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Journal of The Uniformed Services Academy of Family Physicians

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The Uniformed Services Academy of Family Physicians

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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.

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Edition 50

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president's message

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"Be Human and Focus Forward with Gratitude"

Greetings friends! How time flies. It has been a tremendous and humbling honor to serve you as President of USAFP. As my tenure comes to a close and I turn over the reins, I ask you to reflect on principles presented in past submissions: "Be Human," "Focus Forward," and "Be Grateful." I invite you to continue to act in your personal spheres of life, improving your and your colleagues' personal lives at individual levels. Please look forward with optimism and gratitude for our opportunities. There is no question, we face monumental challenges, including leadership reorganization, the rollout of a new electronic health record, and staffing changes. Yet, there are few better problem solvers than uniformed family physicians. We can and will do this! Thank you for continuously helping me become a better person, officer, family physician, and leader.

Please accept my warmest personal appreciation and hope for good health and well-being for you, your families, and loved ones. See you very soon at our next USAFP meeting!

The views expressed in this article are the author's alone as an individual and do not represent any official opinion of the US Air Force, Department of Defense or the Uniformed Services University.

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editor's voice

AARON SAGUIL, MD, MPH, FAAFP

Greetings, Friends!

Since this is my last "editor's voice," I would like to thank you for the privilege of serving as your vice president and editor over the past year. For this last column, I'd like to expand on a story that was on the cutting room floor after the last issue was finalized: one final piece of "advice" that I had to learn through experience. It has to do with work-life balance, but it doesn't come with any moralizing—just a story about how my patients taught me a very important lesson that God really wanted me to hear.

My son, Caleb, was born during the end of my fourth year of medical school. Beth took some time off from teaching in Ocala, Florida, before returning to work. When she did, I stayed home with Caleb prior to the start of residency at Fort Belvoir. Beth and I were only four years into our marriage when my internship began, and, as you might imagine, I was eager to spend time with her and our infant son. The battle rhythm for work and home was wake-up early rounds, patient care, academic conferences, night call (this was before the era of universal night float), rounds again, then off - after seeing and discussing patients. Bike home, see Beth, play with Caleb, study for Step 3, try to review patient information, sleep, then up again.

In those days, I gave my patients my pager number. They didn't call often, but my obstetrics patients used it to let me know if they were going to the hospital or if they had questions. Most of the time, I was pretty okay with it and enjoyed it—it made me feel like a real doctor! Sometimes I was annoyed, especially when Beth, Caleb and I were trying to enjoy our limited family time. In my time away from the hospital, I found myself trying to shield our family from the demands of work. Which was somewhat ironic. I lived on post along with another intern and many of the junior officers who worked at the Pentagon. Between the two of us, we had delivered babies for most of the pregnant officers and spouses in our neighborhood. So, really, there wasn't much of a work-life divide since most of our friends were also our patients. That should have been a hint of things to come, but I failed to grasp it.

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Fast forward, and Beth, Caleb and I make the move to Germany along with our son, Philip, who was born six months before graduation. For those of you who have lived overseas, you know it's a bit of a fishbowl—everyone knows everyone else and most everyone does the same things together. In this environment, it seemed even more important to try and protect my family from work when I was away from the clinic.

I'll take a moment to sketch out the situation on the ground. This was Grafenwoehr before the Brigade moved in. The largest tenant on post was the 7th Army Training Command, headed by a brigadier general that had oversight of the ranges. This was the time after we entered Afghanistan and before we entered Iraq, so there was a certain tension on base with units rolling in for certification before pushing off overseas.

continued on page 8

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Dr. John Lay, MD
LTC(R), US Army
Regional Medical Director
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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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It was a smallish community; many lived on post and some lived in small enclaves of American-purchased housing in the surrounding German communities. We had a physician commander who occasionally saw patients, but the bulk of the provider level work was done by our physician assistant and me. We were the community doctors for roughly 2,000 people.

I was happy seeing patients in clinic. We ran a sick call for a detachment of engineers and others on post, then saw appointed patients throughout the day (mostly dependents and a few retirees—seeing a case of diabetes was a novelty). We usually finished operations by 5 PM, then left everything in the care of an on-call provider until the next day. We pulled call once or twice a week and made sure the weekends were covered in case of an accident on the training range.

So, no moralizing. We are all trying to find our way to care simultaneously for our patients, our families, and ourselves. I trust that you will find your way just as I found mine.

With two young children at home, I'd sometimes make runs to the commissary or post exchange to pick up things that we needed after work (don't get me wrong, Beth handled roughly 99% of the smooth operation of our household). And, every time, there would be curbside consults. Our butcher would ask about additional things she could do for knee pain. Another shopper would ask about a mole she had recently discovered. The patient from the last appointment of the day (the one who had diabetes) would ask if the fruit pie he had selected would be okay for him to eat (it had fruit in it, right?).

I'd make polite deferrals. "How about you come see me in clinic?" I'd say. But inwardly, I'd be nonplussed. Did I really have to be on-call all the time? I just wanted to get home and spend time with my family.

It wasn't just the commissary and the post exchange. It was also the cluster of American occupied homes of which we were a part and our chapel. Several times a week people knocked on the door to ask about medical conditions. I say "we" deliberately—folks would come by to ask Beth questions when I was away (she called it her "MD" by "Mrs."). We couldn't escape it, and I became increasingly frustrated with what felt like a 24/7 call shift.

If it sounds as though I was immature, I readily admit that I was. Being a doctor is a privilege and a common good, and I was treating it like a personal commodity. God convicted me. I was being selfish, and, as a result, I was denying myself rich and rewarding relationships with the people of my community.

Things changed after that realization. I continued to see sick call and appointed patients, but I also started "after work rounds." When I walked into the commissary, I sought out the butcher and asked her if her daughter was able to get back to playing volleyball and if her rehabilitation was progressing. I sought out my patient with diabetes and encouraged him to avail himself of some healthier options (how about real fruit instead of a fruit pie?). I'd be lying, though, if I didn't tell you that I ultimately asked my patient with the mole (she had multiple ones she revealed over time) to see me in clinic. Although I initially told her I was happy to take a look at her latest blemish, I had to ask her not to pull down her pants in the parking lot when she told me it was on her buttocks.

My clinical life had instantly become infinitely more rewarding!

And my family life improved. Not having to make a distinction between work and family when it came to caring for people, I was less guarded with everyone. I still had to be taught not to bring busy work home—charts, administrative ephemera, etcetera (I maintain it is good to try to attempt a work-life balance when it comes to busy work), but I learned a valuable lesson about what made me and my family happy—being connected.

So, no moralizing. We are all trying to find our way to care simultaneously for our patients, our families, and ourselves. I trust that you will find your way just as I found mine. If you (and yes, I recognize this goes out to 3,000 physicians) ever need to talk, I'm happy to listen. Don't worry—it doesn't take away from my personal time; it enhances me and my family's connections.

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consultant's report
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Greetings from the Air Force Medical Readiness Agency (AFMRA), (pronounced *af-m-ruh*)! While it is the middle of winter (if you can call 70 degrees and sun in San Antonio "winter") as I write this, my thoughts are focused on summer, both past and present! Throughout late summer 2019, our assignments officer, Major Scott, and I reached out to those of you who have the option to separate or stay in summer 2020 and discussed your future plans. I have truly enjoyed talking with all of you about your career goals (both in and out of the military). We are in the process of finalizing those plans as the close of the assignment cycle looms on January 31st. Also, it was so exciting to see some of our family physicians get selected for chief of medical staff (SGH) and squadron command positions and to approve others to cross over to join the ranks of the flight surgeons.

So now, in the middle of winter, we are projecting moves for Summer 2020! Summer is the toughest time of year as we bid farewell to those who separate and PCS and await the arrival of the new accessions and inbounds. Complicating matters is that this is all occurring at the same time as approximately 27 of us are deployed in our Air and Space Expeditionary Force (AEF) band for six months supporting job number one: taking care of combatant commanders down range. Meaning assist demand exceeds supply. I encourage those of you who are separating Summer 2020 to work with your leadership to reduce the stress of the "summer turnover." Some ideas are to reduce the time it takes to out-process the base by being proactive and coordinating with base agencies in advance. Consider choosing a separation date later in July to reduce the gap and perhaps even having some overlap with your replacement. Consider taking some leave now and balance the choice of enjoying some breaks from clinic in your last six months versus banking terminal leave for the end. I trust you to ensure a good hand-off on your complex patients. In the end, the stress of vacant positions, ghost panels, and cross coverage is not only felt by us, but also by our patients and could create a safety risk.

While the summer turnover looms ahead, I am hoping that by the time this edition of the journal goes to print most of you are enjoying a smooth, steady state in clinic--the new physicians, physician assistants, and nurse practitioners at the MTFs should have completed their ramp-up and be at full templates. Speaking of ramp-up, the new patient centered medical home (PCMH) Defense Health Agency procedural instruction (DHA-PI) will include a consolidated, multi-service ramp-up guide for those clinicians assigned to a PCMH clinic. This will standardize the process and help clinic leaders project and plan for access decrements during the time the new clinician is orienting to the clinic. The PCMH DHA-PI is routing for review and should be published by summer 2020. Meanwhile, the revised and updated Air Force Medical Home (AFMH) Air Force instruction (AFI) 44-171 is complete but pending publishing as of January. If our AFI is approved for print, it will be complimentary to the DHA-PI... trust me, your AFMRA AFMH team helped write both documents!

The creation of the PCMH DHA-PI is a great example of how our partnership with our sister services and the DHA is growing as AFMRA works on transition efforts and the three services collaborate to strengthen Military Health Service patient centered medical homes and primary care markets! I am very excited to be a part of this community. We have advocates who understand the value of team-based primary care, continuity, and quality peer review. Over time, we expect some functions that AFMRA/AFMH have been providing to transition to the DHA. We are actively working this transition plan. For more information about the DHA Direct Care Optimization Team, visit their Facebook page by searching: DHA Healthcare Optimization Division Q & A Page.

Another exciting event over the past few months was providing information about assignments to the Summer 2020 graduating residents—each PGY-3 received a "dream sheet" to rank order their assignment preferences. This group will be the newest cohort of USAF family physicians to hit the field! So, a big **hooray** to our Summer 2020 graduates who fill the "needs of the Air Force!" We were all in your position once and remember that it can be both exciting and

anxiety-provoking. My message to the graduating residents is to maintain an open mind. Many of our Air Force bases are located in small towns you have never heard of. These bases, while small, usually foster an amazing family friendly atmosphere with unit cohesiveness and a sense of connection with the line mission and the airframes that fly overhead. For any of you who have lived on base and experienced a "commissary consult," you know what I mean! Another important message about assignments is that everything is temporary, and every location has hidden gems. If you end up at a location that is not top of your dream sheet, enjoy the new adventure and exploration of a new region of the country, and, who knows, it might end up being one of your most favorite Air Force assignments! After two to four years, you can move on! Finally, a BIG thank you to those who volunteered for one-year remote assignments to Korea and Turkey. I am positive you will find your experience there professionally rewarding both as a physician and an officer in the Air Force!

