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Polypharmacy: Challenges and Opportunities for the Family Physician

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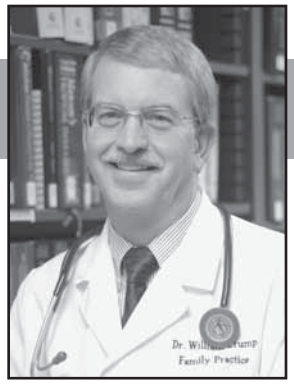
FROM YOUR EDITOR

by William Crump, MD
Madisonville, KY



HOW DO DOCTORS THINK (AND FEEL)?

One of the special privileges of a journal editor is to write periodically about whatever is on his mind, hoping that readers will connect with the ideas. This is a fun time of year for me. I am interviewing bright young people who think they want to go to medical school and making the difficult decisions that go with that process. We recently completed our summer programs for college students and preclinical medical students where our focus is on learning to "think like a clinician." I have begun the year-long process that is "Dean's Hour" with our ten new third-year medical students who are with us in Madisonville for the last 2 years of med school. Much of that time is also spent getting these students to learn the iterative process of decision-making that is required for success in clinical medicine. So, I think a lot about how doctors think.

A recent AMA publication highlighted Dr. Jerome Koopman's book on this topic (1). Although I dove into this book with my usual energy, it was soon dissipated. He did a nice job outlining the kind of errors in thinking that can occur in clinical care, like the "closing too soon" that can occur when something about the patient causes us to rule in or out important diagnoses before we have enough information. But I have to admit that two things he did early in the book made me put it down prematurely. First, when listing the specialties and the thought patterns of each, he seems to have forgotten ours. I hope that this is just a refection of the narrowness of his training. Second, he excludes behavioral/psychiatric illness from consideration. Excuse me, Dr. Koopman, but if you exclude these issues, the rest is really easy in comparison.

The other thing that concerns me about the sensationalism of his book is best summarized by an old aphorism. It is said that when an experienced clinician hears hoofbeats, she thinks first of horses, and then zebras. This highlights the differences between probabilistic thinking (what's it most likely to be) and possibilistic thinking (everything it could possibly be).

We've all worked with inexperienced clinicians who do an MRI on the first 30 patients they see with tension headaches before they learn what that clomping sound on the turf represents. Much of FM residency training is unlearning the possibilistic thinking that is ingrained during most (sub-specialty driven) medical school education. Not only must we be good stewards of the health care dollars that COULD be spent looking for striped horses, but many tests themselves are uncomfortable and invasive. We must be our patient's advocate.

For instance, the 24 year-old with anxiety and abdominal pain COULD have a colonoscopy, but a 54 year-old with a family history of colon cancer in young relatives SHOULD have one. A personal reflection on this issue comes from my current study in preparation for my every- ten- year recertification exam in Geriatrics. I am using the most highly recommended set of texts that, unfortunately, were written by possibilistic thinkers. A common clinical scenario is spun, and the "right" answer is a very rare condition. These kinds of texts are especially dangerous for beginners, because they don't know any better. At least I know that if I've never seen a condition after 13 years in major medical centers and 25 years of community practice (sometimes overlapping), that's probably not the real correct answer in the scenario. So, my plan is to choose mostly zebra answers on the test and then go back to working with horses in my daily practice – I just hope

the exam answers are written by possibilists this time.

I heard a story in medical school at Vandy that a professor of Infectious Diseases was truly impressed with a "local MD" who sent a patient in to a medical center with a correct diagnosis of a liver echinococcal cyst. This was long before the days of CT scans. The intern who had admitted the patient was unimpressed, as he had seen some of the patients who this same doctor sent in almost monthly with the same incorrect diagnosis. It seems that in the mind of this doc, everyone in his town with right upper quadrant pain was (incorrectly) assumed to have been eating worm eggs, and after years of unnecessary referrals, he finally got one right. This is the epitome of possibilistic thinking.

Perhaps the most important part of the aphorism, though, is "… and THEN zebras." The mark of a good clinician is detecting that patient who, among all the common illnesses we see every day, just doesn't fit the usual profile. There was the young woman I saw who had mild shoulder pain when she became supine and was a little dizzy when standing who later was found to have 3 units of blood in her peritoneal space from a ruptured ectopic pregnancy. She reported a "normal" menstrual period 3 weeks before (a decidual reaction), no history of STDs (the bloody fimbria was pristine at the time of surgery), and no recent intercourse (as it turned out, by her definition of recent). For some reason that is difficult to put into words, I did not let her entirely unimpressive abdominal and pelvic exam sway me into sending her home with a potentially life-threatening condition.

So the good clinician dwells in probabilistic thinking and is able to switch to possibilistic just in time. Groopman's book highlights case after case where probabilistic thinking caused serious errors, and I think this is misleading to the lay reader. Folks don't buy books that detail the many correct diagnoses made every day using the probabilistic method.

