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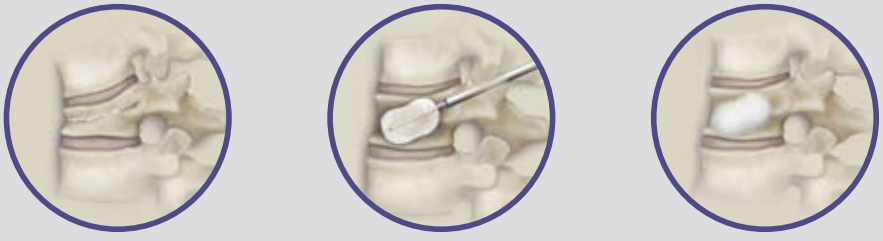

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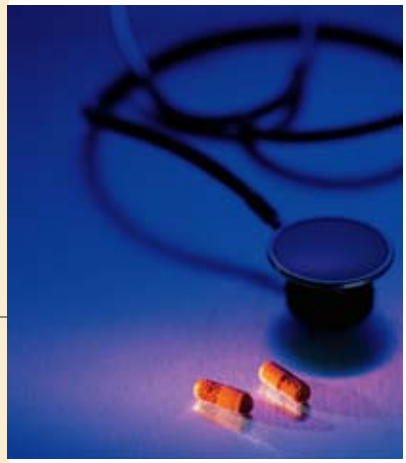

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message from the PRESIDENT

The Art versus Science of Medicine*

Over the past 2 months I have attended the AAFP Scientific Assembly and the Tennessee Academy Scientific Assembly. Both had numerous evidence based lectures that were excellent in content, but the data presented has caused a lively debate within me that I thought I would share with the rest of you.

In Denver, one of the presenters discussed the evidence based data with regards to PSA testing and digital prostatic exams. The gist of the discussion was that the evidence does not support such testing as being of benefit. In Gatlinburg, one of the presenters claimed evidence based data currently does not support breast self exams or physician exams as being of benefit. In each case the data suggests that these modalities could be adverse to one's health.

Now the debate that this touched off has to do with the physical exam aspect of the data. One could extrapolate many aspects of the physical exam lack sufficient evidence to continue to advocate for their inclusion in health care delivery. Does pulmonary auscultation provide benefit in the absence of respiratory symptoms? What about the cardiac exam? Does listening to the heart really make a difference in patients without known cardiac disease? How about funduscopic exams? Given the guidelines for all diabetics to receive yearly dilated eye exams, do we really need to look into the eyes of our patients? I could go on ad infinitum to each of the various aspects of the exam, but I think you get the point. Does the physical exam really provide any evidence based benefit?

Perhaps I am getting to be one of those "old doctors" clinging to relics of the past, but I don't think that is the case. Even in a world populated with technologic advances that enable us to see more and know more about our patients before we examine them, I still believe the physical exam remains a critically important part of health care delivery. The mere act of performing an exam requires one to touch the patient. It is this connectedness that forms the core of the physician-patient relationship. How many times have I heard patients lament the ER physician "never laid a hand on me?"

While elements of evidence based medicine provide significant advances in our understanding of health and disease, there are three critical flaws in advocating blind adherence to these guidelines. One is EB guidelines are based on population studies, but the patient on our table is an individual, not the population. While a population study may indicate little overall value from a certain modality, that modality may be critically important to a specific patient. Like the story of the starfish, it makes a difference to "this one."

The second flaw is how do you account for the "hunch", or intuition? Any MD who has been out for awhile has stories of diagnoses made or successful treatment based more on

EVEN IN A WORLD POPULATED WITH TECHNOLOGIC ADVANCES THAT ENABLE US TO SEE MORE AND KNOW MORE ABOUT OUR PATIENTS BEFORE WE EXAMINE THEM, I STILL BELIEVE THE PHYSICAL EXAM REMAINS A CRITICALLY IMPORTANT PART OF HEALTH CARE DELIVERY.

divine revelation than evidence based fact. Intuition probably is rooted in the mature experience of the veteran clinician. But, isn't that the value of experience, knowing when it is important to break the rules because the rules don't cover every situation.

Finally EB medicine does not account for the significant effects of faith in healing. How does one account for the placebo effect? What about the true medical miracle, where does that fit into the evidence based algorithm? I can acknowledge these may occur rarely, but that doesn't mean they don't exist.

I am not advocating getting rid of EB guidelines as much as I am defending the necessity for protecting the place of art in medicine. Medicine has always been part art and part science. While science has improved medicine, raw science devoid of compassion, absent touch, without faith and unable to appreciate the awe inspiring things we are privileged to see as healers, is medicine that can be packaged, formatted and performed by machine.

The true value of the physician isn't that they know the guidelines and algorithm that give the highest likelihood of successfully treating any presenting ailment, but that they are able to put a human perspective on that ailment.

As we continue the inevitable march towards medicine that is completely evidenced based, driven by a master that demands accountability, there will come a tipping point in which we will no longer need to worry about those ancillary providers who desire to chip away at what we as physicians do, for the entity that will replace us all will be a program, a keyboard and a monitor. There will be those who see this as the advancement of medicine and science. I will see it as the reduction of a once great profession.

I would invite your comments on this or any article in the Journal. Please send your letters to KAFP, P.O. Box 1444, Ashland, KY 41105.

