

# Family Medicine Quarterly

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## Issues in this Issue

Roger W. Schauer, MD

Growing up on a farm I thought of autumn as a time for harvest, a time to ready for winter. At the medical school I now see autumn as a time for new growth as we are reenergized with new faces, new ideas, new voices. Learn more about those students many of you will be mentoring and precepting in coming years in “Characteristics of the Class of 2010”. New growth and new direction are themes in the message from our president, Chuck Breen, as he discusses Academy directions, and in the message from Rob Beattie, as he describes the new face and direction of the Department of Family and Community Medicine. Read about the proposed mentoring opportunities for medical students in the article by Drs. Rob Beattie and Charlie Christianson.

New growth and opportunities were also the theme of the 7<sup>th</sup> WONCA Rural Health Conference, as medical schools from around the world shared their experiences in preparing students for service in underserved areas. More detail can be found in my article “Can educational policy make a difference in primary care?” in this FMQ. (In that context we want to welcome Dr. Derek Wayman back to North Dakota. Dr. Wayman, who joined the Altru clinic physicians in Devils Lake, participated in our Rural Opportunities in Medical Education (ROME) during his third year of medical school.)

Because teaching students in rural areas is more likely to result in their return to rural areas, “teaching the teachers” was another focus of the WONCA meeting. It may come as no surprise to many of our readers, but other schools also find that most community physicians do not feel that they are adequately prepared to teach medical students. Many physicians simply forgot what it was like to be a student, and simply do not recognize their own strengths. Much discussion focused on the students’ need for feedback, both in terms of positive feedback for what they are doing correctly and corrective feedback when indicated. The enclosed “Teaching Points” article – “A Two Minute Mini-lecture; Presentation Skills in the HPI”, is a simple example of timely teaching/feedback intervention. Oral presentation skills are core learning objectives for third year students. This article might provide some useful pointers for you.

Drug and alcohol addiction and treatment thereof have received a lot of press recently. We also know that the North Dakota Board of Medical Examiners periodically needs to address this issue. One resource recently developed in North Dakota is the “Center for Solutions”. See the article by Glenda Springsted-Spencer regarding this treatment option in North Dakota. Also note the article “Suicide Prevention and Physician Care” that addresses a concern and a resource in North Dakota. I especially want to call your attention to the last section of the article “Ten Most Common Errors During a Suicide Intervention”. As I read that it brought to mind my own experiences with adolescents who had attempted or were considering suicide. I recall one sentence from a book about suicide prevention that had a significant impact on how I dealt with talking about suicide, and that was “Suicide is the period at the end of the sentence that nobody read”.

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Dave Peske brings us up to date in his "NDMA Lobby Report" and the outcomes of the recent annual NDMA meeting.

Please plan to join us for "An Evening with a Family Physician" (see Brandy's "Executive Excerpt" for more details about both the upcoming "Evening with a Family Physician" and our next Big Sky meeting).

As always we welcome reports of your activities, articles, letters, or comments about the current issue.

Submitted,  
Roger W. Schauer, MD

### CORRECTION:

In the Summer 2006 Issue, Summer Externships—SEARCH article, Sheila Trontvet was incorrectly listed as Dr. Sheila Trontvet. Sheila Trontvet is a Nurse Practitioner.

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## **A Message from The President**

***Chuck Breen, M.D.***

We are looking forward to the national AAFP Congress of Delegates meeting in Washington at the end of September. The issues we face in our own practice somehow always find a way into the resolutions and bylaws that are debated and eventually voted on. The agenda is almost always focused on better patient care and trying to deliver the best model of health care possible for our country. This is not true of some specialty boards and organizations whose focus is often only to improve their own reimbursement.

It is because size of the AAFP membership and its stance on improving the delivery of economical care that politicians and insurance companies pay greater attention to the AAFP. Of course, North Dakota has a great advantage in representation as each state has equal votes. We expect to bring back a lot of ideas for our state chapter and we will share these when we return.

Of course the AAFP also looks for ways to make improvements for its physicians. One particular area of focus over the past years at the Congress of Delegates has been the relationship with the American Board of Family Medicine. The recent changes in board recertification initially brought on a huge negative response from family physicians and our AAFP was the first to demand changes. The ABFM responded and each year things have improved. They have improved the Self Assessment Modules (SAMs) and now introduced the new Maintenance of Certification for Family Physicians (MC-FP) which allows for a 10 year recertification cycle.

By speaking out for our members, the AAFP has had a great influence on the ABFM. Overall, we will all be better physicians and the yearly SAM should keep us timely on our CME. On a state level, we hope to offer SAM workshops at future meetings so you can finish them in a group setting. Many states are reporting great satisfaction by physicians who participate in them.

This is the time of the year members are planning their CME and we hope Big Sky will be a part of your plans. Brandy and the Big Sky committee have put together a great meeting and hopefully the snow will be as good as last year. Even those who don't ski have a great week out there so please think about it.

## **Executive Excerpt**

***Brandy Jo Frei, Co-Editor***

Life as I knew it is over. I used to have a 2 yr old that tended to be terrible at times but would try all kinds of foods. I now have a 3 yr old who will only eat macaroni and cheese or "proni" pizza and a infant who thinks that since the grandmas hold him the entire time he is with them, Mom should hold him all the time too. I feel so blessed to have these two wonderful children in my life. I can proudly say that we had the same family physician deliver both of our children. Not only is he our doctor, but I feel like he is a friend as well. In the craziness of the summer, there were five babies born to our friends and family. Of them, all but one was delivered by a family physician. In North Dakota, Family Physicians are the preferred choice.

Now that my maternity leave is over, it is time to get back to work. I will be traveling to Washington DC for the American Academy of Family Physicians (AAFP) Congress of Delegates. This is an overwhelming experience that further helps me understand the purpose of the AAFP.

