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VISION

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

MISSION

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

Edition 57

your academy leaders
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Greetings, Friends!

It is so, so good to write to you as you find yourself preparing to enjoy food, fun, family, and friends around the holiday table. We've had a difficult couple of years, and it is good to surround ourselves with the things that bring life savor. For those of you standing guard on freedom's frontier away from your family this holiday season, thank you for your sacrifice; we will keep you in our thoughts and pray for your happy reunion with your loved ones.

I'm already at the halfway point of my presidential year, so I want to make sure that I fill this newsletter with two things near to my heart. Below, I'll discuss our "Better Together" initiative (including our Annual Meeting) and some of the impressive work coming out of your committees. Hopefully, I'll make a strong case for your increased involvement in our Uniformed Services Chapter!

BETTER TOGETHER!

After over a year and a half of what seems like an uphill struggle against the coronavirus, we recognize that we are stronger together, smarter together, and "Better Together!" Through the fall our different affinity groups have continued. Our literary book club has most recently discussed People of the Book by Geraldine Brooks, our leadership book club will tackle Inside the Five-Sided Box by Ash Carter, the journal club reviewed an operationally relevant article on tibial stress fractures, and our fitness club is racking up miles on the Strava app.

If you would like to be involved with any (or all!) of these groups, please use this QR code to get connected.

All of these groups are pointing toward our Annual Meeting in Anaheim, California, which has the theme of…(wait for it)… "Better Together!" We are so thankful to be able to plan an in-person meeting, to reunite after being frontline participants in unfolding history. Just like the more senior of our members recall where they were on September 11th, 2001, we will all remember what we did in the midst of an unprecedented global health crisis. The line up that Steve Young and Mariama Massaquoi have put together for you is breathtaking in its scope and expansiveness. You'll have a "Smarter Together" suite of clinical, practice management, and operational topics from which to choose. You'll have "Stronger Together" offerings including yoga, our fun run, committee meet and greets, and our all-member party. Everything is geared to help us live "Better Together."

COMMITTEES—WHERE GREAT IDEAS BECOME REALITY

I suspect that some of you heard the word "committee" and thought, "Great! Another opportunity to lose time in a meeting." I can empathize. Anytime you involve more than one person in a project, the need to organize and share decision making kicks in, which involves meeting together and working things through. And thus, committees are born.

On the other hand, a group of people working together can be just the ticket for big item, long term success, and that is what your USAFP committees accomplish. To give you an example of what they do for you as a member, let me draw back the curtain a bit.

It is widely acknowledged beyond our chapter that the USAFP research and scholarly activity competition is par excellence. This is only so because of the herculean work of our Clinical Investigations Committee. In addition to providing a venue for many residents and staff physicians to showcase their work (Rise with Research, Poster and Podium presentations), they also organize and publish the omnibus survey. This instrument allows us to canvas our membership, providing data for our own internal investigators to review, and has led to publications in multiple prestigious journals. Hats off to Drs. Oh and Gaddey for their work and the work of their judges and members!

We've also seen an infusion of new leadership on the Education Committee, and they are hitting the ground running. In addition to sponsoring the Better Together Journal Club, they are also working to bring additional opportunities to participate in ABFM KSA sessions outside the annual meeting. This will allow more members to work together to maintain their certification. They are also working to ensure continuity between our meetings and have recently taken

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on the responsibility for creating a place for those interested in point of care ultrasound to meet. Thank you Drs. Meisenheimer, Rogers, and Raymond!

The Resident and Student Affairs committee has likewise been active. In addition to successfully advocating for scholarship funds for full time out-service residents to attend the USAFP Annual Meeting, they also put on the resident and student leadership workshop each year and the perennial, "Doc, You Don't Know Jack." One of their recent initiatives is to add a certificate to the leadership workshop so that attendees can demonstrate their learning to their respective programs. Drs. Honeycutt and Knobloch, we appreciate your work and that of your members!

And those are just three of the committees you can join. Each would welcome you to the group. In addition to these, you can also consider joining the Clinical Informatics Committee; the Constitution, Bylaws and Strategic Charter Committee; the Member Constituencies Committee; the Membership and Member Services Committee; the Operational Medicine Committee; the Practice Management Committee; and the Wellness and Resiliency Committee.

These committees are the entre to other positions within the USAFP and the AAFP. For me, joining the Education Committee allowed me to meet folks who would mentor me through my career. From my start as a member, I later served as chair. From there, I served as a co-chair for an Annual Meeting, joined and led an AAFP commission, and created a network that has continued to open doors to the present day. Please take advantage of the opportunity to do the same for yourself while serving our members!

To get started, just visit the USAFP homepage, select "Committees" and fill out the interest form.

FINAL THOUGHTS

Regardless of how you do it, please make the USAFP your personal resource. Whether you join a committee, take advantage of one of our educational benefits, or simply attend the Annual Meeting, this is your organization. For those who consider themselves junior, let us help you grow your professional network, help you find great role models and mentors, and help accelerate your career. For those a little further along, let us be the place where you can pour your life lessons into eager young officers on the make.

Cheers,
Aaron

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Correctional Medicine, similar to Military Medicine, provides evidenced based medicine to a unique population within a policy focused framework. My experience as a military physician provided for a smooth transition into a challenging and rewarding second career as a correctional health care physician.

John Lay, MD
LTC(R), US Army
Regional Medical Director
Centurion with the Florida Department of Corrections

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

Wow! It's already coming up on the end of the year. As each new year approaches and the past year is in the rear view mirror, I try to take time to evaluate if I have made my intended impact or whether I need to adjust course. What impact have you had on your family? Friends? Co-workers? Is it positive and affirming? How can you change your thoughts, behaviors, or interaction to accomplish your intended goal? In our military roles, we often believe that our service to country takes precedence over all else. But we each encounter many more people outside of our employment than within. Are you investing in your future? What is most important to you? Although this article is short, I pray it challenges you to pursue things that will leave a lasting impression on those most valuable to you.

Better Together

The Better Together Campaign is a initiative by the USAFP to help USAFP members and their families stay connected!

In 2021, let the USAFP be your source of professional affinity offerings (leadership book clubs, robust mentoring opportunities, committee-sponsored groups), personal growth offerings (board game clubs, fitness-oriented clubs, trivia clubs, investing circles), and family friendly offerings (family support club, group watch club, OCONUS club).

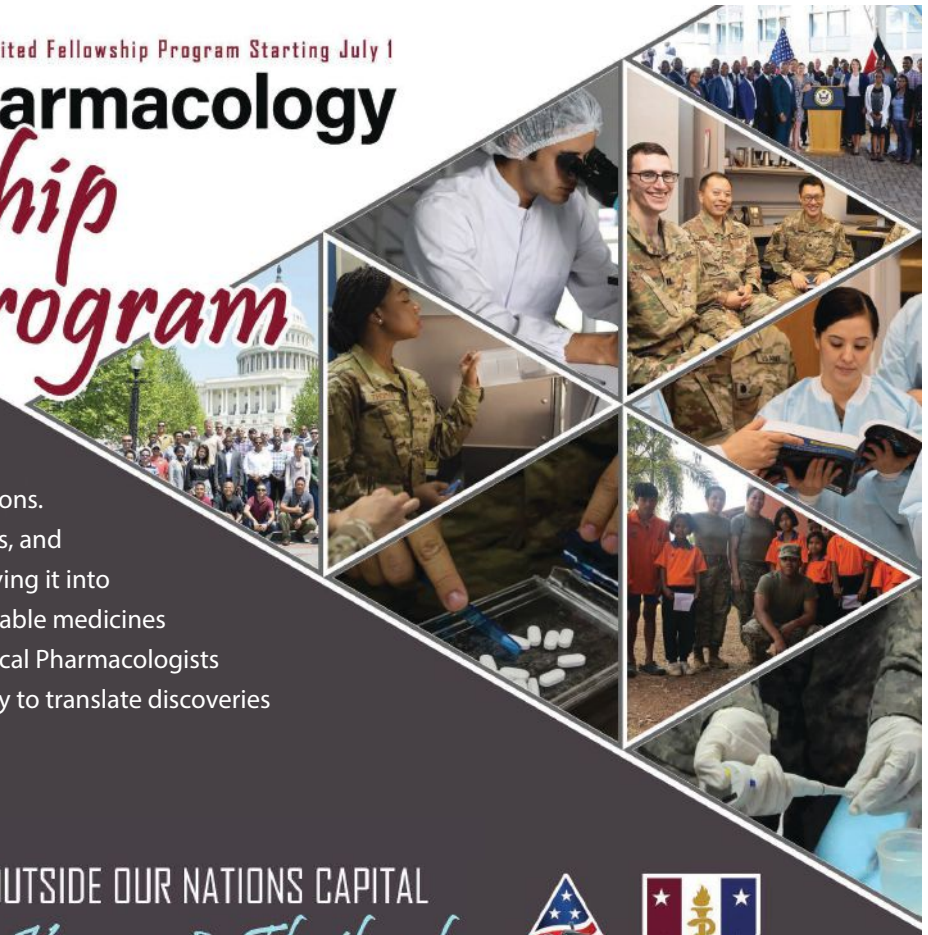
The USAFP hopes that by connecting you to one another you can experience what it means to be "Better Together."

