NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

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ISSUES IN THIS ISSUE

Welcome to this Summer Issue. Generally I talk about growth at this time of the year, but the themes in most of this FMQ's articles seem to point to **change**. Because "Issues" is not intended to be a personal political mantra, I briefly hesitated to use the word "change". But at the end we hope that **growth** and **change** can be mutually beneficial.

In his "President's Message" Dr. Glunberg talks about change as he discusses the medical home and reimbursement issues, and how those may affect some of you, whether you are patients or physicians. These changes may allow for increased opportunity for decision-making and responsibility for all of us. He also asks for your input regarding changes and challenges for the NDAFP. Dr. Beattie addresses **change** in "View from UNDSMHS", and asks that we become politically involved to minimize the pain in change. Bruce Levi includes "change" in the title of his article, then goes on to challenge us to be players in some of those changes, by providing leadership and by working with our legislators. Continuing the discussion about politics, please read Dr. Krohn's article about the need for, and benefits of, being "Doctor of the Day" during our next legislative session.

I also refer you to my article regarding directions in medical education (ICEMEN). Although I wrote that article before I reviewed the articles noted above, it is my sense there is a lot of overlap. That meeting began with the challenge for medical education for s**ocial accountability** and **meeting the needs of underserved populations.** The presentations and discussions in which I was involved during that meeting reminded me of, and re-affirmed, a mission statement and dream Dr. Gerry Sailer shared with me when I first met him in Hettinger in August, 1973 – **that people in rural and remote areas had the same right to quality health care that could be expected in urban centers.** That vision/mission led and sustained me and other physicians through my eighteen years in Hettinger, and influences me today, both in medical education and in articles I seek to publish in the FMQ.

In the "ICEMEN" article I reference "Mission Physician", a program at the Grand Forks Family Medicine Residency. If you are interested in sharing this video with high school students in your community, access the residency website http://www.gfresidency.com . Alternatively, if you are reading this on-line at the NDAFP web site you can either copy or simply click the following hypertext link: http://www.gfresidency.com/4.html . All the referenced articles and web sites for ICEMEN should similarly be available via the hypertext links.

I look forward to future discussions and collaboration with you in as we move to enrich medical education and health care delivery to meet the needs of our population.

Have a great summer.
Roger W. Schauer, MD

Update from the Department of Family and Community Medicine

Robert Beattie, MD

July 1st was a significant date for all physicians who provide care for Medicare patients in North Dakota. Congress failed to pass legislation that would prevent cuts of 10.6% to physician payments. CMS has reacted by holding Medicare claims until July 15th to give lawmakers more time to pass legislation stopping these pay cuts. Opposition to the bill came from Senate Republicans and the White House because it would have paid for the payment provisions by cutting reimbursements to insurance companies offering Medicare Advantage plans (now paid up to 150% of the average).

These cuts in reimbursement are related to the sustainable growth rate (SGR) use by Medicare to balance the overspending in its program, thus made exclusively on the back of physicians. The Medicare Payment Advisory Committee (MedPAC) has advised Congress that the SGR improperly penalizes physicians and should be eliminated or replaced by a method that more fairly recognizes the realities of the Medicare program. Unfortunately the Congress has not found the political will to accomplish any meaningful changes. It has, instead, continued with "Band-Aid" approaches to delay the inevitable crisis that is looming for providers of Medicare services.

The passage of the Medicare Modernization Act (MMA) in 2003 approved prescription drug coverage for us in North Dakota, but had several effects on our reimbursements. One of the enhancements, raising the floor of the work GPCI (geographic practice cost index) to 1.0 will "sundown" on August 1st. This in effect will further cut physician reimbursement by an additional 3.1%. It seems odd that we providers in North Dakota should be facing 13.7% cut, given the fact that we continue to provide, nearly, the highest quality care to Medicare beneficiaries, at the lowest cost, compared to other states.

I realize many family physicians reading this may wonder what this has to do with them. Some may say, "I'm employed by a hospital system and are immune to these effects. " Even the "big" systems will have a difficult time absorbing these cuts, let alone the other Medicare issues plaguing their fiscal stability. It is imperative that we pay attention to the payment environment and be ready to act, when called upon, to contact our Congressional leaders in Washington to take action on our patients best interests.

