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Our New President

Samuel C. Matheny, MD
Lexington, KY

SPECIAL ISSUE

Kentucky Academy of Family Physicians 55th Annual Scientific Assembly Highlights

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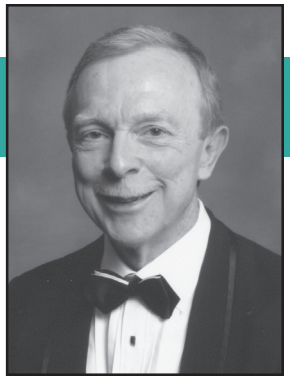

by Samuel Matheny, MD

Of Policies And Pipelines: Family Doctors Make A Difference

By way of introduction, I am a native of Kentucky, from a family of farmers and coal operators, and grew up on a farm near Crab Orchard in Lincoln County. A graduate of Stanford High School and the University of Kentucky College of Medicine, I returned to Kentucky in 1993 after practicing in Arizona, California, and serving two stints in the U.S.Public Health Service to the position of Chair of the Department of Family and Community Medicine at U.K.

But my story of family medicine really begins with Howard Frisbie. Dr. Frisbie, a native of Nebraska, came to Kentucky in the late thirties, was one of the charter members of the Kentucky Academy of General Practice in 1948, and started the first hospital in Lincoln County. A tall, handsome, muscular man with a pencil-thin mustache and a decided limp from a bout with polio, his sometimes blunt demeanor belied his genuine empathy for his many patients and his great sense of humor. A small two-story building served as both his offices and the hospital. He cared for all of my usual childhood illnesses, sometimes by making house calls to our farm, just as he did when attending to my invalid grandmother who lived with us after she suffered a stroke. He also set my many fractures, removed my aunt's gallbladder, saved my father from a near fatal case of acute poliomyelitis, delivered my cousins, and sat beside my dying father and my grandparents in their home. In addition, he was an avid sportsman and member of the school board who eventually was responsible for developing the first non-profit hospital in the county. As I grew older and started showing my own interest in medicine, Dr. Frisbie always managed to find the time to slow down in the midst of his busy practice and relax a bit when I came in to his office as a patient or to his home (his son was one of my best friends), and offer me kind words of encouragement.

Larry S. Fields, MD, AAFP President and Samuel C. Matheny, MD, KAFP President

Flash-forward to 2006, a year which has been pivotal for family medicine in Kentucky and the United States. So far, it is the year that federal support for family medicine teaching programs disappeared as recommended by the Administration and confirmed by Congress. It is also the year malpractice reform was defeated in Kentucky. At the same time, it is the year when proof of the value of primary care and family medicine to the health of the general population began to emerge in the medical literature.

At the annual meeting of the Society of Teachers of Family Medicine, Dr. Barbara Starfield, a pediatrician and internationally known researcher on primary care at Johns Hopkins, riveted the audience with her evidence that there is better health in areas with more primary care physicians, that people whose health care needs are provided by primary care physicians are generally healthier, and that the "characteristics of primary care" are associated with better health (1). Conversely, there may be evidence that greater numbers of non-primary care specialists are not associated with either better quality of care or better results from care (2).
By all accounts, the Commonwealth needs more than 600 primary care physicians (and in rural Kentucky, that means family physicians), and that shortage is even greater when looking at the vacancies in Community Health

Centers in Kentucky and throughout the country who serve the most disadvantaged populations. Eighty-one of our 120 counties have a shortage of family physicians (3). That means over 67% of all of our counties are in health professional shortage areas (HPSA's). This compares to only 25% of the nation's counties that are designated HPSA's. And the problem may grow even worse. With an aging rural population, numbers of medical visits per patient will surely increase, and new demands placed on family physicians, such as those imposed by burgeoning epidemics like Asian influenza or the need for front line physicians to respond to natural or man-made disasters, will increase the vulnerability of our rural communities.