**reprint due to error*

Nowhere DOCTOR

As I sit contemplating what to write for this editorial of the KAFP Journal, wanting both to inspire and enlighten, I came across the song Nowhere Man from the Beatles while looking through a popular on-line store for downloadable entertainment symbolized by the proverbial forbidden fruit. The song allowed me to reflect on why I went to medical school, why we try so hard in our profession, and why when we reach our limits, we pray for the strength to give more.

…he doesn't have a point of view, knows not where he's going to…

Nothing could be further from the truth for the past years of our advocacy efforts. We sought to align our efforts with those of like mind, namely those who strive for greater health and safety concerning citizens of the commonwealth. We have a purpose and that is to improve our efforts with each passing year. We have sought to lead collaboration to balance any efforts, which may be seen as oppositional.

…making all his nowhere plans for nobody.

We are anything but "nowhere physicians" as we stand up for what we believe in asking for greater protection concerning the people we serve. Advocacy is part of what we do on a daily basis and the creed of our academy. We take pride in knowing what is right for our patients, our communities, and the profession in which we are so fortunate to find ourselves.

While others clamor for increased reimbursement, I think that we search for peace- peace in knowing that we live with purpose and a legacy far greater than material wealth. Family Physicians are a benevolent group who provide value and sacrifice. Most would give of themselves to their own detriment and then give thanks for the opportunity to do so.

This past year has been a resounding success for our academy and its advocacy efforts. Through the work that has been demonstrated in efforts to curb the scourge of methamphetamine from our communities, we reached out to fellow physicians, law enforcement, justice, and concerned citizens. We demonstrated that we have served as a catalyst for our state's efforts and a leader among our national chapters. I applaud the efforts of our board, staff, leadership, and member physicians as this work continues to make me proud of the choice for Family Medicine and the opportunity to serve our fellow man on a continual basis, wherever need exists.

…nowhere man, are you listening?

R. Brent Wright, MD, FAAFP *is the Residency Director of the U of L/Glasgow Family Medicine Residency and Vice Chair for Rural Health in the Department of Family & Geriatric Medicine. Recently Dr. Wright was honored with the Kentucky Medical Association's 2010 Medical Achievement Award for Outstanding Contribution to the Field of Medical Education. He serves as the Co-Chair for the Advocacy Committee and is a Past-President of the KAFP.*

Prematriculation medical students as agents of change: THE CHANGE Assessment Project

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ABSTRACT

A summer prematriculation program for medical students in the University of Louisville Trover Rural Track is based at the rural campus in Madisonville, Kentucky. A major focus is allowing the students to develop skills talking with patients in rural clinics. Prochaska's Stages of Change Model was used as the matrix for these discussions. The students conducted brief interviews with patients as they waited to see their doctor and categorized each patient's readiness to change health habits including smoking cessation, nutrition, and activity. Overall, 227 of the 401 patients (57%) continued the "at risk" behavior, including 64 (16%) who had previously moved to a higher stage and then relapsed. Of this 227, 33 (15%) were actively trying to change the behavior. On the positive side, 171 (43%) had made a long-term or permanent positive change. Evaluations by students and sites were uniformly positive, and the students were surprised how quickly they became comfortable talking with patients by actively participating rather than just watching an experienced clinician conduct the interview.

INTRODUCTION

Most students, as they begin medical school, are anxious to begin talking with patients. While some have experience in this role, most do not. During the first year of medical school, students will get some experience talking with standardized patients in controlled environments, but most "shadowing" in the basic science years is just that – watching experienced clinicians work.

University of Louisville Trover Rural Track (TRT) students with a plan to complete their M-3 and M-4 years in Madisonville have a unique opportunity to learn about rural health care before they begin their first year in Louisville. TRT students attend a three week summer Prematriculation program in Madisonville where they shadow physicians, learn how to think like a clinician, and talk to patients directly about their health concerns.

Most beginning medical students lack the content knowledge to talk with patients about clinical medicine, but they all know about health habits. For this reason, the interaction with patients was structured around smoking, exercise, obesity, and nutrition. In order for the Prematriculation students to get a better understanding of these problems, the students use the Prochaska model to interview patients in rural practices, as the patients wait for the doctor in the exam room.

The Prochaska model is termed the "Trans-theoretical model of Health Behavior Change." (1) This method is better known as the "Stages of Change Model." Behavior changes involve process, which describes how; motivation, which involves why; and stages, which show when. Many experienced clinicians have developed their own individual approach to determining which patients are ready to hear about changing their health habits and when the clinician's energy is

MOST BEGINNING MEDICAL STUDENTS LACK THE CONTENT KNOWLEDGE TO TALK WITH PATIENTS ABOUT CLINICAL MEDICINE, BUT THEY ALL KNOW ABOUT HEALTH HABITS. FOR THIS REASON, THE INTERACTION WITH PATIENTS WAS STRUCTURED AROUND SMOKING, EXERCISE, OBESITY, AND NUTRITION.

conintued >>

better spent on other issues.

