# KAFP JOURNAL

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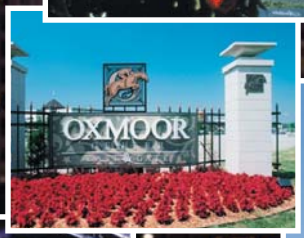


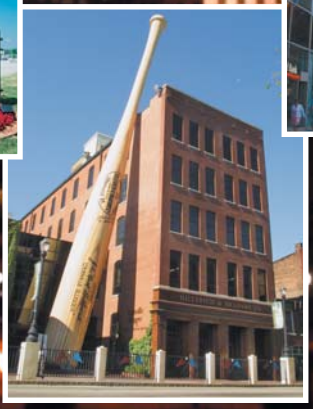


## 55th Annual Scientific Assembly

## May 12-14, 2006

## Louisville Marriott East

## Louisville, KY

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*Pictures are a courtesy of Greater Louisville Convention & Visitors Bureau.*



KAFP JOURNAL

**The Kentucky Academy of Family Physicians**



P.O. Box 1444
Ashland, KY 41105-1444
Phone: 1888-287-9339
Fax: 1-888-287-0662

Website: www.kafp.org

Email: gerry.stover@kafp.org
janice.hechesky@kafp.org




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# FROM YOUR PRESIDENT

**by Bill Crump, MD**

# How bright our future?

As I accepted the role of your president at our May meeting, I pledged to visit each residency program and medical school in our state. The purpose was to bring a positive message about the future of our discipline and to learn more about the opportunities and concerns at each site.

I completed those visits last fall, and it was truly energizing. I re-learned how wide our state is and again learned that there is no substitute for a personal visit. When this process was discussed at our last Board meeting, it was agreed that these visits should become part of the tradition of the presidential year for the KAFP.

I gave a short address at each site, focusing on the definition of success. I first asked the group to provide some words describing a successful individual. With various degrees of prompting needed, the responses were remarkably similar at all sites. Under the category of "productivity," the words included the markers of financial independence: cars, houses, boats, designer clothes, horses, land, and (among the most cynical comment heard) trophy spouse. I then asked the participants to imagine the happiest physician they had known, and under the category of "meaning," I heard words like fulfilled, patient, compassionate, enthusiastic, satisfied, humble, fun-loving, and caring. The non-verbal change while making the second list was interesting. The hesitant revelation of cynical thoughts was replaced by a torrent of positive attributes and smiling faces. This interchange gives me renewed optimism for our future.

## PRODUCTIVITY

Next we spent some time talking about ways to ensure our future productivity. Using the Future of Family Medicine project as a backdrop and my personal experiences in practice in Alabama and Texas as examples, we constructed an image of the future of our practices. I painted the picture that includes a medical home for every American, tended by a caring family doctor. That doctor will be paid (not reimbursed) to do what we do best: manage the care of our patients. This includes the cognitive and procedural things we do ourselves, but it also includes payment for coordinating the basket of services needed by our patients. This image of the future also includes open access, with patients knowing that they can be seen the same day they call when really needed. I described a Medicaid managed care program that I worked with in Texas that used this model to decrease emergency room care significantly while paying a monthly management fee to us.

Then we discussed the shift to population-based practice that is in our future. I foresee that each family doctor will have a clear view of the needs of the 2000 or so souls that comprise her patient panel. Whether they enter the door of our practice in any given year, they are still our responsibility and our partners in promoting the health of the practice. I discussed my experience with an electronic medical record as clearly the best way to shift our focus to the population. How else can a doctor answer the questions: Are all the women in my practice getting mammograms at the correct time? Have all my hypertensives received dietary advice? Have all my diabetics been screened for proteinuria?-and countless others. With Pay for Performance on the horizon (see the last issue of our journal), I shared my experience with such a system. The lesson I learned is that physicians had better be at the table when the measures are chosen, and we'd better have a way to provide data that we trust.

Next I reminded the residents and students to commit to lifelong learning and keep an open mind to what services they will provide in the future, using my own experiences with maternity care and sports medicine as examples. Many in our culture change careers every 6-10 years, and the family doctor will almost surely change the focus of his work at least as often. We do what our patients need us to do, and change is the rule.

We closed this section by summarizing an article from one of our discipline's leaders that makes the case that the 15 minute visit model is obsolete (1). Group visits and virtual care are already here, and he makes a strong case for their future. I asked the participants to choose between two options. If you're a 55 year old with hypertension, option A is the traditional visit. This means leave work, drive to the doctor's office, find a place to park, pay your $25 co-pay, and wait in the waiting room. Then get your 6 minutes with your doctor, wait for your lab to be drawn, take your prescription to the pharmacy, wait some more, and get back to work and have to stay late to finish the day's tasks. Option B is to go to your personal, secure web site and leave a message for your doctor with your recent BP measurements. Later you get her response with advice, including electronic orders for lab to be drawn near your work at your convenience and a prescription sent to your pharmacy. For this you pay your $25 co-pay to your doctor's practice.

Once everyone was assured that face-to-face care was still available when needed and that good patient education is available, most chose option B, with the younger faces in the audience making the choice more enthusiastically. When one does the math, the doctor in this scenario can actually increase the number of patients cared for by 15-25% without an increase in staff by spreading out the

frequency of required face-to-face visits. This model also allows for the longer personal visit needed in times of crisis. In a subscription or "retainer" style practice, wouldn't patients pay a monthly fee for this access at least equal to what they pay for Internet access or basic cell phone use? Time will tell.

