CHALLENGING PATIENTS

Challenging Patients: The Perfect Patients for a Family Doctor

How Family Doctors Can Address the Challenge of Adverse Childhood Events

Understanding the Patient-Provider Relationship When Prescribing Controlled Substances

Difficult Patient Encounters: A Virtual Panel Discussion

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MAFP Aligns with Member and Patient Needs

Kisha N. Davis, M.D.

Well, spring is finally here! Despite the cold and snowy winter, the Maryland Academy of Family Physicians has been actively engaged on many levels.

I recently started the Duke Integrative Leadership Fellowship. As part of that, we are encouraged to define and share our purpose. It is helpful for us all to examine our purpose and then do a check-in to see if our own personal mission and vision is still aligned with the organization that we work for. When there is misalignment, we often feel discouraged, frustrated, and inefficient. How often have you felt like the work you are trying to do with patients is misaligned with the priorities of your organization or the insurance companies that are reimbursing you? Part of our work as an academy is to help bring this into better alignment: whether that is working for legislative reform, providing educational opportunities, or ensuring the public health of our communities- it is all in an effort to help family physicians have greater satisfaction and joy in the practice of medicine. The mission and vision of the Maryland Academy of Family Physicians are:

• **VISION:** Able, responsible, family physicians serving their communities.

• **MISSION:** To support and promote Maryland family physicians in order to improve the health of our state’s patients, families, and communities.

My purpose and reason for being a part of the Maryland Academy of Family Physicians is to help promote our specialty because I believe in the importance of primary care in achieving healthy outcomes. I also believe that we have a unique position and voice to help promote the health and wellbeing of the patients, families, and communities that we serve in a way that inspires. The MAFP will be starting a process to reexamine our mission, vision, and strategic plan to help make sure that we as an organization stay in alignment with the needs and concerns of our members and our patients. I hope that you will join and support us along the way.

I would like to tell you about some of the activities that the MAFP has been involved in over the past few months that highlight our efforts to educate, inform, and shape governmental policy that affects our patients and our profession.

Our Government Affairs Committee (GAC), led by Dr. Matthew Burke, held a very successful Advocacy Day in Annapolis with our lobbyist Eric Gally. Our group of 30 first met with Delegates Dan Morhaim and Clarence Lam, both physicians who shared their perspective as physician in the legislature. We then dispersed across the state house, meeting with a variety of delegates and senators to discuss bills including a ban on the sale of electronic cigarette paraphernalia to minors, a ban on tanning bed use by minors, and an increase on the tobacco tax by $1. Dr. Kate Jacobson and several other physicians and public health advocates testified in favor of a ban on tanning beds (ultimately, a close vote defeated the bill this year). This was just the beginning of our legislative actions for

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the year: since then, the GAC has been active in weighing in on issues from nurse practitioner attestation to syringe exchange programs.

I am excited to see our members and our academy step up and be a voice for our patients and ourselves at the state legislative level.

Another big kudos goes to Dr. Shana Ntiri who led our snowy, yet successful winter conference. The weekend started on Friday with a SAM facilitated by Dr. Kristin Clark on Care of the Vulnerable Elderly. We had a variety of topics from family violence to an update on infectious diseases like measles, once thought eradicated, that are now making their way back. We were also honored to hear from our own Dr. Linda Walsh, the 2014 AAFP Humanitarian Award Winner who shared her story on engaging humanitarian work. Due to snowy weather, we unfortunately had to end early.

As always, our chapter staff Esther Barr and Phaedra Goods deserve a big round of applause for everything that they do in the day to day operations to help our organization run smoothly and efficiently. We’re thankful for them- and for you- as we go forward as an academy!
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Challenging Patients
The Perfect Patients for a Family Doctor

Matthew Loftus, M.D.

We’ve all had them. We can remember them by name and know their medical histories well. We’ve often memorized their phone numbers and dates of birth from the sheer number of times we’ve used both. Patients that challenge us – whether it is because of their medical complexity, obstreperous personality, persistent non-compliance, or affinity for certain substances – will always find their way to our practices and test our patience.

The good news, though, is that family physicians are uniquely prepared to treat the vast majority of complex outpatients and our contribution to teams working with such patients is invaluable. Even more, it is crucial that we embrace our role as the doctors who are best at helping the most challenging patients manage their illnesses so that we can provide the greatest benefit to our communities as family physicians. Our goal for this issue is to help you feel more confident in this role and give you tools to work together with your challenging patients for their wellness.

It’s important to first recognize what makes these patient encounters difficult. It is easy during our busy days to move from one room to the next full of frustration without taking the time to reflect on why our patients are frustrating us or how we might deal with them. Family Medicine, more than any other specialty, recognizes the power of the physician-patient relationship. We usually think of this in positive terms – patients who trust us will be more likely to share more pertinent information or follow our advice – but the inverse is also true: studies of difficult patient encounters demonstrate that physicians who are burned out, insecure, depressed, or have difficulty expressing empathy are more likely to make clinical encounters more difficult. Our ability to care for patients is dependent on our ability to care for ourselves—so if you haven’t read last month’s Maryland Family Physician edition about self-care, go back now before you move on with this one!

Once we are in the practice of maintaining our own emotional health, we can work on understanding the patient conditions that are most likely to challenge us. It’s foolish to think that primary care providers are interchangeable; each of us has unique skills and vulnerabilities that will play out in our practices. While every encounter will present its own challenges (no matter how many times we feel like we are having the same conversation over again), there are a few common themes that have emerged from the body of literature on difficult patients. Dr. Andrea Gauld takes up the most common factor that predicts that a primary care provider will have a different set of patient factors that elicit such a response; for example, some of us will shrug off a manipulative patient but will be unnerved by patients who question our judgment while others will have opposite responses. Because our reactions to particular challenges will often be unconsciously reflected in our body language and tone, the ability to recognize what we are feeling during a visit and consciously craft our response allows us to prevent a negative feedback loop of distrust.

Having identified the elements of a visit or the traits of the patients who aggravate us, meaningfully addressing them is the next challenge—and perhaps the greatest one! Dr. Joseph Nichols discusses some of the factors that shape our most difficult patients at length in his article (p.10), but the prevalence of adverse childhood events or trauma in the lives of patients with negative health behaviors cannot be understated. One of the simplest examples is the story of an obese patient for whom overeating is comforting—not just for how it helps her feel good now, but also because she stopped being sexually abused as a teenager when she became more overweight. Until those feelings are addressed in some way, her diabetes will never be controlled. Taking a good social history and inquiring as to a patient’s motivations for particular behaviors is essential—and, once again, a skill that we as family physicians are better equipped with than any other specialty.

Engaging with our patients is easier once we understand their motivations and our reactions—and sometimes that is enough to align goals and end a war of wills. However, guiding our patients to better self-understanding and self-efficacy is usually still an uphill battle even once both patients and providers have all the necessary information. While doctors often complain that their patients don’t take responsibility for their health, it’s easy to slip into patterns of discussion and advice-giving that attempt to shame patients into following our advice. Asking questions to ascertain their goals and then guiding patients through the benefits and harms of various health behaviors (often through a simple 2x2 chart called...
a “decision balance”) is more effective. If your medical school or residency education never included Motivational Interviewing or cognitive-behavioral therapy, you may find it helpful to take a basic course in these skills to learn them. A number of resources can be found at www.motivationalinterviewing.org and elsewhere online; the vast majority of the material can be self-taught and implemented in your practice day-to-day as you experiment with different approaches that work well for you and your patients. Dr. Kathryn Boling has assembled a “virtual panel” of quality family physicians to discuss more practicalities of how they handle these issues (p.15).

