Family Medicine Quarterly

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ISSUES IN THIS ISSUE
Roger W. Schauer, M.D., Co-Editor

Welcome to our spring issue of the FMQ. The official first day of spring very likely will predate the first day we see blades of green grass this year, but the promise for new growth is there. Speaking of which, see Brandy's column for her news.

In her "Message from the President" Dr. Bittner describes new challenges for us as she entrusts the presidency mantel to Dr. Breen. Thank you Heidi, for your wonderful leadership this past year, for your refreshing columns in the FMQ, and for your current and future commitment to family medicine, to medical education, and to your patients.

Dr. Rob Beattie extends his greetings in his first message as Chairperson of the Department of Family Medicine. We welcome Dr. Beattie to his new role and new challenges, and look forward to working with him as we pursue common goals.

For news about members, please see the article discussing the recent poster presentation at the Centers for Disease Control's National Hepatitis C Conference in Washington, DC. Dr. Jeff Hostetter and Dr. Olimpia Rauta, along with Dr. Kent Martin, led these research efforts. Congratulations, and thank you for demonstrating that research can be completed in North Dakota. We also offer our congratulations to Dr. Richard Larson from Belcourt for being recognized as the outstanding physician in the IHS system this past year. Dr. Larson, in the past year, had also received the "Dean's Special Recognition Award" in gratitude and recognition for being an excellent preceptor, mentor, and teacher for medical students.

Teaching is a major focus in much of this issue of the FMQ. By the time you receive this Spring issue of the FMQ the Liaison Commission on Medical Education (LCME) will have completed its survey of the University of North Dakota School of Medicine and Health Sciences. For those of you who have participated in Joint Commission on the Accreditation of Hospitals (recently renamed the Joint Commission on Accreditation of Healthcare Organizations) surveys, you know the work and self-reflection these surveys entail. We believe a major issue for the LCME surveyors will be how we address documentation of student teaching, specifically feedback to students. In an article reprinted in this issue of the FMQ, "Evidence-based Strategies That Help Office-based Teachers Give Effective Feedback", the authors do a wonderful job of discussing the importance of feedback, ways to provide feedback, and some of the barriers to providing effective feedback to students. A quick summary of the article is the last paragraph, entitled "Recommendations for the Office-based Teacher". Those five points clearly summarize the message in the remainder of the article, but may also lead you to read the entire article. The article immediately following "Teaching About Medical Mistakes" is worth the read, not only for the content but because it is one example of patient-centered teaching and feedback.

If you are interested in purchasing a Personal Digital Assistant (PDA), you might find it helpful to read the third article we reprinted in this issue, "Information Technology and Teaching in the Office – How to Choose Your Newest PDA". If this will be your first PDA, or if the article is not clear, talk to one of our third or fourth year medical students. They have become quite proficient with the use of PDA's, are aware of the immense resources available at the touch of a stylus, and can help you make informed choices. Additional resources are the librarians at the Harley E. French Library of Health Sciences in Grand Forks or the other

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campus libraries.

We reprinted the information about the Dakota Conference on Public and Rural Health, simply to call your attention to it and to the fact that it immediately precedes our own Annual State Meeting. Bioterriorism will be the focus of a number of presentations on Thursday afternoon, March 23rd, just prior to the Academy board meetings. The second article on that page, "Trauma Code Activation" may not be news to those of you who are Medical Directors for a rural ambulance squad. In the event that you do work with ambulance squads and rescue teams in any capacity, the presented information might be helpful.

Dave Peske again brings us up to date on activities of the North Dakota Medical Association and upcoming interim legislative activities in "Legislative Kettle Just Starting to Boil". He highlights a number of issues that will be important to your practice in the very near future and also provides resource information about these changes. Dr. Peske likely will be at our own annual meeting in Fargo but you should also be aware that Dr. Dale Klein of Mandan is now chair of the Commission on Legislation for the NDMA.

I look forward to seeing you at upcoming meetings. Best wishes as we enter spring and summer.

Roger W. Schauer, MD

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Address all correspondence and ads as follows: Co-Editors: Roger W. Schauer, M.D. (rschauer@medicine.nodak.edu) and Brandy Jo Frei, (Brandy@ndafp.org) for the NDAFP, *Family Medicine Quarterly,* University of North Dakota School of Medicine and Health Sciences, P.O. Box 9037, Grand Forks, ND 58202-9037, (701) 777-3200.

A Message from The President
Heidi Bittner, M.D.

Last year my cable was out for 10 days before I realized it; I don't watch much TV. However, it has been on virtually nonstop the past 17 days--tuned into the winter Olympics coverage from Italy. How unbelievable is the human body and spirit! How amazed we are as we watch the Olympic athletes compete, going above and beyond what was thought possible. Yet as family physicians, we see that Olympic spirit every day--in a patient donating a kidney or marrow to save another person, in a single parent holding down three jobs to pay for a chronically-ill child's medicine, in a farmer with a life-threatening limb injury who somehow makes it to a phone to call 911, in the face of every patient coming around the track during the survivors' lap of our Relay For Life. They are all champions to us.

I think our North Dakota Academy of Family Physicians and our UND School of Medicine and Health Sciences has a competition of its own coming up--the challenge of providing primary care to all the residents of our fine state--all of our very own patients. This may mean different things to different people, albeit joining the Admissions Committee, teaching students/residents in our own clinics, promoting family medicine in our communities, mentoring potential family medicine providers, being a NDAFP Board of Directors, a commission or task force member, or even joining me in the AAFP-planned march on Capitol Hill for the fair treatment of our patients. We need to be champions for our patients.