## LEADERSHIP AND ADVOCACY

Next I made my case to the group that organized medicine needs them. To understand what the older docs bemoan as the loss of "the good old days," I suggested studying the "Taylorization" of modern medicine (2). In the 1900s, almost everything was made by skilled workers with knowledge handed down through generations using carefully protected trade secrets. The result was that the craftsmen set the style and pace of their work, and were well-rewarded. Frederick Winslow Taylor was a workshop supervisor at this time who set out to change the way work is accomplished. He broke complex tasks into small individual steps, analyzed each step, and devised the most efficient way to complete each. The outcome was nothing short of a revolution, applied to automobile construction by Henry Ford and fast food by Ray Kroc.

There were two results of this revolution. First, the increase in productivity provided the standard of living that characterizes developed nations even today. Second was the rise of a managerial class whose job it is to organize and supervise a highly regulated workplace. This is perhaps no better summarized than in a chilling quote from Taylor himself:

"In the past, man has been first. In the future, the system will be first."

I agree with the author of reference 2 that this describes the crux of the challenge for the future of medicine in America. We physicians are trained as craftsmen and then enter practice where our activities are constrained by managers who do not understand our craft. Mind you, managers are not bad people – they just don't understand that everything that transpires between humans and their healers cannot be reduced to the most efficient set of steps that then can be measured precisely. So, do we curse the darkness or light a candle? I hear a lot of cursing in our doctors' lounge, but I choose to illuminate. Organized medicine is the best hope we have to maintain a group of physicians who understand the fallacy of the Taylorization of medicine. No one of us can carry the mantle of our guild every day, year in and year out, and still maintain a practice. So, we volunteer to take up this challenge for our elected year of service, or a few years on a key committee. What other real choice do we have?

Many physicians simply get worn-out by the long process of change in bureaucracy and politics – we're accustomed to seeing visible progress as we work. I used the example of liability reform in Texas with the group. When I practiced there in the mid 1990s, it was clear that real reform would only come when a group of key high court justices was replaced. Organized medicine in the state set about to make this happen, and the pace of the effort was almost imperceptible during the 6 years I was there. Last year, almost 10 years after the effort began, the laws were changed and withstood judicial review. The result is that hospital premiums that had increased 30% in 2003 dropped by 17% last year. Ten new insurance carriers entered the state, and there was a 70% drop in the number of lawsuits. No individual physician could claim this victory, but organized medicine in the state, comprised of hundreds of physicians who carried their load for their time, had made a difference. This was the basis of my plea to young physicians to become more involved in the KMA and KAFP. I hope some listened.

## FINDING MEANING

Having spent the first two-thirds of my talk on issues of productivity, we turned to focus on finding meaning in practice. Reflecting back on those words used to describe the happy physician, two groups of workers were described. The first toils through a burdensome job so that he can get to the next vacation or the ultimate prize, retirement. The second group seeks meaning in everyday work, finding fulfillment while earning a living. Several quotes from Dr. Rachel Remen's book formed the backdrop of this discussion (3). The first is as she describes the time just after the unexpected death of her medical partner. The office staff worked through their grief over the next few weeks, then noticed something unusual:

"Then the patients started coming. For almost a year afterwards, several times a week I would open the door to my office and find one of Hal's patients sitting in the common waiting room. At first I would worry that they didn't know about Hal and I would have to tell them, but they all knew. They had just come to the place where they had experienced his listening, his special way of seeing and valuing them, just to sit there for a bit, perhaps to think about difficult decisions which currently faced them. Many patients came. It was terribly, terribly moving."

At this point I asked the audience to consider whether they would like to be remembered in that way. Heads nodded, so I posed the question: Then what happens to us along the way? I shared my personal experience of working with idealistic, committed premed students who return to our summer programs after the first year of medical school as cynics, narrowly focused on the mechanics of medicine. I then watch the cynicism grow through medical school and peak late in residency. Fortunately, many rediscover their idealism late in residency or in the first few years of practice.

Sadly, some do not. Dr. Remen provides a quote concerning her experience that says it well:

"In some ways, a medical training is like a disease. It would be years before I would fully recover from mine."

So I asked the group to consider how to speed this recovery – how can we find meaning even during medical school and residency? I proposed that one way is to fully experience the humanity of those we serve. Again, Dr. Remen provides a perspective:

"Sir William Osler, one of the fathers of modern medicine, is widely quoted as having said that objectivity is the essential quality of the true physician. What he actually said is different and more profound than that. The original quote was in Latin and it is the Latin word *aequanimitas* which is usually translated as "objectivity." But *aequanimitas* means "calmness of mind" or "inner peace." Inner peace is certainly the ultimate resource for those dealing with suffering on a daily basis. But this isn't something achieved by distancing yourself from the suffering around you. Inner peace is more a question of cultivating perspective, meaning, and wisdom even as life touches you with its pain. It is more a spiritual quality than a mental quality."

So, why the disconnect between work and meaning for so many physicians? Again, from Dr. Remen's book:

"Meaning may become a very practical matter for those of us who do difficult work or lead difficult lives. Meaning is strength. Physicians often seek their strength in competence. Indeed, competence and expertise are two of the most respected qualities in the medical subculture, as well as in our society. But important as they are, they are not sufficient to fully sustain us."

As physicians seek meaning in their work, too many become burned-out. Burnout has been described as the dislocation between what people are doing versus what they are expected to do. The result is often cynicism and multiple somatic symptoms. Asked to recall burned out physicians they've known, almost everyone in the audience nodded knowingly. Another phrase often used to describe burnout is "erosion of the soul."

I then shared some advice from one of my medical school mentors, Dr. Anderson Spickard. He and others reviewed the literature on physician renewal and burnout and published a review that summarized the successful strategies (4). We then reviewed the copies of the box I handed out, suggesting that they place it on their refrigerator at home or near where they dictate. I also invited the participants to keep in contact with me over the next year, letting me know which elements of this strategy were most useful to them.

