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# **J**KAFP**JOURNAL**

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# TABLE OF CONTENTS

- 4 ► **Message from Your President**
- 6 ► **Directory**
- 8 ► **A REVIEW OF JNC 8  
THE GUIDELINES, HISTORY, AND DEBATE**  
BY GRETCHEN SPROUSE, MD; RYAN SPROUSE, MD; AND  
MICHAEL KING, MD, MPH
- 14-16 ► **Citizen Doctor of the Year  
Distinguished Service Award  
Friend of Family Medicine  
50 Year Awards  
Seventh Annual Resident Scholarly Exhibit Contest  
Volunteer Exemplary Teaching Award  
Full Time Exemplary Teaching Award**
- 18 ► **Genomics, Personalized Medicine, And Population  
Health: Who Really Needs A Family Doctor?**



# ▶ message from Your PRESIDENT

I wanted to start my year by giving thanks. First I wanted to thank Gerry Stover and Janice Hechesky. They are the brawn behind the KAFP and the annual conference. Without them you would not have regular communication, CME programming or continuing credits. They are an amazing duo.

I also want to thank Patty Swiney for a job well done as President this past year. Patty worked hard to modernize the bylaws and structure of the organization so that every member feels they have a voice in the academy. She also made the Academy more inviting to people who want to take a more active role. We have an unknown depth of untapped skill, talent and resources among our members. Patty's work is making it easier to mine this talent and use it for the greater good. Patty also livened up the KAFP journal with Led Zeppelin, a hard act to follow. She has been a kind and supportive mentor and she is very, very funny. So, thank you Patty.

I wanted to thank Wanda Filer, President-elect of the AAFP. Gerry asked me who I wanted from the AAFP to be present and I requested Wanda. When I was growing up in Pennsylvania, Wanda was a young physician reporter on our local television station. She was very much a role model for me. I saw a bright, young, family doctor, not in New York or Los Angeles, but broadcasting just a few miles from my home. It was hopeful to me. I have watched her career trajectory with admiration and am proud to know that she will be the next president of the AAFP. As I have spent time with her, not as a role model, but as a peer, I am thankful for her mentorship and time and I can't help but be grateful that we

family docs will have her in the driver's seat and on our side over the next three years.

I want to thank the Board members who donate their time and resources and faithfully attend to the business of the Academy without expectation of return or reward. You are noticed and you are appreciated.

I would like to thank my family, Susan, and Sam, who are infinitely patient when I'm hunched over a conference call, late for supper, working past midnight or in another

EACH PRESIDENT ADDS  
A NEW BLOCK TO THE  
FOUNDATION OF THE  
ACADEMY AND EACH  
PUSHES THE ACADEMY  
FORWARD JUST A BIT.





‘boring’ seminar while they are enjoying the pool or room service. I thank them for their sacrifice to the cause.

I am the 67<sup>th</sup> president of the Kentucky Academy of Family Physicians. This is a long and honorable tradition. 2014 marks my tenth year in practice and my tenth year in Kentucky. I am not a native Kentuckian. But Kentucky is my home. Kentucky is my son’s home. Kentucky is our family’s home. Kentucky is my patient’s home. Besides, I’ve finally started sayin’ ‘it’s pourin’ the rain.’ I can’t leave now.

Each president adds a new block to the foundation of the Academy and each pushes the Academy forward just a bit. Our Academy’s mission is to improve the health of all Kentuckians, promote the value of family medicine and serve the needs of the members.

For me, as a physician and as your Academy president, the best way I know how to carry out our mission is to do what I do and be who I am: a family physician. And as a family physician, what I do is take care of my patients. I gather their stories, I meet them where they’re at in their journey, I negotiate, I listen and I act. The act of telling stories and listening is a gift for both parties. We learned that from John Patterson at the annual meeting. I collect my patient’s stories every day, adding one hundred or more a week to my portfolio.

But then, what usually happens? Mostly, they’re forgotten. But, sometimes, I pull them out again. We make a point, tell a story, illustrate the utter insanity of the current healthcare climate. How many of us told a story in the past month to see who had the most ridiculous million dollar work up for a nickel problem? Who played the “my student loan debt is bigger than your student loan debt” game? Who has the longest wait time for a Medicaid MRI peer-to-peer before being cut off?

But, at the annual meeting, I also heard story after story about why you love family medicine – why you go the extra mile when you know you won’t get paid, when you’re already late getting home, when this patient already makes it hard for you to save their life.

I heard what gets you back through the door, day after day, year after year. It’s our patients. It’s what we do and it’s who we are. We’re family docs. Our patients and our convictions and our dedication give us a powerful voice, one that is beginning to be heard loud and clear in the public arena. Family physicians are more than relevant. Family Physicians are the critical foundation for Kentucky’s healthcare framework. You know it and I know, and finally, everyone else knows it too.

