PHYSICIAN SELF-CARE

Physician Heal Thyself... And in the Process Improve Patient Health

The Depressed Physician

The Importance of Spiritual Health

Burned...?

ALSO...
• Welcome to MAFP’s New President: Kisha N. Davis, M.D.
• Dr. Linda Walsh Receives 2014 AAFP Humanitarian Award
• Health is Primary: Family Medicine for America’s Health
• Don’t Miss Special February Events – Advocacy, MC-FP, CME!
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Strengthening Family Medicine in Maryland – Together!

Kisha N. Davis, M.D.

I am so excited to be serving as your new president of the Maryland Academy of Family Physicians. I come to you after a year on the Board of Directors of the American Academy of Family Physicians and I hope to bring some of that knowledge to our Maryland chapter.

There are many challenges that sometimes make it difficult to be a doctor but there are many things on the horizon that make me optimistic about the future of Family Medicine. The first is the Family Medicine for America’s Health campaign that was launched during the AAFP Assembly in October. This national campaign aims to put primary care in the forefront. All developed countries that have made primary care a priority have better health outcomes. This campaign seeks to reeducate patients, the government and providers on the importance of primary care and serves to remind everyone that Health is Primary. Go to the website www.healthisprimary.org to learn more information and stay tuned for more buzz starting in January 2015.

I recently returned from speaking at the California Family Medicine Summit for students and residents. Their enthusiasm and passion for Family Medicine was encouraging and inspiring. For the past few years the number of students matching in to our specialty has been increasing. There is still a ways to go to meet this country’s primary care shortage, but we are reaching the point where the number of slots for primary care won’t meet the need. The AAFP is helping to start the conversation on GME reform to reexamine how this country thinks about assigning residency and fellowship funding. The current system often ties GME funding to large academic institutions which are usually situated in major metropolitan areas. Studies have shown that doctors tend to stay close to where they train and as a result there are shortages of primary care doctors especially in rural areas. Maryland experiences this with two medicine residency programs, both located in Baltimore. I am excited to learn about the opening of our newest Family Medicine residency affiliated with Prince Georges Hospital. However, our eastern and western colleagues are at a loss. There are some bright spots with the University of Maryland’s rural health track. In addition Johns Hopkins School of Medicine has a thriving Family Medicine Interest Group despite not having a department of Family Medicine.

Our chapter is doing great things. We had a significant presence at the AAFP Congress of Delegates where our own Dr. Linda Walsh was recognized with the 2014 AAFP Humanitarian Award for her annual medical missions to the Dominican Republic (see p.18). Dr. Jos. Zebley, Chair of the AAFP Delegation to the American Medical Association (AMA), shared his report and encouraged family physicians to join and influence the AMA. In addition, Maryland was highlighted as our Senator Ben Cardin, MD...
addressed the crowd at the AAFP Political Action Committee (PAC) Reception. Maybe the most significant activity was our chapter leading a movement asking the AAFP to end its alliance with the Coca-Cola Company. While the measure did not pass, it was a valiant effort that was organized by our own resident member of the Board Dr. Richard Bruno who co-authored the resolution.

We have renewed energy and ability to advocate for Family Medicine at the state legislature with the addition of our lobbyist Eric Gally. Our 2014 Advocacy Day was so successful that our own Dr. Matt Burke presented on it at the 2014 AAFP State Legislative Conference in New Orleans this past November. Participation in advocacy helps to make sure our voice is heard in Maryland and around the Nation. We are already well in to planning our 2015 Advocacy in Annapolis. Be sure to save the date (February 5, 2015) to come meet your state legislators and help inform them about the issues that are important to our patients and our profession.

Lastly I’m encouraged by all of you. Many of you have come to me and said that you want to get involved. I hope you meant it because I’m going to come calling. The Maryland chapter is on the move. My goals over the next couple years are first to increase member engagement and connection to the MAFP Board and with each other. As family physicians we often work in isolation, striving every day to do what is best for our patients. What is best for our patients is to have a strong network of family physicians who can support each other. Even more, we as family physicians need to know that there is a strong organization like the MAFP supporting us and fighting for the issues that are important to us. Secondly, I’d like to see the voice of the family physician be even stronger in Maryland and the MAFP is already starting to lead that charge. Being so close to Washington, DC, we are uniquely able to help push forward issues important to Family Medicine both at home and nationally. In order to achieve these goals we will need your voices and your support.

I hope you join us over the next year with several opportunities to learn, network, and advocate (details on p.22).

February 5, 2015 – Maryland State Legislature Advocacy Day
February 21, 2015 – Winter Conference
June 25-27, 2015 – Summer Conference

Stay tuned and get involved!

President (continued)
DISEASES AND HEALTH PROBLEMS LINKED TO SMOKING

1 OUT OF 3 CANCER DEATHS COULD BE PREVENTED

SMOKING CAUSES CANCER

— IN THE —

LUNGS • TRACHEA • BRONCHUS • ESOPHAGUS • ORAL CAVITY • LIP • NASOPHARYNX • NASAL CAVITY • LARYNX • STOMACH • BLADDER • PANCREAS • KIDNEY • LIVER • UTERINE CERVIX • COLON AND RECTUM

And causes leukemia

Smoking can cause cancer almost anywhere in the body.

The Health Consequences of Smoking — 50 Years of Progress: A Report of the Surgeon General, 2014

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Visit smokingstophere.com for more information.
Beginning immediately with the onset of medical school, the practice of medicine is all consuming. Risks to a physician's health begin from day one and include sleep deprivation, excessive work demands, financial stressors (high loan repayments, low residency salaries), fear of litigation, exposure to contagious illness, proximity to human trauma and suffering, and severe time limitations that cause deficits in nutrition, exercise and preventive health treatments. Surveys have consistently documented that physicians work many hours, averaging 50-60 hours per week when not on call.1 Resident physicians routinely work 80 hours a week. Furthermore, female physicians – who in 2010 made up 46.1% of residents and fellows2 – face greater challenges than do their male counterparts in finding balance between work and family responsibility, resulting in increased family conflict and stress.3

Compounding the problem, those who enter the profession tend to have similar personality traits. At the American Medical Association/Canadian Medical Association (AMA/CMA) 2002 International Conference on Physician Health, delegates heard repeatedly that the very traits that make for good physicians make for bad patients.4

In general, physicians are more likely to be independent, competitive, high-achieving and neglectful of their own health needs.5 As a result, they are often noncompliant and over-controlling as patients, with little trust in the medical system. Physicians tend to view illness as personal failure and many dread becoming patients. A 2001 study published in the British Medical Journal revealed that general practitioners (GP) feel pressured to act as if they are well, even when sick. That pressure stems from a fear that patients and colleagues will view the GP's health as an indicator of his/her medical competence.6 Given these risks, how does physician health and lifestyle compare to that of the general population?