And actually, I worry less about the way docs think than I do about how they feel about patient care. There is much emphasis on "professionalism" in medical schools these days, and it is energy well-spent. Some readers may remember my penchant for quoting from Dr. Rachel Remen's "Kitchen Table Wisdom" book that was the basis for the "Doctoring 101" course that we teach during our summer programs (2). This summer, at the suggestion of a student, we substituted "Soul of a Doctor" that is a group of essays written by Harvard clinical medical students (3). A quote from one of these medical students may help frame this important issue:

"Physicians are taught to be doers. Directing patient interviews, examining the body, performing procedures, and prescribing medications constitute the bulk of the job description in today's world of medicine. Listening, perhaps seen as a more passive activity, seems undervalued and tends to get lost in the shuffle. No box exists to check "Listened" on the reimbursement form (not that I would advocate financial valuation of listening). Undoubtedly the "doer" elements form a vital part of both healing and meeting the expectations of patients. But I sense that medicine could mean and be much more for patients if time spent listening to the patient tell his or her story were prized. Might that mean longer patient visits? Possibly.

Others will write this off as the ravings of a naive, optimistic medical student; the advocates of efficient health care will be quick to argue that longer patient visits are not "cost effective." While that may be, we cannot forget medicine's fundamental premise that patients matter most. Complaints about the frantic pace

and lack of human compassion in medicine commonly fill the general public's conversation about health care. The patients who sue their doctors for medical mistakes are the same ones who feel ignored and disregarded by their physicians.

In fact I would argue that in the long run, a reinvigorated emphasis on listening to the patient would be cost effective. I suspect that greater emphasis on hearing the patient's perspective could lead to improved diagnosis, patient understanding of their illness, and patient compliance with medications and preventive practices. All of which would likely lead to a patient population with improved health and fewer patient visits, thus alleviating overcrowded clinics and reducing health care costs."

Another book I can recommend that addresses professionalism from a spiritual perspective is written by a Franciscan Friar who is a physician. A brief quote summarizes his view:

"The human body is the place where human life and human love happen. The crafts of medicine, nursing, dentistry, and all the other healing arts require at least two human bodies-that of the healer and that of the one who is healed. It is in human bodies that the spirit of God transforms the air we merely breathe into the grace of God that touches every cell in our mortal bodies, forms any words of Good News we will ever proclaim, and moves us to works of charity and worship."

This perspective is also eloquently summarized in the Residency Graduation Prayer that is republished as a postscript in this book (see below). It reminds us that however we think, we must feel the call to service that is medical practice. Your comments are appreciated.

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A Residency Graduation Prayer
(St. Vincent's Hospital-Manhattan)

All powerful, all holy, all loving Good and gracious God,

We thank you and we praise you for the privilege of caring for the sick;
For the mysterious beauty of the human body which you have created;
For the gifts of the earth by which we heal;
For the power of your presence in our professional lives.

We ask your grace that we may never consider our intelligence to be sufficient without fervor;
Knowledge without awe;
Counseling without respect;
Examination without reverence;
Diagnosis without meaning;
Prognosis without hope;
Therapy without compassion.

We pray that we may always be grateful to those who have taught us this art.
We pray together for the humility to remain students forever.
We pray today that you will bless our residents as they graduate,
That they may carry within themselves a little bit of this place of healing and learning wherever their careers may take them,
And that, in the spirit of St. Vincent de Paul, they may always hold a special place in their hearts for the sick and the poor of our world.

Amen.

Polypharmacy: Challenges and Opportunities for the Family Physician

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Polypharmacy poses a major public health threat to the United States. In 2000, it was estimated that medication related problems (MRP) cost 106,000 lives and 85 billion dollars per year (1). By comparison diabetes caused 224,092 deaths and cost 91.8 billion dollars in 2002 (2). If polypharmacy were identified as a disease it would not only be identified as a major public health threat but would result in the creation of organizations to combat its harmful effects on our population. The cost of drug therapy related morbidity and mortality is the 5th most costly health condition (3). For every one dollar spent on medication an additional two dollars is spent on managing drug therapy problems (4). In-hospital adverse drug reactions (ADRS) were extrapolated as the 4th to 6th leading cause of in-hospital mortality (5). Yet, polypharmacy does not get the attention proportionate to the severity or magnitude of the problem.

Polypharmacy means "many drugs". Another definition is the use of 5 or more prescribed medications used concomitantly or the use of more medications than are clinically indicated or warranted. Polypharmacy is seen among all age groups but the combination of chronic disease and advanced age increases its occurrence among older adults. Polypharmacy poses the greatest hazard for the elderly due to diminished ability to modify and eliminate medications. Forty-one percent of seniors reported taking five or more prescription medications and more than 50% have two or more physicians (6).

Primary care physicians are particularly skeptical about the ability of the Food and Drug Administration (FDA) to provide guidance concerning medication safety after the recent debacles with Vioxx® and more recently Avandia®. Each of these medications led to excess mortality from cardiovascular disease. The current approval process does not take into account hazards attributable to the use of other medications in conjunction with the specific drug being evaluated. This limitation is particularly apparent during Phase three trials. Most trials exclude individuals with multiple comorbid conditions, the elderly and pediatric patients. Each trial focuses on a single indication for use of the medication and the length of time for the trials are too brief perhaps lasting a matter of months. Patients with chronic diseases, on the other hand, are taking medications that are intended for lifetime use. One can readily appreciate the bias against older adults for whom many of these drugs are indicated. The lack of experience with the effect of medications on patients with an altered metabolism, comorbid conditions, and perhaps on multiple drugs is a serious contributor to medication related problems

Why Geriatric Pharmacotherapy is challenging.

