NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

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Issues In This Issue

Roger W. Schauer, MD

Much like our summer weather, our **Summer** issue of the FMQ is late. Because of tardiness we bring you some timely autumn news, like the **Characteristics of the Class of 2013.** We will post the Class of 2013 membership on the NDAPF website on the "Students and Residents"page at http://www.ndafp.org/students_and_residents.php . Read about the eight senior students, some of whom you mentored and taught, who were elected into the inaugural class of the **Gold Humanism Honor Society**. PG1 FM residents for North Dakota are listed in **New Residents Starting July 1, 2009**.

Read Dr. Glunberg's **Message from the NDAFP President** as he acknowledges the work of other members and alerts us to upcoming challenges. He addresses the TransforMed program, a self-examination of patient-centered characteristics of your practice. We look forward to hearing more from Dr. Glunberg about this, as this assessment may become critical as health care reform moves forward. Thanks to Steve, for his work for the NDAFP and all of us these past several years. As Chairman of the Board he likely will provide more leadership in this rapidly changing arena. Dr. Beattie's **Department of Family and Community Medicine Update** highlights some major discussion points in the health care reform arena and provides an introduction to Bruce Levi's **Policy Update**. Mr. Levi addresses some of the issues raised by Dr. Beattie, but also discusses actions of the **61st Legislative Session** and a preview of emerging issues for the 2011 session. The **minutes** of the **NDAFP Board of Directors** and the **NDAFP Foundation** are included for your review, as is Brandy's **Executive Excerpt,** where she provides a brief review of the NDAFP Annual meeting and the Don Breen Externship.

The rapid evolution of the **digital landscape** may further impact how we think about medical homes and patient-centered care. Richard Usatine, MD, a regular contributor to *The Teaching Physician*, provides an overview of some of the social networking tools our students, children, and grandchildren are using in **Information Technology and Teaching in the Office--*Social Networking in Medical Education: Where Are We Going?*** Some of the tools Dr. Usatine highlighted may have a future role in both medical education and patient communication. A recent issue of the Grand Forks Herald[1] provided a wire service article in its "Health & Wellness" section which addressed "Twitter" and a number of other social networking tools as vehicles for connecting with patients. Emergency Room physicians[2] are finding utility in the technology. The home page for UND provides access to a number of these multimedia resources, including Facebook and Twitter. Your FM clerks likely already utilize some of these tools, and would be willing to discuss and teach their use. After dragging my feet for about two years I finally signed on to Facebook and found myself rapidly connected to people with whom I had lost contact decades ago.

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Department of Family and Community Medicine Update

Robert Beattie, MD

While participating in the annual American Medical Association (AMA) meeting in June, I attended the American Academy of Family Physicians luncheon. This is a regular event sponsored by the AAFP and is an opportunity for the AMA delegates, who are family physicians, to caucus. Dr. Ted Epperly, President of the AAFP, conducted the meeting.

The issue of greatest attention at the meeting, both luncheon and annual AMA, is unchanged from what we hear on the television today… health care reform. The topic has created considerable tension between these two groups over the years. What we learned from Dr. Epperly, however, was the reality that both groups had made considerable progress aligning their views regarding reform. Provided for review was a document from the New American Foundation, listing conditions for fair competition of any public plan. It shares many principals with AMA and AAFP policy.

- **The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace**. In other words, the authority overseeing the marketplace (exchange) and enforcing its rules should not have an incentive to favor the public plan over private plans.
- **The public plan cannot be Medicare**. Creating a market place where private insurance plans could compete fairly with Medicare for the under-65 population would be difficult and complex.
- **The new public plan must be actuarially sound**. This means it must charge premiums that cover its costs. The public plan may not be subsidized using additional government revenues.
- **The public plan cannot leverage Medicare (or any other public program) to force providers to participate**. For example, the public plan cannot require providers to serve public plan patients as a condition of participating in the Medicare program.
- **The public plan should not be required to use Medicare payment rates**. Instead it must offer rates that elicit voluntary participation, which means providers should have some freedom to negotiate with the public plan.
- **The insurance market rules and regulations governing the public plan must be the same as those governing private plans**. These rules and regulations include; guaranteed issue, guaranteed renewal, no pre-existing condition exclusions, etc.
- **The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumable be eligible for subsidies in the new marketplace.** Individuals should be able to apply subsidies to the public or private plan of their choice.
- **Public and private insurers should be required to adhere to the same rules regarding reserve funds**. All insurers should be required to have reserve funds equaling their incurred but not reported (INBR) claims.
- **The public plan would also need to contribute to value-based initiatives that benefit all payers.** For example, if an assessment for funding comparative effectiveness research is levied, private plans and the new public plan must be required to contribute proportionately.

