SPOTLIGHT ON INFECTIOUS DISEASE

The URI, Still a Challenge
Pets and Zoonotic Infection: Understanding the Risks
Dermatologic Sequelae of Infectious Disease - Viruses

ALSO...
- On the Road to Transformation to a Patient Centered Medical Home
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Farewell, Thanks…
And Keep Up The Good Fight!

Even though we sometimes feel that we are under siege, I still believe in my heart that each one of us does a great service to our patients, state and country.

AS MY TERM AS MAFP PRESIDENT

comes to a close, I've been thinking about events over the last two years since I was installed as President in Annapolis. It has been a whirlwind and I've truly enjoyed every moment of my term. I've had the opportunity to increase my understanding of issues affecting family docs throughout the Nation, not just in Maryland. I've had the good fortune to meet and befriend my counterparts from different State Chapters. I've also met many of our constituent members in Maryland. I have to say that I've learned so much from everyone and I think it will help me in my post-presidential career.

I am truly grateful to the members of our Board and to the staff at the Maryland AFP. We have a wonderfully dedicated group of people on the Board. Their energy and devotion to the membership is what makes this Academy a very strong one. Our staff does an exceptional job at handling the day to day operations and keeping the Board apprised of the issues. The Nominating Committee has proposed a slate of great candidates (see p. 26), many of whom are new to the Board. We should be excited about what lies ahead. My successor, Dr. Yvette Oquendo will bring great enthusiasm to the presidency. I have enjoyed working closely with her over the last 2 years.

While I have great optimism for our Academy and for the future of Family Medicine, there are a few things that I feel require persistent diligence. Over the last couple years, I have expressed my concern about potential threats to our specialty. One obvious threat comes from the insurers and government. I don’t think any of us feel they have our best interest at heart, however, we must continue to watch out for assaults on our specialty. The best way to do this is to work with each other and our Academy. DO NOT BECOME COMPLACENT! We have a strong organization that has a strong voice in Annapolis and Washington. We must continue to use that voice to make ourselves heard!

My greatest concern, however, is the erosion of Family Medicine from “within.” What I mean by this is the increasing incidence of practicing only outpatient medicine, urgent care or not doing procedures. By becoming “referalists,” “outpatientists” or hospitalists, we are allowing our specialty to erode. Our subspecialty colleagues enjoyed working closely with her over the last 2 years.

While I have great optimism for our Academy and for the future of Family Medicine, there are a few things that I feel require persistent diligence. Over the last couple years, I have expressed my concern about potential threats to our specialty. One obvious threat comes from the insurers and government. I don’t think any of us feel they have our best interest at heart, however, we must continue to watch out for assaults on our specialty. The best way to do this is to work with each other and our Academy. DO NOT BECOME COMPLACENT! We have a strong organization that has a strong voice in Annapolis and Washington. We must continue to use that voice to make ourselves heard!

My greatest concern, however, is the erosion of Family Medicine from “within.” What I mean by this is the increase in the number of family physicians who are not doing what they were trained to do. By this, I refer to the increasing incidence of practicing only outpatient medicine, urgent care or not doing procedures. By becoming “referalists,” “outpatientists” or hospitalists, we are allowing our specialty to erode. Our subspecialty colleagues

Eugene J. Newmier, D.O.
and, more importantly, the insurers and Government will think that we are no different from Mid level providers. Nurse practitioners have been telling insurers and the Government that they can provide primary care at the same level in a less expensive manner for quite some time. As the need for more family physicians in Maryland increases, the mid-levels are positioning themselves to “fill the gap.” My concern is that the Government will eventually decide they are right. If we do not distinguish ourselves, then our specialty will be in serious trouble. I can foresee a time in the future when insurers, employers and the Government will develop a model where a small group of physicians will oversee a larger group of mid-levels who provide the bulk of primary care. If we, as a group, do not continue to see our patients in the hospital and do what we are trained to do, then we are no different from a mid-level who refers to the hospitalist. Conversely, if we continue to go into urgent care or hospitalist work, then the continuity of care that is the hallmark of Family Medicine will erode. If that happens, then the foundation of our health care system will crumble.

A word of warning to our residents who are reluctant to go into private practice because they would prefer an employed, 9-5 job. Watch out, there may come a time when jobs become scarce because a managed care group or hospital run group realizes that a nurse practitioner can see as many patients in a day at ½ the salary of a fresh graduate from residency. The older, more experienced docs could see the same threat as employers use the same model and eliminate the older doc who doesn’t meet a daily “quota” of patients. Part of the reason that we find ourselves in our current health care situation is because we did not speak up or defend ourselves in the past. I would beseech each member to become active with the AAFP and the MAFP. Our Academy is in great shape but we need YOU to keep it so!

I hope my words in these columns have given you food for thought. Even though we sometimes feel that we are under siege, I still believe in my heart that each one of us does a great service to our patients, state and country. As I finish my term, I would like to thank one more group for trusting me to lead the Academy over the last two years. Thanks to our MAFP members. I have appreciated your letters, emails and calls during my term. I hope that you, your families, patients and practices continue to thrive. Best Wishes to all of you! Auf Wiedersehen!

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“THE TIME HAS COME to close the book on infectious diseases.” There is debate as to whether this quote is accurately attributed to former US Surgeon General, William Stewart in 1967. However, as any family physician can attest, our war against infectious disease continues on.

Mankind’s battle with infectious agents dates back to centuries ago. The Black Death (Bubonic Plague) in the 14th century led to the death of over a third of the European population. Despite all efforts and strategies, this epidemic was not quelled. It maintained its impact on society until the 16th century, when cases decreased. Additional pandemics followed. Yellow fever outbreaks were common in the US and southern Europe in the 18th and 19th centuries and the disease currently remains active in Africa and Latin America. According to the World Health Organization (WHO), yellow fever infections total 200,000 cases a year and 30,000 deaths annually.

The 21st century has also seen its share of pandemics. In 2009, the H1N1 pandemic impacted countries throughout the world. According to WHO, in 2009, there were over 500,000 cases of H1N1 infection and over 11,000 deaths. This estimate is felt to be low, as many countries failed to consistently report cases and mild cases were not reported. Haiti in the last 2 years has been ravaged by an ongoing cholera epidemic. Recent CDC statistics note over 470,000 cases and 6,631 deaths. Indeed, our battle against these infectious agents is never-ending. The book on infectious diseases is not closed. However, we are making progress.

Advances in vaccines and drugs have led to a reduction of many infectious diseases. We only need to look at the impact of the use of vaccines on smallpox and polio prevalence. At the same time, the need for continual vigilance persists. Despite the availability of a measles vaccine, the year 2011 was a particularly active year for measles infections. There were over 100,000 cases in Africa, over 26,000 cases in Europe, over 700 cases in Canada and over 200 cases in the U.S.

So the spotlight is on Infectious Diseases. It is an appropriate topic as this important area of medicine makes up a significant component of our medical encounters. The presentations are diverse – for example, the common cold, gastroenteritis, sexually transmitted diseases, urological infections and various skin infections. It is important that the physician remains abreast of the most current approaches to prevent and effectively manage the myriad of infectious diseases.

In this edition of Maryland Family Doctor, our authors will provide practical information to help you in your day to day practice. Dr. William Sonnenberg reviews the challenges in treating the upper respiratory tract infection. In their article, Drs. Lefkowitz, Conti and Rabinowitz provide a comprehensive overview on pet-related infections. Finally, our Resident Editor, Dr. Ryane Edmonds gives an update on the dermatologic sequela of viruses. I am hopeful that these articles will not only educate you but also serve as a reminder that the book on infectious diseases is most definitely open and we should remember prevention is often the best approach to limit many infectious diseases.