Message from the NDAFP President

Steven Glunberg, MD

This spring I had the opportunity to attend and represent the NDAFP at the Minnesota Academy of Family Physicians meeting in St. Paul as well as attend the AAFP's Annual Leadership Forum in Kansas City. A topic that I heard a great deal about at both meetings is the concept of a medical home. You likely have heard of this already and surely will hear a lot more about this in upcoming months and years. This is an approach to healthcare delivery that hopes to improve health outcomes, enhance access and reduce overall costs. This approach holds a great deal of promise but will require changes on several fronts. It will require payment reform. The payers will need to recognize the medical home and provide a care management fee that fairly compensates primary care for the value it adds to the system. Blue Cross Blue Shield of North Dakota is already involved in one pilot project that I am aware of that provides a per patient per month care management fee. The medical home will require health system redesign to a more primary care based system rather than the overspecialized fragmented care system that we now have with its inherent inefficiencies. It will also require practice redesign for physician's offices by adding capabilities for better care coordination and the physician will assume a new role as the leader of a team providing coordinated patient care. These changes will likely start with the care of patients with a few of the most common conditions that are encountered in the office that consume the most resources. This concept, like any attempt to change our complex healthcare system, is certain to encounter challenges. However, it offers promise as a way to improve patient care and satisfaction while improving compensation and reducing burnout for primary care physicians.

I mentioned in the Spring 2008 Family Medicine Quarterly that our board of directors had met with Novus, a strategic planning consultant to help us review and to start to develop our strategic plan for the next few years. As part of the planning process we would like to receive your input regarding what you see as our most important challenges and what you would like our organization to be as we move forward. Many of you will be receiving a survey from Novus in the next few weeks. It will ask if you think the NDAFP is fulfilling its purpose and if the needs of its members are being met. It will also ask what you think needs to be done to move the organization into the future. I encourage you to take the time to complete the survey because your opinions will be very valuable as we proceed with the development of our new strategic plan. If anyone has

any other ideas or comments regarding this process, please do not hesitate to contact me or Brandy Frei.

I also would like to remind you that the AAFP Scientific Assembly will be held this year in San Diego on September 17-21, 2008 and I would encourage you to consider attending this excellent educational opportunity. If you have not already done so, you may pre-register for the meeting online at the AAFP website until August 13, 2008.

Executive Excerpt

Brandy Jo Frei

Happy Summer!

In conjunction with the Annual Leadership Forum (ALF) held in Kansas City on May 2-3, the Executive Directors from all of the chapters had a meeting. At this meeting I was elected as a representative to Doug Henley's Chapter Executive Advisory Council. This group meets quarterly to discuss how the AAFP and the constituent chapters can work together. If anyone has any issues that you would like me to bring forward, please do not hesitate to contact me. This three year term starts on January 1st, 2009.

For those members that were not able to attend the Annual Meeting this year, you missed out on a great looking polo shirt with the new NDAFP logo on it. We have some shirts left over and if you are interested in purchasing one for $25, please let me know. We also have some windshirts left from the 2007 Annual Meeting that was held in Medora. These are also available for $25. We have a wide range of sizes left in both items, so please order yours today and show your support for the NDAFP.

In other chapter news, we are always looking for individuals interested in becoming involved. Whether it is becoming a board member, becoming an officer, hosting a Don Breen Externship student, or simply attending the CME events that we organize. If you have any questions about any of these opportunities, please do not hesitate to contact me.

I hope you have a great summer!

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Mailing List Update

Brandy Jo Frei

We are in the process of updating the mailing list for this publication. Please let us know if you wish to
1) continue to receive the paper copy or
2) if you would prefer to only receive an online notice that it is available for viewing at the NDAFP website.

If you or if you know of someone that was removed from the list that would like to continue to receive the *Family Medicine Quarterly*, please contact me.

Please contact me at brandy@ndafp.org or 701-772-1730 with your preference. Thank you.

0pening at Central Dakota Clinic for a Family Physician or Internist.

Opening at Central Dakota Clinic in Harvey for a Family Physician or Internaist. If you have any questions and would like additional information, please contact Chuck Nyhus cnyhusmd@hotmail.com
Central Dakota Clinic
922 Lincoln Ave.
Harvey, North Dakota 58341

AAA Membership – Special discounts for North Dakota Academy of Family Physicians members -

Through an exclusive partnership with AAA, North Dakota Academy of Family Physicians members residing in North Dakota can now take advantage of a 15% special savings on AAA membership dues. The AAA membership serves as a passport to dozens of helpful benefits, services and discounts including roadside assistance, travel, auto touring, insurance and more. The value of the numerous benefits of AAA membership is tremendous. For over a century, AAA has been a trusted, nationally recognized organization with a reputation among the motoring public for integrity and quality service. To find out more about extending this exclusive benefit to members, contact AAA @ (800) 342-4254 for a branch closest to you. (effective 5/1/08)

Physician leadership critical to positive change

Bruce Levi

As the crisis in the cost and accessibility of health care heats up in this election campaign cycle, most are looking to physicians for leadership and guidance. Once the elections are over, the game is on.