The Prochaska model can be used to understand negative behaviors as well as develop more positive life styles (2-6). A student's ability to identify behavioral stages will become a valuable skill in their future professional career as well as in their personal life. The students were given a Change Assessment Project (CAP) outline and were introduced to the interview technique in sessions held during orientation for the program. Weekly group sessions with an experienced clinician (WJC) were held to discuss their interactions with the patients and to modify their interviewing skills as needed. Written patient education information on smoking cessation, nutrition, and exercise were provided to the students to use if their interview with the patients revealed that the patient was prepared to make a change. The students went to each site in pairs and at the end of the program, a report was written by each pair and shared with the host site.

As shown in table one, the stages of the Prochaska model that the students recorded were 1) Pre-contemplation (Apathy), 2) Contemplation (Entry stage), 3) Preparation (Commitment), 4) Action (Implementation), 5) Maintenance (Success), 6) Termination (Cure) and 7) Relapse.

METHODS

During the initial training, students were oriented to the Prochaska stages, and advised to use a script like: "Hello, I'm ___ and I've just started medical school at U of L. We've been assigned to learn about the health habits of Kentuckians, especially those that might cause problems for themselves or their families in the future. Can you spare a few minutes to talk? If you have any questions for me and I don't have an answer right now, I'll look them up for you later."

During the summers of 2009 and 2010, the students spoke with individual patients as they waited for the doctor in the exam room. Taking turns, one student primarily conducted the interview while the other took notes and assisted if the first student got "stuck." Students were provided an algorithm of questions, beginning first with smoking. If the patient had never smoked, the students moved on to questions about nutrition and exercise. Most interviews took less than 5 minutes.

Intervention was not a focus for this project, with the student emphasis on correct staging. However, the students were provided some brief scripts that they could use if appropriate, as shown in Table 2. If the patient indicated interest in written materials, the student had some copies of approved patient

TABLE ONE:

PROCHASKA'S STAGES OF CHANGE	
Stage I	Pre-contemplation (Apathy) "I don't have a problem." "My grandpa smoked till he was 90."
Stage II	Contemplation (Entry Stage) "I have a problem." "There's something about myself I need to change."
Stage III	Preparation (Commitment) "I've tried to change, but failed." "I really need to do something."
Stage IV	Action (Implementation) "I'm working hard at this." "I need to talk to someone."
Stage V	Maintenance (Success) "I've made the change, but I feel like I'm slipping back." "I need a boost to keep on."
Stage VI	Termination (Cure) "I quit smoking 35 years ago when my kids were born."

TABLE TWO:

SUGGESTED COMMENTS TO PATIENTS BY STAGE	
Stage I	"I wonder why all these stop smoking campaigns are going on?" "I wonder why all the doctors have quit smoking?"
Stage II	"People who have quit say they have more energy." "I never heard anyone say they were sorry they quit." "I think you're on the right track."
Stage III	"There are groups everywhere that are willing to help you." "This is one of the best things you can ever do for yourself." "Your children will really appreciate this."
Stage IV	"Don't give up - you're doing great." "This kind of effort will really pay off."
Stage V	"I know from talking with other folks, that some people really struggle to begin an exercise program and keep with it. What worked for you?" I know from talking with other folks that some people really struggle to quit smoking for that long. What kept you going?"
Stage VI	"Being rid of that old habit is great, isn't it? What advice would you give to other people that would help them get to your stage and not slide back?"
Relapse	"Nobody makes it on the first few tries." "That's normal." "You know how to do it - just try again." "You've come farther than lots of people." "There was probably a good reason that it happened." "Would you like something short to read about this?"

education information to give to the patient.

Students coded each interaction and entered the information into a standard spreadsheet. They were encouraged to capture verbatim quotes from the patients that indicated their stage of change.

In each pairs' final report, the students provided a detailed description of the site, including patient demographics, payer mix, provider mix, and diagnostic services on site. The stage distribution data for each site was compared to an "all sites" column and these data and the practice description was sent to each site at the end of each summer.

Students provided formative feedback on the program at each weekly group session and summative feedback in their final report. Each also provided anonymous feedback on a formal individual evaluation form at the completion of the program. The physicians at each site provided formal written feedback at the end of each summer session.

RESULTS

During these two 3-week summer periods, a total of 401 patients were interviewed and had complete data, collected from 8 rural primary care sites. Three patients declined to participate or were seen too quickly by the doctor to have time to participate. The stages of change recorded by the students are shown in Table 3. Overall, 227 (57%) continued the "at risk" behavior, including 64 (16%) who had previously moved to a higher stage and then relapsed. Of this 227, 33 (15%) were actively trying to change the behavior. The students were heartened to see that 171 (43%) had made a long-term or permanent positive change.

Patient Responses

There were many patient responses about the subject of smoking cessation. The majority of these comments were positive towards the option to quit smoking but a few were defensive. Some of the most interesting and surprising of these comments were statements like, "I started smoking when I was seven years old and smoked until I was sixty-five. I quit because I could tell that it was affecting my health and my wife wanted me to quit. I just stopped cold turkey and carried a pack of cigarettes around in my shirt pocket for six months until I finally just gave the entire pack away one day." Another comment indicated a desire to quit in order "To serve God." Some defensive patient responses included statements like, "I'm 62 years old, so I don't plan to quit. I like to smoke while I drive." A very interesting case was one where the patient's spouse used bribery as a motivator, offering to buy a new car for his wife as a reward to quit smoking.