Please check the link below to get involved and check out the latest events!

https://usafp.org/usafpbettertogether/

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

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consultant's report
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Happy Fall to all!

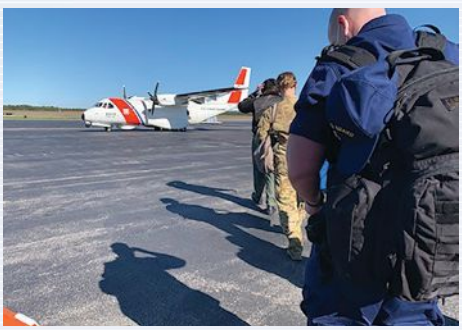
In this edition, another easy read on PHS/ Coast Guard updates and current mandates.

BORDER MISSION SUPPORT

For the second time this year, additional waves of Coast Guard Mission Support were deployed to the SW border. The current deployment started in August. As of this writing, the third wave is currently at the designated sites. Ajo and Naco, Arizona are the identified locations and a combination of both clinical and administrative members of the Coast Guard are deployed. This third team is expected to complete the mission.

HS3 Kane and HS3 Moffett in STA Brant Point, Nantucket MA

HS3 Moffett giving a patient his vaccine



Kaehler Clinic medical team getting ready to board the C144 from Air Station Cape Cod

HS2 Fortuna, HS3 Kane and HS3 Moffett as they provide vaccinations to members of STA Brant Point

GUIDANCE ON COVID 19 VACCINATION

It is now mandatory for CG members both Active and Reserve to receive the FDA approved COVID 19 vaccine (Pfizer). Our agency announced on August 26, 2021 the mandate similar to the DoD's posture. With the FDA's full approval of Pfizer-BioNTech COVID 19 vaccine, the directive requires members who are not fully vaccinated to receive this vaccine unless granted an exemption or accommodation. Members who have received two doses of Moderna or the one dose from Johnson and Johnson are considered fully vaccinated. Permanent requests for medical exemptions are routed to HSWL for approval.

OPPVS

On September 1, 2021 the USPHS' Officer Promotion Package Verification System (OPPVS) was launched. Members of the corps come from various disciplines and the creation of the OPPVS was to provide a standard system for the promotion process. The link for FAQs and timeline for OPPVS is https://dcp.psc.gov/ccmis/promotions/promotions_oppvs_faqs.aspx.

DD214

Form DD214 is now available for PHS officers separating or retiring from the agency after October 1, 2021. In collaboration with DOD, PHS has been granted permission to use the said form. More information is available at CCMIS website. The link to the FAQs is https://dcp.psc.gov/ccmis/separations/DD214%20FAQs.aspx.

DHS COMMISSIONED CORPS MEETING

From the July DHS meeting:

1. HPSP must be submitted with a copy (PDF) of clinical license. Board Certification Incentive Pay requires submission of the board certificate. Submission of such documents are required for renewing contracts, new to the Corps or retiring officers who are aligning their retirement date with their HPSP date. These document/s are all sent to PHS liaison (CDR Ceinos). His email is PHSLiaison@hq.dhs.gov.

2. Medical License – officers need to scan this along with their Board Certification to their own eOPF.
3. Covid 19 Vaccination – upload in eOPF under medical section, then choose immunizations
4. COVID 19 positive results – per MAB the COVID 19 positive results should be upload ed under Medical Records

PROMOTION WEBINAR

The PPAC Mentoring and Career Development Subcommittee have offered a Promotion Webinar slated for October 5, 2021. The target audience are medical officers serving in clinical roles at BOP, DoD, ICE, HIS, NPS, USCG and VA.

2021 ANNUAL COER

The 2021 Annual COER begins from October 1, 2020 to September 30, 2021.

- Online Annual COER is due to the Reviewing Official (RO) by 30 November 2021
- Online Annual COER is due to the Agency Liaison by 31 December 2021
- Online Annual COER is due to Commissioned Corps Headquarters (CCHQ) by 15 January 2022

CARRYOVER LEAVE UPDATE

On October 1, 2021 CCHQ announced that "Continuing Appropriations Act 2022" allows PHS officers to carry over their leave in excess of 60 days for FY2021. Officers will use an added feature in e-CORPS, in the same manner we all request our sick or annual leave. The specifics of the process were included in the email sent to all officers on October 1, 2021.

REFERENCES

1. "COVID-19 vaccine mandated for all military members," United States Coast Guard, August 27,2021. https://www.mycg.uscg.mil/News/Article/2753888/covid-19-vaccine-mandated-for-all-military-members/.
2. "DD 214 FAQs," Commissioned Corps of the US Public Health Service, accessed September4, 2021, https://dcp.psc.gov/ccmis/separations/DD214%20FAQs.aspx.

consultant's report
NAVY

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Greetings, Navy Family Medicine colleagues! As the new Specialty Leader I want to take this opportunity to thank Jim Keck for the kindness and grace he brought to the role over the last 4 years. While filling his shoes is impossible, he has set an impressive standard to strive for.

DIVESTITURES – OVERMANNED TO UNDERMANNED?

As I write this, the National Defense Authorization Act (NDAA) for fiscal year 2022 is being debated. It appears that the previous halt on medical divestitures will be extended for another year. In addition, the Marine Corps has purchased additional Family Medicine billets and we are waiting to see how many billets we will acquire during the 5-year GMO conversion process.

The net result of these shifts may be the opposite of divestiture, an increase in overall billets. Shifts of operational billets will provide some offset, as our Internal Medicine colleagues seek the increased operational role that our specialty claimed long ago.

I encourage you not to allow these pendulum swings to influence your career decisions. Navy Family Medicine will continue to thrive, and past performance is likely a better guide than murky future estimates. Continue to evaluate the satisfaction and opportunities that you find in your Navy career, as well as the quality of the colleagues you serve with.

Dr. Brian Reamy, Senior Associate Dean at USU, points out that military medicine has weathered greater threats than the current uncertainty several times over the last twenty five years. There will continue to be operational, clinic, OCONUS, and academic roles in our specialty for those who seek a career with service, variety, and personal fulfillment.

PROMOTION

Over the past few months, we have seen promotion results for our three common ranks.

Congratulations to the following officers in our FM community who were selected for promotion!

CAPTAIN

Michael Arnold	Daniel Elliot
Jonathan Elliot	Jason Gordon
Sean Leonard	Mark Lund
William Nguyen	Torrin Velasquez

COMMANDER

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Steven Elek IV	Daniel Kuckel
Bruce Matchin	Jean Mathurin
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Sarah Quan	Nolen Roberson
Jesse Schonau	Megan Sick
Ana Solis	Richard Thompson
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Gabriel Hood	Taylor James
Corrine Landis	Alison Matsunaga
Alex Nguyen	Osmund Nogra
Matthew O'Reilly	Scott Paradise
Patrick Reeves	Amira Saad
Joseph Sapoval	Andrew See
Joshua Slep	Jack Stacey III
John Sullivan	Brian Templet
Chelsea Thompson	Eric Vinceslio
Shea Wickland	Tyler Witzel
Josiah Young	Daniel Zhang

Promotion Stats

The statistics for Family Medicine suggest that we need to make a concerted effort to ensure our contributions are properly recognized on an individual level. These numbers are from Joel Schofer, and don't count our promoted folks from the flight surgery or UMO categories.

Rank	In Zone			Above Zone			Below Zone		
	#	% in FM	% in MC	#	% in FM	% in MC	#	% in FM	% in MC
LCDR	39	89%	91%	0	0	29%	3	6%	2%
CDR	8	50%	50%	7	37%	41%	0	0	0
CAPT	2	50%	60%	2	22%	13%	1	5%	2%

While our promotion rates are comparable to the medical corps overall, we are below average for 2 of the 3 in-zone rates. I remain convinced that we can improve these statistics.