So, if it's becoming more obvious that we need family physicians to assure good health, and all indications are that the demands on them will only increase over time, why don't we have a greater concern from the public and our government to demand answers to what we as a society are doing about this potential (and real) crisis? The answers to this question are complex, and our positions as a professional society may sometimes be unclear due to some confusion on our part as advocates for improved primary care to know precisely what we really want and how to achieve it.

The KAFP can start by identifying the most important questions in hopes of developing some consensus around the appropriate action steps. What scholarship and/or loan repayment programs for students and residents could provide the best incentives for practicing underserved areas? The Association of American Medical Colleges has been pushing for a 30% expansion of medical school enrollment nationally by 2015. What should we be promulgating in this state to ensure that this expansion will begin to address Kentucky's shortage primary care physicians? Should we urge that more training occur in rural areas, or suggest some other method? In light of the loss of federal finds, how much additional state money should be allocated to support training programs for family physicians? And maybe most importantly, how do we as individual family physicians mentor and encourage the best high school and college students in our communities to enter medicine, and hopefully return to their communities to practice? Most of us have a Dr. Frisbie at some point in our lives who helped us formulate our enthusiasm and love for the practice of medicine. How can we in turn perform this role and most effectively reach out to these promising young people and assure that the pipeline will not only provide our replacements, but also eliminate the family physician shortage?

KAFP must concern itself with these issues, and as its members we need to actively become part of the solution to these challenges by helping to make a difference, both individually and collectively, by advocating for innovative, effective, and forward thinking educational initiatives within our medical schools; and by collaborating with legislators to fund or provide other incentives that encourage doctors to live and practice in Kentucky. This must be one of the major agendas for KAFP in the near future. Nothing less than the health of our population depends on it.

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Samuel C. Matheny, MD, KAFP President; Larry S. Fields, MD, AAFP President; William J. Crump, Jr., MD, Immediate Past President

FROM THE EDITOR

by William Crump, MD
Madisonville, KY

THE FUTURE OF FAMILY MEDICINE: A VIEW FROM THE COMMONWEALTH'S BLACKTOPS

During my year as KAFP president, I traveled across our state and visited all our residency training programs and student interest groups. As I drove back from each visit, I had a chance to reflect on my impressions. I shared some of these with our annual banquet attendees as my Presidential Address, and I'll do the same here in text.

A recurring impression was that our discipline is at a crossroads. The sentiments of cynicism and idealism kept popping up as a dichotomy among old and young alike: Which shall we be?

On several of my visits, I invited participants to provide some phrases to describe the successful physician. Among the most cynical, I heard things like "the nicest car in the doctor's lot," or the "trophy spouse."

For a lot of years, I have worked with bright young pre-med students just before they begin medical school, and I am continually impressed with their eager idealism. When I see the same students after the first year of medical school, something has changed, and cynicism is the rule. This reminds me of a quote from Dr. Rachel Remen's book (1):

> "Medical training is like a disease. It would be years before I would recover from mine."

Cynicism

So let's think about cynicism for a bit. For a definition, let's turn to Wikipedia (2). A Cynic is someone who maintains that only self-interest motivates human behavior, and tends to dismiss most of accepted wisdom as irrelevant or obsolete nonsense. They view themselves as enlightened free-thinkers, with their critics seen as social pretenders who bury their heads in the sand.

But, too much cynicism may cause psychological distress when cynics see themselves as self-serving inhabitants of a meaningless, shallow world. One view is that excess cynicism lends to dissociation from reality because it leads to easy rejection of hard answers. To support their view, cynics point to media reports of misdeeds of politicians, corporations, and some organized religions. In fact, mass market journalism generally accepts only cynicism as the politically correct view (2).

Now a little about the history of cynicism (3): The Greek word Kynikos means "like a dog." The first cynics were students of the philosopher Antisthenes, who was a student of Socrates. Their goal was to expose foolishness. They hung out in the streets like a pack of dogs, watching the passing crowds, and ridiculed anyone who seemed pompous or pretentious.

