

Washington Family Physician

THE JOURNAL OF THE WASHINGTON ACADEMY OF FAMILY PHYSICIANS

FALL 2019 ISSUE

Crisis Standards of Care: Healing in the Aftermath of Disaster

Welcome to WAFP, DOs!

Allopaths or Osteopaths, We're
All Family Physicians

Service Learning in Residency

Too Often, 'There's No Time For That'

Beyond the Chief Complaint

Discerning What A Patient
Really Needs





Build **YOUR** practice at Family Care Network

An independent, physician owned
family medicine network in the
beautiful Pacific Northwest

- Excellent earning potential
- Independent practice model with central administrative support
- Flexibility to balance work, interests and quality of life
- 11 clinic locations, laboratory and inpatient services

We're growing with our communities and actively searching for physicians, ARNPs and PA-Cs to join our team.

Get to know us at familycarenetwork.com, then let us get to know you.



Birch Bay
Ferndale • Lynden
Anacortes • Bellingham
Mount Vernon

SEATTLE

WASHINGTON
STATE



Family Care Network
We Take Care

apply: familycarenetwork.com/careers | email: fcnhr@fcn.net

IN THIS ISSUE

On Numerous Fronts, WAFP Working to Advance Family Medicine	Russell Maier, MD ... 2
State Legislature: Looking Back at 2019, Looking Forward to 2020	Jonathan and Patricia Seib 3
Too Often, Gender Nonconforming Patients Feel Unwelcome	Chelsea Unruh, MD 5
2019 Congress of Delegates Considers Three WAFP Resolutions	Russell Maier, MD, Gregg VandeKieft, MD, Tony Butruille, MD, and Kevin Wang, MD 7
The Greatest Good for the Greatest Number	Rachel Wood, MD 9
Commentary: Medical Surge in the Era of AGEs	Ned Hammar, MD 13
Submit your Nomination for FPOY and FMEYOY Today! 15
DOs: A Welcome (And a Little Bit About Us)	David Escobar, DO 16
Situational Awareness Helps Minimize Fallout from Distractions	Collena Butler 17
WAFP Annual Calendar 19
Resident Trustee Column: "There isn't really time for that ..."	Brianne H. Rowan, MD 20
Student Co-Trustee Column: Beyond the Chief Complaint	Manon Begert 21
WAFP Welcomes New Members 23
Upcoming Eventsback cover



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Published by

Washington Chapter
American Academy of
Family Physicians
1239-120th Avenue NE, Suite G
Bellevue, WA 98005
425.747.3100
Fax 425.747.3109
www.wafp.net

President: info@wafp.net
Editor: editor@wafp.net
Legislative: info@wafp.net
Members/Students/Residents:
info@wafp.net

Editor

Ned Hammar, MD

Officers

Russell Maier, MD, FAAFP
President

Jeremia Bernhardt, MD
Immediate Past President

Lillian Wu, MD, FAAFP
President-Elect

Angela Sparks, MD, FAAFP
Vice President

Mark Johnson, MD
Secretary-Treasurer

Shawn West, MD
Asst. Secretary-Treasurer

House of Delegates

Jeanne Cawse-Lucas, MD
Speaker, House of Delegates
Jonathan Wells, MD
Vice Speaker, House of Delegates

Trustees

Ann Diamond, MD (East)
Jordan Storhaug, MD (East)
Saul Valencia, MD (East)
Molly Hong, MD, FAAFP (West)
Patrick McLaughlin, MD (West)
Pamela Pentin, MD, JD, FAAFP
(West)

David Escobar, DO
New Physician
Brianne Huffstetler Rowan, MD,
MPH
Resident
Diana Huang, MD
Alternate Resident
Manon Begert, OMS-2
Student
Katie Schmidt, MS-3, MPH
Student

Delegates to AAFP

Russell Maier, MD, FAAFP, Yakima
Gregg VandeKieft, MD, MA, FAAFP,
Olympia

Alternate Delegates to AAFP

Tony Butruille, MD, Leavenworth
Kevin Wang, MD, FAAFP, Seattle

Staff

Kim McCaulou
Brian Hunsicker
Simoné Mansor
Alyssa McEachran
Lindsay Soyer

Non-Member Subscription Rate

\$40 per year to subscribe,
email info@wafp.net

WFP POLICY AND PURPOSE:

ADVERTISING INFORMATION:

The Washington Family Physician (WFP) Journal is the official quarterly publication of the Washington Academy of Family Physicians (WAFP). It serves as the primary communication vehicle to WAFP members. Its purpose is to provide timely and relevant information regarding the practice of Family Medicine, and report results of the policies determined by the Board of Directors and activities of members and committees. In addition to regularly published articles from selected Officers, trustees, and committee chairs, WFP welcomes submission of articles on a wide variety of subjects related to the practice of Family Medicine.

The WFP Journal is distributed to 3,500 WAFP members in Washington State, plus the other constituent chapter Offices of the AAFP throughout the United States.

- Advertising sales and publication production are coordinated by WAFP. Please call for a rate sheet and production specifications. Correctness of advertising is verified through proofs to the advertiser, and liabilities for changes after approval are the responsibility of the advertiser.
- The WFP Journal will accept advertising when it is judged to be in accord with the stated purpose of the publication.
- Advertising in the WFP must meet the standards of generally accepted medical practice or be of interest to the readers because of its relevance to the clinical or socioeconomic practice of medicine.

WFP also welcomes articles written in a respectful and collegial manner that reflect opinion and editorials if, in our opinion, publishing such articles is timely, relevant, and will be of interest to the general membership of the Academy. Such articles will be clearly identified as an individual writer's opinion or point of view.

The views and opinions expressed by all authors in this publication are their own and do not necessarily reflect those of the Academy. Publication should not be considered an endorsement, expressed or implied, by WAFP.

- Advertising accepted by the WFP does not constitute a guarantee or endorsement by the WFP or the Washington Academy of Family Physicians.
- The WFP will not accept advertising of tobacco products or alcoholic beverages.
- The WFP will not accept new product releases.
- The WFP reserves the right to accept or reject any advertising and to evaluate advertising copy to ensure that it does not contain any false or misleading statements, is not in poor taste, and is not offensive in either artwork or text.
- Advertisers and agencies must indemnify and hold the WFP harmless of any expense arising from claims or actions against the WFP because of the publication of the contents of an advertisement.

EDITORIAL DEADLINES:

November 15, 2019: January, 2020 Issue
February 15, 2020: April, 2020 Issue
May 15, 2020: July, 2020 Issue
August 15, 2020: October, 2020 Issue

Printed on recycled paper with soy inks

Washington
Family Physician

Cover photo: "Tree in the Distance" by Flickr user "sea turtle", licensed under Creative Commons BY-NC-ND 2.0.



On Numerous Fronts, WAFP Working to Advance Family Medicine

RUSSELL MAIER, MD, FAAFP, WAFP PRESIDENT, YAKIMA

I hope fall has been treating you well. In our neck of the woods we have the equivalent of Halloween Mardi Gras. The city closes off streets, nearby churches and public institutions open their parking lots, and more than a thousand kids with attendant parents and older siblings throng our street. More than 1,500 kids came by for their treats.

Your academy is working hard to provide you with healthier treats. As a member organization we have been busy responding to your needs, and your requests through the House of Delegates.

At the AAFP Congress of Delegates, we brought forward three resolutions. They were not simple requests. Two addressed concerns with access to care around abortion. Our HOD formed a task force that worked with the authors to ensure that the resolutions would affect policy and pass. We succeeded, in large part, due to our deliberative process and great work from our task force.

When we look at the health of our population and the success of our specialty, investing in primary care has good evidence that patients live longer, are more satisfied, and we spend less money. Our state gets this, and the Health Care Authority has been convening payer and provider meetings. I joined several of our members in late October at the provider meeting. Improving the communication of EMRs and reducing paperwork is part of that investment. We hear that the administrative burden is a pain, and we are making it clear that part of investing in primary care is minimizing the administrative burden. That allows us to spend more time on patient care — and have evening time in our pajamas where we aren't doing charts!

The Academy's Primary Care Investment Task Force has continued to make progress to increase the prominence of primary care in Washington state. The task force, along with WAFP's advocacy consultants, has drafted a bill that will be presented to our champions in the legislature. The state's medical association has formally endorsed our efforts as well; we appreciate the Washington State Medical Association's partnership — as well as that of the state societies for our pediatric and

internal medicine colleagues — in advancing this critical initiative.

Unfortunately the changes in health care led to some losses. For the first time since 1985, a family medicine residency program is closing. The Skagit program, which has produced many local family physicians, is closing. The hospital has expressed concerns over achieving accreditation, yet they closed the program before the routine site visit. Skagit Regional Health has posted an announcement about the closure, which you can read at this address: <http://bit.ly/SkagitFMR>

Kim McCaulou, our new EVP, has hit the ground running. She is meeting regularly with members, has a weekly call with me, and has been out and about engaging our stakeholders. You, as members, have asked for more staff support. There are now five people in the office working hard on your business, with clear goals that include reducing the administrative burdens for committee members while improving the communication with membership.

In working to minimize your time out of office, improve mentorship, and provide a more convenient time for what we used to call PALI, in late January we will hold the winter Board of Directors meeting and Student and Resident Retreat the weekend before Family Medicine Advocacy Day (FMAD). FMAD will be held Monday, Jan. 27, 2020.

I have to say, every time I write that acronym I think of a line from the movie, "Network".

We hope to learn what works well and what can be improved from this multi-event weekend in Olympia. As the Board works through the recommendations from the House of Delegates/Annual Scientific Assembly Task Force this will provide important information. You'll find more information about both events in the coming pages.

I began by mentioning that we are a membership organization. This winter we will be doing a major membership survey to gather data on how we are doing and what you need from us. In part, this will be used for a refresh of our strategic plan in June, and in part it is good governance to ensure we are serving our members. More about the member survey is on page 15.



