PERSPECTIVES ON THE HISTORY AND FUTURE OF FAMILY MEDICINE

Challenges and Opportunities Facing Family Physicians: Now and Into the Future
Thoughts After 30-Years in Practice
The Bag
My Future in Family Medicine

ALSO . . .
• President: Parting Thoughts
• Paving the Way in Residency
• Medical Students Connecting Over the Summer
• 2014 Assembly Photo Journal
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by Yvette Oquendo-Berruz, M.D.

Challenges and Opportunities Facing Family Physicians Now and Into the Future
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Medical Students Connecting Over the Summer

Mission Statement
To support and promote Maryland family physicians in order to improve the health of our State’s patients, families and communities.

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MAFP CME

Membership
Note: Dr. Kisha N. Davis, AAFP’s President-Elect must interrupt her chapter office during her 1-year tenure as New Physician Director on the AAFP Board of Directors, having been elected to that position at the National Conference of Special Constituencies in May, 2013. Her term began with the 2013 AAFP Congress of Delegates (COD) and will run through the 2014 COD. NAAFP President Dr. Yvette Oquendo-Berruz will serve an extended term to cover Dr. Davis’s service on the AAFP Board.
The Maryland Family Doctor

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Parting Thoughts

Yvette Oquendo-Berruz, M.D.

How quickly time has gone by! It has been a true honor to serve as your president for the past two plus years. I have enjoyed working with our Board of Directors with the support of our dedicated staff, Esther Barr and Phay Ellis.

We have had a very busy, productive year. In the area of Education/CME we continue to offer a variety of CME activities such as live conferences in February and June, quarterly journal articles and video-cast CME posted on our website (www.mdafp.org) that are now free of charge to AAFP members.

We continue to look for ways to meet the educational needs and requirements of our membership, and for that reason this year under the leadership of our incoming president Dr. Kisha Davis, we have offered DOT training courses for medical examiners of commercial truck drivers.

In the area of Advocacy and Health Policy, we are very proud for having held our very first-ever “Advocacy Day in Annapolis Family Physicians for Patient.” We are working diligently under the leadership of Governmental Advocacy Committee Chair Dr. Matt Burke in developing meaningful relationships with our state legislators. We are already in the planning stages of a similar program during the 2015 Maryland Legislative Session.

Due to the constant changes in local health policies that affect our patients and the way we practice our craft, it became obvious that we need a more vigilant presence in our local politics and, to that effect, we have made the decision to retain the services of a professional lobbyist to represent the interest of Family Medicine in Annapolis during the 2015 Legislative Session and beyond. We will keep you informed through our website, monthly E-Bulletin and journal of any and all pertinent legislative initiatives and alerts.

We also continue to have a strong delegation from the Maryland Chap-

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ter for the AAFP Family Medicine Congressional Conference, where we have opportunity to lobby our Federal Legislators and Senators in Federal Health Policies that directly affect Family Medicine.

We continue to support the Family Medicine residents and medical students with interest in our specialty. This year we held our very first networking/mentoring workshop for resident and students prior to their attendance at the AAFP National Conference of Family Medicine Residents and Students (see p. 28). With the important success of this workshop, we intend to make this a yearly event.

During my term I had the honor to celebrate Esther Barr’s 30 plus years of employment by MAFP as Executive Director. Without a doubt she is the “backbone” of our chapter and I am lucky to have had the opportunity to serve you with her by my side.

I have to say that I truly enjoyed my term as president and feel confident we stayed true to our organizational mission: “To support and promote Maryland Family Physicians in order to improve the health of our state’s patients, families and communities.”

Finally I exhort you all to join the party – “Celebrating MDAFP, where Maryland Members Converge,” Thursday, October 23, 2014 at Marriott Marquis Hotel in Washington D.C. during the AAFP Scientific Assembly; where I will have the honor to pass the gavel to Dr. Kisha Davis, who, without a doubt, will lead our chapter in an exemplary way. Be there!
Family Medicine Through Three Generations

David W. McClure, M.D.

It seems like yesterday when I was being interviewed during my second year of medical school, at the University of Maryland School of Medicine, about the possibility of joining the Family Practice Club. Back then, a small number of students were selected to join this club to learn about Family Medicine. Dr. Earl Hill was the acting chairman for the Department of Family Medicine. I was disappointed when I was not selected to join this group. Within a week or two, an opening appeared and I was able to join.

Fast forward 35 years and here I am writing the opening statement for this edition of The Maryland Family Doctor. I have been an avid reader of this journal for the last 30 years, and I hope you all enjoy this issue. The history of Family Medicine has always been one of my interests, and in the Winter 1998 issue of The Maryland Family Doctor, then Editor the late Dr. Marion Friedman outlined with great detail how the practice and acknowledgement of family physicians became a reality. I invite you to access that copy and learn about the roots of the specialty.

This issue will highlight three generations of family physicians. Dr. Earl Hill, my mentor, and the director of the Department of Family Medicine during my training is now retired. He shares with us his insight as to what Family Medicine meant to him and what changes he saw over his training and practice years. He also pinpoints several challenges facing all of us in practice today. A good friend and colleague, Dr. Joseph Connelly, discusses his 30 years of practice, his experiences, and where he feels Family Medicine is headed, as he anticipates and looks forward to his retirement years. I myself have included a brief story about my “black bag” and what it has meant to me over a very fast 30 years of practice.

Lastly, I wanted to get a fresh perspective from the next generation of family physicians with input from two family practice residents from the Franklin Square and University of Maryland Family Medicine programs. These are the young physicians who will be caring for all of us. I personally am reassured that the art, the heart and the soul of Family Medicine will be preserved as time goes on.

A longtime MAFP member and frequent contributor to The Maryland Family Doctor, Dr. McClure is new to the MAFP Editorial Board, editing this, his first edition. He lives and practices in Bel Air.

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In the Spring 2014 edition of this publication I thanked MAFP members for the surprise recognition during the February 21st conference, marking my 31 years in the position of executive director.

Clearly it is easier than I thought to keep a secret from me because, during the Installation and Awards Luncheon on June 13th, during the organization’s 2014 Annual CME Assembly in Frederick, another surprise honor was bestowed upon me! This was the event where our new officers were installed, where we honored the late great Dr. J. Roy Guyther with a posthumous MAFP Lifetime Achievement Award, and where the Immediate Past President Dr. Eugene Newmier received his AAFP Award of Fellowship.

What should have tipped me off was, after scurrying around making sure that all was in order for the event, I saw, out of the corner of my eye, my family (why are they here?) sitting at a corner table in the back of the room. Perplexed I went back to join them… when I heard Dr. Oquendo’s amplified voice.

“Will Esther Barr please come to the stage.” What!? NO!! This isn’t in the schedule… Flabbergasted, I was then escorted front and center by Dr. Hill to receive MAFP’s Lifetime Achievement Award… a complete surprise! My subsequent remarks were short, garbled, not at all congruent… I couldn’t even tell you what I said. I did manage to introduce my family, alluding to their part in my successful years with MAFP… but at that point, as soon as I made eye-contact with my husband, I started to tear up, said a quick “thank you” and sat down (still in a daze…).

So, I use this opportunity in writing to convey what I should have said…

Thanks to Dr. Richard Colgan, the mastermind behind MAFP’s Lifetime Achievement Award program established in 1999 with Dr. Hill as its first recipient (see box; I am so honored to be included in this group…). Dr. Colgan and I have collaborated over the years on submitting to the Board names of those worthy of receiving the Award (not given every year), both living and deceased. I am told he suggested me for the award this year (while still alive…). I am humbled by his thoughtfulness and his kind words engraved on the beautiful award which I cherish.
Thanks to others who kept the secret, made arrangements, coordinated planning, namely President Dr. Oquendo, co-worker Phay Ellis and Dr. Nancy Barr. On the latter, daughter Nancy was joined at the event by her Dad Mike (my husband of 44-years), brother Kurt and friend Craig Schoenfeld (whose name I botched up…). Many of you know Nancy is a FP practicing in Baltimore. She has credited my job with giving her valuable early exposure to Family Medicine. She also met so many dedicated FPs, many who became her mentors and teachers once her career path was chosen.