Probably the most famous cynic was Diogenes who would introduce himself as follows. "I am Diogenes the dog. I nuzzle the kind, bark at the greedy, and bite scoundrels." His famous use of a lantern to search for an honest man was actually done during daylight hours to make his point. When Alexander the Great came upon Diogenes sitting in the market place and asked how he could help the old man, Diogenes is quoted as saying "You can step out of my sunlight." More modern cynics include Rabelais, Swift, Voltaire, and Mark Twain. Their common technique is biting sarcasm and mirthful ridicule.

Idealism

So what about Idealism? Idealists pride themselves on being loving, kindhearted, and authentic. The table lists some common preferences of those who would call themselves idealists (4). A definition, again from Wikipedia: Idealism is a philosophy, or understanding of existence, that is the opposite of materialism (5). It's not really about being greedy or not- it's whether the world is a better understood as mental (idealism) or physical (materialism).

In its purist form idealism says that the only things which can be directly known for certain are ideas. This is a very spiritual way of thinking, and is interwoven into most of the world's religions.

Conclusion

So, what's all of this got to do with being a family doctor? Think back to when you made the decision to go to medical school- most of us were idealists, I think. So, what happened? This may be best explained by a quote from Rick Bayan, who manages the website The Cynic's Sanctuary (3):

> "But the best cynics are still idealists under their scarred hides.

We wanted the world to be a better place, and we can't shrug off the disappointment when it lets us down. Our cynicism gives us the painful power to behold life shorn of its sustaining illusions. Thus my own definition of a cynic:

'an idealist whose rose-colored glasses have been removed, snapped in two and stomped into the ground, immediately improving his vision.'

If we were activist, we'd do something constructive about our discontentment. But we're smart enough to know that we won't prevail, and probably a little too lazy to attempt any labor that's predestined to fail. So we retaliate with our special brand of wounded wit. If we can't defeat our oppressors, at least we can mock them in good fellowship. That's about as much justice as a cynic can expect."

Opponents of the cynical view say that cynicism is bad for the soul and leads to an unhappy life. When one begins to believe the view of the world provided by the media as mankind as a whole morally corrupt, it's hard to be enthusiastic about out future. This logically leads to burn-out, and we've all seen too much of that. What are we to do?

My mentor at Vanderbilt, Dr. Anderson Spickard, published a summary of the literature on burnout in JAMA (6). I quoted it in my winter 2005 editorial, and I'll re-use the table again that shows the strategies used by those physicians most resistant to burnout (see Table Two).

So which shall we be: cynic or idealist? On my travels I also heard phrases describing the successful physician in entirely non-materialistic terms. Phrases like those in Dr. Rick Miles' essay in this issue. Words like "blessed" and "energized" that were framed by the sheer wonder of the experience of caring for folks from birth to death.

Lastly, let me say that I can spend this time pondering the meaning of life because I know I have the leadership and advocacy of the AAFP "sweating the details" of practical, material gains for Family Medicine.

Our future is bright, but only if each one of us agrees to spend our time in roles of leadership, getting up to our ears in the mire of payment mechanisms and politics. But I urge us to retreat to our idealism regularly. Only then can we be fully present with our patients who daily share their lives with us.

Thank you.

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1) Remen RN. Kitchen table wisdom: Stories that heal. Riverhead Books. New York. 1996.
2) http://en.wikipedia.org/wiki/Cynicism
3) http://www.i-cynic.com/whatis.asp
4) http://www.ptypes.com/idealist.html
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Table One

The Idealist Prefers:
Superiority
Perfection
Meaning
Purpose
Acceptance
Approval
Altruism
Aesthetics
Accomplishment
Accuracy
Completion
Culmination
Faultlessness
Improvement
Intimacy
Self-actualization
Social Justice

Table Two

Box. Strategies to Prevent Physician Burnout

Personal

Influence happiness through personal values and choices
Spending time with family and friends
Religious or spiritual activity
Self-care (nutrition, exercise)
Adopting a healthy philosophical outlook
A supportive spouse or partner