I have two goals as President. First, I want to focus on carrying out the mission of our Academy by collecting stories through old means and new and, when we advocate in Frankfort, use these stories to personalize the struggle for the health of Kentucky’s citizens, our patients. Our stories, our patient stories, help us to promote our value as family physicians, as clinical team leaders, as community leaders, as employers, and as beacons for improved local economies.

Second, I want to serve you, our members, my colleagues, my mentors and my friends with an Academy that rises to meet your needs as you define them. For CME. For communication. For advocacy. For information. What can I do for you that will make it just a little bit easier to be you and do what you do? It’s impossible to call us homogenous. We’re hospitalists, ER docs, Academicians, office clinicians, sports med physicians and much, much more. We’re students, residents, new physicians, mid-career physicians and retirees. We’re rural, urban and live from Ashland to Paducah. One size doesn’t fit all for us. That’s a big reason why we’re not specialists. We chose family medicine because it gave us the room to create the individual practice we wanted on our own terms. As much as possible, your Academy should do the same. I want to work to find ways to start meeting the needs of our many varied members so that you, can do what you love and take care of your patients. “What can the Academy and I do that will make your life just a little bit easier?”

Thank you. I look forward to serving as your President over the next year.



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#### KAFP BOD & COMMITTEES CONFERENCE CALL

*Tuesday, January 27, 2015 – 7:00pm EST*

#### KAFP KY HOUSE BILL 1 & REMS CME SESSIONS

*Free to KAFP Members*

*Saturday, March 28, 2015 - 8am-12:30pm EST*

*The Campbell House*

*Lexington, KY*

#### KAFP BOD & COMMITTEE LUNCHEON MEETING

*Saturday, March 28, 2015 – 1:00pm EST*

*The Campbell House*

*Lexington, KY*

#### 2015 TEN STATE MEETING

*Feb. 27-March 1, 2015*

*Columbus, OH*

#### 2015 ANNUAL LEADERSHIP FORUM & NCSC

*April 30-May 2, 2015*

*Sheraton Kansas City*

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#### 2015 KAFP & FOUNDATION MEETING

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## A REVIEW OF JNC 8

# The Guidelines, History, and Debate

In December 2013, the Eighth Joint National Committee (JNC 8) published a set of evidence-based guidelines for the management of hypertension (HTN) in adults. It is well known that high blood pressure is a major risk factor for cardiovascular disease and leads to significant morbidity and mortality. About 30.4 percent of all U.S. adults age  $\geq 18$  have HTN, and of those patients, an estimated 53.5 percent have uncontrolled disease.<sup>1</sup> This article will discuss the JNC 8 guidelines, as well as the evidence behind the recommendations and the debate surrounding some of the changes from previous guidelines.

Prior to JNC 8, clinicians relied on JNC 7, which was originally published in 2003. JNC 7 was developed and supported by the National Heart, Lung, and Blood Institute (NHLBI). The development of these guidelines involved a nonsystematic review of a full range of study designs, and the recommendations addressed issues relating to the proper measurement of blood pressure, medication adherence, secondary HTN, resistant HTN, and HTN in special populations.<sup>2</sup>

The JNC 8 panel was formed in 2008, and the group developed its guidelines by a drastically different approach than its predecessor JNC 7. The panel followed the approach of The Institute of Medicine's Report Clinical Practice Guidelines We Can Trust. They chose to address only three primary clinical questions: 1) the threshold at which to initiate therapy, 2) the appropriate treatment goal for therapy, and 3) the comparative benefits and harms of various antihypertensive drug classes. JNC 8 did a systematic literature review, which included only randomized controlled trials (RCTs) and excluded other study formats such as meta-analyses. The panel included experts in HTN, primary care, geriatrics, cardiology, nephrology, nursing, pharmacology, clinical trials, evidence-based medicine (EBM), epidemiology, informatics, and guideline development. An external methodology team reviewed the literature and developed evidence tables and summaries for the panel to examine. In January 2013, the panel's draft guidelines were submitted to 20 reviewers from NHLBI and to 16 federal agencies for external peer review. Only 16 reviewers and five agencies responded. The guidelines were reviewed, but in June

2013, the NHLBI stopped developing clinical guidelines and chose not to carry JNC 8 to completion. In December 2013, the individual members of the panel chose to publish independently in JAMA without having the endorsement of any federal or professional organization.<sup>3</sup>

The final guidelines acknowledge the benefits of a healthy diet, regular exercise, and weight control as recommended by the 2013 Lifestyle Work Group. The panel also emphasized that their guidelines were not meant to be a substitute for clinical judgment. Their final recommendations are discussed below:

1. **In the general population  $\geq 60$  years, initiate therapy at pressures  $\geq 150/90$  and treat to a goal less than those values. (Strong, Grade A) However, if pressures are already at a lower goal (such as  $<140/90$ ) with no associated adverse effects, treatment does not have to be changed. (Expert Opinion, Grade E).** This treatment goal is based on moderate- to high-quality evidence from RCTs that shows reductions in heart failure, stroke, and coronary heart disease in this group. There is low-quality evidence that showed a lower systolic goal of 140 led to no additional benefit when compared to higher goals. It is important to note that this recommendation resulted in dissent among the JNC 8 panel.<sup>3</sup> The members who disagreed with changing the goal later published their thoughts in the article "The Minority View" in *Annals of Internal Medicine*. The authors felt the evidence was based on underpowered studies, and they felt the recommendation would harm high-risk groups such as blacks, those with established cardiovascular disease (including stroke), and those with multiple risk factors. They also stated that a patient's age alone increases the risk for cardiovascular events, and they fear the public health implications that may occur if the average blood pressure in that population were to increase.<sup>4</sup> Again, the majority of the JNC 8 panel held that evidence was moderate- to high-quality and supported the change to a systolic goal of 150 mmHg.<sup>3</sup>

*continued on page 10*





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- In the general population <60 years, initiate therapy for DBP  $\geq$ 90 and treat to a goal <90.** (Strong, Grade A for ages 30-59; Expert Opinion, Grade E for ages 18-29) For those over 30, this is based on high-quality evidence from five studies of diastolic blood pressure that showed reduction in poor outcomes. Studies also showed no benefit for using a lower goal (such as 80 or 85). For those younger than 30, there are no RCTs of sufficient quality to make a recommendation stronger than expert opinion. This population does not experience significant morbidity or mortality from HTN until much later in life, and an RCT would require a longer time commitment.<sup>3</sup>
- In the general population <60 years, initiate therapy for SBP  $\geq$ 140**

- and treat to a goal <140.** (Expert Opinion, Grade E) There are no RCTs that have specifically addressed the ideal SBP targets in those who are younger than 60 years old.<sup>3</sup>
- In the population  $\geq$ 18 years with CKD, initiate therapy at pressures  $\geq$ 140/90 and treat to a goal of less than those values.** (Expert Opinion, Grade E) This recommendation is limited to those up to age 69. CKD was defined as having at least CKD Stage III or having albuminuria ( $>$ 30mg albumin/g Cr). There is insufficient evidence to show that having a lower goal improves mortality or cardiovascular/cerebrovascular outcomes. There is moderate-quality evidence to show that lower goals do not slow the progression of kidney disease. For patients with proteinuria ( $>$ 3 g/24 hrs), one study showed isolated improvement in renal

outcomes, but this was only in post hoc observational analyses.<sup>3</sup>

- In the population  $\geq$ 18 years with diabetes, initiate therapy at pressures  $\geq$ 140/90 and treat to a goal of less than those values.** (Expert Opinion, Grade E) Three trials with moderate-quality evidence found a systolic goal of less than 150 mmHg improves mortality, cardiovascular and cerebrovascular outcomes. There were no RCTs to show that a goal of 140 mmHg improved health outcomes, but the panel chose the lower goal to remain consistent with recommendation #3. There were no RCTs that fit the panel's criteria that showed a lower goal led to better outcomes. There was even one study that showed a systolic goal of <120 did not lead to improved outcomes.<sup>3</sup>
- In the general nonblack population (including those with diabetes), initial treatment should be with a thiazide diuretic, CCB, ACEI, or ARB.** (Moderate, Grade B) Only RCTs that compared different classes of antihypertensives were used; no placebo-controlled RCTs were included. All four classes had similar effects on most outcomes. Thiazide diuretics were the best at improving heart failure outcomes, followed by ACEI, but these findings were not overwhelming enough to consistently recommend them over the other two classes. Studies on beta-blockers varied; some showed similar outcomes to other classes, some had insufficient evidence, and some showed worse outcomes in certain areas. Alpha-blockers were shown to have worse outcomes when used as first-line therapy in one study. There were no appropriate RCTs to recommend other classes of antihypertensives (i.e. hydralazine, furosemide, etc.). Of note, this recommendation should be applied with caution in those



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with CAD and heart failure because the panel did not review RCTs that addressed this population.<sup>3</sup>

**7. In the general black population (including those with diabetes), initial treatment should be with a thiazide diuretic or CCB.** (Moderate, Grade B for general black population; Weak, Grade C for those with diabetes) Thiazide diuretics and CCBs showed similar outcomes in most areas, except that thiazides were slightly more beneficial in preventing heart failure. ACEI sometimes worsened stroke outcomes and were not as effective as thiazides and CCBs. The evidence for this recommendation in diabetic patients was of lower grade than for the general population.<sup>3</sup>