A Snapshot of Physician Health and Lifestyle

Obesity

The CDC statistics on U.S. health report that in 2008, 40% of all American men were overweight and 37% were obese.7 Male physicians fared somewhat better here than the general population with 37% overweight and only 5.3% obese. For American women, 28.6% were overweight and 35% obese. Female physicians came down on the slimmer side as well with only 26% being overweight and a much lower 6.2% classified as obese.8

Exercise

The CDC also reported on exercise habits. In the general U.S. population about 22% of adult men meet federal aerobic and muscle strengthening guidelines. Physicians engage in physical exercise more than the average American. Of all physicians surveyed under 30 years of age, 48% exercised at least twice a week, and the older they got, the more they exercised. After age 61, a whopping 72% are exercising twice a week or more. Of the almost 300,000 surveyed, only 7% of female and 8% of male physicians did not exercise at all.9

Nutrition

A 2013 survey by Medscape found that 62% of physicians who were normal or underweight reported eating a diet rich in fruits and vegetables. The same survey found that 44% of heavier doctors ate higher carbs, more meat and fat, or “on the go” meals. A mere 16% of overweight or obese doctors were on a calorie-restricted diet meant to help them lose weight. Although about half of all doctors surveyed go out to eat once a week, only 15% of overweight and obese doctors eat fast foods. Among normal weight physicians, 10% admit to eating fast food. Nationwide, only 32.5 percent of U.S. adults consume the recommended amount of fruit and 26.3 the suggested number of vegetable servings.10

Vitamins and Supplements

More than 60% of physicians forty-six and older, and 50% of younger physicians, take a form of dietary supplement. The most common supplements consumed were multivitamin, vitamin D, calcium, omega-3 fatty acids and antioxidants.

Alcohol and Cigarettes

Approximately 18% of Americans still smoke.11 Physicians are much healthier when it comes to smoking. Only 2% of male physicians and 1.28% of female physicians smoke. American drinking habits as a whole have stayed steady since the late 1930s with 67% of adults reporting they drink alcohol. Male physicians report that they drink...
more than the average person, with 73.4% reporting that they drink alcohol – however a large percentage drink less than once a week. Female physicians are closer to the national average with about 65% who report alcohol consumption – again, many drinking less than one drink a week.12

Marriage and Relationships

Physicians are more likely to be married than the general population. A 2011 Pew research report found that only 51% of Americans were married. The Medscape Physician Lifestyle survey found that 85% of male physicians were married followed closely by their female counterparts, at 71%. Being married contributed greatly to physician happiness. Physicians of both sexes who were married reported higher levels of happiness than those who were single, divorced, or separated. But the picture is not all rosy. Physicians have a divorce rate that is 10-20% above that of the national average. According to a 1997 US study, psychiatrists have the highest rate at around 50%; surgeons are next at 33%; the profession as a whole has a divorce rate of 29%. The study also found an elevated divorce rate among female physicians and those who married while still in medical school.13

Spirituality

Physicians are remarkably homogenous with the general population regarding their spiritual lives and beliefs. According to a 2008 Pew Report 88% of Americans believe in some type of Universal Spirit or God.14 Similarly, a full 83% of physicians believe in God, with over 40% actively practicing their faith.

Mental Health

Physician depression is at least as common as in the general population, affecting an estimated 12% of males and 18% of females. Medical students and residents screened for depression have even higher rates: 15-30%. Depression in U.S physicians has not been well studied, but a 2011 survey of 50,000 practicing physicians and medical students in Australia demonstrated a dramatically increased incidence of severe psychological distress and a twofold increased incidence of suicidal ideation in physicians compared with the general population.15 Unfortunately, when depression exists, physicians face increased barriers to care: both self-imposed and organizationally. Over half of all doctors felt that their professional reputation would suffer and they would be seen as less competent if colleagues knew they were depressed. In addition, Physicians are concerned about maintaining confidentiality, fear recrimination or discrimination by employers or colleagues, and worry about the impact on obtaining and keeping a medical license.

The overall physician suicide rate cited by most studies has been between 28 and 40 per 100,000, compared with the overall rate in the general population of 12.3 per 100,000. Overall, then, physicians are more than twice as likely as the general population to kill themselves.17 Put into perspective, the yearly number of physicians who kill themselves is equal to approximately two average size graduating classes of medical school students annually. Female physicians appear to be especially vulnerable. Suicide rates for women physicians are approximately four times that of women in the general population.18 The rates for male and female physicians are roughly equal, whereas women in the general population are much less likely than men to complete suicide.

Sleep

Physicians frequently are not getting enough sleep. Healthy adults typically require 6 to 10 hours of sleep in a 24-hour day. The average person needs just over 8 hours of sleep each night. Adults who get fewer than 5 hours of sleep will show a decline in peak alertness. After only one night of missed sleep, a significant cognitive decline may occur. In fact, twenty-four hours of wakefulness produces impairment equivalent to having a blood alcohol level of 0.1%. In addition to the cognitive and motor impairment seen in physicians with sleep deprivation, the emotional effects are considerable. A partial list includes family and marital discord, depression, cynicism, lack of empathy for patients, and suicide.19

Medical Care and Treatment

Physicians are notoriously bad patients. One-third of Australian residents do not have a primary care physician and an equal number of Irish physicians had not been to see a physician (either their own primary care physician or a walk-in clinic) in the past 5 years.20 Multiple research studies across several different countries including England, Australia, and Hong Kong indicate that a large proportion of doctors engage

continued on page 10
in self-treatment with a significant number of physicians admitted to self-prescribing medications, a practice that is considered unethical by all medical associations and has been prohibited by legislation in certain jurisdictions. Rates of compliance for screening tests such as blood pressure measurement, mammography, Pap smears, cholesterol checks, and prostate examination varied from 60% to 85% among Canadian physicians. These studies indicate that not all physicians follow recommended screening practices.

**Alternative Therapy**

More than 33% of physicians utilize alternative or complementary medicine for themselves. Back pain, joint pain, neck pain and arthritis are the most common reasons physicians report receiving alternative medicine treatments. The most popular treatments: massage, acupuncture, and chiropractic or osteopathic manipulation.

