAS).
f. Statistical Tests Used: Sample means, standard deviations and standard errors of measurement for interval variables and frequency distributions for nominal variables for the total sample and for the treatment group. Hypotheses tested with a mixed effects repeated measures ANCOVA.

Results: Controlling for naproxen consumption, there was a significant difference in mean VAS for treatment groups from weeks 0-16 ($p=0.0005$). Subjects who took low dose naproxen + placebo had higher mean VAS than MSM High, MSM Low, Placebo High, and Placebo Low treatment groups ($p=.036$, .006, .002, $<.00001$). Placebo difference in mean VAS from 0-16 weeks was nonsignificant ($p=.313$) while MSM difference was near significance ($p=.051$) without controlling for naproxen consumption.

Conclusion: Our study suggests that if the total doses of analgesics are controlled, MSM has a statistically significant effect. Subjects using MSM required lower doses of naproxen to achieve similar pain scores as subjects taking high doses of naproxen. MSM was associated with a nearly statistically-significant improvement in pain scores over placebo.

2020 Juried Podium Abstracts

FIRST PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

PRIZEN: NON-OPIOID PAIN RELIEF USING BATTLEFIELD ACUPUNCTURE IN PRISON

LT Jacqueline Rine, MD and CAPT Rochelle Nolte, MD; Department of Pediatrics, NMCSD USCG Sector San Diego

Introduction: Auricular acupuncture, including battlefield acupuncture (BFA) has been widely used for pain management. Given the relatively high rate of opioid misuse in incarcerated personnel, alternative methods of addressing pain, such as BFA are important to address the current opioid epidemic. No evidence was found that this technique has been utilized in the federal prison system prior to 2019.

Methods: Inmates at Metropolitan Correctional Center (MCC) San Diego, within the Federal Bureau of Prisons (BOP), were offered BFA for pain management if they presented with pain and a confirmed diagnosis from March-August 2019. The Executive staff approved the procedure, but with standard acupuncture needles given security concerns with the semi-permanent needles. Needles were left in place for 30 minutes while observed, after which all needles were removed and accounted for. The main outcome measured was pre- and post-treatment pain using a Visual Analog Scale (VAS). The goal of each treatment session was a score of 2 or less on the VAS, with return of baseline function of being independent with their institutional activities of daily living. If a patient reached these goals during treatment, no further needles were placed during.

Results: Data was obtained for 62 treatment sessions on 17 unique individuals from March-August 2019. The number of treatments a patient received ranged from 1 for an episode of acute pain, or for a chronic condition for which activity modification and a therapeutic exercise program was prescribed, to 24 in a patient with post-traumatic osteoarthritis of the knee awaiting transfer to his designated facility. Researchers found a statistically significant difference between pre-treatment and post-treatment VAS scores (MD = -6.44, SD 1.85); $t(16) = -13.9, p = < 0.0005$). All patients resumed normal or baseline function.

Conclusion: These results demonstrate similar efficacy of BFA for pain control in the incarcerated personnel as has been demonstrated in other populations.

SECOND PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

RACIAL DISPARITIES IN PAIN MANAGEMENT DURING VAGINAL CHILDBIRTH

Faraz Ghoddusi MD; Jenene Geske, PhD; Stacey Ghoddusi, MPH; Kevin Sisk, DO; Shana Miles, MD: University of Nebraska Medical Center, Omaha, NE; Offutt Family Medicine Residency, 55th Medical Group, Offutt AFB, NE

Introduction: Racial disparities in healthcare access and quality have been extensively documented. With increased attention being paid to pain management, it becomes important to recognize trends in undertreatment of pain. As such, we examined differences in pain medication distribution during vaginal births. Demographics compared include insurance, and race/ethnicity.

Methods: Retrospective analysis of all vaginal deliveries in the Nebraska Medicine system from Jan 2010 – Dec 2017, excluding encounters that included additional procedures (tubal ligation, manual placenta extraction, etc). We reviewed pain medications provided during the labor process, creating subpopulations based on race/ethnicity and insurance payor. Analyzed with Chi-square test for non-parametric groups using descriptive statistics for categorical variables (race and insurance).

Results: N = 8,595 Vaginal Deliveries All insurance providers, other than Tricare, showed statistically significant differences in dispersion of pain medication based on race ($P < 0.001$). Minorities with Tricare received epidurals at a higher rate than other payors, with less variability across race/ethnicity. Given difference in sample size (N = 351), Fisher's Exact test failed to show statistical significance in meds based on race in this group ($p = 0.8524$). Difference in primary language spoken led to even larger disparities in pain medication offered.

Conclusion: Studied patient population was found to have disparities in pain medications given during labor based on ethnicity and race, with largest disparities found when evaluating primary language spoken. Fewer racial disparities were noted in the Tricare population when compared to all other insurance providers. Given trends noted in this study, interventions to reduce disparity could include additional patient education prior to admission, improved continuity of care, improved access to translator services at bedside, and awareness of possible provider bias in patient encounters.

THIRD PLACE POSTER DISPLAY / CLINICAL INVESTIGATION

A QUALITY IMPROVEMENT INITIATIVE TO INCREASE HUMAN PAPILLOMAVIRUS VACCINE RATES IN YOUNG ADOLESCENT MALES

LT Osmund Nogra, M.D., Gloria Calderon, DNP, Naval Hospital Jacksonville

Introduction: Healthy People 2020 set a goal for the Human Papillomavirus (HPV) vaccination rate to reach 80% by 2020. Only 31% of males 11 to 12 had received the HPV vaccine in Naval Hospital Jacksonville Family Medicine Clinic. A Quality Improvement to increase HPV vaccination rates of boys 11 to 12 was initiated using a Plan-Do-Study-Act cycle.

Methods: Cycle one, a telephone reminder using an auto-dial strategy was sent out to remind parents of boys aged 11 to 12 that their son is due to begin, continue or complete the HPV vaccine series. Cycle two, an HPV reminder letter was mailed to parents of adolescent boys ages 11 to 12 to educate and inform them of the importance of the HPV vaccine as a cancer prevention immunization. Finally, cycle three, a discussion and recommendation from

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family medicine providers. These changes were added sequentially between June and December 2018. This study was waived from IRB review.

Results: Pre-intervention, 338 males, 105 (31%) had received the HPV vaccine. Cycle one involved 234 participants; 27 males received the HPV vaccine, an 11.5% uptake. In cycle two, the telephone reminder/recall was continued and added the HPV reminder letter. Cycle two involved 301 participants, 13 males received the HPV vaccine, a 4.3% uptake. During the final cycle, of the 18 males who had an appointment to see a provider, 6 received the HPV vaccine, which is a 33.3% uptake. Post-intervention, HPV vaccination of boys 11-12 increased to 36.7%. Subjects who received a reminder recall and discussion with a doctor were 4 times more likely to receive their HPV vaccine (odds ratio 3.83, CI 1.33 – 11.05) compared to reminder recall alone.

Conclusion: The analysis showed that human interaction was the most effective way to improve HPV vaccine rates. Limitations of this study include its short duration and single facility.

FIRST PLACE POSTER DISPLAY / EDUCATIONAL RESEARCH

IMPLEMENTING A REFLECTIVE PRACTICE CURRICULUM IN A FAMILY MEDICINE RESIDENCY

MAJ Nathaniel Watts, DO; Juliana Ee, PhD; CPT Kassandra Pellegrini, MD; MAJ Zachary Bevis, MD; Ashley Adams, BA; COL Matthew Hing, MD

Introduction: Reflective practice (RP) is a learning process to explore one's knowledge, personal experiences, thoughts, emotions, and behaviors in order to enhance self-awareness. This process facilitates improvement in ethical and professional practice. This project evaluated the efficacy of a RP curriculum in a military family medicine residency.

Methods: Residents and faculty met in small groups, each consisting of 8 participants, to discuss readings and experiences related to pre-selected topics. Topics included Medical Errors, Compassion Fatigue, Obesity, Tribalism, Work-Life Balance, and Conflict Resolution. Outcome surveys delineating the curriculum objectives, including how the RP enhanced knowledge, increased ability to identify biases and personal reactions, shaped perspectives, helped professional development, and stimulated discussions, were administered at the end of each session. Facilitator Observation Forms were administered from session 3 onward. Data available from 5 of 6 sessions, occurring between Oct 2017 and Feb 2019, was described with means, medians, interquartile ranges, counts, and frequencies.

