THE UNIFORMED FAMILY PHYSICIAN

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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 60

your academy leaders
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Hello and Happy Summer!

The summer is always a time of significant change for Family Medicine across the DoD. Approximately 15-20% of our staff family physicians retire or separate or transition to new jobs and locations. These individuals are replaced by graduating residents who transition to their first staff assignments. Newly graduated medical students exchange places with the recently graduated residents to continue the cycle. Throughout this period of transition, our Family Physician community leans on each other and helps those embarking on a journey that peers and mentors have recently travelled. At our USAFP annual meeting in April, we challenged ourselves to each reach out and connect to at least one or two of our members that might walk down paths that we had already experienced. With the annual meeting now three months behind us, now would be an opportune time to reach out to these members to see how they are doing and to see how you may be able to help them grow and develop. The amount of experience and wisdom residing amongst the USAFP community is unbelievable, so take a moment this month to intentionally share and connect with others in our community.

There is a lot of additional change in the world currently. Many of these changes involve topics where people maintain differing underlying beliefs, cultures, and political views that drive strong opinions and emotions. Unfortunately, this has increased the number of people who are choosing to take negative actions towards people of differing thoughts or backgrounds. The DoD has put out a statement that despite recent national changes, it will continue its current policy and stance, with consistency in policy and process for members, patients and physicians across the DoD. Amongst all of this change and dissent, we have the ability to control our own individual actions. I am hopeful that Family Physicians can continue to be the bedrock of DoD medicine and to be the example to our colleagues, our leaders, our service members, and our communities. While we may have different beliefs and opinions, we must consciously choose to treat everyone, even those with differing opinions, with professionalism and kindness and that our actions and our words will reflect this decision.

You are all incredibly amazing. Continue to set the standard!

We are…Family Medicine!

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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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/**

I hope this edition of the *Uniformed Family Physician* (UFP) finds each of you doing well! With luck, many of you had the chance to enjoy the warm weather, spend time with children or other family and friends, and used the time to recharge your batteries. For many of you, this summer may have meant a change in jobs or even a relocation to another assignment. Whatever your summer experience held, I wish all of you the very best as we move into the new fiscal year.

We are fortunate to have another exceptional edition of the UFP, and I could not be more thankful to the authors who spent their time sharing their wisdom and expertise with the rest of us. Stephen Cagle and Michael Kim provide sage advice for Family Medicine residency staff who are assuming research leadership roles within their programs and remind us that there are numerous resources out there to help those getting started in these crucial roles. Joshua Oliver builds upon the theme of research mentorship as he outlines the importance of research as an activity which mitigates against burn-out, and challenges all of us to start small and to bring new family physicians under our wing in this rewarding endeavor.

On the topic of leadership, Adam Kowalski offers a thoughtful review of the book, *The Power of Positive Deviance*. This work illustrates a powerful approach to solving problems within any organization that has proven sustainable when other commonly used change management methods have failed. Tyler Rogers, Erica Meisenheimer, and Tyler Raymond also explore the challenges of working with staff who lack appropriate motivation. By applying lessons from both the fields of education and business, these authors outline several concrete ways that leaders can address the lack of motivation in members of their team to help them overcome these shortcomings on the way to achieving their full potential.

We are also fortunate to have several articles focused on operational medicine topics. Clay Rabens, Sabrina Kunciw, and Jacob Shook dissect the multitude of planning challenges that accompany the provision of combat casualty care in the Arctic environment. This is an area of growing strategic importance and the authors succinctly identify critical concepts that command surgeons and other operational medicine leaders must consider when caring for patients in the extreme cold. Finally, the Operational Medicine committee launched a new series focused on USAFP members serving in operational medicine assignments. A special thank you to Roselyn "ICON" Fuentes, an Air Force Flight Surgeon, for sharing her impressive assignment history and for highlighting how well-suited family physicians are for supporting our warfighters. This series promises to provide a more personal connection with our fellow family physicians from all services who fill these crucial roles.

Thank you again to these and all the rest of our talented contributing authors. As our 2023 Annual Meeting Co-Chairs, Becca Lauters and Dave Garcia, so eloquently state, "We Are…Strong, Diverse, and Flexible. We Are…Family Medicine!"

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John Lay, MD
LTC(R), US Army
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consultant's report
NAVY

Michael J. Arnold, MD, FAAFP
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Greetings, Navy Family Medicine colleagues! It was so great to see many of you at the USAFP Meeting back in March. Since then, so much has changed. The Deputy Surgeon General (DSG), RADM Shaffer, has retired as she warned she would when answering our questions at USAFP, and RDML Hancock is retiring soon along with many of our Family Medicine colleagues that I consider mentors. Our new Corps Chief is RDML Valdes and our own Teresa Allen is just relieving as his Deputy.

DIVESTITURES FADING AWAY?

Reports on the National Defense Authorization Act (NDAA) for Fiscal Year 2023 suggest that Congress will delay any reduction of medical personnel for three more years. After two single year moratoriums, there seems to be an acknowledgement of the lack of promised civilian replacements on which the reduction plan always depended. Our outgoing Corps Chief has been reassuring us that our senior leadership is fully aware that divestitures cannot be implemented as planned without threatening our mission. Unfortunately, the budgeted savings from divestitures has been spent, and the money has not yet been added back through the NDAA.

PROMOTION – FAMILY MEDICINE FEELS THE LOVE

We recently saw the O-6 promotion list and are still awaiting the O-4 and O-5 promotion results at the time of this writing. Congratulations to the following officers in our Family Medicine community who were selected for promotion!

Wendy Arnold
Shari Gentry
John Laird
Jason Palmer
Francesca Cimino
Carlos Gomez-Sanchez
Victor Lin
Janet West

	In Zone			Above Zone			Below Zone			Total Select Rate	
Rank	#	% in FM	% in MC	#	% in FM	% in MC	#	% in FM	% in MC	FM	All
CAPT	4	80%	67%	3	33%	22%	1	5%	1.5%	57%	43%

The positive statistics for our specialty demonstrate that our contributions are being recognized. The promotion opportunities for all physicians went up both in-zone and above-zone, and the opportunities for Family Medicine consistently went up even more. Only General Surgery, Neurosurgery, Orthopedics, Emergency Medicine and Aerospace Medicine had higher O-6 promotion rates than Family Medicine this year, and nearly all were within a few percent points.

The Career Pathway for Family Medicine 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 Naval War College courses that can be taken remotely, is included on both promotion board instructions and the career pathway.

I reached out to colleagues who were not on this list and I encourage anyone who is worried about an upcoming promotion board to contact both myself and Shari Gentry as early as possible. I worked with many of colleagues this promotion cycle to get letters to the board that would improve their chances, and I hope to do more next year.

ASSISTANT SPECIALTY LEADERS – MAYBE NOT A VILLAGE BUT MORE THAN THE ONE OLD MAN

We finally advertised for Assistant Specialty Leaders (ASL). We are the largest specialty in Navy Medicine, and many smaller ones have ASLs. I'm excited to ensure we have a larger team to advocate for individuals and for our specialty. As of publication, applications were still coming in. The decisions will be made by RDML Valdes.

BONUSES – WHEN TO PULL THE TRIGGER?

The most challenging question I receive from colleagues is the question of whether the six-year bonus is coming back next year. The difference between $38k annually for a four-year extension and $50k annually for a six-year extension is significant. The upcoming pay changes are not available at this time. As the DSG told us, BUMED sees the bonus as a retention tool, not an assessment of importance or demonstration of love.

We know that many of our service colleagues have the six-year bonus option, but when that came up in discussion with the Corps Chief and DSG, it did not seem like service equity was a key planning factor. Manning levels, however, do appear to play a role.