Age-related differences in physiology are a fundamental reason why geriatric pharmacotherapy presents a challenge to primary care physicians. Children and young adults tend to be more similar in the amount of lean body mass, liver, kidney and lung reserves. These tissues all play a significant role in medication metabolism. Events along the life span such as illness, accidents, and lifestyle change these tissues in ways that are difficult to predict. The bottom line for primary care physicians is that older adults are more heterogeneous with respect to their tolerance for medication effects. A cautious, personalized approach to prescribing is the best strategy for frail older patients who have diminished reserves. The challenge for primary care physicians is that each year new drugs are available. Each of these new medications is developed with the same limitations. i.e. no experience in older patients. In addition to new medications, there are new off label indications, formularies change frequently with substitution of drugs, and drugs change from availability by prescription-only to access over-the-counter. Finally, older adults commonly consume herbal preparations and nutritional supplements. Many of these supplements have active ingredients which can interact with prescribed drugs. The factors leading to medication related problems are many and often unpredictable. In the next section, we provide specific clinical examples to illustrate these physiological concepts.

Clinical correlations.

It is helpful to think of the body as a medication metabolism machine. The components of this machine include: body composition, liver, kidney and lungs. Body composition can be defined by lean and fat mass. A major component of lean mass is water. A decline in lean mass is always accompanied by a decline in body water. For example usual adult dosing of an aminoglycoside can alter medication distribution and elevate serum levels. The nephrotoxcity and ototoxicity seen with normal adult dosing of aminoglycosides in the elderly is a direct result of low lean mass and diminished body water. Body fat mass is a particular concern for frail elders because psychoactive medications tend to build- up in fat stores. Under these conditions, narcotics, benzodiazepines, antidepressants, and antihistamines have a much larger storage area and are likely stay in the body much longer. Clinically you will see delayed onset of action and exaggerated response to normal adult doses.

The next component of the metabolism machine is hepatic function. Liver function is determined by its cellular integrity and blood flow. Medications whose metabolism is influenced by cellular integrity include benzodiazepines, anti-depressants, warfarin, and many others. Liver cellular integrity is compromised by alcohol abuse, hepatitis, and occupational exposure to hydrocarbons. Patients in this last category include painters, factory workers, and anyone who works with ambient chemicals. Frail elders with diminished liver function will have medication related problems when taking multiple medications competing for the same metabolic hepatic pathway. Clinically you may see rapid onset of unpredictable symptoms indicating altered serum levels of any other medications being taken by the patient. For example, a patient adequately

Figure 1: Estimating Creatinine Clearance

Cockroft and Gault Formula for estimation of Creatinine Clearance

$$\text{Cr Cl} = \frac{(140\text{-age}) \times (\text{IBW kg})^{*}}{72 \times \text{serum creatinine (mg/dl)}} = \text{mg/min}$$

For Females: multiply above formula by 0.85

*IBW: ideal body weight for height. If no height, use actual weight.
Males: IBW = 50 kg + 2.3 kg for each inch over 5 feet.
Females: IBW = 45.5 kg + 2.3 kg for each inch over 5 feet
Obese patients: Formula tends to overestimate creatinine clearance

maintained on warfarin will suddenly exhibit signs of warfarin excess when taking over the counter cimetidine or ranitidine. This is not a drug-drug interaction; it is competition for limited liver metabolic capacity.

The clinical estimation of renal function is an important strategy to prevent medication related problems. Unfortunately, serum creatinine does not accurately reflect medication clearance. With frail, elderly adults whose lean body mass is diminished, the Cockroft and Gault formula should be used to calculate actual creatinine clearance. [See Figure 1]. Consider the example of an 82 year old, 46 kg female with an apparently normal serum creatinine of 1.0mg/dl. However, her calculated CrCl is 31.7 mg/min. At a CrCl of 30 mg/min and below, most drugs require dose adjustments. After titration to maintenance dose on Namenda, we would expect a normal adult dose of 10 mg BID. This patient requires a dose adjustment to 5mg BID to avoid causing iatrogenic mental confusion.

The lung is an overlooked component in medication metabolism. For persons with compromised pulmonary function, metabolism of alcohol and any medication that depresses pulmonary drive have an increased risk for toxicity.

Prescribing Cascade

The prescribing cascade is characterized by the ongoing presence of non-specific symptoms such as gastrointestinal distress, nausea, insomnia, confusion, anxiety, tremor, diarrhea, constipation, edema, and anorexia to name a few. These non-specific symptoms lead to more prescribing, more potential side effects, adverse reactions, drug-drug interactions, and drug disease interactions. This constellation shown in figure 2 and called the Prescribing Cascade. Polypharmacy in the elderly is a predictor of malnutrition, hospitalization, nursing home placement. It can impair mobility and leads to increased morbidity and increased risk of mortality. (7) If you are struggling to identify a diagnostic label, then polypharmacy should be on your differential diagnosis list.