There still appears to be no single path to promotion, which is reassuring considering the variety of ways we serve. The Career Pathway for Family Medicine suggests some of what the Navy values for promotion. This includes at least one operational tour prior to Commander and a senior operational tour prior to Captain. Joint Professional Military Education (JPME-1), a collection of three Naval War College courses that can be taken remotely, is included on both promotion board instructions and the career pathway.

Improving promotion rates is essential for retention and morale in our specialty. I encourage all Navy Family Physicians to review Joel Schofer's 31 August blog on FY23 promotions at mccareer.org and to complete a Career Development Board (CDB) at their local command. In addition, we are endeavoring to establish a Family Medicine virtual CDB program using some of our experienced Captains to provide specialty tailored recommendations. As I write this, I am in discussion with the Corps Chief's office and senior mentors to develop this program.

In the meantime, I encourage colleagues who have previously failed to select or are worried about an upcoming promotion board to contact both myself and CDR Tara O'Connell, our outstanding detailer.

DETAILER UPDATES

Greetings Navy Family Medicine!

As you may suspect, this is going to be a most unique detailing cycle. Billet options have changed markedly over the past year due to multiple ongoing Navy Medicine force shaping processes.

My priorities for detailing will be:

1. All Overseas Billets
2. CONUS Operational Billets
3. CONUS MTF/Shore commands – last priority

Since shortfalls in the Flight Surgery and Undersea Medicine communities are projected to be even more than in Family Medicine, we will be looking at ALL previous FS/UMOs for potential operational orders.

There are several pending decisions that will impact Family Medicine billets. Planning for operational requirements will be affected by the release of GME results in December. Results of Senior Executive Medicine (SEM) and Non-Specialty Specific (NSS) slating will be in December. Due to these factors and the significant Medical Corps manning shortages, please don't expect orders into CONUS MTF/Shore billets to be written until well after the New Year.

I ask for your patience as we all navigate these interesting times! Please reach out to me with any of your questions and concerns.

Tara O'Connell, DO, tara.a.oconnell.mil@us.navy.mil

USAFP 2022: NEED ALL NAMES BY 29 NOVEMBER 2021

The next USAFP Annual Meeting is 30 March – 4 April 2022 in Anaheim, California, and I have faith that a live conference will happen this year. As many of you know, approval for a conference like this is a monumental administrative feat. **Each** individual Family Physician attendee under a Navy Medicine command must be approved **by name** to attend, based on an individual justification. As a result I will need your information by

continued on page 14

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*.

continued from page 13

MONDAY, 29 NOV 2021 to produce the combined package for submission.

As you read this, you should have received several emails from me requesting information. If you plan to attend the Annual Meeting and have not received emails from me, please reach out to me ASAP! If you are not certain if you belong on the list, then contact me!

In general, if you are assigned to a Navy Medicine (BSO-18) command like the Navy Medicine Readiness and Training Commands, you need to be on this list. If you are at a non-Navy Medicine Command and your command is paying for you, you can avoid this process. But, if an entity other than your command (e.g. NMPD&C) is paying for you, we need you to be on the approved list to attend.

Want to review a primary source? Go to https://es.med.navy.mil/bumed/m00/m00c/Pages/conferenceinfo.aspx for more information.

PHYSICIAN ASSISTANT OVERSIGHT IN THE MARINES

At the last USAFP Navy breakout, one of our colleagues asked RADM Gillingham about concerns associated with oversight of Physician Assistants (PAs). In addition to performing an investigation, the Surgeon General requested that we share the findings with the FM community. While some minor issues were found and corrected, there were no safety concerns or inappropriate supervision found.

Some findings highlighted the difference between leadership roles and clinical mentoring. Command leadership is responsible for monitoring utilization and supervision of PAs along with their Specialty Leader. All PAs are required to have both a primary and alternate collaborating physician, which the investigation verified. While PA's can be assigned to leadership positions over physicians, clinical quality reviews are a physician role.

Balancing operational requirements and professional development for junior PAs is a challenge. The PA community makes every effort to initially place new PAs in clinic billets to hone their skills, but a minority of PA billets are in clinics. They count on us to mentor new graduates who are sent to operational units along with reviews from medical leadership. All Navy PAs are certified by their governing bodies at graduation, making them worldwide deployable by BUMED regulations.

GRATITUDE

Thank you for all your daily actions in service to our nation. I am honored by this opportunity to provide a voice for our community. Please reach out to me whenever I can be of help with questions or advice or connect you with other colleagues who can. Stay well, friends, and I wish you a safe and happy holiday season.

V/R, Mike

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Concierge Physicians and the Good Doctor

Wayne Lipton, Managing Partner, Concierge Choice Physicians

A touching tribute from a journalist to the physician who saved her life as a teenager was printed in the *Wall Street Journal* not long ago. The article, titled "The Endangered Good Doctor," discussed the life of Dr. Burton Lee, a renowned oncologist who was famous for his clinical approach with patients. He treated the journalist when she was diagnosed with Hodgkin's disease, and continued to treat her until he passed.

Dr. Lee approached his cases by getting to know the patient as a whole. He felt that a human connection was essential to curing disease. Dr. Lee's very personal style of medicine is described as "endangered." And yet, there are many physicians who still believe in the doctor/patient relationship and work hard to carve out the time for face-to-face patient interaction amid the current culture of depersonalized medicine, and ever-increasing mandates.

We cannot underestimate the calling of medical service. Many doctors and nurses see themselves as life support to patients, who are often at their most vulnerable when they come to visit. Despite doctor shortages and increasing demands, doctors still want to practice medicine in the old-fashioned, highly personalized style. Patients still want that kind of treatment and support from their doctor, which is how concierge medicine came to be.

Concierge medicine gives doctors the time to reassure, hold hands, make a few extra phone calls, personally review lab tests, and answer patient and family questions. This kind of attention and care is not reimbursable by Medicare or any other insurance, but it is invaluable to families, particularly those who are suffering from a chronic condition or seeing multiple providers.

It's also invaluable to today's physicians, many of whom work under extreme pressure. Declining reimbursements, increasing overhead and physician shortages have forced physicians to increase their pace and see more and more patients.

Concierge medicine takes that pressure away for patients and physicians. Doctors with concierge practices collect a membership fee from patients, allowing them to see fewer patients each day and, therefore, to take their time. Patients get the support they need, and physicians get to practice a highly satisfying, relaxed form of medicine.

As a concierge physician nears retirement, their career is extended because the financial burden is eliminated, and their pace is manageable. The patients they treat trust and value their physician's counsel. **The only pressure concierge physicians feel is to find a suitable replacement who will treat their patients with the same dedication, care and support they provide.**

Concierge medicine has been around for more than 20 years. It has continued to increase in popularity, particularly in this last year. The pandemic has proven to medical consumers that there is no substitute for a physician who knows them, and whom they trust.

We survey thousands of patients annually to understand what they value as members in their physician's concierge program. The stories we have amassed from patients whose lives were saved by the personal approach of their physician are endless. There is no greater satisfaction for a physician than to hear that patients are "beyond grateful" for the care and attention they provide, or they are an "angel sent from heaven to bless their life."

The additional revenue that a physician earns in concierge medicine is what makes this kind of time and attention possible. But the physician's personal satisfaction exists outside of the money—it's an answer to a calling that is constantly being threatened in today's high-pressure healthcare marketplace.

Concierge medicine allows doctors to play the supportive role that Dr. Lee played in the journalist's life—counseling her not just on health, but on life choices, with passion and conviction, like a trusted friend and confidant. The "good doctor" is not endangered, it's been reinvented.

CONCIERGE CHOICE PHYSICIANS

If you'd like to learn more about concierge medicine, or if you'd like information on partnership opportunities with concierge physicians nearing retirement, contact: Michele McCambridge, CCP SVP, at mmccambridge@choice.md or visit www.choice.md/doctors.