**The Good News**

Physicians as a whole avoid risky behavior, have very low rates of smoking, rarely drink, exercise more and more as they age, have lower incidence of obesity and thus lack many of the obesity-related chronic illnesses that are threatening to overwhelm the country’s health-care system.

**The Bad News**

Physicians are reluctant to admit to illness or submit to care from other physicians (many self-treat). They have higher divorce rate, higher suicide rates, and get less sleep than what is considered healthy.

**Physician Health Practices: Who benefits**

First, it is important for physicians to practice what they preach. Healthy lifestyles not only benefit the individual physician, but they are likely to benefit the patient population as well. Getting enough sleep, exercising, eating more fruits and vegetables, getting appropriate preventative medical care and treatment are all integral to good health. Setting appropriate limits and pursuing meaningful life relationships and activities outside of work are also important for physicians to have balance, emotional support, and buffers against the stresses of medical practice. Thus, physicians themselves benefit most by incorporating self-care into their routines.

Even so, the practice of medicine often requires self-sacrifice, and many physicians are reluctant to put their own needs above the calling of their work. Physician self-care, however, is much like the safety instructions given on a plane: first put the oxygen mask on yourself, then assist others. Many studies are now looking at the way that physicians’ personal health practices affect their patient populations. Not surprisingly, physicians can be role models for good health and their own health practices influence patient counseling.

Physicians who practice healthy behaviors have more confidence and are more willing to counsel patients about those healthy behaviors. For example, one study revealed that doctors who exercise are more likely to counsel their patients to do the same, and that patients are more willing to try exercising when their doctors disclose their own personal workout habits.

Another study conducted at the University of British Columbia and subsequently published in the Canadian Medicine Association Journal revealed that patients were more likely to follow a recommended vaccination practice that their own doctor follows, compared to those who don’t. The Fall 2010 issue of Preventive Cardiology concluded that doctors who exercised regularly and maintained a healthy weight were most comfortable talking with patients about making healthy lifestyle choices. A survey of 1,000 primary care physicians found that those who exercised at least once a week or didn’t smoke were about twice as likely to recommend five lifestyle changes to patients with hypertension. Those changes: eat a healthy diet, reduce salt intake, attain or maintain a healthy weight, limit alcohol use and exercise regularly.

Much of the research on physician health behaviors is recent, but interest in the topic is growing. Progressively more articles about professional well-being, physician health behaviors, personal growth and life balance can be found in the literature. As recent as 1996, An International Conference on Physician Health was started as a joint effort of the AMA and the Canadian Medical Association. Their conferences are held every 2 years and specifically address the unique health challenges of physicians; the last conference was 2014, in London, England.

As we move forward, individual physicians must strive to find a balance between work responsibility and personal health. But physicians as individuals cannot do this alone. There needs to be a culture shift in medicine - institutional commitment to examine the barriers to physician well-being and a systemic change in the attitudes and expectations that have defined the profession.

Dr. Boling, a former family nurse practitioner, graduated in June, 2014 from the Franklin Square Family Medicine Residency in Baltimore. She practices at Lutherville Personal Physicians, one of Mercy Medical Centers’ community practice sites. New member of the MAFP Editorial Board, she edits this, her first edition of The Maryland Family Doctor.

**Note:** References for this article are posted at www.mdafp.org; Publications tab. CME questions for this article are posted at www.mdafp.org; CME Quiz tab, Winter 2015.
The Depressed Physician

Ansu Punnoose, D.O.

Introduction

Physicians have long had a tradition of being considered different from the rest of society. They have an attitude of perfectionism, which studies have shown, starts from childhood, with the perfect child trying to become the perfect physician. Physicians refuse to believe that the illnesses that they come across on a daily basis could affect their own lives, giving truth to the phrase “doctors make the worst patients.” Self-care among physicians is not a topic generally discussed in professional practice. However, for those physicians suffering from depression, self-neglect along with the stressors of professional practice can take a heavy toll. These physicians believe that they are supposed to be the strong ones who care for the sick, often forgetting that they are also human, requiring help and support.

Burden of Depression

Although the rate of depression among physicians is comparable to that of the general population, physicians’ rate of suicide is markedly higher than any other profession. An estimated average of 400 physicians commit suicide each year and physicians are more than twice as likely as the general population to kill themselves. Lifetime prevalence for self-reported clinical depression in physicians is rated as 12.5% in men and 19.5% in women. In fact, female physicians are three to four times more likely to commit suicide than females in the general population. Depressive disorders often start in earlier years, causing reduction in people’s functioning and is the second leading cause of disability worldwide. Depression in medical students and residents range from 15-30%, although only 22% of those screened positive for depression use mental health services.

Depression during Training Years

Physicians thrive on a competitive nature, which starts early during their medical school years. Prospective medical students and residents, competing for hard to attain spots, are extremely unlikely to report a history of depression during the interview process. Once they enter the field of medicine, the stressors only increase. Long hours, frequent shifts in schedules, fear of error in decision-making and risking patients’ lives, while learning to deal with the sick and dying, being belittled by those above them in the chain of command, and being estranged from their family and support network often contributes to their mental distress. A recent study in JAMA noted that students who discussed their mental health felt that their opinions were less respected, coping skills considered less adequate and were viewed by faculty as unable to handle their responsibilities.

Predictors of Depression

Physicians tend to minimize their own health concerns and often fail to seek treatment. They tend to recommend their patients a sick day without taking time off for themselves. Table 1 shows predictors of depression in general practitioners, with their relationships with doctors and patients as the main stressor. While these stressors increased risk of depression, they did not increase suicide risk in physicians if there was no underlying psychological difficulty. In fact, a psychological autopsy study conducted by Hawton of doctors who committed suicide noted that mental illness and alcohol and/or drug abuse were the most common factors. According to Silverman, a workaholic white male age > 50 or female age > 45, who is divorced, single or currently experiencing marital disruption and suffering from depression, with history of substance abuse problem or risk-taking behavior is most likely at high risk for suicide. Additional risk factors include history of chronic pain or illness, recent change in occupational or financial status, increased work demands, personal losses, diminished autonomy and access to lethal means such as medications or firearms.

Barriers to Care

Depression in physicians may be underestimated due to the stigma that physicians' health is as important as their patients and they deserve the same quality of care that they provide others.

Physicians’ health is as important as their patients and they deserve the same quality of care that they provide others.

