NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

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Roger W. Schauer, MD

It is that time of year again, for the Red River of the North (and its tributaries) to challenge residents in the greater valley, and to share the **2010 Match Day results.** Learn where the students you precepted will spend the next few years of their residency training. For the Class of 2010 (N=55 +3 former graduates), 9 matched in Family Medicine (FM), 3 in Internal Medicine (IM), and 5 in Pediatrics (Peds). For comparison, the numbers for the Class of 2009 (N=60 +3 former graduates) were: FM – 9, IM – 8, Peds – 7. All three North Dakota Family Residency filled their allotted slots, but none of those new residents are graduates of UNDSMHS.

In his **Message…**, Dr. Vetter challenges us to take leadership roles in our communities, but also provides us with three initiatives forwarded by our Academy, as well as pathways for achieving those goals. Bruce Levy's **March Madness** is not addressing basketball, but rather a far more important issue for our patients and us, including the importance of the "Frontier States Amendment".

You still have time to plan to attend the **Dakota Conference on Rural and Public Health**, which this year is at the Alerus Center in Grand Forks, April 13-15. Plenary speakers, including UND president Robert Kelley, and Tom Morris, director of the Office of Rural Health Policy, were challenged to address this year's Dakota Conference theme – **"Health Care in Transition: Creative Strategies".** For details go to http://ruralhealth.und.edu/dakotaconference/. Registration at the door is also an option. Increasing awareness of **traumatic brain injury** in North Dakota, including access to resources, is addressed by Rebecca Quinn, of the Center for Rural Health.

"Patient Witnessed Precepting: Faster Precepting That Is Effective and Fun" carries a message similar to mine a few years ago, when I wrote "You're a Better Doctor when you have a Student". Dr. Heaton's article is well written, with specific suggestions for implementation.

We welcome letters to the editor, questions, comments, and articles you want to share, especially information pertinent to practice or teaching in North Dakota.

Message from the NDAFP President

Richard Vetter, MD

Your Academy Board of Directors recently met and approved the 2010 operating plan that was one of the outcomes of the strategic planning process that was completed last year with the assistance of Eric Monson of Novus. We have tried to narrow our focus to 3 main Initiatives as we realize we have limited resources and staff. I have taken the liberty to include ways to acheive these initiatives. I would encourage each of you to see how you can get involved to help your Academy reach its goals.

INITIATIVE 1: Renewal and New Areas of Focus for Promotion of Family Medicine

Outcome: Increased contact with High School, Pre-Med, and Medical Students

1. Develop approach with high school students. Work with the Mission Physician Program, developed by Dr Bill Mann and the Altru Family Medicine Program, to promote health careers in ND high school students. Please support this program with your time, talent, and treasure.

2. Develop approach with Pre-med students. Consider being a mentor or be willing to be a resource to the Pre-med clubs at our undergraduate universities.

3. Continue your support of our Family Medicine Clerkships, Don Breen externship, and Family Medicine Residency programs.

INITIATIVE 2: Increased Academy involvement with Policy and Payment changes that influence Family Medicine specialty choices.

Outcome: Positive payment changes recognizing Primary Care contribution to health and wellness

1. Work and advocate for this with BC/BS, state medicaid officials, and state legislators for continuing payment reform.

2. Advocate for Healthcare reform as supported by American Academy of Family Practice with our Congressional Delegation.

3. Support FamMedPac with your contributions.

4. Work within each of your organizations to support the ideals of Family Medicine.

5. Participate in the NDMA Doctor of the Day Program

INITIATIVE 3: Focus On Academy Operations

Outcome: Develop new revenue sources and revised operating policies

1. Review and monitor revenue sources (Big Sky, Pharma support, Dues).

2. Annual membership report to Board of Directors (consider serving on the Board).

3. Review duties and terms of officers (support your board and executive director).

4. Further develop NDAFP web-site (please check out web site and links).

5. Attend NDAFP sponsored functions.

I believe that it is imperative for all of us to take a leadership role in our communities in order to fulfill our mission to promote the specialty of Family Medicine, provide an opportunity for collegial fellowship, and to improve the health of the citizens of North Dakota. Please contact me, Brandi, or any of your board members with any concerns or for information on how you can become more involved.