Work

Control over environment: workload
Finding meaning in work and setting limits
Having a mentor
Having adequate administrative support systems

JOIN US AT OUR NEXT MEETING

by Rick Miles, MD
Russell Springs, KY

At a recent KAFP meeting, Dr. John Patterson gave an unusual presentation on Complementary and Alternative Medicine (CAM). There were several excellent lectures on Cardiovascular Disease, Alzheimer's Disease, Bronchitis, Reflux Disease, and more. All were informative and very well done. Dr. Patterson's lecture stands out because he asked us to consider CAM in our own lives. He was not talking about herbal treatments. He was talking about Spirituality including mind, body, soul, and contemplation (or prayer in a Judeo-Christian cultural concept). At the end, Dr. Patterson asked us to contemplate our hands for 30 seconds. He asked us to consider what those hands had done and what we wanted to do with them. He then asked us to consider the moment, that moment where we are now.

That meeting was enjoyable. Good lectures with opportunities for learning were available. But even more enjoyable was the opportunity to visit with old friends. I talked to family doctors that I have worked with and that I have met and known as I participated in the process of organized medicine. I talked to doctors that I served with in leadership roles in the Academy. I also had the opportunity to meet and welcome residents who attended the meeting.

As usual, we discussed the problems of practicing in today's environment. We "old guys" discussed the changes in medical care. The problems of formularies and reimbursements as well as the perceptions of changes in attitudes and involvement by the next generation were discussed.

As I looked at my hands, I answered John's question "What have they done and what do you want them to do?" I thought of the babies they have delivered. I thought of the central lines and chest tubes they have inserted. How many prescriptions have they written? How many pages of notes? Then I come to that moment. The most important thing those hands have done was never foretold to me in medical school. Last week, they brushed back the hair from the face of an 85 year-old woman as I was rechecking her after we had treated her acute episode of heart failure. She smiled back. "Yes, she was breathing better." Then, in a few minutes the hands- my hands -brushed down the back of the hair of an 11 year old girl as I told her that she was being discharged from the hospital, as she was much better.

In the moment I knew that I was content. I was a family physician with 26 years of stress, work, long nights, and a fulfillment of being who I really am. I was in the midst of 30 others who have all done much of the same.

Family docs are an open, loving and wonderful group of people. We are fighting to teach America that we offer the most cost effective and highest quality of care available to society. We offer it with compassion. I implore the new physicians, residents and new students, to join us at some of our meetings. I learned a lot from these 'old boys' and I look forward to learning from the 'young docs' as well.

55th Annual Scientific

The Kentucky Academy of Family Physicians honored physician members who graduated from medical school 50 years ago at the 55th Annual Scientific Assembly Banquet. John Darnell, Jr., MD, Master of Ceremonies, presented awards to the 1956 Medical School Graduates.

Robert M. Blake, MD
Maysville, KY

Herbert Chaney, MD
Dawson Speings, KY

Olie B. Emerine, MD
Elizabethtown, KY

James Frank Kurfees, MD
Anchorage, KY

Charles E. Peck, MD
Russell Springs, KY

Paul R. Smith, MD
London, KY

The following 1956 Medical School Graduates were not able to attend ceremony:

Bacon R. Moore, III, MD
Harrodsburg, KY

And

Patricio F. Soliman, Jr., MD
Saint Petersburg, FL

John Darnell, Jr., MD, Master of Ceremonies, presents an award to Gay Fulkerson, MD from Leitchfield, KY, for her dedication and leadership as this years Program Chair.

c Assembly Highlights

CITIZEN DOCTOR OF THE YEAR FOR 2006

Dr. Ron Waldridge of Shelbyville, Kentucky was selected by his peers for the most coveted award among family physicians in Kentucky. He was named Kentucky Academy of Family Physicians' Citizen Doctor of the Year for 2006 during the 55th Annual Scientific Assembly held at the Marriott-East in Louisville, Kentucky on May 13, 2006. The Kentucky Academy of Family Physicians' criteria for awarding this prestigious honor is that a family physician must be passionately dedicated to his patients, active in building the community, and an invaluable role model to their peers and to medical students and residents.