Table 1: Predictors in Depression in Physicians

<table>
<thead>
<tr>
<th>Predictor</th>
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<tbody>
<tr>
<td>Difficult relationships with senior doctors, staff and/or patients</td>
</tr>
<tr>
<td>Lack of sleep</td>
</tr>
<tr>
<td>Dealing with death</td>
</tr>
<tr>
<td>Making mistakes</td>
</tr>
<tr>
<td>Loneliness</td>
</tr>
<tr>
<td>24-hour responsibility</td>
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<tr>
<td>Self-criticism</td>
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</tbody>
</table>

Physicians’ health is as important as their patients and they deserve the same quality of care that they provide others.
Depressed Physician (continued)

TABLE 2: Risk of caring for “VIP” patients

| Caregivers, family and the patient may deny the possibility of alcohol and substance abuse |
| Caregivers may avoid or poorly handle discussions of death and “do not resuscitate” orders |
| The patient may suffer from emotional isolation when protected from the normal hospital culture |
| The patient’s feelings of shame and fear in the sick role can go uncomforted |
| Caregivers may overlook neuropsychiatric symptoms because they do not wish to “insult” the patient |
| Staff may neglect or poorly handle the patient’s toileting and hygiene |
| Ordinary clinical routine may be short-circuited |
| Caregivers may avoid discussing issues related to the patient’s sexuality |

Physicians associate with the diagnosis. Physicians’ mental health is given a low priority, therefore it is inadequately treated due to reluctance in seeking treatment, causing them to self-diagnose and self-treat. For some, while there is shame in revealing one’s mental health status to a colleague due to fear of receiving “VIP treatment” (see Table 2), for others it is the distrust of other physicians and fear of being discriminated by colleagues or licensing boards. Because patient safety is in question, medical licensing boards and credentialing bodies can solicit information about serious mental illness that could affect a physician’s ability to practice. Other barriers to care include lack of time, cost, fear of documentation on academic records and possible affect on future prospects in career opportunities.

Self-care for Depression

In recent years, physician wellness is emerging as an area of interest. In 2002, the American Foundation for Suicide Prevention came up with a consensus statement intended to encourage depression treatment and to shift professional attitudes and policies to support doctors seeking help. Starting from medical schools, programs are being put into place where students could speak confidentially without it reflecting on their academic record. As physicians working with other physicians, we should be able to pay attention to colleagues who seem troubled and look for warning signs. These signs could include change in behavior toward co-workers and patients, less interest in people and activities, more isolated, change in appearance, physical deterioration, mood swings, longer work hours with less efficiency, repetitive tardiness to work and alcohol or drug abuse.

It is time that physicians acknowledge that they are human. Their health is as important as their patients and they deserve the same quality of care that they provide others. It is imperative that physicians stop diagnosing and treating themselves. Self-care does not mean self-diagnosing. In fact, in physicians whose thought process is clouded with depression, self-treatment could result in more harm than good. They need to make lifestyle changes such as exercise, sleep, eat healthy, make regular doctor visits, and go on vacations – essentially practice what they preach. In addition, for those who are suffering from depression, they need to consider using cognitive behavioral therapy and practice relaxation training. Physicians need to seek additional education and training that allows them to distinguish the difference among stress, burnout, poor boundaries, poor coping mechanisms, depression, risk of suicide, substance abuse and substance dependence. They need to be aware of health programs that provide confidential treatment and assistance to physicians with mental illness and/or substance abuse problems.

As witnessed in the recent death of actor Robin Williams, depression can be a silent killer, veiled behind a smiling, confident, competent face. However as noted by an intern in a recent article in the New York Times about doctors committing suicide, “we masquerade as strong and untroubled professionals even in our darkest and most self-doubting moments.” In order to best understand and treat depression in their patients, physicians need to first acknowledge and address depression in themselves and seek help.

Helpful Resources:

- American Foundation for Suicide Prevention (www.afsp.org)
- Federation of State Physician Health Programs (www.fsphp.org)
- For physicians suffering with depression (www.black-bile.com)
- Personalized litigation stress support for health professionals (www.mdmentor.com)
- Struggling in Silence: Physician Depression and Suicide (video for physicians)
- Out of the Silence: Medical Student Depression and Suicide (video for medical students)

Dr. Punnoose is a R-3 at the Franklin Square Medical Center Family Medicine Residency in Baltimore. She joins the MAFP Editorial Board last year as a Resident Editor. See her additional contribution to Residents Corner on p.25.

Note: References and resource websites for this article are posted at www.mdafp.org; Publications tab. CME question for this article are posted at www.mdafp.org; CME Quiz tab, Winter 2015.
The Importance of Spiritual Health

Matthew Loftus, M.D.

The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated. ~Plato

Family physicians are well-known for their appreciation and practice of a holistic approach to the human body – that is, we recognize that good health is dependent on mind, body, and soul working together in the context of a community. Most physicians assent to these ideas, but evidence suggests that half of all primary care physicians don’t address prayer or other spiritual topics with patients and more than half of patients report that spiritual issues haven’t been brought up in clinical encounters.1,2 We have to study the biomedical model of human health in order to become physicians, but we recognize that many of the health outcomes are shaped by our patients’ cultural values, learned behaviors, and beliefs – even (and sometimes especially) their spiritual beliefs. Thus, the practices of engaging in spiritual disciplines and participating in religious communities are not only essential taking our own rhetoric about holism and wellness seriously, but they are also a means by which we can grow in mutual understanding with our patients.

One of the most prominent and instructive examples of physician spirituality comes from Moses Maimonides (1138-1204 CE), whose attributed oath captures the relationship between God, a physician, and patients in its opening: “The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love of my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.”

One of the most important aspects of prayer for ourselves and for our patients is that it helps us to center us – we recognize that our role as physicians plays out in the larger context of life and that there are a great number of things beyond our control affecting our patients’ health. Prayer is also a weapon against whatever forces harm our efficacy and integrity – Maimonides mentions “miserliness” and “thirst for glory” but one could just as easily add “people pleasing” or “compassion fatigue” to his list! When we pray, we are not only calling on more resources to heal our patients – we are acknowledging that our work is part of something bigger and we are humbling ourselves to shape that work into efforts that fit into that larger context.

The question of prayer with patients is not always a simple one. Many patients would like to have their spiritual needs addressed directly by a provider or by a consultant chaplain – though as one would expect, they are more likely to want these issues addressed when more serious health issues are at hand. It is not just at death, either – according to one study of several hundred outpatients at six different sites, 1 in 5 patients would like to be prayed with during a routine office visit.3 This same study, however, found that less than 10% of patients would want clinical time abrogated in order to address spiritual concerns – although African-American patients and patients of low socioeconomic status were more likely to say this at rates of 10-15% – which still represents at least one or two patients a day for most of us in office-based practice. Thus, there is evidence that prayer with patients – like many other psychosocial interventions – is appropriate when judicious clinical reasoning is applied to spiritual inquiry.

