# Family Medicine Quarterly

**Volume 33, No. 1** **Spring 2007**

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## ISSUES IN THIS ISSUE

Roger W Schauer, M.D.

The groundhog saw his shadow, or maybe he didn't. I can't remember, but it matters little as we have had our biggest dose of winter since Groundhog's Day. As spring comes to us, promising new life and new growth, we bring you this issue of the *Family Medicine Quarterly*. The results of the BIG day (Match Day) for our soon to graduate seniors are included, so you can learn where your student(s) will spend their next few years. Challenges we face in medicine in the near future will be addressed by Dr. Beattie, who also will share with us some evidence about things you do really well. Dr. Breen and Brandy share outcomes of the Big Sky meeting and discuss the upcoming annual NDAFP. Articles by Drs. Beattie and Breen address some of the issues David Peske informs us about in his legislative activities article ("Physicians Push for Healthcare Legislation). Unfortunately, by the time you receive this *FMQ* the legislative session should be wrapped up. I hope you have been able to follow the progress of bills via the regular electronic updates provided by the NDMA. Dr. Eric Johnson provides "fuel for the fire" to address legislation about second-hand smoke.

Attention new AAFP members: The article by Callie Castro, from the AAFP informs us about some money saving resources available to you (unfortunately, I have been around more than seven years). Learn why the Grand Forks Residency "Rocks" in an article submitted by Julie Jeske.

New tools and directions in health care delivery are highlighted in "Distance Therapy For Rural Patients with Eating Disorders"**,** written by Pam Knudson. The article discusses delivery of counseling services via interactive video conferencing for individuals with eating disorders. We know not everyone in rural and remote areas as equal access to counseling services, so this might be a useful vehicle in the near future. I learned that thousands of hours of health care were delivered to rural and remote communities in Northern Ontario via telemedicine. Of course, they have solved a funding problem (government funding) with health care financing & reimbursement, and can work on the delivery aspects of health care – a fundamental activity many of us believed would be our future when we first applied to medical school. Regarding medical school and education, I call your attention to an essay I wrote addressing communication between generations of teachers and students titled "Teaching Though the Generation Gap". Another article that can be helpful regarding teaching students is enclosed "Teaching Essentuals…."

We call your attention to the new Family Medicine Physician faculty position that recently became available in Minot. Also, mark you calendars for the 52nd Annual State Meeting & Scientific Assembly to be held in Medora, June 28-30.

Please feel free to submit an article or comment. We welcome comments and suggestions that can lead to improvement of the *FMQ*. One issue that needs to be discussed for the future is your option to receive the *FMQ* electronically rather than on paper.
I look forward to seeing many of you in Medora in June.

Submitted,
Roger W. Schauer, MD

## North Dakota Academy of Family Physicians

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### Delegates & Alternates to the AAFP Congress of Delegates

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| Chuck Breen, M.D. (Alternate) | Hillsboro |
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|---|---|
| Katrina Gardner | First Year |
| Alisa Boyer | Second Year |
| Josh Ranum | Third Year |
| Rena Nordeng—Zimmerman | Fourth Year |

## AAFP Lends a Hand to New Physician Members

Callie Castro, AAFP Member Relations Specialist

New physicians face the significant debt, start-up costs and dilemmas typical of many new businesses or careers. That's why the AAFP created a program designed to support its newest members.

The first years of practice can be an exciting and trying time. With limited time and resources, new physicians face challenges such as privileging and credentialing, coding and cash flow, and finding time for CME.

*Experience the AAFP* offers new members in their first seven years following residency a sample of AAFP resources and networking opportunities at a reduced cost or free.

Other Academy benefits for new-to-practice-physicians:

- $100 discount to the 2007 Scientific Assembly (Chicago, October 3-7)
- $100 discount off a Family Medicine Board Review course or self-study resource
- $50 discount off a Family Medicine Board Review Express Course

While the AAFP provides all its members with valuable practice and clinical education, *Experience the AAFP* offers tools for the special challenges faced by new physicians. Chapters also offer benefits to new physician members, including; local and interest-based networking, CME opportunities in convenient locations, and grassroots advocacy at the state and local level.

For more information about the ***Experience the AAFP*** program, visit http://www.aafp.org/experience.

The *Family Medicine Quarterly* is published by the North Dakota Academy of Family Physicians and the Department of Family Medicine. Except official reports and announcements, no material in the *Family Medicine Quarterly* is to be construed as representing the policies or views of the North Dakota Academy or Department of Family Medicine. Printed at UND Press. The Editors reserve the right to accept or reject any article or advertisement matter.

Address all correspondence and ads as follows: Co-Editors: Roger W. Schauer, M.D. (rschauer@medicine.nodak.edu) and Brandy Jo Frei, (Brandy@ndafp.org) for the NDAFP, *Family Medicine Quarterly,* UNDSMHS, 501 N Columbia Rd Stop 9037, Grand Forks, ND 58203, (701) 777-3200.

## A Message from The President
***Chuck Breen, M.D.***

What a great job Brandy and her Big Sky committee did again this year putting together a first class meeting. The speakers were great and everything went off without a hitch. The attendance over the past years had been down a little but it is still a great source of income for our academy. Thanks to Brandy and her crew for a great effort.

This past January we had an opportunity to reflect on our relationship with the North Dakota Medical Association. For the past eight years we have had a contract with the NDMA for lobby and legislative support for causes which our academy believes to be important. Bruce Levi and his staff reported to our board the many ways our two organizations have benefited from this contract. We represent the largest specialty organization in the state and we have many members in leadership roles with the NDMA.

