KAFP JOURNAL
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The Official Publication of the Kentucky Academy of Family Physicans

WHO ARE WE?

JUST EXACTLY WHAT DOES A FAMILY DOCTOR DO?

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STRONG MEDICINE FOR KENTUCKY

THE KENTUCKY ACADEMY OF FAMILY PHYSICIANS

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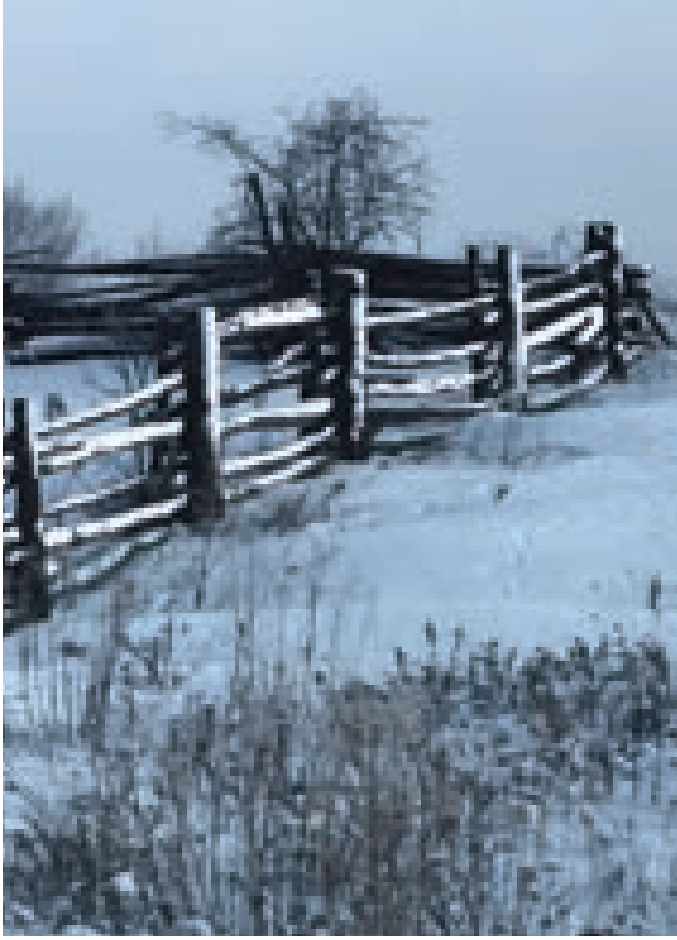

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2009 KAFP CALENDAR

MARK YOUR CALENDAR FOR UPCOMING MEETINGS!

2009 KENTUCKY ACADEMY OF FAMILY PHYSICIANS ANNUAL SCIENTIFIC ASSEMBLY
May 14-16, 2009
Crowne Plaza
The Campbell House
Lexington, KY

2009 TEN STATE MEETING
February 6-8, 2009
East Lansing Marriott
East Lansing, MI

2009 NCSC-ALF
April 23-25, 2009
Hyatt Regency Crown Center
Kansas City, MO

2009 NATIONAL CONFERENCE OF FM RESIDENTS AND STUDENTS
July 30 - August 1, 2009
Kansas City Convention Center-Bartle Hall
Kansas City, MO

2009 AAFP CONGRESS OF DELEGATES
October 12-14, 2009
Weston Boston Waterfront/
Boston Convention and Expo Center
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2009 AAFP ANNUAL SCIENTIFIC ASSEMBLY
October 14-18, 2009
Boston Convention and Expo Center
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message from the PRESIDENT

Few if any can lay claim to the knowledge that predicted the events we have seen unfold over the previous months. This change in our political, social, and economic climate forces us all to look at what is of absolute importance. We are presented with the necessity to examine what is of importance in our personal and professional lives.

Our economy is one of demand. The demand at the present moment is for value. When faced with diminishing resources, we must look at how we can continue with less of what we have been fortunate to enjoy. It is a critical time for family medicine. The continued notices of declining match numbers, residency closures, and diminished reimbursement have not had the collective emphasis we have desired. But what exists now is need for an answer to the myriad of problems we face as a society. The powerful intersection of need and desire holds the promise for our profession as we have never witnessed.

Family medicine is an essential part of the solution for what we face today as a country. As there is a new call for return to fundamentals, let us not be shy to put forward the solution of family medicine. We represent the ultimate value for what has to be addressed in health care. What other specialty looks to include more in one visit than a solitary solution for a single organ system? What other specialty holds the promise to be the principal of the medical home? What other specialty has the research to back up these conclusions with objective data? The answer is family medicine.

As family physicians, we have an innate understanding of what our patients and communities need. For our specialty to succeed, we need to be able to relate this message to those who make decisions. Your voice is crucial within your practice, community, state, and academy. Please do not hesitate to let us know how we can better serve you and your chosen profession.

As Family Physicians, we have an innate understanding of what our patients and communities need. For our specialty to succeed, we need to be able to relate this message to those who make decisions.

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LETTER FROM THE **EDITOR:**

JUST EXACTLY WHAT DOES A FAMILY DOCTOR **do?**

As a new year begins, it is tradition to reflect on who we are, what we do, and what the new year might hold. As a dean of a regional medical school, I am asked some interesting questions. Just before the holiday break, as an M-3 medical student was headed out the door after final exams, he asked, expecting a quick answer: "So what is the difference between FM and IM/Peds?" In that same week, a pre-med student asked: "So what exactly do family doctors do?"