Spiritual practices often flourish best in a religious community. The individualistic approach to personal spirituality, while quite popular today, does not reflect all of the health benefits that accompany the fellowship, encouragement, and support that can be provided within a church, synagogue, mosque, or other religious body.3 Frequent attenders of religious services are noted to have a decreased overall mortality compared to infrequent attenders; reasons that have been elucidated for this include increased rates of smoking cessation and more stable marriages.4 The demands of medical practice on physicians are well-known to readers of this journal; qualitative (though not quantitative) research suggests that religious practice, especially in its communal forms, helps to reduce burnout and sustain doctors through the stressful situations that our work brings us.

Participation in a religious community is also a great way to address public health issues and engage in community development work. There is robust evidence that health programs within faith-based organizations are effective at improving a variety of health outcomes, from self-identified knowledge and increased fruit/vegetable consumption to blood pressure and weight.5 Most of these studies continued on page 14
have been done within communities of low socioeconomic status, speaking to the crucial role that faith and communal spirituality play within poorer places. My own experience of living and worshipping in the disadvantaged Sandtown-Winchester neighborhood of West Baltimore has brought me into contact with so many wise community advocates and leaders who have taught me much about engaging and caring for people different from me. As inequality and self-segregation by class has grown in America, maintaining our connections with others outside of our narrow social circles is all the more important – and worship services are a great opportunity to fellowship, learn, and participate in community life.

Addressing the challenges of spiritual self-care requires discipline and reflection, but the benefits can affect nearly every area of our practice and life. Our training as family doctors has given us a framework for recognizing spirituality as a vital component of health and it is only fitting that we apply this understanding to ourselves as we center ourselves in the universe. We can use this framework to challenge the temptations that steal our joy, meet the needs of our patients in times of great distress, and actively work to root ourselves in communities that we can give to and receive from.

Dr. Loftus graduated in June 2014 from the Franklin Square Family Medicine Residency in Baltimore. He practices at a community health center in Baltimore City and is currently raising support to practice and teach at a maternity and pediatrics hospital in South Sudan. He is releasing a novel about health and community chapter-by-chapter; you can read it at http://trousseausyndrome.wordpress.com/

Note: References and resource websites for this article are posted at www.mdafp.org; Publications tab.
CME question for this article are posted at www.mdafp.org; CME Quiz tab, Winter 2015.
Mr. Xavier is a 45 year old store clerk who awoke one morning with a tight pain in his right shoulder that traveled down his arm. He presented to the local ER because his arm became so weak that he was not able to grip a glass at his job as a store clerk. The ER physician, a 37 year old male, diagnosed a pinched nerve after a 15 minute visit with Mr. Xavier. He prescribed a muscle relaxant, Ibuprofen, and a few tablets of a narcotic pain medication. The patient was advised to follow up with his primary care provider in the next 1-2 weeks.

Two weeks later when Mr. Xavier finally gets in to see his primary care provider he is even more debilitated. After some additional testing Mr. Xavier is diagnosed with tumor in his chest that was pressing against a nerve in his arm. Mr. Xavier reports that “The first doctor couldn’t be bothered by what I was trying to say.”

Could the ER doctor have been suffering from physician burnout?

To address this question lets first look at different question…What is Physician Burnout?

Burnout is a constellation of symptoms characterized by a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when you are overwhelmed and unable to meet constant demands. Over time burnout reduces productivity, saps your energy, and leaves you feeling resentful, cynical, hopeless and helpless, and reduces your sense of personal accomplishment. Although we all have days when we are overloaded, overworked, and unappreciated, the difference between stress and burnout is the ability to recover in your time off.

Doctors who are suffering from burnout are more prone to errors, less empathetic, and are more likely to treat patients as objects or diagnoses. The number of doctors suffering from burnout is staggering. One study, performed by Tait Shanafelt, M.D. and colleagues, found that almost half of the study participants reported emotional exhaustion, feeling detached from patients and work, or suffering from low sense of accomplishment. The highest risk factor was being in a specialty that offered front line access to care including Family Medicine, Emergency Medicine, and Internal Medicine.

What can be done to address physician burnout is an ongoing debate. Strategies include reducing the stigma associated with asking for help for emotional problems, increasing awareness about physician burnout, providing education, and encouraging self care. These strategies must occur at a personal level and at an organizational level. Ultimately reducing physician burnout is good for the doctor, great for the patient, and essential for the health care system.

Dr. Sealy is a Maryland Family Care Physician at Mercy Hospital in Baltimore.
Welcome to MAFP’s New President: Kisha N. Davis, M.D.

Dr. Kisha Davis is the 62nd president of the MAFP and will be added to a long list of accomplished leaders and clinicians who have helped guide the course of Family Medicine, both in Maryland and on the national stage. Kisha and I met while completing our Family Medicine Residency at the University of Maryland Department of Family and Community Medicine program from 2000-2004. It quickly became clear to me, as well as to her colleagues, that she was a “superstar.” Dr. Davis is not only an intelligent and compassionate clinician but a poised and diligent professional. We have remained friends since those years in training and I have had the opportunity to get to know her wonderful family and to witness her numerous personal and professional accomplishments.

Kisha grew up in Gaithersburg, MD where she lived with her parents and 2 siblings. She got her Bachelor’s Degree in Biological Anthropology and Anatomy from Duke University and then completed her Medical Doctorate at the University of Connecticut. During medical school, she participated in numerous student run medical clinics, as well as a mission trip to Zimbabwe where she volunteered at a HIV/AIDS orphanage. After medical school, she returned to Maryland to complete her residency, serving as Chief Resident during her final year.

After completing residency, Dr. Davis worked at the Columbia, MD location of Chase Brexton Health Services where she was able to fulfill her professional dreams of seeing patients from birth to death from a broad range of ethnic and socioeconomic backgrounds. She was able to focus on work with the underserved populations, diabetes, women’s health and HIV. She later went on to complete her Masters of Public Health at Johns Hopkins University where she was part of the Delta Omega Honor Society. Currently, she lives in Gaithersburg with her very supportive husband, Everett, a middle school principal, and their two young sons Spencer and Byron, ages 7 and 4.
During 2011-2012, Dr. Davis had the prestigious honor of being one of 15 individuals selected to receive the White House Fellowship Award. The recipients are individuals from various backgrounds with exceptionally high potential who spend a year learning the governmental process from the inside. The fundamental goals of the fellowship are to promote leadership, education, and service. While it is difficult to summarize the myriad of unique experiences, as well as the educational and growth opportunities, she feels the program enhanced her leadership skills by helping her become a better advocate for both patients and family physicians (Dr. Davis’ article “My Year as a White House Fellow” appears in the Winter 2013 edition of this publication).