Figure 2: Prescribing Cascade

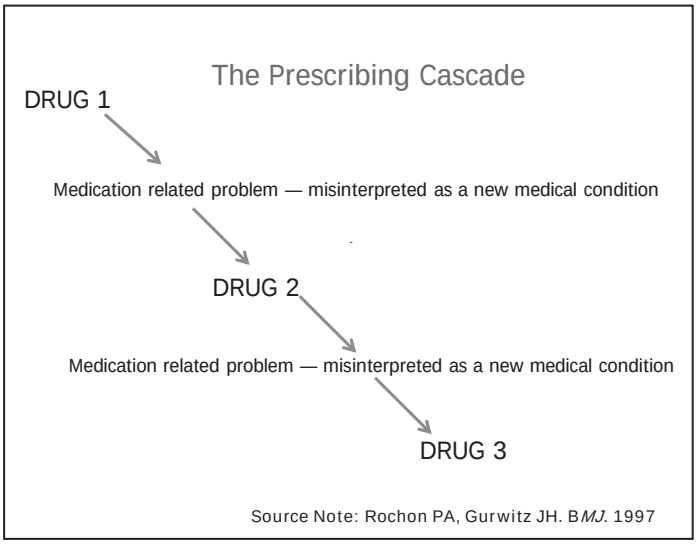

Table 1: Potentially Inappropriate Medications for Older Persons

High Potential for SEVERE MRP	High Potential for LESS severe MRP
Amitriptyline (Elavil®)	Antihistamines(chlorpheiramine)
Chlorpropamide(Reglan®)	Diphenhydramine
Digoxin (Lanoxin®) > 0.25mg /day	(Benadryl®, Tylenol PM)
Diisopyramide (Norpace®)	Dipyridamole (Persantine®)
GI antispasmodics	Ergot mesylates
(Donnatal®, Bentyl®, ProBanthine®)	Indomthacin (Indocin®)
Meperidine (Demerol®)	
Methyldopa (Aldomet®)	Meperidine (Demerol®) oral
Pentazocine (Talwin®)	Muscle Relaxants (Soma®)
Ticlopidine (Ticlid®)	

Note: MRP = Medication Related Problems. Adapted from the Beers Criteria.

Summary

What can the family physician do? First take a careful medication history. Sometimes this can be delegated to a staff member in the office to ask about all medications.

Ask regarding:
(1) Prescribed medications.
(2) Medications prescribed by other physicians.
(3) Medications that are only used occasionally.
(4) Over-the-counter and herbal supplements.
(5) Borrowed medications.
(6) Non oral medications which include drops, patches, crèams, ointments, suppositories, implants, some of which the patient won't necessarily identify as medications.

Table 1 contains a list of medications that are potentially inappropriate for frail, older adults. Originally described as Beers Medications (8), these medications were identified as being particularly problematic. We now know that *any* medication given under the wrong circumstances can cause the syndrome of polypharmacy.

Guide to Careful Prescribing

Basic principles should be adhered to that make prescribing safer. Make an accurate diagnosis and know the particular medication that is likely to be most effective. Be aware of the pharmacology of the drug that is being prescribed. Prescribe as few drugs as possible; perhaps the dose can be maximized before adding another medication. Assess efficacy, is the drug in fact working. Review the need for continued use. Perhaps the drug can now be safely discontinued. Encourage patients to use the "Brown Bag" approach and bring all drugs to each visit then these can be reconciled with medication lists and the patient's sense of what in fact they are taking. Inquire regarding adverse reactions. One can only focus on the more common side effect. Ask about cost and determine whether a less expensive medication can be used. Provide written instructions. Many pharmacies now are doing a better job with this. Verify that the patient can actually read and understand this. Eliminate jargon and speak to the person at a level that is appropriate. Start low and go slow. Be cautious of using new drugs unless this is a life saving situation. Utilize a palm-pilot based electronic aid to help with prescribing. EPOCRATES is a popular software designed for this purpose. Polypharmacy is an epidemic that will increase in importance as the population with chronic diseases increases. Family Physicians are uniquely positioned to meet the challenge in their practices, their communities, and nationally.

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The Department of Family and Geriatric Medicine would like to express our appreciation for a grant from Mrs. Jean Frazier to assist with our work to address the problem of polypharmacy.

A MESSAGE FROM YOUR PAC CHAMPION

John H. Darnell, Jr., M.D.
Flatwoods, KY

Political Action Committee Gives Family Physicians More Powerful Voice

America's health care system is on the cusp of dramatic change, and family medicine is in a prime position to have significant influence on that change. That reality should spur family physicians to invest in advocacy efforts now underway on the state and national levels, say family medicine advocates.

Among the most direct opportunities: supporting the AAFP political action committee, FamMedPAC.

Since its formation in 2005, FamMedPAC has worked to give family medicine a more powerful voice in our nation's capitol. This year, FamMedPAC has helped AAFP promote family medicine as the 110th Congress takes up important healthcare issues such as physician payment reform, Title VII funding for primary care residency programs, and increasing funding for the State Children's Health Insurance Program (SCHIP).