Our specialty has struggled with the answers to these questions for the entire 40 years of our modern re-incarnation. Dr. Kurfees, in his editorial in this journal issue, gives the view of one who has lived the answer. But how does one give a short answer? After all, OB/GYN is clearly the treatment of women only, pediatrics is only children, and internal medicine is only adults. Urology is anatomically defined, as is gastroenterology and cardiology.

My answer is clear, but not short. It's kind of like answering the old question: "So how do you recognize your mother in a crowd?" When you see her, you just know. When you see good family doctoring, you just know.

Family doctoring has less to do with specialty training than with attitude. Although I strongly believe that family medicine residency training is the most efficient way to discover the essentials of good doctoring, it is not necessary, nor sufficient. I have known and now practice among internists, pediatricians, and even an occasional surgeon or subspecialist who "get it." Also, in almost 30 years of training family medicine residents, I realize that we are lucky if half of them leave our programs with "it," and even luckier if most of the other half learn it in practice in time to be good family doctors. So what is "it"?

One of the interesting things I get to do in my dean job is to read books about doctoring, choosing portions to share with the students in our pipeline programs, from high school through medical school. Two are pertinent to the "it" question. Although written primarily to a lay audience, Melissa Ramsdell's series of short essays from doctors of different specialties describing their first year of practice is truly insightful.[1]

FROM A FAMILY PHYSICIAN:

"It is easy to deal with objective disease entities and not deal with the human lives made complicated by disease. To do the latter requires that you get personal with your patients. Any personal relationship requires revealing something of yourself and stepping outside your clinical demeanor, something we are taught not to do in medical school.

"But it was unavoidable after spending time here with the people of eastern

Kentucky. They have a way of disarming you with their unabashed realism, gentleness, and patience… I rarely suffer from burnouts anymore. Here, I learned that caring about people is the best medicine for my patients and for me."

FROM A GENERAL INTERNIST:

"By continually seeing people as their personal physician, you can have an impact on their overall health. When you get to know them, it helps you influence them more… It takes a special type of person to be patient with people and do preventive medicine. If you can get them to quit smoking, you've done something more important than doing a coronary bypass twenty years later, and certainly more cost-effective… Being able to sit down with them and listen to their problems is a privilege."

There are other interesting individual stories from the first year of practice in this book, but I was struck with something else. The hematologist/oncologist talked about helping a patient die, and the plastic surgeon described discovering something important beyond noses and breasts. Many of the "ologists" and other subspecialists worried aloud about being sued, and there was a clearly defined distance between them and their patients. Many, stated outright or between the lines, mused as to whether what they did made a real difference or if it was just a good job in a weak economy. Herein lies some of what makes us different.

Good doctoring happens in that magical moment when the distance between the healer and the healed is suddenly bridged. There is much good talk these days of the value of the patient-centered medical home (PCMH). I see this as an accounting method for good doctoring. If we do good things, our society should value our efforts, and we should be paid accordingly. As I tell my students, the day I am paid as much for working with a family in crisis as I am for delivering a baby, I will know that values have been properly realigned.

As critically important as the new model is, PCMH is just details. It's like describing your mother's nose, and then her eyes, and then the way she holds her head cocked a bit when she first sees you. It's not the same as the process of recognition when you see her among all those other people. It is relationship-centered medical care that makes us different. Described in detail in 1994,[2] this concept is at the heart of good doctoring from my perspective.

Another book I'd recommend, but a much tougher read, is Jack Medalie et al's Life-Changing Stories from Primary Care.[3] In the introduction to the section on family and community, Howard Brody fleshes out this concept of relationship-centered care. He points out that essentially every doctor-patient encounter is a cross-cultural event. Medical school is an acculturation to a different world view:

"Among the critical features of the exceedingly complex medical culture is a need to see the world as a composite of problems with solutions, where the "right" solution is often independent of which person has the problem … Hippocrates laid the groundwork for Western medicine by claiming that no disease was supernatural – that all diseases could be understood by the study of natural biological phenomena- he also laid the foundation for a medical

When seeking meaning, in addition to one's personal faith, it is the land, the families, and the community that provides the answers. Whether rural or urban, primary care or subspecialist, it is understanding and appreciating the relationships of daily practice that defines the good doctor.

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practice in which the physician *no longer feels the need to speak to the patient*." This is the essence of what is not relationship-centered medicine.

"To be human is to be shaped inevitably by one's culture, but to be shaped in a way which is simultaneously and constantly influenced by our family background and by our own individual personality. No two people are members of a culture in quite the same way; simply knowing a list of cultural beliefs and practices is insufficient to understand how any individual within that culture will behave or what he or she will value." Think about the last time you were able to understand your patient's issues quickly because you know his family of origin. You suppose that's why it's called **family** medicine?

Brody goes on to summarize the 3 essential elements common to all healing practices in all cultures:

1) Provide a meaningful explanation for the illness
2) Express care and concern
3) Manage the possibility of mastery and control over the illness or its symptoms.

Good doctoring means accomplishing those three tasks, and this is impossible without solid, trusting relationships. "Perhaps … we could finally come to manage the education of future professionals properly if we could somehow put these nested relationships at the center of the experience of becoming a healer, and emphasize that all else - scientific knowledge, clinical skills, and so on – is critical precisely to the extent that it serves and extends those relationships." Philip Yancy, in his delightful treatise on the Christian concept of grace (another book I strongly recommend), reviews the sociologic concept of the looking-glass self.[4] This view holds that you become what the most influential people in your life think you are. Could it be that our relationships with our patients actually define who we are as doctors?

So, far from being anti-scientific, this concept of good modern doctoring requires both good science and good listening.