In November 2019, the Air Force graduate medical education (GME) program directors and faculty specialty leaders (family medicine obstetrics and sports medicine) participated in Scoring Week and the Joint Service GME Selection Board. Over the course of a week, we scored over 180 joint service packages! We were pleased with the volume and quality of the Air Force applicants for our 54 spots at Nellis, Travis, Belvoir, Eglin, Offutt, and Scott. The applicants included military and civilian medical students and current general medical officers in the field. In addition to our residency selections, six physicians were selected for one-year sports medicine fellowships and one physician was selected for an obstetrics fellowship. We also chose six residents for the operational family medicine (OFM) track, which means they will complete portions of the Aerospace Medicine Primary Course during their family medicine residency and, upon graduation, take an assignment as a flight surgeon. This is an outstanding partnership with the School of Aerospace Medicine (USAFSAM) to increase their ranks with residency-trained family physicians. Our pipeline has not been reduced and continues to support a necessary end-strength to meet critical operational readiness requirements and the National Defense Strategy.

Thank you again for your leadership and resilience over the past year. We adapted and overcame some challenging times in 2019. I have enjoyed every phone call and email as your consultant! I have taken every challenge as an opportunity to remind our colleagues and leaders of the vast knowledge, skills, and abilities that family medicine physicians bring to the Air Force and I need you to do the same. We are expert investigators and problem solvers; it is natural to our specialty--our patients come in with symptoms and leave with a diagnosis (or at least a differential!). I truly believe the future of Air Force family medicine is bright and, as I look towards the upcoming year, I am confident we are heading in the right direction because of dedicated and conscientious people like each and every one of you! Thank you and all the best in 2020!

consultant's report
ARMY

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Happy New Year! I hope that everyone has had the opportunity to rest, relax, reflect, and spend time with those most important to you over the holiday season. 2020 certainly started off with yet another opportunity for Army family physicians (61H) to demonstrate our value to the Army team. As I write this note from Fort Bragg, evidence of this contribution is everywhere. Many of our 61H colleagues have already answered the call. As you saw on the news, thousands of Soldiers deployed during the first week of January. The battalion surgeon for the first unit out the door is an MTOE assigned personnel (MAP) 61H; multiple others have since deployed or are preparing to deploy. All of them were given little to no notice. We asked physicians to report to their units within 24 to 48 hours of notification, including those who are MAP with duty at other installations. Our Corps Surgeon and Division Surgeon, both 61Hs, supported commanders in deploying a medically ready force and a ready medical force faster than we have done in a long time. Family physicians, as part of the medical and administrative team, helped the installation run 24-hour soldier readiness processing (SRP) operations. Readiness and a "fight tonight" mentality are not just buzzwords. They matter, and we can be proud knowing we showed up when our Army called.

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

READINESS

"When Winning Matters, you've got to put everything into each and every practice, each and every opportunity to get better," Army Chief of Staff GEN James McConville

At our recent consultants meeting, we discussed that lethality and readiness remain our top priorities. We contribute to this by improving survivability; ensuring zero preventable deaths; maintaining medically-ready service members who are healthy, resilient, and strong; and being ready to provide care to injured service members and get them back in the fight.

The Army Medical Center of Excellence continues to shape the implementation of individual critical task lists (ICTLs). This shaping is occurring across five lines of effort for a ready medical force: 1) healthcare delivery–readiness capture, 2) military treatment facility (MTF)–readiness platform, 3) education and training, 4) simulation, and 5) an individual soldier readiness dashboard. As a reminder, most 61Hs will utilize the field surgeon (62B) ICTLs. All those 61Hs assigned to field hospitals or combat support hospitals should utilize the internist ICTLs. During the recent emergency readiness deployment exercise conducted by one of our field hospitals, the 61Hs assigned to that unit were mainly working in the intermediate care wards, managing patients on ventilators and performing other hospital medicine skills. In large scale combat operations (LSCO), we can expect to manage patients beyond our typical comfort zone. More to follow in the next update regarding LSCO.

ASSIGNMENTS

Well, we seem to have survived the marketplace. Thank you to everyone for your patience and your engagement. We are now in the phase of clearing the market. I'm working closely with CPT Bentz and our team at Human Resources Command to address any inconsistencies or problems coming out of the market. While we can't release many details at the time of this report, we feel that the marketplace worked well when compared to previous movement cycles. Over 95% of the 140 61H officers identified to move actively participated. There continues to be major interest by both units and leaders for 61Hs to fill corps specific and branch immaterial medical leadership and staff positions. Initial review indicates that the following helped officers in attracting the preference of their desired unit: a completed AIM2 resume, completed professional military education, an updated Department of the Army photo, and a proactive approach in reaching out to prospective units in person or on the phone.

If you participated in the marketplace, please send after action review comments to CPT Bentz and cc me.

JOINT SERVICES GRADUATE MEDICAL EDUCATION SELECTION BOARD

This was a great year for Army family medicine as demand exceeded supply. All of our programs did very well in the selection process, and we have a great group of future family physicians set to join our ranks this summer. We will be maximizing the number of trainees we can take for family medicine. Good news all around! Thank you for spreading the word about what Army family medicine has to

offer and telling your story. What's Your Warrior?

We continue to offer opportunities for fellowship training such as family medicine-obstetrics, sports medicine, faculty development, sleep medicine, hospitalist medicine, pain medicine, emergency medicine-ultrasound, and clinical informatics. Congratulations to all those selected. For those who are interested in these fellowships, we encourage you to apply. I will have a conversation with all fellowship applicants moving forward. Fellowships provide important and valuable additional training; however, in most cases, we do not become strict sub-specialists. We maintain our primary area of concentration as 61H. This is important for many reasons, including our operational roles and the 61H billets you will fill at MTFs with the expectation that you practice general family medicine in addition to your fellowship skill.

CLOSING NOTES:

Congratulations to COL Mary V. Krueger and MAJ Katie L. Westerfield, both of whom earned MHS Female Physician Leadership Awards at the annual AMSUS Conference.

Congratulations to LTC Mimi Raleigh for selection on the principal centralized selection list (CSL) for lieutenant colonel command, as well as alternate selectees LTC Dave Bode, LTC John Gartside, MAJ (P) Omar Shami, and LTC Evan Trivette.

Congratulations to LTC Drew Baird for selection for the 9 "A" proficiency designator.

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!

2020 USAFP Annual Meeting & Exposition 1-6 April 2020

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USAFP Annual Meeting & Exposition

Leadership Through Service

Register today for the 2020 USAFP Annual Meeting & Exposition! The conference will be held from 1-6 April at the Anaheim Marriott in Anaheim, California. Over 40 credits of CME will be offered along with multiple lecture sessions and workshops. As always, USAFP will hold its annual research competition and offer a unique opportunity to network with colleagues all across the globe. For those of you interested in baseball, the USAFP has secured a block of seats for the LA Angels and Houston Astros ballgame on Saturday, 4 April. You can purchase tickets when you register for the conference.

Don't forget to book your hotel accommodations at the Anaheim Marriott!

You don't want to miss this premier CME event!

Online registration and hotel link now available at www.usafp.org

CONGRATULATIONS TO THE NEWLY ELECTED 2020-2021 USAFP OFFICERS AND DIRECTORS

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consultant's report
CG/PHS

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Happy Holidays and Happy New Year! It has been a very busy and productive year for physicians across the Corps.

The Commissioned Corps continues to provide outstanding care and service across the nation. CAPT Brian Lewis, Physician Chief Professional Officer recently sent an update through the "Connections" newsletter that highlighted ADM Giroir's recruitment priorities. There are currently 643 physicians in the Corps across all agencies. Despite this number, more physicians are needed. ADM Giroir's Priorities include: 1) continuing to recruit physicians that serve underserved populations, 2) providing individual clinical care, 3) retaining officers in difficult to retain categories (medical officers, veterinarians, and nurse practitioners), 4) focusing on national health security, global health, hazardous duty, and isolated hardship tours, and 5) developing future leaders and deployments.

A significant portion of that 643 physician base, including myself, answered the call to service this year through challenging deployments. Physicians deployed with nurse practitioners, medics, and health service corpsmen across all agencies to various humanitarian and scientific missions across the nation and around the world. Those that deployed to the southwest border and Florida provided much needed medical care to detainees, caring for tens of thousands of individuals in very challenging environments. Teams also deployed to assist with disaster relief efforts for Hurricanes Barry and Dorian.

You are all appreciated, thank you for all you do!

UPDATES FROM AROUND THE CORPS:

AMSUS Annual Meeting

The 128th Society for Federal Health Professionals (AMSUS) Annual Meeting was held this past December at the Gaylord National Resort and Convention Center. The USPHS AMSUS Committee and other officers that were part of this year's conference did an outstanding job highlighting the achievements of the Commissioned Corps. Health and Human Services Secretary Alex Azar delivered the keynote address, commenting on the history of the Commissioned Corps and its critical role in protecting, promoting, and advancing the health and safety of the nation. ADM Brett Grioir spoke about what it means to be America's Health Responders, how we liaise with multiple agencies, and the modernization efforts of the Commissioned Corps. The Surgeon General went on to award this year's PHS Junior and Senior Officer of The Year recognitions to LT Stefanie Campbell and CAPT Albert Martin Johnson, respectively. Finally, the Military Health System Female Physician of the Year award was given to LCDR Witza Seide, PHS company commander and assistant commandant at the Uniformed Service University of the Health Sciences. Well done!

New features from Commissioned Corps Headquarters (CCHQ)

Deployment updates: All officers can now view their on-call status in the officer secure area under "officer dashboard." The dashboard shows projected readiness status and deficiencies, allowing officers to remedy deficiencies quickly. Officers and their supervisors will also receive automated on-call deployment team reminders ahead of their on-call months.

Readiness updates: To reiterate prior communication by Commissioned Corps Headquarters, on the first day of every month, officers who fail to maintain a basic level of force readiness will receive an automated notification informing them that one or more readiness requirements have expired or are missing. Please pay attention and review your readiness history in the readiness information section of the RedDOG self-service application. For any questions, submit a readiness assistance form (also located in the RedDOG self-service area).

Immunization updates: Officers can view and download their immunization history from the immunizations tab in the readiness information section of the RedDOG self-service application. Make sure to report any issues to the Medical Affairs Branch at PHSCCimmunizations@hhs.gov

Calling all potential new Commissioned Corps USPHS physicians!

