NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

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Roger W. Schauer, MD

We extend our wishes for a great holiday season and happy New Year to all of you.

In recent news, **Dr. H. David Wilson** resigned as dean of the University of North Dakota School of Medicine & Health Sciences. Our curriculum renewal project, which resulted in our Patient-Centered Learning approach to medical education, was made possible because of Dean Wilson's leadership. In the past year he challenged us to improve our current curriculum for years 1 & 2 of medical school, but also to look at updating our clinical education programs for years 3 & 4. I personally am grateful for the support Dr. Wilson has provided for the family medicine clerkship as well as our ROME (Rural Opportunities in Medical Education) program. Best wishes to Dr. Wilson as he pursues new opportunities. **UND President Dr. Robert Kelley** named Dr. Joshua Wynne as the acting dean, and soon will name a search team for the new dean.

In this FMQ we continue to focus on activities of your Academy as well as our continued discussion addressing primary care medical education. To begin, **Dr. Beattie's** "A Review…" **addresses digital media, including the *i*Phones and iPods**. By permission from the "Teaching Physician" we have reprinted "Practicing and Teaching Medicine with the *i*Phone". We previously reprinted a number of Dr. Usatine's articles, including "Practice and Teaching with the PDA", a technology our students are utilizing (see Fall 2008 FMQ). A number of you have asked for more information about the PDA and access to on-line information through our library, because you have seen our students using the technology in clinical practice. The *iP*hone referenced by Dr. Beattie might be out of reach in North Dakota in the immediate future, as AT&T is the exclusive carrier for *i*Phone and AT&T's cell phone access is quite spotty and varied in ND. *i*Pod technology *is* available anywhere and in use in a number of medical schools across the country, where they are recording most or all their lectures to make them available to students at any time. Recent curriculum discussions held in our Office of Medical Education (OME) have addressed the possibility of recording lectures during years 1 and 2, but that technology could also be available for recording clinical lectures so students could review presented information at any time, if they were unable to attend a lecture or wanted that lecture as a resource for patient care activities.

Dr. Glunberg brings us up to date in Academy activities, and both he and Brandy remind us about the upcoming **Big Sky meeting.** Bruce Levi's **"T'was the night before session…"** begins lyrically but then proceeds to discuss our opportunities for input as our elected officials address delivery of health care in our state and in our country. The discussions have begun. One of the opportunities he speaks to that needs your attention is being "Doctor of the Day" at the upcoming legislative session, an opportunity Dr. Krohn wrote about in our summer 2008 issue of the FMQ.

Another meeting that might be of interest to you is the Dakota Conference on Rural and Public Health, held April 1st through the 3rd, 2009, at the Seven Seas Hotel in Mandan. In brief review, the focus of this year's meeting is **"Building and Sustaining Healthy Rural Communities"**. There will be discussion about collaboration as well as technology for communication and medical records. UND president **Dr. Robert Kelley** will be the **keynote** speaker at 8am, Thur., April 2. This would be a great opportunity to hear his views about how the University

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A View from UNDSMHS Dept. of Family and Community Medicine

Rob Beattie, M.D.

I recently returned from a conference on using digital media. The meeting was sponsored by the University of South Florida and Apple Computer. A hundred and ninety one people, representing 85 organizations attended. Some of the session offered included:

Embracing the Digital World
Transforming Medical Education
Mobility in Higher Education and Health Care
3-D Virtual Environment for the Health Care Professional
Systemic Design of Alternative eLearning Environments

Apple, being one of the sponsors, loaned an iPod touch to attendees without their own iPod or iPhone. What an amazingly powerful piece of technical equipment with the intuitive ease of simply using your finger to navigate its breadth of function. It delivers dynamic audio, stunning video and internet access via WIFI connection. It is much like a laptop in the palm of your hand.

We learned many medical schools are recording lectures and presentation content, making it available to medical students for use outside of the normal classroom setting. Some have been archiving this content for many years, representing a valuable and irreplaceable resource. Students use this material in a number of different ways, including test review, transcription of notes and serving as an alternative to attending class when conflicts arise. Some schools have dedicated staff to produce and archive this content, while others leave it to the student body to assign responsibility for turning the equipment on and off. The take-home message is that we, too, need to preserve this resource. The potential and varied use of this content by our students is obvious. What may not be immediately obvious is the availability and use of this content for all of us to use to improve our understanding of emerging concepts in our ever changing profession.

