KAFP JOURNAL

SPRING 2012
VOLUME 75

The Official Publication of the Kentucky Academy of Family Physicans

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CREATED BY:
Publishing Concepts, Inc.
Virginia Robertson, Publisher
vrobertson@pcipublishing.com
14109 Taylor Loop Road
Little Rock, AR 72223

EDITION 14

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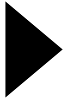

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message from the PRESIDENT

A good story

"I LOOK FORWARD TO SEEING THE WAYS WE MEASURE THE SUCCESS OF OUR NEW STRATEGIC PLAN; HOW SUCCESSFUL WE ARE IN DEVELOPING A "COMMUNITY OF PHYSICIANS" WITH HELP FROM SOCIAL MEDIA AND HOW WELL WE WORK WITH LIKE-MINDED ORGANIZATIONS TO DEVELOP A RURAL PHYSICIAN'S SCHOLARSHIP PROGRAM HERE IN THE COMMONWEALTH."

I am a prolific reader. I love good stories. This past year, serving as your president, I have had the opportunity to visit six states and numerous cities here in the Commonwealth on your behalf. I will have met with every family medicine residency program in Kentucky and delivered my optimistic talk "It's a great time to be a family physician." In my travels, I have heard some great stories: stories of the triumphs and tribulations of family physicians. I visited offices struggling with the thought of implementing electronic medical records. I visited Kentucky's first level 3 Patient Centered Medical Home in Williamstown. I heard from practices making more money this year due to the PPACA, and practices fearful of losing PMPM payments from Kentucky's Medicaid MCOs. The stories I have heard are of courage and resolve in the face of change. They reinforce my belief that family physicians are cut from strong, resilient cloth.

At the AAFP Scientific Convention this past September I had the chance to hear the British inspirational speaker Tynan Ronan, athlete, physician, renowned opera star, and double amputee tell his story. Born into a humble Irish home and born with shortened lower limbs that threatened to sideline him throughout his childhood, Ronan was still "as wild as a March hare" when he was a growing boy, riding horses and racing motorcycles.[1] At twenty, his legs had to be amputated below the knee after an auto accident caused serious complications. Just weeks after the operation, he was climbing the steps of his college dorm. Within a year, he was winning gold medals in the Paralympics as a multitalented athlete. Between 1981 and 1984, Ronan amassed eighteen gold medals and fourteen world records of which he still holds nine. He became the first disabled person ever admitted to the National College of Physical Education. Ronan later became a family physician who specializes in sports medicine.

Though Ronan enjoyed singing as a boy, he did not seriously consider formal voice study until he was 33, when he was well into his residency. His quick success is typical in a life of extraordinary achievement. Ronan won both the John McCormack Cup for Tenor Voice and the BBC talent show "Go For It" less than one year after beginning the study of voice. In 1998, Ronan joined Anthony Kearns and John McDermott as The Irish Tenors, an instant worldwide sensation. Ronan's moving rendition of the anthem "I Don Quixote" from "*Man of La Mancha*" can be seen and heard at the AAFP website.[2]

Ronan credits his parents as well as supportive mentors and teachers for instilling in him the determination necessary for his successes. It was their belief in him and their continued positive encouragement that made him believe that he would succeed irrespective of the challenges in his life. As a parent and teacher, I find Ronan's story inspirational; not only because of Ronan's successes, but from the perspective of Ronan's mentors. Can you imagine all the positive reinforcement it took to make a handicapped Irish boy realize he could ride horses, race motorcycles, become a physician, Olympian and Opera star? I am certainly thankful for all the mentors in my life, especially those who taught me to use praise. It is always gratifying watching a medical student or resident physician not only understand what I am doing or saying, but internalize it, and make it their own. It is even better when I see one develop the confidence and competence to think they can accomplish anything! I hope each of you has had similar experiences, and recognize the need to develop our future workforce. Just as important is how mentoring can change you. To quote Ronan, "It is the helping hand; it shapes and influences our lives."

I want to take this opportunity to thank you all for allowing me to serve as your president. It has been a growth year for me as well as the Academy. The story of the KAFP continues. Going forward, we need to be ever mindful of ways in which our Academy can increase the value of membership for family physicians. I look forward to seeing the ways we measure the success of our new strategic plan; how successful we are in developing a "community of physicians" with help from social media and how well we work with like-minded organizations to develop a rural physician's scholarship program here in the Commonwealth. I look forward to the day that our new vision is realized: "**Family physicians for all Kentuckians**." If you have any ideas or wish to become more involved, please give me a call, send me a text, or post on the KAFP President's blog. I hope to see you all at the Kentucky Academy of Family Physicians 61st Annual Scientific Assembly in Lexington, April 27 -28.

[1] www.ronantynan.net/ronan.aspx, accessed 3/1/2012

[2] www.aafp.org/online/en/home/cme/aafpcourses/conferences/assembly/events/videos/tynan.html, accessed 3/1/2012

Creating an open professional community

If you have not been to our website lately, please check out our new look. Our web address is http://www.kafp.org. On the front page under the 'About' tab is a drop down menu with several choices: select the one labeled 'Strategic Plan.' The taskforce that worked on our new strategic plan began with the goal of developing programs and services that provide 'value to your membership.' I hope you will take some time to review our plan and give me your feedback on my President's blog.

In order to make you aware of these new programs and services, it is important that we be 'connected' to you. One of the goals of our strategic plan is to "create an open, professional 'community' for sharing practical and clinical knowledge." You will find on the bottom of the home page of our website three ways that you can do this: you may elect to be a part of our Facebook community, our Twitter community, or you may want to get RSS Feed updates. I will briefly explain each of these social media formats and what you can expect from them.

