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

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

The mission of the USAFP is to support and develop Uniformed Family Physicians as we advance health through education, scholarship, readiness, advocacy, and leadership.
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In September I had my third opportunity to represent the USAFP and attend the American Academy of Family Physicians Congress of Delegates. Until being called to attend as an alternate delegate two years ago, I had little understanding of the work performed by this body. As members of this national academy, I think it is useful for all members to understand the roles and responsibilities of this organization.

The Congress of Delegates is the Academy’s policy-making body. Its membership consists of two delegates from each constituent chapter; two alternate delegates may be present in a non-voting capacity. In addition to State chapters, constituent chapters include the Special constituencies such as new physicians, residents, students and other constituency groups represented at the National Conference of Special Constituencies. During the two and one-half day meeting (held prior to the Scientific Assembly), the congress agenda includes addresses from AAFP officers, resolutions from chapters and reports from the Board of Directors and commissions.

At the Congress’ reference committee hearings, AAFP members have the opportunity to share their views and help shape new AAFP policies. There are five reference committees: Advocacy, Education, Health of the Public & Science, Organization & Finance, and Practice Enhancement. The reference committees (composed of volunteer members from a variety of states and special constituencies) consider resolutions from chapters. AAFP members present at the hearings may provide information in support or in opposition of the proposed resolution.

The reference committee considers all the information provided and then brings their recommendations to the entire Congress for a final review, further discussion and vote. Topics debated always span a wide array of content areas and this year included topics such as nurse practitioner/physician assistant membership, restructuring representation in the Congress of Delegates, prevention of gun violence, banning the sale of energy drinks to children and contraception education. If you are curious about the actions taken, all reference committee reports and consent calendars are posted on the website for your review.

Finally, the Delegates also elect new Academy officers and three members to serve on the AAFP Board of Directors for the following year. After a rigorous campaign, assembly addresses and public question & answer assembly, voting occurs by ballot. We are truly blessed as an organization to have such an educated and committed group of individuals willing to step forward and serve. I encourage you to take a moment to review some of their campaign materials on line, especially for President-elect Robert Wergin MD; Directors Jack Chou MD, Robert Lee MD and Michael Munger MD; and the most impressive New Physician Member Kisha N Davis MD MPH.

In closing, I wish to share the words of Dr. Glen Stream from his final address as Board Chair. As he finished his comments, he stated the following, “I want to close by sharing some comments from when I stood before you three years ago asking you to elect me and give me this opportunity to serve as an AAFP officer. I spoke of several truths, which I believe now more strongly than ever. The truth is I love this Academy and believe in its members and its mission. Together we can and will achieve great things in serving our members and our patients. And finally, the truth is for Family Medicine, and our Academy, the future is bright.” I couldn’t agree more.
A New Medicine for Health and Wellness?

I found a new medicine.

For coronary artery disease, this medicine was equivalent to a statin. For stroke, this medicine was the best medicine over antiplatelet agents. For heart disease, this medicine was equivalent to ACE inhibitors. This medicine was reviewed in the October 1, 2013 in the British Medical Journal but I’m sure you probably haven’t even heard of this article in the news.

What is this medicine? This medicine is Exercise. Exercise is undervalued, underutilized, and often undermined. As we dive into the details of the Performance Triad, in this issue of the newsletter, I’d like to focus on the best free, time-tested medicine known to man. Exercise.

What is this medicine? This medicine is Exercise. Exercise is undervalued, underutilized, and often undermined. As we dive into the details of the Performance Triad, in this issue of the newsletter, I’d like to focus on the best free, time-tested medicine known to man. Exercise.

From the Health Promotion and Disease Prevention Committee, I hope you get a chance to read the article looking at a specific high intensity exercise program called CrossFit. I will give my viewpoint on this latest exercise craze.

I would also like to use this platform to promote the Health Promotion and Disease Prevention Committee. As family physicians, we need to be on the forefront on health promotion and disease prevention. There is tons of chatter on the internet and the social media media. I bet you’d be surprised at the depth of the different diagnoses and the commonality of the diagnoses. The faculty development fellowship brings another teaching article on overconfidence and bias/errors in medicine. Goes back to that great adage in medicine. “You only diagnose what you know.” Or, “you don’t know what you don’t know.” The IT committee brings us an update on our new electronic medical record. ‘Nuff said, I don’t want to spoil it. Read the article. For those physicians who want to know more or get involved with USAFP, the Special Constituencies Committee wants you! No, you do not just have to be a minority or a woman. If you’ve been a family physician for 7 years or less (which is a LOT of you) then you can participate!! Take a look at the article and find out how. Practice Management article talks about the dreaded peer review. A necessary part of what we do in medicine. And finally, the Clinical Investigation Committee brings a scintillating preview on their upcoming workshop at the annual conference. Makes me yearning for Spring already!

Enjoy this wonderful edition of the Uniformed Family Physician, and get moving!

REFERENCES

Clinical Pharmacology Fellowship

What is Clinical Pharmacology?
Clinical Pharmacology is concerned with better understanding and use of existing drugs, and developing more effective and safer drugs for the future. Clinical Pharmacology allows one to stand between the research lab and the bedside, in a unique position to translate laboratory research into new drug therapies. Clinical Pharmacologists are a bridge between the science and practice of medicine.

Who can apply for the Fellowship?
The Clinical Pharmacology training program is available to active duty Army physicians who are board eligible/certified in a primary specialty and active duty Army PhDs/PharmDs (71A, 71B, or 67E) who have a doctoral degree in one of the life or medical sciences from an accredited academic institution in the United States, Canada, or non-U.S. degree equivalent. A research background, mathematical inclination, and pharmacology/medical experience is preferred. Civilians could be considered if they joined the Army and successfully compete.

Additional activities include:
• Conduct laboratory, animal, or clinical research under the supervision of a mentor
• Participation in the teaching of Clinical Pharmacology to medical students, house staff, and practicing physicians
• Clinical Pharmacology consultations
• Three month rotation with a review division at the FDA
• Regular participation in continuing medical education, research seminars, and journal clubs

Potential Job Assignments
• WRAIR
  (Silver Spring, MD)
• USU
  (Bethesda, MD)
• Overseas labs
  (Thailand, Australia, Kenya)
• USAMMDA
  (Ft. Detrick, MD)
• USAMRIID
  (Ft. Detrick, MD)
• USAMRICD
  (Aberdeen Proving Ground, MD)

Contact: LTC Kevin Leary, MD, kevin.j.leary.mil@mail.mil
Contact: Louis Cantilena, MD, PhD lcantilena@usuhs.mil
Announcing the
2014 USAFP Annual Meeting & Exposition!!

Don’t miss the 2014 USAFP Annual Meeting & Exposition!! We are excited to offer our program in this wonderful venue and location. The schedule includes something for everyone. Wanting to increase your hands-on musculoskeletal exam skills? Sign up for the sports medicine symposium. Are you a M.D. interested in learning OMT? Plan to attend the OMT workshop. Want to learn skills for the deployed setting? Take the acupuncture or eFAST ultrasound course. Need to complete certification requirements? Don’t miss our SAM’s. Just looking to garner some CME? Our mainstage will not disappoint. We also have sessions on faculty development, clinic management, Tri-service medical home and senior leadership.

Over 26 hours of CME will be offered and the price can’t be beat!

The DoubleTree Hotel in Crystal City is a fabulous venue for the meeting. With a skyline view of the Washington Monument and the Potomac River, the hotel is well positioned for an abundance of sightseeing both in and around Washington D.C. Board the Pentagon City Metro light rail, 3 blocks away, for sightseeing on the National Mall. Hotel amenities include complimentary fitness center, heated indoor pool, and easy access to shopping and dining as well as many on site restaurants and quiet areas to sit and enjoy visiting with your colleagues from all over the country.

With all the excitement, we just can’t wait for March to be here. Please join us for Mission USAFP: Learn and Lead. Registration and full conference details are available at www.usafp.org. If you have questions or want to contact the Program Co-Chairs, please e-mail USAFP2014@gmail.com.

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Wow! These are dynamic times! We’ve survived a furlough and government shutdown during war time. Yet you continue to be resilient providing exceptional care state-of-the-art care for hundreds of thousands Soldiers and Families— present, past, and future while deployed and in garrison. You lead in clinical, operational, and academic medicine with distinction at every level. You constantly seek to mentor and are highly sought after mentors. You are exactly the Soldier physician leaders we need to ensure the future of Army Medicine.

ASSIGNMENTS:

As the war comes to its end and we begin restructure operations in earnest. Synchronizing the DoD, Army, MHS, and the AMEDD right sizing and re-alignment has already resulted in significant change with much more to follow (figure 1). Assignments this summer will be affected by changes in all three medical services. The distribution plan remains fairly fluid even as this article is going to press. Migrating toward sites with the largest Troop and Family Member concentrations, joint enhanced multi-service markets, and the busiest medical centers will be strategic themes for all three services (figure 2). The Surgeon General’s high interest programs such as PCMH/SCMH, Behavioral Health Comprehensive Plan, and Performance Triad will continue to be primary lines of effort and influence the assignment process. We will standardize the leadership construct of primary care based on numbers enrolled. Graduate Medical Education, especially for primary care, will remain high priorities even if some restructuring is necessary. Synchronizing between primary care specialties and the BDE Surgeon assignment process will be more heavily emphasized this year. Several among our peers will be selected for command and other 60A/05A positions which will result in at least two department chairs, possibly a residency director position opening. We will need 04-06 level leadership at several sites including Bliss, Irwin, Riley, continued on page 10
Leonardwood, Landstuhl, among a few. Field grade officers who’ve not yet led as brigade or division surgeons will be encouraged to seek this opportunity even if the total number is decreasing.

