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THE MARYLAND family doctor

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EVIDENCE BASED CANCER PREVENTION

Managing the Patient at High Risk for Breast Cancer

Breast Cancer Screening: A Look at the Balance Between Harms and Benefits

Prostate Cancer Screening - Managing Maryland's Men

ALSO...

- POT-pourri Series
- Evidence Based Medicine and the Electronic Medical Record
- TransforMed National Demonstration Project Concludes
- In Memory: John B. Umhau, Jr., M.D., MAFP's 31st President

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Yes, We See It, We Do It, We Teach It...Family Medicine!



by Yvette L. Rooks, M.D.

AS WE CONTINUE TO GROW as a specialty, we need to be innovative in the variety of experiences we offer our medical students as we encourage them to pursue careers in Family Medicine. Throughout my career as a clinician educator, I have been constantly intrigued by the willingness of my students to learn and do more. A house call program was recently created to include third year medical students rotating through the Family Medicine clerkship.

Despite the critical shift in delivery of care and the fact that physicians are medically and legally responsible for managing all skilled care in the home, a comprehensive home care medical education experience remains scant. Consequently, the University of Maryland Department of Family and Community Medicine applied for and received a Bureau of

Health Professions' grant that allowed expansion of its house call program so that third year students would be able to participate. The grant provided funding for a collaboration with Levindale Hebrew Geriatric Center and Hospital. The Levindale home care program is led by a geriatric nurse practitioner. In the house call programs, the primary care provider performs visits two to four half days a week. Each patient is seen on average every three months, or more, as indicated by the acuity of their illness.

The overall goals of the expanded house call program were to: implement a curriculum for all third year medical students to develop skills in investigating and treating the diseases of the homebound patient; assess the social, environmental and psychological factors that can alter the patient's medical management; and assess student attitudes toward home care education. (Please see online addendum for further information.)

Over the course of three years, 316 students were required to make a minimum of two house call visits during their four-week Family Medicine clerkship. The Home Care Curriculum was modeled after the 1990 report by the American Medical Association, "Educating Physicians in Home Health Care," which cited 10 competencies/goals for a model curriculum. Students were given a practical guide containing a variety of articles on providing care in a home care setting, regulations and guidelines, and safety measures for community visits.

The clerkship director met with the students bi-weekly in a small group format and reviewed the case write-ups. The students were expected to develop a care plan for their patients and present such a plan to their peers for discussion. Members of the interdisciplinary teams were present to discuss both the learning objectives and the student observations.

All students completed an electronic evaluation at the end of the clerkship. The students rated the various educational activities in which they participated and responded to several questions about the home care curriculum. The students were asked about the patient's environment, support system and benefits.

Students' overall impression of the house call program was positive. They felt that the actual home visits and time spent with the caretaker(s) were better ways to learn about home care than

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Evidence Based Medicine



by Tracy A. Wolff, MD, MPH

“EVIDENCE BASED MEDICINE IS the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”¹ This commonly cited definition of evidence based medicine by David Sackett has evolved to include the consideration of patient values.

In my work with the US Preventive Services Task Force I am immersed daily in the development of resources for clinicians to practice evidence based medicine. In this work I have heard often about the barriers that exist in practicing evidence based medicine. The most commonly mentioned hurdle is limited time. Fortunately, the development of systematic reviews that synthesize the evidence using a comprehensive, transparent, systematic and unbiased methodology has helped to address this time hurdle. The increase in the number of published systematic reviews and other resources, in many instances, means that clinicians no longer need to search the literature themselves. See the accompanying list of web addresses for searchable databases of systematic reviews. There are also many services that summarize systematic reviews or best-evidence searches into easily-read and succinct formats; several

websites are listed for these, including *Up To Date*, *Bandolier* and *PDQ*.

Another oft-mentioned barrier is the confusion over the numerous, often conflicting guidelines being published. There are many reasons why guidelines may differ. One reason for conflicting guidelines is the varied methods that are used to develop guidelines. Evidence based guidelines are developed based on systematic reviews of the evidence using a defined, transparent, unbiased method of linking the evidence to the recommendation. However, organizations may or may not follow an evidence based development process and, therefore, differing interpretations of the evidence may produce differing guidelines. Many professional organizations produce a mixture of evidence based guidelines and consensus based guidelines. Professional organizations have an obligation to their members to provide guidance and, therefore, may fill in an evidence gap with consensus opinion. With increasing frequency professional organizations are describing the level of evidence for specific guidelines. This allows clinicians to make informed decisions about which guidelines to follow. The National Guideline Clearinghouse is a great resource that allows clinicians to research the various guidelines on a specific topic, see the evidence on which the guideline is based and make these informed decisions. Listed below is the weblink for the National Guideline Clearinghouse as well as a few other resources for primary care guidelines.

I am happy to present this edition of *The Maryland Family Doctor* on evidence based medicine, focusing on evidence based cancer prevention and treatment. There are two articles focusing on breast cancer that include information on addressing patient values in making decisions: Drs. Barton and Shelton discuss the benefits and

harms of screening for breast cancer and Dr. Helzlsouer writes about genetic counseling and management of high-risk individuals. Drs. Lobrano and Lin discuss the recent U.S. Preventive Services Task Force recommendation against screening for prostate cancer in older adults. Evidence based medicine and electronic medical records are the topics of an article by our resident editor, Dr. Al-Abbadi. I have enjoyed editing this edition of *The Maryland Family Doctor* and hope you find it useful in your clinical practice.

Resources for systematic reviews or best-evidence summaries:

Cochrane Reviews:

www.cochrane.org/reviews/index.htm

Centre for Reviews and Dissemination:

www.crd.york.ac.uk/crdweb/

UK National Institute for Health

Research: Health Technology

Assessment:

www.nchta.org/research/index.shtml

AHRQ Evidence-based Practice Center

reviews:

www.ahrq.gov/clinic/epcix.htm

AHRQ Comparative Effective reviews:

www.effectivehealthcare.ahrq.gov/healthInfo.cfm?infotype=rr

Finding systematic reviews in PubMed:

www.ncbi.nlm.nih.gov/entrez/query/static/clinical.shtml

Summaries of cancer prevention and treatment from National

Cancer Institute:

www.cancer.gov/cancertopics/pdq

NIH Consensus Development Program:

www.consensus.nih.gov/PREVIOUSSTATEMENTS.htm

Bandolier:

www.medicines.ox.ac.uk/bandolier/knowledge.html

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by Kathy J. Helzlsouer, M.D., M.H.S.

Managing the Patient at High Risk for Breast Cancer



WOMEN AT HIGH RISK for breast cancer rely on their primary care physicians to help them reduce or manage their risk. One of the first challenges for the primary care practitioner is to identify individuals in high risk groups and offer appropriate management to either reduce their risk or heighten surveillance to improve early detection of cancer. Increased risk may be on the basis of family history or other risk factors. In the Summer 2008 edition of *The Maryland Family Doctor*, identifying individuals with a genetic susceptibility to cancer was reviewed. These and others at increased risk require special interventions and surveillance, but there is a spectrum of risk.

Determining Risk

About 10 percent of women who develop breast cancer have an underlying strong inherited genetic risk. These families tend to have early onset breast cancer affecting multiple generations, possibly bilateral breast cancer and may have a family history of ovarian cancer. Both maternal and paternal family history need to be considered.

Genetic testing is available for two genes, *BRCA1* and *BRCA2*, mutations that explain about 50 percent of inherited forms of breast cancer. Genetic testing is also available for a few other syndromes

that may explain another 3 to 5 percent of inherited forms of breast cancer. Thus genetic testing, while helpful in some families to clarify risk, is not informative for all families. Women from families where a mutation has been identified in a family member may choose to be tested; if they do not carry the mutation (true negative test result) they fall into a risk category that is closer to the general population risk. If a mutation is found, the risk of developing breast cancer over a lifetime may be as high as 87 percent, along with an increased risk of ovarian cancer of 10 to 40 percent, depending on the gene involved. If the underlying genetic factor in the family cannot be determined, the

Mammography remains the principle method of screening for all women, including those at increased risk. For all women, routine screening with mammography is recommended to begin at age 40.

individual remains in a high risk category based on her family history. It is important to note that men who carry a mutation are also at increased risk of cancer, including breast cancer. The lifetime risk of breast cancer for men who carry a mutation is about 6 percent, and a male history of breast cancer warrants consideration of genetic testing of the family.

For the large group of women whose family history does not suggest a strong genetic predisposition, there are generally available statistical models to help determine a woman's risk and determine if she is at a level that requires special

interventions. These models are not appropriate to use when the family history is suggestive of an inherited cancer family syndrome, as the risk is often underestimated in that situation, particularly if the inherited risk is from the paternal side of the family.

The most commonly used model to estimate risk is the Breast Cancer Risk Assessment Tool available at (<http://www.cancer.gov/bcrisktool/>), developed by Gail et al (Gail, 1989 and 2001) of the National Cancer Institute. This model was used to determine risk and eligibility for the two breast cancer chemoprevention trials conducted to evaluate tamoxifen and raloxifene for reducing the risk

of developing breast cancer: P1 - Breast Cancer Prevention Trial, P2 - The Study of Tamoxifen and Raloxifene (STAR) 1998 and 2005; Vogel, 2006. This model has been validated and is appropriate to use for the general population of women when an inherited cancer family syndrome is not suspected (Gail, 2001). The model accounts for the major breast cancer risk factors and calculates five-year and lifetime risk estimates along with comparison to an "average" woman's risk. Women who had a five-year risk estimate of 1.7 percent or greater were considered at increased

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High Risk

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risk and were eligible to take part in the breast cancer prevention trials. This level risk is a reasonable guide to determine who should be counseled regarding chemoprevention and was adopted as the definition of increased risk in the cancer prevention recommendation issued by U.S. Preventive Services Task Force (<http://www.ahrq.gov/clinic/prevenix.htm>).