It is obvious we will be engaged in the discussion of health care reform for the coming months. These principals will help guide our deliberations as new plans are presented in congress. Hopefully we will have meaningful reform that fixes the pieces of the system that are "broken" and maintain the high quality and broad access enjoyed in North Dakota.

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The final article in this issue, **Communicating Laboratory Results: A Quality Assurance Exercise**, also relates to patient communication. Dr. Ann De Jong, who recently completed residency at the Minot Center for Family Medicine, provided an abstract of her study of patient satisfaction regarding communication of laboratory studies. Dr. De Jong is now doing locum tenens work in rural communities in ND. If you want the complete research report, please request that from Brandy or myself.

Best wishes to all.

1. Grand Forks Herald, Saturday, August 1, 2009, page F2. "Doctors, health care groups use Twitter to reach public", by Sandy Kleffman, writer for Contra Costa Times.
2. Annals of Emergency Medicine, Vol 54, Issue 2, Aug 2009. "This Sentence Easily Would Fit on Twitter: Emergency Physicians Are Learning to 'Tweet'", by Eric Berger, special contributor to Annals News and Perspective.

Message from the NDAFP President

Steven Glunberg, MD

We are in the midst of an exciting time for Family Medicine. Healthcare payment reform is on the front burner of President Obama's busy agenda and Family Medicine is in a position to make significant gains. These changes have the potential to improve the outcomes for our patients, increase our compensation for the value we add to our patient's health care and improve our efficiency, which will increase our time available for family as an added benefit. I have mentioned it in this column in the past, but I again urge all our members to prepare their practices to become a Patient-Centered Medical Home. Our board of directors recently approved an agreement with the AAFP to promote its TransforMED program to our members to assist anyone who wants help with making these changes to their practice model. You can learn more about this at the AAFP website and soon this information will be available on the NDAFP website as well.

The past year has gone by very quickly and I want to thank all of you for allowing me to serve as your president. This role will now be passed to the very capable hands of Rich Vetter who brings a wealth of experience to the office. It takes the work of many individuals to make our organization successful and I have learned the president's role is much less important than many others. I want to thank Brandy Jo Frei, our Executive Director, for her efforts over the past year. She is the one person who is most responsible for making the NDAFP an asset to its members. A highlight of her accomplishments over the past year is her re-design of our website. I encourage you to visit it often and I think you will find it very useful. I also want to express a special thank you to my good friend, Dave Field who this year is stepping down from his position as Secretary/Treasurer after serving in this capacity for the past 10 years. He has moved our accounting methods from the paper and pencil era into an era of modern accounting practices and financial management. The organization certainly owes him a debt of gratitude so please give him your personal thanks when you see him. Jeff Hostetter has taken over Dave's responsibilities as Secretary/Treasurer and we certainly appreciate his commitment to our organization. There are many others to thank for making our organization successful including all of the NDAFP officers, board of directors, commission chairs and members, delegates and alternates to the AAFP Congress of Delegates, NDAFP Foundation officers and board members, the Big Sky Conference planning committee and all members who continue to support the NDAFP and our Foundation.

To keep our organization vital and growing in the future, we need to continue to recruit new members. I think one of the most effective ways of doing this is to sit down with new family physicians in your community and explain to them the benefits of belonging to the NDAFP. The few minutes you spend promoting our organization may result in not only a new member but also a possible future leader for the NDAFP.