State Legislature: Looking Back at 2019, Looking Forward to 2020

JONATHAN AND PATRICIA SEIB, WAFP ADVOCACY CONSULTANTS, OLYMPIA

It has been awhile since we had the opportunity to check in, which leaves us some catching up to do in reporting on the 2019 legislative session and the interim activities that followed. But it also has us on the cusp of the 2020 session, on which we will also touch briefly.

Although overtime often seemed inevitable, on April 28 the 2019 legislature adjourned for the year at the close of its constitutionally allotted 105-day regular session. A flurry of last-minute activity served as an appropriate end to an extremely prolific few months, with numerous bills of interest to family medicine making it through the process and on to the governor's desk for his signature. Among them:

- **Tobacco 21 (HB 1074).** Beginning January 1, 2020, the age at which a person may legally be sold cigarettes, tobacco products and vapor products will go from 18 to 21. This marked the end of a five-year effort, during which time the bill became an Academy priority — with family physicians making compelling public health arguments on its behalf at WAFP's annual advocacy day.
- **Vaccinations (HB 1638).** As of July 28, a child may no longer be exempt from the requirement to receive the measles, mumps and rubella vaccine based on the philosophical or personal objection of his or her parent or guardian. This bill too was among the bills identified to legislators as a WAFP priority at Family Medicine Day 2019.
- **Healthy Foods (HB 1587).** The Fruit and Vegetable Incentives Program at the Department of Health will, among other things, provide vouchers to health professionals for distribution to eligible participants for use at an authorized farmers market or grocery store.
- **Public Option Insurance Plan (SB 5526).** Beginning in 2021, a state-facilitated health insurance plan will be available to individuals purchasing insurance on Washington's Health

Benefit Exchange, with the goal of decreased premiums and lower out-of-pocket costs. Although overall provider reimbursement rates are capped, rates for primary care providers are also subject to a floor. Contrary to other provider organizations, in the name of expanding access to care, WAFP ultimately supported this legislation.

- **Dental Coverage for Pacific Islanders (SB 5274).** Beginning in 2020, subsidized dental coverage will now be available for eligible Washington residents who are citizens of the Republic of the Marshall Island, the Federated States of Micronesia, or the Republic of Palau. This is follow-up to legislation passed in 2018 supported by a WAFP House of Delegates resolution which called for subsidized health coverage to these residents.
- **Business & Occupation Tax Surcharge (HB 2158).** Beginning January 1, 2020, certain businesses, including independent physician practices and clinics, will be subject to a 20 percent B&O tax surcharge, with the revenue being used by the state for various education purposes. WAFP joined others in strongly opposing this bill. Although laudable in purpose, it passed with seeming indifference to the challenges already confronting independent practices and the choices it might compel with regard to the participation of these practices in public programs such as Medicaid.

Deserving particular mention is the state's 2019-2021 operating budget, which the legislature passed as HB 1109. Although in detail it is too much to summarize here, a few of the highlights for family medicine include:

- **Generally favorable treatment of health care,** including substantial new dollars for behavioral health programs and public health

continued on page 4

systems. Traditional priorities for WAFP were also maintained, including family practice residencies, the health professional student loan repayment program and Medicaid.

- **Universal coverage work group.** Convened by the Health Care Authority, the work group is directed to study and make recommendations to the legislature on how to create, implement, maintain and fund a universal health care system. Its final report is due in November 2020.
- **Primary care investment study.** WAFP's 2018 House of Delegates adopted a resolution aimed at increasing the proportion of the health care spending in the state devoted to primary care. This initiative has been guided by an Academy Task Force specifically convened for this purpose, is modeled after similar work underway in states such as Oregon, Rhode Island and Colorado, and is also supported by the American Academy of Family Physicians. As a first step, the Academy was successful in procuring an appropriation in the 2019-2021 operating budget funding a study by the Office of Financial Management (OFM). It is using the state's All-Payer Claims Database to determine the current proportion of health care spending which goes to primary care. The final OFM report is due in December 2019.

Along with physician leaders of the WAFP Task Force, we have been part of the advisory group meeting with OFM staff on a biweekly basis over the interim to provide feedback and guidance on the study. It has been an extremely instructive and insightful process, demonstrating both the challenges of transitioning this initiative from concept to concrete action, and the value of the study as a foundation for WAFP advocacy in 2020 and beyond.

In addition to the OFM study, WAFP efforts in the upcoming legislative session will acknowledge and look to benefit from complementary work to prioritize primary care being done by others such as the Health Care Authority and the Bree Collaborative. In fact, the goal is to move this work forward in a way that does not risk damage to all that is already being done — in a short, election-year legislative session charged with adopting a supplemental budget that does not typically lend itself to big new projects.

As such, WAFP will be pursuing legislation in 2020 directing the Health Care Authority to convene a formal “primary care collaborative” including a comprehensive set of stakeholders to build on what’s already being done in this state and in others, and deliver to the governor and the legislature by late next year an actionable roadmap for increasing statewide investment in primary care.

We will end by noting that perhaps as significant as the content of the primary care investment initiative is the transition it reflects in the legislative relations work of the Academy: from an organization which has played exclusively a reactive role responding to legislation brought by others, to one which also takes a proactive leadership role in the development and pursuit of its own agenda. This is a fairly dramatic shift, and its success will, among other things, depend on the ability and willingness of WAFP to prioritize and commit the resources necessary to promote and support a membership that is even more active in the arena of policymaking and politics. The start has been promising, but there’s much more to discuss and do that we encourage you all to be part of.



CORE PURPOSE

Advance and support family physicians in providing optimal health care for all people in Washington State.

CORE VALUES

- Mission-driven
- Mutual respect
- Service excellence
 - Stewardship
 - Evidence-based
- Everyone deserves a family physician

VISION

Thriving family physicians, healthy people and communities throughout Washington State.



Too Often, Gender Nonconforming Patients Feel Unwelcome in Seeking Medical Care

CHELSEA UNRUH, MD, OLYMPIA

A man sits in a waiting room waiting to see his physician. He's a lawyer, dressed in a suit, and is waiting to renew his medications. The medical assistant comes to call him back, "Rebecca, we're ready for you." He grinds his teeth. He legally changed his name years ago, and he has since asked — multiple times — to have it updated. The last time he asked, before he had his gender marker changed, the medical assistant asked, "Well, what's the sex listed on your ID? Female? There you go."

This is a form of harassment that transgender and gender nonconforming (GNC) patients endure on a regular basis in medicine and in daily life. With experiences such as the above, or worse, it's not surprising that one in five transgender respondents of a 2015 survey in Washington state did not see a doctor when they needed to because of fear of being mistreated as a transgender person. That means delaying care for infections, STIs or injuries that can have significant morbidity. Of those who did see a physician, 38 percent reported a negative experience, including refusal of treatment, verbal harassment, or physical or sexual assault. Many transgender patients claim that they have had to give a quick "Trans 101" to the provider in order to get appropriate care.

I authored the Nondiscrimination in Health Care Interactions resolution that was adopted during the 2019 House of Delegates because my transgender/GNC patients are not federally protected against discrimination in a medical setting. Section 1557 of the Affordable Care Act was the first federal nondiscrimination policy for medicine and applied to any entities receiving federal health funds. Currently, this rule no longer covers gender identity or some pregnancy-related services such as terminations.

The legal landscape across the country includes numerous lawsuits, injunctions, stays and various responses from the Department of Health and Human Services and the Office of Civil Rights — all of which would fill this journal several times over. In short, HHS and OCR are revisiting their interpretation of the rule and likely will not include gender identity, leaving

transgender patients more vulnerable than they already are.

The adopted Nondiscrimination in Health Care Interactions Resolution is an attempt to uphold the original intention of Section 1557 and to pressure the state to expand its already robust nondiscrimination policies to include health care interactions. Washington state has nondiscrimination policies in place that protect LGBTQ folks for housing, employment and even medical insurance.

Hospital and medical group entities are still able to make their own nondiscrimination policies that include the LGBTQ community and many have. The American Medical Association has examples of inclusive nondiscrimination policies available to members. The Human Rights Campaign has a Healthcare Equality Index where you can see how different health systems rank in their policies, access, and services for the LGBTQ population. Many hospitals and systems, however, will not change their policies unless there is a federal or state mandate (or fiscal benefit) to do so.

As for me, there are two hospitals in my city, one faith-based and one not, and neither of them include sexual or gender minorities on their nondiscrimination statements. As a sexual and gender minority myself, if I face discrimination as a patient in the ER, as an inpatient, or in a clinic, there are no federal or state protections in place. This means that my patients have no protections either. The prevalence of suicide attempts in the transgender population is 41 percent, which compares to 4.6 percent in the general population and 20 percent in the gay, lesbian and bisexual populations. When a physician refuses to treat a transgender patient, that rate increases to 60 percent.

These aggressions and microaggressions happen in the medical field. They happen in clinic, hospitals and ERs within our state. They happen every day. They happen in Seattle as well as rural areas. Washington has

continued on page 6

the opportunity to be a leader for equality in medicine, and we can help make that happen.

References

2015 U.S. Transgender Survey: Washington State Report. (2017). Washington, DC: National Center for Transgender Equality.

Keith, K. (2019, May 25). HHS Proposes To Strip Gender Identity, Language Access Protections From ACA Anti-Discrimination Rule. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190525.831858/full/>.

Percentage of Hospital Beds in Catholic Hospitals, 2016. (2016, April 26). Retrieved from <https://www.aclu.org/issues/reproductive-freedom/religion-and-reproductive-rights/percentage-hospital-beds-catholic>.

Health and Human Services Office of the Secretary, Office for Civil Rights. (2018, April 25). Section 1557 of the Patient Protection and Affordable Care Act. Retrieved from <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>.

American Medical Association. (n.d.). Creating an LGBTQ-friendly practice. Retrieved from <https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice>.

Human Rights Campaign. (n.d.). Healthcare Equality Index 2019. Retrieved from <https://www.hrc.org/hei>.

Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). Suicide Attempts among Transgender and Gender Non-Conforming Adults. *Suicide Attempts among Transgender and Gender Non-Conforming Adults*.