Facebook defines itself as "a social utility that connects people with friends and others who work, study and live around them."[1] Users must register before using the site, after which they may create a personal profile, add other users as friends, and exchange messages. This includes automatic notifications when users update their profile. Facebook users may join common-interest user groups. We have set up a Facebook page (user group) that is tied into our web page updates. If you have a Facebook account or are just starting one, please select **Like** 'Kentucky Academy of Family Physicians.' This will ensure you get any updates we have made to our blogs and web page. It will, hopefully, provide for more social interaction with your family physician colleagues on issues and keep you updated to KAFP events.

Twitter is a social networking and micro-blogging service that allows you to send short text messages of 140 characters in length, called "tweets," to friends or "followers." If you have a Twitter account, you can follow KAFP activity by following 'KAFPNow.'

RSS Feed sends alert messages to your RSS (Rich Site Summary) Reader when there is an update to our web page and blogs. RSS is a format for delivering regularly changing web content. Many news-related sites, weblogs and other online publishers syndicate their content as an RSS Feed to whoever wants it.[2] It does not provide the message format to allow you to interact with others. If you are not familiar with working with RSS Feed, it is a little more complicated and requires some work to get set up. The Navy has a good website that takes you step by step through the process.[3]

You do not need to be signed up for all three of our social networking services, but I hope you will elect to join one of them. At our upcoming annual meeting at the Campbell House on April 27th and 28th, Gerry Stover, KAFP Executive Vice President, and I will be giving a presentation on the new KAFP strategic plan and social media options. For those of you that are not yet comfortable with social media, it will be our goal and pleasure to provide you with assistance.

I look forward to reading your posts.

1. www.facebook.com, accessed 3/3/2012

2. www.whatisrss.com, accessed 3/3/2012

3. http://www.nps.edu/library/Help/Research%20Tools/Guides/RSSFeeds/SettingUpRSS.html, accessed 3/3/2012

message from the ASSOCIATE EDITOR

I had thought that I would write about our clinic's journey toward a "patient-centered medical home" after the Fall edition of the KAFP journal. Then I received Dr. Thompson's moving and informative piece about refugee health in Kentucky. At my clinic, we have worked with newcomers to the US for years, mostly migrant farm workers. But we, too, have recently begun performing refugee health screenings (RHS) and have welcomed individuals and families from Nepal, Uganda, Congo, Iraq, Iran, and Cuba, to name a few. Let me tell you a bit about how we approached these new communities and individuals.

"WE HAVE CONNECTED WITH THESE PATIENTS BY CAREFUL ATTENTION TO PREPARATION, DELINEATION OF ROLES, TEAM WORK, AND WILLINGNESS TO LISTEN AND WORK WITH PATIENTS BOTH IN AND OUT OF THE CLINIC SETTING."

We met with Luta Garbat-Welch, whom you will come to recognize as the State Refugee Health Coordinator in Kentucky. We were given protocols for screening for various health issues and diseases, and we developed our own system for meeting our patients' needs on the days they would be screened. We prepared our clerical staff for the registration snafus, though not very well, we soon realized. Our clinical assistants proved invaluable in documenting history, vitals, dental screenings, and required and optional laboratory tests. Our nurses kept track of needed immunizations as well as test results and paperwork for the Kentucky Office for Refugees (KOR). The Licensed Clinical Social Workers, who see our behavioral health patients, did a huge part of the social and behavioral health screening of these patients. Finally, the providers addressed medical issues, those known from pre-departure paperwork, and those discovered through history, physical examination and testing performed in our clinic. Given that the 2 or 3 hours

continued on page 10 >>

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the patients spend in our clinic is really not enough time to uncover and address all of their needs, you can imagine what it is like to sit at our nurses station and hear the calls to patients through an interpretation service, such as giving results, confirming follow up appointments, scheduling referrals or additional tests, or explaining medication use and pharmacy services. “What language do you need,” the interpreter service will ask, and our Nurse will cheerfully say, “Nepali,” or “Swahili,” or “Arabic” without blinking an eye.

What have we learned from these experiences? Well, in some cases we learned that we all, no matter where we are from, have many of the same problems. One of our LCSWs described a discussion she had with a colleague who cared for refugees in another clinic. She developed a women’s group to promote discussion and support for common concerns. She was struck by the direction of many of the discussions. “My husband won’t stay home at night,” or, “My husband drinks too much.” It seems like women from Nepal or Africa or the Middle East also need to complain about their husbands. On the serious side, we have seen patients with diabetes, hypertension and depression. We have kids preparing for school and have had one birth since the start of our program. We have learned, or perhaps re-learned about a few parasites and hepatitis B serologies. And we have made a couple of domestic violence reports and referred patients for disability evaluations who could not possibly work.

I think we also have learned much about approaching these communities. We have connected with these patients by careful attention to preparation, delineation of roles, team work, and willingness to listen and work with patients both in and out of the clinic setting. These experiences have moved us well along that patient-centered path. I know the team that works with me gets great satisfaction from the part they play in a patient’s care. It is quite infectious. Every time we see these patients we learn something new about how they have adapted, what they think about their health, and what their explanation of illness is. And of course, in some instances we have had to file away our biomedical explanation of disease and wellness and open our minds to the cultural, spiritual beliefs our new patients have carried with them for scores of years and thousands of miles.

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EVIDENCE-BASED MEDICINE

Managing Chronic Pain in Family Medicine: When "Red Flags" Become Brick Walls

Consider the following patient: A 47 year old man is in otherwise good health, but has chronic and severe neck and upper back pain following cervical spine discectomy 3 years ago. He has no neurologic impairment or radiculopathic symptoms, and his physical examination is unrevealing other than moderate diffuse tenderness over the upper back. He presents as a new patient to your practice, and your best available prior medical records document that he was prescribed oxycodone-acetaminophen (Percocet) by his prior physician, until his insurance changed and he had to change to a new practice. The content of the previous physician notes is sparse and there is not much documentation of a specific treatment plan or goals. It is noteworthy that Percocet was indeed prescribed and there was no specific mention of medication misuse or of the patient being "fired."

