THE UNIFORMED FAMILY PHYSICIAN

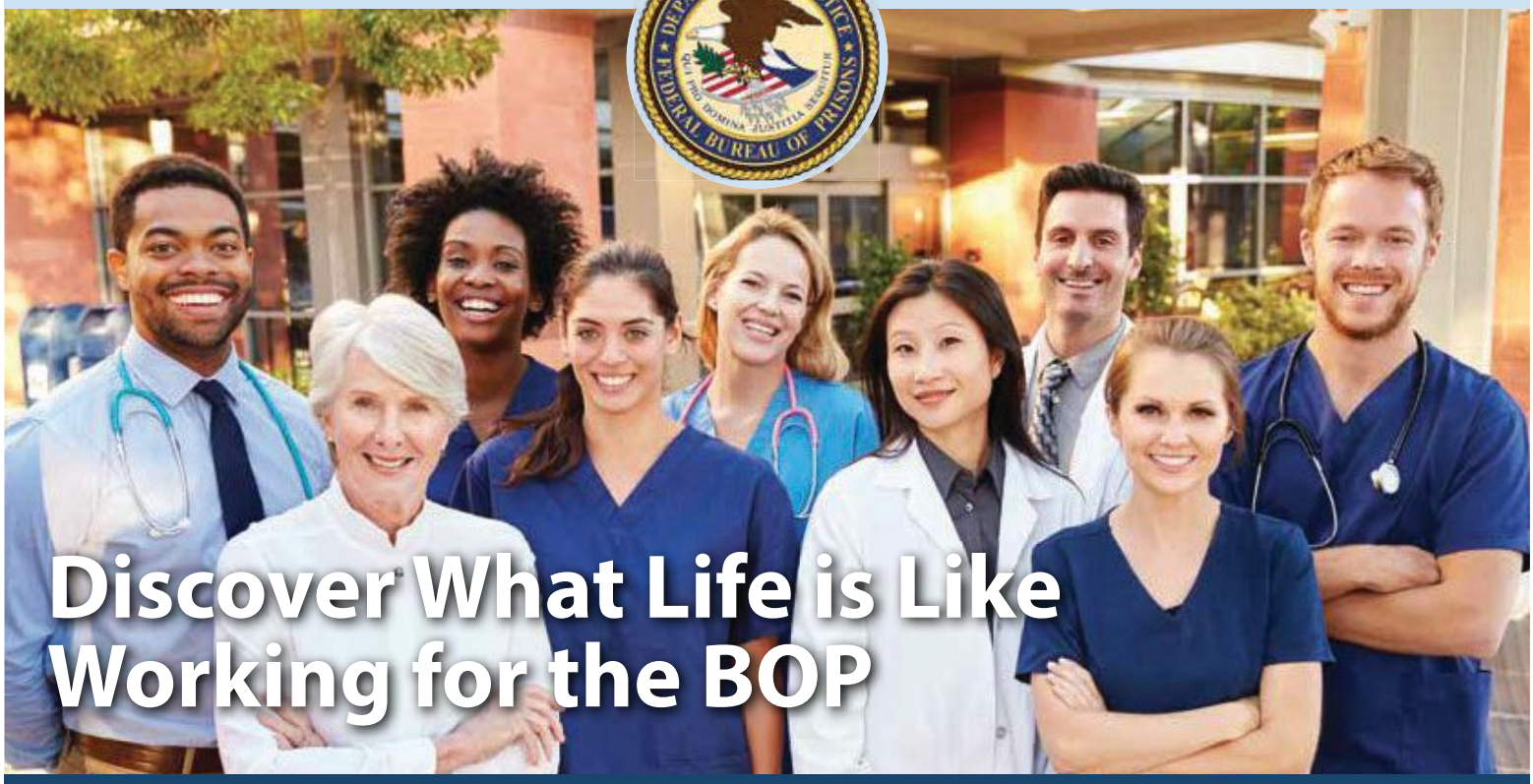
Spring 2023 ▪ Vol. 14 ▪ Num. 1 ▪ Ed. 63

KEVIN M. BERNSTEIN, MD, MMS, FAAFP INSTALLED AS 2023-2024 USAFP PRESIDENT

— SEE PAGE 10

Journal of The Uniformed Services Academy of Family Physicians

SPRINGFIELD, MISSOURI



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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.

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Edition 63

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Esteemed Colleagues, it is a blessing to be able to write my first article for the USAFP newsletter as your newly installed President! Bravo Zulu to the 2023 Annual Meeting Program Co-Chairs, Dr. Rebecca Lauters and Dr. Dave Garcia for putting together an all-star lineup as well as a big shout out to Dr. Marcus Alexander for his year of service as our President!

It was an honor to be installed as your USAFP president by a longtime friend and dedicated leader of Family Medicine, Col (Dr.) Russell Kohl. Dr. Kohl currently serves as Speaker of the AAFP Congress of Delegates. He also serves as the State Surgeon of Missouri and as a Colonel in the Missouri Air National Guard. Over 13 years ago, Dr. Kohl and I had the opportunity to serve together on the AAFP Board of Directors when I was a medical student, and he was the New Physician member.

I would like to take this opportunity to share with you a significant portion of my Presidential Address. My hope is that this message will give you a better understanding of my background, mission, vision, and goals for USAFP in the upcoming year. It is a pleasure serving with you!

To the members of our Academy. Blessings to you! What joy and honor it is to be your USAFP president.

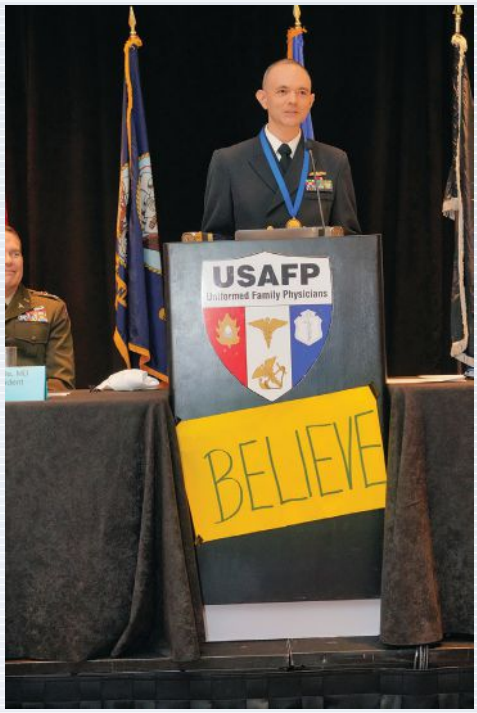
I want us to first pause and express gratitude. I want to thank our amazing peers, colleagues, and friends who have the watch and those who are forward deployed in harm's way. I also want to thank the USAFP staff who does incredible work behind the scenes to support our organization.

I need to also thank my much better half, Anisa. She's my wonder woman and our son Liam's superhero. We met in 2014 while we were both deployed aboard the USS PELELIU. Anisa is a Naval Flight Officer; I love to tell others that she does the "real Navy stuff". I cannot thank her enough for her love and kind heart. Thank you for covering down during the long days at work, time away advocating for our USAFP family, the support and sacrifices you have given to help my career, often at the sacrifice of your own. I love you.

Next, I need to thank my parents who raised me in Deer Park, NY. We initially lived in a converted garage and den in my grandparents' house until I entered middle school when they could finally afford to buy their first house. In a town that had just a handful of Jewish families, I got a chance to embrace religious and cultural diversity and, despite undertones of anti-Semitism including vandalism of our synagogue, my parents helped establish a great foundation for me to rise above the harshness of the world and to embrace diversity. My mother pushed me to be the best version of myself, encouraged me during the toughest of times, to always strive to go above and beyond, to take pride in all work accomplished, and to always find ways to improve. A nurse, she enforced the importance of true, patient-centered care with empathy, while making sure to be respectful and courteous with the entire medical team. She also stressed the importance of good handwriting.

To my dad – the person that truly got me passionate about sports and to be a genuinely good person. I thank him for a life of suffering through fandom of the New York Mets. He could have given me the easy way out by encouraging me to be a Yankees fan. But that's not how Bernsteins roll. You Gotta Believe.

Both of my parents provided me with foundational values that have brought me here today. They were supportive when I came home that day from Penn State when my pre medicine



advisor told me NOT to apply to medical school and to consider alternate professions. They encouraged me when I chose to enroll in a high-risk graduate program at Drexel to prove my worth against the medical school average. They got me to believe when others didn't. They got me to ***believe in believe****. They were there for me when I shocked the family with my decision to join the Navy during my 4th year of medical school as a 1-year HPSP scholarship recipient (that's a lot of student debt!). They were there for me when I needed encouragement during the toughest of times and they still support me today. I am truly blessed and privileged to have my parents and cannot thank them enough.*

Our theme for this year is ***Foundational. Relevant. Family.***

Without mentors to bring you back to your ***foundations****, it's hard to maintain* ***relevance*** *and certainly difficult to achieve goals without your* ***family****. Everybody should have mentors that provide guidance and, at times, save you from yourself. In medical school at Drexel, I had Dr. Dave Berkson, a Family Medicine/Sports Medicine physician was able to merge my love*

continued on page 6

continued from page 5

for sports, preventive health and medicine and opened my eyes to primary care sports medicine. He understood my desire for advocacy and connected me with our Family Medicine and Sports Medicine Interest Groups and recommended I attend the AAFP National Conference and the Pennsylvania AAFP meeting. He is truly part of the family that got me involved with organized medicine and I cannot thank him enough for his mentorship. Thank you, Dave. For everything.

This brings me to Priority #1 for this upcoming year: Let's use mentorship to triple the number of medical students in attendance next year in New Orleans.

If you do not have a mentor, find one. To anyone not a medical student - please mentor them. If you know medical students that are not here and need a mentor, help them identify one. One of our priorities this year will be to re-invigorate the mentorship program via our USAFP website where folks will be able to sign up to be a mentor or to find a mentor.

***Foundational** friendships, maintaining **relevance**, advocating for **Family** Medicine.*

To mentors in the USAFP - the family we have together here today as well as in USAFP past. To mentors at what was the Navy's finest Family Medicine Residency Program in Pensacola, faculty and peers as well as those still in uniform: We continue to keep the Pensacola torch burning until the very end. Keep rocking it out there.

To primary care sports medicine community mentors and dear friends that helped along the way. Thank you for showing me why Family Medicine physicians should be and always will be the right specialty to care for our tactical athletes and warriors. Our USAFP members prove every day why putting Family Medicine physicians within the operational community, embedded with units, squadrons, on ships is the right thing to do. It's the best thing to do. We are and always will be relevant now and into the future.

WE are the team physicians for our patients in all clinical and operational settings. We cost less, refer less, and we save more lives.[1,2] Research from the Graham Center shows that for every 10 additional family doctors per 100,000 people, life expectancy increases across that entire population.[1] We significantly reduce morbidity and mortality in comparison to fragmented, uncoordinated care by proceduralists as well as non-physician primary care clinicians. 2019 CMS data showed that per-patient per-month spending was $43 higher per patient whose primary health clinician was not a primary care physician.[2] If you risk-adjust for patient complexity, the difference was $119 per patient per month, or over $142,000 for a panel of 1,200 patients.[2] We epitomize value-based care. We are NOT providers. We are Family Medicine Physicians. We are valuable and irreplaceable. We are not interchangeable. Ask yourself - if not me… if not us. Then who? What can we do together to advocate for our specialty?

Priority #2 for this upcoming year – increase membership advocacy efforts. I hear the phrase, "If you're not at the table, you're on the menu" thrown around a lot. Let us take that further. If you are at the table, are you doing everything you can to advocate for Family Medicine?

Who was called upon during our war against COVID? Wars in the Middle East? What specialty continues to be called upon in OCONUS and other remote locations to fill gaps in healthcare. Let us not lose sight of the value of Family Medicine, and moreover, let us not let others lose sight of this. We always will be a critical wartime specialty. Believe in believe. Believe in us.

This USAFP community is our family. You are the foundation. You Are Family Medicine.

It's never too late to start advocating for our specialty. It's always too early to give up on leading. Everybody in our chapter is a leader. From butter bars to stars. I encourage you to reflect and refocus on why you are here, why you chose medicine, and why you chose Family Medicine. If you do not have a personal mission or vision statement, I encourage you to develop one.

***My mission** is to inspire all people to lead a life that's healthy and balanced while leading a balanced, healthy life of my own.*

***My vision** is to work as a servant leader while keeping my wife, son, family, friends, colleagues and patients at the center of all decisions including the ability to say "no" to better the lives of people around me while advocating for a better, more equitable health care system for all.*

I now challenge you to create your mission and vision, your North Star.

Use your personal mission and vision to promote and maintain balance. Reference your mission and vision for key decisions you make going forward. If you are not balanced and need help, reach out. One of the things I would like to expand is resources for burnout and moral injury for our USAFP members who are hurting. "I promise you, there is something worse out there than being sad, and that is being alone and sad. Ain't nobody in this room alone" (Ted Lasso).[3] Wellness is very important to me personally and I will work to ensure that we prioritize this and provide more resources to our USAFP membership.

Let's be balanced and let us Be Bold. Be Champions of Family Medicine. ***Believe in Believe.***

We are ***Foundational.*** *We are* ***Relevant.*** *We are* ***Family.***

Thank you so very much for your confidence in allowing me to be your President this year! Thank you to everyone that has been a part of this journey. I cannot wait to see everyone next year in New Orleans!

Believe in Believe. Believe in Us. Believe in Family Medicine.

Always Believe in You - Ted Lasso

1. Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA*. 2019 Apr; 179(4): 506-14.
2. Batson BN, Crosby SN, Fitzpatrick JM. Targeting Value-based Care with Physician-led Care Teams. *JMSMA*. 2022 Jan; 63(1): 19-21.
3. Ted Lasso. Always believe in you. www.youtube.com/watch?v=1F0wHs8Zz3g

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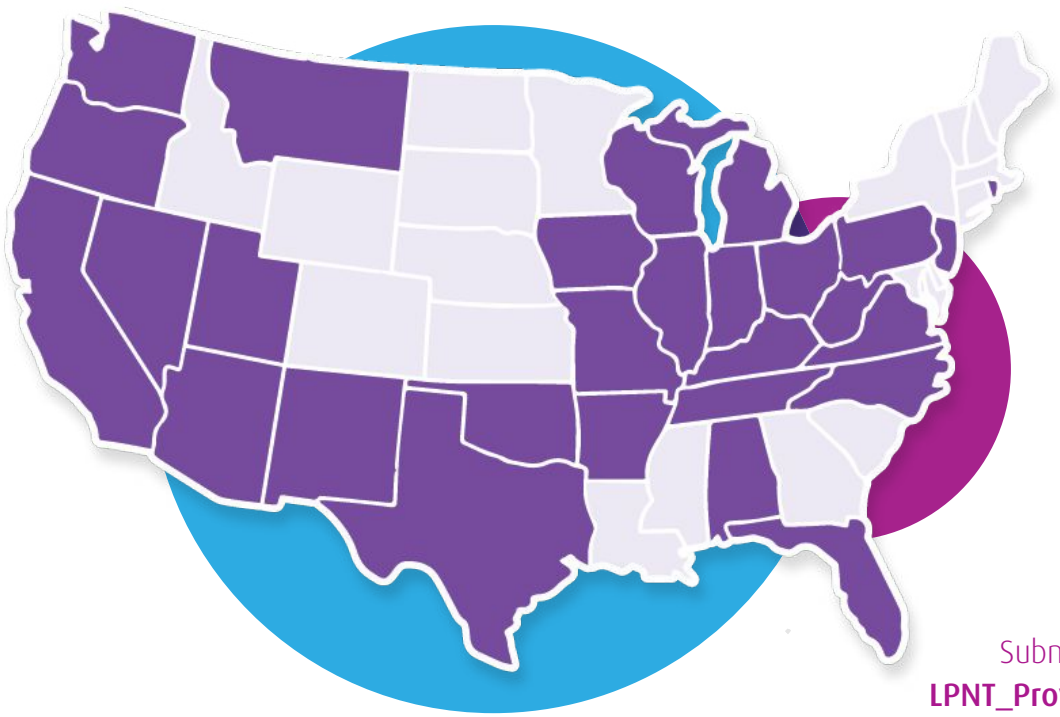

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editor's voice

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/**

Aloha Mai Kākou (warm greetings)!