Now, the time comes to pass that gold (President's) medal on. I hope I've lived up to the expectations and challenges that inherently come along with that deceivingly heavy medal. Like the Olympic winners, I need to thank all those that helped me this year, for it truly is a team event. With this final article, I pass on the NDAFP torch to Chuck Breen, and along with it, the Olympic-like spirit of family medicine. I know he will keep it burning brightly!

A Message from the Executive Director
Brandy Jo Frei, Co-Editor

I officially survived my second Big Sky Family Medicine Update Conference. The conference went very well. We had a number of comments stating that this was "one of the best conferences in years." We hope to do it again next year for the 30th Anniversary. We have already confirmed participation by a number of outstanding speakers who jumped at the opportunity to come back to our conference. Online registration is available now at http://www.ndafp.org, so please don't hesitate in signing up.

I call your attention to a number of events in upcoming months. The 51st Annual Meeting and Scientific Assembly will be at the Ramada Plaza Suites in Fargo, March 24-25. We have some outstanding local speakers as well as a couple of national speakers. Dr. Greg Greek and I are working on scheduling an ALSO course in Bismarck the end of April. Dr. Robert Beattie and I are also trying to set up a date for the Evening with a North Dakota Family Physician that will take place this fall. Please keep watch for these dates as they are announced and mark your calendars to attend.

Just a reminder, I will be taking maternity leave this summer (approximately June & July), but please do not hesitate to contact me if you need something. I will be answering voice mail and email on a limited basis and will be working with a couple of members to cover anything that comes up during that time. With my leave, we will be printing the Summer Issue early, so please have all articles submitted by April 28th. Thank you. - Brandy Jo

Brandy Jo Frei
Executive Director - NDAFP
Mailing Address: 501 North Columbia Road
Grand Forks, ND 58203
Phone (Office): 701-777-3276
(Cell): 701-772-1730
Fax: 701-777-3849
Email: Brandy@ndafp.org
Web Site: www.ndafp.org

A View From UND

Robert Beattie, M.D.
Chair, Department of Family Medicine

Greetings,

I have been in Grand Forks for little more than 2 months, refreshing old memories. Many things have changed during the 19 years since I left for the Bismarck campus to complete my last two years of Medical School. Grand Forks suffered a dreadful flood and fire, but like the Phoenix, risen from the ashes to be reborn a beautiful place to live. UND School of Medicine and Health Sciences changed more than just its name, moving all of its operations to an outstanding, ultra modern complex built around the old St. Michaels Hospital. The American Academy of Family Physicians is promoting the Future of Family Medicine project as the last best hope for family medicine.

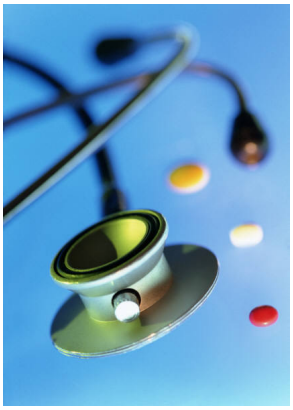
The Department of Family Medicine has experienced some change, now, finding myself the fifth chair of the department in the last 20 years. This reflects stability in the department, yet hints of transformation.

As the AAFP moves forward with its efforts, promoting the specialty of family medicine, our department is challenged with mounting demands. Expectations include, growing the opportunity for exposure of medical students to family medicine, expand the number of students choosing primary care as a career choice, and enlarge the theater of research performed by family physicians for the future of family medicine and our patients.

Family medicine is alive and well in North Dakota, but, like the aging of our state, none of us are getting younger. Accordingly, we need to insure the availability of competent, caring doctors to attend our patient's future needs. The Department of Family Medicine has enjoyed a tradition of cooperation with the North Dakota Academy of Family Physicians in pursuing that goal. On behalf of the Department, I expect to reaffirm this relationship and forge new ones. I hope to schedule site visits with volunteer clinical faculty over the next 6 to 8 months.

I look forward to hearing your suggestions and concerns regarding the Department and the School of Medicine and our mission to educate the future physicians for North Dakota.

Institutions and associations are limited in the scope of what can be accomplished, often restricted to identifying and discussing the problem. But, with the support of family physicians willing to identify and mentor interested students, participate in and develop teaching curriculum and engage the political status quo, we can achieve anything.



Dr. Richard Larson selected as Indian Health Service National Council of Clinical Director's "Physician of the Year"

Belcourt IHS facility - Dr. Richard L. Larson was presented with the **Physician of the Year** award at the Indian Health Service National Combined Councils Conference in Phoenix, AZ on January 30, 2006.

Dr. Larson was nominated by LaVerne Parker, CEO of the Quentin N. Burdick Memorial Health Care Facility in Belcourt, for the award. In her nomination Ms. Parker stated: "Dr. Richard Larson is being nominated for Physician of the Year because he embodies the very highest qualities of the skilled physician in multiple areas of direct patient care over an extended period of time and for his commitment to the care of the patient population he serves".