Dr. William Crump, President of the Kentucky Academy of Family Physicians for 2005 and chair of the nominating committee for the Citizen Doctor of the Year Award, commented, "Ron has served in every leadership position of the Academy and has 'gone the distance' for our patients and specialty. It did not take me long to think of who I wanted to submit to the committee for this prestigious award. His accomplishments as a family physician, father, and community leader are well known."

The Awards Committee selected Dr. Ron Waldridge, II to present the award. Dr. Waldridge, II became emotional as he said, "My father has been my role model." He went on to highlight his father's many accomplishments as a family physician and to describe his role in building infrastructure in numerous community organizations.

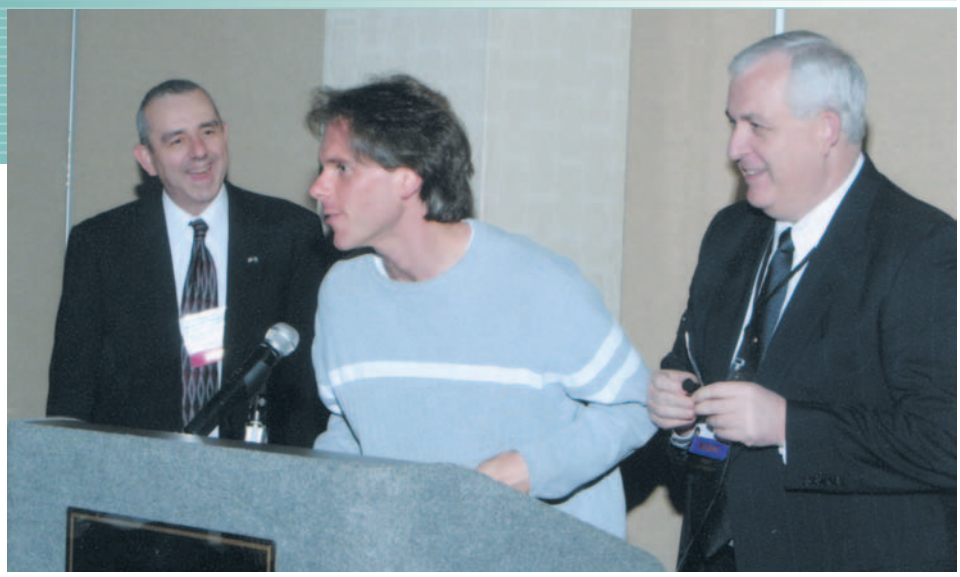
"To be recognized by your peers from among so many deserving family physicians is truly a great honor," Dr. Ron Waldridge said. He then proceeded to introduce his staff, many of whom have worked with him for more than 30 years, as well as his family and friends. This entire group attended the event as a surprise to him.

Dr. Waldridge has been a member of the KAFP since 1969 and in is private practice with his son in Shelbyville.

John Darnell, Jr., MD, Master of Ceremonies; Ronald Waldridge, MD, Citizen Doctor of the Year; Ron Waldridge, II, MD

Ronald Waldridge, MD and wife, Kay Waldridge with family, friends, and office staff.

KAFP's First Annual Resident Quiz Bowl



Mark Roback, PG-1 from Trover Foundation accepting 1st Place Honors. Also pictured Gerry Stover, MS, EVP and John Darnell, Jr., MD, AAFP Delegate.

"The most exciting phrase to hear in science, the one that heralds new discoveries, is not 'Eureka!' (I found it!) but 'That's funny ...' " Isaac Asimov (1920 - 1992).

Dr. Asimov' quote describes the resident participants' response to the event that the KAFP and KAFP Foundation leadership hope will be a stimulus to encourage more resident and student participation at future KAFP Annual Meetings. The KAFP Foundation supported the event's expenses, including participant awards and prize money. Invitations were sent out to all residency programs to identify two residents to represent their residency program as contestants.