There is a new applicant enrollment system (AES). This system will allow for a more effective and efficient process to receive and review applications and will improve communication between Commissioned Corps Headquarters and applicants. New applicants that

continued page 18

IT'S OUR TURN TO SERVE YOU

VA LOAN PROGRAM

If you are a veteran or a current member of the U.S. military, you may qualify for FAB&T Mortgage's VA Loan Program, which currently offers up to 100% home financing, including no down payment!

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continued from page 16

would like to apply to the Corps will be able to use AES to electronically submit their PHS-50 application and supporting documents.

We are all physician recruiters – please spread the word to interested applicants! AES can be accessed at https://www.usphs.gov/apply/apply.aspx

New Commissioned Corps periodic health update (PHU)

Starting 1 January, 2020, the Commissioned Corps is adopting new requirements for health updates with a yearly periodic health update document (PHU), aligning with other uniformed service's periodic health assessments (PHA). A PHU will replace the five-year physical examination submission requirement. In addition, self-reporting medical history for promotion purposes will no longer be a requirement.

Every officer will have a three-month window (based on your birth month) to complete the PHU. The PHU will have five components: 1) medical history, 2) physical examination, 3) behavioral health survey, 4) dental examination, and 5) additional tests as needed. All forms and provider instructions will be included in a single PDF file which can be found on the Commissioned Corps management information system website under forms/medical.

More information can be found at: https://dcp.psc.gov/ccmis/Medical%20Affairs/MA_Periodic_Health_Update.aspx

Leadership Opportunity!

After several years of outstanding service on the awards subcommittee, co-chairs CAPT Edgardo Alicea and CDR Maria de Arman are stepping down. They are soliciting interest for two individuals to replace them as co-chairs in 2020. They both graciously agreed to answer any questions from potential applicants and are willing to facilitate in the transition process. Any officer interested can email them directly at Maria.D.DeArman@uscg.mil and Edgardo.Alicea@uscg.mil

Looking forward to seeing you all in April in Anaheim!

Promoting Research in the Military Environment

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

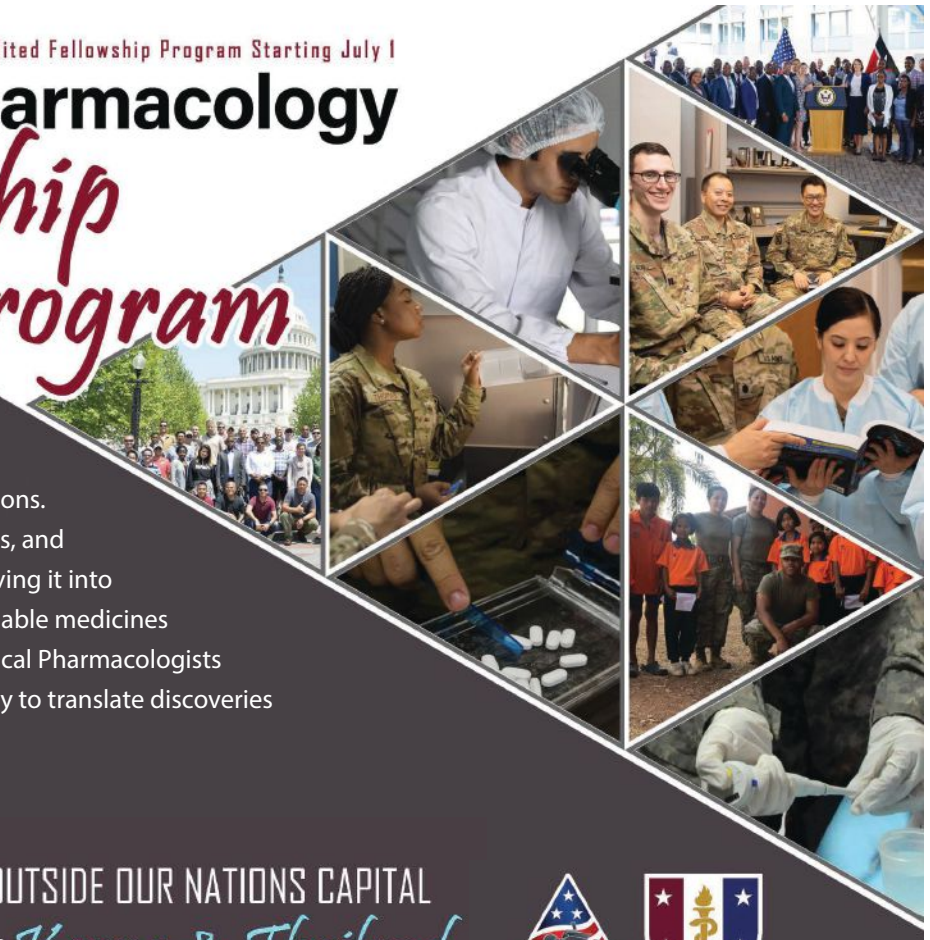
Whether you are deployed or in garrison, the USAFP research judges can help!

Photo Courtesy of U.S. Army

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

Two-Year Accredited Fellowship Program Starting July 1

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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Fellowship Highlights:

- Conduct laboratory, animal, or clinical research under the supervision of a mentor.
- Participate in the teaching of Clinical Pharmacology to medical students, house staff, and practicing of physicans.
- Three month rotation with a review division at the FDA.
- 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 (71A or 71B)
- Active Duty Army Physicians board eligible/ certified in primary specialty

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

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consultant's report
NAVY

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Greetings, fellow FM'ers! It seems like the past six months have seen a steady stream of updates and important information to pass. I have been intentional about sending it out to you via email, but some of it bears repeating to ensure everybody gets the word. With that in mind, let's jump into this edition's topics.

SPECIAL PAYS

The Navy special pays plan was slated to be released in late January or early February, so I hope we all have seen the announcement and guidance by the time this reaches your hands. As I've encouraged in the past, use this annual announcement as a reminder to check your leave and earnings statements to make sure you are getting paid appropriately. If you have a question about your pays that cannot be answered by your local personnel service detachment, send an email to the Bureau of Medicine Navy Medical Special Pays Program at usn.ncr.bumedfchva.mbx.specialpays-bumed@mail.mil. Another resource is the Corps Chief's Office Career Planner, CAPT William Beckman (William.a.beckman.mil@mail.mil).

CONFERENCE APPROVAL:

Our annual meeting is nearly upon us. For those planning to attend, the date (April 1-6, 2020) and location (Anaheim, CA) have been on your calendar for months. Our community's request to attend was submitted on time, and we may have heard a verdict by press time. If not, you can track it (and any other conferences that are being reviewed) right along with me by surfing over to the BUMED's conference information and policy page at: https://es.med.navy.mil/bumed/m00/m00c/Pages/conferenceinfo.aspx. Note that this site is CAC enabled.

POST-USAFP ACTION ITEMS:

Once you return home from attending USAFP, I will need you to add one more item to your "to do" list. I am required to account for EACH and every individual who attended on funded orders, and provide the final dollar cost to the Navy...within 2 weeks of the conference's end. Thus, as soon as you know the cost of your TAD from your DTS voucher, please send that figure to me. IMPORTANT: Please be sure to include the cost of the conference registration fee, which may not be included in your DTS voucher. Finally, if you were originally approved to go, but for some reason could not make it, please let me know that as well.

PROMOTION PREPARATION: SPRING CLEANING

On December 10th, 2019, the FY21 promotion boards and Medical Corps lineal list promotion plan were released. As in prior years, I want to encourage you to use this notice as your annual reminder to prepare for your next promotion by taking a spring cleaning look at your record (via BUPERS Online). This is an essential task, even if you are not in zone. It is even more urgent if you are in-zone for FY22 promotion boards. *Remember, it is your record that gets promoted...make sure it accurately reflects your service.* If you have not yet had a career development board (CDB) at your local command, ask for one. Your detailer and I are also here to provide guidance. If you plan to communicate with the selection board, know that only eligible officers may send in correspondence, and it must arrive no later than 10 calendar days before the convening date of the board. For more details on how to review your record, I recommend taking a look at Joel Schofer's career planning blog at www.mccareer.org. Click on "Joel Schofer's Promo Prep" link. Senior FM's: I encourage you to add this to your resource toolbox to share when mentoring junior officers.

BOARD CERTIFICATION ON YOUR OSR:

Our diligent detailer, CAPT(s) Dabelić, performed a review of community records and noticed that a significant number of individual records do not reflect board certification status. I've already reached out to all those identified, but I encourage you all to make sure that your records are accurate (don't rely on the fact that you are getting board certified pay). You can look at your officer service record (via BUPERS online, https://www.bol.navy.mil/bam/) to check your status. If board certified, your subspecialty code should read "16Q0K." If it reads 16Q0J, then the system is NOT reflecting your board certification status. This is vital for promotion to CDR!

If this is in error, please work on the following steps to rectify it.

1. Go to the website: https://portfolio.theabfm.org/diplomate/verify.aspx
2. Enter the required fields, select verify
3. Scroll down, select 'view/print verification letter online'
4. Open and save generated PDF with your rank and full name

Once you have the verification letter:

1. Send an email to: Mr. Anthony W Frabutt, at anthony.w.frabutt.civ@mail.mil, requesting your subspecialty code be changed to reflect your board certification in family medicine
2. Cc your detailer, CAPT(s) Anja Dabelic, at anja.dabelic@navy.mil

Mr. Frabutt will take your email for action and update the system, which will then be reflected on your officer service record in one to two weeks (many thanks to CAPT(s) Dabelić for her hard work).

JMPE-1 UPDATES

The Naval War College joint professional military education phase one (JMPE-1) process has been streamlined and can now be completed in 10 months. This certification has grown in importance in an officer's professional development, and those approaching their in-zone look for O-5 (and especially O-6) should strongly consider completing JMPE-1. Visit https://usnwc.edu/college-of-distance-education/Online-Program for more information.

NDAA 2020 / POM20 DIVESTITURES

On December 20th, 2019, the President signed the FY2020 National Defense Authorization Act (NDAA). Items include a 3.1 percent pay raise (largest in 10 years), a framework for service members to seek redress for medical malpractice through the military legal system, and the establishment of the Space Force. The Act also addressed the plans for divestitures (cuts) in medical billets across all services (an initiative that was called the Project Objective Memorandum 2020). Currently, the cuts are on hold until a review of the medical manpower requirements of each military department under all National Defense Strategy scenarios is completed. An analysis of affected billets along with mitigation plans will also be performed. I will continue to provide updates as this process moves along. I invite you to reach out to me directly with any questions or concerns.

COMMUNICATION:

With each article, 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 me, 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 family physicians to see if they are getting my emails and to ensure they are in the loop.

That's all for this column. Thanks for all you do every day in support of our mission. Please don't hesitate to reach out to me with any questions or concerns. Stay well.

USAFP MENTORSHIP PROGRAM

Looking for a mentor? Interested in mentoring others?

If so, check out: *www.usafp.org/mentorship*

HOW DOES IT WORK?