After completing her White House Fellowship, she became the Medical Director and Director of Community Health at Casey Health, where she currently works with an integrative medicine team to provide patient centered care.

She has held multiple leadership positions within MAFP, as well as within the AAFP. Most recently, she was elected by her peers to be New Physician Director on the AAFP Board. In that capacity, she made sure the voice of new physicians was heard as the academy conducted business including: approval of AAFP policies and turning the issues and concerns of its members into reality. She had the honor of being on the Board when that body approved funding for the Family Medicine for America’s Health Campaign. She would tell you that her primary responsibility as a board member of the MAFP and AAFP, is to advocate on behalf of family physicians and their patients. With the completion of her service on the AAFP Board in October, 2014, she was installed by AAFP President Robert Wergin as MAFP President.

In Dr. Davis’ Words…

Why become a family doctor?

I loved OB and didn’t want to give up men and old people. I love being able to see people at all ages and all stages. I’m one of those people who actually likes answering those medical questions that you get from your family during the holidays. It is one of the specialties where you actually get to make a difference. You get to be with people over the entire course of their lives. While it is not heart surgery, when people think about [what doctor] has been there for them, they usually think of their family doctor.

What made you want to get involved with the MAFP?

I got involved because Dr. Yvette Rooks (MAFP President 2008-10), who was my residency director asked me to go to a meeting and I liked it. Initially, I didn’t have a great ambition to be part of the MAFP. So now when I see people who may want to get involved, or even those who don’t think they want to be involved, I invite them. They might surprise themselves. Then Dr. Rooks asked me to go to the National Conference of Special Constituencies as the Minority representative. While there, someone asked me to run for New Physician American Medical Association Representative… I did and I won. I ended up in positions I never would have imagined. I was present at the AMA when they brought up the patient centered medical home initiative. At the various conferences, I see a lot of people getting excited about Family Medicine and looking to get connected. One life lesson has been to step up when asked; you never know where it will lead. At the conferences, I also enjoyed the opportunity to network and meet other people; to get away from just practicing and seeing patients. In attending conferences, I found a lot more ways to be active within the Academy.

What are some of the biggest challenges and potential rewards currently for Maryland family doctors?

I think the biggest challenge is that with all the change, doctors may not feel settled with all the regulations of ACA, ACO, PCMH etc. There are so many things diverting your attention from patient care, including not knowing how and what we are going to be paid. At the same time, there is excitement because we get an opportunity to write the story. We get to be at the table and part of the conversation so that when things do settle, it works out in the best interests of our patients and ourselves. It is easier for us, Maryland doctors, to get to DC than others; I think we have more opportunity to take some time off to meet our officials. Maryland family doctors have had a positive relationship with the legislature and the previous Governor’s administration. That is reassuring.

What do you want to accomplish as President of MAFP?

Some of the few things I’d love to see include a Department of Family Medicine at Johns Hopkins, or a presence at the state level where Family Medicine is turned to for answers. What would make me most proud would be to see more of our members actively engaged in our Academy by attending conferences, participating in Advocacy Day, or even joining a committee. I hope that people can feel connected to the MAFP, and that they feel their practice and their patients are better off because they are a member.

Dr. Hines, MAFP Central District Vice President, practices at University of Maryland Midtown, Department of Emergency Medicine, Baltimore.
Even as interest in foreign medical missions grows, there seems to be a growing awareness among healthcare providers that foreign medical mission work is itself plagued with pitfalls. Perhaps this makes it all the more noteworthy that there are individuals who are persevering, in the face of the challenges, to provide long-term sustainable growth in communities desperate for immediate relief. Many, including myself, have had the privilege of learning how to navigate this difficult terrain by the example of Dr. Linda Walsh, who practices most of the time in Jarrettsville, Maryland, but also a significant amount in the Dominican Republic. Since 2003, Dr. Walsh has lead medical teams of physicians, PAs, nurses, EMTs, physical therapists, dental hygienists, medical students, and pharmacy students. Much of Dr. Walsh’s work has indeed been relief-oriented—under her leadership thousands of people have received relief in their suffering. Yet, however extraordinary that surface story might be, it pales in comparison to the year-round work in America that Dr. Walsh does for the communities she serves in the Dominican Republic.

Responding to the lack of education available to the neediest children, Dr. Walsh established and now administers a child sponsorship program. The children and young adults who receive sponsorships are becoming doctors, dentists, and community leaders, working to change these communities from the inside. Similarly, Dr. Walsh is helping to equip a trade school in a needy community to teach computers, hairdressing, baking, and plumbing. She also coordinates support for teacher salaries and school breakfast and lunch programs for primary schools in two communities. More directly addressing public health concerns, she has worked with community leaders to train community health workers. These workers go on to teach others concerning matters such as storage of clean water to reduce incidence of parasites and decreasing salt intake to lower blood pressure.

Dr. Walsh’s work has spurred many others to work to better the situations of others. Several individuals who served with her in the Dominican Republic trace their decisions to pursue careers in medicine to their time working alongside Dr. Walsh. Within her own family, both of her daughters chose to become physicians following their work in the Dominican Republic, and her husband and son-in-law worked with Dominican partners to install a high-output water filtration system, providing clean water to a community of several thousand people.

When Dr. Walsh first saw the community of ‘Esperanza’, the name (which means ‘hope’) seemed sadly ironic. Now, more than a decade later, there seems to

Katherine J. Jacobson, M.D.
be more hope with each passing day. This is certainly due in part to the medical relief that has been provided, but the signs of hope are even more clear in the lives of those in whom Dr. Walsh and others have facilitated a holistic healing. This healing provides opportunities for lasting, profound community development.

For this work, the American Academy of Family Physicians has honored Dr. Linda Walsh with the 2014 Humanitarian Award, which was presented to her in a special ceremony during the AAFP Congress of Delegates in Washington, D.C. on October 22, 2014.