As far as the job is concerned, do you think I haven’t needed help (especially early on) with coming up with creative ideas, with conference registrations, lugging supplies, putting notebooks together (before paperless days…), loading/unloading trucks, blowing up exercise balls (just this year), etc., etc….. Mike, Nancy and Kurt are my power supply… and shadow MAFP staff! My main point, which I was unable to adequately convey at the event, is that I could not have been at all successful for 31 years (to date) as MAFP Executive Director without my family. They are my foundation, my fuel. The support and help they provide me on a daily basis causes me to succeed in the job… in life.

My Own Bag Remembrance

You’ll see on p.18 Dr. McClure’s touching account of his medical bag, what it symbolized and what it meant to him from his medical training up to the present day. Reading the article caused me to remember growing up, the daughter of Dr. Victor Goldberg (University of Maryland class of 1928) who practiced in Baltimore. The office was downstairs in a row house on E. 30th Street. The family lived upstairs in 4 rooms. I accompanied him (and his bag) on many house calls growing up in the 50s. Today, his bag and its contents of various medical implements is in the possession of my FP daughter.

AAFP Scientific Assembly Schedule

National Conferences of Family Medicine Residents and Medical Students:
2015 July 30-Aug. 2, Kansas City (dates/location are tentative)
2016 Aug. 3-6, Kansas City (dates/location are tentative)

Congress of Delegates (CoD) and Scientific Assembly (SA):
2014 Oct. 20-22 (CoD); Oct. 21-25 (SA), Washington, DC
2015 Sept. 28-30 (CoD); Sept. 29-Oct. 3 (SA), Denver
2016 Sept. 19-21 (CoD); Sept. 20-24 (SA), Orlando

Annual Leadership Forum (ALF) and National Conference of Special Constituencies (NCSC):
2015 April 30-May 2, Kansas City
2016 May 5-7, Kansas City

Next Edition
- Focus on Self Care
Challenges and Opportunities Facing Family Physicians Now and Into the Future

C. Earl Hill, M.D.

“It is always wise to look ahead, but difficult to look further than you can see.”
- Sir Winston Churchill

At the age of fourteen I recall a hospitalization which consisted of removal of what was left of my appendix, penicillin I.M. q3h for nine days, and didn’t immediately recognize my good fortune. Shortly thereafter, I realized I wanted to be, not that surgeon, but the family physician who, in my home, had diagnosed my condition and hastened my trip to the hospital. Following the successful outcome, I desired to be the same kind of physician. Parenthetically, he was the father of one of the MAFP’s presidents, Harry Knipp, M.D.

Medicine certainly has evolved since I first began practice in the mid-60s. There has been change which seems to be growing exponentially. Yet, there has continued to be a family doctor, a primary care physician educated in the broad curriculum which stands in marked contrast to the narrow scope of most other specialists.

The number of minorities and women entering Family Medicine has greatly improved the composition of the specialty. The divide between allopathic and osteopathic physicians has diminished markedly over the decades to where it appears not to exist. Recently, the Accreditation Council on Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) agreed to create a single accreditation system.¹

Combining the specialties: FPs and IM Generalists

Should family physicians and general internists become identified only as primary care physicians? The answer is “no, definitely not.” Family physicians have a greater breadth of knowledge and capability in the care and management of their patients’ problems. They are capable of providing care for the whole family while general internists provide care primarily for adults and, in some cases, for teenagers. A relatively small number of these will provide simple gynecologic care.

Some Challenges and Opportunities Facing Family Physicians

Maintenance of Certification

Board certification, re-certification, and the addition of areas of special qualification have improved the capabilities of many of our colleagues in the specialty, as well as the esteem due them. But all has not been rosy. There has arisen numerous concerns about the re-certification process being burdensome including cost, time demands, and the cost-value relationship. There has been a slow but steady increase in the number of FPs raising objection to the efficacy of a complex testing process.

Although participation in the re-certification process has increased, there are concerns that a lower rate of participation by FPs practicing in underserved areas may be due to being overburdened secondary to an inadequate supply or a lack of support for physicians in these settings. On the other hand many ABFM-certified FPs have participated, and there appears to be some limited evidence that this group’s quality of care of their patients has improved. In spite of a concern of many family physicians, it appears obvious that insurers in the near future will be applying additional pressure on providers of care.

Fear of Being Sued

Physicians often express concerns about being accused of malpractice. Some have described the experience of a letter from an attorney as a total surprise. Others have categorized it as a horrible nightmare. Has it actually stimulated a pattern of defensive medicine? It has been postulated that physicians are over-reacting to the threat of a lawsuit although there does not seem to be any reliable evidence to the contrary.

Years ago, a colleague of mine was on-call for another FP and answered a call. Because of the nature of the complaint, he referred the individual to the ER of a nearby hospital. The patient was seen by a covering physician, referred to another physician, but was misdiagnosed and a bad outcome resulted. As expected a lawsuit developed and my friend was swept up in the lawsuit.

The case went to court and the result was a negotiated settlement. Although he, as the referring physician, was found to be not liable by the judge, the insurers for the other two physicians insisted my friend be included in the settlement. This result was recorded by the Maryland Board of Physician Quality Assurance - the only black mark during his decades of practice.
Another approach is for plaintiffs to sue for what might occur in the future. Though not new it is becoming more popular before certain juries. It allows for awards for failure to “medically monitor” adequately a patient who had previously been treated by a defendant physician.

As if there were not enough concern regarding the threat of a lawsuit, novel ways to alter the playing field have emerged in recent years. One is “loss of chance.” This involves speculation on the part of the plaintiff’s attorney as to what might have been the outcome of a certain treatment had there been earlier intervention on the part of the physician. As of 2012, half of the states recognize this type of tort. It allows for the possibility of a substantially larger award for damages.

The Electronic Health Record (EHR)

There continues to be much concern about the adoption of the Electronic Health Record (EHR) by physicians in private practice. One objection is that it interferes with the face-to-face patient encounter and seems to create a barrier, of sorts, to the relationship. Another is that the encounter has to be encoded such that it may interfere with decision-making and result in having to conform to the pre-programmed categories offered by the patient’s insurer. Last, but not least, is the significant cost of such a system. However, the cost of not adopting an EHR system is the penalty imposed by the Center for Medicare and Medicaid Services (CMS) which compound for a few years.

A physician (or practice) preparing to switch to an EHR should visit the practice of several colleagues to witness the EHR system in use in order to ascertain what will work best in a particular situation. Avoid the mistake of trying to keep dual records. Be prepared to train office staff to enter into the database those categories of data that you don’t need to be bothered with. An alternative is to have a “scribe” present during the encounter to take notes and enter them into the system, obviously adding a non-reimbursable cost. A possible objection of some patients is the possibility that confidentiality might be compromised, and they might not be forthcoming with some useful, but embarrassing, information.

Don’t take shortcuts in the purchase of a full system by excluding interfaces such as ECG, monitoring devices, screening tests reminders, medication lists with cross-checking for allergies, as well as laboratory and pharmacy interfaces. Unfortunately, the CDC’s National Center for Health Statistics (NCHS) as of May 2014 has yet to explain why what it terms a “fully functional EHR system” does not necessarily make it a “Meaningful Use System” as required by CMS and insurers for optimal compensation.

According to the CMS, “Meaningful Use” means criteria for reimbursement and penalties for Medicare and Medicaid patients through use of an approved EHR. The deadlines are:

- **2014** – last year to initiate Medicare (MC) Incentive Program
- **2015** – Medicare payments decreased for providers not in MC incentive program
- **2016** – last year to receive MC incentive payments
- **2016** – last year to initiate Medicaid (MA) incentive program

Clinical Guidelines

There have been significant increases in the number of practice guidelines in recent years. Although guidelines have been available for a couple of decades, recent activity in this area has been startling. From 1990 to 2012 their number has increased from 73 to 7,508. Unfortunately, in a typical family practice one does not encounter patients (especially the elderly) presenting with a single problem. Part of the art of medicine is the ability to juggle many of a patient’s problems (comorbidities) while weighing (occasionally conflicting) guidelines for each problem. It has been estimated that several hundred new guidelines affecting family practice are appearing yearly. This deficiency is now being addressed gradually.  