The program uses a brief intake survey to complete/to identify a mentee's needs and then matches that person with a mentor well suited to meet those needs.

WHAT AM I SIGNING UP TO DO?

Participant responsibilities are as follows:

- Communicate with your mentor/mentee at least once per quarter
- Before signing off, select a topic for discussion for the next session
- Continue the program for (at least) the next year
- Complete a brief feedback survey at the end of one year to help improve the program

WHEN AND HOW WILL I GET MY MATCH?

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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How to Stay Out of Trouble in Research and Scholarship

Research misconduct has, until recently, seemed more of a curiosity than an issue to take personally. The fraud in Andrew Wakefield's retracted case series relating autism to vaccination is more shocking than relatable: a series of scattered and embellished cases, all but one without autism.[1] Wakefield had been given $75,000 by a not disinterested law firm prior to falsifying his research, and even drew blood from children at a birthday party without credentials or approval.[2] We're not sorry that he lost his medical license and we've never worried about wandering into behavior like that. Yet, it's still hard to convince some people that vaccines are not responsible for autism, isn't it?

There are more subtle but no less concerning issues in the scientific literature. A meta-analysis showed that two percent of scientists admit to fabricating data and 17 percent know a colleague who did.[3] In the moment, these actions must have seemed explainable, like removing an 'outlier' or two because they obviously don't belong. While the removal will grant 'significance' to the study and may seem benign, it violates academic integrity. We work so hard on the literature review, institutional review board submission, data collection and write up...we just have to 'find' significance. Similarly, statistical vernacular matters. Phrases like 'appears to' and 'trends towards' to explain non-significant data can mislead the reader. The line of integrity can be frayed in other ways: overgeneralizing results to populations not studied, calling for practice changes after the results of a case study, and reporting the 'significance' of results the study was not originally powered to find (and that were discovered only after extensively torturing the data to find a tenuous correlation).

There are myriad examples of studies that muddy the water in this way. The recent REDUCE-IT trial showed that use of prescription icosapent ethyl, a fish oil, showed dramatic improvement in cardiac outcomes in patients with moderate hypertriglyceridemia.[4] The medication reduced both cardiovascular and all-cause mortality with a number needed to treat of 111 over those taking a mineral oil placebo.[4] Maybe prescription fish oils work where supplements fail. Yet, while the treatment group saw expected decreases in LDL cholesterol and C-reactive protein (CRP), the control group saw increases in LDL from 87 to 92 mg/dl and CRP from 2.1 to 2.8 mg/dl.[4] Some theorize that a harm

from the mineral oil placebo may have been wrongly interpreted as a benefit from the fish oil. The laboratory data was hidden in a supplementary appendix, with only a brief mention of the placebo in the *New England Journal of Medicine* article. Furthermore, the pharmaceutical company funded the study and wrote a draft article for the authors. Should we assume that all biases were mitigated and the study results are valid because it was published in a prestigious peer-reviewed journal?

These issues in evidence reporting affect the foundation from which we make decisions. Should the Military Health System pay for this expensive treatment or wait for more data? Should we prescribe icosapent ethyl or not?

It is easy to see how the lines of statistical significance, evidence reporting, and academic integrity can become blurred. Research is hard but also vital to the advancement of our practice. Here is a quick, partial list of how to stay out of trouble in research and scholarship:

- Start your research with institutional review board approval
- State facts and observations clearly and avoid overgeneralizing results
- Resist the temptation to create or uncover significance that is not present
- Recognize that strong attraction to a theory can create bias
- Report and explain all collected data
- Remember that the LACK of significance is often MORE significant
- Always get permission to use tables or figures and cite the source
- If possible, make your own table instead of copying one from a reference
- Keep presentations and posters free of copyrighted images
- Keep your writing unique; avoiding changing a few words or sentences from another person's work (which is still plagiarism). Summarize ideas or concepts in your own words or give the author credit. Plagiarism detection is increasing due to artificial intelligence and improved computing power
- Be skeptical consumers of information. As we apply and teach, we take responsibility for the content we share

As uniformed family physicians, we must avoid any sign of exaggeration or hyperbole. We have to defend our integrity for the reputation of our enterprise and our reputations with our patients. Yet, we also need to continue to respond to both of Dr. Atul Gawande's exhortations to "count something" and "write about it," adding scientific observations to our specialty of uniformed family medicine.[5]

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EVERY DOC CAN DO RESEARCH

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

If interested, please send a request to *direamy@vafp.org*.

Tools Available:

- Every Doc Can Do Research Workbook
- Every Doc Can Do A Poster
- Every Doc Can Do A Scholarly Case Report Workbook

Clinical Investigation Research Tools also available on-line at *www.usafp.org*.

Robert C. Marshall, MD, MPH, FAAFP
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fpnet@msn.com

Clinical Informatics is Critical to Readiness and Operational Medicine

Clinical Informatics is a poorly understood specialty area comprised of physicians, nurses, and those that work in a host of medical care areas, to include the pharmacy, laboratory, radiology, and public health. Most people do not know exactly what clinical informaticists do in garrison, much less in the operational environment. Most people equate clinical informatics with AHLTA, Essentris, CHCS and now MHS GENESIS...the various electronic health records (EHR) used by the DoD.

However, the truth is that clinical informaticists deal with the implementation, optimization, and sustainment of health information technology (IT) systems, change management, leadership, data analysis, machine learning and artificial intelligence for healthcare, training and education, population and preventive health, predictive analytics for healthcare, care coordination, patient engagement, and much more.

While not immediately apparent, each of these specialty areas are critical to the successful deployment, sustainment, and optimization of health technology at every echelon of care in operational and garrison environments. Synchronized use of systems promotes overall readiness of service members and the readiness of the medical professionals who support the fight. This paper provides the reader with snapshots of how and why clinical informatics is a mission essential component of a ready medical force.

READINESS AND OPERATIONAL ROLE

Readiness measures the ability of a military unit, such as an Army or Marine division, a fighter or bomber squadron, or a carrier battle group, to accomplish its assigned mission. Logistics, available spare parts, training, equipment, medical readiness, and morale all contribute to readiness.[1]

While clinical informatics cannot impact non-medical logistics or spare parts, it can impact proper selection of combat medical equipment, medical logistics, medical readiness, preventive health preparations, morale, combat survival, patient tracking, disease non-battle injuries (DNBI), traumatic brain injury outcomes, prevention and rapid identification of post-traumatic stress disorder (PTSD), and pre-deployment morale and psychological health. In addition, clinical informatics informs proper staging and resupply of medical supplies in the deployed setting.

This is possible through the application of the knowledge and skills clinical informaticists learn during fellowship training.

BROKEN DOWN BY AREAS, CLINICAL INFORMATICS SPECIALISTS HAVE THESE IMPACTS:

1. Medical readiness: Medical readiness is a complex intersection of physical health, dental health, and psychological health. To optimize the effectiveness and ultimate lethality of the deployed warfighter, all three of these components must be addressed. Complex parameters require complex information documentation and tracking in advance of potential deployments, which may or may not come with any level of advanced warning. In order to document and track all these parameters and to ensure they are always met at acceptable levels, disparate electronic systems' data must be extracted, aggregated, and presented to medical and combat commanders in an easy to understand and meaningful way. While non-medical data analysts can extract and display data, fellowship trained clinical informaticists can apply the analytic techniques, usability training, and medical knowledge they have to know what pertinent medical readiness data to collect, process, and provide. This knowledge allows them to display health data properly to drive desired outcomes.
2. Proper selection of combat medical equipment: Using a combination of military experience, medical knowledge from their primary clinical specialty, an understanding of clinical research methods, predictive and machine learning data analytics, military clinical informaticists can rapidly scan the medical literature to assess which medical equipment, drugs, and techniques will optimize trauma and DNBI survival in austere combat environments. Using predictive analytics and machine learning, they can determine which of the many potential options are the most cost effective and easiest to use in the field environment. Clinical informaticists can select the right equipment for success in the operational environment.
3. Morale: Morale is tied directly to the

physical and psychological well-being of Active Duty Service Members (ADSM) and their families. Clinical informatics provides the data and communication tools needed to help ADSMs and their operational units monitor both aspects of well-being. In addition, informatics routinely provides valuable reports to operational units about the level of overall unit health and medical readiness. Because informatics also provides functionality and usability support to the patient portal used by ADSMs and their family members, communication about overall family well-being is made easier. The patient portal, securely accessible worldwide, is an effective tool for direct communication to providers and provides immediate access to clinical data and clinical encounter notes.

4. Combat survival
   a. As is well known, combat survival has reached very high levels. A direct reason for this, in addition to outstanding personnel, is the capture, sharing, and publication of data related to interventions and clinical outcomes that have been tested in the combat setting. That capture, sharing, and publication would not be possible without informatics personnel developing tools to easily collect, analyze and report the data from the field.
   b. Informaticists, both physician and nurse, are clinical practitioners and understand the use of clinical information systems (CIS), data analytics, and reporting tools to aid decision making for clinicians and the broad community of users. They are uniquely positioned to recognize and highlight clinically meaningful data and outcomes as well as to optimize interfaces used to capture and present the data to important stakeholders (clinicians, administrators, enlisted and officer leadership and so on). We still have work to do in accurately capturing what occurs in the space between point-of-injury and the initial care site.
   c. Since the corpsman and medic require both hands to care for wounded ADSM's, the ability to capture that care is limited due to patient and personal safety concerns. Informatics personnel, many of whom have operational experience, are in a unique position to help solve this problem and further enhance care and survivability.
   d. The Joint Theater Trauma Registry (JTTR), developed during Operation Enduring Freedom and Operation Iraqi Freedom, has markedly enhanced combat survivability. The ready availability of information and data analytics that power the JTTR allow for comparative evaluations regarding treatments and outcomes. The JTTR, and a previously developed registry (the Viet Nam Vascular Registry) fundamentally contributed to dynamically shaping clinical practice guidelines in operational medicine. These are all within the domain of clinical informatics.
5. Patient tracking: One of the first sets of questions an operational commander asks of the health services team when ADSMs are evacuated from the operational environment is, "Where are my ADSMs, what is their prognosis, and when will they be back?" That information is sourced from various electronic and non-electronic data repositories. While operational commanders may be able to obtain that information, it is often in hard to understand or in an unusable format. The people who can identify the clinically meaningful data and create a tool that makes it easily digestible are clinical informaticists. That is what the operational commander wants and needs.
6. DNBIs: As has been shown in multiple studies, DNBI is the most common cause for loss of battlefield readiness and evacuation. Some DNBI are due to injuries (often musculoskeletal), but others are due to illness. The use of a battlefield-ready/shipboard-ready EHR platform can inform outbreaks of illness, potentially prevent injuries, and identify and prevent other risk factors for DNBI. Clinical informaticists, many with operational and leadership experience, can help design EHR capabilities that allow appropriate data capture, determine the most clinically appropriate and secure methods to share that data, and analyze the data to determine the most appropriate course for commanders to take.
7. Traumatic brain injury outcomes: This and the next topic are linked in some cases, but they are separate issues. Rapidly identifying and treating traumatic brain injury (TBI) tends to have long term, positive outcomes for injured ADSMs. In addition, research based on data captured from the theater EHR can inform the outcomes of established and experimental treatments to improve both clinical outcomes and return to duty. Again, it is the clinical informaticist that has the greatest impact on both the design of the EHR and the workflow that enables data capture and analysis to demonstrate the effects of various interventions that impact clinical outcomes.
8. Prevention and rapid identification of PTSD
   a. While a number of people who suffer from TBI develop PTSD, they are separate issues and the approach to each is individualized.