The latest BUMED manning report has Family Medicine manned to 91%, but that is artificially high with the bolus of on-time residency graduates and without deducting those officers separating or retiring from the service. We are predicting as low as 89% manning levels when the dust settles. However, that is still more than many other specialties including Emergency Medicine (86%), Occupational Medicine (86%), Anesthesiology (72%), or Surgery (67%) and similar to the specialties of Obstetrics, Preventive Medicine, and Orthopedic Surgery.

For folks who are eligible for a bonus in FY 2022, my conservative advice is to take the four years on the table now. If the six-year bonus comes back next year, you will be ahead through Year 3 and by Year 4 will only be $6k behind. If the six-year bonus doesn't come back, you will just carry a $38k loss for four years and be delayed in renewing by a year. With inflation on the rise and the growing need for additional Family Medicine positions from GMO conversions, I'm betting that bonuses rise dramatically several years from now.

But what do I know? I'm not exactly writing to you from my own Caribbean island, and the only time I consistently pick up the check is when we eat out with my adult daughter and her new husband.

My goal is to have orders ready early in the new year.

Regarding OMO billets, we are still deciding on how those will be detailed this upcoming year, but you should expect a call for applicants for anyone interested in an OMO billet and some billets will likely be on the Family Medicine ranking list this fall.

I encourage my colleagues to be open to the multitude of opportunities coming available, take on new challenges, be ready for change and enjoy a career with a myriad of experience. Please reach out to me any time with any questions or concerns you may have.

Shari Gentry, MD, shari.l.gentry.mil@us.navy.mil.

DETAILER UPDATES

Greetings Navy Family Medicine!

I would like to take an opportunity to introduce myself as the new Family Medicine detailer. I am Shari Gentry and I have had an incredible career with the Navy thus far, never leaving any opportunity on the table. I have been at three major Medical Treatment Facilities (MTF), have deployed with the Marines and the Fleet, and have spent some time in academic medicine. It is possible to do almost anything in Navy Medicine if you remain flexible and open to the opportunities that present.

My philosophy as a detailer is to help Family Medicine physicians find those great opportunities and professionally mature. I highly recommend taking operational assignments between MTF tours since this will help you to build a network of connections, maintain clinical skills and broaden your knowledge of the Navy we serve.

Priorities for Detailing remain the same from previous years:

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

My plan for the 2023 detailing cycle is to send ranking lists to our Senior Family Medicine Physicians, Junior Family Medicine Physicians and graduating residents in the September time frame. For Senior Family Medicine Physicians, this should be the same time as the Non-Specialty Specific leadership positions and Senior Executive Medicine positions are made available. Milestone packages have already been submitted and selections should be complete.

While I will immediately start working with individuals, a final decision on your next set of orders cannot be completed until BUMED and PERS finalize:

- Non-Specialty Specific leadership positions
- Senior Executive Medicine positions
- CO, XO and Milestone billets
- GME programs
- Operational Medicine Officer (OMO) billets

GME OPPORTUNITIES

For those interested in fellowships, the BUMED GME instruction is out and MODS is open!

1. Sports Medicine – This is our most important need, which is why we have been approved by ACGME to start a Sports fellowship at Camp Lejeune in addition to Camp Pendleton, which is still temporarily approved for four fellows. Our dreams of making the NCC fellowship a tri-service is limited by the same voracious needs in the Army and Air Force (I want so much to insert a joke about the dangers of ultimate Frisbee and poorly ergonomic desk chairs). If you follow the asterisks in the instruction, you'll see that RADS to NADDS opportunities are available, meaning that if you want to put your career on pause for a year and get your own fellowship through the civilian match, we will support that and welcome you back with open arms. While the standards are often high, I have been assured that you do not have to be as cool as Kerry Sadler to be selected.
2. Geriatrics – This is our second time advertising a geriatrics fellowship, and embarrassingly no one applied last year. If you have an interest, please put in an application. This is a full time out-service fellowship, which means we have to argue against surgical and anesthesia fellowships.

I was hoping that my multiple attempts at persuasion would have added an FM-OB slot, but the BUMED numbers guy held me back. They only list a requirement for two and we have eight, with two that are currently serving as COs. I'm working to try to convince them to increase the requirement in the future.

GRATITUDE

Thank you for all your daily actions in service to our patients and our nation. I continue to be honored by the opportunity to provide a voice for our community and try to help my colleagues. Please reach out to me whenever I can be of help with questions or advice or to connect you with other colleagues. Enjoy your summer.

Thanks, Mike

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You Are a Research Mentor!

Disclaimer: The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government. I do not have any relevant financial conflicts of interest

"How far that little candle throws [its] beams! So shines a good deed in a weary world."

-William Shakespeare, The Merchant of Venice

At the mid-point of my Army career, I am very grateful to be in my current position. As the Research Director within a residency program, I have the opportunity to influence many young physicians and encourage them to pursue careers in academic medicine. However, there were many times when my research career failed to launch. During my undergraduate and medical school education, I tried repeatedly to break into research without success. The problem was not a lack of effort. The problem was I did not know where to start. I needed a research mentor.

That all changed during my intern year of residency when one of my faculty mentioned that a patient we were taking care of represented a great case report and that they

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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.

Uniformed Services University and Walter Reed Army Institute of Research joint Program *with optional rotations overseas*

Fellowship Highlights:

- Conduct cutting edge drug development research across multiple specialties including COVID-19, Pain Control, Antibiotic Resistance, Warfighter Performance.
- Three month rotation with the FDA reviewing drugs in development and/or already approval.
- Robust Didactics and Immersive training to expand your future career potential.

Current Research Interests:

- Applying pharmacogenomics to evaluate risk to warfighter rediness and optimize patient care.
- Using state of the art pharmacometric analysis to determine drug dosing optimization under military relevant conditions such as blast, burn and exercise.
- Rapidly evaluating drugs to repurpose for military medical gap solutions.

Fellowship Eligibility Requirements:

- Active Duty Army PhDs (71A or 71B)
- Active Duty Army PharmDs
- Active Duty Army Physicians Board Eligible/Board Certified in Any Specialty

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usarmy.detrick.medcom-wrair.mbx.clinical-pharmacology-department@mail.mil

ARMY MEDICINE
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were willing to mentor me through the process of writing it and submitting it for publication. As a result of that mentorship, I learned what type of cases are publishable, how to conduct a literature search, how to write scientifically, and how to submit a publication to a peer-reviewed journal. Simultaneously, my mentor walked me through the process of turning that case report into a poster presentation and submitting it to a conference. These were all big wins.

The most important lesson that my research mentor imparted, however, was that I needed to pass on what I had learned to other residents, and that I now had the experience, I had an obligation to mentor others through their case reports and poster presentations. There are those who will minimize the value of case reports, but they are a great way to break into research and learn the fundamentals of the process. If you have published a case report, you are qualified to be a research mentor. After taking up the mantle of research mentorship, you may be surprised how far your candle throws its beams.

If the sentimental introduction did not pull at your heartstrings, a more practical reason to become a research mentor is that it will make you a commodity and give you more control over your military career. It will also make you more competitive for academic positions after leaving the military. Since graduating from Emergency Medicine residency, I have been lucky enough to remain faculty within a residency program. Experience tells me that this is because of early involvement in research. Despite being at an academic center, there are simply not enough faculty involved in research. Indeed, one of the most cited obstacles preventing residents from doing research is the lack of mentorship.[1–4] Yet, the production of scholarly activity remains a requirement for both residents and faculty within a residency program.[2] Demonstrating an aptitude for research mentorship will make you stand out to residency program directors and department chiefs when applying for academic positions.

"If you have published a case report, you are qualified to be a research mentor."