Rarely can a doctor handle very challenging patients alone. Working together with other clinicians – whether it is frequent communication with the ER, establishing a relationship with a counseling practice, or training nurses and medical assistants in your practice to integrate motivational interviewing or follow-up into your practice – is essential. With Medicaid expansion in Maryland and the Medicare waiver experiment challenging hospitals to reduce unnecessary admissions, now is an ideal time for family doctors to demonstrate our worth to the medical system in managing patients with complex medical, behavioral, and social conditions leading to poor health. As much as we might enjoy delivering routine preventive care or seeing simple illnesses, health care reformers will continue to notice that it is more cost-effective to have less highly trained clinicians perform these tasks. It will be up to us family physicians, then, to embrace our role as team leaders and experts in dealing with challenging patients.

The final contribution that family physicians can make is in education. Many readers of this publication are clinical faculty or preceptors and see a variety of students from Maryland and beyond. The majority of students who rotate with us will not become family doctors, but they will all have to deal with difficult patients throughout their careers. There has been much discussion lately in Family Medicine circles regarding “the hidden curriculum” and the negative biases towards patients that students learn from discussions they overhear. Perhaps the greatest contribution that we as preceptors can make to medical education is actively combating this hidden curriculum by explicitly discussing the issues at stake when we see difficult patients with students and encouraging the learners alongside of us to challenge the judgments they are tempted to form.

Dr. Loftus, employed by Healthcare for the Homeless in Baltimore City, 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/. A new member of the MAFP Editorial Board, he edits this, his first edition of The Maryland Family Doctor.

Note: References and resource websites for this article are posted at www.mdafp.org; Publications and News tab. CME question for this article are posted at www.mdafp.org; CME Quiz tab, Spring 2015.

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The Maryland Family Doctor has been reviewed and is acceptable for Prescribed credits by the American Academy of Family Physicians (AAFP). This Spring, 2015 edition (vol. 51, No. 4) is approved for 2 Prescribed Credits. Credit may be claimed for two years from the date of this edition (expiring July 31, 2016). AAFP Prescribed Credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 Credit toward the AMA Physicians Recognition Award.

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How Family Doctors Can Address the Challenge of Adverse Childhood Events

Joseph S. Nichols, M.D.

For many of us, the thrill of the specialty of Family Medicine derives at least in part from the uncertainty of what lies in wait behind the next exam room door. We family physicians pride ourselves on our ability to attend to a wide range of issues which may be simple in isolation, but increasingly complex when a number of simple problems interact with one another. Our reverie concluded, this visit speeds by, as almost all visits do, leaving in its wake the following note:

CC: This 9-year-old female presents in follow up for her asthma.

HPI: She is using her albuterol inhaler twice a week. She had no exacerbations, hospitalizations, urgent care or ER visits, or steroid courses since her last visit. She states she is “sometimes” unable to keep up with her peers at school.

ROS: Significant for nighttime cough once weekly and occasional wheezing, although she has no rhinorrhea, itchy eyes, chest pain or shortness of breath.

SocH: Her mother continues to smoke cigarettes.

Vaccines: She is up to date on her immunizations, having already received her influenza vaccine this season.

Allergies: She has no known drug allergies.

Medications: Her medications include albuterol MDI and low-dose fluticasone inhaler with spacer.

PE: Her vital signs are within normal ranges. Her physical exam reveals an obese child in no acute distress. Her HEENT, cardiac and pulmonary exams are nonfocal today.

Impression: This is a 9-year-old female with moderate persistent asthma, poorly controlled.

Plan: The patient was instructed to increase her daily use of her fluticasone inhaler to the medium-dose range and to avoid her triggers, which include cigarette smoke and colds. An asthma action plan was completed and discussed with the family, and the patient and her mother express understanding of the plan. She will follow up here in 3 months, or as needed.

While from medical standpoint, the above note is justifiable, even laudable in its simplicity. However, a healthy dose of self-reflection might cause one to question whether the above encounter may have missed opportunities to address the underlying needs of the patient. If the above encounter was organized around a different set of assumptions and priorities, the same physician might have drafted the following note instead:

CC: This 9-year-old female presents in follow up for her asthma.

HPI: She is using her albuterol inhaler twice a week. She had no exacerbations, hospitalizations, urgent care or ER visits, or steroid courses since her last visit. She states she is “sometimes” unable to keep up with her peers at school.

Vaccines: She is up to date on her immunizations, having already received her influenza vaccine this season. Her mother continues to smoke cigarettes, because smoking seems to calm her nerves better than the antidepressant she tried, once, which gave her nausea. The patient’s parents were never married. The patient’s father was incarcerated two years ago for possession of heroin, which her mother occasionally abused. The patient and her mother live in a dilapidated rowhouse with inadequate heating, which is infested with cockroaches.

Vaccines: The patient’s mother did not arrange for the patient to get the influenza vaccine this year because she fears the immunization may cause her daughter “to get sick.” Her mother told the nurse she got the influenza vaccine at the pharmacy because she does not want the doctor to lecture to her about this again.

Allergies: She has no known drug allergies.

Medications: Her prescribed medications include albuterol MDI and low-dose fluticasone inhaler. She does not use her fluticasone inhaler because it does not provide the same immediate relief as her albuterol inhaler. She has never seen a “spacer,” although she states that she uses one because it seems important to the doctors and nurses who ask about it.
**PE:** Her vital signs are within normal ranges, with the exception of a BMI-for-age percentile of 97%. Generally, she is an obese child, dressed in an un-washed school uniform. Her HEENT, cardiac and pulmonary exams are non-focal today. Her mother takes incoming phone calls twice during the visit. The mother also raises her voice and snaps her fingers at the patient when the patient does not respond to one of the physician’s questions quickly enough.

**Impression:** This is a 9-year-old female with obesity, moderate persistent asthma - poorly controlled, low medication adherence, and low health literacy. Her obesity worsens the severity of her asthma both indirectly, by promoting chronic inflammation, and directly, by reducing chest wall compliance. The resultant worsening of her asthma limits her ability to participate in recommended levels of physical activity, which further exacerbates her obesity, in turn worsening her asthma. These cascading biological mechanisms may over time affect her social functioning - with deleterious impacts on her already low levels of self-esteem, her school performance, and her potential for educational attainment and future earnings. For the moment, her medical issues are further complicated by financial deprivation, disrupted family structure, parental incarceration, household substance abuse, household mental illness, and low level emotional abuse and neglect.

**Plan:**...Where do we begin?

It may be comforting to assert at the end of the day, “I did my part,” by recommending interventions to our patients in accordance with the most recent guidelines and evidence, as in the first example. Even those of us working in the so-called “safety net,” with patients who deal with these issues more readily, may fail to arrive at more sophisticated approaches to the underlying challenges our patients face. We reassure ourselves: “I did the best that I could.” However, with the benefit of this additional information, one may question whether standard medical therapy alone is likely to significantly improve the well-being of children and families such as these.