The participating residency programs were Glasgow, Hazard, UofL, and Trover Foundation. Dr. Steve Petrany from the WV Academy of Family Physicians and Associate Dean with the Marshall University School of Medicine's Department of Family Medicine served as the event moderator. Dr. Petrany utilized medical quiz cards and some Kentucky local facts to challenge the contestants' knowledge. The quiz bowl went for approximately one hour, with faculty and other physicians in the audience alternating between quietly letting those around them know they knew the correct answer and marveling at some of the correct answers provided by the young physicians.

Dr. Bill Crump presents the 1st Place Trophy to the Trover Foundation. Jami Perry, Mark Roback and Director Lamont Wood, MD proudly accept.

The Trover Foundation team, composed of PG-1s Jami Perry and Mark Roback, clearly staked out 1st place, followed by Glasgow, UofL and Hazard. Dr. Nancy Swikert, President of the KAFP Foundation, presented checks to the respective residency programs for the 1st place which received $3,000; 2nd place $2,000 and 3rd place $1,000. Each participant received a $50 gift certificate as a book allowance. Special thanks go to Brenda Darnell, wife of Dr. John Darnell, Mynra Miller with Eli Lilly, and Dr. Thornton E. Bryan, Jr., who served as score keepers and judges.

Training has already begun for next year's match, with a year's worth of bragging rights at stake.

Mark Your Calendar for Upcoming Meetings!

National Conference of Family Medicine Residency Programs
August 2-5, 2006
Bartle Convention Center/KC Marriot, Kansas City

KMA Annual Meeting
September 14-16, 2006
Hyatt Regency/KY International Convention Center
Louisville, KY

AAFP Annual Scientific Assembly
September 26-October 1, 2006
Washington, DC

UK 38th Annual Family Medicine Review
11/05-11/10/06
Lexington, KY

KAFP 56th Annual Scientific Assembly
April 20-21, 2007
Louisville Marriott East
Louisville, KY

2006-2007 Kentucky Academy of Family Physicians Committee Chairs

Advocacy Committee
Nancy Swikert, MD – email: Ddwarrow@aol.com
Brent Wright, MD – email: bwrightmd@hotmail.com

Education Committee
Charles Kodner, MD – email: charles.kodner@louisville.edu
Paul Dassow, MD – email: pdass1@email.uky.edu

Leadership Committee
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John Darnell, MD – email: johoda@dragg.net

ByLaws Committee
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Mont Wood, MD – email: rwood@trover.org

KAFP Foundation-Research Committee
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FROM THE ASSOCIATE EDITOR

by Charles Kodner, MD
Louisville, KY

Quality, Technology, and P4P

From many different sources, we are hearing more about "quality of care"—how it should be improved, measured, and possibly even used to determine payment. The Future of Family Medicine project describes a need to meet national quality of care standards, and to have support systems to measure and report physicians' performance related to different quality of care standards.[1] Family physicians are increasingly called upon to improve the quality of their care, and their delivery of it—electronic medical records, patient care processes, adherence to guidelines, and other measures to promote a "new model practice." This comes at a critical time for family medicine (as evidenced by the national AAFP's planned rally on Capitol Hill in September) to promote urgent health system reform which will include affordable, accessible, high-quality care as a centerpiece. And increasingly, it seems that voluntary quality-of-care reporting will migrate to "pay for performance," [2, 3] where financial incentives will encourage physicians to achieve progress or benchmark levels for quality and efficiency of care.