It is an absolute honor and privilege to write my first column as your new USAFP Vice President and Editor for the *Uniformed Family Physician* (UFP). I want to begin by expressing deep gratitude to my family, especially my husband, Peter, who is a fellow USAF officer, and my son, Jonathan, who both continue to support and encourage me every step of the way. Like many of you, I was fortunate to attend this year's Annual Meeting in Orlando and I was reminded of how blessed I am to work with such an amazing group of people. At this special gathering, I was able to reconnect with old friends (we now realize that we are no longer the "young ones" in attendance, ouch!) and make new friends and connections to bring forward into this new season. My heart was full of joy as I attended presentations being given by family physicians whom I had mentored when they were residents. The future of family medicine is bright indeed! My heart was also full of gratitude as I took time to reconnect with mentors of my own who returned to USAFP and who continue to support me throughout my journey. I want to give a big mahalo (thank you) to our USAFP staff and my predecessor as USAFP Vice President, Dr. Mark Stackle, for doing such a great job with the UFP this past year. Mahalo for your time and dedication to USAFP and for the smooth handoff of this publication.

USAFP truly grounds me as a physician and I am continually inspired by the work being done by our membership. This edition of the UFP highlights multiple focus areas of our USAFP community. Meghan Lewis and Joel Herness discuss the many benefits of clinical teaching and share ideas about how we can all engage in teaching regardless of duty title and location. As Chef Gusteau says in the movie Ratatouille, "Anyone Can Cook!". In this case, "Anyone Can Teach!" Rob Oh provides highlights of the incredibly successful 2023 Research Competition (great job residents!). Dave Garcia shares his reflections on the MHS GENESIS transition and Barrett Campbell provides great information about clinical informatics. Rachel Carter shares exciting news about the upcoming National Conference of Constituency Leaders (more to follow on this in our Summer newsletter). We also have a compelling book review of "Leadership and Self-Deception: Getting Out of the Box" by Adam Kowalski and a deep dive into Professional Identity Formation by George Mount. Becca Lauters and Breanna Gawrys offer thoughtful advice for curating your own well-being practices which can easily be incorporated into busy schedules. Mahalo nui loa (thank you very much) to all of these authors as well as the other UFP contributors for sharing their time and insights in the development of this newsletter.

I hope that you can sit back, relax, and enjoy this edition of the UFP. I encourage you to scan the QR code below to learn more about how to get involved with USAFP. A great place to start is to join a committee (complete the committee interest form). Please also consider submitting an article for a future edition of the UFP. As your editor, I want this newsletter to represent the diverse voices of our USAFP community and to reflect the amazing work being done on the front lines of family medicine all over the world. I would like clinical, operational and academic perspectives to infuse into this newsletter in order to uplift and inspire all of us in family medicine. Please reach out to me directly if you have ideas for UFP articles. I would love to hear from you! I encourage you to pause and reflect on the theme outlined by our USAFP President. **Foundational. Relevant. Family**. Our USAFP community is all of these things and more. I want to personally thank Kevin for introducing me to Ted Lasso and **Believe in Believe**. I am excited to begin this journey with you all!

Me Ka Mahalo Nui (with gratitude),
Gigi

Hawaiian word of the Quarter: Mana'o'i'o (meaning *to believe or to have faith and hope in)*

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Kevin M. Bernstein, MD, MMS, FAAFP Installed as 2023-2024 USAFP President

Over 550 attendees took part in the 2023 Installation of USAFP Officers and Directors Luncheon on Monday, 3 April 2023 at the Renaissance Orlando at SeaWorld® in Orlando, FL. AAFP Speaker Russell Kohl, MD, FAAFP installed 2023-2024 USAFP President Kevin M. Bernstein, MD, MMS, FAAFP and the other Officers and Directors of the USAFP Board of Directors during the luncheon.

Kevin M. Bernstein, MD, MMS, FAAFP being installed as 2023-2024 USAFP President.

2023-2024 USAFP President Kevin M. Berstein, MD, MMS, FAAFP presents USAFP 2022-2023 President A. Marcus Alexander, MD with the outgoing President's plaque.

Dr. Kohl installed the 2023-2024 USAFP Board of Directors

Pictured left to right are Kelly A. Le, DO, Navy Resident Director: Michaela Ward, HPSP Student Director; Danielle Cain, USU Student Director; Mariama Massaquoi, MD, Army Director; Courtney M. Cowell, MD, Army Resident Director; Kayla S. Watson, MD, Air Force Resident Director; Andrew J. McDermott, MD, FAAFP, Navy Director; Philip A. Wixom, MD, PHS Director; Rebecca A. Lauters, MD, FAAFP, Air Force Director; Jeanmarie "Gigi" Rey, MD, FAAFP, Vice President; Meghan "Mimi" F. Raleigh, MD, FAAFP, President-Elect

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"I truly think that every single person on the care team and administration bring value to the team and really are working together to make sure that we deliver care the best that we can to our patients in our community."

Dr. Shannon Markegard, DO

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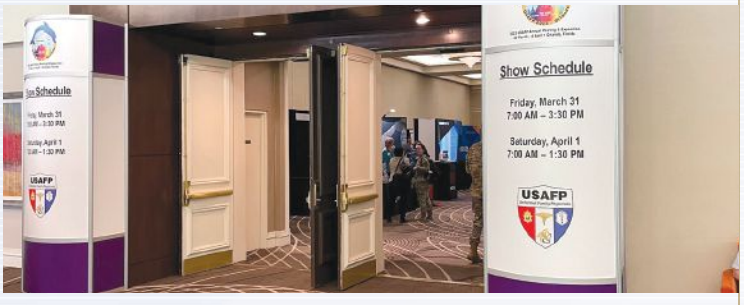
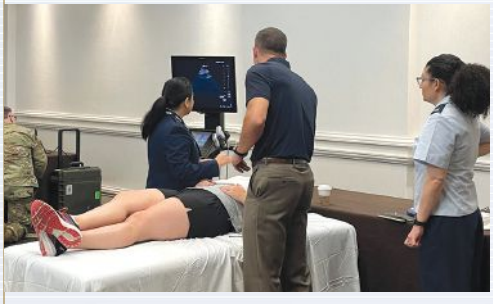
2023 Annual Meeting & Exposition

Over 580 family physicians and other health care professionals attended the 2023 USAFP Annual Meeting & Exposition at the Renaissance Orlando at SeaWorld® in Orlando, FL. The photos and comments show the success of the conference!

- A highly informative event!
- Everything was well organized and convenient. Much thanks.
- Numerous outstanding speakers
- Great location and venue
- Great meeting overall.
- Great program!
- Enjoyed the two a day Keynote
- The layout of the rooms was great.
- Food was great
- All Member party was so much fun (and I don't golf!)
- Can't wait for next year!
- Great breadth of topics and speakers
- Phenomenal presentations and well delivered.
- The hotel was super nice, the pool was amazing. The hotel bar was very conducive to social events. The rooms were generally good for presenting in.
- This was a fantastic venue with lots of surrounding things to do and places to eat. I appreciated the family friendly focus!



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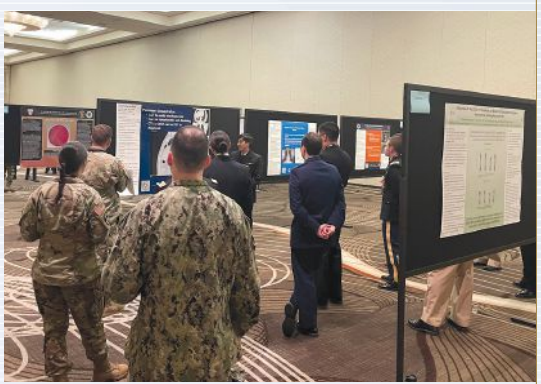

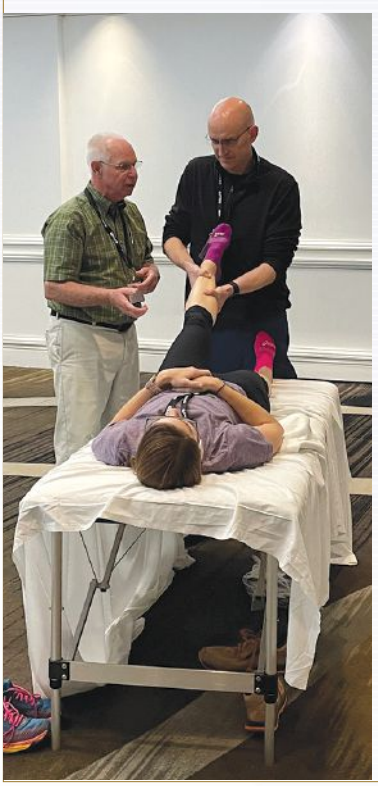


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Melany Vu
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Joshula Will
Ryan Williamson
Ashley Yano

2023 Academy Awards

Michael J. Scotti, MD Family Physician of the Year
Kevin M. Kelly, MD, FAAFP
COL, USA, MC

Dr. Kelly's award reads as follows: "In sincere recognition and deep appreciation for your invaluable contributions to Military Family Medicine, community affairs, patient care, leadership, teaching, and mentorship. As Commander of Martin Army Community Hospital, the Army's largest community hospital, you remain a humble servant leader continually striving to shape a positive and professional work environment. Your dedication of hundreds of hours to develop Soldiers into leaders through professional developments, coaching, and sage career advice in both formal and informal settings is unparalleled and to be applauded. A tireless advocate for graduate medical education and specialty training, to protect and grow the pipeline for Army Family Medicine and role modelling in all settings operational, academic, leadership, and clinical, while providing compassionate, comprehensive, medical care, is what it truly means to be a military family physician."

Dr. Kelly is pictured with USAFP 2022-2023 President Marcus Alexander, MD

Congratulations Dr. Kelly!

Operational Medicine Award
Dawn P. Callahan, MD, FAAFP
LCDR, USN, MC

Dr. Callahan's award reads as follows: "Your contribution to Navy surface medicine in your role as the COMNAVSURFGRU Middle Pacific Group Surgeon as well as the Assistant Specialty Leader for Surface Medicine has been nothing short of inspiring and motivating. Overseeing the health and wellness of 3,500 service members and your unwavering dedication and steadfast support day and night keeps the fleet healthy and ready to forward deploy at a moment's notice. Coordination of care and COVID testing during remote pre-deployment sequesters, active involvement with Navy GME, and continued efforts to maintain an operational ready fleet have directly impacted the Navy's ability to maintain a forward deployed fleet and operationally competent providers during these challenging times. You epitomize the role of a Joint Operational Family Physician in Military Medicine and engender a strong desire for others to follow in your footsteps."

Dr. Callahan is pictured with USAFP 2022-2023 President A. Marcus Alexander, MD.

Congratulations Dr. Callahan!

2023 President's Awards

President's Award
Rebecca A. Lauters, MD, FAAFP, Maj, USAF, MC
and
David S. Garcia, MD, FAAFP, Maj, USAF, MC

Dr. Lauter's award reads as follows: "In recognition and deep appreciation for your outstanding leadership and service to the Uniformed Services Academy of Family Physicians as Program Co-Chair for the 2023 USAFP Annual Meeting & Exposition. Your innovative, comprehensive, and dynamic program focused on the theme "Together - We are Strong Diverse Flexible" exceeded the professional and educational needs of our diverse membership. Through your tireless efforts, you have helped your friends and colleagues in all services to grow as clinicians and leaders."

Dr. Garcia's award reads as follows: "In recognition and deep appreciation for your outstanding leadership and service to the Uniformed Services Academy of Family Physicians as Program Co-Chair for the 2023 USAFP Annual Meeting & Exposition. Your innovative, comprehensive, and dynamic program focused on the theme "Together - We are Strong Diverse Flexible" exceeded the professional and educational needs of our diverse membership. Through your tireless efforts, you have helped your friends and colleagues in all services to grow as clinicians and leaders."

Congratulations
Drs. Lauters and Garcia!

President's Award
Pamela M. Williams, MD, FAAFP
Col, USAF, MC

Dr. Williams' award reads as follows: "In recognition and deep appreciation of your outstanding leadership and service to the Uniformed Services Academy of Family Physicians. Your long standing leadership and mentorship in UME, GME, and USAFP roles has exceeded the professional and educational needs of our diverse membership and shaped the culture and capability of multiple generations of Family Physicians. Through your tireless efforts, you have helped your friends and colleagues in all services to grow as clinicians and leaders."

Dr. Williams is pictured with USAFP 2022-2023 President A. Marcus Alexander, MD.

Congratulations Dr. Williams!

President's Award
Anthony I. Beutler, MD, FAAFP
Col, USAF, MC

Dr. Beutler's award reads: "In recognition and deep appreciation of your outstanding leadership and service to the Uniformed Services Academy of Family Physicians. Your long standing leadership and mentorship in UME, GME, and USAFP roles has exceeded the professional and educational needs of our diverse membership and shaped the culture and capability of multiple generations of Family Physicians. Through your tireless efforts, you have helped your friends and colleagues in all services to grow as clinicians and leaders."

Dr. Beutler is pictured with USAFP 2022-2023 President A. Marcus Alexander, MD.

Congratulations Dr. Beutler!

consultant's report
COAST GUARD/PUBLIC HEALTH SERVICE

Preciosa P. Pacia-Rantayo, MD, FAAFP
USCG Base Cape Cod Kaehler Memorial Clinic

As we just wrapped this year's conference, let us remind ourselves of our theme: Strong, Diverse and Flexible. We are stronger together. There is truly power in numbers. Our role in caring for our patients while meeting other commitments are inherently possible when we join hands. Secondly, our acceptance of each other's uniqueness and differences (diversity) empowers us. It adds to our academy's foundation and is an important bedrock for what we stand for. And lastly, we are flexible: we adapt. The complexities of our health care system with its own administrative burden can be significantly daunting. Still, we find ways to be effective, we persevere, and we make changes. In the end, we as Uniformed Service of Family Physicians continue to excel.

In this edition, we have only a few brief updates from both the USPHS and USCG.

Clinic Holiday Party

Kaehler clinic personnel enjoying hiking in Cape Cod

UPDATES FROM THE COMMISSIONED CORPS:

Below are summary points from the three most recent DHS Commissioned Corps meetings:

- Appointments must be made if officers are wishing to come to Commissioned Corps Headquarters (CCHQ) in-person. This can be done by reaching out to eCMCS or to the appropriate email box. Commissioned Corps Management Information System (psc.gov)
- In the Fall, we announced the addition of the Deployment Preparation Plan (DPP) to our annual requirement for Readiness. Each officer should have submitted the first DPP form. It was due on March 31, 2023. Officers who are missing a DPP will be designated as "Not Qualified".
- The USPHS Retirement policy has been updated. It is under Commissioned Corps Instruction (CCI) 384.03 and it combines regulations pertaining to Mandatory, Voluntary and Involuntary Retirement.
- Officers assigned to non-HHS agency are required to submit the form, "Statement of Counseling –Acknowledgement of Conditions of Details to Non-HHS Agencies". The form allows the officer to acknowledge the potential that he/she may be returned to Health and Human Services (HHS) by a non-HHS agency. It was due on March 15, 2023.
- PHSPay has replaced the paper pay stub. It is available through the Access Management System (AMS), under the Open Access Internet Section.
  First step is to LINK PHSPay Application to AMS
  Log into AMS via https://ams.hhs.gov/amsLogin/SimpleLogin.jsp
- For accountability and visibility, officers are asked to notify the Office of the Commissioned Corps Liaison (OCCL) when they travel overseas for personal reasons.

UPDATES FROM THE US COAST GUARD

- Operation Vigilant Sentry (OVS) continues in Key West, Florida. It is mainly involved in the deployment of personnel, air and surface assets in response to illegal maritime migration in the Caribbean region of the US.
- ALCOAST 052/23 was published recently. It was to solicit both enlisted and officer applications for consideration to attend the Uniformed Services University of the Health (USUHS).