As we have progressed through this legislative session, the NDMA has been in constant contact with us regarding bills that are important to us. Our members benefit greatly from their efforts and this includes those who do not belong to the NDMA. Our influence on state legislation is one of the most important roles of our academy. It is through legislative efforts that we can improve the care for our patients, be a medical home to all families in North Dakota and ensure that family physicians are supported with good reimbursement, tort reform and access.

There seems to be three obvious ways we can continue to affect this legislation. First, we encourage all of our members to be NDMA members. We also need to continue to serve in leadership roles in the NDMA. And of course, the most important thing we can do is to have direct contact with our local representatives and senators. The email updates and pleas to contact our legislators usually hit us on a busy clinic day but nothing speaks louder to them then a call or email from a physician in their district. This is the time to cash in on the respect afforded to us due to our noble profession.

Guy has some great ideas for the meeting on June 28th in Medora. This meeting will be very informal and very affordable with extra time to spend with family, get in some golf or to get in some sightseeing. Make sure you don't miss this meeting – you won't be disappointed!

Chuck

## Executive Excerpt
***Brandy Jo Frei, Co-Editor***

Thank you for the kind words Chuck. It was a great Big Sky Conference. Besides the sub-zero temperatures, I think things went well overall. We received a number of positive comments from the attendees as well. Turn in your time off request now for January 21-25, 2008.

We are in full swing with planning the annual meeting in Medora, ND. It will be different from the typical annual meeting schedule. There will be more family involvement and plenty of time to enjoy yourself in a beautiful area.

It is time for a resolution check in. As far as personal resolutions, I have lost the rest of the baby weight and a few more pounds. I have also scheduled a few get togethers with my friends that I don't get to see very often. Now I just need to start working on healthy recipes for my family. If anyone has any good recipes to share, please let me know. I am always looking for new ideas to get me out of the rut of making the same thing. Professional resolutions: Encourage Involvement by members. I need your help on this one. We are looking for new board members and committee members. If you would like more information, please let me know. Community Projects—We had an outstanding number of Tar Wars presentations done this year. Thank you to the DOC organization for doing most of the presentations. Thank you also to Justin Reisenauer for coordinating presentations with the other third year students. I hope you continue to stay involved. The final resolution is to provide opportunities to increase members skills. I am very happy to report that we have started the initial planning stages to have a Fall CME event November 2-3. We are arranging tickets for a UND hockey game on Friday evening with a CME session on Saturday. Stay tuned for more information on this event.

If you have any questions, please do not hesitate to contact me. I am always looking for ways to help the members, so please tell me what you need help with. Don't forget to send those recipes in. Maybe we will start including healthy recipes in this publication or on the website.

Think Spring!!!!!!

Brandy Jo Frei

## A View From UND

Robert Beattie, M.D.
Chairman, Department of Family and Community Medicine

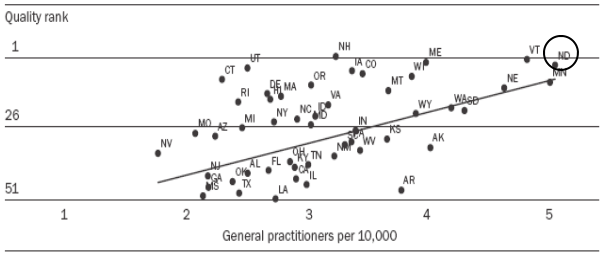
Weather can be a challenge in North Dakota, even more so in March. It will change from 30° something and sunny one moment to 12° below zero, windy and snowdrifts causing hazardous travel the next - unpredictable at best and deadly at its worst. The weather isn't the only thing unpredictable this time of year. Every two years we experience another kind of storm - the State Legislative Assembly - well into its 60th iteration. I am aware of two attempts to amend house and senate bills, instructing the Medical School to divest itself of their Family Medicine Residency training programs. One does have to pay attention!

The department has been engaged in this lawmaking session, advocating at the direction of the Dean of the School of Medicine and Health Sciences. One of the School's priorities is finding a more suitable home for the Center for Family Medicine in Bismarck. Those of you familiar with the CFM can appreciate the obstacle the parking ramp presents to potential patients. We struggle with the lack of off-street parking for the elderly and families with young children. I ask that you contact your legislators and ask them to consider the needs of this program. The CFM-Bismarck is the most successful training program we have, placing over 70 physicians in the state. Not only important to the community of Bismarck, the CFM has provided physicians throughout North Dakota.

Family physicians are quickly becoming the only medical providers willing to supply primary care services in the community. High quality providers are vital to service the need or our patients and a priority output of our residency training programs. The Centers for Medicare and Medicaid Services' own data support the importance of primary care and its relationship to quality and cost. We family physicians do a better job! Primary care physicians provide higher quality care at a lower cost, at least for Medicare recipients. The following graphics make the point.

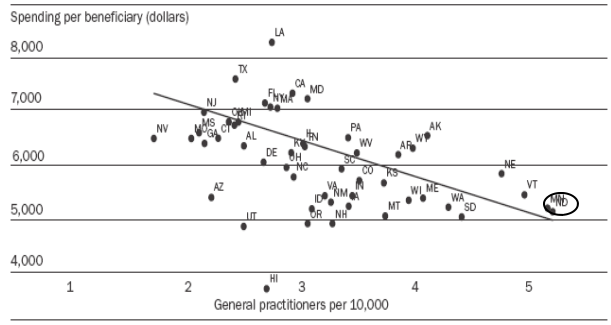
It was important in the 1970s to establish a **North Dakota** source of physicians to care for the people of North Dakota, hence the founding of the training programs we now have. Today, as our state's population gets increasingly older it becomes even more important to address the health care needs of our residents in a manner attentive to, cost, quality and our geography.