Generalists, Specialists, and the Affordable Care Act (ACA)

For more than two decades, we have witnessed the evolution of Health Maintenance Organizations (HMOs) which positioned many primary care physicians as “gatekeepers.” This nudged these physicians away from dependence on their diagnostic acumen toward a greater number of referrals for specialty care. It became prudent to take the easier path as many feared lawsuits over a missed diagnosis or delay of needed care.

However, more specialty care came with increased technology and, therefore, added costs. Many family physicians aligned themselves with HMOs and with hospital corporations, often attracted by the promise of decreased practice costs, increased take-home pay, and added leisure time.

The new bureaucracies will control the access to and timeliness of services. Witness the evolving scandal surrounding the Veterans’ Administration Hospitals - a government-run health care system. The ACA is a system modeled to include many of the same characteristics as the VA system. It seems obvious that responsibility for the provision of patient care will be returned to the family physician as a gate keeper and the gate will be narrower as access to specialty care is slowed or denied.

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Challenges and Opportunities (continued)

The Congressional Budget Office (CBO) estimates an additional 12,000,000 individuals will be added to the Medicaid roles by 2015. Coupled with the already low reimbursement rate provided to physicians for the care of these patients (estimated in 2008 to be 58% of earnings in the private sector), any additional patients added to a practice will further strain the system.

Expanded Insurer Cost Control

Pressed by imposed cost-containment plus the need to keep their stockholders satisfied, Medicare Advantage plans are dropping those physicians they judge to be too costly. Late in 2013, a major health plan dismissed approximately 2,200 physicians from their network. They have done the same in several other states. Narrowing their network has resulted in both primary care and specialty physicians being separated from their patients as the insured are “relocated” into less costly practices. It is vital that physicians maintain a high quality of care to their patients. In this scenario, many patients should become available to these higher quality, more efficient practices. One mechanism to deal with this effort by insurers is for family physicians to join larger networks, if available, and/or become part of a “Patient-Centered Medical Home (PCMH).”

Regaining Physical Examination Skills

Prompted, in part, by a recent article which appeared in an e-magazine, I realized what I had been observing personally and was reported to me by others, physicians were either slowly abandoning or were never adequately trained in the art of “bedside” diagnostic skills. This has likely occurred because of less time spent on rounds in the hospital or in the outpatient examining room. This may well be due to the pressure of more patients, increasing documentation requirements, the ever-expanding number of laboratory tests and imaging tools, and most certainly due to the constriction of reimbursement.

An adequate physical examination is key to a high quality practice and a cost-saver, as seen by those who pay the fees. Conversely, an incomplete examination can increase the number of unnecessary tests with attendant costs, and lead to delayed or missed diagnoses. The latter occasionally results in a lawsuit.

Recently, I had the occasion to read an article in Kaiser Health News titled “Patients Lose When Doctors Can’t Do Good Physical Exams.” In this excellent piece there are examples of overlooked, but obvious to the trained eye, physical findings. Additionally, I would urge readers to refresh your skills in this area by accessing the “Stanford Medicine 25,” a six-year-old program at that school which is required of all medical students to master.

The Health Care Team

The American Academy of Family Physicians (AAFP) envisions a physician-led team of health professionals. Such a PCMH might consist of a combination of primary care physicians, physician assistants, nurse practitioners, registered nurses, home care coordinators, mental health professionals, pharmacists, etc., depending on the size of the practice.

I envision such an organization being charged with maintaining/improving the health of their patients. Both the government and insurers will be providing oversight and assurances that such an entity functions efficiently and effectively in providing care needed by the insured and other members.

This nation needs to improve the way care is provided our citizens. In my experience the situations that affected my patients and concerned me most deeply were those occasions when I referred a patient to a specialist in consultation and/or for care and received no feedback. It is inappropriate to have to pursue information on the status of my referred patient’s health. Of note, this situation existed in a closed health care system. I anticipate that PCMH organizations will preclude this from occurring.

Whatever system evolves in our changing landscape of health care, the Patient-Centered Medical Home should herald a new paradigm of ever-improving health care for our patients.

A parting thought: “The future ain’t what it used to be.” - Yogi Berra

Dr. Hill is a MAFP Past President (1978-79), served in various positions of the AAFP and the AAFP Foundation, including AAFP Vice President (1992). Serving as President of the Maryland State Board of Medical Examiners (1983-88), he is also a past Residency Director (1978-90) and Acting Chairman (1990-92) at the University of Maryland Department of Family and Community Medicine. Dr. Hill is a MAFP Past President (1978-79), served in various positions of the AAFP and the AAFP Foundation, including AAFP Vice President (1992).

4Congressional Budget Office, Table 1: CBO’s Estimate of the Affordable Care Act on Health Insurance
5Centers for Medicare and Medicaid Services, Office of the Actuary, “Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers,” May 31, 2013, p.8
DISEASES AND HEALTH PROBLEMS LINKED TO SMOKING

1 OUT OF 3 CANCER DEATHS COULD BE PREVENTED

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ORAL CAVITY • LIP
NASOPHARYNX
NASAL CAVITY • LARYNX
STOMACH • BLADDER
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The Health Consequences of Smoking — 50 Years of Progress: A Report of the Surgeon General, 2014

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Family Medicine - A Perspective After 30 Years of Practice

Joseph P. Connelly, Jr., M.D.

As I reflect on the current state of Family Medicine, I would like to begin by sharing some of my memories from my younger years. I am in my 29th year, since completion of residency. I lived in Parkville for my pre-med school years and stayed in Baltimore for all of my training. I went to the University of Maryland Baltimore County (UMBC), University of Maryland Medical School and Franklin Square Hospital for Family Medicine Residency. My entire career has been in suburban Baltimore. Once our office was closed for repairs and I shifted to an affiliate office where I was actually able to see the rooftop of the house where I spent my first year of life.

Two established doctors allowed me to join their practice near Franklin Square Hospital upon completion of my residency. We stayed open 7 days a week and closed when the last patient was seen. This could be until midnight and even until 2 AM during flu season. We were open all holidays. Dr. Rombro covered Sunday, Dr. Castro and I covered Friday evening and Saturday. We rotated coverage on the weekends, which afforded me to have Wednesdays off. My wife and daughter usually went to bed by 10 o’clock so I didn’t mind working so late. Except for the extended office hours, my practice was pretty typical of a family physician, which included treating all patients, all ages and all problems. We had a gynecologist in the office and they provided the additional care for women.

When Dr. Rombro retired at age 80, we entered discussion with two organizations to buy our practice. For me, it was a solution on how to avoid having to buy out my two partners. Ultimately, we joined with MedStar Physicians. To this day, I am indebted to my two partners for teaching me a good work ethic, learning how to gain patient respect, and providing a good community service by having such extended office hours.

In order to attract new physicians to our MedStar office, the schedule was adjusted by first eliminating Sunday hours and the Friday night session. A few years later, Dr. Castro retired and four other doctors came and went during the remaining six years I was with MedStar. My wife and I had already made our home in Fallston and occasionally shopped in the Hunt Valley area where we often passed a medical practice I had silently wished to join. Some of my colleagues and graduates of my residency program started this practice in “Four Corners” as it was called north of Loch Raven reservoir in Phoenix, Maryland. This office is affiliated with the Greater Baltimore Medical Center (GBMC). With the retirement of one physician, I was invited to join the practice. It was a very difficult decision to leave so many of my Middle River patients that I had cared for over 24 years.

There is a huge difference between old-school office hours and current office hours. In our privately owned practice we were able to see patients until the last sick patient was seen. Under corporate ownership, there is an advertised closing time and the office staff expects to leave. During my years of private practice, I did hospital rounds for additional income to supplement my office work. When we decided to forego inpatient care, I visualized I would be able to stay at the office a little later and see a few extra patients. As we transitioned to corporate ownership, staying late was not allowed because the office staff objected. Administration agreed with the staff, not wishing to pay overtime, so the office was open from 8:30am-5pm. However, the tide is now changing. As part of our Patient Centered Medical Home (PCMH), extended hours are now expected. Some Physicians start at 7 AM and others finish their shift at 7 PM, allowing for a 12 hour extended day. Saturday hours have been reinstituted and one GBMC practice offers Sunday hours. Finally, some of the philosophy of my original practice style is coming back; we had it right twenty-five years ago, offering extended hours for patient service.