Note: references for this article are posted at www.mdafp.org; publications and news tab.
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IN LATE JANUARY I got a call from Dr. Dean Griffin (MAFP President 1984) informing me of the passing of Dr. William Stewart, a prominent figure in the history of Family Medicine who was the first Chairman of the University of Maryland Department of Family Medicine and President of MAFP in 1969. I was sorry to hear the news. I have heard Dr. Stewart’s name come up through the years, when the early days of the specialty are still oftentimes discussed. His contemporary and colleague, Dr. J. Roy Guyther (also a pioneer in the specialty) wrote of Dr. Stewart’s contributions in his article “History of the Department,” appearing in the Special Supplement to this publication (Fall, 2007) marking the 35th Anniversary of the University of Maryland Department of Family and Community Medicine (see p. 29 for an update on Dr. Guyther’s current activities).

Drs. Griffin and Stewart were colleagues in Westminster, remaining in touch after Dr. Stewart left Maryland. Dr. Griffin gave me the contact information in Colorado for Dr. Stewart’s daughter Cindy Murphy. I contacted her to gather information for this column, the intent of which is to honor his memory and to acknowledge his continuing legacy. The following is an abridged version of the obituary which she wrote for The Carroll County Times.

William L. Stewart, M.D., formerly of Westminster, MD, and recently of Highlands Ranch, CO, died November 18, 2011. Born in Baltimore in 1925, Dr. Stewart was the son of Charles Wilbur Stewart, M.D. and Elsie Hendrix Stewart. He was married to Esther (Penny) Evans Stewart of Westminster, his beloved wife of 58 years, who died in 2008.

William Stewart, who graduated with his M.D. from Johns Hopkins in 1951, was one of the pioneers in the establishment of Family Practice as a medical specialty. He built up a general practice in Westminster from 1952 through 1968 with a couple of years spent as a Captain in the U.S. Army Medical Corps’ Occupational Health Laboratory in Edgewood, MD. He recognized that the medical schools in Maryland were not graduating enough general practitioners to meet the state’s needs and approached the State Legislature about the problem. As a result, he was asked to serve as the first Head of the Division of Family Medicine at the University of Maryland School of Medicine. In 1971, he left Maryland for the opportunity to help build a new medical school from the ground up at Southern Illinois University School of Medicine in Springfield, IL. He served as Professor and Chairman of that Department of Family Practice for almost a decade and implemented many innovative teaching techniques for medical students interested in becoming Family Physicians. Dr. Stewart retired in 1991 as the Chairman of the Dept. of Community Health and Family Medicine at the University of Florida College of Medicine. When he retired, he continued to volunteer in a free clinic for several years.

Over the course of his career, Dr. Stewart was a member of dozens of medical societies, residency review committees, editorial review boards and foundations and wrote numerous articles and speeches – all with the goals of attracting more students and promoting the
highest standards for the education of family physicians. He was awarded the Thomas W. Johnson Award for Outstanding Family Practice Educator of the Year in 1978 by the American Academy of Family Physicians.

Surviving are his daughters and sons-in-law Cindy Stewart Murphy and Keith Schrum of Highlands Ranch, CO and Erin Stewart and Curtis Martin of Bothell, WA, as well as granddaughter Erica Murphy Jones of Columbus, OH.

I’ll Show You a Green Horse

While Dad was a medical student at Johns Hopkins, he was stumped by a question on an exam. He wrote on the examination paper, “If you can show me one practicing doctor in a thousand who can answer this question, I’ll show you a green horse.” Dad’s medical school buddies were sure he’d be thrown out of Hopkins for the remark. Instead, the professor wrote back, “Stewart - you’ve now shown us a horse’s ass.” Dad’s medical school friends got such a kick out of this that for the rest of his life, whenever one of them saw a green horse in a gift shop, they’d buy it and send it to Dad! We even have a few green elephants and green dogs that were sent. Dad kept his green horse collection and I made sure that it went with him at the assisted living facilities where he lived after developing Parkinson’s Disease. The collection (probably about 25 horses of all sizes and materials) was a great conversation starter and Dad never tired of telling the story behind it!
Even though the viral URI is seldom a cause of morbidity or mortality, the typical patient will spend five years of life suffering from the common cold and one year bedridden. This common problem is responsible for 40% of lost time from work and 100 million office visits per year. The child in kindergarten can get up to twelve colds per year and the adolescent and adult will get seven. Women get more colds than men, but less if they work outside the house.

Colds are mostly spread by hand to hand contact i.e. touching nose then touching someone else. Coughing and sneezing are poor ways to spread a cold. Patients are most infective during early symptoms. Risks for cold include poor nutrition, especially low vitamin D, crowding, day care, poor sleep, and low humidity. Heavy exercise seems to be a risk factor while moderate exercise is helpful. Smoking can extend the duration of a cold by 3 days. Smoking should be decreased or stopped. Moderate exercise is allowable. Humidification via vaporizer or humidifer is beneficial. There may be a modest benefit to vitamin D levels and the common cold.

The virus enters the victim through the nose or eyes by touching. It then replicates in the nasal epithelial cells. Damage to the mucosa is slight; most of the symptoms are caused by the immune response. Bradykinin produces local symptoms including sore throat, nasal congestion, watery eyes and cough. Cytokines cause systemic symptoms like chills and fever, headache, fatigue, malaise, anorexia, nausea and depression. Nearly all the symptoms of the common cold come from the immune response rather than the virus itself.

Rhinovirus causes 50% of colds and 90% of colds in the fall. There is a large amount of antigenic types, thus large number of reinfections. Rhinovirus replicates best at 33° to 35°C which is a little cooler than core body temperature. Thus it seldom goes into the lower respiratory tract. It can withstand drying on the skin and a variety of temperatures. Other viral causes include adenovirus, parainfluenza, RSV, human metapneumovirus, and bocavirus.

Methods to prevent the spread of colds include healthy diet, low stress, frequent hand washing and disinfecting surfaces. Special antimicrobial soaps do not appear to be better than plain soap. Increasing fluids is routine advice to help fever, loosen mucus and correct fluid loss but the Cochrane fails to show a benefit. Lately it seems that there is little that vitamin D can’t do, and the common cold is no exception. A study in 2009 looked at almost 19,000 participants comparing number of URI’s versus serum vitamin D levels. Results were adjusted for BMI smoking, asthma and COPD. Exercise has variable benefits with URI’s. Moderate exercise has been shown to result in a 50% reduction in sick days and 30% fewer URI’s. Exhaustive exercise seems to suppress immunity and increase severity and frequency of infections.

Treatment of the URI has shown little changes over the years. There is no need to withhold dairy products. Smoking should be decreased or stopped. Moderate exercise is allowable. Humidification via vaporizer or humidifer is beneficial. There may be a modest benefit to vitamin D levels and the common cold.
dextromethorphan and antihistamine/decongestant combinations. Non-sedating antihistamines are ineffective. There is no effective medication treatment for coughs in children. The FDA recently issued a warning to stop the use of cough and cold preparations in children under 4. It was noted that there were 123 pediatric deaths between 1969 and 2006 due to decongestants and antihistamines without a benefit.

Half of pediatricians recommend alternating ibuprofen with acetaminophen for fever reduction. This advice is given in spite of no evidence for faster nor greater effect. There is no safety assurances for the combination. The dosing schedule is also confusing with dosing of either every 4 or 6 hours.