“I appreciate all I have learned from the people of the Dominican Republic,” said Dr. Walsh. “I have been forever changed by the way I have been welcomed into their homes, schools, and churches…. They have helped me truly understand that it is more blessed to give than to receive.”

Dr. Jacobson, current member of the MAFP Foundation Board of Trustees, is a new physician who has been an active MAFP leader during her student and resident years. She practices at the MedStar Franklin Square Medical Center Department of Family Medicine in Baltimore. She readily accepted this assignment when asked to author an article about her mother.

Note: Dr. Walsh will be a featured speaker for the “Symposium on International Medicine,” at MAFP’s Winter Regional Conference “Topics in Family Medicine, From Here to There and In-Between” on February 21, 2015 at the Sheraton Baltimore North in Towson, MD. Details at www.mdafp.org and on p.23.
New Orleans hosted the annual AAFP State Legislative Conference (SLC) this past November. Four Maryland family physician leaders attended and enjoyed soaking up the Deep South ambience, rubbing elbows with colleagues from other states as well as nationally renowned experts in health care and politics.

The conference took place shortly after two major events: 1) a national midterm election with the lowest voter turnout since the 1940s, and 2) the AAFP Assembly in Washington, DC. Both of those events featured some surprising outcomes which were discussed and examined at the SLC.

The national election resulted in a Republican sweep, with the GOP notably winning their largest share of state legislative seats in history and, federally, the largest House majority since 1928. What does that mean for health care? Continued challenges for the Affordable Care Act can be expected.

A market that seeks value, however, doesn’t care whose party is in office. Reacting to current economic reality, the AAFP at its annual meeting this October launched “Health is Primary” and “Family Medicine For America’s Health.” The former is a PR campaign and the latter is a strategic mission.

Both are designed to promote the value of a strong primary care workforce in achieving the Triple Aim: better care experience for individuals, improved population health, and controlled costs. Whereas the concept is not surprising, some of AAFP’s core strategies are. For one, the AAFP is promoting comprehensive primary care payment.

Comprehensive primary care payment is a move away from traditional fee-for-service medicine. Proponents of comprehensive primary care payment maintain that “insurance” should cover catastrophic care, hospitalizations, expensive testing/treatment, whereas payment for primary care should be administered differently, because everybody needs primary care services. Primary care done well means that preventive care is provided, health is promoted and chronic diseases are managed within a patient-centered medical home, longitudinally and comprehensively, in an equitable fashion for an entire population.

There are different models of comprehensive primary care payment that could be promoted, depending upon state regulations. A per-member, per-month (PMPM) fee that is age- and risk-adjusted and negotiated with third party payers is one model of health care coverage. Another model is direct primary care, which takes the third party payer out of the equation and requires consumers to pay primary care physicians directly for their services, with or without a monthly membership fee.

Who is a health care consumer? In the commercial market place, health care consumers are both individuals and employers. Despite an earlier image of “concierge care” being affordable only by wealthy individuals, increasingly, direct primary care is an attractive option for the largest health care consumers, employers and unions, as well as individuals and families who can only afford high-deductible insurance plans. Access to affordable primary care is appealing to them, and they reward it, often dipping into their health savings accounts or flexible spending accounts.

Comprehensive primary care payment is a departure from the 1990s era of capitation when primary care physicians were the hired “gatekeepers” for payers. In the new model we are seen as trusted advisors, accessible by phone, text, email or in person, telling patients what we will do for them instead of what we won’t do for them.
Beyond issues of payment and promotion of primary care in general, “Health is Primary” and “Family Medicine for America’s Health” focus on reducing health care disparities, improving access to care and ensuring primary care workforce development. If we are to maintain a competitive edge in the market place, our training and expertise must distinguish us from non-physicians so that we can prove our value sustainably. We must also embrace technology, but not simply to report outdated process measures. Rather we must use it to improve access to care and deliver better health outcomes. Ultimately, practice conditions must evolve away from the model of primary care physician as data gatherer and scribe for the health care system and instead restore the joy of taking care of patients.

Considerable brainpower, expertise and know-how have been gathered from around the nation to launch “Health is Primary” and “Family Medicine for America’s Health.” Six major areas will be addressed: practice, payment, workforce education and development, technology, research, and engagement. To learn more, visit healthisprimary.org or fmahealth.org to offer your opinions and hear others.

If you would like to participate locally, join our chapter’s governmental advocacy committee. Our Advocacy Day, a visit with state legislators during Annual Assembly, will be February 5, 2015. All are welcome and CME credits are awarded.

Dr. Czapp, MAFP President-Elect and member of the Government Advocacy Committee, writes this, her 5th consecutive report as a Maryland Chapter delegate to the AAFP SLC. She is Chair of Clinical Integration, Anne Arundel Medical Center, Annapolis.

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Franklin Square Medical Center
by Ansu Punnoose, D.O., R-3

Winter is here, which marks the midway point of the year and beginning of transitions. As our interns adjust to residency life, our third years look towards the light at the end of the tunnel as they prepare their CVs for interviews for jobs and fellowships.

We are excited to work with a number of new faculty members who have joined the Department, including Dr. Martha Johnson, Dr. Kendal O’Hare, Dr. Uchenna Emeche, and our recently graduated alumnus Dr. Sharon Chung. They have all stepped into various roles as preceptors, OB faculty and community health liaison, and have been a great source of learning for our residents.

As always, our residents have been keeping busy. Drs. Jay Chung, R2 and Crystal Peralta, R2 and the rest of the AMA-JHM BP Initiative team flew to Chicago for the AMA-JHM Blood Pressure Initiative meeting, where they provided an overview of the home BP monitoring pilot and shared success stories. Drs. Fatmatta Kuyateh, R3 and Ansu Punnoose, R3 have been involved in promoting health care in their own communities through health fairs. As a member of the Maryland Breastfeeding Coalition, Dr. Punnoose has been emphasizing the importance of breastfeeding education during prenatal period to patients, providers and staff. Dr. Amanda Guzman, R3 continues to serve as the resident liaison for the DHMH Intimate Partner Violence Task Force and is preparing a curriculum to increase DV awareness within residents at the Family Health Center.

Our FM/Preventive Med resident Dr. Richard Bruno, R2 led a planning meeting for the National Conference of Students and Residents in Kansas City, developing the theme and programming for the 2015 conference in July. He also attended the Congress of Delegates in DC, supporting the Maryland chapter’s resolution to end the alliance between the AAFP and Coca Cola. His colleagues and he reserved a booth at the exhibit hall and gathered hundreds of signatures from physician members concerned with the Coca Cola alliance. They published an article on the Union of Concerned Scientists’ website and the DC journal Politico published a story about their efforts.