TABLE THREE:

2009-2010 CAP DATA SUMMARY			
		TOTAL	
		N	%
Stage I	Pre-contemplation (Apathy)	53	13.2%
Stage II	Contemplation (Entry Stage)	44	11.0%
Stage III	Preparation (Commitment)	33	8.2%
Stage IV	Action (Implementation)	33	8.2%
Stage V	Maintenance (Success)	89	22.2%
Stage VI	Termination (Cure)	82	20.4%
Relapse	Relapse	64	16.0%
Total		401	100.0%

"What we found to be the most helpful was to really try to have a conversation with the patient and let them do most of the talking. The patients were very willing to open up to you about their lifestyle habits if you were just ready to listen."

When approached by the CAP students, patients seemed more responsive to the idea of obesity or lack of activity being a serious issue than they were about smoking cessation. Many comments indicated a desire to exercise. A sixty-three year old woman reported that she runs on a treadmill fifty minutes every day. One patient reported that she not only lost 100 pounds through Weight Watchers®, but also got her family involved in the process to lose weight. A few patients were defensive, reporting to the students that they "knew all there was to know" about weight loss.

Student Responses

In their final reports, the students were asked to make recommendations for their practice site. When discussing exercise with patients, they recommended using the word "activity," as most patients considered exercise something that you could only do in a gym. This opened the conversation to alternative forms of exercise, such as using therapy resistance bands as an alternative to more traditional weight-bearing exercises. These resistance bands could offer a dynamic way to exercise for the elderly and obese patients. Another suggestion was a way to provide a trial or discounted membership to a nearby gym. The other recurring suggestion for the sites was that, either by posters or handouts, patients be consistently reminded that smoking was bad for their health and that there were many alternatives for smoking cessation.

As a whole the CAP students viewed this entire experience to be a positive one. They indicated that this process laid the foundation for the way to interact with future patients. Students also stated that they view this project as very useful in learning more about a patient's views and understanding of their unhealthy habits as well as a great way to motivate patients to change behaviors. An example of exactly what students learned from this experience was the statement that "What we found to be the most helpful was to really try to have a conversation with the patient and let them do most of the talking. The patients were very willing to open up to you about their lifestyle habits if you were just ready to listen." This seems to sum up what the students gained from this experience and how they can benefit from

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it as providers.

A few students suggested clarification of coding issues, but the majority recommended continuing the program with no changes. Several emphasized the importance of doing the interviews themselves, rather than "just watching a doctor do it." Perhaps the best summary was "After a short period, talking to patients became second nature."

Feedback from the sites was uniformly positive, and most physicians and staff enjoyed having the enthusiastic young students around. The design of placing the interviews in the exam room where the patient was accustomed to a short wait was ideal, and was not perceived as "slowing down" the usual patient flow. The brevity of the interview was also important.

DISCUSSION

This project accomplished the goal of getting prematriculation medical students comfortable talking with patients. The effort also provided an experiential view of a rural practice, and as each practice was discussed during the final report session, the students grew to appreciate some of the similarities and differences.

The actual breakdown of stages in the summer project may not represent the findings in the larger practice, as it was basically a sample of convenience. Some practices may have also further selected which patients the students interviewed. However, this sample compares closely to the pattern seen in multiple studies using the Prochaska model. In most randomly chosen populations, of patients still "at risk" for the behavior in the first three stages, 40% were staged in precontemplation, 40% in contemplation, and 20% in preparation (1). In our sample, these percentages were 41%, 34%, and 25%, respectively.

These materials are now gathered in a short curriculum that is available for other educators to use. In addition, these students are prepared to understand health behaviors in a way most of their classmates are still learning. A former prematriculation student commented that when these concepts were taught in a 3 hour workshop during the basic science years in medical school, she felt that she "already knew all the answers, which is rare during the first 2 years of med school."

We offer this program for consideration by others as a way to get prematriculation medical students involved talking to patients. Hopefully, the usual consternation

engendered when clinicians encounter patients who are resistant to modifying detrimental health habits will be avoided in these students. Those experienced in the Prochaska model may interpret patient attitudes as a diagnostic/therapeutic challenge, rather than on a visceral personal level. We offer Prochaska's stages and our scripts as useful tools for the busy physician to determine quickly which patients are ready to make important lifestyle changes.

ACKNOWLEDGEMENT

This activity could not have been successful without the cooperation and support of the practices and their patients. Dr. Bill Klompus was responsible for taking the very large literature on the Prochaska model and distilling it down to a set of brief training materials that we continue to use each summer. Steve Fricker designed all the data entry materials, supervised the analysis, and co-taught the orientation and report sessions.