MAJ Lee is back from ILE and can be contacted with any assignment concerns at Comm: 502-613-6497, MC Branch Team Line: 502-613-6838, (DSN: 312) dong.lee@us.army.mil, jason.y.lee7.mil@mail.mil, MC Branch Team Mailbox: usarmy.knox.hrc.mbx.opmd-medical-corps@mail.mil.

Staff satisfaction remains relatively high given the challenges we’ve faced. We retained 69% of FPs who completed their active duty service obligation (ADSO) which is an all time high over the last 5 years. Special Pay has been preserved. We were able to secure $74M for PCMH funds in the upcoming year. The “3Rs” have been restored. TSG has delegated hiring authority to the MTF level for all high interest programs including PCMH/SCMH.

QUICK HITS:

PCMHs continue to consistently outperform non-PCMHs in patient and staff satisfaction, PCM continuity, ER and network leakage, HEDIS and Soldier medical Readiness, and cost containment. We will be publishing new empanelment guidance within the month which will streamline definitions and process, actively incorporate virtual care into the two appointment template, take ER utilization into capacity planning, set standard adjustments for GME and line unit providers (figure 3). USAFP will be from 13-17 March at DoubleTree Hotel in Crystal City, VA. We hope central funding will be available, but the conference will occur independent of central funding this year.

CONCLUSION:

Quote first made famous in late 1500s chiseled into the wall of Gibraltar, also quoted by JFK during USMA graduation near the conclusion of the Korean War: “God and the Soldier, all men adore, in times of danger and not before. When the danger has passed and all things righted, God is forgotten and the Soldier is slighted” (figure 4). The times we’re now in are not surprising as we have seen priorities shift at or near the conclusion of multiple wars in our past (figure 5). I know you all join me in saying “Not on our Watch”! Thank each and every one of you for all you do every day! Never forget! Never quit!

“God and the Soldier, all men adore
In time of danger and not before.
When the danger is passed and all things righted,
God is forgotten, and the Soldier slighted.”
Take Care of Your Patients…
We Will Take Care of the Rest

John C. Lincoln Physician Network – Now Recruiting Physicians

**John C. Lincoln Physician Network** encompasses primary, urgent and immediate care facilities throughout the Phoenix metro area. We offer family and internal medicine as well as sub-specialty services.

The Network is currently seeking experienced family and internal physicians to join our award-winning team.

“I joined John C. Lincoln to practice medicine with a health system that knows our worth and treats us that way.” – James Dearing, DO, Chief Medical Officer of the John C. Lincoln Physician Network

John C. Lincoln Physician Network offers the security of working with a locally-owned and managed health network that has served the Valley for more than 80 years. We have several openings including Immediate Care with expanded evening and weekend hours as well as traditional hours for physicians with existing patient panels. Applicants must be board-certified or board-eligible.

**Benefits for Physicians include:**
- Competitive salary and benefits package.
- JCL Connect electronic health record system from Epic.
- Care coordination among primary and specialty care physicians to achieve optimal outcomes.
- Physician credentialing services.
- Marketing and communication programs and services.

To learn more about the Physician Network visit JCL.com/practices. For more information about physician opportunities visit JCL.com/physicians. Please submit your application or resume with references to Trina Foster, director of Practice Acquisition and Development at trina.foster@JCL.com.
Hello, Navy Family Medicine,
I hope this newsletter finds you all well during this holiday season.

I would like to spend this update addressing some rumors floating around and discussing a few recent changes in Navy Medicine.

CONUS HOSPITAL STUDY
In 2011, Navy Medicine performed an extensive review of our current infrastructure and resources called the CONUS Hospital Study. The resulting report recommended coordinated realignment throughout our Navy Medical Treatment Facilities (MTFs) in the Continental United States (CONUS). After review of the report and approval by SECNAV to proceed, the Navy Surgeon General has directed full implementation by September 2016.

The following are key service changes related to the study:

As a result of these changes, in September 2016, Naval Hospitals Bremerton and Pensacola will close their Family Medicine Residency Programs. Navy Medicine leadership is dedicated to ensuring that the Family Medicine community remains robust and that the quality of training at these facilities remains consistent through closure. Resources will be made available to commands and Program Directors to make sure this happens. Additionally, despite the closure of these programs, the total number of Family Medicine training billets will remain the same -- they will be redistributed over time to other locations with appropriate patient mixes.

More below on how we will maintain the output of Navy Family Physicians in the midst of these changes.

2013 JOINT SERVICE GRADUATE MEDICAL EDUCATION SELECTION BOARD
The 2013 Joint Service Graduate Medical Education Selection Board (JS GMESB) is currently underway as I write. For the first year, this is a fully electronic/virtual process. All scoring is being completed electronically and all panel meetings are being done via tele or video conferencing. Results should be released on 17 DEC 2013.

The JS GMESB will select a full complement of trainees at both the PGY-1 and PGY-2 levels for Naval Hospitals Bremerton and Pensacola. Likewise, the number of training billets at the remaining four locations (Naval Hospitals Camp Lejeune, Camp Pendleton, and Jacksonville and Fort Belvoir Community Hospital) will remain consistent with previous years.

Any applicant selected for PGY-2 training at either Naval Hospital Bremerton or Pensacola will initiate training as selected and will complete their training at that location. As noted above, Program Directors are committed to ensuring that applicants who are selected for training at either location continue to receive the high quality training for which these programs are known.

Any applicant selected for PGY-1 training at either Naval Hospital Bremerton or Pensacola will initiate training as selected and will complete their training at that location. As noted above, Program Directors are committed to ensuring that applicants who are selected for training at either location continue to receive the high quality training for which these programs are known.

Facility | Key Changes | Enrollment Changes | Billet Changes | Cost Savings (Annual)
--- | --- | --- | --- | ---
Lemoore | Eliminate Inpatient Services, Recapture Surgical Cases | +5,000 | -69 | $10M
Oak Harbor | Convert to Birthing Center, Eliminate Inpatient/Surgical | 0 | -55 | $6.2M
29 Palms | No Change | +3,500 | -17 | $2.0M
Beaufort | Disengage OB | +600 | -43 | $4.5M
Pensacola | Close ICU, Convert Emergency Room to Urgent Care Center | 0 | -78 | $10.2M
Bremerton | Close ICU, Convert Emergency Room to Urgent Care Center | 0 | -80 | $7.7M
Jacksonville | No Change | 0 | 0 | N/A
Camp Pendleton | No Change | 0 | 0 | N/A
Camp Lejeune | Increase Primary Care Enrollment, Recapture OB/GYN, Increase Inpatient | +26,000 | TBD | TBD
positions for each program and evaluation of their application package at the 2014 JS GMESB.

**FUTURE TRAINING OPPORTUNITIES**

Navy GME, the Family Medicine Program Directors, and I are currently working on a plan for the future. With the closure of the programs at Bremerton and Pensacola in 2016, we will lose 13 training spots per year. It is imperative that we maintain our full output of 45 residents per year.

In order to accomplish this, we are planning on requesting training complement increases at Camp Lejeune (3 per year) and Camp Pendleton (1 per year). Jacksonville is currently accredited for 13 residents per year but has only been filled to 12; therefore, we would plan on utilizing their full complement starting in 2015. Additionally, we are discussing with the National Capital Consortium an increase of 3 Navy residents per year at Fort Belvoir, and are exploring a collaborative agreement with Madigan Army Medical Center to continue training at Bremerton. Finally, we are in early discussion with the Air Force about starting a new residency program at Joint Base Langley-Eustis.

**FAMILY MEDICINE BILLETS**

With the implementation of the CONUS Hospital Study recommendations, there will be some movement in Family Medicine billets between facilities. There will also be a change in the scope of some billets where Family Physicians will remain. It is likely that outside of the Family Medicine Residency Programs, there will be limited opportunity to practice full scope Family Medicine. Notable exceptions will be 29 Palms and Portsmouth—where the command is actively trying to get local Family Physicians engaged at the Medical Center.

We will be actively seeking to maintain the current level of teaching faculty at both Bremerton and Pensacola through their closure in 2016. Additionally, we anticipate the need for additional faculty at Camp Lejeune, Camp Pendleton, and Fort Belvoir. If you would be interested in a faculty position at one of these facilities, I would encourage you to contact the Program Directors directly.

**TRAVEL**

Travel rules and requirements have been in a state of constant flux. It is important to watch your emails and check the Navy Medicine Conference Approval Website on a frequent basis for the most updated information.

By the time that this newsletter is released, I will have applied for approval for the 2014 USAFP meeting.

As a reminder, any funded travel for a non-DoD sponsored conference requires the conference to be approved through SECNAV. All requests must be in BUMED at least 120 days prior to the first day of the event. All requests for approval must come through the Specialty Leaders. Therefore, if you are interested in attending a specific conference, please ensure that you give me ample time to complete the application.

**IN CLOSING...**

Thanks to each and every one of you for what you do for Navy Medicine and our beneficiaries on a daily basis. Despite the many stresses on us a community, a Navy and a nation, it is clear that you all continue to carry more than your own load every day. I frequently hear about ways that Navy Family Physicians have gone above and beyond to do the right thing—I am thankful that I call you friends and colleagues. Have a safe and happy holiday season!
Hola All!! As the end of a rocky year closes, your PHS directors would like to leave you with a present status of the force in different areas of concern.