Over the years, the biggest change I have experienced has been with the methods of documentation. There is an inherent difference between paper charts and electronic records. At Medstar, I survived uploading data for a prolonged nine-month period before we went “live” with the EMR system called Centricity. This included comparing the paper record with the EMR version and consumed many hours of my free time. Since there were no electronic patient records, everything had to be created from accounts used for billing. Part-time personnel loaded problem lists and medication lists and it was the physician’s duty to take the charts and insure information was entered correctly. At GBMC, where after dictating notes for two years, our paper records were converted to electronic using eClinical Works. Similarly, blank charts were created using billing records. Personnel were assigned to upload medication and problem lists.
During the week prior to the patient’s scheduled visit and we went “live” with an instructor over our shoulders as we completed an office visit. We saw fewer patients during the introductory phase but in contrast to my first experience, no loss of free time occurred.

Since GBMC has embraced the Patient Centered Medical Home (PCMH) philosophy, I am excited to be part of this new style of providing care to our patients. As a result of the Affordable Healthcare Act, physician groups are responding by creating Accountable Care Organizations (ACO) in which multiple specialties are under one management using one EMR. In this ACO, the primary care doctors are central in managing the patient. This is where I think primary care has finally arrived at the top of the totem pole and moreover, Family Medicine certification, in my opinion, is undoubtedly the best. It seems our time has come.

Apparently, our ACO is saving the insurance companies money. New contracts are being offered to GBMC and this encourages me. However, it seems there are increased overhead expenses using an EMR and meeting requirements of being a PCMH such as having supporting personnel to help extract data for meaningful use. I don’t think this style of practicing medicine is going to go away. In our practice, we have a nurse care manager and access to a care coordinator that helps with referrals, accessing records and patient’s admissions. We use the Chesapeake Regional Information System for our Patients (CRISP) for learning if our patients have been hospitalized.

Our practice at GBMC attained Level 3 in PCMH certification. A problem of documentation is recording patient information in the correct place and in the correct manner so reports of our “Meaningful Use” of the EMR is accurate. Our learning curve includes a lot of unexpected nuances and from studying my reports, I have made improvements on how I document. I guess I missed typing class in med school; I never thought I’d be typing more than the staff at the front desk. I wish I had a scribe to document and type for me. Dragon software requires proof reading and correcting errors and does not work well for me. Overall, I have to give so much more time and attention to the detail of patient documentation than ever before. Today’s EMR allows the patient to have Internet access to their chart, a patient portal, to improve communication between their family physician and consultants.

During an office visit, focus on preventative care is required which takes more time for each patient. Because of this, fewer patients are seen in the workday. There are reports that this problem is universal just when there is a growing need for more access to primary care physicians. This is creating barriers for patients trying to have access to healthcare. Overall, I feel that I am offering better care by giving patients appropriate time with a focus on preventive medicine. I think the delivery of health care has improved. We work with and supervise nurse practitioners and physician assistants in the office and at remote locations. Years ago, I was opposed to nurse practitioners petitioning for approval of independent practice. I now see their contribution as a solution for primary care access.

I never envisioned this to be my current practice style 29 years ago. Although, there are the same patient-doctor relationships, there are so many things I would never have predicted. For instance, using a computer in the exam room. I do not type well and need to look at the keyboard often while documenting patient information. With the old style of charting, I could maintain eye contact. On the other hand, I have the benefit of applications like Epocrates in the exam room and use the computer for teaching and instructional material. The EMR keeps us up to date with disease guidelines, preventive care, counseling and educational materials while we are face-to-face with the patient. It just takes a lot more time than it did 2 decades ago.

I love being a family physician and would choose that career again. One of my biggest joys is treating families of multiple generations. I recall Mrs. L, in her 9th decade, who came in with her great-granddaughter and boasted she was Mrs. L’s 102nd offspring. They often came together and I could see how happy they were sharing this time together.

This is where I think primary care has finally arrived at the top of the totem pole and moreover, Family Medicine certification, in my opinion, is undoubtedly the best. It seems our time has come.

continued on page 16
Family Medicine (continued)

- I love taking care of difficult problems, sorting out the symptoms and ordering tests and coordinating consultations trying to solve puzzling problems, but wish I had more time.
- I love the feeling of gaining the patient’s trust sorting through problems ranging from anxiety, heart failure or even cancer, but wish I had more time.
- I valued those patient experiences of doing the right test at the right time and really saving a life. For example, we used to have an X-Ray machine in the office and did Chest X-rays intermittently with annual physicals. Some nodules, although found incidentally, were proven to be cancers, removed and the patient’s life was extended. Even though the patient was referred to a specialist, I know that I was the one who started the process. When they thank you, there’s no better feeling. There are joys, but there are sorrows (and possible lawsuits)…..

Do I worry about lawsuits? Yes, well, no, at least I don’t have to translate my handwriting because it’s typed. We do practice at some level of preventing medical legal problems then and now. Once, I was sued for delayed diagnosis of a torn pectoralis muscle. It was a nightmare for 2 to 3 years. I was a bit gun-shy managing shoulder pain for a few years after. When I think back, for all the good I’ve done, this memory remains with me.

Yes, we all have good reason for practicing defensive medicine. There is a greater focus of using evidence-based decisions in practice. My fear is that with increasing guidelines, we might lose the art of practicing medicine. Changes in the frequency of mammography and prostate surveillance have changed over the years and patients are confused and do not know what to do. When dispute arises, dissatisfaction occurs and lawsuits are now inevitable in today’s society. We need to weigh the needs of the patient when instituting some of these guidelines. There are some guidelines that may not be successfully defended.

The US Preventive Services Task Force now recommends against the use of the PSA and digital rectal exam for detection of prostate cancer. When a cancer diagnosis is delayed, it doesn’t stop the possibility of a lawsuit. This is where the “art of medicine” needs to be preserved in our doctor-patient relationship. We need to do what is right for the individual patient even though population studies may show an appropriate alternative. In this past year, there are new guidelines offered by the USPSTF, ATP-4, and JNC-8. Some of these recommendations are not currently used in our EMR and our PCMH quality of care benchmarks because they have not been updated. In time, hopefully these differences will be resolved and repaired.

Predicting the future is as unpredictable as projecting the changes over the last 25 years. What will the practice of medicine look like in 20 years? It’s hard to predict what it will look like in two years, let alone 20 years. Hopefully, some part of the Affordable Care Act will survive. For my patients who have come in with newly obtained insurance, the change has helped them. With the electronic medical record, the ability of patients to communicate with their physician has improved. The EMR allows communication through a portal and this access to the physician is obtained without office visits or phone calls.

Will the practice of medicine change to the point that the patient will no longer have to see their doctor face-to-face? Patients expect to see their lab and imaging results as soon as they are released, as well as a lab letter or phone call from me. With the EMR, they can request their medications, make their appointments, and ask about their healthcare, a given test or any other question. This adds to my list of things to do. Some days, the catch-up time is up to three hours to complete my documentation. In time, there could be electronic media that puts us face to face through a screen rather than in the exam room. There are certain types of interaction such as counseling for diabetes care that can be done over the phone. These could be provided through Skype or some other type of electronic media. Could there be devices, like a Dick Tracy wrist telephone that puts patients vitals in front of us? Wait a minute; we nearly have that with downloadable telemetry. Will there be implantable chips in patients that alert us to their acute illness and diseases? This seems likely. However, I would still miss being in the exam room with my patients.

I enjoy the bond made between the doctor and the patient behind the door of the exam room. However, I do not enjoy the paperwork after hours once the door opens and the patient leaves. I may be in a generation of doctors who are experiencing the greatest transition in practicing medicine. We left medical school proud to use what we learned to diagnose and treat, grateful for the opportunity to care for others and inspired by the trust patients grant us. The greater focus on preventative care is fulfilling, but threatened by the impersonal invasion of the computer as a third person in the room. I am excited by the personal rewards of treating patients, but fearful of making a mistake. The paperwork or rather “keyboarding” is exhausting and continuous. On the other hand, the computer, keyboarding is exhausting and continuous. On the other hand, the computer, EMR and our new world of virtual information will help in how I will continue to deliver health care.