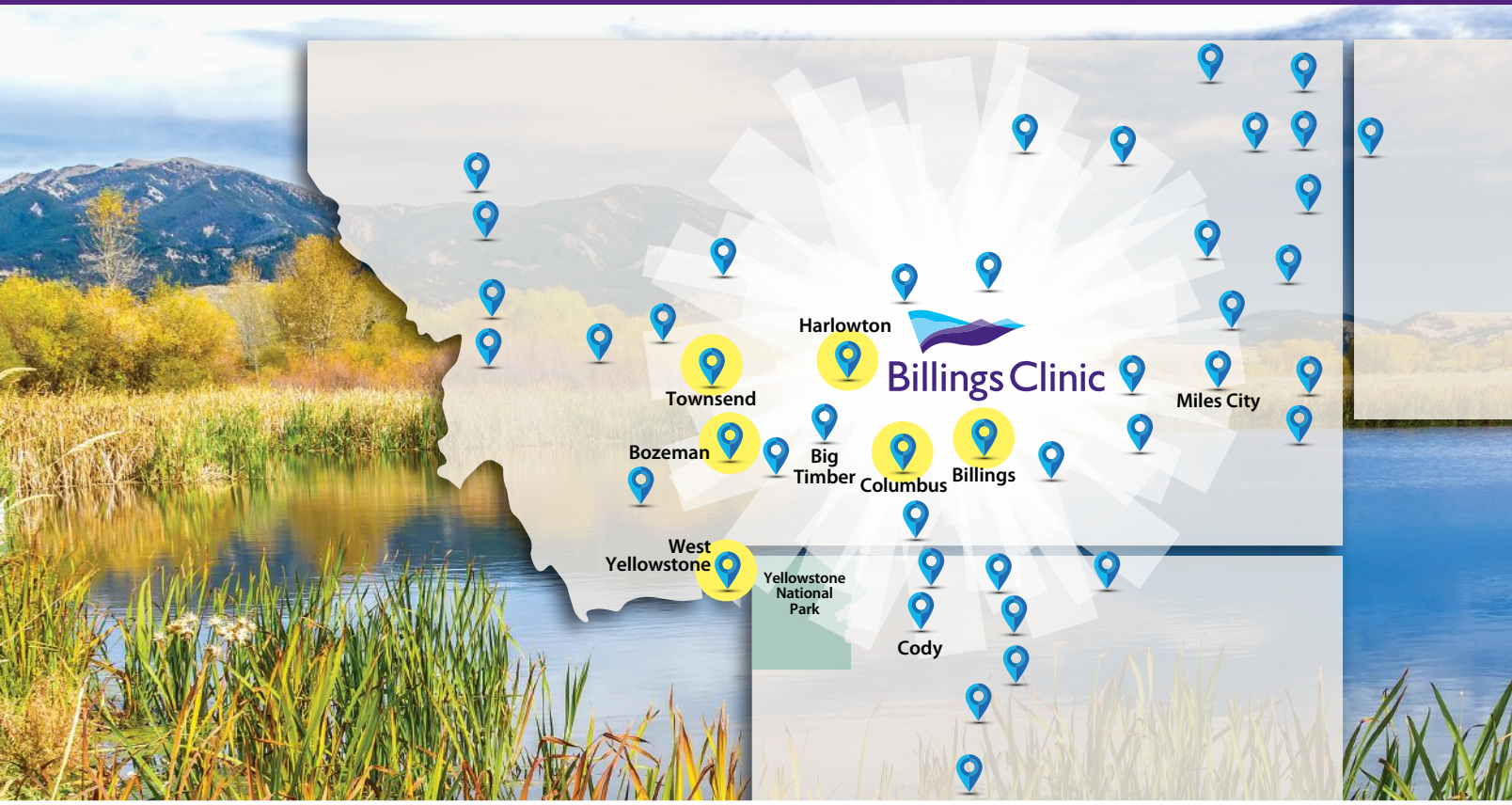
As my term on the USAFP Board of Directors ends this Spring, I would like to thank the entire USAFP family for allowing me to serve. Thank you for the opportunity.

Best to all of you!

REFERENCES

1 "Operation Vigilant Sentry: Stopping illegal migration at sea," United Stated Coast Guard News, accessed April 1, 2023, Operation Vigilant Sentry: Stopping illegal migration at sea > United States Coast Guard News > Press Releases (uscg.mil).

Physician-Led Medicine in the Rocky Mountains



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consultant's report
NAVY

Michael J. Arnold, MD, FAAFP
Uniformed Services University
michael.arnold@usuhs.edu

Greetings, Navy Family Medicine colleagues! It was so great to see many of you at the USAFP Annual Meeting! I want to take this time to ensure we have a shared understanding in this often challenging time of transition.

DHA LOOKS TO BOLD CHANGE

I remain impressed that LTG Crossland came to USAFP after only 3 months as the DHA Director to present her vision for using technology to reduce the administrative burdens on clinical teams. Since DHA doesn't own the personnel who staff the MTFs and is struggling to hire in order to fill gaps left by the Navy and other services, the course she described is a viable way forward. I am interested to hear from the Navy location that becomes a pilot site for the DHA value-based care initiative.

NAVY MEDICINE – PLANNING FOR THE NEXT WAR

Our USAFP Navy breakout also included an overview of the Navy Medicine reorganization in planning for medical response during the next conflict, with the idea of smaller deployed platforms and the need for prolonged casualty care. This starts with the BUMED breakdown into the Maritime Headquarters (or admin) side and the Maritime Operations side.

We also heard about the BUMED Operations goals for organizing us, two of which I found particularly significant to Navy FM:

1. Tie MTF staff to a greater variety of platforms, including the new hospital ship replacements (EPFs). What are currently the Expeditionary Medical Facilities (EMF's) that we pull from for operational taskings will become more organized platforms that train together for specific roles.
2. Take residency faculty off of platforms to protect Graduate Medical Education.

It will be interesting to see how this works out in the future. While current DHA productivity demands have such an impact on MTF Family Physicians (FPs), these platforms will carve out one quarter of the time of these same FPs for the train and equip mission. The inherent conflict between the goal to employ the same people in future combat training and the active duty and beneficiary care mission are acknowledged but not addressed.

NAVY FAMILY MEDICINE – STRUGGLING IN THE MIDDLE

One of the key messages coming out of the Breakout Session is that working at DHA facilities can be extremely challenging, as COs/MTF Directors push us to get closer to productivity metrics based on staffing that has only been aspirational. This was somewhat balanced by folks pointing out that life on the operational side is much better.

I want to ensure you know that I have used our staffing shortfalls to push a consistent message that we have to conceptualize our FPs as the Golden Geese, and that we need to stop sacrificing to short-term productivity in our under-resourced environments. This is also my consistent message to COs, who may not always see me as the happy warrior that I picture myself as.

Our staffing has become much more challenging over the last two years. For nearly two decades, Navy Family Medicine has been staffed between 92-93% of our available billets, which is now down to 84.7%. Our billet gap has increased from 33 to 53 FM roles without a FP when the music stops. Recognizing that overall physician staffing has shifted GMOs from a pool of bodies we can selectively use to unfilled billets that we need to help cover, this is exacerbating the CONUS MTF shortfalls. This summer, we will be gapping 65 of our 179 CONUS MTF billets. Retaining FP's is becoming more and more important, and that's the message I am sharing.

DETAILER UPDATES

Greetings Family Medicine Community!

It was a true pleasure to meet many of you in person at USAFP to discuss the detailing process, review your record, discuss career management and next duty station opportunities. If you were not able to attend or meet me while at the conference and would like to schedule a time discuss the same items, please email me at shari.l.gentry.mil@us.navy.mil to schedule a phone call.

The 2024 detailing process will begin soon so be on the lookout for key opportunities (read Dr. Arnold's emails thoroughly!) This spring, the BUMED Milestone and Command screening opportunities will come out and I encourage senior FM physicians to apply – we need your leadership! This summer, I will send out ranking lists for anyone with a PCS in 2024 as well as the non-specialty specific billet opportunities. In the fall, I will start putting orders in once I have seen everyone's input for next duty station though I will wait until late fall for anyone applying to a BUMED Milestone, Command screen or non-specialty specific opportunity.

As we start the 2024 detailing cycle, please remember that operational billets will be the top priority followed by OCONUS

continued on page 22

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continued from page 20

and then CONUS duty stations. If you have not been in an operational billet (Fleet or Fleet Marine Forces), I strongly encourage you to look at those opportunities as a way to learn about the Navy you serve in and have a refresh from the Military Treatment Facility. We need leaders in both environments and it's extremely important for promotion to be able to navigate in both!

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

PROMOTIONS – NEVER LOOKING BETTER

There are several reasons that promotions will be better this year than previous years:

1. Staffing – When there are less physicians, promotion rates go up and zones come faster. We lost a lot of above zone folks, so it's a great time to be in zone. Watch those zones, if you think you have two years to be in zone, it may just be one.
2. Rule Changes – Last year, all officers who were getting out of the Navy in the next several months were taken out of the pool for in-zone promotions. This has been changed and will increase promotions rates by more than 5%.
3. Promotion Rates – Promotion Rates are basically as high as they have ever been – 90% for O-5 and 95% for O-6. While the 95% promotion rate for LCDR is a new statutory requirement, that rule change will help that a lot. Please look at the Officer Data Card – basic deficiencies here have been problematic for great folks who were not selected for promotion.
4. One-of-One Fitreps Valued – One of the traditional issues with operational tours is that the 1-of-1 Fitness Reports common in operational jobs were difficult to compare to the MTF physician with the clear breakouts among peers. The Board Precept letters have been saying that they value operational tours despite 1-of-1 Fitreps, and I've seen more and more promotions of primarily operational colleagues. Soft breakouts are essential and line CO's tend to be outstanding at this.

In the next issue, I hope to be sharing promotion board information to make sure that it met my predications.

BONUSES

I have no insight into future bonuses, but I have been reminding my bosses that FP bonuses have contributed to our current staffing crisis. Introducing the 6 year bonus for just 2 years and then taking it away while it remained available to our Army and Air Force peers correlates precisely with the highest attrition we have seen in the last 20 years. I also made the point that our FP gaps are more important to running the beneficiary care mission and will be just as important in the next conflict. I'm curious to see how this messaging resonates when the money is allocated.

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 connect you with other colleagues who can. Enjoy your summer!

Thanks, Mike

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George R. Mount, MD, MHPE
Program Director, Leader & Faculty Development
Madigan Army Medical Center
george.r.mount.mil@health.mil

Leading Toward a Leader Identity

"Physicians implicitly must do two things: teach and lead. Teaching is the root of the word doctor, and passing on knowledge to patients and trainees is a mandate. Leading is also a critical professional skill. Leading health care teams, leading patients and leading trainees are all required." – *All Physicians Lead, The U.S. Army Medical Corps Leadership Development Program, February 2013.*

As military medicine faces unprecedented challenges, the above quote holds true and implies a critical call to action. Indeed, solutions to these challenges ultimately depend on the efforts of effective physician leaders at all levels. Yet, military physicians, particularly those in the early stages of their careers, often struggle as frontline leaders. While these struggles undoubtedly reflect underdeveloped leadership skills, a lack of identity as a leader also plays a critical role. What does it mean to identify as a leader? Turning to professional identity formation (PIF) provides an informative construct. PIF has been defined as the transformative process through which one integrates the knowledge, skills, values, and behaviors of a professional with one's own identity and core values.[1] PIF's importance in medical education is well-recognized, and some have argued that PIF stands as the foundational goal in all medical education endeavors.[2] The Accreditation Council for Graduate Medical Education (ACGME) further defined this goal's importance within the core competency of professionalism for medical trainees and, more recently, within the Clinician Educator Milestones to include a Milestone focused on leadership skills.[3] Uniquely, military physicians are tasked with forming professional identities as military officers and physicians.[4] One's ability to form an identity as a leader is undoubtedly an inherent component of this unique task.

As military medical educators, we recognize the imperative to lead our trainees toward an identity as a leader. Let us explore what it means to impact professional identity and how we might, as educators and leaders, contribute to the formation of leader identity in our students, trainees, and peers. Before we review techniques and strategies to impact one's identity as a leader, exploring research on medical leader identity formation provides valuable instruction. Though most of the evidence on PIF in medical education has traditionally focused on physician identity, a few groups have explored medical leader identity formation more specifically. Maile et al. argued that medical leader identity formation begins before medical school and is influenced, shaped, and challenged throughout a physician's career. They posit that forming a leader identity requires support during and after training while recognizing and adjusting for various threats to creating this aspect of professional identity.[5] As medical educators and leaders, ensuring this required support will no doubt allow us to lead the next generation of military physicians toward a leader identity.

With a clearer understanding of the conceptual aspects of leader identity formation, let's now consider how one might impact this critical process. Pedagogical interventions aimed at PIF are numerous and varied, so only a few will be considered here (Figure 1).

Figure 1. Interventions to Impact Leader Identity

Consciously providing leadership opportunities at all levels, and importantly labeling them as such, offers critical leadership skill development and can enhance a participant's conceptualization of their identity as a leader. Role modeling by senior leaders, mainly if employed with the explicit intent to highlight leader activities in all aspects of medical care, provides a vivid example of medical leadership in action. Narrative and

reflective practice are common interventions employed in PIF and would be expected to impact medical leader identity similarly. The potential of these practices is supported by their inclusion in many leadership development programs.[6] Adhering to the maxim that what you measure is what you value, we should incorporate leadership assessment tools in our training environments. An excellent example of this practice already exists in military medicine, with the Uniformed Services University's leadership assessment tool utilized for our uniformed medical students.[7,8] In the graduate medical education realm, as we continue to build and enhance Military Unique Curricula (MUC), consideration for forming a leader identity and assessing core leadership skills must be part of our efforts.

As one embarks on this critical work, a few caveats and words of caution are warranted. Given the potentially life-changing impact of identity formation, interventions aimed at impacting an identity as a leader should be rigorous, with a clear understanding of the various theoretical perspectives underpinning PIF.[9] Moreover, our trainees and peers come to military medicine with myriad personal and professional identities. We must exhibit care in respecting the intersection of these identities with those we hope to foster as military physicians and leaders. This care includes paying particular attention to the personal identities of individuals from groups traditionally underrepresented in medicine.[10] Additionally, forming an identity as a physician leader is an ever-evolving process, so we must consider leader identity formation as a journey rather than a destination to achieve a specific or "ideal" identity as a physician leader.

In sum, military officers and physicians must lead at all levels. Yet, many may struggle to form a professional identity as a leader. A better understanding of professional identity formation will help medical educators and military officers develop processes and interventions to close this leader identity gap. Moreover, doing so carefully, with an evident appreciation for the potential pitfalls in this critical process, will ensure our efforts have the intended impact. Namely, we must aim to enable all military physicians to comfortably identify as a leader if we are to meet the crucial dictum that "All Physicians Lead!"

If exploring concepts such as professional and leader identity formation resonate with you, please consider the unique training experiences provided by the military's only Leader and Faculty Development Fellowship. A 2-year program at Madigan Army Medical Center, the Leader and Faculty Development Fellowship's mission is to develop military physicians capable of leading and equipping physicians at all levels and to advance military medicine through innovation and research. Fellows complete a Master's degree program (MPH, MBA, MHPE, or MEd-HPE) while utilizing a curriculum built on three pillars: Lead, Equip, and Advance. Interested officers can apply for the fellowship through the Joint GME Selection Board process, which opens to applicants on July 1st. For more information about the fellowship, don't hesitate to contact me, my associate program director LTC Ashley Smith, or any of our current or past fellows.

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committee report
CLINICAL INFORMATICS

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As the field of healthcare continues to rapidly evolve, the importance of clinical informatics cannot be understated. Clinical informatics involves the use of technology and data to improve patient care, optimize clinical workflows, and enhance the overall effectiveness of healthcare delivery. Any successful effort to implement changes involving technology or data will involve trained informaticists.