RECRUITING:
The Coast Guard has a tacit agreement with our sister services that we will not actively recruit from their ranks. If officers who are preparing to depart their service are interested in PHS/CG, we will speak with them and offer the opportunity to remain in uniform and to continue serve their country. We have begun to recruit annually at the National Conference of Family Medicine Residents and Students in Kansas City, MO in hopes of exposing students, in particular, to opportunities in the CG. We do not hire General Medical Officers. Residency completion (and thus Board Eligibility) is required.

STAFFING:
CG typically runs at 90-95% staffing of physicians, with many assignments being considered mission critical based on being single physician locations. Roughly 2-4 new accessions occur annually to fill gaps resulting from retirements and transfers to other PHS Agencies or Operating Divisions, so recruiting is a year-round process. Assignment decisions are finalized in January/February after completion of the internal rotation/assignment process for those current CG Officer who are tour complete. Currently vacant billets are the second flight surgeon billet (O-5) at Air Station/Kodiak, AK, and the single medical officer billet (O-4) at Ketchikan, AK. Vacancies for Assignment Year 2014 are TBD.

TRAINING:
All CG physicians are required to complete MCBC and C4 once during their career (completion during prior service counts). Flight Surgeon training is provided by the Coast Guard for officers assigned to aviation medicine duties. Follow on training for flight surgeons in Aviation Mishap Investigation and Prevention is made available annually. Flight surgeons are required to attend Operational Medicine training triennially (Uniformed Services Academy of Family Physicians Annual Meeting). Both USNAC and USAFP are fully funded training during non-crisis budget years. Basic Life Saving and Advanced Cardiac Life Saving are required for physicians serving in the CG, and training is typically accessed at nearby MTFs (via the Military Training Network) or through civilian sources via local funding.

GOVERNMENT SHUT-DOWN AND FURLOUGH:
Unformed Public Health Service Officers continued to work at their respective agencies throughout the shut-down, however, had the shut-down continued they would not have received their once a month pay on 01 November. Fortunately, with the resumption of government operations, PHS Compensation Branch released pay on 01 November. Unfortunately, some of our PHS colleagues with pay status changes (e.g. special pay, additional dependent allowances, etc) may not see their changes reflected until 01 December.

ANNUAL COMMISSIONED OFFICER EVALUATION REPORT:
After a delay in release of the online COER form due to the Government shutdown, the 2013 Annual COER is now available online in the Secure Area of the eOPF. Officers should remember to allow time for local Command review and endorsement.

COAST GUARD TRAVEL & CONTINUING MEDICAL EDUCATION:
Although the final travel restrictions are still unclear, it is highly likely that the amount of authorized travel is going to be reduced again from previous years’ levels. It’s important for CG Providers to keep this in mind as they plan to meet their continuing medical education requirements.

UPDATED AERO GUIDE RELEASED:
On 17 Oct 2013, CGHQ released an update to the Coast Guard AERO Guide with the invaluable assistance and input from the medical staff at Personnel Services Center. Aviation medical colleagues are encouraged to review the document located on the Aviation Medicine Webpage of the Coast Guard Intranet.

INTERESTING CASE FILE:
A young CG cadet presented with a history of mental slowness and academic difficulty after reportedly hitting her head 2 weeks prior. After a thorough history and examination, it was determined that this cadet had been a straight A student in a competitive engineering program and that she had some decline in grades and some emotional issues prior to this head trauma for about the prior 6 months or so. Though her grades declined she was able to do pretty well in her classes until a test day prior to presentation which she did very poorly prompting her to seek medical attention. On exam, she had problems communicating and had significant memory impairments. She was removed from
While we often see pretty routine patients at the Coast Guard Academy and other training centers, this case is a lesson that we must still take thorough histories, conduct good physical exams and get help when needed.

classes and limited from any physical requirements. An MRI was taken which was normal and she was sent to Neurology for an evaluation where she had an abnormal EEG with slowing seen and abnormal spikes. A spinal tap was done which showed white cells but no growth on cultures consistent with aseptic meningitis. She was admitted to the hospital where she developed orofacial dyskinesias, seizures and became minimally responsive and almost catatonic. While it appeared she understood she became nonverbal while hospitalized. She also developed autonomic instability with great variations of blood pressure and pulse with standing and walking. She was treated with antibiotics, then steroids, then immunoglobulin and finally plasmapheresis. A test for autoantibodies to NMDA came back positive and she was definitively diagnosed with an anti-nmda receptor encephalitis. She had multiple imaging studies looking for a tumor source but none was found. She slowly recovered after plasmapheresis and with rehabilitation and lots of determination has returned to the Coast Guard Academy where she has gone back to doing extremely well in her classes and in her PFE tests. This has been a great ending to a terrible condition.

While we often see pretty routine patients at the Coast Guard Academy and other training centers, this case is a lesson that we must still take thorough histories, conduct good physical exams and get help when needed. A book written by New York Post reporter Susanah Cahalan called “Brain on Fire: My Month of Madness” details this condition and this reporter’s problem with getting medical care professionals to take her seriously and get her the care she needed. It is cases like this that do not fit nicely in many folks’ 20 minute paradigm of a patient visit and why often productivity should be second to outcomes’ based assessments.

We remind you to support your chapter and join us next year at the USAFP Annual Meeting at the DoubleTree Hotel in Crystal City. If you have any ideas for future CG/PHS articles or have an interesting case to share with your colleagues please do not hesitate to contact your PHS/CG Directors. Have a safe end of year!

Are you ready for a change? Do you want to give back to your community? Join a community and migrant health center without giving up the luxury of a good salary, beautiful, state-of-the-art facilities, and a well-balanced home life!

We are currently looking for OB/GYN physicians to join our dedicated teams of mission-driven physicians. If you have a passion for providing highquality healthcare in a multi-cultural environment, we would like you to consider becoming a member of our team! A few of our benefits include:

- A competitive productivity-based compensation program with potential of $250k+
- A comprehensive benefits package
- A great work/life balance with 28-hr week schedules
- Hiring bonus and relocation package
- Loan repayment options
- Visa sponsorship
- Monthly stipend for 4th year residents

If this sounds like the opportunity you have been looking for, please apply online or contact us to learn more about what we have to offer. Call us toll free at 877.983.9247 or email us at providerjobs@yvfwc.org. Our mission celebrates diversity. We are committed to equal opportunity employment. Apply at http://www.Click2apply.net/9z94wdn

Yakima Valley
Farm Workers Clinic

While we often see pretty routine patients at the Coast Guard Academy and other training centers, this case is a lesson that we must still take thorough histories, conduct good physical exams and get help when needed. A book written by New York Post reporter Susanah Cahalan called “Brain on Fire: My Month of Madness” details this condition and this reporter’s problem with getting medical care professionals to take her seriously and get her the care she needed. It is cases like this that do not fit nicely in many folks’ 20 minute paradigm of a patient visit and why often productivity should be second to outcomes’ based assessments.

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Have you ever been in a situation where you felt 100% sure about something only to realize that you were completely off the mark? New research in neuroscience seems to suggest that our brains have “the power to create a feeling of knowing – a sense of certainty that we are correct in what we know.” (Madeleine L. Van Hecke, 2010) It is that sense of knowing something for sure, even though we may not be able to prove it at the moment, which is at the heart of neurologist Robert Burton's book *On Being Certain*. Burton’s research seems to suggest that our brains are very good at creating a feeling of knowing something which is so convincing that it supersedes logic and allows us to accept beliefs that we really ought to be questioning. I'm sure there may be plenty of good reasons why our brains evolved to allow these sorts of mental imageries but I feel it can have important implications in medicine and how we ultimately take care of our patients.

The American Journal of Medicine published a very in depth supplement in May 2008 attempting to get at the root of medical practice errors, particularly in medical diagnosis, titled *Diagnostic Error: Is Overconfidence the Problem?* Interestingly, even though the literature seems to suggest an across the board diagnostic error rate of around 5-10%, most physicians individually rated their personal error rates at <1%. It was rather amusing that most of the physicians who were informed of the higher error rates attributed them to being performed by “other” physicians who they regarded as being less skilled. It was very disheartening to discover that very few of the physicians studied felt a need to improve their own diagnostic abilities and were convinced that there is much room for improvement in diagnosis – but by other physicians! Logically, it seems that physicians’ overconfidence in their ability is clouding the attention they are willing to give to reducing their own diagnostic errors.

Recent surveys reveal patients reporting frequent experience with diagnostic errors and these errors concern them significantly within the healthcare system. (Berner, 2008) Furthermore, research into diagnostic errors show that they are alarmingly high and this is true for both relatively benign conditions and more urgent ones in which rapid and accurate diagnosis is essential such as myocardial infarction, pulmonary embolism, and dissecting or ruptured aortic aneurysm. In fact, the second-leading cause of malpractice claims in the United States and abroad are due to diagnostic errors. The vast majority of claims reflect just 6 situations: failure to diagnose cancer, injuries after trauma, surgical problems, infections, heart attacks, and venous thromboembolic disease. (Berner, 2008) Though it may be very difficult to determine a precise frequency of diagnostic errors, a growing body of literature has confirmed these errors do in fact occur and oftentimes at rates higher than we may acknowledge.