Background:

Dr. Richard Larson is a member of the Turtle Mountain Chippewa Tribe. He is a graduate of the University of North Dakota School of Medicine (UNDSM) Grand Forks, ND. Dr. Richard Larson became a member of the Medical Staff at the Quentin N. Burdick Memorial Health Care Facility out of residency training and continues to practice on his home reservation. He has shown a deep commitment to his practice and patients through his work as a family practice physician and Director of the Emergency Room. Dr. Larson also serves as a mentor and teacher to students from the UNDSM. Dr. Larson has been recognized recently for his outstanding work in the area of mentoring and teaching of Medical students associated with the UNDSM.

Under Dr. Larson's leadership, the Emergency Room has been certified as a Level IV ER. The ER has been certified since 1998 and continues to meet the certification requirements today. Dr. Larson is well recognized in the "hospital community" and local community for his dedication to care of the patients under his service. Dr. Larson is often seen at the hospital before his tour and long after his tour to complete charting and see inpatients.

Dr. Larson has also served as the Chief Executive Officer during the interim period when the Quentin N. Burdick Memorial Health Care Facility was between CEO's. Dr. Larson has also been the Clinical Director for the facility for at a time when the facility was in transition and under a great deal of stress because of insufficient members of primary care providers.

Intervention:

Dr. Richard Larson has been able to accomplish the above tasks because of his great commitment to the people and the community. He is willing to work weekends to provide education to the EMT's and to act as a mentor and recruiter for potential physicians and employees. He frequently goes above and beyond to accomplish the mission of the Indian Health Service by coming in early and staying late to see patients and complete his documentation. The Quentin N. Burdick Memorial Health Care Facility is very fortunate to have a physician with the commitment and caliber of Dr. Richard Larson.

Outcome/Impact:

The Emergency Room has been certified as a Level IV Trauma Center, the first in the Aberdeen Area. This allows the facility to bill at a higher rate for trauma patients. The ER originally received certification in 1998 and continues to be certified. Dr. Larson was recognized by UND School of Medicine for his mentoring and teaching in 2005. The facility has the largest OPV's in FY-2005in comparison to other facilities within the area of the same size. Dr. Larson has served as the CEO in 2005 during the interim prior to the official selection of a CEO. Dr. Larson continues to serve as the Medical Director of the ER and in this capacity provides education to the EMT's on a regular basis in addition to his regular duties as an FP.

Bismarck Physicians Present Research at the CDC National Hepatitis C Conference in Washington DC

Four Bismarck physicians traveled with staff from the North Dakota State Penitentiary to Washington DC in December 2005 after being invited to present preliminary findings about the efficacy of Hepatitis C treatment that is being given to prisoners in the state correctional facilities.

Dr. Kent Martin from Q&R Clinic in Bismarck, Dr. Jeff Hostetter and Dr. Olimpia Rauta both of the UND Center for Family Medicine Bismarck and Dr. John Hagen from the State Prisons Division presented a poster about the initial success of treating hepatits C with consensus interferon rather than peginterferon alph-2b at the Centers for Disease Control's National Hepatits C Conference in Washington DC. The epidemic increase in methamphetamine use in North Dakota has fueled a vast increase in the number of prisoners who have active hepatitis C in North Dakota prisons. In order to address this public health emergency, the medical staff at the Department of Corrections and Rehabilitation (DOCR) has enlisted the help of Dr. Martin, an infectious disease specialist. Initial treatment with peginterferon alph-2b interferon proved to be too costly to maintain for the large number of prisoners that require treatment. Additionally, the side effect rate in the prison population was unacceptably high. His research discovered little known data that indicated consensus interferon could be equally as efficacious and have a much lower side effect rate.

The DOCR implemented this treatment regimen and Dr. Hostetter, Dr. Hagen, and Dr. Rauta have tracked the results. Initial data is very promising and patients are tolerating the therapy much better. Additionally, the cost of medications are 35% less and the need for sub-specialty referral has declined to near zero. The result has been an effective treatment regimen that is sustainable within current medical budget of the DOCR. The data collection is ongoing and final results plan to be submitted for publication. These initial findings were well received. Other DOCR medical staff involved in this effort and who accompanied the group were Kathleen Bachmeier, Director of Medical Services DOCR and Beth Taghon, RN.

Legislative Kettle Just Starting to Boil

David Peske, NDMA Director of Governmental Relations

The 2006 election is less than eight months away, and the 2007 Legislative Assembly begins two months later. What new healthcare proposals will be introduced then? NDMA will be encouraging each District Medical Society to invite local legislators and candidates to their fall meetings to exchange views on healthcare issues…they need to hear from you, and you need to know how they may vote on issues impacting your practice of medicine. NDMA's Commission on Legislation, now chaired by Mandan family physician **Dale Klein, MD**, is developing a legislative agenda for consideration at the NDMA annual meeting in September. Physicians wishing to discuss concerns related to state laws and medical practice are encouraged to contact the NDMA office.

Interim Legislative Committees

The **Budget Committee on Health Care** is considering whether a comprehensive study of North Dakota's healthcare needs to the year 2020 should be performed following the 2007 legislative session. Representatives of NDMA, the UND School of Medicine, Center for Rural Health, and Blue Cross Blue Shield of ND have all presented testimony on the topic. The committee requested that a bill be drafted to create a Board of Allied Health, which would license any new allied profession or an existing profession that no longer wishes to maintain its own board. Another bill would consolidate the licensing boards for psychologists, addiction counselors, social workers, and marriage and family therapists. The committee chair also plans to submit a bill requiring insurers to pay pharmacists a set minimum fee for filing prescriptions.