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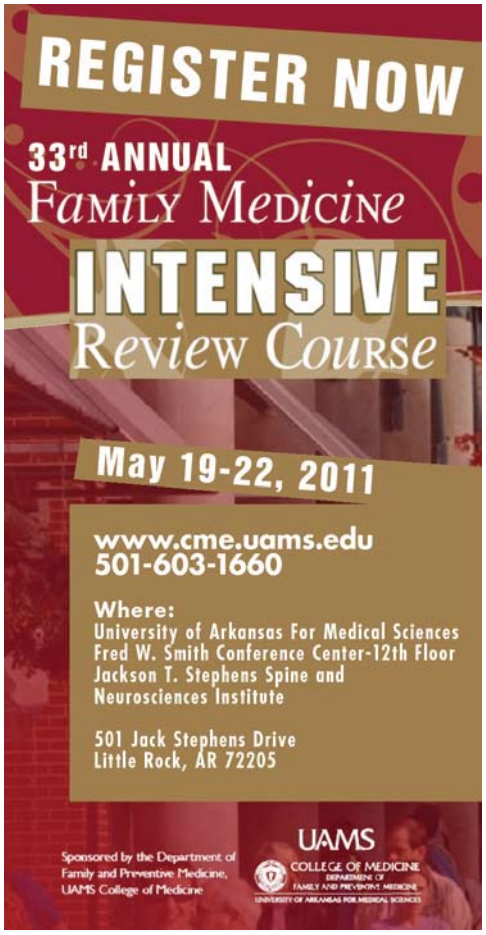
Dr. Bill Crump *was born in Savannah, Georgia and graduated from the University of Georgia. He completed medical school at Vanderbilt and then a Family Medicine residency at the University of Alabama in Birmingham. He completed a Faculty Development Fellowship at the University of North Carolina at Chapel Hill and was on the faculty at the University of Alabama's Huntsville campus for 10 years and then the University of Texas' Galveston campus for 6 years. He has been in his current position for 13 years as Associate Dean for the University of Louisville regional medical school campus in Madisonville, Kentucky.*



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KAFP President

PROGRAM GOALS Those attending this program will receive current information on a diversity of medical subjects pertinent to patient care in daily practice. Subject material was chosen based on assessment needs, future trends, and relevance to quality patient care. At the conclusion of the program, registrants will have a working and applicable understanding of these topics and will be provided a syllabus for future reference. This meeting allows the opportunity for physicians, faculty, residents, students and other health care professionals to interact academically, professionally and socially.

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COMPLIMENTARY NMR LIPOPROFILE® TEST LipoScience is offering free NMR LipoProfile testing. The test measures LDL particle number (LDL-P) and standard lipid parameters to aid in the management of cardiovascular disease using nuclear magnetic resonance (NMR) technology. The testing will be conducted during exhibit hours in exhibit hall. For best results, patients should be fasting.

PAPERLESS Everyone will be receiving a USB Flash Drive instead of a paper Binder. Your CME Syllabus and Congress of Delegates Handbook will be included on flash drive. Everyone is encouraged to bring your own laptop.

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Wednesday, June 22, 2011	
6:30pm-10:00pm	Board of Directors/Committees Dinner Meeting
9:00am-12:00am	Hospitality Suite
Thursday, June 23, 2011	
8:00am-11:00am	Congress of Delegates Breakfast Meeting
2:00pm	KAFP Golf Tournament on the Donald Ross Course
8:00am-5:00pm	Exhibit Setup
9:00pm-12:00am	Hospitality Suite
Friday, June 24, 2011	
7:00am-8:00am	Breakfast & Exhibit Expo
7:00am-3:30pm	Resident Scholarly Research Exhibits
8:00am-12:00pm	Autism Workshop *Elizabeth Mumper, MD, FAAP, President & CEO of the RIMLAND Center, Lynchburg, VA; Assoc. Professor of Pediatrics at the Edward Via Virginia School of Osteopathic Medicine*
10:00am-10:30am	Break & Exhibit Expo
12:00pm-1:00pm	Spouse Social
10:00am-11:30am	Lunch & Exhibit Expo
12:00pm-1:30pm	Past Presidents Luncheon
1:30pm-4:30pm	Diabetes SAMs Prep Session *Robert L. Wood, MD, Residency Program Director, Trover Health Systems Family Medicine Residency Program, Madisonville, KY*
3:30pm-4:00pm	Break & Exhibit Expo
6:30pm-10:00pm	Resident Quiz Bowl , Awards & Reception
9:00pm-12:00pm	Hospitality Suite
Saturday, June 25, 2011	
7:00am-8:00am	Breakfast & Exhibit Expo
8:00am-9:30am	Major Depressive Disorders *J. Sloan Manning, MD, Assoc. Professor Dept. of Family Medicine, Univ. of NC at Chapel Hill; Co-Director, Mood Disorder Clinic; Moses Cone Family Practice Residency, Greensboro, NC*
9:30am-10:30am	Addressing Concerns About Vaccines *Gary Marshall, MD, Chief of Division of Pediatric Infectious Diseases, Professor of Pediatrics, Pediatric Clinical Trials Unit, University of Louisville, Louisville, KY*
10:30am-11:00am	Break & Exhibit Expo
11:00am-2:00pm	7 Steps: Ways Medical Providers Can Help Kids Prevent Obesity *Christopher Bolling, MD, FAAP, Obesity Chair, KY-AAP, Co-Chair Provisional Section on Obesity/American Academy of Pediatrics, Volunteer Associate Professor of Pediatrics, Univ. of Cincinnati College of Medicine.*
12:00pm-1:00pm	Lunch & Exhibit Expo
1:00pm-2:00pm	AAFP Chapter Lecture Series: Cardiac Testing This activity is supported by an educational grant to the AAFP from Astellas.
2:00pm-3:00pm	The Business of Medicine Pat Smith, RMC, RMM
3:00pm-3:30pm	Break & Exhibit Expo
3:30pm-4:30pm	Complex Regional Pain Syndrome *Stephen Bruehl, Ph.D, Assoc. Professor of Anesthesiology, Vanderbilt University, Nashville, TN*
4:30pm-5:30pm	Planning for Your Practice and Accountable Care *Kevin Pearce, MD, MPH; Mark D. Birdwhistell, MPA; Douglas L. McSwain, JD*
6:30pm-9:30pm	Reception and Annual Awards Banquet
9:00pm-12:00pm	Hospitality Suite