NORTH DAKOTA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

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Register Now for Dakota Conference on Rural and Public Health

Tara Mertz, Communications Specialist, Center for Rural Health

The 25th annual Dakota Conference on Rural and Public Health, an interdisciplinary forum for sharing strategies for building and sustaining healthy North Dakota communities, is set for April 13-15 at the Alerus Center in Grand Forks, N.D.

This year's conference, themed "Health Care in Transition: Creative Strategies," will offer participants a chance to hear from some of the most knowledgeable people in the areas of rural and public health. In addition to preconference workshops, a variety of breakout sessions, poster presentations and the annual awards banquet, the following keynote presentations highlight the conference:

- **"Health Leadership for the Emerging Future"** by **Jim Hart**, MD, director, Executive Program in Public Health Practice and the North Central Public Health Leadership Institute, University of Minnesota School of Public Health

- **"Innovative Approaches to the Challenges Facing Health Care Delivery in Rural North Dakota"** by **Robert Kelley**, PhD, president, The University of North Dakota

- **"Food is More than Something to Eat"** by **Wanda Agnew**, PhD, director, Nutrition Service, Bismarck Burleigh Public Health; **Sandra Poitra**, RD, LD, community dietitian, Quentin N. Burdick Memorial Health Care Facility; and **Karen Ehrens**, LRD, health and nutrition consult, Ehrens Consulting

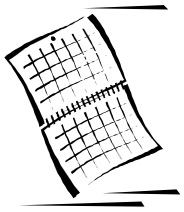
- **"Rural Health Care in Transition"** by **Tom Morris**, director, Office of Rural Health Policy, Health Resources and Services Administration, Department of Health and Human Services

"The purpose of an annual statewide health care conference, such as the Dakota Conference, is not only to instill newfound skills, knowledge and resources," said Lynette Dickson, project director at the Center for Rural Health at The University of North Dakota (UND) School of Medicine and Health Sciences and chair of the Dakota Conference committee, "but also to challenge and motivate people to integrate what they have learned to their individual program, organization or facility."

Health professionals from all disciplines in addition to researchers, educators and all those interested in improving rural and public health in the state should register online by noon on Friday, March 19, at www.ruralhealth.und.edu/dakotaconference, where a complete schedule and more information can also be found.

The Dakota Conference is facilitated by the Center for Rural Health. Support is provided by Altru Health System, North Dakota Public Health Association, North Dakota Rural Health Association, UND College of Nursing and UND School of Medicine and Health Sciences Department of Family and Community Medicine. Platinum sponsors include Experience HealthND and the UND School of Medicine and Health Sciences.

Contact: Tara Mertz, communications specialist, Center for Rural Health, 701-777-0871, taramertz@medicine.nodak.edu



MARK YOUR CALENDARS!!

April 13-15, 2010
Dakota Conference — Grand Forks, ND

July 15-17
NDAFP Annual Meeting — Medora, ND

September 9-10, 2010
NDMA Annual Meeting — Fargo, ND

September 17-18, 2010
Advanced Life Support in Obstetrics
Minot, ND

January 17-21, 2011
34th Annual Family Medicine Update
Big Sky, MT

January 16-20, 2012
35th Annual Family Medicine Update
Big Sky, MT

"March Madness" Begins: Health System Reform Turns Into Parliamentary Debate

Bruce Levi

The yearlong debate over health care reform — certainly an unusual process involving big ideas, passionate convictions and lofty principles — is headed toward a highly unlikely endgame: a clash between parliamentary procedure attorneys.

As Democrats prepare to use a parliamentary procedure called reconciliation to move much of the reform package, there will be high drama. And there will be the requisite dose of sound bites from the many orators of the House and Senate, as well as the media and just about everyone else.