From the perspective of my own mental health, research also provides a complement to patient care. It has been very well documented that the medical profession is associated with anxiety, depression, and suicidality—or what is collectively called burnout.[5,6] Having a sense of purpose is protective against this burnout.[7] I love what I do, but if my only professional outlet was patient care, I suspect I would be much more susceptible to burnout. The additional sense of purpose I gain from research mentorship is incredibly fulfilling and protective. In discussions with friends and colleagues from other specialties, I doubt very much that this is a sentiment unique to the practice of Emergency Medicine. That sense of purpose is something that can be passed on to our learners through mentorship thereby protecting them from burnout as well. Research, therefore, may not only be protective against the mental health consequences of burnout; it may also prevent physicians from leaving patient care as a result of burnout.

Another concept that has come to prominence within graduate medical education is Diversity, Equity, and Inclusion (DEI). Recently, the Accreditation Council for Graduate Medical Education has included the concepts of DEI within the core competency of professionalism.[2]patient care (both inpatient and outpatient This means that as faculty we are responsible for teaching and modeling DEI. As someone who is white, male, and heterosexual, it can be difficult to determine how I fit into that education. However, when I reflect on who my fellow research colleagues are, the majority of them look like me. Indeed, multiple studies of the demographics of researchers demonstrate that physicians that are members of minority groups are less likely to pursue careers in research.[1,8] When you are offering to mentor learners through their first case reports, consider to who you are making that offer. All learners need our help, but I would ask you

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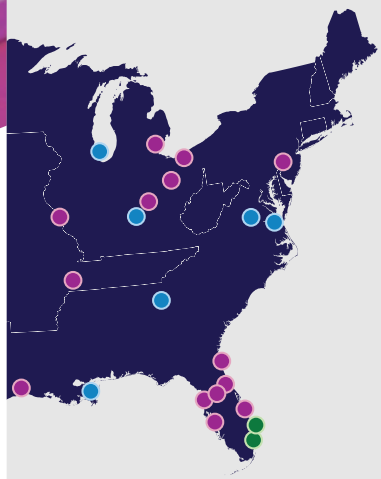

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to reflect on the following question. Are you extending that offer to those who do not look like you? The intent of that question is not to shame you, as it is an area where I need to improve as well. The intent is to highlight an opportunity to improve DEI within your department.

Hopefully, I have piqued your interest in research mentorship. As a closing thought, I would like to leave you with some simple advice on starting your journey as a research mentor. If you come to work every day with the intent of finding interesting cases, you will find them. This is an easy way for you to create opportunities for your learners. Becoming a research mentor is as simple as that. If you can do that, you will have a large impact on your learners' careers. "So shines a good deed in a weary world."

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Research Mentor: Fake it 'til you Make it or is there a Better Way?

Are you the director of the research curriculum at your residency? Does your program have a Research Director? Have you ever taken a step back and thought "are we utilizing this role in the best way that helps us fulfill our mission?" What kind of person makes the best Research Director at a residency? These are the questions that face residency leaders as they explore ways to promote vibrant research programs for their residents. Unfortunately, there is little evidence on the most effective way to train and recruit faculty and residents in promoting scholarly work within a Family Medicine residency. One thing that is clear, however, is that identifying a Research Director is a critical component to promoting scholarly activity in a program and enhancing a curriculum in evidence-based medicine. The USAFP also firmly believes in the importance of this role and the Clinical Investigation Committee helps fund a local research mentor from your residency program to attend the annual conference and also hosts a focused workshop for them each year.

BUILD THE TEAM

You may wonder where do I start? First, you need to build your local team. Go grab a battle buddy, wingman, or shipmate to be your co-director! The task of leading a residency research program is a mountain to climb and it is easier to do it with a partner. This trusted colleague can help track projects and mentor residents and junior faculty. As a busy faculty member with numerous tasks, it is impossible to focus on just a singular job. Between deployments, PCS moves, or TDY, every program will benefit from having two research coordinators. You can strengthen the team even further by assigning a senior resident as a "Research Champion." This resident can help communicate what is happening in the program and track upcoming conference submission deadlines. Having a fellow resident communicate an enthusiastic and clear message about the value and enjoyment of research can ensure that scholarship remains a fully embedded element of your program. By building a strong research team, you will be well on your way to making your program successful!

NETWORK

Were you given the job since no else was interested or because you presented once at a conference? Are you struggling to determine where to start? This is a familiar story and experience for many research coordinators. If you are facing a similar predicament, there are numerous resources available to help you. First, reach out to your program director or other residency faculty – they may have some thoughtful suggestions on where to begin. Additionally, consider reaching out to research leaders in other programs to share ideas and stimulate innovation. If you need help connecting with the greater Family Medicine research community, the Clinical Investigations Committee can help – just ask! These fellow research leaders can serve as sounding boards for projects or even provide additional sites for research studies. They also may be doing some things that you could implement. Each program is looking to make their research program as strong as possible and have likely tried different initiatives that may or may not have worked. By capitalizing on this robust Family Medicine research network, you can accelerate getting your program established or launch it to the next level. But wait, if it seems like everyone is new to this and no one knows what is going on, now what do I do?

SEEK MENTORSHIP

Find and seek mentorship. At the local level, reach out to senior mentors in your program. Many of these individuals will have experience and insight with research and scholarly activity from their career in academic medicine. Utilize the Military Primary Care Research Network at the Uniformed Services University (USU), USU faculty, or the Clinical Investigation Committee judges. All information can be found on the USAFP Research website: https://www.usafp.org/research/. All these resources were built with you in mind - the 'boots on the ground' family physician practicing and teaching full spectrum Family Medicine who wishes to pursue and embed scholarly activity into their programs.