Physician overconfidence can have a tremendous impact on making diagnostic errors. Overconfidence falls primarily into attitudinal and cognitive domains but complacency can also be an important factor. The attitudinal aspect reflects the physician’s arrogance in believing “I already know all I need to know.” This attitude expresses apathy to utilize any decision support or feedback no matter what the situation. A striking decline in autopsies performed in recent years would support this argument despite the useful information that doing so can provide. (Berner, 2008) Interestingly, Sir William Osler was a strong proponent of learning medicine both at the bedside and in the autopsy suite. To compound this, the lack of knowledge seeking behavior is also disheartening. “Even when information resources are automated and easily accessible at the point of care with a computer, a tiny fraction of the resources were actually used.” (Rosenbloom ST, 2005) Furthermore, the use of decision-support tools which have the potential to improve care and decrease variations in the delivery of care are often disregarded by clinicians.

The cognitive realm of physician overconfidence tends to reflect problems gathering accurate information from the...
Physician overconfidence can have a tremendous impact on making diagnostic errors. Overconfidence falls primarily into attitudinal and cognitive domains but complacency can also be an important factor. The attitudinal aspect reflects the physician’s arrogance in believing “I already know all I need to know.”

The complacency aspect of overconfidence should also not be discounted. This belief that “nobody’s perfect” is due to several factors including a lack of insight in the amount of error that physicians really do make, tolerance of the errors made, and the feeling that errors are inevitable and there is not much we can do to prevent them. To highlight this, research has demonstrated that only 1% of physicians admit to having made a diagnostic error in the past and when they were asked directly about them they had difficulty recalling even a few memorable errors they had made in the past. (Berner, 2008)

It is important to understand that overconfidence can play a major factor in making diagnostic errors because physicians tend to overestimate the accuracy of their diagnosis. Also, contrary to popular belief, most cognitive errors do not come

continued on page 18
from the challenging cases, but rather, in those that the physician felt most certain. It is with these cases where the patient presents with a seemingly routine problem resembling a previous pattern which the physician has likely seen many times in the past can get them in trouble. It is with these slam-dunk cases that physicians tend to just stop thinking about the case, predisposing them to the pitfalls in the attitudinal and cognitive errors that were discussed previously. The failure to consider other contexts or other diagnostic possibilities lends to their failure in recognizing the shortcomings derived from heuristic thinking.

So how can we prevent ourselves from becoming a victim of overconfidence? First, and foremost, we have to recognize and acknowledge that we all make much more diagnostic errors than we actually admit to. We should also better understand the shortcomings in our heuristic thinking and prevent it from leading us to make errors in attitude and cognition. In addition, we should not let complacency influence us into believing that making diagnostic errors is inevitable. Understanding the cultural impact in medicine where it is often considered a weakness and a sign of vulnerability for clinicians to appear unsure – where confidence is valued over uncertainty – may also need to be reevaluated. It has been argued that physicians lack strong direct and timely feedback regarding our decisions given we do not tend to deal with our errors on an average day. This should be addressed and attention should be given to help remedy this. This is best summarized in the following quote by Frank Keil: “How can I know what I don’t know when I don’t know what I don’t know?” (Rozenblit, 2002) We must embrace the systems designed to aid our diagnostic decision making and take the time to utilize the myriad of resources, patient care guidelines, and decision trees that are available to us now at the point of care. It is my hope that this article will serve to help put our certainty in check and allow us to reflect and better understand how being overconfident can influence our actions.

BIBLIOGRAPHY

University of Colorado Denver and Health Sciences Center
Department of Family Medicine Assistant Professor

Faculty – Rose Family Medicine Residency
Job Posting #7217 – Position #F00679

The Department of Family Medicine at the University of Colorado Denver Health Sciences Center is seeking a full-time ABFM-certified or eligible family physician for our community based program. The Rose Residency is located at Rose Medical Center, ranked nationally as a top 100 hospital, and is supported by the Colorado Health Foundation, a non-profit organization dedicated to making Colorado the healthiest state in the nation. Applicants must possess or be eligible for medical licensure in the State of Colorado. Applicants must demonstrate experience and competence in teaching and patient care. This position is full-time and applicants for full-time positions will have priority; applicants for part-time position at 0.5 FTE or higher will be considered. Obstetrics and hospital call required. Women and minorities encouraged to apply. Detailed job descriptions and qualifications required can be found on jobsatcu.com and the Department’s website, http://fammed.ucdenver.edu/home/careers.aspx.

JOB RESPONSIBILITIES: Applicant will be a core member of the Residency Teaching Faculty: Teaches residents, supervises residents and students in the provision of patient care, provides direct patient care in the inpatient and outpatient setting, participates in scholarly activity, serves as a leader and role model for residents.

REQUIRED QUALIFICATIONS: MD/DO degree, Colorado Medical License, DEA Certificate, Board Certified/Board eligible in Family Medicine. Practices full spectrum of Family Medicine, including Obstetrics and inpatient medicine. Must obtain Medical Staff privileges within the HealthONE LLC d/b/a/ Rose Medical Center and obtain Medical Staff Privileges at University of Colorado Hospital.

PREFERRED QUALIFICATIONS: Experience in family medicine teaching/practice preferred.

Salary is commensurate with skills and experience. The University of Colorado offers a full benefits package. Information on University benefits programs, including eligibility, is located at http://www.cu.edu/pbsl. Applications are accepted electronically at www.jobsatcu.com. Review of applications will begin September 1, 2013 and continue until position is filled.

“The University of Colorado Denver and Health Sciences Center requires background investigations for employment.”
“The University of Colorado is committed to diversity and equality in education and employment.”

When applying at www.jobsatcu.com, applicants must include:
1) A letter of application which specifically addresses the job requirements and outlines qualifications
2) A current Curriculum Vitae

Questions should be directed to regina.garrison@ucdenver.edu
Greetings from Afghanistan! In the continuing series of What Every Deploying Doc Should Know About, I have been asked to cover common Role 2 conditions and care. This article will not address trauma care or the always developing innovations in battlefield medicine. The Tactical Combat Medical Course at Fort Sam Houston, Texas prepares deploying docs for trauma management and should be attended by all providers deploying in support of Role 1 or 2 facilities. This article will describe common, non-trauma, medical conditions currently being seen by Role 2 providers in Afghanistan.

Military Family Medicine residencies fully prepare graduates to provide comprehensive care for their patients. However, the deployed environment is significantly different from our traditional hospital-based training environments. Available resources define the scope of your practice while deployed. It is imperative that you identify resources available to you as soon as possible, preferably prior to your deployment. Identify resources for your aid station and supporting facilities. Do you have a physical therapist? A slit lamp? Tele-radiology? Are you reading your own x-rays? How are you going to get ice-packs or ice to treat sprains and strains? How do you move urgent and non-urgent patients? Identify resource gaps and bridge those gaps if possible. Define your aid station’s scope of practice and communicate your capabilities to your subordinates and leaders.

Contact your Command Surgeon cell for the laydown of available medical resources. The laydown describes where all medical assets are located from Role 1 aid stations up to Role 3 hospitals. Ideally, the laydown lists available specialists and locations. However, this list is regularly not current due to frequent replacements, turnover, and service variations. Fortunately, you can always pick up the phone and call a higher level of care if you have a question. Most consultants are happy to discuss a case with you. Battalion Surgeons are an excellent resource as well. Specialists (i.e. GI, Neuro, Allergy) often deploy as Battalion Surgeons, so be sure to identify unit surgeons co-located with you. Remember that unnecessary patient movement puts everyone at risk. Identifying and using local resources could decrease movement requirements.

At the Role 2 level you may have increased radiologic or surgical support. On the other hand, you may have minimal support with no lab or x-ray. Don’t forget you are the first higher level of care for Role 1 facilities that have even fewer resources than you. Either way you will see everything from the very common to those zebras you learned about in medical school (the ones you thought you would never encounter). Throw in contractors and third country nationals and this is where you as a Family Medicine Physician truly have an opportunity to shine.

Musculoskeletal and sports medicine injuries are the predominate conditions encountered at the Role 2 (see Table 1 on page 20). Resources that I have found indispensable are: “Fracture Management for Primary Care” (excellently written and laid out in a very sensible fashion: needs referral vs. ok to manage); “The Sports Medicine Patient Advisor” (requires a photocopier to give out handouts); “Instructions for Sports Medicine Patients” which comes with a CD-Rom that you can use to print out handouts (if you have a computer and printer). These resources provide physical therapy practices, assistance with interpreting x-rays, and splinting techniques.

Dermatologic conditions are common. Frequently, the condition has been ignored for far longer than it would have been at home or has been treated with multiple courses of anti-fungals or steroids leading to interesting presentations. Your favorite dermatology reference (Habif or Fitzpatrick’s) are invaluable. If you are stumped, use the dermatology telemedicine service (take a picture and email it to the dermatology military list server).

A high yield area that many Family Medicine physicians may feel uncomfortable with is ophthalmology. Your skills will be invaluable if you can perform a good exam with an ophthalmoscope, or even better, with a slit lamp. Bring a reference like the “Wills Eye Manual,” and develop the ability to accurately describe your eye exam to a consultant. Performing and communicating a good eye exam will allow you treat many conditions that might otherwise require evacuation to a higher level of care.

You will see a lot of gastrointestinal diseases, respiratory issues, and kidney stones. Menstrual irregularities commonly occur from changing types of...
Military Family Medicine residencies fully prepare graduates to provide comprehensive care for their patients. However, the deployed environment is significantly different from our traditional hospital-based training environments.