Since conventional treatment options for the common cold fail to impress, patients often resort to complimentary medicines. $300 million per year is spent on Echinacea. It is claimed to help WBC function. One study tested 3 different preparations on 437 volunteers exposed to rhinovirus type 39. There was no difference in secretion volume, PMN’s, interleukin-8, nor viral titers. Zinc is suggested and did show a benefit in a trial in 1984, but subsequent trials failed to show benefit. There was a concern over financial bias.

The common cold is a uniquely human affliction. Higher primates such as chimps can be infected but they don’t even have an increase in mucous production. This lack of an animal model is part of the research problem. In some respect, little has advanced since the time of Benjamin Franklin who said, “People often catch cold from one another when shut up together in small close rooms, coaches, etc. and when sitting near and conversing so as to breathe in each other’s transpiration.”

Dr. Sonnenberg is a family physician in private practice in Titusville, PA. He is the current Vice President of the Pennsylvania Academy of Family Physicians.

Note: references for this article are posted at www.mdafp.org; publications and news tab.
While most emerging infectious diseases are zoonotic (shared between animals and people) in origin, you don’t have to travel to exotic locations to contract zoonoses. If precautions are not taken, the family dog or cat as well as other household pets can be a source of human exposure for a wide range of zoonotic pathogens (Rabinowitz and Conti). More than 50% of US households have a cat, dog, or other pet. Therefore, when a physician is caring for a family, it is more likely than not that the family includes at least one pet. The timely diagnosis, treatment, and most importantly, prevention of the broad range of pet-related zoonotic disease all require awareness on the part of the family physician. At the same time, physicians must keep in mind that the psychosocial benefits of owning pets and the “human animal bond” are thought to outweigh the risks of pet-related zoonotic infection in most cases (Friedman). This article will review characteristics of pet associated zoonoses. In addition, simple measures such as handwashing and proper disposal of pet feces can reduce risk.

**Internal and External Parasitic infections**

Common pet-related infections are due to internal and external parasites. Perhaps the most well known pet-related parasitic infection is toxoplasmosis, caused by *T. gondii*. The parasite undergoes sexual reproduction in cats and is fecally excreted as oocysts by newly infected cats. The oocysts become infective to other animals after one to five days, therefore promptly disposing cat feces reduces infection risk. While contact with cat feces is a risk factor for human infection, perhaps a more important risk factor is eating undercooked meat (source 17 from original article). Dogs may serve as mechanical vectors of toxoplasmosis due to rolling in cat feces. The oocysts become infective to other animals after one to five days, therefore promptly disposing cat feces reduces infection risk. While contact with cat feces is a risk factor for human infection, perhaps a more important risk factor is eating undercooked meat (source 17 from original article). Dogs may serve as mechanical vectors of toxoplasmosis due to rolling in cat feces. Acute human infection in adults is usually either asymptomatic or a self-limited mononucleosis-like illness. Immunocompromised individuals are at risk of more severe infection with neurological complications. If a previously unexposed woman is infected during pregnancy, the fetus can develop congenital toxoplasmosis with serious developmental defects. Other notable parasitic infections from household animals include toxocariasis/ocular or visceral larval migrants (roundworm, from dogs, cats) leading to cases of preventable blindness in children or a factor in asthma (Hotetz et al), cutaneous larvae migrants (hookworm, from dogs, cats), and echinococcosis (tapeworms, from dogs). It is equally important to be aware of infections that are not zoonotic but often erroneously attributed to pets; an example is pinworm infection due to (*Enterobius spp*; dogs and cats are not carriers of this roundworm).

**Scabies mites** have adapted to different species, and while dogs can infect humans with *S. scabiei canis*, usually such zoonotic scabies infections resolve spontaneously as the mites fail to reproduce on the human host. Ticks may enter a house on a dog or a cat, and removing a tick from an animal is a risk factor for infection with Lyme disease, Rocky Mountain Spotted fever or other tickborne disease. Flea infestation on cats has been a risk factor for transmission of Cat Scratch disease (Klotz) as well as plague to nearby humans.

**Bacterial infections**

The most common bacterial disease related to pet ownership is probably gastroenteritis due to campylobacter (from cats and dogs) and salmonellosis (from reptiles, ducklings, chicks, cats, and dogs) infection. Other bacterial zoonoses from pets include leptospirosis (from dogs, cats, multiple others), Chlamyphila pneumonia (psittacosis) (birds), brucellosis (breeding dogs) and rat bite fever (streptobacillus) (rodents). Fish aquaria can be a source
of infection with *M. marinum*. In plague-endemic areas, infected cats have been reported to have passed the infection to humans. Dogs and cats can be colonized with Methicillin resistant Staphylococcus aureus (MRSA), and transmission of MRSA can occur between humans and pets. (Manian)(Bender et al)(Morris et al).

**Fungal infections**

Fungal dermatophytosis (ringworm) is one of the most common pet-related infections. There are an estimated 2 million human cases per year caused by exposure to animals, especially dogs and cats which may or may not have associated lesions (Stehr).

**Viral infections**

While rabies is rare among vaccinated US dogs and cats, cat cases outnumber dog cases and both pose a risk to humans. Other pet-associated viral zoonoses include lymphocytic choriomeningitis virus (from pet rodents such as hamsters, guinea pigs, and mice) which can cause fatal disease in immunocompromised individuals. Pet rodents have been sources of human cases of monkeypox and cowpox (Nivone, Campe). During the H1N1 influenza pandemic, household cats and ferrets became infected with the flu, apparently by humans (“reverse zoonosis”), but transmission from pets to humans has not been reported.(Campagnolo et al, Swenson et al)

**Key Points in the History**

- Many pet-related infections go undiagnosed or unreported. To detect pet-related infections, the physician must carry a high index of suspicion. One way is to ask questions about the patient’s exposure to and health of these animals as part of the medical history, especially for a patient with fever, respiratory or diarrheal disease. Red flags in the history include the patients’ exposure to high risk pets such as kittens, puppies, ducklings, chicks, reptiles, or other exotic animals, immunocompromised pets, or pets with diarrhea or acute respiratory infection.
- Exotic pets carry increased risk of exotic pathogens, an example being a recent outbreak of monkeypox in the Midwest traced to imported African rodents. Wild animals kept as pets may as pets may pose a greater infection risk.
- Pets that roam outdoors may have greater contact with wildlife and the pathogens they carry.
- People at increased risk of zoonotic infection include infants and small children, elderly, and immunocompromised persons.
- Not surprisingly, the particular habits of pet ownership may play a pivotal role governing transmission of pet pathogens. Sleeping with pets has been linked to cases of the plague, cat-scratch disease, and Chagas disease (Chomel). Close animal contact, including biting, scratching, licking, and kissing, has resulted in transmission and infection from *Capnocytophaga canimorsus* (Valtonen), lymphocytic choriomeningitis and *Pasteurella* spp (Kimura).

**Prevention**

Prevention of zoonotic infections have been outlined in consensus guidelines (CDC 1, CDC 2), and include routine veterinary care for all pets, hand-washing, proper hygiene in disposal of animal waste, appropriate diet for the pets, and timely treatment for diseased pets. Specific recommendations for all patients include hand-washing after handling pets and pet dishes, and avoiding contact with animal feces and vomitus through proper disposal. Infants and children younger than age 5, older individuals, the immunocompromised, and pregnant women should avoid puppies and kittens younger than six months, baby chicks and ducklings, reptiles, and pets with diarrhea. Pregnant women should avoid handling cat litter, keep cats indoors, and not feed cats uncooked meat to reduce the risk of toxoplasmosis.