He has also been prescribed gabapentin (Neurontin), meloxicam (Mobic), and methocarbamol (Robaxin), all of which provide mild but inadequate pain relief. He has had refills on these medications, but ran out of Percocet about 3 months ago. He describes his pain as "much worse" during these past few months. A KASPER report shows no opioid prescriptions other than the Percocet which he mentions, as well as two ER visits where he was given short-term (3-5 days) prescriptions for hydrocodone-acetaminophen (Lortab). You obtain additional ER records which show a positive urine drug screen for marijuana on one occasion 6 months ago.

The patient has been to the office twice now as you gather additional information and continue his non-narcotic medications. Two additional urine drug screens are negative and the patient indicates he has stopped using marijuana, since he understands that such use would preclude him getting opioids which he truly feels are necessary. An updated cervical spine MRI confirms his post-operative changes and moderately severe multi-level disc disease without spinal or foraminal stenosis.

Previous records also indicate that he has seen pain management specialists and received spinal injections as recently as 2 years ago, but you do not yet have records from the specialist practice; the patient confirms that he had injections, but claims they did not help, and he does not wish to repeat injections. He also has no interest at all in further surgery. He has likewise been through a course of physical therapy two years ago after surgery, but found that it did not relieve his pain either.

Finally, the patient gives you additional information that he has briefly tried other opioids, such as morphine and hydrocodone, and he feels that the Percocet really provided superior pain relief while the other two medications caused intolerable drowsiness and did not provide any pain relief.

***

What is the right thing to do with such a patient? He has what would seem to be a "legitimate" painful condition, with confirmation on a recent MRI. He has obvious concerning features or "red

continued on page 12 >>

flags" for possible medication misuse, including a history of substance abuse, and a claim that "only one drug works." He also has prescriptions from other providers, namely the ER physicians, but no other evidence of "doctor-shopping" on his KASPER. But according to our best available recommendations these are considered "weak" red flags. Noting that concerning factors or behaviors should not be ignored, but also "should not necessarily result in discontinuation of treatment," one review describes various factors as "more predictive" or "less predictive" of substance abuse or addiction, as in Table 1.[1]

Perhaps understandably, primary care physicians will be very reluctant to manage such patients on their own. They can consume time and resources, are not likely to improve, carry an unavoidable risk of medication misuse, may attract other "chronic pain patients" to the practice, and in general are challenging to manage. It is tempting to refer such patients for chronic pain management specialist care, but increasingly such specialists are focusing on interventional care, and are not willing to be the primary source of care for solely medication management.

Current KBML guidelines[2] emphasize that physicians should "view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic." Appropriate management emphasizes clear documentation, record-keeping, and treatment goals, and requires, in brief, the following:

- that patients are medically evaluated, with documentation of appropriate history and physical examination, diagnostic studies, treatments used, risk factors for substance or medication abuse, and other factors
- that patients have a clear diagnosis that supports the use of opioids, and have failed other treatments after a suitable course of therapy
- that there is clear documentation of a treatment plan and goals of therapy, including pharmacologic and non-pharmacologic treatments
- informed consent and agreement between physician and patient, after discussion of the risks and benefits of treatment
- optionally, a written agreement outlining these goals as well as the responsibilities of physician and patient
- that there is periodic review of therapy, with documented evidence of benefit from controlled medications, e.g. suitable pain relief and have suitable documentation of their care and progress over time
- that there is appropriate monitoring for medication use and possible signs of misuse
- that consultation is used appropriately

But even with such factors in place, primary care physicians may be reluctant to take on management of these patients.

Patients with obvious diagnoses—severe knee arthritis, neuropathic pain that has failed anti-epileptic treatments, etc.—and who take opioids with good pain relief and no concerning features at all, are easy to manage. Patients who are more obvious "drug seekers," who have only vague or nonanatomic pain symptoms, or who have serious concerns such as active substance abuse, etc. are likewise easy to identify and appropriately deny prescriptions for opioid medications.

But what about patients who have a legitimate painful diagnosis, but also have some "red flags" for medication misuse, though no actual evidence of such misuse? There may yet be a strong temptation for primary care physicians to avoid managing such patients on their own.

We should ask, though, whether this is the "right" thing to do. What is the primary care physician's responsibility to their patients? What is the role for further education about

Table 1: Aberrant drug-taking behaviors predictive of addiction-related outcomes[1]

Probably more predictive	Probably less predictive
Selling prescription drugs	Aggressive complaining about need for higher doses
Prescription forgery	Drug hoarding during periods of reduced symptoms
Stealing or borrowing another patient's drugs	Requesting specific drugs
Injecting oral formulation	Unapproved use of drug to treat another symptom
Obtaining prescription drugs from nonmedical sources	Obtaining similar drugs from other medical sources
Concurrent abuse of related illicit drugs	Reporting psychic effects not intended by the clinician
Unsanctioned dose escalations (multiple times)	Unsanctioned dose escalations(1 to 2 times)
Recurrent prescription losses	

chronic pain management in the primary care setting? The proven benefit for opioids in osteoarthritis and other conditions is poor overall, but the evidence for NSAIDs and other regimens is also poor. We need to carefully select which treatments we use in particular patients. Some will do well with opioids, some will not. Clearly careful documentation and monitoring is necessary, but these both take time that is often scarce in the first place.