WAFP to Relaunch Key Contacts Program

**KEY
CONTACTS
PROGRAM**

In an effort to bolster its advocacy efforts, WAFP will relaunch its key contacts program. A key contact is a WAFP member who has, or is willing to build, a relationship with their elected officials in the Washington State Legislature.

Legislators benefit from the input of family physicians; very few of the 147 members of the legislature have worked in a health care service setting. Moreover, as a family physician, you speak on behalf of your patients — many of whom are also likely constituents.

If you'd like to be considered for our key contact program, please contact Brian Hunsicker, WAFP's director of external affairs, at brian@wafp.net.

Family Medicine Advocacy Day Registration is Open

WAFP members are now able to register for Family Medicine Advocacy Day (formerly known as the Policy Advocacy Leadership Institute, or PALI) on Monday, Jan. 27, 2020, in Olympia.

The day typically begins with attendees in group discussions with elected officials and policy makers from the legislative and executive branches, as well as other speakers. WAFP priority issues will be also be discussed, and a light breakfast will be served. After an offsite lunch, attendees disperse to meetings with their legislators.

Registration is now open at <http://bit.ly/2020FMAD>.

The deadline to register is Jan. 17, 2020.

2019 Congress of Delegates Considers Three WAFP Resolutions



RUSSELL MAIER, MD, FAAFP, AAFP EASTSIDE DELEGATE, YAKIMA
GREGG VANDEKIEFT, MD, MA, FAAFP, AAFP WESTSIDE DELEGATE, OLYMPIA
TONY BUTRUILLE, MD, AAFP EASTSIDE ALTERNATE DELEGATE, LEAVENWORTH
KEVIN WANG, MD, FAAFP, WESTSIDE ALTERNATE DELEGATE, SEATTLE

The 2019 AAFP Congress of Delegates (COD) met in Philadelphia from September 23-25, just prior to the 72nd annual Family Medicine Experience (FMX). The Congress, comprised of 119 voting members, is the AAFP's policy-making body and elects the AAFP Board of Directors and officers. The COD addresses a broad range of clinical, public policy and financial issues affecting family physicians and our patients.

History was made at this meeting — the academy elected our first African-American woman as president-elect! Ada Stewart, MD, who attended WAFP's House of Delegates in May, gave an impassioned and stirring speech on the role family physicians play in providing health care to all Americans.

Washington state was represented at the Congress of Delegates by delegates Russell Maier, MD (Yakima) and Gregg VandeKieft, MD, MA (Olympia) along with alternate delegates Tony Butruille, MD (Leavenworth) and Kevin Wang, MD (Seattle).

Also attending the COD were WAFP Immediate Past President Jeremia Bernhardt, MD; WAFP Executive Vice President Kim McCaulou; and Alyssa McEachran and Brian Hunsicker, staff.

The delegation was pleased to see the AAFP's follow-up on the 2018 resolutions offered by the WAFP and adopted by the COD.

- **Climate CME and Public Health:** The Commission on Continuing Professional Development approved resources on the patient care section of the AAFP website, as well as a new session

at the 2019 FMX called Climate Change: Managing Health Impacts in Your Practice.

- **Medical Aid in Dying:** While Washington's resolution was not adopted in 2018, it formed the basis of an amended resolution that was passed by a 2/3 majority. AAFP took its position of engaged neutrality to the American Medical Association House of Delegates. Though AMA opted to maintain its existing policy at its 2019 Annual Meeting, it did approve the AMA Council on Judicial Affairs to continue its work on the topic.
- **Support National Paid Family Leave:** The resolution was referred to the AAFP Board, which then referred it to the Commission on Governmental Advocacy. The commission voted to accept the resolution for information.
- **Treating Opioid Use Disorder in Hospitals and Drug Treatment Facilities:** This resolution was referred to the AAFP Board of Directors, which further referred it to the Commission on Health of the Public and Science. In response, the commission modified its policy statement on substance use disorders to include hospitals and drug treatment facilities. AAFP further committed to advocating for legislation that requires access to opioid agonist or partial agonist therapy at hospitals and all state-certified drug treatment facilities.

Three resolutions passed by the 2019 WAFP House of Delegates were taken to the AAFP Congress. One was

continued on page 8

adopted, one was not adopted, and one was reaffirmed as current policy:

1. Promoting Access to Abortion Care by Supporting Skilled Providers — Substitute Adopted

The final substitute resolution adopted reads:

RESOLVED, American Academy of Family Physicians support family physicians who have the training, experience, and demonstrated competence in providing medication and first trimester aspiration terminations.

Though passionate testimony was heard both in favor and in opposition, the reference committee recommended adoption with only one variance from the original resolution: Changing the language to focus exclusively on family physicians, a move that had the support of the AAFP Board. After extensive debate on the floor of the Congress, often as much about process as policy, the resolution ultimately passed as the reference committee had recommended.

Part of our success in this contentious area was our state process — a HOD discussion, referral to the Board of Directors, and a WAFP task force that worked to ensure we were bringing forward resolutions that advanced the AAFP's policy.

2. Assuring the Availability of Abortion — Reaffirmed as Current Policy

Washington was one of five constituent chapters to submit resolutions requesting that the AAFP forcefully defend patient access to abortion care. The reference committee believed these asks were covered by AAFP's policy, including a patient's right to informed decision making.

3. Allying with Osteopathic Family Physicians — Not Adopted

The resolution sought to allow members of the American College of Osteopathic Family Physicians in those states without an ACOFP state chapter to become members of their AAFP constituent chapter. While the resolution would be more inclusive of osteopathic family physicians, the reference committee agreed with those in opposition. They cited AAFP's linked membership structure — making this change, they noted, would require a bylaws change — as well as the growing

percentage of DOs that comprise AAFP's membership. That, they said, was evidence of AAFP's already welcoming stance toward osteopaths.

The complete summary of the proceedings of the 2019 COD can be accessed at <http://bit.ly/2019AAFP COD>.

The Congress also elected new AAFP leadership. Dr. Gary LeRoy (Ohio) assumed the presidency of the AAFP. Dr. John Cullen (Alaska) is now the Board of Directors' chair. And, as noted, Dr. Ada Stewart (South Carolina) was chosen as president-elect.

Three new directors — Dr. Andrew Carroll (Arizona), Dr. Steven Furr (Alabama) and Dr. Margot Savoy (Delaware) — were elected to three-year Board terms. Dr. Brent Sugimoto (California) was elected as the new physician representative to the Board. Dr. Kelly Thibert (Ohio) was elected as resident representative to the Board. And Ms. Margaret Miller (Tennessee) was elected as medical student representative to the Board.

Dr. Alan Schwartzstein (Wisconsin) was re-elected Speaker, and Dr. Russell Kohl (Oklahoma) was re-elected Vice-Speaker.

Thank you for the privilege of representing Washington state at the AAFP. Washington continues to be one of the most active, effective and highly respected AAFP state chapters in the nation, largely due to the engagement and participation of our members and leadership.



WAFP leadership and staff eats as one does in Philadelphia: cheesesteaks at Jim's on South Street. From left, Kim McCaulou, WAFP executive vice president; Brian Hunsicker, director of external affairs; Jeremia Bernhardt, MD, WAFP immediate past president; Tony Butruille, MD, AAFP Eastside alternate delegate; Gregg VandeKieft, MD, MA, FFAFP, AAFP Westside delegate; and Russell Maier, MD, FFAFP, AAFP Eastside delegate.



Crisis Standards of Care: The Greatest Good for the Greatest Number

RACHEL WOOD, MD, MPH, FAFP, OLYMPIA

What if a regional earthquake damaged multiple outpatient and inpatient care facilities? Would you be able to continue caring for patients as usual? When would you have to change your standard of care?

If the country saw a novel influenza virus emerging, as happened in 2009, but with more severe consequences, how would you continue to provide care to your patients? What if one-third of the usual staff at your clinic were either out sick or incapacitated?

What are Crisis Standards of Care?

The National Academy of Medicine in 2009, defines Crisis Standards of Care as:

A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.¹

This article is to inform you about efforts in developing a framework for Crisis Standards of Care that are happening around the State of Washington.

In an overwhelming disaster, there may be limited resources available to deliver the conventional standard of health care. You may be working with staff with less advanced training than normal. You may be unable to provide the preferred types of medications and medical supplies for your patients. You may be providing care in a shelter, in a gym or via the internet. Conventional standards of care may need to be adjusted in disaster situations. Medical surge is defined by the Centers for Disease Control and Prevention as “the ability to provide adequate medical evaluation and care during events that

exceed the limits of the normal medical infrastructure of an affected community. This surge can be viewed on a continuum based on resource availability and, inversely, demand for care. As the severity of the disaster increases, there are greater needs with fewer resources. Can society agree, beforehand, on when standards of care need to change, from conventional care to contingency care to crisis standards of care?

THE CONTINUUM OF CARE: CONVENTIONAL, CONTINGENCY AND CRISIS				
	Effect on Standard of Care	Resource Constrained	Practicing Outside Experience	Focus of Care
Conventional	No	No	No	Patient
Contingency	Slightly	Slightly	No	Patient
Crisis	Yes	Yes	Yes	Population

Conventional care is the usual type of care. There are the usual staff, the usual supplies and the usual space in which to provide care — and no overt crises.

Contingency care may be perceived by the patient as care as usual, and the goal of the care team is minimize any deviation from conventional care. However, optimal resources may not be available and/or a situation may warrant special protocols. For example, during flu season, you might schedule patients with flu-like symptoms to come into your clinic at the end of the day so as to not expose other patients. The focus is still on the individual patient but awareness of population health is now considered. Another example: In the fall of 2009 when the newly developed H1N1 vaccine first became available, there wasn't enough vaccine for all high-risk groups to receive it right away — a resource shortage.

Crisis care is perceived by all, whether health care provider, patient, family member or the community at large, as care outside the usual standards. In crisis care, you, as a family physician, will face limited resources.

continued on page 10

You may not be able to provide the same standard of care to every patient that you do normally. The focus of care is on the health of the population: the greatest good for the greatest number of patients.