**One Health**

There is a growing awareness of linkages between the health of humans, animals, and their environment. The concept of “One Health” stresses the need for close collaboration and communication between human health providers and veterinarians to prevent zoonotic infections and balance the risks of infection with the positive benefits of pet ownership (Rabinowitz and Conti). Public health practitioners can help inform these collaborations. Ensuring pets receive regular preventive veterinary care including de-worming and vaccinations is a key part of reducing zoonotic risk.

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**Note:** references for this article are posted at www.mdafp.org; publications and news tab.
Viruses are everywhere! These infections present in many different ways. Some of them are visible. In this article we will discuss some of the top dermatologic infections caused by viruses, their prevalence, pathophysiology, signs & symptoms, diagnosis and treatment. Some are quite contagious, some are dangerous, and some are just irritating. Let’s talk about what to do when our patients present with them.

**Herpes Simplex Viruses**

Herpes simplex virus (HSV) is typically a mucocutanous infection affecting the orofacial areas (HSV-1) and genital areas (HSV-2). Lesions are typically painful and self limited. They may present as small grouped vesicles on an erythematous base and can be recurrent. Approximately 80% of the population has antibodies to HSV-1 and HSV-2 causes genital ulcerations in up to 50% of sexually active people. Infection of the virus is caused by direct contact of mucosal sites or areas of abrasion on the skin. The virus can remain dormant and become active during periods of illness, stress, menses, etc.

Oral mucocutaneous lesions present as acute herpetic gingivostomatitis and herpes labialis. Children are generally affected by the former displaying vesicles, erosions, and erythema of the lips, tongue, buccal mucosa, and/ or palate. Common symptoms of viral syndromes may be associated, such as cervical adenopathy, fever, malaise and myalgias.

The terms cold sores or fever blisters refer to Herpes labialis and characterize reactivated HSV-1. They are demonstrated as grouped vesicles on erythematous denuded skin, usually the vermilion border of the lip. Genital herpes infections, HSV-2, appear as erosions or ulcers on the external genitalia occurring 7 to 10 days after primary exposure. This rarely presents as intact vesicles. Patients affected commonly have recurrent genital disease (40%). Both herpes labialis and genital herpes infections can have preceding prodromal symptoms of pain, burning, or itching prior to outbreaks.

Experienced clinicians can usually properly diagnose these infections by visual examinations, however there are confirmatory tests. Only primary infections may be confirmed by serology. A viral culture can help to confirm the diagnosis. The direct fluorescent antibody (DFA) is less specific test but useful. The Tzanck smear can be valuable in the rapid diagnosis of herpes virus infections, but it is less sensitive than culture and DFA.

The gold standard of HSV treatment is Acyclovir; however other antivirals, such as famciclovir and valacyclovir, are also quite effective. Suppressive treatment is warranted, for patients with recurrent infections (more than six episodes per year). Immunosuppressed individuals with severe disease or complications require weight based treatment with Acyclovir 10 mg/kg IV every 8 hours for 7 days. Table one demonstrates other treatment options.

**Herpes Zoster**

**Definition and Etiology**

Herpes zoster, commonly known as shingles, can affect up to 10% to 20% of adults. Underlying immunosuppression is common and the virus presents as an acute, painful dermatitis in a dermatomal pattern.

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>ACYCLOVIR</th>
<th>FAMCICLOVIR</th>
<th>VALACYCLOVIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary HSV</td>
<td>200 mg PO 5x/day or 400 mg PO tid for 10 days</td>
<td>500 mg PO bid or 250 mg PO tid for 7 days</td>
<td>1 g PO bid for 10 days</td>
</tr>
<tr>
<td>Recurrent HSV</td>
<td>400 mg PO tid for 5 days</td>
<td>750 mg PO bid for 1 day</td>
<td>2 g PO bid for 1 day</td>
</tr>
<tr>
<td>Recurrent HSV</td>
<td>400 mg PO bid</td>
<td>250 mg PO bid</td>
<td>1 g PO or 500 mg PO qd</td>
</tr>
</tbody>
</table>
In Herpes Zoster, the varicella virus initially invades the skin or mucosal surfaces and travels to the sensory ganglia, lying dormant for the lifetime of the patient. Trauma, surgery of the spine, radiation therapy, stress, and immunosuppression can all lead to its reactivation and presentation as a dermatomal dermatitis. This primarily affects adults. It begins as pain and paraesthias in a dermatomal pattern followed by grouped vesicles in the same area days later. Patients may have some viral prodrome of malaise and fever but this is not typical. About 50% of cases present in thoracic level dermatomes but it can present at any level. Symptomatic treatment of pain and dysesthesia is the norm. Immunocompromised patients may actually have disseminated zoster. It’s less common in the immunocompetent. A good physical exam is appropriate to diagnose Herpes zoster but it can be confirmed with an HSV viral culture or direct fluorescent antibody. If it’s caught by a physician within 24-72 hours of its onset, antiviral therapy is warranted. Outside of that, rest, pain management, and warm compresses should be used. Disseminated Herpes Zoster and Ophthalmic Zoster must be treated with IV acyclovir.

### TABLE 2: TREATMENT OF HERPES ZOSTER

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>ACICLOVIR</th>
<th>FAMCICLOVIR</th>
<th>VALACLOVIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herpes zoster</td>
<td>800 mg 5x/day x 7-10 days</td>
<td>500 mg tid x 7 days</td>
<td>1 g tid x 7 days</td>
</tr>
<tr>
<td>Disseminated zoster</td>
<td>10 mg/kg IV q8hr x7 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Herpes zoster,** commonly known as shingles, can affect up to 10% to 20% of adults. Underlying immunosuppression is common and the virus presents as an acute, painful dermatitis in a dermatomal pattern.

### Warts

**Definition and Etiology**

Human papillomavirus virus (HPV) is the virus that causes Warts. As you know, it’s also the virus that causes cervical cancer, but that is another discussion. Warts are common and typically benign, affecting 10% of the population. This virus is easily spread by casual touching or sexual contact (anogenital warts). Direct contact through broken epidermis facilitates inoculation of the infection, which may take anywhere from 2-9 months to emerge. Those who are immunocompromised can develop persistent fulminant warts evident on physical exam.

There are over 100 different HPV strains and many other diseases occur due to this infection. Greater than 30 strains are sexually transmitted, making HPV the most common sexually transmitted disease. Regarding warts, the common wart (verruca vulgaris), and the most common type, **continued on page 18**
The treatment of warts is quite variable and frequently challenging. Destruction is the most common approach. Methods include: cryosurgery, electrosiccation, curettage, and application of topical medications such as trichloroacetic acid, salicylic acid, topical 5-fluorouracil, podophyllin, and cantharidin. One very useful, non medical therapy, is actually the use of duct tape. It’s an old wives tale, but it works. More stubborn warts may warrant treatment with laser therapy, injection with candidate antigen, or imiquimod cream (Aldara- an immunomodulator). Aldara is proven to treat condyloma acuminatum, and some clinicians have see it’s beneficial effects as an adjunctive therapy with common warts.

There are not any documented methods to prevent common wart transmission. Genital wart transmission is associated with the number of sexual partners. Gardisil Vaccine is the newest approach to preventing genital warts (and cervical cancer in women). Available since 2006, it is safe and recommended as a 3 part vaccine for males and females ages 9-26.

**Molluscum Contagiosum**

The Poxvirus causes Molluscum contagiosum. It’s common in children, especially those with atopic dermatitis, sexually active adults, and patients with human immunodeficiency virus (HIV) infection. Prevalence is about 5%. Transmission is facilitated via direct skin contact, mucous membrane contact, or via fomites (inanimate objects or substances capable of carrying infectious organisms). Once contact is made by the virus, it will replicate in cell cytoplasm, inducing herperplasia, and forming its distinctive appearing lesion. Classically, it appears as a pink, or flesh-tone, dome-shaped, umbilicated papule with a central keratotic plug. The intertriginous sites; axillae, popliteal fossae, and the groin, are the most common sites of infection. Again, like the other viral dermatologic infection, clinical presentation and/or biopsy are diagnostic. Resolution is typically spontaneous; however, immunocompromised patients may have persistent infection. The treatment modalities are similar to that of warts, cryosurgery and curettage being the most effective. Children can be treated with topical cantharidin, which is very effective and well tolerated.