Our self-assurances are made more palatable by the assumption that in most instances we can adequately meet the medical needs of our patients in isolation, without considering the harmful social and environmental factors that might be interacting with the pathophysiology of the patient. However, a growing body of evidence from fields as diverse as neuroscience and epigenetics disputes this conventional wisdom. Researchers have proposed a new basic science of pediatrics, concerned with the interactions between an individual’s physical and social environments, resulting physiologic adaptations with the individual, and the impacts that disruptions in these external and internal environments may have on learning, behavior and well-being. This ecobiodevelopmental model provides us with a framework to explain the mechanisms by which the ecology of childhood relates to adverse health outcomes later in life, which longitudinal epidemiologic studies have previously described.

Observant physicians have long noted the disproportionate burden of illness that seems to accrue to patients with obvious socioeconomic disadvantages. We have begun to recognize the prevalence of these effects among the wider U.S. population and the extent to which even relatively “minor” social disruptions experienced in childhood may ripple into significant effects on health over the life course. These associations were explored in a landmark 1998 study from the Centers for Disease Control and Prevention and Kaiser Permanente, that related the experience of adverse childhood experiences (ACEs) in 17,000 middle class Americans to negative physical and mental health outcomes, ultimately affecting over 60% of the adults studied.

As depicted in Table 1, ACEs are commonly experienced by U.S. children across all races, ethnicities, socioeconomic strata, and regions. The above case is meant to represent an extreme scenario, wherein the patient has been or is currently exposed...continued on page 12
to at least seven ACEs. However even a much lower dose of adversity can increase the risk of ill health in later life. For example, in a recent national survey, children with only two or more ACEs were nearly 60% more likely to have asthma, compared to children for whom no ACEs were reported, even after adjustment for age, gender, race/ethnicity and household income.³

A close review of the evidence behind ACEs and their relationship to health supports the popular notion that the start that a person receives in life cannot sufficiently predict where he or she ends up. One model explaining this discrepancy invokes a combination of factors such as “hard work,” “talent,” and “luck” to explain why a few thrive in spite of circumstances wherein many others struggle to survive. The track record of physicians helping patients to modify their risk of disease based on the preceding three factors is checkered at best, and some of us have probably never bothered to try. Can we think about the problem a different, more useful, way?

The ecobiodevelopmental model offers insights on the reasons why many children grow into successful adults despite the adversities they faced throughout life. Researchers term the general explanation for this anomaly “resilience,” though our knowledge of its structures and mechanisms is evolving and future research will hopefully add to a growing list of factors that promote resilience. This list currently includes intelligence, relationships with parents and caregivers marked by warm attachments, the motivation to engage with the physical and social environments, the ability to regulate emotions, and the presence of social structures such as supportive faith communities and well-functioning schools. Table 2 lists the prevalence of some of these factors within Maryland.

The Family Medicine approach to primary care lends itself uniquely to intervening with children who have experienced adversity. For instance, the availability of care in a family-centered medical home – which assesses the social determinants of health and works to promote resilience in patients and families – may play an important role in decreasing the eventual prevalence of chronic disease by mitigating the effects of ACEs.¹ These advanced medical homes can refer patients to one of the several evidence-based, effective clinical treatments that currently exist for ACE affected children, including Trauma Focused Cognitive–Behavioral Therapy⁴ and Parent–Child Interactive Therapy.⁵ Both of these approaches take an inter-generational approach, working to improve parenting skills and to establish behaviors that promote resilience in both the child and parent.

Recent national calls to action from prominent voices such as the Robert Wood Johnson Foundation⁶ and the Institute of Medicine⁷ have highlighted the importance of child development and adverse childhood experiences. In the near future, there will likely be the funding and attention necessary to drive continued efforts towards addressing these important problems. Those physicians who are ready to begin preventing our vulnerable patients of today from becoming our most difficult patients of tomorrow have many resources to draw on. For starters, the American Academy of Pediatrics has produced the Trauma Toolbox for Primary Care, a six part guide designed with the primary care practice in mind, which references many other resources primary care practices need to begin assessing and addressing the impact of adverse childhood experiences. As for the rest of us…

“Doctor, your next patient is ready.” ■

Dr. Nichols is the Director of Scholarship and Discovery for the Department of Medicine at MedStar Union Memorial Hospital. He practices Family Medicine at Total Health Care, a federally qualified health center in Baltimore.

Disclaimer: The patient cases depicted in this article are works of fiction, created for educational purposes. While plausible, any resemblance to actual events is unintended and coincidental.

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, Spring 2015.
Controlled substances such as benzodiazepines and opioids are commonly used to treat a variety of illnesses that range from acute anxiety attacks to chronic pain. During residency training, physicians are exposed to the effectiveness of these medications as well as the pitfalls of their use. Upon graduation from residency, physicians begin to establish their own personal guidelines for writing controlled substance prescriptions. Due to the current prescription drug epidemic, some physicians have limited their prescribing of controlled substances while others have made no changes to their prescribing habits. This variability in practice, while commonplace and appropriate, can lead to difficult interactions when a provider acquires a new patient who is currently on a controlled substance. In order to improve the provider-patient relationship when such an incident occurs, it is important for the provider and the patient to understand the risks and benefits of using controlled substances.

The most commonly controlled substances prescribed in the United States for the past year include opioids, benzodiazepines, and stimulants. Opioids have been used for centuries to treat acute and chronic pain. However, in recent years opioids have been the frontrunner of the prescription drug epidemic. Abuse of and addiction to opioids usually results when a patient is prescribed opioids for pain relief but continues use after medicinally appropriate. It is becoming increasingly common for patients to use long-acting opioids for chronic non-cancer pain. It is important for providers who prescribe these medications to have open discussions with their patients regarding the expectations of treatment. Providers should initially attempt to use non-controlled substances to help treat chronic pain such as tricyclic antidepressants, duloxetine, gabapentin, pregabalin and NSAIDs before starting a patient on long-acting opioids. Benzodiazepines are most effective in treatment of acute anxiety attacks; however, they are commonly and inappropriately prescribed for long-term use. Long-term benzodiazepine use has been linked to increased risk of Alzheimer’s disease and hip fractures from falls in the elderly. When used at the appropriate doses for treatment of attention deficit hyperactivity disorder (ADHD), stimulants have little long-term risks associated with them. The toxicities of stimulants tend to emerge when used at excessive doses in patients without a clear diagnosis of ADHD.

The U.S. Food and Drug Administration’s (FDA) Controlled Substances Act was passed by Congress in 1970 and introduced the concept of placing medications into five schedules based on addiction and medicinal potential. If a drug is on the controlled substances list then it will have certain prescribing restrictions based on its schedule. These restrictions were put in place to limit overuse of controlled substances as well as ensure consistent follow up with the patient. However, most patients are unaware of these restrictions and may become frustrated when they are unable to refill or obtain a controlled substance. A survey of 178 family physicians in Canada revealed that 95% of survey participants experienced at least one incidence of minor abuse from a patient seeking a controlled substance during their careers. In this survey the definition of minor abuse ranged from disrespectful behavior.