Dr. Connelly is a MAFP Past President (1993) and current President of the MAFP Foundation. He practices at GBMC at Hunt Manor in Phoenix, MD.
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The Bag

The bag now sits on my windowsill, next to the model Dodge Viper an elderly couple gave me, and the old coconut character my oldest daughter gave me from a spring break college vacation. It sits there alone, used and abused for over 30 years, and there are no plans to bring it out of retirement. Sit back and let me tell you the story about “the bag.”

A little background about the bag: What is the typical answer on any medical school application: I always wanted to be a doctor, but in my case, it was a true statement. I never even imagined doing anything other than carrying a black bag and seeing patients, either in the office setting, hospital, or with a home visit. Yes, I did grow up with the television characters, Marcus Welby, M.D., and his motorcycle driving partner, Dr. Kiley, and the idea of becoming a family physician was growing in my mind.

Growing up, did all the typical jobs, delivered newspapers for too many years for the lowest pay scale in history, cut grass for several neighbors for about 10 years and painted curbs for a summer job for the city of Havre de Grace. While in college, was a lifeguard (also taught swim lessons) for four years, I even tutored for extra sub money, so the work ethic was always there, but I wanted more, I wanted to hold a black bag with medical instruments and “take care of people.”

When I was in college, the resident assistant on our floor received a stethoscope from his parents when he was accepted into medical school, and I craved the black bag even more.

My neighbor, a local family physician, once promised me if I was ever accepted into medical school, he would reimburse me for the bag and the medical instruments. I never forgot that pledge.

Medical school acceptance: what a great feeling, (how I was accepted is another story), and into the second semester, we were finally able to order our black bags and medical instruments. I finally held the black leather bag in my hands. For me, this meant I was on my way to becoming a real medical doctor. The family physician neighbor covered the whopping cost of $156! I vowed to myself that I would take the bag everywhere, and for about 32 years I held true to that promise. Whenever I could I would carry it around during my residency, but the legend of the bag was well earned. During residency, I often had to take the bus, and walking off the bus while wearing my little white coat and carrying the black bag did lead to some bullying behavior from rougher individuals, but the bag endured. When I started in private practice with my confidence growing, the safety of the bag was secure, and it was welcomed immediately by my patients.

I would always bring my bag with me for home visits and for every visit in the office. Over the years, it encountered many personalities and living conditions. For example, one of my elderly patients would secretly let me know she was shipping marijuana from England, but of course, only for “medicinal purposes.” In an unfortunate situation, I had an elderly
The bag once helped me with a legal situation. I was rushing to the nursing home to see a patient and forgot to fasten my seat belt. That day, on the exit ramp, the state police were stopping every car to check for seat belt usage. When the police officer saw the black bag sitting in my front seat, he told me to buckle up and did not bother to issue me a citation.

The bag once helped me with a legal situation. I was rushing to the nursing home to see a patient and forgot to fasten my seat belt. That day, on the exit ramp, the state police were stopping every car to check for seat belt usage. When the police officer saw the black bag sitting in my front seat, he told me to buckle up and did not bother to issue me a citation. I learned my lesson to always buckle up...

The bag had its share of excitement over the years. It accompanied me for 20 years of Friday night high school football, and on two occasions, a strong running back ran out of bounds and fell onto the bag. The metal casing did bend, and since then, it has never closed properly, but those incidents gave it even more character. It even became somewhat of a celebrity when one of my nurse practitioner students offered and drew a professional style picture of my black bag as a favor for the personalized teaching he received. That wonderful drawing hangs proudly in my room (picture insert).

As the years went on, the bag, even with the wear and tear starting to show, became a favorite of my patients and they were always glad to see it. They often talked about it, and wanted to know its origin, was it from my father?, or was it handed down in the family?). The answer is no, it was once a brand new black bag that was taken everywhere by its proud owner. You know you have been practicing for a long time when many of your patients ask to see the black bag because they say it makes them feel more comfortable and secure during the exam.

Everything was going well, the bag was my buddy, and I always knew we would never part. Along the way, though, came something called EMR (electronic medical records), and with this system, we were all issued a large, heavy laptop which had to be carried into each room. It soon became obvious that the days of the black bag were over and I would have to give up my long time friend and companion.

The laptop made it impossible for me to also carry my black bag, so what do physicians do? They learn to adapt, and that means the otoscope is in my right pocket, with some ear pieces in my left pocket, a prescription pad is in my back pocket, and a small notepad is in my other pocket.

The bag now sits on the shelf, and its only function is to decorate my room, and occasionally I reach into the bag to pull out a cerumen spoon to clean out some ear canals.

I left my old prescription pads in the bag, (with EMR, 99% of the prescriptions are done electronically), along with my reflex hammer and tuning fork, (does anyone really use them anymore?), and various other things that tend to accumulate in your “junk drawer” at home.

For the past year, many of my patients ask about the whereabouts of the black bag, and offer their own stories about its wonderful run. However, over the last several months, the comments are starting to dwindle, and soon, the black bag will no longer be discussed once the door is closed. I am now destined to sit in front of my laptop and try to offer personalized Family Medicine with a smile and hope it can compare to the old fashioned way of dealing with our patients. I am sure many of you know exactly what I mean.

I will never forget the black bag, over these thirty plus years, it has meant everything to me, and it has been a source of comfort to me and my patients. I hope the next generation of family physicians can convey some type of personalized comfort while using the newest and fastest technology available. However, it always comes down to the care of the patient, they are the ones that matter, and the reason we all chose to become family physicians.

Dr. McClure, editor of this edition, practices at Harford Primary Care, a group practice in Bel Air.
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As a Family Medicine resident now in my final year of training, this is the perfect time for me to reflect on my experiences in the field. Even in the short time since my matriculation through medical school to the present time, there have been so many changes in medicine. When I initially started my journey, as a newly minted intern, I was filled with bounds of optimism. I thought my time would be spent talking with patients, and providing them with the care they required. My goal, as stated in many medical students’ personal statement was “to help people,” right?

What I quickly learned was spending time with patients was merely a fraction of the responsibility of a physician, whose time is often split between office visits, lab reviews, prior authorizations, coding/billing, and advocating for patients. In addition to that, working in an urban environment, a host of other issues require attention, such as underinsurance, no insurance, psychosocial concerns, like homelessness, lack of food, disability claims, and everything in between. As a new doctor, I felt completely overwhelmed with the daily responsibilities placed upon me. Most days I wondered if I would be up for the challenge, and if so, could I do this for the next 30+ years?

Time literally flew by, and now, as a third year resident, I definitely feel more comfortable in my shoes. With all of the daily events in our Family Medicine office, there is never a dull moment. I have had the opportunity to be the first person to touch a new born as they enter the world, given the child their first well child exam, and follow them into their toddler years. There were times when I met with a woman suffering from depression once a week to “check in” due to her distrust of psychiatrists. Plenty of “hi-5s” have been handed to my favorite patients who have gotten their hypertension controlled with medication compliance following years of noncompliance. Residency has been a time of tremendous growth.

Most of my patient interactions have provided me with learning experiences, even when they were not so pleasant. Almost once a day, or more, a disgruntled patient yells at me over wait-times, or pain medication denial, or any complaint under the sun. My fellow residents are like family, always available for venting, advice, and side-bar consults. My attendings have given me space to learn, grow, and make mistakes as the years have passed on, which is exactly what any young doctor needs in order to eventually practice without constraints. Teamwork is the essence of Family Medicine. Again, I came into the field thinking that I would help people. In reality, I do help people with the help of many others, such as the case managers, social workers, specialists, nurses, medical assistants, and many more who come together to address the needs of individuals. All of us make up the medical home, which is a popular phrase in the primary care world. Home is definitely where the heart is!

With the recent changes of medicine in the news, it seems as though America is finally starting to recognize that primary care is the “heart of the medical field,” in which changes must originate in order to make substantial progress. As more medical homes are established, great change is occurring in the field. Changes such as electronic medical records are making it easier to place the focus back on the patient with increased time allotted from less paper chart surfing. Care coordination teams increase patient satisfaction, as more staff are dedicated to help with patient needs. The ACA is granting more access to the uninsured to allow them to receive catch-up, as well as preventative care. All of these changes are exciting for me, as a young doctor, embarking on the future. I feel excited, intimidated, and motivated to take on the future challenges. Earlier I asked myself if I could live with practicing medicine as I had in my intern year for the next 30 years? The good news is that I won’t have to find out that answer! Medicine has changed exponentially in these past three years, and I can only imagine what lies ahead.