The Clinical Informatics Committee is here to support you and your efforts to care for patients and communities. From medical students interested in working with data to answer their clinical questions to board-certified clinical informaticians, there is a place for you on the committee.

From an ACGME perspective, clinical informatics directly supports a Systems-Based Practice. Operationally, clinical informatics ensures accuracy in assessing and delivery readiness while advising commanders as to requirements. Clinical Informatics facilitates an adaptive practice, integrating multiple patient data sources, social determinants of health, and improving patient-directed communication.

Clinical informaticists play a critical role in operationalizing the use of technology and data within healthcare systems. They are responsible for designing and implementing systems that allow for the collection and analysis of patient data, as well as developing strategies for using that data to inform clinical decision-making. These professionals are also tasked with ensuring that electronic health records (EHRs) are used effectively, both in terms of patient care and operational efficiency.

In recent years, clinical informaticists have played an important role in the implementation of the Military Health System (MHS) GENESIS EHR. Success in implementation relies on end-user feedback, facilitated by informal and formal leaders within the informatics space.

Moving forward, our committee aims to provide an integrated look at practice management and operational medical systems in our quarterly newsletter. Our goal is to showcase the ways in which clinical informatics can improve the delivery of care within our healthcare system. We plan to cover a variety of topics individually and with other committees, including:

- Best practices for implementing and optimizing MHS GENESIS workflow for family physicians
- Strategies for using data to inform clinical decision-making
- Innovations in healthcare technology and their potential impact on patient care
- Updates on the implementation of the MHS GENESIS system and its ongoing evolution

We will also explore how we can work to emphasize value and enable LTG Crosland's expressed vision of evolving healthcare. Where do you see opportunity today to enable change tomorrow? Moving from legacy systems towards a converted healthcare ecosystem which leverages technology to seamlessly provide insights and drive action is imminently achievable if we capitalize on warranted deviation from our current norms.

We hope that our newsletter will serve as a valuable resource for members of the academy who are interested in learning more about clinical informatics and its role in modern healthcare delivery. We encourage members to reach out to our committee with any questions or suggestions for future newsletter topics.

Barrett Campbell, MD, MBA, MS, FAAFP
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- Rapidly evaluating drugs to repurpose for military medical gap solutions.

Fellowship Eligibility Requirements:

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FOR MORE INFORMATION CONTACT:

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2023 USAFP Research Competition Recap!

Strong. Diverse. Flexible. Our 2023 conference theme reflected the truly amazing research being conducted by USAFP members. The annual research competition is a fantastic way to showcase the terrific work being done on the front lines. Of 158 abstracts submitted, only 20 were selected to compete at the podium for a conference of nearly 600 uniformed family physicians. Another 22 abstracts were selected for poster presentation. This best of the best competition truly highlighted the strength of the research and the diversity of presentations. The abstracts of all the winning presentations are presented below. We hope that these highlighted members showcase the terrific work being done out there and inspire others to present their own research in New Orleans in 2024.

I also want to mention our workshop at the conference. Our workshop on Writing for Publication focused on our goal of publication. We all know of research projects that we have poured intense energy and time into, only to see them wither on the vine and be orphaned. The CIC is committed to help get those orphaned projects published and disseminated into the world. To that effect, every podium presentation in Orlando has been paired with a research judge to help them publish their paper. We know that because these projects are so good, many, if not all of them, could be published in a Medline indexed journal. We are here to help! Below is the list of researchers and their paired research judge who stands ready to help shepherd them through the publication process.

Continue the great research, discover that great case report, and if you want to come to New Orleans, why not try and present your research and get an invite? Our submissions for the research competition for NOLA 2024 starts in July!

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2023 Juried Podium Award Winners

Case Report 1st Place Medical Student

Primary Author: Cora Blodgett, 2LT

Title: Vagus Broke Her Heart: A Case of Symptomatic Bradycardia from a Vagal Nerve Stimulator

Introduction: Vagal nerve stimulators (VNS) used for refractory seizures and depression have the risk of stimulation-associated side effects including hoarseness, throat pain, cough, voice alteration, and shortness of breath. Rare complications include bradycardia with complete atrioventricular (AV) block.

Case Presentation: A 45-year-old female with past medical history of uncontrolled epilepsy treated with multiple anti-seizure medications and VNS placed eight years ago presented to the emergency department with one-week history of shortness of breath and lightheadedness. Patient was normotensive with cyclic bradycardia. Exam was significant for 2/6 holosystolic murmur and surgical scar on the left lateral neck. Labs were significant for potassium of 2.9 mmol/L. Multiple electrocardiograms showed complete AV node dissociation and ventricular heart rate as low as 42 beats per minute. Subsequent episodes of bradycardia were associated with VNS device signaling. Potassium was repleted and episodes of bradycardia resolved with deactivation of the VNS.

Discussion: VNS may cause hoarseness, throat pain, cough, and shortness of breath. Limited case reports of VNS-induced arrhythmia have been published. Physiological disruption or device malfunction are proposed etiology of VNS cardiac effects. Proposed adverse side effects of VNS system malfunction include AV block, bradycardia, syncope, and hypotension. Patients are monitored with a lead test at time of device placement and regular interrogation for the first year post-implantation. Although VNS device manufacturers produce programming wands which gather device data and program settings, there are no published guidelines proposing regular device interrogation of VNS.

Scholarly Question: Should vagal nerve stimulators be regularly interrogated in a primary care setting?

Conclusion: Although VNS are relatively safe and tolerable, rarely symptomatic bradyarrhythmia may occur. Regular device interrogation may prevent side effects of system malfunction and determine candidates for device replacement or reprogramming, though there are no current published guidelines for recommendations regarding VNS device interrogation.

Case Report 1st Place

Primary Author: LT Bradford Matheus, DO

Title: "Bad to the Bone": A Case of Atypical Osteomyelitis

Introduction: What do you do when osteomyelitis is strongly suspected but biopsies/cultures result negative? We present a case of right foot osteomyelitis status post podiatric surgeries, that after a negative bone biopsy and blood cultures, required Next Generation Sequencing (NGS) to identify an atypical causative pathogen, Gardnerella Vaginalis.

Case Presentation: A 66 year old male with history of peripheral vascular disease and bilateral bunions status post podiatric surgeries requiring hardware, was admitted for right lower extremity and foot pain/swelling. During inpatient stay, infection wasn't suspected given exam, vitals, and labs. He was diagnosed with postsurgical pain and discharged. A month later he returned with new drainage around his right metatarsal surgical site. Bone scan suggested right first metatarsal head osteomyelitis, with subsequent bone biopsy and multiple cultures negative. He was non-responsive to empiric vancomycin, and later TMP-SMX after discharge. One month later he was admitted a third time, at which point infectious disease recommended NGS that resulted positive for G. Vaginalis and this patient was treated with a 6 week course of clindamycin resulting in resolution.

Discussion: Traditionally, identification of definitive pathogen in osteomyelitis requires bone biopsy. Given that typical microbiologic yield of bone biopsies can be 37-87 percent, there is need for alternative sensitive pathogen identification modalities when osteomyelitis is strongly suspected. NGS is already being widely utilized in pediatric cases where osteoarticular infections, bacteremia, or febrile neutropenia is suspected and may be a helpful tool in adults with biopsy-negative osteomyelitis.

Scholarly Questions: Would the use of next generation sequencing on initial presentation of presumed osteomyelitis be more cost effective than conventional bone biopsy with regards to delay of diagnosis of causative pathogen and morbidity from adverse outcome?

Conclusion: NGS may have utility in infectious pathogen identification where no clear organism is able to be identified via traditional cultures.

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Case Report 2nd Place

Primary Author: Capt Alexander Beckstead, MD & Capt Vi Tran, MD

Title: Can't You Cystatin-C, My Kidney is Fine?

Introduction: Independent of age, sex, and body composition, certain ethnic minorities and individuals with higher muscle mass have elevated serum creatinine levels on average which may result in overestimation of renal disease. We present a misdiagnosed case of kidney disease based on serum creatinine illustrating the utility of confirmation testing with cystatin-c evaluation.

Case Presentation: A 35-year-old Black male with a history of well-controlled HIV was referred to a nephrology clinic after he was found to have consistently elevated creatinine. We diagnosed kidney disease stage 3A based on the estimated glomerular filtration rate (eGFR). Further evaluation showed isolated elevation of creatinine with unremarkable urinalysis and other labs. Creatinine elevation predated diagnosis and treatment of HIV. We performed cystatin-c-based eGFR (eGFRcys) showing the absence of kidney disease.

Discussion: The 2009 Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) calculation of eGFR based on serum creatinine concentration uses age, sex, and race with a recommendation in 2021 to exclude race. Both equations are less accurate in Black patients, individuals taking medications that interfere with creatinine secretion and assay, and patients taking creatine supplements or protein intake. These clinical scenarios decrease eGFRcr but don't change measured GFR or eGFRcys. Diagnosis of kidney disease requires GFR ≥60 mL/min/1.73 m2 with kidney damage (proteinuria or radiologic abnormalities, etc.) or GFR ≤60 mL/min/1.73 m2. Using serum creatinine and serum cystatin-c, eGFRcr-cys yields improved concordance to measured GFR across race groups than GFR estimation based on creatinine alone. Confirmation with cystatin-c can avoid unnecessary expensive diagnostic workup, misdiagnosis, incorrect dosing of drugs, and accurately represent the military readiness of patients.

Scholarly Question: Can confirmation screening of kidney function with cystatin-c in Black patients and patients with high muscle mass reduce misdiagnosis of kidney disease?

Conclusion: In patients diagnosed with renal disease solely by creatinine-based eGFR who lack other kidney disease features, we recommend using confirmatory eGFRcr-cys.

Case Report 3rd Place

Primary Author: CPT Sean M. Rogers, DO

Title: Presumptive Diagnosis of Myasthenia Gravis following Fumigation Exposure

Introduction: Myasthenia gravis is a rare autoimmune disorder affecting the neuromuscular junction of skeletal muscles. Numerous conditions are known to precipitate myasthenia gravis. Exposure to pyrethroids, common fumigation agents, has not been noted extensively in the literature.

Case Presentation: A 33 year-old male was admitted to the ICU with delirium, tachycardia, apnea, and abdominal pain. Evaluation including toxicity screens, CT, MRI, and EEG were negative. After 72 hours, he continued to have fluctuating muscle weakness and respiratory distress after minimal exertion, which was inconsistent with an acute toxicity. He reported that two weeks prior to presentation, he had entered his home within one hour of fumigation with pyrethroids. Given concern for a neuromuscular junction disorder, the patient was transferred to a tertiary care center. Electromyography demonstrated fatigable muscle weakness suggestive of myasthenia. Acetylcholinesterase receptor antibodies and muscle tyrosine kinase antibodies were negative, and a thymoma was not detected. A presumptive diagnosis of antibody negative Myasthenia Gravis was made. Treatment with pyridostigmine and prednisone led to symptom improvement, and he was discharged on azathioprine.

Discussion: Myasthenia gravis is an autoimmune disease caused by antibodies against the acetylcholine receptor. It commonly presents with fatigable ocular and bulbar weakness progressing to respiratory, axial, and limb weakness (Heir 2018). Acute toxidromes, stroke, endocrine abnormalities, and sepsis may present similarly to a myasthenic crisis. Precipitants include infection, tapering of immunotherapeutic medications, drugs, and pregnancy (Amato, 2022). Pyrethroids are not known to provoke myasthenia. Nevertheless, their mechanism of action interferes with the neuromuscular junction (Bradberry et al. 2005).

Scholarly Question: Can pyrethroids cause or unmask neuromuscular junction disorders?

Conclusion: When Family Medicine Physicians are considering a neuromuscular junction disorder, precipitating toxins should be considered. Further studies should be done to determine if pyrethroids, a common insecticide agent, can unmask or worsen myasthenia.

Case Report 3rd Place

Primary Author: Capt Andrew S. Dickson, DO

Title: High-Altitude Induced Splenic Infarction in a Patient with Sickle Cell Trait (SCT)

Introduction: Sickle Cell Trait (SCT) is a generally benign condition with few physical manifestations, however, when exposed to physiologic stress, SCT rarely results in complications commonly associated with Sickle Cell Disease (SCD). Presented is a case of a patient with SCT exposed to high-altitude leading to splenic infarction.

Case: A 46-year-old former active-duty male with previously asymptomatic SCT presented with left upper quadrant abdominal pain, decreased fluid intake, and dark urine after a camping trip at 10,000 feet elevation for two days. Laboratory results showed rhabdomyolysis with a CK of 5,035 u/L (range 39-308 U/L).

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Computed tomography of the abdomen showed multiple areas of splenic infarction. He was admitted for 24 hours and treated with supplemental oxygen, fluids, and pain control. He recovered completely without any additional medical or surgical interventions.

Discussion: High altitude induced splenic infarction in individuals with SCT is rare. According to a comprehensive systematic review of case studies from 2021, only 22 cases were documented in the United States (US) from 1970-2020. Misdiagnosis of the underlying cause of splenic infarction may be more common than what is reported. Only the military and NCAA routinely screen for SCT in the US. Most identified cases of splenic infarct due to SCT are treated with symptomatic care, including descent to lower altitude, supplemental oxygen, pain control, and fluids. Splenectomy was performed in 5 of 22 documented cases in the US. Awareness of SCT causing splenic infarct and increased screening for SCT may decrease the risk of unnecessary anticoagulation and splenectomy for patients with splenic infarct.

Scholarly Question: Should more populations be screened for sickle cell trait?

Conclusion: Splenic infarction in SCT is rare. Verify or test for SCT and SCD prior to splenectomy and anticoagulation in patients with splenic infarction.

Clinical Investigation 1st Place Resident

Primary Author: CPT Meghan Jastrzembski, DO & CPT Paige Williams, MD

Title: Military Family Medicine Physicians' Management of Intimate Partner Violence

Introduction: Intimate Partner Violence (IPV) has insidiously eluded physicians for years. 10-30% of people fall victim during their lifetime. The US Preventative Services Task Force (USPSTF) recommends that women of child bearing age be screened and if positive, be counseled and offered interventions. There are 10,000 reported incidents of IPV involving service members annually. This study looks at the level of training, comfort, and current practices of military family physicians addressing IPV.

Methods: Design and Setting: Cross-sectional study using voluntary, anonymous data from the 2022 Uniformed Services Academy of Family Physicians (USAFP) Annual Meeting Omnibus Survey.

Study Population: USAFP members attending the meeting

Intervention: None

Main outcome measures: Level of training, comfort, and current practices of military family physicians

Statistical analysis: Descriptive statistics and chi-square tests.

Results: The response rate was 61%, n=323. 73% of respondents lacked confidence in addressing the health outcomes of IPV and 84% are unable to confidently provide comprehensive counseling. There was no statistically significant difference between genders in their comfort addressing health outcomes or counseling IPV patients (p=0.436 an p=0.134 respectively), even though there is a statistically insignificant marginal increase in the percentage of woman physicians who have seen multiple IPV patients during training than men (39.7 vs 27.7, p=0.045). Additionally, 65% and 83% were not fully aware of the resources provided by the military or their community, respectively. During residency, 36% received no formal training with only 18% receiving more than one formal training. There is no statistically significant difference in the formal training residents have received regardless of how long ago they trained (p=0.791).

Conclusion: Many family physicians lack the confidence to treat IPV patients. Family physicians lack formal training as well as exposure to patients experiencing IPV, which is surprising with the prevalence of IPV. Further studies could elucidate opportunities to improve training for family physicians and to identify ways to screen more effectively.

Clinical Investigation 2nd Place Resident

Primary Author: Capt Evan R. Locke, MD

Title: Variation in Time to Gender-Affirming Hormones in Adolescents and Young Adults in the US Military Health System

Introduction: Transgender and gender-diverse (TGD) military-affiliated dependents were officially authorized to receive gender-affirming medical care in September 2016. This study identified recent diagnoses of gender dysphoria among this population and described time-to-receipt of gender-affirming medical care.