I closed the talk expressing my wish for each of the participants to have a life full of meaning. A familiar story recounted in Dr. Remen's book emphasized the importance of finding meaning in everyday work:

"A great Italian psychiatrist, Roberto Assagioli, wrote a parable about interviewing three stonecutters building a cathedral in the fourteenth century. The effect of their sense of personal meaning on their experience of their work is the same as the effect meaning has for us today. When he asks the first stonecutter what he is doing, the man replies with bitterness that he is cutting stones into blocks, a foot by a foot by three quarters of a foot. With frustration, he describes a life in which he has done this over and over, and will continue to do it until he dies. The second stonecutter is also cutting stones into blocks, a foot by a foot by three quarters of a foot, but he replies in a somewhat different way. With warmth, he tells the interviewer that he is earning a living for his beloved family; through his work his children have clothes and food to grow strong, he and his wife have a home that they have filled with love. But it is the third man whose response gives us pause. In a joyous voice, he tells us of the privilege of participating in the building of this great cathedral, so strong that it will stand as a holy lighthouse for a thousand years."

"Competence may bring us satisfaction. Finding meaning in a familiar task often allows us to go beyond this and find in the most routine of tasks a deep sense of joy and even gratitude."

I see a bright future.

Bill Crump, M.D.
January, 2006
Madisonville, KY

### 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

1) Scherger JE. The end of the beginning: The redesign imperative in family medicine. Fam Med 2005;37:513-6.
2) Rastegar DA. Health care becomes an industry. Ann Fam Med 2004;2:79-83.
3) Remen RN. Kitchen table wisdom: Stories that heal. Riverhead Books. New York. 1996.
4) Spickard A. Jr., Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. JAMA 2002;288:1447-50.

# KAFP Associate Editor Announcement

Dr. Charles Kodner has been named one of the two Associate Editors of the Journal of the Kentucky Academy of Family Physicians. Dr. Kodner is Associate Professor and Director of the Primary Care CME Review course at the University of Louisville Department of Family and Geriatric Medicine where he has been on faculty since 1997. He is involved with medical education at all levels and directs the Introduction to Clinical Medicine course for first and second year medical students, which emphasizes clinical exam skills, ethics, communication skills, evidence-based medicine, and many other topics. Dr. Kodner completed residency training at St. John's Mercy Medical Center in St. Louis, Missouri, before moving to Kentucky.

## FROM YOUR ASSOCIATE EDITOR

**by Charles Kodner, MD**

# A New Model for Continuing Medical Education

Imagine how CME might work in the not-too-distant future…

You are a family physician in a small group practice, and you are planning your CME activities for the year.

A flyer arrives in the mail, advertising a New Model CME program, which will present a typical set of lectures on a variety of interesting medical topics, but will also include a "Kick Up Your Practice" focus on treating Polycystic Ovarian Syndrome (PCOS).

You remember seeing a number of women over the past year who might have had PCOS—you ordered a number of lab tests and ultrasounds, sent a few to a local endrocrinologist and some to a gynecologist, and started a couple on Metformin, but were always unsure about the exact diagnosis or best next step. A recent American Family Physician article was helpful, but didn't provide all the details you needed to manage your specific patients. Also, you think about your other patients who might have PCOS but haven't been evaluated for it yet.

The conference sounds interesting, and you sign up for it, including the new PCOS focus sessions. A few weeks later, you get a pre-conference package in the mail: the "PCOS Self-Test" includes directions to take an online quiz, and also a set of paperwork to help assess your actual practice regarding women who have, or might have, PCOS. The whole package looks pretty cumbersome at first, but includes a phone number at a regional office named by the KAFP to contact when you are ready to get help with your practice assessment.

The online quiz goes quickly, and you learn about which lab tests are more or less helpful and think about changing the way you order lab tests for such patients; also you realize that PCOS is more common than you thought, and perhaps a few screening questions might be useful in your patient intake forms. You decide to contact the regional office, and a few days later you schedule a visit to your practice for the "CME assessment associate. " It takes about an hour for her to meet with your practice manager and identify a number of charts to review based on your office billing and coding data. She helps pull these charts and assists your staff in quickly reading through a selected set of about 40 charts, but maintains a strict "distance" from chart content to protect confidentiality. Based on non-patient-identifiable information extracted from the charts, she assists your office staff to provide summary information to you about how many of your young female patients might have PCOS, and how many labs you have actually ordered. The information is not particularly surprising, but is interesting and reinforces what you learned in the online quiz.

A couple of months later, the actual conference takes place—the lectures are interesting and cover a good variety of topics, and it's a good CME program overall. Midway in the week, there is a lecture on PCOS that reinforces what you had learned already, but fills in a few gaps or questions you had thought of while

taking the quiz. You learn that the speaker was involved at all stages of creating the quiz and the plan for your office chart review—you had brought your quiz results and office assessment results with you to the conference, and can think of ways to improve your care for this group of patients in your practice.

The next day, there is a lunch-time small group discussion session with other physicians to discuss PCOS cases, and you learn that you have not been alone in learning new ways to optimize the care of these patients. The group has some good ideas to share, and you take these ideas back to your practice after the conference.

About six months later, your staff is guided through a repeat chart assessment by the CME associate via teleconference. Your office intake form has identified a few women at risk for PCOS, and you were able to implement an efficient way to provide simple testing and counseling for them; also you had ordered different labs, not ordered as many ultrasounds or referrals, but had actually identified more patients to begin on treatment or refer for appropriate counseling.

During the conference, you see some flyers from the conference organizers that next year's special focus topic will be "chronic stable angina." This is also a common problem in your group's practice, and sounds like another good opportunity to make your clinical practice even better.