As a first step, we will be surveying the interests and needs of our students as well as inventorying our present equipment and potential needs to begin this activity. I would appreciate hearing from you regarding your interest in having access to such a resource. Would this be of value to you if there were CME attached to this activity? I look forward to your thoughts about how this could impact your practice.

I would like to wish you all a save and blessed holiday season.

Message from the NDAFP President

Steven Glunberg, MD

Brandy and I are planning to contact the family physicians in the state by letter who are not members of the AAFP and NDAFP and ask them to become a member of our organizations. We may wonder why a physician would not want to be a member of their specialty society, and there may be several reasons. I think a common reason in family medicine is that individuals who have been trained in family medicine may not feel they belong in this organization because they but are not practicing in a traditional "full service" family practice that most of our predecessors practiced. This should remind us that our family medicine training provides us with the skills and knowledge to fill many roles in primary care. Not all choose to be or are capable of being a "Heidi Bittner", our remarkable colleague who practices cradle to grave care and does emergency c-sections during her lunch hour. Some of us maintain only out-patient practices; others practice in an emergency room or walk-in clinic setting. Others limit their practice to women's health, occupational health, sports medicine or other focused areas of medicine. I am quite sure that our organization has never had a president with a more focused practice than I have, limiting my practice to college health the past few years. We also have members of our board of directors who do not practice in a traditional primary care practice model. I believe our organization should be and I think is inclusive of all who are trained in family medicine and use that training in whatever practice model they are working in.

This is a concept that some disagree with and they feel if a primary care physician is not practicing the full spectrum of family medicine he or she is not a family physician. With the changes that have occurred in the practice of medicine the past several years and with the changes that are likely to occur in the future, I believe this thinking needs to evolve so our organization is of value and is an effective advocate for family physicians regardless of the practice model they choose. Brandy and I will try to convey this philosophy to our non-member colleagues in the state.

During our October commission and board of directors meetings it was decided the NDAFP would add another recognition award to our current awards. Nominations are now being accepted for the first annual "Friend of Family Medicine Award". This award is to recognize an individual's contributions to our specialty or our academy. This is in contrast to our Family Physician of the Year Award whose recipient is selected primarily for their contributions to their patients. Any NDAFP mem-

ber may nominate an individual and the award is open to non-members as well as members of the NDAFP. Our Executive Committee will choose the recipient from those nominated and the award will be presented each year at our annual meeting. Additional information about nominating someone you feel is deserving of this honor is available in this issue of the FM Quarterly.

I also want to take this opportunity to remind you of the upcoming 32nd Annual Family Medicine Update at Big Sky, MT scheduled for January 19 to 23, 2009. Registration information can be found in this edition of the FM Quarterly or online at www.ndafp.org. Our Big Sky Committee has always done a tremendous job putting together an excellent program and this year will be no exception.

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can work with communities throughout our state. For more information about the conference, see the "Mark Your Calendar…".

The final article for your attention is **"Teaching Points – a 2-minute Mini-lecture: Post Traumatic Stress Disorder in Primary Care Patients"** (PTSD). These learning points might be useful for teaching students, but the article may be also helpful to those of you who are seeing young men and women with PTSD for various reasons, including recent service in Iraq and Afghanistan. More than thirty years after the Vietnam War ended I was working with veterans of that era who still had to deal with PTSD in many aspects of their daily lives.

Please provide comments, perspectives, feedback, articles, or questions for Brandy or myself. The FMQ is one opportunity to connect with your colleagues.

NORTH DAKOTA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

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Executive Excerpt

Brandy Jo K. Frei

Merry Christmas and Happy New Year Everyone!!

Another year has flown by in the blink of an eye. With the many continued successful events that we had throughout the year, it is easy to see that we have another great year ahead of us.

The 32nd Annual Family Medicine Update Conference is quickly approaching. January 19-23 will bring many regular faces to our meeting as well as some new ones. The snow is already good, the lectures will be great, and all you need to do is pack your bags.

The AAFP Annual Leadership Forum (ALF) and the National Conference of Special Constituencies (NCSC) will be held in Kansas City April 23-25. This is a great opportunity to network with other physicians across the country as well as work on your professional development. If you are interested in either of these conferences, please do not hesitate to contact me.

The NDAFP Annual Meeting will be held in Bismarck June 18-19th. This planning for this meeting is in full swing already. With lots of great family activities planned you will not want to miss this years meeting. We will be enjoying an evening at the zoo, a picnic in the park, and will close out the conference with an exciting riverboat cruise. We hope to have more information out soon, so please mark those days on your calendar now.