DEVELOP A TRACKING SYSTEM

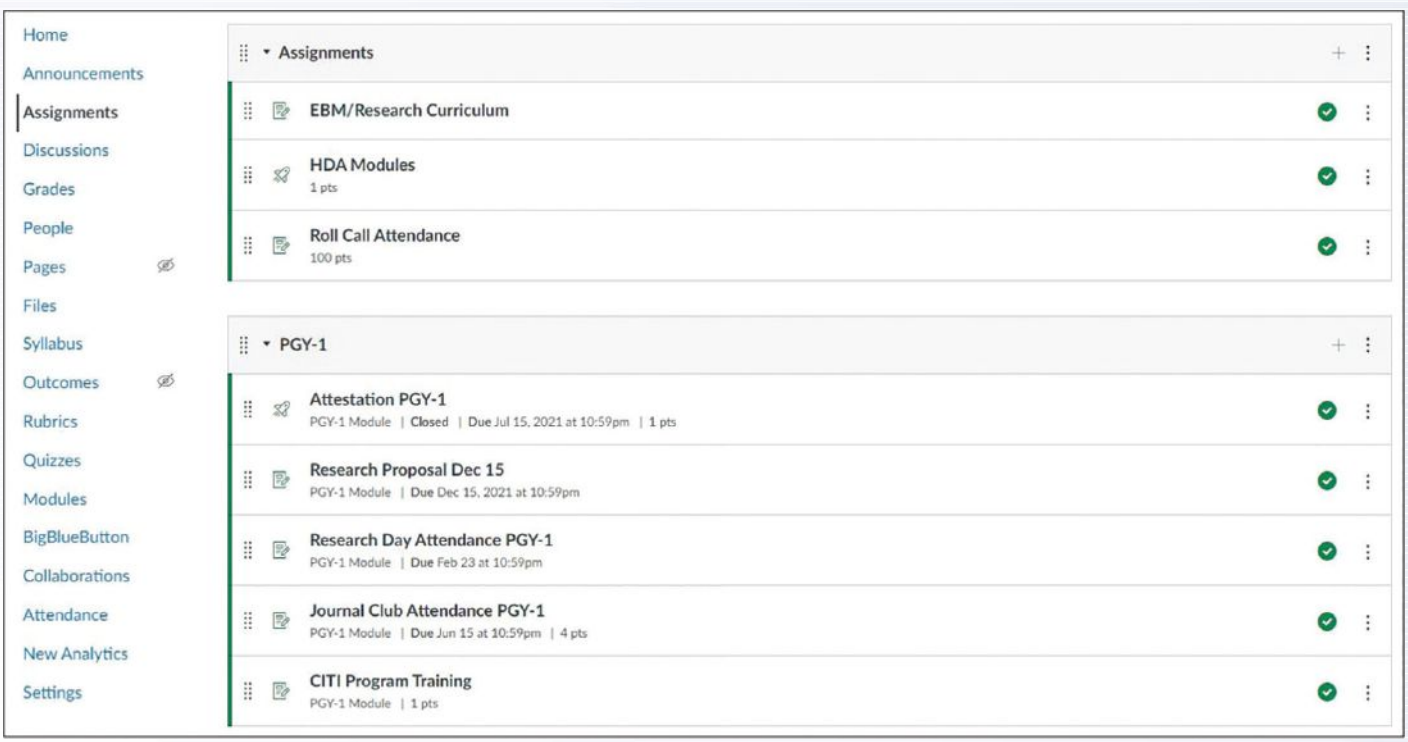
To be successful, it is imperative to develop a system for tracking research and other scholarly activity efforts. Historically, research tracking has been accomplished with Excel spreadsheets and frequent email exchanges. This approach can be quite cumbersome for busy family physicians with so many things to do. Fortunately, there are useful tools available to streamline your research tracking efforts. One which we have found useful is Canvas, (www.instructure.com/canvas). Canvas is a free e-learning platform that allows you to build assignments and reminders that automatically go out to the learners and allows them to upload completed assignments online. Figure 1 provides an overview of the types of information that can be tracked in Canvas.

Like with many useful tools, the initial setup of your Canvas account can take time, but once complete, it allows automation of many key research management tasks, including sending regular reminders to residents about upcoming due dates, and tracking their progress toward completing their scholarly activity requirements for graduation.

BE PERSISTENT

Lastly, no matter where you are starting from, remember that establishing a successful research program in your residency can take time. You do not have to be a full-time researcher or accomplished grant writer to be an effective research leader. You simply need the passion and determination to incorporate the ideas highlighted above to gradually build your program. There will inevitably be some setbacks, but it is critical to stick with it! In just three short years, we helped transform a program from low levels of scholarly output to achieving the coveted USAFP's Scholarly Activity Award! By building your local team, establishing a network, finding mentors, employing a tracking system, and staying persistent, you, too, can propel your research program to new heights!

Figure 1



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Should you take over a concierge medical practice?

A Q/A that will help you decide if you're right for concierge care

Wayne Lipton, Managing Partner, Concierge Choice Physicians

What is concierge medicine?
Concierge medicine is a style of practice where patients pay a monthly or annual fee in exchange for more time with their physician, greater support, convenience and connectivity. In short, it's a highly personalized form of medicine built on a strong doctor/patient relationship.

Why choose concierge medicine?
Concierge medicine is considered a highly satisfying style of medicine for physicians because it allows them to practice an old-school style of medicine, where they can spend as much time as necessary with patients, without the pressure of volume care or big box medicine. The annual fee they receive allows them to maintain a lucrative, but smaller patient panel with greater independence and control, without sacrificing revenue.

Patients report high levels of satisfaction with their concierge doctors. They appreciate being able to easily connect, get support managing their treatment regimens from all of their healthcare providers, and the greater emphasis on preventive wellness.

What kind of doctor can practice concierge medicine?
The best physicians for concierge medicine are those who see patients on an ongoing basis. Obviously, primary care physicians, but also specialists like cardiologists, rheumatologists, endocrinologists, and even pain medicine physicians. The most important feature is that the physician can serve as a patient's go-to or main physician.

Where is concierge medicine flourishing?
Concierge medicine is growing across the country. Not just in large cities, but even in rural areas where easy access to medical care isn't always possible. Some of the biggest concierge hot spots are: California, Virginia, New York, New Jersey and Texas. In fact, we have several physicians in these areas with thriving medical practices who are looking to retire and transition their concierge practice to a new physician who shares their philosophy of care.

What makes a good concierge physician?

- ✔ Physicians who value the time they spend with patients and who enjoy practicing a highly personalized form of medicine make excellent concierge physicians.
- ✔ Doctors who have worked for large healthcare organizations or institutions who may now be looking for less pressure and a better pace would appreciate the independence that comes with a concierge practice.
- ✔ Older, experienced physicians who want to extend their careers by 10 years or more, may find satisfaction in transitioning to a style of medicine that puts the emphasis on patient care, not productivity.

Does this satisfying practice style interest you?
If so, then you should learn more about the private practice opportunities in our network. The first generation of concierge clients are retiring, and they are looking for qualified, compassionate physicians to take over their private concierge practices and care for their patients.

To learn more about opportunities near you, particularly in California, Virginia, New York, New Jersey and Texas, contact Michele McCambridge, CCP's Senior Vice President at mmccambridge@choice.md.

All inquiries will be kept confidential.

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Committee Updates and Motivating Learners

We are excited to celebrate the start of a new academic year and, for many of you, new assignments, new teammates, and new learners. The Education Committee and our subcommittees (the USAFP Annual Meeting Committee and the Point of Care Ultrasound (POCUS) Committee) have been busy this spring working to solidify our processes moving forward. We are looking forward to offering several virtual KSAs in the future. Additionally, we are proud to support the USAFP Journal Club initiative. Look out for more information on these initiatives, including dates, very soon! We are also working with some of our military program director members to address the proposed new ACGME requirements, and will have a report on those once the ACGME finalizes them in September.

MOTIVATING LEARNERS

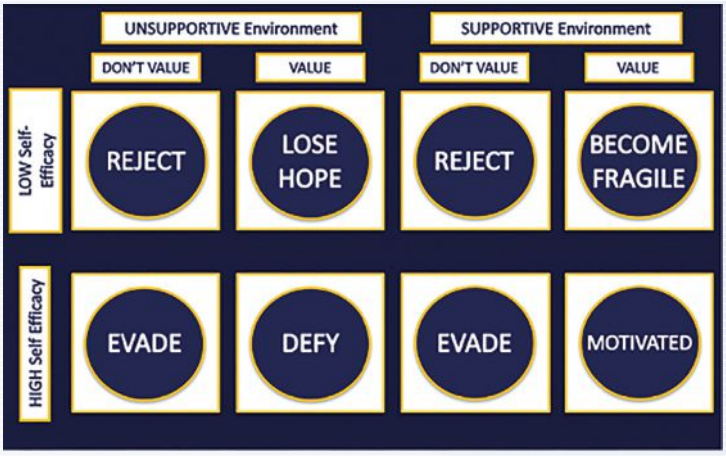
As you settle into your new jobs and positions, many of you have the opportunity to teach. Whether you are faculty working in an ACGME residency program, a physician teaching a new nurse in a clinical setting, an operational doc teaching our awesome enlisted medics or corpsman, or even a flag officer training your staff at the strategic level, most of you will have the opportunity and responsibility to teach. This responsibility is one that we are privileged to have. As you prepare to engage and teach adult learners, it is important to identify those individuals that may be struggling. Learners struggle for a number of reasons, and it is important that we identify those reasons in order to pinpoint the cause. As leaders and teachers, we recognize the importance of this assessment because learning deficiencies do not magically resolve without some type of intervention. We also understand that learners in difficulty impact the morale of the team, the reputation of their organization, and, ultimately, the safety of patients and other service members.