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SPECIAL EVENTS:

☐ Wednesday, June 22, 2011 Board of Directors Dinner Meeting & Committees	No Charge
☐ Thursday, June 23, 2011 COD Breakfast (KAFP BOD & Delegate/Alternates Only)	No Charge
☐ Thursday, June 23, 2011 Golf Tournament (Attendees/Family Members/Vendors)	_____ *($100 per person)*
☐ Friday, June 24, 2011 Resident & Student Reception /Quiz Bowl	No Charge
☐ Friday, June 24, 2011 Spouse Social	No Charge
☐ Friday, June 24, 2011 Past Presidents Luncheon *(Past Presidents & Spouses only)*	No Charge
☐ Saturday, June 25, 2011 Reception and Awards Banquet	_____ *($70 couple/$40 each)*

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ELDER ABUSE & NEGLECT:
THE ROLE OF THE FAMILY PHYSICIAN

ELDER ABUSE HAS REMAINED THE STEPCHILD IN THE SPECTRUM OF ABUSIVE BEHAVIORS WITH CHILD ABUSE AND SPOUSE ABUSE RECEIVING MORE ATTENTION AND MORE FUNDING.

Elder abuse is a significant problem that robs victims of quality of life in the last phase of their life. It is estimated that between 4% and 10% of those over 65 years of age are victims of either abuse or neglect.[1] Closer to home, in Kentucky in 2007, there were 45,048 reported cases of elder abuse or neglect. Of those cases, 9,660 were adults 60 or older.[2]

Reported cases represent the tip of the iceberg. Previous studies would suggest that only one in fourteen cases ever comes to the attention of any authority.[3] Elder abuse has remained the stepchild in the spectrum of abusive behaviors with child abuse and spouse abuse receiving more attention and more funding. Surprisingly, elder abuse is most often perpetrated by family members, with sons and daughters being most frequently cited, followed by spouses and other relatives. The usual victim tends to be frail and most are females over the age 80. Victims may also have a dementing illness and may be dependent on a family member with whom they reside. Less frequently, a healthy older adult may also be a victim, so there really is no stereotypical victim.

In 1998, the Commonwealth of Kentucky established local coordinating councils on elder abuse to intervene in cases of elder abuse and develop crisis response teams. Kentucky Statute KRS209 protects older residents of the Commonwealth from abuse, neglect, and exploitation, which mandates reporting of suspected elder abuse and neglect to the Cabinet for Health and Family Services. Most counties have a subunit of Adult Protective Services (APS) who will manage any reports. This process assures the protection of the identity of the reporter. If they take the case, APS is mandated to conduct an investigation and be available for the provision of services. In contrast to child abuse statutes, a competent older adult has the right to refuse services.

There are many different definitions of elder abuse. The American Medical Association defined abuse and neglect as "an act of omission or commission that results in harm or threatens harm to the health and welfare of an older adult".[4] The World Health Organization defines elder abuse as a simple or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, which causes harm or stress to an older person.[5] Elder abuse is separated into seven major categories.

Physical Abuse: Defined as the use of physical force that may result in bodily harm, injury, physical pain or impairment. Examples would include beating, punching, or restraining an older adult.

Sexual Abuse: Is nonconsensual sexual contact of any kind with an elderly person. Age does not confer immunity from rape or sexual assault.

Emotional or Psychological Abuse: The infliction of anguish, pain or distress through verbal or nonverbal acts. Examples would include screaming, swearing, denigrating, or threatening with placement in a nursing home.

Financial abuse/material exploitation: The illegal use or improper use of an elder's funds, property, or assets. Examples include stealing social security checks or tampering with a will or inheritance.

Neglect: The refusal or failure to fulfill any part of a person's obligations or duties to an elderly person. Examples would include a care-

giver who fails to meet the essential needs of an elderly person such as failing to feed, clothe or assist with toileting.

Abandonment: The desertion of any elderly person by an individual who has physical custody of the elder or by a person who has assumed responsibility of providing care to an elder. Examples are leaving an older dependent adult at home, restraining them, or abandoning them at an emergency room.

Self Neglect: The result of an adult's inability to perform essential self-care tasks including providing essential food, clothing, shelter and medical care. Perhaps this is the most frequent and one of the most difficult types of abuse and neglect to address.[6] Some experts suggest that noncompliance with medical recommendations should be included.

CASE EXAMPLE

A 77-year-old female is admitted to the hospital through the emergency department with a diagnosis of dehydration and uncontrolled hypertension. She appeared disheveled at the time and was accompanied by her only son who resided with her in her home. He looked equally disheveled. There was no record of recent medical care. In the hospital she was rehydrated, blood pressure was controlled, and after three days she was ready for discharge. The morning of discharge she reported to the family medicine resident who was rounding in the hospital that she was going to die. Her discharge was delayed and she was subsequently interviewed by the resident and the attending who were focused on ruling out life threatening medical diseases, the risk of suicide, and significant depression. Her son was questioned and he reported that oftentimes she behaves like this. A day later, she was discharged and two days later the homicide squad called the attending physician. The patient had been murdered and was found with a plastic bag over her head, tied with a bootlace with multiple knots. The autopsy showed that previously she had been a victim of sexual assault. Her son was charged with first-degree murder.