After I return, it is time to focus on the medical students. We are having the Evening with a ND Family Physician on Thursday, October 26th, at the Alerus Center in Grand Forks. This will be held during National Primary Care Week. The medical students will have a number of activities planned for this week.

Big Sky Planning is in full swing as well. Brochures went out and we have a number of individuals that have already registered. This year is the 30th Anniversary and we are hoping for a big turnout. We have brought back a number of excellent speakers from previous years. We have also added a few changes: a full color brochure with a number of wonderful action shots from the mountain, door prize drawings with prizes from a number of Big Sky Businesses, and some new exhibitors in the exhibit hall. I hope to see you all there.

Please keep in mind the Annual Meeting next year has been moved to the end of June in Medora. Be sure to put it on the family calendar. More details will be coming soon.

## A View From UND

Robert Beattie, M.D.

Chairman, Department of Family and Community Medicine

This is an exciting time, submitting the first report from the Department of Family and Community Medicine. The change became official July 1, 2006 after approval by the State Board of Higher Education at their June 15<sup>th</sup> meeting.

The combination of these two departments better describes the reality of who we are in our rural state. Family Physicians provide the bulk of community medicine services. How many of you assist with local disaster preparedness, are acting coroner or participate with the State Health Department's endemic surveillance program? All of these activities, as well as service to the disadvantaged and medically underserved are activities many, especially those beyond our state borders, would describe as community medicine. For many of us, it's what we do every day. Community Medicine brings several successful programs to Family Medicine:

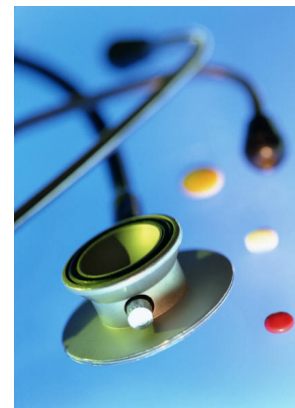
- The Tobacco Quit Line is a joint project with the Mayo Clinic Nicotine Dependence Center, the North Dakota Department of Health and the Department of Family and Community Medicine. There is no other program in the country with this level of cooperation among entities to provide cessation services to the public. The Quit Line, recently featured in North Dakota Medicine, is noted to have a cessation rate of nearly 40% at 6 months after calling. This success is enviable among smoking cessation call centers countrywide. Read the whole article at <http://www.ndmedicine.org/summer2006/Quitline.cfm>. Drs. Eric Johnson and Donna Anel, co-medical directors with the Tobacco Quit Line, will be presenting a 3 part educational series on tobacco issues over the BT Wan system in October. Look for more information on this topic later in the month. The Department will be exploring opportunities to further our partnership with the North Dakota Department of Health.
- The Physician Assistant Program started in Community Medicine as the Medic Program, training Army Medics for transition to civilian relationships with practicing physicians. The Program has evolved to a Masters level training program, placing PAs throughout the country.

The department is presently assessing our Resident training programs. Many programs have uniquely

established themselves by expanding their training. We too could develop offerings to include a MPH degree, rural health policy and leadership development, Preventive Medicine or other Fellowships experiences. This is one way of adding value to our programs, conceivably making them more attractive to graduating medical students.

One of the roles in our newly constituted department is expanding our education mission. The Department of Family Medicine focused on educating medical students and residents and some faculty development. The new department will continue its tradition in student and resident learning and develop programs focused on the needs of the practicing physician, providing Continuing Education, such as the tobacco series above, would be one example. These endeavors will only be successful if you tell us what sort of educational activities you want or need.

Please drop by and say "hello" the next time you are in Grand Forks.



## Characteristics of the Class

Judy L. Demers

The Class of 2010 (entering on August 7, 2006) is composed of 62\* individuals. The following provides statistics in relation to class members.

**Sex:** Male = 31 (50.0%) Female = 31 (50.0%)

**Age:** ---at date of matriculation (8-7-06)

Range = 21-42 yrs	21 yo = 2	26 yo = 7
Mean = 24.2 yrs	22 yo = 17	27 yo = 2
Median = 23 yrs	23 yo = 13	28 yo = 3
Mode = 22 yrs	24 yo = 11	34 yo = 1
	25 yo = 5	42 yo = 1

### **State of Residence** (7 states)

ND = 45 (1 INMED)	AZ = 1 (INMED)
MN = 7 (1 INMED)	SD = 1 (INMED)
MT = 5 (All WICHE)	UT = 1 (INMED)
OK = 2 (Both INMED)	

**Ethnic Background:** Ten (16.1%) of the students self report an ethnic minority background. Seven are American Indian; two are Asian-Pacific; and one is Hispanic.

\* Three previously admitted students are joining the class of 2010, bringing the total to 65. In addition, two of the entering INMED students who are now part of the class will transfer to the University of South Dakota at the completion of Year 02.

### **Majors\*\*:** Bachelor's Degree -

Biology/Human Biology/Zoology = 35  
Chemistry = 7  
Psychology = 4  
Biochemistry = 3  
Clinical Laboratory Science = 2  
Honors = 2  
Interdisciplinary Studies = 2  
Physiology = 2

One major each: (N=14)  
Anthropology/Middle Eastern Studies  
Global Studies  
Athletic Training  
Kinesiology  
Cell Biology & Neuroscience  
Microbiology  
Communications  
Neuroscience  
Dietetics

Occupational therapy  
Electrical Engineering  
Pharmaceutical Science  
Forensic Science  
Philosophy

\*\*Total exceeds 62 due to students having more than one major or more than one Bachelor's degree.