Birth control immediately prior to deploying. Other common deployment issues include insomnia, anxiety, and depression. Know the location of the nearest combat stress or mental health support facility. Most deployed locations have internet connectivity, so you can access to UpToDate or other medical reference sites. In areas without internet access, smartphones and tablets may provide the majority of resources you used at home.

In closing, remember that you have been well trained. The austere environment is considerably different from our training environments. Available resources will define your scope of practice while deployed. Continue to do your best, remember where your references are, know where and whom to consult when needed. Prepare for the commonly seen conditions listed in the table. Do these things and you will be an excellent example of the best that Military Family Medicine has to offer!

<table>
<thead>
<tr>
<th>TABLE 1: Conditions seen in 2 months at a Role 2 in Afghanistan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MUSCULOSKELETAL</strong></td>
</tr>
<tr>
<td>Low Back pain (and more and more)</td>
</tr>
<tr>
<td>• MSK</td>
</tr>
<tr>
<td>• Somatic dysfunction</td>
</tr>
<tr>
<td>• Sciatica</td>
</tr>
<tr>
<td>• OA</td>
</tr>
<tr>
<td>• Piriformis syndrome</td>
</tr>
<tr>
<td>• Acute radiculopathy/herniated disc</td>
</tr>
<tr>
<td>Upper mid back pain</td>
</tr>
<tr>
<td>• Muscular imbalance-too much chest muscle not enough back muscle</td>
</tr>
<tr>
<td>• Posterior ribs</td>
</tr>
<tr>
<td>• Shoulder trigger points radiating to back</td>
</tr>
<tr>
<td>Shoulder pain</td>
</tr>
<tr>
<td>• Rotator cuff tendonitis</td>
</tr>
<tr>
<td>• Bicipital tendonitis</td>
</tr>
<tr>
<td>• AC joint separation</td>
</tr>
<tr>
<td>• Shoulder subluxation</td>
</tr>
<tr>
<td>• Shoulder dislocation</td>
</tr>
<tr>
<td>• Pectoralis major tear</td>
</tr>
<tr>
<td>Knee pain</td>
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<tr>
<td>• Patello-femoral joint dysfunction</td>
</tr>
<tr>
<td>• Patellar tendinopathy</td>
</tr>
<tr>
<td>• Plica syndrome</td>
</tr>
<tr>
<td>• TB syndrome</td>
</tr>
<tr>
<td>• Pes anserine bursitis</td>
</tr>
<tr>
<td>• LCL and MCL strains</td>
</tr>
<tr>
<td>• ACL tears</td>
</tr>
<tr>
<td>• Meniscal tears</td>
</tr>
<tr>
<td>Ankle pain</td>
</tr>
<tr>
<td>• Sprains</td>
</tr>
<tr>
<td>• Post tibial tendinopathy</td>
</tr>
<tr>
<td>• Peroneal tendonitis</td>
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<tr>
<td>• Fracture</td>
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<tr>
<td>Foot pain</td>
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<tr>
<td>• Ingrown toenails</td>
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<tr>
<td>• Plantar fascitis</td>
</tr>
<tr>
<td>• Morton's neuroma/metatarsalgia</td>
</tr>
<tr>
<td>• 5th metatarsal fx</td>
</tr>
<tr>
<td>• Stress fractures</td>
</tr>
<tr>
<td>• Turf toe</td>
</tr>
<tr>
<td>• Great toe dislocation/disruption of sesamoid plate</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>• Finger, toe, wrist, and ankle fractures</td>
</tr>
<tr>
<td>• Dequervain’s</td>
</tr>
<tr>
<td>• Medial and lateral epicondylitis</td>
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<tr>
<td>• Carpal tunnel/unlar neuropathy</td>
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<tr>
<td>• Snapping hip syndrome</td>
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<tr>
<td>• Jersey finger/mallet finger</td>
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<tr>
<td>• Jaw fracture</td>
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<tr>
<td><strong>GI</strong></td>
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<tr>
<td>Abdominal Pain</td>
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<tr>
<td>• Constipation/diarrhea</td>
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<tr>
<td>• GERD</td>
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<tr>
<td>• Food poisoning/gastroenteritis</td>
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<tr>
<td>• Hernia’s (inguinal/umbilical/ventral)</td>
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<tr>
<td>• Appendicitis</td>
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<tr>
<td>• Cholelithiasian</td>
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<tr>
<td>• Perforated diverticulum</td>
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<td>• Varicocele</td>
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<td>• Testicular torsion</td>
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<tr>
<td>• Pancreatitis</td>
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<tr>
<td>Rectal bleeding</td>
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<tr>
<td>• anal fissures/hemorrhoids</td>
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<tr>
<td>• Crohn’s Disease</td>
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<tr>
<td>Jaundice</td>
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<tr>
<td>• Toxic hepatitis from supplement use (multiple)</td>
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<tr>
<td>• Liver /pancreatic masses</td>
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<td><strong>DERM</strong></td>
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<tr>
<td>• Guttate psoriasis</td>
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<tr>
<td>• Eczema</td>
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<tr>
<td>• Tinea everywhere -feet, hands, corpus etc etc</td>
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<tr>
<td>• Boot dermatitis (stasis)</td>
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<tr>
<td>• Molluscum</td>
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<tr>
<td>• EIC’s/abscess/cellulitis</td>
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<tr>
<td>• Folliculitis</td>
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<tr>
<td>• Contact dermatitis (laundry soap most common causative agent)</td>
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<tr>
<td><strong>OPTHO</strong></td>
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<tr>
<td>Managed by FM</td>
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<tr>
<td>• Conjunctivitis (bacterial, viral, and allergic)</td>
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<tr>
<td>• Chalazion</td>
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<tr>
<td>• Iritis (several)</td>
</tr>
<tr>
<td>• Preorbital cellulitis</td>
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<tr>
<td>• Staphylococcal Keratitis</td>
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<tr>
<td>Referred</td>
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<tr>
<td>• Retinal detachment</td>
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<tr>
<td>• Optic Neuritis</td>
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<tr>
<td><strong>OTHER</strong></td>
</tr>
<tr>
<td>• Vaginal discharge</td>
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<tr>
<td>• Irregular bleeding</td>
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<tr>
<td>• Nephrolithiasian</td>
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<tr>
<td>• Herpes genitalia/facial/whitlow</td>
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<tr>
<td>• Hypo and hyperthyroidism</td>
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<tr>
<td>• Hashimoto’s thyroiditis</td>
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<tr>
<td>• Pilonidal cyst</td>
</tr>
<tr>
<td>• Thrombophlebitis of the lower extremities</td>
</tr>
<tr>
<td><strong>WAR SPECIFIC STUFF</strong></td>
</tr>
<tr>
<td>• Finger injuries crush/lacerations</td>
</tr>
<tr>
<td>• Shift work sleep disorder</td>
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<tr>
<td>• Insomnia</td>
</tr>
<tr>
<td>• Anxiety/depression/combat stress</td>
</tr>
<tr>
<td>• Concussions TBI (blast and just work related)</td>
</tr>
<tr>
<td>• TM perforations</td>
</tr>
<tr>
<td>• Burn and fragmentary injuries</td>
</tr>
<tr>
<td>• Dog bites/rat bites</td>
</tr>
<tr>
<td>• Rhabdomyolysis</td>
</tr>
</tbody>
</table>

Military Family Medicine residencies fully prepare graduates to provide comprehensive care for their patients. However, the deployed environment is significantly different from our traditional hospital-based training environments.
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Email: providers@dignityhealth.org

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Many of us have seen and read about an Interagency EHR with the VA. Much of the information in the lay press is partial or inaccurate, so you are now going to receive the “truth” (as I know it) about AHLTA, Essentris and the next generation EHR.

The most recent published information on the iEHR cites full operating capability (FOC) by 2017. It is likely that target will be missed, so count more on 2018/2019. While I would love to be wrong about that, the ugly reality is that I am probably not. As such, we will be using AHLTA, CHCS and Essentris for 4-6 more years (at least). More on that below.

So, why do we want or need an Interagency EHR? We already share lots of information with the VA, right? Yes, we do, but there are many holes in the content and reliability of that data. As many of you know, we have lots of patients that see both DoD and VA providers, folks who are transferred between VA and DoD hospitals after injury and patients who see civilian providers (more on how the iEHR would better support that later).

I encourage each and every one of you to be very vocal to your leadership that the clinical community has to drive the entire acquisition process…and that includes all support and ancillary staff.

One of the major concepts with the PCMH is care coordination, and key to that coordination is sharing information, which we can do but only on a limited basis. In addition, even with care within the DoD system, information sharing in a way that is actionable is limited. Tried to keep up with internal consults recently? Not easy, is it?

Right now, the actual plan is somewhat up in the air as there has been another “adjustment” to the team leading the transition to the next generation EHR. However, there are some things I can say:

1. It appears we will be going for a complete core...be that a COTS (Commercial Off The Shelf) solution [ex. Epic, Cerner, Allscripts] or an open source product like one of the Open VistA’s. It is unclear if VA VistA will be part of the process, but there is political pressure for that.
2. It appears that the hope for a common data platform for both VA and DoD is not going to happen. That is unfortunate, as that would have made data/information sharing much easier.
3. Some of you, especially those working at Tripler and FHCC in Chicago, have probably heard of a thing called JANUS (now called JLV – Joint Legacy Viewer) as an interim solution to surface both DoD and VA data in a common GUI. That is moving forward, but it is most helpful in those settings where significant shared patients exist (Pensacola, Nellis, etc).
4. The likelihood for the MHS (Military Health System) to move off of a “.mil” domain and onto a “.gov” do-

**EVERY DOC CAN DO RESEARCH**

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

If interested, please send a request to direamy@vafp.org. Tools Available:

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

Clinical Investigation Research Tools also available on-line at www.usafp.org.
main to make data sharing much easier with both the VA and our civilian partners is likely very slim. While not at all perfect, and feasible and reasonable alternative is a thing called an “MHS Enclave.” While the technology behind it is not important to you, the ability to better share data is…and the possibility it could reduce latency (delay) in our own EHR.