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The one uniting factor is the effect of clinical informaticists on identifying the most clinically effective interventions and tools to put in the hands of the operational health care providers to prevent, identify, and rapidly intervene to optimize outcomes and return to duty.

b. Through extensive data analysis and application of machine learning and artificial intelligence capabilities, it is possible to identify those ADSMs at greatest risk for developing PTSD. It is also possible to identify the most effective interventions to "enhance resilience" and reduce the risk of developing PTSD. Extensive research is ongoing for both pharmacologic and behavioral treatments of PTSD.

9. Pre-deployment morale and psychological health: While this relates to #3 above, it is also a separate issue. When a unit is told they will deploy, there are a number of impacts on morale and psychological health. Some of these are minor and related to manageable stress. Others can lead to significant dysfunction and affect readiness. By continuously capturing and analyzing data from the EHR—whether by standard population health techniques, or advanced techniques like combining natural language processing with machine learning and artificial intelligence—the clinical informaticist can identify problems well before they are visible to the command. This allows the command to intercede in various ways to address ADSM and family morale and psychological health issues before they result in adverse effects on readiness and deployability.
10. Virtual Health: Virtual health and telemedicine bring specialty expertise to the battlefield, aboard ships, and to other operational settings to enhance medical care and survival. Prolonged field care, associated with future, near peer combat scenarios, demands virtual health solutions to maintain combat survival at the levels we have experienced over the past 19 years. Virtual health reduces the costs and risks involved in bringing ADSMs to specialty care. Virtual health can specifically enhance lethality by offering physical and mental health treatment to forward deployed areas and reducing the need for medical evacuation. It also decreases personnel downtime and gaps in coverage of mission-critical positions by reducing the time that ADSMs spend away for medical care. Clinical informaticists understand both the clinical perspectives and the health IT perspectives that allow virtual health solutions to be developed and deployed in the most cost efficient and clinically effective configurations.
11. Systems Integration
    a. ADSMs receive health care from a variety of sources, both military and civilian, with many different EHRs. Medical logistics, deployability tracking, and training status systems add further inputs. Operationalizing this data to build and maintain situational awareness is a complex task requiring knowledge of system interoperability, clinical practice, and mission planning. Clinical informaticists are uniquely trained to integrate disparate data from many systems to create actionable intelligence for the commander.
    b. As an example, a deployed ADSM was receiving controlled substances from his civilian mental health provider without unit surgeon knowledge. Upon identification of this situation, a clinical informaticist queried prescription databases to identify other ADSMs within the unit receiving similar medications. He further reduced operational risk by creating appropriate management plans and coordinating combatant command waivers.
    c. A further operational example is the identification of prior heat injuries through medical record queries. Appropriate identification mitigates risk through prevention and early identification. Heat injury is not always self-reported, and examining 10,000 individuals' records by hand is not feasible. Utilizing data analytics, this task becomes trivially simple to accomplish and markedly reduces operational risk.

Almost every major request to the medical department from operational commanders, both in garrison and during deployment, deals with information provided from medical record data extraction: medical and dental readiness, immunization status, medical supply and resupply status, location of evacuated sick and wounded, expected return to duty, and the status of ill or injured family members of deployed ADSMS, for example. The only specialty that specifically has the ability to mine this data as their domain are the clinical informaticists (physician, nurse, pharmacy and others), a relatively new but essential member of the operational medical community.

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1. Heritage Foundation, 2000 Vanderploeg, R. D., Schwab, K., Walker, W. C., Fraser, J. A., Sigford, B. J., Date, E. S., ... & Defense and Veterans Brain Injury Center Study Group. (2008). Rehabilitation of traumatic brain injury in active duty military personnel and veterans: Defense and Veterans Brain Injury Center randomized controlled trial of two rehabilitation approaches. *Archives of physical medicine and rehabilitation*, *89*(12), 2227-2238.

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Top Medical Apps for Spring 2020

Greetings! Here are four recent apps that will help ensure you are practicing the best evidence-based medicine (EBM) at the point of care!

1. **LactFacts: An Evidence-Based Collection on Breastfeeding**

Most providers and patients are aware of the benefits of breastfeeding; it is universally recommended by the World Health Organization, the American Academy of Pediatrics, and numerous other healthcare organizations. Furthermore, it is our "duty" in primary care to promote breastfeeding. The United States Preventive Services Task Force (USPSTF) "recommends providing interventions during pregnancy and after birth to support breastfeeding (Grade B)." One new app on breastfeeding is called LactFacts. The app comes from the Institute for Breastfeeding and Lactation Education (IABLE), a non-profit focused on promotion and support of breastfeeding. The current president of IABLE is Dr Anne Eglash, a family physician and professor at the University of Wisconsin School of Medicine and Public Health. Her team has developed an outstanding point-of-care evidence-based medicine app for breastfeeding. Their LactFacts tackles a clinical question regarding breastfeeding each week and includes a synopsis of the findings with links to PubMed and their own LactEd website. Additionally, they produce a free podcast that is also accessible via the website. Finally, members of IABLE can access even more resources online including patient handouts, a video and image library, and more.

Evidence based medicine

The LactFacts app contains answers to clinical questions about breastfeeding posted each week. It reminds me of the Daily POEM from Essential Evidence Plus, but focused on breast feeding. Each "fact" contains a short summary with a link to the article on PubMed and a link to a more detailed discussion on the LactEd website from IABLE. Some of these questions are then turned into podcasts available through the app. The author team from IABLE consists of experts in the breastfeeding field and range from family medicine physicians and pediatricians to lactation consultants.

Price

- App is free.

Likes

- Concise summaries of clinical questions on breastfeeding with links to the article and more.
- Podcast series on variety of topics with links from the app.
- Links to handouts on breastfeeding from IABLE (but requires membership).

Dislikes

- Required IABLE membership to get patient handouts.
- Some answers to clinical questions very concise.
- Won't completely fill the need for a concise reference on breastfeeding.

Overall

A great free app for primary care providers and lactation consultants to keep up with the latest evidence in breastfeeding to ensure the best, most-accurate counseling of our patients. Combination with free podcasts from the same author team makes it unbeatable.

Available for Download for iPhone, iPad, and Android.

- https://apps.apple.com/us/app/lactfacts/id1455008108
- https://play.google.com/store/apps/details?id=org.lacted.lactfacts&hl=en_US

2. **Heartpedia: A Visual Feast for Explaining Common Pediatric Heart Defects**

Murmurs are exceedingly common in children, including newborns. Most murmurs are benign flow murmurs which will simply "disappear" as the child grows. However, some murmurs are the stigmata of serious and even life-threatening cardiac defects. Explaining these complex conditions to families is challenging, as even normal heart

anatomy is difficult enough to explain. Thankfully, the team at Cincinnati Children's Heart Institute teamed up with Critical Care Media Lab to create a free, interactive guide to these defects and their repair. The app has 3D models of more than 12 different defects. Each section includes detailed text explaining the condition, symptoms, repair, risks, and outcomes. Additionally, each model can be viewed on different planes and axes with labels on or off. Finally, a quality YouTube video rounds out the explanation of each defect with more animations and explanations.

Evidence based medicine

Heartpedia is an app for patients, families, and medical providers to explain the most common pediatric heart defects and their repair. The app is written by a team of pediatric cardiologists and heart surgeons at the Cincinnati Children's Heart Institute. The app appears to be based on both medical evidence and expert opinion. No references/links are provided.

Price

- o Free.

Likes

- o High-quality 3D models of heart defects with labels, animation, and links to videos.
- o Extensive explanatory text for each defect explaining surgical correction and outcomes.
- o Available for Android.

Dislikes

- o Videos not embedded in app–require connection to YouTube.
- o No references provided for data on outcomes.
- o Fine as is, but could divide information into sections for patients and families and providers.

Overall

The new Heartpedia app from Cincinnati Children's Heart Institute and Critical Care Media Lab is a knockout app for viewing and explaining children's heart defects. The app covers all the "common" (and uncommon) defects in a stunning visual and text-based app that is sure to be popular with any provider who cares for these patients. The app is written to be usable by patients and parents, but is likely best used in conjunction with providers to help further explain the complexity of these defects and their repair. This is a true winner and is available for free.

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continued page 29

Available for iPhone, iPad, and Android.

- o https://apps.apple.com/us/app/heartpedia/id885512669
- o https://play.google.com/store/apps/details?id=com.cardinal.childrensheartencyclopedia

3. **EMRA Transgender Care Guide: A Quick Reference for EM and Primary Care Providers**

The Emergency Medicine Resident Association (EMRA) is one of the most prolific resident groups with an outstanding website and a history of making numerous medical apps that are just as useful for EM attendings and primary care providers as they are for EM residents. The group recently relaunched their mobile app, MobilEM. The app is a shell that contains free content and paid subscriptions. The free content includes the Transgender Care Guide, as well as the Splinting Guide, Top Clinical Prediction Rules, and Neonatal Resuscitation. Their paid apps currently include titles such as Antibiotic Guide, Ortho Guide, and EKG Guide and range in price from $1.99-$9.99 per year. The Transgender Care Guide is broken down into five chapters including: terminology, risk factors, history and physical, medical transition, and surgical transition.

Evidence based medicine

The app lacks any references natively, but if you explore the online version of the guide, it does contain approximately 11 references ranging from 2000-2017. The information is based on reputable guidelines from national and international organizations and peer reviewed research articles in the emergency medicine and endocrinology related literature.

Price

- o Free

Likes

- o Well-organized layout and sequence of information.
- o Detailed definitions and helpful tips on evaluation and examination.
- o Free content within the larger EMRA series of apps and guides.

Dislikes

- o No illustrations or videos on proper examination tips or pitfalls.
- o Not detailed enough for providers who care for transgender patients regularly.
- o No references in the guide itself (but available online on the EMRA site).

Overall

The utility of the app likely depends on your practice and the patients that you typically see. However, this definitely is an app that emergency medicine and primary care providers should consider as a quick reference. However, the online version of the guide is more detailed and a reference app such as UpToDate has considerably more information on the topic.