The **Budget Committee on Human Services** continues to review numerous strategies, as directed by legislation passed in 2005, to potentially improve health care services provided to ND Medicaid beneficiaries and the operation of the program. These include:
- Monitoring 2000 Medicaid beneficiaries with chronic high-cost conditions such as asthma, diabetes, depression, congestive heart failure, and chronic obstructive pulmonary disease, to improve their health status through better case management;
- Controlling high-cost medical procedures by requiring prior authorization for MRI, CT, and PET scans;
- Contracting with an outside vendor of actuarial services to improve its operation as an insurance provider; and
- Replacing the Department's 25-year old information management computer system, at a potential cost of over $57 million, with an expected savings of $32 million in the first seven years.

This committee, also studying the functions of public health units across the state, has asked the **UND School of Medicine** to explain its role and involvement with the health units.

NDMA is also following other health issues being reviewed during the interim, including: status of the medical liability environment in ND, and the drug rebates obtained through the pharmacy benefits management industry (IBL Committee); allowing jail personnel to provide prescription and OTC drugs to inmates (Government Services Committee); and the shifting of costs to treat accident injuries if no-fault auto insurance is repealed (Transportation Committee).

Have You Been "Enumerated"?
Included in the HIPAA rules enacted over the past years is a requirement that physicians and clinics replace their current billing identifier numbers with a single unique **National Provider Identifier**. This new NPI will be the only identifier that HIPAA-covered entities may use to submit electronic claims to health plans, and must be in use no later than May 23, 2007. Each plan will notify providers when they are ready to accept the NPI; small health plans are given an additional year to comply. The state of Minnesota has already passed legislation requiring that providers use the NPI within two years following the federal deadlines. Individual physicians, or their health systems, should now apply for an NPI by phone or on-line. The website is: www.cms.hhs.gov/NationalProvIdentStand/. The National Plan and Provider Enumerator System, through Fox Systems of Fargo, will assign each NPI.

Workforce Safety & Insurance
NDMA commented on proposed revisions to several workers compensation administrative rules, including one requiring that drugs used to treat an injured worker must be generic, or if the treating physician prescribes "brand necessary," they must be able to document the patient's adverse response to an ingredient in the substituted generic drug that is not contained in the branded medication. NDMA opposed this proposal, and recommended that these issues be considered by physicians serving on the newly-appointed WSI Medical Guidance Council. The Council, with seven physicians and one chiropractor, was created to advise WSI on experimental and new procedures, standards of care, and further define treatment protocols.

Board of Nursing Practice Opinions
The ND Board of Nursing's Nursing Practices Committee has drafted three Advisory Opinions designed to clarify the nurse's role in the management of pain, their role in the use of non-patient specific prescription protocols, and their ability to practice safely. The prescription protocol guidelines would advise that only an RN, not an LPN, may administer treatment under a protocol. This opinion has prompted opposing comments from the Health Department and hospital and nursing home organizations, who cited large financial and staffing burdens. A total of seventeen guideline opinions, which have the effect of neither law nor rule, are posted on the Board's website at www.ndbon.org.

Prescription Drug Monitoring
Legislation enacted last year directed the Department of Human Services to develop an electronic prescription drug monitoring program to help prevent and detect abuse and diversion of controlled substances. A work group, including NDMA and representatives of other interested organizations, has submitted a grant application seeking $372,000 in federal funds to begin implementation, with start up in 2007. The program is expected to provide physicians and pharmacists with access to password-protected drug profile information on individual patients, and to help deter illegal "doctor shopping" and drug diversion activities. When funded, the program will be administered through the ND Board of Pharmacy.

To contact Mr. Peske, please send e-mail to dpeske@ndmed.com.

NDMA Annual Meeting and CME, September 14-15

Mark the calendar to attend the NDMA Annual Meeting in Bismarck this fall. NDMA members are also encouraged to identify and nominate a physician for the Physician Community and Professional Services Award, and a layperson for the Friend of Medicine Award. Nominations are due by July 28.

TENTATIVE ANNUAL MEETING AGENDA

March 23—25th, 2006
Ramada Plaza Suites, Fargo, ND

"A Little Bit of Everything"

Thursday, March 23, 2006

5:00 p.m.	NDAFP Foundation Board of Directors Meeting with dinner
7:00 p.m.	Welcome Social for Dr. Robert Beattie
7:30 p.m.	NDAFP Board of Directors Meeting

Friday, March 24, 2006

7:00 a.m.	Registration/Breakfast/Exhibits Open
8:00 a.m.	**Management of Migraines in Primary Care** **James Banks, III, MD** Roanoke, VA
8:45 a.m.	**Strep Throat: Muddying the Waters?** **Aaron Jost, MD** Fargo, ND
9:30 a.m.	Refreshment Break/Exhibit Visiting.
10:00 a.m.	**Clearing the Confusion: Osteoarthritis, Family Medicine Physicians & Their Patients: A Case Based Approach** **Thomas Bent, MD** Laguna Beach, CA
10:45 a.m	**Primary Care Orthopedics** **Howard Berglund, MD** Fargo, ND
11:30 a.m.	**North Dakota Tobacco Quitline** **Erik Johnson** Grand Forks, ND
11:45 a.m	**Annual Business Luncheon** Sponsored by the **North Dakota Beef Commission** Bismarck, ND
1:15 p.m.	**Pain Management** **Michael Gonzales, MD** Fargo, ND
2:00 p.m.	**The Hidden Disorder: Practical Approaches to Proper Diagnosis and Treatment of Adult ADHD** **Thomas Bent, MD** Laguna Beach, CA
2:45 p.m.	Refreshment Break/Exhibit Visiting
3:15	**Primary Care Urology Problems** **Ted Sawchuk, MD** Fargo, ND
4:00 p.m.	**Gastric Bypass Surgery** **Tim Monson , MD** Fargo, ND