The base for the reform package is the Senate bill passed just before Christmas. But beyond that and true to the weather making the rounds in North Dakota, health care reform remains within a fog of controversy with new expectations set for passage before Congress' Easter recess.

While the AAFP and others praised the passage of the Senate bill in December, it was certainly within the context of setting the framework for reform and a base to begin to strengthen primary care, as well as ongoing concerns over the need to further improve the legislation. NDMA also weighed in, giving our Delegation a ten-page letter citing the pros and cons about the bill. NDMA president Dr. Kimberly Krohn and I met with our Congressional Delegation in early March, discussing NDMA's previous positions on the Senate bill and the process, as well the fate of the "Frontier States amendment," which would improve North Dakota's position dramatically in addressing the unfair geographic disparity of Medicare payments to physicians and hospitals.

Senator Kent Conrad as chair of the Senate Budget Committee is square in the middle of the debate, arguing that "reconciliation" can only achieve changes in budget issues and suggesting that the President might first have to sign a House-passed Senate bill before changes could be made to the bill through reconciliation.

But that's for the parliamentary attorneys. Whether the votes are there in the House to pass the Senate bill is another question. Aside from whether the House trusts the Senate to craft an appropriate budget reconciliation bill, other potentially major issues loom including Senate provisions related to insurance coverage of abortion.

Senator Conrad participated in the bipartisan health care summit convened by President Obama at Blair House on February 25. While Senator Conrad as a participant in the Summit issued a press release that expressed optimism that the summit could help bridge the remaining differences and advance a reasonable and responsible approach to health care reform, our discussions suggested a more polarizing impact on the political environment.

Senators Conrad and Byron Dorgan and Congressman Earl Pomeroy all understand the historic importance of the "Frontier States amendment" and all expressed commitment to supporting legislation only if it includes the provision, which as authored by Senator Dorgan and included in the Senate bill would establish a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index for states. The floors would only apply in states in which 50% or more of the counties within the state are "frontier," i.e., counties in which the population per square mile is less than six. This would apply to North Dakota, South Dakota, Montana, and Wyoming which currently are below the 1.0 floors.

The Frontier States amendment is not a special deal as some claim in the media, but rather recognizes and resolves historical unfairness that exists in Medicare payments to states that have been known to be challenged by our own geography, akin to the "Buffalo Commons" notion in my view. It is no different than existing payment accommodations made to other states challenged by geography such as Alaska and Hawaii. While we face a 21% SGR cut and nationally decry how inadequately our Congress has "kicked the can" down the road on that issue, we have long advocated that we actually take cuts similar to the 21% cut *each and every year* in our state because of the geographic adjusters that reduce all our Medicare payments, even our PQRI bonus payments.

The "frontier states" amendment would have a substantial financial impact and go far beyond any other proposals for addressing the Medicare payment disparity issue for North Dakota. Senator Dorgan reports, based on *Milliman* and CBO estimates, that the "frontier states" amendment would result in a $16.5 million increase for physicians services (18.5%) beginning January 1, 2011. The amendment would also result in a $51.7 million increase for hospital inpatient (12.8% increase) beginning January 1, 2011, and outpatient services (9.9% increase) beginning October 1, 2010. Over the ten-year period, this equates to $650 – 660 million. Overall for the states included, the CBO scored the amendment at $2 billion over ten years.

Business As Usual on SGR Fix

NDMA has worked with AARP and other groups in con-

tinuing to pressure Congress for a permanent solution to the "sustainable growth rate" (SGR issue). In early March, President Obama signed into law the "Temporary Extension Act of 2010." Among other things, this law extended through March 31, 2010, the zero percent update to the Medicare Physician Fee Schedule that was in effect for claims with dates of service January 1 through February 28, 2010. The AAFP reacted to one-month extension in recognizing it as a method of buying time, but not building physician confidence and trust in a "system on which millions of elderly, disabled Americans and military families with TRICARE depend. Instead, it contributes to the growing cost of permanently resolving a problem that has dragged on for nine years."