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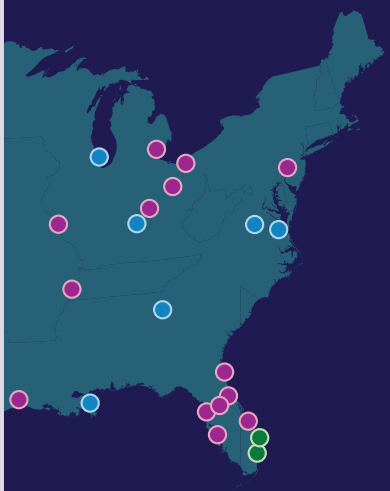

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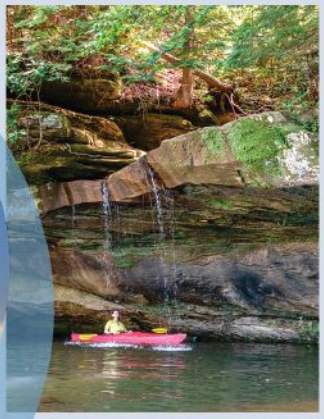

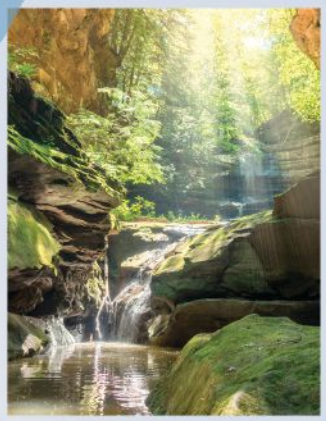

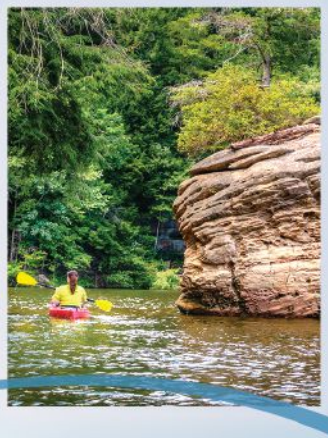

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Mission Command for Medical Corps

Disclaimer: The views contained within this article are those of the authors' and do not necessarily reflect those of Madigan Army Medical Center, the US Army, or the US government.

Introduction: Changes faced by today's military medical leader are simultaneously familiar and continually evolving; The Defense Health Agency transition, MHS GENESIS rollout, and medical force realignment set against a backdrop of a global pandemic and geopolitical instability. Despite this dynamic and challenging operating environment, the Military Health System (MHS) mission remains resolute:

> *To ensure America's 1.4 million active duty and 331,000 reserve-component personnel are healthy so they can complete their national security missions and to ensure that all active and reserve medical personnel in uniform are trained and ready to provide medical care in support of operational forces around the world.*
>
> (Military Health System, n.d.)

How can we as medical leaders support mission success in today's complex operating environment? One framework can be adopted from our brother's and sister's-in-arms: Mission command.

> *Mission command – a key component of the command and control joint function – enables military operations through decentralized execution based on mission-type orders…and empowers subordinates' initiative to make decisions based on the commander's guidance.*
>
> (Joint Publication, 2018)

While principles of mission command have been employed by various leaders throughout US military history, it was not formally adopted as Army doctrine until 2012 (Sharpe & Creviston, 2015). This framework for military leadership enables front-line leaders to make rapid, agile decisions, and to demonstrate creativity in order to adapt to needs on the ground. The principles of mission command are broadly applicable and were adopted as Joint Doctrine in 2018 (Joint Publication, 2018). Applying the principles of mission command is critical for the medical corps leader supporting operational units. In addition, mission command offers valuable principles and lessons to leaders throughout the MHS.

What are the principles of Mission Command? The seven principles of mission command are: *competence, mutual trust, shared understanding, commander's intent, mission orders, disciplined initiative, and risk acceptance.* Here, we will describe each principle, identify how these are applied in the medical corps, and describe what we achieve through use of mission command principles.

COMPETENCE:

> *Commanders and subordinates achieve the level of competence to perform assigned tasks to standard through training, education, assignment experience, and professional development.*
>
> (U.S. Army, 2019)

Competent medical care forms the foundation of the MHS. The trust placed in the medical team by the soldiers, sailors, airmen, families, and commanders we serve is based on our ability to provide competent, high-quality medical care.

We build and demonstrate competence through adequate training, clinical experience, and ongoing professional development. As leaders, we must ensure professional development is prioritized so that military leaders continue to provide the highest quality leadership to the health system.

MUTUAL TRUST

> *Mutual trust is shared confidence between commanders, subordinates, and partners that they can be relied on and are competent in performing their assigned tasks.*
>
> (U.S. Army, 2019)

In medicine, we demonstrate trust by working together as a team to carry out our respective duties to provide patient care. In an operating room, the surgeon trusts the operating room tech to ensure the sterility of instruments. The anesthesiologist trusts the surgeon to communicate key portions of the procedure. The patient trusts the OR team to make decisions and act in a way that ensures their best possible outcome.

Mutual trust enables effective, safe, high-quality, and efficient patient care by allowing each team member to focus on their portion of the patient care task. Trust is built by fulfilling our medical and military oaths and carrying out our duties in a way that is consistent with the military values.

SHARED UNDERSTANDING

> *Shared understanding of an operational environment, an operation's purpose, problems, and approaches to solving problems… along with the flow of information to the lowest possible level, forms the basis for unity of effort and subordinates' initiative.*
>
> (U.S. Army, 2019)

In medicine, we use communication tools such as TEAMSTEPPS, SBAR, and handoff formats to create shared understanding. We use medical terminology to precisely communicate information about our patients. Patient handoffs and huddles are all opportunities to build shared understanding. This shared understanding allows the team to work collaboratively and adapt to changes in the patient's status or within our environment.

COMMANDER'S INTENT:

The commander's intent is a clear and concise expression of what the force must do and the conditions the force must establish to accomplish the mission. It includes the purpose, end state, and associated risks. (Joint Publication, 2018)

In this dynamic time, use of commander's intent is vital to the success of the MHS. Leaders communicate intent by identifying priorities of care and staff safety needs.

Commander's intent allows us to respond to unforeseen changes which impact the clinical care environment. These changes may stem from military operations, disease threats, the natural environment, or the socio-political environment. A clear commander's intent is critical to adapting to the dynamic environment and ensuring our patient care mission is met.

MISSION ORDERS

Army commanders issue orders to give guidance, assign tasks, allocate resources, and delegate authority… Mission orders are directives that emphasize to subordinates the results to be attained, not how they are to achieve them…

(U.S. Army, 2019)

In medicine, we use orders to communicate what must be done for the patient's management to achieve the best possible outcome. Rather than carrying these orders out ourselves, we trust our personnel, their training, and experience to achieve the best patient outcome possible. In addition, as physicians, we are ultimately responsible for the patient care outcome within the system and must maintain this level of responsibility. Therefore, we must ensure that our orders are communicated clearly and effectively, and follow-up on the completion of these orders. Well-written orders incorporate intent and allow all members of the team to perform to their highest level.

DISCIPLINED INITIATIVE

Disciplined initiative refers to the duty individual subordinates must exercise initiative within the constraints of the commander's intent to achieve the desired end state…Leaders and subordinates who exercise disciplined initiative create opportunity by taking action to develop a situation without asking for further guidance.

(U.S. Army, 2019)

Disciplined initiative is a critical component of medicine's culture of safety. When a safety risk is identified, we expect and empower all members of the healthcare team to act immediately to reduce or eliminate that risk. We then identify the root cause of that threat to safety, whether it developed from the patient's condition, the environment, or policies and procedures. Often this results in quality or process improvement initiatives, which demonstrates the role of disciplined initiative in creating sustained improvements in healthcare delivery.

RISK ACCEPTANCE

Commanders analyze risk in collaboration with subordinates to help determine what level of risk exists and how to mitigate it. When considering how much risk to accept with a course of action, commanders consider risk to the force and risk to the mission against the perceived

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> *benefit…An unrealistic expectation of avoiding all risk is detrimental to mission accomplishment.*
>
> (U.S. Army, 2019)

Risk acceptance is inherent to leading in the modern medical environment. To ensure optimal health of the population we serve, leaders must recognize their resources and limitations. Risk acceptance is seen in a commander's decision to declare a Mass Casualty incident (MASCAL). In this situation, the commander accepts the risk associated with an altered standard of care, recognizing the inability to provide the usual standard of care to all casualties given the available resources. For effective risk acceptance leaders must understand and explicitly state which risks exist and are being accepted.

INTEGRATION

The leader has unique responsibilities within the mission command framework. The leader is responsible for creation of an environment which fosters effective mission command. Three principles are the leader's primary responsibility and should not be delegated: Mission orders, commander's intent, and risk acceptance. Without clear intent, orders, or risk acceptance by leaders doubt will develop within the team. Disciplined initiative, trust, and shared understanding are impaired by doubt within individuals. Leader's ownership of risk acceptance is vital to trust between leaders and subordinates. It is the leader's responsibility to clearly communicate their intent and mission orders so that subordinates understand the purpose, desired end state, and acceptable risks associated with the mission.