5. Depending on the acquisition, we should be able to have a single system for all aspects of care (inpatient, outpatient and ED). It is also highly possible to avoid the issues with creating theater/operational only versions of the EHR using a thing called remote virtualization. More on this later.

I encourage each and every one of you to be very vocal to your leadership that the clinical community has to drive the entire acquisition process…and that includes all support and ancillary staff. I have great worry that the acquisition and IT people will make the decision for us, despite constant input from clinicians, and we need the vocal support of all the clinical end users to ensure we avoid CHCS III/AHLTA II as a potential outcome.

**CURRENT SYSTEMS:**

**AHLTA**

The next major version of AHLTA (3.3.8) will be released in early 2014. Among updates and bug fixes, one of the major features will be the inclusion of ICD-10 coding. When released, ICD-9 coding will be enabled, and the ICD-10 coding will reside behind a switch. On or about 01 October, that switch will be activated, thus enabling ICD-10 codes. Testing of those codes has already been accomplished, and it seems to work reasonably well. The only major issue was with “E” codes (injury). There should be plenty of time to correct that before release.

**CHCS**

The only updates to CHCS will be the ICD-10 codes as well. Everything else will remain the same, including the DOS 3.0 interface.

**ESSENTRIS**

Standard content for Perinatal, Perioperative and Med-Surg services will be released over the next several months. These new notes use standard database items in the background to allow a number of new functions and are intended to make clinical reporting tools, information sharing and information flow better. They are also designed to improve and standardize workflow. Lots of strategic reasons for this, but the major goals are to make patient care safer and improve outcomes. I recommend using the new notes and flowsheets for a while before providing feedback.

**HAIMS (Health Artifact and Image Management System)**

This is a new system that is being implemented across the MHS. It allows for the storage of multiple images and artifacts (and in multiple formats…Word, PDF, etc) into regional and local repositories that can be shared across the Enterprise. It also allows for viewing PACS images outside of your MTF (e.g. San Diego can see radiographs taken at Womack/Fort Bragg). It can be accessed both via the Internet and from inside AHLTA directly. It will eventually take the place of Clinical Notes.

There are other projects ongoing to help with care, but these are the major, Enterprise-wide systems. Future discussions can delve into some of these systems, such as patient check-in kiosks, clinical dashboards, virtualization, behavioral health tools and more.
First of all, we would like to thank all of you who responded to the USAFP member survey. I am continually impressed with the caliber of responses that are received, which help provide the board and committees guidance on member needs. In responding, many members expressed desire to have the committee work on providing information or guidance on issues such as work life balance, professionalism, and mentorship. Unsurprisingly, these are issues that are near and dear to physicians’ right out of residency, our “New” physician constituency. New physicians and women are the most well represented constituencies of those answering the survey. In reviewing the answers to what members wanted this committee to focus on, it became apparent that there are several members who are unsure of the purpose of the Special Constituencies committee.

The American Academy of Family Physicians (AAFP) established a National Conference of Special Constituencies (NCSC) because the Board felt that there was merit to a forum where members of these populations could share ideas, develop leadership skills, participate in the organization’s governance, and inform the leadership about their concerns. This was done at a time when there was recognition of the increasing diversity of the AAFP’s membership and an expanded focus on the importance of cultural competency in providing patient-centered care. Since 1990, the NCSC has served to inform the greater AAFP membership about the needs of diverse portions of the patient populations we serve. The AAFP Congress of Delegates has used this voice to consider the policies it puts forth.

The Special Constituencies Committee reflects that purpose for USAFP. We assist the membership by providing resources regarding cultural competency and issues that are important to us, which may or may not be unique to an identified constituency. We also serve as a platform for USAFP to be involved with NCSC and promote leadership and involvement. Janet West, MD a new physician member from the Navy was elected to be one of the AAFP’s delegates to the American Medical Association’s Young Physician Section at the 2012 NCSC. Additionally,

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!

Please e-mail Dianne Reamy, RN, USAFP Research Coordinator for resources or to find a mentor at direamy@vafp.org.
The Special Constituencies committee reflects that purpose for USAFP. We assist the membership by providing resources regarding cultural competency and issues that are important to us, which may or may not be unique to an identified constituency.

as mentioned on USAFP’s website, the committee exists to promote enfranchisement and inclusivity. As USAFP members, we have been called into two professions: that of Medicine and the Profession of Arms. As such, it seems difficult to imagine that we would act in a manner which would disenfranchise or exclude others. Rather, we like to view it as a statement of our organization’s desire to maintain a plurality of ideas.

We look forward to continuing to serve you by providing a forum to explore ideas and as a hub for resources regarding cultural competency. A large portion of the memberships’ requests deal with how to start out as a new military physician, so our principal focus will lie there. However, some of you are interested in things such as how we can affect health disparities, how to work on retaining women military physicians, and how we should respond as physicians to the integration of gays and lesbians in our military. We welcome any members who would like to join the committee and assist in developing resources.
Peer Review – It Can Have Purpose

If you Google “medical peer review” you will find numerous articles on the formal process that occurs in response to an adverse event. What you won’t find is a wealth of information on the continuous retrospective chart review process that we are also responsible for conducting. This process is for quality assurance and quality improvement (QA/QI). I became interested in this process at my last post when I came into the OIC role early January 2011 and had a host of OPPEs (ongoing professional performance evaluations) due and realized that many of my providers were significantly behind on their chart reviews. I started wondering why that was and what was the true purpose we were trying to achieve with these chart reviews? Was it a check the box process, which is what it seemed to have become, or was there an educational purpose to it?

First, peer review has been defined as a “continuous, systematic and critical reflection by a number of care providers, on their own and colleague’s performance, using structured procedures, with the aim of achieving continuous improvement of the quality of care” (Grol, 1994). The AAFP states that the “end product of peer review should be improvement of patient care through physician education and health system improvement.” Although both definition and purpose apply to the formal process, they can be extended to the less formal QA/QI process.

After doing some research and a small survey of the providers on post, what I found out was both surprising and informative. First, despite thoughts to the contrary, most providers felt that the 2-5 minutes per chart that they were spending was the ideal amount of time to spend. Almost 50% of the providers felt uncomfortable making comments on chart reviews due to concerns about possible backlash or confidentiality issues. Conversely, there was overwhelming feeling of frustration about the lack of feedback from the peer review system. Finally, of my providers, 60% felt that we were not meeting the goal of peer review as laid out by the AAFP. Another survey by Richard Grol (1994), conducted on 234 providers, found that they felt the most useful aspects of peer review to be: 1) exchanging experiences, 2) becoming aware of system and personal knowledge gaps and 3) being informed of new guidelines.

**KEY INGREDIENTS OF PEER REVIEWS**

Dr. Marc Edwards (2009) argues that that there can be many benefits to a comprehensive peer review approach. He suggests that a peer review system should have the following key ingredients:

- **Performance not competence evaluation**

  Dr. Edwards states that “competence is an enduring quality that is unlikely to change quickly in the absence of a physician health problem” but that performance is more encompassing and context sensitive. This means that performance will vary more when processes are not well controlled. Competence only looks at standard of care of the provider, whereas performance looks at the whole encounter.

- **Quality improvement project**

  Peer review should be approached as a QI project, not a judgmental or punitive process. This should help take the stigma out of the process and relieve some of the providers’ fears about their participation in the process. Providers often are hesitant to report on one and another due to fear of retribution or getting a friend or colleague in trouble. The AAFP recommends “Physicians conducting peer review should be afforded confidentiality, but the evidence and clinical decision making used in developing peer review decisions should be transparent and open to scrutiny.” (AAFP 2011)

- **Self-Improvement**

  Providers must approach peer review as a self-improvement, learning process. Professionals are often resistant to the idea that they might not be doing things perfectly. In order for peer review to be effective and achieve its goals, then the provider must be open to feedback. The AAFP recommends “Physicians conducting peer review should be afforded confidentiality, but the evidence and clinical decision making used in developing peer review decisions should be transparent and open to scrutiny.” (AAFP peer review policy 2011)

- **Standardize the process**

  Employees within the same MTF, within the same specialty should be subject to the same peer review process, no matter in which location they work. This reduces complaints and confusion. It ensures everyone is subject to the same standards within a department.

- **Timely Feedback**

  If the point of a peer review process is education and to improve performance, both of the system and the individual,
Almost 50% of the providers felt uncomfortable making comments on chart reviews due to concerns about possible backlash or confidentiality issues. Conversely, there was overwhelming feeling of frustration about the lack of feedback from the peer review system. Finally, of my providers, 60% felt that we were not meeting the goal of peer review as laid out by the AAFP.

then constructive feedback is essential. The AAFP recommends that there should be a process for rebuttals as well. It is highly recommended that if there is a serious concern, then the person should be talked to in person, either by the reviewer or the supervisor, if the reviewer is hesitant to do it. The supervisor should also be made aware of serious chart review concerns as soon as possible.