Dr. DeRouen is a R-3 at the University of Maryland Family Medicine Residency. She joins the MAFP Editorial Board this year as Resident Editor. See her additional contribution to Residents Corner on p. 26.
The Transformative Nature of Family Medicine

Ansu Punnoose, D.O.

Health care in the United States has gone through a transformation in the past few decades, and I do not see an end to this transformation in sight. While many aspects of the change have been beneficial, such as modernization of equipment and analysis, better treatment options and procedures for once incurable diseases, and electronic medical records that group patient documentation and ease access to patient records, it is not a stretch to say that some parts have been detrimental not only to the patients, but also to the system at large. I believe that the family physician has been impacted the most by these changes, but I also believe that said physician is the answer to many of these issues.

With the rising cost of attending university and medical school, the new generation of doctors are drawn to specialties with better compensation, causing a drought in future primary care providers. Meanwhile, although EMR has been advertised to be the solution to the issues that plagued paper charting, I believe it has caused problems of its own. Many older primary care providers are leaving practices because they cannot keep up with the transition to EMR charting. This lack of primary care providers has been most evident in the rising visits to the emergency room, increasing health care costs for the same visit that would be a fraction of the cost at the doctor’s office.

Also, due to rising health care costs, private practices are dwindling, while hospital based offices are growing. The physician is starting to forge a stronger relationship with the computer to keep up with documentation on their EMRs, perhaps forgoing or forgetting the bedside manner they may have relied on earlier. In medical school, we were taught the uniqueness of each patient, yet EMR seems to be clustering patients into certain categories to satisfy arbitrary guidelines. These guidelines determine reimbursement, which seems to favor procedures, quantity of patients seen, and the number of checked boxes in EMR.

Perhaps it is time to acknowledge that a holistic approach to medicine is what is necessary to combat the many issues we are seeing in the transformation of medical care in the United States and a family physician is best equipped to provide that care. The doctors of the past were the same, providing care in the community, making home visits, taking more into account than lab work. I believe the future of Family Medicine consists of a new generation of physicians who are armed with modern tools but with an altruistic mindset to love and heal their patients.

During my past few years in residency, I have had the distinct honor of working with some amazing family physicians. It is easy to be frustrated when I may see a pregnant patient for a prenatal visit, and do my best to provide OB teaching, but then realize that the same patient has no access to resources to care for her child or even herself. I may see an obese family, whom I can lecture to eat better and exercise, and then realize the family lives in a community with no easy access to a grocery store. The physicians I have seen who have overcome such problems are the ones who realize that health doesn’t start and stop at the doctor’s office, rather it starts at the patient’s home and in their community. I see many of the same family physicians whom I work with side by side, not only doing their job in the hospital, but also working in the community and with families, at times in their homes, to make a real change. They do not limit themselves to the four walls of their practice, but go beyond to provide a lasting impact in the community as patient caregivers, and as patient advocates.

We know that office and hospital based health care services are a small fraction of the social determinants which affect a patient’s health. Education, work environment, housing are some of the many factors that also play a significant role and it is essential as physicians to be aware and address these factors. Establishment of a Patient Centered Medical Home is one of the many ways we are addressing the issue of reaching people beyond the health services we provide for them in an office. It has broadened the horizons of medicine by making primary care a team based model. We are no longer encapsulated within our office practicing the science of medicine limited to our patients’ vitals and lab results, rather we get to go back to the roots of Family Medicine. The PCMH model reminds us that our specialty is that of a holistic nature, centering on the patient, their families and their social infrastructure. It also reminds us that physicians are just one set of players in patient care. Our patients have a life outside of our office over which we have very little control and the best approach to address their need is by collaborating and communicating with the other players involved in our patient’s care within their community or at the least, being able to direct patients to such resources.
There is a huge need for family physicians because we are best equipped to address the health and social disparities that contribute to our patient’s health. As family physicians, we have access to patients of all ages and various medical problems, as well as an understanding of the psychosocial factors that affect health. Thus, when I think of the future of Family Medicine, I see a future where family physicians are working with schools, community centers, local businesses, community leaders and with other health care providers towards the same goal to provide the best opportunities for our patients to take control of and improve their health. Collaborating with other professionals and establishing community networks is a way to reach patients on a personal level and ensure a better outcome for their health. Advocating for our patients’ needs helps us to address the social determinants that affect a patient’s health. It is when we work as a whole to attend to the various factors contributing to our patient’s health that we can expect the most drastic outcomes that benefits our patients and our health care system.

Dr. Punnoose is a R-3 at the Franklin Square Medical Center Family Medicine Residency in Baltimore. She joins the MAFP Editorial Board this year as a Resident Editor. See her additional contribution to Residents Corner on p. 26.

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I’m very excited to tell you about another successful AAFP National Conference this past August in Kansas City. Overall it was a packed three days, with representatives from both Family Medicine residencies; MedStar Franklin Square Medical Center and the University of Maryland, and dozens of Maryland medical students from the University of Maryland and Johns Hopkins (see p. 26 for student recaps).

A few weeks before National Conference, the MAFP created a unique new Networking/Mentoring Dinner Workshop at a local restaurant. During this workshop students and residents learned about the myriad of opportunities at National Conference, including educational programming, networking, and the resolution process. It was an excellent event with stimulating discussion and company.

Once we got to Kansas City, the two Maryland residency programs had booths set up next to each other on the exhibit hall floor, making for ease of student visitors to talk with both programs, while allowing residents the opportunity to interact.

On Thursday night, we had a joint University of Maryland & Franklin Square residency dinner. Thanks to Peter Burkill (UM, R-3) and Daniel Gold (FSq, R-3) for organizing this wonderful opportunity to meet medical students from around the country. Many students described their interest in training in Maryland, citing its diversity, proximity, and in some cases family ties.

On Friday, Elizabeth Wiley (UM, R-2) Alternate Delegate from Maryland, chaired one of three resident reference committees and took testimony on a number of important resolutions from the residents. She and her committee then met alone to discuss whether to adopt, adopt with amendment, not adopt, or accept for reaffirmation the 15 resolutions presented.

On Saturday morning, the Congress of Delegates sessions brought much resolution debate, and officer elections. Our resolution entitled “End the AAFP Alliance with Coca Cola” passed through both the student and resident congresses and will be sent to the national congress of delegates assembly this fall in DC (along with Maryland/Rhode Island’s same resolution submitted earlier). If it passes there, the board of directors will decide at their meeting next year whether to renew the alliance or act in the best interest of patients by not accepting any more money from Coke.

Dr. Wiley and I collaborated with other students and residents on 9 other resolutions that were either passed or accepted for reaffirmation through the resident congress:
1. Support LGBT nondiscrimination at the WHO’s World Health Assembly
2. Support clinical trial data transparency via AllTrials.net
3. Support access to essential health benefits including contraception
4. Encourage state chapters to investigate state-based single payer
5. Oppose capping the Public Service Loan Forgiveness program
6. Support the IOM’s new GME recommendations
7. Establish best practices in patient encounter and competency tracking
8. Support diversity in national conference programming
9. Allow electronic submission of resolutions
10. Develop education for students and residents concerning rural medicine (I co-authored with some medical students from Arkansas)

I was elected to Resident Chair of the National Conference so will be planning and executing National Conference next year. I am very excited to take on this role!

I would like to thank the Maryland Academy for helping make this trip possible for many of us, and for putting on the pre-conference workshop dinner. I hope we can continue this wonderful tradition. See you next year!

Snapsots from the 2014 AAFP NCFMR, August 7-9, Kansas City

Dr. Liz Wiley (UM, R-2) chairing a reference committee at the NCFMR Congress.
The University of Maryland Resident Selected for Leadership Academy

Peter Burkill (R-3), one of the University of Maryland’s Chief Residents, has been selected to participate in a program sponsored by Primary Care Progress and Iora Health. They have combined forces in a pilot program to develop a new cadre of leaders in primary care innovation and dissemination. The Primary Care + Innovation Academy will engage a group of six primary care medical residents from across the nation for a four-month curriculum that combines a two week immersion in advanced clinical innovation in primary care, along with training in enhanced communication and community engagement strategies.