Available for iPhone, iPad, and Android.

- o https://apps.apple.com/us/app/mobilem/id1474834329?ls=1
- o https://play.google.com/store/apps/details?id=com.emra.mobilem

4. **Taping Handbook: A Helpful Guide to Proper Application of Kinesio Tape**

As a lifelong runner, I have had my share of musculoskeletal (MSK) injuries, including stress fractures of the hip, calf strains, and low back pain. At one point, I was willing to try just about anything for a chronic calf injury. At about the same time, it seemed like you couldn't watch a sporting event (particularly a running event) and not notice the number of athletes wearing colorful kinesio tape. I bought a book about it, some tape, and special (expensive!) kinesio scissors. In my "n of 1" trial, kinesio tape was inconclusive to ineffective. That hasn't stopped the continued growth of kinesio taping as yet another alternative medical treatment. I still recommend it to patients willing to try something that is relatively low cost, has some evidence to support its use and likely has minimal risk of harm. The "craze" of kinesio taping dates back to the 1970's in Japan and the founder of kinesiology (kinesio) taping, Dr Kenzo Kase, a Japanese chiropractor. He combined his know-how of human anatomy and MSK manipulation and worked with industry to create a special type of tape that was durable, flexible and hypo-allergenic (for most). From there the phenomenon went global. Today, thousands of practitioners and likely legions more of patients apply kinesio tape for everything from common MSK conditions to complex medical conditions, including stroke.

Editor's note: If you or a patient is experiencing stroke symptoms, please call 911 as opposed to delaying care to apply kinesio tape.

One of the most common questions among athletes and practitioners interested in kinesio taping is the "how-to" of applying it. Where does it go for a particular condition or body

part? How should it be cut and applied? A new app called the Taping Handbook provides step-by-step instructions for kinesio taping of more than 40 body regions from head to toe, including common MSK conditions such as shoulder pain, tennis elbow, low back pain, knee pain, Achilles tendinopathy, and plantar fasciitis.

Evidence based medicine

The app lacks any general information about kinesiology or kinesio tape. No evidence-based medicine links or articles are included. A search of PubMed reveals no indexed articles by the inventor, Dr Kenzo Kase; however, nearly 400 articles are indexed under "kinesio taping" for a variety of medical conditions. Several recent systematic reviews claim the superiority of kinesio taping over placebo or other conservative modalities for back pain and a variety of other MSK conditions. Other studies are inconclusive or show no benefit.

Price

- o Free

Likes

- o Step-by-step instructions with quality illustrations.
- o Detailed information on anatomy of each body region.
- o Taping applications well-divided by body region and medical condition.

Dislikes

- o No videos on proper application; only pictures.
- o No information or evidence on kinesio taping.
- o Not available for Android.

Overall

The Taping Handbook app could bring the increasingly popular kinesio taping to more providers and patients. The app is easy to use and includes quality instructions and detailed information about the anatomy involved. The app does lack general information and evidence about kinesio taping, types of tape, scissors, etc. However, the app is free and would be applicable to provider and patient alike.

Available for iPhone and iPad; not available for Android at this time.

- o https://apps.apple.com/us/app/taping-handbook/id1483125039

Editor's note: These reviews have been published previously on the imedicalapps webpage.

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Exploring Ways to Get Involved in USAFP and AAFP, Part 1

Happy New Year! As we turn the page to 2020 and anticipation builds for another fantastic annual spring meeting in Anaheim, our Resident and Student Affairs Committee wanted to spread the word on ways to get the most out of your USAFP membership. This will be accomplished in two parts, with the focus first on the "local" level (our home chapter, USAFP). Stay tuned for a future committee report that highlights opportunities at the national level.

1. **Get Yourself to the USAFP Annual Meeting & Exposition**

   I'd add this to the list of opportunities many more times if I could. There is not a better event out there for a military family physician, whether you are looking for continuing medical education, reconnecting with old friends, networking with new peers and mentors, or enhancing your scholarly activity portfolio. We have an exciting update to this year's resident and student leadership seminar as well. We're expanding with additional sessions that now cover an entire day's worth of workshops, and we've created a resident and student leadership development certificate to award to attendees present for all sessions. If there are still opportunities within your schools or residency programs to attend this year in Anaheim, jump on them! But more importantly, for those unable to attend this year, it's not too early to start thinking about next year's meeting. That's right, the 2021 meeting submission deadlines are just around the corner.

   For many programs, residents invited to present at USAFP either on a submitted topic or scholarly activity are more likely to get approval (and financial assistance) from their programs, as their participation helps to fulfill Accreditation Council for Graduate Medical Education scholarly activity requirements. If you're interested in pairing with a faculty mentor to present on a topic, the call for speakers often arrives within a month after the conclusion of the current

year's meeting, with submissions accepted into mid-May. Scholarly projects can come from a variety of sources, to include clinical research, educational research, and case reports. Abstract submissions are due in late September or early October. Additionally, if you've got an interesting scholarly question for military family physicians, the annual omnibus survey competition is another great way to get yourself to the USAFP Annual Meeting, with submissions due in early December each year.

For our HPSP student members, November is usually the month to start looking for e-mail communication from your service-specific HPSP coordinators about applications for scholarship funding to attend the meeting. If you haven't heard about this opportunity by the beginning of the next calendar year, you're always welcome to reach out to our Resident and Student Affairs Committee co-chairs (make sure to check http://www.usafp.org/committees/resident-student-affairs for the most up to date contact info). And for our USUHS student members, check in with your family medicine interest group leadership in the fall for more info on how to get funding to attend!

2. **Consider Serving as a Resident or Student Representative to the USAFP Board of Directors**

Every year, three residents are selected from the Army, Navy, and Air Force to serve as a voice for their fellow residents on the USAFP Board of Directors. Similarly, two medical students are selected, one from USUHS and another (as of March 2019) from our HPSP membership. Second- and third-year students are eligible to apply. In addition to advocating for your peers at the various board meetings throughout your year-long term, you'll have the opportunity to represent USAFP at the annual AAFP National Conference of Family Medicine Residents and Medical Students and sponsor projects aimed at increasing the outreach to, and wellness of, our chapter's resident and student membership. If these positions interest you, make sure to seek out a faculty member at your residency program or medical school to mentor you through the application process (or, as above, reach out to our Resident and Student Affairs Committee co-chairs for more information).

3. **Join a USAFP Committee**

The committees of USAFP are where the work of the chapter occurs. While there are limited director positions available each year to residents and students, the committees are open to all those interested in their specific subject areas. A great committee for residents and medical students is the Resident and Student Affairs Committee. Because our initiatives are directed toward improving and expanding the resident and student experience in USAFP, it's important to get your unique voices. There are also many more outstanding committees looking for resident and student voices. A list of the committees (and contact info to get involved) can be found at http://www.usafp.org/committees. If you're able to attend a USAFP annual meeting, there are always committee interest meetings in which you can meet committee chairs and get some in-person insight into the committee's plans for the upcoming year.

Hopefully you've gleaned some new ways to join or grow in our USAFP family. We in the Resident and Student Affairs Committee look forward to helping all of you establish the USAFP as your professional home early in your careers!

MEMBERS IN THE NEWS

The USAFP Board of Directors encourages each of you to submit information on USAFP "Members in the News" for publication in the newsletter. Please submit "Members in the News" to Cheryl Modesto at *cmodesto@vafp.org*.

NEWSLETTER SUBMISSION DEADLINE

REMINDER: The deadline for submissions to the Spring magazine is 10 April 2020.

RESEARCH GRANTS

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

RESEARCH JUDGES

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

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

Please write to me...
Aaron Saguil, MD, MPH, FAAFP
aaron.saguil@usuhs.edu

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

Janelle Marra, DO
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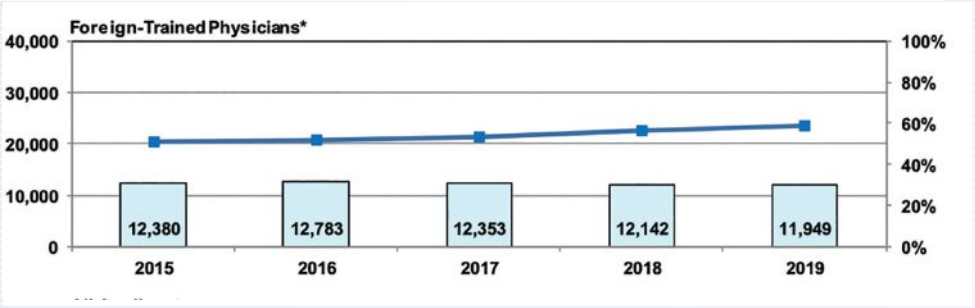
International Medical Graduates



While a majority of physicians practicing within the military have trained in U.S. accredited medical schools (D.O. or M.D.), up to 25% of physicians practicing in the United States or Canada are considered international medical graduates (IMG). IMGs who wish to commission in the military must have the Educational Commission for Foreign Medical Graduates (ECFMG) certification, have completed first year graduate medical education (GME) in an Accreditation Council of Graduate Medical Education approved program, be licensed (unrestricted) to practice in the U.S. or its territories, and be engaged in clinical practice. Based on National Resident Matching Program information, 13% of 2019 applicants for GME were considered IMGs. Of those applicants, 59% (both U.S. citizen and non-U.S. citizen IMG's) matched to first year GME programs. The top three programs into which they matched were internal medicine, family medicine, and pediatrics.

IMG's help fill gaps in many areas of medicine. In the majority of cases (98%), IMG's are multilingual, which helps with medical communication to patients who may not be proficient in English as a primary language. IMGs also have a unique training experience which helps develop cultural competency for the region in which they were trained. Non-US born IMG's also bring unique ethnic and cultural experiences that may help decrease

U.S. Citizen Students/Graduates of International Medical Schools									
Active Applicants*	5,080	100	5,075	100	5,069	100	5,323	100	5,014	100
Matched PGY-1	2,997	59.0	2,900	57.1	2,777	54.8	2,869	53.9	2,660	53.1
Unmatched PGY-1	2,083	41.0	2,175	42.9	2,292	45.2	2,454	46.1	2,354	46.9
Withdrew	540	7.7	569	8.1	594	8.3	650	8.8	691	10.0
No Rank List	1,355	19.4	1,342	19.2	1,486	20.8	1,391	18.9	1,212	17.5
Total	**6,975**	**100**	**6,986**	**100**	**7,149**	**100**	**7,364**	**100**	**6,917**	**100**
Non-U.S. Citizen Students/Graduates of International Medical Schools									
Active Applicants*	6,869	100	7,067	100	7,284	100	7,460	100	7,366	100
Matched PGY-1	4,028	58.6	3,962	56.1	3,814	52.4	3,769	50.5	3,641	49.4
Unmatched PGY-1	2,841	41.4	3,105	43.9	3,470	47.6	3,691	49.5	3,725	50.6
Withdrew	740	7.9	805	8.3	778	7.7	841	8.3	898	8.9
No Rank List	1,701	18.3	1,866	19.2	2,065	20.4	1,869	18.4	1,796	17.9
Total	**9,310**	**100**	**9,738**	**100**	**10,127**	**100**	**10,170**	**100**	**10,060**	**100**

https://mkonrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf

Ana Solis

Autonomous University of Baja California, Mexicali
Naval Hospital Camp Pendleton Family Practice Residency Training Program

Ana was born and raised in a small rural community in the Mexicali valley about two hours south of the Mexican border. Despite many obstacles, she graduated from the Universidad Autónoma de Baja California. After completing medical school, she moved to California.