Discussions are still underway in the House and Senate on the next steps to address the Medicare payment crisis. On March 10, the Senate passed HR 4213 that would further extend current Medicare physician payment rates until October 1, 2010. The legislation will now be sent to the House, where amendments are possible. Consequently, it is not certain if this extension of Medicare payment rates can be signed into law before the current Medicare physician payment freeze expires on April 1.

Work Begins on 2011 Session Agenda
March 2010 will likely redefine "March Madness" with a dramatic resolution or end to health system reform. While we continue to slog through this difficult process, preparations are beginning for the 2011 ND Legislative Assembly with the state party conventions in late March.

Our NDMA Commission on Legislation has started the process of developing a preliminary agenda for consideration by the NDMA House of Delegates in September, with several NDAFP members participating on the Commission. The Commission met March 9 and discussed a wide range of issues including further rebase efforts in Medicaid physician payments, proposed UNDSMHS class size increases, and commercial insurer practices, as well as expected challenges in the 2011 session, including another effort to repeal or reduce ND's medical liability $500,000 cap on non-economic damages.

The effort in our Legislative Commission is just beginning. If you have issues or initiatives you would like the Commission to consider for the 2011 session, please let the NDMA office know.

Head Injury Assoc. of ND (HIAND) is revived

Rebecca Quinn **,** Project Coordinator, Ctr for Rural Health

Over 9,000 people in North Dakota sustain a traumatic brain injury (TBI) each year and with the help of state appropriated funds from the 2009 North Dakota Legislature, the Head Injury Association of North Dakota (HIAND) is revived. With the mission to advocate for the head injury population of North Dakota; establish support groups for survivors of head injury and their families; network information; bring awareness to the public; and provide local and national leaders for the purpose of bringing quality of life and coping mechanisms to those involved with head injuries, the HIAND is increasing awareness about TBIs throughout the state. In addition to bolstering understanding of TBIs, the HIAND provides information referral, peer counseling and informal support services.

A TBI is an insult to the head or penetrating head injury that disrupts the functioning of the brain. TBIs cause unpredictable consequences by affecting the way people think, act and feel. The effects of TBIs are complex and vary greatly from person to person, with no two brain injuries being the same. Some of the possible consequences include the following:

- Physical: paralysis, seizures, headaches, fatigue, sleep disturbances, impaired balance
- Sensory: vision, speech, hearing, and coordination problems
- Cognitive: impaired reasoning or memory, difficulty making decisions, slowed processing speed, attention difficulties, impaired judgment,
- Social/personality: inappropriate social behaviors, anxiety, depression, impulsiveness, restlessness, irritability, sudden changes in mood

The signs and symptoms of TBIs can be subtle and may not appear until days or weeks following the injury. The specific symptoms may also vary depending on which part of the brain has been affected. If headache, confusion, neck pain, blurred vision, instability, fatigue, ringing in the ears, or slowness in thinking, reacting, speaking, or reading occur following an injury, it is advisable to contact a physician immediately.

Like most injuries, prevention is the key to avoiding TBIs. Wearing a helmet, being a cautious driver, reducing the risk of falls, wearing a seat belt, using children's safety seats, and not shaking infants are steps that can help ensure a healthy future without a TBI.
For more information on TBI, peer counseling or informal support services, please contact the HIAND.
HAIND (701) 390-1000 braininjurynd@me.com

Excerpeted from "For the Office-based Teacher of Family Medicine"

Patient Witnessed Precepting: Faster Precepting That Is Effective and Fun

by Caryl J. Heaton, DO, UMDNJ-New Jersey Medical School(Fam Med 2009;41(10):696-8.)

The traditional process for teaching in a family medicine residency may not be the best choice for teaching students in a private office. Residency teaching has usually encouraged the faculty preceptor to stay in the "precepting office." The faculty is assigned from one to four residents who come to knock on the door. The faculty physician is "unencumbered" with patient care of their own. Teaching can be brief or in depth, but it takes place, primarily, out of the view of the patient.