**EXHIBIT 8**
**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**



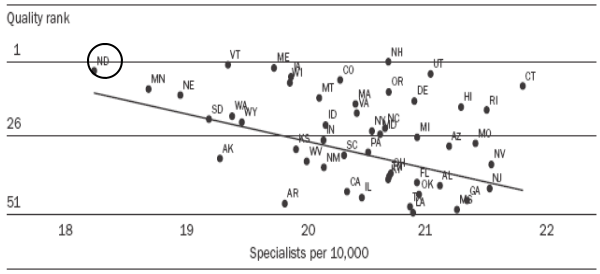

**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

**EXHIBIT 9**
**Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000**



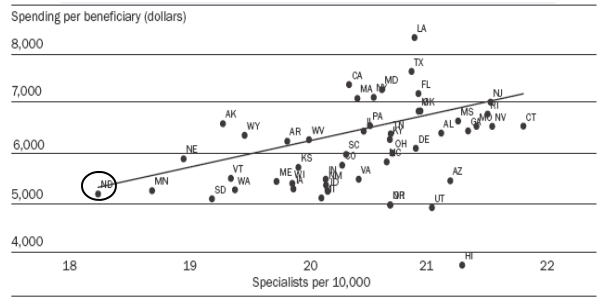

**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

**EXHIBIT 6**
**Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

**EXHIBIT 7**
**Relationship Between Provider Workforce And Medicare Spending: Specialists Per 10,000 And Spending Per Beneficiary In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

## Distance Therapy For Rural Patients With Eating Disorders

Pamela Knudson, UNDSMHS Public Affairs Director

The Neuropsychiatric Research Institute (NRI) in Fargo has received a major grant from the National Institutes of Health (NIH) to continue a project aimed at helping patients in rural areas who suffer from eating disorders.

Dr. James Mitchell, Fargo, will lead the study. He is president of NRI and chairman and professor of clinical neuroscience at the University of North Dakota (UND) School of Medicine and Health Sciences.

The project, using telemedicine, allows patients to receive psychotherapy treatment that is not available in their home communities, Mitchell said.

He and his colleagues recently completed a study that shows this type of distance technology, "televised cognitive behavior therapy (CBT)," is as effective as therapy provided in-person.

The researchers compared CBT delivered via telemedicine and CBT delivered in person, involving patients in rural and smaller urban areas in North Dakota and northwestern Minnesota, Mitchell said. The two methods "were equally effective and acceptable to patients, with good maintenance of treatment effects at one-year follow-up."

The new five-year grant, totaling $2.5 million from NIH's National Institute of Mental Health, funds an effort to deliver CBT to patients with bulimia nervosa in rural settings via telemedicine. It supports researchers' efforts to compare variations in telemedicine-delivered CBT to unsupervised self-help.

"This additional study allows us to pursue our goal of developing delivery systems for effective and cost-effective intervention for patients in rural areas, where specialized treatments are usually not available," Mitchell said.

Bulimia nervosa (BN) is a prevalent form of eating disorder among late adolescent and young adult women, he said. Most practicing psychotherapists who treat patients with BN have not been adequately trained to deliver the care that has emerged as a recommended standard.

"Therefore there appears to be a growing discrepancy between what is being used experimentally in academic centers and recommended by researchers in the field and what is available in the community," he said.

Internationally recognized for his work in eating disorders, such as anorexia nervosa, bulimia nervosa and obesity, Mitchell is the author of numerous books in his field of study and has written extensively for publication in scientific journals.

The recipient of numerous awards and honors, Mitchell was named in 2003 as a McCann Scholar, a prestigious honor given to a select few outstanding mentors in medicine in the United States. At UND, he holds the Lee Christoferson, M.D./Neuropsychiatric Research Institute (NRI) Chair in Neuroscience and the Chester Fritz Distinguished Professorship, the latter is the highest faculty honor bestowed by UND.

## Grand Forks Residency "Rocks"

Julie Jeske-Altru Corporate Development

Second-year family medicine residents from Altru's Grand Forks Family Medicine Residency (GFFMR) are participating n a unique program designed to provide support and nurturing for new mothers and their babies. The Rocking Chair Project, a non-profit organization, works with residency programs to present underserved moms with a glider rocking chair upon the birth of her child. GFFMR is one of 28 residency programs throughout the United States selected for the 2006-2007 academic year, and the only participant in North Dakota.

The chairs are provided free of cost to the mothers and the participating resident physicians. Intended to provide support and nurturing for both mother and baby, the chairs are shipped to the designated families shortly after delivery. According to Greg D. Greek, MD, residency program director, the project provides true dividends in terms of richer physician-patient relations. " It creates an indelible awareness of the depth of need experience by some patients in the resident's care." The program's grant will pay for seven chairs. To date, three rockers have been delivered and assembled by the residents. "We are hopeful that we will again participate in this worthwhile project in the coming academic year."

## Physicians Push For Healthcare Legislation

David Peske, NDMA Director of Governmental Relations

**NDMA and NDAFP on The Hill** - The number of bills introduced in the 2007 Legislative Session is very similar to 2005, with 417 in the Senate and 521 in the House. Of the total 938, more than 25% were defeated in their originating chamber before the "crossover" deadline on February 16. However, NDMA lobbyists were again involved with over 150 health-related bills this Session, with more than 100 remaining in play after crossover.