Chronic non-cancer pain management is probably one of the most challenging issues for modern primary care medicine. However there also seems to be a tendency to let "red flags" become "brick walls" that prevent many patients from getting appropriate pain relief or treatment in the absence of data that supports this decision. Red flags are clearly concerning, but in some of these patients, a more healthy approach might be to provide effective and appropriate pain relief, with suitable monitoring, rather than to hope they can find suitable care somewhere else. Prescribing "with caution" in such cases, should not mean "don't prescribe at all."

As our discussions of this complex subject proceeds, we should be cautious that the many "red flags" patients have for medication misuse are not ignored, but also do not stand in the way of appropriate care.

1. Nicholson B. Management of Chronic Noncancer Pain in the Primary Care Setting. Southern Med J 2007; 100(10): 1028-36.
2. Kentucky Board of Medical Licensure, Opinion Regarding the Use of Controlled Substances in Pain Treatment. Accessed via http://kbml.ky.gov/NR/rdonlyres/B0538843-6E6D-48B2-B67B-A5D0E6C37C77/0/BoardOpinionUseofControlledSubstances.pdf on January 19, 2012.

CHARLES KODNER, M.D.

Dr. Kodner is Associate Professor in the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine where he has been on faculty since 1997. He is involved with medical education at all levels and directs the Introduction to Clinical Medicine course for first and second year medical students, which emphasizes clinical exam skills, ethics, communication skills, evidence-based medicine, and many other topics.

Dr. Kodner completed residency training at St. John's Mercy Medical Center in St. Louis, Missouri, before moving to Kentucky.

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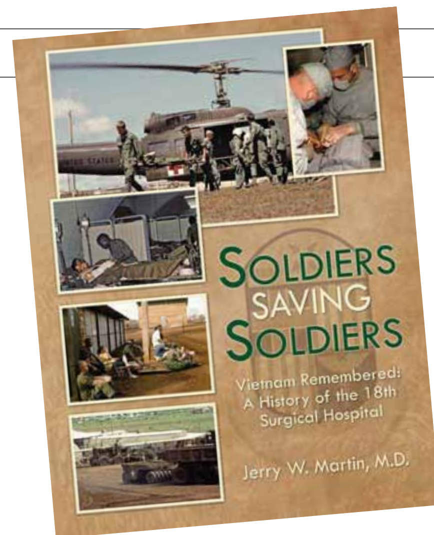

"Soldiers Saving Soldiers" by Jerry Martin, MD of Bowling Green, Kentucky, is the story of the 18th Surgical Hospital and the doctors, nurses, medics and support personnel who were stationed at Pleiku, South Vietnam during the Vietnam War. In particular, it centers on the experiences of Dr. Jerry Martin, who was stationed there from June 1966 until June 1967.

About the Author:

Jerry W. Martin, M.D., was born in Providence (Webster County), Kentucky, on November 28, 1935, to Charles R. Martin, Jr. and Rosena Playl Martin.

He graduated from Providence High School in 1954 and continued his education, first at Vanderbilt University from 1954-55, and then at Western Kentucky State College where he earned his Bachelor of Science degree in 1958. He attended medical school at the University of Louisville School of Medicine, earning his M.D. in 1963.

He married Jimmie D. Hobgood December 18, 1955. They have two daughters, Melissa Martin Johnson, R.N., and Mary Elizabeth Martin, B.S., D.V.M. and one son, Charles Stanley Martin, B.S., B.A., M.A., J.D. They also have one grandchild, Elizabeth Johnson Hathaway, B.A., and one great grandchild, Sarah Elizabeth Hathaway. After engaging in the private practice of Medicine, Surgery, and Obstetrics in Bowling Green for one and one-half years, Dr. Martin was drafted into the United States Army, receiving the Reserve Commission of Captain in the Medical Corps on January 15, 1966.

Following graduation from the Army Medical Services Officers Basic Course at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, San Antonio, Texas, he was assigned to the 18th Surgical Hospital located at Ft. Gordon, Georgia.

He and nine other physicians originally assigned to the 18th Mobile Army Surgical Hospital (MASH) accompanied the unit to the Central Highlands in Pleiku Province, Republic of Vietnam in 1966. It is during this period and upon these experiences that his book, "Soldiers Saving Soldiers," is based.

Upon his return to America from Vietnam, he served as Director of the Outpatient Clinic at Ft. Campbell, Kentucky until his Honorable Discharge from the U.S. Army December 11, 1967.

He served as Associate Professor at the University of Louisville Department of Family Medicine, and as Western Kentucky University Team Physician from 1968-2002.

He is a Founding Fellow of the American Academy of Family Physicians (AAFP) and a Charter Diplomate of the American Board of Family Medicine. He served as President of the Kentucky Academy of Family Physicians (KAFP) from 1985-86, and was named KAFP Doctor of the Year in 1990.

Dr. Martin served as a Member of the Kentucky Medical Association (KMA) Board of Trustees 1987-93. He has been a member of the Royal Society of Medicine since 1992.

He served as KAFP's Delegate to the AAFP for six years, from 1992-98, and as a member of its Bylaws Committee from 1993-1996. He was Chairman of the Bylaws Committee in 1996.He then served as an AAFP Delegate to the American Medical Association (AMA) 1996-2008.

He is a lifetime member of KMA, the AMA, the KAFP and the AAFP. After 38 years of private practice, he retired in January 2002. He and his wife live in Bowling Green, where he continues to be active with writing, reading and photography.

For information on how to get a copy of Dr. Martin's book, "Soldiers Saving Soldiers," visit http://acclaimpress.com/store.aspx?panel=3&productid=131&categoryid=1

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letter to KAFP

Dear Dr. Crump:

I am writing to respond to an article in the recent KAFP Journal. Let me say first that I have been a member of the KAFP since its beginning. I was a charter member, and did solo Family Practice for 40 years before retiring. I recently began doing home call service for needy disabled and immobile patients. I am a young 77, still very active in Geriatric medicine and do my best to stay current and informed.