Results: Respondents (N=80 over 5 sessions) evaluated individual objectives with a mean of 7.1 to 7.8 on a 10-point Likert scale. Faculty rated the RP sessions the highest, with a median total score of 49 (IQR: 43-55) of 60 points, while PGYII's rated them the lowest (median: 40.5, IQR: 36-50). The topics of Medical Errors and Tribalism received the highest rankings. Respondents rated facilitator leadership with a mean of 3.9 to 4.5 on a 5-point Likert scale. PGYI's rated facilitators the highest, with a median total score of 36.5 (IQR: 33-40), while PGYII's, PGYIII's, and Faculty rated facilitators similarly. Facilitators were rated highest on inclusion of all participants, but rated lowest on establishing ground rules.

Conclusion: Overall, the reflective practice curriculum has been a helpful and positive learning experience. Facilitators could benefit from training on clarifying ground rules and expectations in leading the group process.

FIRST PLACE POSTER DISPLAY / CASE REPORT

SILLY RABBIT, KAWASAKI IS FOR KIDS! A RARE CASE OF ADULT-ONSET KAWASAKI DISEASE

Ethan Harris, MD, LT, USN; Rachel Concepcion, DO, LT, USN; Shira Paul, MD, LT, USN; Naval Hospital Camp Pendleton, Oceanside, CA

Introduction/Objective: Kawasaki disease (KD) is an acute, systemic, necrotizing vasculitis that primarily occurs in young children with only 111 adult cases published worldwide. Those affected are at risk for cardiovascular sequelae, particularly if untreated. Presented is a rare case of acute KD in a young adult male.

Case Presentation: A 21-year-old active duty Caucasian male was transferred to our facility with 7 days of fever, fatigue, jaundice, polyarthralgia, rash, and injected conjunctivae. His fevers had not responded to broad-spectrum antibiotics. He was diagnosed with Kawasaki disease based on fever duration and exam findings of limbic-sparing conjunctival injection, erythematous polymorphic exanthem with palmoplantar desquamation, lymphadenopathy, and 'strawberry' tongue. The patient was treated with 2g/kg intravenous immunoglobulin (IVIG) and aspirin with complete convalescence. Serial echocardiography and coronary CTA demonstrated no coronary artery aneurysm. He made excellent recovery and returned to full duty status 6 months post-treatment.

Discussion: Kawasaki disease is an unusual and likely under-diagnosed cause of acute febrile illness in adults and confers potentially fatal cardiovascular risks if untreated. KD should be considered when a patient presents with fever >5 days plus four of the following: polymorphic exanthem, lymphadenopathy, mucositis, bulbar conjunctivitis, palmoplantar edema/desquamation, or coronary aneurysm. Treatment guidelines for adults are the same as children: single-dose IVIG and high-dose aspirin. Our case adds to the literature a rare case of a Caucasian adult with classical Kawasaki Disease in the setting of trans-Pacific deployment.

Scholarly Questions: What proportion of Kawasaki cases can be explained by exposure to endemic regions (i.e. SE Asia)?

Conclusion: Though Kawasaki disease is uncommon in adults, this case demonstrates the importance of prompt recognition and treatment in a child or adult with prolonged fever and mucocutaneuous findings. Further investigation is needed to validate adult diagnostic criteria, pathophysiology, and long-term sequelae/prognosis.

SECOND PLACE POSTER DISPLAY / CASE REPORT

THE BEE'S KNEES: TAKING THE STING OUT OF ANTERIOR KNEE PAIN WITH HYDRODISSECTION OF THE INFRAPATELLAR FAT PAD

CPT Emily Buck, MD; CPT Stephanie Skelly, MD Family Medicine Residency, Madigan Army Medical Center, JBLM, WA

Introduction/Objective: Patellofemoral pain syndrome (PFPS) accounts for approximately 17% of knee pain. The infrapatellar fat pad (IFP) may become impinged at the patellofemoral joint and is an overlooked contributor to PFPS. PFPS typically improves with physical therapy (PT), however, there is no standard treatment for IFP impingement.

Case Presentation: A 21-year-old female athlete presented with three years of left greater than right anterior knee pain with high-impact activity that did not improve with PT. Exam demonstrated tenderness laterally and medially to the left patellar tendon, pain with extension, and left quadriceps and hip-flexor tightness consistent with PFPS. MRI revealed left IFP impingement, patellar chondromalacia, and subchondral degeneration. IFP hydrodissection was performed with 2 ml of 1%-lidocaine and 1 ml of normal saline via a landmark-guided lateral approach. The patient reported pain reduction and improved range of motion both immediately and two months post-procedure.

Discussion: The IFP is a nociceptor-innervated structure that may contribute to PFPS. Pain is infrapatellar, worse with high-impact activity, and associated with decreased hip abductor and flexor mobility. The mainstay of PFPS treatment, both with and without IFP impingement, is PT. No literature is available describing injections or hydrodissection in the management of PFPS with IFP impingement. Hydrodissection has been reported in the treatment of Achilles' tendinopathy, utilizing high-volume saline to separate the pre-Achilles' fat pad from the tendon. Similarly, our patient's injection likely assisted in separating the IFP from the posterior patella. The optimal volume and mixture for hydrodissection of the IFP are unclear.

Scholarly Questions: Is there a place for IFP hydrodissection in treating patients with PFPS with IFP impingement?

Conclusion: Hydrodissection may be useful in conjunction with PT for relief of PFPS with IFP impingement. Further research is needed to integrate this procedure into Family Medicine Practice.

SECOND PLACE POSTER DISPLAY / CASE REPORT

NEEDLES OVER NAUSEA: ACUPUNCTURE FOR PREVENTION OF MOTION SICKNESS

Brooke Organ, DO and Christopher Ledford, MD; Eglin Family Medicine Residency, Eglin Air Force Base, FL

Introduction/Objective: While motion sickness is a commonly encountered syndrome, well-studied treatment options for its prevention are limited, including environmental cueing, ginger, acupressure, and medications such as scopolamine and antihistamines. This case outlines an acupuncture treatment for prevention of motion sickness.

Case Presentation: A 9-year-old male with Autism Spectrum Disorder suffering from profound motion sickness had failed ginger, antihistamines, scopolamine patches, and antiemetics, and before resorting to diazepam, sought a trial of acupuncture. Treatment was initiated with PyonexTM needles in body and auricular acupuncture points known to affect nausea and the vestibular system. Seven treatments were completed over the course of several weeks leading up to a 10-day family road trip. His parents reported he had not had an episode of emesis related to motion sickness since his first acupuncture treatment, and for the first time was able to enjoy a family vacation, including riding roller coasters with his siblings.

Discussion: Clinical evidence for the efficacy of acupuncture in motion sickness is promising, but underpowered due to study issues like heterogeneity and blinding. Acupuncture may be an effective treatment, but unlike medications, is extremely low-risk for harm. This is especially appealing in special populations like pediatrics, or military members on special duty status, where using medications with significant adverse effects is of greater concern. Military aircrew in training commonly encounter motion sickness leading to delays in progression and lost duty time. Current guidance for prevention relies on the eventuality of sensitization, and adaptation protocols provide only temporizing measures with deleterious effects.

Scholarly Questions: Could a standardized auricular acupuncture protocol be employed for prevention of motion sickness in military aircrew?

Conclusion: Though few rigorous scientific studies exist on the efficacy of acupuncture for treatment of motion sickness, this account demonstrates dramatic benefit in a refractory case. Acupuncture may be considered as a first-line treatment for prevention of motion sickness.

THIRD PLACE POSTER DISPLAY / CASE REPORT

BATTLEFIELD ACUPUNCTURE USED AS ADJUNCT FOR PAIN MANAGEMENT IN HEAT STROKE: A CASE SERIES

Samantha Green, MD, CPT, MC; Audrie Konfe, MD, CPT, MC; Mary A. Noel, MD, MAJ, MC Martin Army Community Hospital, Fort Benning, Georgia

Introduction/Objective: Objective Battlefield acupuncture (BFA) has been gaining popularity for management of pain in military medicine. Presented is a case series demonstrating BFA as an effective treatment modality for headache and muscle pain in three Servicemembers (SM) with multi-organ dysfunction as a result of heat stroke.