Setting clear boundaries is one way a physician can enhance their relationship with a patient on controlled substances and hopefully lessen or avoid abuse from these individuals. Physicians need to be comfortable talking about their personal prescribing practices of controlled substances with patients, as well as what the patient should expect while under their care.

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ior to verbal threats. Seventeen percent of physicians stated they experienced one episode of major abuse in their career that was defined as assault or stalking. Unfortunately, this data is not surprising but it is eye-opening even given the small sample size.

Setting clear boundaries is one way a physician can enhance their relationship with a patient on controlled substances and hopefully lessen or avoid abuse from these individuals. Physicians need to be comfortable talking about their personal prescribing practices of controlled substances with patients, as well as what the patient should expect while under their care. This can be done via a one-on-one conversation or creating a patient contract which clearly outlines the physician’s policy on controlled substances. In the literature patient contracts are mostly from the perspective of patient being on long-acting opioids for chronic pain. Recent opinion pieces are calling into question the effectiveness of patient contracts as there is little evidence behind the effectiveness of their use, and if they may actually damage the provider-patient relationship. While there is no ideal way to set boundaries with a patient on controlled substances it is important that the physician discuss the long-term risks and potential benefits of these medications, establish their own personal protocol for prescribing controlled substances, and clearly communicate those protocols to their patients.

Dr. Gauld is Assistant Professor, Notre Dame of Maryland University School of Pharmacy; Clinical Pharmacist, MedStar Franklin Square Medical Center Family Health Center.

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, Spring 2015.
Difficult Patient Encounters: A Virtual Panel Discussion

Kathryn A. Boling, MD.

When I was asked to write an article about dealing with difficult patients, I started with a bit of background research. There were plenty of articles and advice tended to differ depending upon the perspective of the author. This caused me to wonder: what do my colleagues do? I contacted some friends and mentors and sent them questions about this subject. Their answers were diverse and thoughtful. I hope you enjoy them as much as I did.

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Multiple studies of primary care physicians and specialists have identified some of the characteristics of difficult patients and difficult patient encounters. I included this list in my virtual panel discussion – all the participants had a chance to view this list prior to answering the questions.

1. Violent or verbally abusive/angry patient
2. Unsolved, repeated complaints
3. Multiple complaints at every visit and never satisfied
4. Psychosomatic patients
5. Resistant to treatment—always a reason why something will not work
6. Seeking secondary gain
7. Manipulative and/or lying
8. High anxiety level
9. Demanding, boundary-breaking and exploitative of the physician
10. Drug seeking

1. What are the characteristics that cause you to view a patient encounter as difficult?

Boling: For me, a patient encounter is difficult when it leaves me feeling frustrated, angry or powerless to help. This could be due to individual patient characteristics (demanding, verbally abusive, manipulating) or because of more universal issues like patient’s lack of sufficient funds to pay for medication or inadequate mental health resources in the community.

Barr: I really don’t like patients who complain of the same things visit after visit with no end point in sight. I also do not like patients who scare me or patients who are manipulative (especially ones that try to play on my sympathy.)

Rixey: I view patient encounters as difficult when I notice that my compassion is not what it should be. When I start to blame the patient. I don’t remember feeling this way until the system placed the primary care physician in a position to assume responsibility for outcomes that are the result of behaviors that are often the result of social determinants. I struggle when I know that my patients and I are wasting resources continued on page 16
Patient Encounters (continued)

Treating complex, late-stage medical problems that are best addressed upstream.

Shreve: This is an interesting question, but I never give this a thought until after the office visit is over. When I sit there and tell myself, “I am mentally worn out after that last patient,” then I realize that I just had a difficult encounter. I don’t stop myself and think about this during the office visit, as I am there for the patient. Many times, the common characteristics are very much like the difficult patient types listed at the beginning of this article.

Ramirez: Patient encounters are difficult when the expectations of the provider are not in line with that of the patient. Patients who are angry, aggressive, condescending, verbally combative, defensive, disrespectful, impatient, manipulative, and resistant to care. I find that patient’s attitudes about prior providers may color their interaction with me as their new provider.

2. What patient behaviors or characteristics do you find most frustrating to deal with in your practice?

Barr: Drug seeking patients and patients who are unwilling to change behaviors that are causing them harm.

Shreve: Drug seeking and those who want to play the “sick role” or who seem to think that they are my only patient.

Ramirez: Patients who are angry, aggressive, condescending, verbally combative, defensive, disrespectful, impatient, manipulative, resistant to care.

Boling: Patients who are overly-demanding, those who come to their appointments with a long list of complaints and expect all of them to be addressed, and patients who are manipulative and/or drug seeking.

Rixey: It is more the system characteristics that frustrate me rather than individual patient characteristics. I need time to understand who the patient is and why they do what they do. How often do we ask ourselves “what practice or provider behaviors or characteristics do our patients find most frustrating to deal with.” Perhaps if we started there…

3. What coping methods do you use to deal with difficult patients?

Ramirez: I often find that many of the “difficult” behaviors displayed by my patients are reflections of the chaos that may be occurring in their lives. For other patients I have found these to be symptoms of underlying and undiagnosed mood disorders, often-times depression. With the exception of the manipulative and those that are resistant to care, I find that listening to the underlying frustration helps me gain access to what is really going on in their lives and I can then help them navigate towards wellness. This process does take time and requires trust.

Boling: First and foremost, compassion. Many times the patients who present as difficult are actually fearful. I listen, explain things as clearly as I can, and am honest when patients ask me difficult questions. I try to de-escalate when patients are angry or upset. I use humor when I can – that always helps me cope and seems to help patients too.

Barr: Now that I’m a little older, I often will tell the patient that I am bothered and why. That helps me a lot and often, actually seems to help the patient. I admit when I am frustrated and don’t know what to do. I also find it very helpful to talk to colleagues, especially those with more experience. I am a teacher, so sometimes when a student or resident has a difficult encounter, helping them process that also helps me deal with my tough ones.

Rixey: Start by trying to understand why patients feel that encounters are difficult-scared, vulnerable, don’t understand, overwhelmed, telling themselves a story that replays over and over… Even though the DSM has gotten away from the multi-axial diagnosis, it is a wonderful way to approach patients:

1. Do they have a mental illness?
2. Are they cognitively limited or do they have a personality disorder?
3. What are their medical conditions and the demands on those conditions that they don’t comprehend?
4. Are their problems related to primary support group, social environment, education, occupation, housing, material resources, access to health care and the legal system?

Then I take three deep breaths; stop telling myself a story and try to let go of trying to change them. Maybe even make a home visit to get a better handle on their “community” or lack thereof.

Shreve: For the patients that bring an entire 8.5 x 11” sheet with complaints, I allow them to tell their story without referring to their list, to see how many complaints can be connected together. I often let them know that I have goals for the office visit, and I would like to meet one goal, and they can address 1-2 concerns, so together, we have tackled 3 problems. Then I bring them back frequently.