Executive Excerpt

Brandy Jo Frei

The annual meeting was held in June in Bismarck. What a great time! The riverboat cruise was absolutely perfect. I hope that those that could not make it this year, make plans to join us next year as we head back to Medora. The dates will be announced shortly.

At the annual Meeting this year, NOVUS, a consulting firm from Fargo, provided a recap of the recent membership survey that was done. We have addressed some key issues that we are going to look into further and then set up a formal plan of action for the next few years.

This summer there were 15 students that participated in the Don Breen Externship Program. This program continues to be a huge success. The students preview their medical career future and see some of the many aspects of Family Medicine. The majority of the participants finished the externship with more interest in Family Medicine. Hopefully we are able to continue to nurture their family medicine interest.

Please do not hesitate to contact me with any concerns, issues, or wishes to volunteer as projects develop. Thank you and enjoy the rest of the summer.

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Policy Update

Bruce Levi

Health System Reform Takes Brief Reprieve in August Recess

Both the U.S. House of Representatives and Senate have begun their August recess; a time for reflection on the course of health system reform in Congress that has taken on a rather frantic pace. The House is considering HR 3200, "America's Affordable Health Choices Act of 2009," which has been marked up in different forms by three House committees. The AAFP has responded to a House health care reform bill, saying in a recent letter to the three committees responsible for drafting the legislation that it supports the bill -- certain provisions in particular -- but that it has concerns about various parts of the legislation.

Over the August recess, the three committee products will be combined in some form into a single bill for consideration on the House floor. Discussions with Congressman Pomeroy indicate that improvements are possible in the House legislation when Congress returns in September. In late July, the House Energy and Commerce Committee announced an agreement on HR 3200 that payments in the proposed public plan option should be based on negotiated rates rather than on the Medicare fee schedule.

The NDMA annual meeting is September 24-25 in Bismarck, and we expect that health system reform including the House package will be a primary consideration – please plan to attend as Dr. Kimberly Krohn takes over the reins as NDMA President!

The Senate Finance Committee has been working behind closed doors, with no expectation for marking up legislation until September 15. It is expected that the Senate will not initiate a permanent fix to the Medicare physician payment formula as included in the House package; instead, the legislation is likely to prevent a 21.5% Medicare physician payment cut that is scheduled for January 2010, with a very slight increase in payments but does not include a long-term replacement of the Sustainable Growth Rate (SGR) formula.

Expect the process to continue through the rest of this year; NDMA's Council and Commissions are continuing to meet on these issues, working almost daily with the offices of our Congressional Delegation in addressing the impact of proposals on North Dakota patients and physicians. Relying on principles developed on our Medicare Payment Task Force, an additional "framework" will be considered by the NDMA Council in August.

NDMA continues to compile information for you to download from the NDMA website, accessible from the homepage at www.ndmed.org.

NDMA Expresses Opposition to HR 3200; Recognizes Positives

HR 3200 includes provisions key to comprehensive health reform, including:

•Coverage to all Americans through health insurance market reforms;
•A choice of plans through a health insurance exchange;
•An end to coverage denials based on pre-existing conditions;
•Fundamental Medicare reform, including repeal of the flawed SGR formula;
•Additional funding for primary care services, without reductions on specialty care;
•Individual responsibility for health insurance, including premium assistance to those who need it;
•Prevention and wellness initiatives to help keep Americans healthy; and
•Initiatives to address physician workforce concerns.

While there are positives in HR 3200, there are many elements of the legislation not supported by NDMA – particularly provisions to create a public plan option that would be linked to Medicare reimbursement and provisions that do not sufficiently address the disparity in Medicare payment for states such as North Dakota. NDMA and the ND Healthcare Association (hospitals) issued a joint media statement on July 16, indicating support for positive aspects of the bill and agreeing with Rep. Pomeroy's opposition to the bill and need for improvement, which stated as follows:

Like Congressman Pomeroy, we strongly support the goal of bringing affordable health care to all North Dakotans.