Case Presentation: Three trainees were admitted to the intensive care unit after experiencing heat stroke with max core temperatures ranging from 108.1-109°F. All three SMs experienced multi-organ dysfunction to include acute kidney injury and hepatic dysfunction. Upon return to baseline mental status, all three complained of diffuse muscular pain and headaches. BFA was performed for

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treatment of their pain. In two SMs, they had complete resolution of headache and reduction in muscular pain. One SM had no response.

Discussion: In patients with multi-organ dysfunction, impaired renal and hepatic function significantly limits pharmacologic options for pain management. Opioids and typical conservative management of acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs) must be approached with caution in these patients due to risk of further hepatic or renal injury. Two Cochrane reviews confirm that traditional acupuncture reduces headaches. A large meta-analysis concluded that traditional acupuncture is effective in treating musculoskeletal pain. Currently, no research exists on efficacy of BFA in the inpatient setting. One cross-sectional study demonstrated that approximately 80% of patients demonstrate some type of pain reduction immediately after BFA in the outpatient setting.

Scholarly Questions: Does BFA in patients with multi-organ dysfunction create a statistically significant reduction in pain scores?

Conclusion: This case series demonstrates a safe and effective option in the treatment of headache and muscular pain in patients with multi-organ dysfunction associated with heat stroke. This relatively benign method of pain control could be utilized in non-pharmacologic pain protocols at hospitals who treat SMs with heat stroke. Future studies are needed and should include a larger sample size, randomization, and blinding.

THIRD PLACE POSTER DISPLAY / CASE REPORT

A MISBEHAVING SCAR: MAKING THE DIAGNOSIS OF SARCOIDOSIS FROM ATYPICAL SKIN FINDINGS

CPT Kristen Barta MD, CPT(P) Amanda Nopakun MD, CPT James Kwon MD, Tyler Raymond DO, MPH, FAAFP, Gary Clark MD, MBA, FAAFP, MAJ John Fowler MD; Madigan Army Medical Center, JBLM, Tacoma, WA

Introduction/Objective: Confirming sarcoidosis is a challenge given the multi-system nature of the disease and lack of a definitive diagnostic test. Skin manifestations are common, particularly changes in tattoos or old scars. Skin biopsy is a minimally-invasive procedure allowing for early diagnosis.

Case Presentation: A 56-year-old African American male presented to the ED for hypertensive emergency. He reported cough, dyspnea and 25-lb. weight loss over 6 months. A chest x-ray showed adenopathy and a subsequent CT chest demonstrated numerous pulmonary nodules suspicious for scarcoidosis. He had additional features of sarcoidosis, to include leukopenia, cough, parotid fullness, hypercalcemia, skin findings, and an elevated ACE level. He had a history of keloids with recent changes and newly developing papules. Shave biopsy demonstrated non-caseating granulomas. Subsequent bronchoscopy also suggested sarcoidosis.

Discussion: Skin is the second most common organ affected by sarcoidosis, occurring in 25-30% of patients. Skin lesions are often an early finding with multiple clinical presentations. Several cases have demonstrated non-caseating granulomatous inflammation in areas of trauma known as "scar sarcoidosis." Patients may present with painful, erythematous or violaceous discoloration around areas of trauma. Others develop painless nodularity in atrophic scars that have been present for years. There are also several reports of papulo-nodular lesions limited to the area of a tattoo. A thorough dermatologic examination is crucial in the evaluation of patients with suspected sarcoidosis. In our case, a patient with a known history of keloids noticed recent changes without new trauma.

Scholarly Questions: Does early skin biopsy facilitate a more timely diagnosis of sarcoidosis?

Conclusion: Family physicians frequently encounter keloids, hypertrophic scars and tattoos. Asking about changes in the absence of new trauma should be considered to help identify patients presenting with early findings of sarcoidosis. Biopsy of these lesions may allow for earlier diagnosis and a decreased need for more invasive procedures like bronchoscopy.

UTILITY OF POCUS IN TENDON RUPTURE

LT Spencer Dean DO, Naval Hospital Jacksonville, FL; LT Michael Johnson DO, Naval Hospital Jacksonville, FL; LT Kerry Sadler MD, Naval Hospital Jacksonville, FL; LCDR Kevin Bernstein MD, Naval Hospital Jacksonville, FL

Introduction/Objective: Tendon rupture affects competitive and recreational athletes (military members). Military members develop tendinopathy (a precursor to tendon rupture) at a rate of 6.8% (1). Cases of tendon rupture can be diagnosed clinically with special ROM and provocative tests, but frequently imaging is performed as well to grade the injury and determine if treatment should be surgical or not.

Case Presentation: Two healthy AD males ruptured tendons while participating in recreational sports. The injuries were evaluated clinically by Family Medicine physicians; POCUS confirmed the severity of the tears which led to rapid referral and aided in surgical planning.

Discussion: Ultrasound and MRI are diagnostic modalities utilized in evaluating the severity of a tendon ruptures. MRI has long been the gold standard for soft tissue imaging; however, ultrasound is a quick, portable, inexpensive alternative option. Since 47% of in-theater injuries are musculoskeletal, POCUS offers a unique modality to quickly evaluate MSK injuries and determine the appropriate level of care. Military Family Physicians would benefit from formal training with this imaging modality given the austere front-line environment.

Scholarly Questions: Is there a benefit to training military family medicine residents in point of care ultrasound (POCUS) to evaluate acute tendon injuries?

Conclusion: POCUS provides an efficient and inexpensive diagnostic tool to improve point of injury evaluation and assist in rapid decision making, resulting in improved patient outcomes. Formal training

in POCUS for Family medicine residents will assist operational missions by expediting diagnosis and treatment of the warfighter with a tendon injury

GENERALIZABILITY OF CURRICULAR CHANGES TO INCREASE SCHOLARLY ACTIVITY IN FAMILY MEDICINE RESIDENCY PROGRAMS

Maj Roselyn Clemente Fuentes, Capt Christine Broszko, Eglin AFB Family Medicine Residency, FL; LCDR Rob Lennon, Pennsylvania State University; CAPT James Keck, CAPT Kristian Sanchack, Naval Hospital Jacksonville, FL

Introduction: Scholarly activity (SA) is an Accreditation Council of Graduate Medical Education (ACGME) requirement for Family Medicine residents. Engaging residents in scholarly activity can be challenging. Naval Hospital Jacksonville Family Medicine Residency (NHJ) pioneered a curriculum that led to a dramatic, sustained increase in resident SA. We sought to determine the generalizability of this curriculum to other family medicine residency programs.

Methods: Curriculum generalizability was tested at two family medicine residencies. Three curricular interventions were identified: a three-hour case report workshop, a written practical guide to scholarly activity, and a resident peer research leader. One program implemented all three elements. The other implemented the workshop and written guide, but did not identify a resident peer leader. SA was measured using the annual ACGME program director report and compared to the previous three years of SA using a 2-sample test for equality of proportions with continuity correction. Resident attitudes about SA pre- and post-intervention were evaluated by survey.

Results: The program implementing all three interventions increased their conference presentation 302% ($n=34$, $p<0.001$). The program that did not identify a resident peer leader had no significant change in SA as reported to the ACGME.

Conclusion: The correlation between a resident peer research leader and increased resident scholarship observed at NHJ is now observed at another program, suggesting that the NHJ curriculum may be generalizable, with dramatic improvement in ACGME reportable SA within one year of implementation.

GOING THE EXTRA MILE: A CASE OF NEW DIAGNOSIS OF DIABETES DURING A PRE-PARTICIPATION PHYSICAL

CPT Eric Gresham, MD; MAJ Mark Robinson, MD; LTC Heather O'Mara, DO; Tripler Army Medical Center, Family Medicine Residency, Honolulu, HI

Introduction/Objective: Pre-participation physicals are often required by schools. There is much debate as to their utility. The Lown Institute's Right Care Alliance Children's Health Council's evidence-based review identified the pre-participation sports physical as one of five 'don't' recommendations due to time, cost, low sensitivity and specificity, and weak evidence to prevent sudden cardiac death. However, sports physicals may be the only instance youth interact with their primary care provider.

Case Presentation: A Samoan 16-year-old presented to clinic for a pre-season physical for football. He reported no complaints, no significant past history and had a negative review of symptoms. He had an elevated blood pressure and was in the 96th percentile for Body Mass Index. The remainder of his exam was normal. Given the patient's BMI, screening labs were ordered, returning a hemoglobin A1C of 12.2%. The patient was initiated on treatment and close follow-up attempted. He presented 3 weeks later with a 20 lb weight loss, and was later diagnosed with Type I Diabetes Mellitus.