I had one elderly patient with cyclical vomiting syndrome. She had been to three different GI doctors, who all scoped her, and had also been to two primary care physicians and a general surgeon. I just listened to her and started addressing diet, her mood. Her mood, surprisingly, had never been addressed. I brought her back every week for two months, partly because if I didn’t, then she would just go to the ER. But placing myself as a barrier to the ER and earning her trust, she has not been to the ER in more than six months. Buspar, Zantac, and a little TLC fixed her. Now she is happy, healthy, and has gained weight.

4. How do you handle demanding patients?

Rixey: Find shared goals and be clear on what lines you have drawn in the sand.

Shreve: I set firm expectations. I often say, “I treat you with respect and I ask that
you do the same for me and my staff.” Once they have some guidelines, and they feel that they have been heard, they are often very compliant patients.

**Boling:** This may me my biggest challenge. I have no trouble setting limits and sticking to them. My issue is when to step in and set those limits. When someone is crazy demanding right up front, I set a boundary pronto. But when the demanding behavior happens in little increments, I’m not as proactive.

**Barr:** Tough to answer. In some cases, I set limits with them, in other cases I just suck it up and take whatever they are dishing out. I really don’t have a great answer for this. I’ve been told that I’m good with difficult patients, but I’m not sure what that means. I do think I have some tough ones though! For example, I have a patient with a myriad of medical problems and psychiatric issues who calls 1-4 times a day and ties up our phone staff for sometimes up to 40 minutes at a time. She’s just impossible to hang up on. I just had the conversation with her that she may call once a day and the phone staffers are going to talk to her for up to 5 minutes after which they are to say this sentence, “It has been 5 minutes and I am going to leave this message for Doctor Barr now.” She was absolutely okay with this limit because she has had so many limits set on her behavior before due to her personality disorder. I should’ve set this limit 6 months ago!

**Ramirez:** Set strict boundaries and limits with consequences for unacceptable behavior (e.g. firing a patient from the practice who threatens to sue after being refused a particular treatment that is not evidence based or repetitively being rude to support staff)

5. **How do you handle the prescribing of narcotic pain medication for chronic, non-cancer pain?**

**Shreve:** I do monthly office visits with a strict pain management contract that includes mandating imaging, random drug screens, and physical therapy. I have a limitation to the quantity and dosing, and if there is any concern, they are referred to pain management.

**Barr:** I handle it case by case. Some patients I am not even involved in their pain management, others I prescribe regularly. Others I decline. I do not have a blanket policy.

**Boling:** As a policy I do not prescribe narcotic pain medication for chronic pain. If a patient comes to me already on narcotic pain medication, I will give them a month

continued on page 18

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View MAFP CME policy at http://mdafp.org/members/requirements/ or see elsewhere this section.

Questions? Contact MAFP at info@mdafp.org or call 410-747-1980.
Patient Encounters (continued)

or two of refills while they either transition
to a pain management doctor (I have a list
of referrals) and continue with me for the
remainder of their care or switch to some-
one who is willing to prescribe for their
chronic pain as well and act as primary care
physician. Of course, for acute pain I do pre-
scribe appropriate pain medication.

Rixey: It’s a moving target and differ-
ent for everyone… start with do no harm.

Barr: I have a very quick pace and some
of these folks just need a little more time in
their visits.

Rixey: Feeling impotent is very uncom-
fortable. When recognized it is a powerful
motivator to try something new.

7. What characteristics are
present in mutually satisfying
patient encounters?

Boling: When the patient’s expecta-
tions have been met and they are happy
with the care provided. When I have acted
in a loving manner towards my patient and
they reflect that love back to me. When
the patient is better after treatment or
has accomplished a goal or made healthy
changes in diet and lifestyle.

Rixey: Nonjudgmental understand-
ing, relationships that span generations,
occasional victories beyond cerumen
extraction, a good birth, graduations, wed-
dings, retirement, a good death, and funer-
als after a life well lived.

6. Looking inward, what
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might contribute to a negative
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motivator to try something new.
Shreve: What is working for me is having reliable staff that patients get to know. My CMA is well known to all of my patients, who are made aware that she and I work as a team. They learn to trust her and know that she speaks for me when I often cannot personally return a phone call. Because of this, we can tag team and lay clear expectations to the patients in terms of how office visits will be conducted, how frequently they need to be conducted, etc. Follow up visits may need to occur frequently, and patients are expected to make these appointments when they head to our “check out” area. On their clinical summary papers that they receive at the end of an office visit, I write down “2,” and the front staff know that I need two time slots for the next office visit. Allowing more time for these patients helps to keep the general flow in the office and increases both patient and physician satisfaction.

Boling: Reimbursement that is better tied to patient complexity (taking the patient as a whole into account — not just their medical diagnosis) to allow for adequate time in a visit. Decrease insurance company’s incentive to second-guess the physician and require multiple pre-authorization for medication — especially when the patient has been taking it long term with good results. Adequate support staff to handle the increasing administrative burden. Better access in the community to mental health services.

Dr. Boling is a member of the MAFP Editorial Board. We thank her for compiling this virtual panel discussion.
“We create the patients we hate.” I learned this phrase from one of my mentors in Family Medicine during medical school. This particular doctor was a substance abuse specialist who also ran a very popular medicine practice. Each day, we would talk with patients and learn more about their stories. There was one particular patient who became addicted to oxycodone after a back injury. When he was no longer prescribed oxycodone, the patient began buying pills off the street. Eventually, he began using heroin because it was cheaper and easier to find. After each similar tale, my mentor would empathetically look at his patient and tell them, “No one, when asked at 5 years old, what do they want to be when they grow up, states, ‘I want to be an addict.’ Just as no one states that they want to grow up to have diabetes. Both diabetes and substance abuse are chronic diseases that are affected by lifestyle choices, but can be managed with medication and close follow up.”

This thought process has stuck with me from that time when I was a third year medical student who silently rolled her eyes when she saw a patient with a history of substance abuse, to now as a third year resident working in a population full of people with substance abuse disorders. Working in Baltimore, I have come into contact with many patients who have been labeled as demonstrating “drug seeking behavior.” When reviewing their file or speaking with them, many of their stories meld together: “I started having knee pain, tooth pain, abdominal pain, heck, brain pain, and my provider gave me Percocet. They continued to give them to me because it is the only thing that helps the pain.” When I would attempt to dissuade them from masking pain with opioids, I would typically receive pushback, verbal abuse, or even threats of violence. As my mentor said, “We create the patients we hate.”

As I began to progress through residency, I too started to grow annoyed with these people: these problem makers, these “seekers.” Recently, a great amount of literature has come out through various avenues highlighting physician opioid overprescribing and the drug epidemic in Baltimore. Many of these patients were receiving a pill shaped band-aid ill-suited to address years of psychiatric disorders and inherited familial addiction. Others were benefiting from selling their prescribed painkillers for a profit. Given the high prevalence of addiction and my budding change of heart with this specific population, I decided to delve a little deeper into the substance abuse world by doing an elective at a local substance abuse center.

This was the best decision EVER! During my elective, I learned so much about the patients that I had dreaded so much. I learned about the history of addiction medicine, the Baltimore heroin epidemic, and various methods of treatment. I spoke with patients, provided them with medication, and sat in their group sessions. I joined them as they met with their counselors to discuss their inner-most secrets, revealing what, when, and how they were driven to use substances. I witnessed how society ignites the addiction crisis, and how medical professionals perpetuate the cycle.