"FamMedPAC helped make this happen," says Michael Fleming, MD, chair of the FamMedPAC Board of Directors. "In the last election, the PAC contributed to 87 incumbents or candidates. The PAC also supported several victorious open seat candidates, running for Congress for the first time. That puts the AAFP in a strong advocacy position."

In the last election cycle, the first for FamMedPAC, more than 1,000 AAFP members contributed almost $400,000 to the PAC. "This is a great success," said Dr. Fleming, "But we can, and need, to do better." So far in 2007, more than 940 AAFP members have contributed over $230,000 to the PAC.

"Every member of AAFP needs to consider supporting the PAC," said John Darnell, MD, KAFP's PAC Champion. "As one of the largest medical societies, AAFP and FamMedPAC have the potential to become one of the most powerful voices in the healthcare debate. As the only political action committee whose sole purpose is promoting the viewpoints of family physicians and family medicine, the PAC will help us elect legislators who support our agenda and help improve healthcare for all Americans."

"I support FamMedPAC," said Nancy Swikert, MD**,** "because I am convinced it will help my practice and my patients." Dr. Swikert is a member of Club George, made up of AAFP members who agree to contribute $365 a year – one dollar a day – to the PAC. "It's easy to think of giving just a dollar a day to the PAC. The PAC can even take the contribution directly from my credit card each month, so I hardly think about it."

The PAC is working with the chapters to promote its activities and to raise awareness about the importance of political involvement. The PAC Chapter Champion program hopes to recruit AAFP members in each chapter to promote the PAC at chapter meetings and to act as liaisons between chapter members and the PAC. The PAC Web site (www.fammedpac.org) tracks each chapter's contributions by total and percentage, and tries to foster competition among them to see which chapter can achieve the highest level of support for the PAC.

"Once we get the word out about the importance of the PAC, I am convinced our Chapter will be one

of the leaders in this effort," said Dr. Darnell. "We may not be the largest Chapter in AAFP, but our members will step up and do the right thing if asked."

The potential strength of FamMedPAC is emphasized by Mark Cribben, FamMedPAC's Director, when he speaks to AAFP members. "If every member of AAFP contributed just $100 per year to the PAC, we would have over $8 million to spend on political activities each year. That would make us the largest medical PAC in the country, and allow us to elect more family medicine-friendly candidates to Congress."

Cribben adds: "If we reach that level, that's not just a headline in AAFP News Now, that's a headline in the New York Times!"

You can learn more about FamMedPAC at

www.fammedpac.org, or call Mark Cribben at 1-888-271-5853.

FROM YOUR EDITOR

by William Crump, MD
Madisonville, KY

REALLY Rural Family Medicine

In this issue of our journal we have two articles about medical mission work. Dr. Eddie Prunty from Muhlenberg County gives us a personal essay about his trip to Ecuador, and a faculty and resident from Dr. Brent Wright's residency program in Glasgow summarize their experience. Medical missions have always been with us, but recently medical students and residents have discovered these trips as powerful means of personal fulfillment.

As Dr. Prunty says, sometimes we're not even sure how we got involved in an individual effort, but it somehow takes on a life of its own. For some, the ability to do procedures that privilege battles keep them from doing at home is the attraction. For some, the smiling faces of those most in need give them a "recharge" after dealing with the hassles of state-side practice. For some, this service is an ideal opportunity to win souls, and evangelism is at its best when stripped of all materialistic distractions.

For all though, there is that feeling when you finally lay your head down after a busy day: " I did something important today." Many medical students now look for residency programs that provide medical mission opportunities, and this may be a competitive advantage in these days of declining interest in family medicine. Who better to lead a medical mission team than a Family Doc, womb to tomb to the world?

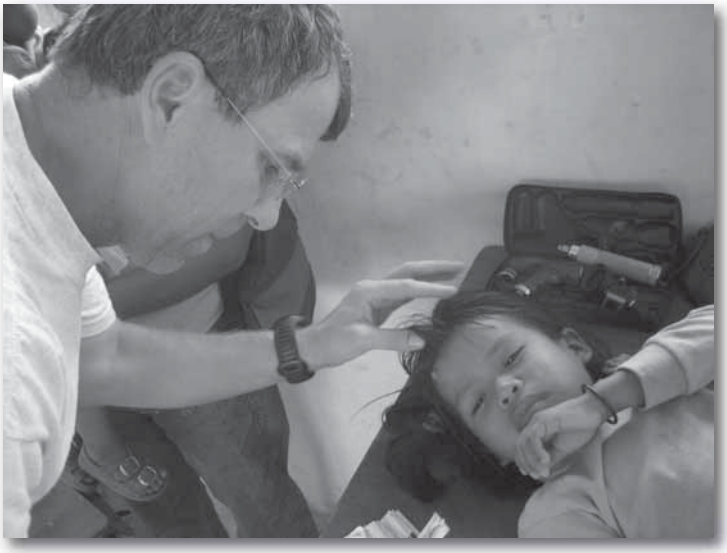
If you have interest in medical missions, please let us know and we'll connect you with like-minded folks.