Discussion: The pre-participation physical is often viewed as a cardiovascular risk tool. With poor sensitivity and specificity, the value of this visit has been questioned. However, while American Association of Pediatrics recommends annual preventative visits, evidence demonstrates only 63% of Medicaid beneficiaries had such an appointment in 2013. This patient was seen in his primary care home, and as part of a comprehensive visit, his elevated BMI was addressed allowing for diagnosis of significant pathology.

Scholarly Questions: Should routine pre-participation youth physicals be performed?

Conclusion: Evidence demonstrates many children do not routinely see their primary care providers. For this reason, the American Association of Pediatrics recommends the pre-participation evaluation be conducted in the medical home as part of a wellness exam. Providers address preventative health issues, immunizations, anticipatory guidance and more, making a significant impact on a youth's overall health.

PERCEPTIONS OF GENDER AND RACE EQUALITY IN LEADERSHIP AND CAREER ADVANCEMENT AMONGST MILITARY FAMILY PHYSICIANS

Mariama Massaquoi, MAJ, MC; Tyler Reese, MAJ, MC; Dana Nguyen, COL, MC, Carl R. Darnall Army Medical Center, Fort Hood, TX; Madigan Army Medical Center, Tacoma, WA; Department of Family Medicine, Uniformed Services University, Bethesda, MD

Introduction: There is increasing interest in assessing gender and race-based disparities in academic medicine, healthcare leadership in civilian medicine and the U.S. Military Health System. Approximately 18% of U.S. active duty officers are women, and 23% are racial minorities. This study evaluates the following factors among uniformed services family physicians: Gender and race representation in attaining early career leadership positions during training and two years post-residency; perceptions regarding leadership opportunities and advancement.

Methods: Registered attendees ($n=300$) of the 2016 USAFP Annual Meeting were given a voluntary and anonymous online questionnaire. The main outcomes measured: early leadership assignments and perceptions

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about command/leadership support, gender roles in leadership assignment, confidence to achieve leadership goals and being passed over for leadership positions.

Results: 68% of registered attendees completed the study questionnaire. Statistically significant results, adjusting for Service, grade, race and gender were: Non-Caucasian family physicians were less likely to be Chief Residents (OR 0.23, 95% CI 0.01-1.00); and less likely to have leadership positions within two years post-residency (OR 0.30, 95% CI 0.10-0.91). Female family physicians were more likely to agree that gender has a role in assigning leadership positions (OR 2.33, 95% CI 1.01-5.39). There were no significant differences in perceptions of command support, confidence in achieving leadership level, or being passed over for leadership positions.

Conclusion: The findings of this research study illustrate that there is a degree of gender and racial disparity that warrants further objective investigation. Evaluating composite personnel records of Services' family physicians would provide invaluable information to compliment this study and determine if these disparities are present and need to be addressed on a larger scale. Data from the AIM2 can provide more information on career progression, such as officer and unit preferences. This study increases awareness of the need for Service leaders to continue developing a diverse, ready medical force.

TINGLING FINGERS OF A NAVY HELICOPTER PILOT

Brian Y. Park D.O. LCDR MC(FS) USN
Naval Hospital Camp Pendleton, California

Introduction/Objective: Dexterity and fully functioning senses are critical to operating an aircraft. Any sensory issues in an aviator triggers acute and comprehensive evaluation in prevention of aviation mishap however, this case illustrates the need to look at the whole person, not just symptoms.

Case Presentation: A 26year old previously healthy active duty female helicopter pilot presents with intermittent tingling and numbing of all her fingers for the past 6 months that is typically worse in the morning and after flights. On exam, she was noted to have forward head posture with bilateral anteriorly rotated scapula with winging, tight and hypertrophic trapezius muscles consistent with upper cross syndrome. Rest of the exam showed normal sensory and motor without any signs of atrophy. Numbness could not be reproduced. EMG by neurology were normal and after intense physical therapy, OMT and dry needling to correct her posture, her symptoms resolved.

Discussion: Upper cross syndrome is a complication of a chronic poor posture that leads to muscle imbalance and can manifest as pain or sensory dysfunction. It was first described by Dr. Vladimir Janda, MD from Czechoslovakia in 1979. Forward head posture and anteriorly rotated scapula leads to tightness of paraspinal, trapezius and pectoralis muscles and lengthening and weakening of anterior neck and periscapular muscles. And the anterior rotation of the scapula can compress on brachial plexus, leading to intermittent numbing and tingling of fingers. If unrecognized, it can lead to unnecessary tests and prolonged physical therapy sessions without improvements.

Scholarly Questions: Can early recognition and treatment of poor posture and muscle imbalance reduce the risk of distal sensory issues?

Conclusion: Aviators are at risk for poor posture that can lead to upper cross syndrome. Any aviator with sensory problems in upper extremity should be evaluated for this syndrome in addition to neurologic studies to hasten return to flight status.

SHOULDER INJURY RELATED TO VACCINE ADMINISTRATION: A COMMON VACCINATION REACTION

CPT Madison Paul, MD; Lindsay Lynn, LPN; Dr. Edward Kwon, MD; National Capital Consortium - Family Medicine Residency, Fort Belvoir, VA

Introduction/Objective: Localized reactions are common vaccine adverse events. We report a case of shoulder injury related to vaccine administration (SIRVA) following Shingrix. Our goal is to educate military physicians on basic vaccine administration to help prevent SIRVA.

Case Presentation: A 73y/o female presented for a well-woman exam where she received the Shingrix vaccination. Soon after administration, she developed severe shoulder pain and decreased range of motion. Physical exam revealed an inability to abduct her arm beyond 30 degrees. She was diagnosed with SIRVA and advised to consider a steroid injection. She deferred further interventions, instead electing to proceed with conservative management including Ibuprofen and physical therapy. After one month the patient regained full range of motion, but continued to complain of mild-moderate shoulder pain.

Discussion: SIRVA occurs when a vaccination is inadvertently administered into the shoulder bursa. It can happen with any vaccination and is thought to be a localized immune-mediated inflammatory reaction. The first case was reported in 2006. In 2017, it was added to the National Vaccine Injury Compensation Program. Pain starts within 48 hours of administration, is associated with decreased range of motion, and is not relieved by over the counter analgesics. It is often misdiagnosed as a normal pain reaction after injection, and so the exact prevalence is unknown and thought to be underreported. SIRVA is managed conservatively with NSAIDS and physical therapy, with consideration for steroid injections to prevent adhesive capsulitis. Proper vaccine administration is the only way to prevent SIRVA and includes: 1) proper needle length selection, 2) injecting 2-3 finger breadths below acromion, and 3) injecting at a 90-degree angle.

Scholarly Questions: What is the impact that a universal vaccine administration training program can have on preventing SIRVA?

Conclusion: SIRVA is an important clinical and military readiness topic. Proper vaccine administration technique can minimize the risk of SIRVA.

CONSIDER CLOZAPINE INDUCED MYOCARDITIS WHEN ON CLOZAPINE

Carissa Rittberg, DO, Rukayat Balogun, MD; David Grant USAF Medical Center, Travis AFB, CA

Introduction/Objective: Clozapine is effective for preventing relapse, re-hospitalization and suicidality in treatment-resistant schizophrenia. It has limited use due to concern of potentially fatal side effects, such as Clozapine-induced myocarditis (CIM). CIM can mimic common conditions making diagnosis difficult.

Case Presentation: A 35-year-old female with schizo-affective disorder started on Clozapine two weeks prior to presentation. She was initially diagnosed with sepsis secondary to atypical pneumonia. She had been treated with fluids, Doxycycline, Zosyn, Azithromycin, and Tamiflu with minimal improvement. She still had tachycardia, chest pain and shortness of breath at rest. Her elevated troponin was initially presumed to be a Type 2 NSTEMI from pneumosepsis. Cardiac ECHO showed preserved ejection fraction with wall motion defects. She was started on indomethacin and colchcine for peri-myocarditis with rapid improvement. Cardiac MRI showed resolution of wall motion defects.

Discussion: As demonstrated by the case, the initial diagnosis of CIM may be difficult as the initial symptoms are vague and often mimic other common conditions, such as the flu or sepsis. The incidence of myocarditis is accepted as 3% and the mortality 10-50%. It is estimated that 20% of patients with schizophrenia experience treatment resistance. Only 10-20% of patients that could benefit from this medication receive it due to concerns of adverse effects. An Australian study found that 83% of patients developed CIM 10-33 days after initiating treatment; they therefore recommended instituting a surveillance protocol during the first four weeks after starting the medication. It has a 100% sensitivity for symptomatic CIM.