"The centrality of relationship as a way of both knowing and healing in primary care brings us back again to the importance of local knowledge. One forms relationships not with abstractions, but with

specific people, families, and communities … even caring physicians dedicated to these relationships may fail, but physicians neglectful or dismissive of these relationships will almost certainly fail." Is it any wonder that our current medical system in America fails so many of us?

The importance of local knowledge is almost second-nature to most Kentuckians. The geographer Cutchin, studying rural Kentucky physicians, reported that remaining in practice for longer periods was associated with finding meaning in the overarching concept of the sense of place.[5] When seeking meaning, in addition to one's personal faith, it is the land, the families, and the community that provides the answers. Whether rural or urban, primary care or subspecialist, it is understanding and appreciating the relationships of daily practice that defines the good doctor. In my experience, a key difference between burned-out physicians and those who keep their enthusiasm for practice is this difference in attitude. The former are just "passing through" the community in which they live. The latter have deep roots and understand that sense of place.

So how do we help students recognize our specialty in a crowd? Invite them to spend awhile with you. They'll get it. Comments appreciated.

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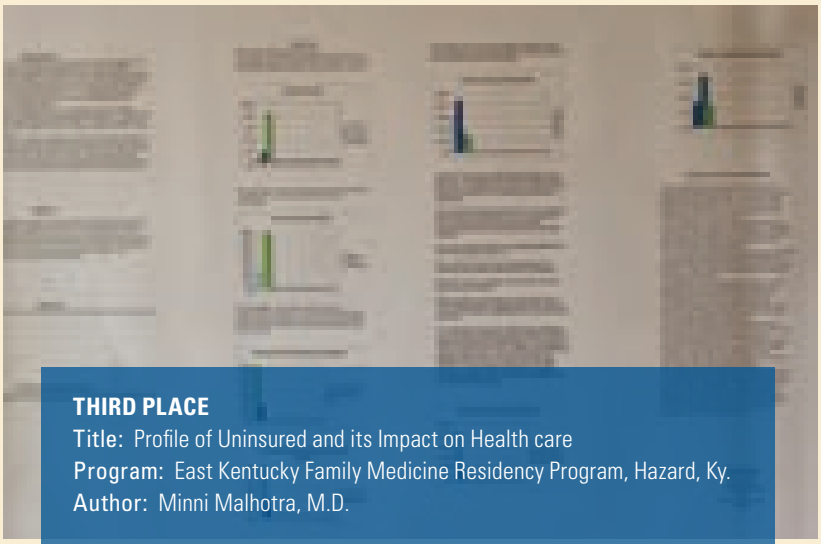
The KAFP misidentified one of the residents that participated in several events. The KAFP would like to give Dr. Minni Malhotra, M.D., special recognition for her Third Place-Resident Scholarly Exhibit and for being one of the team members that took first place in the Resident Quiz Bowl.

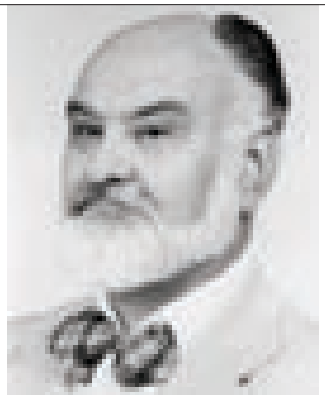


THIRD PLACE
Title: Profile of Uninsured and its Impact on Health care
Program: East Kentucky Family Medicine Residency Program, Hazard, Ky.
Author: Minni Malhotra, M.D.

Baretta Casey, M.D., MPH, presented Third Place Award to Minni Malhotra, M.D.

Nancy Swikert, M.D., and Helene Zukof present the First Place Award to the team from East Kentucky FMRP, Minni Malhotra, M.D., and Key Douthitt, M.D.

WHO ARE WE?



A well trained sensible family doctor is one of the most valuable assets in a community, worth today, as in Homer's time, many another man. . .few men live lives of more devoted self-sacrifice.

Sir William Osler[1]

The American family physician is more important than ever. I am now old and a "consumer" of medical care, having six "specialists" and several outstanding family doctors. I realize more than ever how important the generalist has become.

Specialists used to refer to their practices as "limited to…" They were and are "limiteds," although having extensive knowledge about a limited number of disorders, they show very little aptitude or interest in the "complete history and physical," often ignoring everything except the narrow area of their expert knowledge. As needed as they are, they now merge more toward super technicians than physicians. We were the ones that used to be criticized as the LMD, the chief complaint doctor.

I went to one of my very competent "limiteds" who perfunctorily did his H&P. Afterwards, I asked him to look at a lump on my back. I thought it to be a lipoma but could not see or palpate it adequately because of its location. Whereupon, he informed me, "I'm not a bump doctor; you'll have to see your family doctor." Elementary to good care is always, "Listen to your patient, always look at his concerns, always touch what is appropriate." (I might add an old Chinese proverb: "If a man cannot smile, neither should he own a shop.") A kind mien is healing.

The well-trained family physician is vital as never before as the "orchestra leader," coordinating the prescribing, investigating, the referrals, the collection of all studies, and the oversight of all care of his or her patient. This should all be done in the context of the complete physical examination and at least an annual update of the H&P.

I have no idea what the average person does for medical care, the confusing, bewildering array of procedures, subspecialties, now-here-now-there, confusing medicine, prescribed by many doctors without full cognizance of the other specialty prescription, not used by every physician, with serious interaction, and on it goes. As a mature, schooled physician-consumer, I wrestle constantly with decisions. I have no idea what the average person does without a family doctor's office to help sort out the bewildering mess.