I would like to introduce a different model of teaching—Patient Witnessed Precepting (PWP). Teaching medical students can be more effective and more rewarding, at least for me, if the teaching takes place directly in front of the patient. Our three-person office takes a student year round, and my partners still use the traditional model of having the student present in our faculty office before seeing the patient. My process is different. If the student starts to present I say, "Wait a minute, tell me when we get in the room."

PWP has also been called "exam room staffing" and "teaching in the patient's presence" (TIPP). There have been few objective evaluations on patient witnessed teaching, but the early research suggests a preference by patient and faculty[1] and a split decision as to the degree to which the learners like it.[2] The components of PWP are listed in Table 1.

Setting Expectations

The introduction to PWP occurs on the first day that I work with a student. I explain that I do all teaching in front of the patient. I introduce the student to the patient and ask them to take a history of the chief complaint and to do an appropriate physical examination. I tell them that I will double check all pertinent physical exam findings. I tell them I am happy to double check their "normals," and I must be told about all "abnormals," even if they aren't sure. I tell them that I may do parts of the physical exam while they are presenting the patient. I ask them to have an assessment and plan ready and that we will discuss this in front of, and with, the patient.

I go to see another patient while they are in the room. They can take their time, but I will interrupt if they take too long. If they finish before me, they can start writing the note. All of our students have access to our electronic health record. I tell them that I am willing to discuss almost anything in front of the patient but that they should tell me privately about any "loaded" history such as substance abuse, dangerous mental health symptoms, or possible abuse. We establish a code to leave the room, if needed. Lastly, I have them act as a "scribe" of the encounter for me in writing the note. They only record the things that we discuss together and the physical examination that I perform in the note. I double check and co-sign any note they write. I warn students that the temptation may be to write more, but the note must be a record of only what the licensed physician knows, says, and does.

Student Presentation

The process of teaching with the patient looking on is not so different from teaching done in your office. After greeting the patient I say something like, "You've already talked to Jeff, he's a third-year student getting pretty near to the end of his rotation, and he is going to tell me what he found out." The student presents the history, and I ask clarifying questions using the one-minute preceptor microskills steps.[3] I may not always get the order in exactly the way it was first described, but I stick to this process pretty faithfully.

There are several advantages in PWP. The patient can immediately fill in any gaps in the history. If there are any questions the student forgot to ask, we can turn directly to the patient. The patient learns from the teaching. Questions such as "Do you think this patient will benefit from antibiotics?" or "What options do we have to lower the blood pressure?" lead to a discussion that helps the patient to have a better understanding of their condition. In addition, the patient feels that they are an integral part of the process. The patient is reassured that their story has been accurately told and that you heard every word. The student writes the note. This saves some (maybe a lot of) time at the end of the day. The notes are usually specific and complete but still require me to do some editing.

Focus of the Encounter

The challenge of PWP is to keep your focus on the student when the student is presenting and to appropriately turn it to the patient when the teaching is done. It is easy to take over the encounter if the student has missed an important question. The key is to turn back to the student and resume teaching. I will say something like, "OK, now let's see what Jeff thinks is going on," to get back to the student.

I try to make sure that at some point I turn all my focus to the patient. It is often to make sure that they were

following the discussion. I used to worry that if we got into basic science or pharmacology they would be somehow annoyed, but that does not seem to dim their enthusiasm for this process at all. I still do the critical parts of the physical exam, and occasionally I perform parts of the exam that the student did not do. Patients appreciate that they have been examined by two physicians.

Summarizing the Plan

PWP does not diminish my standing with patients, if anything, I feel that they are more impressed with the fact that I am a teacher of medical students. A discussion of "Is this good control?" helps the patient put the state of their chronic medical condition into perspective. The follow-up question "What does she need to do to get her diabetes under excellent control?" can become a robust group discussion with the patient taking an active role. At times I give both the patient and the student an assignment based on the visit. I have even been known to give myself an assignment, to model lifelong learning.