Ongoing research is trying to improve the prediction of these models, but changes to the model currently offer only marginal gains. These models perform well, but there are always some exceptions that should be considered in estimating risk. For example, one risk factor that affects prevention recommendations is the degree of breast density noted on mammography examination. Currently, this factor is not incorporated into the Gail model. Dense breast tissue has been shown to decrease the sensitivity of mammography to detect breast cancer and is independently associated with an increased risk of future development of breast cancer.

Ionizing radiation exposure, especially during the adolescent period, is a risk factor for breast cancer. Since it is a rare exposure, it is not incorporated into general models for risk estimation. Women with scoliosis who may have had multiple x-rays in their teen years, a history of Hodgkin's disease treated with mantle irradiation, or individuals treated for acne, particularly of the neck and back, should all be considered at increased risk based on their exposure history. Available models may underestimate their risk as this factor is not considered. These exposures should be asked about as part of the medical history to identify these women.

Managing Risk - Prevention

The U.S. Preventive Services Task Force (<http://www.ahrq.gov/clinic/prevenix>.

htm) offers guidance for use of preventive and screening interventions. Counseling women at increased risk about the use of chemoprevention, using the trial eligibility guidelines of 1.7 percent or greater five-year risk estimate as determined by the Breast Cancer Risk Assessment Tool, is recommended by the task force.

Two medications are approved for reducing the risk of developing breast cancer: tamoxifen and raloxifene (Vogel, 2006). Raloxifene is approved for use after menopause. Tamoxifen may be used for pre- and post-menopausal women. The STAR trial established that both raloxifene and tamoxifen are equivalent in reducing the risk of invasive breast cancer, although only tamoxifen showed a decreased risk of pre-invasive forms of breast cancer. The degree of risk reduction is about 50 percent, and because these medications are selective estrogen-receptor modifiers, they only reduce the risk of estrogen-receptor positive breast cancers. Based on long term follow-up of the P1 trial, the benefits for risk reduction persist beyond the recommended five years of treatment (Fisher et al.).

Raloxifene was associated with fewer side effects than tamoxifen, including endometrial cancer and deep vein thrombosis. Both medications may exacerbate menopausal symptoms. When taken by premenopausal women, tamoxifen may lead to menopausal symptoms but does not cause menopause, so women in their reproductive years need to use barrier contraceptive methods.

While this high risk group includes women with mutations in *BRCA1* or *BRCA2*, there is limited information on the degree of benefit with chemoprevention, particularly for women who carry a *BRCA1* mutation (King et al.). Mutations in this gene are commonly associated with estrogen-receptor negative breast cancer (~83%). Thus, these women are unlikely to have a significant benefit from chemopreventive agents. The

opposite is true for women who carry a *BRCA2* mutation; the majority (~76%) of breast cancer is estrogen receptor positive. In the P1 trial, 19 women who developed breast cancer were found to carry a *BRCA1* or *BRCA2* mutation. Eight women carried a *BRCA1* mutation; five had taken tamoxifen and three had taken placebo. Thus, there was no evidence of benefit. Among the 11 women who carried a *BRCA2* mutation, three had taken tamoxifen and eight had taken placebo. The degree of risk reduction for *BRCA2* carriers was similar to all women on the trial. These results are consistent with what is known about the distribution of estrogen receptor status of breast cancers occurring among *BRCA1* or *BRCA2* carriers. Until the development of agents that can successfully lower the risk of estrogen-receptor negative breast cancer, only a small subgroup of women who carry a *BRCA1* mutation would likely benefit from use of either tamoxifen or raloxifene.

Risk-reducing Surgery - Prophylactic Mastectomy

Prophylactic mastectomy can reduce the risk of breast cancer by 90 to 94% (Hartmann, 1999 and 2001). This option should be reserved for women at very high risk of breast cancer due to either an inherited predisposition or other risk factors that increase the risk of breast cancer to a similarly high level. Women who carry a mutation in *BRCA1* or *BRCA2* are at sufficient risk of a primary and secondary breast cancer. Counseling should include discussion of risk-reducing mastectomy. Women from families where an inherited predisposition is suspected, but for whom genetic testing is negative, should also be counseled about the availability of surgical options, including breast reconstruction. This discussion should always include the availability of close surveillance and chemoprevention as alternatives.

Prophylactic Oophorectomy

Evidence has shown that women who had their ovaries removed at a young age, e.g., 35, had a decreased risk of breast cancer, with a risk reduction similar to that seen with the use of tamoxifen, about 50 percent. However, the risks of premature menopause, osteoporosis and even premature mortality, may outweigh the benefit. Women who carry mutations in *BRCA1* or *BRCA2* are at a significant increased risk of ovarian cancer in addition to breast cancer. For this group of women, risk-reducing oophorectomy should be discussed, because there is no currently proven effective method for the early detection of ovarian cancer. The timing of this surgery must be put in the context of completion of child bearing and discussion of the impact of early menopause.

Screening

Mammography remains the principle method of screening for all women, including those at increased risk. For all women, routine screening with mammography is recommended to begin at age 40. However, for certain groups of women at high risk, screening should begin earlier than for the general population and additional screening modalities may be indicated. For example, in women with a strong family history of breast cancer, the general rule is to begin routine screening by age 30, or 10 years before the earliest age of onset of breast cancer in the family. The use of ultrasound and MRI should be considered.

The addition of other modalities such as breast ultrasound and breast magnetic resonance imaging (MRI) for women at increased risk helps to improve the sensitivity of screening, but, at the expense of an increase in the false positive rate, i.e., lowered specificity. For women who carry mutations in *BRCA1* or *BRCA2* or with a suspected inherited syndrome based on family history, breast MRI has been shown to have a

higher sensitivity than mammography, but the modalities are complementary (Warner et al.). MRI should not be used in place of mammography.

A recent study also demonstrated the additional benefit of ultrasound when used with mammography for women with dense breast tissue (Berg et al.). These studies show an impact on sensitivity, but no information is available regarding the effectiveness in reducing breast cancer mortality beyond that with mammography alone. Nevertheless, current recommendations issued by the American Cancer Society include annual MRI screening in addition to mammography (Saslow et al.) for women at a lifetime risk of 20 to 25 percent. This would include women who carry a mutation in *BRCA1* or *BRCA2*; women with suspected inherited syndromes who have not had genetic testing or for whom genetic testing is not informative; women with a history of exposure to ionizing radiation in adolescent or early adult years; and women with a combination of risk factors contributing to high risk as determined by validated risk models, assessment of the density of breast tissue and history of results of atypical hyperplasia or lobular carcinoma in situ in prior breast biopsies. MRI may also be considered for women at moderate increased risk (15 to 20 percent lifetime risk) or with specific risk factors such as very dense breast tissue. Though the role of ultrasound is not specifically addressed in their recommendations, this should be considered for women with dense breasts, based on the previously cited research results (Berg, 2008). The decision to include adjunct screening modalities should be based on clinical risk assessment and determination of breast density on mammogram.

Health care providers should include breast cancer risk assessment as part of a general health assessment in women. The risk assessment should be updated

periodically as risk factors such as family history, reproductive factors and breast biopsies change over time. A variety of options are available to women for managing their risk, including primary prevention as well as improving early detection of breast cancer. Genetic counseling and testing is available to help clarify risk and to appropriately focus management strategies. ■

Dr. Helzlsouer is director, Prevention and Research Center, Mercy Medical Center in Baltimore, MD. She has recently been appointed by Governor Martin O'Malley as chair of the Maryland Council on Cancer Control (see p. 23).

Editor's Note: References for this article appear at www.mdafp.org. Click the "Publications and News" tab.

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Guidelines

American Academy of Family Physicians:

www.aafp.org/online/en/home/clinical/clinicalrecs.html

US Preventive Services Task Force:

www.ahrq.gov/clinic/prevenix.htm

National Guideline Clearinghouse:

www.guideline.gov/. ■

¹ Sackett DL, Rosenberg WMC, Gray JAM, Haynes, et al. *BMJ*. 1996; 312:71-72 (13 January)

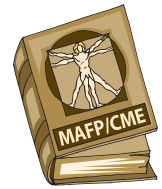
Dr. Wolff is medical officer, U.S. Preventive Services Task Force Program, Center for Primary Care, Prevention and Clinical Partnerships, Agency for Health Research and Quality in Rockville, MD. She is an MAFP Western District Director and a member of the MAFP Editorial Board. She edits this, her 5th edition of *The Maryland Family Doctor*.



by Mary B. Barton, MD, MPP and
Erica I. Shelton, MD, MPH

Breast Cancer Screening

A Look at the Balance Between Harms and Benefits



THE US PREVENTIVE SERVICES Task Force (USPSTF) and other well-respected entities have made authoritative recommendations that, at times, differ regarding breast cancer screening for the general population. Family physicians may wonder why different authorities make different recommendations and may be uncertain, given these differences, of how to implement these recommendations into their practices. It is possible in some cases that both sets of recommendations have something to offer. Recommendations from specialty organizations may target the general population but also speak to patient populations that are particularly at risk. In general, their recommendations aim aggressively to capture early disease occurrence. In contrast, USPSTF recommendations are geared toward patients in the general population with average risk of a given disease and in focusing specifically on the harms of screening may appear more conservative than those of specialty organizations.

Because USPSTF recommendations are designed for use in the general population, they must balance the benefits of early disease diagnosis with the harms of screening. Harms (or burdens) might include false positive tests, risk of biopsy, recall visits for further testing as well as staff and clinician time.¹ In dealing with the general population framework, USPSTF must consider how a relatively infrequent harm (e.g. 6 percent of mammograms read as falsely positive), could still manifest as a large number

of individuals.^{2,3} As part of this population framework, USPSTF also seeks to measure benefits and harms of the follow-up tests and treatments for a given condition in a specific population.^{3,4} These downstream events must be considered as consequences of the screening program. This article provides examples of how USPSTF assesses the harms of breast cancer screening.