Methods

Design: Retrospective cohort

Setting: Military Health System (MHS) Data Repository

Study Population: Military-affiliated dependents aged 14-25 years with an ICD 9/10 code suggestive of gender dysphoria who received TRICARE Prime care between September 2016 and December 2021

Intervention: None

Main Outcome Measures: Median time-to-gender-affirming-hormones, median time-to-gonadotropin-releasing hormone agonists

Statistical Tests Used: Kaplan-Meier Estimates, Cox Proportional Hazard Models

Results: Of 3299 patients, 985 received gender-affirming hormones. Median time-to-gender-affirming-hormones was 1418 days. Compared to 14-17 year olds, 18-25 year olds took significantly shorter time to initiate hormones (HR=2.69 (95%CI 2.37-3.06)). Patients who received mostly purchased-care,

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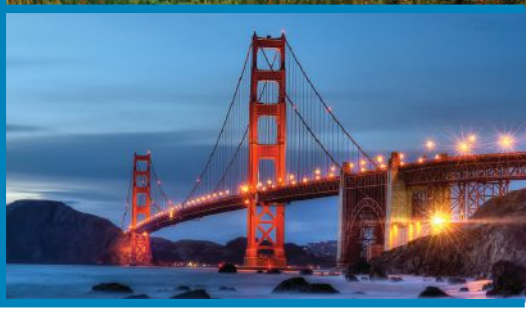

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compared to mostly direct-care started hormones significantly faster (HR=1.38 (95%CI 1.18-1.63)). Individuals with senior officer sponsors started hormones significantly faster than those with junior enlisted sponsors (HR=2.12 (95%CI 1.21-3.71)), but this effect did not persist in multivariable analysis. A total of 150 (7.8%) of 1,928 youths aged 10-16 initiated gonadotropin-releasing hormone agonists.

Conclusion: TGD military-affiliated youths generally take a considerable amount of time to initiate gender-affirming hormones. Factors which influenced time-to-hormone initiation included age and use of purchased- or direct-care. These findings may reflect influences of the unique social factors experienced by military-affiliated dependents on access to gender-affirming care. A larger sample size may be needed to assess potential inequities among groups; however, it is possible that those receiving care in this low- or no-cost healthcare system have some protection from sociodemographic inequities. The low percentage of eligible patients on puberty blockers may suggest lack of comfort among clinicians. Research is needed to assess and reduce barriers to gender-affirming medical care in the MHS.

Clinical Investigation 3rd Place Resident

Primary Author: CPT Benjamin Garcia, MD

Title: Are Military Providers PrEP'ed?

Introduction: From January 2021 to June 2022, 433 new HIV infections were identified among United States service members. The ability to reduce the incidence of HIV within the military requires identifying individuals with high-risk sexual behavior, counseling on risk reduction methods, and offering medications proven to decrease the transmission of HIV. The purpose of this study is to assess military family physician's confidence to identify, prescribe, and monitor HIV PrEP in those at highest risk of infection and inform ways to implement HIV PrEP prescribing at the primary care level within the Military Health System.

Methods: Descriptive study involving voluntary anonymous survey data from registered attendees at the 2022 Uniformed Services Academy of Family Physicians (USAFP) annual meeting. Descriptive statistics and chi-square analysis were used to assess the confidence of military family physicians to identify, prescribe, and monitor HIV PrEP.

Outcomes: Most survey respondents (94.5%, n=291) were willing to prescribe HIV while only 50.3% (n=147) of survey respondents reported prescribing HIV PrEP in the past. Respondents in Air Force and Navy compared to the Army were significantly more confident in identifying candidates for HIV PrEP (p=0.002, 95% CI 0.14-0.65 and p=0.022, 95% CI 0.05-0.61, respectively), starting a patient on HIV PrEP (p=<.001, 95% CI 0.36-0.89 and p=<0.01, 95% CI 0.43-1.02, respectively), and monitoring a patient on HIV PrEP (p=<0.001, 95% CI 0.38-0.94 and p<0.001, 95% CI 0.35-.098).

Conclusion: Although most military family physicians are willing to prescribe HIV PrEP, there are significant gaps in prescribing. Centralizing resources that target provider knowledge about HIV PrEP while also findings ways to address health care system barriers would be helpful in increasing HIV PrEP prescribing at the primary care level within the Military Health System.

Educational Research 1st Place

Primary Author: Maj David Garcia, MD, FAAFP

Title: Cultural Influences Fostering Increased Resident Scholarly Productivity

Background and Objectives: Scholarly activity is a core requirement set by the Accreditation Council for Graduate Medical Education (ACGME). A previous study documented a significant 302% increase in scholarly activity at Eglin Family Medicine Residency after a standard set of multilevel cultural interventions from 2016-2019. Few researchers have explained why such interventions to increase scholarly activity are effective. Prior work suggests that many different interventions are helpful. Why? Our qualitative study took a multilevel approach to explain accompanying cultural factors to determine how specific interventions led to the observed increases in quality and quantity of resident scholarship.

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- Weight Management

Radiological testing is also part of the services offered through our group at Tower Pointe Medical Center on West Alexander in Greenwood. At this facility, we are able to provide MRI, CT scans, Ultrasounds (both General and Vascular), routine films and nuclear medicine studies. We also offer services in sleep medicine with a state-of-the-art Sleep Lab.

Greenwood is a picturesque town situated in the foothills of South Carolina and on the shores of Lake Greenwood. It is a three-hour drive to Charleston's beautiful beaches, two hours to the Appalachian Mountains, and equivalent distances to both Atlanta and Charlotte. It is called both "the Emerald City" and "the Lakelands" due to its desirable climate and the numerous lakes in close proximity. It offers year-round golf, seasonal watersports and excellent hunting and fishing opportunities.

Self Regional Healthcare is a non-profit hospital, is the region's largest employer and enjoys the benefit of a large, private endowment ensuring its financial solvency. It provides care to the residents of Greenwood, Abbeville, Laurens, Saluda, McCormick, Edgefield and Newberry Counties. Self Medical Group is the large medical practice division of Self Regional Healthcare that employs 60 primary care physicians and 53 specialists in addition to 44 hospital-based physicians.

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Methods: Using a grounded theory qualitative approach, we interviewed a cross-section of high and low performing residents (12) and faculty (5) using a semi-structured interview guide. Data analysis occurred concurrently with interviews. The team iterated the interview guide three times until core code saturation was achieved. Then axial coding occurred and development of a grounded theory of scholarship cultural change occurred.

Results: During the transformation period of 2016-2019, participants identified mentorship availability, interest/opportunity alignment, research mechanics demystification, leadership support affecting productivity and research begets research as key factors which promulgated the culture change leading to increased scholarship productivity. No single factor led to increased scholarship. Collectively they mutually reinforced each other.

Conclusions: This explanatory inquiry developed a multilevel model that other residencies should consider to foster these factors together as opposed to emphasizing only one or two to increase resident scholarship productivity. Additionally, our research suggests such multilevel changes help both low and high performing residents.

Educational Research 2nd Place

Primary Author: Capt Kryls Domalaon, MD

Title: Family Physician Education and Barriers to Promoting Smoking Cessation: A Multi-Service Investigation

Introduction: Cigarette smoking remains the leading cause of preventable disease and death in America. Brief discussions with doctors increase cessation rates by two-thirds, and physicians trained in smoking cessation are more likely to perform counseling. Multiple organizations also recommend connecting counseling with lung cancer screening (LCS), yet physicians and patients report a lack of such integration. We sought to characterize the education received and the barriers to providing smoking cessation counseling, and to determine its integration with LCS among military Family Physicians.

Methods

Design & Setting: Cross-sectional study as part of the IRB-approved Omnibus Survey

Study Population: Registered attendees of 2021 Annual Conference

Main Outcome Measures: (1) Assess the amount of formal smoking cessation education during and after residency, (2) Assess barriers to providing smoking cessation within the military healthcare system, (3) Assess if physicians connect smoking cessation counseling and LCS

Statistical Analysis: Descriptive statistics with chi-square analysis

Results: With a response rate of 61% (n=323/487), most participants reported receiving <3 sessions of formal education during (72.9%) and <3 hours after residency (76.2%). 48% cited their healthcare system never or rarely provided resources on smoking cessation. Time was the largest barrier to promoting smoking cessation (62.6%) and to integrating it with LCS (56.7%), although a considerable percentage also cited lack of supporting staff (34.3%). Further, only 50.6% of respondents reported always counseling on smoking cessation with LCS.

Conclusion: Smoking cessation education is provided in family medicine residencies but rarely offered by the healthcare system after this initial education. Time and lack of support staff/resources are recognized as notable barriers within the military healthcare system. A large proportion of uniformed Family Physicians also do not link LCS guidelines with patient education on tobacco cessation and resources. Further research is needed to guide interventions to overcome these challenges within the military healthcare system.

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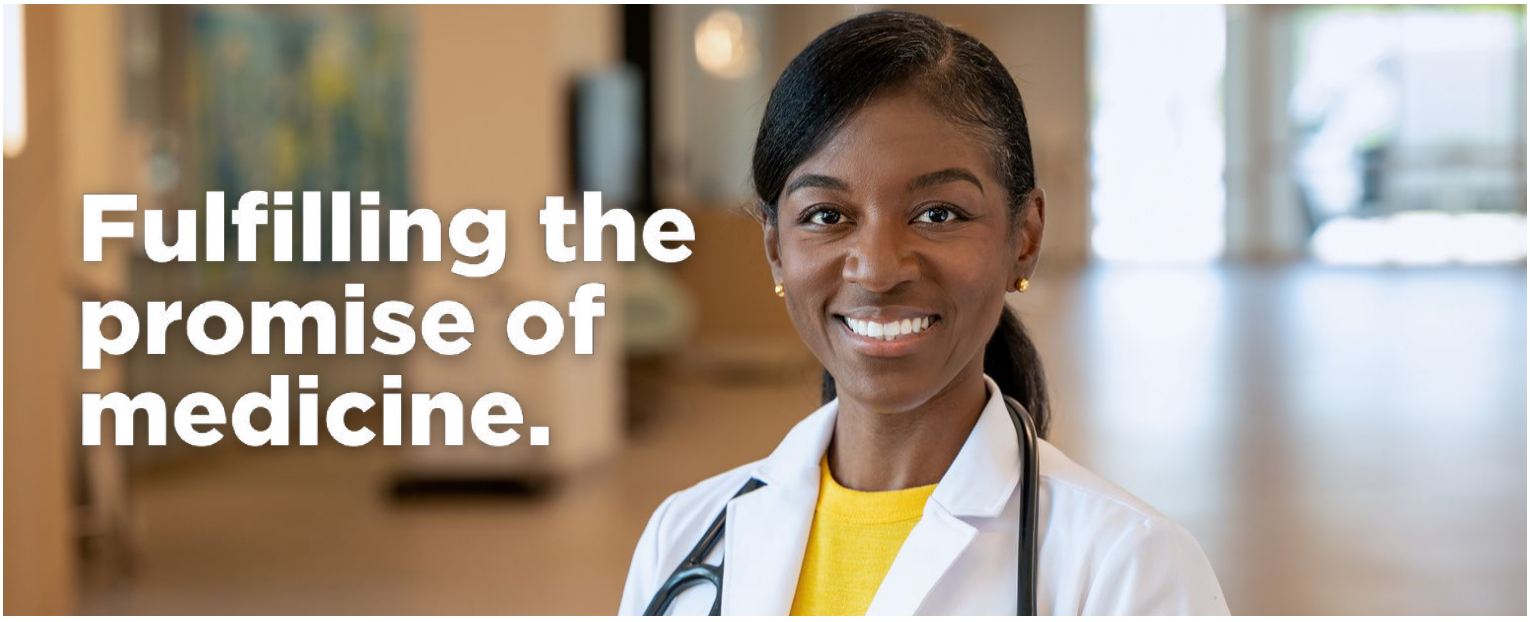

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2023 Juried Poster Abstract Winners

Poster Case Report 1st Place Medical Student

Title: Cold Feet When Joining the Army

Primary Author: 2nd Lt Kohen Webster Newsome, MS3

INTRODUCTION/OBJECTIVE: Popliteal artery entrapment syndrome (PAES) occurs in approximately 1% of the population, typically with exertional cramping, numbness, burning, or aching pain that resolves after rest. The incidence has increased as awareness and diagnostic modalities have improved, however, diagnosis is still often delayed. This is a case of popliteal artery entrapment, visualized on point-of-care ultrasound with confirmation arteriography.

CASE PRESENTATION: A 23-year-old active duty male presented with bilateral lower leg pain for several months. The patient reported pain with any activity, improvement with rest, and that his feet would turn purple after standing for more than ten minutes. Point of care ultrasound indicated near complete occlusion of the popliteal arteries with plantar flexion. Diagnosis of PAES was confirmed with CT arteriography and the patient was referred to vascular surgery for surgical intervention.

DISCUSSION: Popliteal artery entrapment usually presents as intermittent foot and calf pain after exercise that resolves with rest. It is rarely so severe that any movement will bring on claudication symptoms and extremity color change. Diagnostic imaging often requires multiple modalities, including MRI and arteriography, however, POC ultrasound can indicate PAES. Research suggests surgical intervention usually provides significant symptomatic relief, however, surgical symptoms may persist. If untreated, popliteal artery stenosis and thrombosis may develop, in addition to distal artery thromboembolism. As ultrasound has become more prevalent, delayed diagnosis and the above complications may be reduced.

SCHOLARLY QUESTIONS: How effective is diagnostic US at identifying the severity of PAES?

CONCLUSION: PAES, though rare, has increased in incidence due to advances in diagnosis and awareness. POC ultrasound is a useful first-line imaging modality to identify PAES. Although symptoms of PAES are not compatible with active duty service, expedited diagnosis and treatment may prevent complications and allow a service member to return to duty.

Poster Case Report 1st Place Resident

Title: No Time to Die: HLH Requires Rapid Recognition and Management

Primary Author: CPT Mark Vanzo, DO

INTRODUCTION/OBJECTIVE: Hemophagocytic Lymphohistiocytosis (HLH) is a life-threatening syndrome progressing to multi-organ failure caused by dysregulated immune cells. It is diagnosed clinically and confirmed by immunologic markers. The barrier to good outcomes is delayed diagnosis and treatment.

CASE PRESENTATION: A 19-year-old male presented to clinic with a viral syndrome managed with supportive care. He represented later with fevers, rigors and myalgia. Labs demonstrated transaminitis, hyperbilirubinemia, and severe pancytopenia. CT showed splenomegaly. He was started on broad-spectrum antibiotics and transferred to the nearest MTF. He subsequently had hypertriglyceridemia, elevated ferritin and fibrinogen, raising concerns for HLH. LP and MRI ruled out CNS involvement. Hematology recommended dexamethasone and cyclosporine. Definitive treatment, etoposide, was started after bone marrow biopsy ruled out leukemia and demonstrated hemophagocytosis. Later, elevated CXCL9 and IL-18 confirmed diagnosis. Viral titers suggested EBV as the trigger and he fully recovered.

DISCUSSION: HLH is characterized by abnormally activated cytotoxic T cells. Usually familial, a rare secondary form exists, often triggered by lymphoma or infection. It often presents with rapid clinical deterioration and carries high mortality risk. Diagnosis requires 5 of the following: fever, splenomegaly, cytopenia in two cell lines, hypertriglyceridemia/hyperfibrinogenemia, hyperferritinemia, hemophagocytosis on biopsy, low/absent NK-cell activity, and elevated IL-2. Additional derangements may include hepatocellular injury, coagulopathy, and elevated inflammatory markers. Treatment begins with an 8-week regimen of etoposide, dexamethasone, and cyclosporine. CNS involvement carries a worse prognosis requiring intrathecal therapy. Patients also benefit from supportive measures like transfusions, neutropenic precautions, and opportunistic infection prophylaxis.

SCHOLARLY QUESTIONS: Is it safe to treat for clinically suspected HLH without access to confirmatory biomarkers?

CONCLUSION: This case presents the challenge of a rare, life-threatening disease where diagnosis may require unavailable laboratory tests, and at the same time, requires prompt diagnosis and treatment for good outcomes. If HLH is suspected, treatment should begin in stepwise fashion while awaiting definitive work up and management.