As physicians, military officers, and leaders, we have an obligation to all learners to assist them when they are not doing well. There are many aspects that impact a learner's performance, but signs of learners in difficulty include avoidance, poor task completion, inappropriate interactions, ineffective time management, falling behind their peers, mood changes, and complaints from peers and others. It can be easy to miss these signs since they are often subtle. Teachers must intentionally engage with their learners in order to detect some of these behaviors. Learners find themselves in difficulty for a number of reasons. Today, we want to focus on learners who lack motivation, discuss concepts that impact motivation, and explore some options to improve motivation.

Motivation refers to the personal investment that an individual has in reaching a desired outcome or goal. In learning, motivation influences the direction, intensity, persistence, and quality of behaviors in which learners engage. We are going to examine two models regarding motivation. The first is from the education literature, *How Learning Works* by Susan Ambrose and her colleagues, and the second is from the field of business management, *Developing Management Skills 10th edition* by David Whetten and Kim Cameron.

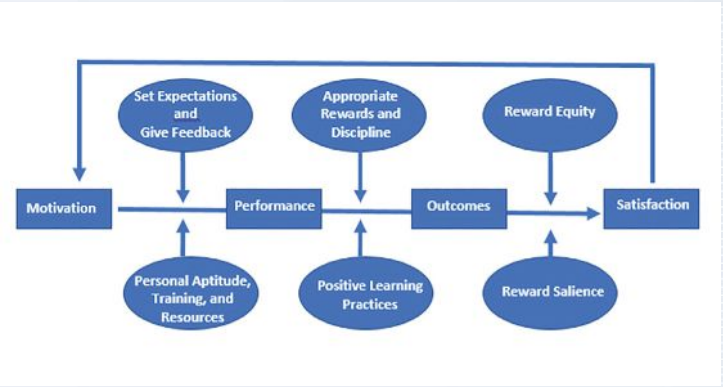
Ambrose describes the extrinsic influence the learning environment has on motivation levels by highlighting the importance of a supportive environment and the negative consequences of an unsupportive learning environment. She also outlines the intrinsic impact of self-efficacy, the individual belief in one's capacity to be successful, and perceptions of the value the learner places on the objective or goal. When a learner has low self-efficacy and does not value the goal or objective, they will reject the learning opportunity regardless of the environment. Similarly, if someone has high self-efficacy, but do not value the learning opportunity, they will evade. For learners with low self-efficacy who do value the learning opportunity, they will either lose hope if placed in an unsupportive environment or become fragile and unable to perform in a supportive environment. If an

individual possesses high self-efficacy and also values the learning opportunity, but find themselves in an unsupportive environment, they will defy those unsupportive people and attempt to achieve despite this lack of support. Some will argue that these learners are motivated. Ambrose argues, however, that in an unsupportive environment, the energy required to defy and overcome takes away from the learner's motivation in the long run and is unsustainable. She argues that sustained learner motivation requires high self-efficacy, a perception of value in the learning opportunity, and a supportive learning environment. These concepts are more clearly described in the graphic below.



Whetten and Cameron describe similar concepts when discussing how to motivate employees in the business world. These principles from the business environment also apply to motivating learners in our settings. Whetten and Cameron lay out the hypothesis that satisfaction in the workplace positively impacts motivation which then translates into improved employee satisfaction. They believe that if leaders can positively influence the extrinsic and intrinsic components of the team that impact satisfaction, they will improve motivation. Extrinsic components that address learner performance include a clear goal setting process that includes the learner, is specific, consistent, challenging, and is aided by frequent, specific, and accurate feedback. Intrinsic components that impact learner performance include the individual learner having the aptitude, training, and resources to do their job.

Once performance (the attempt to learn) is optimized, other extrinsic and intrinsic elements influence the outcome of the learning process. Extrinsic factors like appropriate rewards and discipline in the learning environment directly impact learning outcomes. Intrinsic components such as an individual's learning practices also impact learning outcomes. Once the learning outcomes are established, learners are satisfied as long as they perceive reward salience, or the idea that the learner's personal learning needs were satisfied. Learners also achieve greater satisfaction when they perceive reward equity, the idea that everyone in the process was treated fairly. When learner satisfaction is high, this motivates learners to seek additional opportunities to learn.



As you trudge through your daily routine, we encourage you to seek opportunities to motivate learners who are struggling using some of these techniques. Helping them find ways to value the learning opportunity, or empowering them to have stronger self-efficacy can effectively motivate learners. Doing this when setting clear goals and providing equitable rewards for good performance can result in better learning outcomes and can improve the morale of your team.

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EVERY DOC CAN DO RESEARCH

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"Medical Challenges in the Arctic and Lessons Learned So Far"

For most reading this article, you have probably spent most of your career, if not all of it, focused on USCENTCOM Area of Operation (AOR) problem sets. Now, as our nation pivots its focus towards peer-to-peer or near-peer conflict throughout the USEUCOM and USINDOPACOM AORs, we must start thinking about how our military is going to operate in environments much different than what it has become accustomed to over the past several decades.

During the USAFP annual meeting in Anaheim this past Spring, our team highlighted one of these new environments, the Arctic and Sub-Arctic, during our presentation. If you were unable to attend that session in April, this will summarize the key points we highlighted:

1) The Arctic is important to our national defense strategy
2) Performing combat operations and providing medical care in the Arctic environment is exceedingly difficult
3) There are a myriad of problems to solve going forward if we are going to win in the Arctic.

Our intent is not to give you all the answers to this complex problem set nor provide detailed information on how to treat cold weather injuries. Instead, as USAFP members stationed in Alaska and operating in this environment, our primary aim is to encourage our community to start thinking about this problem set, as well as to generate interest in those wanting to help find solutions. Lastly, for those interested, we have placed our original presentation slides in the "USAFP Annual Meeting & Expo" app that you can download from your favorite app store or if you did not attend, please call the USAFP Headquarters office.

The strategic importance of the Arctic cannot be overstated. Currently, eight countries are formally recognized as Arctic nations and are members of the Arctic Council: Canada, Denmark (controls Greenland), Finland, Iceland, Norway, Russia, Sweden, and the United States. China has also inserted themselves into this group as a "near Arctic" state since they have strategic interests in the region. When you look at this region from the top of the globe, you will notice that the Arctic spans the AORs of three geographical combatant commands (COCOM), including USNORTHCOM, USINDOPACOM, and USEUCOM. The Arctic also includes all time zones, and has the potential to connect nearly 75% of the world's population. Additionally, the Arctic is an arena of intense competition given its vast untapped natural resources, expanding economic shipping lanes, and strategic basing opportunities for global power projection. It is estimated that 13% of the world's oil, 30% of the world's untapped natural gas, and approximately $1 trillion worth of rare earth minerals lie offshore under the ice in this contested geography waiting to be claimed.

Additionally, climate change is causing Arctic sea ice to melt in areas that have previously prevented transoceanic travel. Given that 90% of global trade travels across the world's oceans and seaborne trade is expected to double in the next 15 years, shipping lanes like the Northwest Passage, Northern Sea Route, and the Transpolar Route become exceedingly valuable to countries trying to move goods from Asia to Europe. For countries like China and Japan, such a northern route could cut shipping times in half compared to their current, more circuitous options: the Cape

Route around the tip of Africa or through the Strait of Malacca and Suez Canal. This is also why Russia has invested more heavily in ice breaker ships than any other Arctic nation; they want to promote the use of the Northern Sea Route that parallels their vast coastline for international commerce and economic gains.