So, as you can see, the viral form of infectious disease can affect the skin in many different ways. Fortunately, we can diagnose them with a good history and physical exam. Treatment modalities are variable so it’s important than we properly recognize and diagnose these illnesses. Always think of immunosuppression in those who present uncommonly or in extremely difficult to treat patients. As family physicians, we treat the whole body. Remember to always, think of diabetes, HIV, cancer, and other ailments that may be associated with your patient’s dermatologic presentation.

Dr. Edmonds is a PGY-II at the University of Maryland Family Medicine Residency. This is her 2nd clinical article for The Maryland Family Doctor publication.
On The Road to Transformation to a Patient Centered Medical Home

Niharika Khanna, MBSS, M.D., DGO

On the road with the Maryland Learning Collaborative Practice Transformation Coaches to visit a practice in a rural community that is transforming to a patient centered medical home, we drive through tree lined narrow lanes. The homes are small, scrubbed clean porches, neat front yards, lots of trucks and potholes in the driveways. Crossing a large transformer station we reach a small, single story, brick building that is labeled ‘Medical Practice’. It is 7:30 am, the door is open and the sign says, ‘OPEN’. We walk through the door to a brightly lighted clinical space; we realize immediately that this is a very special practice. There are two family physicians and two staff members who care for the rural community that surrounds them. The community is aging and there is increasingly higher utilization of the practice and a lot of admissions to surrounding hospitals. Sometimes the hospitals inform the primary care physicians about the care that was rendered; sometimes there is no communication whatsoever. Every visit by a patient to their practice becomes a fact finding mission for the staff and the physicians as they try to piece together what happened at any specialty consultations, hospitalizations and new events that have relevance to bio-psychosocial functioning of their patients. The family practitioners are convinced that they are providing excellent medical care. From the patient and staff picture on the walls, the evidence from the practice; we agree. Is there a vulnerability in this practice to the winds of change; or could it be that there is a health system that needs to change its values to recognize true everyday heroes in our society? What would happen if we allow a practice like this to close because they just cannot afford to keep their doors open? How would we measure this loss: in human terms, in statistical terms, in quality assurance terms or, will we say there is no measure and let this one go? In this practice, we know that practice transformation using the coaching/learning collaborative model is not only impossible and unsustainable; but there may be minimal practice reserves that can tolerate this change. There is clearly a need for additional resources if transformation is to occur, and there may be a need to re-visit our measures of success to map the change that this practice undergoes towards becoming a patient centered medical home.

In response to the national movement towards newer and advanced models of healthcare, the patient centered medical home model was selected by the State of Maryland as its building block towards achieving higher quality patient centered care, improved population health and to moderate per capita costs. The Maryland Healthcare Commission (MHCC) and Community Health Resource Commission (CHRC) jointly supported the creation of the Maryland Learning Collaborative (MLC) to educate, advise and consult for 53 primary care practices in their transformation journey to patient centered medical homes. Fiscal support from commercial health insurers and Medicaid supports transformation process implementation, including care management integration into primary care practices. The MLC is supported by the Health Information Exchange (HIE) and the Regional Extension Centers (REC) for Maryland. The MLC team hosts large and regional collaborative learning events where practice transformation is the sole focus area and each of the 53 practices is held up to the most rigorous National Council on Quality Assurance (NCQA) recognition standards as PCMH. The MLC core team of practice coaches and lead physicians also travel the state to visit the 53 practices to support their transformation. These impressions are gained from having had the privilege of being part of this team (not the official report).

Going into Maryland communities to visit primary care physicians who take care of the old, the infirm, the vulnerable populations is a true privilege. These visits are the beginnings of true insight and opportunity for our team to see firsthand how primary care is delivered around the State of Maryland. Sitting in waiting areas of these practices watching patients come into and leave from practices gave us an understanding of the patients’ joy at having their own physician in their community who cares for them and who is available for their needs. The road to primary care practice transformation is a journey towards healthcare efficiency, cost savings and improved quality measures for disease, patients, physician and health care system. Being on this road with the 340 primary care physicians and practitioner colleagues within the Maryland Learning Collaborative, supported by the State of Maryland and health insurance carriers is an incredible continued on page 20
Going into Maryland communities to visit primary care physicians who take care of the old, the infirm, the vulnerable populations is a true privilege. These visits are the beginnings of true insight and opportunity for our team to see firsthand how primary care is delivered around the State of Maryland.

Journey. Health care reform has reenergized the primary care community in Maryland to achieve the goals of improved health care quality and cost savings. It is also clear that one size cannot fit all!

There are unique challenges to delivery of optimal care for patients who have higher bio-psychosocial burden of multimorbidities. It is true that health care is harder to streamline and to stratify when the population served is so diverse in its burden of disease, its level of health literacy and socio-ecological predictors of health.

The Maryland Learning Collaborative team knows that we are rising to a challenge that all our supporters have presented and we know that our primary care colleagues are looking for the tools needed to educate, advise and consult with them. I know that we collectively recognize the challenges and the pitfalls in transforming our most vulnerable practices into patient centered medical homes and we also recognize that peer learning and change management is a large part of primary care transformation.

An elder physician at one of our practices gave me some advice while visiting with his practice: “don’t forget that we have provided great medical care to an entire generation before medical care became good documentation, and be sure to tell medical students and residents that!” There is no doubt in my mind that great medical care is our goal, and we know that the precedents of the past lay heavily on our minds when we recreate some of the structural elements of the old general practices. On the road it seems clear that the training of future physicians of the next generation, medical students and residents, must include time to observe transformed practices and possibly those in transition to becoming patient centered medical homes. The varieties of practice adaptation in each family practice, internal medicine and pediatric practices leads us to believe that young learners will benefit from direct observation of this process of change that ultimately forms the building blocks of healthcare reform. Our task is to ensure that everyone, including students, government, insurance carriers, policy makers and stakeholders remember that physicians and practices taking care of one patient at a time is exactly what healthcare is about. We know that the value of primary care to the health care system will be measured by an existing yardstick. Developing new yardsticks to measure change and demonstrating the positive effects on health systems, disease, patients and physicians will take rigorous and systematic process of query. At the MLC, we know that the privilege to share the day to day lives of primary care practitioners in Maryland comes with a great responsibility.

Dr. Khanna, Associate Professor, Department of Family and Community Medicine, University of Maryland, Baltimore, is Program Director for The Maryland Learning Collaborative. Learn more at http://medschool.umaryland.edu/familymedicine/mdlearning/

Note: references for this article are posted at www.mdafp.org; publications and news tab.
MD Tech

Take Back Control!

Matthew Hahn, M.D.

When we initially conceived of a technology column for physicians, I thought the subject matter I would be writing about would primarily relate to rating and reviewing new gadgetry and cutting edge “apps.” As it turns out, however, this MD Tech series has focused more on issues peripheral to the technology itself, like obtaining government IT incentive payments and how to make EMR purchase decisions. I come back to these issues time and again because, when I speak with my physician colleagues or read of their experiences, these are the issues that appear to be the most important.