The House health care reform proposal, while it includes many important features including permanent reforms of the unsustainable formula for providing resources for physician services, does not go far enough in addressing the unfair geographic inequity in how health care resources are allocated among states such as North Dakota. In addition, we agree with Congressman Pomeroy that there must be appropriate payment for any new programs that cover the uninsured. The House health care proposal creates a flawed public health insurance option that risks dismantling of North Dakota's health care delivery infrastructure, jeopardizing access to much needed care and services.

Congressman Pomeroy's decision to oppose the House

reform bill in its present form is appropriate, and we look forward to working with him and Senators Conrad and Dorgan to bring about health care reform that helps, rather than hurts, North Dakota.

61st North Dakota Legislative Assembly

New legislation includes rebase of Medicaid physician payments; new facility for the Bismarck Center for Family Medicine

NDMA lobbyists tracked and participated in deliberations on over 100 bills and resolutions during the session, which adjourned on May 4 and were present every day of the session. Many of our NDAFP member physicians actively participated in the session by providing testimony, contacting legislators or participating in the NDMA Doctor of the Day Program. "Thank you" to all these physicians.

NDMA came to the 2009 session with a membership-driven agenda developed by the Commission on Legislation, chaired by Dale Klein of Mandan, approved by the NDMA House of Delegates in September 2008, and refined by both the Council chaired by NDMA Vice President Kimberly Krohn and the Commission on Legislation prior to the start of the session.

The NDMA legislative agenda for 2009 included proposed efforts to enhance North Dakota's practice environment for physicians and to improve the health of the public. Particularly gratifying was the appropriation for funding a new facility for the Bismarck Center for Family Medicine and other UNDSMHS budget initiatives and enhancements. Other major health care accomplishments achieved by legislators in the 2009 session include the following:

●Improved Medicaid physician payments rebased closer to cost (near BCBSND rates), based on NDMA methodology developed pursuant to legislation we achieved in the 2007 session;

●Protected our current medical liability reforms including defeat of a bill that would have repealed our current $500,000 cap on non-economic damages in medical liability lawsuits; and strengthening the requirement that an expert opinion be filed within 90 days after filing of a medical liability lawsuit

●Supported legislation providing a presumption in favor of the treating physician in WSI matters;

●Supported funding for health information technology including leverage of federal HITECH Act funds and infrastructure for plan development;

●Advocated for legislation allowing a physician to rely on the consent of a minor for pregnancy testing, pain management related to pregnancy, and prenatal care under certain circumstances;

●Supported Measure 3 and subsequent funding for a CDC-based tobacco prevention and control program for North Dakota. Funding became very controversial during the session and the bill introduced to implement Measure 3, SB 2063, was defeated in the House. The legislation adopted in the waning hours of the session in HB 1015 appropriated almost $13 million for the program, and added provisions requiring that any moneys in the water development trust fund can be spent only pursuant to legislative appropriations and requiring the tobacco prevention and control executive committee to submit a biennial budget to OMB as required by other state agencies. The bill also requires the executive committee to report to the Legislative Council's Budget Section quarterly on the implementation of the comprehensive tobacco prevention and control plan and outcomes achieved, for the 2009-10 interim, and includes language ensuring that the executive committee is a state agency.

●Passage of legislation responding to the performance audit of the UND School of Medicine & Health Sciences, including the purpose of the Medical School, duties of the UNDSMHS Advisory Council and the UNDSMHS loan fund. The Legislative Assembly enacted the following new UNDSMHS statement of purpose: "*The primary purpose of the UND School of Medicine and health Sciences is to educate physicians and other health professionals and to enhance the quality of life in North Dakota. Other purposes included the discovery of knowledge that benefits the people of this state and enhances the quality of their lives.*"

● **Support public health initiatives.** NDMA was involved in supporting many public health initiatives, including the passage of legislation prohibiting the sale or distribution of bottle rockets by fireworks retailers. Other bills include the appropriations bill for the Department of Health, which provides funding for tobacco prevention, the medical loan repayment program, Women's Way, suicide prevention, Russell-Silver Syndrome grants, newborn hearing screening, colorectal cancer screenings, stroke registry and prevention, and tobacco prevention and control and other programs.