The United States has recognized the importance of the Arctic and the strategic issues noted above for some time. U.S. Air Force pioneer, General Billy Mitchell, told Congress back in 1935 that, "in the future, whoever holds Alaska will hold the world. I think it is the most important strategic place in the world." It was not until recently, however, that the United States reinvigorated our nation's strategic approach in the Arctic. A new Department of Defense Arctic Strategy, as well as subsequent service-specific Arctic Strategies have been released in the past few years. All of these documents highlight the importance of defending the homeland, competing to maintain favorable regional balances of power, and ensuring common domains remain free and open.

One of the clearest examples of this strategic refocusing can be seen in the recent build-up of national defense assets in Alaska. Currently, Alaska is home to the largest collection of 5th Generation Airpower (i.e. F-22 and F-35 aircraft) anywhere in the world, advanced early warning radar systems, ballistic missile defense systems, two Army Brigade Combat Teams with sustainment and garrison enablers, and two Role 3 Military Treatment Facilities (673rd Medical Group at Joint Base Elmendorf-Richardson and Bassett Army Community Hospital at Fort Wainwright). Additionally, Alaska's Joint Pacific Alaska Range Complex (JPARC) offers an ideal training environment to prepare for the high-end fight in a harsh, unforgiving environment.

Large-scale combat exercises like RED FLAG-ALASKA, NORTHERN EDGE, ARCTIC WARRIOR, and ARCTIC EDGE are critical to hone the required skills needed to operate in the Arctic. Finally, Alaska is a perfect launching point to get anywhere in the northern hemisphere within a one-day flight.

It has been during some of the above exercises that our team recognized that we as Family Medicine physicians can make significant impacts in three key areas for medical operations in the Arctic: Point of Injury (POI) Care and Medic Training, Casualty Evacuation Planning and Execution, and Role 1 facility set up.

When temperatures drop below -20 ^{0}F, every step of every process in providing POI care is arduous. Medics and providers are already fatigued from living, sleeping, and operating at these extreme temperatures for a prolonged period, so caring for casualties will be even more challenging. Therefore, it is critically important to train our medics while in garrison about the importance of protecting the patient (and themselves) from hypothermia and frostbite, tricks to prevent Class VIII medical supplies from freezing, and how to apply tourniquets and perform other medical tasks while your dexterity is limited due to your extreme cold weather (ECW) clothing.

Deliberately planning and executing casualty evacuation in the Arctic environment is another critical area where you can make a significant difference in medical operations. Factors such as temperature, road conditions, visibility, terrain, and vehicle capabilities must be considered. Strykers, Medical Evacuation Vehicles (MEVs), and Field Litter Ambulances (FLAs) cannot drive on unplowed surfaces, making all plowed roads a vital resource for all operations that use wheeled vehicles. Plowed roads will quickly become congested, reducing evacuation times. Off-road transport over open snowy terrain is also difficult and typically done by snowshoe, skis, snow machine, or Small Unit Support Vehicle (SUS-V). Additionally, most aircraft have difficulty operating at temperatures below -40 ^{0}F due to fuel gelling or freezing. Visibility (already difficult in the monochromatic landscape) can be made even more difficult when vehicles kick up clouds of fine snow creating white-out conditions. Traveling down narrow and slick plowed roads, with limited visibility, leaves little room for error. However,

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of all the planning factors, the most critical is time. Every task, every movement, every operation will take longer in the Arctic. You must employ the Arctic time planning factor -- every task, movement, or operation will take 3-4 times as long to complete in the Arctic compared to more temperate climates. Unless you have considered this and mitigated the risks, patients will suffer, and lifesaving care will be delayed.

Lastly, appropriately setting up a Role 1 facility in an Arctic environment is another focal area where significant gains can be made. Having heat in the Role 1 facility is priority #1. Without heat, the Role 1 cannot be considered at "Full Operational Capability" (FOC). As noted above, Class VIII medical supplies will freeze, battery powered devices will drain quickly, and casualties can deteriorate rapidly. Remember that hypothermia is one of the critical elements of the "Triad of Death" which include hypothermia, coagulopathy, and acidosis.

In an ECW environment, triage at the Role 1 must now take place inside a warm tent that is large enough to accommodate mass casualty (MASCAL) scenarios. If floor insulation is available, it should be used to keep the patients off the cold ground and out of any pooling melted snow. Both the triage and treatment tents should have redundant heater and power systems, and it is essential that everyone on the team knows how to operate them. Finally, without enough heaters, the Role 1 cannot conduct split operations, compromising the ability for the medical team to conform to the maneuver plan.

In conclusion, the Arctic environment presents unique and challenging problems that most medical personnel are not

adequately prepared for yet. Similar to operating in a CBRN environment, providing medical care in an ECW environment is slow and cumbersome but doable. We still have a lot of work to do to become more proficient in this AOR, but with continued work, experience, and technological advances over time, we'll be ready to go at 50 below!

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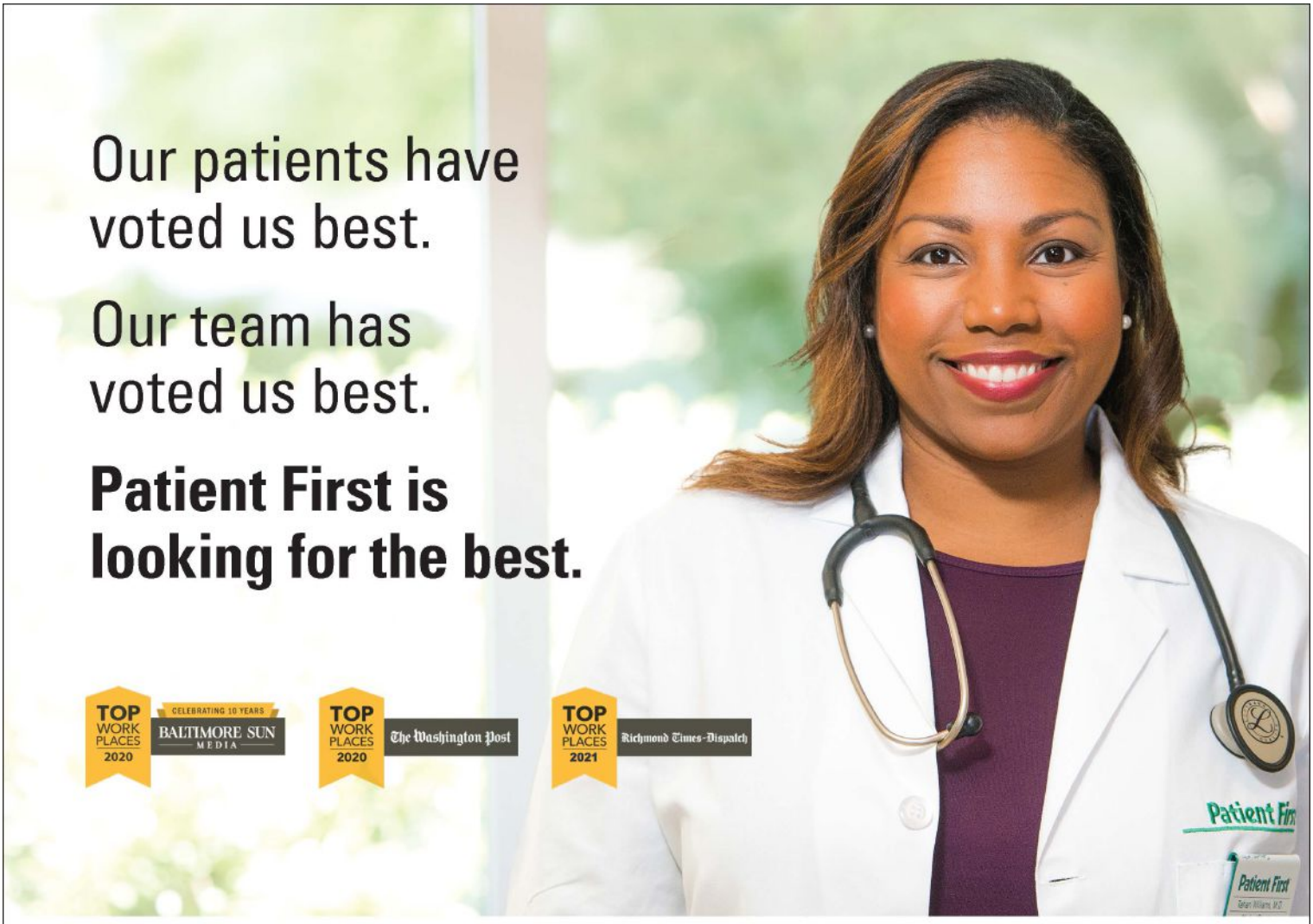