In extreme conditions, you may be on your own managing complex obstetrical patients and postponing all chronic disease management appointments. Crisis care may mean that for eight patients requiring a ventilator, there are only four — or, in the event of the Cascadia earthquake, no ICU, no hospital or clinic, no electricity. Who gets care? Who decides?

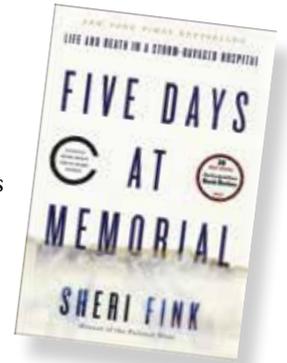
Crisis standards of care may help isolated pockets of providers to have an idea, before the disaster, of what the indicators may be for moving to crisis standards. If communications are cut off, the local health care team and the community at large will do well to have developed guidelines for making heart-wrenching decisions about resource allocation.

There are five key elements to crisis standards of care: strong ethical grounding; integrated and ongoing community and provider engagement; assurances regarding legal authority and environment; clear indicators and triggers and lines of responsibility; and evidence-based clinical processes and operations.

A goal of crisis standards of care is to allow clinicians to make population-based medical decisions, thus doing the greatest good for the greatest number of people. Other goals are to work most effectively in the environment as the disaster unfolds, return to contingency and conventional care as soon as possible, triage resources, and provide an environment to support medical providers.

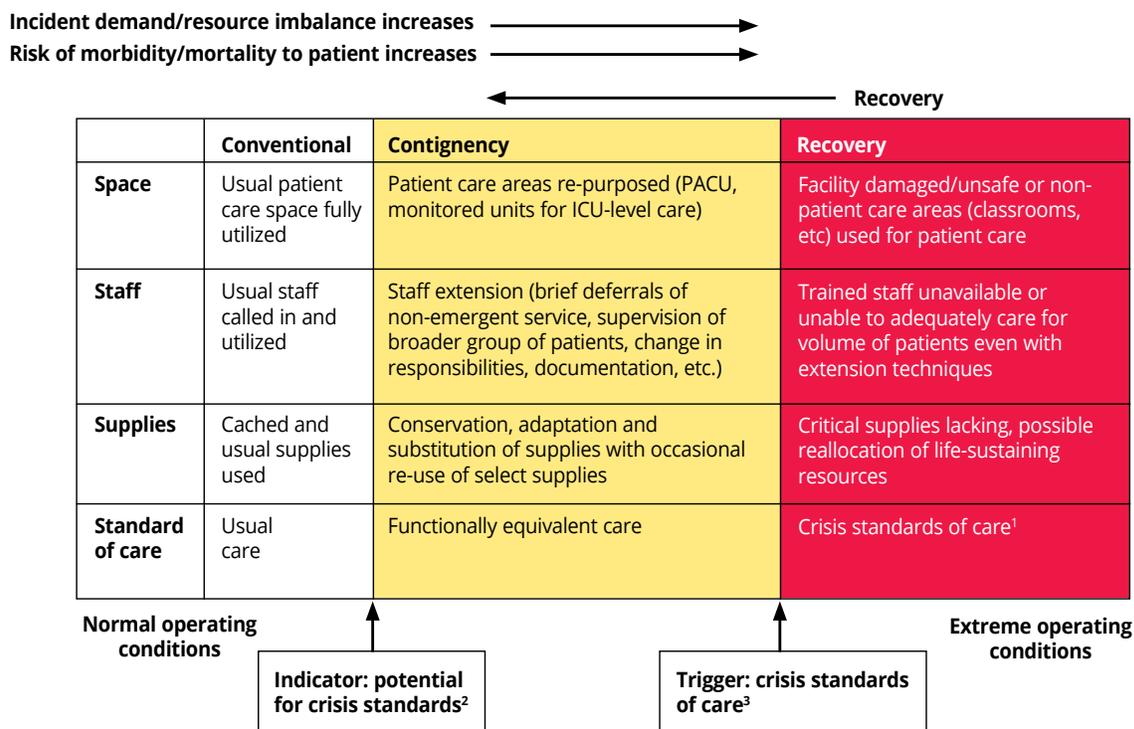
Why is this Important?

Hurricane Katrina forced providers to make heart-wrenching decisions about life and death. Sheri Fink, MD, PhD, describes some of these in her book, *Five Days at Memorial*. After Katrina, the Institute of Medicine published three different works in 2009, 2012 and 2013 about the process of developing crisis standards of care. Fink discusses the difference between the experiences for patients and medical providers in 2005 at Memorial Hospital in New Orleans and in 2011 at Bellevue Hospital in New York City.



continued on next page

Continuum of Medical Surge



The outcomes for patients and health care providers were different between Katrina and Sandy. Part of the difference was due to clinicians understanding the concepts of scarce medical resource allocation. Work is happening in Washington state and around the country to begin developing a framework for making ethical decisions about medical care in a disaster.

Although much of disaster and surge capacity planning focuses on hospital-based care, more than 85 percent of health care is delivered in outpatient settings. The Robert Wood Johnson Foundation states that there are 500 million visits to primary care physicians in this country each year.

Involving outpatient providers in disaster response means they have an awareness of their role in their facility and system, and they have a way to coordinate their practice with broader community efforts. If outpatient health care is still available, and outpatient facilities understand their important role during and after a disaster, the community will be better able to assist those in need.

What is happening in Washington state?

In our state, work began a few years back to develop a framework for Washington State Crisis Standards of Care. This framework is being developed by the state Disaster Medical Advisory Committee (DMAC), developed by the Washington State Department of Health and administered by the Northwest Healthcare Response Network. This framework is a living document and addresses state efforts to maximize scarce resources during times of crisis. It builds upon valuable work done in multiple regions in Washington as well as throughout the country. This framework describes the ethical structure of transparency, fairness, proportionality and accountability when allocating a scarce resource. It further identifies general processes for coordinated decision-making across the state.

In 2016, the Department of Health developed the State Disaster Medical Advisory Committee. This is a group of clinicians and ethicists to advise the state health officer in preparedness and response operations.

In 2018, DOH conducted seven community engagement sessions with diverse groups across the state. The work built on prior community engagement sessions done in King and Pierce counties. The report from those meetings is now being written to summarize public input on allocating scarce resources. In addition to public focus

groups, the Northwest Healthcare Response Network and the REDi Healthcare Coalition are working to build regional Disaster Clinical Advisory Committees (DCACs).

Finally, work on a regulatory level is ongoing. A matrix of potential waivers of health care regulations and a flow chart on how the waiver process works is being developed. Consistency in implementing changed standards of care across all intrastate jurisdictions similarly affected by a crisis situation is important to retain the public's trust in the crisis response and recovery activities.

What is the role of family medicine within crisis standards of care?

Family physicians around Washington can connect with their patients and their communities around disaster planning and the potential for scarce resources. You can speak with your patients who rely on prescription medications about having a one- to two-week supply on hand in case there is a severe winter storm or flooding — though insurance and pharmacy regulations can make such efforts challenging at best, not least for patients on controlled substances. This may mean your patients could have to pay out of pocket for an extra seven to 14 days of medications, which will help when they have no access in a disaster. You may suggest to your patients that they talk with their medical supplier about having extra oxygen on hand, or develop an emergency dialysis kit and associated materials for emergency use in case their supplier can't deliver or they cannot access dialysis care. Other preparations for disasters can include gathering pertinent paperwork: photo IDs, out-of-area contacts, medical insurance cards, medical vendors contact information and account numbers.

Family physicians and their office staff members may want to assign a staff "champion" for clinic preparedness activities, so that the clinic can stay open for their own patients and surge for additional patients who live nearby in a disaster situation. Family physicians already talk with their patients about advance directives. Consider discussing with your patients and families their values about life and death if an entire region of the state is affected by a disaster all at once and not everybody can get the necessary care to survive.

Washington state continues to work on public and

continued on page 12

health care provider engagement in crisis standards of care planning. Consider getting involved with your regional Disaster Clinical Advisory Committee. You can find out more by contacting the health care coalition in your part of the state: Northwest Healthcare Response Network (in Western Washington, Thurston County and north); REDi Coalition (in Central and Eastern Washington); and the Southwest Healthcare Preparedness Region (Clark, Cowlitz, Klickitat, Skamania and Wahkiakum counties). More information about the public’s priorities for health care resource allocation in a disaster will be available in the next year as well as information about potential waivers of health care regulations. While ethical decisions about allocating health care resources are never easy, staying informed about ongoing efforts regionally and statewide, and preparing your patients for disasters, will help us all be more resilient.

References:

- Washington State Department of Health Emergency Preparedness and Response staff
- Northwest Healthcare Response Network staff
- Dr. Sheri Fink, author “Five Days at Memorial”
- “Beyond Hurricane Heroics” *What Sandy Should Teach us all about Preparedness*, Sheri Fink, MD, PhD, Special Report, Stanford Medicine Magazine.
- National Academy of Medicine, 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press, pp. 14-15.
- *National Academy of Medicine, 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press. (p.40)

ETHICS VALUE STATEMENTS – (Q-SORT)

You have to save the greatest number of people, even if it means that some aren't going to be treated and will die.	Pregnant women should be given priority medical care.	How someone survives is important. People shouldn't be given priority if they are going to survive but be in a coma.
Priority for medical care should be given to patients expected to live the longest.	During a disaster, getting people treated quickly is more important than making sure it is fair.	People should be given medical care on a first come, first served basis. People should be treated in the order they arrive in the hospital.
First responders should have priority for medical care because they are important for everyone's safety.	Give priority for medical care to the patients with the best chance of survival. Otherwise, it's not the best use of resources.	It is important to give priority to certain groups. Otherwise, the hospital will fill up with people who get there first, and those who get sick later may not get medical care.