This description of how CME might work is certainly more involved than simple lecture attendance! But it represents an idea for how CME might be implemented in a real-world setting, in a way that has a more direct impact on the care of patients. The ideas in this "new model" are based on the most current literature about the effectiveness of CME programs, and I wanted to share just a few of these ideas with you.

I have been privileged over the past few years to be able to develop Continuing Medical Education (CME) programs through the University of Louisville, and also through the KAFP.

I have always been impressed by the high quality of the speakers and their presentations, and the keen interest of the physician audience. Of course, many physicians obtain their CME credit through journals, online or video materials, or other means.

Many lectures, articles, and other CME materials include what are known as "learning objectives"—what the physician should do differently after completing the CME. This emphasizes that the ultimate purpose of CME is not just to collect CME credit hours, nor even to provide new bits of knowledge or information, but to change the way physicians practice to improve the health of patients.

Unfortunately, the existing studies of CME indicate that current CME programs really don't change physician practice very much. It has long been recognized that didactic (lecture) education essentially doesn't change physician practice or performance at all. Lecture-based conferences are pretty easy to organize though, and remain a large component of CME activity nationwide.

The good news is that there are some types of CME activities that seem to be effective at changing or improving physician practice. Things that work include:[1]

- learning experiences that include pre-tests or assessment of clinical practice needs
- interactive education, with interaction among physician learners and an opportunity to practice new skills (cognitive or procedural )
- sequenced, multi-faceted (not just lecture) educational sessions
- use of educational materials such as published recommendations, guidelines, and electronic materials
- outreach visits—the use of a trained person to meet with physicians in their practice setting to provide information to improve practice performance
- patient-oriented or patient-mediated interventions
- clinical practice audits with feedback
- reminders about screening practices

This certainly sounds like a lot of work for physicians, conference organizers, conference faculty, and just about everyone else. But it also represents an opportunity for improvement, and possibly even for a new way to collaborate with pharmaceutical corporate supporters to generate CME activities. This is CME that will actually improve physician practice and patient health.

I think that, with a lot of hard work, a "new model of CME" could be just around the corner. Our national and state Academies are well-placed to begin developing the content and mechanisms to incorporate CME like this into our traditional systems, and I look forward to the day when CME is as effective as it can possibly be to help us improve the health of our patients.

## References

1. Mazmanian PE. Continuing medical education and the physician as a learner. JAMA 2002; 288(9): 1057-60.
2. Davis D. Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA 1999; 282(9): 867-74.

# Louisville – Come Spend the Weekend with your FAMILY!


## Host city for the 2006 KAFP Annual Scientific Assembly

As the 16th largest city in the U.S. and the largest city in the state, Louisville Kentucky is home to over 90 attractions, 17,000 hotel rooms and 2,500 restaurants and the world famous Kentucky Derby horse race. Whether you are planning to visit Louisville for pleasure or attending a meeting or convention, you are sure to find thoroughbred horse racing, bourbon, bluegrass music, sporting events and more!

Located on the banks of the Ohio River, greater Louisville is easily accessible. Spend a day visiting Louisville's many museums and historical homes. The Louisville arts community has gained international acclaim and is one of only nine U.S. cities with a professional opera, ballet, theatre, orchestra and children's theatre. Louisville's family-friendly attractions include the Belle of Louisville, Six Flags Kentucky Kingdom, Churchill Downs, Kentucky Derby Museum, Louisville Slugger Museum and the Louisville Bats.

Visit Louisville Kentucky…"We've Got It!"

## Official Call for the 2006 KAFP Congress of Delegates

Notice is hereby given of the 55th Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held in Louisville, KY, May 12-14, 2006 at the Louisville Marriott East.

Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 46th Annual Meeting of the Congress of Delegates will be held in the Summitt, May 12, 2006 at 11:45am-1:45pm to receive and act upon reports of officers and committees, to elect officers and to transact any and all business that may be placed before Congress.

All Officers, AAFP Delegates/Alternate Delegates, Regional/District Directors are requested to register in advance. Please complete registration and fax to 1-888-287-0662. If you should have any questions please contact Janice Hechesky at 1-888-287-9339.

## *Call for Resolutions for 2006 KAFP Congress of Delegates*

Please note the following deadlines for submission of Resolutions to be presented to the 2006 KAFP Congress of Delegates:

Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' kits is April 1, 2006. If a Resolution is not received by the KAFP office prior to April 1, 2006, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on May 12, any Resolutions pertinent to the objectives of the KAFP. Resolutions so offered shall be presented to the Congress of Delegates without debate at that time. Resolutions presented from the floor of the Congress are to be provided in triplicate form, with one copy to the KAFP Speaker, on copy to the KAFP Executive Vice President and one copy retained by the presenter.

### Important Resolution Writing Tips:

"Whereas" clauses explain the problem and/or situation.
"Resolved" clauses must be written to stand alone.
(Only "Resolved" clauses are subject to be voted on and adoption, meaning that whatever the action is called for in the Resolution must be clearly stated in "Resolved" portion of the Resolution. Keep the "Resolved" clauses focused on what is desired as the end result.)