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THE POWER OF POSITIVE DEVIANCE

BY RICHARD T. PASCALE, JERRY STERNIN, AND MONIQUE STERNIN

Throughout our military careers, many of us will have the privilege of serving in various leadership positions. These critical roles include being a staff physician at the front line of patient care; running a busy clinic as the officer in charge or department chief; leading residents as graduate medical education faculty; working as a medical advisor to a senior commander, or even advising policy makers at various organizational levels. But, no matter which of these roles we find ourselves in, one consistent leadership skill needed is the ability to elicit positive organizational change. Any problem that an organization faces requires some degree of change, whether it is developing a new process or system or improving an existing one.

There are many popular approaches to process improvement, such as the Six Sigma methodology, lean manufacturing, continuous improvement ("kaizen"), Plan Do Check Act (PDCA), and understanding the theory of constraints. In The Power of Positive Deviance, Richard Pascale, Jerry Sternin, and Monique Sternin introduce a less well-known management approach known as Positive Deviance (PD). The use of PD tends to be most useful when organizations know "what" to do but not "how" to do it, and have failed previously with top-down or outside-in approaches.

Pascale, Sternin, and Sternin outline three core elements of PD:

1. There are already answers to a group's seemingly intractable problems.
2. Members of the community/organization have these answers.
3. Innovators who have solved the problems (positive deviants) have succeeded despite being faced with the same limitations as others in the group.

The approach came from author Jerry Sternin, a humanitarian, who in the 1980s and 1990s spent his time working to reduce malnutrition in poor Vietnamese villages. For years, the local governments had recruited outside experts to come to Vietnamese villages and analyze factors like living

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conditions and available resources. Non-governmental agencies and other organizations would provide food, educate the population on various agricultural techniques, and offer other "help" to improve nutrition within the population. These efforts typically only led to short-term, poorly sustained improvements. When his organization, *Save The Children*, gave him a small window of time to make an impact there, Sternin tried a novel approach of applying PD to the village where he was working. PD had existed in the academic nutrition literature since the 1960s, but had not been successfully operationalized prior to that time.

Sternin's team gathered villagers together, identified who had the best nourished children, and then met with the mothers to see what these women were doing differently compared to their peers. Sternin discovered that the families of the best nourished children employed unique child rearing habits that were not necessarily complicated, and were easy for others to implement. Sternin further recognized that certain cultural norms or ways of thinking were the key barriers to overcome, rather than relying on education provided by outsiders like himself. Families with the healthiest children as assessed by metrics such as Body Mass Index (BMI) and frequency of illness had seemingly small differences in behavior. These differences included small changes like feeding children more food when they had diarrhea, providing more frequent small meals rather than fewer large ones, and adding sweet potato greens which were readily available but often overlooked as "peasant food." Those groups who adopted these strategies experienced significant improvements in combatting malnutrition. Over a two-year period, malnutrition dropped 65-85% in every village he visited, and these improvements were sustained for years, as villagers were more open to employing simple solutions already in use by others in their community.

After this success, Sternin and his wife moved to Egypt where they became involved with helping their local community near Cairo address a very different but severe problem -- eliminating the practice of female genital mutilation. Like malnutrition in Vietnamese villages, the practice of female genital mutilation persisted despite years of government education efforts. By leveraging the expertise of those who had successfully spoken out to resist this practice in the past (often

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these individuals were older sisters or parents who resisted the practice in their families), Sternin's team created vocal community leaders who generated much more buy-in than outsiders telling the community to stop this practice. This approach created a groundswell movement that led to the local government sponsoring an initiative in multiple governorates that was supported by UNICEF and reduced the number of victims by several thousand people in a five-year period, much greater progress than had been seen in decades.

After experiencing success in two different fields, the Sternins established the Positive Deviance Initiative at Tufts University with the goal of expanding PD to different sectors. In his foreword for the book, Atul Gawande urges our country to apply these concepts to our healthcare system. Jerry Sternin and his team did, in fact, have success working with the VA Healthcare system in Pittsburgh, PA. By applying the tenets of PD, the Pittsburgh VA drastically reduced the spread of Methicillin Resistant Staph Aureus (MRSA) infection over a two-year period. The key to accomplishing this was empowering employees at the lowest levels to share their individual successes and then promoting these homegrown solutions across the organization instead of relying on outside consultants to recommend solutions.

The Power of Positive Deviance provides several additional vignettes, as well as a field guide for those interested in exploring PD, as a tool for tackling the challenges leaders face in their community. Typically, PD is not a "quick fix" approach, and can take months to years to reap the benefits. PD is not a doctrine or a rigid set of steps to follow, but rather a philosophy or methodology that should be adapted to the organization and problem at hand.

The key principles of PD include:

- The community owns every step of the process.
- PD focuses on strengths/assets and uncommon, but successful behaviors or strategies (positive deviants).
- The community designs ways to implement these positive deviants to make them more common.
- PD leverages existing formal and informal networks and generates new ones.
- PD promotes further and lasting change by promoting the community to monitor its own progress.
- PD typically depends on leaders or sponsors committing up front to the PD process.

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The basic steps in implementing the PD methodology are:

1. The community defines or reframes the problem. This is done by recruiting members of the community interested in effecting change, helping them visualize a future that is different from the past, and doing so by exploring behavioral norms, common barriers, and stakeholders.

2. The community determines common practices. This is done by holding discussions with members of the community to learn more about common practices and using "participatory learning and action" activities like mapping or prioritizing, to help generate data and promote buy-in.

3. The community discovers positive deviants. This step focuses on identifying those in the community who exhibit the desired outcome as well as those who do not, conducting interviews with those individuals, and finding how their practices correlate with the desired outcomes.

4. The community designs and develops activities to expand the PD solutions. The final step engages stakeholders and applies the discovered PD behaviors or strategies, typically starting small to demonstrate success and then involving the community in various ways to more widely promote the PD behaviors or activities.

Hopefully, this review provides you an additional leadership tool to leverage if you are faced with a challenging or persistent problem that requires both technical and behavioral solutions. The PD concept combines elements of bottom-up refinement with empathic, participatory methods, and requires a deliberate commitment that will take time to yield results. It empowers a leader to be respectful of the organization's culture and norms while tapping into the community's inherent ability to overcome its problems where outsiders or "experts" have not previously succeeded. For more information, the Positive Deviance Initiative has additional literature and resources available at www.positivedeviance.org.

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In each issue of The Uniformed Family Physician, the Operational Medicine Committee will be highlighting an operational assignment and a Uniformed Family Physician who has been in the job. The first of these series is on USAF Flight Medicine.