Even patients with difficult or confusing problems can be included in PWP. I will occasionally describe my thinking about my toughest patients to the student in that patient's presence. It reaffirms (to the patient) that I have considered multiple possibilities and that I have done appropriate testing. To this point I have never had a student who came up with a clear answer that had stumped me, but that day may come, and it may be right in front of the patient. I am prepared for it, because these students are pretty bright.

If you have a student function as a scribe for your notes, you should have documentation in your office that attests to the process. (See Table 2.) This attestation should be signed and documented by every physician in the practice that uses PWP. Your organization's legal department (if you have one) may also want to have a look at this.

PWP has allowed me to see patients faster with students than without them. I have to spend some time reviewing their notes, but this is more than compensated for by the fact that they save me time doing the "scribing" first. Occasionally I have to send an e-mail to a student about an important change that I may have made in the documentation, and this gives good immediate feedback to the student. But the best reason for PWP is to bring the patient overtly into the teaching process. I can't prove its better care, but I am sure that it's more fun. You might want to give it a try.

Correspondence: Address correspondence to Dr Heaton, UMDNJ-New Jersey Medical School, De-partment of Family Medicine, Behavioral Health Science Building E 1559, 183 South Orange Avenue, Newark, NJ 07103. 973 -972-7828. Fax: 973-972-7997. heaton@umdnj.edu.

References

1. Petersen K, Rosenbaum ME, Kreiter CD, Thomas A, Vogelsang SA, Lawry GV. A randomized controlled study comparing educational outcomes of examination room versus conference room staffing. Teach Learn Med 2008;20(3):218-24.
2. Anderson RJ, Cyran E, Schilling L, et al. Outpatient case presentations in the confer-ence room versus examination room: results from two randomized controlled trials. Am J Med 2002;113(8):657-62.
3. Neher J, Stevens NG. The one-minute precep-tor: shaping the teaching conversation. Fam Med 2003;35 (6):391-3.

Table 1
Components of Patient
Witnessed Precepting

1. Set expectations.
2. Focus and respond to the student presentation.
3. Mindfulness of the patient.
4. Provide feedback and teaching to the student and the patient.
5. Wrap-up and summarize expectations.*The Teaching Physician 10* January 2010

Table 2
Documentation

"Medical students from — (University or Universities) — will see patients in this office and write a note in the medical chart that documents my direct activity with the patient. They will document only the components of the visit that are discussed and evaluated by myself. I review all medical documentation, and my signature attests to activity, evaluation, and discussion performed by myself."

RESIDENCY SITES CLASS OF 2010
3/18/2010

NAME LOCATION	PROGRAM
Armstrong, Lacey University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota	PSYCHIATRY
Blanchard, Miran University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota	TRANSITIONAL
Mayo School of Graduate Medical Education Rochester, Minnesota	RADIATION - ONCOLOGY
Bro, Nathan University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota	TRANSITIONAL
University of Utah Affiliated Hospital Salt Lake City, Utah	ANESTHESIOLOGY
Darveaux, Jared University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota	INTERNAL MED.
Dixon, Daniel Grand Rapids Medical Education and Research Center/Michigan State University Grand Rapids, Michigan	ORTHOPAEDIC SURGERY
Eaton, Mark Allina Family Residency Program St. Paul, Minnesota	FAMILY MEDICINE
Eken, Joshua University of Iowa Hospitals and Clinics Iowa City, Iowa	MED –PRELIM/ NEUROLOGY
University of Iowa Hospitals and Clinics Iowa City, Iowa	NEUROLOGY
Eklof, Jonathan University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota	TRANSITIONAL
Foster Weber, Tiffany University of Utah Affiliated Hospitals Salt Lake City, Utah	OBSTETRICS/ GYNECOLOGY
Gaddie, Todd Creighton - Nebraska Health Foundation Omaha, Nebraska	ORTHOPAEDIC SURGERY
Gardner, Katrina Sacred Heart Medical Center Spokane, Washington	FAMILY MEDICINE RURAL TRACK
Gorby, Ashley Indiana University School of Medicine Indianapolis, Indiana	PEDIATRICS
Gross, Justin Mayo School of Graduate Medical Education Rochester, Minnesota	SURGERY- PRELIMINARY
Gullicks, Donald University of Missouri Columbia Program Columbia, Missouri	OBSTETRICS/ GYNECOLOGY
Hagel, Ashley Hennepin County Medical Center Minneapolis, Minnesota	GENERAL SURGERY
Hanson, Chad University of Minnesota Medical School Minneapolis, Minnesota	RADIOLOGY- DIAGNOSTIC
Haus, Jason University of Michigan Ann Arbor, Michigan	ANESTHESIOLOGY
Hefty, Matthew Grand Rapids Medical Education and Research Center/Michigan State University Grand Rapids, Michigan	GENERAL SURGERY