### **College/University Attended for Bachelor Degree Study (N=30)**

University of North Dakota = 18  
University of Mary = 3  
University of Minnesota = 6  
Macalaster College = 2  
North Dakota State University = 5  
St. John's University = 2  
Concordia College = 3

One student each: (N=21)

Arizona State University  
Northern Arizona University  
Augsburg College  
Northwestern College (St. Paul, MN)  
Augustana College  
Smith College (Massachusetts)  
Bethel College  
Southern California University of  
Brigham Young University Health Sciences (Whittier)  
College of St. Scholastica  
St. Olaf College  
East Central University (Oklahoma)  
University of Arkansas  
Gonzaga University (Spokane)  
University of Colorado  
Mankato State University  
University of Redlands  
Minnesota State University (Moorhead)  
University of St. Thomas  
Montana State University  
Mount Holyoke College (Massachusetts)

### **Graduate/Advanced Degrees** (5 Institutions)

Georgetown University – MS  
University of Minnesota – MS  
Mayo Medical School – MSPT  
University of North Dakota – MS  
Southern California University of Health Sciences –  
Doctor of Chiropractic

### **Majors/Graduate – Advanced Degrees**

Biophysics/Physiology	Pharmacology/Physiology
Chiropractic Science	Physical Therapy
Kinesiology	

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## Mentoring Third-Year Students

By Rob Beattie, M.D. & Charles E. Christianson, M.D., Sc.M.

Here at the Department of Family & Community Medicine we are looking at new ways of enhancing how we interact with medical students and with our clinical faculty around the state. We have several works in progress which will provide an opportunity for greater interaction between students and practicing family physicians.

One idea addresses identifying and maintaining student interest in family medicine through initiation of a mentoring program. Each student who arrives at the medical school with an interest in family medicine and willingness to participate in this program would be assigned to a faculty mentor or resource person. This faculty member would be available to meet with the student, answer questions about medical school and the student's future training and career, and generally offer a supportive relationship. But what will happen in the critical third year? Family physicians around the state could fill this role. The process would help to connect practicing physicians to students through a relationship, not just an educational experience, and would lay a foundation of experience for the students to draw upon for their future relationships as mentors of the next generation of students. Our department would work with professional organizations such as NDAFP and NDMA to provide organized training for clinical faculty to help them fulfill this role. We are calling this the Student Advisement Resource (STAR) program.

Another way in which practicing physicians might mentor third-year students is developing from our professionalism activity. For the last two years we have offered a pilot program on the Grand Forks campus, in which students meet once a month after-hours with a family practice faculty member. At this meeting the students have the opportunity to share and discuss their experiences in the clinical setting. The kinds of topics of interest to the students include issues in end-of-life care, conflicts they see among physicians and between physicians and nurses caring for the same patient, how to deal with patient drug-seeking behavior, and bashing of family medicine by other specialties. This reflection and sharing is an important part of the process of developing an identity as a physician. We would like to expand this program to all of our third-year students around the state, and will need more faculty mentors to do so. The ideal mentor is an experienced physician who does not otherwise supervise the students or give them a grade. Many of you fill this bill. The Depart-

ment of Family & Community Medicine and the North Dakota Academy of Family Physicians might collaborate to provide some training for this role.

We look forward to developing these activities with input from our clinical faculty, and offering students more opportunity for mentoring from family physicians.

## Can Educational Policy Make a Difference in Primary Care

By Roger W. Schauer, MD

The World Organization of National Colleges, Academics, and Academic Associations of General Practitioners/Family Physicians (WONCA) recently met in Seattle to discuss methods and findings as medical schools around the world attempt to prepare providers for service in underserved areas in their respective countries. The subtitle for the meeting was "Transforming Rural Practice Through Education", but the presentations focused on what we have learned from rural practice education. My invitation to attend the WONCA meeting came about because of our recently published report about our own experience with Rural Opportunities in Medical Education (ROME)<sup>1</sup>.

Many of you already are aware of our ROME program, as well as the RPAP (Rural Physician Associate Program) for Minnesota. The University of Washington also developed a continuity rural experience (WWAMI Rural Integrated Training Experience, or WRITE). Common to these three programs is an integrated, longitudinal medical education experience in a rural community. Length of time varies from 20 weeks (WRITE), to 28 weeks (ROME) to 36 weeks (RPAP). Worldwide it is estimated that there are about 20 medical schools that have integrated continuity rural clinical experiences for medical students. In Australia, Canada, and the UK medical students are spending an entire year in the rural setting. Common to all the schools, in the USA and worldwide, is that examination outcomes are at least as good as, and sometimes, better, for students in the rural, integrated programs compared with those in tertiary medical centers. Student satisfaction with the experience is universally extremely positive.

This meeting came one week after the publication of "Primary Care – Will It Survive?" in the NEJM.<sup>2</sup> In his "Perspectives" article Dr. Bodenheimer addresses a number of issues that adversely affect student decisions about selecting primary care careers, including apparent patient frustration and dissatisfaction. He also suggests some system changes that will need to occur to reverse the cur-

rent trend. Issues like better patient outcomes and lower costs should be brought to the attention of those individuals instrumental in developing policy.

Policy regarding medical education must include preparing students to serve in underserved areas. At the WONCA meeting programs from around the world reported that students who experience rural health care education in these continuity programs (generally longer than one or two months) are much more likely to subsequently practice in a more rural based community. Policy and support (government and institutional) are common in the infrastructure of these successful programs.