**8. In the population ≥18 with CKD, initial or add-on treatment should include an ACEI or ARB.** (Moderate, Grade B) This recommendation is regardless of diabetes status or race, and it is primarily for improving renal outcomes rather than cardiovascular outcomes. Of note, at age 75, this recommendation becomes less reliable, so thiazides and CCBs become other appropriate therapies. For black patients with CKD, the panel relied only on expert opinion for guidance. In those with CKD and proteinuria, an ACEI or ARB is recommended as initial therapy, but in those without proteinuria, any of the four first-line classes can be used. Often, more than one medication is required to reach goal pressures anyway; therefore, blacks with CKD will not often be left on an ACEI or ARB as monotherapy.<sup>3</sup>

**9. The primary objective is to attain and maintain goal BP. If this is not reached after one month, either increase the dose of the initial drug or add a second drug from the classes recommended in #6. A third drug can be added if further titration fails (without using both**

**Management Algorithm per JNC 8 Guidelines**

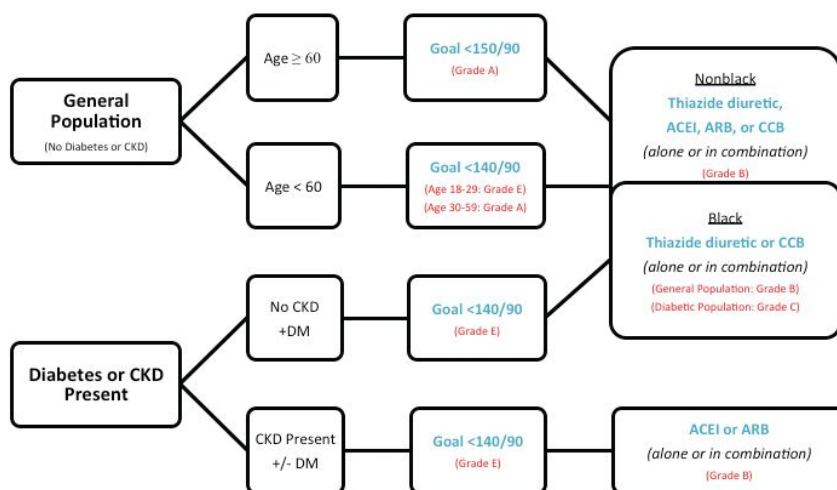


Figure 1. This algorithm was modified from JNC 8 as published in JAMA; it includes the grades of evidence used for each recommendation (in red). The algorithm applies to adults age ≥18 with HTN. Lifestyle interventions should be implemented in all patients throughout this algorithm.<sup>3</sup>

CKD: Chronic Kidney Disease. DM: Diabetes Mellitus. ACEI: Angiotensin-Converting Enzyme Inhibitor. ARB: Angiotensin Receptor Blocker. CCB: Calcium Channel Blocker. "+": with. "+/-": with or without

**an ACEI and ARB together). Other classes of hypertensive medications can be used if still needed, and referral to a hypertensive specialist should be considered.** (Expert Opinion, Grade E) There are no RCTs to compare strategies for titrating antihypertensive drugs. This recommendation is simply to help providers implement recommendations #1 through #8.<sup>3</sup>

Many feel that JNC 8 made positive strides by following a new approach and restricting their literature search to include only RCTs which have >100 subjects and demonstrate patient-oriented outcomes. As we know, RCTs are less subject to bias and represent the gold standard for determining efficacy. The panel also focused their efforts by answering only the three most important clinical questions. They used a diverse group of clinicians and experts in developing

their recommendations, and they have openly shared their review process. Finally, simplifying treatment goals for hypertensive patients so that most are <140/90 could lead to better implementation in the community.<sup>5-7</sup>

Alternatively, some feel that JNC 8 was too limited in scope because it only addressed three questions and did not address patients who have either multiple comorbidities or who have only mild HTN with low overall risk. Another criticism is that by using only RCTs, the panel did not consider the totality of evidence on the issue of HTN. As previously mentioned, there is also a fear that the simplification of the guidelines could lead to an increase in the average blood pressure levels across the older population. If over half of patients are not controlled at a goal of 140/90, the fear is that over half of the population would continue to be

*continued on page 12*

uncontrolled at the higher goal of 150/90 which could lead to increased adverse outcomes. There is also an argument that the guidelines are not reliable because they were not endorsed by any federal or professional agency after the withdrawal of the NHLBI.<sup>5-7</sup>

These professional agencies are now voicing their opinions of these guidelines. For example, the President of the American Heart Association (AHA) wrote a general letter in March 2014 urging that the JNC 8 guidelines not be accepted.<sup>8</sup> The American College of Cardiology (ACC) also seems to refute the changes. There are reports that the AHA and ACC will work together to publish their own updated guidelines in 2015.<sup>9</sup> Conversely, the American Academy of Family Physicians (AAFP) has recently completed its “rigorous endorsement methodology” and has chosen to endorse the JNC 8 guidelines.<sup>10</sup>

For now, each provider and medical group must weigh the evidence and decide what is best for the care of their patients. Ideally, the current debate will lead to a more thorough evaluation of the current literature and will spark new studies to answer the vital questions that remain.