By taking a closer look at the addiction epidemic, I have a clearer view. I am no lon-ger afraid of patients with substance abuse problems. As my former mentor once taught me, addiction is a chronic medical disease akin to diabetes.

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Dr. DeRouen, R-3 at the University of Maryland Family Medicine Residency, is a member of the MAFP Editorial Board. See her additional contribution to Residency Corner on p. 27.
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Nutrition Basket of Services for Family Medicine

Bonnie T. Jortberg, PhD, RDN, CDE

Over 70% of patients that present in Family Medicine clinics everyday have one or more chronic diseases. Evidence-based guidelines from the US Preventive Services Task Force, The American Diabetes Association, The American Heart Association, and others recommend intensive self-management support for these patients to engage them in self-care activities. However, most Family Medicine practices lack the time, staff, and resources to fully provide self-management support services to their patients. This is reflected in a recent report from the Centers for Disease Control (MMWR 2014;63:1045-9), which found that only 6.8% of insured patients with a new diagnosis of diabetes participated in self-management education within the first year of diagnosis.

Several of the new payment models and primary care initiatives are emphasizing the need for robust self-management support services that can be provided within the Family Medicine practice. For example, one of the primary tenets of the Patient-Centered Medical Home (PCMH) is to engage patients and families in their own care. The new strategic effort from the Family Medicine community, “Health is Primary: Family Medicine for America’s Health” will focus the first year of its campaign on actionable information about how to improve health through exercise, nutrition, prevention, and chronic disease management. Payment initiatives such as Meaningful Use, Pay 4 Performance, and value-based-purchasing are tying payments to practices based on improvements in quality metrics, including demonstration of coordinated patient care plans.

Registered Dietitian Nutritionists (RDNs) are one of the recognized experts in providing Medical Nutrition Therapy (MNT) and patient self-management support. Nutrition counseling provided by a RDN has been shown to improve health outcomes for type 2 diabetes, weight management, disorders of lipid metabolism, and hypertension. Primary care physicians report seeing the benefit of including RDNs on their health care teams to provide MNT and patient self-management support, yet typical fee-for-service has limited the full integration of RDNs into Family Medicine. The good news is that through the Affordable Care Act, there is a renewed emphasis on prevention and wellness services. This makes it easier for RDNs to provide comprehensive MNT and patient self-management support within a family medicine practice. For example, Medicare considers RDNs a “qualified medical professional” for performing the Annual Wellness Visit, the Subsequent Annual Wellness Visit, the Initial Personal Prevention Exam, Chronic Care Management, and Intensive Behavioral Therapy for Obesity. Providing these services, in addition to MNT for patients throughout the life cycle including pediatrics, can make it financially feasible for Family Medicine practices to hire RDNs as integrated members of their health care team.

The PCMH and Per-Member-Per-Month payments are also mechanisms for Family Medicine practices to provide nutrition and self-management support to their patients. Take, for example, Janette Neel, MS, RDN, CDE, who works at the St. Anthony Family Medicine Residency Practice in Westminster, Colorado. Janette provides traditional nutrition services, such as nutrition counseling and diabetes education; she is also a member of the integrated health team, which includes behavioral health professionals, care managers, and volunteer health coaches. Janette has a defined role for population management within the practice; specifically, she manages the diabetes registry and assists the health coaches in identifying high-risk patients for outreach. Data from the registry is also used by their integrated team and the clinic’s Diabetes Quality Improvement Team to identify gaps in care and opportunities for improvement.

Janette demonstrates how RDNs can enhance the work of family medicine practices and states, “I think dietitians are well-suited to working in a PCMH. RDNs have excellent clinical training and patient-engagement skills that are an ideal fit for this model of care. PCMH emphasizes disease prevention, self-management support, and collaborative population management; RDNs have been addressing these aims for many years. Our training underscores the importance of whole-person and patient-centered care and we are invested in helping patients attain positive health outcomes. Rather than accepting referrals as an outside consultant, being physically located in the primary care clinic is ideal for patient access, provides the RDN with full access to the patients’ medical records, and allows for immediate communication amongst the team members.”

To find a RDN in your area, check out the Academy of Nutrition and Dietetics “Find a Registered Dietitian”: www.eatright.org.

Dr. Jortberg is Assistant Professor, Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO.

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, Spring 2015.
The American Academy of Family Physicians (AAFP) seeks participation from all members in its policy-making process. The AAFP Congress of Delegates (COD) considers resolutions submitted from state chapters and from member constituency groups. Any member/s can submit a resolution/s at the chapter level. Attendees of the annual National Chapter Constituency Leadership Conference (Women, Minority, New, IMG, GLBT physicians) and of the National Conferences of Family Medicine Resident and Medical Students can submit resolutions at each of these conferences which, when approved, are submitted to the COD. Members should be aware of the AAFP policy-making process and to be trained in resolution writing to express their voices in areas of interest on issues related to medical education, public health, advocacy, Academy affairs, etc.

The workshop aims to:
- Provide a dynamic forum for members of the DCAFP and MDAFP Chapters to network, share information, and build skills in resolution writing.
- Promote advocacy for Family Medicine.
- Discuss issues of vital interest to Family Medicine and generate resolutions, which can potentially influence AAFP policy and activities.

Through their active involvement in the workshop, participating members:
- Will have gained greater understanding of the resolution writing process.
- Will be empowered to develop and submit resolutions to their respective chapters or at AAFP conferences where resolution writing is part of the proceedings.

Resolution Writing Workshop Facilitators:

Kisha N. Davis, M.D.  
President, MDAFP

Oritsetsemaye Otubu, M.D., M.P.H.  
President, DCAFP

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Welcome Colleagues

On behalf of the Maryland Academy of Family Physicians (MAFP) Board of Directors and Education Committee, we ask that you seriously consider attending the 2015 MAFP Family Medicine Experience! (formerly Annual CME Assembly), where we will present, Essential Evidence 2015 in Ocean City, Maryland. The Assembly will provide a range of learning on evidence-based CME topics with the sights and sounds of the ocean just steps away. Activities are planned for participants to connect and re-connect with new and known colleagues and to learn more about MAFP’s districts and leadership opportunities. We are excited that AAFP President Robert Wergin will be in attendance to offer his national perspective on Family Medicine and the Academy in Maryland and to hear from YOU! We are personally looking forward to seeing you there and sharing in the Family Medicine Experience!

Kisha N. Davis, M.D.
President

Shana O. Ntiri, M.D.
Education Chair

SPECIAL GUEST
Robert Wergin, M.D.
President, American Academy of Family Physicians
Keynote Address and Installation of Officers

Essential Evidence Update 2015

Many of you will recall M AFP’s 2012 Annual CME Assembly which took place at Turf Valley, Maryland. The entire 2 ½ day program was delivered by a faculty of four renowned family physicians from across the country. The comprehensive, evidence-based program was favorably received by the audience, the faculty expressed interest in returning and MAFP’s program committee decided that the team would be invited back. This is the year! Each attendee will receive a course book for on-site and take-away reference.