Adapted from presentation by Suzet McKinney, DrPH, MPH Deputy Commissioner of Health, Chicago Department of Health 2014, Public Health Preparedness Summit, Atlanta, Georgia

Medical Surge in the Era of AGEs

NED HAMMAR, MD, WASHINGTON FAMILY PHYSICIAN EDITOR, PORT ANGELES



Rachel Wood, MD, MPH, FFAFP, in this quarter's journal, nicely summarizes current thinking about how we as medical providers might respond in a "surge." As your editor, I had to look up the CDC's definition of "medical surge." I won't spoil

it: read Dr. Wood's "Crisis Standards of Care," page 9. But it got me thinking. A surge in general terms is "a strong, wavelike, forward movement, rush, or sweep;" in meteorology it is "a strong change in pressure that is in addition to normal changes." Both definitions hinge on a shared sense of what is calm or normal. How do we do define normal in a time of abnormal global adversity?

In 1999, Drs. Robert Anda and Vincent Felitti broke new ground with the ACEs study. Adverse childhood experiences, as we appreciate even more fully after 20 years of neuroscience elucidating the biochemical pathways of stress on the developing brain, are associated with all manner of poor health outcomes in adults. How then do we reconcile ourselves to an increasing prevalence of ACEs? This finding, corroborated by the recent finding that U.S. lifespans are decreasing for three years running, goes against our culture's most deeply held narrative of progress. It's unprecedented, and shocking. How does one prepare for a surge when the wave of our normal daily existence is already overwhelming?

Every challenge holds an opportunity which can be accessed if that challenge can be fully understood. To understand our present situation, I believe we need a new term, and propose "adverse global experiences," or AGEs. This is the era in which we live. An AGE is an ongoing experience or condition that negatively affects the health of all humans and indeed all life. The climate crisis, mass species extinction, human population growth, and massive inequities of wealth and power all have hugely negative impacts that are well described in the scientific literature. This global adversity threatens our very existence.

One way to contextualize this — and one with immediate and sobering implications for medical readiness here in the Pacific Northwest — is to consider

Washington Family Physician

the Cascadia megaquake. I can't recommend highly enough the 2015 New Yorker article "The Really Big One." Author Kathryn Schulz takes us through a fascinating tour of history and science, all building to one very basic fact. For the past 10,000 years, mega-earthquakes have unleashed 900 times more power on our coastal home than the "7's" that ravaged, for example, Haiti in 2010 or Japan in 2016; both measured magnitude 7.0 on the Richter scale. These earthquakes occur on average every 243 years. We are 76 years overdue.

To stick with our surge analogy, it's actually relatively easy to prepare for a regional magnitude 9 earthquake and the resulting 100-foot tsunami. What's hard is to wrap our heads around something like the slowly rising waters brought on by anthropogenic global warming. So let's briefly put some numbers to the four AGEs.

The climate crisis. The latest revision estimates that the homes of 300 million people will be underwater by 2050. Arctic permafrost is thawing at a rate that, until about two years ago, scientists thought would not happen until century's end, causing methane — with a heat-trapping capacity 30 times that of carbon dioxide — to literally boil from northern seas. The health consequences of an overheated planet are being described in increasingly graphic detail in scientific journals; suffice it to say they are not pleasant.

Species extinction. From microscopic marine life to terrestrial megafauna to birds to insects to frogs to parasites, every indicator we can measure supports the idea that we are in the midst of Earth's sixth mass extinction. With the one notable exception of humans and our domesticated crops and animals, extinction rates vary between 10 times and over 1,000 times the background extinction rates.

Human population growth. Just the numbers, for tenfold increases, with the time delta in parentheses:

- 150-70,000 years ago: emergence of *Homo sapiens*.
- 10,000 years ago: 10 million (approximately 100,000 years).
- 500 BC: 100 million (about 7,000 years).
- 1804: one billion (2500 years).
- 2050, estimated: 10 billion (250 years).

Wealth inequality. Stephen Bezruchka, MD, MPH, at the University of Washington, and countless others have documented the negative health effects of inequality, which is only increasing. Based on a

continued on page 14

recent Bloomberg analysis of adults, with conservative extrapolation to include children, one can draw an “L-curve” of inequality. Graphing everyone’s wealth in stacks of \$100 bills, the world’s poorest 2 billion people have less than a single bill each to their name. One must get past the world’s poorest 5 billion people before anyone has a wealth of just \$10,000, or a 1 centimeter high stack of \$100 bills. As family physicians we might reach a stack a meter high, or a worth of \$1 million. One of the world’s 2,700 billionaires’ 1 kilometer stack of bills is taller than the Burj Khalifa tower in Dubai, the world’s tallest human-made structure. Amazon founder Jeff Bezos has a 100 kilometer stack of bills, twice as tall as the top of the stratosphere.

Viewed in this context, it becomes clear that what might have seemed some far distant threat is actually unfolding, in real time, all around us. We are already in

a medical surge. The question now is: do we retreat to the ever-shrinking higher ground that the privilege of our position in society affords us? Or do we link hands with our patients in common cause for the preservation of life — all life, our life — on Earth?

In every challenge lies an opportunity if we can understand and grasp it. For a few short years more we have the opportunity to build a more just, equitable and sustainable society. Beyond that window the future looks like a surging wave of ever greater height. Would that we act now.

Reference

Hammar N. ACEs in the Era of Inequality and AGEs. 2018. Retrieved from <https://firstdonoharmhome.files.wordpress.com/2018/12/acces-in-the-era-of-inequality-and-ages.pdf>

WAFP Foundation Streamlines Application Process for Awards

WAFP members who are interested in applying for awards from the WAFP Foundation now have a centralized location to do so.

Access the online form by using the QR code that accompanies this story. Simply use your cell phone to snap a photo of the QR code, and you will be redirected to the form.

This website accepts submissions for the following:

- Alfred O. Berg, MD, Award for Excellence in Family Medicine Research Scholarship (open to fourth-year medical students)
- Diverse Constituencies Awards (open to first-year medical students)
- Roy Virak Memorial Family Medicine Resident Scholarship (open to second-year residents)
- Family Medicine Advocacy Summit travel stipend (open to one resident and one medical student; event is May 18-19, 2020, in Washington, DC)
- National Conference of Constituency Leaders travel stipend (open to three second- or third-year residents; event is April 23-25, 2020, in Kansas City, MO)
- Accountable Communities of Health participation stipends (open to those in the Active membership category)
- Vision 2020 leadership development award (open to those in the Active membership category)

Some awards require the submission of a personal statement or letter of recommendation. Those documents, along with any questions, may be emailed to wafpfoundationawards@wafp.net.

Apply
Online
TODAY!



Submit your Nomination for FPOY and FMEOY Today!

The WAFP is now accepting nominations for the 2020 Family Physician of the Year (FPOY) and 2020 Family Medicine Educator of the Year (FMEOY). Both awards will be presented at the 2020 WAFP Annual Meeting at Semiahmoo Resort in Blaine on May 8.

Family Medicine Educator of the Year

Nominations for FMEOY are due **Jan. 31, 2020**. The WAFP Foundation Board of Directors selects the recipient, and considers the following in its deliberations:

- Nominees' recognition for exemplary teaching skills and outstanding progression of abilities over several years by medical students, residents, or peers; or
- Nominees' development and implementation of innovative curriculum, teaching model(s) or program(s) in a variety of educational spheres; and
- Nominees' membership in WAFP (nominees must be members to be considered).

All candidates must be either a full-time or part-time family physician who hold a regular faculty appointment, and teach and practice exclusively in an academic setting. Candidates may also be a volunteer family physician who do not practice in an academic setting but engage in volunteer teaching activities.

Nominations must include a 2020 nomination form (available at <http://bit.ly/2020-FMEOY>); a copy of the nominee's current curriculum vitae; and between three and five letters of recommendation. At least two of the letters of recommendation must be submitted from individuals who are current or former students/residents who have been taught by the nominee. Nominations should be emailed to info@wafp.net.

Family Physician of the Year

The Family Physician of the Year Award honors a physician who exemplifies, in the tradition of family medicine, a compassionate commitment to improving the health and well-being of people and communities throughout Washington.

Any WAFP member in good standing, with a few exceptions, is eligible for the award; current members of the WAFP Board of Directors and previous FPOY winners are not eligible. Previous nominees, if they have not won the award, are eligible. Likewise, any current WAFP member is welcome to submit a nomination.

Nominations for FPOY are due **Jan. 31, 2020**.

Nominees should exemplify the ideals of family medicine, including providing comprehensive, compassionate services on a continuing basis to his/her community, and possessing personal qualities that make him/her a role model to professional colleagues.

Nominations must include a 2020 nomination form (available at <http://bit.ly/2020-FPOY>); a current curriculum vitae; a head-and-shoulders photo of the nominee; and up to eight pages of supporting letters or documentation. Letters can come from colleagues or patients.

Nominations should be emailed to info@wafp.net.

WAFP to Survey Members in Early 2020

Help shape WAFP's future by participating in the Academy's upcoming member survey. The survey, which will include more than demographic questions, is expected to be distributed in early March 2020.

In addition to welcoming resident and medical student participation, the survey will also utilize focus groups and meetups.

This is your chance to weigh in on the Academy's direction and advocacy efforts. Your voice matters! Keep an eye out for additional information in the coming months.



DOs: A Welcome (And a Little Bit About Us)

DAVID ESCOBAR, DO, FAAFP, WAFP NEW PHYSICIAN TRUSTEE, ARLINGTON

I am a doctor of osteopathic medicine (DO). I'm a family physician. And within the WAFP I serve as your new physician trustee. In each of these roles I welcome my fellow DOs to join the WAFP — and for my MD colleagues, here's a little bit about us. (Hint: we're a lot like you!)

I so often find friends and family are confused by what a family physician does. The old mantra was once we “know a little about a lot” in medicine. In recent years, I am finding we have to know a LOT, about a lot, as access to primary health care shrinks in our rural communities and as patients' acuity grows increasingly complex. We are the content experts for managing patients of all ages with any number of health care needs, especially in our rural communities in Washington state. In addition to our clinical acumen, we have to increasingly be mindful of the shifting landscape of law and policy with regard to health care. We are called upon to step into roles as health care advocates and policy warriors in our communities.