This can be pretty intimidating. But I think that measuring the "quality" of our medical care, and making sure we are delivering the best medical care available, really is going to be good for us, our patients, and our country (if we do it well). What I have found most interesting lately is the complexity of using the scientific evidence and practice guidelines available as quality of care standards. With this in mind, I would like to share some information from recent publications about this topic. When high-level, national efforts to ensure and measure "quality of care" reach the trenches of individual insurers, physicians, and practices, we will find that we actually have to decide what particular things to measure, and how to measure them. Family physicians will need to be familiar with some of the issues related to doing this, in order to best present themselves and the exceptional care which they provide. Perhaps more than other specialties, family physicians have an intuitive sense of how to apply overall guidelines and recommendations to meet specific patient needs. Translating this intuition into the language of quality-of-care measures will be vital to protect our own practices as well as deliver real high-quality patient care. I hope that sharing some of this information will be helpful toward this end.

The most interesting article describes the experience of the San Francisco VA Medical Center's attempts to meet national targets for colorectal cancer screening, with the threat that failure to increase screening rates could have important financial consequences. What could make more sense than applying national guidelines for the importance of colorectal cancer screening as a performance measure for quality of care? But things are not so easy, and the lessons they learned have important messages for family physicians grappling with similar issues. Here are the main take-home points:

1. "Performance measures are not the same as practice guidelines." Guidelines are intended to provide scientifically-grounded information on how best to care for patients. Performance measures are standards which, if not met, should indicate substandard quality of care. Translating guidelines into standards isn't easy.

2. Severity of illness matters. The VA study found that the target population for promoting colorectal cancer screening did not have an upper age limit, and potential patients were not excluded even if screening was documented to not be medically indicated. Many of the patients considered eligible candidates for colorectal cancer screening were 75 years or older, or had multiple comorbid illnesses, including multiple patients for

whom screening was very clearly not appropriate. Family physicians do an excellent job of adapting guidelines to individual patient circumstances and preferences, and it is important to make sure these factors are represented fairly in any performance measures applied to our practices.

3. Higher screening rates aren't always better.
While it's important to remember and consider appropriate screening and other quality-of-care measures in patients, more isn't always better. The VA study found that many of the "screening" colonoscopies ordered were actually obtained to diagnose patients with anemia, rectal bleeding, or other conditions. The target screening rate should not simply be matched to the highest rate of testing achieved in some other practice or setting, but should be matched to provide screening to the particular group of patients who would benefit the most**.** This group should be used as the "denominator" in determining how quality-of-care measures are used.

4. Patient preferences and clinical judgment are important.
Patient-centered care involves discussing the risks and benefits of any treatment or screening plan**.** Quality-of-care or performance measures should be able to assess not just whether a test was done, but whether the physician and patient discussed it and both decided it was appropriate.

Quality-of-care measures are coming, and many physicians may already be using these measures. But the measuring isn't always easy, and I hope these ideas are helpful to guide our practices to present themselves the best way possible in this new era of medicine. As the authors of the VA study state: "If one is not careful, performance measures can become scientifically insupportable algorithms that classify high rates of a procedure as good regardless of who received it, why it was performed, or whether the patient wanted it." As family physicians we have yet another opportunity to defend the best interests of patient-focused care.