As much as I have championed nurse practitioners through the years, they are limited and should be used for selected, supervised exams for which they are specially trained. I love two nurses, my wife and my daughter, but nurses are not trained as doctors; they are specifically not trained in algorhythmic logic of history taking and do not have years of interpretation of physical signs. I have experienced this

first hand as a patient over the last 10 years, offering answers to queries that required branching logic in follow-up, realizing the examiner did not get it and, subsequently, did not perform the physical correctly either. "Today's experienced clinician needs close to two million pieces of information to practice medicine. Doctors subscribe to an average of seven journals, representing over 2,500 new articles each year."[2] This does not begin to mention meetings and computer programs. Is this true of nurses? Is diagnosis and independent prescription writing by a nurse good medicine?

Nor will near-family-doctors do. OB-GYN is considered a primary care specialty, but it is not unless he or she takes journals and attends meetings that deal extensively with the warp and woof of family medicine; namely, lipid disorders, hypertension, C-V disease, arthritis, pneumonia, blood disorders, outpatient surgery other than gynecology, and so on. Can a woman get all her care here?

I had lunch with a young internist assigned to a rural post to pay back Kentucky loans. He freely and pointedly, with anxiety, recounted how poorly he was suited to a rural, catch-anything, family practice. Reflect on the internists training; it is splendid for urban medicine where specialty support is next door.

There remains, for now, one of God's best gifts to America, you, the Family Doctor. We are overworked and underpaid but greatly appreciated by those who know us best, our patients. They are your real treasure, doctor.

Pediatricians are a doc's best friends in new - born and neonatal problems, but unneeded for most care of children over three to five years of age. Recently, an otherwise competent pediatrician sent a 16-year-old boy with an ordinary ingrown toenail to a foot specialist. The well-trained family doctor should be able to manage most pediatrics, prenatal care, normal deliveries, general internal medicine and surgical diagnoses, pre-op and post-op routine care, assist at surgery, do office gynecology and selected outpatient surgery (closed fractures, cysts, lacerations, I&Ds, etc.).

God knows how many times in my practice and those of others how the surgeons downtown were extolled, but there would have been no such outcome had not a competent family doctor met the critical needs of the highway wreck. Resuscitation, conservation of tissues, management of fracture, treatment of shock, ALS, stemming the hemorrhage, all addressed and cared for before the level four trauma center ever gets wind of the incoming victim.

I think the sub-specialist often does not comprehend the breadth and depth of experience of a family doctor nor the nature of that practice. "Nobody can know enough to do family practice." Well, we do and do it well. In 1981, I had a prolonged running battle with the editor of *Modern Medicine*. We exchanged much correspondence. Modern Medicine had published an article to the point that statistics did not bear out the worth of annual pap smears. (I wonder if he would publish that today!) My argument, from a country doctor's point of view, was a pap smear is not a pap smear. Whatever one finds statistically, the annual contract with the woman is much more than scraping the cervix. One asks about health (hers and her husbands), blood pressure, mother's arthritis, the children's shots, "Better get them in before school starts, they won't let them in class." Beyond scraping cells from the cervix, the bimanual for ovarian enlargement as cancer of ovaries is too often silent until far advanced. The bimanual allows assessment of carcinoma of the lower colon, rectal disease, hemorrhoids, tubal thickening, etc., as you well know. Breasts are examined, mammograms set up. The weight is checked. Discussion of diet is done. Blood pressure is evaluated.

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A problem list is made. Many times at the end, trying to discharge her, she cries, her husband is drinking and abusing her. So on it goes. My point is the narrow specialist's view of the statistics and annual checking of the pap smear is **not** the contract. But, I could not convince him. Women tell me they are psychologically reassured by the exam. I told my patients, "Make it a birthday present to yourself each year."

As students, specialists at the medical school were quick to condemn the "LMD" as a "chief complaint doctor." But, this is what one sees now in specialty medicine. We often made the specialist look good even though we were faced with the challenge of *forme frust* disease. By the time we referred, signs and symptoms were more apparent and came with lab and x-ray work already done. It was ever thus; it is our lot, and it tests our mettle.

The Bush Administration ignorantly wanted to cut funding for one of America's best; the frontline, primary care doctors that make medicine great – trench doctors are one of God's best gifts. Note Sir William Osler's quote, a role model of mine for 58 years.

Problems for us linger and have for all my many years. The public does not know we too are specialists; that sub-specialty care is often not needed, is expensive and complicates management. We are available where the patient lives. We will talk to them on the phone! (Something less and less done by sub-specialists who talk only through referral letters or ARNPs.)

The Academy has made efforts in the past (e.g.; Reader's Digest entries) to inform the public regarding our competent, complete, convenient care, but the effort must be ongoing.

Many other issues face us; socialization will end the medicine America has known, but funding must be solved. However, there remains, for now, one of God's best gifts to America, you, the family doctor. We are overworked and underpaid but greatly appreciated by those who know us best, our patients. They are your real treasure, doctor.

James F. Kurfees, M.D., is an emeritus professor of family medicine, an ordained minister, and owns a M.Th. and Ph.D. (Ab.D) in Theology. He is professor of science and theology at Louisville Bible College.

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2. Dennis L. Kasper, et al., *Harrison's Principles of Internal Medicine*. Ed. 16. (New York: McGraw-Hill. 2005.) 6

JOHN DARNELL, M.D.