Dr. Solis had a dream to become a US Naval officer and begin working as a nursing attendant on a surgical ward in the Navy Hospital in San Diego while simultaneously studying for her medical licensure. She was admitted to the UCLA IMG Program with advanced standing and graduated in 2009. Given the challenges of being an international medical graduate and pursuing a U.S. Naval career, she applied to Family Medicine residency training programs in both the civilian and military match. Dr. Solis' dream to become a naval officer has been realized. She will be joining the Naval Hospital Camp Pendelton Family Practice Residency Training Program in June 2010. The Navy is very pleased to match Dr Solis, as their need for Spanish-speaking physicians even in the US Armed Forces, continues to grow.

https://www.uclahealth.org/family-medicine/img-program/class-of-2010

racial and ethnic barriers in medicine.

In a survey of non-U.S. born, primary care IMG's in 2010, responders reported experiencing workplace bias and discrimination in interactions with patients, peers and supervisors; professional limitations in specialty choice, geographic location of practice, or potential for advancement; and difficulty in transitioning to the culture and practice of medicine in the U.S. The survey also identified that many IMG's have a unique lived experience, especially with regard to the healthcare of other regions, as well as experience in diseases not commonly seen in the U.S. Responders also reported their minority status allowed them to better empathize with a variety of patients from racial and ethnic minorities.

Another interview of non-U.S. born IMG's, asking them how they could have been better supported, led to the following recommendations. First, upon beginning residency, they recommended that residency programs consider integrating workshops on patient-centered care, cultural sensitivity, and patient interviewing. During residency, they recommended facilitating mentoring with peer and intergenerational colleagues, fostering relationships with wider IMG and immigrant communities, and being aware of any institutional barriers to their integration that may be present. During transition to post-residency, IMG's needed help navigating administrative issues such as visa and immigration policies that may impact their assimilation to the workforce.

Many IMG graduates wish to find ways to give back to their home countries or ethnic communities, and quite a few find themselves drawn to global healthcare and the care of immigrant populations.

RESOURCES

https://www.aafp.org/medical-school-residency/residency/apply/img.html
https://www.ecfmg.org
https://www.yousmle.com/img-guide/#Definitions_What_is_an_IMG
https://www.blog.myresidencylist.com/img-friendly-states-family-medicine/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3257160/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917670/
https://www.ama-assn.org/education/international-medical-education

Powell-Dunford N1, Gaydos SJ[1], Bishop MA[2], Buatti JM2, Kinard JL[3]
1. U.S. Army School of Aviation Medicine, Fort Rucker, AL
2. Medical Evacuation Concepts & Capabilities Division, CDID, Fort Rucker AL
3. Air Command and Staff College, Maxwell Air Force Base, Montgomery, AL

Implications of Multi-Domain Operations for the Uniformed Family Physician

'The nature of war is immutable...the character of war has changed'
- GEN Mark A. Milley, 20th Chairman, Joint Chiefs of Staff

Near-peer, large scale combat operations (LSCO), anti-access area denial (A2/AD), complexity, lethality, kinetic—what does it all mean and what does the uniformed family physician need to know about it? The specter of an enemy who is able to compete with our military (a near-peer) has implications across the services and domains—sea, space, air, land and cyber. Truly, the character of warfare has changed. The military will be challenged across all domains. No longer can we overwhelmingly and reliably defeat our adversaries at will. Examples of adversary A2/AD technologies, such as electronic jamming and long-range precision fires, will challenge our freedom of movement; we may not even be able to evacuate casualties. How can a uniformed family physician prepare for this form of warfare?

1) *Know your enemy*: Attend the 'big table' meetings to see exactly what your organization is up against. These meetings are often held in secret internet protocol router network (SIPR) rooms and battle labs. Your invitation to them is through established trust (and a standard security clearance). Do your basics well, and show you care and want to train your medics and corpsmen for multi-domain operations (MDO). You need to know what the enemy is capable of in order to prepare.

2) *Train for prolonged field care (PFC) in the MDO environment*: Can your medical personnel treat, hold, and sustain casualties when evacuation is delayed beyond doctrinal norms? Are you capable of performing minor surgical procedures and do you have printed references available to guide you? Having the Joint Trauma System PFC clinical practice guidelines on your cell phones and tablets can be lifesaving. However, will your aid station have hard copies when communications are degraded? PFC is not glamorous, but realistic training on the topic is critical.

3) *Read WWI, WII, and Korean War medical history*: The challenges medical personnel of these eras faced are similar to those in a projected near-peer fight, where logistics, supplies, and human capital are strained or exhausted. Note that Corps and Echelons Above Brigade (EAB) elements fight in these types of conflicts; you must educate yourself beyond the support of the tactical Brigade-centric conflicts of the past two decades.

4) *Know the doctrinal terminology*: Clearly articulating MDO concepts in the proper verbiage will help guide your way forward strategically and lend credibility to your cause. A few examples include:

Layered standoff (ref: The U.S. Army in Multi-Domain Operations 2028): Our adversaries will seek to separate us from allies at every level. What this means to us: We need to establish and maintain our international medical relationships by aggressively networking with the international medical community as soon as we can, ideally before deployment. Train with allied partners in theater, or learn a foreign language.

Compressed operating environment (ref: Multi-Domain Battle: Evolution of Combined Arms for the 21st Century): 'The ability of adversaries to both expand the battle space and converge capabilities compresses the strategic, operational and tactical levels of war for Joint Force and allied commanders...Compression compels the Joint Force and partners to defend against attacks from virtually anywhere in the world.' What this means to us: Continuous tactical proficiency in all medical tasks is imperative, regardless of duty station or physical location. We must understand how we work together with the joint and multi-national medical capabilities around us. What access to joint medical assets (e.g., shore-to-ship) is available? What additional support are we providing to the joint force (e.g., ship-to-shore)?

Resilient formations (ref: Multi-Domain Battle: Evolution of Combined Arms for the 21st Century): 'Formations which are capable of conducting semi-independent, cross-domain maneuver throughout the depth of the battle space from any location in the world to the point of conflict to address the enemy's lethality and ability to contest the Joint Force in all domains.' What it means to us: We need to ensure all service members are capable of assuming leadership in medical care. Are remotely staged outposts competent in all medical tasks, especially Tactical Combat Casualty Care and PFC? It is critical that we circulate throughout our formation to ensure adequate medical training. Augment clinical skills through attending service specific or joint courses, such as the Medical Evacuation Doctrine Course or the Joint Medical Operations Planning Course.

5) *Be flexible, mobile, and anticipate no safe area*: Long-range precision fires may threaten areas previously considered 'safe.' Are your corpsmen drilling regularly with fire-fighting elements aboard the ship? Are we all practicing our mass casualty drills on the airfields and near the aid stations? Can we, regardless of age or gender, drag adult casualties during times of chaos? If we are 'lucky' and only have one or two severely burned patients as a result of enemy artillery, do we know how to contact the Brooke Army Medical Center Institute of Surgical Research Burn Unit to help us manage the initial stages of fluid resuscitation (833-ADVSRLN/DSN 312 429-9089)? 'Fixed' field hospitals will need to move in order to keep up with maneuver units or avoid enemy fires. Embrace the pain of training for this and assist with tent setup and pull down—don't be the lazy doc who complains or feels 'above' doing the hard work. Clearing a medical facility and moving field hospitals are onerous tasks, but they are necessary for success in MDO.

6) *Prepare mentally for the scope, scale, and tempo of casualties*: In LSCO and MDO, we must anticipate overwhelming casualties paired with limited supplies, which will drive heart-wrenching choices. In the setting of overwhelming casualty streams, we may be reduced to simply treating pain in casualties who we would normally be able to save, time permitting, in order to move immediately to those who can be put back into a fight. Our priority must be to conserve the fighting strength.

7) *Understand the medical scheme of maneuver and common operating picture*: Evacuation may be a combined (e.g., air, sea and ground), joint, and multi-national function. Evacuation will be a mixed effort involving movement of casualties through dedicated medical evacuation platforms (MEDEVAC) and non-medical platforms (CASEVAC). Be part of the evacuation planning for your unit. Make recommendations to continually improve the support and evacuation plan. Ask questions. What level of care is available (e.g., Role 1, Role 2)? What MEDEVAC assets are supporting the operation? Are there planned aeromedical and ground evacuation routes? Is there any known "limit of advance" established for evacuation assets due to the A2/AD threat or ground obstacles? In the scheme of maneuver, will threats change throughout the course of operations? What is the treatment and casualty holding plan if communications are down? If aircraft or ambulances are unavailable, are there unconventional assets available for patient movement (e.g., trains, trucks, wagons or animals)? Is there a plan to use accessible waterways via boats, barges or rafts? It is better to conceptualize these scenarios in advance of any combat operations.

8) *Harness new ways of medical resupply and sterilization*: Although drones demonstrate promise in delivering lifesaving equipment, it is likely that select expendable medical equipment may need to be re-used after sterilization when normal resupply channels break down. Sterilization for re-use of equipment may need to occur though the most basic mechanisms once the ability to resupply is exhausted.

9) *Ensure a walking blood bank*: In MDO, refrigeration and blood delivery may be unreliable. Remember that nothing can substitute for whole blood when it comes to hemorrhage resuscitation. Prepare in advance through type and titer screening of your military population. Work with your local blood bank and chain of command to plan and train for this contingency well prior to deployment. It will be an all hands-on deck effort, but may be lifesaving.

10) *Understand dense urban environment (DUE) considerations*: Aviation assets are at increased risk in the urban environment, further restricting movement and driving alternative (typically slower) methods of evacuation. The DUE also involves subterranean operations. Anticipate highly contaminated wound patterns and be prepared to treat patients appropriately. Ensure medical personnel conduct (safe) nighttime training and approach the DUE environment as realistically as possible.

The future of combat operations is likely very different than the low-intensity conflict defining recent decades. From learning new terminology to ensuring trauma proficiencies in your medics, it is important to appreciate the demands of medical care in LSCO and MDO. Success in these environments will test the entire force. Meeting the medical challenges starts with you—the uniformed family medicine physician.