Can one physician or group of physicians make a difference, or must we all simply wait around and wait for the system to change? Knowledge, experience, collaboration and persuasion – these are the tools we can use now to meet the challenges facing our health care system.

At the recent annual meeting of the American Medical Association attended by NDMA Alternate AMA Delegate Robert Beattie and NDMA Board Chair Kimberly Krohn, our new AMA president Nancy Nielson called on physicians to not only point out the need for change and the need to tackle the issue of the uninsured in this country, but to design and build a solution. That solution should not be built in an atmosphere of partisan, sometimes poisonous politics. Instead, the solution should be designed in an atmosphere of cooperation through bridges built between medicine and insurers and with a message to government to "get out of the way" and let innovations in health care delivery and in health insurance flourish.

Physician leadership and engagement will be critical to make positive changes. The AMA approach is one approach. The AAFP's call for fundamental reform of the health care delivery system, implementation of the patient-centered medical home, and MEI-based Medicare payment system is another, consistent approach. All our national, state and specialty societies have the opportunity to be a part of the efforts to meet the advocacy challenges we face now and after the November election. Several physicians, including Drs. Beattie and Krohn, are serving on a Task Force recently formed by Senator Kent Conrad to develop federal legislation to accomplish Medicare physician and hospital payment reform.

Advocacy challenges exist at the state level as well. The NDMA Commission on Legislation, chaired by Dale Klein, has been meeting since February, developing a preliminary agenda for the 2009 ND Legislative Assembly.

Much of the activity surrounding the next state legislative session is already occurring, including the public discourse on the projected budget surplus, now hovering over $740 million, and several initiated measures.

State Legislation

The budget surplus impacts our discussion of the need to rebase the Medicaid physician and hospital fee schedules to reflect actual costs, as well as efforts to improve funding for the Medical School and residency programs. Last session, physicians and hospitals initiated a successful effort to appropriate dollars for the ND Department of Human Services to hire a health care consultant during the 2007-08 interim to develop a method for rebasing hospital, physician, and ambulance services payment rates under the Medicaid program to actual cost. The Department is required to develop cost estimates for the 2009-11 biennium on this actual cost basis and report its findings directly to the 2009 appropriations committees. The vendor selected by the Department is The Public Consulting Group, which will develop cost data for physicians based on existing survey data and calculate a conversion factor for actual cost reimbursement and an estimated cost to bring the current physician fee schedule to that level. The Department agreed to allow us to form a workgroup to assist the vendor in its study. NDMA has garnered a group of clinic managers which has met on several occasions with the vendor. It is expected that the study will be complete in July.

On a related note, the Department has agreed to NDMA's request to involve us for the first time in the preparation of the Department's Medicaid budget assumptions on utilization and cost for their 2009-11 budget. The most recent preliminary budget information indicates a current shortage of funds ($5.2 million) for projected physician Medicaid payments for 2007-09.

While we have teed up Medicaid as a major issue for the 2009 session, another major focus will be our state trauma system. The American College of Surgeons team conducted a comprehensive on-site trauma system review on April 27-28, as a result of NDMA and NDHA-backed legislation in the 2007 session. This consultation provides a critical analysis of our current trauma system and recommendations for systems improvement which will likely result in legislation. This analysis will be considered in conjunction with a parallel assessment of the state's Emergency Medical Services system which was performed by the National Highway Traffic Safety Administration in early April. The need for medical directors and improved funding within these systems were primary recommendations.