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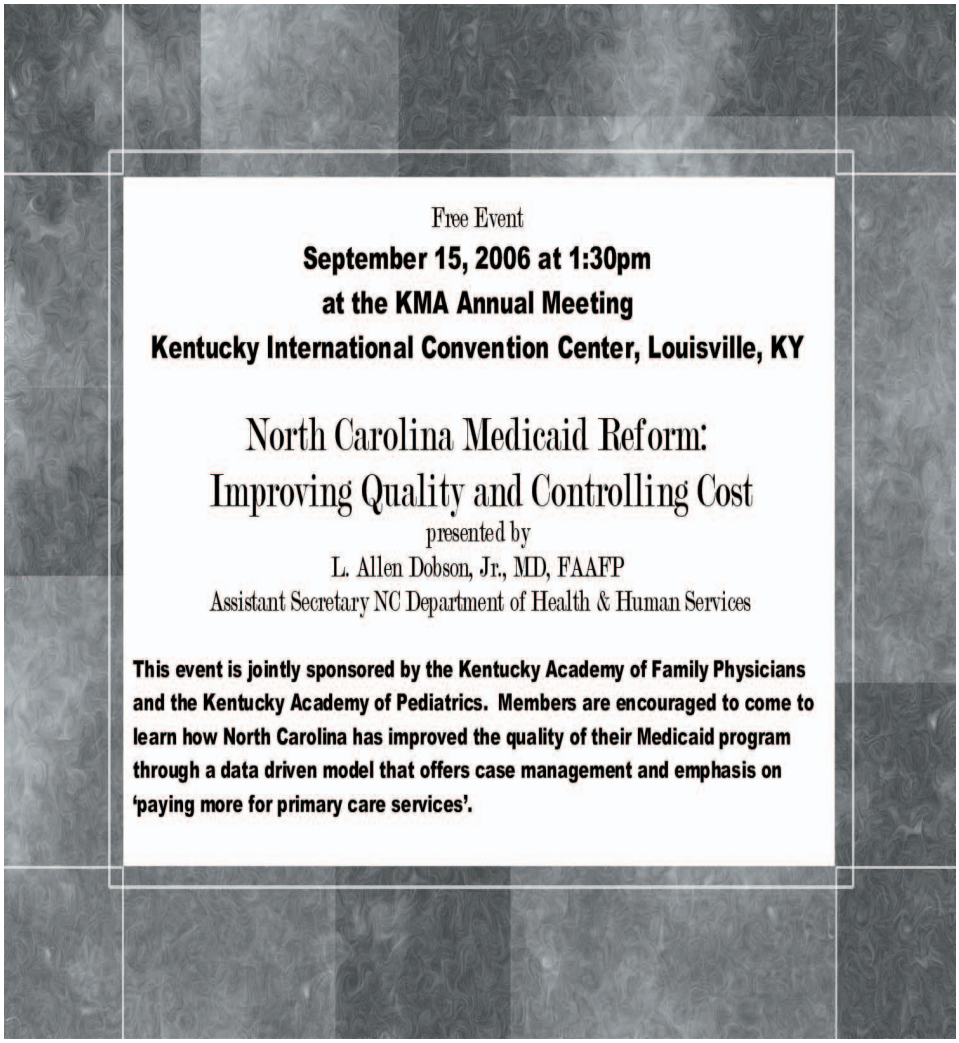
UK-Hazard Family Medicine Resident Wins Two National Awards

Dr. Peter M. Abadir, family practice resident at the East Kentucky Family Medicine Residency Program in Hazard, was selected as one of two recipients to receive the 2006 AAFP's Resident Community Outreach Awards. His outreach project focused on organizing a comprehensive, multi-agency health fair in Hazard that provided services to approximately 150 local residents; writing a weekly newspaper column, "Ask Your Neighborhood Family Doc"; and making monthly appearances on WYMT-TV to discuss health-related issues. Dr. Baretta Casey, Director of the UK Center for Rural Health and East Kentucky Family Medicine Residency Program. "He cares for the community, its population and their health care needs. Peter exemplifies all the traits one would hope to see in an upcoming family physician,"

Additionally, Dr. Abadir was selected as one of 20 recipients of the 2006 AAFP/Bristol Myers Squibb Award for Excellence in Graduate Medical Education. Dr. Doug Hensley, AAFP Executive Vice President, wrote in the award notification letter — "You will join a very select group of previous winners who represent the most outstanding family practice residents in the country. (We) appreciate your hard work and commitment to the ideals of family medicine. We salute your achievement." "I'm very honored to be chosen. I just do what I do because when I see a need, I want to help where I can," Abadir said. "I am especially excited about the Award for Excellence because it is a testament to the quality of education that we have at the residency program in Hazard."

Both awards will be presented to him during the AAFP Scientific Assembly, to be held in Washington, D.C this September. In addition to his award Dr. Abadir has pending publication of his research findings in Hypertension in the Journal of the American Heart Association, and will serve as his program's Chief Resident.

Dr. Abadir lives in Hazard with his wife, Magdoline, and two sons, Michael and Luke.



The Kentucky Academy of Family Physicians

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