# Mark Your Calendar for Upcoming Meetings!

**AAFP Annual Leadership Forum &**
**National Conference of Special Constituencies**
May 4-6, 2006
Hyatt Regency Crown Center, Kansas City, Missouri

**KAFP 55th Annual Scientific Assembly**
May 12-14, 2006
Louisville Marriott East, Louisville, KY

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

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

## 2005-2006 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**
Pat Williams, MD – email: jennyca@morganhaugh.com
John Darnell, MD – email: johoda@dragg.net

**ByLaws Committee**
E. C. Seeley, MD – email: eseeley@andover.org
Mont Wood, MD – email: rwood@trover.org

# PLAN TO ATTEND TODAY!

# 2006 KAFP 55th Annu

## Schedule at a Glance

***Thursday, May 11, 2006***

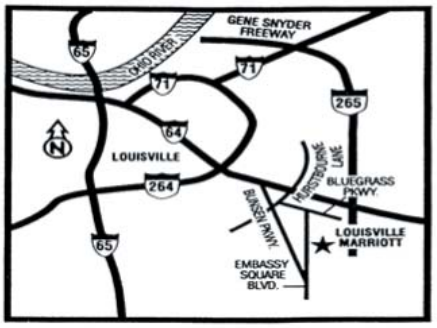
7:00 PM *Board of Directors Dinner Meeting*

***Friday, May 12, 2006 (8 CME)***

7:00 AM *Registration/Continental Breakfast/Exhibits*
7:50 AM *Welcome by:* Gerry D. Stover, EVP KAFP
8:00 AM *Overview of Scientific Program,* Gay Fulkerson, MD Program Chair
8:15 AM Migraine
9:15 AM Hearing Loss
10:15 AM *Break/Exhibit Visitation*
10:45 AM Respiratory Tract Infection
11:45 PM Registrants & Exhibitors - Lunch & Exhibit Visitation
11:45 PM Congress of Delegates Luncheon Meeting
1:45 PM Type 2 Diabetes
2:45 PM Stress Urinary Incontinence What Matters?
3:45 PM *Break/Exhibit Visitation*
4:15 PM Cardiovascular Disease Update
5:15 -5:45 PM *Audience Question & Answer Session*
6:00 PM *Resident/Student Reception*

***Saturday, May 13, 2006 (8.5 CME)***

7:00 AM *Registration and Continental Breakfast/Exhibits*
8:00 AM Gastroesophageal Reflux: Much More Than Heartburn
9:00 AM Botulinum Toxin Therapy in Neurology
10:00 AM *Break/Exhibit Visitation*
10:30 AM AECB Bronchitis 2hr Workshop
12:30 PM Registrants & Exhibitors - Lunch & Exhibit Visitation
12:30 PM Past Presidents Luncheon
1:30 PM CAM and You: How Physicians can Benefit from Complementary and Alternative Medicine
2:30 PM Update on State Health Issues
3:30 PM *Break/Exhibit Visitation*
4:00 PM Alzheimer's/Dementia
5:00-5:30 PM *Audience Question & Answer Session*
6:30 PM *Reception/Annual Banquet*




***Sunday, May 14, 2006 (4.5)***

7:30 AM *Registration/Continental Breakfast/ Exhibits*
8:00 AM Clearing the Confusion: Osteoarthritis Family Medicine Physicians & Their Patients: A Case Based Approach
9:00 AM The Hidden Disorder: Practical Approaches to Proper Diagnosis and Treatment of Adult ADHD
10:00 AM *Break*
10:15 AM Treating Opioid Dependence with Buprenorphine: Assistance with New Medication; 1hr Workshop
11:15 AM Risk Management
12:15-12:45 PM *Audience Question & Answer Session*

*Schedule is subject to change.*

# al Scientific Assembly

## Program Goals

Registrants for this program will receive current information on a variety of medical subjects pertinent to patient care in the daily practice of family medicine. Subject matter was chosen based on assessed education needs of the KAFP membership. At the conclusion of the program, registrants should have a working and applicable understanding of the topics.

## CME Credit

This activity is being reviewed for 21 prescribed credits by the American Academy of Family Physicians and 21 hours of AOA Category 2-A credit.

## Who Should Attend

Family Physicians and other health care providers including MD/DO specialties, PAs, RNs, etc.

## Why Attend

- Quality cost-effective CME program
- Earn over 21 hours of approved CME
- National and Local Speakers
- Connect with your Colleagues
- Gather information and knowledge from Local and National Companies displaying their products

## REGISTRATION FORM for the *KAFP 55th ANNUAL SCIENTIFIC ASSEMBLY*

PLEASE COMPLETE THIS FORM, KEEP COPY FOR YOUR FILES, & SEND WITH PAYMENT TO:
KAFP, P.O. Box 1444, Ashland, KY 41105, fax to 1-888-287-0662

Name_____ Profession (MD, PA, RN, etc.)_____
(PLEASE PRINT)

Address_____

Spouse/Guest Attending _____

City/State_____ Zip_____

Phone/Work_____Fax_____Email_____

| | Before April 1st | After April 1st | |
|---|---|---|---|
| ☐ KAFP & Other AAFP Members | 375.00 | 425.00 | _____ |
| ☐ Life Members | N/C | N/C | _____ |
| ☐ Non Members of the AAFP | 380.00 | 455.00 | _____ |
| ☐ Health Care Professional (PA, RN, Etc.) | 130.00 | 180.00 | _____ |
| ☐ Residents & Students (no charge except Banquet) | N/C | N/C | _____ |

EXHIBIT AREA IS RESTRICTED TO REGISTRANTS ONLY.

SPECIAL EVENTS:

☐ Friday, May 12, 2006 at 6:00pm
Resident & Student Reception — N/C _____

☐ Saturday, May 13, 2006 Past President's Luncheon (Past President's & Spouses only) — N/C _____

☐ Saturday, May 13, 2006 Spouse Tea Social — N/C _____

☐ Saturday, May 13, 2006 at 6:30 pm
Reception/Banquet — $55 per couple or $30 each _____

Discount Code _____

TOTAL AMOUNT _____

***Cancellation Policy:*** *We encourage you to register early to help with our counts and avoid any delays the day of meeting. We will give 100% refund if notified in writing or by phone by* **April 12, 2006**.