We will hold the ALSO program September 11-12 in Grand Forks. We will also continue with the Fall CME program. Once the hockey schedule is released we will select a date.

Please do not hesitate to contact me with any suggestions you may have for dates, locations, speakers, additional activities to be offered, or any other ideas that you would like to include. We are looking for ways to make these events appealing to the most individuals.

With the many activities planned for next year, the new website to be up and running after the new year, and the desire to make this an even better organization than it already is, I hope you take the time to get more involved in academy activities. I am here to help, so please do not hesitate to contact me.

.'Twas the Night Before Session …
Bruce Levi, NDMA Executive Director

"And all through the House … and Senate" many are stirring and hanging their stockings with care in hopes that legislators will soon be there, to fill them up.

There will be no settling down for a "long winter's nap" -- the ND Legislative Assembly begins January 6. An aggressive legislative agenda for medicine is in place and your personal involvement is key to a successful outcome.

2009 Brings Opportunities
In previous sessions, physicians have diligently argued for the most vulnerable of your patients in seeking a reasonable resolution to the dilemma of Medicaid access and reimbursement for services, as well as access to health care for children and minors. In the upcoming eighty legislative days, or less, this issue will again be a priority for physicians who are ethically bound to respect the law but also to recognize their responsibility to change laws that are contrary to the best interests of patients.

Hopefully, the poetry of the legislative session overall will result in improved access and quality to medical care for North Dakotans. There is tremendous opportunity – opportunity encouraged in some areas by support from Governor John Hoeven's 2009-11 executive budget.

The opportunity to address the fact that the state pays only 51 cents for each dollar of physician care provided each Medicaid patient, by implementing a cost-based payment system for physician and hospitals as validated by the state's own consultants. Governor Hoeven's executive budget would rebase physician payments with a 20.66% increase in the first year of the 2009-11 biennium (14.05% for hospitals); a 7% inflator would apply to the second year.

The opportunity to create an environment in which fair contracts are offered by commercial insurance carriers for physician care, rather than on terms unilaterally imposed upon us. Insurance Commissioner Adam Hamm's efforts to change the way BCBSND does business with physicians and hospitals would be further enhanced by legislation developed by NDMA.

The opportunity to ensure even greater stability in our medical liability insurance market, by enacting changes proposed to our certificate of merit law and Good Samaritan law, and enacting protections for emergency volunteers.

The opportunity to improve patient care and safety, and to create an appropriate infrastructure for using health information technology in ways that help patients and improve care.

The opportunity to set a new course in how injured workers receive medically necessary care from their physician, with less interference and paperwork.

The opportunity to ensure that patients receive medical care only from health professionals who are qualified to provide care both appropriately and safely.

The opportunity to strengthen the ability of our Medical School and residency programs to "home grow" the physicians needed for tomorrow. The Governor's budget authorizes $1.3 million to assist in stabilizing operations of the Bismarck and Minot Centers for Family Medicine, adds $600,000 from the general fund to create a RuralMed program which will fund tuition scholarships to encourage students into family medicine, and allocates $225,000 of one-time general fund dollars to implement an electronic medical records system to link the Centers for Family Medicine clinics and hospitals for training purposes.

The opportunity to build a better capacity to retain and recruit the physicians we need to maintain the high quality of care North Dakotans have come to expect, and to create a favorable practice environment for physicians to practice quality, safe medicine.

The opportunity to improve the health of North Dakotans by giving them tools to live healthier lifestyles and, by 2020, to be the "healthiest Americans." In implementing Measure 3, the Governor's budget would establish a Comprehensive Tobacco Control Advisory Committee special line item with $18.6 million of special fund authority as a pass-through grant to the committee.

The opportunity to ensure that health insurance coverage is both accessible and affordable for all, and that all have a medical home from which to receive care. The Governor's executive budget would raise the eligibility threshold for Healthy Steps (SCHIP) to 200% of the poverty level; and increases the medically needy income levels from 64 percent to 83 percent of the federal poverty level.

Our healthcare system in North Dakota is at a crossroads. We're experiencing shortages and practice challenges in our physician workforce. A recent study shows that our dominant commercial insurer has underfunded health

care in our state in a manner that has resulted in physician and hospital payments and premium resources far below other states in our region. Poor, disparate payment by government payors has compounded the difficulty of the situation. While we continue to tout our high quality for less cost, and continue to force efficiencies as a result of our "poor payor" status, it is only a matter of time when we will no longer have the resources to continue to deliver the same quality and efficient care your patients expect.