There are many other issues being considered in preparation of medicine's preliminary 2009 state legislative agenda. The NDMA Commission on Medical Education chaired by Roger Schauer is developing a working paper

on physician workforce issues which may result in recommendations, including proposed legislation. A joint study between NDMA and the ND Board of Medical Examiners is also ongoing, with focus on the North Dakota Medical Practice Act and the impact of current statutory language on scope of practice issues. We are also rewriting the North Dakota Good Samaritan Law to protect physicians and other health practitioners who respond to public health threats and emergencies and to address recent interpretations of the law by the North Dakota Supreme Court. As the result of another court opinion, some finetuning will be required on our expert opinion requirement which requires a plaintiff to serve the defendant an affidavit containing an admissible expert opinion within three months of commencing a medical liability action. Also being considered are possible legislative responses to inappropriate insurer practices and another try at clarifying minor consent for prenatal care. We also will see legislation to modernize statutes relating to the School of Medicine in response to the performance audit.

Initiated Measures
Voters will also likely address several initiated measures in November – measures that may have substantial impact on the 2009 session. The NDMA Commission on Legislation is reviewing the initiated measure regarding the creation of a CDC-based tobacco prevention and cessation program for North Dakota with funds from new dollars available from strategic contribution funds under the tobacco settlement. The measure is consistent with NDMA policy which has been in place since 2000.

Other initiated measures relate to the structure of Workforce Safety and Insurance (CEO under the authority of the Governor rather than the WSI Board), limitations on future budget increases by the state or political subdivisions requiring a 60% vote of the people for increases exceeding the CPI, decreases in individual and corporate income taxes, and others. You can view the initiated measures on the Secretary of State website at http://www.nd.gov/sos/electvote/elections/pending-measures.html.

Several themes emerge from our ongoing advocacy. While ND healthcare has become increasingly integrated and efficient, quality improvement and patient safety remain the stalwarts of the independent profession of medicine. Physicians cannot become complacent in an environment that is moving to the "commoditization" of medical care away from the personalized patient/physician relationship. The best way to push back on the loss of physician autonomy is to continue to support your local, state and national medical societies, including the NDAFP, so the medical profession is strong and independent voice for family medicine and your patients.

North Dakota Conference on Injury Prevention & Control
Hosted by:
North Dakota Department of Health
Division of Injury Prevention & Control

"Preventing and Responding to Injuries"

October 28 - 30, 2008
Seven Seas Hotel
Mandan, ND

Purpose: To encourage professionals to develop multifaceted approaches to promoting awareness, prevention and intervention of unintentional and intentional injuries in North Dakota.

Topics will include:
• Child Passenger Safety • Suicide Prevention • ATV Safety• Bullying • Home Safety • Domestic/Sexual Violence • Internet Stalking • Farm Safety • Mental Health at Work • School Bus Safety • Playground Safety • Traumatic Brain Injury • Dating Violence • Clergy and Domestic Violence • Cultural Competence • Forensic Investigation • Water Safety • Tween Safety • AND MANY MORE

Application for contact hours has been made to Community Health Section, North Dakota Department of Health, an approved provider of continuing nursing education by CNE-Net, the education division of the North Dakota Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Application has been made for CEU's for other disciplines.

For more information and registration call 1.800.472.2286 or visit www.ndhealth.gov/injury/trainings.html.

Being Doctor of the Day is a Great Experience

Kim Krohn, M.D.

Years ago, I answered the plea of the NDMA to staff the Doctor of the Day clinic at the North Dakota State Capitol. I only did it once or twice, because I found it really boring, lonely, and kind of contrary to the tenets of family medicine. "Why couldn't the legislators access their own doctors for their health problems in Bismarck?" I thought. "This is like a Convenience Clinic without any resources!" In addition, I was concerned about using my influence as a physician in an inappropriate way—I didn't feel comfortable lobbying and doctoring in the same setting. After a several year break, I returned to the Capitol the winter of 2007 and found being Doctor of the Day rewarding not only for my professional growth, but also from the standpoint of providing a needed service. I'd like to stimulate some of our members to consider volunteering to be Doctor of the Day in the future—you might find it as fun and rewarding as I have.

Because I am on the Executive Committee of the NDMA, I felt that I couldn't continue to ignore this important project. So, I signed up for about four Mondays during the 2007 legislative session. I could go down to Bismarck Sunday night and return Monday night. February 5 was my first shift. The week before, I e-mailed my local legislators and told them I was coming. Almost all of them ended up seeking me out and making sure I knew everything that was going on that day at the Capitol. One joined me for dinner at the Kelly Inn Sunday night, and invited other legislators to join us. This gave me a great opportunity to feel comfortable around more of the legislators. One of the attendees at our dinner was a freshman representative who had graduated from Minot High with my step-son!