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Louisville, KY 40299
Phone (502) 499-6220 Fax (502) 493-8465
Group Name: Kentucky Chapter American Academy of Family Physicians
Conference Date: Friday, May 12, 2006 – Sunday, May 14, 2005
Rate: Single/Double $94.00 (+ 13.95% tax) & King $124.00 (+ 13.95% tax)

***FAX REGISTRATION FORM TO KAFP 1-888-287-0662***

# Check out the latest KAFP eNews!

## KENTUCKY ACADEMY OF FAMILY PHYSICIANS January 2006

e-News from KAFP is a monthly newsletter for Kentucky Academy of Family Physicians (KAFP) members. Please contact Gerry Stover (gerry.stover@kafp.org) if you have any comments or suggestions or you want to receive this fax by email.

### KAFP and KAFP Foundation Annual Meeting

Dr. Gay Fulkerson, Scientific Assembly Program Chair for 2006, has been busy planning the program for this coming May 12 – 14th. The winter issue of the Journal will be out soon and it will contain early registration information.

### Physician Days at the Capitol

KAFP is partnering with KMA to do multiple days at the Capitol. KMA staff will meet with KAFP members and provide a legislative update and useful information for your visit. You must call your legislator ahead and make an appointment to talk with him/her. You can make an appointment with your legislators by calling (502) 564-8100. The legislators convene on the House and Senate floors at 2pm daily. You may return home then or stay and observe the proceedings from the gallery. Drs. Nancy Swikert and Brent Wright encourage each of you to participate in KMA's Physician Day at the Capitol. Dates and information can be found at http://www.kyma.org/legislative/Physician_Days_Calendar.pdf. If you have difficulty with getting this file or are interested in participating, please email gerry.stover@kafp.org.

### UofL Department of Family and Geriatric Medicine's Primary Care Review Course

The 28th Annual Primary Care Review & ACLS Course will be held at Jewish Hospital in Louisville it starts on March 11th & 12th with the ACLS program then 13th through 17th is the Review Course. Registration information at http://www.chse.louisville.edu/primarycare06.html or by calling 502-852-5329.

### KAFP Needs YOU!

As the May Scientific Assembly and KAFP Congress of Delegates quickly approaches we are in need of Delegates to the KAFP Congress. The KAFP Congress meets annually to review the prior year's program accomplishments and upcoming program activities, act on resolutions introduced by members, elect officers of the KAFP and conduct other business as needed. If you may be interested, please email gerry.stover@kafp.org or call the office at 888-287-9339 for more information.

### Kentucky Pediatric Society – offering FREE CME

The Kentucky Pediatric Society is partnering with area health departments in implementing a new rural statewide education/awareness training program, P.A.T.H.S, Prevention and Awareness of Teen Hardships and Suicide. Provider workshops will enable primary care providers to aid in the advanced identification and diagnosis of mental illness and improve the treatment and management of mental health care services. All trainings will take place on Friday mornings from 9am-Noon, January-June, 2006. More information go to — http://www.kyaap.org/index.php?c=calendar

### Mark Your Calendars

KMA Annual Conference will be September 14-16th at the Hyatt Regency Hotel/Kentucky International Convention Center in Louisville. KAFP portion of the KMA meeting will be on Friday September 15 starting at 1pm. This year's theme is barriers that prevent physicians from providing health care for their patients.

Kentucky Ambulatory Network (KAN) conference is scheduled for March 31st and April 1st. This year's theme will focus on pay for performance, consumer driven healthcare, and quality healthcare initiatives.

**If you're not receiving the KAFP eNews**
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# Traveler's Health: Update

Robert L. Wood, M.D.
Director, Family Medicine Residency Program, Trover Foundation, Madisonville, KY

Each year, more and more Americans are traveling to International locations. They often have questions about vaccines and health risks that they will face. Interestingly enough, many don't seek advice from their physician. A study by Hammer, et al (1). of International Travelers found that only 30% sought advice prior to departure and only half of those needing protection from malaria were prepared. Another study by Van Herck (2) showed that only 48% had sought pre-travel advice and often times it was less than a month prior to departure.

The Family Physician is often in an excellent position to meet these needs. They know their patients and can tailor their needs to their destination. It does take some preparation and a logical approach.

One of the most important factors is time. The more time prior to departure to allow the vaccines to work, the better. Six months would be optimal but most patients will usually come see their physicians about one month prior to departure (2). Some of the vaccines require two or three injections over six months for full immunity. One month prior to departure will usually give enough time for adequate short-term protection.

Initially the physician must evaluate the patient's current health; including acute and chronic illnesses, what medication they are taking, what allergies they have, including presence of egg allergies. They also must ascertain if their female traveler is pregnant.

The physician will need to know their destination (resort area vs. remote mission site), purpose for the visit, activities in which they will be participating (open air preaching at night vs. lying on the beach), and how long they will be gone. This information can change what the traveler will need for the trip. After determining the patient's destination and itinerary, a brief physical exam with PMH, current meds, social history and review of systems will help determine the patient's ongoing medical needs for their trip. It is at this point were I will sit down with the patient and cover such areas as what vaccines they will need, travelers diarrhea, dietary precautions, use of mosquito repellants, avoidance of malaria and dengue fever, HIV risks in the area and avoidance of rabies. I also discuss safety issues, possible need of an International Health Insurance Policy, and Medical Evacuation Insurance should they be injured. The patient needs to be aware of this information and this allows them to think about it before departure.

Patients are encouraged to keep their medications with them. Some countries require documentation verifying the need for the medicines. Some sources suggest taking a medical kit for minor illnesses and injuries. This is especially helpful in remote areas.

There are many sources for Traveler's Health Information. They give recommendations for vaccines, malaria protection and other types of information. The Centers for Disease Control site at cdc.gov and World Health Organization at who.int are both very helpful and easy to use. They also have sections that can be printed and given to the patient for at home reading.

Air travel can be associated with prolonged immobility. In patients that are predisposed to DVT's, this can be a problem. They should be encouraged to get up and walk around the cabin every hour or two to help prevent DVT's.