All mission command principles must be understood and practiced by members of the team for effective mission accomplishment. The seven mission command principles are synergistic with trust among team members forming the foundation of effective mission command. Trust is built and fostered through a shared mental model, disciplined initiative, and competence. The principles of mission command apply to all levels of the military Medical Corps, from direct bedside care through the highest levels of MHS leadership. As medical leaders operating in a complex environment, Medical Corps officers can and should use the principles of mission command to ensure optimal performance of the healthcare team in delivering the highest quality patient care.

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Step into Research with the Omnibus Survey

After two years, I am so looking forward to seeing many of you in Anaheim next March! My thoughts echo a common refrain after a Passover Seder, "Next year, may we meet in Jerusalem!" In addition to reconnecting with colleagues, I always look forward to the research competition. I'm blown away by how much I learn.

While the case reports and case series make me consider diagnosis differently, the studies are the ones that most often change my practice. But where do they come from? Most of us are not Paul Crawford, and lack the drive to run clinical trials while continuing to practice, teach, and grow a truly impressive beard. Yet we still have a motivation to improve practice in our specialty, to meet Atul Gawande's exhortation to "Count something".[1]

The USAFP Omnibus Survey was developed from two major assumptions.

1. Military Family Physicians are worthy of study – our practices, opinions, and values
2. Research becomes more feasible when tasks are offloaded, including
   a. Institutional Review Board approval
   b. Expert validation
   c. Survey dissemination

Over the past five years, we have studied our members' responses in the areas of bedside ultrasound use, transgender patient care, burnout, telemedicine, acupuncture, satisfaction, grit, contraception, breastfeeding, removing the diagnosis of diabetes, running gait training, pharmacogenetics, medication assisted treatment for opioid use disorder, ambulatory blood pressure monitoring, performance of IUD insertions and endometrial biopsies, importance of obstetric care, research posters, imposter syndrome, point of care ultrasound, and systemic racism in medicine. Since researchers are promised one year of exclusive access to results, any USAFP member can request data from any but the last three.

We are once again calling for survey proposals.

Survey research is not easy, as we know from responding to questions that make no sense. I believe the best guide for developing surveys was authored by our military medicine colleagues, CAPT (ret) Anthony Artino, COL (ret) Jeff La Rochelle and COL Kent Dezee, (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4059192/pdf/MTE-36-463.pdf)[2] They list 7 steps to development of a good survey:

1. Conduct a literature review
   How is the topic defined and what theories exist? Are there existing measures? Can you adapt an existing questionnaire?
2. Conduct interviews of colleagues
   Do your colleagues use the same terms and concepts as the literature?
3. Combine the literature and interviews
   Ensure terms and concepts bridge the gap between existing scholarship and military Family Physicians.
4. Develop survey questions
   Usually between 6 and 10, must be clear and unambiguous. See the table for common errors.
5. Conduct expert validation
   Have senior mentors review prior to proposal submission. The Clinical Investigations Committee will also perform this task.
6. Conduct cognitive pre-testing
   Another Clinical Investigations responsibility, this involves determining how respondents will interpret the items compared to the survey team's intent.
7. Conduct pilot testing
   The final responsibility of the Clinical Investigations team, this involves testing the survey on a small sample of potential respondents.

What in the vast world of military Family Medicine are you thinking about? What interest of yours would be advanced by understanding a sample of your colleagues?

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Table: Common Mistakes in Survey Design

Mistake	Explanation
1. Writing Statements	Questions are easier to conceptualize
2. Negatively worded items	"Do you not believe that structural racism is not a problem in medicine?"
3. Biased language	"Is it important to provide trauma-informed care?" ("Are you a bad person?")
4. Responses don't match question	"Is listening to patients important? Never, sometimes, …"
5. Double-barrel question	"How often do you order radiology and specialty consults for shortness of breath?"
6. Too many or too few responses	Four or five usually enables choice without confusion
7. Unequally spaced responses	"How often do you update medication lists? Almost never, seldom, quite a bit, usually."

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committee report
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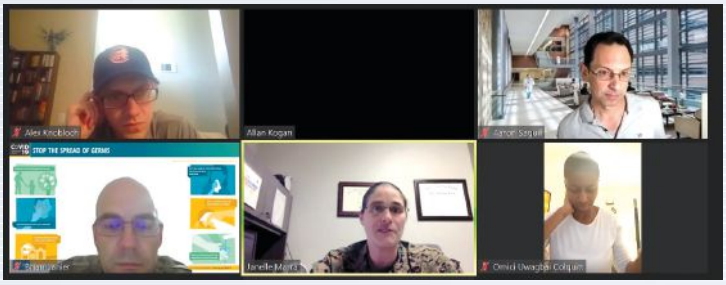
COMMITTEE UPDATE:

As we say goodbye to summer and welcome the fall, we hope everyone is staying safe and healthy. The Education Committee has been busy helping lay the groundwork for some fun and exciting opportunities over the next couple of months.

JOURNAL CLUB:

The Education Committee is proud to be the committee sponsors for one of this year's Better Together Initiatives, the USAFP Better Together Journal Club! The club met on October 21, 2021. It was led by CDR Marra, and discussed her article, Accuracy of the Tuning Fork Test for Determination of Presence and Location of Tibial Stress Fractures in a Military Training Population, published in the July/August Military Medicine!



FALL VIRTUAL GROUP KSA:

One of the Committee's roles is to provide CME opportunities; to that end, we are excited to introduce an additional group KSA outside of the annual meeting. This fall, we will host a virtual group KSA via ZOOM on December 7, 2021, at 1500 EST. Mark your calendars! We will be covering the new Health Counseling and Preventive Care KSA. Scan the QR code for registration information.

FACULTY DEVELOPMENT OPPORTUNITIES

As we move further into the new academic year, many recent graduates or new faculty may be feeling a little overwhelmed. Take a deep breath. That is totally normal! Many of us, including those who are not as new, may be fighting the imposter phenomenon as we try to precept residents who may sometimes know more about a given topic than we do. This is okay. The best way to approach this is to find opportunities for faculty development! Luckily the military supports and provides multiple options for faculty to get these experiences. From single faculty development workshops to fulltime 2-year fellowships, opportunities abound for military teaching faculty to improve their skills. Below are just some of the programs of which fellow military Family Physicians have taken advantage. While this list is certainly not exhaustive, we hope it will lead you in the right direction.

1. **Madigan Leader and Faculty Development Fellowship:** This program is a 2-year fellowship based at Madigan Army Medical Center at Joint-Base Lewis McCord. The fellowship has had graduates from both Army and Navy and is open to all specialties. This 2-year program includes a master's degree of your choice (historically, MPH or MBA, though other opportunities may also be available). Fellows' time is divided between leadership and faculty development (70%) and clinical responsibilities at Madigan (30%). Please see QR code for more information.

2. **Uniformed Services University of Health Sciences Health Professions Education:** This program is open to all three services and has multiple levels of degree options, ranging from an introductory certificate to a PhD in Health Professions Education. The goal of this program is to educate physicians who will serve as academic leaders and who will contribute to the continuous advancement of health professions education. The length of the program ranges based on degree sought. Please see the QR code for more information.

3. **Uniformed Services University of Health Sciences Faculty Development Certificate:** This option is a flexible opportunity for those faculty who are unable to dedicate their time to a full degree program. The program provides education and training focused in the areas of teaching, academic leadership, and research. Seminars are conducted throughout the year at various MTFs, providing credit towards the certificate program. Please see the QR code below for more information.

We are also very excited to learn that USU is now offering an Allyship Program as a faculty development initiative for those interested in pursuing advanced training in the area of diversity, equity and inclusion. Graduates of the program will commit to developing and fostering relationships with students built on trust, knowledge, openness, and accountability through empathetic

conversations, active listening, and non-defensive engagement. It is only open to USU faculty. Those who complete 9 hours of faculty development, along with participation in a journal club, and respond to two reflective prompts, will receive designation as a Faculty Ally. Check out the USU faculty development self-service page using the QR code to learn more information!

4. **University of North Carolina Faculty Development Fellowship:** The UNC Faculty Development Fellowship is an intensive experience that includes 6 weeks in residence in Chapel Hill, NC, spread over the course of the year. It is designed for early career faculty members within the first 3-5 years of a faculty role. Over the last 40 years, the fellowship has graduated over 500 physicians who have gone on to lead and serve as faculty within the discipline of family medicine. For more information please see the QR code.