Friday Evening Banquet

6:00 pm	**Social** **Youth Dinner/Entertainment**
7:00 pm	**Dinner**
8:00 pm	**Program** **- With Special Guest: Dr. Larry Fields** **President - AAFP**

Saturday, March 25, 2005

7:00 a.m.	Breakfast / Past President's Breakfast
8:00 a.m.	**Treating Opiod Addiction** **Kent Diehl, MD** Bismarck, ND
8:45 a.m.	**Psych** **Andrew McLean, MD** Fargo, ND
9:30 a.m.	**Issues and Answers in Type 2 Diabetes** **Jeff Unger, MD** Chino, CA
10:15 a.m.	Break
10:30 a.m.	**Cardiology** **Philip Hoffsten, MD** Pierre, SD
11:15 a.m.	**Gynecology** **Greg Glasner, MD** Fargo, ND
12:00 Noon	Meeting adjourns

Welcome to the 51st Annual Meeting and Scientific Assembly of the North Dakota Academy of Family Physicians. Active, life, resident and student members along with other medical professionals are invited to join us. This will be an excellent opportunity for all in attendance to combine quality CME with enjoyable family time.

OBJECTIVES: This program will provide current information on a diversity of medical subjects pertinent to patient care in daily practice.

RESERVATIONS: A block of rooms has been reserved at the Ramada Plaza Suites. The rate is $89.00 for a conventional room and $99.00 for a two room suite. The cut off date for the block of rooms is **March 3rd.** Telephone number is **(701) 277-9000.** After this date, reservations will be made strictly on a space available basis.

CREDITS: This activity has been submitted to the AAFP for up to 10 prescribed credits.

Trauma Code Activation

Submitted by ND State Trauma Committee

There have been some concerns by the ND Department of Health and the State Trauma Committee on Trauma Code Activations. It has been found on frequent designation site visits that the numbers of major trauma injuries are way more significant than the actual trauma codes that have been activated. One of the major concerns to this problem is that the appropriate trauma team is not available in the required amount of time to address the patient's injuries, therefore resulting in the delay of emergency treatment, longer lengths of stay in the ER, and a delay in transfer of patients to higher level facilities when required.

According to the North Dakota Trauma Guidelines manual, section 33-38-01-03 **Activation of trauma codes for major trauma patient**: emergency medical services and trauma centers shall assess patients and activate a trauma code if the patient meets the major trauma definition. The criterion for a major trauma is taken from the Committee on Trauma-American College of Surgeons, pg 14 and is as follows:

Glasgow Come Scale….. <14
Systolic BP…….. <90
Respiratory Rate ……. <10 or >29
Revised Trauma Score…. <11

All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
Flail Chest
Combination trauma with burns
Two or more proximal long-bone fractures
Pelvic Fractures
Open and depressed skull fractures
Paralysis
Amputation proximal to wrist and ankle
Major Burns

Monitoring of the Trauma Activation Codes will be done closely in the future by the trauma teams for all Level IV and V designation site visits, and penalties may be applied to those facilities that have large discrepancies between the major trauma patients and the actual trauma codes that were activated. Trauma Code education is being coordinated at this time to be done at the regional meetings, conferences, and in newsletters concerning this issue. The Department of Health is here to assist your trauma center to ensure injured patients are cared for in a timely manner by highly trained personnel within the trauma center to reduce death and disability among the general public.

The Department of Health would like to recognize all facilities for the trauma care that they provide and for their dedication to the citizens of North Dakota. Their hard work is greatly appreciated and by working together on this issue we can improve the quality of care and the outcomes of major trauma patients.
Please contact Amy Eberle, ND State Trauma Coordinator at any time with questions. She can be reached by phone: 701-328-1026, or by email: aeberle@state.nd.us .

2006 Dakota Conference Focuses On Strengthening Communities

GRAND FORKS, N.D. -- The 21st annual Dakota Conference on Rural and Public Health, an interdisciplinary forum for sharing strategies for building and sustaining healthy rural communities, is set for March 22-24 at the Holiday Inn, Fargo, N.D.

This year's conference themed "Emerging Health Issues: Preparing for Tomorrow," will offer participants a chance to hear from some of the most knowledgeable people in the areas of rural and public health. Oral and poster presentations will address health care administration, health promotion and disease prevention, environmental health and occupational health, and diverse populations and health disparities.

"The purpose of an annual statewide health care conference, such as Dakota Conference on Rural and Public Health, is not only to instill newfound skills, knowledge and resources," said Lynette Dickson, project director at the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences and chair of the Dakota Conference committee, "but also to challenge and motivate people to integrate what they have learned in to their individual program, organization or facility."

This year's **keynote speakers** include **Dr. Patricia Mail**, president of the American Public Health Association; **Alan Morgan**, president of the National Rural Health Association, **Captain, B. Kevin Molloy** of the U.S. Public Health Service; and **Dr. Sarah Patrick**, director of the Center of Excellence in Women's Health Demonstration Project for Region VIII, University of South Dakota School of Medicine and Health Sciences.