A note of thanks to my supporters for my campaign for the AAFP Board of Directors:

I want to first thank my wife Brenda and my children for all their years of supporting and encouraging me to be active at both the state and national level with family medicine. A commitment to run for a national office means that your family will have to make sacrifices of family time and financial resources. Again, I say thanks to my family for making these sacrifices. My next thanks go to my KAFP family – Larry and Nancy for being my co-chairs for my campaign; Brent, Pat, Max, Mont, and Sam for working my campaign booth; and to all KAFP officers, active, tetired, student and resident members and the KAFP staff for all their financial support, campaign letters and moral support. Though my campaign was not successful, I believe we "fought the good fight."

MICHAEL T. RUST, FACHE, *PRESIDENT,* **KENTUCKY HOSPITAL ASSOCIATION**

KENTUCKY MEDICAID DSH

In a recent Letter to the Editor, the writer was lamenting the difficulty of accessing care for the large indigent population of Kentuckians. I thought it might be helpful for readers to have some background and information about the Medicaid disproportionate share hospital program which provides free hospital care to the poor.

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to financially support states in their efforts to sustain hospitals that serve a significant number of low income patients with special needs. Congress recognized that safety net hospitals typically incur higher uncompensated care costs than other hospitals and rely heavily on Medicaid and authorized DSH payments to assist states in financing the programs.

At a minimum, Medicaid law requires states to designate as disproportionate share hospitals all hospitals meeting one of the following criteria: a Medicaid utilization rate one standard deviation or more above the mean for all hospitals in the state, or a low income utilization rate exceeding 25 percent.

Congress also provides flexibility in how the program is administered by the state by allowing the state to go beyond the Federal minimum criteria and make DSH payments to hospitals with Medicaid inpatient use rates as low as one percent. This flexibility results in wide variation among state DSH programs in how DSH payments are rendered and the types of hospitals that receive payments. In Kentucky, any hospital with one percent Medicaid utilization eligible is designated for Medicaid DSH.

> Most uninsured Kentuckians that do not qualify for Medicaid still lack the resources to pay for their medical care.

The Kentucky Hospital DSH program was created in 1993 to provide free hospital care to indigents and return a portion of the newly levied hospital provider tax back to hospitals. Kentucky is the only state to tie Medicaid DSH payments to services provided to the indigent instead of increasing Medicaid payments based upon the level of Medicaid patients served.

In Kentucky, no uninsured patient with documented income below 100 percent of the federal poverty level is billed by a hospital for care they receive, which sets Kentucky hospitals apart from other states.

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Congress recognized that safety net hospitals typically incur higher uncompensated care costs than other hospitals and rely heavily on Medicaid and authorized DSH payments to assist states in financing the programs.

To qualify, the individual must not be eligible for Medicaid or have health insurance coverage. Kentucky's billing prohibition is required by statute and has been in place since the Medicaid DSH program was enacted. Initially, payments to hospitals were intended to cover the cost of caring for these indigent patients. However, **indigent care costs have skyrocketed while Medicaid DSH payments have remained frozen**.

Last year (2007), **Kentucky acute care hospitals provided services costing $311 million just to the uninsured below poverty that were not billed for their care**. Yet, **Medicaid's frozen DSH payments covered only $139.5 million, or 45 percent of these costs, not charges**, leaving a shortfall of $171.5 million in unreimbursed indigent care costs for which patients were not billed.

Kentucky continues to lag behind the national average in available Medicaid DSH funding due to our state's federal DSH cap. The situation is deteriorating more each year as DSH funding drops both in overall state Medicaid spending as well as rising hospital indigent care costs.

Under the Medicaid Modernization Act of 2005 (MMA), federal DSH allotments are frozen at the one-time 16 percent increase provided in 2004 until such time that the pre-MMA allotment, adjusted annually for inflation, exceeds that amount. Only states designated as "low DSH" under the MMA have been receiving increases in their DSH allotments.

Kentucky's DSH allotment is not commensurate with the number of Kentuckians in poverty.

- **Kentucky ranks 45th lowest in median household income ($37,566)**, 13 percent below the national average ($46,037).
- **Kentucky has the eighth highest percent of non-elderly population below 125 percent of poverty, yet our state ranks 22nd lowest in DSH funding per capita**. Of the 21 states that receive a higher DSH allotment per person, only four states have a higher percent of poor, non-elderly population.
- Kentucky has historically spent less of its total Medicaid dollars on DSH payments than the national average.
- Because average income is low, **most uninsured Kentuckians that do not qualify for Medicaid still lack the resources to pay for their medical care**, as compared to the majority of the states with higher average income levels.

Other states, with lower poverty rates but higher DSH allotments, are not even spending all of their allotted DSH funding.

KHA and Kentucky's federal delegation are working on the development of legislation that would help address this problem by establishing a pool of unspent DSH allotments that could be redistributed to other states, such as Kentucky, with limited DSH funds and growing indigent care needs.

Michael T. Rust, FACHE, is President and chief executive officer of the Kentucky Hospital Association (KHA). He is the third president in the 68 year history of KHA. Mike has a master's degree in health care administration from the University of Tennessee, Knoxville, Tenn. and a master's degree in public health and an undergraduate degree from Glenville State College in Glenville, W.V.

"Nutrient Rich Foods" FOR THE RIGHT START IN LIFE

Many American children are overweight, but just as troubling is the fact that many are also undernourished. Because kids do not eat enough of the right foods, they aren't getting enough of five key nutrients: calcium, magnesium, potassium, vitamin E, and fiber, according to the 2005 Dietary Guidelines for Americans (DGA).[1]

The guidelines identified four "Food Groups to Encourage" from the USDA's *MyPyramid*: fruits, vegetables, whole grain foods, and low-fat and fat-free milk or milk products. Encouraging kids and families to eat adequate quantities of these nutrient-rich foods can help ensure that they are getting balanced nutrition from their diets.