Mark H. Ebell, M.D., MS,
Course Director
Deputy Editor, American Family Physician
Editor-In-Chief, Essential Evidence
Professor, College of Public Health
University of Georgia, Athens, GA

Gary S. Ferenchick, M.D.
Professor and Division Chief
Department of Internal Medicine
Michigan State University
East Lansing, MI

John M. Hickner, M.D. MS
Professor and Chair
Department of Family Medicine
University of Illinois
Chicago, IL

Heather Laird-Fick, M.D., M.P. H.
Associate Professor
Department of Internal Medicine
Michigan State University,
East Lansing, MI
FREE!

Training on state mandated developmental screening of children

Contact:
Marti Grant, R.N., M.A., Consultant
443-621-8361 (cell) or by email at garymarti1@verizon.net

Dessert will be provided for lunch time training at your practice location!

You and Your Staff Will Learn About:

• The American Academy of Pediatrics (AAP) Policy on developmental screening of all children under 6 years of age
• Why early screening for development is important
• Current approved/recommended screening tools in Maryland
• Nuts and bolts on implementing the recommended ASQ or PEDs screening tool in your practice
• How to interpret and document screening results
• Referral resources and tracking of referrals

Don’t wait!
Get your training for state mandated developmental screening.
Training includes:

- Using the brief tobacco intervention with patients who use tobacco
- Referring patients who are ready to quit to the evidence-based Maryland Tobacco Quitline
- Describing FDA approved pharmacotherapy to help patients stop using tobacco

Training provided for free by the Center for Tobacco Prevention and Control.
Franklin Square Medical Center
by Ansu Punnoose, D.O., R-3

Our residents started 2015 with the annual resident retreat, filled with mandatory togetherness including ice skating and spending quality time together relaxing outside of the hospital (see pictures). We are thankful for our attendings who stepped in to make this happen.

Speaking of faculty, our own Dr. Uchenna Emeche was recently published in the Annals of Family Medicine’s point-counterpoint article addressing superutilizers. Dr. Scott Krugman (chairman of Franklin Square’s Department of Pediatrics and one of our beloved faculty members) was interviewed by WBALTV11 to speak about the measles outbreak and importance of vaccinating children. Dr. Matthew Burke, faculty and chair of the Governmental Advocacy Committee, led the Maryland Academy of Family Physician’s 2nd Annual Advocacy day in Annapolis. He was joined by residents Dr. Cynthia Omokaro (R1), Dr. Melanie Powell (R1), Dr. Fatmatta Kuyateh (R3) and Dr. Ansu Punnoose (R3), where they had the opportunity to speak to delegates about three bills that MAFP supports including a ban on the use of tanning devices by minors, an increase in tobacco taxes, and a ban on the use of tanning devices by minors.

We are so proud that Dr. Kuyateh was recognized for her promotion to the rank of Lieutenant Commander in the U.S. Navy Medical Corps and was presented with her second “challenge coin.” We’d also like to give kudos to all those involved with the AMA-JHM Blood Pressure Initiative including our residents Dr. Crystal Peralta (R2) and Dr. Jay Chung (R2); they’ve accomplished a lot so far. Dr. Avinash Narine (R3) also joined their team and is working on the community engagement pilot for phase 2 of the initiative, where he will be developing community partnerships for supporting blood pressure control outside of the Family Health Center. He and Dr. Richard Bruno (R2) hosted a free grocery store tour at a local grocery store for members in the community to learn about label reading and shopping for good food on a tight budget. We anticipate wonderful results from this project. Dr. Bruno is also serving on the AAFP Commission on Education as part of his role as Resident Chair of the National Conference of Students and Residents this past summer. He recently attended the AAFP winter cluster meeting in Kansas City to continue improving and promoting Family Medicine.

Many more exciting things are in the horizon. Stay posted with us on our Facebook page.

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

Posters, Presentations, and Conferences – Dr. Hersch Bhatia (R2), and Dr. Jennifer Christie Gourdin, (R2) are both presenting at the American Society for Sports Medicine in Hollywood, Florida in April 2015.

Dr. Elizabeth Wiley (R2) presented on legal and ethical implications of current trade agreement negotiations on health at the UNESCO Bioethics Conference in Jerusalem in January 2015. Dr. Wiley also presented on public health stakeholder engagement in trade agreement negotiations at the American Public Health Association Annual Meeting in New Orleans in November, 2014.

Dr. Jason Singh (R3) will be presenting a hospital medicine topic at the upcoming Society Society of Teachers of Family Medicine conference.

Honors – Dr. Amna Choudry (R1) was recently recognized by UNICEF for her dedicated work on child protection programs. She has also been accepted into the Madison 100, an organization that recognizes the top 100 women in DC between the ages of 21-30 who are dedicated to philanthropy and social service.

Babies, Babies, and MORE Babies!! – Our residency is having a baby epidemic. continued on page 28
There are WORKPLACES. And there are FAMILIES.

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Residency (continued)

Dr. Maggie Sass (R3) gave birth to Charlotte Sass on Jan 6th, 2015. She loves to snuggle with mom and dad and REALLY enjoys bath time.

Dr. Kerry Reller (R2) delivered Lily Reller on Dec 18, 2014. Her hobbies include long naps with mommy on the couch.

Here is a picture of both babies bonding during a playdate.

In other news, at this writing, there are several babies on the way. Dr. Jason Singh, and his wife are prepping for Baby #2 due in March. Dr. Brit Doss (R1) and her husband are thrilled to meet their new bundle of joy in June. Dr. Cat Chamberlain, R1, and her partner will be adding a cute little baby to their family (which includes the cutest dog) in July.

2015 University of Maryland Family Medicine Residents
**TREASURER**  
2015-17; two year term  
Ramona G. Seidel, M.D., Annapolis

**VICE PRESIDENTS**  
Eastern District  
2015-17; two year term  
Kim Herman, M.D., Denton

**Western District**  
2015-17; two year term  
Kristin Clark, M.D., Ellicott City

**DIRECTORS**  
2015-16; one year term  
Central District  
Neil Siegel, M.D., Baltimore

**Eastern District**  
Jennifer A. Hollywood, M.D., Easton

**Southern District**  
F. George Leon, M.D., Waldorf

**DELEGATE TO AAFP**  
two year terms, 2-terms limit/2nd  
2015-17  
Adebowale G. Prest, M.D., Hebron

**ALTERNATE DELEGATE TO AAFP**  
two year terms, 2-terms limit/2nd  
2015-17  
Eugene J. Newmier, M.D., Cambridge

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**PRESIDENT-ELECT**  
2014-2016; two year term  
Patricia A. Czapp, M.D., Annapolis

**SECRETARY**  
Central District  
2014-2016; two year term  
Jocelyn M. Hines, M.D., Baltimore

**Southern District**  
2014-2016; two year term  
Trang M. Pham, M.D., Pasadena

**DELEGATE TO AAFP**  
two year terms, 2-terms limit  
2014-16  
Yvette L. Rooks, M.D., Baltimore

**ALTERNATE DELEGATE TO AAFP**  
two year terms, 2-terms limit  
2014-16  
Yvette Oquendo-Berruz, M.D., Columbia

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**IN MID-TERM**

**SECRETARY**  
Central District  
2014-2016; two year term  
Jocelyn M. Hines, M.D., Baltimore

**SECRETARY**  
Southern District  
2014-2016; two year term  
Trang M. Pham, M.D., Pasadena

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**CONGRATULATIONS FOR SPECIAL APPOINTMENTS, HONORS, FEATURES, ACHIEVEMENTS!**


**Eugene J. Newmier, D.O.** of Cambridge has been awarded the Beta Chapter of the Alpha Omega Alpha Honor Medical Society’s Volunteer Clinical Faculty Award for his contribution with distinction to the education and training of clinical students. He accepted his award, given annually to a

continued on page 30
Members (continued)

deserving community physician, at a cer- 
emony in Baltimore on March 26, 2015.