Monitor Outcomes

Even though this is a non-judgmental process, it is also a QA/QI process with measurements and must be tracked. The Army requires it to be mentioned in the semi-annual OPPEs. Peer review participation and performance should be part of providers’ performance objectives. Supervisors should not be caught by surprise by results and problems should be identified and addressed early. Results for providers that are not directly supervised by the MTF (i.e. unit providers) should have their results shared with them and their supervisor. This allows the supervisors to have a better understanding on how their providers are performing clinically, which is useful when filling out recredentialing paperwork and evaluations.

BUILDING A PEER REVIEW SYSTEM

So we have reviewed the purpose and key objectives of a peer review system. How is that translated into practicality? Some thoughts to consider if you are interested in updating or changing your peer review process:

Electronic versus Paper

Paper reviews requires MANY more man-hours and resources to prepare. A benefit to paper, though, is that it can be made anonymous. Paper is also often perceived by providers to be easier to use due to not having to log onto a system and look up charts. Paper chart reviews can be easily done intermittently (i.e. 5 minutes here and there of down time between patients). Electronic reviews have the potential to be more accessible (could be done at home without bringing “paper records” home). They use overall less material and manpower resources but can be more time consuming for the provider who has to log on and off of ALTHA. Electronic reviews are also hard to make anonymous.

How to get feedback to providers?

Email? Verbally? Copies of the handwritten or typed reviews? This has the potential to take a significant amount of time and resources if a process isn’t set up and streamlined. Supervisors also need to consider how to get feedback to those providers that you don’t see very often (volunteers, locums, unit providers, etc...).

How to manage disputes

Professionals often don’t like criticism, no matter how constructive. How do you protect anonymity (if you can get it in the first place), validate results and mediate any disputes?

Scoring system

You need to take a good look at what elements are important enough for you to review. The list needs to be succinct but cover what needs to be covered. 30 questions is probably too many; 3 or 4 is probably not enough. Do you evaluate chronic disease metrics and if so does that change your scoring system, since some charts will have this and some not? Do you use a Yes/No question system or a Likert scale? What are your cut off points for concern or those requiring Focused Professional Performance Evaluation (FPPE) action?

The items identified by the providers in my survey were: thorough history, appropriate physical, detailed assessment, appropriate medication usage (to include antibiotic usage and dosing), appropriate utilization of ancillary services and documentation of follow up.

Procedures

Should procedures be reviewed differently than other chart reviews? Which procedures should be reviewed, how frequently and using what scale (review steps above)? I caution you to be careful when determining this. For example, we had a policy that all procedures had to have 100% chart review, this included joint injections. We had a sports medicine provider working within our clinic. If this policy were to be applied, we would have been chart reviewing close to 100% of his charts or 15-20 charts per day, which would have been extremely overwhelming.

Motivation

How do you motivate your providers to make peer review a priority in addition...
to all their other time consuming requirements? How do you get your unit providers (which you are not in the supervisory chain for) to participate and give you charts, if they are not seeing patients within the clinic?

Organizational considerations

Many of our providers carry licenses from different states than the one they work in. These different states have different licensing requirements for different professions. Peer reviews should ideally be done by peers “people of the same level and profession” but this isn’t always possible. In addition many PAs and NP’s need to meet certain chart review requirements for their state licensure. The Army regulation states that the state license maintenance requirements must be met by the individual and it is their responsibility to inform the supervisor of these requirements. The supervisor must be aware of, document and meet those requirements.

You can find state requirements at http://www.nccpa.net/StateBoards and http://www.aanp.org/.

The peer review process doesn’t have to be a “check the box” ordeal. In fact, there seems to be interest and value in having a comprehensive peer review system that meets the goal of “improvement of patient care through physician education and health system improvement” (AAFP, 2011).

REFERENCES


Desert Senita Community Health Center (DSCHC) has an immediate opening for a full-time staff physician, who will be part of a multi-disciplinary team which includes medical, dental, behavioral health, and pharmacy professionals. Office hours are Monday through Thursday, 8 a.m. to 7 p.m., and Friday 8 a.m. to 5 p.m. This is an outpatient only position, with 15 appointment slots per day on average. No hospital privileges required. Duties include active participation in quality improvement initiatives and periodic on-call duties until 11pm. This position could also evolve into the Chief Medical Officer role. One to two years’ experience desired; bilingual applicants are strongly encouraged to apply.

DSCHC has provided services in Ajo for over 50 years, originally as an outpatient clinic for the hospital which closed in 1986 and now as a Federally-Qualified Health Center (FQHC). DSCHC offers a wide array of services, including primary and preventative health care for all lifecycles; dental services; and behavioral health counseling. DSCHC also has an on-site lab, x-ray services, pharmacy, visiting specialty services such as cardiology, ultrasound, and mammography, and a variety of case management, education, outreach, and other support services. As the sole provider of health care services, DSCHC has a diverse patient population which includes both year-round and winter residents.

DSCHC is located in the community of Ajo in rural southern Arizona, in the middle of the beautiful Sonoran Desert. Some local items of note include:

- There is little to no pollution or traffic.
- Hiking and nature activities are available in and around the Ajo area at Cabeza Prieta National Wildlife Refuge, nearby Organ Pipe Cactus National Monument, and other desert areas.
- There are many active civic organizations in Ajo, such as the Ajo Rotary Club, Ajo Elks Lodge, Masonic Lodge, and the Ajo Lions Club.
- Other local activities include the local county library and its programs, ballet folklórico (Mexican folk dancing) groups, Pima County Parks and Recreation athletic leagues for both youth and adults, and the local International Sonoran Desert Alliance and its business enterprise activities.
- Mexican beaches and resort areas are approximately 2 hours away.
- The Curley School has a local artisan housing project which has involved the historical and functional renovation of the former K – 12 school into living and working spaces for artists, artisans, and crafts-based, imaginative businesses.

Medical, dental, short-term/long-term disability, life insurance, and 403(b) retirement plan benefits and moving expenses provided. DSCHC is located in a health professional shortage area (HPSA) with a score of 19, and National Health Service Corps Scholar placement and Loan Repayment is available. Interested applicants should submit a resume, cover letter, and 3 professional references by email to fdriver@desertsenita.org OR via fax to 520-387-5347 (Attention: F. Driver) OR via regular mail to Desert Senita Community Health Center, Attention: F. Driver, 410 N. Malacate Street, Ajo, AZ 85321.
When crafting a survey, one of the biggest challenges medical educators face is writing a set of clear, unambiguous items that respondents can understand and respond to accurately. Writing good items is both an art and a science. Nevertheless, there are many evidence-based recommendations that can be used to guide the item-writing process. Below are recommendations that address five commonly asked questions about how to write good survey items.

**TABLE 1: Evidence-based best practices for writing survey items.**

<table>
<thead>
<tr>
<th>Frequently Asked Question</th>
<th>Best Practice</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should I write my survey items in the form of a question or a statement?</td>
<td>Where possible, write survey items in the form of a question rather than a statement.</td>
<td>Questions are more conversational and respondents are more practiced at answering questions as opposed to rating a set of statements.</td>
</tr>
<tr>
<td>What type of response options should I use, agreement response options or some other type?</td>
<td>Avoid agreement response options. Instead, use construct-specific response options where possible.</td>
<td>Agreement response options do not emphasize the construct being assessed and may encourage respondents to acquiesce; that is, to agree with the item, regardless of its content.</td>
</tr>
<tr>
<td>How many response options should I use?</td>
<td>Use at least 5 response options and no more than 9.</td>
<td>Using too few response options tends to reduce the reliability of a set of survey items. Providing too many response options will not be meaningful to most respondents. Also, using too many response options can give the false impression of high precision yet is unlikely to improve reliability.</td>
</tr>
<tr>
<td>Should I use an odd or an even number of response options?</td>
<td>Use an odd number of response options if your construct has a conceptual midpoint.</td>
<td>Although there is no definitive answer to the question of whether to use an odd or an even number of response options, in many cases, having a midpoint can encourage accuracy. This is particularly true if your construct has a conceptual midpoint (e.g., a “neutral” point) which many constructs do.</td>
</tr>
<tr>
<td>How should I label my response options: with numbers, verbal labels, or both?</td>
<td>Label all points along your response scale (not just the end points) using construct-specific verbal labels.</td>
<td>Because of the additional information respondents must process, providing both numbers and verbal labels may increase cognitive effort and can extend response time.</td>
</tr>
</tbody>
</table>

**REFERENCES**


Dr. Artino is an expert in survey design at the Uniformed Services University. Despite that, he’s also top-rated, fun, and entertaining instructor! We invite all USAFP members to attend Dr. Artino’s fantastic survey design workshop, “You Can’t Fix by Analysis What You’ve Spoiled by Design” on Sunday, March 16 at the 2014 USAFP Annual Meeting in Washington DC. Following the general workshop, Dr. Artino will lead a closed session for the USAFP research judges and invited local research mentors from DOD Family Medicine Residency Programs.

Whether you’re using surveys for research, education, or quality improvement purposes, Dr. Artino will give you the fun and fast tools you need to make a better survey. You won’t want to miss it!!!!!
I have a confession to make. I am a CrossFitter. I am currently a fellow in the Sports Medicine Fellowship, and coming out is scary. What will my fellowship director, my fellow fellows and the academic gurus at Uniformed Services think of me? I’ve heard it all. It’s insane. It’s dangerous. It causes rhabdomyolysis. Many have incredulous looks as they ponder why someone would do 100 pull-ups, 100 pushups, 100 sit-ups and 100 air squats, as fast as you can. I admit it; I thought it was crazy too. It was a fateful day in Iraq, where my first CrossFit workout kicked my little toosh in 2006. It was “Helen.” Three rounds for time of 400 meter run, 21 kettlebell swings and 12 pullups. I was hooked. 7 years later, I stand faster, stronger and fitter and continue to drink the kool-aid.