BSE and CSE Screening

Trials show no mortality benefit from breast self-examination (BSE), but there is an increase in benign biopsies, and this could lead to harms.⁵ Trials determining effectiveness of clinical breast examination (CBE) for the reduction of breast cancer mortality are ongoing. Available trials demonstrate CBE sensitivity of 40-69 percent, specificity of 86-99 percent and positive predictive value from 4-50 percent for the detection of breast cancer.⁶ A 2002 USPSTF review found no evidence that the addition of CBE provided greater screening benefit than mammography alone.² Experts infer from indirect sources that CBE could be efficacious, though the ideal trial to determine its benefit has not been performed.⁶

Mammography Screening

Trials reviewed by the USPSTF demonstrate that screening mammography reduces breast cancer mortality for women aged 40-69 years, but data is limited for women aged 70 years and over.⁷ Mammography screening in the U.S. occurs throughout the healthcare system, in both public and private settings, while in the UK and northern European countries, such as Sweden and Norway, there are national screening programs.⁸ While certain characteristics of the test are consistent – sensitivity of

mammography and cancer detection rates – between the U.S. and northern Europe, other aspects of program administration vary. For example, in the U.S., 11 percent of mammography screenings are read as abnormal compared to 2-5 percent in Sweden.¹ Furthermore, recall and open surgical biopsy rates are twice as high in the U.S. when compared to the UK.⁹

Given these statistics, harms from routine breast cancer screening among the general population must be critically assessed. Harms from screening mammography include the consequences of false positive and false negative results. In one 10-year study, one third of women screened had abnormal results requiring additional evaluation, although no cancer was demonstrated.¹ Moreover, younger women had higher false positive rates requiring additional imaging to interpret results.¹ Nevertheless, in the U.S., false positive rates do not adversely affect adherence rates for subsequent screening.⁸ Other screening harms include pain during procedures, anxiety and psychological distress.^{1,8}

Another aspect of screening harms is over diagnosis of invasive or in situ breast cancer that would not become clinically evident over the course of a woman's lifetime.¹⁰ This theoretical concern is challenging to address: One cannot necessarily predict which diagnoses would meet this criterion, or which individual women would meet an unrelated cause of death. Few methodologic approaches exist to determine rates of over-diagnosis on a population level. One approach is to consider a fraction of ductal carcinoma in situ (DCIS) to be nonprogressive, meaning that the lesion would never become an

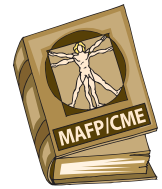
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Prostate Cancer Screening

Managing Maryland's Men

by Marcia B. LoBranco, M.D., MPH and Kenneth W. Lin, MD



AS THE MOST COMMON non-skin cancer in U.S. men, with one in six receiving a diagnosis in their lifetimes, prostate cancer is a significant health burden nationally and in the state of Maryland. Although national mortality rates have been falling since 1991, an estimated 186,320 new cases will still be diagnosed in 2008, and more than 28,000 deaths will be attributed to the disease¹. Though Maryland's overall prostate cancer mortality rate of 29.9 deaths per 100,000 is similar to the nation's, there are wide disparities at the county level. Specifically, Baltimore (44.3), Calvert (41.5) and Somerset (39.4) counties have far higher prostate cancer death rates². Stark racial disparities exist as well. Nationally, black men have a 60 percent higher incidence of prostate cancer and twice the mortality rate of white men³. The Maryland numbers are strikingly similar.

Since its approval by the FDA in 1986, the prostate-specific antigen (PSA) test has been used for screening for prostate cancer. By convention, PSA levels ≥ 4 ng/ml have been accepted as abnormal and an indicator for referral for biopsy. Many family physicians who serve populations with higher prostate cancer incidence and death rates have taken an aggressive approach to cancer detection by routinely screening all men over a certain age with PSA and referring those with elevated levels. How does this approach compare to evidence-based guidelines?

In 2002, the U.S. Preventive Services Task Force (USPSTF) concluded that there was insufficient evidence to recommend for or against routine screening for prostate cancer. In the August 5, 2008 issue of the *Annals of Internal Medicine*, the USPSTF published an update of its

recommendation. While the evidence remains insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years (I statement), the USPSTF now recommends against such screening in men age 75 years or older (D recommendation)⁴. The evidence suggests that most PSA-detected cancers take more than 10 years to affect health, and men aged 75 and older are much more likely to die from other causes, such as heart disease or stroke, than to obtain any benefit from treating a screen-detected prostate cancer. Hence, screening is unlikely to be beneficial, but may lead to important harms, including anxiety, biopsies or the side effects of unnecessary treatment. Although the USPSTF notes that older men, African-American men and men with a family history of prostate cancer are at increased risk, it comments that "gaps in the evidence regarding potential benefits of screening also apply to these men."

Other organizations have evaluated the evidence differently, making recommendations about "high risk" groups. For African-American men and those with first degree relatives with a history of prostate cancer before age 65, the American Cancer Society recommends considering PSA testing starting at age 45⁵. We advise caution in adopting this approach due to limitations in the evidence. Although men at increased risk for prostate cancer may be more likely to benefit from screening, they are also more likely to be harmed by the adverse effects of the cascade of screening, diagnosis and treatment. Further, it should be especially troubling to family physicians who care for African American patients that although prostate cancer screening rates for black

men have been steadily increasing, screening rates for other preventive services with evidence of proven benefit, like colonoscopy for colon cancer (A recommendation from the USPSTF) for this group have remained flat or are declining⁶.

What is the bottom line for primary care clinicians in Maryland? As most organizations recommend, prostate cancer screening should only be performed after having an individualized discussion with each patient about both the potential but uncertain benefits and known harms of screening and the patient's values and preferences. Clinicians should not skip these discussions in "high risk" men. In fact, we believe that these are the men for whom these discussions are probably the most important. For assistance with these conversations, the USPSTF has produced a helpful video at <http://www.ahrq.gov/clinic/ivideos.htm>⁷.

Until more evidence becomes available, more testing for prostate cancer does not equal better care. As is the case for many other medical interventions that have uncertain benefits, we conclude that for prostate cancer screening, having a thorough discussion of the options is, in fact, the best medicine.

Two useful online resources for clinical information about prostate cancer decision-making are <http://www.ahrq.gov/clinic/uspstf/uspSprca.htm> and <http://www.cdc.gov/cancer/Prostate/> ■

Dr. LoBranco is a Preventive Medicine resident at the Johns Hopkins Bloomberg School of Public Health. She is currently rotating at the U.S. Preventive Services Task Force (USPSTF) Program, Center for

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The Varenicline (Chantix) Dilemma

by N. Joseph Gagliardi, M.A., M.D.

AS FAMILY PHYSICIANS, WE encourage our patients to quit smoking tobacco products. There are several smoking cessation aids available. Of all such aids, varenicline (Chantix) has been declared the “most effective drug available for increasing smoking cessation.” (Medical Letter 11/19/07).

Varenicline was released by the FDA on May 11, 2006. It became available to the public by prescription in August 2006. On February 1, 2008, the FDA issued a warning about the safety of Varenicline. The FDA alert and public advisory noted:

1. Patients should tell their health care provider about any psychiatric history prior to taking varenicline.
2. Patients should report to their doctor the following: visual, unusual or strange dreams; mood and/or behavior changes.
3. Healthcare professionals, patients, patients’ families and caregivers should be alert to and monitor changes in mood and/or behavior in the patient taking varenicline.

A more recent FDA alert, May 16, 2008, approved new prescribing information and recommendations. Those recommendations are:

1. Healthcare providers should monitor all patients taking varenicline for symptoms of serious neuropsychiatric symptoms.
2. Patients with serious psychiatric illness such as schizophrenia, bi-polar disorder, major depressive disorder, may experience worsening of their pre-existing psychiatric illness while taking varenicline.
3. While varenicline has demonstrated clear evidence of efficacy, it is important to consider these safety concerns and alert patients about these risks.

On July 14, 2008, *The Medical Letter* concluded that “the benefits of using the drug (varenicline) to stop smoking may outweigh the risks.”

Maternal Smoking During Pregnancy May Portend Misbehavior in Children

The National Institute on Drug Abuse (NIDA) recently published a summary of studies associating behavior problems in children one to seven years of age with exposure to pre-natal maternal smoking. The research was conducted by Dr. Laura Wakschlag of the Institute for Juvenile Research at the University of Illinois.

According to Dr. Wakschlag, 12-24-month-old children exposed to prenatal smoking exhibited not only higher rates of disruptive behavior, but also escalating patterns of such behavior. Unexposed children presented with a more stable pattern of behavior. For example, 24 month old exposed toddlers were 11 times more likely than non-exposed toddlers to demonstrate severe forms of hitting, throwing

and smashing toys, stubborn defiance, temper tantrums and uncontrolled outbursts of screaming and yelling.

Another study documented double the rate of anti-social behavior known as oppositional defiant disorder (ODD) in seven-year-old boys exposed to prenatal smoking compared to unexposed seven-year-old boys. ODD has been considered a precursor to various conduct disorders in adolescents including vandalism and aggressive behavior.

Although no difference was found in the incidence of Attention Deficit Hyperactivity Disorder (ADHD) between exposed and unexposed children, the incidence of co-occurring ODD and ADHD in children whose mothers smoked during pregnancy was twice that of unexposed children.

One theory presented by Dr. Wakschlag is that prenatal exposure to smoking disrupts social information processing. However, this theory is still under investigation.