Herman, Nathan
Creighton – Nebraska Health Foundation, Omaha, Nebraska — PSYCHIATRY

Hess, April
University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota — INTERNAL MED

Hoffert, Kyle
Mayo School of Graduate Medical Education, Rochester, Minnesota — FAMILY MEDICINE

Hoffman, Kelsey
Barnes-Jewish Hospital, St. Louis, Missouri — INTERNAL MED

Jallen, Stephanie
University of Florida COM-Shands Hospital, Gainesville, Florida — PSYCHIATRY

Johnson, Amanda
Tulane University School of Medicine, New Orleans, Louisiana — OBSTETRICS/ GYNECOLOGY

Johnson, Jennifer
Akron General Medical Center/ NEOUCOM, Akron, Ohio — OBSTETRICS/ GYNECOLOGY

Jones, Aaron
University of North Dakota School of Medicine and Health Sciences, Fargo, North Dakota — TRANSITIONAL

University of Iowa Hospitals and Clinics, Iowa City, Iowa — RADIOLOGY-DIAGNOSTIC

Kamlitz, Kendra
University of Kansas School of Medicine - Wichita, Wichita, Kansas — GENERAL SURGERY

Kingsley, Kathryn
Alaska Family Medicine/ Providence Hospital, Anchorage, Alaska — FAMILY MEDICINE

Koeck, Emily
Beth Israel Deaconess Medical Center, Boston, Massachusetts — GENERAL SURGERY

Krebsbach, Lacey
Grand Rapids Medical Education and Research Center/Michigan State University, Grand Rapids, Michigan — OBSTETRICS/ GYNECOLOGY

Lalich, Ian
Mayo School of Graduate Medical Education, Rochester, Minnesota — OTOLARYNGOLOGY

Lavik, Gillian
Mary Immogene Bassett, Cooperstown, New York — GENERAL SURGERY

LeBlanc, Justin
Intermountain Medical Center, Murray, Utah — TRANSITIONAL

Cleveland Clinic Foundation, Cleveland, Ohio — RADIOLOGY-DIAGNOSTIC

Leigh, Dustin
University of Nevada School of Medicine, Las Vegas, Nevada — GENERAL SURGERY

Lichter, Jessica
University of Washington Affiliated Hospitals, Seattle, Washington — PEDIATRICS

Martin, Erica
Gundersen Lutheran Medical Foundation, La Crosse, Wisconsin — TRANSITIONAL

Mayo School of Graduate Medical Education, Rochester, Minnesota — RADIOLOGY-DIAGNOSTIC

Mattson, Jocelyn
University of Iowa Hospitals and Clinics, Iowa City, Iowa — ANESTHESIOLOGY

Mayer, Sara
University of Minnesota Medical School, Minneapolis, Minnesota — **NEUROLOGY**

McLeod, Matthew
University of Minnesota/ Health East St. Joseph's Hospital
St. Paul, Minnesota
FAMILY MEDICINE

Miller, Megan
Grand Rapids Medical Education and Research Center/Michigan State University
Grand Rapids, Michigan
OBSTETRICS/ GYNECOLOGY