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**Gretchen Sprouse** recently completed her Family Medicine residency at the University of Kentucky, and she is currently the Maternity and Women’s Health Fellow at East Carolina University. She is originally from Palestine, WV and did both undergraduate and medical school at West Virginia University. She enjoys teaching, women’s health, and global missions.

**Ryan Sprouse** recently completed his Family Medicine residency at the University of Kentucky, and he is now the Primary Care Sports Medicine Fellow at East Carolina University. He is originally from Keyser, WV and did both undergraduate and medical school at West Virginia University. He plans to practice general primary care with an emphasis in Sports Medicine when his training is complete.

**Michael King, MD, MPH, FAAFP** is an Associate Professor and Residency Program Director in the Dept. of Family and Community Medicine at the University of Kentucky College of Medicine. He completed his medical school, residency and masters degree at the University of Kentucky.



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# ▶ 50 YEAR AWARDS

The Kentucky Academy of Family Physicians honored members who graduated medical school 50 years ago at the 63rd Annual Scientific Assembly awards ceremony. Patty Swiney, M.D., Immediate Past-President, presented awards to the 1963 Medical Student Graduates.



The following honored physicians were not able to attend the event:

**Kenneth A. Hafendorfer, M.D.** *from Louisville, KY*

**Lloyd L. Browning, M.D.** *from Louisa, KY*

**Noman E. Edwards, M.D.** *from Louisa, KY*

**Prospero Ishkanian, M.D.** *from Louisville, KY*

**Darrell Dean Life, M.D.** *from Wilmore, KY*

# ▶ SEVENTH ANNUAL RESIDENT SCHOLARLY EXHIBIT CONTEST

We would like to thank all the residents that submitted an exhibit. We know how hard you have worked and your dedication is worth rewarding. This year's contest was sponsored by our good friends at JenCare®. Boris Beckert, M.D., JenCare Medical Director for the Kentucky Market and JenCare Representatives Karen Guye and Rebecca Woods were honored to present awards to the winners.



## FIRST PLACE

**Title:** A New Look at Diabetes Care: What about the patient centered medical home really makes a difference?

**First/Corresponding**

**Author:** Leonora Evans Hollmann, D.O., M.P.H, PGY3 and Stephanie Schultz, M.D., PGY3 from Baptist Health Madisonville Family Medicine Residency Program



## SECOND PLACE

**Title:** Tobacco Cessation Counseling in a Family Medicine Residency Practice

**First Author:** Larissa Kern, M.D., PGY3 from University of Kentucky Family & Community Medicine Residency Program

## THIRD PLACE

**Title:** Improving Depression Screening in a Family Medicine Practice:  
**Application of the 8-Step Problem-Solving Method**

**First Author:** Robin Polly, D.O., PGY3 from the University of Kentucky Family & Community Medicine Program



## FOURTH PLACE

**Title:** Early Diagnosis of Hairy Cell Leukemia in a Rural Community

**First Author:** Karen Weaver, M.D., PGY3 from the Glasgow Family & Geriatric Medicine/University of Louisville



# CITIZEN DOCTOR OF THE YEAR

Glenn Loomis, M.D., President & CEO of St. Elizabeth Physicians, was the recipient of the Kentucky Academy of Family Physicians highest award – Citizen Doctor of the Year for 2014. Dr. Loomis was recognized at the Kentucky Academy of Family Physicians (KAFFP) 63rd Annual Scientific Assembly held at the Campbell House in Lexington, Kentucky on November 15, 2014. The Citizen Doctor of the Year Award honors an outstanding, community-minded family physician who provides compassionate, comprehensive care. Dr. Loomis was recognized for his work in establishing some of the first Patient Centered Medical Home (PCMH) practices in the Commonwealth. PCMH has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a concept where patients are treated with respect, dignity, and compassion and enable strong and trusting relationships with their family physicians and staff. The award was presented to him at a special event at St. Elizabeth Physicians' quarterly provider meeting on November 20, 2014. St. Elizabeth Physicians is the multi-specialty physician organization of St. Elizabeth Healthcare.