HISTORY

Elder abuse has been present since antiquity. In contrast with popular beliefs, many times older adults were not revered but were victims of abuse and neglect. Even in the last two centuries, there is evidence from sermons and court cases that older adults were abused primarily by family members who sometimes kept an older adult at home to assure the transfer of the inheritance rather than honoring a commitment. Elder abuse was first described in the literature in 1975 by Baker who coined the term "granny battering".[7]

ROLE OF PHYSICIANS

The role of physicians, thus far, in contributing either to the study or investigation of elder abuse and neglect has been disappointing, particularly when this is contrasted with the contribution that physicians have played in addressing the problem of child abuse and neglect and spousal abuse.[8] Physicians may have been judged harshly on the basis of only documenting their contribution as measured by the number of reported cases to APS. What is not known is how often physicians intervene without involving any outside agency despite mandatory reporting in most states. The authors suspect that physician intervention may prevent or halt the progression of abuse.

ROLE OF THE FAMILY PHYSICIAN

The family physician is ideally positioned to detect, intervene and monitor cases of abuse and neglect. The physician's position is unique for several reasons. Family physicians typically enjoy a long-term and trusting relationship with most of their older patients. Furthermore, they have the knowledge of the family whereby they may simultaneously be providing care to multiple generations within the same family. This is likely to provide insight about family dynamics, stresses, strains and the presence of alcoholism or drug abuse. Not all abuse is perpetrated by a malicious family member. There are many instances where a family member is overwhelmed, such as providing care to a demented parent. In this instance, what is needed is respite and help in the home that can be mobilized by the family physician. The family physician has the authority to question and to examine the possible victim and verify the presence or absence of suspected abuse. No other medical professional enjoys the same opportunity other than the emergency physician. It is likely in the future that the family physician will be relied on even more heavily to engage in addressing this problem because of the decline in the number of individuals now pursuing careers in general internal medicine.

BARRIERS TO DETECTION

Frequently the older adult may be unwilling to report a family member who is abusing them. They may have a fear of retribution and fear of the consequences should the abuse be verified, which might result in nursing home placement, an outcome the older adult does not desire. Another barrier is whether the victim is believable, particularly if there is some evidence of dementia or other cognitive impairments.

Barriers for the physician may result from unawareness or a lack of belief that abuse takes place in their community. The time allotted to office visits is so short that there may not be adequate time to engage in questions. The caregiver, who may also be the perpetrator, may interfere and dominate when accompanying the victim to the office visit. Other factors include the challenge of separating accidental injuries from injuries inflicted by a perpetrator.

Given that older adults fall more easily and more frequently and break and bruise more easily, the physician faces a diagnostic challenge in separating a deliberate injury from an accidental injury. There may also be an intimidation factor by the abuser or by the family. Other issues include unfamiliarity with Adult Protective Services and a fear that opening Pandora's Box with questioning may result in a huge commitment of time. Finally, a lack of reimbursement for extended visits is certainly a hindrance to detection.

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INTERVIEW

The physician should attempt to assure privacy and confidentiality. It is essential that the victim be separated from the caregiver during the interview and that adequate time is allowed for the victim to respond. Additional suggestions include not blaming the victim and not confronting the perpetrator. It is not the responsibility of the physician to either prove or disprove whether abuse exists. That is the responsibility of Adult Protective Services. Some measure of the victim's cognitive status is important in that demented older adults may frequently enter a paranoid stage, as a result of their memory loss, where they are convinced that either they are being poisoned or someone is stealing from them. One can progress from open-ended questions as suggested by Yaffe with his screening tool EASI [9] to more direct questions such as, "Is someone hurting you?", "Has somebody beaten you?", "Has somebody stolen from you?".

The physical examination in suspected cases should be comprehensive. Undressing the patient and checking areas that generally are concealed, such as the inner arms, an unusual site for injury, the perineum, and the feet. Shoes and hose can conceal a multitude of indicators of neglect or abuse.

If there is evidence of bruising, the location of the bruising should increase the suspicion, particularly in the areas previously described. If all of the bruising is attributed to one accident but the bruises show various stages of resolution, then one accident is highly unlikely. Answers about the circumstances of the injury and ultimately the mechanism of the injury and physical exam findings should all reconcile. Some adults may be victims of force feedings, as evidenced by contusions of the hard and soft palate. In addition, one may discover the presence of cigarette burns or bite marks that certainly suggest physical abuse. Injuries from a weapon such as a stick, rope, or extension cord result in characteristic outline. Similarly, bruising from being slapped will reveal a typical appearance.[10]

LONG TERM CARE

As many family physicians provide care to older adults in long-term care settings (who are the most vulnerable in our society) they are in a position to detect cases of institutional abuse. Abuse in institutional settings is most often perpetrated by staff, but occasionally there can be resident on resident abuse. In this situation, a report needs to be made to the State Ombudsman to conduct an investigation.