I am writing in response to the article by Dr. John Patterson titled "Coal's Impact on the Health of Kentuckians & their Environment." Although I am in favor of "clean the air" as much as anybody, and I share some of Dr. Patterson's concerns that he expressed, I remain a bit frustrated. His recommendations and those of the A.M.A. seem to totally ignore some very basic facts and understanding of what will happen to Kentucky, and this entire country, if coal-fired power plants are rapidly condemned by people reading his column or listening to the well-financed environmental groups.

I can speak about this because for over 20 years I have been a director of an Electric Generating CO-OP while practicing medicine. Ninety seven percent of all electricity produced in Kentucky comes from coal-fired power plants. This same type of plant produces the majority of electricity in this entire country. I and our board of directors have worked very hard to see that our plants have devices that markedly reduce air pollutants. Despite the fact that we can remove 93% of most of the harmful gases, we are now being told by a federal agency (not by elected officials) that we must add additional equipment to increase this to 97%. Doing this will cost several million dollars per unit in some cases.

Obviously, the electric bills of our consumers will escalate. Several large commercial industries that rely on low-cost electricity will leave Kentucky when this happens. They have already said as much. At present time Kentucky has among the lowest electric rates in this entire country. And my co-op has among the lowest rates in Kentucky.

I am irritated when I read comments similar to a few of those made by Dr Patterson that tend to incite thoughtless "knee jerk" reactions, like suggesting we simply do away with coal as a source of fuel. My co-op has signed an agreement with a company that is researching an innovative way of burning coal with pure oxygen. The end result of this, if it works, will be a removal of most of the harmful contaminants including nitrous oxide. We are to be a test site for the entire country doing this. It is innovations and research like this that we need to be asking of our elected officials. That is the correct advocacy call. I want to "advocate for Kentucky people" too, but not by rushing into a decision that could triple the average electric bill.

Yes, I'm appalled by mountain top removal coal mining. I'm also frustrated that many KY coal mines are now successfully concentrating their efforts on sending coal to China – which incidentally opened one new coal-fired electric generating plant every week last year. I guess we need to triple our electric rates by abandoning coal to prevent global warming? But that's a different topic.

Electric coal-fired plants all need to clean up their act. I realize there are several coal-fired offenders, and this has to be corrected. They have to install scrubbers and devices, but most need financial help to do it unless consumers pay the big price. We need an all-out effort in federally funded research to come up with a solution on how to clean up our most abundant source of fuel. We don't need to throw the baby out with the bath water, and that's what many will agree to when they read articles like this or listen to the wealthiest of all lobbyist groups in congress, the environmental organizations. And I don't need to name them. Just look at who is making the most noise

James G. Sills, M.D., F.A.A.F.P.

Dr. James G. Sills graduated from the University of Louisville School of Medicine in 1959. After completing his internship at Springfield City Hospital in Springfield, Ohio, he practiced in Hardinsburg, Ky. from 1960 until his "retirement" in 2000. He remains active in patient care, performing home visits for elderly and disabled individuals. He is currently Board Chairman of Big Rivers Electric Corporation which generates and supplies electricity to over 111,000 homes, farms and businesses in 22 counties in western Kentucky.

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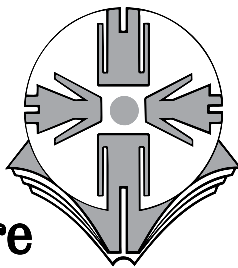

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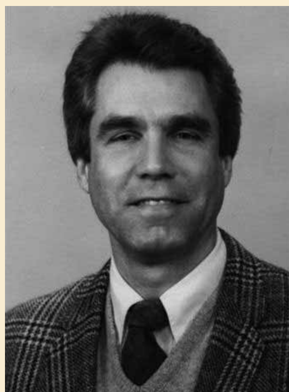


Dr. Patterson's reply to Dr. Sills

I want to thank James E. Sills MD, FAAFP for taking the time to thoughtfully respond to my KAFP Journal editorial Coal's Impact on the Health of Kentuckians and their Environment- A Call for Medical and Public Health Advocacy.

Let me begin by honoring Dr Sills' longstanding commitment to family practice and KAFP and his service to the people of Kentucky. We both gave substantial portions of our lives to solo family practice (though his 40 years well surpasses my 30 years in that role). We also share a commitment to serving the underserved, reflected by his return to a home care practice for the disabled and immobile and by my supervision of UK medical students at the Student-Run Salvation Army Clinic in Lexington. Having worked in the trenches as long as we both have, I suspect Dr. Sills and I agree on most things having to do with medicine and public health.

In fact, I suspect we even agree on most things about coal fired power plants. Dr Sills states at one point "electric coal-fired power plants all need to clean up their act," something we clearly agree on. As a board member of a rural electric cooperative, he describes a pilot research effort to study innovations that may substantially reduce pollution from these plants. I consider this very good news. I hope it works.

Subsequent to writing this KAFP coal editorial, I submitted a very similar document as a resolution which passed the House of Delegates at the KMA annual meeting this past September. The KAFP editorial and the KMA resolution were both an effort to clearly cite scientific research documenting the medical and public health harm done by an energy strategy dependent on coal. The resolution was entitled 'Coal's Impact on the Health of Kentuckians and their Environment.' Co-sponsors of the resolution included Rice Leach MD, MPH (former Kentucky State Commissioner of Health and current Commissioner of the Lexington-Fayette County Health Department), Barbara Phillips MD, MSPH (UK pulmonologist) and Kathryn E. White MD (anesthesiologist and recent past president of the Lexington Medical Society). Speaking forcefully in support of this resolution was KAFP's own Baretta Casey MD (family physician, coal miner's daughter and director of the UK Center for Excellence in Rural Health in Pikeville).