5. **WWAMI Network Faculty Development Fellowship and Certificate Program:** For those who work in programs or hospitals that are part of the Washington, Wyoming, Alaska, Montana, Idaho "WWAMI" Network, there are two options: an in-person fellowship and an online certificate. Your program must be a paying member of the WWAMI network to access this training, which is provided by the University of Washington Family Medicine Department. See the QR Code for more details:

While there are many more faculty development programs available, those listed above have worked with extensively with military family physicians and are well-vetted resources.

The Education Committee is currently re-vamping our website to provide a repository of CME and Faculty Development resources. If you have had experiences with other Faculty Development programs, please email one of us above so that we can add it to the site. Stay tuned for the new resource site, which will be available this winter!

committee report
MEMBER CONSTITUENCIES

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10 Year Anniversary of Repeal of Don't Ask Don't Tell

On September 20th 2021, the military celebrated the 10-year anniversary of the implementation of the repeal of Don't Ask Don't Tell, marking a decade of open service of Lesbian, Gay and Bisexual (LGB) service members. Between 1993 and 2011, an estimated 13,000 service members were discharged for having a minority sexual orientation, minority gender identity, or HIV+ status. An estimated 100,000 service members were discharged between the period of WWII and the implementation of the repeal in 2011. Many of these service members were given other-than-honorable discharges, affecting their ability to obtain care at VA hospitals, utilize VA loans, or utilize their GI bill benefits. Open service of transgender service members beginning in 2016, was temporarily reversed from 2019-2021 and reinstated by executive order in January 2021.

"On this Day and every day, I am thankful for all the LGBTQ+ servicemembers and veterans who strengthen our military and our nation." - on September 20th, 2021, President Joseph Biden

With open service, the approach to social history, including discussion of sexual orientation and gender identity is even more critical. In a study by McNamara (2021), only 5% of military medical clinicians inquired about sexual orientation. In this study, 76% of service members were out to their medical team, but rates were lower in bisexual service members than gay or lesbian. This study also found that the higher the education level of officers were less likely to be open about their sexual orientation or gender identity. Many resources exist to try to improve cultural competency on LGBTQ+ patients and improve medical communications, including a programs like "Do Ask, Do Tell" https://doaskdotell.org, Project Rainbow Shield, https://modernmilitary.org/portfolio-items/rainbow-shield/ and the AAFP LGBTQ+ Tool kit https://www.aafp.org/family-physician/patient-care/care-resources/lbgtq.html

From my initial commissioning through HPSP, in 2004, to my current position as a regimental surgeon, many things have changed. We have transitioned from "Don't Ask, Don't Tell" to "Do Ask, Do Tell" Military service. I am grateful I can now serve openly as a bisexual female physician, and share my rainbow family with my military family.

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"Even If the Policy Changes, the Culture Remains the Same": A Mixed Methods Analysis of LGBT Service Members' Outness Patterns **https://journals.sagepub.com/doi/pdf/10.1177/0095327X20952136**

Tips for Successful Staff LGBT+ Competency training https://assets2.hrc.org/files/assets/resources/HRC_ACAF_Successful_Training_Tips.pdf

LGBT Training curricula for primary care practitioners: https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula

National LGBTQIA+ Health Education Center https://www.lgbthealtheducation.org/resources/in/introduction-to-lgbtqia-health/type/webinar/

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 Winter magazine is 20 December 2021.

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...
Leo A. Carney, DO, FAAFP,
HQMC – Health Services
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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.

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Student Director Report on the Virtual 2021 AAFP National Conference

The virtual 2021 AAFP National Conference of Family Medicine Residents and Medical Students this past July re-emphasized issues of health equity and social justice in medicine. The current COVID-19 pandemic has highlighted existing health disparities in healthcare access, disease vulnerability, and health outcomes in the United States. Following this focus, the conference honed in on aspects of how family physicians are well suited to address these complex systemic issues given their unique positioning and malleability.

The uniformed family physician or medical student may pause to question how applicable these messages are for the military or other centralized health systems, designed to deliver equal care to its beneficiaries. Furthermore, uniformed family physicians and students serve within a framework predicated on equal pay across grade levels and meritorious advancement. It would therefore seem health equity and social justice for uniformed healthcare personnel should be less concerning in comparison to their civilian counterparts.

In some facets, access to a centralized healthcare system does seem to reduce or eliminate healthcare disparities when compared to the general population. Under the Military Health System, for example, racial disparities in lung cancer survival are decreased, and colorectal cancer screening rates have been found to be higher among black Tricare beneficiaries compared to white beneficiaries.[1-2] Improvements were also seen in racial disparities among patients initiating HAART therapy or PCP prophylaxis for HIV treatment and prevention, as well as treatment for PTSD, depression, or alcohol use disorder.[3-4]

Yet within the same system, racial disparities persist for outcomes of conditions such as traumatic brain injury (mortality)[5] and breast cancer (stage at diagnosis, receipt of chemotherapy and/or hormonal therapy, and mortality after breast-conserving surgery).[6-9] Chronic conditions including hypertension, hyperlipidemia, and diabetes continue to be more prevalent among minority beneficiaries,[10] and even measurements of health literacy like contraceptive knowledge may be disparate.[11] Additionally, socioeconomic differences among MHS beneficiaries affect health, as lower military pay grades are associated with a higher prevalence of smoking,[12] and veterans with lower incomes show a higher rate of oral/dental concerns.[13]

Knowing centralized healthcare does not automatically achieve health equity, the question then becomes how uniformed family physicians and medical students may strive for improvement? At the AAFP National Conference, several speakers offered solutions and hope to make strides in this area.

1. IDENTIFY PERSONAL BIASES.

In their presentation "The Importance of Self-Awareness in Healthcare", Drs. Wright-Jones, DO, FACOFP and Zawilinski, PhD so eloquently posited: "Do you have a brain?...Yes...You have bias."[14] By acknowledging that one inherently has bias, one can start to move from a place of humility towards better health equity. Rather than simply going through results of one's own Implicit Association Test statically, biases should be reassessed continuously as an intentional reflective practice.

As Dr. Ravi, MD, MPH, MSHP cautions in her presentation "Addressing Extreme Health Inequities: Transforming Principles into Practice", clinicians may erroneously label someone as a "difficult patient", "poor historian", "borderline", "frequent flyer", or "another pain patient" to someone with a history of severe trauma.[15] When such character-based judgments about a patient arise, one can then consciously scrutinize those thoughts. Perhaps more information about the patient's history or present situation needs to be obtained for better overall individualized care.

2. INCORPORATE ANTI-BIAS AND HEALTH EQUITY CURRICULA INTO MEDICAL EDUCATION.

In a presentation by students Deborah Fadoju and Rosevine Azap with Dr. Olayiwola, MD, MPH titled "Sounding the Alarm: Six Strategies Medical Students Can Use to Champion Anti-Racism Advocacy," this may take the form of removing "race-based medical misinformation,"[16] or specifically including teachings on social determinants of health, as suggested by Dr. Johnson, MD, MPH in their presentation "Equitable Medicine:

Fighting the Effects of Social Injustice on Health Disparities."[17] Furthermore, new medical knowledge can also be influenced through "anti-racist publishing", as Drs. Sexton, MD, FAAFP, Crichlow, MD, FAAFP, and Schrager, MD, MS describe it in their presentation "The Path Toward Social Justice: the Role of Family Medicine Journals."[18] This encompasses efforts to include diverse authors and staff, publish content about race/racism, and identify/correct misconceptions about race in research and publications.

3. CREATE POLICIES AND RELATIONSHIPS WHICH ENCOURAGE SOCIAL JUSTICE.

Dr. Ravi describes how a clinic's late-arrival policies or delayed scheduling of occupational health-related visits might adversely affect patients who are socially disadvantaged.[15] Intentionally reviewing policies in this light might reveal possible amendments to improve access and outcomes. Additionally, supporting collegial relationships among those Underrepresented-in-Medicine through platforms such as mentorships, pipeline programs, or committees may open the space for dialogue and action to further social justice within the health professions.

Perhaps some of these ideas from the AAFP National Conference give one pause for reflection or a moment of inspiration. Ultimately, more equitable healthcare to servicemembers is paramount to the USAFP mission of advancing joint readiness. Hopefully it moves one to find a small action that can be taken toward health equity and social justice as a uniformed family physician or medical student.