- 1) Schauer, RW. & Schieve, D. Performance of Medical Students in a Nontraditional Rural Clinical Program, 1998-99 through 2003-04. *Academic Medicine*, Vol 81. No. 7/July 2006
- 2) Bodenheimer, Thomas. Primary Care – Will It Survive? *The New England Journal of Medicine*. Volume 355:861-864. No. 9/Aug 31, 2006

### **Center for Solutions**

Glenda Springsted-Spencer

It began soon after Adam took that first bite of forbidden fruit in the Garden of Eden - the search for answers to counter the problematic use of alcohol and drugs. The chain of trial-and-error treatment methodologies has been as long and unusual as in any field of medicine. Historically, problem drinkers have been whipped and beaten, dunked and electrically shocked. Addicts have been drugged with hallucinogens, poisoned using a variety of potions, chained down, terrorized and dialyzed. Drug users have been fined, put to work, imprisoned, sent to boot camps, and some therapists have even attempted to “scare-them-straight”. However, modern scientific research is revealing a great deal about the nature of drugs, the nature of addictions, new treatment methodologies, and even new ways to prevent addictions. That is the good news. The bad news is that very little research has found its way into practice. We practitioners have established habits of practice, and habits take time to change.

For over 60 years, the majority of counselors in the field of addiction treatment have been practicing the course of treatment referred to as the Minnesota Medical Model, better known as the traditional 12-step program. As the name implies, 12-step programs lead participants through a series of steps in a recovery process, typically lasting 28 days. To help maintain the recovery process, participants typically commit to attending

on-going weekly Alcoholics Anonymous meetings.

Unlike the traditional 12-step programs that require participants to declare that they are powerless over their addiction, the Center for Solutions works with patients to help them realize they have the power and the control to overcome the addiction – the patient has the power to decide. In doing so, the Center for Solutions utilizes a treatment modality that is a blend of solution focused therapy and motivational enhancement. This model of treatment offers a cutting-edge approach that aligns the client and the therapist. The responsibility of the therapist is to motivate the client, to believe in the client when the client does not believe in himself, to teach the client a new way of looking at themselves and their problems. Therapists do not change people; people change themselves. A truism that speaks to the importance of self-talk and self-change says:

- People don't believe what you tell them.
- They rarely believe what you show them.
- They often believe what their friends tell them.
- They always believe what they tell themselves.

Alcoholics and addicts want to feel good, but most often they come to treatment telling themselves their lives are “train wrecks” – addicts typically fail to see the exceptions to the bad times and they lack the self-confidence to believe in themselves. Cognitive restructuring is important, as you cannot help them change their behavior without helping them first change their thinking .

The Center for Solutions believes in the holistic approach that treats the entire person. Many addicts come in with co-occurring disorders that mandate a multidisciplinary approach to the treatment process: physicians treat the co-occurring disorders pharmacologically as the addiction counselor helps the addict reframe their thinking. Medication management is an important component of treatment, as there is a belief if you do not address depression, anxiety and other co-occurring disorders, the recovering addict will address those conditions by self-medicating upon discharge. Many substance abuse treatment clients need intervention modifications and additions to enhance treatment effectiveness.

Laura Ingalls Wilder wrote her “Little House” book series describing the trials and tribulations of a family facing the challenges of frontier life in Walnut Grove, Minnesota. The life she described was challenging, certainly. The Center for Solutions is frequently described as the “Little House on the Prairie” in reference to its rural setting and that classic series of tales. Each client that enters treatment brings his/her own life story and life experiences, with all of the factors etched deeply in the

depths of their conscience that makes them who they are. The secret to solutions focused therapy is the process that unlocks those memories, brings them to the surface, and allows them to be dealt with in a very safe, secure environment.

The Center for Solutions has been a division of the Towner County Medical Center in Cando for four years. The Center for Solutions is located in a rural setting, providing a tranquil environment for the residential treatment of 12 patients. After four years of success, Center for Solutions is undergoing an expansion that will add over 9,000 square feet to its facility, and space to treat a total of 25 clients.

Glenda Springsted-Spencer is the program director and person responsible for creating the program in Cando. Dr. Russell Petty serves as the program's medical director, while Dr. Greg Volk provides psychological services. The Center for Solutions has a staff of 14 employees, made up of four counselors, a case manager, a registered nurse and behavioral technicians.



The following article is reprinted by permission from the July 2006, *The Teaching Physician*.

### **Teaching Points—A 2-minute Mini-lecture Presentation Skills and the HPI**

*By Alec Chessman, MD, Medical University of SC*

*Editor's Note:* July marks the start of clinical rotations for many medical students, and now may be a good time to review a basic clinical skill—oral presentation of the History of Present Illness (HPI) to the preceptor. In this scenario, Dr Jedburg (Dr J) works with a third-year student (MS3.)

**MS3:** I saw Ms Hollander, who is here because she's been feeling bad. She's had some aches and pains too, but I don't think she's concerned about those. I spent a long time talking with her, and I'm not sure that I have that much to show for it. She has some trouble with sleep. And she feels lightheaded at times. I asked her if that occurred when she stood up, but I don't think so. She has had surgery—had a hysterectomy a few years ago. She didn't have any murmurs or carotid bruits.

**Dr J:** Wait. I'm sorry. How old is she?

**MS3:** 54 years old.

**Dr J:** And her main reason for being here is that . . .

**MS3:** She feels bad, mainly tired.

**Dr J:** And that's been going on for how long now?

**MS3:** A few months but getting worse for about a month.

**Dr J:** OK, so that's the information that should go in the first sentence of your presentation. Age, sex, reason for being here, and duration—those are the most important things to put in your first sentence. When you have a good first sentence, any listener can pay full attention to everything else that follows. Try it: age, sex, main concern for this visit, and duration.

**MS3:** The patient is a 54-year-old woman who is here because she feels bad in general, mainly tired, for the past few months, worsening over the past month particularly.

**Dr J:** That's great. Now I have a differential diagnosis in mind, and I can listen to the HPI better. Most of the important information is contained in the history, especially the HPI. This presentation skill will serve you well in the future when you call up a consultant, and you want to convey the story efficiently and get the listener up to speed as quickly as possible, so he or she can address your questions appropriately.