Poster Case Report 2nd Place Resident

Title: Implant Implications: Can Etonogestral Implant Cause Symptoms of PCOS?

Primary Author: CPT Virginia Phillips, MD

INTRODUCTION/OBJECTIVE: Nexplanon (etonogestrel implant) has a wide range of documented side effects but has not been

known to cause or exacerbate polycystic ovarian syndrome (PCOS) symptoms. This case report raises the possibility of androgen excess, or PCOS-like symptoms, being a Nexplanon side effect.

CASE PRESENTATION: A 22-year-old overweight female with a family history of PCOS presents to clinic with a six-month history of pelvic pain, nipple discharge, atypical hair growth, and rash. History revealed Nexplanon placement eight months ago. Her exam showed acanthosis nigricans in bilateral axilla and the posterior neck, hirsutism, and buffalo hump. Laboratory evaluation showed insulin resistance by two-hour oral glucose tolerance test (OGTT). Her transvaginal ultrasound was consistent with PCOS. Following Nexplanon removal, her symptoms, including pelvic pain, hirsutism, and nipple discharge began improving within the next month.

DISCUSSION: PCOS is the most common cause of androgen excess and hirsutism in women . This patient met criteria for PCOS and had evidence of insulin resistance with the development of acanthosis nigricans and abnormal OGTT . Symptom onset and improvement correlated closely with the patient's Nexplanon placement and removal. While she likely has a predisposition for developing PCOS , we suspect the Nexplanon was the cause of her PCOS symptoms. However, worsening PCOS symptoms or inducing first presentation of PCOS is not a documented association with Nexplanon.

SCHOLARLY QUESTIONS: In women predisposed to developing PCOS, could etonogestrel implant induce or worsen symptoms of androgen excess?

CONCLUSION: This patient was likely predisposed to developing PCOS in her lifetime, and it can be easy to exclude Nexplanon as a contributing factor to her presentation. However, given the rapid improvement following Nexplanon removal, non-classic side effects of hormonal birth control should always be considered in our patients who present with new-onset androgenic symptoms.

Poster Case Report 3rd Place Resident

Title: Mucus in the Middle: Recurrent Right Middle Lobe Infections with Positive Fungal Culture for Curvularia in an Immunocompetent Young Adult Male

Primary Author: CPT Daniel Idelkope, MD

INTRODUCTION/OBJECTIVE: Middle Lobe Syndrome (MLS) is a rare condition that can often be overlooked due to misclassification as simple lobar pneumonia without recognition of a recurrent pattern. It does not have an exact definition but is characterized by recurrent or fixed right middle lobe opacification with atelectasis of the affected lobe. The underlying

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pathology is typically broken down into obstructive and non-obstructive etiologies, and here is the presentation of a patient with nonobstructive right MLS who was found to have a fungal culture positive for Curvularia.

CASE PRESENTATION: A nonsmoking, immunocompetent 23 year-old male presented to the emergency department with acute right-sided pleuritic chest pain and fever. He reported history of asthma and previous right-sided pneumonias in childhood and recent RML pneumonia 5 months prior. CT imaging revealed complete consolidation of the right middle lobe. Multiple bronchoscopies were performed with diffuse mucus plugging throughout the right middle lobe with bacterial and fungal cultures positive for Actinomyces and Curvularia. He was treated with antibiotics and itraconazole with initial clinical improvement with plan for lobectomy after 2 week course of treatment.

DISCUSSION: Guidelines for treatment of MLS are scarce, however, studies report prolonged antibiotic courses, therapeutic bronchoscopy, and lobectomy as successful treatments. This case is atypical as he has fungal colonization in the setting of MLS. Recurrence is common among patients treated with conservative measures and can ultimately require surgery. For patients that require lobectomy, multiple studies have reported 100% improvement in symptoms with a majority having complete resolution of their symptoms.

SCHOLARLY QUESTIONS: When should surgical lobectomy be considered for patients with MLS?

CONCLUSION: Previous case reports and studies support lobectomy as safe, effective, and curative treatment for MLS. This case illustrates gaps in treatment guidelines for MLS, offering an approach to managing MLS complicated by bacterial and fungal colonization.

Poster Case Report 3rd Place Resident

Title: Pan-Hypopituitarism Presenting as Hypoactive Delirium

Primary Author: CPT Phillip Scheanon, MD

INTRODUCTION/OBJECTIVE: Delirium is a common cause for admission in the elderly, and frequently occurs during hospital stays even when not the admitting diagnosis. Hyperactive delirium is most classic; however, hypoactive delirium is more common and difficult to diagnose. Presented is a case of presumed sepsis with development of hypoactive delirium.

CASE PRESENTATION: A 94-year-old male presented with poor nutritional intake and decreased activity. Patient was febrile with a sacral decubitus ulcer. He was admitted for presumed sepsis and started on antibiotics. Initial laboratory examination was significant for depressed thyroid function which was thought to be euthyroid sick syndrome. Later, a brain MRI showed a mass within the sella turcica. Despite treatment, he developed hypoactive delirium and became non-conversant on hospital day five. Further labs suggested pan-hypopituitarism. Patient received Levothyroxine and Hydrocortisone on day six and by day nine returned to normal baseline sensorium and discharged in stable condition.

DISCUSSION: Hypoactive delirium can be a result of a vast number of disease processes leading to altered mental status or sedation but is often misdiagnosed as depression or fatigue. Pan-hypopituitarism is an impairment in the secretion of all pituitary hormones and can mimic sepsis. Many cases are idiopathic in nature but can also be the result of a mass obstructing the sella turcica. Rapid diagnosis is important as progression can be permanent with increasing mortality secondary to cardiovascular and respiratory disease along with neuropsychiatric manifestations.

SCHOLARLY QUESTIONS: Can ensuring normal pituitary hormones early during treatment of elderly patients decrease their risk of developing delirium?

CONCLUSION: Hypoactive delirium is the most common form of delirium and is often misdiagnosed. A variety of things cause delirium and physicians should maintain a broad differential to prevent anchoring biases. Pituitary hormone deficiency can increase the risk of hypoactive delirium and correcting abnormal levels early, regardless of the cause, may decrease the risk.

Research 1st Place

Primary Author: Capt Xenia Brianna Gonzalez, MD

Title: Healthcare Inequities in Time to Gender-Affirming Hormone Therapy among US Military Service Members

INTRODUCTION: Beginning July 2016, transgender active duty Service members in the United States military were authorized to receive gender-affirming medical care. This study aimed to identify possible inequities in gender-affirming hormone prescriptions for active duty Service members across the Military Healthcare System (MHS).

METHODS: Design: Retrospective Setting: MHS Data Repository Study Population: Service members in TRICARE Prime, with a gender dysphoria-related ICD 9/10 code, between July 2016-December 2021 Interventions: None Main Outcome Measure: Time-to-hormone initiation Statistical Tests Used: Kaplan-Meier Analysis, Univariable/Multivariable Cox Proportional Hazards Models

RESULTS: A total of 2,540 Service members were included (54% age 18-25y; 73% white, 16% Black; 14% Latinx ethnicity; 64% Junior Enlisted; 37% Army, 25% Air Force; 46% first TRICARE enrollment gender marker female). The median time-to-gender-affirming-hormones was 363 days; an estimated 67% (95%CI 64.5%-69.5%) of patients had started gender-affirming hormones within 2 years of diagnosis. Compared to junior enlisted Service members who had a median days-to-hormones of 400, senior enlisted

members (308, adjHR=1.34 (95%CI 1.17-1.54)) and junior officers (249, adjHR=1.50 (95%CI 1.16-1.96)) started hormones significantly faster. Senior officers did not significantly differ. Furthermore, compared to Army Service members (median days-to-hormones=430), Air Force Service members had a shorter time-to-gender-affirming-hormones (303, adjHR=1.21 (95%CI 1.05-1.42)). There was insufficient evidence to reject the null that white patients had different times-to-hormone initiation, relative to other races or ethnicities. Among those initially diagnosed in 2019 and 2020 (i.e., during a transient pause in some allowable care), the median time-to-hormone was 668 and 547 days, respectively.

CONCLUSION: Two in every three Service members initiate gender-affirming hormones within two years of a gender dysphoria-related diagnosis. Junior enlisted Service members experienced inequitable initiation timing, potentially consistent with a lack of agency and leadership support. The Air Force's unique, centralized process may expedite care. Significant research is needed to provide actionable transgender stakeholder engagement.

Poster Original Research 2nd Place

Primary Author: CPT Preston DeHan, DO

Title: Event Termination Criteria: Preventing Exertional Heat Illness

INTRODUCTION: Exertional heat illness (EHI) encompasses many syndromes occurring during physical exertion in high environmental heat or humidity. In 2019, there were 507 incident cases of heat stroke and 2,174 incident cases of heat exhaustion among U.S. Armed Forces service members. Below, we hypothesized that instituting time gates during physical events at Ranger School would result in an overall decrease in number of EHI's.

METHODS: Design: Single site, retrospective cohort study. Setting: Ranger Training Battalion, Fort Benning, GA Study Populations: 11 Ranger classes per year during Fiscal Years (FY) 17-20. N=14,761. Control group FY 17/18. Study group FY 19/20. Interventions: Removing soldiers from participation if not meeting expected 'time gates'. 5-mile run (40 minutes or less) time gates at mile 2.5 under 21 minutes and mile 3.75 under 31 minutes. 12-mile ruck march (3 hours or less) time gates at mile 6 under 1hr 33min, mile 8 under 2hr 02min, and mile 10 under 2hr 31min. Main Outcome Measures: Soldiers diagnosed with EHI. Statistical Test Used: Chi-squared test for EHI rate comparison, Independent t-test for weather comparison

RESULTS: During summer months (May through October), the control group had 4.41/1,000 (Total EHI per 1,000 person-days) and the experimental group had 2.23/1,000 (p=0.0194). Using time gates during the summer months statistically reduced the number of EHI. No statistical significance between groups when assessing annual data (p=0.09). No significant weather differences among study groups.

CONCLUSION: We studied soldiers in the Ranger Assessment Phase at Fort Benning, GA due to high rates of EHI during the 12-mile ruck march and 5-mile run. Given the success in the summer months, units may consider implementing time gates during their training to include basic training, infantry basic officer leadership course, Airborne School etc. Doing so could decrease the number of EHI's and increase the number of service members in the fight.

Poster Original Research 3rd Place

Primary Author: MAJ Kathryn E. Oppenlander, MD

Title: Efficacy of Formal Curriculum on Healthcare Disparities in a Military Family Medicine Residency

INTRODUCTION: Attention to healthcare disparities (HCD) has increased, and the Accreditation Council for Graduate Medical Education (ACGME) has clear guidance for implementing HCD education. Despite this guidance, formal curriculums on HCD and their effectiveness are lacking in medical literature. The aim of our project was to see if a formal curriculum improved understanding and confidence in HCD.

METHODS: Formal HCD curriculum was implemented during the 2021-2022 academic year (AY). Design: Single group, pretest-posttest Setting: Darnall Army Medical Center Family Medicine residency program Study Populations: Residents and faculty Interventions: Five lectures with guided discussion were given following episodes of the documentary series "Unnatural causes…is inequality making us sick." Additionally, five lectures were given on implicit bias and mitigation strategies. These lectures involved group activities, self-reflection, and guided discussion. Residents and faculty were encouraged to identify a HCD in every scheduled lecture during the AY that they presented, which required critical evaluation of the literature and assessment of specific populations and disease states. Main Outcomes Measured: Effectiveness was measured using data from the ACGME annual survey as well as pre-and post-intervention survey data on a 12 question, 5-point Likert scale assessing understanding, confidence, and personal mitigation strategies. Statistical Tests: Paired sample t-test

RESULTS: The percentage of residents reporting receiving education on HCD increased from 72% on the 2021 ACGME survey to 100% in 2022 (N=18). There was a significant improvement in the response rate in 11 of the 12 questions on the pre-and post-survey (Mean 0.75-1.69; Standard Deviation 0.78-1.45; t 2.94-6.65; p <0.05).

CONCLUSION: A formal curriculum in the military family medicine residency setting was effective in improving HCD knowledge, awareness, and mitigation strategies in academic and clinical practice. Further study is needed to see if results are replicable in other residency settings. Additionally, use of a validated survey may provide more confidence to curriculum effectiveness.


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Educational Research 1st Place
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Assigned Judges CIC - Publication Assignments

Assigned Judge	Author	Title
Jules Seales	Capt Andrew S. Dickson, DO	High-Altitude Induced Splenic Infarction in a Patient with Sickle Cell Trait (SCT)
Jennette South-Paul	Maj David Garcia, MD, FAAFP	Cultural Influences Fostering Increased Resident Scholarly Productivity
Carl Covey	Capt Kayla Mowatt, DO	Severe Headache as an Anginal Equivalent; A Case of Cardiac Cephalgia
Carl Covey	CPT Austin Tannenbaum, MD	Case Report: Prolonged Post-Circumcision Bleeding
Carl Covey	Capt Evan R. Locke, MD	Variation in Time to Gender-Affirming Hormones in Adolescents and Young Adults in the US Military Health System
Anthony Viera	CPT Hayley Spires, MD	A Rare Case of Apixaban-Induced Acute Interstitial Nephritis
Matthew Pflipsen	CPT Ryan Coffey, MD	Hemophagocytic Lymphohistiocytosis due to previous SARS-CoV-2 infection
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Michael Arnold	Capt Francesca Ursua, MD	Late-Onset GBS Bacteremia Due to Breastmilk Colonization
Anthony Viera	LT Clayton Fuqua, MD	Tick-ed Off About RUQ Pain: Alpha-gal Syndrome
Matthew Pflipsen	CPT Sean Rogers, DO	Presumptive Diagnosis of Myasthenia Gravis following Fumigation Exposure
Jules Seales	Alexander Beckstead, Capt, MD	Can't You Cystatin-C, My Kidney is Fine?
Michael Arnold	Cora Blodgett, 2LT	Vagus Broke Her Heart: A Case of Symptomatic Bradycardia from a Vagal Nerve Stimulator
Carl Covey	CPT Benjamin Lampe, MD	That 'Warms my Heart'
Michael Kim	Capt Kryls Domalaon, MD	Family Physician Education and Barriers to Promoting Smoking Cessation: A Multi-Service Investigation
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Omnibus		
Michael Kim	R. Dillon Hill	Uniformed Family Physicians Attitudes toward Post- COVID - 19 Cardiac Evaluation
Tyler Rogers	Raymond Vickery	Negative Self-Conscious Emotions in Learning Environments

Outstanding Achievement in Scholarly Activity

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Teaching Outside of the Classroom

When thinking about family physicians who teach, often what comes to mind is residency or medical school faculty who are rounding on the inpatient wards, precepting in clinic, and lecturing in large academic medical centers. However, most USAFP members do not work in an academic setting. Is teaching really just reserved for this small cohort?

Incorporating teaching into your practice has many documented benefits. Observational studies have demonstrated an increase in job satisfaction when physicians teach regularly. Some have noted the benefits of sharpening their own skills, and a sense of responsibility to recruit and train the future of medicine.

Faculty physicians have designated time set aside for teaching activities as part of their primary duties. Non-faculty physicians must seek out their teaching opportunities, which can understandably feel daunting. Barriers include lack of mentors, time, resources, and opportunities. Few group practice managers or commanders will offer to carve out time for you to teach just because you want to and it can be challenging to justify the need.

Those challenges considered, it is possible to teach in a non-faculty role and the professional fulfillment it offers can absolutely be worth the effort. Whether you're looking to develop your CV for future academic positions, add variety to your clinical practice, or contribute to the larger medical community, here are some ways that others have scratched the teaching "itch" outside the academic setting.