Now comes the decision of which vaccines are needed. The CDC web site is a very reliable site and is updated routinely. You can give up to four vaccinations at one time. If you have two live attenuated vaccines, they must be given at the same time or separated by four to six weeks.

## VACCINATIONS

Patients need to be up to date on Tetanus/diphtheria, their MMR and other childhood immunizations. They also need to be vaccinated for several other illnesses that may be present at their destination.

## HEPATITIS A

Hepatitis A is a common infection that is present not only in developing countries, but in popular tourist spots in Western countries. Transmission occurs by direct person to person contact or consumption of contaminated water, ice, shellfish, uncooked vegetables and fruits. There is more risk at remote sites with poor sanitation.

Two monovalent Hepatitis A vaccines are available for persons two years of age or older. They both are inactivated vaccines. They are give at zero and six months. One month after vaccination, 95-100% of patients will have immunity. Travelers needing protection for less then one month can receive passive immunity with immune globulin given with the first dose of vaccine. This has been hard to obtain since the 9/11 events.

## HEPATITIS B

Hepatitis B infection risk is low except for those going to live longer than six months in an endemic area or those going to do medical work who might be exposed to blood. There are two monovalent Hepatitis B vaccines available and they can be given at zero, one and six months. Ninety percent of patients have immunity after the second dose.

## YELLOW FEVER

Yellow Fever is a mosquito-borne viral infection. Illness ranges

from flu-like symptoms to severe Hepatitis and hemorrhagic fever. It occurs in sub-saharan Africa and the tropical areas of Central and South America. It is preventable by a live attenuated vaccine. It is the only required vaccine in endemic areas. It must be administered at an approved Yellow Fever Vaccination Center and travelers must have a completed International Certificate of Vaccination signed and stamped with the date of vaccination. The vaccine must be given at least ten days prior to admittance into at risk areas.

Contraindications include age less than nine months, pregnancy, egg allergy and immuno-suppression. Travelers also need to use mosquito repellant and nets when appropriate.

## TYPHOID FEVER

Typhoid Fever is an acute life-threating febrile illness caused by exposure to the bacterium Salmonella Entericatyphi. It is present in Africa, India, Asia, South America and Central America. It is recommended for those persons traveling to endemic areas for greater than three weeks. There is an oral live attenuated vaccine and an inactivated intra-muscular vaccine. Both vaccines provide up to 50-75% protection. The oral vaccine is given on day zero-three-five-seven. It must be kept refrigerated. It is effective after one week and lasts for five years. Co-administration of an antibiotic with the vaccine should be avoided. The intra-muscular vaccine is a single I.M. injection. It provides immunity for two years.

## MENINGITIS

Meningococcal disease is characterized by onset of fever, headaches, stiff neck, nausea and vomiting. Vaccination is needed for sub-saharan Africa. It is required for visiting Saudi Arabia for a patient to go to Mecca. It is needed during the dry period from December until June. It is a quadrivalent vaccine and needs seven to ten days to provide protection. It is effective for 3 to 4 years.

## MALARIA

Malaria is a serious illness transmitted by the Anopholes mosquito. It is responsible for two million deaths annually. The risk and prophylaxis depend on the destination. Prophylaxis is provided by Chloroqine in areas without resistances. For those areas with resistance, Mefloquine, a combination of Atovaquone-Proguanil or Doxycycline can be used. Each has its adverse effects and advantages and the physician should evaluate these medications before choosing one. The patients also should be encouraged to use mosquito repellant (up to 30% DEET) when they go out at night. They should consider sleeping under netting and wearing lightweight long sleeved shirts and long pants. Patients should be warned that they could develop Malaria 18 months after exposure.

## DENGUE FEVER

Dengue Fever is a disease of the tropics caused by the Flavivirus. Fatality rate is about 5%. Protection is by mosquito repellant worn during the day when the Aedes aegypti mosquito is feeding.

## RABIES

Travelers to developing countries should avoid contact with dogs and other animals. Pre-exposure rabies vaccine is recommended for travel to remote areas if the traveler will be in the endemic area for a prolonged period of time. In the event of a bite, the wound should be cleaned and vaccination should occur. For those who have had a pre-exposure vaccination, two more injections immediately and three days later will be needed.

There are many issues that must be dealt with during a Travel Health Visit. The Family Physician is in an excellent position to provide this service. It does require some reading and investigation but will be worth the effort for your patients and you.

## WEBSITES

Centers for Disease Control – cdc.gov

World Health Organization – who.int

International Society of Travel Medicine – istm.org

International Association for Medical Assistance to Travelers – iamat.org

Pan American Health Organization – paho.org

Public Health Laboratory Service (UK) – phls.co.uk

Health Canada – hs-sc.gc.ca

Travel Doctor – traveldoctor.co.uk

Travel Health Online – tripprep.com

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## REFERENCES

1. Hammer DH, Connor BA. Travel health knowledge, attitudes and practices among United States travelers. J Travel Med 2004; 11:23-26.

2. Van Herck K, Zuckerman J, Castelli F, Van Damme P, Walker E, Steffen R. Travelers' knowledge, attitudes, and practices on prevention of infectious diseases: results from a pilot study. J Travel Med 2003; 10:75-78.

3. Oliver, Corliss, Wood, Robert, King, Richard. Travel Medicine: The Role of the Family Physician in Raising Awareness and Compliance, unpublished, submitted for publication.

# KAFP Needs Your Input!

Please take a few minutes to complete this survey and fax back to 888-287-0662 by February 28, 2006 and we will enter your name in our drawing. You will be eligible to win either a $250 cash prize or one of three dinner certificates valued at $100 each.