The Medical Association requested introduction of several legislative proposals which are included in the summary of select bills below. All healthcare bills can be accessed at the NDMA website: www.ndmed.org; on the homepage, click on 2007 Bills. Topics addressed include Medical Practice, Insurance, Medicaid, Other Health Professionals, and Public Health. The status of many of these bills will not be determined until sometime in April, so it is not possible to report the final outcomes at this time. This is especially true for one of NDMA's major efforts, achieving a meaningful increase in the Medicaid reimbursement levels for physicians and other providers (see SB 2012).

**Expressions of Empathy**

NDMA has successfully enacted **HB 1333**, allowing health professionals to say "I'm Sorry" to a patient or their family. The law, patterned after legislation enacted in a majority of other states, excludes statements of sympathy made by a physician from being used against them in a medical lawsuit as evidence of liability. The bill, introduced by Bismarck Representative Larry Klemin, passed the House 74-17 and the Senate 43-0 and was signed by the Governor in early March. The statute becomes effective on August 1, 2007.

**Care for Pregnant Minors**

The second bill developed to improve the provision of healthcare in North Dakota is **SB 2181**, which would authorize a minor to consent and contract for medical and other healthcare services to determine the presence of or to treat pregnancy and conditions associated with pregnancy. The goal is to provide early and appropriate care to the minor and her child to best assure their positive health status. Current law already allows a minor to receive treatment without parental consent for drug and alcohol problems, for sexually transmitted diseases, or in an emergency. At the same time, the bill recognizes the ethical imperative for physicians to encourage the minor to involve her parents or guardian. A healthcare professional would not be compelled to provide treatment based on the minor's own consent, and they would be authorized to inform the minor's parent or guardian of any health care services given under various circumstances. The bill passed the Senate unanimously, and as in 2005, has come under criticism in the House. Organizations supporting the bill include the ND Academy of Family Physicians, ND Society of OB/GYN, ND Academy of Pediatrics, ND Healthcare Association, and ND Nurses Association. Another bill, **HB 1162**, also seeks to amend the same statute to clarify, for EMS providers called to an emergency scene, that a minor may not refuse to give consent for care deemed necessary by the EMS team.

**Medicaid Reimbursement**

NDMA, NDHA, and others are vigorously advocating for an increase in Medicaid reimbursement to bring all traditional Medicaid providers up to at least the Medicare fee schedule. **SB 2012** increases the appropriation for payments to Medicaid providers to four percent each year of the biennium, up from the Governor's proposed three percent annual hike. Funding was also added to provide the same annual inflationary increase for long-term care facilities. This was only the beginning of the process, and the House will now address the budget needs of healthcare providers before a final resolution is reached in conference committee at the end of the session in April.

**Prescription Drugs**

**HB 1422** would continue to make all psychotropic, cancer, and HIV drugs available to Medicaid patients without being subject to a prior authorization (fail-first) process. Under **HB 1431**, pharmacists would be required to dispense epilepsy and anti-convulsant drugs with no substitutions allowed unless consent of both the prescriber and patient are obtained. The Department of Human Services is opposed to both provisions, noting they will hinder the ability to control costs of the Medicaid drug benefits program. **HB 1256** would create a prescription drug and device donation program, allowing the return and redispensing of unopened products to patients instead of being destroyed. And, under **SB 2134**, pharmacists would be required to submit data on all controlled substance, carisoprodol, and tramadol prescriptions they dispense to a central repository administered by the Board of Pharmacy. The data could be accessed by physicians wishing to check on their patients' drug compliance or misuse, as well as by health professional licensing boards and law enforcement agencies engaged in investigating prescribing misconduct or diversion activities.

**Practice Incentive**

The House voted to expand funding for the State Health

Department's physician loan repayment program, hoping to attract more physicians to practice in doctor-short ND communities for at least two years, with up to $90,000 of their educational loans paid for in return. The funding was increased in **HB 1004** from $75,000 to $225,000, but remains under review in the Senate Appropriations Committee. A late amendment to the Workforce Safety and Insurance agency budget would authorize WSI to create opportunities to advance the provision of occupational and preventive medicine services to the states' workforce, including a scholarship program for physicians to receive residency training.

**Trauma System**

**HB 1290** provides funding to the Health Department to contract with an American College of Surgeons trauma team to conduct a comprehensive review of the current emergency services system in place across the state, and to provide recommendations on how North Dakota's system can be improved. Several other bills attempt to provide tax breaks or funds for local EMS services struggling to remain viable, and another requires counties to be involved in studying the provision of EMS to their residents.

**Tanning Booths and Tattoos**

Dermatologists seeking to protect minors from the harmful effects of ultraviolet radiation from tanning lamps have championed **HB 1154**, requiring that no child under the age of 14 may use a commercial tanning facility without the written order of a physician, and children age 14 to 17 must have written parental consent. This bill also requires the Health Department to inspect tanning facilities, and physicians and others to report treatment of injuries sustained due to tanning burns. **HB 1505** requires the Health Council to regulate commercial tattooing and body piercing businesses, and **SB 2352** penalizes any person who tattoos or pierces a person under age 18 unless the parent is present and has provided consent.

**Lay Midwives**

Recent adverse events related to home births overseen by lay midwives sparked introduction of **SB 2377**, which has now been amended to require a Legislative Council study of the provision of obstetrical services by a layperson, including whether current law regulating the practice of medicine and the practice of nursing adequately addresses the obstetrical services provided by lay midwives.