Based on these studies, there seems to be a significant risk for children exposed to pre-natal smoking to develop disruptive behaviors that may have dire consequences later in life. The studies did control for parenting styles and parental anti-social behaviors. ■

Dr. Gagliardi continues his POT-pourri series on substance abuse topics. He is associate medical director of the Kolmac Clinic.

Editor’s Note: References for this article appear at www.mdafp.org. Click the “Publications and News” tab.

Prostate

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Dr. Lin is a medical officer at the U.S. Preventive Services Task Force (USPSTF) Program, Center for Primary Care, Prevention and Clinical Partnerships, Agency for Healthcare Research and Quality, Rockville, Maryland. A member of the DC-AFP, he is an assistant professor of Clinical Family Medicine at Georgetown

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Editor’s Note: References for this article appear at www.mdafp.org. Click the “Publications and News” tab.

In Memory



John B. Umhau, M.D., MAFP's 31st President November 9, 1926 – April 16, 2008



by William P. Jones, M.D.

THE MAFP FAMILY RECEIVED a shock when the death of our former president, John B. Umhau, M.D., was announced. John succumbed to a brain injury due to a fall. It was only a few months ago that we saw the vibrant, irascible John at the MAFP Regional Conference in College Park. It was fitting that the regional conference was his final MAFP activity; he began these meetings as the "mini conferences" years ago. They have been a successful CME offering to our members since their initiation. A motion to award Dr. Umhau the MAFP Lifetime Achievement Award posthumously was overwhelmingly approved by the MAFP Board at its summer meeting. Anyone wishing to send condolences to the Umhau family or contributions to the charities they've selected may contact the MAFP office at 410-747-1980 or info@mdafp.org.

John was very proud of his roots. Born in Washington, D.C. and educated in the public schools of the district, he was elected president of his high school class at Coolidge High School. Next, he attended The George Washington University for both his undergraduate and medical degrees. The year after his graduation he married Janet F. Nufer and began his medical career and his family. The family was blessed with three sons: John, William and Andrew, all of whom became physicians.

He served his internship at the Galinger Municipal Hospital in Washington. Next he established his practice in his home in Chevy Chase, Maryland, where he practiced until his death.

His career has included a wide array of involvement in various medical organizations. John was a charter fellow of the American Academy of Family Physicians. He was an attending at both Suburban Hospital in Bethesda and Shady Grove Adventist Hospital in Gaithersburg. He was heavily involved in the governance structure of Suburban's medical staff; he was chief of staff from 1976-1979. As president of the Southern Medical Association's Primary Care Section, John was always recruiting new members. He also occupied just about every office in the Montgomery County Medical Society and served as president in 1973-1974.

John was a senior federal aviation administrator, senior medical examiner and had been an accident investigator. He was a clinical instructor in Family Medicine at Georgetown University and a preceptor for medical students at the University of Maryland and The George Washington University medical schools.

He received numerous awards, including University of Maryland Recognition for Advancing Education Research and Patient Care, a Professional Service Citation from the Federal Aviation Administration, a Recognition Award for Continuing Education to further Professional Growth from the AAFP, a Certificate from the PDFSuburban Hospital for Valued Service, a Citation from the Department of Surgery of Suburban Hospital for his Efforts to Promote and Provide the Ultimate in Excellence of Patient Care, three awards from the Montgomery County Medical Assn. and



Dr. Umhau

the Alumni Service Award from The George Washington University Alumni Assn.

Outside of medicine, John was heavily involved in community and other personal activities, including the Aircraft Owners and Pilots Association (He held a private pilot's license). He served the George Washington University Medical Alumni Association as their president from 1989-1992. Others included National Lutheran Home Board of Trustees; Troop physician for Troop 255 Boy Scouts of America; Bethesda Chevy Chase High School Russian Exchange Program, serving as physician to the students from 1988 to the present; member Columbia Country Club; Cosmos Club; Institute of Parliamentarians; General Society of the War of 1812; Potomac Corral of Westerners; Sons of the American Revolution; St. Andrew's Society of Washington, D.C.; and the Pilgrims of St Mary's.

John was my medical mentor. We first met when I was a staff physician at Suburban Hospital. He was chief of staff and I was his vice chief. He made sure that I was involved in the entire spectrum of the office and even absented himself for a meeting so that I might chair a meeting of the medical staff. Later, I became his assistant on the Mini Conference Committee and after he was sure I had a handle on the job, he left me as chairman. I chose him to be my advisor when I was president of the MAFP, and I relied on his calm reassuring judgment when I had a particularly difficult problem.

John and Jan invited my wife Pat and me to the Cosmos Club for dinner last

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In Memory

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year. Not only did we have a delightful dinner, but we were treated to a lesson in history from the 'professor.' We will certainly miss him.

Mrs. Umhau's Comments

"John would be overwhelmed, as I am, by the heartfelt messages of sympathy, appreciation and admiration that have

come from friends and colleagues from near and far. One aspect of his character that has not been mentioned was his delight in interacting with children, from pillow fights with his sons and playing on the floor with his 10 grandchildren to performing magic illusions for his young patients... re-joining a cut rope or finding a missing coin behind an ear. Another aspect of his character was his sense of romance. We watched sunsets together around the world and, as a published

photographer, he had the pictures to prove it. I cannot think of him without a smile in my heart."

John and Janet were married for 55 years. ■

Dr. Jones was MAFP president 2001-2002. He is currently legislative chair and the Maryland Chapter's alternate delegate to the AAFP Congress of Delegates. He lives and practices in Davidsonville, Maryland. He and Dr. Umhau were close friends.

Breast Cancer

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invasive cancer. Recent reviews suggest that untreated DCIS does not progress in 45-85 percent of cases over a mean period of 8-22 years.^{11, 12, 13} Therefore, many women receive treatment for DCIS with potential harm without the possibility of benefit.

An optimal approach to assessing rates of over-diagnosis would be to compare cancer diagnoses in a screened population to an unscreened population followed until death. This evidence is not often available, and in its place some investigators have used screening trial data to model the proportion of cancer diagnoses that represent over diagnosis.^{10, 14, 15, 16} Estimates of over diagnosis using trial data range from 1-30 percent of diagnosed cases in women aged 50-69 years, thus indicating an area of significant uncertainty when making population-based recommendations.¹⁷

Therefore, randomized control trial evidence demonstrating that breast cancer screening reduces mortality is necessary but not sufficient to support routine screening among the general population.⁴ Benefits and harms of the screening tests as well as the follow-up tests and treatments must be considered. Critics argue informed choice should have a pivotal role in screening performance. However,

routine cancer screening has at present received public support without question.⁴

It has been suggested that community norms relating to the harms of screening might be incorporated into systems-level approaches to screening in the community. For example, in thinking about the optimum approach to implementation of screening recommendations in the community, one could consider the following steps: 1) After the benefits of breast cancer screening as well as the harms of false-positive results (e.g., anxiety and additional imaging or biopsy) are fully explained, the screening preferences of women should be ascertained through community surveys.⁴ Some researchers have already begun exploring this topic through such questions as "How many false positives are women willing to endure to save one life by early detection of breast cancer?"¹⁸ 2) Once these preferences are known, they should be matched with screening performance.⁴ For example, if 65 percent of women aged 55 to 65 state that they are willing to endure the false positives of annual mammography screening, then screening adherence rates of 65 percent of women in this age group would indicate a successful screening program. This method provides a better indication of successful screening that speaks to the psychological and physical needs of informed patients, rather than simply looking for 100 percent participation rates without regard for the harms of screening in a given population.

Translating these ideas into practice may prove challenging; however, clear recognition that all screening tests include potential harms as well as potential benefits is an important element to population level recommendations that are evidence based. ■

Dr. Barton is the scientific director of the United States Preventive Services Task Force Program; Center for Primary Care, Prevention and Clinical Partnerships; Agency for Healthcare Research and Quality; Department of Health and Human Services. Her responsibilities include supporting and providing oversight for the methodologic, evidence review and recommendation-making work of the USPSTF. Her research interests include clinical epidemiology and health services research related to cancer screening and prevention in terms of access, test performance and outcomes.

Dr. Shelton is a preventive medicine resident at Johns Hopkins University Bloomberg School of Public Health in Baltimore, MD. Her research interests include health disparities among underserved populations, injury prevention and control, as well as health services research and health policy.

Editor's Note: References for this article appear at www.mdafp.org. Click the "Publications and News" tab.



by Salah Al-Abbadi, M.D.

Evidence Based Medicine and the Electronic Medical Record



EVIDENCE BASED MEDICINE (EBM) has become a major factor in our decision making process for patient care. With new medications, new technologies and increasing liability, there is a rising demand for safer methods for treating our patients.

In our residency training programs there is a pervasiveness to use widely researched treatment modalities in addition to individual attending preferences. Also, in this internet age, there is an improved access to online publications that can provide rapid reviews of the most up-to-date research available. All of these make EBM not only very accessible, but also the standard by which to practice medicine in the future.

Most of us are also familiar with the concept of the Electronic Medical Record (EMR). In literature it has been addressed by different labels, such as Health Information Technology or Electronic Health Record. The EMR is essentially a computer-based medical record that provides easy access to patient data and information. A complete EMR includes clinical documentation (notes), patient data (labs, radiology results, other test results) and computerized order entry (for tests and medications). Other added features include messaging between providers and staff, decision support systems and patient access to information.

The EMR is widely gaining popularity and usage in many hospitals. One of the reasons is improved billing accuracy.

This has become more relevant in dealing with the increased demand for documentation required by insurance companies and Medicare. Since this is often used to justify their physician reimbursement, it becomes imperative that doctors have an EMR in place that makes this process as efficient and as accurate as possible.