Another bill revises the state's criminal laws relating to breastfeeding and addresses workplace breastfeeding policies. Led by the advocacy of Dr. Joan Connell, the bill states: "If the woman acts in a discreet and modest

manner, a woman may breastfeed her child in any location, public or private, where the woman and child are otherwise authorized to be."

The state's coroner laws were also revised, including the expansion of eligibility for serving as a coroner to all individuals who meet the qualifications, training and continuing education requirements determined by the State Forensic Examiner. Dr. John Baird was instrumental in developing the legislation and moving it through the legislative process.

Many public health issues did not survive the session. For example, the legislature defeated proposals for primary seat belt enforcement, a prohibition of wireless communications while operating a motor vehicle, restrictions on minors while driving, an expansion of the state's smoke-free workplace law to bars and hotel and motel rooms, and a prohibition on smoking in vehicles when an individual aged sixteen or younger is present in the vehicle.

Looking to 2011

Much was accomplished by the 61st ND Legislative Assembly, and many individual legislators took up our various causes. Please let your legislators know that you appreciate their service – and keep them apprised of your concerns.

The work in preparing for the 2011 has already begun. Several studies were proposed for interim ND Legislative Council committees to address health care issues between legislative sessions. Many of these studies were prioritized by the ND Legislative Council on May 20, including these studies: 1) issues relating to unmet health care needs, 2) access to psychiatric services and mental health commitment procedures, 3) factors impacting the cost of health insurance, 4) the needs of pregnant minors and whether additional education and social services would enhance the potential for a health child and a positive impact for the minor, 5) consideration of workers compensation laws with respect to prior injuries, preexisting conditions and degenerative conditions, 6) the emergency medical services funding system, 7) the state immunization program, 8) workforce needs, and 9) the impact of traumatic brain injuries.

With national health care reform being debated in Congress, it will be an active interim legislatively. As the work continues, your help in supporting NDAFP and your state medical society are critical in ensuring we have the resources and expertise to continue to be successful.

NDAFP Board of Directors Meeting Minute

June 18, 2009, Ramkota Hotel

The meeting was called to order at 9:15am.

Novus, LLC provided a strategic planning report. Handouts available upon request from Brandy Frei.

The prior meeting minutes were approved with discussion in regards to changing the committee structure.

The committee reports were presented. External Affairs was deferred to the business meeting. The Internal Affairs report was provided by David Field. A current investment report was presented. The CME committee had no changes at this time. The Resident and Medical Student Committee had no report. The Foundation report was given by Kim Krohn. The endowment fund pledge drive is in its final year of an initial 3 years pledge. There will be a request for a renewal of pledges. The Foundation received the boards approval to re-appoint the current officers and board members.

New business was presented. Kim Krohn spoke about the Practice Enhancement Forum that will be presented in October of 2010. Kim Krohn and Charlie Christianson are mentors for anyone interested. This program will count towards the ABFM Part IV.

The meeting was adjourned at 11:50am.

NDAFP Foundation Meeting Minute

June 18, 2009, Ramkota Hotel

The meeting was called to order. Due to limited attendance there was some general discussion but no official agenda.

1.The officers need to be confirmed or we need to recruit some new officers and board members. Potential candidates include Jon Rice, Guy Tangedahl, and Dale Klein.

2.It is time for the 3rd payment to the endowment fund.

3.Need to present financial statements to include separate account for endowment. Will research AAFP, DMF, and other local foundations.

4.Need to assign duties to all members.

5.Kim Krohn suggested starting a self evaluation form to encourage more participation by all.

Characteristics of the Class of 2013

Judy DeMers

The Class of 2013 (entering on August 3, 2009) is composed of 62* individuals. The following provides statistics in relation to class members.