DAIRY FOODS: RICH IN NUTRIENTS, BUT LACKING IN SOME DIETS

The dairy group, one of the highlighted food groups, is often underestimated as a source of key nutrients. Known as a superior calcium source, dairy foods also deliver potassium and magnesium – three of the five "nutrients of concern for children."

A number of studies have shown that getting calcium is a key to building peak bone mass and preventing osteoporosis and fractures later in life. The American Academy of Pediatrics calls dairy foods "preferred" sources of calcium compared to supplements and other foods. [2]

Unfortunately, half of children ages 2 through 8 and three quarters of children ages 9 through 19 don't get the recommended daily amount of milk or milk products.[3] The 2003-2004 National Health and Nutrition Examination Survey found that African-American children have lower intakes of calcium, magnesium, and potassium than children of other races and ethnicities.[4] This is consistent with a recent finding that adolescent African-Americans eat and drink less dairy than non-African-Americans.[5]

All children 2 to 8 years should get at least two cups a day of low-fat or fat-free milk or milk products and three cups a day once they turn 9. The American Academy of Pediatrics recommends four dairy servings a day for adolescents.[6] The first step to putting these guidelines into practice is to be aware of them – but 60 percent of parents don't know how much calcium their kids are supposed to be getting.[7]

A DOCTOR'S INFLUENCE – IN AND OUT OF THE OFFICE

Physicians can start by promoting healthy eating in the counseling room. Asking patients about their eating habits, educating them about the importance of balanced nutrition, and recommending a healthy diet that includes low-fat dairy, fruits, vegetables and whole grains are positive steps a healthcare provider can take. A doctor can also help by referring a patient to a registered dietitian when appropriate.

Outside the office, physicians can make a difference in community schools. A respected voice can encourage schools to promote nutrient-rich foods lacking in children's diets and discourage the marketing and availability of foods and beverages low in critical vitamins and minerals.

Poor nutrition in American children isn't only a behavior gap; it's a knowledge gap. Because of their expertise and the respect they command in their communities, health professionals have an important role to play in closing that gap and steering families onto a healthier path through education, guidance and active involvement.

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[1] U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 6th Edition, Washington, DC: U.S. Government Printing Office, January 2005., p. 7.

[2] Frank R. Greer, M.D. and Nancy F. Krebs, M.D. "Optimizing Bone Health and Calcium Intakes of Infants, Children, and Adolescents." Pediatrics (2006). 4 Sept. 2007 <http://pediatrics.aappublications.org/cgi/content/full/117/2/578>.

[3] National Dairy Council, unpublished data based on the National Health and Nutrition Survey, 1999-2002

[4] Fulgoni, Victor. "Dairy Consumption and Related Nutrient Intake in African-American Adults and Children in the United States: Continuing Survey of Food Intakes by Individuals 1994-1996, 1998, and the National Health and Nutrition Examination Survey 1999-2000." J Am Diet Assoc. (2007). 4 Sept. 2007 <http://lib.bioinfo.pl/pmid:17258962>.

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[7] Opinion Research Corporation for GTC Nutrition

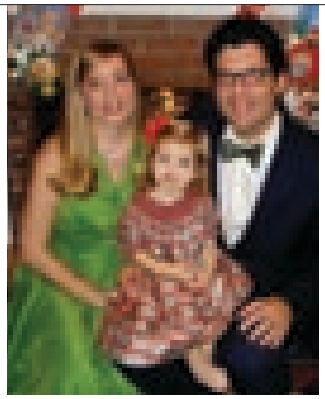
Arlene Murrell, MS, RD, LD, CLE, *Nutrition Affairs Account Manager*

Arlene Murrell is a registered dietitian and certified lactation educator and currently serves as the Nutrition Affairs Account Manager for the Southeast Dairy Association. Arlene brings extensive experience in public health in New York City, South Carolina and Georgia to the Dairy Association. As Director of Nutrition for the Women, Infant and Children (WIC) services program, Arlene provided nutrition expertise to the medical community for over 20 years.

An accomplished public speaker, Arlene has conducted presentations for multiple university health programs, as well as the Utah Nurse's Association; Kentucky Cabinet for Health Services; North Carolina Department of Environment, Health and Natural Resources Division of Maternal and Child Health; and the Catawba, N.C. Health District Teen Pregnancy/Parenting Project.

Arlene received her Bachelor of Science degree in foods and nutrition from Marymount College in Tarrytown, N.Y. She completed her dietetic internship and earned her Master of Science degree in foods and nutrition from Winthrop College in Rock Hill, S.C. She is an active member of the American Dietetic Association, the Georgia Dietetic Association and the Greater Atlanta Dietetic Association.

At the dairy association, Arlene consults with key health professionals and helps develop teaching resources. She enjoys teaching health professionals and consumers the importance of dairy throughout life.



NO REGRETS

"You're doing WHAT?" A chorus of voices asked me this question as I sent in my application for medical school. I had achieved my ARNP degree and was working as a family nurse practitioner in the Vanderbilt Asthma and Allergy clinic in Nashville, Tenn. Most of my family and friends could not fathom why I would want to spend the next seven years of my life in medical school and residency when I was already practicing in the field of medicine.