Conflict does not come naturally to physicians. Incoming medical students usually self-select as those seeking to be healers and counselors, arbitrators and facilitators. But if there is one defining characteristic of family physicians it is that we rise to the occasion. We do not shrink from the advocacy challenges to which we are called. In parallel to these struggles, osteopathic physicians have traditionally had to fight just to practice medicine in the United States. From its founding in 1892, the osteopathic profession has battled simply to exist. We now enjoy the fruits of those battles with full practice rights, board certifications in all medical disciplines, and coworking with our MD colleagues. This unique history sometimes makes it even more challenging to explain to my friends and family just what an osteopathic family physician does.

Because of our unique history and American founding, osteopathic physicians and surgeons often describe ourselves as being unique and apart in our approach to medicine; that we look at the “whole person”

and not just the disease(s) afflicting our patients. In this sense, we offer a more holistic perspective on health care as a foundational component of our training (regardless of specialty). However, this holism is also at the core foundation of the practice of family medicine. To quote from the Folsom Report in 1966: “Every individual should have a personal physician who is the central point for integration and continuity of all medical services to [their] patient . . . [the physician's] concern will be for the patient as a whole, and his relationship with the patient must be a continuity one.”¹ Hence, family physicians and osteopathic physicians share a common origin story. We both care wholly for patients by taking into account the totality of their health.

Family physicians, whether trained as DOs or MDs, share a passion for patient wellness, wholeness and advocacy. It should come as little surprise that 56 percent of all U.S. osteopathic physicians practice in primary care specialties.² Hence, there is a wonderful opportunity for Washington state osteopathic family physicians to join the Washington Academy of Family Physicians: we are stronger together. As a state chapter of the national American Academy of Family Physicians, we are actively involved in professional and patient advocacy, and we welcome with open arms all family physicians to join. We are particularly excited to continue supporting and inviting osteopathic family physicians to become members. At the end of the day, we are all family docs doing the best we can for our patients in a volatile practice environment. Please consider joining the WAFP today by contacting the WAFP office at info@wafp.net.

1. Folsom, MB. (1966). National Commission on Community Health Services: Health is a community affair. Harvard University Press, Cambridge.
2. AACOM. (2017). Number of US Osteopathic Physicians Reaches All-Time High. AACOM News, available at: <https://www.aacom.org/news-and-events/news-detail/2017/01/19/2016-omp-report-profession-reaches-all-time-high>



Situational Awareness Helps Minimize Fallout from Distractions

COLLENA BUTLER, OMS-4, YAKIMA

“Hey! I haven’t seen you in a while, how’ve you been? How’s your new cabin up in mountains?”

“Oh, it’s amazing. We’ve got great views of the Cascades, and it’s incredible how clear the sky is at night. You’ll have to come by some time. We’ve got plenty of space and are just a quick drive to hikes and skiing nearby.”

This seems like an innocent enough conversation, right? Talking about the beauty of the Pacific Northwest, a place we’re lucky enough to call home. Talking about the calm nature can bring to our stressful, busy lives. Talking about the privilege of being able to comfortably afford a second home. Laughing about the fun of a weekend away from the stressors of work life.

Given a little more context, this conversation was completely juxtaposed to the events going on in the room. This is the conversation I heard as I was helping deliver a 20-year-old woman’s first baby. This is the conversation I heard as I looked up and saw the woman’s scared, sweaty and determined face. This was the conversation I heard when I made eye contact with her mom and her partner, who looked back at me pleadingly and stunned. This was the conversation this woman’s physician was having with a nurse in the delivery room as she was in labor.

Later that night, after she delivered a healthy baby boy without complications, I was driving home and couldn’t help but think of all the distractions that arise in day-to-day medical practice. That’s when I noticed a notification pop up on my phone.

Distracted doctoring is no different than distracted driving.

Texting while driving is associated with a 23-fold increased risk for crashing, and using a cell phone while driving reduces the amount of brain activity devoted to driving by 37 percent¹. Multitasking is dangerous, regardless of the context.

Similar to distracted driving, distracted doctoring is a serious problem. Distraction is often named as a factor that reduces productivity and efficiency, which can ultimately contribute to errors that impact patient safety.

A key exercise in decreasing distractions is acknowledging and practicing situational awareness. An idea that originally stems from the Korean War, it is the practice of maintaining a cognitive state of being aware of what is happening around oneself and understanding how evolving events could affect one’s goals and objectives². In simpler terms: It is the ability to maintain the “big picture” and think ahead².

This is important because awareness of one’s environment is critical for decision-making. Some examples of distracted practice from clinical experience include:

- Conversing with colleagues, patients and/or families (in person or on the phone), while continuing to perform a clinical task such as documenting, preparing medications, carrying out orders or caring for a patient³
- Reading and replying to text messages on hand-held devices during patient care rounds or during a procedure³
- Thinking about something else other than the current task at hand³

This goes further than having conversations during inappropriate times, though. More broadly, this applies to technology in patient care. This is something I, as a medical student, constantly remind myself of and try to work on. It’s easy to seek the comfort of the keyboard, hiding behind the computer due to my lack of clinical confidence. It’s also comforting to be able to look things up quickly, like when a patient asks about side effects of a medication you just can’t remember. The thing is, many nuanced patient interactions are missed when your fingers are glued to the keyboard.

I thought about how, as medical students, we pursue medicine as a calling. That it is a calling, however, does not preclude it from also being a job. And, like all jobs, we’re not immune to distractions or becoming so comfortable in our role that we may not realize what is right in front of us.

continued on page 18

With the easy accessibility of tablets, smartphones and computers at the bedside, physicians are multitasking more and more. Although their use is intended to increase efficiency, it can often lead to distraction and medical errors. In fact, human factors which include “distraction” are responsible for up to 80 percent of health care errors⁴.

One study showed that while in the examination room with patients, physicians spent 52.9 percent of the time on direct clinical face time and 37.0 percent on EHR and desk work⁵. Another study showed that computer use occupied 40 percent of interns’ time; furthermore, interns spent 12 percent of their time in direct patient care and 64 percent in indirect patient care⁶.

Family physicians have the unique ability to be at the front line of care — often the first one patients turn to for help. I encourage us to be mindful of distractions that come up in our day-to-day practice, whether that be conversations with colleagues or the magnetic-like draw of the keyboard and smartphone. Whether in the delivery suite or in the outpatient clinic, I do think we are all well aware of the fact that patients need our

complete attention. Situational awareness is essential for reducing errors and improving quality care.

1. Sinsky CA, Beasley JW. Texting while doctoring: a patient safety hazard. *Annals Of Internal Medicine*. 2013;159(11):782-783. doi:10.7326/0003-4819-11-201312030-00012.
2. Edozien LC. Situational Awareness and Its Application in the Delivery Suite. *Obstetrics & Gynecology*. 2015;125(1):65-69. doi: 10.1097/AOG.0000000000000597
3. D’Esmond, LB. Distracted Practice and Patient Safety: The Healthcare Team Experience: A Dissertation. (2016). University of Massachusetts Medical School. Graduate School of Nursing Dissertations. Paper 41. DOI: 10.13028/t8h0-6m04. https://scholarship.umassmed.edu/gsn_diss/41
4. Human factors, including “distraction” are responsible for 80% of healthcare errors (Pape, 2003; Sitterding, Broome, Everett, & Ebright, 2012).
5. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. ;165:753-760. doi: 10.7326/M16-0961
6. *J Gen Intern Med*. 2013 Aug;28(8):1042-7. doi: 10.1007/s11606-013-2376-6

Registration Open for 2020 Student & Resident Retreat

Registration is now open for the 2020 Student & Resident Retreat, to be held Jan. 25-26 in Olympia.

The keynote session will focus on statewide investment in primary care with Tony Butruille, MD, chair of WAFP’s Primary Care Investment Task Force. The closing plenary will be on physician advocacy in the community with Enrique Leon, MD, a member of the Board of Directors of Tacoma Public Schools.

In addition, workshops are planned on point-of-care ultrasound; coding; dermatologic procedures; partnering with American Indian communities; vaccine hesitancy; short counseling interventions; trauma-informed care; advocacy; suboxone; vaginal deliveries and repairs; paracenteses, thoracenteses and lumbar punctures; and wilderness medicine.

Residents have their own track of workshops. Topics include dermoscopy, gender-affirming care, POEMS and vasectomy.

As always, there will be a social hour on Saturday evening.

Register today at <http://bit.ly/2020SRRetreat>. Space is limited, so don’t delay!

The 2020 Family Medicine Advocacy Day — formerly known as the Policy Advocacy Leadership Institute, or PALI — will immediately follow the retreat on Monday, Jan. 27. This is a chance to hear representatives from the executive branch as well as meet with your local legislators. Registration is also open for that event. Sign up at <http://bit.ly/2020FMAD> or learn more on page 6.



WAFP Annual Calendar

2020

Medical Student and Resident Retreat

Jan. 25-26, 2020
Olympia, WA

WAFP Board of Directors and Committee Meetings

Jan. 25, 2020
Olympia, WA

Family Medicine Advocacy Day

Jan. 27, 2020
Olympia, WA

AAFP National Conference of Constituency Leaders

April 23-25, 2020
Kansas City, MO

AAFP Annual Chapter Leader Forum

April 23-25, 2020
Kansas City, MO

WAFP Board of Directors Meeting

May 6, 2020
Blaine, WA

63rd House of Delegates

May 7, 2020
Blaine, WA

WAFP Foundation Annual Meeting

May 7, 2020
Blaine, WA

71st Annual Scientific Assembly

May 8-9, 2020
Blaine, WA

AAFP Family Medicine Advocacy Summit

May 18-19, 2020
Washington, DC

AAFP National Conference of Family Medicine Residents & Students

July 30-August 1, 2020
Kansas City, MO

AAFP Congress of Delegates

Oct. 12-14, 2020
Chicago, IL

AAFP Family Medicine Experience (FMX)

Oct. 13-17, 2020
Chicago, IL



“There isn’t really time for that ...”