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RADICAL CANDOR: BE A KICK ASS BOSS WITHOUT LOSING YOUR HUMANITY

BY KIM SCOTT

Last year, I started my review of *Brave New Work* by saying, "The year 2020 has been one for the books." Unfortunately, 2021 seems to be well on its way to making an even more unique mark in history. As leaders, we have the responsibility to be creative, innovative, and dependable, taking the curve balls as they fly, while leading a team of human beings with their own unique personal and professional lives. 'Radical candor', as explained in great detail by Kim Scott in her book, is a tool that every leader can use to hold their team accountable while also caring for them personally.

Kim Scott led multiple teams at Google before being hired by Apple to create a course on leadership and management. She has also served as an executive coach for CEOs of companies such as Dropbox and Twitter. With all of her experience, she wrote this book, full of amazing ideas and tangible recommendations, to improve your leadership style. The book has so many awesome concepts, but I would like to focus on the main concepts of what 'radical candor' is and then the concepts of 'rock stars' and 'super stars'.

First, she poses to questions to evaluate how well you are managing your people:

-How well did you challenge them directly?

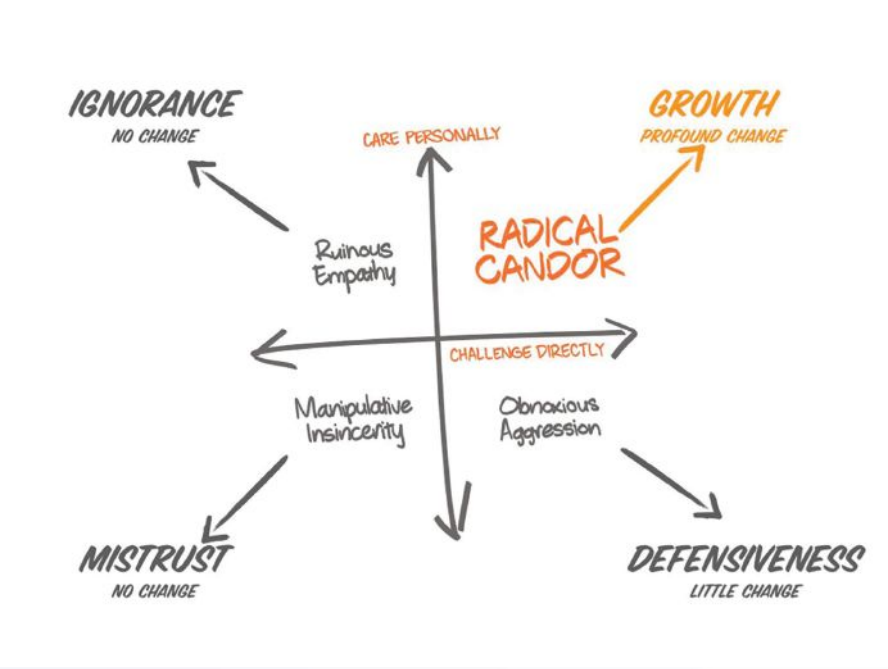
-How much did you care about them personally?

Challenging directly involves telling people when their work needs to be better, and when it is great, or giving the tough feedback, sometimes even firing someone. Caring personally means 'giving a damn' as Scott puts it. It means sharing more than just your professional self. If you do either of these poorly then you find yourself in one of the less impactful quadrants. She breaks it down like this (image 1):

1. **Manipulative Insincerity**: The leader is bad at challenging people and does not care about them. These leaders are the ones that will tell someone they did a nice job, when they really did a terrible job, just to get them out of their face. As you can imagine, this will result in reinforcing bad performance for the employee and the organization. Most employees will see through this and you will lose their trust which results in no change.

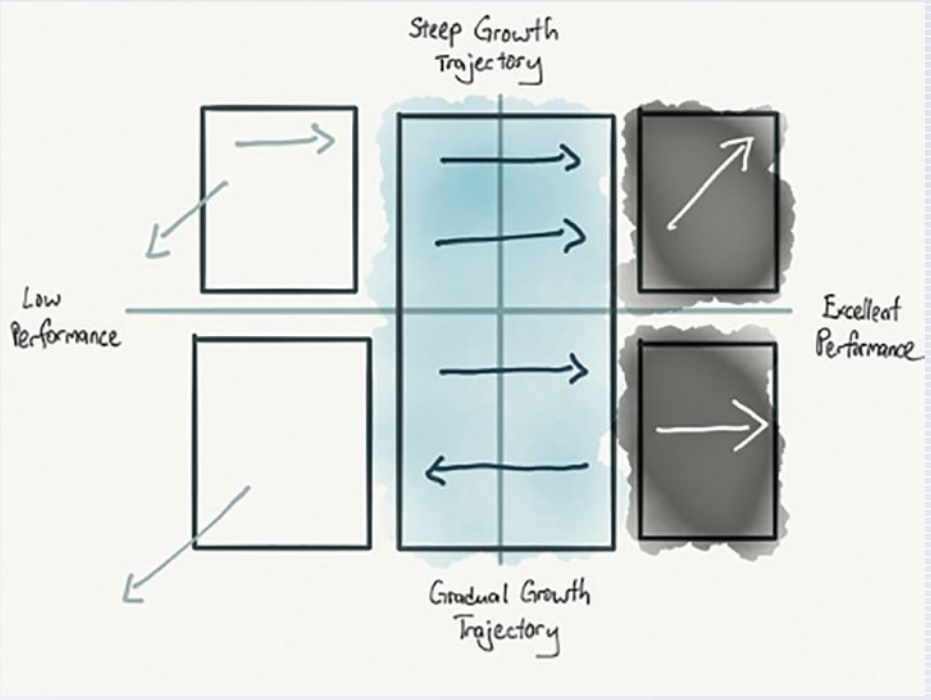
2. **Ruinous Empathy**: The leader is great at caring personally about people, but lacks the ability to challenge them directly. As the quadrant name suggests, this will ruin both you as a leader and your subordinates. People need to know what they need to work on or your organization simply won't improve. This leads to ignorance and no change.

3. **Obnoxious Aggression**. The leader is great at challenging directly, but lacks the empathy to care personally. Basically, you are a jerk. What is interesting is that Scott describes this as the second most successful form of feedback. This



is because these leaders actually give feedback, which is essential for effective leadership; however, being obnoxiously aggressive leads to defensiveness and less change than if you also cared about your subordinates.

4. **Radical Candor**: The leader challenges employees directly because they care personally about the employee and want them to perform to their potential. This is what the entire book is basically about and can result in growth for the employee and organization with big change. She gives GREAT ideas on how to do this. For example, if you are someone who doesn't do well with subordinates who cry. She recommends keeping bottles of water in your office and when the employee starts to cry offer a bottle of water and excuse yourself to go get some tissues for the employee. This gives them time to get themselves together. Of course, if you don't mind the tears, that is fine too.



Scott recommends that you use Radical Candor with praise and criticism. She recommends starting with praise for subordinates and then offering them the opportunity to give radically candid criticism to you. If you have a team that is hesitant to give you criticism, she recommends the following:

1. Don't let people off the hook when they try to refuse. Use silence to get them to say something.

2. Reward them for their criticism. Give them praise and actually do something to address what they have told you.

3. This can be done in one to two minute conversations between meetings, patients, etc.

As you can imagine, using Radical Candor takes practice and it is okay if you find yourself in some of the other quadrants from time to time. Most of us have a quadrant that we tend to lean towards. It is good to know so that you know what to work on as you try to improve. One of the concepts that really resonated with me was the concept of rock stars and superstars.

The leaders described in these quadrants are largely the focus of the book, but Scott also describes that your subordinates and teammates are one of two types of people. They are either rock stars who are on a slower growth trajectory or they are super stars who are on a steep growth directory. This may be a little confusing as we often think of rock stars and super stars as the same, but I love how she describes the rock stars as the back bone of your organization. These are the people who are happy to come to work and do their job. They do it well and meet your expectations, but they have no interest in quick promotions, doing extra work, trying to climb the ladder, etc. She describes superstars as the employees with a steep growth and career trajectory. These are the 'go getters' who want the challenge and to climb the ladder. She describes how to intentionally use their talents while you have them so you can support their movement upwards. My favorite part is that both rock stars and super stars are still expected to have excellent performance (see image 2) and that it is okay if your subordinates are a rock star sometimes and a super star at other times. Life happens and sometimes you need to be able to be flexible. She goes on to discuss how promoting a rock star can be detrimental. I have used these concepts with resident advisees. I explain the concepts and ask how they identify. Then based on their answer, I know how much to try and push them. Again, I expect excellent performance from all of them, but it is okay if some don't want the extra publications, responsibilities, and duties. She describes the conversations she has with new employees in detail and how to use that conversation to build trust and to evaluate if they are interested in being a rock star or superstar.