Love it, hate it or neutral, you probably have heard of CrossFit. You may have even done a CrossFit workout. From its grass roots beginning in the year 2000, to over 7000 worldwide affiliates, 10 million CrossFitters, 35,000 trainers, Reebok swag and the “Games” televised on ESPN, CrossFit is taking the fitness industry by storm. CrossFit is especially popular among military servicemembers with CrossFit gyms popping up downrange and on military bases. As military family physicians, I am confident that you will run into people who CrossFit. In this article, I hope I can give you a basic understanding of what CrossFit is about and take a closer look at the general underpinnings of CrossFit as an exercise program.

WHAT IS CROSSFIT?

“100 words” of CrossFit is a foundational statement by the CEO, Greg Glassman. This is probably the best definition to describe what this movement is about.

“Eat meat and vegetables, nuts and seeds, some fruit, little starch and no sugar. Keep intake to levels that will support exercise but not body fat. Practice and train major lifts: Deadlift, clean, squat, presses, clean&jerk and snatch. Similarly, master the basics of gymnastics: pull-ups, dips, rope climb, push-ups, sit-ups, presses to handstand, pirouettes, flips, splits, and holds. Bike, run, swim, row, etc, hard and fast. Five or six days per week mix these elements in as many combinations and patterns as creativity will allow. Routine is the enemy. Keep workouts short and intense. Regularly learn and play new sports.” Greg Glassman

The pyramid is another way to view CrossFit. See Figure 1. If you notice, CrossFit emphasizes nutrition as the base. That is a topic for another day. Then, metabolic conditioning (or aerobic exercise), gymnastics, weightlifting and finally, sport.

Next, is to understand the basic programming of the workouts and the type of movements. Generally, CrossFit workouts are boiled down into this statement: “Constantly varied, functional movements performed at high intensity.” Let’s break this down.

Constantly Varied

Routine is the enemy. Working on bench press and legs alternating with “cardio” can become stale. Performance also peaks and levels at 6 weeks if you don’t vary the routine. The theory is that by constantly varying different types of movements and exercise, the recreational athlete or Warrior will be able to face anything that comes at them. Tony Horton, who popularized P90x, stated it well with his concept of “muscle confusion.” CrossFit attempts to train for the untrainable, with constantly varied exercise.

Functional Movements

CrossFit promotes functional, two-joint movements—movements that you will do during life normal activities. For example, when have you done a bi-...
Overall though, considering the type of movements of CrossFit, one can predict a constellation of injuries consistent with the different movements. Physicians should ask for and look for injury patterns consistent with patterns involving Olympic lifting, gymnastics, calisthenics, and plyometrics.

caps curl in life’s activities? Most biceps movements involve supination and arm flexion, generally involved in lifting and reaching for things. How about overhead lifts? Do you routinely isolate your deltoïds and keep your back inclined to put a heavy box on top of a shelf? Top functional exercises includes the squat (body-weight) and the deadlift. For example, a squat is simply the ability to sit and get up from a chair. Or, better yet, getting up from the ground (try doing a Turkish Get-up—great for the core!). A deadlift is simply picking something off the ground. Whether it is a 20-lb box, a fallen Soldier on the battlefield, or a pencil dropped on the ground, we all have to do this basic functional movement.

Performed at High Intensity

High intensity training is a huge part of CrossFit. There are scores of published articles looking at high intensity exercise. High intensity training can improve cardiovascular fitness, body composition and modify cardiovascular risk factors (improved lipid profiles, insulin sensitivity, blood glucose), often in a fraction of the time. An easy to read review article published in the Australian Family Physician journal on HIT can be found at this link.¹

http://www.racgp.org.au/afp/2012/december/evidence-based-exercise/. For example, one cycling study found high intensity interval sprints, as compared to traditional endurance training, to exert similar benefits of performance on 2 different time trials. The HIT group, however, exercised 20% less than the traditional group.²

Another recent study looked at HIT on half marathon performance and body composition. The study randomized 34 recreational runners to two groups. An “After Work” group that did 30 minutes of intense training 4 days a week and one 30 min endurance run once a week after work (total 2.5 hours) versus a “Weekend” group that ran for 2 sessions totaling 2.5 hours on the weekend only. After 12 weeks, both groups ran a half marathon as part of their final test. At the end of the study, there was no significant difference in half-marathon time. However, the “After Work” group had significantly improved oxygen uptake (VO2 max), velocity at peak lactate threshold, and had lower visceral fat compared to the “Weekend” group.¹

This study was nice since it tried to replicate “real-world” scenarios.

IS CROSSFIT EFFECTIVE?

The American College of Sports Medicine guidelines for exercise was revised in 2011 and is consistent with the American Heart Association guidelines for exercise. Basically, both societies recommend:

1. At least 150 minutes a week of moderate aerobic activity at least 5 days a week OR
2. At least 75 minutes a week of vigorous aerobic activity at least 3 days a week AND
3. Resistance exercise: 2-3 days a week

CrossFit exercises are different in that resistance exercises are often combined with their workouts. Adding the intensity, gives the workout both an aerobic and anaerobic component. Bottom line, a short intense workout that simultaneously improves both aerobic and anaerobic capacity. Let’s look at this in more detail.

A recent study sponsored and published by the American Council of Exercise¹ described physiologic response and caloric burn for two CrossFit workouts. One called “Fran” and one called “Donkey Kong.” “Fran” consists of 21 repetitions of thrusters (squat to overhead press using a weighted barbell) and 21 pull-ups, then 15 burpees and 15 pull-ups, and finally 9 thrusters and 9 pull-ups. “Donkey Kong” consists of 21 repetitions of burpees, kettlebells and box jumps, then 15 burpees, kettlebells and box jumps and finally 9 burpees, kettlebells and box jumps. On average, both workouts were completed in less than 12 minutes (although there was a great range) and burned an average of 20 calories/minute in males and 12 calories/minute in females. Interestingly, both workouts kept the participants heart rate at 90% of maximal heart rate and at 80% of VO2 max throughout the workout—levels that supports improvement of cardiovascular endurance; i.e. improvement of aerobic capacity. Also, blood lactate levels were high after workout (average 15.9 mmol/L for men and 12.4 mmol/L for women. Theoretically, increasing your lactate threshold can improve exercise endurance, since you can continue to process lactate without having to rest. I know this was a lot of numbers. Bottom line, this study demonstrates that an average 12-minute CrossFit exercise (incorporating both resistance and body weight exercises) can burn an average of 240 calories in males, 144 in females, and can potentially deliver both an aerobic and anaerobic training benefit.

Unfortunately, there are very few published studies in the medical literature focused on CrossFit. The only study published in the PubMed database...
showed improved VO2 max and decreased body fat in 43 subjects after 10 weeks of CrossFit. There were no control group for comparison.5

IS CROSSFIT SAFE?

No fitness activity is devoid of injury. From walking, running, football, to military physical training, the risk of injury always exist. Quantifying the injury risk of CrossFit, however, is currently unavailable in the literature. Overall, understanding the type of movements CrossFit, one can predict a constellation of injuries consistent with the different movements. Physicians should ask for and look for injury patterns consistent with patterns involving Olympic lifting, gymnastics, calisthenics, and plyometrics. One study just published attempted to quantify the injury rates from CrossFit and other HIT. This research found no difference in injury rates from those participating in HIT type exercises compared to normal Army Physical Training (PT).6 More studies looking at the benefits and risk of CrossFit are greatly needed.

MY PATIENTS ARE INTERESTED IN TRYING, WHAT DO I TELL THEM?

There are two basic ways to begin CrossFit. Everything to get started is published and free to use on www.crossfit.com. If they want to start on their own, a good rule of thumb is to learn the movements and exercises for their own, a good rule of thumb is to teach the fundamentals and have good coaches. Most CrossFit gyms will give you a free introduction workout to get a feel of both the workout and the coaching team.

BOTTOM LINE

Clearly, more research needs to be done on CrossFit. Exercise is medicine, and this movement, if nothing else, has gotten people excited about fitness. While caution should not be thrown to the wind, we should also not throw the baby out with the bathwater. I hope this article gives you a basic understanding of CrossFit and the theories behind the movement. I also hope it stirs a response among our readers. What have been your experiences? Good or bad? Finally, to the other closet CrossFitters out there, what’s your “Fran” time? My PR is 5:52, Rx’d.

REFERENCES
Babiash P, Porcari J, Steffen J, Doberstein S, Foster C. CrossFit: New research puts PR is 5:52, Rx’d.

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 Mary Lindsay White at mlwhite@vafp.org.

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

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Applications for research judges are accepted on a rolling basis. Please contact Dianne Reamy (direamy@vafp.org) to request an application.
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Congratulations to the following USAFP members!

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USAFP Student Member Mark Prats Appointed to AAFP Commission

Congratulations to USUHS student and USAFP student member Mark Prats on being appointed to the AAFP’s Commission on Health of the Public and Science. This action was taken by the AAFP Board of Directors following the recommendation of the Resident and Student Screening Subcommittee. The appointment is for a one-year term starting January 1, 2014 and ending December 31, 2014.

The mission of the American Academy of Family Physicians (AAFP) is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

Congratulations Mr. Prats!
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