Ecuador

by Marshall E. Prunty, M.D.
Greenville, KY

Marshall E. Prunty, MD is in solo practice in Greenville, Kentucky. He is a volunteer Clinical Associate Professor of Family Medicine at UL and UK. Dr. Prunty graduated from the University of Kentucky College of Medicine then completed his residency in Family Practice at The Medical Center in Columbus, Georgia.

In May, I participated in a medical brigade to the Amazon Basin of Ecuador. The Timmy Foundation in Indianapolis sponsored the trip. The mission of this foundation includes organizing brigades of medical and pharmacy students with medical professionals to work in Third World Countries.



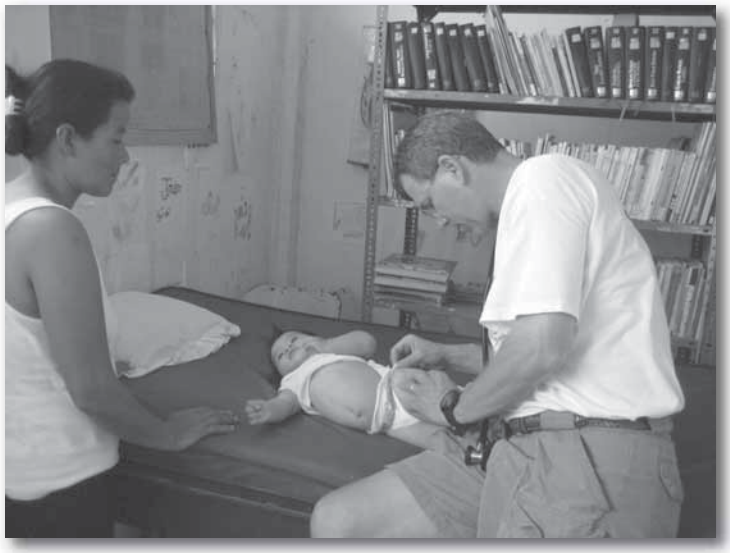
I was invited to participate by Beth Payne, a U of L medical student I met initially in 2000 when we both went to World Youth Day in Rome. A member of her class who had been on a trip before was organizing the trip to Ecuador but they were in need of a medical professional. My initial response was that it just wasn't possible due to the length of time I would need to be out of my office (two weeks). I am still not certain how I ended up acquiescing to her request but I am certain God was grinning somewhere in that exchange.

The weeks leading up to the trip included obtaining supplies for use while in the country. The medical students had several fund-raising activities in order to purchase medications and provide medical consults for conditions beyond our scope of care. Through the generosity of two local pharmacies, I was able to obtain about $1000 worth of medications and my local Rotary Club sponsored me for $500.

The day to leave for Ecuador finally arrived. I wrote in my journal to start the trip: "The unknown is not a condition it is an opportunity." For me to go on this trip was stepping way outside my comfort zone, but anticipation helped to relieve some of the anxiety.

Our brigade consisted of fourteen U of L first-year medical students, two practitioners, two physicians, one third-year pharmacy student, and one administrative participant. We flew from Louisville to Quito, Ecuador. There, a Timmy Foundation representative who had organized the clinics we would attend while in the country, two Ecuadorian interpreters and a bus driver joined us.

After a brief night's rest, we prepared for our trip to Tena. The journey took us through the Andes Mountains, down into the Napo River Valley, one of the tributaries feeding the Amazon River. The trip was only about 150 miles but due to the condition of the roads it took 6 hours to arrive at our destination. Our home for the next



eight days was a resort in the town of Missiahailli about 6 miles from Tena. The town is most famous for the monkeys that populate the town square. The mischievous mammals are adept pickpockets!

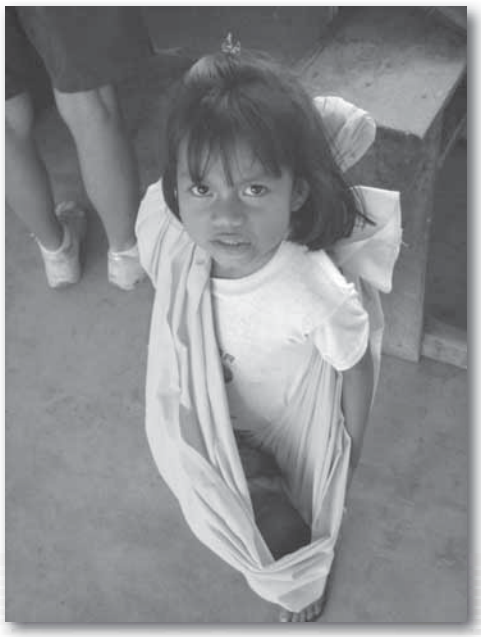
Over the next week we attended 6 clinics, taking care of all sorts of medical problems. Our facilities usually consisted of local school buildings that we improvised into a makeshift area for triage, exam rooms, pharmacy and waiting area. The typical order of the day consisted of the students dividing up the various duties of triage (obtaining vital signs and initial history), pharmacy, or shadowing one of the medical professionals. During a routine day we cared for about 160 patients. While most of the patients had minor illnesses, we also saw two patients with significant heart disorders (requiring a consultation with cardiologists in Quito), several hernias requiring repair, and a small child with a severe infection of his spine.