For more information contact Bismarck State College, conference coordinator, at 1-800-852-5685 or go to www.bismarckstate.edu/cce/ruralhealth/. Continuing education hours are available for those who qualify.

The following articles are reprinted by permission from *The Teaching Physician,* January 2006, page 4 & 7.

Excerpted from "For the Office-based Teacher of Family Medicine"

Evidence-based Strategies That Help Office-based Teachers Give Effective Feedback

By Alison Dobbie, MD, Department of Family Medicine, University of Kansas; and James W. Tysinger, PhD, Department of Family and Community Medicine, University of Texas Health Science Center at San Antonio (Fam Med 2005;37(9):617-9.)

Medical students and residents want and need feedback from preceptors to improve their clinical performance, yet both learners' reports and audiotapes of actual preceptor-learner encounters indicate that feedback is not often provided in most ambulatory teaching encounters.[1-4] The feedback that learners do receive during office-based teaching tends to be brief and nonspecific (eg, verbal comments such as "right" or "I agree").[1] Possible reasons why preceptors give minimal or nonspecific feedback may include lack of training in delivering feedback,[2,5] the desire not to offend,[6] and the wish to maintain learners' self-esteem.[7] In this article, we share some recent findings from the literature on the need for feedback and reports of effective strategies and techniques that preceptors can use to enhance the quantity and quality of their feedback during office teaching.

Learners Desire for and Recognition of Feedback

Evidence indicates that learners greatly desire and value feedback. Schultz and colleagues reported that 95.6% of 1,592 students and residents surveyed believed that feedback was important for learning.[8] In that study, learners ranked "gives constructive feedback" as second in importance and "gives timely feedback" as sixth out of 37 preferred preceptor behaviors.[8]

Students also consider giving feedback as an important aspect of quality teaching. In a study of 82 internal medicine clerkship students, Torre and colleagues reported that "high-quality feedback" and "proposing a plan" were the two learning activities most strongly associated with learners' perceptions of high-quality teaching.[9]

However, while students value feedback, they may not ask for it, recognize it, or remember having received it. In a study of internal medicine clerkship students, Sostok and colleagues found that when asked to recall the content of scheduled feedback sessions, faculty reported delivering a mean of 3.3 feedback items, but students reported receiving only 2.7 items. Of more concern is that there was only a 34% agreement between faculty and student reports on the content discussed.[10]

Gender Differences Concerning Feedback

Preceptors should consider some important research findings when giving feedback to learners. Schultz and colleagues reported that female and male learners equally value feedback.[8] However, findings from other studies indicate that female and male learners do not receive feedback in equal amounts or with similar content. Carney and colleagues looked at different preceptor-student dyads and reported that female preceptors were more likely to give feedback on clinical skills to male students than to female students. In this study, the dyad incorporating the most giving and receiving of feedback was male preceptors with male students.[4] Similarly, O'Hara and colleagues reported that female preceptors were more likely than male preceptors to comment negatively on female students' clinical skills and more likely to comment on male students' maturity and/or character.[11]

Written Versus Oral Feedback

Evidence indicates that written feedback is as acceptable and effective as oral feedback.[12-14] Schum and colleagues asked preceptors to issue preprinted feedback notes with "well done" or "needs improvement" to medical students. Of feedback notes issued, 69% of notes were "well done," and learners reported identical satisfaction between oral feedback and the written notes. In fact, more than 90% of students considered feedback from the notes more constructive, timely, and concrete than from other forms of feedback.[12]

Giving Negative or Constructive Feedback

Many preceptors are reluctant to give negative or constructive feedback because they fear that it may upset learners and/or adversely affect the teacher-learner relationship. However, evidence from the psychology and management literatures suggests that most individuals value constructive feedback that is designed to improve their performance, provided it is given privately,[15] kindly, and consistently by a supervisor whose expertise they respect and whose motives they trust.[16] However, too soft a delivery, especially when delivered face to face, can dilute the feedback message. Colletti reported that preceptors

on her surgical clerkship gave less negative feedback and awarded students higher grades in face-to-face feedback sessions than in written evaluations prepared in private.[17]

Recommendations for the Office-based Teacher

We offer some evidence-based suggestions from the literature that office-based teachers can use to improve their feedback in the ambulatory clinical setting.

(1) Give students and residents feedback since most learners strongly desire it. If you provide it, they will more likely rate your teaching as high quality.

(2) Be clear about when, where, and how you plan to give feedback, since learners do not always recognize it. For example, on the learner's first day in your office, tell him/her that you will give routine feedback at the end of each morning and afternoon clinical session.

(3) Acknowledge potential gender differences in giving and receiving feedback. Remember that although all learners value feedback equally, studies demonstrate that female learners often receive a smaller amount of feedback or less helpful feedback.

(4) Give feedback orally and/or in written format, since learners find both formats acceptable. Preprinted "well done" or "needs improvement" notes in different colors can be useful prompts for feedback.

(5) Give negative or constructive feedback when required, ensuring you do it privately, in a spirit of unconditional positive regard, and in a way clearly designed to improve the learner's performance. It may be useful to prepare negative or constructive feedback comments privately before sharing them with the learner, as you are then more likely to deliver the message that will allow the learner to change his or her behavior.

Using these evidence-based recommendations may allow preceptors to increase the amount and quality of their feedback to medical students. Increasing feedback will likely improve student satisfaction with the office teaching process, thus enhancing the educational experience for both parties.