Legislative Updates
As in past sessions, NDMA will provide you with weekly updates of the legislative activity in Bismarck – with hearing schedules, testimony and opportunities for you to become as involved as you wish throughout the session. Your involvement is a critical element of NDMA's grassroots contact with legislators. In addition, if you have an interest in a particular bill and would like to testify, please let us know.

The NDMA session updates and alerts will again be sent by e-mail to both NDMA members and non-members. If you don't receive the updates, we don't have your e-mail address. If you or any of your colleagues wish to receive updates, please call the NDMA office at (701) 223-9475 and provide us with your e-mail address. If you are receiving the e-Checkup currently, you will continue to receive legislative updates at that same address.

A new and improved NDMA website at www.ndmed.com will be uploaded just prior to the start of the session, with links and the latest legislative news. Our hope this session is to provide better coordination between the e-Checkup e-mails and the website, so messages are not as lengthy and less susceptible to spam filters.

Of course, if you ever have a question or concern regarding any legislative activity, please call the NDMA office.

Be the "Doctor of the Day"
The 2009 NDMA Doctor of the Day Program will begin the week of January 12, and continue into April. This is an excellent opportunity for you to observe the 2009 ND Legislative Assembly in action and involve family members if you wish.

NDMA or NDAFP members wishing to sign up for the Doctor of the Day Program may do so at any time by calling the NDMA office at 1-800-732-9477 or 223-9475.

As the Doctor of the Day, the physician provides primary care services to legislators and staff in a designated room at the capitol, where basic exam equipment and OTC medications are available. Coverage is usually needed from 8:30 am to 3:30 pm daily, but may be tailored to your availability. The physician is equipped with a pager, allowing you to observe the legislative session and discuss issues with your local legislators if you wish. These are important services appreciated by legislators, and provide physicians with significant visibility among legislators throughout the session.

Physicians are not expected to respond to medical emergencies while in the capitol. However, physicians are encouraged to check with their liability insurance carrier to determine if coverage is provided in this setting under their current policy.

NDMA will again provide hotel accommodations as necessary for those volunteers from outside of Bismarck-Mandan who may need to arrive the night before their service.

Making it Happen
The daily presence of medicine at the capitol throughout the session is critical. The Doctor of the Day program has always created good will for organized medicine over the many years it has been in place. Other professionals claiming "doctor" status would undoubtedly fill the gap if we were in the future unable to garner sufficient interest by physicians to participate.

Your lobbyists can do only so much in coordinating testimony and monitoring the 140+ healthcare-related bills that come before the legislature each session. Both Dean Haas and I will be at the capitol every day of the session. Dale Klein has done an excellent job as chair of our Commission on Legislation to identify an appropriate legislative agenda. Now it is up to you to do your part. Your grassroots contacts with your legislators are equally important. Let them know prior to the session of your interests and concerns. Please keep us in the loop on what you hear.

As the poem goes, in our efforts in the coming weeks we need to raise "such a clatter," so legislators will seriously look at what is the matter. We have "nothing to dread," with the exception perhaps of lost opportunities as the session takes it course. While the legislature may not fill our stockings, the fact that we've worked together to ensure that those stockings are there hung "by the chimney with care" is doing what's right for your patients.
Happy Christmas to all!

Reprinted by Permission from the Teaching Physician, October 2008 Volume 7, Issue 4

Teaching Points— A 2-minute Mini-lecture Post-traumatic Stress Disorder in Primary Care Patients

By John R. Freedy, Medical University of South Carolina

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 Freedy (Dr F) works with a second-year resident (PGY-2) who has seen a woman who has had several traumatic events in her life.