As our interns adjust to residency life, our third years look towards the light at the end of the tunnel as they prepare their CVs for interviews for jobs and fellowships.

Drs. Dan Gold, Fatmatta Kuyateh, Ansu Punnoose and Arifuz Zaman along with faculty members attended the 33rd Annual FMEC Region Meeting held at the Crystal City Marriott in Arlington, VA, where our team won the Best Residency Fair Group Costume for our recruitment booth, costumes and song on “Gridlock in Healthcare,” written for us by our recently graduated alumnus and editor of the Winter edition of the Maryland Family Doctor, Dr. Kathryn Boling.

Please stay tuned for more at the MedStar Franklin Square Family Medicine Residency…. and don’t forget to “like” us on FaceBook!
Residency Corner (continued)

University of Maryland by Erkeda DeRouen, M.D., R-3

Wedding Announcement
The UMD residents would like to send a warm CONGRATULATIONS to our very own, Dr. Jennifer Christie (PGY-2) who married her longtime love, Daniel Gourdin in Florida on November 15th.

Transgender Care
Mali Zuses, PGY-3, attended the inaugural Gender Conference East in Timonium Maryland in November 2014, which focused on the care of transgender patients.

Physician Wellness
Elizabeth Wiley, PGY-2, has been diligently working to change the culture of medicine. She was recently re-elected to serve on the World Medical Association (WMA) Junior Doctors Network Executive Board. Dr. Wiley assisted with the organization of a physician well-being mini-conference at WMA General Assembly in Durban, South Africa. She also co-authored a World Medical Journal article entitled, “Junior Doctors’ Work Hours: from regulations to reality.” Kudos to this hard working resident!

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The Myrtle Beach area is a wonderful place to live with its warm weather, beautiful wide sandy beaches, and laid back southern atmosphere. The area also offers diverse cultural and educational interests, entertainment venues, an array of restaurants, over 100 golf courses, excellent schools, and an impressive university influence. These are just a few of the reasons that make living and working here so great!

The blushing bride with two residents, Erin Jones (PGY-2) and Cynthia Calixte (PGY-2).

Mali Zuses and her son, who is a little doc-in training, Bear Zuses.

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Liz Wiley is above (likely planning something AWESOME!)
Just under 200 MAFP members from Maryland made the short trip over to Washington, D.C. to participate in AAFP’s 2014 Congress of Delegates (COD) and Scientific Assembly this past October 20-24. A complete rundown on happenings can be viewed at www.aafp.org. Let us show you in photos, the many ways Maryland Chapter members made us proud in DC.

MD Chapter representatives were front and center at the AAFP PAC Reception where Senator Ben Cardin was special guest.

New AAFP Fellow Dr. Shana Ntiri accepting her award from AAFP President Dr. Robert Wergin.

Dr. Eugene Newmier makes a point at the COD Town Hall Meeting about “the difficulty of meeting quality measures… when patients don’t take responsibility for their own health.”

Spotted at The Party were MAFP Past Presidents Drs. Howard Weeks (l) (1974) and J. Richard Lilly (1973).

Drs. Adebowale G. Prest (l) an Yvette Oquendo-Berruz represent MAFP members at the 2014 AAFP COD.

Celebrating MAFP were (l-r) Drs. Jocelyn Hines, Kindra Smith, Danielle Jean (holding her door prize) and Mozella Williams.
Members (continued)

Congratulations for Special Appointments, Honors, Features, Achievements!

Kisha N. Davis, M.D. of N. Potomac, MAFP President, was keynote speaker at the California Academy of Family Physicians Family Medicine Summit for Students and Residents on November 1, 2014 in Los Angeles, CA.

Louis Kovacs, M.D. of Baltimore was featured in “Medicine & Science On The Move” in the October 26, 2014 edition of The Baltimore Sun for having joined the Arnold Palmer Sports Health Center at MedStar Union Memorial Hospital.


Matthew Loftus, M.D. of Baltimore authored “Medicaid should cover hepatitis-C prescriptions by primary care docs,” an Op Ed piece in the September 26, 2014 edition of The Baltimore Sun (see Dr. Loftus’ article in this publication on p.13).

The following MAFP members were among 510 physicians named from 102 specialties named in the 2014 Top Docs edition (November 2014) of Baltimore Magazine: Jason Black, M.D., Tracy Gutierrez, M.D., Joyce King, M.D., James R. Richardson, M.D., Yvette L. Rooks, M.D., Jacqueline Shepard-Lewis, M.D.

The following MAFP members were awarded the degree of Fellow of the American Academy of Family Physicians at the 2014 Fellowship Convocation in Washington DC in October:

John Michael Brooks, M.D.
Matthew Thomas Burke, M.D.
Michael W. Costello, M.D.
Eugene J. Newmier, D.O.
Shana O. Ntiri, M.D., MPH
Mercy Obamogie, M.D.
Donald R. Richter, M.D.
Ariel J. Warden-Jarrett, M.D.

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Justin Cross, M.D.
Melissa Denham, M.D.
Dorita C. Egudu, M.D.
Lindiwe F. Greenwood, M.D.
Kathleen G. Hill, M.D.
Anugeet Kaur, M.D.
Aysha Khan, M.D.
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Tiffany Mapp, D.O.
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Natalie Moore, M.D.
Mercy Obamogie, M.D.
Immirne M. Ouwinga, M.D.
Gerren Perry-Fabrizio, M.D.
Sophia A. Purekal, M.D.
Birju H. Ringwala, D.O.
Courtney K. Ryan, M.D.
Monia Sarfaty, M.D.
Lisa Singletary, M.D.
Salvador Sylvester, D.O.
Debra A. Vereen
Heather E. Walker, M.D.

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Charles A. Olaleye, M.D.
Ekenesenarienrein C. Omokaro, M.D.
Christopher Riley, M.D.

STUDENT
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Garrick Anderson
Brenton Andreasik
Rochelle Arbuah
Ashley Barnes
Nisha Basappa
Samuel Black
Alexandra Blaes
Nicole Bouchard
Shawnecca Burke
Ian H. Bussey
Sarah Chang
Chris Charock
Yifei Chen
Amy Cheng
Nubal Cherian
James Cometto
James Comotte
Timothy Cox
Gordon Crews
Johathan Danquah
Valerie Dawson
Claire DeLaurentis
Taylor T. DesRosiers
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Padmini D. Herath
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