**Smoke-free Workplaces**

**SB 2164**, introduced by the only physician serving in the ND Legislature, Sen. Ralph Kilzer of Bismarck, sought to improve on the smoke-free law enacted in 2005 by removing the exemptions granted to free-standing bars and rooms in truck stops. Numerous physicians and healthcare organizations attended the hearing in unanimous support of the measure, but bar owners from across the state lobbied against what they considered government interference in their freedom to choose how to operate their businesses. The bill failed by a vote of 30-15 in the Senate.

**Other Bills of Interest**

Readers are urged to access additional healthcare bills on the NDMA website.

**SB 2303** would create a state health information technology committee, with representation from physicians, hospitals, insurers, and other stakeholders, to address the future use of electronic medical records and interoperability of technology systems. Although SB 2303 was defeated in the House, the basic structure of an HIT committee may be inserted into the state information technology department budget bills. **SB 2163** would adopt the Revised Uniform Anatomical Gift Act in place of the current state law, and Senate Bills **2212** and **2308** would fine tune the advance directive statutes. **HB 1254** would have aligned enforcement of the seatbelt law with all other current traffic laws instead of it being a 'secondary' violation, but the bill was defeated in the House. **HB 1423** would have allowed eight-year olds to ride small ATVs and dirt bikes after taking a safety course; after hearing opposition from pediatricians and other safety groups, the Senate defeated the bill.

NDMA would again like to acknowledge that family medicine specialists have been the mainstay of the 2007 **Doctor of the Day program**. This program, so greatly appreciated by the legislators, has really showcased the importance of primary care physician services, and given the volunteers an inside look at the legislative process. There are still many days in April not yet covered, so anyone interested in serving may contact NDMA to sign up as the Doctor of the Day.

*To contact Mr. Peske, send email to dpeske@ndmed.com.*

## RESIDENCY SITES - CLASS OF 2007

NAME/LOCATION — PROGRAM

**Aberle, Nicholas** — ORTHOPEDIC SURGERY
Creighton-Nebraska Health Foundation – Omaha, NE

**Bakke, Rebecca** — PEDIATRICS
Ohio State University Program/ Children's Hospital – Columbus, OH

**Barbot, Pierre** — OBSTETRICS/GYNECOLOGY
Grand Rapids Medical Education & Research Center/ Michigan State University – Grand Rapids, MI

**Becker, Brenda** — EMERGENCY MEDICINE
Michigan State University - Kalamazoo, MI

**Beller, Ashley** — FAMILY MEDICINE
Montana Family Medicine Residency Program – Billings, MT

**Biegler, Peter** — TRANSITIONAL (Year 01)
UNDSMHS - Fargo, ND
Mayo School of Graduate Medical Education Program – Rochester, MN — RADIOLOGY/ DIAGNOSTIC

**Boyum, Heidi** — PATHOLOGY
University of California (Davis) Health System Program Sacramento, CA

**Brown, Christina** — FAMILY MEDICINE
Altru Health System Grand Forks, ND

**Carpenter, Matthew** — ORTHOPEDIC SURGERY
Medical College of Wisconsin Affiliated Hospitals Program - Milwaukee, WI

**Chalmers, Aaron** — SURGERY/GENERAL
University of Wisconsin Hospital & Clinics - Madison, WI

**Cleland, Esperanza** — INTERNAL MEDICINE
University of South Dakota School of Medicine Program Sioux Falls, SD

**Deal, Eric** — ORTHOPEDIC SURGERY
University of Wisconsin Hospital & Clinics - Madison, WI

**Feist, Aaron** — EMERGENCY MEDICINE
Regions Hospitals/Health Partners St. Paul, MN

**Foy, Lindsey** — PEDIATRICS-PRELIM/ CHILD NEUROLOGY (Year 01)
University of Michigan Hospitals - Ann Arbor, MI
CHILD NEUROLOGY
University of Michigan Hospitals - Ann Arbor, MI

**Giddings, Kate** — OBSTETRICS/GYNECOLOGY
Sparrow Hospital/Michigan State University Program - Lansing, MI

**Graziano, Kelli** — INTERNAL MEDICINE
University of Utah Affiliated Hospital - Salt Lake City, UT

**Hintz, Kadon** — EMERGENCY MEDICINE
Grand Rapids Medical Education & Research Center/ Michigan State University – Grand Rapids, MI

**Homan, Zena** — OBSTETRICS/GYNECOLOGY
University of Illinois College of Medicine, St. Francis Med Center - Peoria, IL

**Hoyt, John** — INTERNAL MEDICINE
Mayo School of Graduate Medical Education Program - Rochester, MN

**Johnson, Mandi** — FAMILY MEDICINE
Altru Health System - Grand Forks, ND

**Johnston, Megan** — FAMILY MEDICINE
Memorial Hospitals of South Bend Program - South Bend, IN

**Juhl, Kirsten** — INTERNAL MEDICINE
University of Minnesota Medical School - Minneapolis, MN

**Keene, David** — Planning a research year

**Klemin, Jill** — Deferred Residency

**Klemin, Peter** — OBSTETRICS/GYNECOLOGY
University of Wisconsin Hospital & Clinics – Madison, WI

**Kling, Brianne** — OBSTETRICS/GYNECOLOGY
Banner Good Samaritan Medical Center Program - Phoenix, AZ

**Kummet, Gary** — TRANSITIONAL (Year 01)
UNDSMHS - Fargo, ND

**Kunkel, Melissa** — PEDIATRICS
University of Minnesota Medical School - Minneapolis, MN

**LaPointe, Jennifer** PATHOLOGY
University of Washington School of Medicine - Seattle, WA

**Liden, Mats** TRANSITIONAL
UNDSMHS - Fargo, ND (Year 01)
University of Nebraska Medical Center College of Medicine RADIOLOGY – DIAGNOSTIC
Program - Omaha, NE