Sex: Male = 22 (35.5%) Female = 40 (64.5%)

Age: ---at date of matriculation (8-3-09)

Range = 21-36yrs
Mean = 24.2 yrs
Median = 23 yrs
Mode = 22 yrs

21 yo = 1
22 yo = 18
23 yo = 13
24 yo = 14
25 yo = 4
26 yo = 2
27 yo = 3
28 yo = 3
29 yo = 1
33 yo = 1
34 yo = 1
36 yo = 1

State of Residence (8 states)

ND = 49 (I INMED)
MN = 6
OK= 2 (Both INMED)
MT = 1 (WICHE)
AR = 1 (INMED)
AZ = 1 (INMED)
MO = 1 (INMED)
PA = 1 (INMED)

Ethnic Background: Nine (14.5%) of the students self report an ethnic minority background. Seven are American Indian and two are Asian/Eastern Pacific.

*Four previously admitted students are joining the class of 2013 in August, bringing the total to 66. In addition, two of the entering INMED students who are now part of the class will transfer to the Sanford School of Medicine at the University of South Dakota at the completion of Year 02.

Majors*: Bachelor's Degree -

Biology = 32
Chemistry = 9
Zoology = 6
Psychology = 4
Exercise Science = 2
Interdisciplinary Studies = 2
Philosophy = 2
Biochemistry = 3

One major each: (N=15)

Anthropology
Behavioral Neuroscience
Cell Biology
Cellular & Molecular Biology
Child Development
Classics
Forensic Science
French
German
Mathematics
Political Science
Statistics
Clinical Laboratory Science
Women's Studies
Entrepreneurship

**Total exceeds 62 due to students having more than one major or more than one Bachelor's degree.

College/University Attended for Bachelor Degree Study (N=26)

University of North Dakota = 17
University of Minnesota- Twin Cities = 3
North Dakota State University = 9
University of St. Thomas = 3
Concordia College = 5
Gustavus Adolphus College = 2
Minot State University = 3
St. Olaf College = 2

One student each: (N=18)

Cleveland Chiropractic College
University of Kansas
College of St. Benedict
University of Mary
Montana State University
University of Northern Colorado
Northeastern State University (Oklahoma)
University of Pittsburgh
Northeastern University (Boston)
University of Oklahoma (Norman)
Oberlin College
University of Sioux Falls
Texas A&M University
University of Wisconsin – River Falls
University of Arizona
Washington University (St. Louis)
University of Idaho
Westminster College (Salt Lake City, UT)

Graduate/Advanced Degrees (4 Institutions) with Majors

Dartmouth College (MPH) – Public Health
Luther Theological Seminary (M.Div) – Religion
Saint John's College (Annapolis, MO (M.A.) – Liberal Arts
University of Wisconsin - Madison (M.S.) - Chemistry

Information Technology and Teaching in the Office—*Social Networking in Medical Education: Where Are We Going?*

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

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The Internet and cell phones have changed our world forever. There are more ways to communicate with each other than ever before. While there are many pluses to this age of nonstop communication, there are issues of privacy and time that can't be neglected. I personally walk around with two cell phones on my belt, each on a different network. One is an iPhone so that I can read and respond to multiple e-mail accounts and surf the Internet. The other is a basic phone that I use to keep in contact with my family and friends. Social networking software has now taken us beyond cell phones, text messaging, and e-mail. My Facebook account now allows me to communicate with family, current friends, old friends, students, and colleagues in a way that was not possible 10 years ago.

So, can Facebook and other social networking software be valuable for medical education? There have been a few articles that have addressed this issue. The most comprehensive article is titled "Networking in Medical Education: Creating and Connecting."[1] In this article, Dr Supe states, "There are three key aspects to social network-ing that sustain user interest. These are (1) a sense of community, (2) the development of friendships, (3) ease with which they can interact with other users and ultimately learn from them." She goes on to say that "Networks can be solutions looking for a problem to solve or an opportunity to exploit." "In an optimized personal network—less is more—you leverage a minimal number of contacts to maximize your work efficiency and effectiveness. Other nonessential contacts may provide ben-efits, like a sense of belonging, friendship, or juicy gossip."[1] From a narrowly utilitarian perspective, however, the time invested in maintaining these network contacts does not provide sufficient work-related returns."[1]

One social network is the FAIMER Institute, which has created international networks of medical educators. This is especially directed toward medical educators and third-world countries looking for support and faculty development.[2] Another interesting site is the Medical Education Evolution site on Ning (http://medschoolevolution.ning.com). Ning is another type of online social networking group.