Corresponding Author: Address correspondence to Dr Dobbie, University of Kansas, Department of Family Medicine, Mail Stop 4010, 3901, Rainbow Boulevard, Kansas City, KS 66160. 913-588-1927. adobbie@kumc.edu.

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Teaching About Medical Mistakes

By Bruce Gebhardt, MD; Sarah Pritts, MD; Nancy Elder, MD; University of Cincinnati

Editor's Note: The process of the 2-minute mini-lecture is to get a commitment, probe for supporting evidence, reinforce what was right, correct any mistakes, and teach general rules. In this scenario, Dr Pritts (Dr P) works with a third-year student (MS3) who has seen a young woman and discovers a medical mistake.

MS3: I just saw Ms Adams, who is here to get started on birth control pills. She is a 25-year-old woman who you've seen since birth! She says you take care of her entire family, and they just love you. Anyway, she is otherwise healthy and was on birth control pills in the past without problems.
Dr P: OK, before you start someone on oral contraceptives, what past medical and family history would you ask about?
MS3: Well, I would certainly ask about breast cancer and blood clots.
Dr P: Very good. I would also ask about heart disease, migraine headache, and other gynecologic cancers. Do you know what the evidence says about the risk of breast cancer, blood clots, or heart attack is in birth control pill users?
MS3: I know the risk is increased, but I can't tell you by how much.
Dr P: That might be a good homework assignment for you today. You check it out, and we'll discuss it tomorrow. I'd like to know where you find the answers as well. But, now, what other information would you like about this patient, and what exam would you do?
MS3: Well, I'd want to know what pill she used last time. She said it worked fine; she only stopped because her relationship ended. Now, she has a new boyfriend, but I'd make sure she knows the pill doesn't prevent infection.
Dr P: All good points. What about the exam?
MS3: I'd check her blood pressure, do a pelvic and Pap, and maybe do a pregnancy test.
Dr P: Correct. Check the chart to see when her last Pap was.
MS3: Let's see. Her last Pap was 9 months ago and showed ASCUS [atypical squamous cells of undetermined significance].
Dr P: She had ASCUS? Was any follow-up done after that, like a colposcopy, repeat Pap, or HPV [human papilloma virus] typing?
MS3: No, I don't see anything.
Dr P: Well, let me check the chart, please. Hmmm, you are right. Unfortunately it looks like this was mistakenly filed without my signing off on the Pap. Dang, this makes my heart sink; it is every physician's nightmare. OK, we have to handle this now. How would you go about this?
MS3: Well, it's not your fault. Sounds like the staff didn't follow procedure. But, you obviously need to tell her.
Dr P: Absolutely, I need to tell her and explain how this error occurred. However, I would not blame the staff. It is ultimately my responsibility. I have found that it is best to say "I'm sorry this happened, I made a mistake. This is what we do now about the ASCUS, and here is how I propose to change office procedure so that this does not happen again." This is awful, but part of being a doctor, unfortunately. It has taken me awhile to learn how to deal with my emotions and feelings of guilt when I make mistakes. Luckily, I have very understanding partners to hash these things out with. We actually make a point of talking about our mistakes. We also include the staff and encourage them to talk with us. We do not blame but work to learn from and prevent mistakes from occurring again.
MS3: If you say you are sorry, won't she sue you?
Dr P: Well, medical mistakes and malpractice suits are not always related. You can make a mistake and not get sued, or you can make no mistake and get sued. And there is evidence showing that patients want us to say "I'm sorry." Patients want us to acknowledge responsibility when we do something wrong. They may still want and even deserve monetary compensation for the mistake, but I find it the right thing to do regardless. Hopefully, our longstanding relationship will make her a bit more understanding. OK, waiting will not make this any easier, let's go and explain this to the patient. We will recommend repeating a Pap today with HPV typing. If the Pap shows ASCUS again, and the HPV is high risk, then she will need a colposcopy. If it is ASCUS but a low-risk HPV, we can treat the Pap as normal, but I like to repeat the Pap again in 6 months.

Alec Chessman, MD, Medical U of S Carolina, Editor
Betty Gatipon, PhD, Louisiana State U, Coeditor

Information Technology and Teaching in the Office - *How to Choose Your Newest PDA*

By Richard Usatine, MD, University of Texas Health Science Center at San Antonio

Whether you are buying your first PDA or upgrading to a new one, the following pointers will help you decide how to spend your money wisely. There is nothing like a fast, sleek PDA full of up-to-date software to help you practice and teach 21st century medicine. Don't let the students and residents outdo you in the PDA department. While they may teach you some tricks to get the most from your PDA, there is no reason that you have to carry around an outdated PDR or PDA in your clinical setting.

First, Choose Between Palm OS and Pocket PC
Start out by deciding which operating system (OS) is best for you. While there are other OSs for handheld devices, Palm OS and Pocket PC account for the vast majority of the PDA market. Devices using the Palm OS are the most popular in the medical field. As the Pocket PC devices have become more affordable, their use has risen. However, some free medical software is written for the Palm OS only. A number of physicians have produced their own applications and offer them free to others to be downloaded over the Internet. One explanation for this is that it is easier to write programs for Palm OS than for Pocket PC. Most of the large, commercially available medical programs are now available in both formats.

New software (StyleTap™) is now available to run Palm OS programs on the Pocket PC. This makes the Pocket PC more appealing as a medical assistant because the Pocket PC user can now take advantage of free Palm OS programs such as Eponyms, MedCalc, MedRules and MentSTAT.