PGY-2: Ms B is a 43-year-old woman who is new to the area in the past few months. She's here today for a physical exam. She's pretty healthy, really. A bit of minor low back strain from time to time. This is not bothering her right now. I want to order a mammogram; its been over 1 year, but her previous mammogram was fine. She's never had an abnormal pap smear; the last one was less than a year ago. I plan to follow-up with that next time. She's not on any medications so won't need refills.
Dr F: Anything else of interest?
PGY-2: I'm not really sure. I was in there for more than 30 minutes. She kept dropping "bombs" about psychosocial issues. I didn't really know what to do. With everything else we needed to talk about, I didn't feel there was time to address these bombs.
Dr F: When you say bombs, what do you mean?
PGY-2: Well, about 5 years ago, she left an abusive marriage. She hadn't seen him in about 2 years, and he lives in a different state. Apparently, last week he just showed up to see their kids.
Dr F: Okay, how did seeing him affect her and their children? Did you ask her if she is safe at present?
PGY-2: Like I said, I had so much to cover, there really wasn't time to get into details. I'm not sure what I'd be able to do about her psychosocial issues anyway. By the way, she also told me that she was raped at age 25 and that she was sexually abused by her stepfather as a child.
Dr F: Okay, let's just take a deep breath here. I think you may be feeling that your job is to "fix it" with this patient. Obviously, it's not possible to fix the impact that each of these traumatic events had upon her sense of self, certainly not in your first meeting! So, we need to start by having you define what your role is with this patient at this time.
PGY-2: What do you mean, my role? I'm just trying to get through a complicated history and physical. All this psychosocial stuff is overwhelming. I just don't know what to do!
Dr F: Let's start with the idea that you are feeling what she is feeling—anxious and overwhelmed. This is a key clini-cal finding; you have recognized what she feels about herself and her life. It is anxiety provoking and overwhelming! Right now, your job is not to fix that for her. Rather, your job is to tolerate these feelings, her feelings, while you do two things. First, you need to take the time to form a relationship with her. Second, you need to gather clinically relevant information that helps you to understand the major factors that may now, or in the future, impact her health.[1,2]
PGY-2: Well, she already has a psychologist that she has been seeing to talk about these issues. Isn't knowing that she is going to someone enough?
Dr F: Let's talk about what this patient needs from you. Like any patient, she needs to know that you understand what is important to her. This is how you go about forming a trusting doctor-patient relationship with her. Communicate to her that you know what is important in her life.[1,2] Do you think it is an accident that she told you at least three times that she has been abused repeatedly in her life?
PGY-2: I guess not, but it still seems hard to address psychosocial needs with so little time.
Dr F: It is a challenge but not impossible. For example, I want to tell you about a study that some colleagues and I conducted at this clinic. We interviewed 411 adult patients and asked about traumatic life events, mental health symptoms, and patient attitudes about their doctors. Almost 90% of patients agreed it was appropriate for their family doctor to ask questions about traumatic life events and related mental health issues. But, only 25% of men and 40% of women reported that their family doctor had asked them about such things.[3]
PGY-2: So, you're telling me that patients don't mind being asked about sexual abuse, rape, or other traumatic events? That's pretty amazing!
Dr F: That's what adult patients tell us. They think it is appropriate for their family physician to ask about traumatic events and about how such events impact their mental health. Think about it—people often come to their doctor to fight a sense of being alone or isolated with regard to some problem.[1,2] So, a key task to forming a meaningful doctor-patient relationship, particularly if the patient has experienced a traumatic event, is your being willing to ask some simple questions about such events and how these events affected the patient.
PGY-2: Okay, I see what you are saying, but I still worry that I will get bogged down in too many details. I mean, what do I do if the patient falls apart?
Dr F: Remember, your task here is twofold. First, you

are trying to form a trusting doctor-patient relationship. That comes from her experiencing that you understand how her past rape or other traumatic events are an important issue in her life. Second, you are trying to gather clinically relevant information. You don't have to fix anything today. While you've picked up on her underlying anxiety, it is not your task to take that away from her right now.[1,2] Her psychologist or other aspects of her support system will help her to cope with her emotions. By not overreacting, you are providing her with a model that there is no need to be frightened by what she is feeling about herself.

PGY-2: I think I see what you are getting at, I should just accept that she may leave here today feeling overwhelmed or anxious. It just doesn't feel right, but I see what you are saying.

Dr F: Our assessment is that feeling overwhelmed and anxious is a natural state for her given that she has been repeatedly abused throughout her lifetime. I mean, first she is sexually abused as a child by her stepfather, then she is raped at age 25, finally, she is physically abused, and goodness knows what else by her ex-husband. It would be disrespectful of me as her physician to make her pretend that such events in her life have not been terribly painful.[4] By offering her a chance to be herself with me, no need to pretend that she feels better than she does, she gains a sense of acceptance from me that may carry over until the next time that I see her.[1,2]

PGY-2: Now I see what you are getting at. I'm serving as sort of a role model. If I can discuss what is most important to her, even briefly, without becoming overly emotional, I am really conveying a sense of validation and respect toward her.[1,2]

Dr F: That's right, and a sense of hope, an expectation really, that she can cope with whatever is going on in her life, well enough until you are able to see her again. Why don't you go wrap things up with her for today but offer the opportunity to see her back in a few weeks. You might tell her, "I just want to check back in with you to see how you are managing all of this stress in your life." I think she'd appreciate the offer.