Scholarly Questions: With surveillance protocols for CIM, could more patients with resistant schizophrenia be safely managed with clozapine?

Conclusion: Clozapine is an effective medication for treatment-resistant schizophrenia that has dangerous side effects that can be difficult to diagnose. In the correct population, clozapine could have life-changing effects if physicians appropriately monitor for side effects.

TRANSITION FROM ACTIVE DUTY TO MILITARY RETIREMENT: FACTORS IMPACTING TYPE 2 DIABETES AND PRE-DIABETES SELF-MANAGEMENT

Tyler Rogers, MD; Carla Fisher, PhD; Easton Wollney, MA; Dean Seehusen, MD; Paul Crawford, MD; Christian Ledford, PhD

Introduction: Transitions can make it challenging to maintain healthy lifestyles critical to type 2 diabetes (T2DM) and prediabetes (preDM) self-management or disease risk reduction. Retirement requires adaptation with new skills for a healthy adjustment. Military retirement is especially challenging, occurring during midlife and often coinciding with a second career. Military retirees demonstrate poorer behaviors than their civilian counterparts, and a full military career does not provide protection against obesity and associated co-morbidities, including T2DM.

Methods: Twenty military retirees participated in a semi-structured interview. The participants were asked to describe their perceptions and experiences with T2DM/preDM. Keeping and comparing memos, interviewer reflexivity/responsivity, maintaining methodological coherence/congruence, and using multiple coders during analysis were strategies to maintain rigor. Transcripts were analyzed for themes using the constant comparative method. Thematic saturation was reached when at least 30% of participants reported the theme, with theme saturation ranging from 30%-85%. Participants were identified from a subset of surveys that were sent to patients from two U.S. Military Medical Centers. Participants were aged 44-63(M=56), with fifteen diagnosed with T2DM and five with preDM. They have been retired between 6-22 years (M=14). Most were male (75%) and identified as either black (40%)

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Matches are made on a rolling basis. Mentees should expect to receive an email identifying their mentor within 3 weeks of signing up.

IS THERE ANYTHING I CAN DO TO HELP?

Definitely! The success of the program is directly tied to member participation. Please consider signing up and sharing this information widely with your military Family Medicine colleagues, including retirees.

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or white (40%).

Results: Participants linked five factors to their T2DM/preDM diagnosis (when diagnosed post-retirement) or to their inability to manage their disease: 1) diet/eating habits, 2) physical activity, 3) weight fluctuation, 4) healthcare interactions, and 5) systematic barriers. Military retirees' struggled to maintain critical self-management behaviors once they were off active duty, with greater independence

Conclusion: Results support diabetes education during military retirement transitions. Military retirees need help maintaining healthy diets, physical activity, and weight management outside of the structured, health-focused military environment. They may also benefit provider training to improve counseling for patients with T2DM and preDM in retired military members. Education would enhance military retirees' self-management.

NOT SO PRIVATE FIRST CLASS: A CASE OF OUTHOUSE INDUCED LATRODECTISM

LT Elizabeth Shields, MD, Family Medicine PGY-1, Naval Hospital Camp Pendleton; LCDR Emory Winship, MD, Internal Medicine, Naval Hospital Camp Pendleton

Introduction/Objective: Marines on MCB Camp Pendleton train in environments with the risk of black widow spider exposure. While no recommendations exist for when to treat, this case demonstrates the benefit of early anti-venom administration for rapid recovery, especially in our warfighting population.

Case Presentation: 20 y/o active duty male presented with dyspnea, abdominal muscle spasms, tremors, diaphoresis, and penile pain 40 minutes after using a portable toilet during a field exercise. Patient had noticed a spider with an hourglass pattern underneath the toilet seat after finishing a bowel movement. During evaluation the patient was hypertensive, tachypneic, and uncomfortable appearing despite receiving lorazepam and morphine. There was 1cm of erythema on the central glans penis. Labs were remarkable for slightly elevated CK and leukocytosis. The following day he had bilateral lower extremity edema, inguinal lymphadenopathy, abdominal soreness, and severe bilateral ankle pain. Anti-venom was administered and in <12 hours his symptoms resolved and he was discharged back to duty.

Discussion: 2600 latrodectus (Black widow) exposures are reported annually. The primary habitat is outdoors in firewood, garages, trash, and outhouses in the southeast and western US. Alpha-latrotoxin irreversibly binds to presynaptic neuron receptors which results in massive neurotransmitter exocytosis. Classic symptomatology includes pain, muscle rigidity, vomiting, and sweating. Initial management includes local wound treatment and tetanus prophylaxis. Muscle spasm pain is managed with narcotics and benzodiazepines. Minor symptomatology is self-limited but severe symptoms may require anti-venom; which is safe and highly effective. Although rare, severe allergic reactions can occur.

Scholarly Questions: What preventative medicine interventions and treatment recommendations can be employed to limit the risk of latrodectism or provide quick recovery from envenomation in military training environments or overseas?

Conclusion: Black widow envenomation can cause significant morbidity to military personnel who routinely work in high risk environments. Early identification and anti-venom administration enables quicker return to duty.

LOW-DOSE SERTRALINE AS A RISK FACTOR FOR EXERCISE-INDUCED RHABDOMYOLYSIS

JD Wolfe, MD; Brett Rasmussen, MD; David Moss, MD; Nellis Family Medicine Residency Program

Mike O'Callaghan Military Medical Center, Las Vegas, NV

Introduction/Objective: Rhabdomyolysis is a common condition among the active duty population. Selective Serotonin Re-uptake Inhibitors (SSRIs) may lower the threshold for rhabdomyolysis. This case describes an active duty male with rhabdomyolysis who had recently started sertraline. The objective of this case report is to present a potential rare complication of SSRIs in an active duty military member.

Case Presentation: A 21 year-old, active duty male presented to clinic with bilateral upper extremity pain and associated paresthesia. The patient reported performing his typical upper body workout routine several days prior to presentation. He had appropriate PO intake prior to exercise and no recent illnesses. He had no extreme heat or humidity exposure. The patient had started Sertraline for depression 4 weeks prior. On laboratory evaluation, his CK level was > 14,000 U/L and myoglobinuria was present. He was admitted to the hospital and started on appropriate therapy with resolution of symptoms.

Discussion: Exercise-induced Rhabdomyolysis is a rare complication of SSRIs. Although not proven, the likely mechanism is that SSRIs allow for more excitatory neurotransmission and a decreased threshold for myocyte injury. There have been cases linked to various other SSRIs. In particular, our literature search identified 6 case reports associated with Sertraline. Most of these cases involved individuals on several different medications and varying doses of Sertraline. Although our patient was on the minimal effective dose for Sertraline (25mg), he reported improvement in mood suggesting steady-state had been achieved. This case suggests an association between Sertraline and rhabdomyolysis.

Scholarly Questions: Is SSRI use a predisposing factor for rhabdomyolysis? Should other antidepressants be considered risk factors?

Conclusion: SSRIs are not commonly associated with Rhabdomyolysis, but may be important to consider as a risk factor. Further investigation is warranted in order to determine a causal relationship between antidepressants and a condition that disproportionately effects the active duty population.