## DISTINGUISHED SERVICE AWARD

Baretta R. Casey, M.D., MPH, a family physician from Lexington, KY, was the recipient of the Kentucky Academy of Family Physicians (KAFFP) Distinguished Service Award for 2014. The KAFFP Distinguished Service Award recognizes a family physician that has served in leadership positions with the KAFFP such that their action has advanced the specialty of family medicine. Dr. Nancy Swikert stated this about Dr. Casey, "She has been a physician leader that puts the interest of others before herself. She works tirelessly for her patients, colleagues, and the specialty of family medicine. I know of no other individual that is deserving of this honor." Dr. Casey received the award at the Kentucky Academy of Family Physicians (KAFFP) 63rd Annual Scientific Assembly held at the Campbell House in Lexington, Kentucky on November 15, 2014.



## FRIEND OF FAMILY MEDICINE



Senator John Schickel from Union, Kentucky will be the first recipient of the Kentucky Academy of Family Physicians 'Friend of Family Medicine' award. This award recognizes an individual for their leadership in promoting the values and principles that family medicine holds dear, that of putting the interest of the health and welfare of the people of the Commonwealth of Kentucky before their own. Senator Schickel has, through his actions during the 2013-2014 session, promoted the needs for Kentuckians by supporting access to primary care through the patient centered medical home model. He has embraced the philosophy that healthcare is a team effort where family physicians, nurses, pharmacists and other allied health care workers coordinate the care of their patients. Senator Schickel received the award at the 63rd Annual Scientific Assembly held at the Campbell House in Lexington, Kentucky on Saturday, November 15, 2014.

# VOLUNTEER EXEMPLARY TEACHING AWARD



Robert L. Wood, M.D., a family physician from Madisonville, KY, was the recipient of the Kentucky Academy of Family Physicians (KAFP) Exemplary Teaching Award for 2014. The “Exemplary Teaching Award” is presented to active members who have excellent teaching skills coupled with having implemented an outstanding educational program or developed an innovative teaching model. The awards are given in two categories: full-time and volunteer. Dr. Wood received it for the category of Volunteer Teacher. He was nominated by faculty and students from both the University of Kentucky College of Medicine and the University of Louisville School of Medicine. Dr. Patty Swiney, KAFP Immediate Past-President, stated, “He is the first recipient in the history of this award to get a nomination from the faculty and students from both schools of medicine.” Dr. Wood received the award at the Kentucky Academy of Family Physicians (KAFP) 63rd Annual Scientific Assembly held at the Campbell House in Lexington, Kentucky on November 15, 2014.

# FULL TIME EXEMPLARY TEACHING AWARD








Jon Becker, M.D., Program Director in the Department of Family and Geriatric Medicine at the University of Louisville, was the recipient of the “Exemplary Teaching Award” for full time faculty. This award is presented to an active member who has excellent teaching skills coupled with having implemented an outstanding educational program or developed an innovative teaching model. Jessica Schum, co-Chief Resident says of our recipient, “He is a true advocate for residents. He pushes the department to give us the best opportunities and environment to learn ... he pushes us residents to move outside our comfort zone ... he is a dedicated and hardworking leader.” Neil Patil, co-Chief Resident with Dr. Schum stated, “He is the epitome of a teacher who involves his residents in their educational growth as well as their personal growth. Dr. Becker has changed the way the program as a whole looks at the educational development of the residents and has made needed adjustments to keep this as the primary goal as our program continues to adapt, change, and grow.” This award was presented to him on December 16<sup>th</sup> at a special event in the Department by Lisa Corum, MD, KAFP President-Elect.

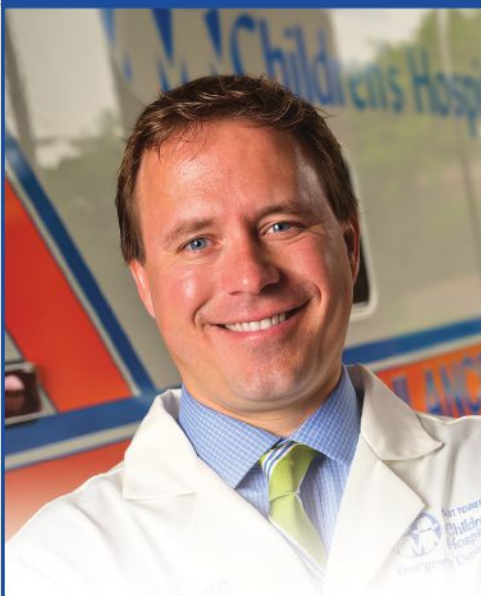


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BY BILL CRUMP, M.D.