Now, the next step is the rest of the HPI. Even when the patient's main concern is something you're not familiar with, you can gather all of the important information if you get all of the important HPI points. Do you use a mnemonic device to remember the HPI?

**MS3:** Yes, I use OPQRST.



O=Onset and duration of symptoms  
P=Provocative and palliative factors  
Q=Quality  
R=Region affected  
S=Severity and associated symptoms  
T=Timing

O: It came on gradually. She has been feeling bad for several months, worse over the past month.

P: It seems to be made worse by being on her feet all day. Nothing seems to help, though she tried some iron supplements.

Q: I don't know what to say about quality or region.

R: So that covers R, too.

S: The tiredness is severe. No associated symptoms that I can think of.

T: It occurs pretty much every day.

**Dr J:** If you get nothing else out of this first week, how to gather, organize, and present the HPI will be a great outcome. You mentioned no associated symptoms? Here's where it can get tricky. It's all well and good when a patient doesn't spontaneously mention any symptoms, but—sometimes—you have to ask about specific symptoms directly. The patient may have a symptom that is related, but she won't think to mention it to you. So it can be very helpful to list all the pertinent negatives; it shows the preceptor that you've thought of a differential diagnosis and have collected evidence related to it. Nobody expects you to have a complete differential at the start of your clinical rotations. Don't worry if your list of pertinent negatives is short. One of the major goals for this year is to broaden and deepen your differential diagnoses for typical presentations.

**MS3:** OK. Well, I thought of anemia. Partly because she thought she needed iron.

**Dr J:** Excellent point. Let's come back to that, too.

**MS3:** And hypothyroidism, maybe depression.

**Dr J:** That's great. So any sleep disorders, too?

**MS3:** I thought of that. And maybe heart failure.

**Dr J:** You are generating some great ideas to check out. And so, in your presentation, you can summarize the lack of symptoms in certain areas fairly quickly. It depends on your preceptor, your own style, and how busy you are. You could say "No orthopnea, paroxysmal nocturnal dyspnea, shortness of breath, or dyspnea on exertion," or you could say "No heart-related symptoms."

But let me get back to the anemia point. You said you thought of that because the patient thought of that diagnosis. That should be part of the HPI, too. Always include any ideas that the patient has about the underlying cause. One benefit from doing so is exactly what you found—the patient helped you make a more com-

plete differential diagnosis.

But, even if you can't figure out exactly what is going on with the patient, you can directly address her concerns about cause. So without necessarily making the actual diagnosis, you may be able to take away the patient's fears about some underlying, dangerous problem. And uncovering the patient's fears can make it easier to get more information, too.

The other point that should be in the HPI is the effect on the patient's life from this problem. In this woman's case, how has this "feeling bad" affected her daily life? Has it kept her from any activities—kept her out of work, for example? Or kept her from social events? Or interrupted hobbies? If the symptom or problem is getting in the way of the person's life greatly, then I will be more aggressive about finding the underlying cause.

In summary, here are the major points we covered on HPI:

- (1) Age, sex, main concern, and duration—in the first sentence.
- (2) Even if it's a concern that is unfamiliar to you, try to incorporate all the key elements of the HPI into the presentation's first paragraph (OPQRST).
- (3) Include pertinent positives and negatives for associated symptoms.
- (4) Add in to HPI
  - a. Patient's ideas about cause and the underlying meaning
  - b. Effects or impact on daily life

**Alec Chessman, MD, Medical University of South Carolina, Editor**

**Betty Gatipon, PhD, Louisiana State University, Co-editor**



## Suicide Prevention and Physician Care

Mark LoMurray

The North Dakota Adolescent Suicide Prevention Project – Sources of Strength recently received national recognition through the American Public Health Association, epidemiology section as a national Field Project award winner in the area of public health. The project trained over 40,000 North Dakotans, including 7,500 teen leaders between years 2000-2004. Some very promising and hopeful outcomes emerged with a 47% decrease in suicide fatalities for North Dakota youth ages 10-19 when comparing the 1990's with years 2000-2004. North Dakota Youth Risk Behavior Survey data showed a 20%-29% decrease in three of four suicide questions for 9th – 12th graders from 1999 to 2003. The project had multiple strategies and here are several that could impact physician response to patients struggling with suicide ideation.

1. Beyond depression – while depression is a significant risk factor associated with suicide do not overlook increased aggression and conflict, trauma issues (rape, physical fights, deaths, injury, harassment, etc), substance abuse, and impulsivity as core risk factors associated with youth suicide.
2. Enhance your clinic visits by using quick and easy to score mood and risk behavior screening tools that can be completed in waiting rooms by adolescents during sports physicals, injury, or illness visits.
3. Increase your staff's intervention skills by reviewing Niemeyer and Pfeiffer's study on ten most common errors during a suicide intervention.
4. Anticipate high follow-up failure by suicidal individuals due to stigma, co-existing problems, lack of insurance, distance of travel, lack of transportation so be proactive and use phone follow-up, community and school resources, and load family interventions and resources into the first five day window of a suicide crisis. Use the crisis to maximize positive change.
5. Use the Sources of Strength as a model for having conversations about other strengths in a patient's life and make cross system referrals from the medical system to spiritual leaders, mental health, recreation or activity programs, and other active youth development efforts in your region. Do not rely on medication alone to keep a suicidal individual safe.

6. Become active in community prevention that increases awareness of suicide as the #2 cause of death for North Dakota teens. Encourage community strengthening efforts, specifically mentoring, teen-led prevention, and a variety of small support groups throughout the schools, faith-based communities, and community-based settings.

7. Think relationally – who is available to mentor and support this adolescent through a tough time. If there is no one, finding someone may be the most important part of your treatment plan.