These concepts are just a few of the many that Kim Scott explains in the book *Radical Candor*. She really outlines amazing tools to allow you to care personally for subordinates and challenge them in a meaningful way. I highly recommend reading it to gather even more insights. I plan on rereading every couple of years just to remind myself of her great ideas!

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CALL FOR TALENT

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OMT BEDS NEEDED!

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Please check www.usafp.org for Registration and the preliminary program.

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USAFP Academy Awards

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This honor is bestowed on a Uniformed Family Physician who exemplifies the tradition of the family doctor and the contributions made by family physicians to the continuing health of the people in the Uniformed Services.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2022.

Eligibility Criteria:

1. Provides his/her community with compassionate, comprehensive, and caring medical service on a continuing basis.
2. Directly and effectively involved in community affairs and activities that enhance the quality of life of his/her home area.
3. Provides a credible role model as a healer and human being to his/her community and as a professional in the science and art of medicine to colleagues, other health professionals, and especially, to young physicians in training and to medical students.
4. Must be in good standing in his/her medical community.
5. Must be a member of the USAFP.

OPERATIONAL MEDICINE AWARD

This honor is to recognize a Uniformed Service Family Physician that has exhibited outstanding achievement in the provision, promotion or research in operational medical care.

To nominate your peers for this outstanding award, please send a letter of support to Matt Schulte (mschulte@vafp.org) no later than 12 January 2022.

Eligibility Criteria:

1. Demonstrated substantial contributions, dedication, initiative, leadership and/or resourcefulness in providing patient care in any operational environment.
2. Outstanding service, devotion, dedication or compassion while performing his or her duties in any operational environment.
3. Concepts, procedures or methods developed by the nominee which resulted in significant reduction in morbidity or mortality, workload required for mission accomplishment, financial expenditures or material utilization.
4. Involvement in continuing education as a researcher, participant, organizer or sponsor which directly and materially improves operational medicine.
5. Humanitarian or military community involvement that substantially improves the health and readiness of the service member, their families or the supported population.
6. Any other substantial contribution directly related to operational medicine not described above.
7. Must be in good standing in his/her medical community.
8. Must be a member of the USAFP.

Members in The News

USAFP MEMBER LAUREL A. NEFF, DO SELECTED FOR AAFP COMMISSION CHAIR

Congratulations to Dr. Neff on being selected to serve as Chair of the AAFP Commission on Education. This selection was announced during the AAFP's Special Session of the Congress of Delegates September 27-28, 2021. She has served as a member on the commission for the last four years and will serve as Chair for a one year term. The Commission on Education provides a venue for the development of recommended policy and the dissemination of expertise and new information related to the education and professional development of family physicians until completion of the residency training period. Its priority areas of attention include the following.

SCOPE OF WORK

- Workforce - Support the "pipeline" of family physician development, from student interest in family medicine careers to family physician workforce policy. Inform and monitor the development and administration of targeted AAFP strategies that lead to student choice and output of family physicians at a rate that is consistent with the organizational aims and informed by data of public needs.
- Student Interest/Student Choice - Support an understanding of the factors that contribute to student choice of family medicine as a specialty. Facilitate the portfolio of interventions used to promote family medicine careers including communications, admissions/pipeline, role models/mentors, educational opportunities, and medical education financing.
- Student and Resident Issues - Protect the interests and well-being of all students and residents as learners and developing professionals. Increase AAFP resident member engagement and competency in population health by demonstrating knowledge and competency of applying risk stratification to a patient population. Monitor and advise the Board on the impact of changes in the resident clinical learning environment including residency duty hours' restrictions, and provide recommendations regarding pertinent Academy policy.
- Curriculum - Promote the evolution of the training curriculum for family medicine to meet the needs of the future, and support for the infrastructure to provide it. Collaborate with the academic community to develop and maintain curriculum tools and resources that support quality family medicine education. Maintain Recommended Curriculum Guidelines for Family Medicine Residents.
- National Conference - Oversee the planning and evaluation of the National Conference, paying particular attention to the nature and range of education sessions. Ensure the effective and efficient operation of the resident and student congresses. Facilitate the screening process for appointing resident and student members to AAFP commissions and other leadership positions. Cultivate leadership competencies and provide experiences for aspiring and developing family physicians.
- Educational Awards - Recognize the exemplary contributions to the discipline of family medicine through its educators by collecting nominees and make recommendations for national awards.

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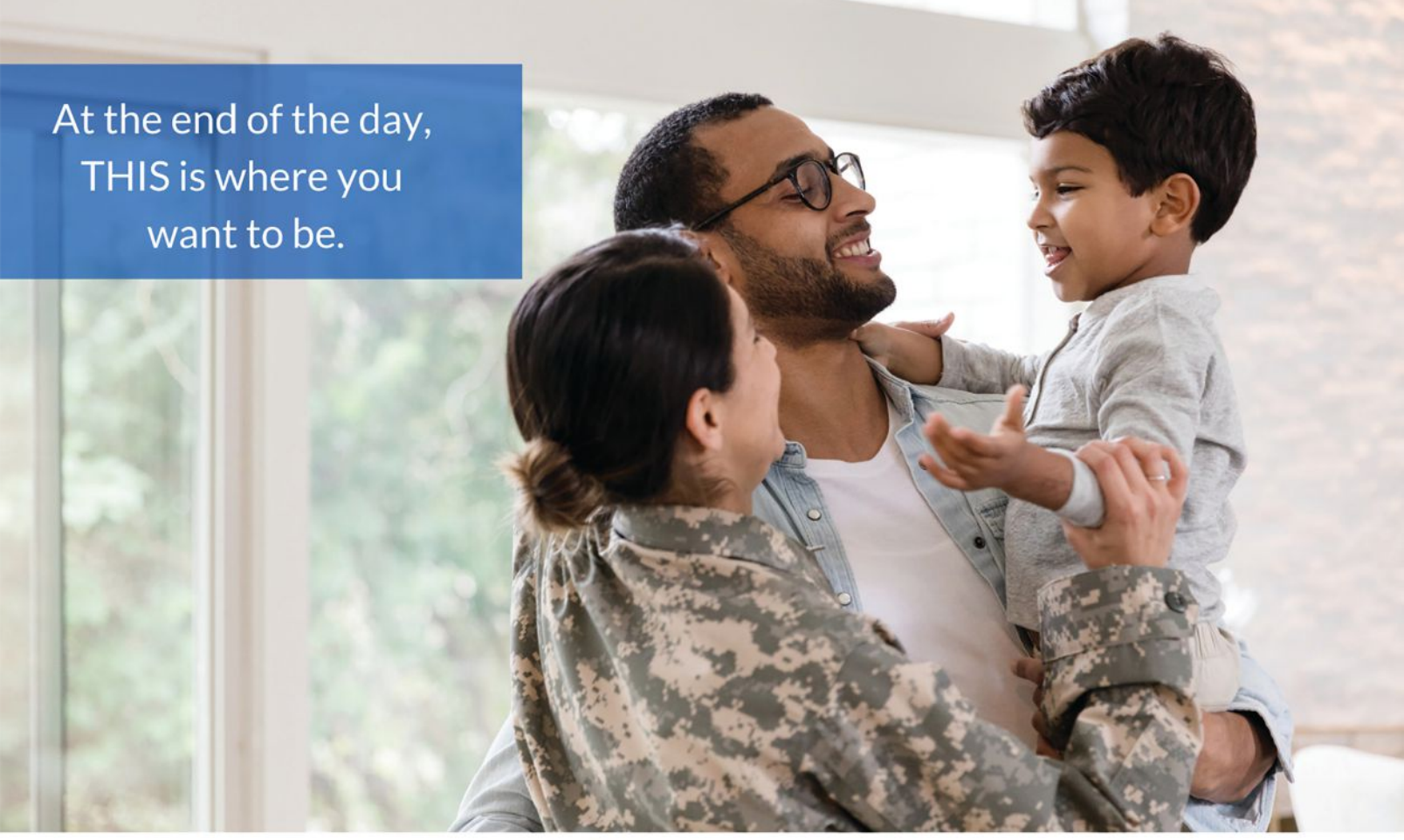

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