CLERKSHIP STUDENTS IN CLINIC

If you happen to be geographically close or otherwise affiliated to a training program, you can coordinate your clinic as a clerkship site for medical, physician assistant, and/or nurse practitioner students. You will need to advocate for the benefit of teaching within your clinic, obtain support from your command and discuss the requirements, time, potential teaching decrement. You can receive Category 1 CME credit for teaching students, up to 60 credits per 3-year cycle. The Uniformed Services University of Health Sciences (USUHS) is a great place to start. If you spend meaningful time teaching their students, you may apply for an assistant professor appointment through the Department of Family Medicine (https://medschool.usuhs.edu/fam/faculty-development-opportunities). You will have to make sure your clinic has an active training agreement, and there may be documentation required during or after the rotation back to the school's course coordinator. Students enjoy the one-on-one experience in the "real world" of military medicine, and you may find fulfillment with honing your skills, reviewing basic science concepts, and mentoring the next generation of military clinicians.

TEACHING OTHER CLINICIANS

As family physicians, our broad scope positions us well to coordinate educational opportunities for fellow clinicians both within and outside our clinics. Peer teaching, grand rounds with other departments, weekly team-based simulation, case reviews and radiology rounds are just some examples of what others have done to bring together colleagues for learning and community building. Consider hosting a "lunch & learn" and rotating the teaching responsibility amongst your colleagues. This can be a great way to share the work and appreciate their passions within medicine. Peer-teaching can be especially rewarding in the deployed setting and provides a unique opportunity to review trauma and theater-related topics. With some advanced planning and paperwork up front, you can get your activities approved for AMA continuing medical education (CME) hours through the DHA's Continuing Education office - just go to this website to get started: https://www.dhaj7-cepo.com.

TEACHING TECHNICIANS AND NURSES

Imagine a time when you, your technician, and your nursing team were all on the same page in clinic. With thoughtful education and communication, patient care flows more safely and efficiently.[4] Once your support staff has learned the "what" to do in clinic, sit down on a regular basis and teach them the "why." During training days or other dedicated time, you can review in-office procedures with your team: everything from basic indications, equipment setup, steps they can anticipate, and post-care instructions. This will help the entire team feel more prepared and in-office procedures will flow with ease. Education and proper protocols help the team work together to answer patient questions at the lowest level which utilizes your time more effectively. Similarly, go a step beyond the online training for clinic support staff protocol (CSSP) trainings with provider or nursing-led clinic-wide education. Teaching your team common pitfalls or patient education highlights can improve patient satisfaction while reducing the "Hey, doc, what do you want me to do?" line outside your office.

RESUSCITATION COURSES

Military family physicians are often certified in several resuscitation courses,

including BLS, ACLS/ALS, PALS, NRP and ALSO. Teaching these courses can be professionally fulfilling and a great way to cement your own mastery of the content. If you're currently certified in a course and feel comfortable with the material, it is easier to gain instructor status than you may think. Reach out to your local MTF education and training center about requirements and when they are offering instructor courses. Typically, you'll need to complete an instructor course and be observed teaching at least one class to gain initial instructor status. Most courses require you teach a minimum number of courses per year, so make sure to check that you can meet the time commitment before signing up. For ALSO, an instructor course is offered most years at the USAFP National Meeting or other AAFP conferences.

TEACHING PATIENTS

Easily overlooked, the easiest way to teach in a clinic setting is to teach those we see the most – our patients! Utilizing patient education handouts for common conditions can save time and improve patients' understanding of their conditions by answering common questions, and empowering them to be an engaged member of the healthcare team. Within MHS GENESIS, patient education handouts are easy to find and can be printed at the time of the appointment or sent through the patient portal. Additionally, with a bit of template adjustment, you can work with your nursing team, disease manager or clinical pharmacist to create group patient education classes with shorter (10 min) individual appointments that follow. This model works great for conditions such as diabetes, hypertension, or behavioral concerns such as insomnia and stress management.[5] Clinics may already have classes set up on a regular basis that you may be able to volunteer at. Leading your patients in an afternoon "Walk with Doc" is another commonly utilized method for teaching and promoting a healthy lifestyle.

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USAFP committees are charged with contributing to the overall mission of the USAFP by focusing on the strategic goals of the organization, communicating information to the Board of Directors, and assisting leadership in the decision-making process for current and future initiatives. The primary function of a USAFP committee is to involve members in their areas of interest and expertise. USAFP members are encouraged to participate on a committee(s). Participation on a committee(s) is a great way to enter the leadership pipeline of the USAFP. Each committee page has "Committee Interest Form" to inquire about joining.

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 7 July 2023.

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. *dreamy@vafp.org*.

RESEARCH JUDGES

Applications for research judges are accepted on a rolling basis. Please contact Dianne Reamy (*dreamy@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...
Jeanmarie B. Rey, MD, FAAFP,
jeanmarie.rey@usuhs.edu

PROMOTING RESEARCH IN THE MILITARY ENVIRONMENT

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

Whether you are deployed or in garrison, the USAFP research judges can help! Visit us online at http://www.usafp.org/committees/clinical-investigations/ for resources or to find a mentor.

committee report
MEMBER CONSTITUENCIES

Rachel Carter, MD, FAAFP
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Greetings Friends, Mentors, and Colleagues to borrow a phrase from the prior Co-Chair. It was an exciting and informative USAFP annual meeting in Orlando and Derrick Thiel and I are now installed as this year's co-chairs of the Member Constituencies Committee. Mariama Massaquoi has moved on to be a new Army Director for USAFP and I am thankful for all of her hard work during her time as co-chair. Last year the Member Constituencies Committee began an important initiative for problem solving called "Challenge Accepted". Any member who has an issue of any type can reach out anonymously to the committee. We will then reach out to appropriate leaders and resources for the particular challenge faced to brainstorm and create solutions. We hope to continue this initiative this year. In addition, this year we hope to expand the member constituency report to include interviews with members of our constituencies and interesting articles on pertinent topics.

For those that are unfamiliar, USAFP models after the American Academy of Family Physicians (AAFP) in designating New Physicians, Minority Physicians, Women Physicians, LGBTQ+ Physicians, and International Medical Graduate (IMG) Physicians as important member constituencies that historically have unique struggles and have not had a voice to help meet these challenges. The AAFP created the National Conference of Constituency Leaders (NCCL) in 1990 and it provides a forum for discussion and problem solving. The constituencies propose amendments to tackle issues important in the lives and practices of family physicians that are then delivered to the AAFP for action. Why do I bring this up? I'm talking about this because the NCCL was held May 9-11 at the Sheraton in Kansas City, Missouri. It is run in conjunction with the Annual Chapter Leadership Forum where our USAFP leadership also participates. For the fifth year in a row USAFP sent a full delegation to NCCL. We will share more about what took place at this year's NCCL in our next newsletter.

LGBTQ+ – Sterling Brodniak, MD
New Physician – Alexis Aust, MD
Minority - Mariama Massaquoi, MD
Woman – Eileen Tatum, MD
IMG – Rachel Carter, MD

Our delegates in the past have authored and supported multiple resolutions that have been accepted by the AAFP. USAFP delegates have also been elected as constituency co-conveners and represented their constituencies at the AAFP Congress of Delegates. It is a fantastic opportunity for a Family Physician to create change and to learn about Family Medicine Advocacy at the highest levels. You can find more information about NCCL on the AAFP website. If you have a suggestion for a resolution or you would like to represent USAFP at a future NCCL, please email USAFP at mlwhite@vafp.org.

Many may be wondering where does Diversity, Equity, and Inclusion (DEI) fit in. The short answer paraphrased from our new USAFP President, Kevin Bernstein, MD, is that it fits in everywhere. Every committee and every member has a part to play. The Member Constituency Committee will be working closely with the other Committees to further USAFP's DEI aims. Standby for more in future reports and if you have an idea you want to see acted upon, reach out and let us know!

CHALLENGE ACCEPTED

Are you facing a problem at your current duty station and not quite sure how to solve it? Is there a new task you've been asked to take on? Are you in a position with no prior experience? Is there a cultural environment that you're unfamiliar with and not sure how to adapt?

Well, you don't have to tackle it alone. The Member Constituencies Committee has developed an opportunity to present your challenge to USAFP leaders, so that we can address your problem together – Challenge Accepted!

Just click on the link or scan the QR and fill out the anonymous survey, so that we can gather the appropriate resources and leaders to discuss a new challenge every month via zoom. There's no issue too big or too small, and we can help find a solution together.

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David Garcia, MD
Eglin AFB, FL
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On 27 Mar 2023, the National Capital Region went live with MHS GENESIS bringing the total number of users to greater than 160,000.[1] Last year, on 24 Sep 2022, the Military Health System (MHS) reached a major modernization milestone. With the wave rollout of MHS GENESIS, greater than 50% of all MHS users were now using a modern electronic health record.[2]

For perspective, in 2017, when I first heard about the upcoming transition, I was stationed at Edwards AFB, a small outpatient clinic. If you are like me, however, you fear change. Our clinic was to be part of the first wave of the MHS GENESIS transition. I knew that I did not want to be first in line and I greatly feared this transition. To resist assimilation, I fled to Eglin AFB in Florida's panhandle. But there, alas, the MHS GENESIS wave finally engulfed me.

My fears of the GENESIS transition were never realized. I am not a super-user or a clinical informaticist, but I want you to know that MHS GENESIS transition has been a game changer at Eglin AFB for practice management (in a positive way). I have seen it speed up my workflow tremendously. Take, for example, the simple task of sending a medicine to an off-base pharmacy. Before MHS GENESIS, we would need to actually call the pharmacy ourselves and waste a significant amount of time navigating phone trees and leaving messages for prescriptions. With MHS GENESIS, however, I am now able to select any in-network pharmacy and boom, the digital magic happens without a telephone! Furthermore, my ability to communicate with patients has dramatically improved. At the end of each patient visit, I can email a visit summary including an updated medication list (yes, finally!) and patient to-do list from consults to exercise prescriptions. The EHR is now more patient-focused and greatly enhances my efficiency as a family physician.

Beyond these communication enhancements, MHS GENESIS has compelled our MTFs, departments and clinics to examine workflows. We built workflows around the inherent limitations of CHCS/AHLTA. With these restrictions now lifted, there are many dynamic possibilities in this new system. Function follows structure. Possibilities are emerging that were unthinkable before. Moreover, the ability to build your own standard note templates and then carry these templates with you as a user from location to location is huge! No longer are you wedded to the TSWF-Core for everything. MHS GENESIS has great text expansion and note template functionality built into it! Even better, we can use each other's templates!

Of course, with any massive change, there will be growing pains. Thankfully, leadership has addressed this by allocating TDY funds for trained clinicians to come and teach you best practices. At Eglin AFB, we had USAFP members, Col Dillon Savard and Col Matt Snyder walk us through how to use MHS GENESIS to our advantage. They were incredibly helpful with seeing the potential opportunities and pitfalls ahead. If you have already made this transition, consider "paying it forward" by volunteering to go to a transitioning base. If you are about to transition, think strategically about who you would like to come and teach you. While no change is easy, the practice management potential is incredibly exciting!

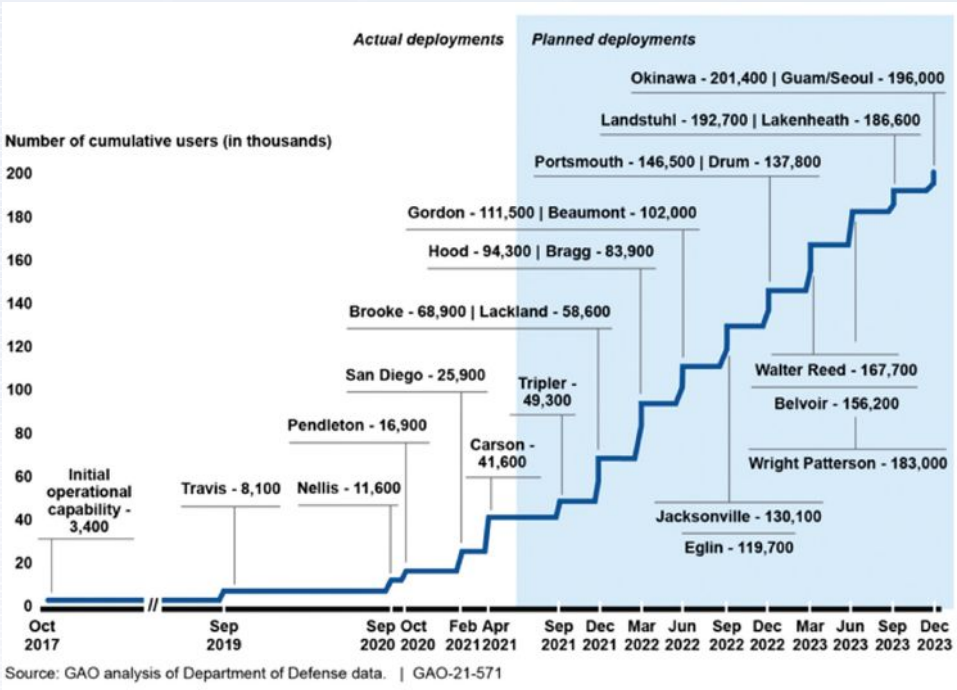
In upcoming newsletters, we will be exploring features in MHS GENESIS that you can use today to manage your practice more effectively. Imagine if you had a well-designed pediatrics template for 7-18 year olds (aka "quick visit")? Well, all you would have to do is pull in "AMB Pediatric Well Visit (7-18 years)" and everything is easily accessible. So much better than AHLTA!

Reflect with us as we have crossed the 50% mark for the wave rollout of MHS GENESIS. If you haven't transitioned, what are you afraid of? If you have transitioned, how has MHS GENESIS improved your clinical practice?

Do you have an idea to ease the MHS GENESIS transition of other USAFP members? We would love to hear from you! Check out our work on the USAFP website (https://usafp.org/practice-management-committee/), join the conversation on Facebook (https://m.facebook.com/groups/397970390919944/?ref=share&mibextid=SDPelY) or simply by searching for our private user dot phrases under the user David.Garcia.0005 with the beginning handle ".usafp". We already have a standard back pain A/P and a standard basic physical exam for you. Our goal as the Practice Management committee is to provide you with resources and tools to make this transition easier.

Here's to working better together and going home on time! - Your USAFP Practice Management Committee

Figure 1. DOD expected GENESIS rollout (5)



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2024 USAFP Annual Meeting & Exposition Call for Speakers

FOUNDATIONAL. RELEVANT. FAMILY.

Thank you for your support and dedication to the Uniformed Services Academy of Family Physicians through your interest in presenting at the 2024 USAFP Annual Meeting & Exposition in New Orleans, LA from 23 March – 28 March.

We are excited to come together to celebrate our passion and diversity in medicine, teaching and research as we continue to spearhead the specialty of Family Medicine forward.

With this year's theme, "Foundational. Relevant. Family." we hope to showcase the breadth of Family Medicine, our ability to adapt to the evolving nature of military medicine, and our essential role as the leader and back-bone of the Medical Corps.

A new topic this year is the spouse/support/family category. This will allow any USAFP member's spouse/support/family to also submit a topic for consideration. In 2024, we will work to identify a track of topics that are specific to spouse/support/family.

If you have questions, please contact us at **usafp2024@gmail.com**.

Andy McDermott, MD & Kerry Sadler, MD
Co-Chairs, 2024 USAFP Annual Meeting

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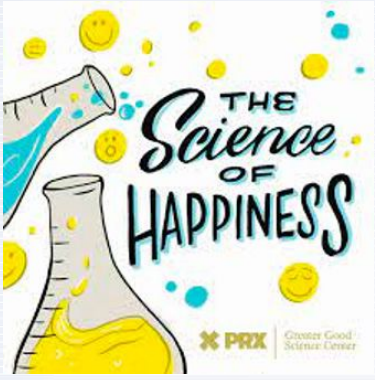
Practical Resources for Emotional Well-being

Spring is the perfect time to focus on building up our own personal and emotional well-being. As we climb out of a long winter and face the summer PCS season head-on it can be hard to key into our intrinsic motivation for things like working out, spending time out of the house and being more social. During challenging times it can be hard to remember to take care of ourselves. Yet, if we don't take care of ourselves, our personal and professional lives can suffer. In this article, we would like to share a few quick and useful resources to help you curate your own best practice and promote well-being.