This current column will focus on who should make decisions about an EMR purchase… an incredibly important aspect. Just to be clear, the answer is that physicians should make those decisions! What I often hear from physicians is their sad lament that because they relied on others...experts, so to speak, they ended up in trouble.

The story goes something like this, “I took a job with this large organization so that I could just be a doctor again. Then, the organization purchased an EMR and, even after months of use, it is so cumbersome, I have to stay an extra 2-3 hours every evening just to complete my notes.”

Then comes the worst part, “I’m not sure how much longer I can do this.”

To make matters worse, many physicians are being pushed, because of increasing administrative costs and shrinking payments, to higher productivity standards. Ironically, it is the very administrators who are largely responsible for those (non-medical) high costs, and who chose the clunky EMR, who are demanding that physicians see more patients. One physician described an image that continues to haunt me...of administrators going on long lunches, and leaving at 5pm, while the physicians work through lunch, remaining late into the evening.

This sad state of affairs stems from two misconceptions:

1. Physicians do not have the expertise to evaluate and select an EMR.
2. Administrators, IT staff and various consultants are more capable, and better suited than physicians to make these decisions.

Neither is true… nor has to be true! Taking control of these decisions is one of the keys to rescuing modern medicine, as well as to enhancing your career satisfaction.

Here’s how you decide if an EMR is right for your practice. Use it! Before considering a product, get on the computer, start up the software, pull up a test patient record, and give it a try… to do what you do all day, which is documenting your care. Document a patient’s past medical history. Write a SOAP note. Create and send a prescription, refill prescriptions. Order tests and view test results. Communicate with colleagues and other staff. Is it fast or slow? Is it simple to use or is it cumbersome? You must take the time to go through this process in order to adequately evaluate an EMR. You must insist that EMR vendors allow this process, or do not consider their product.

With a good EMR, as with any other software, within a relatively short time, you should be able to understand the bulk of the system, to see and feel how you can accomplish your work. If this does not happen, then the system likely isn’t the right choice for you. I have yet to meet a non-physician who understands and values the important details of patient care to the extent that they can provide the answers to these questions. Not a surprise because they did not go to medical school, do not see patients and, therefore, don’t really know what makes an EMR clinically useful or useable. Only you, the physician, can do that...and should do that.

I remember the comments of a state Regional Extension Center (REC) employee at an EMR demo (to be fair to our friends at the Maryland REC, this was in Pennsylvania). After viewing the demo, the REC staff concentrated on the EMR’s ability to interface with the state’s HIE. At the time, I said, “what’s an HIE?” My next question was, “why is that important?” I know now that HIE stands for health information exchange. Not that HIE interfacing isn’t important but it was not, and should not be, the basis of an EMR purchase decision.

The more we cede control of the practice of medicine and the important decisions that affect our careers and our ability to deliver medical care, the worse it will become. Physicians must overcome their fear of the business of medicine and of making decisions about health information technology. Instead, we must embrace, excel at and teach to others these aspects of practice management which are now integral to being a doctor.

Dr. Hahn is co-owner of Hahn and Nelson Family Medicine in Hancock, Maryland. A MAFP Western District Director and member of MAFP’s Technology Committee, he writes this, the 4th of a series of articles about various aspects of technology and practice automation.
Starting next academic year, we will see exciting changes in our program. We will be welcoming 2 additional residents to our 8-8-8 program, as we are introducing a combined family medicine-preventive medicine dual program. These residents will complete their residency and MPH within four years.

This development leads to curriculum changes, where all residents participate in a four week practicum of their choosing. The practicum experience is allowing us to get creative in knowing our patients, so that we can better serve our community. Matthew Loftus, M.D. (PGY-1) has focused on high-risk patients who are defined as those frequently admitted to our inpatient team, noncompliant with medications and treatment, or who have been identified as having high-risk behaviors. When he was successful in contacting them personally, conversations revealed their understandings of their health, what their goals were to help improve their health, and what they felt that they needed from their primary care physician and our office to meet their healthcare goals. Dr. Loftus then communicated this information to the primary care physician. Dr. Loftus viewed his experience as a way to learn “creative problem solving and addressing broader issues in medicine…we are encouraged to help our patients in whatever way best helps them to live a healthy life.”

Courtenay Morrow, D.O. (PGY-2) is currently involved in a project to analyze pediatric immunization data and patterns, a study which she will broaden to involve adult immunization rates in our local Healthcare for the Homeless population. Ruth James, M.D. (PGY-3) focused on home visits with her panel of patients with chronic illnesses and mental illness co-morbidities, with an emphasis on medication reconciliation. Joseph Nichols, M.D. (PGY-1) is currently working on analyzing the impact that palliative care consultation has on hospital readmission rates on patients seen in the ICU. I am currently working on a collaboration with the Maryland State Department of Education and a local middle school health teacher, assessing the comprehensive health curriculum, in an attempt to improve health literacy.

The practicum experience is allowing us to reach out to our patients in a unique way that bonds us with the community in which we serve. As the focus on primary care medicine and the patient centered medical home evolves over the next several years, this practicum experience will provide our residents with a better understanding of how we need to view a patient’s health as being an integral part of school, work, and home; not just what we see in the office.

U of MD Family Medicine Residency Updates!
by Ryane A. Edmonds, M.D., PGY-2, University of Maryland

Now with more than half of this academic year in residency complete, our residents at the University of Maryland continue to strive for excellence. In this Residents Corner, I sing the praises of my fellow residents, a group truly committed to Family Medicine and the community. Check out how these new family physicians are changing the world!

The third year residents (PGY 3s) are going out with a bang! This year, Dr. Binetou Fall completed an internship at the National Institutes of Health focused on Health Policy. Chief Resident Dr. Carlos Duarte has an interest in pursuing a master’s in public health. In his words he would like to “learn more about the role that the environment, social and cultural factors, and access to care play in determining outcomes in healthcare. Also, how primary care physicians become can more knowledgeable about these variables and deliver optimal, culturally sensitive and cost effective care along the entire care continuum.” Chief Resident, Dr. Leoni Prao matched as the
next Sports Medicine Fellow at the University of Maryland. She is very involved in the world of sports medicine and will be presenting a case report at the American Medical Society for Sports Medicine (AMSSM) Conference later this year in Atlanta.

Happy newlywed Chief Resident Dr. Kevin Carter is on several Family Medicine committees including Resident Director on the Maryland Academy of Physicians Board of Directors.

In addition, check out Dr. Michael Pitzer’s (PGY-2) monthly "Sideline Report" in the American Medical Society for Sports Medicine newsletter (www.amssm.org). Also, Dr. Marshala Lee (PGY-1), has hit the ground running in residency. She is very interested in childhood obesity and is quite involved in writing and implementing a grant for the “Better My Identity” program to promote wellness among 5th grade students in Baltimore who attend the University of Maryland Family Medicine Residency clinic. The program is designed to increase physical activity, healthy eating and emotional well-being for these children and their families.

These are just a few of the great things residents are doing at University of Maryland. Residency is a time of intense training and these physicians are to be commended for their many achievements. Family Docs do it all!
Dear Colleagues:

Join us for “Essential Evidence Update 2012” presented in a NEW learning format! The format is different than what many of you have come to expect in group CME events. A nationally renowned faculty of four presenters will deliver a comprehensive 2½ day program consisting of shorter 30-minute topic segments covering a broad field. Each learner will receive a 261-page syllabus (yes, real paper) to be used during the presentations and afterwards as a handy desk reference. Course Director Dr. Mark H. Ebell and his team have put together a unique and truly evidence-based program for Maryland Academy members and guests.

The MAFP Education Committee learned of this educational opportunity a couple of years ago after it was used successfully by another AAFP chapter. With the positive responses received from that chapter, the MAFP Board’s decision was to proceed.