The medicine was inspiring that Monday, as well. I checked in with Peg at the information station in the main legislative hall at the Capitol, and she contacted me by phone to let me know when someone needed to be seen for medical care. Dave Peske, our NDMA and NDAFP lobbyist, met me and filled me in on the important and/or relevant hearings that would be held that day. He introduced me to a lot of folks and I accompanied him to the hearings when I could. Otherwise, I saw senators and representatives, some Capitol employees, and family members for various ailments large and small. All were very appropriate, and similar to what we do in our clinics every day. It was great to be able to tell them that I would be back next week, in case they had any problems with the treatment prescribed. For all "patients" seen, leaving the Capitol and seeking care even in downtown Bismarck would put them at risk of missing important legislative events.

I was able to feel comfortable with separating the doctoring from the lobbying. I saw many of the legislators that were important for the various bills and issues we were following for medical problems in the doctor of the day clinic. This made it a little easier outside the clinic to talk to them about our issues because I had already met them, and maybe enhanced their comfort in speaking with me, but did not result in a feeling that there was an inappropriate overlap. I wore a white coat in the clinic and took it off when walking the halls of the Capitol, attending committee hearings, and joining my local legislators in the cafeteria and on the Senate and House floor. (Our Minot contingency was very generous in extending invitations to view the action from the front row.) The legislators seemed to really value the input of a physician.

Later in the session, I was asked by the NDMA to help with a grant application from a community group. It required some information about the knowledge and attitudes of our state legislators about and towards colorectal cancer screening. I was able to easily contact more than ten legislators that I felt comfortable polling, got immediate replies, and was able to provide the information needed for the grant application.

An unexpected result of participating in the Doctor of the Day Program was a mention in the congressional record. The North Dakota Senate passed a concurrent resolution-- which listed the names of all of the doctors participating-- recognizing and expressing appreciation to the doctors of the day. We're part of history!

Obviously, the individuals staffing the Doctor of the Day clinic should be physicians comfortable with primary care. My first choice, of course, would be family physicians. We make up ¼ of the physicians in the state. The laws that are made by our citizen legislature in Bismarck should have input from family physicians. Volunteering as Doctor of the Day is a great way to become involved in the legislative process, meet our legislators, and provide a needed service as well. Our next legislative session will not commence until early January 2009. I hope that our NDAFP members will be ready to go as the very best representatives of our patients to the legislators.

Future Directions in Medical Education - Report on ICEMEN

Roger W. Schauer, MD

More than a decade ago the World Health Organization challenged medical educators and policymakers around the world to develop responses to two overriding goals, including 1] **social accountability** and 2] **meeting the needs of underserved populations**.[1] In June representatives of medical schools from around the world met in Sudbury and Thunder Bay, Ontario, to discuss progress, successes, and challenges in addressing those goals. The meeting, entitled the "International Conference: Community Engaged Medical Education in the North" (ICEMEN), was co-sponsored by the Northern Ontario School of Medicine (NOSM) in Sudbury and Thunder Bay and Flinders University School of Medicine in Adelaide, Australia. Major themes of the plenary sessions and workshops included focus on **longitudinal integrated curriculum, community engagement and distributed medical education, student leadership, and faculty development.** My purposes in providing this report and my comments are to share information, to briefly address some aspects of medical education in North Dakota, to stimulate conversation, and to ask for feedback from you, our faculty.

Plenary speakers for ICEMEN included deans, former deans, and others in leadership roles in medical schools from Johannesburg, South Africa, to Sudbury, Ontario, and from Tromso, Norway to several Australian medical schools, including those located in Adelaide, Newcastle, Darwin, & Bunbury. A representative from the Global Health Education Consortium joined us as well, to discuss medical education programs in medical schools on every continent (except Antarctica), as well as a number of schools on island nations. Faculty representatives from medical schools in the United States and Canada with longitudinal integrated curricula were also present, and led discussions and presentations about their curricula. Included were schools with a rural focus (North & South Dakota, Minnesota, Washington/Montana, & New Mexico in the US, and multiple Canadian medical schools, from the Pacific to the Atlantic) as well as urban medical schools with a variety of integrated programs (Cambridge program at Harvard, University of California in San Francisco). Our own Rural Opportunities in Medical Education (ROME) program is an example of longitudinal integrated curricula.[2]