The EMR is also an invaluable source of patient information. EMR databanks can be mined to help facilitate clinical trials, and this can be used to contribute to research that eventually can become part of EBM. Furthermore, a hospital's EMR that is connected to a local practice may prevent duplication of lab tests, imaging, etc. As a result, charts also become more legible and are not as easily lost as paper charts - an added advantage that everyone can appreciate.

The increased availability of the EMR has helped to bring EBM guidelines to the forefront of patient care, particularly the software systems that include clinical decision support systems (CDSS). CDSS relies on EBM, and essentially assists physicians with different aspects of a patient's management, such as a referral for a colonoscopy for all patients that are over the age of 50, or warnings about medication interactions. These types of EMR have been shown to statistically improve health care in general. A systematic review of literature on EMR and its impact on medical care was published in 2006 in the *Annals of Internal Medicine*. This study showed that practices with an EMR that followed EBM recommendations had improved quality of medical care, reduced medication errors and stricter adherence to clinical guidelines¹.

Although most of the studies done have been positive, not all studies have shown a marked improvement with the addition of the EMR. One study published in the *Archives of Internal Medicine* in 2007 used a retrospective cross-sectional analysis of ambulatory care visits from 2003-04. Using 17 indicators to measure distinctions in quality, there was no significant difference in 14 out of 17 between those practices that had an EMR versus those that didn't. The study suggested that "clinicians, health system leaders and researchers should continuously measure the quality of medical care as EMR use expands." It is important to note that there are different brands and types of EMR; some lack clinical decision support and others are not necessarily programmed for quality control. The study does mention this as a possible explanation for the reduced efficacy shown².

Some studies have shown mixed results. One published in *JAMA* in 2005 specifically evaluated the effects of CDSS on practitioner performance and patient outcomes. The study showed that, although there was an improvement in performance, results in patient outcomes were unclear. The authors also brought up several criticisms, including user dependence and the possibility of a diminished capacity for independent decision making³. This previous study does not take into account some of the major impacts that an EMR with a CDSS may have on patient safety. For example, Esse Health, a group practice based in St. Louis, Missouri, had been sending out repeated warnings from the EMR regarding the risks of Cox-2 inhibitors (such as Vioxx), resulting in a

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Change Leads to Practice Transformation

This is the final of three articles written by Dr. Seidel about her solo practice having been one of 36 practices of all sizes chosen by AAFP to participate in the TransformMED pilot project. She writes after her two-year participation in the project. Prior articles by Dr. Seidel, as she progressed through the project, appear in the Fall, 2006 and Summer, 2007 editions.

by Ramona G. Seidel, M.D

AFTER TWO YEARS IN THE NATIONAL Demonstration Project, I still find myself trying to define TransformMED to physicians I meet. Many physicians in Maryland continue to be unaware of this project; others seem confused about its nature. (Refer back to earlier articles, or better yet, connect to www.transformed.com to learn the details of the project and the process.)

Inherent to our specialty are essential core values that are also at the heart of the TransformMed model of care. Because these values (such as “comprehensive care over a lifetime”) are not new, it has been hard

In successfully adopting even one of the many tools proposed in the new model of care, a practice will begin the process of transformation.

to convey what sets this model apart from a “business as usual” medical practice. The core value set includes attention to patient safety and satisfaction, care of chronic diseases and community outreach efforts, among other things. TransformMed does not re-define these core values. Rather, it empowers us to maintain these ideals while delivering high quality health care within the current dysfunctional health care system. In summary, TransformMed is not so much about *what* to do as it is about *how* to do it.

Another area where confusion seems to lie is the false perception that a practice is not transformed unless all the components of the TransformMED model have been put into place. Physicians with whom

I speak often respond with disbelief at the possibility of adopting all the components of this new model of care (clearly an enormous task). Any large task requires one to start with a goal-oriented vision (A return to the core values of Family Medicine seems like one good goal.) and an organization not afraid to make changes, one step at a time. Even after two years of participation, some practices are just beginning to use electronic medical records. Others continue to struggle with staff team building, open access, communication or the financial aspects of running their practices. One

practice went out of business. However, all the physician participants in the National Demonstration Project of TransformMED learned how change can be successfully implemented. In this sense, TransformMED is a process, more than a product.

Somewhere in the midst of this process we learned that in order to adopt new ways of doing what we have always wanted to do (based on our core value set), we would need a toolbox. The tools include electronic medical records, group visits, virtual communication and “advanced access” to care (sometimes referred to as open or same day access). In successfully adopting even one of the many tools proposed in the new model of care, a practice

will begin the process of transformation. An easy first step could be development of a practice website. The most transforming first step for many practices has been implementation of regular office meetings. Success with a first step, even a small one, causes forward momentum which leads to more positive change. The transformation begins when the physicians and staff go from a place of learned helplessness (amidst the regulatory bureaucracy of government and third party payers) to informed hopefulness.

During the last year of the National Demonstration Project, attention was focused on the concept of the Patient-Centered Medical Home. The term medical home has even been heard in national politics during this election year. No one can predict whether substantial national change is afoot. What I can predict (because I have seen it) is that moving your medical practice toward the TransformMED model will bring eventual reward. Dr. Bruce McElroy of Central Oregon Family Medicine (one of the participating practices) summarized this best when he said, “It’s remarkable to actually cut hours, have a life and still feel that job satisfaction.”

It is my sincere hope that the TransformMED project (or process) will create a glimmer of hope for the future of our specialty. ■

Dr. Seidel is an MAFP Southern District director and chair of the MAFP Education Committee. She practices in Annapolis.



Facing and Managing Change in Family Medicine

A Look Back in Photos from MAFP's Annual Assembly



Topic presentations stimulate questions from the audience.



New MAFP President Dr. Yvette Rooks presents a commemorative plaque to outgoing President Dr. Jos Zebley.



AAFP Board Chair Dr. Rick Kellerman with newly installed MAFP President Rooks, her daughter, Madison and her mom, Vivian.



Mrs. Peggy Phillips accepts MAFP's Lifetime Achievement Award given posthumously to Dr. M. Dudley Phillips, MAFP's 33rd president.



Activity surrounds the speaker's podium between presentations.



AAFP's Kevin Burke and Mark Cribbin, MAFP President Dr. Jos Zebley and MAFP Lobbyist Eric Gally presented a legislative/political update at the Keynote Luncheon.



MAFP's own Phay Goods and the Magestic Notes wow the crowd with musical entertainment.



The Zebley for AAFP Vice Speaker campaign committee meets at Rocky Gap.



Several University of Maryland Family Medicine residents were present at their director's (Dr. Rooks, center) installation as MAFP president.



MAFP officers and directors installed by AAFP Board Chair Dr. Rick Kellerman. Photos by William P. Jones, M.D.

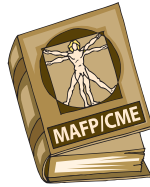
Save the Date

MAFP 2009 Annual CME Assembly & Trade Show

Wednesday, June 17-Saturday, June 20 • Clarion Fontainebleau Hotel and Conference Center • Ocean City, MD

The 2009 Scientific Assembly Committee has met and is off to a great start in planning another quality CME program and exciting event that you won't want to miss. Back in Ocean City after three years, we promise a memorable educational and social experience. Plan on great CME and terrific accommodations in one of Maryland's most beautiful, active and dramatic locations. You'll get great CME, food, fun, entertainment... and the ocean! Watch for details or contact MAFP at 410-747-1980 or office@mdafp.org. ■

journal cme quiz



Articles:

1. Managing the Patient at High Risk for Breast Cancer p. 7
2. Breast Cancer Screening: A look at the Balance Between Harms and Benefits p. 10
3. Prostate Cancer Screening: Managing Maryland's Men p. 11
4. The Varenicline (Chantix) Dilemma p. 12
5. Evidence Based Medicine and the Electronic Medical Record p. 15

The Maryland Family Doctor has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians (AAFP). AAFP accreditation for the current cycle began on **October 1, 2008**. Term of approval is for two years from this date. This **Fall, 2008 edition (vol. 45, No. 2)** is approved for 1.75 Prescribed credits. Credit may be claimed for two years from the date of this edition. Note: total per-edition credit over the course of this term is subject to change based on topic selection and article length.

AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 credit toward the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as Category I.

To obtain the credit certificate, complete and return the post-test directly to the Maryland Academy of Family Physicians. A certificate of completion will be sent to you. **AAFP members will be responsible for reporting the credits to AAFP.**

MAFP journal CME credits are acceptable for the Maryland Chapter's mandatory CME credit requirement. Questions? Contact the MAFP office, 410-747-1980, info@mdafp.org.

Answers p. 26

Instructions: Read the articles and answer all questions. Mail, fax or email the quiz form (pages 18, 19 and 22) within two years (by October, 31, 2010) to:

Maryland Academy of Family Physicians

5710 Executive Drive, #104

Baltimore, MD 21228

410-747-1980, 410-744-6059 (fax), office@mdafp.org (e-mail)

Name: _____

AAFP Membership #: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone #: _____

Fax #: _____

E-Mail Address: _____

Questions Article #1:

1. Which of the following is true regarding risk of breast cancer?
 - A. Approximately 35% of women who develop breast cancer have a strong genetic risk.
 - B. Genetic testing is available for nearly all inherited risks.
 - C. If a mutation is found, the risk of breast cancer is very high (up to 87%).
 - D. Men who carry the BRCA mutation are not at increased risk.
2. Which of the following is true regarding the advantages and disadvantages of risk calculation tools?
 - A. These tools work well for women with and without histories suggestive of an inherited cancer syndrome.
 - B. There are tools that have been validated in the general population of women.
 - C. These tools include most important risk factors, including breast density.
 - D. The tools only predict short-term risk of breast cancer.
3. Which of the following is true regarding preventive medications for breast cancer?
 - A. The STAR trial showed that raloxifene and tamoxifen are equivalent in reducing the risk of invasive breast cancer.
 - B. Preventive medications reduce the risk of breast cancer approximately 75%.
 - C. The risk reduction with preventive medications appears to be only short term (< 3-5 years).
 - D. Studies show that raloxifene and tamoxifen have equivalent side effect profiles.
4. Which of the following is true regarding the effectiveness of preventive medications in association with BRCA mutations and estrogen receptors?
 - A. Tamoxifen and raloxifene are equally effective in estrogen positive and negative receptors.
 - B. BRCA1 mutations are associated with estrogen positive cancers.
 - C. BRCA2 mutations are associated with estrogen positive cancers.
 - D. Tamoxifen but not raloxifene are effective in estrogen negative cancers.
5. Which of the following is true regarding the effectiveness of management options in women at high risk?
 - A. Prophylactic mastectomy reduces risk of breast cancer by 90-94%.
 - B. It is not appropriate to discuss prophylactic mastectomy with women with BRCA mutations.
 - C. Prophylactic oophorectomy reduces the risk of ovarian cancer but has no effect on breast cancer reduction.
 - D. Mammograms are the only option for screening in high risk women.