Are we on the cutting edge? Will this set the course for live MAFP CME in the future? Your responses will help us decide. Take a look at the materials posted at www.mdafp.org. We look forward to seeing you at the conference and to having your feedback!

Eva S. Hersh, M.D.
2011 Assembly Program Chair
PROGRAM FACULTY

Mark H. Ebell, M.D., MS,
Course Director
Associate Professor
University of Georgia
Deputy Editor, American Family Physician
Editor-in-Chief, Essential Evidence

Gary S. Ferenchick, M.D.
Division Chief
Department of Internal Medicine
Michigan State University

John M. Hickner, M.D. MS
Professor and Chair
Department of Family Medicine
The Cleveland Clinic

SPECIAL ASSEMBLY PARTICIPANTS AND EVENTS

Eugene J. Newmier, D.O.
Outgoing MAFP President
Welcome to One and All!

Yvette Oquendo-Berruz, M.D.
Incoming MAFP President
Embarking On A New Journey

Jeffrey M. Cain, M.D.
President-Elect, AAFP
Presenting Keynote Address
Perspectives on Maryland and National Health Reform Initiatives
Presiding at Installation of MAFP Officers
Members to Vote for Officers & Directors and Change in Board Structure

Nominations Slate

The MAFP Nominations Committee recommends the following slate. Nominations from the floor will be accepted. Elections will take place at the Annual Business Meeting Luncheon on Friday, June 22, 2012 at Turf Valley Conferences in Ellicott City, MD. Newly elected officers will be installed later that day by AAFP President-Elect Jeffrey Cain, M.D. at the Installation Luncheon.

2012 MAFP Nominations Committee

Yvette L. Rooks, M.D., Chair (Immediate Past President)
Eugene J. Newmier, D.O. (President)
Yvette Oquendo-Berruz, M.D. (President Elect)
Trang Pham, M.D. (Vice President)
Kevin Ferentz, M.D. (Committee Chair & Member-At-Large)
Kevin Carter, M.D. (Resident Director)

2012 MAFP Nominations Slate

PRESIDENT-ELECT
2012-2014; two year
Kisha N. Davis, M.D., Gaithersburg
(assuming office 9/1/12)

SECRETARY
2012-2014; two year
Eva S. Hersh, M.D., Baltimore

VICE PRESIDENTS
2012-14; two year terms
Central District
Jocelyn M. Hines, M.D., Baltimore
Southern District
Ramona G. Seidel, M.D., Annapolis
Eastern District
2012-13; one year to complete term
Andrea A. Mathias, M.D., Snow Hill
Western District
2012-13; one year to complete term
Matthew A. Hahn, M.D., Hanover

DIRECTORS
2012-13; one year terms
Central District
Nancy B. Barr, M.D., Baltimore
Mozilla Williams, M.D., Baltimore
Eastern District
Andrew S. Ferguson, M.D., Chestertown
Rosaire M. Verna, M.D., St. Michaels
Southern District
Trang M. Pham, M.D., Pasadena
Patricia A. Czapp, M.D., Annapolis
Western District
Kevin P. Carter, M.D., Silver Spring
Kristin M. Clark, M.D., Ellicott City

DELEGATE TO AAFP
2012-14; (two year terms, 2-terms limit)
Howard E. Wilson, M.D., Bowie

ALTERNATE DELEGATE TO AAFP
2012-14; (two year terms, 2-terms limit)
Yvette L. Rooks, M.D., Baltimore

IN MID-TERM
PRESIDENT-ELECT
2010-12; two year term
Yvette Oquendo-Berruz, M.D.

TREASURER
2011-13; two year term
Christine L. Commerford, M.D., Baltimore

DELEGATE TO AAFP
2011-13; (two year terms, 2-terms limit)
William P. Jones, M.D.

ALTERNATE DELEGATE TO AAFP
2011-13; (two year terms, 2-terms limit)
Adebowale G. Prest, M.D.

Draft Bylaws Change

In accordance with the Bylaws of the Maryland Academy of Family Physicians (MAFP) CHAPTER X-AMENDMENTS, this will serve as notification that the MAFP Board of Directors recommends the following changes to the MAFP Bylaws document. Subsequent to the Board meeting on November 13, 2011 where the changes were initiated, the MAFP Bylaws Committee submits the following changes which will be voted by members present at the MAFP Annual Meeting on Friday, June 22, 2012 at Turf Valley Conferences in Ellicott City, Maryland. Any MAFP member wishing a copy of the current Bylaws document may view it at www.mdafp.org or contact the MAFP office at info@mdafp.org or 410-747-1980.
MAFP Bylaws Committee
Yvette Oquendo, M.D., Chair
Adebowale G. Prest, M.D.
Eugene J. Newmier, D.O. ex officio

Excerpt from the Board of Directors Meeting Minutes 11/13/11: After detailed discussion and due consideration, upon proper motion, second and unanimous favorable vote, the size of the MAFP Board of Directors will remain the same with 4 VPs and 4 Directors each representing one of the 4 districts of the state. In addition there will be 4 at-large Directors who will be nominated based on qualifying criteria as determined by the nominating committee.

The Bylaws committee will draft a change in language to accommodate the modified structure which will be presented to the Board at the Winter or Spring meeting and voted at the Annual Business Meeting in June, 2012. If approved, the new Board structure would take effect with nominations for 2012-2013 at-large directors.

Key: box = delete, bold underline = new language

CHAPTER VIII - OFFICERS AND DIRECTORS
The officers… shall be a President, President Elect, Secretary, Treasurer, four (4) Vice Presidents (one from each geographical district as defined in the Bylaws), eight (8 four (4) Directors (two one from each geographical district as defined in the Bylaws), four (4) at-large Directors, …

CHAPTER XVI - ELECTION OF OFFICERS
Section 1. Nomination Procedure. At least ninety (90) days prior to the annual meeting, the President shall appoint a Nomination Committee… The committee’s duty shall be to present nominations for the following offices:
A. For a term of one year:
   eight (8) four (4) Directors (two one from each of the geographical districts as defined in Section 4) four (4) At-Large Directors …

Section 4. Geographical Districts. Geographical districts in the State of Maryland are:
A. Central - Baltimore City and Baltimore County
B. Eastern - Cecil, Harford, and all counties east of the Chesapeake Bay
C. Southern - Anne Arundel, Calvert, Charles, Prince George’s and St. Mary’s Counties
D. Western - Allegheny, Carroll, Frederick, Garrett, Howard, Montgomery, and Washington Counties.

CHAPTER XVII - DUTIES AND TERMS OF OFFICERS
Section 2. President Elect. …The office of President Elect shall rotate annually to each geographical area as defined in the Bylaws, depending upon the availability of a suitable candidate:

continued on page 28

CME Author Disclosure Statements
The authors of CME articles in this publication, except for any listed below, disclose that neither they nor any member of their immediate families have a significant financial interest in or affiliation with any commercial supporter of this educational activity and/or with the manufacturers of commercial products and/or providers of any commercial services discussed in this educational material.

MAFP receives no commercial support to offset costs in the production of The Maryland Family Doctor Publication.

Next Edition
□ Focus on Long Term Care
Section 6. Directors. The term of office of Director shall be for one (1) year and shall begin at the conclusion of the Annual Meeting of the Maryland Academy of Family Physicians at which the election occur and expire at the conclusion of the next Annual Meeting or when a successor is seated. There shall be eight (8) Directors, two (2) **one (1)** from each Geographical District as defined in these Bylaws and **four (4)** At-Large Directors, who shall be elected each year.