Our medical students are already using Facebook, Yahoo groups, and other social networking software. Results from one study reveal that medical students and residents are using Facebook, and about two thirds of users maintain public profiles.[3] "While there is variation in the types of information provided within profiles, many medical students seem unaware of or unconcerned with the possible ramifications of sharing personal information in publicly available online profiles even though such information could impact their professional lives."[3] This article gives examples of less than professional communications and photos found on the sites of the medical students and residents in the study.

I was introduced to social networking software through my college daughter and my medical students. When we started our Humanism in Medicine Fellowship, the medical students immediately created a Yahoo group so that we could communicate with each other beyond the world of e-mail and listserves. We are able to track our seminars in the Yahoo group, which we set to automatically send e-mail reminders before each seminar occurs.

I then joined Facebook so that I could see my daughter's photos online and communicate with her at college. Shortly thereafter, a national group of medical students created the National Association of Student Run Free Clinics as a Facebook group. I happily joined this group. The group was useful to promote the national conference of students and faculty involved in the area of student-run clinics. Because we were planning a student-run clinic meeting in Savannah, Ga, I was pleased to have this Facebook group to advertise our meeting at STFM's Predoctoral Education Conference.

Some students have asked me to be their Facebook friends, and I have accepted these online relationships. I have not had any inappropriate communications from medical students, and I see nothing in this group that represents a breach in professionalism. When I gave an elective talk to our medical students on a new book that I recently coauthored, the students used Facebook to help promote this speaking event. I appreciated this greatly.

The Family Medicine Digital Resources Library (FMDRL) is a form of social and educational networking that has been successful within STFM for the last 5 years. Faculty members post their educational presentations, curricula, and other educational ideas to share

freely with our community of family physicians. As a cofounder of FMDRL with Jacob Reider, MD, and others, I am delighted to see how this has grown to now encompass more than 1,600 resources with multiple active groups.

FMDRL allows the groups from STFM to have Wikis and discussion groups. Some groups have taken full advantage of this networking software to create growing and evolving ideas and documents. Each user can set up a My FMDRL page with a photograph and some biographical information.

While many medical students are on Facebook and faculty are beginning to join them, there are other social networking sites, including MySpace, Twitter, and Ning. Medical schools are more likely to be using sites and software such as Blackboard to host courses and promote communication between professors and students, but there is a place for social networking software to grow in medical education. A number of student groups in our medical school use Facebook for their student organizations. One such group is doing medical mission work on the border with Mexico. Students use the software Evite to keep track of invitations to social/professional events. Yahoo groups is still a viable option to enhance communication.

What are the downsides to this expansion of social networking? In a discussion held recently on the Predoctoral Education Listserve, a number of faculty members expressed concerns about their individual and family privacy. If you use Facebook with your family members and friends and then become friends with students, the default setting would allow the students to see photographs and information posted by your family members. This may not be acceptable to faculty wanting to keep a wall between their private and professional lives. So far this has not been a problem for me, but I am aware of the issue. The other issue is time. Is there sufficient benefit to justify more time in front of a computer with more messages to read and answer? While in the midst of this discussion on our listserve, one of our colleagues created a Facebook for Predoctoral Educators. Right now, there are 23 members and very little discussion. Will this ever replace or overtake our listserve?

What about blogs? Blogs have been used for students to record the reflections on experiences with in school and or on-away electives. Our students are required to create a blog when they go to India for an away elective. Students provide interesting insight into their experiences in the health care system of India. The explosion of inexpensive high-quality digital cameras has enhanced all online sharing of experiences through images. When we give our students digital cameras to photograph their experiences on their family medicine rotation, their images are shared using Internet software.

Whatever your opinion is of social networking software, it is clearly part of the new generation. We can ignore it or join with our students to reap the benefits of this new technology.