# GENOMICS, PERSONALIZED MEDICINE, AND POPULATION HEALTH: **who really needs a family doctor?**

The appearance of the first few words of the title in a recent editorial caught my attention, hoping that some esteemed cardiologists at a big name institution had finally tumbled to the importance of what we family docs do every day<sup>1</sup>. Before I share my disappointment, a couple of cases from my own recent experience:

JW is a 48 year old woman I have seen over the last 10 years with mixed anxiety and depression who generally presents with a somatic complaint that is easily evaluated and treated, and to whom, reassurance is appreciated. The time she had an unusual breast calcification was a bit more stressful for us both, but a close personal relationship I had with a good surgeon resulted in a very quick and reassuring biopsy.

This time she complained of back pain at work and was referred to the occupational medicine physician under worker's compensation. A few days after her outpatient consultation with him, she was on my schedule for an urgent evaluation. She described the pain as radiating down her left leg and leaving a "funny" pain/numbness in her foot. He did some x-rays and she heard him say that he was concerned it might be an aortic aneurysm or something like multiple sclerosis. He advised a CT scan and neurologist consultation. She was, quite simply, terrified. She had not been able to sleep and was afraid to work, and had been just staying at home.

Her exam showed a classic positive straight-leg raise and bow string test on the left, decreased sensation in the L-4/L-5 distribution, normal strength throughout, and no other neurological findings. Her pulses were excellent in both lower extremities and she had normal capillary refill. Reflecting on her history, I had helped her quit smoking 8 years ago, she had a low LDL cholesterol, no diabetes, and an unremarkable family history. I told her it seemed like a small "slipped disc" to me, and left the room to review her films.

Her films were done at another facility, so I didn't have access. When I returned to the room and told her this, one could observe her become more tense. "What should I do?" she said with a quivering voice. I told her that if I were her, I'd take the NSAID that we've used before for musculoskeletal pain, return to the occ med doc as planned in two days and ask him to call me while she was there, and stop worrying. She agreed to do all but the latter. I made a mental note to consider adding gabapentin later if the NSAID didn't allow her to work.

The call didn't come, and I assumed things must have settled down because I didn't hear from her as I usually would. About a week later I got a 20 page fax from a physician group I didn't recognize that included a neurologist note complete with NCV and EMG, CT and MRI that showed a mild L-4/5 radiculopathy with a bulging disc at that level. He had also done a huge lab evaluation for

vasculitis and connective tissue disease that showed only a minimally elevated RA titer with a low sedimentation rate that generally means nothing. He made an appointment for her with a rheumatologist.

So she came to me again, distraught (the last thing she heard was "could be rheumatoid arthritis"), and the pain was no better. She now had an appointment with a spine surgeon and a rheumatologist and had seen plenty of on-line photos of "crippling RA." Again, "what should I do?" I told her I thought in her situation the RA titer was a false positive and suggested we start a trial of increasing doses of gabapentin. Once we saw how much she could do at work and home, she would be ready to discuss options with the spine surgeon.

On her way out, she said "you made me feel SO much better," and she was optimistic again. I thought to myself, "Well, I guess that's my job." I also had to shake my head, knowing that our health system would pay our office about 5% of the total cost of her evaluation by others for my simple history, physical, assessment, and plan.

The next was an OB patient:

SR is 19 years old, pregnant with her first child at about 18 weeks. Just as we were about to load up and leave our prenatal clinic that is 45 minutes way from Madisonville where we needed to be at noon conference in an hour, our receptionist called me and said SR had just arrived, an hour late for her appointment. Knowing that it's often difficult for SR to get away from her job on time, I could sense our receptionist's disapproval as I said that we would see her. And the look on our nurse's face was even more expressive. She set all of our portable office back down, and brought SR back to be seen.

As I entered some notes, the PG-2 resident saw her first as we usually do. I could hear the Doppler crackling and whining with occasional static but not the regular "baby music" that is a good, loud, reassuring fetal heartbeat (FHTs). I looked up to see our nurse joining him in the exam room with another Doppler, also followed only by noise. Thoughts raced in my head. We had heard the FHTs last visit, and an ultrasound 2 weeks ago confirmed her dates.

As I considered the worst, images of the three generations of this family that I know came to mind. And how this young woman, the oldest in her generation, was clearly the shining star. She had done well in school, followed all the rules (and this family has a bunch of rules) and married well. This pregnancy was carefully planned to allow her to continue community college on time so she could begin nursing school while her extended family provided the best day care. How was I going to tell her if the news was bad?

I had struggled with these antiquated Dopplers for 10 years, and knew they each had loose wires that had to be coddled just right to make a good connection. I conjured up all of my professional demeanor and entered the exam room with a reassuring smile on my

face. She was supine on the table staring at the ceiling with both hands white-knuckled on the sides of the exam table. Both resident and nurse looked as if they'd rather be anywhere but here. I added much more gel to her belly, took the better of the two Dopplers, asked the resident to hold one of the connections tightly, and proceeded to search for this 2 centimeter flickering heart. Thankfully, we found it quickly and the rhythmic beat filled the room.