Questions Article #2:

6. Which of the following is true regarding the benefits and harms of screening for breast cancer?
 - A. Although some women experience anxiety as a result of false-positive screening results, for most of these women this psychological response does not have lasting consequences on their likelihood of continuing future screening.
 - B. Mortality reduction is the only factor to be considered when determining implementation of a screening program.
 - C. Consideration of follow-up tests and treatments are not necessary when determining evidence to institute routine screening programs.
 - D. Effectiveness of screening by clinical breast examination (CBE) has been shown to be comparable to mammography screening in several randomized control trials.
7. Which of the following is most consistent with the USPSTF recommendations on breast cancer screening?
 - A. The evidence that mammography screening reduces mortality from breast cancer is strongest for women aged 40-69 years.
 - B. Physicians should recommend performance of breast self-examination (BSE) to all female patients over age 40.
 - C. Inclusion of CBE provides greater screening benefit than mammography alone.
 - D. BSE, in combination with CBE and mammography, provides optimal screening of breast cancer.
8. Which of the following is not considered a potential harm or burden of screening that is investigated by the USPSTF?
 - A. false positive tests
 - B. risk of benign biopsy
 - C. patient anxiety
 - D. cost-effectiveness
9. Which of the following is true of breast self-examination (BSE)?
 - A. Trials indicate BSE shows some mortality benefit.
 - B. Trials indicate BSE increases benign biopsies resulting from workup of BSE findings.
 - C. Physicians should recommend BSE be performed by all female patients over age 40.
 - D. BSE, in combination with CBE and mammography, provides optimal screening of breast cancer.
10. Which of the following is considered a valid methodologic approach to ascertain the proportion of overdiagnosis within a population?
 - A. Compare cancer diagnoses in a screened population to an unscreened population followed until death.
 - B. Assume all ductal carcinoma in situ (DCIS) represents a nonprogressive form of breast cancer and therefore an over-diagnosis of cancer.

- C. Assume cancer diagnosed within older age groups to not become clinically evident prior to an unrelated cause of death.
- D. Compare cancer diagnoses in a screened population to an unscreened population followed over a length of time twice that of the lead-time.

Questions Article #3:

11. According to the USPSTF, which group of men should not be screened for prostate cancer?
 - A. Men with a first degree relative with a history of prostate cancer
 - B. All men older than 50
 - C. Men 75 years old and older
 - D. African-American men
12. Men at higher risk for a diagnosis of prostate cancer include:
 - A. Men with a first degree relative with a history of prostate cancer
 - B. African American men
 - C. Men 75 years and older
 - D. A and C only
 - E. A, B, C
13. In counseling men about prostate cancer, USPSTF encourages primary care physicians to:
 - A. Recommend prostate cancer screening to men over 50.
 - B. Refer older men to a urologist.
 - C. Refer high risk men to a urologist.
 - D. Discuss the uncertain benefits and potential harms of PSA testing.
14. Most prostate cancers found by screening:
 - A. Require immediate excision
 - B. Are fast growing and aggressive
 - C. Are slow growing and take years to affect health
 - D. Have poor 5-year survival rates
15. All men between the ages of 50 and 75 should have an annual PSA test
 - A. True
 - B. False

Questions Article #4:

16. The most recent FDA alert concerning Varenicline includes:
 - A. It is not effective as an aid in quitting smoking.
 - B. Patients with co-occurring psychiatric disorders may experience worsening of their symptoms.
 - C. Physicians need to closely monitor patients on Varenicline.
 - D. Advice for families of patients using Varenicline.
 - E. B, C, D
 - F. A, C, D

continued on page 22



Summer 2008 Medical Students Experience Family Medicine



IN SPITE OF THE challenges and many negative comments we hear about waning interest among medical students in the specialty of Family Medicine, this segment illustrates that the specialty is alive and well and that many medical students are seriously considering becoming family physicians. We urge readers to support the MAFP Foundation so that we can keep the momentum going.

University of Maryland Family Care Track

Thanks to the generosity of the MAFP Foundation, 18 medical students (see list) participated in the first Family Care Track (FCT) summer mentoring program. One of the requirements for these rising 2nd-year medical students was to spend 80 hours working with a family doctor. The FCT program has been a huge success based on the feedback we received by those who had completed the first 12 months of this program. All of the participants felt the program was "very good" to "excellent."

Each student had an end of the summer essay assignment. There were so many great essays that we are not able to publish each one, but have pulled excerpts from many. Here you will find some of the insights gained by these students.

Richard Colgan, M.D.

Director of Undergraduate Education
University of Maryland Department of
Family and Community Medicine
Editor in Chief, *The Maryland Family
Doctor*

2008 FCT Participants (all MAFP student members)

Mawuena Agbonyitor
Kelly Bianco
Christina Boyd
Vi Dang
Yael Eskinazi
Kristen Hood
Samantha Hyner

Leah Kaye
Talia Landau
Kathleen Langan
Matthew Loftus
Stephen Lu
Deesha Mago
Heather Mezzadra
Lindsay Quade
Kathleen Stephanos
David Suskin
Dina Sztein

"Eighty hours of total immersion during the summer was what attracted me the most to the FCT. I believe that from this experience I would be able to reasonably assess whether Family Medicine was in my future. I think the FCT is definitely a big step in the right direction... it benefited me greatly." - Vi Dang

"I am sure that my experience in this program has provided me with invaluable experiences as a student and will help me in the future as a physician. For one, my medical knowledge has vastly improved over the last year. I can 'speak doctor' and understand medical terminology with more confidence. My interactions with patients feel more natural. I also feel more competent when speaking with attending physicians, residents and medical students" - Lindsay Quade

"Change is on the horizon, and Family Medicine leads the efforts on all levels. During what could be seen as unfortunate and trying times, it is impossible to ignore the progress and successes attributed directly to the ingenuity and perseverance

of the professionals I encountered this summer" - Leah Kaye

"This experience is one that I will not forget and hope that I can model myself after in the future." - Kathleen Langan

"My summer experience was an invaluable one both for teaching me about how to properly see patients and giving me a good picture of what Family Medicine is and how beneficial it is to patients. I enjoyed every minute that I was in the clinic, and I found the summer both rewarding and enjoyable." - Dina Sztein

"Under the guidance of Drs. Cothran and Zebley, I was able to gain a unique glimpse into the field of Family Medicine and take a step ahead of many of my classmates in interactions with patients." - Kathleen Stephanos

"This experience definitely met and exceeded my expectations. It allowed me to work with a wonderful mentor and learn about Family Medicine and medicine in general" - Kelly Bianco

"My perceptions of Family Medicine did not so much change through the course of the summer, as they were enhanced. I was able to see just how diverse the work of the Family Medicine doctor is. The doctors I worked with seemed really pleased with their jobs and their work hours. They seemed to have a really great balance between work and family life which, personally, is something that I value in my future career." - Christina Boyd

"I was continually amazed by my mentor's familiarity with multiple generations in a single family - treating grandparents, children and grandchildren. The breadth of the field is both intimidating and exciting." - Yael Eskinazi

"The most beneficial part of following Dr. Motter was being able to watch her interactions with patients. At the end of appointments, numerous patients would rave about my preceptor and tell me how lucky I was to have her as a mentor." - Kristen Hood

(A memorable moment was) "when a long time patient of my mentor revealed that he was moving back to his home country for retirement. Nearly in tears, the patient thanked my mentor so beautifully for the care he had received over the years. It is hard to capture in words the emotions and energy in the room during this exchange, but by the end I was nearly in tears as well." - Samantha Hyner

"I think it is very valuable to be able to experience different styles of doctoring, and I was very appreciative for the chance to learn from so many different people. I thoroughly enjoyed the two weeks of shadowing that was assigned to us through this program." - Talia Landau

"Prior to my shadowing experience I knew that being a family doctor was a very important profession, but I did not realize how big of a part a family doctor plays in his or her patients' lives. As I look back on my summer shadowing in the Family Medicine clinic at University of Maryland, I realize that I grew as a student, a future doctor and as a person." - Heather Mazzadra

"One of the benefits of being a family doctor is the rapport one can build with patients. It was interesting to see how each doctor adapted to seeing new patients and their interactions with patients they had seen for a long time." - Stephen Lu

"My primary attraction to the career of medicine was to the personal doctor-

patient relationship, which I think is epitomized in a patient's relationship with his or her primary care provider." - Deesha Mago

"My understanding of the discipline of Family Medicine grew this summer by leaps and bounds. I was able to observe just about every aspect of Family Medicine. Family Medicine is the most versatile of all specialties in medicine. I saw compassion, wisdom and thoughtfulness exemplified in many encounters." - Mathew Loftus

AAFP National Conference of Medical Students, Kansas City

The MAFP Foundation makes it possible for medical students from Maryland to travel to Kansas City to attend the annual AAFP National Conference of Medical Students (NCMS). The 2008 conference was held July 30-August 2. Here are comments from several who attended:

From Sarah E. Lusk, MS III, Johns Hopkins University School of Medicine (MAFP's official delegate to the 2008 NCMS and current MAFP student director):

The 2008 National Conference for Family Medicine Students and Residents asked "Where Will Family Medicine Take You?" For the weekend of July 30 to August 2, Family Medicine brought students and residents from all over the United States to Kansas City. It was a great opportunity to learn about all of the different ways my peers were advocating for their fellow students, their communities and Family Medicine as a whole. As a student delegate, I saw first-hand that the discussions taking place in the exhibit hall and the workshops, as well as in our home states, could be transformed into policy.