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PHYSICIAN FAMILY PRACTICE, GP-0602-15, MAYPORT FL	DE-10502483-19-KC
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PHYSICIAN PEDIATRICS, GP-0602-14, WHIDBEY ISLAND WA	DE-10531530-19-WHB
PHYSICIAN PSYCHIATRY, GP-0602-15, CAMP LEJEUNE NC	DE-10653215-20-KC
PHYSICIAN PSYCHIATRY, GP-0602-15, CAMP PENDLETON CA	DE-10818702-20-KC
PHYSICIAN PSYCHIATRY, GP-0602-15, PORTSMOUTH VA	DE-10546502-19-NB
PHYSICIAN PSYCHIATRY, GP-0602-15, PORTSMOUTH VA (Child and Adolescent)	DE-10544295-19-NB

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Janelle M. Marra, DO, FAAFP
Naval Hospital Camp Pendleton, CA
Jmarra08@gmail.com

Healthcare Disparities in Times of a Pandemic

Over the past month, we have been mapping the curve, and hoping we can minimize the impacts of a novel strain of coronavirus and the presenting illness, COVID-19. As we are still in the thick of this pandemic, the complete picture of where we will be in an upcoming month, or more, is unclear. As the initial information is being collected on mortality, there are some concerning statistics regarding minority health outcomes. Initial data reported in a recent Reuters article, from Illinois, is showing that although African Americans make up only 14.6% of the state's population, they have made up 30% of the state's cases and 40% of the COVID-19 related deaths. Similar data has been found in Michigan, as the population is only 14% African American, but 40% of the state's reported deaths are African American. Many public health experts are speculating potential causes for these disparities, including higher levels of comorbid conditions (such as asthma or diabetes), lower socioeconomic status, or prior discriminatory experiences in healthcare. Similar data was found during the H1N1 Pandemic in 2009, with examples including Minnesota, which had an 11% population of non-white citizens, but this section of the population had 31% of hospitalizations during the pandemic. It's thought that members of a racial minority group that are also members of a sexual orientation minority group may experience even higher rates of healthcare disparities (termed intersectional minority stressors). Unfortunately, the data is even less available to examine the demographic of sexual orientation, so this is often overlooked as a variable.

Many discussions on minority healthcare disparities come back around to the Social Determinants of Health

April 3, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Data Collection and Public Release by HHS Agencies of COVID-19 Testing, Hospitalization, and Mortality by Race and Ethnicity

Dear Secretary Azar:

On behalf of our physician and medical student members of the American Medical Association, the American Academy of Pediatrics, the American Academy of Family Physicians, the National Medical Association, the National Hispanic Medical Association, the Association of American Indian Physicians, and the National Council of Asian Pacific Islander Physicians, we urge the U.S. Department of Health and Human Services (HHS) to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race, ethnicity, and patients' preferred spoken and written language related to the testing status, hospitalization, and mortality associated with the pandemic novel coronavirus, COVID-19. These data are essential to understanding the unique challenges and inequities facing communities of color and individuals with Limited English Proficiency (LEP). Our physician members are wholly committed to the health and safety of all our patients during this crisis, including those who are historically marginalized, minoritized, and medically underserved. However, to date, federal COVID-19 data collection efforts do not contemplate race, ethnicity, or patients' preferred spoken or written language. Clear data on our patients' access to timely testing, clinical encounters, and mortality rates will help to best prepare our physician members to coordinate medical resources to leverage the greatest and most equitable level of care possible for all patients in a timely manner. We also urge HHS to work with state and local public health offices and clinical data registries, where possible, to minimize data burden collection for front-line clinicians, and to ensure that data collection efforts prioritize cultural sensitivity and patient privacy.

It is well-documented that social and health inequities are long-standing and systemic disturbances to the wellness of marginalized, minoritized, and medically underserved communities. While COVID-19 has not created the circumstances that have brought about health inequities, it has and will continue to severely exacerbate existing and alarming social inequities along racial and ethnic lines, e.g., in housing stability, in employment status, in healthcare access, and in food security. Minoritized, marginalized, and medically underserved communities experience higher rates of chronic disease, such as diabetes, hypertension, and asthma, compared to non-Hispanic White communities.[1] These health conditions

[1] Thorpe, K.E. et al. 2017. "The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases." Health Affairs Blog. Available at, https://www.healthaffairs.org/do/10.1377/hblog20170817.061561/full/

(SDOH). AAFP has The EveryONE Project, with goals of achieving healthcare equity in all communities. On the website for the project they have many tools, including a Social Needs screening tool, which we should consider integrating in many of our patient's visits, especially during this time of increased stressors.

Over the upcoming months, I anticipate we will continue to see more information on the patient being affected and their outcomes. If you are responsible for collecting data in your area, please look at your methods for collecting more complete data, including the variables of race and sexual orientation. As we are able to evaluate for multiple variables, we are able to examine the disparities that may have persisted, and address them, getting us one step closer to healthcare equity.

As I was writing this article, the AAFP, in combination with American Medical Association, National Medical Association, American Academy of Pediatrics, National Hispanic Medical Association, Association of American Indian Physicians, and the National Council of Asian Pacific Islander Physicians compiled a letter to the Secretary of the U.S. Department of Health and Human Services on the importance of collecting data which includes race, ethnicity and primary spoken and written language. Please see the attached letter to review the key points.

Please stay safe during these challenging times and take care of each other.

Table 1. Measures of Exposure, Susceptibility, and Access to Care[14]

Measures of Exposure to Influenza
Structural Measures
➢ Working
➢ Living in a metro area
➢ Living in an apartment building
➢ Number of adults in household
➢ Number of children <18 in household
Work-Related Measures of Inability to Social Distance
➢ Difficulty staying home from work for 7-10 days
➢ Not able to work at home
➢ Will not get paid if stays home from work
➢ Does not have sick leave at job
➢ Could lose job or business if not able to go to work
➢ Job can only be done at workplace
Other Measures of Inability to Social Distance
➢ Difficulty finding daycare not with a group of children
➢ Difficulty avoiding public transportation
Measures of Susceptibility
Self-Reported Chronic Conditions
➢ Heart disease
➢ High blood pressure
➢ Cancer
➢ Diabetes
➢ Asthma
➢ Lung disease
➢ Immunosuppression
Measures of Access to Care
➢ No regular healthcare provider
➢ No health insurance
➢ Lack of insurance or money make it difficult to get flu shot
Measures of Discrimination
➢ Ever experienced discrimination/hassle when seeking health care

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Reuters , Jan Wolfe, African Americans more likely to die from coronavirus illness, early data shows https://www.reuters.com/article/us-health-coronavirus-usa-race-idUSKBN21O2B6

predispose them to greater risk of mortality should they contract COVID-19.[2] Additionally, language barriers for LEP patients or community members may increase exposure to misinformation about the impact and nature of the disease.[3] Therefore, such communities are disproportionately vulnerable to the uncertainty surrounding the preparation for and response to the COVID-19 pandemic.

We have seen these trends in previous pandemics. For example, the 2009 H1N1 pandemic demonstrated the need for a holistic understanding of race and ethnic implications prior to and during pandemic scenarios to maximize public health resources and advance equity in health care delivery. Researchers Quinn and colleagues (2011) conducted a large-scale study to explore risk of exposure, susceptibility, and accessibility by racial and ethnic groups and discovered that risks varied significantly.[4] Several similar epidemiologic studies and reviews have reported higher rates of hospitalization in the U.S. from H1N1 among low-income individuals, those living in impoverished neighborhoods, and people of color and diverse ethnic backgrounds.[5] These findings highlight the urgency to adapt our country's COVID-19 response to monitor and act on these inequities via explicit data collection on race, ethnicity, and language needs. Well-designed, ethically sound research aligns with the goals of medicine; addresses questions relevant to the populations studied; balances the potential for benefit against the potential for harm; employs study designs yielding scientifically valid and significant data; and helps to generate useful knowledge. Without the data, we cannot apply a full science-based approach to inform decisions that may save lives.