**Luebke, Aaron** INTERNAL MEDICINE
University of Utah Affiliated Hospitals – Salt Lake City, UT

**Lyste, Derek** FAMILY MEDICINE
Altru Health System - Grand Forks, ND

**Maanum, Scott** SURGERY/GENERAL
Central Iowa Health System (Iowa Methodist Medical Center) Des Moines, IA

**Marks, Noah** ORTHOPEDIC SURGERY
Louisiana State University Program - New Orleans, LA

**Martinez, Alicia**

**Matthews, Jeremiah** EMERGENCY MEDICINE
Indiana University School of Medicine – Indianapolis, IN

**McCoy, Andrew** SURGERY/PRELIMINARY
Mayo School of Graduate Medical Education Program
Rochester, MN (Year 01)

**Miller, Sarah** INTERNAL MEDICINE
Johns Hopkins University/Bayview Medical Center Program - Baltimore, MD

**Miller, Stephanie** NEUROLOGY
Mayo School of Graduate Medical Education Program
Rochester, MN

**Morrison, Andrea** PEDIATRICS
Ohio State University/Children's Hospital – Columbus, OH

**Newman, David** INTERNAL MEDICINE
Hennepin County Medical Center – Minneapolis, MN

**Nordeng Zimmerman, Rena** FAMILY MEDICINE
Idaho State University—Pocatello, ID

**Perkerewicz, Jedidiah** OBSTETRICS/ GYNECOLOGY
St. Joseph Mercy Hospital Program – Ann Arbor, MI

**Polovitz, Kathryn** MEDICINE PRELIM/
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**Pullen, Samantha** TRANSITIONAL
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**Zimmermann, Ryan** FAMILY MEDICINE
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**Bakke, Andrew** EMERGENCY MEDICINE
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**Bratvold, Jared** GENERAL SURGERY
Texas Tech University Affiliated Hospitals - Lubbock, TX

**Newman, Tracie** PEDIATRICS
University of Minnesota Medical School – Minneapolis, MN

**Wilder, Andrew** RADIOLOGY/DIAGNOSTIC
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**Wilkins, Sarah** PATHOLOGY
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*A second graduate also matched in Diagnostic Radiology. This physician has asked that the Match results remain confidential.

## Second Hand Smoke'-Not So Passive

*Eric Johnson, MD*

Passive Smoking, more commonly referred to as 'Second Hand' Smoke, is the tobacco smoke breathed by non-smokers. In recent years, the detrimental health effects have become more widely known and accepted. No longer simple theory, the deadly impact of Second Hand smoke is strongly evidence based. Family Physicians have opportunity to be advocates for indoor clean air legislation, both locally and state wide. Although North Dakota has a state law prohibiting smoking in most indoor facilities, exemptions exist which place the public, particularly workers in these environments, at risk for Tobacco Related Disease.

The 2006 Surgeon Generals Report on the Involuntary Exposure to Tobacco Smoke (1) outlined the negative effects of Second Hand smoke on health in non-smokers. Second Hand Smoke is thought to have at least 250 toxic chemicals, of which 60 are carcinogenic (2)(3). Studies documenting the harmful effects of Second Hand smoke date to the 1960's, culminating in the 1986 Surgeon Generals Report, the first such report devoted solely to this topic. The earliest such data focused on spouses of smokers, and now data exists for many different populations and exposures, including workplaces.

At present, the Surgeon General's report summarizes adverse of effects of Second Hand Smoke on non-smokers. Lung disease and cardiac disease are the primary risks, and the public may not fully appreciate the impact. Current estimates are that 40,000-45,000 persons die annually in the United States from Second Hand Smoke related disease. Approximately 70% of these persons die from cardiac disease and another 10% die from pulmonary diseases, usually chronic obstructive pulmonary disease or cancer. This translates to 80-140 deaths annually in North Dakota.

Several recent studies have demonstrated risk associated with Second Hand Smoke exposure. Two of the more well known are the so-called 'Helena'(4) and 'Pueblo'(5) studies. In these cities, in Montana and Colorado respectively, the number of hospital admissions for acute myocardial infarction declined significantly following the implementation of an indoor smoking ban in public facilities, only to have the trend reverse following repeal of these resolutions. Relative risk of Passive smoking has been estimated at 80-90% of Active smoking, offering significant risk of mobidity and mortality(6).

Indoor Clean Air Legislation can have short term benefit as well. In a study of Irish non-smoking pub workers, FEV1 values improved after Ireland's comprehensive ban became effective(7). Similar data was noted in California bar employees (8). Smoking in the general population declines following the implementation of smoking bans as well (9)(10), and in special populations (i.e. adolescents) (11).

Over 80% of North Dakota adults over the age of 14 do not smoke (BFRSS, 2005, ND Dept. of Health). In areas where indoor smoking bans are in effect in North Dakota, overwhelming majorities have supported them in post-implementation surveys (i.e. Grand Forks, 80%+ on many parameters, 2006, Grand Forks County Health Department). Indoor clean air legislation does not primarily target the smoker, only the infliction of injury upon others. These issues can also be viewed in a worker's rights context as well, as all workers are entitled to safety in the workplace.

Family Physicians can be effective local advocates for indoor clean air legislation, and effective means for treating tobacco exist. Newer medications, such as varenicline (chantix), as well as buproprion and nicotine replacement (patches, gum, etc), combined with counseling (e.g., Tobacco Quitline or Tobacco Cessation Class) are generally safe with good outcome data.

"The right to swing your fist ends at my nose"- Oliver Wendell Holmes, Jr.