Social accountability is addressed and measured, from the pre-admissions process through graduation, residency selection, and ultimate service location, by **a** number of schools. Some, such as Northern Ontario School of Medicine (NOSM), have specific mandates to search for and prepare future medical students from remote, rural, underserved, and/or under-privileged populations. Examples of pre-admission programs include the NOSM "Summer Science Camp", which provides opportunities for high school students from rural, remote, Aboriginal, and Francophone regions in Northern Ontario to explore health-care careers while gaining hands-on experience.[3] NOSM further addresses social accountability by placing pairs of students into remote and aboriginal communities (some accessible only by airplane) for a month of their first year of medical school. Most of that month is spent in the community, learning about health care needs and resources (or lack thereof) in that community, rather than in a clinic or health care setting. In effect, those placements may be similar to a hands-on anthropology experience. Another model program, the "Community Medical Outreach", established by Florida State University,[4] provides an opportunity for premedical students or future candidates for medical school to work with volunteer physicians and enrolled medical students to provide care in underprivileged and underserved communities in Florida. In addition to the obvious service and medically-relevant learning, this kind of model also speaks to **student leadership** and **community engagement**.

Several North Dakota programs, address **social accountability, community engagement,** and **student leadership.** The "Mission Physician" program offered by the Grand Forks Family Medicine Residency[5] is available to rural North Dakota students prior to their senior year in high school, and is similar in opportunities and curriculum to the aforementioned NOSM program. Also available in North Dakota is the "Summer Institute" program, through the Indians Into Medicine [INMED] in the UND School of Medicine and Health Sciences. This annual summer academic enrichment opportunity brings up to 90 junior high, high school, and college preparatory American Indian students to the campus for science, math, and introduction to health careers opportunities.[6] The "Mentoring Youth Program" in Bismarck[7] is an example of community engagement for our own medical students. This program does not address preparing those young people for health related careers, but focuses on improved relationships and societal function for those youth (maybe also an "anthropologic" experience)..

Significant discussions at the week-long meeting focused on moving **3rd year medical student education** from teaching hospitals to the community, and from traditional time & focus-limited clerkships **to longitu-**

dinal, integrated community-centered medical education. Challenges shared by other schools as they initiated integrated continuity curricula were similar to those we saw/see in North Dakota in context of curriculum change. Chief among those, in some form or another, was "what's wrong with the way it has always been". Sir (Dr.) William Osler, more than a century ago, forwarded and supported patient-centered learning with comments such as "He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all." In that context, the following is also attributed to him - "If you listen carefully to the patient they will tell you the diagnosis".

Integrated, continuity curricula share a common aspiration – patient-centered, contextual learning. Length of programs varies from six to twelve months, but the intent is to avoid focus on specific clerkship time blocks. Instead of mandating specific traditional clerkship objectives, curriculum discussion needs to focus on how to best facilitate student learning in context of longitudinal patient care in the community. Ultimately that might require some other on-campus experiences after completing the integrated program, either during year 03 or year 04.

Meta-analysis of outcomes for longitudinal integrated programs has not yet been completed, but individual school reports delivered at the ICEMEN conference as well as a number of previously published articles are encouraging regarding outcomes for medical students involved in integrated, longitudinal learning. Compared to traditional clerkship models, those outcomes include higher clerkship exam grades, improved USMLE (or equivalent exam) scores, improved clinical exam competence, improved relationships with patients and other health care workers, level of confidence in their own skills, and greater numbers of those students returning to serve in remote or rural communities. Those better outcomes appear time-related. Programs nine to twelve months in length appear to have somewhat better outcomes than do the shorter programs. Data from our ROME program, while only seven months in length, also demonstrated academic outcomes at least as good as or better than those for our traditional clerkship students,[2]

While placing medical students in communities with underserved populations speaks to **community engagement and distributed medical education**, challenges exist and must be addressed. Physicians in underserved communities frequently share concerns that they do not have the time or the skills to do the teaching. Teaching students adds to the length of the day, especially early on during any clinical rotation. "Payback" may occur later in the longitudinal experience, when students become more competent, more confident, and become contributing members of the health care team. Concerns about teaching skills are also very real and important. Most of us (author included) are cast into the role of "teacher" without benefit of instruction about how to teach. F**aculty development** opportunities have been available for some time, although access to those opportunities may be limited because of practice schedule and location challenges. On the plus side, many teaching physicians have commented that the presence of medical students helps them remain more current with emerging knowledge as well as how to quickly access new information and resources.