The trip also provided for opportunities to learn more about Ecuador. On Sunday, the group hiked into the rainforest to a waterfall. Later that afternoon we took a trip down the Napo River visiting an indigenous community to see how they provide for themselves. Finally, after traveling back to Quito on the night prior to our departure, we had a very entertaining history lesson of the city of Quito and of Ecuador given by "El Diablo."

Like any new experience, I learned a great deal about faith, my medicine, and myself. I learned that I do not like cold showers (actually, I already knew that but this trip confirmed it). I don't like cilantro. I either need to learn better Spanish or speak only English. This last discovery came about as a result of trying to wish a patient "I hope you get better" but saying "I hope you die!" Thankfully she couldn't comprehend my Muhlenberg-accented Spanish. My favorite part of the trip was interacting with the children at the end of the day. The medical students were wonderful--playing soccer with the local kids, swinging them around, or teaching them "Duck, Duck, Goose." The latter was especially entertaining. The beauty of these children was that I could see how easy peace could be if we just looked at each other through the eyes of a child. They cared not about our skin color, our affluence, our accent, or our nationality. They responded to us because we showed an interest in them. The heat, sweat, dirt, poverty and fatigue somehow all melded together to create something beautiful.

More significantly, though, I learned what it felt like to be totally powerless. In my day- to- day world I have control (or at least I like to think I do) of what happens with all sorts of devices and medications that enable me to effectively treat a wide variety of medical illnesses. In Ecuador I had only rudimentary equipment (A stethoscope, an otoscope and an ophthalmoscope), no diagnostic equipment, no lab, and an inadequate formulary. I had the knowledge of what to do but not the ability--powerlessness.

But out of this impotence came strength. The reality is that it really never was my ability; that often it is just touch, patience, compassion, and the willingness to be there that heals the most. It was in this that I fully realized modern medicine may heal on one level (physical) but true healing occurs on many levels.



In reflecting on the trip, I realize again that in doing this mission work what I received was inevitably far greater that what I gave, that beauty occurs all around us, that love knows no bounds, that compassion covers many injustices, that courage requires action, that healing is a gift, and that the unknown is an opportunity.

International Medicine and Residency Training

R. Brent Wright, M.D.
Residency Director
U of L/Glasgow FMR

There are times when thirty-six months does not seem adequate to train residents in the board specialty of Family Medicine. Learning never ceases and as we mature in our practicing lives we gain knowledge from continuing education and perspective from our time with patients. With so much to accomplish during residency training, it seems almost impossible to consider emphasis on International Medicine; however, international exposure helps to give residents and faculty alike a view of the world that can be enlightening as we face our daily challenges.

In 2003 the University of Louisville/ Glasgow Family Medicine Residency began participation with the University of Louisville International Service Learning Program (ISLP). The ISLP had been very successful with bringing together many disciplines to assist different cities and villages in the country of Belize. The process was appropriate to Family Medicine because the program sought to address more than temporary or acute issues, but problems that were multifactorial. The program had formed a continual relationship with each of its destinations and this continuity of service made for an easy integration of our residency's philosophy.

The first year with the ISLP included work of a faculty scholar to assess the program's work in Belize and evaluate the appropriate involvement of Family Medicine residents within clinical settings. Medical students had historically traveled with the group under oversight provided by attending physicians. The opportunity for resident involvement was great. During successive years faculty and residents from our residency participated with the ISLP work in Belize. This International work was not only beneficial to the residents who were able to attend, but in providing perspective to other residents within the program.

Service is an important part of any international involvement. This participation is never easy, from the time to be coordinated away from routine responsibilities to the time away from family and loved ones. Medical students searching for Family Medicine programs are committed to service and they are constantly looking for programs that will provide them exposure to international experiences. The growth of many individuals has been witnessed with our international work and further insight is best expressed from those who have worked diligently in this regard.

FACULTY PERSPECTIVE

Sherry G. Jones, M.D.
Assistant Residency Director
U of L/Glasgow FMR

While much has been written about the future of Family Medicine, recently this future has taken a global focus. With increasing medical student interest in international medicine opportunities, Family Medicine is presented with a unique set of possibilities. According to family physician Andrew Bazemore, M.D., Ph.D., of the Graham Center, "Medical coursework in international health is becoming more widespread as schools recognize the many benefits of such training." The breadth of training within Family Medicine lends itself to the complexities of international endeavors. Even limited exposure to international experiences can give students and residents an appreciation of how comprehensive medical training can make a profound difference in a community with limited resources.

The experiences that have enriched my life through teaching Family Medicine in Honduras, Moldova, Guatemala, and Belize have strengthened my passion for the specialty. Our profession has the unique opportunity to combine prevention and intervention while caring for diverse populations. The renewed enthusiasm for the profession helps to enrich my experiences within my community. It is easy to be content with the latest research, sophisticated lab studies, and intricate technology, but international medicine reminds us that our current views are challenged when viewed through the eyes of another culture.

RESIDENT PERSPECTIVE

Mark E. Humphrey, M.D.
Resident
U of L/Glasgow FMR

Medical students have shown increasing interest in global health over the past decade while demonstrating a decreasing interest in Family Medicine. Incorporating an international experience within Family Medicine training increases the resident's ability to recognize the importance of culture and personal beliefs as it relates to health. Fostering this kind of exposure allows for a new frame of reference to approach more subtle cultural differences. This recognition serves to promote healthcare that is more attentive by addressing cultural perspectives.