THE FUTURE

It is likely with the increase in the frail elderly population, with smaller families and fewer individuals to provide care, and with a reduction in social services, that elder abuse and neglect will increase. Family physicians will have a central role in the future as they reestablish as the dominant primary care specialists. With the advent of the patient centered medical home with a family physician in a leadership role, and with support from an interdisciplinary team, the potential to engage in prevention in high risk situations to detect, intervene, and provide ongoing care will become a reality. Societies are judged by how they take care of their most vulnerable, including the very young and the very old. Family practitioners can play a key role in improving the care of these vulnerable groups.

REPORTING

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MARSHALL E. PRUNTY, M.D.

Lamentations on MORALITY

Moral: 1.Of or concerned with the judgment of the goodness or badness of human action or character. 2. Teaching or exhibiting goodness or correctness of character or behavior. 3. Conforming to standards of what is right or just in behavior; virtuous.

While many arguments exist as to the cause, almost no one will argue with the observation that society has witnessed a significant moral decline over the past 50-60 years, and as a nation we suffer many ills because of it. We have become so jaded by the lack of mores that we accept the premise that teenagers are going to be sexually active and 13 year olds having babies is not a tragedy. One of the common tag lines used to defend all sorts of immoral behavior is, "We cannot legislate morality." This may be one of the more inane statements I have heard, as the very substance of a preponderance of our laws derives their legitimacy from some moral precept.

Part of the problem with the loss of morals is a lack of expectation. Today we expect teenagers to be sexually active, even excusing it as almost animalistic instinct with no cognitive content or control. But if this were true, why was there not a teenage baby boom in the era before contraceptive availability?

We don't expect and respect our youth enough to get behaviors that are beneficial to society. As an example, recently headlines were made when Brigham Young University dismissed a ballplayer for violating the school's honor code. The player's sin? – having sex with his girlfriend. While you may think I am contradicting what I just said, the point is that BYU has a moral expectation of their students and apparently the majority complies.

Another casualty of the loss of morals concerns heroes. These are individuals that society holds in high esteem as an example to be emulated. Today many of our so-called heroes are just as debased as much of the rest of society. We excuse their excesses as a legitimate consequence of their stature. In many instances we honor their ability while we look askance and grin over their dalliances.

One example of this was the year a quarterback was recognized as the NFL Player of the Year while he had a child with one model and had another one pregnant. I made the case to a friend that it is a shame that we hold up a player like that in front of our kids. He replied that it was a football award and not a moral award. My rebuttal was to question if the NFL would have honored another quarterback if he had the same statistics while also being involved with dog- fighting. I don't think they would.

Ultimately virtue arises from moral principles and we as a society have increasingly discarded our principles as antiquated, obsolete or just too costly. Yes, principles do have consequences and frequently those consequences involve some cost. Going back to the BYU example, kicking their starting center off the team will cost them a high seed in the NCAA basketball tournament and likely result in a much earlier exit. That alone will be a loss of several million dollars. Couple that with the decrease in donations expected from a title run and you can see that what was lost will be much more than a few games. I applaud BYU for sticking to their principles, though, because the question no one seems to ask is, "What does compromising our principles cost?"

Whether we like it or not, the moral fabric of a society depends upon a political structure rooted in moral principles. Discarding or ignoring those principles has cost us dearly as a society. With the relaxation of sexual mores have come STDs, abortion and teenage pregnancy. No- fault divorce brought us high divorce rates, and single parent and fatherless families. As we've courted gambling we see bankruptcies, more broken homes, increased poverty, and violent crime. And as we've ignored our opportunities to cut into the drug trade, we've abandoned our kids to a life of hell.

One such opportunity occurred during this last session of the Kentucky General Assembly. Senate bill 45 concerned making pseudoephedrine (PSE) a scheduled drug, thus requiring a prescription in order to obtain it. Since we are talking about a drug necessary to make methamphetamine, and considering all of the damage meth does to our society, families and individuals who become addicted, actually removing PSE from the market would be reasonable. Many drugs have been removed from the market which caused a lot less injury and damage. Therefore, making PSE a scheduled drug is a reasonable measure that received the support of the Kentucky Academy of Family Physicians, Kentucky Medical Association, Kentucky State Police and Kentucky Board of Pharmacy. In Oregon and Mississippi, two states where making PSE a scheduled drug has been done, there has been a huge reduction in the number of meth labs.

At the time of this writing, the bill has not come to the Senate floor for a vote. One can hope that our legislators will defer to the expertise of those with the experience and knowledge of the medication and the illegal drug. In the final analysis, this is an opportunity to make the moral choice.

America has been likened to a shining city on a hill. While the last several years have seen her light dimmed, America remains a beacon for the rest of the world. Senate Bill 45 gives Kentucky the chance to be the light for that beacon. One can always hope our legislators will flip that switch.

CALL FOR RESOLUTIONS
for 2011 KAFP Congress of Delegates

Please note the following deadlines for submission of Resolutions to be presented to the 2011 KAFP Congress of Delegates:

Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' handbook is May 1, 2011. If a Resolution is not received by the KAFP office prior to May 1, 2011, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on June 23, 2011, 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.

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.

OFFICIAL CALL FOR THE
2011 KAFP Congress of Delegates

Notice is hereby given of the 60th Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held at French Lick Resort, IN, June 22-25, 2011.

Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 51st Annual Meeting of the Congress of Delegates will be held Thursday, June 23, 2011 at 8:00am-11:00am 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 April 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.*

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