C**ommunity engagement** goes beyond simply distributing students to off-campus clinical learning and teaching sites. With "engagement" the greater community takes on some aspects of responsibility for the student(s) experience, from welcoming the students into the community, to community events, community projects (working with young people, or special interest groups, or elderly, etc), possibly providing or assisting in housing, and providing opportunities for social and recreational events. In essence, this is an opportunity, over a prolonged period of time, to begin recruiting future providers. That concept ties directly to discussions we had in the North Dakota Health Care Workforce Summit meetings.[8]

Medical students in North Dakota have long been "distributed" to learning opportunities around the state, initially on the Bismarck and Fargo communities, but also with Family Physicians in rural communities throughout the state. However, those traditional clerkships are time and objective limited. Students in integrated continuity programs, like the ROME program initiated in 1998, see patients and families in their own context, from prenatal care through care of elderly and end-of-life care. In addition the longitudinal nature of such a program partially addresses an underlying goal of distributed medical education - engagement with and in a rural community.

Challenges and opportunities exist. Although students repeatedly talk about the large numbers of patients that have co-morbid emotional or psychiatric problems complicating other medical problems, we have been unable to include the neuroscience component in ROME to date. Traditional general surgery experiences are becoming more limited (in our ROME program and elsewhere). Discussion about surgery experiences in

longitudinal integrated curricula at ICEMEN focused on the benefits of learning about indications for surgery, or referral for surgery, in the primary care setting. That discussion took a turn after a lively evening debate between two medical school deans titled "The Teaching Hospital Is Extinct". The consensus position and middle ground at the end of the debate was that the traditional teaching hospital was in reality becoming a research facility, and provided better experiences for 4th year students and residents. Further, the experiences of patients presenting with the problem(s) in the primary care setting, evaluation for indications for surgery, and the referral and transport issues were of immense learning value, and that the surgical techniques could be better taught later.

Faculty development was again addressed in the closing plenary session of ICEMEN by Dr. Ian Couper, Professor of Rural Health and Chair of Rural Health in the Department of Family Medicine at the University of Witwatersrand, South Africa. In his presentation, **"The Community of Learners",** Dr. Couper challenged us to consider 10 points as we re-think the "how, what, and by whom" of medical education. When addressing curriculum for 3rd year student we need to consider changes in the areas of pedagogy, content, and relationships. Regarding pedagogy, he encouraged us to look at 1] movement from the tertiary teaching center to the community, 2] movement from training to mentoring, and 3] movement from observer to actor. For context he addressed 4] movement from control to freedom, 5] from program to process (the process of care), 6] from extraneous to essential, and 7] from the part to the whole. His closing remarks focused on relationships in the learning environment, with movement 8] from intimidation to intimacy, 9] from high tech to high touch, 10] from tradition to innovation (including influences of service learning).

The ICEMEN conference provided reaffirmation that we are moving in the right direction regarding medical education in North Dakota. We will face new challenges as we move forward with educational innovations to prepare learners for their vocation in health care. In spite of economic and system challenges, providing health care to citizens of the world is a privilege. In a slight paraphrase of a comment by Dr. J Campbell Murdoch, Professor of Rural and Remote Medicine at the University of Western Australia, our challenge is to provide the opportunity for our students to attain the "kind of knowledge needed to provide healthcare for people anywhere".

References

[1]For more detail about those challenges, see "WHO The world health report 1995 - bridging the gaps". Available at http://www.who.int/whr/1995/en/

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[3]Summer Science Camp, Northern Ontario School of Medicine, available on-line at http://www.normed.ca/communities/general.aspx?id=4924&terms=Summer+Camp

[4]Heravi M, Bertram JEA. A novel resource model for underprivileged health support: Community Medical Outreach. *Rural and Remote Health* 7 (online), 2007: 668. Available on-line at: http://www.rrh.org.au/home/defaultnew.asp

[5]Mann W. Mission Physician,. FMQ, Vol 33, # 4, Winter, 2007. Also available on-line at http://www.ndafp.org/pdfs/Winter%202007.pdf

[6]INMED Summer Programs, available on-line at http://www.med.und.nodak.edu/depts/inmed/SummerPrograms.html

[7]Mentoring Youth Program. Information available on-line at http://www.med.und.nodak.edu/bismarck/youthprogram.cfm

[8]North Dakota Health Care Workforce Summit. FMQ, Vol 33, # 3, Fall, 2007 Also available on-line at http://www.ndafp.org/pdfs/Fall2007.pdf

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Interpreting the Medical Literature—How Do We Train Learners (and Remind Ourselves) About the Role of Statistics

By Thomas Agresta, MD, University of Connecticut
Richard Usadine, MD, University of Texas Health Science Center at San Antonio

You have a student who is seeing Mrs. Smith, a 28-year-old woman recently diagnosed with polycystic ovary disease who desires to have children and has been trying to conceive for more than a year. She is also concerned about diabetes risk. The resident working with the student pulls up an article and immediately tells you that you should refer to an infertility specialist for treatment with Clomiphene since that is the best treatment with a difference that is statistically significant.[1]

You congratulate the pair of learners for rapidly searching out answers from the literature and remind them that you need to review this information with Mrs. Smith to ensure that it is relevant to her.