I have no objection to a career in nursing; the profession is both honorable and challenging. I cherish the broader exposure to and more direct involvement with patients that my experience as a nurse provided. Indeed, my background as a nurse practitioner added much to the "toolbox" that I utilize to care for patients. However, I soon began to aspire for the additional tools that a degree in medicine provides. While nursing gave me an excellent exposure to the more practical aspects of health care, I also desired the more detailed training of medical school.

I felt that a medical school education would supplement my previous training in four major ways. First, a medical degree would enable me to become more comfortable with complex health issues and multiple interrelated health conditions. Second, my training in medical school and residency would give me much more experience in procedures within the fields of obstetrics, dermatology, emergency medicine, and inpatient medicine. Third, medical school would fulfill my intellectual curiosity by giving me a broader background in the theory behind modern medicine. I desired a greater understanding of the anatomy, physiology, and pathology that gave a scientific basis for the care of the patient. Finally, medical training would give me more autonomy in the practice of medicine. While a nurse practitioner must work under a physician's supervision, a doctor may enjoy the fulfillment that comes from a position of more responsibility. In addition, a physician is well-suited to work in an under-served area where there is little access to other health professionals.

Initially, I attempted to convince myself that I was satisfied with my accomplishments and could go the rest of my days without adding to them. My life was easy and happy. It consisted of a secure job, no debt, and plenty of recreational time. My aspiration for medical school was the secret longing that I buried deep within me. However, I soon realized that secrets are difficult to keep. The heart's desire, though squelched, is difficult to extinguish. Several years passed, and the inclination for more challenges and opportunities persisted. My fascination with medicine grew, and I yearned for the greatest possible understanding of the field that I love.

A question repeated itself in my mind over and over again: "Why not?" Four main answers surfaced. First, I had not reconciled my career aspirations with my desire to have a family. Physicians seemed just as likely to spend nights, weekends, and holidays in the hospital rather than in the home. On the contrary, my job as a nurse practitioner offered relatively set hours. Second, the amount of effort involved in this quest seemed enormous. I knew that I would have to spend countless hours studying, followed by long nights of call with little sleep. Third, at $200,000 plus, the cost of attending medical school seemed prohibitative. Had I managed to pay off my nursing school debt only to borrow more? Finally, the time commitment was significant. At age 28, I could not imagine what my life would be like at age 35, when the four years of medical school and three years of residency would come to an end. Did I want to commit such a large percentage of my life to a frivolous pursuit?

As the twentieth century turned into the twenty-first, I continued to ponder my question. The obstacles that once seemed so daunting began to shrink. Medicine has become a more welcoming field for women in particular. Careers for physicians that allow for more balance between professional life and family are becoming a viable option. I realized that I would devote effort to whatever I did in life, whether I worked as a nurse practitioner or as a physician. Seven years seem long but are short

in comparison to the rest of my life. Life itself passes by in an instant. At the end of my time on earth, I did not want to look back and have any regrets. Eventually, I decided that I could not ignore the desire of my heart. The benefit of living my dream far outweighs the costs, even if they are considerable. I resolved that my perceived obstacles would simply work themselves out.

I am the first to admit that my journey has been a difficult one. I have borne not one, but two children during my family medicine residency. I have aged seven years and added multiple furrows to my brow. However, I have discovered that the sacrifices I made have been much easier to bear than I anticipated. I have likened myself to a marathon runner who finds pleasure in the journey, however tiresome it may be.

As the years have passed, I've noticed one other motivation behind my efforts. I refer to this as my calling. A person might state many things about their spouse which they admire, but it is difficult to explain exactly why two people are in love. In the same way, I will never be able to truly rationalize my decision. Furthermore, as a spiritual person, I believe that my destiny is not entirely up to me.

I have almost reached the end to my family medicine training. I have sharpened my tools and added to my toolbox. In deciding to change my life by entering medical school, my new life has changed me. My relatives still look at me quizzically, but they have begun to accept my path in life as much as they accept me as a person. My husband and I will soon be moving to Knoxville, Tenn., for his career, and I look forward to the opportunities available for physicians there. I have listened to my heart, and I challenge anyone reading this to do the same. The sun sets quickly after it rises, and I try to make the most of the day. I have no regrets.

Robin Mahlow grew up in Nashville, Tenn., and received her undergraduate degree in biology from Samford University in Birmingham, Ala., in 1995. She attended the Vanderbilt School of Nursing in Nashville and was awarded her master of science in nursing degree in 1998. After practicing as a nurse practitioner at the Vanderbilt Asthma and Allergy Center for several years, she entered Ross University School of Medicine in Dominica and completed her M.D. in 2006. She is currently finishing her training at the University of Louisville/Glasgow Family Medicine Residency Program and will graduate this summer. She and her husband Jeremy were married in February 2006 and have one daughter Eleanor with another baby due in April 2009.

LIFE ITSELF PASSES BY IN AN INSTANT. AT THE END OF MY TIME ON EARTH, I DID NOT WANT TO LOOK BACK AND HAVE ANY REGRETS.

THOMAS J. WENGER, M.D., *COMMUNITY HEALTH CENTERS OF WESTERN KENTUCKY, INC.*

LETTER TO THE EDITOR:

TIME AFTER TIME DURING THE COURSE OF A WEEK IN OUR RURAL COMMUNITY HEALTH CENTER, PATIENTS WITHOUT INSURANCE ARE DIAGNOSED WITH SEVERE, LIFE-THREATENING ILLNESSES, AND WE PRIMARY CARE PROVIDERS ARE OFTEN LEFT WITH THE AWFUL REALIZATION THAT WE HAVE NOWHERE TO SEND THIS PATIENT AND NO MEANS TO GET THEM CARED FOR APPROPRIATELY.