In about 15 minutes, the resident physician returns and the conversation continues.

PGY-2: That went a lot better than I thought it would. She gave me a hug as she left and said she would be back in 3 weeks. I'm a little nervous about where all of this will take us—me and her that is.

Dr F: Well, let's remember that your anxiety about all of this is a clinical finding. You are picking up on the fact that she is feeling overwhelmed and anxious, remember?

PGY-2: I know you're right, Dr F, but I still feel like I'm getting in over my head.

Dr F: I'm actually glad to hear you say that you feel over your head. That tells me both that you recognize the im-portance of this patient's psychosocial problems and that you recognize that you need more knowledge and skill to properly address her psychosocial problems.

PGY-2: Okay, but where do I get the knowledge and skill to deal with this patient's problem? I'm not being trained as a psychiatrist in this residency!

Dr F: You're right, you are not her psychiatrist, but you are her family doctor. Did you know that family doctors and other primary care clinicians provide most of the mental health care delivered in the United States?[5]

PGY-2: I didn't know that. Is that really true?

Dr F: It is true and let me tell you why. There are a lot of barriers to seeking mental health care.6 From the patient's perspective, there are many advantages to seeing a family doctor: accessibility (it is easier to get an appointment with a family doctor), cost (it is cheaper to see a family doctor), insurance issues (most plans limit visits to mental health specialists), trust (patients generally trust their primary care doctor), and privacy (no one but the patient and the doctor need to know why the patient is being seen).

PGY-2: So from my patient's point of view, it may be a lot easier for her to see me for a mental health problem instead of a psychiatrist or other mental health specialist?

Dr F: That's right. I'm not saying that you can't or shouldn't ever refer to a mental health specialist. But, I am saying that you should listen to your patient's psychosocial concerns carefully, be aware that your patient may want and trust your help with such problems, and develop the knowledge and skill base necessary to manage such problems and to recognize when referral is appropriate.

PGY-2: So, I should be willing to talk to my patient more about these psychosocial issues and how these impact her mental and physical health. I also need to improve my knowledge and skill base about how traumatic events may affect mental and physical health. Is that right?

Dr F: That is what I'm saying. You should also be willing to provide mental health treatments within your scope of expertise: psychotropic medications, education, basic psychological counseling. You will learn to recognize when referral is appropriate.[2,7] At your stage of training, most doctors err on the side of referring too early. Without sufficient trust between you and your patient, they are less likely to accept your referral to speak with a mental health specialist. The patient may even view a premature mental health referral as a rejection by their primary care physician.

PGY-2: I think you're onto something, Dr F. Less than half of my patients referred for mental health issues actually show up at their scheduled mental health appointment. You're saying I should "hold onto" those patients longer, talk to them more, and develop my knowledge and skill base further so that I'm more comfortable with

at least initially ad-dressing their mental health concerns.
Dr F: That's exactly right. Let me give you some resources to read over. Once you've read over these sources, I want us to talk again so that you will be better prepared to understand and address this patient's mental health needs when you see her next (see below for list of resources suggested to PGY-2).
PGY-2: Thanks Dr F, I'll read these things over and then you and I can talk again.
Dr F: I'll look forward to it!

Suggested Resources for PGY-2:
• Bisson J. Clinical evidence concise: post-traumatic stress disorder. Am Fam Physician 2006;73: 120-4.
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Mark Your Calendar For The Dakota Conference in April!

Wendy Opsahl

The 24th annual Dakota Conference on Rural and Public Health, an interdisciplinary forum for sharing strategies for building and sustaining healthy rural communities, is set for April 1-3, 2009, at the Best Western Seven Seas Hotel & Waterpark in Mandan, N.D.