You now probe a little deeper regarding the article, trying to get a grasp on the learners' understanding of the content of the article as well as their ability to interpret literature effectively.

Asking the simple question—does this study apply to Mrs Smith?—brings out the fact that the article is focused on patients already in infertility treatment, perhaps not all comers in a primary care office, but your learners are confident that it is appropriate. Since Polycystic Ovary Syndrome and infertility are relatively common in a primary care practice, you decide that all members of the team could benefit from a more thorough review of the topic. The resident also has a journal club that she is responsible for in 3 weeks and decides to use this article to review. You encourage the student to help in this since they were involved in the original patient encounter that began this practice-based learning experience.

You realize that this is an article on treatment and therefore direct the learners to the online site of Users Guides to the Medical Literature from *JAMA* to have them begin to prepare for their presentation. A week later the resident returns with several questions regarding the statistics used to analyze the data. The first question that they ask you is about the power of the study. It seems they readjusted the numbers partially through the study because they had lower than expected live births in all the groups and therefore were able to have the same 80% power with fewer patients. You refer the learners to the *Rice Virtual Online Statistics* text and tools to review power analysis and sample size requirements. They are able to use the tools to actually predict needed sample sizes for various levels of α and β error (also reviewed) and graphically display what happens when you vary these numbers. The learners then realize they can actually use these tools live—during the journal club to demonstrate these principles to remind all about these common statistical principles.

The next series of questions they have revolve around the actual statistical tests used in the article. These go something like "What is a Fischer's exact test or a Wilcoxon rank-sum test?" You yourself are a bit rusty on these concepts (or never learned them as many clinicians would likely respond). So you decide to look together at these terms in the online texts and under what circumstances they should be used. It becomes clear that you can find many of the actual statistical calculators on the Web and with a little guidance and reading you can use them to help teach learners about how to interpret articles. This now becomes part of your standard toolkit for residents and students when they are faced with formal analysis of the literature.

It should be noted, however, that for most of our students' and residents' work, it is not important to be able to use these tools, but it is important to understand and trust the principles behind their use in research articles.

Internet Tools for Understanding Statistics

Title	*URL*	*Comments*
Users Guide to Medical Literature	www.cche.net/usersguides/main.asp	*JAMA* articles—good overview useful for longitudinal curriculum and one-time reviews
Rice Virtual Lab in Statistics	http://onlinestatbook.com/rvls/index.html	Online statistics text
Rice Virtual Lab—Simulations	www.ruf.rice.edu/~lane/stat_sim/	Java simulations demo concepts
VasserStats	http://faculty.vassar.edu/lowry/VassarStats.html	Online Stats Calculator
SticiGui	www.stat.berkeley.edu/~stark/SticiGui/index.htm	Statistics text and calculator

By using these resources in a structured manner with specific articles or clinical questions in mind, we encourage critical thinking among our learners. It is important to instill in them the background needed to understand the difference between the types of research articles and how to think about them critically. It is just as important to help them realize when not to do primary literature review and use the tools of information mastery instead. So, try out some of these sites for your own learning and think how you might incorporate them into your curriculum to support an active learning environment.

REFERENCE
1. Legro R, Branhart H, Schlaff W, et al. Clomiphene, metformin, or both for infertility in the polycystic ovary syndrome. N Engl J Med 2007;356(6):551-66.

IMPORTANT DATES TO MARK ON YOUR CALENDAR

September 5-6, 2008
ALSO Bismarck, ND

September 18-19, 2008
NDMA Annual Meeting Grand Forks, ND

November 1, 2009
NDAFP Fall CME Grand Forks, ND

January 19 - 23, 2009
32nd Annual Family Medicine Update
Big Sky, MT

June 17-19, 2009
NDAFP Annual Meeting & Scientific Assembly Bismarck, ND

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