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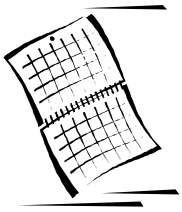

MARK YOUR CALENDARS!!

September 11-12, 2009
ALSO **Grand Forks, ND**

December 12, 2009
Fall CME **Grand Forks, ND**

January 18-22, 2010
33rd Annual Family Medicine Update
Big Sky, MT

UND Medical School Inducts First Members of Gold Humanism Honor Society

Wendy Opsahl

(June 19, 2009: GRAND FORKS, N.D. – Eight senior medical students from the University of North Dakota School of Medicine and Health Sciences were the first members inducted to a new chapter of the Gold Humanism Honor Society on Thursday, June 18. Keynote speaker Stephen Tinguely, M.D. '78, provided an inspiring commentary on humanism in medicine. An associate professor and chair of pediatrics at the UND school of Medicine and Health Sciences, Fargo, has throughout his career epitomized the qualities of a humanistic physician.

The UND chapter joins 77 other medical school chapters across the country in recognizing senior medical students who demonstrate exemplary humanism and professionalism throughout their medical education. Creation of the chapter was made possible by a grant from the Arnold P. Gold Foundation.

Fifteen percent of the class was selected through a process including peer nomination and subsequent confirmation by the school's Gold Humanism Honor oversight committee. Each student's clinical performance and record of community service was considered.

Members of the class of 2010 include:

Miran Blanchard
Dan Dixon
Katrina Gardner
Chad Hanson
Erica Martin
Jennifer Mullally
Luke Van Alstine
Stacie Wellman

"We are very pleased to bring this recognition of the importance of humanism to our school," said Judy DeMers, associate dean for student affairs and admissions. "We congratulate these students on their commitment to patient care and dedication to the medical profession."

Communicating Laboratory Results: A Quality Assurance Exercise

Ann De Jong, MD, Completed as PGY-3 at Minot Center for Family Medicine

ABSTRACT

Introduction: The review and communication of laboratory test results is one of the most critical tasks a physician performs. This exercise in quality assurance examined the overall patient satisfaction with the communication of laboratory results.

Methods: Thirty laboratory encounters were identified. The laboratory test, date of test, result date and notification date were recorded. The patients were then surveyed as to the timeliness, understanding, follow up and overall satisfaction.

Results: Lab results were conveyed an average of 2 days from date of test. Patients notified by phone and by letter rated their overall satisfaction 5 out of 5 as compared to patients who were notified in person who rated their overall satisfaction 4.7 out of 5.

Discussion/Conclusion: There was a slight patient communication preference to phone calls and letters. This finding was not statistically significant. Thus, as physicians are compelled to pursue efficient and reliable systems of relaying laboratory results, we may consider communicating laboratory results as preferred by the patient to promote effective patient interactions and enhanced understanding.

New Residents Starting July 1, 2009

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Jennifer Sheffield, MD: American University of the Caribbean, Netherlands Antilles

Misbah Altaf, MBBS: Sind Medical College, Karachi, Pakistan

Patricia Bramati, MD: Univeridad de Buenos Aires, Argentina

Sanjay Patel, MD: Baroda University Government Medical College, Baroda, India

Ashwini Tirhtahalli, MBBS: Rajiv Gandhi University of Health Sciences, Karnataka, India

Grand Forks

Olumide Ajayi: American University of Antigua

Renato Bernado: Davao Medical School

Andrew Gasparini: UND SMHS

Jon Kolberg: UND SMHS

Sara Mees: UND SMHS

Johanes Prawira: Universitas Diponegoro

Fellows in OB

Jessica Kumar, MD St. Cloud MN

Eric Thomson, MD Des Moines, IA

Minot

Owadini Bandara, MD: University of Sri Jayawardenepura in Sri Lanka

Gilbert Falcon: UND SMHS

Mark Longmuir: UND SMHS

Olubukola "Buki" Olatunji, MD: University of Ibadan in Nigeria

Vikash Priyadarshi, MD: Jawaharlal Nehru Medical College, Belgaum in India

Marisa Upton: UND SMHS

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