BRIANNE H. ROWAN, MD, MPH, WAFP RESIDENT TRUSTEE, TACOMA

It is 9 p.m. on a Thursday, and clinic is wrapping up but no one seems eager to leave. A few patients linger in the warmth of the waiting room chatting with our social worker. One of the nurses is passing around a birthday card for a volunteer. The pre-med students and I are chatting about the MCAT. I have work tomorrow, but I don’t mind being here late because Neighborhood Clinic, Tacoma’s largely volunteer-run free walk-in clinic, is both a community that I enjoy belonging to and a rejuvenating reminder of the reason I went into medicine in the first place.

Neighborhood Clinic was founded in 1983, by the Rev. Bill Bischel and parish nurse Gloria of St. Leo’s Catholic Church in Tacoma. The clinic was their response to their sick neighbors living homeless outside and a solution to the health care access crisis for the many uninsured in the area. More than 35 years later, the clinic continues to serve the local community, especially the immigrant and homeless population in Tacoma.¹ Just as importantly, however, Neighborhood Clinic, like many other free clinics, also serves as a community-based service learning center. Undergraduate students, social work students, nursing students, medical students and family medicine residents learn from practicing health care workers, who model how to use their skills and social capital to better their community.

The term “service learning” was coined in 1967, but its roots can be traced back as far as the 1930s when John Dewey began to advocate for “experiential learning” as a way to promote both education and citizenship.² It wasn’t until the early 2000s, however, that service learning started to become integrated into mainstream medical student education.³ Importantly, service learning in medical school isn’t just an opportunity for medical students to be exposed to clinical medicine earlier — it is actually designed with the goal of helping students adopt a community health perspective “rather than approaching individual patients and their pathologies one symptom at a time.”⁴ Studies suggest that, indeed, students who begin their medical education with service learning are

more likely to carry a community-based perspective throughout their medical education.⁴

Residency programs, on the other hand, haven’t fully caught up to this philosophy. While it’s true that nearly every family medicine residency program has some sort of community engagement activity, the culture around these activities varies. When interviewing at residency programs, I was surprised at the number of responses that erred on the side of hesitancy. “Residency is hard ...” “Well you really need to know the medicine first ...” “Once residency is over ...” Whether intentionally or not they were essentially saying, “*There isn’t really time for that.*” Even at programs where service opportunities abound, I still had the sense that by asking the question, I took the risk of coming off as though I was underestimating the academic rigors of residency.

The amount of medical knowledge that a family medicine resident is expected to learn in three years of residency is immense. And honestly, I might not believe it were possible if it weren’t for the incredible faculty who model what it looks like to successfully practice excellent evidence-based family medicine. Importantly though, and what is often underappreciated, is that what our faculty models for us goes beyond just choosing the right antibiotic. They model how to provide excellent patient care *and also find the time to ...* teach, organize a food drive, be the team doc for a local high school, serve as a board member for local nonprofits, serve on the school board, advocate politically, chair a WAFP committee, or be the medical director for Neighborhood Clinic just to name a few.

In 2012, the American Board of Family Medicine and others came together to redefine the changing role of the family physician in America’s health. Their definition calls on family physicians to extend their roles beyond the clinic walls and be “leaders of health care systems and partners for public health.”⁵ Having our faculty model this balance is a start, but living up to this goal

continued on page 22

Beyond the Chief Complaint

MANON BEGERT, OMS-4
MEDICAL STUDENT CO-TRUSTEE, YAKIMA



A patient is complaining of typical URI symptoms: voice hoarseness to the point she can't fulfill the duties of her job because she works as a receptionist answering phones. Her face is covered by a mask, so it is difficult to get a great read of

her facial expression, but she definitely appears run-down and in a bad mood. She gives me lots of short, pointed answers as we run through my typical review of systems, hearing some classic responses along the way: can't stop gaining weight, sleeping 2-3 hours at a time because of her 9-month-old daughter, no time for exercise, feeling tired all the time, haven't been able to work, etc.

I tell her my typical line for URIs: "It sounds like you've had multiple URIs, and they are likely viral. Your exam looks normal, so we are less worried about strep or other bacterial infections. Unfortunately, we don't have any great treatments for viral infections, and you just have to wait it out. There are a few over-the-counter remedies to recommend and write down for you." She is visibly upset, but it's not a huge surprise. No one likes being told there is nothing we can do for you.

I leave the room feeling defeated. I always hate these visits, feeling like there is little to offer to patients who are feeling terrible and have given up their day, have waited patiently to be seen, and are wanting a quick fix to get back to their normal lives. I can relate. I too hate the week-long suffering through a URI with no great options to make it all go faster.

I return to my preceptor, give him my quick presentation, and we enter the room together. Within a minute, the patient begins to cry. My first thought is, "Wow, she is really taking this URI thing hard." I've seen people become upset upon hearing there is nothing to offer, but this seems a bit extreme. My preceptor asks a few more questions and finally gets to the most important one: how has your mood been lately? Suddenly, the conversation has completely switched gears. We are now talking about peripartum depression,

something our patient has been dealing with since the birth of her daughter nine months ago. I think back to all those ROS questions I so quickly ignored, assuming they were just the typical answers every patient gave me — tired, gaining weight, not sleeping well — all signs of possible depression that were simply overlooked. But this had nothing to do with her chief complaint.

So much of our training is spent on learning from a book rather than learning from the patient¹. Even on my clinical rotations I often spent more time on a computer than interacting with patients, whether it be charting or reading up on a diagnosis. And indeed, so much of how we are evaluated as medical students and even as physicians is based on our ability to study from books or chart on a computer. From board scores to billing, we are rewarded more for what is done on a computer than what is actually done with the patient. Moreover, I remember learning to always address each visit through the lens of the chief complaint — one joint above, one joint below. But how much are we missing if we limit our assessment to such a narrow window?

We've all seen plenty of doctors that rather than seeing the patient with a new complaint in the hospital and assessing them, order more tests or more treatment without even giving the patient a second glance. "She has nausea? Give her a Zofran. Now she is complaining of dysuria? Let's get a UA."

How many tests and costs might we cut down on if we had just gone and asked a couple more questions? The truth is, some of these additional tests actually lead to misdiagnosis when our clinical judgment could have been more useful in determining how to diagnose and treat the patient². And we've seen countless times how additional tests can lead to unnecessary pain and anxiety for patients. What if we had truly assessed the chief problem behind that complaint. Maybe they really wanted someone to talk to but felt they needed a complaint to warrant some attention.

Unfortunately, patients don't always give us the diagnosis from the chief complaint. And often the chief complaint isn't really what is most important to the patient or the most pressing issue being faced at that moment in time. While we can quickly order many tests, they still may fail to give us the answers we are really looking for. Many times, mental health issues such as peripartum depression so easily fall through the cracks as the patient concocts other complaints because they are

continued on page 22

will also require a shift in residency culture to prioritize service learning and the teaching of advocacy, equity and leadership. Currently, most of this teaching is done in the form of optional extracurricular activities, rather than as a required aspect of training. While there are benefits to residents choosing to give “off the clock” time to the community, there is also an expectation that core aspects of being a family physician will be taught within the core curriculum. If today’s residents are going to balance clinical practice with societal obligations we need to be taught, in a structured way, how to do this well. As noted by the Society of Teachers of Family Medicine, “too often we assume that if someone is an effective clinician, they can transition to be an effective leader. The skills required to provide comprehensive, compassionate care to patients may be important in a leader, yet alone are not sufficient.”⁶

Prioritizing service learning within residency will not only better prepare us residents for what the future of family medicine requires of us, but it will also better prepare us to find satisfaction and joy in our careers. Dr. Henry Retailliau, a longtime volunteer at Neighborhood clinic, emphasizes that, “the sense of mission and purpose [gained from serving your community] is foundational for your future in medicine. Burnout is so prevalent, in large measure, because doctors lose their sense of purpose. Residency is a time to reinforce that sense of purpose, not lose it in the minutiae of charts and insurance documentation, which tends to numb your brain and remove you from why you became a doctor in the first place.”

Service learning and the teaching of advocacy, equity and leadership should be integral to family

medicine training, not just an extracurricular add-on. Neighborhood Clinic is just one example of how service learning can cultivate a resident’s community engagement skills (although even it remains an optional evening activity). If we can’t make the time in our training programs to teach family medicine residents how to be active community leaders now, how do we expect them to find the time to do it in the future? “My not-so-secret hope,” says John VanBuskirk, Neighborhood Clinic’s medical director and family medicine residency faculty, “is that volunteers carry this spirit of service forward throughout their life and career.”

1. Neighborhood Clinic History from Benita Ki, Executive Director.
2. Giles & Eyler. The Theoretical Roots of Service-Learning in John Dewey: Toward a Theory of Service-Learning. 1994. <https://digitalcommons.unomaha.edu/cgi/viewcontent.cgi?article=1152&context=slceslgen>
3. Stewart and Wubbena. A systematic review of service-learning in medical education: 1998 - 2012. *Teach Learn Med.* 2015. DOI: 10.1080/10401334.2015.11011657
4. Stewart and Wubbena. An overview of infusing service-learning in medical education. *Int J MEd Educ.* 2014. DOI: 10.5116/ijme.53ae.c907
5. Phillips et al. Heath is Primary: Family Medicine for America’s Health. *Annals of Family Medicine.* 2014. http://www.annfammed.org/content/12/Suppl_1/S1.full
6. Society of Teachers of Family Medicine. Creating Leaders in Family Medicine. *Annals of Family Medicine.* 2015. <http://www.annfammed.org.offcampus.lib.washington.edu/content/13/2/188.long>

ashamed or may not even fully be aware of the real issue, but just know they need help and want to feel better³. Although I missed the diagnosis on my initial assessment of the patient, the experience reminded me of the need to look beyond the chief complaint to address what is truly most important: to read between the lines and care for the whole person.

1. Fred HL. Hyposkillia: deficiency of clinical skills. *Tex Heart Inst J.* 2005;32(3):255–7.
2. Feddock CA. The lost art of clinical skills. *Am J Med.* 2007;120(4):374–8.
3. Fred H.L. When the chief complaint tells it all. *Tex Heart Inst J.* 2015;42(2):105–106.