One could watch everyone in the room relax, and she looked at me and said, almost inaudibly, "thank you, I feel so much better now." My heart rate was still too close to that of the fetus to think it then, but later, again, "Well, I guess that's my job." I also could very clearly remember that in that same room 6 years ago the outcome was not so good. "Thank you, God."

So why was I so disappointed in the editorial from the cardiologists? Their extolling the benefits of population health started out well, as I agreed that we are responsible for the patients in our practice whether we see them or not. In fact, one of the key strategies of the Patient Centered Medical Home (PCMH) for which I routinely advocate is the ability to manage our patients actively between office visits. I was disappointed because their view of population health was studying "big data" from electronic health records (EHR) to find the folks who have the disease that belongs to each "ologist" and then studying outcomes of various interventions on that population. As I stared at the barely intelligible notes that our EHR created for me on these two patients, I couldn't find anything describing the importance of what happened. In fact, as I discuss EHR templates with family docs around the country, they decry the loss of nearly everything important that happens in an office visit, hidden by the haze of useless details.

Well, at least I could agree with the editorialists about personalized medicine, right? Disappointed again. This term to them meant knowing the genetic markers of a cancer to choose the best

chemotherapy or the precise hepatitis C genotype to choose treatment. This aspect of genomics is in its infancy, but soon knowing the patient's molecular make-up will really help with choice of treatment of more diseases. Anybody who has been in practice for awhile has seen that a medication that works in one member of a family is often the best first choice for other relatives.

So what do we family docs mean by personalized medicine? To me, it is the realization that precious few illnesses are truly cured, and that the somatic symptoms for which regular folks seek medical attention require a healing force that can't be pressed into a pill. What most patients seek is careful listening by a trusted

*continued on page 20*

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doctor, a physical exam with the therapeutic effect of touch, and then reassurance and symptomatic treatment with few side effects. But they also trust us to find the “zebras among the horses” that do require further testing and consultation. The dance that results is best done to a score written by the relationship between the healer and the healed. This is personalized care, and cannot be provided by a stranger.

A book I’ve recommended before in these pages is Jack Medalie et al’s *Life-changing stories from primary care*<sup>2</sup>. In the introduction to the section on Family and Community, Howard Brody fleshes out this concept of relationship-centered care

“To be human is to be shaped inevitably by one’s culture, but to be shaped in a way which is simultaneously and constantly influenced by our family background and by our own individual personality. No two people are members of a culture in quite the same way; simply knowing a list of cultural beliefs and practices is insufficient to understand how any individual within that culture will behave or what he or she will value.”

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

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

Good doctoring means accomplishing those three tasks and this is impossible without solid, trusting relationships. Philip Yancey, in his delightful treatise on the Christian concept of grace (another

book I strongly recommend), reviews the sociologic concept of the looking-glass self<sup>3</sup>. This view holds that you become what the most influential people in your life think you are. Could it be that our relationships with our patients actually define who we are as doctors?

And Brody again:

“The centrality of relationship as a way of both knowing and healing in primary care brings us back again to the importance of local knowledge. One forms relationships not with abstractions, but with specific people, families, and communities. ... even caring physicians dedicated to these relationships may fail, but physicians neglectful or dismissive of these relationships will almost certainly fail.” Is it any wonder that our current medical system in America fails so many of us?

So I’m not sure exactly how or why I made these patients feel better, but I know it has something to do with our relationship. So in this brave new world of “big data,” genomics, and modern population medicine, who needs a family doctor?

We all do. Comments appreciated.

Bill Crump, M.D.  
Madisonville, KY

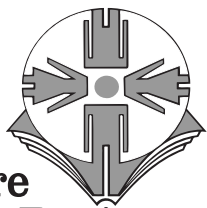
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## Baptist Health Madisonville

# Physician Student Loan Repayment Program

If you can answer “Yes” to these three questions, you may be eligible to receive funding to repay some of your medical student loans.

1. **Are you now or would you be interested in practicing in one of these Kentucky counties?** Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, McLean, Muhlenberg, Todd, Trigg, Union, or Webster
2. **Are you board certified or board eligible in one of the following specialties?** Family Medicine, General Pediatrics, General Internal Medicine, or OB/GYN
3. **Have you been practicing for less than one year?** The Baptist Health Madisonville Loan Repayment Program provides up to \$20,000 per year for up to three years for qualified candidates to help repay loans that supported medical school expenses

### Deadline to apply: April 1, 2015

For more information on this program and how to apply, please contact:

**Mr. Robert Brooks or Mr. Steve Fricker**

Baptist Health Madisonville  
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