For more information or assistance, contact the North Dakota Tobacco Quitline Physician Consultants at the Department of Family and Community Medicine at the University of North Dakota School of Medicine and Health Sciences. 701 777-3191, Eric L. Johnson, M.D.ejohnson@medicine.nodak.edu, Donna A. Anel, M.D., M.P.H. danel@medicine.nodak.edu, www.med.und.nodak.edu/depts/fammed/tobaccoquitline.html


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## Teaching Through the Generation Gap

*Roger W. Schauer, MD*

Concerns about perceived changes in attitudes of current medical students and residents are frequently raised by both clinical and academic faculty at medical schools and residencies across the nation. Changing values, priorities, and/or commitment to the medical profession are cited as potential negative issues for the future of medicine. Discussions sometimes commence with comments about current student/resident time commitment to study and patient care. Other concerns are priority issues such as family, down-time, recreation, or potential income.

During a recent continuing education presentation in Grand Forks Dr. Lawrence Smith shared an experience he had with a group of Family Medicine residents. Dr. Smith informed us that the generation gap issue first became evident to him during a case conference where it appeared that no one was paying attention to the speaker. Dr. Smith related that he stood up, interrupted the presentation, and asked "is anyone having any fun?" The silence in the room was interrupted only when he asked one of the residents if she would share with the group why she was crying. Her response was "Dr. Smith, I am afraid to love medicine as much as you do. I have a family I care about". At this point in his presentation to us Dr. Smith began talking about the challenges of learning from, and embracing the generational differences, rather than attempting to change, or "fix them."[1]

We all bring our own stories, our own history, to any of our relationships, whether those relationships are with our patients or the students and residents in our midst. In addition to our individual stories there may be a larger pattern of learning to consider. Generational differences in values and priorities have recently been addressed by a number of authors, the popular press, and the talk-show media. We, as teachers and mentors of medical students and residents, might consider how these generational differences impact our teaching and mentoring relationship with our learners.

Research about generational difference, first published in 1991 by William Strauss and Neil Howe, has stimulated discussion and controversy.[2] Strauss and Howe found cyclical patterns regarding values and priorities, and that the cycles could be grouped by generation of birth. Their research identified a revolving pattern of generational types in America since the founding of the original colonies. This recurrent pattern of types and archetypes, or "turnings," seems to recur after every fourth generation. The generational groupings seem to average about 20 years, but frequently seem to have a demarcating event or series of events that impact the up and coming generation.

Strauss and Howe provide examples of four generations from the 20th century. The "Silent" or "Mature" generation includes those who were born prior to and during the depression and WW II. The "Boomer" generation includes those born during or post-WW II through about 1960, and includes a significant number of physicians currently in practice. "Generation Xers" (or the "13th Generation," so referenced to reflect the thirteen generations since the beginning of the settlement of America) were born 1961 through 1981. Many young practicing physicians, and most of the current medical residents, are late members of Generation X. The "Millennial Generation" ("Generation Y") was born after 1981 and includes the great majority of our current matriculating and up and coming medical students.

Each generation is shaped by history. In turn each generation reacts differently to history, and thus also shapes history. Values and priorities change as we learn and grow. These periods of change within each generation relate somewhat to the tasks in our own life cycle. They include "rising adulthood," which are the activity or building years; "midlife," or leadership years; and "elderhood," or stewardship years. For example, I am an early "Boomer" (born 1944), and was affected by the experiences my parents had during the depression and WW II. I was also affected by the national prosperity and world peace during my formative secondary education years. During my "rising adulthood" I witnessed and learned about health care from physicians and others who were part of the "Silent" generation. My children (Generation Xers) grew up learning about and from my values, values that were influenced by the Viet Nam conflict and other controversies and events that arose in the 1960s and early '70s. Maybe it is because I am now moving into my "elderhood", or stewardship years, that I feel it is important that we understand these changing values, and consider how those changes affect our teaching and mentoring of the next generation of physicians.

The values of the Boomers and Generation Xers certainly impact the Millennial Generation. The importance of healthy life styles, of healthy relationships, of self-care was not addressed (maybe implied or expected, but certainly not emphasized) when I was in college, medical school, or residency. The focus was on getting the job done, getting through school, learning to provide the best possible care for our patients, and establishing a practice. These were goals that are certainly worthy and laudable.

Today our learners expect to care for themselves, to care for their relationships, and to care for their patients. As their teachers and mentors we need to understand and appreciate the balance of competing loyalties of our students. Perhaps we also need to adapt and adjust some of our own priorities as we learn from them.

I welcome comments and thoughts about your challenges and successes in bridging some of these generational issues as you teach and learn from our students.

1. "Professionalism and Generation Gap" presentation at Altru Hospital, July 19, 2006, by Lawrence Smith, MD, Chief Academic Officer, Long Island Jewish Health System, Long Island, NY.

2. Books by William Strauss and Neil Howe include "Generations"(1991), "13th Generation" (1993), "The Fourth Turning" (1997), and "Millennials Rising" (2000).