CHAPTER XXII - TAKING EFFECT OF THE BYLAWS

These bylaws shall take effect immediately upon their adoption, June 24, 2011

22, 2012.

Time Limit for Board Eligible Status

The term ‘board eligible’ has never been recognized by member boards of the American Board of Medical Specialties (ABMS), including the American Board of Family Medicine (ABFM) but the term continues to be used by credentialing organizations and others to recognize non-certified physicians as having equivalent status. In practice, no limit exists on how long a non-certified physician could remain board eligible. The abuse of the board eligible term and status perpetuated the ability of poorly qualified physicians to practice outside of their initial certification with a risk to patients and resulted in a lack of relationship between the initial certifying examination and training as a concurrent/synergistic measure of physician competency.

In an effort to resolve this confusion for the credentialers and the patients, all member boards of the ABMS agreed to establish parameters under which non-certified physicians could actually be recognized as being board eligible and to further define the time limit for such board eligible status.

The ABFM Board of Directors decided at its meeting in October, 2011 that it would define board eligibility as the first seven years after loss of certification or the completion of an ACGME accredited residency training program. Therefore, beginning January 1, 2012, a physician will have seven years in which to successfully complete his or her initial certification examination after completing training or, if previously certified, will have seven years after the loss of certification to successfully complete the examination.

Lower Your Vaccine Costs with Atlantic Health Partners!

Atlantic Health Partners is pleased to announce a new program with TransactRx that enables physicians to provide vaccines to most Medicare Part D patients. As you may know, Atlantic offers our members the lowest prices on vaccines, and now with TransactRx your practice can provide vaccines to Medicare patients. The TransactRx program endorsed by Atlantic provides you:

- Easy online access to patient specific Part D vaccine coverage
- Ability to get fairly reimbursed for vaccines covered under Part D
- Real-time out-of-pocket (copay) cost and reimbursement information
- Electronic claims submission for vaccines covered under Part D

MAFP is an Atlantic Health Partners participating organization (click on the AHP icon at www.mdafp.org). There is no cost to join Atlantic Health Partners or to benefit from this new service. Also, don’t forget these additional Atlantic benefits:

- **Discounted medical, surgical and office supply programs**
- **Discounts on a patient recall program**
- **Immediate customer service to address any vaccine related issues**

Contact Jeff or Cindy at info@atlanticchealthpartners.com or 1-800-741-2044 to find out how your practice can benefit from Atlantic Health Partners Savings and TransactRx.

Congratualtions to MAFP Members for Special Appointments, Honors, Features, Achievements!

Smaldore Family Practice Celebrates 20 years in Bel Air: Twenty years ago, Smaldore Family Practice Associates opened in Bel Air, Maryland. Its mission then and now was to serve families who reside in Harford, Baltimore and Cecil counties. **Drs. Kellie and Steve Smaldore**, are both graduates of Philadelphia College of Osteopathic Medicine, St Joseph’s Hospital and the Family Practice Residency Program at Franklin Square Hospital. Their partner, Dr. Gregory Dohmeier, joined the...
practice in 1975 after graduating from Kirksville College of Osteopathic Medicine, Community Hospital of Lancaster, and the Family Practice Residency Program at the University of Maryland.

Smaldore Family Practice Associates currently has 5 practitioners on staff, seeing close to 100 patients a day. Many of the original patients have grown with the practice and are now bringing their children for care. On the 20th anniversary of Smaldore Family Practice Associates, accolades came from many colleagues, hospital personnel, practice staff and patients. The doctors were surprised and moved by a special video presentation at the celebration luncheon on April. Excerpted from an article by Julie Sirgany-Green, Office Manager.

Patricia A. Czapp, M.D. of Annapolis has been appointed to the AAFP Commission on Health of the Public and Science, a 3-year term. She joins Dr. Yvette L. Rooks of Elycott City who is is mid-term on that Commission. Dr. Czapp has also been appointed to the Board of Directors of the Mid-Atlantic Business Group on Health (www.mabgh.org)

J. Roy Guyther, M.D. of Mechanicsville was featured in “St. Mary’s Storyteller Publishes Eighth Book” appearing in the January 26, 2012 edition of The Washington Post. continued on page 30
Dr. Guyther, a MAFP Past President (1958), a Past President of MedChi (1982) and a Past AAFP Family Doctor of the Year (1979), now retired at age 91, continues to be as active as he is able. Of late, he has been quite prolific in writing stories about life in his Southern Maryland Community where he was born and returned to practice medicine in beginning in 1951. As noted on p.10 in the piece on his colleague Dr. William L. Stewart, Dr. Guyther was a pioneer in Family Medicine. His longtime position on faculty at the University of Maryland School of Medicine continued to the year of his retirement in 1995. He has written oftentimes on a variety of topics for MAFP publications, the most recent of which was “A History of the Department” published in the Special Supplement to this publication (Fall, 2007) marking the 35th Anniversary of the University of Maryland Department of Family and Community Medicine.

James R. Richardson, M.D. of Ellicott City wrote “Myths and Misses About Alzheimer’s Disease” appearing at the social media site for physicians KevinMD.com The link to the article: http://www.kevinmd.com/blog/2012/01/myths-misses-alzheimers-disease.html

Donald R. Richter, M.D. of Oakland and Ramona G. Seidel, M.D. of Annapolis were featured in “FPs Share Their Experiences With PCMH Pilot Projects,” lead article in the December 1, 2011 edition of AAFP News Now.

The following have articles published in “The Reader’s Issue” (Volume 12, Issue 4) of Maryland Medicine:

- Matthew Loftus, M.D., “Life Can Unexpectedly Change in a Moment!”
- Richard Colgan, M.D. and Mozella Williams, M.D., “University of Maryland School of Medicine Increases Medical Student Education in Primary Care”

Student member Max Ramano, of Baltimore, authored “The right to birth control: Politics aside, access to contraception is basic to good health care,” an Op Ed piece published in the February 15, 2012 edition of The Baltimore Sun. Contributing to the article were student members Meghana Desale, Naomi Rios along with others attending the Johns Hopkins University School of Medicine.

Welcome New and Transferred Members (November 1, 2011-January 31, 2012)

**ACTIVE**

- Dani S. Boulattof, M.D.
- Amanda K. Combs, M.D.
- Lorren M. Donmoyer, M.D.
- Timothy O. Ehiabor, M.D.
- John Foxen, M.D.
- Paulette L. Grey, M.D.
- Andrea D. Hulse, D.O.
- Yalda Jabbarpour, M.D.
- Arman Janloo, M.D.
- Zahra Kiran, M.D.
- Dhirendra Kumar, M.D.
- Barry M. Magnus, M.D.
- Asia T. McDonald, M.D.
- Victor McGlaughlin, Jr., M.D.
- Jennifer M. Nelson, D.O.
- Contah Nimely, M.D.
- Monika Schlammlanger, M.D.
- Anna Stuart McCall, M.D.
- Alan R. Weinstock, M.D.
- Kimberly Zawistoski, D.O.

**STUDENT**

- Armond Allkanjari
- Laura Andersen
- Amal Chaudhry
- Ijeuru Chiteka
- Melyssa K. Hancock
- Soo Yong Jung

**RESIDENT**

- Ashley S. Blackledge, M.D.
- Kathryn A. Boling, D.O.
- Georgia A. Bronfield, M.D.
- Brian D. Mancke, M.D.
- Anne Savarese, M.D.

**In Memory**

The Maryland Academy of Family Physicians is saddened by the passing of its past member William L. Stewart, M.D.

formerly of Westminster who was MAFP President in 1969 (see p. 10). A memorial contribution has been made in his honor to the MAFP Foundation.
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