Having a compassion for the underserved in other countries leads to compassion for the less fortunate here in our country. International rotations remind us that we need to be involved in the community in which we live, to improve its overall health. It teaches the basics of public health, from water to living conditions. They help remind us that even though we may become frustrated by those who may be insincere in their use of medical care, each person we meet in the exam room needs our utmost compassion and understanding.

Mark Your Calendar for Upcoming Meetings!

Ten State Meeting
February 8-10, 2008
Hilton - Hartford, CT

Kentucky Academy of Family Physicians Board of Directors & Committee Meeting
Thursday, May 15, 2008 at 6:00pm Eastern Time
Louisville Marriott East - Louisville, KY

Kentucky Academy of Family Physicians Annual Scientific Assembly
May 16-17, 2008
Louisville Marriott East Hotel - Louisville, KY

Kentucky Academy of Family Physicians Annual Scientific Assembly
May 15-16, 2009
Crowne Plaza-The Campbell House - Lexington, KY

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The Kentucky Academy of Family Physicians

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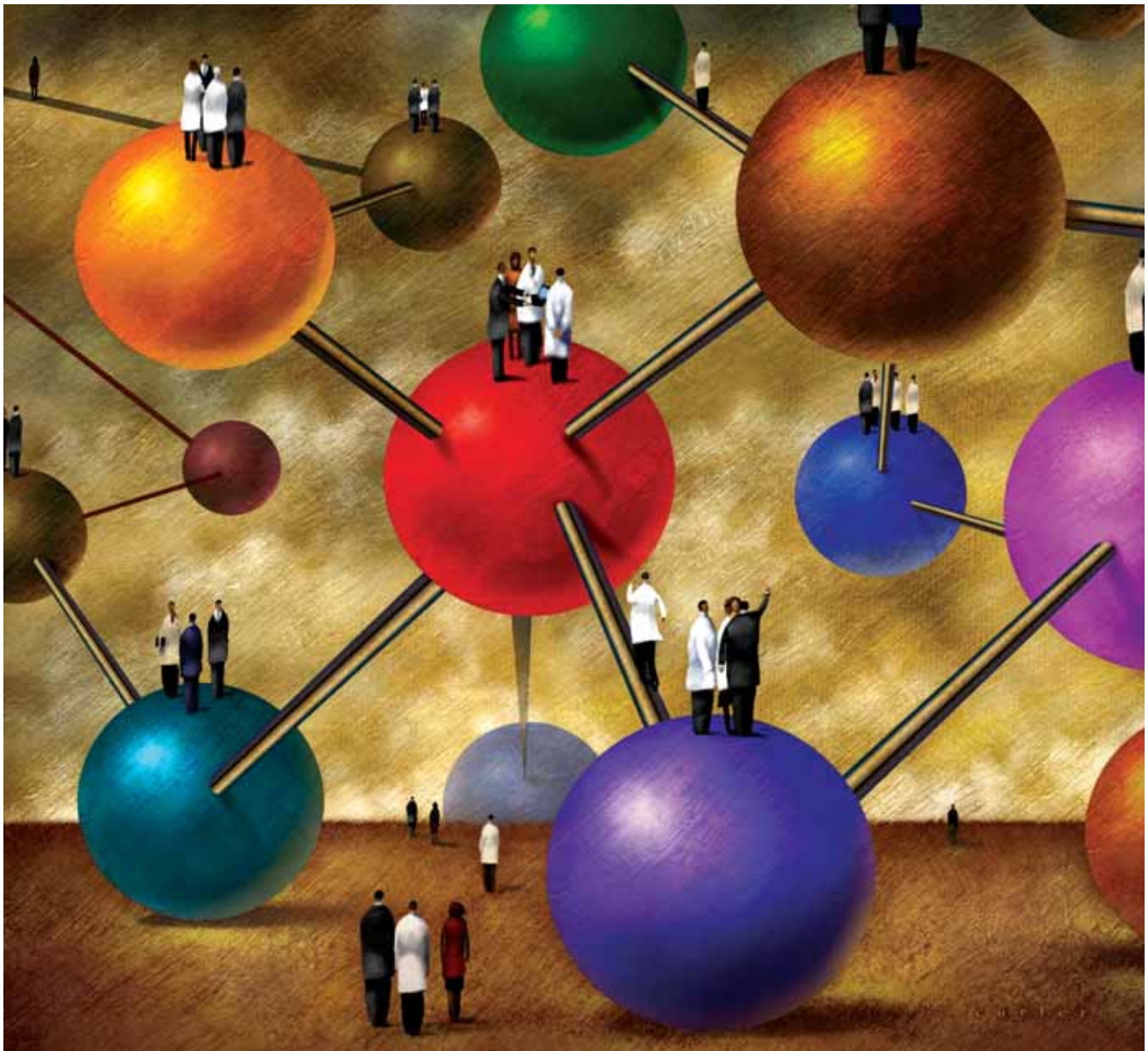

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