WAFP Welcomes the Following New Members:

Active Members

Scott Agee, DO, Tacoma
Letizia Alto, MD, Bellevue
Margie Apacible, MD, Camas
Dane Bay, MD, MPH, Renton
Walid Behnawa, MD, Auburn
Allyson Campanelli Spence, DO, Puyallup
Sarah Campbell, MD, Omak
Kyra Carpenter, DO, Wenatchee
Rajalakshmi Cheerla, MD, FAAFP, Bellingham
Kevin Costa, DO, Spokane
Minoo D'Cruz, MD, Seattle
Georgina De La Garza, MD, Spokane Valley
Richard Demmler, MD, Coupeville
James Denisar-Green, MD, PhD, Ellensburg
Thuy Do, MD, Seattle
Douglas Dunham, MD, Walla Walla
Marina Dupree, MD, Kent
Erica Gadzik, MD, Bellingham
Mark Garcia, DO, Auburn
Michael Goodblatt, MD, Lacey
Kashish Goyal, MD, MBBS, Seattle
Bradford Granath, MD, FAAFP, Seattle
Audrey Gray, MD, MPH, Everett
Matthew Hallowell, MD, Renton
Mary Heady, DO, Port Orchard
Neal Heimer, DO, Port Townsend
Kacy Herron, MD, Seattle
Jennie Huang, MD, Seattle
Anna James, DO, Olympia
David Jimenez-Celi, MD, Lynnwood
Kyle Jordan, MD, Kirkland
Sophia Kim, MD, MPH, Ridgefield
Doug Kim, MD, FAAFP, Federal Way
Eun Young Kim, MD, Bothell
Stephen King, MD, Vancouver
Sujit Kumar Kotapati, MD, Bellingham
Sheila Kredit, MD, Olympia

Chau Le, DO, Camas
Zheru Li, MD, Vancouver
Marlin Lobaton, DO, Bellevue
Kiran Master, MD, Renton
David McCaleb, MD, Olympia
Jessee Meek, DO, Redmond
John Merrill, DO, MS, Clarkston
Sarah Mun, MD, Richland
Seema Nair, MD, Seattle
Samantha Newbould, MD, Everett
Dane Nimako, MD, Seattle
Kevin Ochoa, MD, Pasco
Andrew Odle, MD, Liberty Lake
Gina Perez-Baron, MD, Seattle
Charissa Rogers, MD, Shelton
Nishant Sharma, MD, Bremerton
Jazab Sheikh, MD, Moses Lake
Serena Shung, MD, Bellevue
Catherine Smith, DO, Seattle
Gurkaran Thiara, MD, Bellingham
Brandi Tolman, DO, Everett
Sahand Vafadary, MD, Moses Lake
Hsin-Yi Janey Wang, MD, Seattle
Darren Willius, DO, Lakewood
Jaquelyn Yeh, MD, Seattle
Laxmi Yerram, MD, Lake Forest Park
Ashley Yoder, MD, University Place
Minnie Yordon, MD, Seattle
Ahmed Yousif, MD, Silverdale

Resident Members

Logan Brau, DO, Tacoma
Gabriela Cash, MD, Bremerton
Cecile Dinh, MD, MPH, Silverdale
Kayla Fix, DO, Spokane
Justin Fu, MD, Seattle
Hallene Guo, MD, Seattle
Alireza Hadi, DO, University Place
Kaitlyn Hite, MD, Bremerton
Benton Huang, MD, Bremerton
Christian Kishlock, MD, New Castle, DE
Jessica Lee, DO, Bremerton

Ann Lin, MD, Seattle
Callie Linehan, MD, Seattle
Lisa Matelich, MD, Spokane
Cliff Moeckelmann, MD, Tacoma
Eunice Nachinga, MD, Valhalla, NY
Charles Nguyen, DO, Seattle
Teresa Porter, MD, Tacoma
Sanjana Rao, MD, Tacoma
Teresa Straub, DO, Bremerton
Samuel Wilcox, MD, Bremerton
Tyler Wines, MD, Bremerton

Student Members

Grayson Baden, Spokane
Inderbir Bains, Spokane Valley
Wade Banta, Anchorage, AK
Madeleine Birch, Seattle
Emily Brestin, North Bend
Rachel Brock, Spokane
Yi Cai, Seattle
David Caldwell, Seattle
Sarah Case, Seattle
Christopher Chalaka, Spokane
Joan Chen, Seattle
Justin Cillay, Spokane
Chelsea Clarke, MPH, Mount Vernon
Chris Colasurdo, Yakima
Cheri Cornwell-Eshete, Federal Way
Matthew Coyne, Arlington
Joanne De Howitt, Spokane
Virkamal Dhaliwal, Spokane
Karn Dhillon, Spokane
Ngan Do, Seattle
Mitchell Dumais, Veradale
Parick Erstad
Melissa Estabrook, Spokane
Ashley Folkers, Tumwater
Gravie Friesen, Spokane
Colin Froines, Seattle
Shawna Greenleaf, Seattle
Zhanna Grigoryan, Renton
Chung Huang, Spokane

continued on page 24

New Members continued

Emily Huebner, Seattle
Nafeesa Imtiaz, Bothell
Tiffany Jaramillo, Kenmore
Jennifer Jensen, Seattle
Lily Jeong, Seattle
Kevin Khoo, Bellevue
Sara Knauft, Bellingham
Charles Kopp, Anchorage, AK
John Kunthara, Seattle
Tiffani Lautenslager, Ellensburg
Justine Lawson, Spokane
John Lazar, Seattle
Rachel Levenseller, Spokane
Grant Linnell, Spokane
Hanna Mackie, Kalispell, MT
Doyle McCarthy, Seattle
William Mellor, Colfax
Rob Meyer, Spokane
Yelena Mishkov, Spokane
Geoffrey Mitchell, Spokane
Chris Moore, Lakewood
Monica Mueller, Spokane

Kirsten Myers, Spokane
Nicole Naiman, Seattle
Belle Ngo, Lynnwood
Greta Niemela, Spokane
Erwin Odongo, MS, Brooklyn, NY
Kathy Po, Lynnwood
Yuliya Pomeranets, Oak Park, IL
Derek Prince, DPT, Spokane
Mark Ragheb, PhD, Puyallup
Cheyenne Rahimi, Walla Walla
Elizabeth Rasmussen, Spokane
Rebecca Resnick, Seattle
Laurisa Rodrigues, Pueblo, CO
Manuel Rodriguez, Yakima
Giandor Saltz, Denver, CO
Jagdeep Sandhu, MD, Seattle
Roya Sharifian, Bellevue
Jasmine Sidhu, Mukilteo
Alix Silha, Spokane
Mariah Smith, Stanwood
Paxton Smith, Cheney
Natalie Smith, Seattle

Mary Smithers, Edmonds
Meigan Sobczyk, Auburn
Carlie Sorensen, Spokane
Jeffrey Sterritt, Redmond
Aaron Stewart, Seattle
Isabella Stokes, Seattle
Cassandra Sunga, Seattle
Benjamin Titus, Bellevue
Phanith Touch, Kirkland
Carson Twiss, Yakima
William Veloso, Eagle, ID
Chloe Waham, Yakima
Lara Westbrook, Seattle
Erik Willis, Puyallup
Maresa Woodfield, Seattle
Simean Yang, Richland
Eileen Yee, Vancouver

Transitional Members

Jacob Cravens, MD, Tacoma
Radhima Ohri, MD, Tacoma

The Core Content Review of Family Medicine

Why Choose Core Content Review?

- **Online and Flash Drive Versions available**
- **Cost Effective CME**
- **For Family Physicians by Family Physicians**
- **Print Subscription also available**



The Core Content Review of Family Medicine

Educating Family Physicians Since 1968

PO Box 30, Bloomfield, CT 06002

*North America's most widely-recognized program for
Family Medicine CME and ABFM Board Preparation.*

- Visit www.CoreContent.com
- Call 888-343-CORE (2673)
- Email mail@CoreContent.com

Your health
BEFORE
all else.

— INTRODUCING —
PHYSICIAN HEALTH FIRST

You work hard to take care of your patients. The AAFP works hard to take care of you. AAFP Physician Health First is the first-ever comprehensive initiative devoted to improving the well-being and professional satisfaction of family physicians, and reversing the trend toward physician burnout. So you can stay passionate about your purpose: providing quality patient care.

Discover a wealth of well-being at
aafp.org/mywellbeing

The AAFP Physician Health First initiative is made possible by your generous contributions to the American Academy of Family Physicians Foundation.



aafpfoundation.org



AMERICAN ACADEMY OF
FAMILY PHYSICIANS



WASHINGTON ACADEMY OF FAMILY PHYSICIANS
1239—120th Avenue NE, Suite G
Bellevue, WA 98005

UPCOMING EVENTS

Medical Student and Resident Retreat

Jan. 25-26, 2020 — Olympia, WA

WAFP Board of Directors and Committee Meetings

Jan. 25, 2020 — Olympia, WA

Family Medicine Advocacy Day

Jan. 27, 2020 — Olympia, WA

AAFP National Conference of Constituency Leaders

April 23-25, 2020 — Kansas City, MO

AAFP Annual Chapter Leader Forum

April 23-25, 2020 — Kansas City, MO

WAFP Board of Directors Meeting

May 6, 2020 — Blaine, WA

63rd House of Delegates

May 7, 2020 — Blaine, WA

WAFP Foundation Annual Meeting

May 7, 2020 — Blaine, WA

71st Annual Scientific Assembly

May 8-9, 2020 — Blaine, WA

AAFP Family Medicine Advocacy Summit

May 18-19, 2020 — Washington, DC

AAFP National Conference of Family Medicine Residents & Students

July 30-August 1, 2020 — Kansas City, MO

AAFP Congress of Delegates

Oct. 12-14, 2020 — Chicago, IL

AAFP Family Medicine Experience (FMX)

Oct. 13-17, 2020 — Chicago, IL