Operational Medicine Job Profile: Air Force Flight Surgeon with Lt Col Roselyn "ICON" Fuentes

TELL ME ABOUT YOUR CURRENT AND PREVIOUS OPERATIONAL JOBS YOU HAVE HELD.

I am an Air Force MTF flight surgeon attached to an F-16 unit, but I have flown on over ten different aircraft including the AC-130 gunship and with Air Force Special Operations Command (AFSOC) units. As a flight surgeon, my focus is on maintaining the health of the aircrew and other operators to safely perform the mission. Additionally, the role includes a strong occupational medicine component and the necessity to be familiar with the overall operational mission of the base. I have deployed in support of Operation Allies Refuge as a civil surgeon and helped make aeromedical disposition decisions for some of the several thousand Afghan refugees that were evacuated. I am about to take on the role of Chief of Aerospace Medicine at an overseas base.

WHAT KIND OF TRAINING AND PREPARATION DID YOU HAVE TO DO?

I needed to complete the Aerospace Medicine Primary (AMP) courses (now known as the Air Force Operational Medicine or AFOM 101/102 along with AMP 201/202) at Wright Patterson AFB as well as the Aircraft Mishap Evaluation course; Survival, Evasion, Resistance, and Escape (SERE) school at Fairchild AFB; water survival; the altitude chamber; and the centrifuge up to 9 Gz. Once you start flying, you need to complete aircraft-specific training. The job requires familiarity with the military standards and aircrew-specific health requirements.

WHAT ARE SOME OF THE REWARDING AND CHALLENGING ASPECTS OF YOUR JOB?

The most rewarding aspect is getting a close-up view of operations and seeing the impact that you have on the mission. There is an opportunity to truly integrate with the flying units and know your patients. The challenging aspect is the mission never stops and there are many unique missions happening on the base at any given time. Flying with different aircraft and doing shop inspections really helps with familiarization of the unique missions and position requirements. You'll learn from hands-on experience that the job stressors are quite different for an F-16 pilot, a KC-135 boom operator, an AC-130 gunner/loadmaster, or an air traffic controller.

TELL ME ABOUT A UNIQUE EXPERIENCE(S) YOU HAD IN YOUR POSITION.

Despite my busy operational medicine responsibilities, I still find opportunities to teach, do research, and lead. One unique project I was recently involved with was Operation Blood Rain which was a project with AFSOC to determine the viability of delivering whole blood via airdrop (https://pubmed.ncbi.nlm.nih.gov/34105118/).

HOW DID YOU FEEL YOUR FAMILY MEDICINE TRAINING PREPARED YOU FOR OPERATIONAL MEDICINE?

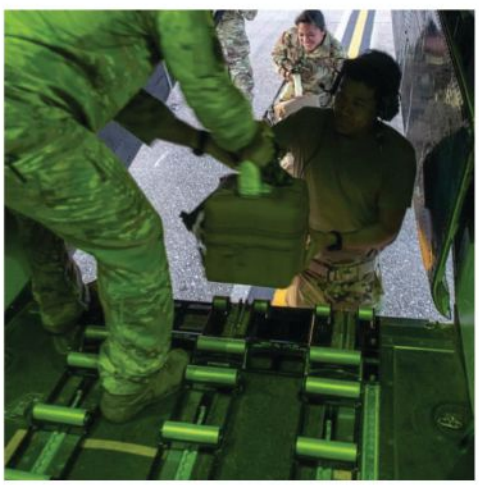
Family Medicine training prepared me well for operational medicine. Like Family Medicine, every day in flight medicine is different – ranging from the clinic, shop visits with public health or occupational medicine, responding to in-flight emergencies in the ambulance, doing the Wing safety brief, and of course, flying. With a background in Family Medicine, you have a strong foundation to address issues that come with normal human physiology in abnormal environments. You provide the full scope of primary care to service members ranging from their late teens to those nearing retirement age. A family physician's training in musculoskeletal injuries, competence in women's health, and chronic disease management make uniformed family physicians well suited for operational assignments.

WHAT ADVICE DO YOU HAVE FOR THOSE WANTING TO GO INTO AN OPERATIONAL POSITION?

If you are a student or resident, seek out operational rotations. You can find additional information on the Air Force Research Laboratory website: https://www.afrl.af.mil/711HPW/USAFSAM/.

One of the specific opportunities available to those in residency is to participate in an operational medicine rotation. Additional details can be found here: https://www.afrl.af.mil/711HPW/USAFSAM/ogme/.

Also, remember that all military medicine is operational. We are all expected to figure out how to provide the best medical care in sometimes less than ideal conditions. Master the medical aspect but do not forget to take into consideration the occupational and mission effects that medical issues or treatments can have on your patients. If you are interested in learning more, please reach out to the current consultant, Colonel Anthony "MAGIC" Mitchell (anthony.l.mitchell6.mil@mail.mil).



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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 Summer magazine is 10 October 2022.

RESEARCH GRANTS

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Dave and I are extremely excited about USAFP 2023 in Orlando. Thank you to everyone for the robust response to our speaker call. We are hard at work reviewing the submissions and shaping them into a cohesive complement of CME. We anticipate sending out speaker invitations by September. Along with our usual robust CME, research and fellowship, we will hold a Fundamentals of Critical Care Support Course (FCCS) as a pre-meeting event in conjunction with the VA Sim Center (just a few minutes from the Orlando Renaissance Hotel). This course prepares healthcare professionals to manage critically ill patients during the first 24 hours of presentation. Developed by the Society of Critical Care Medicine (SCCM), this course is perfect for those returning to inpatient medicine, deploying to an austere location, returning to Academic medicine or who want to further hone their critical care skills.

For more information you can visit:
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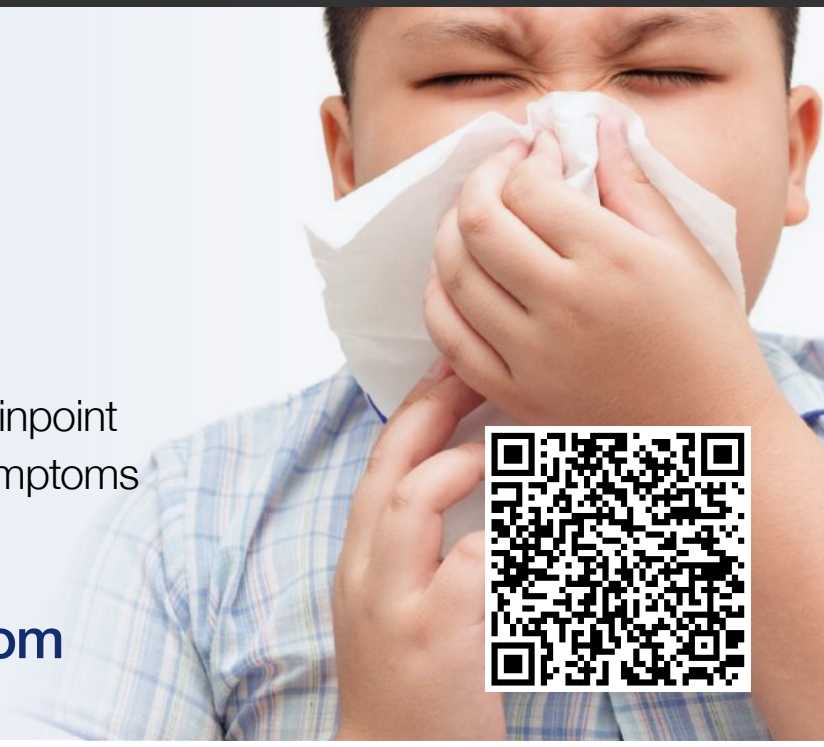

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