There is an excellent podcast produced by the University of California Berkeley's Greater Good Science Center (https://ggsc.berkeley.edu/) called "The Science of Happiness".[1] In this short weekly 15-20 minute podcast, they discuss evidence-based practices for mindfulness, gratitude, resilience, and connectedness. A great thing about the recommended practices is that they only take 5-20 minutes and can be easily incorporated into a busy clinic day or home routine.



Before you roll your eyes, we want to assure you that mindfulness and emotional well-being are NOT all about meditation. Many of these simple practices focus on reflection, appreciation, and positive thinking, among other activities. The focus on mindfulness in this podcast is evidence-based. Mindfulness has been shown to be an effective tool for addressing anxiety, mood symptoms and decreasing chronic stress.[2] It has also been shown to moderately improve symptoms associated with burnout in health care professionals.[3,4]

One of the practices we have found particularly helpful is the 36 Questions for increasing closeness. This practice takes about 45 minutes and is designed to build close relationships by engaging in "reciprocal self-disclosure" (aka sharing personal thoughts with someone else).[5] It was originally studied on strangers in a lab who were compared to participants who asked 36 superficial questions. The pairs in the study reported increased feelings of closeness despite sharing differing core beliefs and attitudes. The participant's average level of closeness matched what they reported feeling in their closest relationships.[5] Additional studies have been done using the same 36 questions applied to various groups to include those high in unconscious racial bias or negative cultural attitudes toward their partner. In those subsequent studies, they saw reduction in stress biomarkers, increased behavior of participants to seek out more interracial interactions, and more positive attitudes toward the differing culture.[5]

Another aspect of personal well-being is gratitude, and studies have shown that those who practice regular gratitude

have less stress and depressive symptoms.[6] A regular gratitude practice can also impact productivity and adherence to healthy behaviors.[7] This can take one of many forms: keeping a regular gratitude journal, taking the time once a month to write a gratitude letter to someone, or simply just letting someone know that you appreciate them.[8]

Other free, high-quality tools that may help you and your patients are "Chill Drills" an app created by Military One Source [9] and the "Mindfulness Coach" App [10] created by the Department of Veterans Affairs. As with anything that is as personal as your own emotional, physical and spiritual well-being, there is no one size fits all. It is important to find a tool that keeps you motivated and works for you. In future newsletters we will bring you other tools for sleep, physical and financial well-being. Be well!

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10. https://mobile.va.gov/app/mindfulness-coach

WELLNESS AND RESILIENCY COMMITTEE RESOURCES

Social:
Look on Military One Source for some tips on how to build a Resilient Family by staying connected within your community:

Emotional:
Test yourself on the self-compassion scale and use Dr. Neff's resources to improve your score:

Environmental:
See what you can do to reduce light pollution and plan a trip to appreciate the stars at an International Dark-Sky Place near you:

Spiritual:
Practice Yoga Nidra during your 20 minute lunch break:

Physical:
Sign up for a fun-run to set your sights on a future fitness goal:

Financial:
Use AAMC's FIRST resources to help set a budget and manage your loans with webinars and fact sheets:

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Leadership and Self-Deception (getting out of the box)

BY THE ARBINGER INSTITUTE

This quarter we review the Arbinger Institute's profoundly insightful book, *Leadership and Self-Deception: Getting Out of the Box*.[1] Unlike many other leadership books, this narrative shares its lessons by following the story of Tom, a new manager for a sales company, and the lessons he learns from his new supervisors at the company, Bud and Kate, and their mentor Lou. *Leadership and Self-Deception* tells its story in three parts, the first defining **what is "the box"**, the second **what it means to be "in the box",** and third **how to get "out of the box"**. Simply put, it is a metaphor for a mindset that all people fall into in which we become inward focused, selfish, and blindly lose our empathy, altruism, and faith in humanity.

In today's Western society, we are constantly but subtly encouraged to pursue our own self-interests ahead of those around us. Naturally, it is easier to put our own hopes, dreams, and desires first since we are more aware of them. But as this mindset creeps in and perpetuates, that we are somehow superior or more important than others, it starts to impact our values and behaviors. This is the state of **self-deception**. Meanwhile, we still have desires to help others when we perceive that they have needs from us, and the book posits that honoring these opportunities to be kind and helpful is aligned with our **true self**. When we resist the urge to help others, we are not honoring our true selves and commit **self-betrayal.** Our minds work to rationalize this self-betrayal, and do so by projecting negative beliefs or values towards others to justify our actions (or inaction), which deepens the self-deception. This is being "in the box." Once we are "in the box", it becomes a vicious cycle that we are not aware of; we hold negative views of others and then look for opportunities to justify them and to deepen our self-deception. While most people are unaware that they themselves are "in the box", they are fairly intuitive and can perceive these negative attitudes people hold towards them. Thus, when a person is treated as an object instead of a person, it further reinforces any self-deception they have, and a group of people can all perpetuate these negative attitude exponentially.

Bud and Kate teach Tom about self-deception through sharing stories, and through their discussion we learn how we can apply this framework to our own lives. In an early example, they imagine a scenario on an airplane. Bud shares a story about when he was sitting on a plane while traveling by himself. He had an open seat next to him and he really wanted to have the extra space. He put his briefcase on the open seat next to him and read the paper, secretly hoping that no one would try to sit there and ready to react negatively if anyone dared to try. Although others needed to find a seat, he viewed them as hindrances to his own comfort. In a second instance, on another flight he and his wife were traveling together and their tickets were mixed up, so they could not sit together. A woman was sitting, like he had done previously, with her briefcase blocking the open seat next to her. Instead of focusing inwardly, she realized their situation and kindly offered the seat (moving her briefcase) so they could sit together. This stark difference in mindset and behavior completely transformed how he interacted with and treated other people moving forward.

In a second example, Bud shares that early in his marriage, he and his partner were sleeping and they were awoken by their infant crying. He woke up and felt the need to get out of bed to help his partner so that she could continue sleeping. Instead he resisted this urge to help. This was an act of self-betrayal. His mind justified why he did not act on that urge to help by viewing himself as hard-working, tired, and deserving of extra sleep. This also resulted in him projecting negative attitudes and beliefs onto his partner for not waking up to help feed their infant. This single action of self-betrayal started him down a path of continuing to deceive himself and he put himself "in the box".

After learning how to be aware of when we are "in the box", the book shifts to how to get out of "the box". Bud, Kate, and their mentor Lou, teach Tom that the key to getting out of "the box" is not through changing behaviors, but really about being self-aware of "the box" and changing attitudes. As a metaphor for resisting others needs and desires and putting our own needs ahead of others, being "in the box" keeps us from helping and caring for others or putting their needs ahead of our own. The moment we realize that we are "in the box" and want to come out, we are "out of the box" in that moment. This allows us to act on those intrinsic desires to help others and avoid self-betrayal and self-deception.

As both military and medical leaders, how often are we "in the box"? How often do we project negative attitudes towards our supervisors when they are unyielding with clinic schedules, assigning additional duties, or requiring us to attend meetings? How often do we grumble when we are given additional students to supervise, see more patients or complete additional last-minute training requirements? How often in clinic do we get frustrated with patients who do not follow our medical advice, who bring up another problem after boundaries were already set for today's visit, or who have seemingly unrealistic expectations about what we are able to offer? All of these are instances from my own experience over the last few weeks as an Army Family Physician, and I am willing to bet yours isn't much different. After reading this book, I realize how often I have been "in the box", projecting negative feelings towards others and losing sight of their humanity in small ways that have compounded more than I realize.

Moving forward, we can use this wisdom to remind ourselves that those we come into contact with are more like us than not, have needs that we can help serve and in doing so, inspire others to have the same level of compassion and empathy. It is a daily battle, and the point is not to recognize when others are "in the box", but to get out of "the box" ourselves. By continually getting out of the box and emphasizing the worth of others, we can inspire a culture in which we all embrace a desire to help others and uphold humanism in medicine.

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new members

THE USAFP WELCOMES THE FOLLOWING NEW MEMBERS...

ACTIVE

Brian Bowditch MD
Heather Daugherty MD
Lori Gatzke MD
Elizabeth Lafleur MD, PhD
David Laughlin DO
Christopher McGuire MD, MPH
Travis Russell MD, MBA, MHA, CPE, FAAFP
Tracy Shuman MD

STUDENT

Nazanin Ahmadian
Arnulfo Ahumada
Shannon Alsobrooks
Abbey Anderson
Robert Atkinson
Ahmad Avery MPH
Logan Bader
Trevin Ball
Reese Beard
Suzanne Bent
Jade Bowman
Megan Bradley Kimble
Kiley Brady
Benjamin Brooke
Brent Bubany
Robert Buckshaw
Nicholas Burpee
Miki Calderon RN, BSN
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Shakori Cardin
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Emmanuel Coriolan RN, MSN, BSN
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Timothy Erton
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Krystal Glasford
Kathryn Godwin
Nelly Gorodetsky
Jennie Guerra
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Meredith Hayes
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Brendon Henry
Brandon Hillery
Daniela Hinchman-Dominguez
Lily Horst
Caleb Hudson
Brittany Hume-Dawson
Cody Jackson
Daniel Johnston
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Jonathan Wang
Erika Wicher
Gregory Williams
John Wonacott
Cheyenne Wong
Claire Wright

MEMBERS IN THE NEWS

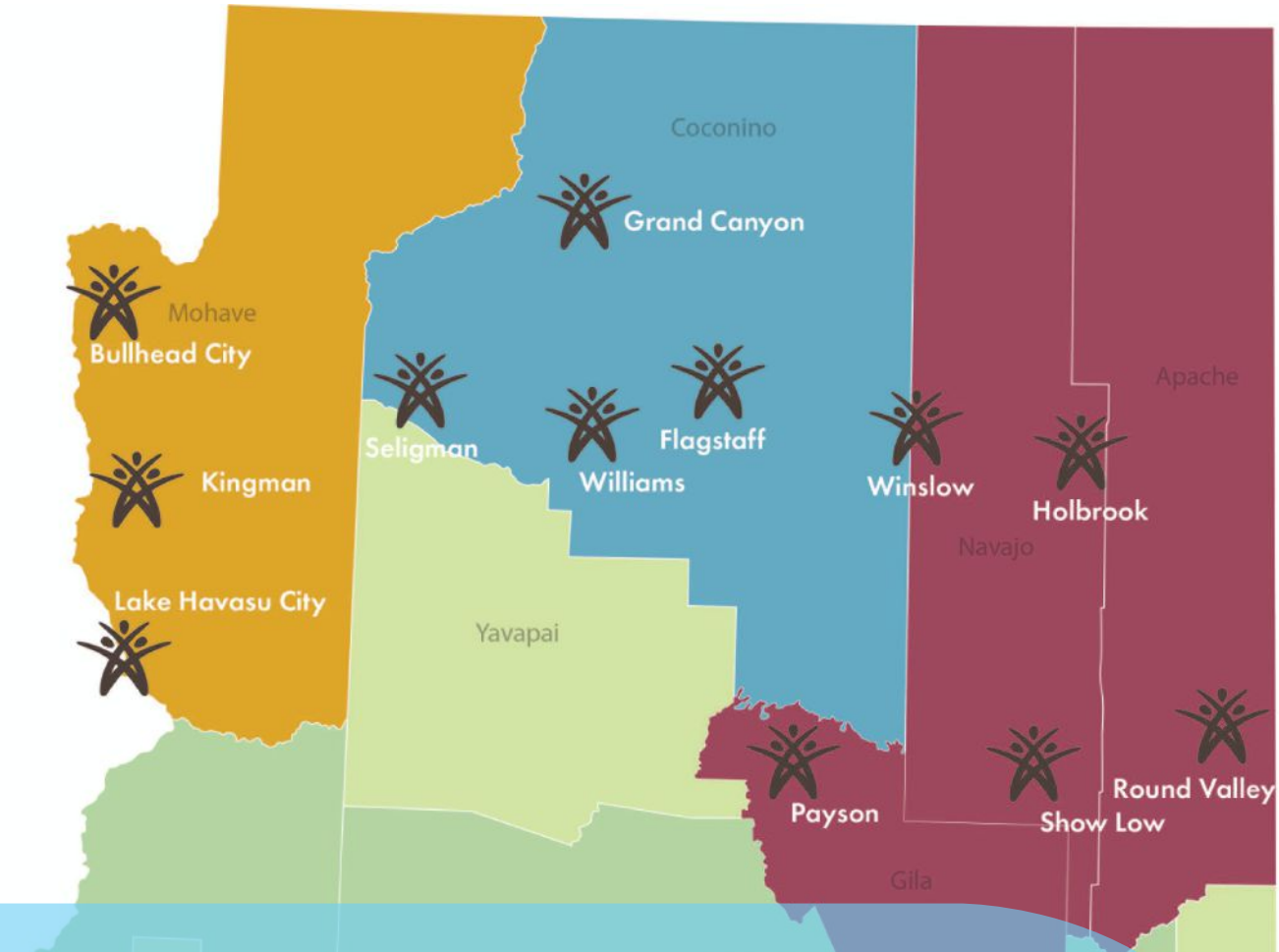
CONGRATULATIONS TO THE USAFP MEMBERS THAT RECEIVED THE AAFP DEGREE OF FELLOW

Pictured are those who were in attendance at the 2023 Annual Meeting receiving their AAFP Degree of Fellow.

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

Congratulations to the following USAFP members!

Rebecca Allen DO, FAAFP
Brock Cardon MD, FAAFP
Rachel Carter MD, FAAFP
Bridget Caulkins MD, FAAFP
Katie Coble MD, FAAFP
Alex Houser DO, FAAFP
Dave Riegleman MD, FAAFP
Thomas Rogers MD, FAAFP
Haroon Samar MD, FAAFP
Paul Seales MD, FAAFP
John Sullivan DO, FAAFP
Gillian Wackowski DO, FAAFP
Todd Wical DO, FAAFP



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For more information, contact Team Talent at (928) 522-9514 or teamtalent@nchcaz.org.

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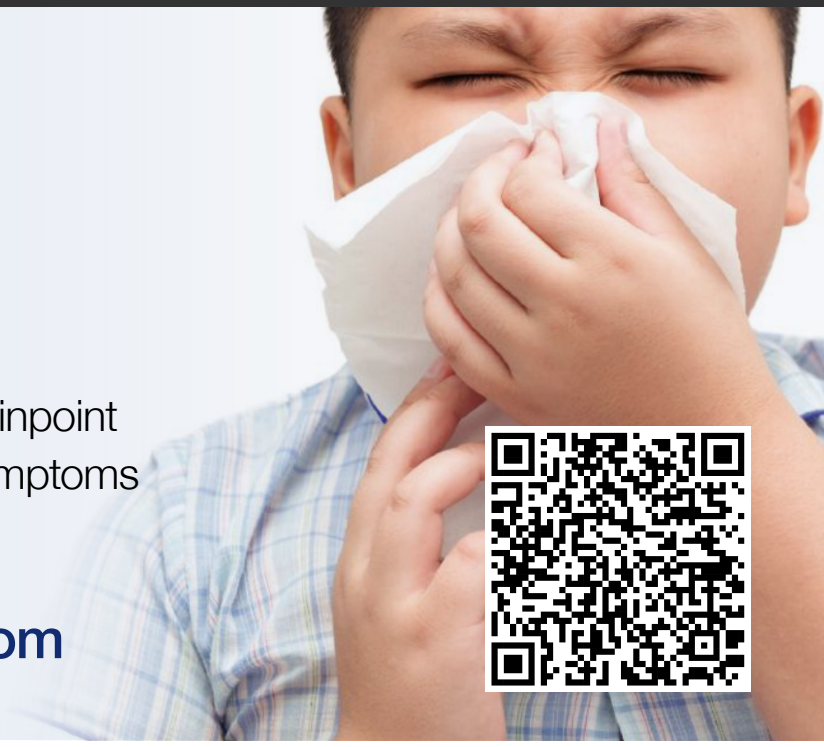

Review these helpful resources:

Allergen Reference Encyclopedia >

Provider Resource Library >

On Demand Education >

On-site or virtual education is available in support of all Federal contracts. Contact us for more information.

DoD Reference Laboratories:

- Wilford Hall ASC
- Eisenhower AMC
- William Beaumont AMC
- Tripler AMC

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