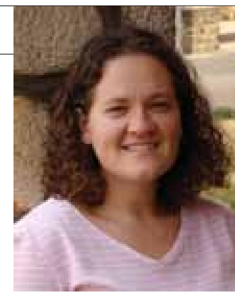
The following Resolved sections of the resolution will now give direction to the KMA Board. Those sections are: 'Resolved, that KMA use CME course material created by credible physician organizations, including the AMA, to inform member physicians of the patient care and practice-related issues related to the health effects of the extraction, transportation, processing and combustion of coal, and be it further Resolved, that KMA explore ways to educate the public and make publicly visible its support for national and state laws, rules and regulations that protect individual health and public health from the health effects of the extraction, transportation, processing and combustion of coal.'

I am not well-informed enough to respond to Dr. Sills' comments regarding the economic impact of regulations aimed at reducing medical and environmental harm done by coal. Dr Sills' emphasis on this economic issue makes sense given his position as a rural electric cooperative board member. However, he doesn't address at all the literature references citing the impact of coal on heart disease, stroke, cancer, chronic respiratory disease, birth defects, mental retardation, neurologic and developmental disabilities. I know he has seen this harm to human health during his long career in medicine. It's just that this connection is hidden from view, not easily seen until public health/epidemiologic studies link the dots.

Now that the dots have been connected and we know the many harmful effects of coal, we must all ask ourselves what price we are willing to pay for coal based energy. And whether we as a profession will speak up to protect the innocent victims (our patients, our neighbors and our families) of coal based electricity.

I am pleased that the physician members of the KMA House of Delegates have chosen to educate our colleagues and the public so we can all make better-informed decisions about this important medical and public health issue.

KARA BETH THOMPSON, MD, FAAFP
Family Health Centers- Americana,
Louisville KY



FROM ALL OVER THE WORLD...

Refugee Health in Kentucky

Dawit arrived in Louisville with his wife and three children, hoping for innumerable opportunities: medical, educational, financial. Hope has sustained this family for many years, through war and famine and separation and complicated medical diagnoses. Dawit was born in Ethiopia to parents of Eritrean origin. When war broke out between Ethiopia and Eritrea in 1998, Dawit was deported from Ethiopia and conscripted into the Eritrean army. He left his wife and young son behind in Ethiopia.

Years later, the family was reunited in a refugee camp for Eritreans located in Ethiopia. Their first daughter was born shortly thereafter and diagnosed with Trisomy 21. Trying to get advanced medical care for their daughter's heart condition, hypothyroidism, and breathing issues was frustrating in a developing country. While moving through the refugee process to be relocated to another country, the family's third child was born, and he was diagnosed with ambiguous genitalia. The family hoped for resettlement in the United States.

In August 2011, Dawit's family left Ethiopia. During the layover in Miami, Florida, Dawit went to the emergency room at Jackson Memorial Hospital for his daughter with Down syndrome to be evaluated for shortness of breath. Fortunately, she was diagnosed with only a viral upper respiratory infection and allowed to continue on the plane to her next stop. The family has resettled in Louisville, Kentucky, and they have had a "crash course" in the American healthcare system: numerous appointments with primary care providers and specialists, admissions to the hospital, and surgeries.

This story is not uncommon. Since 1994, over 20,000 refugees and other populations* have resettled in Kentucky. They come from all over the world [table 1] and settle in Louisville, Lexington, Bowling Green, and Owensboro. A refugee is "any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."[1] Refugees are **legal** immigrants, and they are entitled to assistance provided by local resettlement agencies after their arrival to the United States.

Table 1: Countries of origin for Kentucky refugees

Bhutan	Democratic Republic of Congo	Viet Nam	Togo
Myanmar/ Burma	Sudan	Korea	Sierra Leone
Cuba	Uzbekistan	Afghanistan	Palestinian Territory, Occupied
Somalia	Ethiopia	Bosnia	Ukraine
Burundi	Eritrea	Russian Federation	Rwanda
Iraq	Liberia	Albania	Haiti
		Iran	

Internationally, the Office of the United Nations High Commissioner for Refugees (UNHCR) is the organization that determines international refugee status. The United States President, with the cooperation of federal agencies, identifies and prioritizes the nationalities for refugee resettlement for each upcoming year, as well as determines the total number of refugees who may enter the U.S. from each nation. Each state has a designated point of contact, the State Refugee Coordinator, who is responsible for the statewide administration of each refugee resettlement program which falls under the jurisdiction of the national Office of Refugee Resettlement, and distributes federal funding. The Kentucky Office for Refugees (KOR) functions as the State Refugee Coordinator's office in Kentucky and "provides leadership, policy guidance and advocacy on issues affecting refugee resettlement; plans and develops programs; assists in coordination of services and makes rules and regulations pertaining to refugee resettlement programs in Kentucky."[2] Locally, resettlement agencies [table 2] provide immediate support for up to 90 days, and ongoing care for up to five years from the date

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Table 2: Local Resettlement Agencies

Kentucky Refugee Ministries *(Louisville, Lexington)* • Migration and Refugee Services, Catholic Charities *(Louisville)*
International Center *(Bowling Green, Owensboro)*

of U.S. arrival. These agencies assist in accessing community services, housing, education, English as a Second Language classes, insurance, public services, job training, employment and US citizenship. Cash and medical assistance, provided to those who are ineligible for Medicaid/TANF (Temporary Assistance for Needy Families) services, are limited to eight months. The goal is to have individuals employed within 120-180 days, although in today's economy this often takes much longer.