### Increasing Proven Protective Factors – Cross System Referrals

Prevention research clearly points toward areas of resiliency, assets, or protective factors that keep teens safe. Unfortunately, traditional suicide prevention and intervention strategies have tended to focus on only three core protective factors (medical, mental health access, and family support), often at the exclusion of others. Yet the research seems clear, the more assets or strengths teens have, the healthier and safer they will be.

It is important that professionals, gatekeepers, and teen leaders understand where strength and healing come from. It is as important as knowing suicidal warning signs.

A clear suicide prevention message needs to increase clusters of protective factors, no one source of strength should be seen as adequately protective when dealing with suicide issues.

- Teen leaders need to know that positive friends are important, but other adults and areas need to be involved.
- Parents need to know that care, boundaries, and consistency are important, but other areas of support are needed.
- Physicians need to understand that medication can help, but other supports need to be pursued as well.
- Spiritual leaders and pastors need to know that prayer and faith can be powerful, but that other supports are important as well.

### Using Sources of Strength as Part of a Suicide Intervention

Listening, determining risk, and making a referral are the first orders of business during a suicide intervention. But, here are a few strength-based questions to ask...

- In your family who is most supportive and helpful to you? When did you talk to them last?
- Who tend to be your healthiest friends?
- Who are some healthy adult friends in your life? Have there been any in the past? Teachers?
- What activities such as sports, art, music, do you or did you enjoy?
- What opportunities have you had to help someone else recently?
- Where are you spiritually? With God? Prayer?
- Have you been to counseling or talked to someone about this before? What part was most helpful?
- Have you ever gone to a support group?
- Have you been on medication before? Did it help?
- Of these areas which two are strongest for you now?
  - Medical Access
  - Family support
  - Positive Friends
  - MENTORS
  - Positive Activities
  - Generosity
  - Spirituality
  - Mental Health
- Which area would you most like to strengthen?

### **Ten most common errors during a suicide intervention**

Angela Pfeiffer and Robert Niemeyer conducted extensive testing on 215 medical students, master level counselors, addiction counselors, and crisis workers on their suicide intervention skills.

*They found ten common errors:*

1. Superficial Reassurance - Out of an intense desire to assist, some helpers offer reassurance that comes across as trivial to the person in crisis. "You're so young, how can you think of killing yourself." The response is intended to encourage, but they risk alienating a teen who feels they are not being heard and are misunderstood.
2. Avoidance of Strong Feelings - When confronted with intense depression, grief, or anger some helpers retreat into trivial reassurance, professionalism, advice giving, or passivity. When confronted with deep feelings of, "no one cares if I'm alive or dead," it's important not to move into an analytical discussion of their feelings. Establish empathy by putting feelings into words. For example, "With all the hurt you've been experiencing, it must be impossible to hold those tears in."
3. Professionalism - Given the intensity of some suicide interventions, it isn't surprising that some helpers

insulate themselves with an air of professionalism. "You can tell me, I'm been trained to be objective." While intended to put the client at ease, it can come across as disinterested or hierarchical. A better response might be, "It sounds like some of your ideas are pretty frightening to you, and you think I might be shocked to know what you're really thinking."

4. Inadequate Assessment of Suicidal Intent - Surprisingly, many helpers ignore suicidal statements. Pursue necessary questions about what clients have been thinking, for how long, and check out any specific plans or attempts.
5. Failure to Identify the Precipitating Event - Asking about key incidents and events can help move interventions toward necessary action plans. "It sounds like everything collapsed around you when your wife died three years ago, but what has happened recently to make you feel even worse—that dying is the only way out?"
6. Passivity - 25% of physicians and counselors took a passive stance when confronted with intense emotions. "Go ahead, I'm listening." It was not unusual for contact to be broken off. Early stages of suicide interventions need to be active, engaging, empathetic, with the helper structuring the interaction.
7. Insufficient Directness - A phone conversation with a suicidal person ends with, "Ok, but call back if you keep feeling suicidal." At a minimum get a verbal no suicide contract.
8. Advice Giving - At times helping may come across simplistic. "Try not to worry about it." or, "Focus on the positive." Concrete action ideas are often helpful, but only after the helper has established trust and a thorough understanding of the client's situation. Action plans should come from the client's tentative ideas, rather than from the authoritative advice of the helper.
9. Stereotypic Response - When trying to save time during a crisis intervention, a helper may fit the client into a category of diagnosis based on race, sex, age, class, etc. Focus on the individuality of each person and their emotional uniqueness.
10. Defensiveness - Suicidal teens can often be angry, aggressive, or rejecting of the helper's attempts. To react defensively, use sarcasm, or put-downs erodes the small trust that exists. "How could you ever help me, have you ever tried to kill yourself." A quick witted comment can come out as a put-down. Maintain a caring stance, and acknowledge fears and concerns. "It must be hard to seek help when it's tough to trust people." The helper has the responsibility to reach across a gulf and establish a working partnership.

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## The NDMA Lobby Report

David Peske, NDMA Director of Governmental Relations

### Legislative Session Preparations

NDMA President Shari Orser is asking all District Medical Societies to invite local legislative candidates to their fall meetings, to foster some initial interaction prior to the November elections. Many NDMA efforts focus on physician and patient advocacy issues, especially those impacted by state legislative activities. It is most beneficial for member physicians to maintain a close relationship with their local legislators, and to provide them with medicine's perspectives and input on practice issues. Two NDMA members are running for seats in the ND Senate this fall: Ralph Kilzer, MD, an incumbent in Bismarck's District 47, and David Humphrey, MD, in District 21 in Fargo. A complete listing of candidates running in legislative districts within each Medical Society's boundaries is available by contacting NDMA staff.