American Academy of Family Physicians Conference Ambassadors

Six of our residents (Janna Becker, Hersch Bhatia, Peter Burkill, Jennifer Christie, Erin Jones, and Elizabeth Wiley), travelled to Kansas City, Kansas for the Annual National Conference of Family Medicine Residents.
and Medical Student, where they engaged in conversation about the exciting goings on in Family Medicine. They also worked the UM Residency booth at the Residency Fair, meeting with some of the hundreds of medical students interested in Family Medicine who attended the conference.

As a bonus, the UM resident representatives from the 2013 AAFP Conference were featured online, in the AAFP journal throughout the year to highlight the “face of Family Medicine.” Also, it was quite a surprise for the representatives to be featured as ‘physician models’ on the hotel banner for the conference this year. You can see the Banner below, as well as a picture of this year’s resident representatives.

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The MAFP Foundation conducted the first-ever National Conference of Family Medicine Residents and Medical Students (National Conference) Mentoring/Networking Workshop for chapter leaders, faculty, residents and students representing our chapter at the upcoming 2014 National Conference and Congresses in KC at the 2014 AAFP NCFMR/MS, August 7-9. The event took place on July 24, 2014 at Matthews 1600 in Catonsville (Baltimore County). Our MAFP national Congress of Delegates delegation was present to instruct and interact with the student/resident delegates, informing them of the AAFP policy-making process. This was also a good opportunity for those who have attended past conferences to inform 1st-time attendees about what to expect at the residency fair, how to get involved in chapter/national activities, etc. The opportunity for everyone to meet and network together was valuable. There will be an agenda, but flexibility was the key as participants crafted the event to be most useful to them.

After the event, participants offered (overwhelmingly favorable) comments and constructive pointers for possible similar future, perhaps annual such initiatives. All in all, in the course of the 3-hour event, the following goals were met: 1) to achieve increased preparedness for the conference/congresses in KC, 2) to learn of the issues of importance among residents and students, 3) to stimulate interest in leadership in the chapter and in AAFP among students/residents, 4) to evoke interest in attending subsequent Family Medicine-centric events which focus on clinical, practice management and leadership aspects, 5) to give current chapter leaders an outlet for sharing their experience and knowledge, 6) to meet peers in an informal social setting.

Medical Students Converge, Make Connections
MAFP Foundation Hosts Its First Pre-National Conference Mentoring/Networking Workshop

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MAFP Foundation Provides Stipends to Students Attending the 2014 AAFP National Conference of Medical Students (NCMS)

This past Summer (August 7-9) medical students from Maryland and across the United States attended AAFP’s popular annual resident/student conference in Kansas City, MO. As always, the MAFP Foundation helped with travel expenses. Readers can see that the conference, again this year, was a career plan-altering experience for many medical students. It is the mission of the MAFP Foundation to support medical student initiatives in fostering the specialty of Family Medicine.

Rattner and Britz Represent Maryland Chapter at 2014 Medical Student Congress

This year student members of AAFP submitted 27 resolutions with over 20 of them being approved by the Student Congress for review by the AAFP Board of Directors.

Medical students representing states from around the nation shared their perspectives on important issues from providing equal standards of health care to immigrants, to advocating for making Sovaldi, the novel Hepatitis C, drug affordable, ensuring universal access to contraception, and advocating for a single payer health system.

Furthermore, students pushed to promote Family Medicine by adopting resolutions to increase educational activities and networking around Direct Primary Care, culinary and nutrition education for family physicians and trainees, and increased networking and mentorship among minority students, residents and physicians.

It was inspiring to hear the positions from AAFP student members and know that we contribute to the future of AAFP policy dealing with innovative patient care,
social justice and fostering the specialty of Family Medicine. The great energy compelled me to write and support several resolutions myself.

The national conference was a great experience. I feel privileged to have been chosen to represent the Maryland Chapter at the Student Congress. I was enlightened in learning about exciting ways family doctors work on global health initiatives, addiction medicine and women’s health. I also had the opportunity to connect with various Family Medicine residents and physicians from programs and practices all over the country. I left feeling energized and eager to begin my Family Medicine rotation at Franklin Square next month and follow the diverse transformations in the field of Family Medicine.

Adi Rattner (JHU, MS-3), Delegate

It was a great honor to serve as the MAFP’s Alternate Delegate to the Student Congress. Admittedly, I had been previously unaware of the many AAFP leadership opportunities for students and it was inspirational to see my peers who have taken on such roles and who are encouraging and motivating future family physicians. I also volunteered to serve on a Reference Committee which was another unique experience for me. Having the opportunity to not only hear testimony on new resolutions, but to then help decide the action to take regarding these resolutions allowed me to be part of the policy-making on behalf of the Maryland Chapter. I love the fact that students have such a strong voice within the AAFP.

Sarah Britz (UM, MS-4), Alternate Delegate

Other Reflections...

As a first-time national conference attendee, I was truly impressed with the energy, positivity and overall enthusiasm for Family Medicine by fellow students, residents, physicians including the AAFP leadership. Had I not already decided that Family Medicine was the path for me, this conference surely would have persuaded me. It was such an amazing opportunity to meet people from across the country who share my passion for Family Medicine and I am grateful to have been able to make so many connections. I left the conference feeling inspired about becoming a family physician. I plan to continue to be involved as a resident and beyond.

Sarah Britz, UM MS-4

The AAFP National Conference met and exceeded my expectations in many ways. On the first day of conference, I had the opportunity to attend a few different educational sessions where I could hear from different family physicians and medical students throughout the country. One session in particular, titled “Becoming Family Medicine: Reshaping the Landscape of Health Care,” provided a lot of insight on the role family physicians have in health care, and what impact we can make in terms of reducing health care costs and improving patient outcomes. The strong data presented by Dr. Robert Phillips left an impression on the audience, showing us (as students and residents) that we hold an important role in society as health care delivery is changing. I also attended the Joint Business Session of Resident and Student Congresses on the first day of conference. It was exciting and inspiring to hear what different residents and medical students from all over the country are doing to address issues important to family physicians.

The Expo Hall was by far the most rewarding aspect of conference. By meeting residents and faculty from different programs across the U.S., I was able to get a better idea of what I’m looking for in a residency program and what aspects of Family Medicine are important to me. I spoke with a lot of different programs and got valuable information that will guide me as I apply this Fall. Family Medicine draws a diverse group of people, but at the very core we all have the same passion for patient care and longitudinal relationships.

Angela Chiang, UM MS-4

I really enjoyed my time at the AAFP National Conference in Kansas City. As a medical student at Johns Hopkins, we get very minimal exposure to Family Medicine, and often when it is mentioned, the tone is negative and dismissive. This conference gave me exposure to the full spectrum of exciting career options and opportunities available to a family doctor.

Not only was I able to meet residents from a broad range of programs across the country, I also attended some very interesting and educational seminars. I learned continued on page 30
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skills in wilderness medicine, heard lectures on palliative care and addiction medicine, and brushed up on identifying common dermatologic lesions. I also had some of my misperceptions about the options for practicing OB within Family Medicine corrected and was able to talk one on one with doctors who work in a variety of settings—from extremely rural to urban underserved, and from direct primary care to academic medicine models of practice.

All the possibilities I was exposed to over the weekend left me with even more questions about what I want to do with my future. Certainly though, it made me consider a career in Family Medicine more seriously than I ever had before. Thanks to the MAFP Foundation for its support in sending me to Kansas City to discover family med!

Juliana Macri, JHU MS-3

The AAFP Conference in Kansas City was a very worthwhile experience, and I would highly recommend it to any 4th year medical student planning to pursue residency in Family Medicine. Most valuable for me was getting to spend time in the Expo Hall, chatting with student and faculty representatives from a huge array of residency programs. More than just giving me important information about the nuances of the programs, it was nice to see how many like-minded future colleagues are out there doing great, socially-conscious work in Family Medicine. I also enjoyed some exposure to the AAFP legislative process through working on some resolutions along with others from the Maryland delegation. I gave testimony to the Student Congress urging them to pass a resolution for the AAFP to end its financial alliance with Coca Cola, and the resolution passed—thanks largely to the leadership of Richard Bruno and Liz Wiley, two residents from the Maryland State delegation. I look forward to attending another conference in Kansas City as a resident, when I will have more time to devote to the legislative/advocacy agenda, away from the stress of residency applications! Also notable was bonding time with my fellow Maryland med students as we discussed our experiences over barbecue at several of KC’s famous culinary institutions.