I was truly amazed at the amount of teaching that went on during the business/policy sessions which were set up to encourage questions about the process of creating and voting on resolutions. It

was encouraging to see so many people willing to help students bring their ideas into an organized and productive discussion.

Many issues came up during the business sessions, including whether or not the AAFP should accept funds from the pharmaceutical industry to sponsor scholarships. After much debate, the student congress voted against a resolution to ask that the AAFP phase out pharmaceutical industry support by 2015, but did vote in favor of looking for alternate sources of funding for student scholarships to NCMS. This forced all of us to think about the students we were representing and the reality of the pharmaceutical industry's role in our education. This is certainly an issue that will continue to be debated. Other resolutions debated spoke to issues such as the sale of tobacco products in retail health clinics, presenting contraception topics at future NCMSs and improving Family Medicine Interest Group leadership development.

As a participant in the Minority Issues Discussion Group, I co-authored four resolutions aimed at increasing the visibility of the opportunities available to minority students interested in Family Medicine, as well as developing mentoring opportunities. We brought these issues before the group in Reference Committee with ultimate adoption. It was amazing to realize that a group of people who did not know each other a few days before but shared a similar concern were able to come together and bring forth some concrete ideas for change.

It was an honor and privilege to serve as the MAFP's delegate to this exciting conference. I look forward to continuing to build upon what I learned and the networking relationships I formed with other students at the conference. This opportunity has shaped my understanding, not only of organized medicine, but also of the role of future family physicians in shaping policy. ■

President

continued from page 5

lectures and small group discussions. The students highlighted the potential patient and student benefits of the house call program.

The expanded house call program exposed students to patients with a spectrum of illnesses and a variety of living situations. Students were able to experience how environment, socioeconomics and family and social support affect the quality of life of patients, and this was an invaluable contribution to their education.

Student-reported patient and educational benefits of house call program:

Patient Benefits

- Greater/increased access, quality of care and continuity of care
- Enhanced doctor-patient relationship for patients with multiple chronic diseases and high functional limitations
- Improved/lengthier patient interaction

- Comfort in one's own home
- Caretaker support from medical team
- Medical and illness impact on the whole sphere of patient's life
- Lengthier patient interaction

Educational Benefits

- Witness psychological aspect of living within the community
- Opportunity to interact with family
- Unique interdisciplinary care
- Greater awareness of patients' living environment

The health care environment is constantly changing. Medical school education must be adapted to change if students are to be adequately prepared to practice upon completion of their medical education. The increase in the development and implementation of effective home health care programs is one such change. We as medical educators must constantly strive to be innovative in developing creative and alternative ways to educate students in venues appropriate to

all sub-sets of our population. The house call program for third year students developed at the Department of Family and Community Medicine at the University of Maryland School of Medicine provides a unique educational experience, exposing students to community service, interdisciplinary care and health care in a predominantly geriatric, homebound population. Given students' positive perception of this home care experience, medical educators would be advised to include curriculum initiatives similarly designed ■

Dr. Rooks is vice chair, residency director and team physician (University of Maryland at College Park) for the University of Maryland Department of Family and Community Medicine in Baltimore. She was installed MAFP president in June, 2008, for a two-year term.

Editor's Note: An addendum to this article appears at www.mdafp.org. Click the "Publications and News" tab.

Journal CMA Quiz

continued from page 19

17. Maternal pre-natal smoking may be associated with :
 - A. Significant anti-social behavior in toddlers
 - B. Increased risk of an exposed child developing co-occurring Oppositional Defiant behavior and Attention Deficit Hyperactivity Disorder
 - C. Increased risk of becoming a smoker in the exposed child
 - D. Anti-social behavior in adolescents
 - E. C, D
 - F. A, B, D
18. How many physicians in the US are using the EMR?
 - A. < 20%
 - B. 30%
 - C. 50%
 - D. 90%
19. The most commonly cited barrier to EMR adoption is
 - A. concerns for patient privacy
 - B. software compatibility
 - C. uncertainty about the return on the investment
 - D. concern that a system would become obsolete
 - E. not finding a system that met their needs
 - F. capital cost
20. Potential EMR advantages include:
 - A. Increased adherence to guidelines
 - B. Reduction in medication errors
 - C. Improved quality of care
 - D. All of the above
21. EBM in EMR
 - A. Is in all EMR programs
 - B. Is found in clinical decision support systems
 - C. Cannot affect a patient's quality of care
 - D. Can cause a reduction in physician performance
22. What are online personal health records?
 - A. Patients maintaining and updating their own charts
 - B. Inter-hospital patient records
 - C. Physician's office EMR application

Questions Article #5:

18. How many physicians in the US are using the EMR?
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 - C. Physician's office EMR application



News For and About MAFP Members

J. Richard Lilly, M.D. Honored for Exemplary Service



Maryland Secretary of Health John M. Colmers (l), presents a governor's proclamation to Dr. J. Richard Lilly in recognition of his many years as chairman of the Maryland Council on Cancer Control.

Along with many other organizations with members on the Maryland Council for Cancer Control (MCCC), MAFP was pleased to honor its member and past-president, J. Richard Lilly, M.D., who, with the council's meeting on June 20, 2008, completed his nine-year tenure as council chair. MAFP Executive Director Esther Rae Barr, a member of the council, presented to Dr. Lilly MAFP's certificate of recognition and appreciation for his excellent work. Dr. Lilly practices in Hyattsville.

The 25-member MCCC is an independent commission established under Executive Order in 1997. Its members, appointed by the governor, are selected from state agencies and organizations involved in cancer screening, prevention and treatment services, as well as members from the general public and major academic medical institutions. The MCCC advises the governor, government officials, public and private organizations and the general public on comprehensive

state policies and programs necessary to reduce the incidence and mortality of cancer in Maryland. More information can be found at <http://www.msa.md.gov/msa/mdmanual/26excom/html/05can.html>.

In a letter to Dr. Lilly, Maryland Governor Martin O'Malley stated: "...I am pleased to thank you for your service as chair of the Maryland State Council on Cancer Control over the past nine years and thank you for your dedication to reducing the burden that cancer has on Marylanders. During your tenure as chair, you have provided leadership to bring the major academic health centers closer through their work on the Cancer Council.

"Through your leadership, the Cancer Council oversaw the development of the Maryland Comprehensive Cancer Control Plan... Thanks to your direction in its development, the plan is now recognized as the model for cancer planning across the country.

"Your leadership was instrumental in the passage of numerous beneficial public health policy initiatives related to cancer and tobacco control at the local, State and federal levels.... The citizens of Maryland are in your debt for aiding in the passage of critical measures aimed at reducing the burden of cancer.

"Please accept my sincere appreciation for your exemplary contributions to the Maryland State Council on Cancer Control. On behalf of our One Maryland initiative, I thank you for your commitment and dedicated service to the residents of Maryland..."

Governor O'Malley has named Kathy J. Helzlsouer, M.D. (author of the article in this publication on p. 7) as Dr. Lilly's successor as MCCC chair.

Robert M. McDonald, M.D., Past MAFP Vice President, Past Membership Chair January 9, 1931-June 26, 2008 (excerpted from www.delmarvaobits.com)



After a short illness, Robert M. McDonald, M.D. of Easton passed away at age 77. Born in Edgewood, PA, he attended the University of Pittsburgh School of

Medicine, graduating in 1957. After practicing in Gibsonia, PA, he moved to Easton in 1965 where he opened his practice of Family Medicine. He moved his practice to Oxford where he practiced until 1976. For the next two years he was chief of emergency room service at Dorchester Peninsula Regional Medical Center. In 1985 he returned to family practice, opening his office in Easton. He spent more than 40-years caring for his patients, becoming a part of their lives. Many times he saw patients in the office or made house calls and was paid with crabmeat, a duck or goose or a fresh coconut cake.

Dr. McDonald, a member of several professional and civic organizations, was an MAFP Eastern District vice president and membership chair for several years. He was the 2006 Outstanding Rural Health Practitioner of the Maryland Rural Health Association.

Dr. McDonald is survived by his wife of almost 32 years, Judith (nee Ross), two daughters, two sons, a step-daughter, three grandchildren, three great-grandchildren, one step-grandson and one sister.

Appointments, Features, Honors, Special Achievements

Charles W. Bennett, M.D. and Sylvia Batong, M.D., both of Lusby were

continued on page 24

Membership New

continued from page 23

featured in "Family Doctors Called Scarce; Shortage is Worst in Rural, Poorer Areas, Report Contends" in the August 12, 2008 *The Baltimore Sun*.

Michael J. Fadden, M.D. of Hurlock has been appointed to serve on the Task Force to Review Physician Shortages in Rural Maryland of the Senate Finance Committee of the Maryland General Assembly. The task force will examine recruitment and retention issues related to primary care physicians in rural areas of Maryland; the funding of programs to

encourage practice in those areas, including financial and tax incentives; new academic physician recruitment programs to enroll and encourage students interested in rural life and practice; and federal and state programs to equalize physician distribution across geographic areas. The task force will report its findings to the governor.