1. Do you use CAQH (http://www.caqh.org) for your provider enrollment with insurance plans? (Yes / No). If Yes, then 'What do you like or dislike about it?' and if No, then 'why don't you use it?'

2. Do you have an Electronic Health Record? ( Y / N ) If Yes, vendor is _____ _____; if No, then are you considering purchasing one in the next 12 months ( Yes / No)?

3. Do you have e-prescribing? ( Y / N ) If Yes is it RxNT / Doc-First / with E.H.R. _____ (other)?

4. Rank the top five 'denials' with 1 being the most frequent that you find with your claims processing –

   _____ Patient subscriber Identification is incorrect or missing
   _____ Patient's name/address do not match insurer's
   _____ Physician not credentialed or enrolled
   _____ Service not Medically Necessary
   _____ Duplicate claim
   _____ Other, please specify_____

5. What are 3 insurance carriers you have the most difficulty with and why?

| Carrier | Issues |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

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# The Kentucky Academy of Family Physicians

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**Gerry D. Stover, MS, EVP, gerry.stover@kafp.org • Janice Hechesky, Executive Assistant, janice.hechesky@kafp.org**

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**Alternate** ***Nancy Swikert, MD***, 8780 US 42, Florence, KY 41042, Office: 859-384-2660 Fax: 859-384-5248 email: Ddwarrow@aol.com

**Alternate** ***Mont Wood, MD***,200 Clinic Dr., Madisonville, KY 42431, Office: 270-825-6690 Fax: 270-825-6696 email: rwood@trover.org

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### KAFP Resident/Student Member

**Resident** ***Stacy Taylor-Hunt, DO,*** 297 Peach St., Hazard, KY 41701, Office: 606-439-3557 Fax: 606-439-1131 email: stacy.taylor-hunt@uky.edu

**Student** ***Kristin Freeman***,2025 S. Shelby St., Louisville, KY 40217 Home: 502-636-5565 email: kmfree01@gwise.louisville.edu

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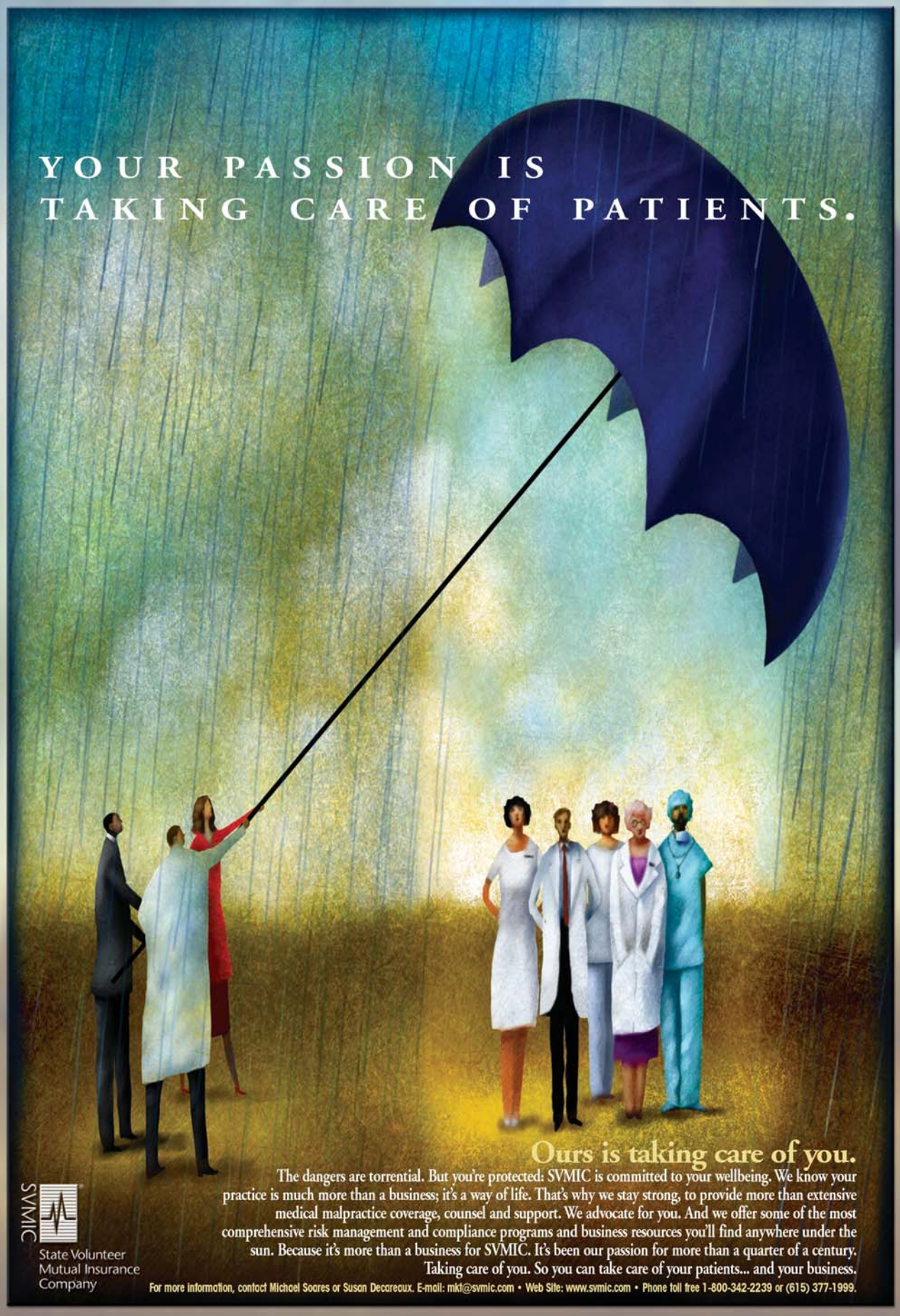
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