***Excerpted from "For the Office-based Teacher of Family Medicine"***

**Teaching Essential Elements of Routine Encounters: The "A"s and "Ex"s of Achieving Patient-Physician Satisfaction**

*By Terry E. Shlimbaum, MD, and Nancy B. Ruddy, PhD, Hunterdon Medical*
*Center Family Medicine Residency Program, Flemington, NJ.*
*(Fam Med 2006;38(7):469-71.)*

As physicians, we strive for the perfect mix of interpersonal skills and technical competence to create winning, mutually satisfying encounters. If we can discern our patient's concerns and agendas, and use our knowledge and communication expertise to address these concerns, satisfaction will be consistently achieved.[1-4]

Although the "bread and butter" of a physician's schedule are patients who have relatively simple problems with predictable agendas and questions, students and residents, even those with excellent interpersonal skills, often find routine visits to be unsatisfying. This may be due to the fact that less-experienced clinicians tend to have more difficulty determining the patient's agenda, while experienced physicians have learned what patients really want and to anticipate these needs. Anticipating the patient's agenda is a key interpersonal skills competency that teachers should strive to help their learners demonstrate.5 The following model serves as a useful teaching tool to help learners analyze routine visits during precepting:

Encounter Satisfaction = Acknowledgment + Anticipation + Experience + Expectation + Explanation. ES = 2A + 3Ex.

*Acknowledgment*

Acknowledgment of a patient's symptoms and a thorough review of the history and context of those symptoms reassures the patient that the doctor listened carefully and appreciated his/her concerns. Multiple studies have shown that effective communication, empathy, and attentiveness to patients' concerns relates to patient satisfaction.[3,4,6-8] Patients need to know that the physician or learner understood their problem and how it affects them. To acknowledge and demonstrate their comprehension of a patient's concern, learners can review the history with the patient and add their perception of how the condition affects the patient's life. For example, the learner can say to the patient, "You have told me that these joint pains started 2 weeks ago without any associated injury, and they are now disabling and affecting your daily activities."

*Anticipation*

Physicians often can anticipate the questions or concerns that patients with a certain symptom are likely to have. A failure to anticipate patient expectations or concerns can create barriers for further communication since patients may perceive a lack of understanding.[9,10] For example,
failing to anticipate that a person with a prolonged viral syndrome may want an antibiotic, or not realizing that a person with a severe headache may fear a brain tumor compromises the encounter. Frequent call backs, complaints, and record transfers follow such failures. Learners must anticipate their patients' needs and address them during the encounter to avoid frustration and dissatisfaction for both the learner and the patient. Teachers can help learners accomplish this by reviewing the chief complaint with them before the patient encounter as well as during the precepting discussion. In reviewing or discussing the patient's chief complaint, teachers can ask learners questions such as, "What do you think most people with a headache are concerned about?" or "What do you think the person with acute low back pain expects from this visit?" to help them anticipate the patient's real concern.

*Experience*
Physicians who share their experience with the presenting problem establish credibility and appear knowledgeable to the patient.[3,11,12] For example, the physician may say, "In a typical day, I see two to three people with . . ." or "In my experience . . ." to reassure the patient that he/she sees a problem frequently and has a track record in this area. Students and residents often struggle with their relative inexperience and may be uncomfortable reassuring the patient in this way without direct training in how to do so. To offset their lack of experience, learners can either share knowledge related to classroom experience by saying "When we learned about this in class, our professor said that . . . " or by referring to recent research articles.

*Expectation*
Expectation refers to explaining the physician's expectations about the usual course of an illness. Imparting these expectations gives the patient guidelines for what is considered "normal" and symptoms or signs that are "cause for concern." Including this element in the closing forces the physician to be specific and knowledgeable about the true course of certain illnesses. By learning to give an appropriate range of "normal" courses, students and residents can avoid many post-encounter problems.

*Explanation*
The extent to which the patients understand their problems is positively correlated with patient satisfaction.[3,13,14] Artful, experienced clinicians customize the explanation to the person's ability to comprehend, based on their intellectual and emotional status. Anatomical models and patient handouts can be helpful. Certain patients may benefit from a slower, simpler explanation or the opportunity to meet with a patient educator. Teachers must help learners to assess a patient's comprehension of a diagnosis or management plan and take the time to carefully explain items without the use of medical terms, which learners often use without realizing it.

**Application of the Model During a Patient Encounter and During the Precepting Process**
Frequently, learners will intermingle different parts of the visit, such as diagnosing and offering treatment before listening to the complete history and examining the patient. This intermingling can lead to confusion and miscommunication. To communicate more effectively, it is usually best
to separate the data collection (history and physical exam) from many tasks of this model, especially the "Ex"s (experience, expectation, and explanation), which are best performed at the close of the visit when patients are most ready to listen.

Reviewing the "A"s and "Ex"s with learners during the precepting process allows them to distill the critical components of a successful encounter and determine if they have completed each task. Similar to the BATHE[15] mnemonic that gives learners an approach to handling psychosocial issues, this formula helps them address key elements of the physician-patient encounter in a more-medical, yet still patient-centered, way. As learners have more successful, satisfying routine encounters, they will excel at establishing healing relationships. In addition, higher satisfaction with routine encounters can have a major impact on one's overall contentment and practice.

**Summary**
Learners may have unsatisfying encounters when people present with frequently encountered problems. In these cases, establishing a healing relationship requires a special skill set, which most physicians learn from experience. Teaching learners the essential components for addressing patients' concerns in a knowledgeable and empathetic manner may circumvent some of the frustration and dissatisfaction that less-seasoned clinicians experience with routine encounters. This model can serve as a valuable teaching tool to help learners evaluate their own performance

with routine encounters and to target areas in need of improvement.

*Acknowledgment:* A seminar of similar content to this paper was presented with instructional videos at the Society of Teachers of Family Medicine 2005 Northeast Region Meeting in Hershey, Pa.

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**William Huang, MD, Baylor College of Medicine, Editor**

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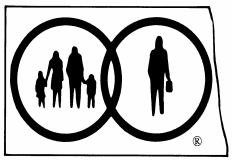

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