This year's conference, themed "Health Care in Crisis: Creative Strategies," 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 (UND) 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 and topics include:
-"Adapting to Change: Yes We Can" by Jim Hart, MD, Director of the Executive Program in Public Health Practice and the North Central Public Health Leadership Institute, University of Minnesota
-"Food is More than Something to Eat" by Wanda Agnew, PhD, director of nutrition services at Bismarck Burleigh Public Health, and Karen Ehrens, LRD, a health and nutrition consultant with Ehrens Consulting.
-"Creative Innovations in the Provision of Public and Private Health Care" by David P. Lawton, PhD, public health informatics coordinator, Nebraska Department of Health and Human Services
-Dr. Robert Kelley, President, University of North Dakota

For more information, visit ruralhealth.und.edu/dakotaconference. The Dakota Conference is facilitated and sponsored by the Center for Rural Health. Additional sponsors are Altru Health System; North Dakota Public Health Association; North Dakota Rural Health Association; UND College of Nursing, and the UND School of Medicine and Health Sciences Department of Family and Community Medicine.

Information Technology and Teaching in the Office

Practicing and Teaching Medicine With the iPhone

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

The iPhone is the coolest new PDA/Smartphone on the market, but can it help a physician teach and practice medicine? The original iPhone with the original software was not capable of running medical applications. The new Apple software now accommodates third-party applications, including the immensely popular and useful Epocrates. The new G3 iPhone is half the price and twice the speed as the first iPhone. Epocrates has released a free Rx package for the iPhone that has the same functionality as the free Rx package for Palm devices and Windows devices. It has one new cool picture function with pill pictures and a pill ID finder. Unfortunately there is a second lag time between the time that you start Epocrates and the time you have access to the touch keyboard to search for medications. The extra Epo-crates features that you can purchase for other operating systems are not available for the iPhone. The ones that are especially useful include the drug calculator for pediatric dosing and the Infectious Disease tool. With the pill ID tool you can describe an unknown pill and find the name of the medica-tion that goes with it. The application can be found at www.epocrates.com/products/rx/iphone.html or in the Apps Store in iTunes.

The next most important development in iPhone usage for medical applications is the production of the iSilo™ program for iPhone. iSilo is a sophisticated document reader that allows you to read many medical applications created for the PDA. The best collection of medical applications for iSilo and the PDA can be found at MeisterMed's Medical iSilo™ Depot. Currently, the iSilo introductory price is only $9.99, and this is a bargain since it is half the price of iSilo for the Palm. Most of the MeisterMed products are available for free, including DermMeister, which was created by Dr Andrew Schechtman and me. Other valuable MeisterMed products provide help with topics such as sexually transmitted diseases (STDs), antibiotic prophylaxis, ICD-9 codes, electrolytes, and flu vaccinations. This is just the tip of the iceberg, so I suggest you go to the following Web sites: www.meistermed.com/iphone.htm and www.meistermed.com/isilodepot/index.htm.

Other valuable applications for the iPhone include Mediquations, which was designed and developed by a third-year medical student from the University of Texas Medical Branch. Mediquations includes 104 formulas and scores, and the price is only $4.99. This replaces Medmath or MedCalc used on the Palm PDAs. A completely free medical calculator can also be found, and while it only has a dozen formulas, it has a nice pregnancy wheel. Two more pregnancy wheels are freely available through the App Store (use the Healthcare and Fitness tab). Eponyms (with a long list of diseases and signs named after famous doctors) has been recreated for the iPhone and provides definitions and some historical information. There are a number of ruler programs that turn your iPhone into a measuring device. This can be helpful if you can't find a ruler around the office and need to measure some-thing on the patient.

This has been a quick review of the medical software available for the iPhone in September 2008. People are feverishly creating new applications for the iPhone, and so there is much more to come. The iPhone itself is an amazing PDA/Smartphone that functions as a phone, an e-mail device, a Web browser, and a camera. The GPS, the maps, and the iPod make this an innovative all-in-one technology tool. At the price of $199 plus monthly fees, you can't go wrong if you like technology and want to be at the cutting edge of portable technology for the practice and teaching of medicine. One barrier is that you must use AT&T cell phone service to use the iPhone. If you don't have an iPhone now, one of your students will show up with one in your office. Let them give you a tour, and you will be tempted to get one in the future.