Another important component of the resettlement process is the Refugee Health Screening (RHS). Prior to overseas departure, each refugee undergoes an Overseas Medical Exam, in which diseases that could be a contraindication to their entrance into the U.S. (Class A) [table 3] or those that require immediate evaluation after arrival in the U.S. (Class B) are identified. The purpose of the domestic RHS is to 1) provide follow-up (evaluation, treatment and/or referral) of Class A and B conditions identified during overseas medical exam, 2) identify communicable diseases of potential public health importance, 3) diagnose health conditions that adversely impact effective resettlement, and 4) introduce and integrate the client into the U.S. healthcare system.[3] The State Health Coordinator for KOR, Luta Garbat-Welch, MPH, works with physicians and nurse practitioners as they provide standardized care at the RHS. She states,

> "The Kentucky Refugee Health Screening Program insures that refugees receive a comprehensive medical exam in accordance with guidelines provided by the CDC-Division of Global Migration and Quarantine. These guidelines take into account the healthcare needs of refugees, many of whom may not have previously had access to healthcare services. Local Refugee Health Screenings providers ensure that RHS are provided in response to the cultural and linguistic needs of newly arriving refugees. This holistic provision of a comprehensive medical exam provides a foundation for refugees' integration into their new home."

The RHS is a comprehensive medical exam, which includes a social, ethnographic, religious, and educational history, as well as past medical and family histories. Mental health is also addressed through a limited screening. The physical exam includes a vision screen and a gross dental examination in addition to the more typical features. Laboratory evaluation includes a complete blood count; screening for tuberculosis, Hepatitis B, and HIV; and depending on age, a lead level, urinalysis, total cholesterol, HDL, and RPR. Patients, who did not receive presumptive treatment for intestinal parasites prior to overseas departure, perform stool exams for ova and parasites. Vaccines are either administered at the RHS or referrals are made to local health departments.

Another integral component of the RHS is a further introduction into the American medical system. Physicians and nurses explain using the pharmacy, obtaining refills, and making appointments. Discussing hygiene, over-the-counter medication use, diet and nutrition, and preventive health are additional educational elements.

Patients are often referred to physicians and practices in the community for specialty or continuing care. Providing language access to these patients is paramount to appropriate communication, and it is also a requirement by Title VI of the Civil Rights Act of 1964. This law ensures, "no person in the U.S., on the ground of race, color or national origin, be excluded from participation from, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal Financial Assistance." For physicians, this means that any agency or clinic receiving Medicare or Medicaid reimbursement is obligated to provide written and oral language assistance with no cost to the patient who has limited English proficiency, regardless of their insurance coverage. In Louisville, Catholic Charities has a language interpretation program which allows physicians to have live in-person interpretation. Phone services are another common means to provide meaningful language access.

Cross cultural medicine is not without challenges. Understanding a patient's religious and cultural beliefs, literacy levels, and impressions of Western medicine can be difficult. Yet, providing care to those who are appreciative, who are often overlooked, and who are testaments to the human spirit can be fulfilling.

Due to the almost weekly doctor's appointments for members of his family, Dawit has yet to find a job. His daughter has undergone cardiac surgery, and is scheduled for tonsillectomy soon. She has started school in the Jefferson County Public School system in the exceptional child program. The oldest son is thriving at school, recently receiving all A's

Table 3: Class A Conditions

Excludable conditions that require a waiver for entrance into the U.S.
Active or infectious tuberculosis
Untreated syphilis
Untreated chancroid
Untreated gonorrhea
Untreated granuloma inguinale
Untreated lymphogranuloma venereum
Hansen's disease
Addiction or abuse of specific substance without harmful behavior and/or any physical or mental disorder with harmful behavior or history of such behavior, along with likelihood that behavior will recur
Any quarantinable, communicable disease specified by current or future Presidential Order. Currently these include Pandemic flu, SARS, viral hemorrhagic fevers, cholera, small pox, yellow fever, diphtheria, plague

on his report card. The youngest son has had genital surgery, and is recovering well. Dawit and his brave, resilient, and persistent family, are discovering the compassion and care that typifies family medicine.

More information about the Refugee Health Screening process can be obtained from the State Health Coordinator for Kentucky Office for Refugees, Luta Garbat-Welch, MPH at 502.365.4713. Resources for cross cultural medicine can be found in Table 4.

Acknowledgments: The author wishes to recognize Luta Garbat-Welch, MPH for her tireless dedication to the health of refugees in Kentucky and for her assistance in this article.

* For the purposes of this article the term refugees includes people formally designated as: refugees, asylees, certified victims of human trafficking, Amerasians, Cuban and Haitian entrants and special immigrants from Iraq and Afghanistan

1. Office of Refugee Resettlement, http://www.acf.hhs.gov/programs/orr/about/whoweserve.htm. Accessed January 5, 2012

2. Amy Shelton, Luta Garbat-Welch; Kentucky Office for Refugees; "Refugee Resettlement in Kentucky"; January 2011

3. Office of Refugee Resettlement; "ORR Manual for the Administration of Refugee Assistance and Services 2010"; ORR State Letter #95-37; 364

Table 4: Resources for cross cultural medicine

Centers for Disease Control -Immigrant and Refugee Health
http://www.cdc.gov/immigrantrefugeehealth

Ethnomed — information about cultural and medical beliefs of immigrants
http://ethnomed.org/

Health Roads Media — health information in multiple languages
http://www.healthyroadsmedia.org/index.htm

Clinician's Corner — collection of resources for refugee health
www.health.state.mn.us/divs/idepc/refugee/cliniccorner/index.html

KARA BETH THOMPSON, MD, FAAFP

After growing up in Shelby County, Kara Beth traveled east to Transylvania University for her BA then west to University of Louisville School of Medicine for her MD. Kara Beth flew south to Florida Hospital in Orlando, where she completed her family medicine residency, as well as a fellowship in obstetrics. She then journeyed to Africa, where she worked for 2 years developing a primary care residency at Mbingo Baptist Hospital in Cameroon. Now she finds herself back in Louisville, continuing to practice international health at Family Health Centers-Americana.