The NDMA Doctor of the Day program has again been approved for the 2007 legislative session and will begin during the second week in January. Physicians are encouraged to set aside a day to visit the state capitol, and while providing basic care services to legislators, experience the inner workings of the lawmaking process. Health screenings, specialty society visits, and some 'worksites wellness' events for legislators will be scheduled throughout the session.

The Association's Committee on Medical Political Action (COMPACT) has been renamed the NDMA Political Action Committee to better reflect its identity and function. Contributions are passed along to the candidates selected by the PAC board prior to the November election.

### NDMA Annual Meeting Actions

The NDMA House of Delegates, meeting in Bismarck on September 14-15, approved two legislative proposals for introduction during the 2007 North Dakota Legislative Assembly:

- "I'm Sorry" medical liability legislation which would allow physicians to express empathy with their patients in the event of an unintended outcome of the care they have provided, without the expression or apology being used negatively in a subsequent liability lawsuit against the physician; and

- The reintroduction of legislation allowing a minor to provide consent for medical treatment related to pregnancy care. Proponents of the measure will again place

strong emphasis on the family communication and bonding aspect of the proposal, along with the necessity of allowing physicians to provide the most appropriate care for all pregnant women.

The House of Delegates also adopted measures supporting:

- Reaffirmation of NDMA efforts to address the continuing inadequate reimbursement of physicians and hospitals by the ND Medicaid program, as well as urging ND Workforce Safety and Insurance to develop a physician reimbursement system that pays for medical services to injured workers consistent with the commercial insurance market;

- Enactment of further limitations on smoking in public places, expanding upon the clean indoor air legislation passed by the 2005 Legislative Assembly;

- The ND Department of Health's budget request for an increased appropriation for the physician loan repayment program, and calling for minimum funding of \$300,000;

- A resolution calling for delayed implementation of the ND Prescription Drug Monitoring Program until appropriate liability protections for physicians are assured through either rules or legislative provisions;

- Establishment of a provider-led ND patient safety organization;

- Coordinated efforts to address cancer-related treatment and care issues through actions developed in the ND state cancer plan;

- Maintenance of a state policy environment and funding to assure there is an adequate supply of physicians and other health professionals to serve our state residents;

- Congressional action prior to the October recess to avert the 2007 5.1% cut in physician reimbursement and enact a 2.8% payment update, and to replace the Sustainable Growth Rate (SGR) reimbursement system with one that adequately keeps pace with increases in medical practice costs, along with incremental efforts to eliminate or reduce the impact of the geographic practice cost indices (GPCIs) used to calculate Medicare physician payments in ND;

- A request that BlueCross BlueShield of ND utilize a portion of its surplus for regular 2007 physician and hospital payment adjustments, as well as enhancements to restore past reimbursement shortfalls, instead of us-

ing it entirely for a general premium refund; and

- A request that the ND Board of Medical Examiners consider hiring a physician to serve as the next executive secretary of the Board.

Two resolutions were referred for further consideration:

- A resolution to increase the education and awareness of the medical consequences of osteoporosis was returned to the Commission on Medical Services to investigate means to implement the intent of the measure; and

- A resolution encouraging ND pharmacies to stock the Plan B morning-after pill as a behind-the-counter medication for women 18 and older was referred to the Commission on Ethics for further discussion of issues including the recognition of conscientious refusal, prompt referral, and notification to prescribers when a legal prescription will not be filled.

### **Interim Legislative Committee Studies**

The Budget Committee on Health Care convened its last meeting in September and further considered issues it has been studying. The Committee is proposing bills to require state regulation of acupuncturists and to create a consolidated board to license the counselor professions. It is also recommending that the 2007 legislature initiate a future study of the healthcare needs of North Dakota out to year 2020. In addition, the Committee met jointly with the Budget Committee on Human Services to receive information on pharmaceutical industry practices and drug pricing. The Human Services Committee also discussed reports from the Department of Human Services regarding program management initiatives, status of the prescription drug monitoring program, and the costs of increasing current Medicaid provider reimbursement rates to the level of Medicare rates, which NDMA and others had requested the Department investigate. The interim committees will prepare final reports containing recommendations for consideration by the full Legislative Council in November.

### **Family Physician Honored**

During its 119<sup>th</sup> Annual Meeting, NDMA presented its 2006 Physician Community and Professional Services Award to Mayville family physician Glenn Thoreson, MD. Dr. Thoreson, a past NDMA President, Councillor, and Delegate from the Tenth District Medical Society, has practiced in Mayville since 1969 and continues to be active in numerous community endeavors.

Other awards presented during the meeting were the NDMA Friend of Medicine Award, to Carol Meidinger, long-time Health Department safety program manager, known widely as the "car seat lady" for her work in child

passenger protection and safety campaigns, and the ND Psychiatric Society Mental Health Service Award, presented in memory of Susan Stenehjem-Brown, a leader in the addiction treatment profession who worked in Bismarck and Fargo until her death earlier this year.

### **Congressional Issues Update**

NDMA and AMA, along with numerous other state and national medical organizations, have remained deeply involved with the ND Congressional Delegation on several issues. The primary issue is the need for Medicare Sustainable Growth Rate (SGR) legislation to avert the 5.1% cut in the reimbursement rate for 2007 and enact a 2.8% physician payment update, and repeal the SGR payment system and replace it with one that adequately keeps pace with increases in medical practice costs. ND's Congressional Delegation is in support of the SGR provisions, and their continued efforts are needed to assure that appropriate language is placed into a budget bill for consideration prior to adjournment in late September.

### **Other State Issues**

- The state general fund appropriation to the UND School of Medicine has stayed relatively static at about \$30 million for several biennia, and NDMA participated with Dean H. David Wilson in requesting that the Governor include additional increases in his proposed budget to the 2007 Legislative Assembly.