2009 BIG SKY MEETING AGENDA

Sunday, January 19, 2009

3:00pm	Registration in the Firehole Lounge-until 6:00pm
5:30 p.m.	Welcome Reception: Upper Atrium – until 7:00pm

Monday, January 19, 2009

7:00 a.m.	Testosterone Deficiency in Men – *Lynn Kohlmeier, M.D.*
7:40 a.m.	West Nile Virus Infection – *Paul Carson, M.D.*
8:20 a.m.	Recent Acute Care Literature Update: Part 1 – *Edward Panacek, M.D.*
9:00 a.m.	Follow-Up of Bariatric Surgical Patients – *Bill Geiger , M.D.*
	BREAK
4:30 p.m.	Infectious Disease Pearls – Part II – *Paul Carson, M.D.*
5:10 p.m.	HRT – *Lynn Kohlmeier, M.D.*
5:50 p.m.	Recent Acute Care Literature Update: Part 2 – *Edward Panacek, M.D.*

Tuesday, January 20, 2009

7:00 a.m.	MRSA Overview – *Paul Carson, M.D.*
7:40 a.m.	Tricks of the Trade – *Edward Panacek, M.D.*
8:20 a.m.	Appropriate Testing to Diagnose Causes of Abnormal Liver Chemistry Tests – *Bill Geiger, M.D.*
9:00 a.m.	Ten Years Younger? An Evidence Based Lifestyle Program Geared to Assess and Enhance Physiological Markers of Wellness and Fitness – *Steven Masley, M.D.*
10:00 a.m.	WORKSHOP: Cutting-Edge Nutrition for Family Physicians – *Steven Masley, M.D.*
	BREAK
4:30 p.m.	What to Expect When Your Patients are Not Expecting: Infertility 101 – *Randle Corfman, Ph.D., M.D.*
5:10 p.m.	Fibromyalgia and Polymyalgia – *Bill Geiger, M.D.*
5:50 p.m.	New Drugs and Therapeutics Update – Part 1 – *Rick Clarens, M.D.*

Wednesday, January 21, 2009

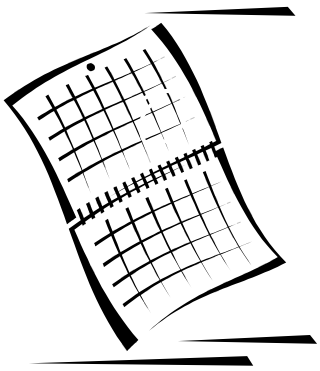
7:00 a.m.	Amenorrhea, Ovulation Abnormalities and Polysystic Ovarian Syndrome – *Randle Corfman,Ph.D., M.D.*
7:40 a.m.	New Drugs and Therapeutics Update – Part 2 - *Rick Clarens, Pharm D.*
8:20 a.m.	Outpatient Management of Heart Failure for Primary Care – Beyond ACE Inhibitors and Beta-blockers – *Steven Ommen, M.D.*
9:00 a.m.	Survival Medicine - *Randle Corfman, Ph,D., M.D.*
	BREAK
4:30 p.m.	Managing Pain in Patients with Addictive Disorders – *Ted Parren, M.D.*
5:10 p.m.	Effectiveness and Safety of Agents for Type 2 Diabetes - *Rick Clarens, Pharm D.*
5:50 p.m.	Mission Physician – Bill Mann, M.D.

Thursday, January 22, 2009

7:00 a.m.	Pregnancy and Substance Abuse – *Ted Parren, M.D.*
7:40 a.m.	Diagnosis – *Bill Mann, M.D.*
8:20 a.m.	Managing Cultural Conflicts in Medicine – *David Satin, M.D.*
9:00 a.m.	The Difficult Doctor Patient Interaction – Basic Communication Survival Skills – *Ted Parren, M.D.*
	BREAK
4:30 p.m.	Treating Non-Patients – *David Satin, M.D.*
5:10 p.m.	Cardiac Evaluation Prior to Non-Cardiac Operations – *Steve Ommen, M.D.*
5:50 p.m.	Sexual Dysfunction – *Thomas Hutchens, M.D.*

Friday, January 23, 2009

7:00 a.m.	Comparisons of Canadian and US Health Care Systems – Is Universal Health-Care the Way to go? – *David Satin, M.D.*
7:40 a.m.	Pelvic Prolapse – *Thomas Hutchens, M.D.*
8:20 a.m.	Triage of the Downed Athlete – Bill Mann, M.D.
9:00 a.m.	Adjourn



IMPORTANT DATES TO MARK ON YOUR CALENDAR

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

April 1-3, 2009
Dakota Conference **Bismarck, ND**

June 18-19, 2009
NDAFP Annual Meeting & Scientific Assembly **Bismarck, ND**

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

Date to be announced
Fall CME **Grand Forks, ND**

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

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