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Give Back: Help Future Family Physicians Achieve Their Goals

Were you helped along your educational journey to become a family physician? Did you have an exceptional/memorable learning experience? Did you receive financial assistance from the MAFP Foundation? Even if not, the MAFP Foundation exists exclusively to foster the specialty of Family Medicine through educational support for medical students.

With testimonials such as those appearing herein, the future of the specialty is secure. Help enthusiastic medical students realize their goals. It’s easy to donate. Simply click on the Foundation tab at www.mdafp.org, email info@mdafp.org or call 410-747-1980. Acknowledgement and recognition will follow. Thank you!

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Assembly CME Videos
Available for Viewing – Reviewed and Approved for All Professional CME Needs

Did you miss the June, 2014 MAFP CME conference? Six of the presentations, along with presentations from the February 2014 conference, are available for you to earn CME credit according to your schedule in the comfort of your home or office? FREE to members!

View at www.mdafp.org

2 GREAT MAFP CME CONFERENCES IN 2015!
Mark Your Calendars
Details to Follow in MAFP publications, at www.mdafp.org or call 410-747-1980

MAFP Winter Regional Conference: (theme to come)
Saturday, February 21
Sheraton Baltimore North, Towson, Maryland
Pre-Conference ABFM SAM Study Hall
Friday, February 20
Module: Care of the Vulnerable Elderly

MAFP 2015 Annual CME Assembly
Thursday, June 25-Saturday, June 27
Clarion Resort Fontainebleau Hotel, Ocean City, Maryland
ABFM SAM Study Hall: Thursday, June 12
Module: TBD
Education, Baseball, Football and Fun!
June 12-14, 2014, Frederick, Maryland
Annual CME Assembly
Pictorial Highlights

Dr. Howard E. Wilson proudly displays his MAFP Award of Special Recognition given upon the completion of his term as AAFP Delegate, and after having served in every capacity of Chapter leadership, including first 2-year president 2004-06. Joining him are Mrs. Lynetta Wilson (L), MAFP President Dr. Yvette Oquendo-Berruz and AAFP President Dr. Reid Blackwelder.

Dr. Kristin Clark poses a question during the Scientific Session.

Special guest, AAFP President Dr. Reid Blackwelder delivering the keynote address... illustrating, by wearing/shedding several ties throughout the talk, the many roles family physicians enact in their daily quests to provide quality patient-centered care.

MAFP learners take advantage of alternative seating during session... Engage the core!

Dr. Blackwelder engages with a member during session break.

MAFP Executive Director Esther Barr waves to her family during her (surprise) acceptance of the MAFP Lifetime Achievement Award.

Dr. C. Earl Hill (at podium) presents the MAFP Lifetime Achievement Award (posthumous) to Dr. J. Roy Guyther. Accepting the award are Dr. Guyther’s daughter, K.T. Logan and son Joseph Guyther.

MAFP Executive Director Esther Barr waves to her family during her (surprise) acceptance of the MAFP Lifetime Achievement Award.

AAFP President Dr. Reid Blackwelder bestows the designation of AAFP Fellow on MAFP Immediate Past President Dr. Eugene J. Newmier.

The MAFP family with special guest, Baltimore Ravens’ Chris Canty (c) who joined us in the Fuel Up to Play 60 event.
Recent Family Medicine alumnus and current faculty Dr. Kate Jacobson, and 3rd year Resident Dr. Ansu Punnoose accompanied 13 other team members on a trip to the Dominican Republic this past summer for a medical mission. Armed with suitcases containing medications, medical supplies, glasses, clothing and shoes, they traveled to 7 villages and conducted 10 medical clinics. They set up clinic/pharmacy stations in churches under the shades of trees and even sugar cane plantations with sessions consisting of approximately 50-60 patients. Not only did Drs. Jacobson and Punnoose have the opportunity to use their medical knowledge and bring healing to many people, they also witnessed transformation taking place in some of the villages including a water purification system, as well as the beginning stages of a vocational school to help people develop skill-sets.

Dr. Jacobson is currently a Trustee on the MAFP Foundation Board of Directors. Dr. Punnoose is a resident member of the MAFP Editorial Board this year (see her articles on pp. 22 & 26) NOTE: Dr. Jacobson’s upcoming article about her mother, MAFP member Dr. Linda Walsh, being the recipient of the 2014 AAFP Humanitarian Award, for her annual medical missions to the Dominican Republic, will appear in the Winter edition.

Medical Mission Brings Hope, Healing and Help

Congratulations for Special Appointments, Honors, Features, Achievements!

Nancy Beth Barr, M.D. of Elkridge and Kisha N. Davis, M.D. of North Potomac have been appointed by Governor Martin O’Malley to the Maryland Advisory Council on Heart Disease and Stroke. Dr. Barr, a MAFP Board Member, is Medical Director of the Family Health Center at Franklin Square Medical Center in Baltimore. Dr. Davis, soon-to-be installed MAFP President, is Director of Community Health Institute at Casey Health Institute in Gaithersburg.

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Kathryn Boling, M.D. of Baltimore appeared July 29, 2014 on Fox 45 Morning News where she discussed diet and how certain foods can decrease cancer risk. https://www.dropbox.com/s/v9nsq6r8ti9buxy/FOX45.mp4

Melly Goodell, M.D. of Fallston, Chair, Department of Family Medicine at Franklin Square Medical Center in Baltimore, was a keynote speaker at the PCMH conference, “Building the Patient-Centered Medical Home: Inspiration and Tools to Help Transform Your Practice,” in Tuscaloosa, Alabama in July, hosted by the University of Alabama’s College of Community Health Sciences.

Niharika Khanna, M.D. of Columbia represented MAFP at the Patient Centered Primary Care Collaborative Western Regional Conference June 9-10, 2014 in Denver. Dr. Khanna, a MAFP Board Member, is Associate Professor, University of Maryland Department of Family and Community Medicine and Director, Maryland Learning Collaborative.

Matthew Loftus, M.D. of Baltimore was featured in “JKCF Recognizes 3 Scholars for Outstanding Achievements in Public Service,” an article on the Jack Kent Cooke Foundation website for being 1 of 2 awardees of the 2014 Matthew J. Quinn Prize ($10,000) for “outstanding extraordinary achievements in their communities. Details at http://blog.jkcf.org Dr. Loftus was also featured in “Downwardly Mobile for Jesus,” an article at http://america.aljazeera.com discussing his family’s move to the Sandtown Winchester neighborhood, poverty stricken and high crime area of Baltimore City.

Jean Masoso, M.D. of Baltimore, R-2 Franklin Square Residency, for being awarded the 2014 Thomas Holcomb Award for excellence in Pediatrics. Dr. Masoso is the 25th annual winner of this award.

The following members volunteered their time and talents in service as judges for the Primary Care Challenge, a competition for physicians and medical students for innovative ideas in the practice of PC medicine (see August, 2014 MAFP E-Bulletin at www.mdafp.org). MAFP was an organizational co-sponsor.

Nancy B. Barr, M.D.
Niharika Khanna, M.D.
Kenny Linn, M.D.
Mozella Williams, M.D.


Dr. Adebowale Prest (R), MAFP Senior Delegate to the AAFP Congress and Executive Director Esther Rae Barr represented the Maryland Chapter at the 2014 Southeastern Family Medicine Forum in Orange Beach, AL. This annual conference brings together 12 Chapters of the AAFP for valuable exchange of information and networking.

In Memory
The Maryland Academy of Family Physicians is saddened by the passing of its members James L. Forsberg, M.D., Eldersburg Thomas F. Herbert, M.D., Easton (formerly Ellicott City) Bennett A. Porter, M.D., Hermitage, TN (formerly Ocean City) Memorial contributions have been made to the MAFP Foundation to honor them.
It doesn’t matter where you’re from.

It doesn’t matter how old you are.

It doesn’t matter where you live.

You deserve high-quality health care.

Families deserve high-quality health care.

Everyone deserves peace of mind.

Everyone deserves a partner in health.

Everyone deserves a family doctor.

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Randy Rawson
American Boiler Manufacturers Association

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Kathy Thompson
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