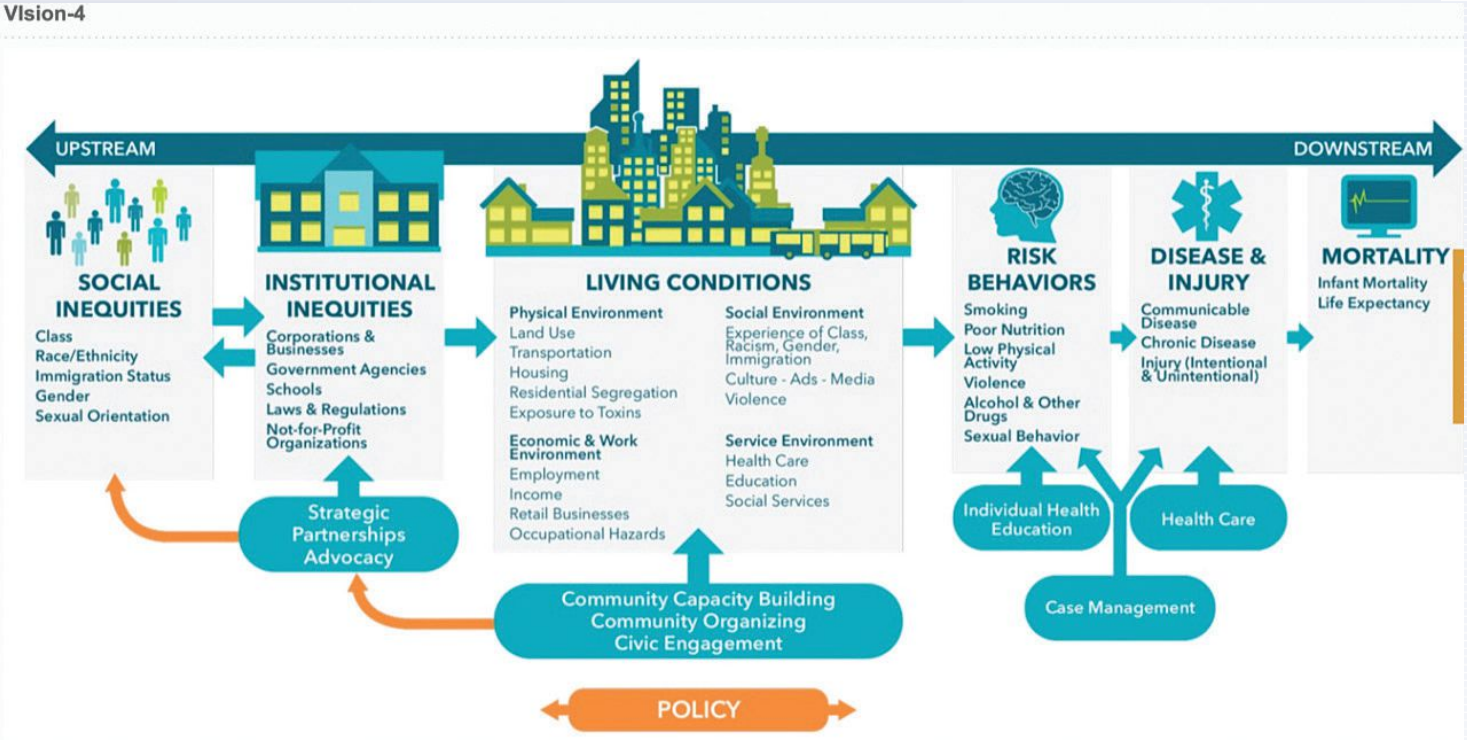
Pandemics, such as COVID-19, highlight the inadequacies in our current health system, the lack of coordinated preparedness to fend off rampant disease, and the fragile state of the public health safety net system that supports people of color and persons with LEP. These conditions significantly impact our patients' and their families' ability to take care of their most basic health needs. For the sake of our national well-being, it is imperative to hasten all efforts to disaggregate and make publicly available the COVID-19 testing, hospitalization, and mortality data by race, ethnicity, and preferred spoken and written language of patients. Without such granularity, clinical providers, researchers, and policymakers risk misunderstanding the unique characteristics that impact health behaviors, beliefs, usage of medical spaces, and other factors distinctly impacting health outcomes of marginalized, minoritized, and medically communities. Thank you for your consideration of our request.

Sincerely,

American Medical Association
American Academy of Pediatrics
American Academy of Family Physicians
National Medical Association
National Hispanic Medical Association
Association of American Indian Physicians
National Council of Asian Pacific Islander Physicians

[2] The Centers for Disease Control and Prevention. 2020. "People Who Are At Higher Risk for Severe Illness." Available at, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html
[3] Kaplan, J. 2020. "Hospitals Have Left Many COVID-19 Patients Who Don't Speak English Alone, Confused and Without Proper Care." *ProPublica*. Available at, https://www.propublica.org/article/hospitals-have-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care
[4] Quinn, S.C. et al. 2011. "Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic." *American Journal of Public Health*. 101(2): 285-293.
[5] Kumar, S. et al. 2012. "The Social Ecological Model as a Framework for Determinants of 2009 H1N1 Influenza Vaccine Uptake in the US." *Health Education & Behavior*. 39(2):229-243.

continued on page 48



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American Journal of Public Health, Social Justice in Pandemic Preparedness, 2012 April, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3489368/

AAFP Social Needs Screening tool https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

AAFP The EveryONE Project https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html?cmpid=everyone_hp_hops_cfd_col_fmx

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- Alerts and announcements
- Ask the Expert

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Alex Knobloch, MD, CAQSM
Travis AFB, CA
acknobloch@gmail.com

Exploring Ways to Get Involved in USAFP and AAFP, Part 2

Greetings from the Resident and Student Affairs Committee! Hopefully you found Part 1 in the last edition of the Uniformed Family Physician helpful as you begin to plot out your path to increase involvement in our home chapter. To recap:

- Get Yourself to the USAFP Annual Meeting & Exposition (it's never too early to start planning in the spring to get yourself to the following year's meeting!)
- Consider Serving as a Resident or Student Representative to the USAFP Board of Directors
- Join a USAFP Committee

If you misplaced your copy of that edition, you can always find PDF versions of all UFP editions on the USAFP website (http://www.usafp.org/about-usafp/uniformed-family-physician-newsletter/). Now, let's turn our attention to Part 2, where we focus on opportunities available through our chapter at the national level (AAFP).

1) AAFP COMMISSIONS

AAFP commissions make recommendations to the Board of Directors regarding policy, development of new programs and projects, improvements to current activities, and potential discontinuation of activities. Just like our committees at the USAFP (chapter) level, these commissions are where a lot of the work of the national academy occurs, and they need student and resident perspectives. Currently, students and residents can be appointed to Commissions on Continuing Professional Development, Governmental Advocacy, Health of the Public and Science, Membership and Member Services, and Quality and Practice. And like many of the opportunities that will be discussed in this report, these positions are excellent opportunities to network with senior family medicine physicians. We even have senior leaders from our own chapter sitting on some of these commissions. If the work of any of these groups speaks to you, please reach out and we can connect you with these individuals to provide additional insight. The time commitment is moderate, with approximately seven days away from your school or program for in-person meetings, plus ongoing communication in between these meetings.

2) REPRESENTATIVES AND LIAISONS TO OTHER ORGANIZATIONS

Both students and residents have the opportunity to serve as representatives of AAFP to other organizations, including the American Medical Association, the Association of Family Medicine Residency Directors, and the Society of Teachers of Family Medicine, to name a few opportunities. Each has varying time commitments, depending on the position (make sure to check out the AAFP website if you're interested; the link is included at the end of this report). Similar to the positions on the AAFP commissions, these representative and liaison roles provide excellent networking and mentoring opportunities, while allowing students and residents the chance to provide needed voices for even more national organizations.

3) ELECTED POSITIONS

Students and residents each have three elected positions to consider: Delegate to the AAFP Congress of Delegates, Chair of the National Conference, and Member of the AAFP Board of Directors. The Delegate position requires a moderate time commitment, representing student member interests at the AAFP Congress of Delegates and functioning as a member of the AAFP Commission on Education. The Chair of the National Conference helps coordinate student and resident activities for AAFP members throughout the year, provides input into planning the theme, programming and special activities for the upcoming National Conference, and functions as a member of the AAFP Commission on Education. The position on the Board of Directors allows the student or resident to lend their unique perspectives to all AAFP Board deliberations and communicate issues of importance to the appropriate AAFP commissions,

as well as multiple other tasks over the course of the term. While all are highly competitive positions, the latter two positions involve substantial time commitments over the course of a one-year term and some level of previous national AAFP experience. However, the unparalleled experience and networking gained will certainly be worth it for those elected.

4) FAMILY MEDICINE LEADS

Family Medicine Leads is an AAFP initiative focused on filling the family medicine workforce pipeline with the best and brightest, as well as supporting the development of future family medicine leaders. Through the program, scholarships are awarded to help with costs of attending the AAFP National Conference of Family Medicine Residents and Students held every summer. Additionally, they offer an Emerging Leaders Institute, which is a year-long experience that includes scholarship-funded attendance at the National Conference of Family Medicine Residents and Students, additional workshops on personal and professional development, and opportunities for networking with other emerging family medicine student and resident leaders.

These are just some of the opportunities available. Please check out the AAFP website for more details and specific requirements for applying for each of the above positions (https://www.aafp.org/membership/involve/lead/students-residents.html) or the scholarship opportunities (https://www.aafp.org/about/awards-scholarships/student/nc.html and https://www.aafp.org/about/awards-scholarships/student/nc/eli.html). If you have any questions, please reach out to your 2020-2021 resident and student directors or our Resident and Student Affairs Committee co-chairs (all of our contact info can be located at the beginning of each edition of the UFP). We'll get you pointed in the right direction!