StyleTap™ Platform runs most applications for the Palm OS platform on Microsoft Windows Mobile™ Pocket PC handhelds. It supports most of the thousands of application programs written for the Palm OS 5.2 platform and earlier versions. Applications written for Palm OS platform show up as native Windows Mobile-based Pocket PC programs and operate in the same way. On the latest Windows Mobile-based Pocket PC devices, StyleTap Platform takes full advantage of high-density VGA screens for maximum readability. Price: $29.95 (US), size: 1.3 MB, OS: Windows Mobile™ 5 for Pocket PC, 2003 (including Second Edition and full VGA support), Pocket PC 2002 or Pocket PC 2000.

Palm OS devices had the advantage of having a longer battery life, but this is changing. One has to regularly charge both types of devices, because it is possible to lose all your files and information if the battery runs out completely. Newer PDAs have backup systems or batteries that prevent this from happening.

Both types of devices come with slots to add memory. Memory cards come in a number of forms, but they all work in a similar fashion to allow more data and program storage on your PDA. These cards are needed to store and run some of the best programs.

Decide on Some Hardware Features—Cameras and Phones
The built-in digital cameras are a fun addition to some of the new PDAs. You can use these cameras to document medical findings in your electronic medical record (EMR), store the photo electronically, or print the photo for your paper charts. These cameras usually shoot photos at a resolution of 640 x 480 pixels. They don't replace better-quality digital cameras but can be handy when it is the only camera you have.

If you want to combine your PDA with a phone, consider the Treo.™ The Treo 650 smartphone combines a cell phone with a PDA. The wireless technology allows for e-mail and Web access. There's also Bluetooth® technology, an MP3 player, and a digital camera that can capture video. The color screen has a 320 x 320 resolution, but it is smaller than the typical PDA screen. The advantage is that you have many devices in one instrument. The disadvantages are that the internal memory for the PDA (23 MB) is less than the higher-end PDAs (64MB), and the screen is smaller. Many physicians, students, and residents are choosing this option and loving their new PDA/phone.

Wireless
Wireless networks are not needed in the medical school/hospitals/clinics to make PDAs valuable tools. Most software is installed by downloading it from the Internet and using a synchronization cradle that is plugged into the USB port of the computer. This software does not depend on wireless access to run.

Wi-Fi=wireless using the standard 802.11 technology that allows your laptop or PDA to connect to the Internet. Most new PDAs contain an integrated wireless card for Wi-Fi that must be within range of a wired access point for Internet connectivity. These PDAs can be prompted to search for a wireless network and connect to it automatically. This could be a wireless network in your hospital, office, home, or "public" hotspot (public wireless network access point). Once you are connected, you can surf the Internet. Special PDA-friendly Internet sites send the PDA smaller, more readable pages. Some Web sites have special pages that detect when you are connecting with a PDA and will transmit news, weather, and entertainment information in a readable format for the small screen.

Bluetooth technology is a second wireless option. Bluetooth is used to transmit signals from one elec-

tronic device to another within the same room. A number of Palm OS and Pocket PC models contain Bluetooth technology. These models can communicate with Bluetooth-enabled cellular telephones or printers. Bluetooth has been used to send faculty didactic lecture notes from a single handheld device to an entire intern class with just a few key strokes and in a couple of seconds.

PDA Products
Web sites can help you review the prices and features when you are choosing the exact product to buy. Palm and Sony make Palm OS devices. Hewlett-Packard, Toshiba, and Dell make excellent Pocket PC devices. Dell currently has the best prices for the Pocket PC. You can use Froogle to compare prices.

Minimum suggested features for a PDA (without phone):
• Color screen 320 x 320, backlit display
• Minimum internal memory (built in storage) 32 MB
• Minimum processor speed 126 MHz
• With 128 MB expansion card for large programs

Palm choices: prices as of December 22, 2005:
• Palm Tungsten E2 $199—meets minimum requirements and at a low price
• Palm TX $299 Palm—320 x 480 screen with 128 MB internal memory
• Tungsten C $399—has great little keyboard and is very fast and reliable
• Palm Tungsten T5 $399—320 x 480 screen with 160 MB flash drive
• Palm Lifedrive $499—large capacity 4 GB built-in storage, Bluetooth and Wi-Fi, 320 x 480 screen
www.palmone.com/us/products/compare/

Pocket PCs: prices as of December 22, 2005:
• Dell Axim X51v Handheld 624 MHz $399—highest resolution 480 x 640 VGA display, Wi-Fi and Bluetooth
• Dell Axim X51 Handheld 520MHz $319—320 x 480 display with Wi-Fi and Bluetooth
• Dell Axim X51 Handheld 416MHz 320 x 480 display with Bluetooth only http://www1.us.dell.com/content/products/compare.aspx/pda?c=us&cs=19&l=en&s=dhs.

Whichever model you choose, make sure you get the best software to meet your needs as a physician and teacher of medicine. One good Web site to help you choose your software
is maintained by our medical school library: http://www.library.uthscsa.edu/internet/pda.cfm.

Richard Usatine, MD, University of Texas Health Science Center at San Antonio, Editor
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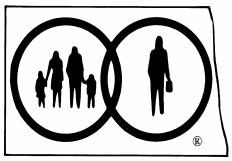

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Co-Editors:
Roger W. Schauer, M.D. (rschauer@medicine.nodak.edu)
Brandy Jo Frei (Brandy@ndafp.org)

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