Morgan, Daniel
University of Kansas School of Medicine – Wichita Wesley Program
Wichita, Kansas
FAMILY MEDICINE

Mullally, Jennifer
Mayo School of Graduate Medical Education
Rochester, Minnesota
PEDIATRICS

Nelson, Jeffrey
University of Minnesota/ St. John's Hospital
St. Paul, Minnesota
FAMILY MEDICINE

Ott, Rachel
Hennepin County Medical Center
Minneapolis, Minnesota
GENERAL SURGERY

Parker, Mahate
University of Oklahoma College of Medicine - Tulsa
Tulsa, Oklahoma
OSTETRICS/ GYNECOLOGY

Redig, Rachel
Grand Rapids Medical Education and Research Center/Michigan State University
Grand Rapids, Michigan
EMERGENCY MEDICINE

Rios, Rodrigo
Children's Mercy Hospital
Kansas City, Missouri
PEDIATRICS

Sabb, Kris
Northridge Hospital Medical Center Program
Northridge, California
FAMILY MEDICINE

Singh, Priyanka
University of North Dakota School of Medicine and Health Sciences
Fargo, North Dakota
PSYCHIATRY

Sollin, Tracy
University of Arizona Affiliated Hospitals
Tucson, Arizona
PATHOLOGY

Stevens, Patrick
University of Connecticut Health Center
Farmington, Connecticut
OTOLARYNGOLOGY

Tobiasz, Ana
Grand Rapids Medical Education and Research Center/Michigan State University
Grand Rapids, Michigan
OBSTETRICS/ GYNECOLOGY

Van Alstine, Luke
Mayo School of Graduate Medical Education
Rochester, Minnesota
ANESTHESIOLOGY

Van Ningen, Aaron
University of Wisconsin Hospital and Clinics, Madison, Wisconsin
PEDIATRICS

Wellman, Stacie
Idaho State University
Pocatello, Idaho
FAMILY MEDICINE

GRADUATES:

DeFoe, Adam
Creighton University School of Medicine
Omaha, Nebraska
RADIOLOGY-DIAGNOSTIC

Glynn, Alicia
Case Western Reserve University (Metro Health) Program
Cleveland, Ohio
EMERGENCY MEDICINE

Holmes, Janalee
Cleveland Clinic
Cleveland, Ohio
OTOLARYNGOLOGY

Faculty Position - Family Medicine physician faculty position. We are recruiting for a full-time Faculty member who is ABFM certified or eligible. The chosen applicant will be an Assistant or Associate (depending upon experience) Director in a fully accredited, 15 resident, university administered, community-based family medicine residency program in Minot, North Dakota.

The successful applicant will be expected to participate in clinical care, teaching, and scholarly activity. Competitive salary and benefit package for the right candidate. Send a letter of interest with CV and 3 letters of recommendation to Robert W. Beattie, M.D., Chair, Department of Family & Community Medicine, University of North Dakota School of Medicine and Health Sciences, 501 N. Columbia Road, Stop 9037, Grand Forks, ND 58202-9037 email: beattie@medicine.nodak.edu fax: 701-777-3849 call: 701-777-3200. **UND is an equal opportunity affirmative action employer.**

Program Director – The University of North Dakota Center for Family Medicine-Bismarck is seeking a Program Director to lead a FM residency program with an emphasis on rural family medicine. The applicant must be an ABFM certified family physician with experience in residency education and administration. Academic rank commensurate with experience. The program is a fully accredited 5-5-5 program located in the upper Great Plains. Please send letter of interest, CV, and 3 letters of recommendation to Robert W. Beattie, MD, Chair, Department of Family & Community Medicine University of North Dakota School of Medicine and Health Sciences, 501 N Columbia Road, P.O. Box 9037, Grand Forks, ND 58202-9037 email: beattie@medicine.nodak.edu fax: 701-777-3849 call:701-777-3200. UND is an EO/AA employer.

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