Yvette Oquendo-Berruz, M.D. of 
Columbia has been appointed to the Hori- 
zon Foundation Board of Directors for a 
3-year term beginning January 1, 2015.

Manisha Sharma, M.D. of Baltimore had published her Op Ed piece, “Confirm 
our top doc now” in the December 8, 

Joseph W. Zebley, III, M.D. has been re-appointed Chair of the AAFP Delega-
tion to the AMA for a 2-year term which 
began January 1, 2015.

In Memory
MAFP deeply regrets the passing of its member 
William C. Weintraub, M.D., 
of Annapolis 
A Contribution to the MAFP Foundation 
has been made in his honor.

Welcome New and Transferred Members 
November 1, 2014 - February, 2015

ACTIVE

Tessie G. Aikara, M.D.
Sijuwola Ajinwun, M.D.
Oluremi R. Akinlade, MBBS
Sharon Y. Alongi, M.D.
Eman H. Al-Samra, M.D.
Deepa P. Arya, M.D.
Praveen Bolarum, M.D.
Martina P. Callum, M.D.
Martha J. Chalmers, M.D.
Shanita Chase, M.D.
Jasmine Chen Gatti, M.D.
Roxane I. Hilton Clarke, M.D.
Paulette L. Grey Riveria, M.D.
Arthur S. Hansman, M.D.
Monique A. Husbands-
Onyeukwu, M.D.
Martha E. Johnson, M.D.
James G. Jolissaint, M.D.
Adeola A. Jolayemi
Frederick C. Kass, M.D.
David R. McBride, M.D.
Khanh K. Nguyen, M.D.
Laura L. Riggins, M.D.
Bonnie B. Roberts, D.O.
Debjeet Sarkar, M.D.
Jyotsana Singh, MBBS
Komal S. Soin, M.D.
Naima S. Spradley, M.D.
Minh D. Ta, M.D.
Ken M. Tashiro, M.D.
Bonnie H. Templeton, M.D.
Doria E. Thomas, M.D.

INACTIVE

Kevin D. Burns, M.D.

RESIDENT

Nikhil G. Desai, D.O.
Tamkeen M. Farooq, D.O.
Ypapanti Meris, M.D.
Melanie Powell, M.D.
Rachael M. Randall, M.D.
Hasan M. Shihab, M.D.
Patrick R. Smith, M.D.
Arifuz Zaman, M.D.

STUDENT

Filalat Akinyemi
Abinet Aklilu
Sassan Andalibi
Mirela Bacevac
Monica Choksi
Margaret Connolly
James R. Cooper
Daniel Eichberg
Matthew Evans
Mark Facchin
Durga Sivacharan Gaddam
Anna Glitterman
Sarah Green
Stephen Groves
Shanzay Haider
Caroline Haislip
Ian Harrold
Joseph Hartstein
Gregory Iannuzzi
Rupal Jain

Cecile L. Karsenty
Kristen LoGrande
Merab Okeyo
Jahin Patel
Sweta Patidar
Waqrun Rashid
William J. Richbourg
Patricia Richey
Jennifer Schmidlt
Zachary Strasser
Rebecca Tennis
Rachel Troch
Neil Vranis
Jessie Werner
Kimberly M.R. White
Katherine J. Williams
Richard Wrobelwski
Mike Yang
Xueming Zhang
Mountain States Medical Group and Russell County Medical Center, located in Lebanon, Virginia, are currently seeking a Full Time, Board Certified, Family Medicine or Internal Medicine Physician. The qualified candidate will join a Brand New, Out-Patient Clinic in Lebanon, Virginia to provide services to their Community and Russell County Medical Center. This will be a Hospital Employed position with the following incentives:

- Competitive Salary and Bonus
- Full Benefits
- Paid Malpractice
- Generous Sign On Bonus
- Relocation Assistance
- Educational Loan Assistance
- CME Reimbursement
- PTO

Please Contact:
Tina McLaughlin, CMSR, RCMC Senior Physician Recruiter
276-258-4580 • mclaughlint@msha.com

An independent, primary care, multi-specialty practice located in Chilhowie, Virginia is currently seeking a BE/BC, MD/DO, Virginia Licensed, Family Medicine Physician to join their group Full Time. The group has 2 Physicians and 1 Nurse Practitioner. One Physician is retiring and group is recruiting to replace this physician. The clinic is certified as a rural health clinic and provides a complete range of primary care services. The candidate will step into a thriving, completely independent, 60 year old practice that has many loyal patients, a hardworking loyal staff with low turnover and excellent standing in the community. Johnston Memorial Hospital located in Abingdon, Virginia and Smyth County Community Hospital located in Marion, Virginia will be assisting the group with the following for the qualified candidate:

- Income Subsidy for first 1-2 years
- Sign On Bonus
- Relocation Assistance
- Educational Loan Assistance
- Call: Phone Call Only, Every 3rd Week

Group will provide:
- Competitive Salary
- Opportunity to Earn Above Average Income
- Comprehensive Benefits Package
- Medical/Dental/Vision Benefits
- 401K Retirement Package with Match Program
- Malpractice Insurance Provision
- Allowance for Dues/Continuing Education

Please Contact:
Tina McLaughlin, CMSR, JMH Senior Physician Recruiter
276-258-4580 • mclaughlint@msha.com

A well-established, financially sound, private group. The incoming candidate will have the opportunity to work with quality colleagues with outstanding training. Smyth County Community Hospital opened a brand new facility Spring of 2012 and has a well-established Hospitalist program to manage admissions, etc. The Hospital will also be offering a Competitive Income Subsidy, Sign On Bonus, Educational Loan Assistance, Relocation Assistance and possible in-training stipend. The group will provide a strong benefits package.

Please Contact:
Tina McLaughlin, CMSR, SCCH Senior Physician Recruiter
276-258-4580 • mclaughlint@msha.com

Russell County Medical Center, located in Lebanon, Virginia, is currently assisting a Private, Out-Patient Clinic, C-Health in locating Full-Time, BE/BC, Family Medicine Residency trained Physicians to join C-Health. C-Health provides care to the community in three locations: Lebanon, VA, Honaker, VA and St. Paul, VA. C-Health is a stable and established group of 4 Physicians and 11 NPs. Russell County Medical Center will be providing the following incentives:

- Competitive Income Guarantee
- Generous Sign On Bonus
- Stipend Agreement
- Relocation Assistance
- Educational Loan Assistance

C-Health will provide:
- Medical Benefits
- Malpractice
- CME
- PTO
- CME

Please Contact:
Tina McLaughlin, CMSR, RCMC Senior Physician Recruiter
276.258.4580 mclaughlint@msha.com
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