To close, I'd like to pass along a challenge to our resident and student members that was shared with our committee by our previous USAFP President, Dr. Jonas. Over the course of the next year, find someone, a peer or a junior resident/student, who isn't as involved in USAFP or is unsure of what our chapter can offer resident and student members. Encourage them to discover some of the resources our chapter provides, like the Essential Evidence Plus POEM e-mails. Point out ways that they can punch a ticket to the USAFP Annual Meeting. Help them make USAFP their professional home, just as we hope you already are. Their career will be richer for it, and our chapter will be enriched as well.

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John J. O'Brien, MD, FAAFP
Madigan AMC
JBLM, WA
Scubadoc99@icloud.com

The Infinite Game

BY SIMON SINEK

The best authors entertain us while also providing us a unique perspective on the world, helping to put events into an understandable context, as well as offering guidance on how to improve our lives. From the acclaimed author of Start With Why, Simon Sinek presents another superb addition to our understanding of leadership and life in The Infinite Game.

Why this book matters: Infinite games are all around us (and we probably didn't even realize it): in business, health, relationships and many other areas. We need to recognize that the rules for infinite games are **much different** than the more typical finite games we are used to playing.

What are the differences between Finite and Infinite Games? Games are everywhere; if there are at least 2 "players", a game exists. Classically, we view most games as the familiar "finite games" such as chess or football, with known players, fixed rules, and a clear beginning, middle and end. But many of the "games" that we play are not so clearly finite. To be successful at playing a game, you need to know which kind of game you are playing.

In 1986, Professor James Carse wrote a ground-breaking treatise Finite and Infinite Games: A Vision of Life as Play and Possibility. In contrast to finite games, "infinite games" are played by known and unknown players. There are no exact or agreed-upon rules. Though there are typically norms, conventions, or laws that govern how players conduct themselves, within those broad boundaries, the players can operate however they want. The manner in which they play is entirely up to them and can change at any time.

Trait	Finite Game	Infinite Game
Players	Known	Known and Unknown
Rules	Fixed	No Exact Rules
Referee	Yes	No
Time Frame/ Finish Line	Finite /Yes	Infinite /No
Goal	Win	Keep Playing
Examples	Football/Chess	Business, Geopolitics, Relationships, Health

Infinite games have infinite time horizons, and without a finish line, no one can ever "win" an infinite game. Critically, you cannot lose an infinite game unless you "stop playing". In fact, the primary objective is to keep playing, and thus perpetuate the game.

To represent the difference, Simon explains why the US "lost" the Vietnam War, despite winning nearly every battle and regularly decimating our adversary. US Generals were fighting (and "winning") a finite game, while the North Vietnamese viewed the war as a struggle for their independence and survival, an infinite game that they would fight until their last breath.

Mr. Sinek has expanded upon Professor Carse's work, after he began to notice Infinite games all around us. There is no such thing as winning in marriage or friendship, long-term education, business, careers, or global politics.

In the business world, the finite approach to short-term profit and success received a major boost in 1970, when Nobel-winning Economist Milton Friedman published the essay "The Social Responsibility of Business is to Increase its Profits." He insisted that "there is one and only one social responsibility of business, to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game." (i.e., the sole purpose of business is to make money for the shareholders).

Widely accepted, this approach has led to the short-term business mindset, unethical behavior, and a substantial growth in income inequality. Clearly, the business world needs a new mindset, but the infinite mindset can just as easily apply to many other circumstances.

Health should also be viewed from an infinite mindset; there is no one thing that we can do to get in shape and live a healthy lifestyle. We can't simply go to the gym for nine hours and expect to be in shape. However, if we go to the gym every single day for 20 minutes, we will absolutely get in shape. Consistency becomes more important than intensity. And though we may have finite fitness goals we want to reach (lose 20 pounds or run a half marathon), if we want to be as healthy as possible, the lifestyle we adopt matters more than whether or not we hit our goal on the arbitrary dates we set. With any health regimen, there are certain things we need to do—eat more vegetables, move/exercise on a regular basis, and get enough sleep. Adopting an infinite mindset is exactly the same

PRACTICAL CONSIDERATIONS WHEN DECIDING HOW TO LEAD:

- We don't get to choose whether a game is finite or infinite
- We do get to choose whether or not we want to join the game
- Should we choose to join, we can choose whether we want to play with a finite or infinite mindset

So, how do we lead with an infinite mindset?

The rest of the book provides **guidance on**

the 5 essential practices that you need to play in infinite games. Highlights from each section:

1. Advance a Just Cause:
   a. We need to have a specific vision of a future state that does not yet exist, a state which is so appealing that people are willing to make sacrifices in order to help advance toward that vision
   b. We can develop our own, or join another's Just Cause
   c. Working to advance a Just Cause gives our work and our lives meaning
   d. A Just Cause inspires us to stay focused beyond the finite rewards and individual wins
   e. Russian botanist Nikolai Vavilov committed his life to ending hunger and preventing future food crop ecological disasters by building a massive seed collection in the 1920s. Housed in Leningrad, Vavilov and his team protected the collection during the 900-day World War II Nazi siege of the city. Instead of eating the seeds, over 1 million Russians died from starvation, including his team, so that they could keep the seed collection protected for future generations
   f. The Founding Fathers of the United States risked their lives by signing the Declaration of Independence, knowing that they would likely be hanged as traitors if the American Revolution failed
   g. A Just Cause must be:
      i. For Something: affirmative and optimistic
      ii. Inclusive: open to all those who would like to contribute
      iii. Service oriented: for the primary benefit of others
      iv. Resilient: able to endure political, technological and cultural change
      v. Idealistic: big, bold, and ultimately unachievable

2. Build Trusting Teams:
   a. The Navy Seal selection process screens applicants for both performance and trust, and board members will prioritize Medium Performance/High Trust Sailors over ones with High Performance/Low Trust.
   b. High trust is necessary for smooth information flow from frontline employees to the top of an organization
   c. Ethical Fading: condition in a culture that allows people to act in unethical ways in order to advance their own interests, often at the expense of others, while falsely believing that they have not compromised their own moral principles
   d. "Ethical Fading" in the military: Drs Wong/Gerras, 2 retired Army Officers, wrote "Lying to Ourselves: Dishonesty in the Army Profession", about systemic ethical fading due to excessive process, procedure, or demands placed on Soldiers. This combination of training requirements and other tasks were simply impossible to complete, but reports show that everything was done.

3. Worthy Rival
   a. Find another player in the game that does something (or many things) as well or better than us, that has strengths and abilities from which we could learn a thing or two.
   b. We should choose our Worthy Rivals because there is something about them that reveals our weaknesses and pushes us to constantly improve.
   c. Apple welcomed IBM into the personal computer market, and used its presence to drive innovation, while IBM focused more on competing with Apple for market share
   d. World Geopolitics seemed clearer when the USA and USSR were generally balanced rivals during the Cold War

4. Existential Flexibility
   a. The capacity to initiate an extreme disruption to a business model or strategic course in order to more effectively advance a Just Cause.
   b. When an infinite-minded leader with a clear sense of Cause looks to the future and sees that the path they are on will significantly restrict their ability to advance their Just Cause, they flex.
   c. Walt Disney, after creating numerous ground-breaking animated movies (his Just Cause: inviting people to leave the stresses of life behind and enter a more idyllic world of his creation), risked his entire wealth to open Disneyland, taking his Cause to the next level.

5. Courage to Lead
   a. In business, leaders often make decisions which go against positive vision statements, in order to increase profits.
   b. CVS, when evaluating its Just Cause for improving the health and well-being for its patrons, made the difficult financial decision to eliminate tobacco products from their stores (loss of $2 billion/year)
   c. CVS customers actually smoked less (didn't transfer to other stores), and bought more smoking cessation materials; health companies decided to sell more products in CVS; stocks dipped briefly but increased greatly over the next few years.
   d. The Courage to Lead is a willingness to take risks for an unknown future and ignore the naysayers who question our dedication to our Just Cause.

CONCLUSION:

- Infinite Games are all around us, we need to learn how to play
- Finite leadership techniques will lead to short-term gains. Go for the Infinite Mindset
- "Health" is an Infinite Game! Consistency is more important than intensity in our (and our patients') health behaviors
- Reject the win/lose mindset of finite games, and instead pick a Worthy Rival to drive you to constant improvement

new members

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