- Revisions to the Uniform Anatomical Gift Act (UAGA) were recently adopted by the National Conference of Commissioners on Uniform State Laws. Bismarck District Judge Gail Hagerty requested that NDMA review the latest revisions. The new provisions update the original 1968 and 1987 versions of the Act, and now among other changes would allow a broader prioritized list of persons who may approve an anatomical gift on behalf of a deceased person, including an adult grandchild or an agent acting under a health-care power of attorney or advance directive. Legislation to adopt the new provisions will be introduced in 2007.

To contact Mr. Peske, send e-mail to [dpeske@ndmed.com](mailto:dpeske@ndmed.com).

## Congress of Delegate 2006 D.C.

On behalf of your NDAFP delegation to Washington, D.C I send you warm greetings. The delegation this year consisted of Heidi Bittner, Chuck Breen, Guy Tangedahl, Dale Klein and Brandy Frei with the Congress of Delegates events running Sept. 25 thru Sept. 28.

The highlight of this years Congress was a gathering of physicians on Capital Hill for a rally with the main theme of "Fix it Now". The Fix was referring to the current problems with Medicare, national problems with access to care, and the decreasing numbers of primary care physicians. There was also a media blitz revolving around the need to increase the number of primary care physicians. A recent study released the day of the Rally showed that by 2020 we will need about 39% more Family Physicians. This is due to the increasing incidence of chronic disease and aging of our population teamed with the news that the American College of Pediatrics announced no plans for increasing the number of physicians and that only 13% of Internal Medicine graduates stay in general Internal Medicine. Your delegation did an Associated Press release and a NPR interview regarding the needs in North Dakota. The data for our state showed a need of 24% more Family Physicians.

Jim King from Tennessee was elected the new president-elect for our Academy. He visited our state meeting three years ago in Mandan. He comes from a small Family Practice office and I think is a good choice. Three new board members were elected including Rolland Goertz from Texas, James Dearing from Arizona, and David Avery from West Virginia. The outgoing president was Larry Fields from Kentucky. He has come to our last two annual meetings and also the Night with the Family Physician.

Many resolutions were considered. Multiple ones dealt with pay for performance (P4P), and our Academy is looking for ways to help with this but no consensus was reached. There was also much discussion about Minute clinics. Our board reviewed the largest three ambulatory care clinics and is trying to work with them to develop standards. None of them state they want to be the medical home for patients, leaving that job for us. Interestingly, Wal-Mart which has started a large chain of acute care clinics approached IBM to do their healthcare and were told no. IBM then approached our Academy for the proper way to set access for healthcare. Single payer systems were also discussed. Our Academy is on record that we want universal coverage. They have presented the first part of a study on that issue with the follow up to come next year. I urge you to go to [aafp.org](http://aafp.org) and review the appropriate board reports dealing with these subjects. (Board Reports P,M,Q)

FamMedPac is our new political action compact. In its first year it collected about \$300,000 dollars to use in Washington. I urge you all to contribute thru our web-site. The Congress of Delegates contributed \$29,000 during the session to the PAC. A little know fact is that if each of the members of the American Academy of Family Physicians contributed

\$100/year, we would have a PAC larger than the trial lawyers.

Some useful tidbits I picked up include a website that allows you to see the VA formulary ([www.pbm.va.gov/PBM/natform.htm](http://www.pbm.va.gov/PBM/natform.htm)) and a website that will allow you to look at what a veteran has had done at a VA clinic ([www.myhealth.va.gov](http://www.myhealth.va.gov)) with the veterans consent. Also I did not realize that the info collected from pharmacies and then filter to the pharmaceutical companies was done thru the AMA. This is worth about 16 million to the AMA. They also have an opt out option. Go to the AMA website and choose to opt out. They have one place for members and one for non members ([www.ama-assn.org/ama/pub/category/12054.html](http://www.ama-assn.org/ama/pub/category/12054.html)). Some companies may not give you as many samples if they can not track your data so there are some consequences to consider.

The thrifty award goes to Guy Tangedahl in Washington. He walked from Washington National Airport to the Hilton Towers. Only took him 2 ½ hours. He said next time he is going to get luggage with wheels.

Thanks for your support.

Respectfully submitted on behalf of the delegation,  
Dale Klein, M.D.

### **IMPORTANT DATES TO MARK ON YOUR CALENDAR**

**October 26, 2006**

**Evening with a ND Family Physician  
Alerus Center, Grand Forks**

**January 15 - 19, 2007**

**30th Annual Family Medicine Update  
Big Sky, MT**

**June 28-30, 2007**

**52nd Annual State Meeting & Scientific  
Assembly  
Medora, ND**

**January 21-25, 2008**

**31st Annual Family Medicine Update  
Big Sky, MT**

*Mark your Calendar & Register today*



# *30th Annual Family Medicine Update*

Huntley Lodge, Big Sky, Montana  
**January 15-19, 2007**

*Sponsored by the North Dakota Academy of Family Physicians*

**Registration Fee: (Before Dec. 1, 2006)**

**NDAFP Members—\$450.00**

**All Others—\$525.00**

**NDAFP Resident—Free\*\***

**Out-of-State Residents—\$300.00**

**Medical Students—Free\*\***

\*\*Please register for accurate counts.

**After Dec. 1st, please add \$50.00 late fee to the registration fee.**

**25+ Prescribed AAFP credits will be offered  
& Family Activities**

Send to: NDAFP Big Sky, 501 N Columbia Rd, Grand Forks, ND 58203

Fax: 701-777-3849 or **online registration at <http://www.ndafp.org>**

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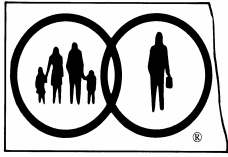
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