Yvette L. Rooks, M.D. of Ellicott City, MAFP president, has been appointed vice chair, Department of Family & Community Medicine, University of Maryland School of Medicine. She continues her duties as residency director and team physician, University of Maryland at College Park.

Ramona G. Seidel, M.D. of Annapolis and **Joseph W. Zebley, M.D., III** of Baltimore were featured in "Primary Docs Could Earn More for Coordinating Care" in the July 25, 2008 *Baltimore Business Journal*. ■



Drs. Jos Zebley (l) and Bill Hakkarinen study salad-making instructions during a team-building/cooking exercise at the 2008 Southeast Family Medicine Forum (SEFMF) August 14-16 in Roanoke, WV. The 2009 SEFMF will be hosted by the Maryland Chapter, August 20-22 in Annapolis.

In Memory

The Maryland Academy of Family Physicians deeply regrets the passing of its members, **Oscar A. Farias, M.D.** (Crofton) and **Robert M. McDonald, M.D.** (Easton). Contributions to the MAFP Foundation have been made in their memory.

Evidence Based

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prescription rate less than half of the national average, years before the FDA withdrew them from the market⁴.

Despite all of the established benefits from the addition of EBM to EMR, there are several barriers that have kept doctors from implementing them in their offices. The limitations are mostly due to slow adoption of the EMR in private practices across this country. According to an article published in the *New York Times* in June 2008, fewer than one in five doctors in the United States are using the EMR⁵.

What are some of the barriers to adoption of EMR? A national survey of 2,700 physicians revealed that the biggest hurdle in implementing the EMR was financial⁶. The cost for an individual doctor or a small practice is about \$40k-\$60k for initial EMR setup, not including the annual software maintenance fees. While these expenses can be daunting, the government has recently provided help to physicians.

There is a new \$150 million Medicare pilot project that will offer financial incentives to local medical practices that adopt the EMR. This project is currently being run in 12 cities and states, including Maryland and Washington, D.C.⁷

There are other incentives that may indirectly benefit practices with an EMR. Microsoft and Google have recently joined the health care arena by beginning to create online personal health records. These are planned in a way so individual patients will have access to them and ultimately be responsible for their own medical records. It is believed that once these online services take off, patients will be more likely to choose a practice that already has an EMR, as opposed to one that is solely paper-based and thus unable to offer patients online access to their individual health records⁷

An integration of EBM with EMR brings together widely accepted treatment guidelines with the newest organizational record keeping software. The EBM shows that, for the most part, EMR has helped

improve quality of care for patients. The EMR (with CDSS) has helped in bringing EBM closer to physicians by way of point of care reminders of guideline recommendations. The result from this combination is greater efficiency and quality of care for our patients. Despite the considerable initial cost that goes into set-up, primary care physicians should strongly consider implementing the EMR into their private practices. Its cost-effectiveness (over the long run) and ease of use has been established, as well as its effects in streamlining most businesses. It is simply, without a doubt, the future of medicine in this country. ■

Dr. Al-Abbadi writes this, his first in a series of articles as MAFP's resident editor. He is a PGYII at the Franklin Square Hospital Center Family Medicine Residency Program.

Editor's Note: References for this article appear at www.mdafp.org. Click the "Publications and News" tab.

education



Members Vote To Keep MAFP CME Policy

WITH THE NEEDED QUORUM present at the 2008 MAFP Annual Business Meeting (June 27; Rocky Gap Lodge), greater than two thirds of the members present voted to keep the MAFP CME policy which requires that active and supporting members acquire and report 6 AAFP prescribed credits from MAFP CME programs every three years. The 3-year period mirrors a member's period of re-election to AAFP/MAFP membership as determined by AAFP. The entire policy follows. Of note is that there was an additional motion, second and vote that removed the penalty aspect of the policy from the Bylaws. This change was effective immediately.

The feeling at the Business Meeting was that with more members knowing of and complying with the policy, with several waivers in place to assist members and with MAFP and AAFP staff being able to carefully track credits and work with members on an individual basis, very few members have actually been dropped from the membership rolls since the policy's enactment in 2000.

Board Adds Waiver Request Fee

The MAFP Board of Directors further discussed the policy at its summer meeting on August 10, 2008. It was determined that those requesting one-time waivers will be charged a \$50 administrative fee. Those failing to pay the fee will not receive waivers. The names of those members failing to comply with the MAFP CME requirement will have their names presented to the MAFP Board of Directors for determination by the Board.

Questions? Contact the MAFP office at info@mdafp.org or 410-747-1980.

AAFP/MAFP CME Requirements for Active/Supporting Members

Active and Supporting Family Physician Members must accrue at least 150 hours of AAFP Prescribed and Elective credit within each 3-year reporting period, of which:

- At least 75 must be AAFP Prescribed credit; of which at least 6 of those must

be obtained from MAFP sponsored programs every 3 years (eg. CME conferences and journal CME).

- At least 25 are from live learning activities.
- Not more than 25 are from enrichment activities.
- Not more than 30 are from presentation or publication of an original scientific or socioeconomic paper pertaining to medical care.
- Not more than 45 are from publication in a state or national "refereed" journal.
- Not more than 15 are from preparation and presentation.

Members are encouraged to review the document *AAFP Continuing Medical Education Requirements for Members* at www.aafp.org/PreBuilt/cmea_memberrequirements06.pdf or contact the MAFP office to request a copy; office@mdafp.org.

The AAFP will send Maryland Chapter members, at regular intervals, correspondence showing each member's reported number of hours and reminding members of what is required. All details about the AAFP/MAFP's CME records, reporting and information can be obtained through the AAFP web site at www.aafp.org/cme, toll free at 800-274-2237 (ask for the CME Records Department) or the MAFP at 410-747-1980; office@mdafp.org (e-mail).

Other Aspects of MAFP CME Policy

The MAFP Board of Directors has approved the following:

1. MAFP members who are faculty members at MAFP conferences may claim the credits for those sessions (even if they are not registrants) for the MAFP CME requirement.
2. MAFP members who are authors of CME articles published in *The Maryland Family Doctor* may claim those credits (according to AAFP policy; www.aafp.org) for the AAFP and MAFP CME requirements.
3. MAFP CME credits will be waived for

those Active and Supporting members who relocate to the Maryland Chapter within 6 months of the end of their cycle of AAFP reelection.

4. Active and Supporting members who have not met the chapter requirement to report at least 6 chapter credits within their AAFP reelection cycle may receive a waiver for that cycle, to be made up in the subsequent AAFP Reelection cycle, by following the process noted below:
 - Member must contact the MAFP office submitting a request (written, email, phone call) for a one-time waiver for the chapter requirement indicating a desire to continue membership, pledging to acquire the credits during the next AAFP reelection cycle. There is a waiver request administrative fee of \$50.
 - Member *must make up* waived credits in the subsequent AAFP reelection cycle (in addition to the required 6 credits).
 - If failing to acquire the required chapter hours in the subsequent AAFP reelection cycle, MAFP will not accept another waiver request from member.
5. Reinstatement after drop: Active and Supporting members taking advantage of item #4 and who are dropped from the membership roles for failing to meet the chapter CME requirement (and terms of the one-time waiver) may reinstate if they acquire and report enough MAFP CME credits to cover past and current periods of re-election. If a member is dropped for failure to meet the chapter's CME requirement, that member may be reinstated upon making up the needed credits. The number of credits required would need to total those owed for the waived and subsequent periods of re-election as well as the current period, as electronic tracking does not allow for the application of credits to prior periods. Further, reinstatement must occur during the 3-year re-election period immediately following the period for which the member was dropped. ■

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Answers to Journal

CME Quiz p. 18

- | | | |
|------|-------|-------|
| 1. C | 10. A | 19. F |
| 2. B | 11. C | 20. D |
| 3. A | 12. E | 21. B |
| 4. C | 13. D | 22. A |
| 5. A | 14. C | |
| 6. A | 15. B | |
| 7. A | 16. E | |
| 8. D | 17. F | |
| 9. B | 18. A | |



calendar



2008

October 28-November 2

STFM Northeast Regional Conference
The New Deal: A Medical Home for All
Convention Center, Baltimore

2009

February 21

MAFP Winter Regional CME Conference
New Models in Practice Management
Loews Hotel, Annapolis

June 17-20

MAFP Annual CME Assembly & Trade Show
Clarion Fontainebleau Resort &
Conference Center, Ocean City

2010

February 20

MAFP Winter Regional CME Conference
Sheraton Hotel, Columbia

June 23-26

MAFP Annual CME Assembly & Trade Show
Westin Hotel, Annapolis

AAFP Scientific Assembly Schedule

2009	October 14-18	Boston
2010	September 29-October 3	Denver
2011	September 19-21	Chicago
2012	October 15-17	Philadelphia
2013	September 23-25	San Diego

Next Edition

Focus on Family Medicine and the Law

Correction

Corrections to the Summer, 2008 edition
pp. 16-17:

Author's correct name: Nazli B. McDonnell,
M.D., Ph.D.

Correction in Bio: Dr. McDonnell does not
have an office in Baltimore.

Required Sentence: Dr. McDonnell is
supported by intramural funds of the
National Institute on Aging (NIH).

page 10: Photo by William D. Hakkarinen,
M.D.

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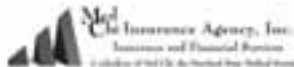
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¹U.S. Department of Agriculture and U.S. Department of Health and Human Services. Dietary Guidelines for Americans 2005. 6th Edition. Washington, D.C.: U.S. Government Printing Office, January 2005. www.healthier.us.gov/dietaryguidelines.com



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