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SPECIAL THANKS
TO ACADEMY MEMBERS TEACHING MEDICAL STUDENTS: WHY IT'S SO IMPORTANT

The University of Louisville and the University of Kentucky Family Medicine faculty wish to express a sincere and genuine "thank you" to all of the KAFP members who have volunteered their time to teach our medical students.

Every year we are responsible for providing the instruction in the required third-year family medicine clinical clerkships. Between the two schools, this means that at least 270 students need clinical assignments. Our ability to adequately accomplish this responsibility is limited by the number of full-time family physician faculty and clinical experiences that can be offered on-site.

Additionally, the departments may need student experiences with family physicians in the first or second year of medical school, or on other elective rotations in the fourth year. At the same time, we are responsible for family medicine residency training programs. In tertiary medical centers, there is simply a limit on the availability of quality experiences in family medicine. If it were not for our community-based faculty, our job would be extremely difficult or near impossible.

There are at least three reasons why your contribution is so important:

1. It's a unique learning experience for the student. The opportunity for students to see family physicians providing care in a clinical practice setting is quite exceptional. Often there is a difference in the patient population. The student is also afforded the opportunity to observe the workings of a clinical practice, understand the leadership role of family physicians, and perceive how that the demands of a practice must be balanced with that of the preceptor's other life responsibilities, including family, church, school, and community. One student recently commented that, "Dr._____ did a great job of teaching through example and his lessons weren't only pertinent to medicine but also to life. (It was) the best experience of medical school."

2. Preceptors also benefit. Good students have inquisitive minds. Preceptors encourage students to seek the answers to puzzling questions, including use of a new drug, appropriateness of a laboratory exam, or the efficacy of a treatment plan. Students also assist in providing helpful information from patient interviews and can improve the satisfaction of the patient visit by the extra attention given. Finally, the personal benefit to a preceptor's participation in the learning process can be extremely rewarding. Preceptors sometimes see a notable change in the knowledge and skills of their students within a few weeks on a rotation, and the transformation can be remarkable.

3. Preceptors often have a major influence on students' career decisions. Medical schools are responsible for the general training of physicians, and family medicine is an essential part of that education, with its emphasis on the complexity of care in a continuity setting, and the importance of the family and the community. This is a basic component of medical education, regardless of whether a student eventually decides to be a family physician, or an ophthalmologist. A student with the attributes to be an excellent family physician is often encouraged to pursue this goal by an interested preceptor. Plus the student has the additional opportunity to understand more about the community. As one student said, " Dr. ___ is a phenomenal physician who loves to teach. It allow(ed) one to basically interview a potential town of practice."

KAFP also thanks each of you who serve as teachers for your exceptional efforts and hope that you will continue in this crucial role. We encourage those who have not had the opportunity to participate to consider being a preceptor, even if for a few weeks a year. For both you and the student, it may be a life-changing experience.

James O'Brien, *Chair, Department of Family and Geriatric Medicine, University of Louisville*

Kevin Pearce, *Chair, Department of Family and Community Medicine, University of Kentucky*

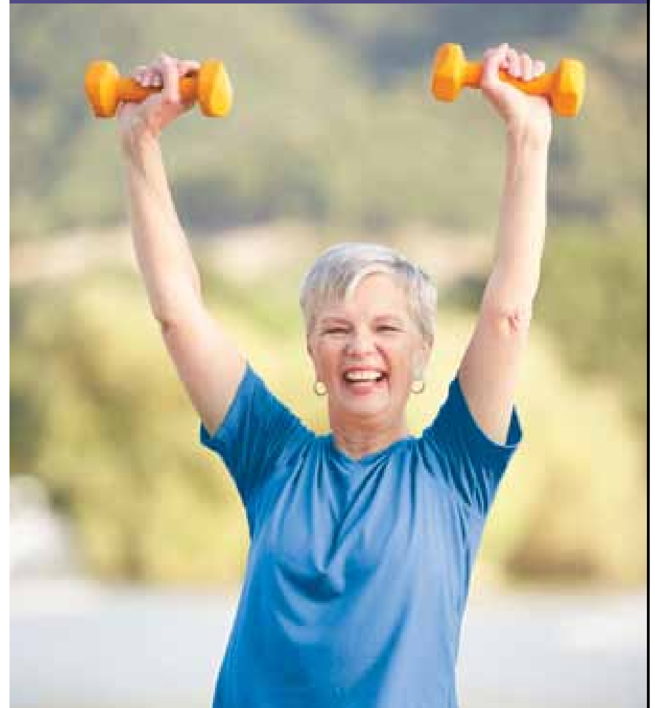
Donna Roberts, *Director, Family Medicine Pre-doctoral Program , University of Louisville*

Sam Matheny, *Director, Family Medicine Pre-doctoral Program, University of Kentucky*

TAKE CHARGE

Don't turn your back on back pain.

If you're over 50 or have osteoporosis, it's important that you don't ignore your back pain. It may signal a spinal fracture. See your doctor right away if you think you may have one.



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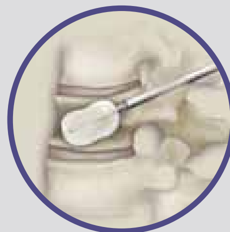

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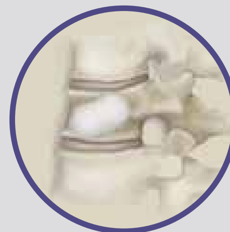

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