The complexity of health care delivery in general and in rural Kentucky in particular was nicely reviewed in the article by Michael King, M.D., in the winter issue, volume 60, of the KAFP Journal. Several recommendations for improvement in this difficult situation were made including increasing, by several methods, the supply of primary care physicians and reducing the focus on subspecialties in the medical school residency programs. But a piece of the puzzle missing from the picture was not discussed, and, in my opinion, it is equally important to the development of a solution to the problem.

Time after time during the course of a week in our rural community health center, patients without insurance are diagnosed with severe, life-threatening illnesses, and we primary care providers are often left with the awful realization that we have nowhere to send this patient and no means to get them cared for appropriately. We can hold things together with ingenu-

ity and a wish-and-a-prayer, but eventually we must search for a way to get the patient the specialty care needed before it is too late, an all-too-often fruitless endeavor.

For example, a 58-year-old uninsured man was diagnosed recently in the office with atrial fibrillation and severe CHF who did not have the money to pay for a cardiology office visit or money to buy his medications; he is being treated to the best of our capability although a thorough workup is obviously needed.

Another case is a 27-year-old man with an abnormal brain MRI obtained 6 months ago who has not been able to get biopsied until recently and has a malignant brain tumor.

I am reminded of the television series MASH. "Hawkeye" Pierce and his cohorts, like many Kentucky primary care doctors at the frontlines and in the trenches in the fight against disease and neglect in a rural and indigent population, treat a never-ending flow of battlefield casualties, ready the injured that they cannot handle by themselves to be airlifted to the specialists in the rear, and call in the helicopters to carry away the severely wounded … But what if there were no helicopters?!

One fact of rural and indigent health care needs to be recognized as a crucial missing part of the current health care delivery system: There may not be any HELICOPTERS!!

"Helicopters," figuratively speaking, are the means of taking patients from the primary care physician to the next level of care in an indigent or insurance-poor population.

Where are the "helicopters"? It is not merely that some specialists are unwilling to take the patients without insurance and without financial resources, because many specialists DO accept our referrals of these folks. But there is no RELIABLE system of specialist referral, and there needs to be a much better way to handle this huge problem. As one of our nurses commented, "We can tell them what they are going to die from, but we can't get them fixed."

WE NEED TO BUILD SOME HELICOPTERS.

Thomas J. Wenger, M.D., is employed by Community Health Centers of Western Kentucky located in Greenville, Ky. Dr. Wenger graduated from Baylor Medical School in Houston, Texas, interned at Methodist Hospital in the Texas Medical Center in Houston, then spent two years at the U.S. Naval Hospital in Orlando, Fla. He practiced in Corpus Christi, Texas for 19 years and Buena Vista, Colo., for 11 years before moving to Kentucky in 2006. He is married to Kay Andrews Wenger of Corpus Christi, Texas, and they have two sons and three grandsons.

Tidbits on Resolution Writing

"Whereas" clauses explain the problem and/or situation the resolution is addressing; and "Resolved" clauses are action statements and/or the desired end result if this resolution is approved.

Call for Resolutions for 2009 KAFP Congress of Delegates

Please note the following deadlines for submission of Resolutions to be presented to the 2009 KAFP Congress of Delegates:

Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' handbooki is April 1, 2009. If a Resolution is not received by the KAFP office prior to April 1, 2009, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on May 5, 2009, 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, one copy to the KAFP Executive Vice President and one copy retained by the presenter.

Official Call for the 2009 KAFP Congress of Delegates

Notice is hereby given of the 58th Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held in Lexington, Ky., May 4-6, 2009 at the Crowne Plaza-Campbell House.

Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 49th Annual Meeting of the Congress of Delegates will be held May 15, 2009 at 11:45 a.m. - 1:45 p.m. 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. Registrations will be mailed out in February and can be accessed from the KAFP web site www.kafp.org. *If you should have any questions please contact Janice Hechesky at 1-888-287-9339.*

In recent years, Americans have learned *how to eat* by learning *what not to eat*. Is it working?

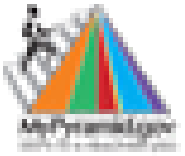
AMERICANS CONTINUE TO BE OVERWEIGHT AND UNDERNOURISHED.

Now a shift in thinking is under way to help Americans "get more nutrition from their calories," as recommended by the 2005 Dietary Guidelines for Americans.

As health professionals, you can play a pivotal role in educating your patients on how to base their food decisions on a food's total nutrient package rather than solely on what to avoid, such as calories or fat.

The nutrient rich foods approach is a fresh, realistic solution to help people evaluate food and beverage choices and get more nutrition per calorie, build healthier diets and achieve better health. Based on the concept of nutrient density, a long-standing dietary principle and the cornerstone of the Dietary Guidelines and MyPyramid, the nutrient rich foods approach can help Americans learn how to choose nutrient-dense foods and beverages first within each basic food group – milk, fruits, vegetables, meat & beans, and grains. Recent research shows consumers view the nutrient rich foods approach to eating as a new and positive way to think about making healthy choices – they like that it shifts their thinking from how not to eat to **what to eat**.

Help your patients embrace the nutrient rich foods approach. Show them that nutrient-rich foods are familiar and easy to find, so healthy eating doesn't have to be difficult, stressful, or negative. Visit **www.lsuhp.org** for more information, including science-based resources, recipes, meal ideas and a supermarket shopping list to help your patients build and enjoy a nutrient-rich lifestyle.



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