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Growing Physician Leaders: Empowering Doctors to Improve our Healthcare

BY LTG (R) MARK HERTLING

This quarter's article reviews a book central to our purpose in the leadership book review. *Growing Physician Leaders* by LTG (R) Mark Hertling is a synopsis of what he and his team have done at the Florida Hospital in Orlando to organically grow physician leaders. Relying heavily on lessons learned from the military (and yes, the book is a little "Armyish"), LTG (R) Hertling lays out the absolute importance of physician leadership (both in formal and informal positions), the characteristics and qualities essential for leadership, and lessons learned by the participants in their leadership development efforts. He concludes each chapter with a "war story" from his own career to highlight important concepts and to provide context for the principles about which he writes. For most of us, leadership and leadership training is part and parcel to our careers since the military stresses this at all levels; however, in the civilian world, institutional emphasis on growing and developing leaders is rare. I recommend reading this book not only for your own development and to remind yourself of core leadership principles, but also for perspectives on how we can create physician leaders within the military and in our future civilian careers.

GROWING PHYSICIAN LEADERS

Leadership, as we all know, is a mix of character, talent, skills, care, and dedication. But how do you create leaders? More specifically, how do you create physician leaders? LTG (R) Hertling, in his role at Florida Hospital, created the "Physician Leader Course" to answer this precise question. He begins his book by stressing the need for physician leadership and describing some of the barriers to physicians becoming engaged, competent leaders. Some of these barriers are present in our system: administrative burdens, over-prioritization of workload and relative value units, a hierarchy of non-clinical positions that greatly outnumber the physician leadership positions, and a lack of engaged physicians who desire to get in the ring and lead. He contrasts this with the military which has a very defined and tiered leadership structure that integrates both academic leadership training and opportunities for direct leadership. He also stresses that "good leaders are made, not born. And that *includes* physicians."

He then goes on to break down many of the core attitudes and competencies needed for leadership. He defines a leader as someone who "must be willing to act decisively, exhibit courage and candor when required, and do all of this in the best interest of the organization." Furthermore, an ideal physician leader is "someone who selflessly and humbly serves patients and the healthcare organization." Successful leaders must be able to lead up (which can be doubly difficult in our organizations due to rank) and be committed to team and organizational success in ways beyond excellent clinical care. Physicians appointed to leadership roles frequently demand a voice simply

by virtue of their position or title; but, in the same way that we must communicate in meaningful ways for our patients, physicians in leadership positions must be able to "speak the language" of the organization. Otherwise, physician input will not be received and integrated into decisions. This is akin to a hospital administration declaring a new policy without considering its clinical impacts; it's frustrating, confusing, potentially disrespectful to clinicians' value, and creates divisiveness. Often without realizing it, we can do the same thing when we don't consider other perspectives and the needs of the organization.

CHARACTER, SKILLS, AND COMPETENCE

Successful leaders have a combination of character, skills, and competence that are reflected in their professional and personal values and ethics. Physician leaders uniquely possess the professional responsibility and skills to lead healthcare organizations. However, these skills are not fully innate. Just as we had to learn to take medical histories, place central lines, read x-rays, or have end-of-life conversations, we must invest the time in learning ways to lead. Not a single one of us will master them all; this is why leadership is a team sport. But we must be honest with ourselves and seek counsel to develop ourselves as leaders. LTG (R) Hertling describes three different leadership scenarios in which leaders must apply different approaches and skills: when you're creating a new team, when joining a good team, and when you're needing to sustain a great team. In all three situations, leaders must set priorities and develop trust (which have been discussed in other leadership book reviews); but the manner in which this is done and the strategies for doing so differ. As we all move frequently in our careers, it's imperative that we heed this advice and assess the situation we are in to determine the best path to success. And not just for your success, of course, but for the success of the organization.

To be successful, physician "leader's words and actions must remain in sync." And as such, physician leaders must maintain professional demeanors and attitudes at all times, and in all situations. Furthermore, "values reflect what the leader really believes and mirror what the leader sees as most important." Think about yourself: what do your values and actions say are most important to you? We can't just say "I'm a doctor and therefore listen to me". We also have to quit assuming that others are too ignorant to understand the problem or make the right choice. We expect administrators and policy makers to know our perspectives; we must invest the time to know their viewpoints and constraints if we expect to be invited into the conversation. Whatever role you are in, spend the time to make relationships and understand all aspects of the problem. If you're in a position to ensure physicians have a seat at the table, make sure it happens. Expend the resources to develop junior physician leaders and involve them in the process. Nothing states that putting physicians in leadership roles will solve all problems, but all too often (as many of us have witnessed) decisions made without physician involvement aren't very satisfactory. Lastly, we need to hold our physician leaders accountable....this may be one of the most important, yet most difficult, tasks to accomplish.

A BIGGER BROADER VIEW

The final two chapters of the book deal with the perceived incompetence of those at "higher" headquarters and the need for physicians to drive solutions to the challenges in health care. In both cases, in order for physicians to be involved, listened to, and have a seat at the table, we must know the vernacular and decision-making process. All too often, as medical experts, we expect our opinions to be instituted without comprehending the full picture. As LTG (R) Hertling points out, how often do physicians know the "strategy, direction, or objectives" of the hospital or system? How well do we understand the myriad of decision makers and influencers in our own hospitals and clinics? Things like personnel management, medical logistics, policy determination, and strategy implementation must be learned in order to grasp the full situation and find complete solutions, not just the singular problem driving your involvement in the conversation.

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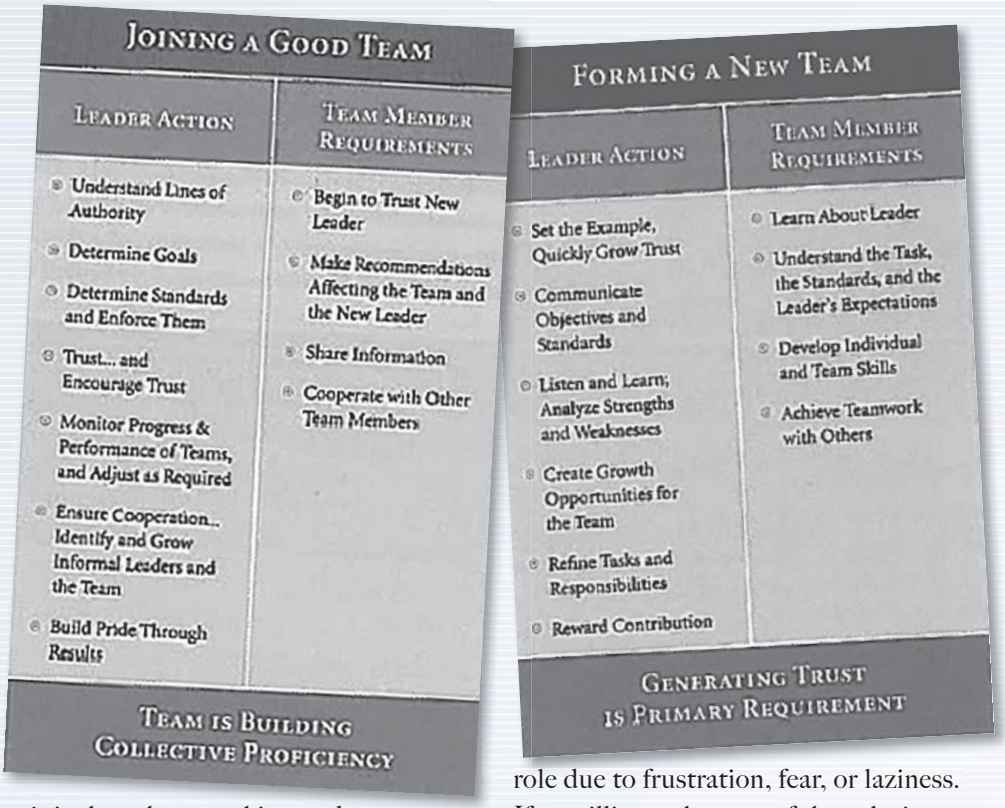
Just as administration needs to understand the clinical impacts of a decision from "higher," we must understand the "business of medicine." This imperative is then expanded by the book to our nation's health system and how physicians are too far removed from policy making roles with a lack of understanding or involvement in the financial components of healthcare.

APPLICABILITY WITHIN THE MILITARY HEALTH SYSTEM (MHS)

With the ongoing transitions within the MHS, the need for leadership throughout all levels of the organization has never been greater. The entire system needs thoughtful, knowledgeable, clinically-minded leaders to help us reform without losing sight of what's most important. Whether in a formal or informal position of leadership, whether a junior officer or senior leader, the principles in this book will remind you of and refresh your focus and desire to lead. I would also highly recommend this for our residents and those teaching and leading in residency programs. The book is not groundbreaking, but it is thought provoking and a great reminder of why we do what we do.



Physicians are inherently servers, self-sacrificing for others, and possess an obligation to help correct that which is wrong. As a whole, we can ensure the right decisions are made for the right reasons: for the care of our patients and the care of the organization. Tragically, despite having the substrate to be phenomenal leaders, too many have abdicated the role due to frustration, fear, or laziness. If unwilling to be part of the solution, how can one complain about the result?

So what do YOU say? Ready to be in the ring and lead?

From all of us, keep leading and keep reading! We challenge you to prioritize your self-learning by reading one non-fiction book a month. And we always welcome your feedback on how we're doing and what we can do better. Here's to you and a great 2020!

MEMBERS IN THE NEWS

CONGRATULATIONS TO USAFP MEMBER AND COMMITTEE CO-CHAIR JANET WEST, MD

JANET WEST, MD, FAAFP, NAVAL HOSPITAL JACKSONVILLE, HAS BEEN SELECTED BY THE AAFP BOARD OF DIRECTORS TO SERVE A 2-YEAR TERM AS AAFP AMERICAN MEDICAL ASSOCIATION (AMA) DELEGATE. DR. WEST HAS SERVED THE ACADEMY THE PAST SIX YEARS AS AMA DELEGATE AND BEEN A GREAT VOICE FOR THE AAFP AND THE SPECIALTY OF FAMILY MEDICINE.DR. WEST DEEPLY UNDERSTANDS THE POWERFUL VOICE OF THE AMERICAN MEDICAL ASSOCIATION IN OUR CHALLENGED HEALTHCARE SYSTEM AND COURAGEOUSLY ENSURES THAT FAMILY MEDICINE AND THE VOICE OF THE AAFP ARE WELL-REPRESENTED.

CONGRATULATIONS DR. WEST!

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new members

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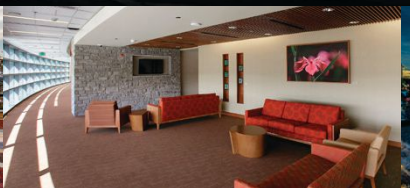

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